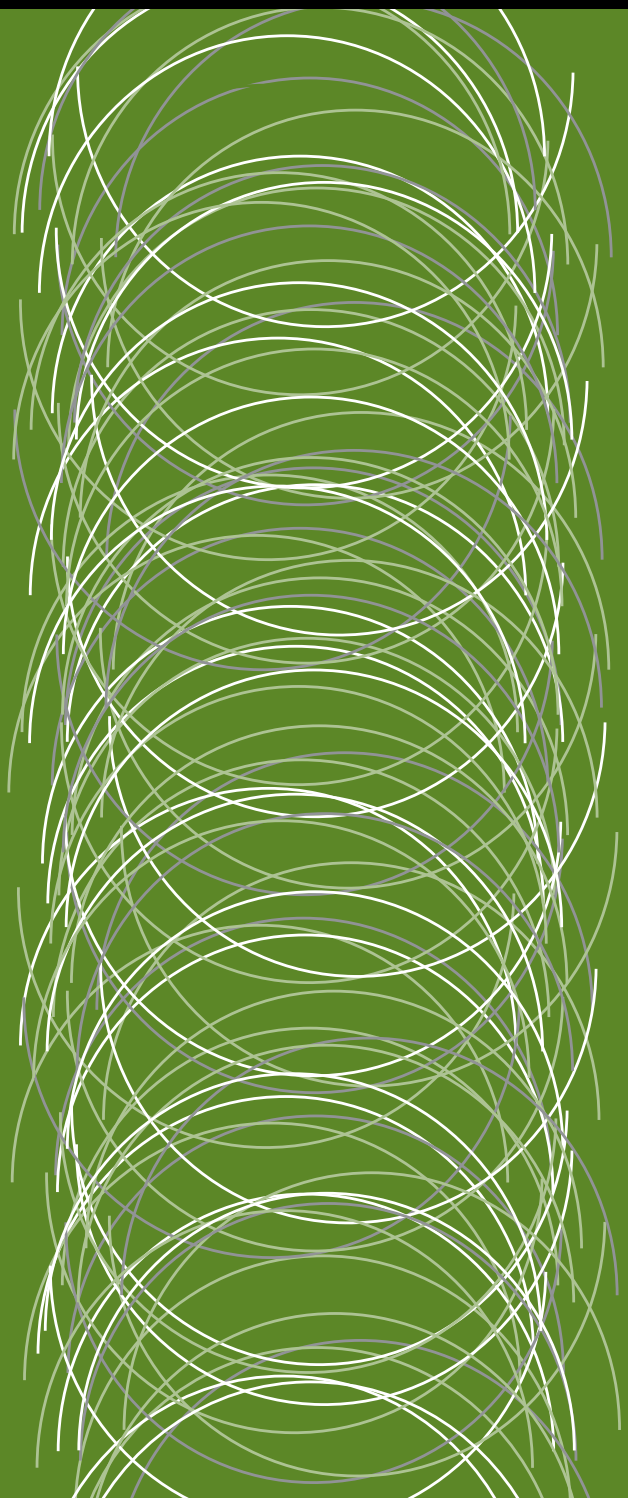
Australian Medical Council Limited

# Accreditation Report: The Education and Training Programs of the Royal Australasian College of Medical Administrators

AMC



**Specialist Education Accreditation Committee**
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# Executive summary: Royal Australasian College of Medical Administrators

The Australian Medical Council (AMC) document *Procedures for Assessment and Accreditation of Specialist Medical Education Programs and Continuing Professional Development Programs, 2011* describes AMC requirements for accrediting specialist programs and their education providers.

An AMC assessment team assessed the education, training and professional development programs of the Royal Australasian College of Medical Administrators (RACMA) in 2008. On the basis of this assessment, the Council accredited these programs for four years, until December 2012, subject to conditions.

In July 2012, an AMC team completed the follow-up assessment of the College's programs, considering the progress against the recommendations from the 2008 AMC assessment. Under the AMC accreditation procedures, the 2012 review may result in the extension of the accreditation to six years from the original assessment, that is until December 2014.

The team reported to the 5 November 2012 meeting of the Specialist Education Accreditation Committee.

The Committee considered the draft report and made recommendations on accreditation to AMC Directors within the options described in the AMC accreditation procedures.

This report presents the Committee's recommendations, as presented to the November 2012 meeting of AMC Directors, and the detailed findings against the accreditation standards.

**Decision on accreditation**

Under the *Health Practitioner Regulation National Law Act 2009*, the AMC may grant accreditation if it is reasonably satisfied that a program of study and the education provider meet an approved accreditation standard. It may also grant accreditation if it is reasonably satisfied that the provider and the program of study substantially meet an approved accreditation standard, and the imposition of conditions will ensure the program meets the standard within a reasonable time. Having made a decision, the AMC provides its report to the Medical Board of Australia to enable the Board to make a decision on the approval of the accredited program of study as providing a qualification for the purposes of registration.

The AMC's finding is that, overall, the education, training and continuing professional development programs of the Royal Australasian College of Medical Administrators meet the accreditation standards. Since its accreditation by the AMC in 2008, the College has significantly enhanced its educational and training activities. The College has largely addressed the recommendations made by the AMC in 2008. There are some notable strengths including the implementation of the Medical Leadership and Management Curriculum, and the embedding of the curriculum in selection and assessment processes. The College's continuing professional development program is well established.

The AMC notes that since the 2012 review the College has considered and begun to address a number of the recommendations in this Report.

The November 2012 meeting of the AMC Directors resolved:

(i) That the education and training programs and the continuing professional development program of the Royal Australasian College of Medical Administrators be granted ongoing accreditation to 31 December 2014, subject to satisfactory progress reports to the Specialist Education Accreditation Committee.

(a) By the 2013 progress report, evidence that the College has addressed the following conditions:

1 Fully implement the process for teaching and assessing the defined competency of Scholar. (Standard 3.3)

2 Review the requirements for the management practice folio to ensure the aims and requirements are clear for each cohort of trainees, and provide appropriate tools to support candidates to satisfy the requirements. (Standard 5.1)

3 Report on the implementation of the research-based case study. (Standard 5.2)

6 Implement processes for engaging other health care professionals and consumers in the evaluation process. (Standard 6.2.2)

7 Document and publish the criteria used to adjudicate applications to the accelerated pathway, including the weighting applied to various elements of the selection process. (Standard 7.1.3)

8 Develop mechanisms to ensure that trainees have access to timely and correct information about their training status to facilitate their progress through training requirements. (Standard 7.3.3)

9 Develop a policy to guide the resolution of conflicts or disputes between candidates and supervisors or preceptors. (Standard 7.4.2)

10 Formalise the procedure for candidates seeking reconsideration or review of a decision to clarify the stages that precede a formal review as outlined in the policy "Review of Decisions of Board and its Committees". (Standard 7.4.3)

12 Work with the Medical Council of New Zealand to ensure that New Zealand Fellows are aware of the annual, rather than triennial, requirement of at least ten hours for peer review, and that the Continuing Education Program includes a professional development activity that meets the Medical Council of New Zealand's requirement for an annual audit activity. (Standard 9.1)

(b) By the AMC review of the College's comprehensive report in 2014, evidence that the College has addressed the following conditions:

4 Develop a formal mechanism to enable early identification and remediation of under-performing candidates. (Standard 5.2)

5 Develop ways to collect qualitative information on outcomes. (Standard 6.2.1)

11 Develop a process for evaluating de-identified appeals and complaints. (Standard 7.4.4)

13 Include consumer involvement in Continuing Education Program (CEP) reviews. (Standard 9.1)

This accreditation decision relates to the College's programs of study and continuing professional development program in the recognised medical specialty of medical administration.

In 2014, before this period of accreditation ends, the AMC will seek a comprehensive report from the College. As well as reporting on the conditions listed under (b) above, the report should outline the College's development plans for the next four to five years. The AMC will consider this report and, if it decides the College is continuing to satisfy the accreditation standards, the AMC Directors may extend the accreditation by a maximum of four years (to December 2018), taking accreditation to the full period which the AMC will grant between assessments, which is 10 years.

At the end of this extension, the College and its programs will undergo a reaccreditation assessment by an AMC team.

**Overview of findings**

The findings against the nine accreditation standards are summarised below. Only those sub-standards which are not met or substantially met are listed under each overall finding.

Conditions imposed by the AMC so the College's programs meet accreditation standards are listed in the accreditation decision (pages 2 to 3). The Team's commendations of areas of strength and recommendations for improvement are given below for each set of standards.

| | |
|---|---|
| 1. The Context of Education and Training (governance, program management, educational expertise and exchange, interaction with the health sector and continuous renewal) | Overall this group of standards is MET |

*Commendations*

A The reform of the College governance and organisational structure since the 2008 AMC accreditation assessment which has led to more fellows contributing to the College's education and training activities.

*Recommendations for improvement*

AA Given the importance of the role of Jurisdictional Coordinator of Training, communicate their role to health departments.

| | |
|---|---|
| 2. The Outcomes of the Training Program (purpose of the training organisation and graduate outcomes) | Overall this group of standards is MET |

*Commendations*

B The clarity and focus of the curriculum document in terms of its articulation of the organisational purpose of the College and the learning outcomes of the training program.

| 3. The Education and Training Program – Curriculum Content<br>(framework; structure, composition and duration; research in the training program and continuum of learning) | Overall this group of standards is MET |
|---|---|

Standard 3.3 is substantially met.

*Commendations*

C The College Medical Leadership and Management Curriculum.

D The initiation of the RACMA Young Doctors' Program.

*Recommendations for improvement*

BB Progress in the implementation of the health services evaluation research requirements of the program. (Standard 3.3)

CC Continue to review and strengthen processes for assessing applications for recognition of prior learning and advanced standing to ensure consistency in decision-making. (Standard 3.4)

| 4. The Training Program – Teaching and Learning | Overall this group of standards is MET |
|---|---|

*Commendations*

E The focus on, and achievements in, the development of online learning resources.

F The introduction of the webinars for education support for both candidates and fellows as part of their continuing professional development, as well as the enhanced support for supervisors and preceptors.

G The pilot of the MiniMex Simulated Management Learning initiative.

*Recommendations for improvement*

DD Continue to monitor the educational relevance of the masters degree courses, as the curriculum changes, particularly with respect to the College's new research and leadership requirements. (Standard 4.1.2)

| 5. The Curriculum – Assessment of Learning<br>(assessment approach, feedback and performance, assessment quality, assessment of specialists trained overseas) | Overall this group of standards is SUBSTANTIALLY MET |
|---|---|

Standards 5.1 and 5.2.1 are substantially met.

*Commendations*

H The increasing range of assessment methods, which are appropriately aligned to the components of the fellowship training program.

I The opportunity provided for unsuccessful examination candidates to receive one-on-one feedback from the Censor on examination performance.

*Recommendations for improvement*

EE Review the effectiveness of College procedures for communication with candidates over changes to assessment requirements and timing to ensure it is clear and timely. (Standard 5.1)

FF Continue to develop and apply well documented processes for reviewing the quality, reliability, consistency, and rigour of its assessment approach and methods. (Standard 5.3)

GG Provide supervisors who are not College fellows access to professional development in assessment methods and in providing feedback to candidates. (Standard 5.3)

| 6. The Curriculum – Monitoring and Evaluation | Overall this group of standards is MET |
|---|---|

Standard 6.2 is substantially met.

*Commendations*

J The ongoing development and review of the RACMA fellowship training program, combined with evidence of debate and reflection within the College committees and the fellowship.

K The introduction of candidate and supervisor annual surveys.

*Recommendations for improvement*

HH Seek external expertise to evaluate the fellowship training program. (Standard 6.1)

| 7. Implementing the Curriculum - Trainees<br>(admission policy and selection, trainee participation in governance of their training, communication with trainees, resolution of training problems, disputes and appeals) | Overall this group of standards is SUBSTANTIALLY MET |
|---|---|

Standard 7.1.3 is not met. Standards 7.3.3, 7.4.2, 7.4.3 and 7.4.4 are substantially met.

*Commendations*

L The College's active role in seeking government-funded Specialist Training Program places, and in selection to those positions.

M The inclusion of candidates in the governance structure of the College and decision-making on matters relating to education and training.

*Recommendations for improvement*

II Improve communication with candidates regarding training program requirements with a focus on clear presentation of changes to the program that clarify which candidates are affected. (Standard 7.3.1)

| 8. Implementing the Training Program – Delivery of Educational Resources<br>(supervisors, assessors, trainers and mentors; and clinical and other educational resources) | Overall this group of standards is MET |
|---|---|

*Commendations*

N The development of a comprehensive faculty education program.

O The opportunities for feedback from candidates regarding supervisor performance, by means of the candidate survey and candidate training reports.

P The development of accreditation procedures aligned with the curriculum and consistent with AMC standards.

Q Collaboration with jurisdictions and private health providers to achieve additional training positions for candidates by means of Specialist Training Program and other sources of funding.

*Recommendations for improvement*

JJ Ensure that all aspects of the faculty education program relevant to workplace supervisors are available to all supervisors, including those who are not fellows of the College. Progress reports on the delivery of the faculty education program to supervisors, preceptors and censors will be required. (Standard 8.1.1)

KK Continue implementation and evaluation of new accreditation procedures, including an assurance that all positions accredited for training have been assessed in accordance with the newly developed policy. (Standard 8.2.2)

| 9. Continuing Professional Development<br>(CPD programs, retraining and remediation) | Overall, this group of standards is MET |
|---|---|

Standard 9.1 is substantially met.

*Commendations*

R The successful blueprinting of the continuing education program against the curriculum.

S The range of continuing education resources available on the College website and the strong focus of the continuing education program on continuous quality improvement.

T The significant improvement in the number of fellows participating in the continuing education program.

## Introduction: The AMC accreditation process

The Australian Medical Council (AMC) was established in 1985. It is a national standards body for medical education and training. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.

### The process for accreditation of specialist medical education and training

The AMC implemented the process for assessing and accrediting specialist medical education and training programs in response to an invitation from the Australian Government Minister for Health and Ageing to propose a new model for recognising medical specialties in Australia. A working party of the AMC and the Committee of Presidents of Medical Colleges was established to consider the Minister's request, and developed a model with three components:

- a new national process for assessing requests to establish and formally recognise medical specialties
- a new national process for reviewing and accrediting specialist medical education and training programs
- enhancing the system of registration of medical practitioners, including medical specialists.

The working party recommended that, as well as reviewing and accrediting the training programs for new specialties, the AMC should accredit the training and professional development programs of the existing specialist medical education and training providers—the specialist medical colleges.

Separate working parties developed the model's three elements. An AMC consultative committee developed procedures for reviewing specialist medical training programs, and draft educational guidelines against which programs could be reviewed. In order to test the process, the AMC conducted trial reviews during 2000 and 2001 with funding from the Australian Government Department of Health and Ageing. These trial reviews covered the programs of two colleges.

Following the success of these trials, the AMC implemented the accreditation process in November 2001. It established a Specialist Education Accreditation Committee to oversee the process, and agreed on a forward program allowing it to review the education and training programs of one or two providers of specialist training each year. In July 2002, the AMC endorsed the guidelines, *Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures*.

In 2006, as it approached the end of the first round of specialist medical college accreditations, the AMC initiated a comprehensive review of the accreditation guidelines. In June 2008, the AMC approved new accreditation standards and a revised description of the AMC procedures. The new accreditation standards apply to AMC assessments conducted from January 2009. In 2010 the AMC made some additional changes to the standards, including new explanatory notes to clarify AMC expectations regarding the principle of 'no disadvantage' to existing trainees when colleges change training program requirements; and changes to bring standards into line with the requirements of the Medical Board of Australia,

particularly its registration standards concerning continuing professional development. The relevant standards are included in each section of this report.

A new National Registration and Accreditation Scheme for health professions began in Australia in July 2010. The Ministerial Council, on behalf of the Medical Board of Australia, assigned the AMC the accreditation functions for medicine.

From 2002 to July 2010, the AMC process for accreditation of specialist education and training programs was a voluntary quality improvement process in which all specialist colleges had agreed to participate. From 1 July 2010, the Health Practitioner Regulation National Law Act 2009 makes the accreditation of specialist training programs an element of the process for approval of programs for the purposes of specialist registration. Similarly, the Medical Board of Australia's registration standards indicate that continuing professional development programs that meet AMC accreditation requirements meet the Board's continuing professional development requirements.

From 1 July 2010, the AMC presents its accreditation reports to the Medical Board of Australia. Medical Board approval of a program of study that the AMC has accredited forms the basis for registration to practise as a specialist.

**Assessment of the programs of the Royal Australasian College of Medical Administrators**

When the specialist accreditation process was first implemented, the AMC established a process to grant initial accreditation to the education providers in the recognised medical specialties, which was based on a review of the providers' policies and documentation. Initial accreditation continued, subject to satisfactory progress reports, until an assessment by an AMC team. In June 2003, the AMC, on the advice of its Specialist Education Accreditation Committee, granted initial accreditation to the Royal Australasian College of Medical Administrators as the training organisation for the specialty of medical administration.

In November 2007, the AMC appointed Professor Andrew Coats to chair the assessment of the education and training programs of the Royal Australasian College of Medical Administrators, referred to as the College from here on in the report. The AMC then began discussions with the College about the timing of the review and the process that would be followed in the review.

The AMC appointed other members of the Medical Administrators Assessment Team (called 'the Team' in this report) in February 2008 after the College had an opportunity to comment on the individuals proposed. The members of the 2008 Team are listed in Appendix 1.

The review process followed the standard AMC accreditation procedures, namely:

- a meeting between the AMC Secretariat staff, the President of the College, the Censor-in-Chief and College senior staff in October 2006
- preparation by the College of a detailed accreditation submission
- a Team meeting in March 2008 to consider the College's submission and to plan the review
- feedback to the College on the Team's preliminary assessment of the submission, the additional information required, and on the Team's plans for site visits and meetings

- AMC surveys of candidates (48 per cent of the College's candidates responded), and preceptors (51 per cent of supervisors responded)
- invitations to other specialist medical colleges, medical schools, health departments, College-identified stakeholders, and health consumer organisations to comment on the College's training and professional development programs
- a program of site visits and meetings in New South Wales, New Zealand, Queensland, Victoria, South Australia and Western Australia between 9 and 16 June 2008.

In November 2008, having considered the report on this assessment, AMC Directors agreed:

(i) That the AMC grant accreditation of the education and training program and the professional development programs of the Royal Australasian College of Medical Administrators for four years, until December 2012 subject to review by the Specialist Education Accreditation Committee by June 2011 of a report that demonstrates the successful review of the College's goals and membership, and the alignment of its training and assessment across jurisdictions.

(ii) That, in the usual progress reports to the Specialist Education Accreditation Committee, the RACMA comment on its response to the recommendations in the Accreditation Report, giving specific attention to:

- findings of the constitutional review
- clarification of the role of the membership category
- development of a clear statement of the goals of training
- progress on how the competencies and curriculum have been developed and how they have been embedded into the training program and assessment
- formation of a candidate committee and review of the feedback processes/ mechanisms for candidates and preceptors
- how the College is addressing the training gaps and access issues for rural candidates
- progress on the continual development of the roles, responsibilities, selection and appointment, reporting, training and support of supervisors, censors and preceptors
- progress on the challenges raised by the external reports commissioned by the College
- progress on how the College is managing the transition to compulsory CEP, and the review of participation rates, retraining and remediation of fellows.

Between formal accreditations, the AMC monitors developments in education and training and professional development programs through progress reports from the accredited medical education providers. The College has provided three progress reports to the AMC since its accreditation in 2008. These reports have been reviewed by a member of the AMC team that assessed the program in 2008, and the reviewer's commentary and the progress report then considered by the AMC Progress Reports Working Party. The AMC has considered these reports to be satisfactory.

In 2011, the AMC began preparations for the 2012 review of the College's programs. On the Specialist Education Accreditation Committee's recommendation and after the College had

an opportunity to consider the proposed membership, the AMC Directors appointed a team to complete this review. The 2012 Team was chaired by Professor Michael Kidd. The membership is given in Appendix 2.

In May 2012, the College provided an accreditation submission outlining progress on the recommendations and challenges facing the College. The Team met in May 2012 to consider the submission, and then discussed plans for the review with College officers and staff.

The Team completed its review between 17 and 19 July 2012. The review comprised a program of site visits in New Zealand, Victoria, and Western Australia; consultation with jurisdictions, trainee organisations, other colleges, and medical schools; and meetings with College officers, committees and staff.

### Australian Medical Council and Medical Council of New Zealand relationship

Since most of the specialist medical colleges span Australia and New Zealand, the Medical Council of New Zealand (MCNZ) is an important contributor to AMC assessments.

In November 2010, the AMC and the MCNZ signed a memorandum of understanding to extend the collaboration between the two organisations. The two Councils are working to streamline the assessment of organisations which provide specialist medical training in Australia and New Zealand. The AMC continues to lead the accreditation process and assessment teams for bi-national training programs will continue to include New Zealand members, site visits to New Zealand, and consultation with New Zealand stakeholders. In future, these processes will specifically address New Zealand requirements.

While the two Councils use the same set of accreditation standards, specific legislative requirements in New Zealand require the bi-national colleges to provide additional New Zealand–specific information during the assessment. The College's assistance in responding to these requirements is acknowledged.

### Appreciation

The Team is grateful to the College staff and fellows who prepared the accreditation submissions and managed the preparations for the 2008 and 2012 reviews. It acknowledges with thanks the RACMA fellows in Australia and New Zealand who have coordinated and hosted site visits from AMC Team members, and those who met Team members.

A list of the organisations that made a submission to the AMC in 2008 and/or 2012 is at Appendix 3. A summary of the AMC Team's program of meetings and visits for these reviews is provided in Appendix 4.

### Report on the 2008 and the 2012 AMC assessments

This report contains the findings of both the 2008 and 2012 AMC assessments.

Each section of the report begins with the relevant accreditation standards, current at June 2012. The findings of the 2012 Team are provided as commentaries following the relevant sections of the 2008 report. It should be noted that the report by the 2012 Team addresses progress by the College against recommendations made by the AMC in 2008. In areas where the College has made no substantial change and no recommendations were made in 2008, the 2012 Team has not conducted a comprehensive assessment.

# 1 The context of education and training

The accreditation standards concerning the context in which education and training are delivered are as follows:

- The education provider's governance structures and its education and training, assessment and continuing professional development functions are defined.
- The governance structures describe the composition and terms of reference for each committee, and allow all relevant groups to be represented in decision-making.
- The education provider's internal structures give priority to its educational role relative to other activities.
- The education provider has established a committee or committees with the responsibility, authority and capacity to direct the following key functions:
    - planning, implementing and reviewing the training program(s) and setting relevant policy and procedures
    - setting and implementing policy and procedures relating to the assessment of overseas-trained specialists
    - setting and implementing policy on continuing professional development and reviewing the effectiveness of continuing professional development activities.
- The education provider's education and training activities are supported by appropriate resources including sufficient administrative and technical staff.
- The education provider uses educational expertise in the development, management and continuous improvement of its education, training, assessment and continuing professional development activities.
- The education provider collaborates with other educational institutions and compares its curriculum, training program and assessment with that of other relevant programs.
- The education provider reviews and updates structures, functions and policies relating to education, training and continuing professional development to rectify deficiencies and to meet changing needs.
- The education provider seeks to maintain constructive working relationships with relevant health departments and government, non-government and community agencies to promote the education, training and ongoing professional development of medical specialists.
- The education provider works with healthcare institutions to enable clinicians employed by them to contribute to high quality teaching and supervision, and to foster peer review and professional development.

## 1.1 Organisational structure and governance in 2008

The College has a forty-five year history in Australia. It began with a resolution in 1963 by the Medical Superintendents' Association of Victoria to form a professional association with the aim of promoting and advancing the study of health services management by medical practitioners.

In 1967, the Australian College of Medical Administrators was formed and incorporated under the Companies Act of Victoria, with 279 founding fellows. In 1979 it became the 'Royal' College.

Recognition of medical administration as a distinct specialty was achieved in Australia in 1980, when the National Specialist Qualification Advisory Committee, recognised the College as the examining body in the new specialty of medical administration.

In August 1998 the College changed its name to the Royal Australasian College of Medical Administrators in acknowledgement of the incorporation of New Zealand. In New Zealand, medical administration has been recognised as a vocational scope of practice since 2001.

*A History of Medical Administration in New South Wales 1788-1973*, by CJ Cummins, describes the evolution of health administration in Australia and how the specialist roles, responsibilities and structures, legislation and regulations, emerged to support the decision making and governance of health services.

The College has three categories of membership or affiliation. These are described below, and the number of doctors filling each category at September 2007 is provided.

- Fellows of RACMA (457): The requirements for the award of fellowship include registration as a medical practitioner, at least three years clinical experience, at least three years approved administrative experience, completion of an approved university masters degree (such as health administration or business administration), satisfactory completion of a case study and success in the final oral examinations. Once granted fellowship, continuing education and recertification provisions apply.
- Candidates (91): This applies to doctors in training who have enrolled with the College and are undertaking the educational and administrative training requirements for election to fellowship.
- Member (244): This category is specifically designed for clinicians and other medical graduates with an interest or involvement in management and administration. It does not require additional formal training or qualifications but does require a willingness to participate in RACMA's continuing education program.

The College is governed by a Council that comprises fellows from each Australian state, territory and New Zealand, a candidate representative, the Immediate Past-President, the Censor-in-Chief and the National Director Continuing Education/Recertification.

College office bearers, including the President, Vice-President, Immediate Past-President, Honorary Secretary, Honorary Treasurer, Censor-in-Chief and the National Director Continuing Education/Recertification make up the Executive of Council.

The College's training, assessment, and continuing professional development activities are managed by a number of boards and committees. The principal committees are as follows:

The Board of Training and Continuing Education is made up of the Censor-in-Chief (Chair), the National Director for Continuing Education/Recertification (Deputy Chair) and at least six other Censors. The Board makes recommendations to the Council concerning the curriculum and other candidate requirements, and the criteria for continuing professional development for fellows and members. It examines candidates and reports the results to

Council. The Censor-in-Chief leads the education program, and the National Director Continuing Education/Recertification coordinates and develops the activities for continuing professional education of College fellows and members.

The Continuing Education Program (CEP) Committee is chaired by the National Director for Continuing Education/Recertification and its members are the state, territory and New Zealand Continuing Education Program Coordinators. These local CEP Coordinators support and verify participation in ongoing professional development by fellows and members. The CEP committee develops policy and procedures, establishes educational frameworks, and has a monitoring and evaluation role. It meets at least five times per year.

State, territory and New Zealand committees are made up of members of Council from the jurisdiction, with at least four additional fellows from the jurisdiction. At least one member may be a candidate. Office bearers of these committees include the Secretary, Treasurer, Chair of the Board of Studies, Scientific Program Coordinator and the Continuing Education Program (CEP) Coordinator. Each Committee is responsible for the activities of its Board of Studies, implementing College policy and administering College affairs at a local level.

Each state, territory and New Zealand Committee has a local Board of Studies, whose members are appointed by the local committees. The Chair is an ex-officio member of the local Committee and the Censor-in-Chief is also involved in making this appointment. All members of the Board of Training and Continuing Education resident in the jurisdiction are ex-officio members of the Board of Studies.

The Boards of Studies oversees candidate progress; provides candidate preceptors; assists candidates with examination preparation; advises the Censor-in-Chief on the appropriateness of training positions; coordinates training programs and develops standards for accreditation of training positions; reviews candidate's training and progress reports; and counsels candidates.

At the local level, the College has identified the following key training roles:

- Chairs of Boards of Studies supervise candidate progress, support and assessment. They liaise with the Censor-in-Chief and the local committee and attend Censors' meetings.
- Each candidate has a workplace supervisor, who is generally the candidate's line manager. This person does not need to be a fellow of RACMA.
- Each candidate is assigned a preceptor, who is a senior College fellow who provides advice and education to support the candidate and report annually on the overall progress of candidates towards fellowship.

These roles are discussed further in section 8 of this report.

A small national secretariat, led by the Chief Executive, Dr Karen Owen, manages the College.

The College's education and training activities have been supported by College fellows acting as part-time consultants. The roles have included a Policy and Research Officer; an Education Coordinator who has supported the educational activities of the College, particularly the fellowship training program; the continuing education program, and

management for clinician training program; and two positions established to assist with the College's preparation for AMC accreditation.

### *1.1.1 2008 Team findings*

The Team congratulates the College on its forty-fifth year and on its tenth anniversary of the formalised Australia and New Zealand relationship.

The College retains a large Council, which has a membership based principally on representation of fellows of the various College regions/jurisdictions. It includes a candidate member, but the Team noted that the lack of non-executive or other external input, as well as the absence of formal representation by the member class of College affiliate.

Many fellows of the College are experienced board members in their own right, used to high level governance and management of large complex corporate entities. Despite this, the lack of external board members risks denying the College the greater perspective, contacts and wider professional expertise that the inclusion of non-executive directors might bring to the College. This might in turn be an opportunity to engage more directly with state and federal health authorities and other natural partners.

In recent years, the College has devoted considerable thought to its strategic direction, its organisation and governance structure.

In 2006, the College commissioned a review of the College constitution, governance and mission by DLA Phillips Fox. The Team commends this review. It has raised a number of important strategic issues for the College, such as the way the discipline of medical administration is described, the role and make-up of the College Council, the roles of office bearers, and the College's role in articulating standards of professional practice. Many issues raised in the DLA Phillips Fox review are consistent with issues identified by the AMC Team. The AMC will wish to be informed of the outcomes of the College's deliberations and to see the College complete its response to this important review in the near future.

One issue the Team specifically identified is the need for the College to address the role, responsibilities and representation of the member category. Both candidates and fellows expressed the view that the use of post-nominals by members should be consistent with a degree of rigour in assessing the qualifications, skills, character and achievement of members that is higher than the present requirements. The Team supports this view. Equally, concern was expressed that any major change in the requirements to become a member of the College risks alienating this class of College stakeholder and putting the overall financial position of the College at risk if not done carefully, with due consultation and consideration of the consequences of various options being pursued.

As is the case for all the Australian colleges, individual fellows make substantial contributions to governance and management of key functions often over many years. In this College, some individual fellows carry large loads and have developed considerable expertise and knowledge of College processes. The Team commends the College's moves to document the knowledge of key individuals and formalise its processes for making key training decisions.

College fellows and candidates who met the Team spoke very positively of the services provided by the College's Secretariat. In addition to managing the day-to-day business of the College, the staff support the strategic projects and long term developments of the College.

There is a devolved regional board of studies model for much of the governance and supervision of candidate selection, training program management and educational delivery. The Team commends the College for its own in-depth analysis of the strengths and weakness of such a model. The Team was, however, concerned about considerable variability in the rigour of the educational programs on offer in different states and territories, which does not provide the same quality of experience or breadth of opportunity for candidates in all of Australia and New Zealand. Whilst recognising the need for local accountability and the variation in resource availability across regions, the Team recommends the College draws up a plan for greater consistency of educational experience across regions. The Team also recommends the College establish formal mechanisms to both monitor and reduce variability across regions. This may involve a move to greater national oversight of the minimal and aspirational levels of educational delivery and program management across states and territories (including New Zealand). On the wider issues of governance, leadership and maintenance of standards, the potential for unacceptable variability in standards should be addressed by stricter central controls in any review of College governance.

The Team commends the College and its Chief Executive on the vision enunciated in the RACMA strategic plan and on the implementation milestones expressed during the Team's meetings at the College. The Team recognised the need for executive and leadership time, beyond the demands of day-to-day operational management issues, to promote and progress several necessary high-level initiatives. These include, amongst others: the strategic positioning of the College as a leading advocate and commentator on quality and sustainable health care leadership; documenting policies and best-practice guidelines for those College activities that presently are known by key officers, but which are not consistently documented for others to follow. The Team believes that the resources available to the relatively small secretariat may be stretched in delivering these important initiatives.

### 1.2 Challenges for the College in 2008

The College's accreditation submission identifies a number of significant challenges.

The College has a number of significant complementary relationships, in particular with the Australian College of Health Service Executives, which includes both medical and non-medical health managers, and with the Hong Kong College of Community Medicine.

The College's membership figures show an overall decline since a peak in the mid-90s. The total number of candidates and the relative proportion of candidates to fellows have also declined. In New Zealand the situation is somewhat different, with the College there being relatively new and growing quickly, in part because of the support for the appointment of chief medical officers in the New Zealand District Health Boards.

The College has identified the ageing medical administration workforce as a challenge, with 64 per cent active fellows over 50, and only 5 per cent less than 40 years of age. Even when candidate numbers are added to active fellows, only 14 per cent are less than 40 years of age.

In 2005 the College commissioned a report to examine issues around recruitment and retention of the medical manager workforce. This document identifies a number of challenges

to recruitment and retention, including the decreasing and unpredictable number of training positions; changing emphasis in the roles of medical administrators and lack of clarity about these roles; and also the lack of clarity around the differences in competencies and roles between the clinician managers who are part-time administrators and medical administrators. It provided 20 recommendations to the College concerning the definition of the discipline and articulation of the skills of medical administrators, promotion of the contribution of medical managers to health services management, and the development of a workforce strategy.

2008 Commendations

A The College's decision to commission the DLA Philips Fox review of its constitution.

B The commitment of the Secretariat and fellows to review and reform College procedures and processes.

C The significant energy invested in documenting the knowledge of key individuals and formalising its processes for making key training decisions.

*2008 Recommendations*

1 Complete its consideration of the DLA Philips Fox constitutional review.

2 Clarify the role, representation and requirements of the member category of membership.

3 Consider the introduction of mechanisms to ensure consistency across jurisdictions, in any review of the governance, of the College which focuses on the role and independence of action of state and territory boards of study and the standards applied by them.

7 Consider strengthening its national secretariat.

### 1.3 Governance and program management in 2012

The College adopted the new RACMA constitution at its 2009 AGM and implemented it from March 2010.

The changes include replacing jurisdiction-based nominations and elections with national nominations and elections to designated Officer roles/positions e.g. President, Vice President, Chair Education and Training, and Chair Finance and Audit. The College Board now includes one non-medical member appointed by the Directors who brings expertise to the Board in the areas of business, education and/or community.

A new Education and Training Committee, chaired by a Board Director, is the College's peak body responsible for oversight of the College education, training and continuing professional development programs. This Committee is supported by a number of sub committees, including:

- Continuing Education Program Committee is responsible for development, implementation and evaluation of the Continuing Education Program for fellows and associate fellows.

- Board of Censors, a new committee, advises on and conducts all formative and summative assessments of candidates in the fellowship training program of RACMA.
- Credentialling Committee, a new committee, advises on policy, regulations and procedures governing applications for all membership classes and for accreditation of training posts.
- Training Committee, a new committee, advises on and plans for the delivery of the RACMA Medical Leadership and Management Curriculum. In practice it advises on development of syllabi at the national and jurisdictional levels.
- Curriculum Steering Committee, a new committee, is responsible for development, and evaluation of the Medical Leadership and Management Curriculum.
- Annual Scientific Program Committee oversees the organisation and program design of RACMA's Annual Scientific Meeting.

All the committees except for the Credentialling Committee and Continuing Education Program Committee have candidate members.

The new constitution also changes the make-up and terms of reference of the regional committees, called the RACMA Jurisdictional Committees. Since 2008, the College has reviewed the operation of these committees and established the new role of Jurisdictional Coordinator of Training. These Coordinators are the members of the national Training Committee and are represented on the Credentialling, Curriculum and Annual Scientific Program Committee. The Training Committee's work includes reviewing and articulating the jurisdictional syllabi against the College's national program of training workshops and assessment.

The new constitution also changes the categories of membership or affiliation, removing the category of member. A number of members have taken steps to complete the fellowship program of the College. The College introduced a new non-specialist membership category of associate fellow with arrangements to transfer members to associate fellowship.

The College has also established an accelerated pathway to fellowship which has provided an opportunity for senior medical managers to complete training and to attain fellowship. A number of members have entered this pathway. This pathway is described in more detail in section 3 of the report.

Since 2008, the College's national secretariat has been strengthened and is providing additional resources to support the members of the College. In 2012, the College has five staff EFT in ongoing roles and six EFT undertaking projects.

These changes have taken place during a time of significant health workforce reform in both Australia and New Zealand and changes in expectations about the roles of medical administrators in innovation and meeting workforce challenges.

### *1.3.1 2012 Team findings*

The College has made significant changes to its governance structures since the 2008 review including the development and adoption of a new constitution and the subsequent revision of the membership of the College Board and the categories of College membership.

The Team noted that further work has been undertaken to describe the composition and terms of reference for each of the committees within the governance structure of the College, including the roles of jurisdictional committees. These changes ensure consistency across jurisdictions, including state and territory boards of study and the standards applied by them. There is also consistency between Australia and New Zealand.

In 2008, the AMC Team had commented on the need to document policies and best-practice guidelines for College activities. The College's accreditation submission describes the considerable work to document and standardise College training policy.

The new organisational structure provides the opportunity for greater involvement of more RACMA fellows in the activities of the College. Fellows who met the Team expressed support for the changes and commented on the re-invigoration of the College which had resulted. The College's enhanced capacity to manage its education programs was demonstrated in the Team's meetings with the College's education and training committees. In addition to managing the current programs, these committees are overseeing a wide range of projects and piloting a number of new developments.

In 2008, the AMC had recommended that the College review the role, responsibilities and representation of the member category. The College has responded positively to this recommendation.

The College has strengthened its educational role by implementing a new non-specialist training pathway for associate fellowship in 2011. There are 40 doctors training in this pathway. The College indicated they are clinician managers and fellows of other specialist colleges who seek some formal training and exposure to medical management professional development programs. While the new pathway to associate fellowship is not part of the AMC accreditation assessment, since it does not lead to a qualification to practise as a specialist medical administrator, the Team was interested to learn that the Board is considering articulation between this program and completion of the fellowship program. The AMC will wish to be informed of these developments in progress reports.

The Team noted strong support among the membership of the College for the changes in governance and the increase in the assistance available from the national secretariat. The College's expanding operations have been supported by expanding resources.

The Team commends the College on the substantial reforms of the College governance and organisational structure since the 2008 accreditation assessment.

In feedback to the College on its progress reports, the AMC Specialist Education Accreditation Committee had indicated that recommendations 1 and 7 from the 2008 report had been addressed. The Team has confirmed this, and considers that recommendations 2 and 3 have also been addressed.

### 1.4 Educational expertise and exchange in 2012

Since 2008, the College has strengthened its engagement with international organisations concerned with leadership in medical management. It has played an active role in the establishment of the World Federation of Medical Managers which brings together international leaders in medical management from Australia, New Zealand, Hong Kong, Canada, UK, Ireland, Italy, Indonesia, USA, Denmark, Netherlands, Israel and Africa.

Locally, in the College's education processes it has focussed on standardisation across jurisdictions over the past four years in areas of selection, curriculum roll out, accreditation of training positions, the roles of jurisdictional committees and the position of the Jurisdictional Coordinator of Training. Through the Training Committee, these Coordinators have monitored and advised on the development of syllabi at the national and jurisdictional levels.

It has used appropriate educational expertise to extend the education activities for candidates and fellows, including the introduction of webinars for both candidates and fellows as part of their continuing professional development and support for supervisors and preceptors.

In recognition of its expanding educational activities, the Censor–in-Chief has established a Lead Censors Group with censors with expertise in examinations, simulated learning, case study assessment and reflective writing. These Censor Co-ordinators will facilitate training of groups of censors to undertake the various formative and summative assessment activities.

#### *1.4.1 2012 Team findings*

The College uses educational expertise in the development, management and continuous improvement of its education, training, assessment and continuing professional development activities. The College's additional educational supports were valued by many of the College members who spoke with the Team.

The College's international engagement with other medical management societies and education bodies is commended.

The consistency in training standards across the jurisdictions and the two nations is a significant achievement. The Jurisdictional Coordinators of Training have been brought together within the Training Committee. The reforms utilise the curriculum as a framework.

### 1.5 Continuous renewal

The College has demonstrated a culture of review and its commitment to adapting its governance and program management structures to meet future challenges, through its response to the 2008 AMC accreditation report.

### 1.6 Relationships to promote education and training of specialists

In 2008, state health departments had a formal well-established communication process with the College, and departments were willing contributors to discussion on topics such as workforce planning, and the identification of new training posts. Private sector agencies have limited dealings with the College, but employ a number of fellows, members and candidates.

#### *1.6.1 2008 Team findings*

Some jurisdictions would have welcomed greater consultation about the College's role and the support it can provide to the various jurisdictions on increasing training posts.

Some health departments commented on the opportunities for an increased focus on safety and quality approaches, and indicated that training in root cause analysis would be beneficial. These departments were keen to expand the collaborative approaches.

As with other colleges, training in medical administration is provided largely in a service environment. The jurisdictions employ the candidates and supervisors and are an important

part of the milieu in which training is provided. At a state/territory jurisdiction level, executives met by the Team were highly supportive of the College, the influence of its fellows on the quality of the services provided, the candidates and College processes.

Communication between the College and the health departments generally was described as adequate, although some respondents indicated that communication directly to the health department concerning the training/service interface would be desirable, rather than just via the accredited hospitals.

The College identified the need to provide appropriate numbers of specialist practitioners for workforce requirements as an issue of ongoing concern. It would appear that ongoing shortages of applicants in relation to accredited locations may continue for the foreseeable future. Queensland Health has supported and funded a number of formal training positions and associated costs.

The College acknowledged the need to develop these relationships and identified a range of activities to date. However, it reported variable relationships with some state health departments, the reasons for the variability partly due to significant structural reform occurring in some states, with changes in key personnel, and the time required to develop these relationships. Responsibility for the delivery of health within Australia is split between the Commonwealth and states/territories.

There is a wealth of opportunity for training in medical administration in non-traditional training settings. The Team encourages the College to continue to explore these opportunities and to assume a key role in the development of medical administrative leadership in a wide variety of settings.

**Interactions with the health sector in 2012**

Since 2008, the College has strengthened its engagement with state/territory health jurisdictions and the New Zealand Ministry of Health.

The College centrally and the Jurisdictional Committees in Australia and the New Zealand Committee have embraced an advocacy role and engagement with their respective health department/health services. This has resulted in additional training places including, for the first time, plans to fund registrar posts in New Zealand. The College submission also outlines a number of collaborative projects with Australian state health departments.

The College has engaged well with the Australian Government Department of Health and Ageing in securing funding to support the growth of the training program through the Specialist Training Program.

### *1.6.2 2012 Team findings*

The College is active in working with the health sector and has constructive working relationships with relevant health departments and government, non-government and community organisations. This was confirmed in the submissions received from health departments, health workforce agencies, and non-government and community organisations, and in the Team's discussions with representatives of health departments. The Team's discussions also indicated a mismatch between the College's view of the central role of the Jurisdictional Coordinator of Training and the knowledge in health jurisdictions of the role.

The College continues to develop strategies to address challenges in recruitment and retention of medical administrators, both through direct relationships with health jurisdictions and the development of the new associate fellow pathway and the accelerated pathway to fellowship. Challenges remain, however, concerning the changing scope of work of medical administrators and the decline in some of the traditional entry pathways. The Team considers that the College is well-positioned to address these challenges.

2012 Commendations

A The reform of the College governance and organisational structure since the 2008 AMC accreditation assessment which has led to more fellows contributing to the College's education and training activities.

*2012 Recommendations for improvement*

AA Given the importance of role of the Jurisdictional Coordinator of Training, communicate their role to health departments.

# 2 Purpose of the College and outcomes of the training program

The accreditation standards are as follows:

- The purpose of the education provider includes setting and promoting high standards of medical practice, training, research, continuing professional development, and social and community responsibilities.
- In defining its purpose, the education provider has consulted fellows and trainees, and relevant groups of interest.
- The education provider has defined graduate outcomes for each training program including any sub-specialty programs. These outcomes are based on the nature of the discipline and the practitioners' role in the delivery of health care. The outcomes are related to community need.
- The outcomes address the broad roles of practitioners in the discipline as well as technical and clinical expertise.
- The education provider makes information on graduate outcomes publicly available.

## 2.1 Organisational purpose in 2008

The vision of RACMA as defined in the Strategic Plan 2006-2009 is '*to be valued by our Membership, and recognized internationally, as the Australasian medical college that provides professional education, leadership, advice and expertise in medical management that promotes safe and effective healthcare*.'

### *2.1.1 2008 Team findings*

Whilst medical administration is recognised as a specialty in Australia and as a vocational scope of practice in New Zealand, internationally the discipline is not so clearly distinguished and recognised. The College's accreditation submission indicates that there is no comparable training for the specialty of medical administration elsewhere, although the expertise encompassed by the discipline is recognised in the USA, the UK, and elsewhere in Europe. In the UK, the British Association of Medical Managers assists clinicians to develop leadership and management skills via education and networking. In the US, the American College of Physician Executives aims to develop physician leadership among its members. This College is recognised by the American Medical Association as the specialty society representing physicians in management, but the discipline it is not a recognised subspecialty.

In Hong Kong, a training program in administrative medicine exists, based on the RACMA model. This discipline is a subspecialty of the Hong Kong College of Community Medicine.

The Team considers that the College needs to develop compelling evidenced-based arguments to support medical administration as a specialty, acknowledging the important contribution well-trained medical administrators make to complex modern health care systems. The Team is convinced of the value of the College and the specialty, but is less convinced that this message has been either well communicated or appreciated by key decision makers in the health care sector.

Given the lack of international comparator entities, the College needs to be very clear about the value it adds. The Team remains concerned that the College is not adequately

communicating a succinct statement of medical administration as a specialty and the value trained medical administrators make to modern health care provision. This is a prerequisite for developing the core components of an adequate specialist training program. The Team was aware that even within the College Council there was a view that the message could be clearer, and that the College could undertake this aspect of its role better. The College's own documentation says that what medical administrators do has not been sufficiently and clearly enunciated. The Boyd and Gruner report indicates that the College needs to articulate this message more clearly. The Team recommends further work in this area.

In its supplementary material to the Team, provided in May 2008, the College indicated that it had commenced a dialogue at Council level about the role of the medical administrator, and what it means to be in good standing as a medical administrator (Council paper). The issue of professional standards for medical administrators has been raised in a paper published in the College's journal, *The Quarterly*. Material has been prepared and circulated to all members about the value proposition of fellowship. This material is also reflected in a new College brochure distributed at career expos and to clinicians enquiring about membership. Council has adopted a definition of medical administration which has been communicated to the AMC and the MCNZ, yet the Team remained concerned that this message is not clear or visible to stakeholders; in fact it remained confused as to what this message is. The Team noted the MCNZ's clear definition of medical administration as a vocational scope of practice as 'administration or management utilising the medical and clinical knowledge, skill, and judgement of a registered medical practitioner, and capable of affecting the health and safety of the public or any person. This may include administering or managing a hospital or other health service, or developing health operational policy, or planning or purchasing health services. Medical administration does not involve diagnosing or treating patients.' The College is recommended to consider, adopt and promulgate amongst its own membership and the wider health community, its view of the role of the medical administrator.

The statement of purpose is at variance with the three-year strategic plan that sets higher goals. The statement '*to be valued by our membership…*' is somewhat introspective and confusing when the context of membership probably means fellowship. The Team would encourage the College to engage the broader community and health consumers as it develops its mission and refines its purpose.

The College's documentation indicates that it believes that high quality medical management is crucial to the overall safety and quality of medical service provision, particularly in acute hospitals. The Team would encourage the College, as the professional body for the recognised medical specialty of medical administration, to take the lead in developing professional standards relevant to the discipline and to continue to develop and implement strategies to strengthen the discipline in Australia and New Zealand. The Team would encourage the College to be proactive in engaging with health services and state, territory and national health departments. Feedback to the Team during this review indicated support for the College strengthening its role in improving health outcomes, promoting better health systems, and promoting health policy that supports good care and responsible decisions. These are key roles of most medical colleges in Australia.

*2008 Recommendations*

4 Articulate and promote its role in improving the health outcomes of the populations which RACMA members serve. The College should promote wider knowledge of

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|---|---|
| | medical administration globally, and contribute to better systems of health care management through its membership, education, research, leadership and advocacy. |
| 5 | In annual reports to the AMC, report on progress to address the challenges raised by the external reports commissioned by the College. |
| 6 | Consider, adopt and promulgate amongst its own membership and the wider health community the College's view of the role of the medical administrator. |

## 2.2 Organisational purpose in 2012

The organisational purpose of RACMA is unchanged. The College has demonstrated continued commitment to setting and promoting high standards of practice in medical administration, training, research, continuing professional development, and social and community responsibilities. In defining its purpose originally, and during the recent revisions of the RACMA constitution and the curriculum, the College has consulted fellows, trainees and other relevant groups including health services, government departments and consumer groups.

### *2.2.1 2012 Team findings*

Prior to the 2012 accreditation assessment, no recommendations against Standard 2 remained outstanding from the 2008 report. The College was requested to provide a short summary addressing Standard 2 in its submission for the 2012 visit. This material was considered at the preliminary Team meeting in May 2012, when the Team raised several issues in relation to Standard 2 for exploration at the accreditation visit. All issues were satisfactorily addressed.

Following consideration of the 2011 Progress Report, the College was commended for the clear and accurate way in which it defined its purpose through the curriculum document. The Team wishes to reiterate this commendation.

The Team noted that the vision of the College was unchanged since the last assessment but had been better communicated to stakeholders. The Team was advised that the values statement was in the process of review.

## 2.3 The goals of education and training in 2008

The primary goal of the College is the development of competent medical administrators. In the last ten years, the College has given considerable attention to articulating the competencies that relate to this goal, taking account of the changing role of the medical administrator and other developments, like the focus on generic roles and competencies of medical practitioners in work such as the CanMEDS framework.

A survey of 102 RACMA fellows, members and candidates, undertaken as part of the examination of recruitment and retention issues, identified five key competencies expected of medical administrators:

- communication
- personal leadership skills
- ability to engage medical staff

- strategic thinking
- analytical skills.

The College has articulated the following as key characteristics to be developed during candidacy:

- contemporary knowledge of medicine, health and management issues and how these are interlinked
- ability to link clinicians, especially medical clinicians, with health services management and planning functions
- understanding of systems that contribute to effective health services delivery
- recognised profile in the health community
- skills to lead various clinical and administrative teams
- ability to lead safety and quality initiatives
- effective resource managers
- maintainers of strong professional and ethical standards
- breadth of experience
- ability to articulate a vision and drive improvement
- ability to encourage and assist with the education and research activities carried out in hospital and health care settings
- ability to provide expert advice to non-clinician management relating to the best and most appropriate clinical choices for the health service organisation and its patients
- ability to provide expert advice to clinicians and the most appropriate means of managing services to ensure optimal patient outcomes with the resources available.

The College has stated that it is continuing to evolve its training program to focus on development of the key competencies.

In addition to these statements, the College has used the CanMEDS framework, which articulates seven key roles of medical expert, scholar, communicator, collaborator, manager, advocate and professional, to categorise required knowledge skills and behaviours, the relevant learning opportunities and the way in which the competency is assessed. For the role of medical expert, for example, the College identifies the following competencies:

- demonstrates intelligent leadership
- able to influence medical staff behaviour
- able to devise and implement appropriate clinical governance systems
- able to manage health care provision for all patients (clients) of a health system.

### 2.4 Graduate outcomes in 2012

The RACMA Medical Leadership and Management Curriculum, launched in 2011, clearly outlines the learning outcomes for RACMA candidates. These learning outcomes are arranged around RACMA's adaption of the CanMEDs roles and are achieved through

supervised workplace training/experience, learning programs provided by RACMA and higher degree study. Candidates develop an individual training plan in collaboration with their supervisors that aims to address gaps in their achievement of the learning outcomes. The progression of candidates in each role from novice to expert is mapped out in the curriculum, as is the assessment of each learning outcome.

The College's curriculum uses the definition of medical administration which had been adopted by the Medical Council of New Zealand, namely 'administration or management utilising the medical and clinical knowledge, skill, and judgement of a registered medical practitioner, and capable of affecting the health and safety of the public or any person. This may include administering or managing a hospital or other health service, or developing health operational policy, or planning or purchasing health services.'

### *2.4.1 2012 Team findings*

Feedback from fellows, candidates and other stakeholders was universally positive about the curriculum document and the structure that it provides for the selection, training and assessment of candidates and for the continuing professional development of fellows, associate fellows and others interested in medical administration. Some comments were made about a perceived bias of the curriculum towards medical administration within health services (and in particular the Director of Medical Services role), while most, including the Team, were comfortable that all the major roles of a medical administrator were adequately addressed.

The Team considers recommendations 4, 5 and 6 from 2008 have been met.

2012 Commendations

B The clarity and focus of the curriculum document in terms of its articulation of the organisational purpose of the College and the learning outcomes of the training program.

# 3 The education and training program – curriculum content

The accreditation standards are as follows:

- For each of its education and training programs, the education provider has a framework for the curriculum organised according to the overall graduate outcomes. The framework is publicly available.
- For each component or stage, the curriculum specifies the educational objectives and outcomes, details the nature and range of clinical experience required to meet these objectives, and outlines the syllabus of knowledge, skills and professional qualities to be acquired.
- Successful completion of the training program must be certified by a diploma or other formal award.
- The training program includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, and encourages the trainee to participate in research.
- The training program allows appropriate candidates to enter research training during specialist education and to receive appropriate credit towards completion of specialist training.
- The program structure and training requirements recognise part-time, interrupted and other flexible forms of training.
- There are opportunities for trainees to pursue studies of choice, consistent with training program outcomes, which are underpinned by policies on the recognition of prior learning. These policies recognise demonstrated competencies achieved in other relevant training programs both here and overseas, and give trainees appropriate credit towards the requirements of the training program.
- The education provider contributes to articulation between the specialist training program and prevocational and undergraduate stages of the medical training continuum.

## 3.1 The curriculum in 2008

An AMC accreditation process normally includes an in-depth analysis of the core curriculum. At present, the College does not have a formally documented curriculum to support the objectives of the fellowship training program. This has been justified in the past by the very broad range of experience and expertise of the founding members of the College. As the College develops its view on the key components of the role of a medical administrator and enunciates the necessary skills, it will develop the components of a curriculum and develop processes that map the detail on how the curriculum equips candidates with these skills. The College's accreditation submission indicates that it began discussions about the required process and resources in 2007, that it has sought funds to support a consultative process led by educational expertise in curriculum development, and that it has set a timeline for completion by 2012. Because it forms such a central part of the College's educational strategy, the AMC will be expecting the College to address the accreditation standards it has set on this topic as a priority. As a result, the Team recommends a shorter time-span with subsequent review of progress, a feature that will inevitably entail an earlier review of the College than would otherwise be the case.

### *3.1.1 2008 Team findings*

The Team was impressed by the College's initiatives, particularly in recent years, to review and develop the education and training in medical administration. The survey of fellows, members and candidates has been very valuable in the identification of the competencies of the medical administrator.

In general, both preceptors and candidates considered the new competency framework to be helpful and well structured. Candidates indicated that they were able to use the framework to identify gaps in their training and to seek opportunities for acquiring these competencies. The majority of candidates were clear about the educational objectives.

The Team expressed some concern, however, that these competencies are quite broadly expressed and some lack specificity, for example 'breadth of experience', 'ability to articulate a vision' and 'able to influence medical staff behaviour'. It recommends that further effort be put into developing component assessable skills that underpin these attributes, detailing how they could be demonstrated, taught and assessed in building up the competencies sought. In doing this the College should ensure these lists inform and are informed by the key roles of a trained medical administrator referred to above.

The contextualisation of the CanMEDS framework has resulted in a useful spread of core knowledge, skills and attitudes.

A curriculum is an essential component of any education and training program. The work already completed to identify the competencies of a competent medical administrator is a valuable beginning to specifying the curriculum. The Team recognises the significant work and resources required for this process, but it encourages the College to complete and implement the curriculum as soon as possible. The AMC should seek annual reports on the College's progress, expecting real progress in the form of a first draft by the middle of 2010.

Candidates requested greater consultation and input into the training program redesign.

2008 Commendation

D The College survey of fellows and the development of the competency framework.

*2008 Recommendations*

8 Further strengthen the training program by articulating a clear statement of the goals of training, and further develop the set of competencies into a curriculum map against which the training program and assessments could be blueprinted.

9 Continue the work of developing and promoting the curriculum documents to enable a successful implementation of the curriculum as soon as possible, and report to the AMC on the implementation.

10 Embed the curriculum in all areas of education and training including selection, assessment, recognition of prior learning, professional development, appraisal of overseas-trained specialists, and report annually on progress in these developments.

## 3.2 Curriculum framework in 2012

The RACMA Medical Leadership and Management Curriculum, launched in 2011, clearly outlines the curriculum framework for RACMA candidates.

This builds on the work, well underway in 2008, to define key competencies of medical administrators, and to use the CanMEDS framework to categorise required knowledge skills and behaviours, and learning opportunities. In 2010, the College reviewed its mapping of College competencies to the CanMEDS framework. It also benchmarked its emerging curriculum against Canadian, US, and UK work in medical management curricula as well as the Australian Curriculum Framework for Junior Doctors.

The College agreed to continue with the CanMEDS model as the curriculum framework, but the central role is that of Medical Leader, rather than Medical Expert. The curriculum review project has generated a revised set of competencies and capabilities, as well as study themes for each CanMEDS role. The Medical Leadership and Management Curriculum adds a focus on leadership and strengthens training in research.

### *3.2.1 2012 Team findings*

Significant progress has been made towards embedding the curriculum in all areas of the training program. The learning outcomes are used to assess candidates for advanced standing, and are used by candidates and their supervisors in development of training plans. They guide in-training assessment, the scholar role assessment, the assessment of reflective writing activities and the content of the oral examination. Continuing professional development is also informed by the curriculum framework. The framework would be used to assess international medical graduates in the event that this was required. The curriculum framework is publically available.

Feedback from fellows, candidates and other stakeholders was universally positive about the curriculum framework and the structure that it provides for all training and continuing professional development activities.

Prior to the 2012 accreditation assessment, several recommendations against Standard 3 remained outstanding from the 2008 report. The College was requested to address these recommendations and to provide a short summary addressing Standard 3 in its submission for the 2012 visit.

The 2012 Team considers recommendations 8, 9 and 10 from 2008 have been met.

## 3.3 Structure, duration and sequencing of training in 2008

The fellowship training program has three main components:

1 a minimum of three years full-time or equivalent, supervised medical management experience in a recognised workplace

2 formal academic studies in an Australian or New Zealand university in a masters degree or equivalent, which contains the core subject matter required by RACMA

3 satisfactory completion of the RACMA training program which includes the following elements:

- participation in two College workshops in years one and three, or the candidate's final year
- participation in the College preceptorship program
- submission of a case study, and for candidates new to the program from 2008, a management practice folio
- oral presentation and assessment of the case study during the four-day workshop
- submission of three consecutive annual preceptor reports during the training period
- successful completion of the oral examination involving at least four viva voce examinations.

Candidates are required to complete a minimum of three years' full-time supervised training in medical management. This requirement may be met over an extended period of up to six years part-time, to provide the flexibility required by some candidates. Practical medical management experience is obtained in a variety of fields such as hospitals, mental health services, community health services, statutory authorities and government departments. There are also candidates who hold positions in pharmaceutical companies, community health, medical boards, the military, and health insurance organisations.

Formal academic studies entail completion of a university masters degree program usually over a three to four year period. The College requires that the masters degree includes at least the core elements of health care systems; health law; health economics; financial management in health; epidemiology and statistics; and two appropriate management units. Candidates have the opportunity to further explore areas of interest to a greater breadth and depth in the electives. Appropriate management electives may include public health; quality and safety; medical ethics; governance; leadership; organisation; and human relations or industrial relations.

### *3.3.1 2008 Team findings*

The new competencies framework, which is influenced by the CanMEDS framework, is regarded by candidates, supervisors and preceptors as providing an improved structure and making it easier to identify gaps in training. Some candidates were concerned that they would not be able to reach these competencies in their work experience due to variability of posts and supervisors. Attaining the required experience seemed somewhat ad hoc, relying on preceptors or candidates being able to arrange posts/visits/workshops. This could be a particular issue in candidates in 'non-training' posts.

Since February 2008, all new candidates are required to undertake a 'table top' audit in consultation with supervisors, to assess gaps in their training post and to ensure that the gaps are redressed through opportunities provided in the candidate's training plan. The College indicated that the early analysis of data from these 'table top' audits had identified some common gaps. As more of this feedback is received, it is intended that the Censor-in-Chief will evaluate the training program with a view to addressing common gaps.

Senior fellows are involved formally and informally in the curriculum design and delivery of certain modules at some institutions. The College does not have an involvement in the maintenance or assessment of standards of any particular course. In its accreditation submission, the College indicated that it would like to strengthen its involvement with the providers of what are regarded as the key masters degree programs at the University of New

South Wales and the Monash University Master of Health Services program, and it had commenced these discussions. If the College is to continue to rely on external providers for the major academic component of its fellowship requirements, then it will be necessary for it to strengthen its capacity to influence the content and quality of this training.

On the whole, the competency framework is broad enough to encompass the New Zealand health system, but candidates and preceptors in New Zealand identified curriculum gaps in cultural competence/Maori Health, and the funder/provider split in medical management (doctors having responsibility for both the budget and for the delivery of care to patients). Candidates have been advised to attend a workshop on cultural competence delivered by the Australasian Faculty of Public Health.

The Team understood that the competencies covered normal work practices within the specialty. Nevertheless, fellows indicated several areas that formed part of the assessment regime but were not part of the competency framework. In developing a curriculum, the College is asked to consider formal tuition and assessment in areas that may not be fully covered in the competencies, such as handling health services in times of disaster or distress, or under public or political attack, and the training of a medical administrator as an agent for transformation and change. The College is encouraged to develop closer alignment between its new curriculum, the competency framework used, and the skills recognised widely as being those the professional is uniquely qualified to provide.

*2008 Recommendations*

11 Consider incorporating formal training in direct consumer communication.

12 Develop an ongoing process for obtaining feedback from candidates on the components of the training program.

15 Ensure the training and assessment addresses gaps identified through the process of curriculum development. In particular, consider the requirements of fellows specific to New Zealand, including issues such as the funder/provider split, obligations to the Treaty of Waitangi, and issues relating to cultural competence and health disparities of New Zealand Maori and other ethnic minorities.

16 Foster greater collaboration between rural areas to overcome training gaps.

### 3.4 Structure, duration and sequencing of training in 2012

The College's fellowship training program continues to have three main components:

- a minimum of three years' full-time or equivalent, supervised medical management experience in a recognised workplace
- formal academic studies in an Australian or New Zealand university in a masters degree or equivalent, which contains the core subject matter required by RACMA
- satisfactory completion of the RACMA-delivered training, such as College workshops and written tasks and assessments.

As noted earlier in the report, the College has introduced an accelerated pathway to fellowship. Successful applicants for this pathway are judged as demonstrating a high level of

existing competency against the RACMA *Medical Leadership and Management Curriculum*. For each successful applicant, the College identifies competency gaps and develops an annual training plan to guide the study to address these gaps. Candidates are awarded advanced standing for the practice component of the fellowship training program. They complete a modified fellowship training program over a minimum 12 months.

The RACMA Medical Leadership and Management Curriculum outlines the progression of trainees from novice through to expert in each of the roles and learning outcomes. Entry-level candidates (occupying 'registrar' posts) are expected to commence at the 'novice' level. Candidates awarded advanced standing in the standard pathway generally enter at the 'apprentice' level, whilst candidates in the accelerated pathway generally enter at the 'competent' or 'proficient' level. The curriculum specifies the workplace activities that should be undertaken at each level of progress.

### *3.4.1 2012 Team findings*

The Team found that the curriculum very clearly outlines the education objectives and outcomes, including suitable educational experiences and the qualities to be acquired at each stage of training.

The 2008 accreditation report includes recommendations on two specific areas of the curriculum: direct consumer communication, and requirements specific to New Zealand, including cultural competence.

The College's 2012 accreditation submission outlined the College's initial discussions with the Consumer Health Forum of Australia and plans to strengthen consumer input into the curriculum over the next two years. The College has run a webinar on 'Consumer Engagement', facilitated by the CEO of Consumers Health Forum of Australia.

The accreditation submission also outlines ways in which cultural competence has been embedded in the curriculum. From 2012, all candidates will undertake cultural competence training as a pre-requisite for fellowship. The first module of this training, which comprises online and webinar training in Aboriginal and Torres Strait Islander and Maōri Health, was piloted in late 2011. The College plans to develop further modules, for example in refugee health.

In 2008, the AMC also recommended further collaboration between rural areas to overcome training gaps. The College has addressed training gaps through the Training Committee, the development of the College curriculum and the new educational resources it has developed.

The 2012 Team finds that the Recommendations 11, 12, 15 and 16 have been met.

## 3.5 Research in training in 2008

The College has defined the competencies of the scholar role as requiring analytical skills and exposure to evidence-based practice. The College requires analytical thinking in written work and has taken initiatives to boost research capacity through such ventures as invitation of a journal editor to attend one of the compulsory workshops and plan for writing a workshop. Candidates are encouraged to submit manuscripts to *The Quarterly*. There is no formal requirement to undertake research within the training program, though this could be a component of a candidate's masters degree.

### *3.5.1 2008 Team findings*

The AMC has articulated the position that all medical college trainees should be research literate, and that there should be opportunities for some to pursue an extended period of research activity. As hospital managers, FRACMAs may well be required to rule on research projects within their jurisdictions and would therefore require an understanding of research methodologies and ethics in research it would be especially useful for candidates to undertake formal research training and have recognised opportunities for research during their training. The College has established links with universities and particularly schools of public health, and also has access through its fellows and trainees to extensive data on health care and outcomes. The College has the opportunity to extend these connections for formal research partnerships and to encourage trainees to avail themselves of the opportunity of research supervision at a nearby university. Opportunities to encourage research further through formal recognition, recognition of research periods for training and a stronger recommendation for participation in research are all opportunities for the College to strengthen this aspect of their development of the specialty. In addition, financial support of research, dissemination of research findings through networks and the development of formal training in research methods are all areas the College could support by prioritising them in the training program.

2008 Commendation

I The move to encourage research and analytic writing skills among candidates.

*2008 Recommendation*

18 Establish a clear process for teaching and assessing the defined competency of Scholar. The College could give consideration to funding research initiatives, to supporting new researchers, in recognising more formally research participation and in making research activity more weighted in the requirements of fellowship training.

## 3.6 Research in training in 2012

New learning and assessment requirements for the Scholar role have been introduced for doctors commencing RACMA training in 2012. These requirements have been implemented across the three elements of the training program: RACMA-delivered content, the masters programs and workplace training. RACMA webinars and workshops include sessions on research methods and evidence-based practice, masters programs undertaken by candidates must include research subjects and candidates must now participate in a health service evaluation research project during their training. They must make an oral presentation of their findings (or a progress report) at a pre-fellowship course and must submit a written report to the College for assessment. A Censor for Research has been appointed.

The College does not have a research grant program nor a foundation aimed at attracting donations to support research at this time. There is no College-based research or trials group.

Appropriate candidates are permitted to enter research training during fellowship training and will receive credit towards the completion of the Scholar role learning outcomes. Research activity also will be considered towards recognition of prior learning.

### *3.6.1 2012 Team findings*

During the visit, the Team gained the impression that the health services evaluation research project was not widely understood. Few if any candidates had commenced the process and the staff admitted that the processes were being "bedded down". Some stakeholders reported limited opportunities for participation in research with heavy workloads and few appropriate supervisors being the key reasons. The AMC will require further updates on the Scholar role assessment.

The 2012 Team finds that recommendation 18 from 2008 has been met.

## 3.7 Flexibility in training in 2008

The College fellowship training program is an advanced training program completed in a minimum standard period of three years full-time. It is possible to undertake the training program in six years part-time. Extensions of time are approved by Council on recommendation of the Censor-in-Chief. Training can be undertaken at a single health service (as many candidates occupy substantive positions), although candidates are strongly advised to diversify their training. Candidates have an on-site supervisor and a College preceptor for the duration of their training. When a candidate relocates their employment position during their fellowship training program, a new supervisor is approved. A new preceptor is allocated only if the candidate moves between states, the preceptor moves between states, or the candidate requests a new preceptor.

The College regulations include provision for part-time and interrupted training, and candidates generally regarded the College as supportive of flexible training. The College requires that the training period does not exceed six years, which allows for interrupted and part-time training periods. There are opportunities for part-time work in many areas of medical administration, and the College is cognisant of the need for the candidate and preceptor to work together to ensure the core competencies have been achieved. Candidates need to discuss this with their preceptor and supervisor to determine whether part-time training is possible in their workplace. Candidates interviewed indicated that the support from the College to allow flexible training was a key strength and attraction of the training program.

The majority of College candidates enter training with recognition of prior learning. Senior fellows of other specialist medical colleges who wished to obtain a FRACMA have been able to enter the accelerated pathway to fellowship with recognition of prior learning (RPL).

The College has recently reviewed its policies and the concept of an accelerated pathway will now be replaced by a redefined policy on the Recognition of Prior Learning which was accepted by Council in February 2008. The policy defines RPL as the acknowledgement of skills and knowledge obtained through learning achieved outside the College education and training program.

The Censor-in-Chief may recognise knowledge and extensive experience at a senior management level by granting exemptions for periods of supervised medical administration experience of up to two years and for relevant academic studies already undertaken.

Exemptions are determined on an individual basis. To establish RPL, the Censor-in-Chief evaluates documents submitted by the candidate at the time of application to the training

program. These documents may include: university transcripts, position descriptions for work experience, statements of length of service in these positions, line positions and levels of authority in organisations, time in each position spent on administrative activities, reporting lines and supervisors, evidence of achievements in the workplace and health system, reports of interviews from Chairs of Boards of Studies or coordinators of government funded training schemes, interviews with the prospective candidate and referee reports.

The Censor-in-Chief advises the candidate, the Chair of the Board of Studies and the preceptor at the time that Council accepts the candidate into the fellowship training program.

Since 2002, 60 per cent of new applicants for candidacy have been granted RPL, with a duration that varies between six months and two years. The College application process was reviewed in 2007/2008 and a separate and additional application form for advanced standing, which includes RPL, is being introduced.

### *3.7.1 2008 Team findings*

Candidates interviewed indicated that the perceived support from the College to allow flexible training was a key strength and attraction of the training program.

The Team commends the College for its flexibility and support for individual circumstance.

The College provides material to candidates about the components of training in a range of forms including the College handbook, the candidate Assessment Guide, and information and links in the *Candidates Corner* of the College website.

There are multiple pathways to fellowship, with the majority of candidates gaining RPL.

Although the process of the awarding of RPL has been perceived as systematic and clear by the majority of applicants, there appear to be differences among regions, and comments from candidates suggest that there is a need for added clarity and consistency of the process.

The Team commended the College for embarking on the task to improve transparency and standardisation of the decision-making process leading to the award of RPL, by way of plans to create a blueprint that documents the steps in the decision forming process.

2008 Commendation

H The College's review of policy and procedure for recognition of prior learning.

*2008 Recommendation*

17 Continue its commitment to providing a blueprint that details the decision-making process leading to the award of RPL, which would benefit future Censors-in-Chief, as well as clarify the process for candidates applying for credit for prior learning.

## 3.8 Flexibility in training in 2012

In 2008, the College was beginning work to improve transparency and standardisation of the decision-making process leading to the award of recognition of prior learning, by way of a blueprint which documents the steps in the decision making process.

In 2011, the Board approved a revised policy and procedure for managing applications for advanced standing. To assess prior learning, competencies are assessed against the learning outcomes articulated in the College curriculum, and those already achieved are recognised. These competencies have been gained in other training programs, here and overseas, previous university study and through workplace experience.

As the accelerated pathway has developed for very experienced medical managers, the cap of 24 months on RPL for the candidates in the standard pathway has reduced to 18 months. Accelerated pathway applicants may be granted 24 to 36 months advanced standing.

Candidates may pursue studies of choice in terms of their workplace training experience and masters degree subjects, and topics of choice for their reflective writing and health services evaluation research.

### *3.8.1 2012 Team findings*

The 2012 Team finds that the standards related to flexible training have been met and has no new recommendations.

RACMA training remains flexible with respect to part-time and interrupted training, and the location and nature of training posts.

The College has strengthened its processes for assessing applications for recognition of prior learning and advanced standing. Despite these developments, some confusion remains for candidates about these processes, and there were some examples of candidates having very different experience with the application of the policy.

## 3.9 The continuum of learning in 2012

RACMA contributes to the articulation between the specialist training program and prevocational and undergraduate stages of the medical training continuum through its Young Doctors' Program.

The RACMA Young Doctors' Program is designed to introduce senior medical students and recent graduates to the College and the world of professional medical leadership. The Team learned that the College has launched the program, giving participants access to RACMA resources and events, and networking opportunities. A survey of RACMA's Young Doctor program participants revealed a preference for regionally-based introductory workshops, and these will commence in 2012.

### *3.9.1 2012 Team findings*

The Team commends the new doctor initiative, as medical administration traditionally has been a specialty practiced by older doctors who have not participated in a structured 'registrar-style' training program.

2012 Commendations

C The College Medical Leadership and Management Curriculum.

D The initiation of the RACMA Young Doctors' Program.

*2012 Conditions to satisfy accreditation standards*

1 Fully implement the process for teaching and assessing the defined competency of Scholar. (Standard 3.3)

*2012 Recommendations for improvement*

BB Progress in the implementation of the health services evaluation research requirements of the program. (Standard 3.3)

CC Continue to review and strengthen processes for assessing applications for recognition of prior learning and advanced standing to ensure consistency in decision-making. (Standard 3.4)

# 4 Teaching and learning methods

The accreditation standards are as follows:

- The training is practice-based involving the trainees' personal participation in relevant aspects of the health services and, for clinical specialties, direct patient care.
- The training program includes appropriately integrated practical and theoretical instruction.
- The training process ensures an increasing degree of independent responsibility as skills, knowledge and experience grow.

## 4.1 Teaching and learning methods in 2008

The principal structured educational activities provided by RACMA are the workshops. Candidates complete:

- A two-day induction workshop early in year one introduces them to the College program at the beginning of the candidacy and management training period. It covers among other issues: preceptors, competencies, communication and general budget and management roles related to employment.
- A four-day pre-fellowship workshop in the final year provides preparation for the oral examination. Amongst other issues it covers: College examination, presentation skills, case study presentations, health and law, and issues relating to oral examination. This workshop is normally held in March or April each year and includes presentation of the candidate's case study.

The College publishes the requirements to be met by applicants for candidacy on its website and in the College Handbook.

In 2007, the College wrote to all candidates' supervisors advising them about changes to the process for the recognition of training plans, and seeking their participation in an audit of the candidate workplace and training experiences. Responses to this audit are still being received.

The College has begun to implement plans to strengthen the liaison of preceptors with supervisors and candidates in relation to the development and monitoring of candidates' training plans. A supervisors induction kit is being prepared.

There is no limit to the length of time that a candidate may spend in one position; however a candidate who is not considered to have gained an acceptable range of experiences in one position will be advised to attain an alternative position. This may be facilitated by the College, for example, candidates working in the Defence Forces or undergoing a rotation in a public health service as a medical administration trainee.

The College does recognise that many candidates are relatively senior and may have had prior management roles before commencing candidacy; hence undertaking training in more than one site is less important.

There is no requirement for institutions to provide formal education to candidates. However, many do through existing in-service training, and also support trainee attendance at external

training sessions. The survey of preceptors conducted by the AMC revealed that most believe that the College's process encourages hospitals to provide appropriate educational support and resources for learning.

Candidates complete a report in conjunction with their workplace supervisor and preceptor regarding their activities and achievements during the preceding 12 months. Both experienced and new fellows are involved in the feedback process. The initial review of the candidate's training plan is undertaken by the Censor-in-Chief and may also involve the Chair of the relevant Board of Studies, where recognition of prior learning may be sought.

### *4.1.1 2008 Team findings*

Training is on the whole self-directed, with candidates expected to seek out their own opportunities for learning.

The new competencies framework, which is influenced by the CanMEDS framework, is regarded by candidates, supervisors and preceptors as providing an improved structure and making it easier to identify gaps in training. Some candidates were concerned that they would not be able to reach these competencies in their work experience due to variability of posts and supervisors. Attaining the required experience seemed somewhat ad hoc, relying on preceptors or candidates being able to arrange posts/visits/workshops. This could be a particular issue in candidates in 'non-training' posts.

Since February 2008, all new candidates are required to undertake a 'table top' audit in consultation with supervisors, to assess gaps in their training post and to ensure that the gaps are redressed through opportunities provided in the candidate's training plan. The College indicated that the early analysis of data from these 'table top' audits had identified some common gaps. As more of this feedback is received, it is intended that the Censor-in-Chief will evaluate the training program with a view to addressing common gaps.

In New Zealand, and each Australian state and territory, the College Board of Studies manages the local delivery of training. The size of the fellowship, and the number of candidates varies from region to region, as does the support and educational activities available for candidates.

During the Team's site visits, differences were apparent in support offered to candidates in different states, territories and New Zealand, ranging from a full workshop program and regular weekly or monthly meetings, to minimal participation in formal teaching. Differences were also evident between rural and city positions, with rural candidates often more isolated and unable to attend meetings. Certain regions have more optional formal training opportunities such as lectures, workshops, symposia and other meetings which are potentially available to candidates in other regions. Queensland, in particular, is to be commended for such extra provision.

A number of trainees hold rural hospital positions, and this was seen as an increasing opportunity for posts. The training program in rural areas varied significantly and was reliant on the skills, interest and support of the preceptor, supervisor or health unit. During site visits some rural candidates indicated they were disadvantaged in terms of meetings with their preceptor and ability to attend group training sessions. A coordinated approach to supporting candidates in rural areas can assist in overcoming some of these inequalities. Distance can be a factor and improving use of technology assists greatly.

The workshop was valued highly by candidates, not only for the educational opportunities but also for the interaction with other candidates and College officers. The College is congratulated on the development of these courses, in which the College clearly invests considerable thought and preparation.

Candidates were keen to have a more formal teaching framework, and made various suggestions about workshop frequency and timing to improve accessibility.

The College began a review of the workshop content when it redefined the required competencies. At the time of the Team's assessment, documentation of the formal mapping of workshop content against the competencies had not been completed. The College indicated that the content of the workshops is mapped to emerging trends in medical management and the workshops are used to identify issues not addressed in the masters degree programs which are essential for medical administration.

The candidates' academic studies are provided through the university masters degree program, which the College describes as providing the 'theoretical component underpinning the construction of knowledge about the medical management process.'

The College reviewed the masters programs chosen by candidates in 2006. The review found considerable diversity in the candidates' choices, and the College decided that, in future, candidates should assume responsibility to select the appropriate higher degree program to meet their own and the College's requirements for content and experience. Standardisation is achieved by a checklist of the modules that must be completed to comply with the requirements of the curriculum for fellowship. When the candidate is accepted, the College reviews the content of their intended master degree program and provides advice on any perceived gaps and options for addressing them.

Senior fellows are involved formally and informally in the curriculum design and delivery of certain modules at some institutions. The College does not have an involvement in the maintenance or assessment of standards of any particular course. The College indicated that it would like to strengthen its involvement with the providers of what are regarded as the key masters degree programs at the University of New South Wales and Monash University, and it had commenced these discussions. If the College is to continue to rely on external providers for the major academic component of its fellowship requirements, then it will be necessary for it to strengthen its capacity to influence the content and quality of this training.

On the whole, the competency framework is broad enough to encompass the New Zealand health system, but candidates and preceptors in New Zealand identified curriculum gaps in cultural competence/Maori Health, and the funder/provider split in medical management (doctors having responsibility for both the budget and for the delivery of care to patients). Candidates have been advised to attend a workshop on cultural competence delivered by the Australasian Faculty of Public Health.

The Team understood that the competencies covered normal work practices within the specialty. Nevertheless, fellows indicated several areas that formed part of the assessment regime but were not part of the competency framework. In developing a curriculum, the College is asked to consider formal tuition and assessment in areas that may not be fully covered in the competencies, such as handling health services in times of disaster or distress, or under public or political attack, and the training of a medical administrator as an agent for

transformation and change. The College is encouraged to develop closer alignment between its new curriculum, the competency framework used, and the skills recognised widely as being those the professional is uniquely qualified to provide.

2008 Commendations

E The articulation of self-directed and adult learning principles.

F The well-developed educational programs to support candidates in some regions.

G The use of masters degree programs which reduce costs, enhances educational rigour (provided courses are assessed and only good quality courses are accepted) and increases the diversity of input into the training of candidates. This is a pragmatic approach for a small college and, as the College develops, this will change and the College will need to ensure ongoing quality assurance processes for all components of the candidates' training program including the masters degree. The AMC will want to see progress in this direction in subsequent reviews.

*2008 Recommendations*

11 Review the educational program, in consultation with candidates, possibly increasing the use of videoconferencing, online educational packages, to ensure equitable access to educational opportunities for all candidates.

12 Use opportunities locally for the College boards of studies to encourage greater alignment of university masters degree courses to the needs of candidates, and to contribute to the development of relevant units of study within these courses.

### 4.2 Teaching and learning methods in 2012

As outlined in section 3, the training program is practice-based involving the trainees' participation in a minimum of three years' full-time or equivalent, supervised medical management experience in a recognised workplace.

Since 2008, the College has expanded the educational resources available to candidates nationally, especially the online resources, to supplement the regional workshop programs and weekly or monthly meetings.

The new educational activities include:

- A series of monthly interactive webinars on management and leadership topics is delivered by College faculty and open to all candidates.
- The Author in the Room series is presented by experts who have written articles for The Quarterly, RACMA's publication. RACMA members can listen to a presentation by the author and then engage in an online discussion on the topic.
- From 2012, all candidates are able to access on line learning modules covering topics such as Indigenous Health, Ethics and Research Methodologies.
- There are also new peer review groups, and peer review and self-audit tools for medical managers that are available to members of RACMA and fellows of other specialty medical colleges.

- The College is currently piloting the simulated learning management exercise, MiniMex, to test interpersonal and communication skills. The purpose of the MiniMex is to provide candidates with feedback on their practical management skills in a series of simulated mini management exercises. The pilot comprised five active stations testing a range of management activities that a medical administrator would be expected to undertake during the course of their work e.g., counselling a junior medical officer, preparing a briefing document, preparing a presentation, and counselling an distressed patient. The pilot was run with15 volunteer candidates and censors acting as examiners.

The College has also introduced a requirement for an annual training plan, developed by the candidate in consultation with their preceptor and supervisor. The training plan should include educational activities organised by RACMA and others, and workplace-based activities to develop the skills and knowledge required for successful completion of the fellowship training program. Candidates are advised to refer to the RACMA national training calendar and the table of learning and assessment activities in the curriculum when developing their training plan.

The College has reviewed the masters degrees programs undertaken by candidates against the College curriculum, and has added additional subject requirements in research methods and leadership which will be phased in from 2012.

### *4.2.1 2012 Team findings*

The development of the RACMA Medical Leadership and Management Curriculum has been central to the expansion of the College's educational resources. The curriculum details a range of learning activities for candidates. Its development has also allowed the College to map other training program requirements against the core curriculum content requirements. This development has supported work towards the standardisation of teaching and learning experiences for candidates.

As noted elsewhere, the majority of candidates enter the College fellowship training program with advanced standing and recognition of prior learning. About 25 per cent of the candidate group is international medical graduates. Candidates' training pathways are therefore very variable. The introduction of the annual training plan and more guidance to supervisors, preceptors and candidates about College expectations and requirements, allows training to be tailored more appropriately to the needs of individual candidates.

The MiniMex pilot is an exciting development. The writing of management scenarios has engaged a number of fellows in contributing to the College's educational activities. The feedback from the candidates who have participated in the pilot has been very favourable. They have particularly welcomed the opportunities for immediate feedback on their performance. The evaluation of the pilot has encouraged the Board of Censors and the Training Committee to review how MiniMex could be implemented in the curriculum as a training, feedback and possible assessment tool. It has also identified opportunity for improvement, including the need for consistent role play and the need to engage actors/drama students for this exercise. The Team understands the College will continue to develop the MiniMex over a three year period. It looks forward to reports on these developments. This is an innovative approach that could be considered for use with associate fellows and fellows.

The further development of the workshop program and the introduction of webinars for candidates and fellows are commended. The Team noted the positive feedback received from

all interviewed on these sessions. Not only have the available educational sessions increased, but the College has also taken the opportunity to address many more topics. The focus on cultural competence and Indigenous health was seen as very positive.

The Team noted the response to the accreditation from the Royal Australian College of General Practitioners which pointed to joint interests in cultural awareness training, research methods and consumer engagement and suggested future involvement by other specialist colleges in these programs would be welcomed.

While these developments are exciting, the magnitude of the change being introduced by the College is causing anxiety for some candidates, who are unsure about how these new developments apply to their specific training circumstances. The College needs to continue to review and strengthen its processes for communicating with candidates.

In 2008, the AMC recommended that the College pay attention to the ongoing quality assurance processes for all components of the candidates' training program. The Team explored the outcomes of the College's national review of the masters degree program, and its consultation with candidates and higher education providers about its curriculum requirements. The College monitors the masters degrees and acknowledges that it is difficult to keep up with the range and variety.

Team members received feedback from a variety of key stakeholders in both New Zealand and Australia concerning the masters degree programs and the level of engagement of providers in the College's curriculum changes. The College appears to have communicated well about its requirements for fellowship, especially the new research methods requirements.

Feedback from candidates interviewed by the Team suggests that completing the academic requirements is not an issue for them, and they agreed this learning is a valuable adjunct to other learning during the Program.

2012 Commendations

E The focus on, and achievements in, the development of online learning resources.

F The introduction of the webinars for education support for both candidates and fellows as part of their continuing professional development, as well as the enhanced support for supervisors and preceptors.

G The pilot of the MiniMex Simulated Management Learning initiative.

*2012 Recommendations for improvement*

DD Continue to monitor the educational relevance of the masters degree courses, as the curriculum changes, particularly with respect to the College's new research and leadership requirements. (Standard 4.1.2)

# 5 Assessment of learning

The accreditation standards for assessment are as follows:

- The assessment program, which includes both summative and formative assessments, reflects comprehensively the educational objectives of the training program.
- The education provider uses a range of assessment formats that are appropriately aligned to the components of the training program.
- The education provider has policies relating to disadvantage and special consideration in assessment, including making reasonable adjustments for trainees with a disability.
- The education provider has processes for early identification of trainees who are under performing and for determining programs of remedial work for them.
- The education provider facilitates regular feedback to trainees on performance to guide learning.
- The education provider provides feedback to supervisors of training on trainee performance, where appropriate.
- The education provider considers the reliability and validity of assessment methods, the educational impact of the assessment on trainee learning, and the feasibility of the assessment items. It introduces new assessment methods where required.

The accreditation standard on the assessment of overseas-trained specialists is as follows:

- The processes for assessing specialists trained overseas are in accordance with the principles outlined by the AMC and the Committee of Presidents of Medical Colleges Joint Standing Committee on Overseas Trained Specialists (for Australia) or by the Medical Council of New Zealand (for New Zealand).

## 5.1 Overall assessment and examination policies in 2008

The College's examination and assessment requirements were detailed in the accreditation submission and are available to candidates in documentary form and on the website. Further information is given to candidates at College workshops.

The assessment processes are divided into formative and summative divisions. The formative assessments are the responsibility of the Board of Training and Continuing Education and then delegated to the College Censors.

### *5.1.1 2008 Team findings*

The College has documented the procedures for the assessment and examination of candidates. The College's policies are available on the website and in the College handbook. Many of these procedures have only recently been introduced and a process of evaluation is being undertaken. During the accreditation process, and from the feedback obtained, the Team felt that there was some confusion on the part of preceptors, censors and candidates over the details. The Team noted that other colleges have produced a guide to education and training for their specialty area and would encourage the College to consider this proposition.

To some extent the curriculum has been mapped and matched to assessment. This is clear in terms of summative assessment where it is clear that the oral examination is designed to

cover all areas of the curriculum. Mapping of competencies of the medical administrator have been charted to the CanMEDS roles, although the College's statement that it does not have a defined curriculum leads the Team to recommend that the College use a new curriculum, once developed, as a basis for developing a blueprint for each summative examination, for clarifying the weightings for each component and the compensation policy, and for making more transparent the question setting and marking processes and criteria.

The requirements for formative assessment include:

- a university masters degree
- management practice portfolio/case studies
- induction and pre-fellowship workshops
- preceptor and supervisor reports.

Although the College describes the above as formative, most appear to constitute major summative components, for example, the case study is a barrier assessment, and the masters degree course is assessed only when completed. The College is advised to consider in more detail the separation of formative and in-training assessment and to consider ways to ensure there is an adequate element of the latter in its programs.

## 5.2 Range of assessment formats in 2008

### Workshops

As noted in section 3 of this report, the induction workshop is a compulsory attendance, two-day event, designed to be undertaken during the first year of candidacy. It has a broad range of topics including introduction to administrative issues as well as preparation for the examination. Performance of individuals at the workshop is not assessed.

The pre-fellowship, four-day compulsory workshop discusses high-level medical administrative issues and has an important component of examination preparation including trial examinations. At this workshop, candidates present and are formally assessed on their case study.

There was very positive feedback from candidates and recently qualified fellows on these workshops. Attendance at workshops is mandatory. As noted in section 3, candidates would welcome more frequent workshops.

### Preceptor and supervisor reports

Candidates are required to submit annual preceptor reports during training, with three satisfactory reports required for candidates to sit the oral examination and progress to the award of fellowship. Preceptors are expected to meet supervisors at the beginning of each period of employment and on an annual basis, to obtain information on the candidate's work experience and progress toward attainment of competency.

The *Report on Candidate by Preceptor and Supervisor* is structured to assess candidates' performance against the CanMEDS competency framework and to identify requirements arising from the review. Candidates are scored on a ten-point scale: with scores of one to three indicating little competence, four to seven indicating competent, and eight to ten

indicating high competence. The candidate, the preceptor and the workplace supervisor are all required to sign the form.

The College indicates that the Chair of the relevant Board of Studies should also review the Preceptor report with the individual candidate.

Preceptors are also expected to meet their candidates every three months to discuss the candidates' experiences and where they tie into RACMA requirements.

The Team considered the methodology of utilising a structure of preceptors and supervisors to be an excellent initiative. The system is designed to foster sound and continuous assessment methods.

Concerns were raised by preceptors, supervisors and candidates about the validity, reliability and reproducibility of the reports. The College does have processes for the review of these reports, but it was not clear how the reports were scored to confirm that on completion of the required reports the candidate was eligible to sit the final examination.

The Team did have some concerns that the College had not recognised or responded to feedback from the preceptors, supervisors or candidates on the issue of these reports. The Team considered this was an oversight that would benefit from more attention and possible review. In particular, it identified the following areas to be considered in more depth:

1 The candidate survey and the Team's discussions with candidates during the accreditation indicated that candidates would like clearer guidelines on the requirements assessed by the preceptor and supervisor report. Sixty per cent of the candidates who responded to the survey returned either a strongly disagree, disagree or neutral response to the statement 'the report provides useful feedback on performance'. Candidates also were unclear on the implications of an unsatisfactory report.

2 The College could consider allowing candidates to enter a separate rating which would serve to emphasise the importance of self-assessment, and would indicate areas worthy of preceptor or censor review where the candidate and supervisor scores were significantly at variance.

3 The usefulness of the form could be enhanced by clearer guidance on the intent of the section 'requirements arising'.

4 The guidance says, 'The candidate's performance is rated against broad CanMEDS competencies'. Given the feedback from candidates, the Team feels this may be insufficient, and advises a review of the guidance for the completion and use of this form. Although the College provides standardised forms for these assessments, the headings used are broad, and they appear not clearly linked to a curriculum. In these circumstances, it is difficult to determine what standards the supervisors are applying when they are assessing the trainees' performances. This can raise questions about the equitable nature and validity of these assessments.

5 Concerns were also raised about the College's processes for reviewing the preceptor's reports, and whether they were being analysed meaningfully. The College is advised to consider this criticism and act accordingly to review and then explain the processes in more detail to candidates and preceptors and supervisors alike.

The College provides compulsory training for preceptors and is proceeding to design a contract for preceptors to further confirm their responsibilities in terms of reporting.

Preceptors confirm that reporting regulations and mechanisms have now become stringent, and loopholes allowing candidates the ability to sit the examination without completing reports have been closed.

There were questions about the consistency of assessment structures generally. A suggestion would be that a better 'template' could be utilised to assist in this. In addition, there is a problem for a College with small numbers of trainees in maintaining confidentiality and anonymity in reporting.

**Management practice folio and case study**

Until 2008, candidates were required to produce a written report of a management experience to demonstrate:

- ability to identify an important health service management issue
- ability to assess and research the issue
- capacity to relate this appropriately to theory, knowledge and best practice
- ability to take management action
- ability to document the case study in a clear and professional manner and, if selected, to
- present the case study to a peer group in a clear and professional manner.

The College's assessment guidance to candidates indicates that written skills and presentation skills are important to work effectively as a medical manager. Both these skills are assessed as part of the case study. The case study focuses on the core competencies required of candidates. In the case study, the candidate is expected to describe a management activity and analyse it by review of the relevant management literature and practice. Any lessons for health service management practice should be identified.

The written report has a word limit of 3,500 words, which the College indicates is a ceiling, not a target. The second part of the case study is a mandatory twenty minute oral presentation. Presentations are delivered at the four-day pre-fellowship workshop. Presentations are followed by ten minutes of questions from other candidates.

The management practice folio was introduced for all candidates at the College's two-day workshop in 2008. Candidates who are sitting the oral in 2008 or who have already completed a case study, but are not sitting the oral until 2009, are exempt. There is a transition period for those sitting in 2009 and an abbreviated management practice folio. Continuing candidates in 2008 have the option to complete a case study instead of the management practice folio.

The folio was introduced to address the concern of the censors in regard to the standard of writing displayed by candidates in their case study.

The management practice folio will comprise reflective reports and written case studies by the candidate, derived from their work experiences in the three years of candidacy. It will emphasise documentation of experience and reflection in an experiential model of learning.

The candidate will choose the work experiences and accomplishments through self-assessment against College competencies and in discussion with supervisors and preceptors.

The candidate's specific competency needs/gaps are used to guide planning for the required medical administration experiences. These workplace experiences may be varied and a selection can be prepared for the management practice folio and assessment by the College. These may include:

- published journal articles based on work experiences
- reflective evaluations of workplace experience
- letters to the editor of respected publications and related to relevant issues in the candidate's workplace or health services system
- business case for the introduction of technology or new service delivery in the workplace
- a medico-legal case analysis undertaken in the workplace
- a case study on a health service management issue encountered or project undertaken
- a business plan developed in the workplace
- an audit of governance or quality improvement activities and health care outcomes from the workplace
- others as appropriate.

The folio of works selected by the candidate must be approved by, and completed to the satisfaction of, the College. Preceptors and supervisors should assist and support candidates to gain the relevant experience to undertake this work. Written folio pieces are to be evaluated annually with Censor involvement. This will assist in identifying any candidate who may be experiencing difficulty. In the third year of candidacy, candidates will give an oral presentation at the four-day workshop based on a reflective management submission in the management practice folio.

The Team noted that there was overall agreement that the case study was not achieving all of the desired aims, especially those of clear written and verbal expression. Concerns were raised that every candidate submitting a case study in 2007 received a failure mark at the first time of presentation. The Team believes this is reflected in a level of dissatisfaction with the case study expressed in the AMC survey of candidates. There is a widespread belief that communication between the Censor-in-Chief's instructions at the workshop and the censors who actually marked the case studies could have been better. Assessment feedback regarding the case study was revealed to be an area of candidate dissatisfaction. Candidates reported that they were often left uninformed about why their work was found to be unsatisfactory.

The management practice folio should broaden the scope and eventually incorporate and replace the case study. At present the College appears to have worked out neither the methodology for assessment of the folio, nor how consistency will be achieved. In addition, it was not clear if the aims of the management practice folio were well understood by candidates and preceptors. Some believed that the folio should reflect the candidates' everyday work, and other candidates believed they should be providing specifically developed theoretical responses. If this is to be in place for 2008, then the College will need to take rapid action to clarify and communicate the aims and the assessment strategy.

The Team encourages the College to expand the quantity of information about the management practice folio, possibly by the use of a library of examples and other methods.

**Fellowship Examination**

The fellowship examination is an oral examination held annually. It involves assessment in all areas of the College curriculum. Each candidate is examined on the basis of an oral response to four unseen case studies, which are selected from four sets of two case studies, i.e. the candidate has a one in two choice for each of the four viva examinations.

Candidates are expected to demonstrate knowledge in the following areas:

- general management principles
- current health policy initiatives
- legal issues in health services management
- financial management in health services
- planning of health services, including epidemiological studies
- recent advances in health care
- analytical and presentation skills
- personal attributes of leadership.

Candidates are examined by a pair of examiners. Each examiners marks independently, and their mark is blinded until a later meeting. Post-hoc alteration of the closed marking system may take place. Candidates may pass, fail or be awarded a supplementary examination.

The Censor-in-Chief informs each candidate of the results of his/her oral examination. If required, a supplementary examination takes place immediately after the original examination and consists of another case scenario which is assessed by a fresh pair of examiners. The Censor-in-Chief also reviews any candidate's appeal for approval to sit the oral examination and the results of that examination.

The oral examination format has developed over many years. The College is considering an alteration of the process to increase the number of stations and introduce short cases.

It is clear that the primary aim is to confirm competency, but excellence is also rewarded by a prize for the outstanding candidate in each examination.

2008 Commendation

J The annual assessment through preceptor and supervisor report.

*2008 Recommendations*

19 *Review the process for the* Report on Candidate by Preceptor and Supervisor.

### 5.3 The assessment program and range of assessment formats in 2012

Since 2008, the College has made a number of changes to its assessment methods. It has detailed these in progress reports to the AMC. The 2012 accreditation submission describes further changes to be introduced from 2012. The changes made and planned since the 2008 assessment are as follows:

- The preceptor report has been reviewed and redeveloped into the In-Training Assessment (ITA) Report mapped to the curriculum and progression model. From 2012, candidates, their preceptor and supervisor must complete these forms every six months rather than every twelve months.
- The design of the management practice folio has changed with further changes occurring from 2012.
- Changes to the case study requirement are planned.
- The MiniMex, described in section 4 of the report, has been piloted as a formative assessment activity, and will be evaluated over the next three years with a view to contributing to summative assessment.
- New assessment guidelines are being developed for the formative and summative aspects of assessment in the Research Training Program.
- The College piloted, and in October 2012 introduced, compulsory questions in the pre-fellowship oral examination.

Beginning in 2012, candidates undertake an assessment of progress, the ITA report, which reflects the curriculum requirements and progression model every six months. The report maps to the curriculum and the candidate's annual training plan. This will facilitate improved implementation of the workplace training components and monitoring of the candidate's progress by linking evaluation and feedback with training priorities. The ITA is reviewed by the Jurisdictional Coordinator of Training and the candidate's progress is discussed with the Censor-in-Chief. The College will enter the data from the ITAs in its education database to enable jurisdictional and national level reports to be generated. The College is considering seeking external expertise to support evaluating the effectiveness of the workplace training programs in achieving curriculum goals and objectives.

The management practice folio is now aligned to progression through the training program and certain components have to be reviewed as satisfactory each year. Over time, the number of compulsory tasks in the folio has increased and the list of other tasks has decreased. For candidates enrolling from 2012, the folio will become an evidence folio and include a prescribed range of candidate work. It has changed from "a collection of written practice works derived from the workplace" to a "collection of works with a mix of written, reflective and experiential reports and/or writings about management practice learning". The College identifies this as a formative assessment activity, but mandates completion of the folio.

With the changes to the case study, the requirement for reflective writing will move to the curriculum leadership theme as a formative learning activity of the management practice folio. Journal writing will replace the reflective case study for all candidates commencing in 2012. Standard pathway candidates presenting for the exams in 2012 and 2013 will write the reflective case study in its current form but in their oral assessment may present either their reflective written case or an alternative management case which has been signed off by their preceptor and Jurisdictional Training Coordinator. Accelerated pathway candidates

undertaking exams in 2012 and 2013 will complete the reflective case study in its current form. From 2014, the College plans to change these requirements again.

The final pre-fellowship oral examination continues to contain four questions. From October 2012 the exam will have two compulsory questions; a change piloted in the 2011 national trial examination. A supplementary scenario may be offered to candidates at the examination in the event of borderline evaluation.

### *5.3.1 2012 Team findings*

Since 2008, there has been significant development of assessment strategies, and alignment of assessment to the curriculum. The Team commends the College's work in this area. The AMC will require updates on these developments in progress reports.

A range of documents is provided to candidates to explain the requirements and process for assessment of key components in the fellowship training program.

Candidate concerns remain regarding the lack of clarity concerning the aims of and requirements for completion of the management practice folio. The College's own survey report for 2011 recommends that the requirements be reviewed, and cites dissatisfaction with the number of tasks, the clarity of requirements, deadlines, feedback and point system. There have also been problems with the electronic management tool for the folio which have created frustration for candidates. The Team supports the survey report's recommendation.

Because of the significant changes in this area, it can be difficult for candidates to understand the effect on their training and the summative assessment requirements they will face. The College is implementing some of the changes over time, for example the changes to the case study requirement, which compounds the amount of change occurring. For some recent changes, candidates felt the communication was unclear and with too limited notice. The College has investigated these complaints and changed its communication procedures as a result. Trainees are understandably anxious about changes to assessment requirements and it is important that communication to candidates about these developments is clear and timely.

The College has taken steps to clarify the case study requirements and to improve its guidance to candidates, preceptors and case study examiners since 2008. These guidelines will need to change again as the case study changes from a reflective writing exercise to a research based case study. The College has appointed a Censor for Research and Case Studies which should help support the transition to this new requirement. It is too early to judge the success of the change in the case study.

2012 Commendations

H The increasing range of assessment methods, which are appropriately aligned to the components of the fellowship training program.

*2012 Conditions to satisfy accreditation standards*

2 Review the requirements for the management practice folio to ensure the aims and requirements are clear for each cohort of trainees, and provide appropriate tools to support candidates to satisfy the requirements. (Standard 5.1)

| | |
|---|---|
| 3 | Report on the implementation of the research based case study. (Standard 5.2) |
| *2012 Recommendations for improvement* | |
| EE | Review the effectiveness of College procedures for communication with candidates over changes to assessment requirements and timing to ensure it is clear and timely. (Standard 5.1) |

### 5.4 Procedures for performance feedback and review in 2008

The College accreditation submission outlines the following points at which candidates receive performance feedback:

- Preceptor reports and workplace assessments are discussed with the candidate and signed.
- Candidates are given pass or fail feedback on their case study, with more detail available in discussion between a candidate and the candidate's preceptor.
- For the oral examination, the Censor-in-Chief advises candidates of a pass or fail at the end of the examination, with confirmation by letter and oral feedback. If a candidate fails the oral exam but passes the written components of their traineeship, the Censor-in-Chief meets the candidate to provide guidance and direction to assist preparation for re-assessment. A candidate's preceptor and Chair of Board of Studies may also receive feedback directly from the Censor-in-Chief to enable them to support the candidate.

A candidate may be required to rework their written case study following assessment by the Censor for Case Studies. Candidates who fail the case study presentation may proceed to the oral examination later that year, but must successfully present the case study at the four-day pre-fellowship workshop the following year before they can be elected to fellowship.

Candidates who do not pass an oral examination may complete a supplementary examination on the same day, as previously described. Candidates who fail the final oral examination may apply to re-sit the examination the following year. There are no limits on the number of times that a candidate may sit the oral examination, although in the past no candidate has presented more than twice, and candidates who have failed twice are encouraged to reconsider membership. A candidate who fails the oral examination is not elected to fellowship.

The first year of candidacy is a probationary year in which the candidate's suitability for the specialty of medical administration is assessed. Suitability is evaluated through regular meetings between the candidate, their supervisor and preceptor in the first year, as well as an evaluation by the Chair of the Board of Studies, which includes:

- a meeting between the candidate and the Chair of the Board of Studies
- a review of the preceptor/supervisor reports for the first year of candidacy
- a review of the candidate's academic transcript for the year
- possible discussions between the Chair of the Board of Studies and the candidate's supervisor and preceptor where continuing candidacy is at risk.

The Chairs of the Boards of Studies then discuss with the Censor-in-Chief any candidate whose performance is considered unsatisfactory, and then discuss with the candidate whether they should continue in the training program. This may result in either the candidate undergoing a further trial in a different workplace or the candidate not being recommended for College support in a new workplace.

The College's submission indicates that generally a new workplace is unwilling to take on a candidate under these circumstances and the candidate drops out of the program.

The College constitution clearly defines the reasons a candidate can be dismissed from the program. The College candidate assessment guide adds that candidacy can be ceased by the Censor-in-Chief, on the recommendation of the relevant Chair of Board of Studies; however, the candidate has the right of appeal. The appeal process is under review.

If the candidate seeks remedial training this may be provided by:

- another year of candidacy, which must be assessed as a pass
- repeating the introductory workshop
- additional coaching and trial examination, for up to five attempts
- allocating a new preceptor.

### *5.4.1 2008 Team findings*

There are no formal processes of preceptor education in terms of performance feedback. Examination feedback is given verbally to candidates on the day. In 2007 there was a further feedback session on a later date so that a candidate was able to be more receptive. The processes for feedback appear to not yet be standardised and this should occur for candidates, preceptors and censors.

There is a need for more formal preceptor education on performance feedback. Standardisation of the feedback process would benefit candidates, preceptors and censors.

*2008 Recommendations*

22 Review procedures regarding unsatisfactory performance, performance feedback, remedial work, re-assessment and counselling including:

- providing greater direction on examination performance feedback to ensure a more consistent approach, for example, by providing written guidelines for those involved.
- reviewing and strengthening processes for providing constructive feedback to candidates who are required to re-submit their case studies.

## 5.5 Performance feedback in 2012

The 2008 AMC accreditation report made recommendations in two areas concerning performance feedback to trainees. These related to improved and more consistent

examination performance feedback, and strengthened processes for providing constructive feedback to candidates who are required to re-submit their case studies.

The College's progress reports since 2008 and its accreditation submission outlined a number of changes to processes for providing feedback to trainees.

In 2009, the College introduced a structured procedure for giving feedback to candidates who had failed the case study and the oral examination. It has enhanced these procedures by training and calibration exercises for examiners for the case study and the oral examination.

The faculty education program provides training in giving performance feedback to candidates. In addition, examiner training in giving feedback continues. Examiners provide written and verbal feedback during trial exams, at oral presentations and in the MiniMex.

The national trial examination, which candidates undertake during the pre-fellowship workshop, now mirrors the conduct of the summative pre-fellowship oral examination. Candidates are assessed by censors and receive feedback at the end of each examination.

From 2012 the candidates no longer receive their pre-fellowship oral examination results at the examination. They are available electronically 48 hours after the examination period. Unsuccessful candidates are offered a formal one-on-one feedback session with the censor.

Reflective case study guidelines covering assessment, rewrite and resubmission are available to candidates. Candidates receive written feedback on their reflective case study and how it can be improved if they are required to undertake a rewrite. The Censor in Chief moderates the case study raw scores and speaks to the preceptors of candidates who fail or receive a rewrite so that the preceptor is better able to support the candidate in the re-writing.

### *5.5.1 2012 Team findings*

The College had improved the processes for performance feedback to candidates.

Whilst the College has informal processes for addressing the training needs of candidates who are underperforming the Team considers that these should be formalised. The Team notes that the six monthly ITA report and the moderation process which will follow each reporting period will enable the College to identify those candidates having difficulty much earlier than the previous 12 monthly report and to target appropriate support to them.

As noted above, the last two annual candidate surveys indicated some dissatisfaction with the management practice folio, including the timeliness of feedback to candidates, and the College has addressed this issue.

2012 Commendations

I The opportunity provided for unsuccessful examination candidates to receive one-on-one feedback from the Censor on examination performance.

*2012 Conditions to satisfy accreditation standards*

4 Develop a formal mechanism to enable early identification and remediation of under-performing candidates. (Standard 5.2)

## 5.6 Assessment quality in 2008

The College has not yet progressed to an analysis of its examination methodology. It is stated that small numbers preclude such assessment, but the Team considers that such an analysis should be performed to ensure that there is transparency, consistency and reliability of the examination process.

The Team was also concerned that although College officers had a strong belief in the value and reliability of their examination processes, there appeared little in the way of formal review by a competent educational expert body and the external review was limited in scope. This concern was compounded by considerable criticism from the consumers of the process, the candidates, most especially in the conduct of the supplementary examination.

The structure of the oral examination makes it impossible to quarantine candidates. Despite comments that this was not an issue it may lead to complaints of a failure in process.

*2008 Recommendations*

20 Develop a process to collect data, then analyse and act upon the results obtained, with the aim of an improvement in quality, reliability, consistency, rigour and professionalism in the processes of assessment and examination, performance feedback and counselling.

21 Consider the advice of an appropriately qualified and experienced educational expert to assist in these developments.

## 5.7 Assessment quality in 2012

The Board of Censors oversees the development of assessment programs and advises the Education and Training Committee. Its role includes review of assessment tools in terms of their utility and mapping to the curriculum and the curriculum progression model.

The College has engaged appropriately qualified staff and educationalists to assist in the review and improvement of its assessment methods. It has provided examiner calibration and standard setting exercises for those examiners involved in assessing the 2011/2012 reflective case study and the October 2011 and March 2012 pre-fellowship oral examination. Scores were reviewed to monitor consistency of examiner performance in the oral examinations.

The College provides examiners with a range of resources and guidance with respect to the conduct of the pre-fellowship oral examination.

### *5.7.1 2012 Team findings*

The College submission and progress reports to the AMC have documented developments in setting and reviewing the standard of examinations, guidance to examiners and other assessors, and in examiner calibration.

The Team noted that the 2011 supervisors' survey indicates a desire for training in assessment tasks. The College has developed webinars for fellows on in-training assessment, and a workshop on assessment specifically for the censors. Training of fellows in the

performance of MiniMex is planned. Since not all supervisors are fellows of the College, the College needs to provide access to professional development in assessment to supervisors who are non-fellows.

The changes to assessment methods make ongoing review of validity and reliability especially important. The College needs well documented methods for doing this and regular reporting of these statistics.

Recommendation 21 from 2008 is met. Recommendation 20 is replaced by Recommendation AA in this report.

*2012 Recommendations for improvement*

FF Continue to develop and apply well documented processes for reviewing the quality, reliability, consistency, and rigour of its assessment approach and methods. (Standard 5.3)

GG Provide supervisors who are not College fellows access to professional development in assessment methods and in providing feedback to candidates. (Standard 5.3)

### 5.8 Assessment of international medical graduates in 2008

The College receives very few applications from overseas-trained specialists. Like other specialist medical colleges, it has two processes for the assessment of overseas-trained specialists seeking registration to practise in Australia:

1 The specialist assessment procedure is used to determine the comparability of training and qualifications of overseas-trained specialists with Australian-trained specialists. The procedure is administered by the AMC, but assessment of the applicant's training and experience is undertaken by the relevant specialist medical college.

2 The area of need assessment process is used to assess the doctor's qualifications for a particular position following the declaration of an 'area of need' by a state or territory health department. The procedure is administered by the AMC, and assessment of the applicant's training and experience is undertaken by the relevant specialist medical college. While the documentation requirements and processing arrangements are broadly similar to those for applicants through the standard pathway listed above, some differences arise because of the need for accelerated and parallel processing of area of need applications by the AMC and the assessing college. RACMA has assessed one area of need application.

In New Zealand, practitioners are registered under the provisions of the *Health Practitioners Competence Assurance Act 2003*, and the Medical Council of New Zealand is responsible for deciding on a doctor's suitability for registration within a vocational scope of practice. For those doctors deemed suitable for registration, the Council grants provisional vocational scope of practice to work under supervision and assessment for a period of between twelve months and two years. The Council authorises a change from provisional to vocational scope of practice when the doctor has satisfactorily completed the period of time, satisfied all assessment requirements, and shown competence and suitability for independent, unsupervised practice.

The College's accreditation submission outlines the following process for dealing with applications referred from the AMC:

- Overseas-trained specialists are required to contact the College and seek advice and assistance from the Censor-in-Chief regarding the assessment for admission to fellowship.
- The Chair of the Board of Studies in the relevant Australian state/territory, or New Zealand, or person nominated by the Censor-in-Chief, assesses the applicant's qualifications.
- If the primary assessment is satisfactory, the applicant is called for a structured interview. A panel of three College fellows conducts the interview. The panel considers the applicant's curriculum vitae and responses to health management scenarios of a similar content and complexity to the viva examination for internal candidates. It involves a 20-minute examination comparable to that used in the College fellowship examination.
- Most applicants complete further requirements which include: complete a minimum of 12 months experience in an appropriate position with the support of a College-appointed preceptor, sit the fellowship examination, and attend the College workshops.

Applicants are expected to have completed a relevant masters program overseas and to study additional units, such as a module on the Australian Health Care System, or to complete an Australian masters degree program.

Appeals from applicants are made in the first instance to the AMC and then are processed under a new College appeals process outlined within the policy document *Review of Decisions of Council and its Committees*.

**Stakeholder comments on the College's assessment processes**

The College considers very few applications from overseas-trained specialists who are seeking recognition of their qualifications and experience through the nationally agreed specialist-assessment pathway. This is, in part, because of the lack of comparable training organisations in medical administration internationally. Because the numbers are so small, it has not been a high priority to formalise elements of the process.

The College submission to the AMC made no mention of the use of referees. Although it is recognised that the AMC guidelines also do not mention referees, it is suggested that if used carefully they can be a valuable resource.

In submissions to the review process, where there was comment on the assessment of overseas-trained specialists, it was positive and without reservation.

The Team noted that the College treats applications with due seriousness and rigour.

The very small number of applications from overseas-trained specialists has led to some difficulties in complying with AMC guidelines. The Team recommended that RACMA note the guidelines especially in regard to the possibility of perceived bias, and consider training censors to be involved with assessment of overseas-trained specialists in avoiding such difficulties.

***Candidates whose initial training is not in Australia or New Zealand***

From the responses to the AMC survey of College candidates, the Team noted the high number of candidates who had completed their initial training outside Australia and New Zealand. These candidates, while a heterogeneous group, have additional requirements for support, for example, in report writing and in understanding the workings of the Australian and New Zealand health systems.

In relation to overseas-trained candidates, the College is encouraged to consider their specific training and professional development needs and to identify their success in College programs compared to Australian and New Zealand trained candidates, in particular monitoring systems for 'underperforming' candidates.

2008 Commendations

S The College's openness to advance enquiry from potential overseas candidates and responsiveness in dealing with early enquiries.

T The seriousness, circumspection and seniority accorded the process of assessment.

*2008 Recommendations*

38 Note the AMC guidelines for assessment of overseas-trained specialists in regard to the possibility of perceived bias and consider training Censors to be involved with the assessment of overseas-trained specialists to avoid such difficulties.

39 Develop a statement of principles on the selection of candidate referees, a process of due diligence in review of the reports, and the status and independence of referees used by overseas-trained specialist candidates. Construction of a template for examination of referees is recommended [with provision for review once it has been used in practice].

40 Consider the specific training and professional development needs of overseas-trained internal candidates, to identify their success in College programs compared to Australian and New Zealand trained candidates, in particular the establishment of monitoring systems for 'underperforming' candidates.

## 5.9 College assessment of specialists trained overseas in 2012

The College continues to have small numbers of applications for assessment of specialists trained overseas. It has processed three applications since 2008.

In 2008, the AMC made recommendations concerning better documentation and standardisation of these assessment processes. The College approved a revised policy on assessment of international medical specialists and has developed a series of interview questions, based on the RACMA competencies to assist in the assessment of overseas applicants. In response to the College's 2011 progress report, the AMC had advised the College that this recommendation had been met.

The College continues to have a significant proportion of candidates (25 per cent) who are international medical graduates without a prior specialist qualification in medical

administration. The College acknowledges they may have additional learning requirements, not only to orient them to medical management practice in Australia and New Zealand, but also to complete some of the College's assessment requirements, such as the reflective writing task. The College has been funded under the Australian Government Department of Health and Ageing Specialist Training Program to develop a support program for international medical graduates in its fellowship training program. It has also promoted the scholarly doctor outreach coaching program and the cultural context and communications webinar series to candidates who are international medical graduates.

### *5.9.1 2012 Team findings*

The College considers very small numbers of applications from overseas trained practitioners for assessment of qualifications, skills and experience in the specialty of medical administration. Nevertheless, it has a clear assessment policy and a process for an applicant to progress to fellowship of the College. The assessment takes into consideration previous education, training and work experience.

The key stakeholders' responses to the Team acknowledged the work of the College in accommodating overseas-trained specialist applicants and indicated that the process was well known and understood.

The Team was unable to discuss experiences of the process directly with any applicant during the assessment for logistic reasons. The Team did note the feedback from the representative from the Hong Kong Academy who outlined the support available to overseas-trained specialist applicants through a memorandum of understanding. Applicants for candidacy felt welcomed and supported.

Feedback from other stakeholders on these College processes was limited, but the process was seen as robust and fair, with document review and formal review with the Censor-in-Chief and other independent members of the academic board.

The Team noted in the 2012 submission that the College indicates, "It is too early in this submission to report on the outcomes of the Scholarly Doctor and cultural awareness programs on IMGs". The Team discussed this with the training committee and others and noted the commitment but acknowledged small numbers involved.

The Team also noted that the changes in the In-Training Assessment process and the moderation process which will follow each reporting period will allow early identification of candidates having difficulty.

Recommendations 39 to 41 from 2008 are met.

# 6 Monitoring and evaluation

The accreditation standards are as follows:

- The education provider regularly evaluates and reviews its training programs. Its processes address curriculum content, quality of teaching and supervision, assessment and trainee progress.
- Supervisors and trainers contribute to monitoring and to program development. Their feedback is systematically sought, analysed and used as part of the monitoring process.
- Trainees contribute to monitoring and to program development. Their confidential feedback on the quality of supervision, training and clinical experience is systematically sought, analysed and used in the monitoring process. Trainee feedback is specifically sought on proposed changes to the training program to ensure that existing trainees are not unfairly disadvantaged by such changes.
- The education provider maintains records on the outputs of its training program, is developing methods to measure outcomes of training and is collecting qualitative information on outcomes.
- Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to evaluation processes.

## 6.1 Evaluation and review of the training program in 2008

New fellow surveys are undertaken periodically. Graduating candidates are surveyed each year to evaluate levels of satisfaction with the training program and qualitative comment is also sought.

### *6.1.1 2008 Team findings*

The College's accreditation submission lists a number of methods of evaluating the training program. The Team commended the College for plans for a candidate database and for survey of new fellows. The Team also commends the move to a requirement for participation in CEP, and the increased level of audit of CEP participation.

As the College continues to review its training processes, it needs data to inform change. The College needs prospective and formal evaluation plans which can be reported and used to drive quality improvement. This would include formal review of the outcomes of the examination, and the processes for examination and assessment. The College does not yet have a systematic method to gain candidate feedback on the quality of their training positions, including the adequacy of their supervision. The Team encouraged the College to develop such a method.

The Team recommends the College consider seeking feedback on the training process from unsuccessful candidates. Feedback should be formally invited from candidates on their experience of supervision and of all withdrawals from the program. Consideration of an external survey of candidates who have recently withdrawn, and an analysis of compounded statistics over time are strongly encouraged.

The Team recommends that the College develop mechanisms to follow-up on the reasons candidates withdraw (particularly in the case of candidates who had been making satisfactory progress) in order to inform improved recruitment and retention strategies.

Documentation on the following could inform decisions about the training program and examination process:

- the number of times a candidate fails an examination
- formal record of progress throughout the program to enable the College to identify and assist poor performing candidates
- the demographics of candidate performance at examinations, including performance of overseas trained specialists
- the performance of the examination processes and assessors in terms of reliability and ability to discriminate good from poor performance
- reasons why candidates leave the training program, or take excessive time to progress through to the final examination
- follow up of FRACMAs in terms of their future work performance.

The AMC expects specialist colleges to seek feedback on the College's training programs from a number of stakeholders such as hospital administrators, related specialties, and consumers. These processes seem to be underdeveloped for RACMA. The Team encourages the College to establish processes to facilitate this. It would, in addition, provide another avenue to publicise the contribution of medical administrators to health services management.

2008 Commendation

U The College's plans for a trainee database and the new fellows survey.

*2008 Recommendation*

41 Develop monitoring and evaluation procedures on the following:

- feedback on the training process from unsuccessful as well as successful examination candidates
- formal feedback from trainees on their experience of supervision
- feedback to supervisors and preceptors on their performance as supervisors
- collection of data on examination outcomes, including psychometrics of the examination, and examiner performance
- collection of data on candidate progression, time in program, reason for delays, withdrawal
- streamline and regularise feedback processes by the use of templates.

## 6.2 Outputs and outcomes of training in 2008

The College's records of outputs of the training program since 1990 indicate the following:

- Most candidates complete the program within a three to six-year time period.
- Over the past decade there has been an average of 8.9 graduates per year.
- The pass rate is quite variable from year to year, although failure rates are not generally very high.
- Withdrawal rates can be high.

The College collects data about training outcomes by surveying graduating candidates each year. In 2006 and 2007, comprehensive surveys of new fellows were also performed.

The number of candidates entering the program over the last ten years has varied significantly from year to year. Between one and 16 candidates commenced each year, with an average of 7.8 per year.

Over the past decade there has been an average of 8.9 graduates per year. The pass rate for the final oral examination has varied from 33 per cent to 100 per cent between 1991 and 2007. Data are not kept for the number of attempts at the examination, but candidates who are unsuccessful after two attempts are encouraged to consider membership, rather than fellowship, of the College.

Although failure rates are not unacceptably high, and the majority of failures in recent years relate to a lack of preparation on the part of the candidate, the Team and the candidates shared a concern that there is little analysis of the consistency in standards or of variations in pass rates between regions and over time. The College indicates that most of those who failed did not seek advice from either the Chair of the Board of Studies or the preceptor, nor did they join a study group. Most refused offers of assistance prior to the orals or took on these offers too late. The Team looks forward to seeing how the College works to define the curriculum, clarify competencies required and enhance preceptor training impacts on pass rates, and encourages the College to obtain expert external assessment advice in analysis of the patterns of pass and fail in their examinations. These issues are discussed by the Board of Censors as part of the examination process and were fully discussed with the Chairs of the Boards of Studies to identify the contributory factors.

In the past ten years, 1996 to 2005, there have been 196 new candidates enrolled in the RACMA fellowship program, 89 candidates have graduated to fellowship and a larger number, 125, have withdrawn from candidacy before completing fellowship training. This is a high rate for a postgraduate program and the College is strongly advised to review this and seek more detailed feedback of the reasons for this, for consideration by the College Council.

The College reported that candidate resignations were generally for individuals enrolled in earlier periods. Reasons for resignation are varied. Candidates sometimes had resigned and transferred to membership. Where the College was given a reason, 14 stated a career change, four stated that their career choice did not require FRACMA, six indicated that they were retiring and eight were struck off for being unfinancial. For the rest, no clear reason is known.

### 6.3 Monitoring and evaluation in 2012

Since 2008, the College has introduced several measures to improve monitoring and support evaluation in the fellowship training program. Significant developments include the annual survey of candidates, the annual survey of supervisors which began in 2011, and annual

analysis of summative assessment results. Candidate and supervisor surveys are analysed and reported to the candidates and to the Candidate Advisory Committee as appropriate, and to the Education and Training Committee with recommendations for follow up action. The National Office undertakes follow up action after the relevant committee's approval.

The College continues to evaluate individual educational events, such as the workshops and webinars via survey. In the most recent survey, candidate responses relating to the reflective study case experience were positive, reflecting the College's changes to the guidance on this activity. Positive feedback about the workshops has continued.

## 6.4 Outputs of the training program in 2012

The College maintains records on the outputs of its training programs. The College's supplementary information for the AMC Team included information on membership of the College over time, with numbers of candidates, the age profile and retirement intentions of fellows shown by Australian state/territory and for New Zealand. During discussion with the Team, the College Board outlined the ways in which it considered this information and developed strategies to respond. The Accelerated pathway, which provides a pathway for senior and experienced managers to complete training and assessment and move to fellowship, was cited as one response to the need for more senior fellows.

In 2008, the AMC noted the large number of candidates who withdrew from the program before completion. In 2012, the College provided information on the numbers withdrawing from 2009, which show 12 in 2009, five in 2010 and four in 2011. The College's enquiries into the reasons for withdrawal suggest that changes in life circumstances and careers lead to withdrawal from the program. The College is also encouraging candidates who have made no progress over a ten year period to withdraw from the program.

### *6.4.1 2012 Team findings*

There is good evidence of ongoing review and evaluation of the fellowship training program. Since 2008, the College has reviewed its curriculum. This project has encompassed all aspects of the curriculum including content, teaching and learning strategies, assessment methods, training post accreditation and program outcomes. Candidates, preceptors, fellows and external educational experts have been involved in these processes.

The College is developing and implementing tools to evaluate and monitor the College's programs and these changes. Examples include the annual survey of candidates, the newer annual supervisors' survey and the planned exit interviews of recent graduates. The College's accreditation submission provided information on a number of changes proposed by candidates through the surveys and the College's response to them. The Team applauds the College's willingness to seriously consider trainee and supervisor feedback.

The College recognises the growing complexity of the fellowship training program and the increasing challenges inherent in improving the program. The Team encourages the College to seek external expertise to evaluate the program.

The Medical Leadership and Management Curriculum is now well established, although the College is continuing to make changes and improvements especially in learning and teaching activities and assessment. The AMC expects the College would begin to move from major program changes to evaluation and fine-tuning.

The Team noted the College's analysis of its membership data. It supports the way in which the College is considering and responding to this information, guiding positive responses to pathways for training fellows for future leadership roles in the College and health services. The membership data may also stimulate discussion with the various jurisdictions and universities on future workforce implications.

The College's annual survey of candidates and its steps to implement a similar process for supervisors are commended. The number of responses for the candidate survey is low (38 per cent). If this is to be the College's principal mechanism for seeking candidate feedback, the Team encourages the College to consider ways in which the response rate can be improved.

As noted in section 5 of the report, the College has introduced measures to analyse the consistency in standards and the variations in pass rates between regions and over time. The College has investigated the reasons for a 45 per cent pass rate for the pre-fellowship oral examination in 2011, which was well below the usual pass rate. The College has identified candidate isolation and lack of preparation as contributing factors. It continues to consider measures to address this outcome.

The accreditation standards require that education providers collect qualitative information on outcomes. The College currently does not achieve this; despite its significant work to articulate the value and role of the medical manager and leader in the health care system, it has no systematic way of assessing whether or not the standard of its new fellows meets stakeholder and community expectations.

Consistent with the accreditations standards, the Team encourages the College to develop specific plans for engaging a wider group of stakeholders in program evaluation. The College's accreditation submission had outlined plans for engagement with health consumers, via the Consumers Health Forum of Australia. Representatives of the Consumers Health Forum of Australia interviewed by members of the AMC Team indicated that their engagement had been limited, but they were committed to working with RACMA in continuing to explore the most appropriate process for consumer engagement in both the fellowship training program and the continuing professional development program.

In their formal response the Consumer Health Forum welcomed ongoing efforts by the professional colleges to incorporate consumer input and engagement into their work. The Consumers Health Forum acknowledged the College's engagement during 2012, with a view to integrating consumer perspectives into their work.

The Team considers recommendation 41 from 2008 has been met.

2012 Commendations

J The ongoing development and review of the RACMA fellowship training program, combined with evidence of debate and reflection within the College committees and the fellowship.

K The introduction of candidate and supervisor annual surveys.

*2012 Conditions to satisfy accreditation standards*

5 Develop ways to collect qualitative information on outcomes. (Standard 6.2.1)

6 Implement processes for engaging other health care professionals and consumers in the evaluation process. (Standard 6.2.2)

*2012 Recommendations for improvement*

HH Seek external expertise to evaluate the fellowship training program. (Standard 6.1)

# 7 Issues relating to candidates

The accreditation standards relating to selection into the training program are as follows:

- A clear statement of principles underpins the selection process, including the principle of merit-based selection.
- The processes for selection into the training program:
  - are based on the published criteria and the principles of the education provider concerned
  - are evaluated with respect to validity, reliability and feasibility
  - are transparent, rigorous and fair
  - are capable of standing up to external scrutiny
  - include a formal process for review of decisions in relation to selection, and information on this process is outlined to candidates prior to the selection process.
- The education provider documents and publishes its selection criteria. Its recommended weighting for various elements of the selection process, including previous experience in the discipline, is described. The marking system for the elements of the process is also described.
- The education provider publishes its requirements for mandatory experience, such as periods of rural training, and/or for rotation through a range of training sites. The criteria and process for seeking exemption from such requirements are made clear.
- The education provider monitors the consistent application of selection policies across training sites and/or regions.

The accreditation standards relating to training involvement in governance of their training are as follows:

- The education provider has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

The accreditation standards relating to communication with trainees are as follows:

- The education provider has mechanisms to inform trainees about the activities of its decision-making committees, in addition to communication by the trainee organisation or trainee representatives.
- The education provider provides clear and easily accessible information about the training program, costs and requirements, and any proposed changes.
- The education provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

The accreditation standards concerning dispute resolute are as follows:

- The education provider has processes to address confidentially problems with training supervision and requirements.
- The education provider has clear impartial pathways for timely resolution of training-related disputes between trainees and supervisors or trainees and the organisation.

- The education provider has reconsideration, review and appeals processes that allow trainees to seek impartial review of training-related decisions, and makes its appeals policies publicly available.
- The education provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

### 7.1 Process for selection to medical administration training in 2008

The College's accreditation submission provided the following information on the number of applicants accepted into candidacy over the last three years.

| Year | 2005 | 2006 | 2007 |
|---|---|---|---|
| Total | 21 | 19 | 15 |

Training opportunities have decreased in the last ten years due to the lack of funding in many health services, which in turn has led to a decrease in the numbers of junior medical administrator positions.

The requirements for eligibility to be considered for recommendation for candidacy are:

- a medical degree from a recognised Australian or New Zealand university, or equivalent
- current medical registration and good standing in Australia or New Zealand
- clinical experience of at least three years in an Australasian health system, or one that is comparable
- a suitable management position that will allow access to supervised medical management experience, and will allow the candidate to develop the competencies necessary for fellowship in an appropriate timeframe.

Potential candidates must supply evidence of the above requirements, along with the required application form and fee, a detailed curriculum vitae, an academic transcript, contact details of at least two referees (preferably three), and a document addressing the essential and desirable selection criteria detailed on the College's applicant information guide.

The College selection criteria cover a range of attributes and measures of suitability for medical administration, and include:

- interest in medical management and evident commitment to the pursuit of a career in medical management as a specialty
- possession of the personal attributes of flexibility, insight and resilience
- possession of good communication skills
- possession of sound analytical skills.

Applications are processed by the Censor-in-Chief, who takes into consideration input from the applicant's referees, the organisations and/or funding organisations in which the applicant plans to train and, if required, advice from the Chair of the Board of Studies of the appropriate regional committee. The Censor-in-Chief then makes a recommendation to Council, and notifies successful applicants in writing immediately after the Council decision. Unsuccessful applicants are notified as soon as possible and are provided feedback by the

Censor-in-Chief or the Chair of the Board of Studies as to reasons for their inability to meet the criteria for candidacy. Unsuccessful applicants have the right to request review of the College application decisions through a formal review process organised by the Censor-in-Chief, which includes a formal interview of the applicant by the Chair of the relevant Board of Studies, who then reports to the Censor-in-Chief about the suitability of the applicant. They also have available to them a review mechanism external to that conducted by the Censor-in-Chief. This process does not disadvantage the applicant in any future decisions.

### *7.1.1 2008 Team findings*

The College is not primarily involved in the recruitment or selection of candidates to available positions, and is not the employer of any candidate appointed to a position. Application for candidacy is separate from, and in addition to, these processes. Not strictly a selection process, it is more an assessment of suitability to become a candidate. Applicants apply for workplace positions in a variety of settings (extending to pharmaceutical companies, mental health sector, and pathology services) and are selected as part of the normal recruitment process of the employer and/or the relevant government jurisdiction. Many of these positions are substantive management positions, while the remaining positions are trainee positions, usually partially funded by government. Eligibility and selection criteria for these workplace positions are made known to the applicants by the intending employer.

Once appointed to these positions, individuals can then seek RACMA candidacy. There is a shortage of medical administrators in Australia and all appropriately qualified applicants are accepted into the training program. There is no quota set for training placements.

2008 Commendation

O The College's clearly documented selection process and requirements.

*2008 Recommendation*

31 Seek opportunities to engage more proactively with employers in the candidate selection process.

## 7.2 Admission policy and selection in 2012

The College's accreditation submission provided the following information on the number of applicants accepted into candidacy over the last three years.

**Applications for Fellowship Training Program Candidacy**

| | Standard Pathway | | | Accelerated Pathway | | |
|---|---|---|---|---|---|---|
| **Year 1** | **2010** | **2011** | **2012** | **2010** | **2011** | **2012** |
| **Applications** | 14 | 18 | 19 | 45 | 44 | 22 |
| **Accepted** | 13 | 17 | 18 | 32 | 24 | 13 |
| **Withdraws/ Deferred** | 1 | 1 | 2 | 4 | 4 | 4 |

The overarching requirements for recommendation to candidacy remain unchanged since 2008. Descriptions of selection criteria, admissions processes, and relevant application forms are publicly available on the College website. Progress has been made since 2008 in improving the rigour of the selection process, with development of standard templates for applications, structured interviews for applicants to the accelerated pathway, and the establishment of the Credentialling Committee to make recommendations to the Education and Training Committee on policy and practice in candidate selection. The application and selection process is evaluated in the annual candidate survey, and most respondents rated the process as good or acceptable in the 2011 survey.

The most significant change to admission policy and selection since 2008 is the differentiation between standard pathway and accelerated pathway applicants for candidacy. Applicants for the accelerated pathway to the RACMA fellowship training program must meet all the requirements for entry via standard pathway as well as additional accelerated pathway requirements. Following an application addressing the published selection criteria, applicants need to demonstrate to a panel of senior RACMA fellows that they have relevant existing competencies (advanced standing) which will qualify them for entry to a modified training program. The mechanism for assessment of their application is a folio of evidence and a two-hour interview.

The interview includes standardised questions based on medical management scenarios, similar to those used in the pre-fellowship oral examination. Successful accelerated pathway applicants are given two to three years advanced standing and reduced training requirements. They are still expected to submit a reflective case study for assessment, and to pass the pre-fellowship oral examination in order to attain fellowship of the College.

### *7.2.1 2012 Team findings*

In feedback to the College on its progress reports, the AMC Specialist Education Accreditation Committee had indicated that recommendations from the 2008 report had been addressed but that feedback from trainees, supervisors or directors of training during the 2012 review may require revisiting some of the recommendations apparently completed.

With respect to recommendation 31, the Team recognises that the College has a limited role in the employment of candidates who enter the training program in the context of substantive medical administration positions. The College's active role in the establishment of Specialist Training Program funded positions, and selection to those positions, is commended. By applying consistent accreditation procedures for existing and newly created positions, the College can ensure adequate training opportunities for candidates in very varied positions. This is also commended. The Team considers recommendation 31 met.

The application process and selection criteria for standard pathway candidates are clearly documented and in the public domain. Whilst selection criteria for acceptance onto the accelerated pathway are also available, there is some ambiguity around the weighting of various elements of the selection process. The marking system for the process of evaluating accelerated pathway candidates is not clearly outlined. For example, the College website states that "Postgraduate studies e.g. Fellowship of another specialist medical college or formal postgraduate studies in health or business management from a RACMA recognised university, would be an advantage", but the extent of that advantage or the relative value of the examples provided is not enunciated.

## 7.3 Candidate participation in education provider governance in 2008

An elected candidate representative sits on Council and reports to Council formally and through contact with other Council members on matters of concern for candidates. All current candidates of the College who are of good standing are eligible to nominate for this position for a two-year tenure, and must be nominated by two fellow candidates. A biographical profile with contact details of the elected candidate representative is included in the *Candidates' Corner* of the College website.

The local committees in each state, territory and New Zealand are made up of members of Council from the jurisdiction, with at least four additional fellows from the jurisdiction, and it is noted that at least one member may be a candidate.

There is currently no RACMA candidate committee, nor a candidate society or group.

### *7.3.1 2008 Team findings*

Engaging candidate participation in College governance is difficult, given the small number of candidates. The elected candidate representative is well enabled and supported by the College to inform fellow candidates about the College governance and training regulations. Candidate training matters is a regular item on the Council agenda.

Unfortunately, many of the candidates interviewed were not aware of the identity of their candidate representative, or how to contact this person. The candidate representative reported that interaction with fellow candidates was infrequent and informal, occurring during face-to-face encounters with local candidates in the workplace, and with candidates from other regions at the workshops. Although it is clearly stated that at least one member of each local committee may be a candidate, it is unclear whether there is candidate representation on each local committee. If there are candidate representatives on the local committees, there does not appear to be any communication between them.

Candidates interviewed by the Team considered that it was important for the candidates' views to be heard by the College and supported improved mechanisms for College consultation with candidates. Candidates felt it would be feasible and empowering to form a RACMA Candidate Committee, as well as organise an annual meeting of candidates to provide a forum for discussion. As candidates understandably will have limited experience in the governance of the College, it would be appropriate for the College to inform the candidate body about the formation and important roles of this committee and to provide more guidance as to how committee members can contribute to College affairs. It is also important to offer the Candidate Committee secretarial and information technology support to conduct their meetings and maintain communication lines.

The Team suggests that state committee meeting agendas regularly include a candidate report to augment communication between candidates and the College. The Team also recommends the RACMA Candidate Committee be nurtured by the College as a platform to ensure communication between candidates from each Australian state and territory and New Zealand.

As candidates are the ultimate consumers of the training program and represent the future members of the College, their participation in College affairs, in particular with respect to their training, is imperative. The Team considered that enhancing opportunities for candidate

engagement and participation in College governance would help dispel the remoteness that some candidates feel from the College, and would encourage candidates to participate in College activities upon qualifying, thus ensuring the ongoing success of the College.

There was evidence that candidates support each other informally at regional level. The Team found that there was potential for candidates to be isolated in rural rotations, or in regions where candidate numbers were low. Unless they actively sought out fellow candidates, these candidates tended to lack adequate peer support. The two and four-day workshops are the only opportunities for fellow candidates to come together to exchange views, ideas and examination preparation techniques. Many new candidates had the foresight to view their preparation for the fellowship examination as a task best begun at the commencement of training. These candidates were unclear about which topics are examinable, and were frustrated by the lack of opportunity to meet candidates more advanced in their training who had recently attended the four-day workshop and who may act as resources to guide their learning.

Although candidates praised the recent changes on the College website, improvements can still be made. Based on data collected by the College, only a minority of candidates were accessing their login-enabled candidate areas. A few candidates had been unsuccessfully attempting to update their management practice folio online, a feature not yet developed on the website. An online forum, on which candidates could exchange study material and examination resources, would be a beneficial addition.

Currently, there may be a candidate member of a local Board of Studies, although this is not required, and there is no candidate member of the Board of Training and Continuing Education. As candidates have a vested interest in the quality of training and education provided, and are essentially the consumers of the training and education product of the College, a strong case can be made for candidates to be involved in the decision-making processes that directly impact on them. As the Board of Training and Continuing Education recommends and reviews the curriculum, and the Boards of Studies is involved with the development of standards for accreditation of training positions, the inclusion of candidate members is strongly advocated by the Team.

2008 Commendations

P The College's inclusion of an elected candidate representative on the Council.

Q The College's recent commitment to updating and improving the College website.

R The College Secretariat's high quality support for candidates with regard to dissemination of information and addressing candidate questions about their training.

*2008 Recommendations*

32 Provide information to new candidates regarding the avenues for candidate representation in College governance, the names and contact details of current RACMA and local representatives (if applicable), and information on how they are chosen.

33 Ensure that there is a candidate representative on each Australian state/territory and New Zealand Committee, and that the candidate report is a regular item on the local committee meeting agenda.

| | |
|---|---|
| 34 | Facilitate the formation of, and promote awareness of, a RACMA candidate committee to include the College candidate representative, local candidate representatives as well as other interested and motivated candidates, and offer secretarial support for the new committee. |
| 35 | Consider playing a role in facilitating communication amongst candidates nationally and/or internationally through its website, for example, establishing a candidate online forum, and education of candidates regarding login access to candidate areas on the site. |
| 36 | Consider the inclusion of a candidate representative on any education committee of the College, particularly those involved with curriculum review. |
| 37 | Conducts an annual survey of all candidates (regarding quality of workplace experience, levels of supervision, training and teaching) in addition to the New Fellow Survey. |

## 7.4 Candidate involvement in College affairs in 2012

Candidates are represented by a member on the College Board as well as on key College committees including the Education and Training Committee, the Training Committee, the Curriculum Steering Committee and the Scientific Program Committee. Jurisdictional Committees also have candidate members. The Candidate Advisory Committee is a new committee of the Board, with revised terms of reference approved in 2009. The committee is chaired by the Candidate Board Director.

### *7.4.1 2012 Team findings*

Candidate involvement in College governance has been strengthened significantly since 2008.

The Team considers recommendations 32, 33, 34, 35, 36 and 37 from 2008 have been met.

## 7.5 Communication with trainees in 2008

Candidates are generally satisfied with the timeliness of College communications. They were grateful for the efforts of the College Secretariat in providing regular electronic newsletters and in responding to candidates' queries. College staff were praised for their helpful and professional support.

## 7.6 Communication with trainees in 2012

The College has developed many mechanisms for communicating with trainees, including website development, e-bulletins, information within the College journal *The Quarterly* and targeted emails and letters. The College has a policy regarding the implementation of changes to the training program, which includes guidance on communication of proposed changes. The mechanism includes opportunity for input from the Candidate Advisory Committee.

### *7.6.1 2012 Team findings*

The Team observed significant efforts on the part of the College to communicate effectively with trainees. The College website contains clear and accessible information about the training program, including costs and requirements of training. Mechanisms for

dissemination of information to trainees about the activities of decision-making committees and proposed changes to the training program exist, and are generally used effectively. The Team did identify significant concerns from many candidates about the communication of a recent decision regarding the timing of the pre-fellowship oral examination. The impression of the candidates interviewed was that this decision had not been discussed with the Candidate Advisory Committee prior to its announcement, and the communication of the decision was sub-optimal, with some affected candidates omitted from the email communication. Improvement in communication with candidates regarding planned changes is desirable.

Some concerns were raised during the visit about the timeliness and accuracy of information provided to candidates about their own training status. It seems that, in some instances, College faculty (including preceptors and Jurisdictional Coordinators of Training as well as supervisors) are unsure of the requirements for candidates. Some candidates also described uncertainty in interpreting official College communications about training requirements in terms of the applicability of announcements to their own situation. Accreditation standard 7.3.3 requires such information to be readily available. This situation could be improved by equipping Jurisdictional Coordinators of Training and/or preceptors with comprehensive information about training requirements and their applicability to candidates at different stages of progression through training, particularly as changes to the training program are implemented. Candidates should also be informed of a mechanism for obtaining up-to-date information relevant to their own situation from the College administration.

### 7.7 Resolution of training problems and disputes in 2008

The College has informal and formal disputes resolution processes in place to address the different potential problems during a candidate's training period, in the areas of preceptor/candidate relationships, case study assessment, final examination assessment and assessment at the end of the probationary period (first year) of candidacy.

A candidate who perceives their relationship with their preceptor to be unsatisfactory for personal or training reasons can ask the Chair of the local Board of Studies to assign another preceptor. Candidates disputing the assessment of their case study are required to contact the Censor-in-Chief, who will initiate a re-assessment process.

Candidates may appeal their final examination result or process, under the *Guidelines for Appeal under RACMA Examination Procedures*. This document is supplied to all candidates and is also available on the College website. An appeal must be lodged in writing with the Chief Executive within fourteen days of the written notification of the examination result. The Appeals Committee in this case consists of a fellow of the College appointed by the President of RACMA, a fellow resident in the same state as the applicant and a senior academic in management at an Australian university. Candidate representation in the appeals process is only present at the level of the Committee for the Review of College Decisions.

Recently, a probationary one-year period of candidacy was introduced. Where the Censor-in-Chief, on the recommendation of the relevant Chair of Board of Studies, ceases a candidacy the candidate may appeal within one month of having been formally notified. The candidate must submit written information to support their appeal. The Appeals Committee, consisting of two Censors and the Vice-President of the College, will meet within two months of the appeal being lodged, and hand down their decision within one month of this meeting.

There have been no formal appeals under the College's policies in the last three years.

### *7.7.1 2008 Team findings*

Candidates in general did not voice any concerns about appeals processes. All candidates interviewed felt comfortable seeking dispute resolution through the College's formal processes. Preceptors and committee members interviewed felt that the College training program fostered sound dispute resolution skills, which meant that fellows and candidates were able to address difficulties during training locally and at an early stage. The candidates were of the same opinion.

Nevertheless, the College undertook a review of its appeal processes in 2007, and has plans to review policies and procedures in accordance with recommendations in the *ACCC/AHWOC Report to Australian Health Ministers*.

## 7.8 Dispute resolution and appeals process in 2012

The College continues to rely on informal processes for dispute resolution, in addition to provisions for a formal appeals process. A policy addressing the process for Review of Decisions of Board and its Committees was approved by the Board in January 2012. This provides an opportunity to refer a decision to a specially convened Review Committee, which presides over a final stage of reviewing an appealed decision. The policy advises that candidates should initially "seek reconsideration and review of the original decision by the Board or committee, which made the decision" prior to progressing to a formal review. Such reconsideration does not constitute a review as outlined in the policy. The initial reconsideration process appears to be informal, and documentation around this stage of the appeal procedure is lacking.

Difficulties between trainees and supervisors (or preceptors) are generally managed in an informal way by Jurisdictional Coordinators of Training. The College does not have a formal policy or protocol to guide the management of such situations.

### *7.8.1 2012 Team findings*

The Team was made aware of situations involving conflict between candidates and their supervisors or preceptors. These situations are infrequent, and are generally successfully managed by Jurisdictional Coordinators of Training. Candidates and supervisors attest to the accessibility of Jurisdictional Coordinators, and candidates experiencing difficulties are able to approach them with concerns as they arise. Changes to supervisor or preceptor allocations have sometimes been necessary.

The Team considers that Jurisdictional Coordinators of Training, preceptors, supervisors and candidates would all benefit from a clearly articulated College policy guiding the approach to training-related disputes between trainees and supervisors or trainees and the College.

The Team was advised of approximately four "complaints" from candidates that have been managed and resolved by the Chief Executive of the College. The process for this appears to be informal, and documentation was not available. There has not been an instance of a decision being referred to a formal Review Committee. The Review Policy is publicly available, but the initial stages of reconsideration and review of decisions are not clearly delineated.

To the Team's knowledge, the College does not have a process for evaluating de-identified appeals and complaints to determine if there is a system problem. As the College had not yet had a formal appeal, this is understandable. However, the evaluation of reviews and reconsiderations, as well as complaints, may be of greater use in helping to identify system problems. The Team encourages the College to develop such an internal review mechanism.

2012 Commendations

L The College's active role in seeking government-funded Specialist Training Program places, and in selection to those positions.

M The inclusion of candidates in the governance structure of the College and decision-making on matters relating to education and training.

*2012 Conditions to satisfy accreditation standards*

7 Document and publish the criteria used to adjudicate applications to the accelerated pathway, including the weighting applied to various elements of the selection process. (Standard 7.1.3)

8 Develop mechanisms to ensure that trainees have access to timely and correct information about their training status to facilitate their progress through training requirements. (Standard 7.3.3)

9 Develop a policy to guide the resolution of conflicts or disputes between candidates and supervisors or preceptors. (Standard 7.4.2)

10 Formalise the procedure for candidates seeking reconsideration or review of a decision to clarify the stages that precede a formal review as outlined in the policy "Review of Decisions of Board and its Committees". (Standard 7.4.3)

11 Develop a process for evaluating de-identified appeals and complaints. (Standard 7.4.4)

*2012 Recommendations for improvement*

II Improve communication with candidates regarding training program requirements with a focus on clear presentation of changes to the program that clarify which candidates are affected. (Standard 7.3.1)

# 8 Implementing the training program – educational resources

The accreditation standards relating to supervisors are as follows:

- The education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the training program and the responsibilities of the education provider to these practitioners.
- The education provider has processes for selecting supervisors who have demonstrated appropriate capability for this role. It facilitates the training of supervisors and trainers.
- The education provider routinely evaluates supervisor and trainer effectiveness including feedback from trainees and offers guidance in their professional development in these roles.
- The education provider has processes for selecting assessors in written, oral and performance-based assessments who have demonstrated relevant capabilities.
- The education provider has processes to evaluate the effectiveness of its assessors/examiners including feedback from trainees, and to assist them in their professional development in this role.

The accreditation standards concerning clinical and other educational resources are as follows:

- The education provider has a process and criteria to select and recognise hospitals, sites and posts for training purposes. The accreditation standards of the education provider are publicly available.
- The education provider specifies the clinical and/or other practical experience, infrastructure and educational support required of an accredited hospital/training position in terms of the outcomes for the training program. It implements clear processes to assess the quality and appropriateness of the experience and support offered to determine if these requirements are met.
- The education provider's accreditation requirements cover: orientation, clinical and/or other experience, appropriate supervision, structured educational programs, educational and infrastructure supports such as access to the internet, library, journals and other learning facilities, continuing medical education sessions accessible to the trainee, dedicated time for teaching and training and opportunities for informal teaching and training in the work environment.
- The education provider works with the health services to ensure that the capacity of the health care system is effectively used for service-based training, and that trainees can experience the breadth of the discipline. It uses an appropriate variety of clinical settings, patients and clinical problems for training purposes, while respecting service functions.

## 8.1 RACMA censors, preceptors, supervisors, and executive coaches in 2008

The key roles with responsibility for the training and assessment of candidates are Censor-in-Chief; Censors; preceptors and supervisors. These are detailed below.

The **Censor-in-Chief** is appointed by the College's Council and is responsible for:

- chairing the Board of Training and Continuing Education

- supervising the overall educational and examination program of the College
- the maintenance of educational standards for award of fellowship and continuing education and demonstration continuing professional development
- developing the program of study in association with individual Censors
- conducting examinations
- recommending applications for candidacy and membership to Council
- determining eligibility for admission to College training programs via acceptance of applications from candidates
- conducting recognition of prior learning processes
- ensuring that each candidate has a recognised training plan.

The Board of Censors and the state, territory and New Zealand Boards of Studies assist the Censor-in-Chief with the education and examination program of the College.

**Censors** are RACMA fellows usually of at least five years' standing. Expressions of interest in becoming a censor are invited and the Chairs of the state, territory and New Zealand Boards of Studies encourage fellows to apply. Selection of censors involves a panel consisting of the Censor-in-Chief and two other censors.

Censors are appointed for a period of five years with the term being renewed by a panel chaired by the Censor-in-Chief. New censors attend a professional development workshop run by the Censor-in-Chief and every three years censors must attend a reaccreditation workshop to continue in their role. These workshops are designed to ensure that censors have access to current thinking in assessment and education evaluation processes, assessment issues and techniques.

Censors are members of the Board of Training and Continuing Education and assist and support the work of the Censor-in-Chief. The censor assesses candidates to ensure that they meet the standards of the fellowship training program. Censors participate in an annual peer review process.

The key accountabilities of censors are:

1 to assist the Censor-in-Chief and Chairs of the Board of Training and Continuing Education with the maintenance, improvement and design of assessment processes in the College training program

2 to evaluate candidate progress.

Each candidate has a **supervisor** who is normally in a substantive position within the candidate's organisation, as the candidate's line manager. The supervisor oversees a candidate's day-to-day work. The supervisor may or may not be medically qualified and may or may not be a fellow of the College. The role of the supervisor is to understand the core competencies and skills prescribed by the College to be acquired during the minimum of three years of full-time medical administrative experience.

In almost all cases the candidate is in a substantive position reporting to a line manager who becomes their supervisor for the workplace component of the training program.

The College provides each candidate with a **preceptor** for the duration of the fellowship training program. A preceptor is a FRACMA of at least three years' standing, who is actively engaged in the field of medical administration. Preceptors are appointed by recommendation of the Chair of the state, territory or New Zealand Board of Studies to the Board of Training and Continuing Education. Each preceptor may oversee two candidates at any time. New preceptors must attend one of the annual workshops run by the Censor-in-Chief and every three years preceptors must be reaccredited to continue in their role by attending a further workshop. Preceptors may have up to three, 3-year terms.

The preceptor plays a vital role in providing education and support to candidates during fellowship training. The primary objective of preceptors is to provide advice and education to support the formal training programs undertaken by candidates studying to be fellows of RACMA and to report annually on the overall progress of candidates towards fellowship.

The Chair of the Board of Studies allocates preceptors to candidates. Candidates can be involved in selecting their preceptor. This normally happens when the candidate advises the Chair of the Board of Studies that they have a preferred preceptor in mind. The preceptor works with the Censor-in-Chief, the Chairs of the state, territory and New Zealand Boards of Studies and other preceptors. In addition, the preceptor has a key role in liaising with the candidate's supervisor to monitor the candidate's progress, provide information about College education and training policies and programs, and to progress any training issues.

The preceptor is involved in workplace evaluation together with the candidate and their supervisor, to assure the College that the workplace is able to provide the candidate with the necessary access to resources and support to undertake the fellowship training program.

The key accountabilities of the preceptor are to:

1 provide an overview of the candidate's training program, and assist the candidate with progress towards attainment of medical management education standards by:
   - assessing the candidate's suitability for a medical management career at the end of the first year of training and preparing a report for the Chair of the Board of Studies
   - monitoring the candidate's progress in the achievement of goals
   - guiding the candidate in selecting appropriate workplace training experiences that will contribute appropriately to attainment of the medical management competencies and provide the best opportunity to obtain the FRACMA
   - meeting with the candidate's workplace supervisor to discuss candidate duties and liaising with the supervisor on matters and issues that arise during candidacy
   - conducting an audit in the candidate's workplace to ensure that College standards required to support training of the candidate are in place or will be available to the candidate
   - ensuring that the competencies and performance standards for the medical administrator are understood by the candidate
   - reporting on candidate progress by formally completing the College assessment tool by 31 August each year, in conjunction with the candidate's workplace supervisor, at a formal meeting.

2 provide input to the appropriate Chair of the Board of Studies in relation to the quality of workplace training experiences and resources

3 recommend to the appropriate Chair of the Board of Studies whether the particular workplace is suitable for future candidates

4 assess the candidate's written tasks and provide advice on content and quality prior to submission for formal assessment, signing-off that this has been done

5 discuss with the appropriate Chair of the Board of Studies any concerns about the suitability of the candidate for a career in medical management

6 be responsible for the candidate's progress through:

- reporting to the Censor-in-Chief on a candidate's progress in their workplace training, their academic studies and preparations for assessment
- ensuring adequate communication between the candidate and the College and between the candidate and their workplace supervisor
- support of the candidate regarding the range and status of educational, training, assessment and examination activities provided by the College
- undertaking and submitting to the College annual reports on the progress of the candidate
- liaising with their candidate(s) monthly to monitor progress, discuss education issues, impart knowledge as appropriate, help to settle any issues and generally monitor the well-being of the candidate

7 represent the College externally through interactions in the candidate's workplace and other appropriate forums relating to the College's fellowship training program

8 regular evaluation of the role of the preceptor is provided through candidate surveys.

**Training for supervisors and preceptors in 2008**

The College has not provided specific training for supervisors. It is reviewing this requirement and has most recently invited all supervisors to participate in the audit process to recognise a candidate's training plan. As well, it has prepared a supervisor induction kit.

The College has relied on its preceptors to liaise with candidates' supervisors and hence the training emphasis has been with preceptors. Each preceptor attends a half-day College training and assessment workshop at least every three years. The program for the 2007 workshop included the following:

- new competencies framework
- role of the preceptor
- working with the new competencies; assessing knowledge, skills and behaviour
- preceptor/supervisor reports
- recognising and assisting candidates with problems
- recognition of candidate training plans.

The purpose of the workshop is to ensure that preceptors have a thorough understanding of College requirements for fellowship, the examination processes and candidate assessment, and to discuss key issues that may arise in relation to career counselling of candidates. Additionally, this ensures a uniform approach to formative assessment as well as preparing the candidate for the summative assessments.

After the appointed three years, preceptors are required to attend another workshop in order to stay abreast of the College's requirements and to maintain their skills. The College is developing an on-line preceptor education package which will be introduced in 2008.

**Mentoring in 2008**

Mentoring has been recognised by the College for some time. Eighteen months ago, the College started the process of educating and signing up recently graduated fellows as mentors at the time of their new fellow orientation. Three of 12 recent graduates have taken this up.

The preceptor has a role as both mentor and coach for the candidates and is introduced at commencement of the training. RACMA believes it is an effective strategy to contribute to competency and career development.

Preceptorship commences as soon as an applicant has been accepted into candidacy. The Censor-in-Chief, but most particularly the Chair of the relevant Board of Studies, assists the candidate to select an appropriate preceptor. Candidates may have a fellow in mind to be their preceptor. If this is the case, the Chair of the Board of Studies will evaluate if this is appropriate or not, and arrange for the candidate and nominated preceptor to meet and commence establishing their relationship. Experienced fellows of the College are invited to be preceptors.

In the event that a relationship does not develop appropriately, the Chair of the Board of Studies will appoint a new preceptor for a candidate. There are some occasions when it can be difficult to allocate preceptors who are within reasonable proximity, or who are appropriately senior to some candidates. This has happened with candidates in more remote areas, those who relocate their substantive positions during the training period and those in particularly senior management roles when they come to the fellowship training program.

The preceptor role was reviewed in early 2007 and a revised position description developed and communicated. Preceptors' positions of responsibility within the College and participation are recognised as a continuing education activity.

### *8.1.1 2008 Team findings*

The preceptorship program is a strength of the College fellowship training program. Candidates value this system highly. Preceptors contribute greatly to examination preparation and provision of support to candidates. They are able to identify gaps in training and take actions to ameliorate them. They play a central role in the College training program. Preceptors need a detailed understanding of the College processes and the requirements for candidates to complete the training requirements.

In general, preceptors believe that they are able to assist their candidates to meet RACMA competency requirements. Preceptors recognise a gap, overall, in experience in the private sector and the College is actively examining this.

Although every candidate is expected to have a preceptor, there are reported gaps in these appointments. For rural candidates, the preceptor may not be located in the same city or town, and there were some examples of difficulties in the regular communication required for this relationship to work well.

The Team is concerned that the formal feedback process to preceptors is underdeveloped. The College indicates that the preceptor workshops provide opportunities for feedback to them. However, since attendance is required only every three years, this may be seen as insufficient. During the Team's interviews preceptors themselves indicated that they would like to have a formal evaluation process.

The College acknowledges that gaining adequate attendance at preceptor workshops has been difficult. The College is congratulated for developing an on-line package to overcome this.

Apart from the final section in the Preceptor Report Form that invites non-confidential comments from candidates, there is no formal mechanism for the candidates to evaluate the quality of training and supervision they have received. It is unclear whether, and how, the information collected from the candidate comments is utilised. The College undertakes a new fellows survey yearly, and all examination candidates are invited to complete a confidential exit questionnaire.

It is of concern that the surveys are subject to positive bias as they only seek feedback from candidates who are likely to have had a less problematic path through their training. Considering the high attrition rate of candidates, seeking feedback from those who have decided not to pursue their fellowship, including their reasons, could help the College take steps to prevent increase of, or reduce, this drop-out rate. The College could gain useful information from an annual survey of candidates to gather feedback regarding the quality of workplace experience, levels of supervision, training and teaching.

The Team recognised the critical role the preceptor plays. If the preceptor is enthusiastic, well informed and concerned about the welfare of candidates, then candidates are generally highly satisfied. A poorly performing preceptor would be of great detriment to the training program in an institution. The Team believes that, given the importance of the preceptor, there should be a mechanism to monitor ongoing performance. Candidate evaluation of the adequacy of the preceptor should be sought on an annual basis. Nevertheless the College has processes to address difficulties between a candidate and a preceptor and will re-assign candidates to a new preceptor when the relationship is not working well. The Team commends the College's moves to provide additional support for supervisors. This role is not highly defined, and it highlights the significance of the College-appointed preceptor role.

The College should implement a systematic process for the selection and training of examiners, censors and preceptors in written, oral and performance based assessment and examination. This needs to take into account a balance in gender, cultural background, nature of practice and its location.

Candidates have concerns that sometimes preceptors and supervisors are unclear of the goals of the training program, may be difficult to engage with, or receive regular feedback from, for a variety of reasons, including their very busy work. A contract for preceptors is to be introduced; it is hoped this will improve the situation in this area.

The College only has a small number of fellows and those who are interested in education are already intimately involved. This makes a conventional mentoring structure, as defined in the AMC accreditation standard, difficult to achieve. The College is encouraged to undertake its proposed processes of an annual reminder to fellows of the opportunity to take up mentoring positions, and to utilise the services of those fellows who are outside the educational arena for candidates to become involved. Perhaps a formal requirement for fellows is that they agree to act as mentors for a certain number of years.

Supervisors and mentors, and indeed censors, could all benefit from training that includes formal consumer input.

2008 Commendations

M The College's actions to strengthen the relationship between supervisors and preceptors.

N The College's on-line package for preceptor training.

*2008 Recommendations*

27 Continue to develop and define the roles, responsibilities, selection and appointment, reporting, training and support of and for supervisors, censors and preceptors.

28 Implement a systematic process for the selection and training of examiners, censors and preceptors in written, oral and performance based assessment and examination. This needs to take into account a balance in gender, cultural background, nature of practice and its location.

29 Develop a formal feedback mechanism for preceptor performance; including formal feedback from candidates.

30 Consider a requirement for fellows to agree to act as mentors for a certain number of years.

## 8.2 College accreditation processes in 2008

RACMA training does not fit the model of most medical colleges in which registrars assist with patient care, working closely with, and under, the supervision of their specialist supervisor, and generally move through many rotations to gain broad experience.

The College has evolved away from a formal workplace accreditation process to accreditation of individual training plans. Each candidate has a recognised training plan that is specific to the candidate. An applicant for candidacy must be able to satisfy all College criteria for a training plan before the Censor-in-Chief can recommend to Council that the applicant be accepted. There is thus no equivalent to 'limited accreditation'.

To address these objectives, the College has set organisational and candidate objectives. The College requires employing organisations to:

- provide appropriate facilities
- provide documentation of its role

- participate in an external accreditation program, and
- support the candidacy.

The candidate's training program must meet the College's criteria, which include:

- appropriate support, supervision and facilities
- appropriate scope and responsibilities
- exposure to a suitable variety of medical administration tasks and issues
- time and relevant facilities for study and professional development
- a documented program of performance assessment
- appropriate information technology support
- a suitable work environment.

While the candidates are not directly involved in providing clinical care, the accreditation status of the organisation is taken into account in the position accreditation decision, and organisations accredited by the Australian Council on Health Care Services are preferred.

The College does not restrict the number of candidates and has no control over the number of available positions. Most candidates hold substantive positions with mechanisms provided by the College to ensure adequate support and supervision. For these reasons, the College has not relied as heavily as other medical colleges on a training organisation accreditation system, based on audit by visitation, to ensure that training requirements in the workplace are met.

In the past, the College implemented more formal processes to evaluate candidates' workplace training experiences, and training programs were approved, generally, within Australia and New Zealand. Where an accredited position did not provide the opportunities to obtain all the necessary managerial skills, it was the responsibility of the candidate to ensure that such skills were acquired prior to examination.

It emerged in 2004 that this process was too difficult for the College to administer systematically. In addition, as the majority of training posts in medical administration are associated with candidates in substantive management positions, the process was not always appropriate. Thereafter, rather than accredit institutions and posts, the College began to recognise individual training plans as suitable for training.

### *8.2.1 2008 Team findings*

College policy gives broad indication of selection, post accreditation and program structure, which is then interpreted by the various state, territory and New Zealand Board of Studies. This leads to significant variation in interpretation of the guidelines. The Team would encourage the College to increase the opportunities for discussion regarding inter-jurisdictional variation and the resultant scope for a variable training experience.

Like all the specialist medical colleges, RACMA provides training in a complex environment influenced by health policies, legislation and structures of multiple jurisdictions. Given the current critical workforce shortage facing the College, it is essential that it develops sound working relationships with all key stakeholders.

The College indicated it has not encountered conflict between its educational aspiration and the needs of the service providers, but envisages that such issues would be identified through the accreditation process with the Board of Training and Continuing Education taking appropriate action. The Team expects the College to monitor and report on this situation.

The College needs to advocate at an international, national and state and territory level with health departments for funded training positions, training infrastructure support, and specialist recognition for award purposes is to be considered a high priority. The funding of candidate positions by negotiation with funders appears vital to the future of the College.

The process for accreditation of training posts entails an individual approach to each post/candidate/supervisor proposal, which means it appears difficult to create guidelines. In general, candidates expressed satisfaction with the range of experiences they received but some candidates were in posts that were narrow. There is considerable variation in candidate training experience at different workplaces, and variation in the teaching of core and elective units in different masters programs. There is no mandatory requirement for candidates to train in specific environments, such as rotating to rural positions. The Team considers that the College needs to develop a stronger and clearer process to monitor the amount and range of candidates' experience. This will become increasingly important as the range of training sites and posts expands. It would provide a strong basis for the College to address ongoing deficiencies with hospitals and/or health departments.

Disaccreditation of a training post poses logistical difficulties. It appears then, that some candidates may continue in potentially unsuitable posts. Those in actual training posts were more likely to be rotated through appropriate experiences.

The Team would encourage the College to specify in greater detail the standards to be attained for accreditation. The information on training opportunities and expectations of training institutions should be made as explicit as possible.

College officers have, however, demonstrated on a number of occasions their willingness to intervene when training in a particular site becomes suboptimal. Such interventions may indicate that the College needs a more active and visible role in accreditation. The College does not always make an initial site visit prior to granting accreditation for the purposes of training. The Team was acutely conscious of the competing demands placed upon the College and its fellows, and therefore their limited capacity to undertake site accreditation.

The specification of the curriculum would offer an opportunity to set standards that relate to the curriculum, and to assess the clinical/educational experience offered by posts against these standards. The Team would encourage the College to clarify the minimum requirements for a training location, and to move to a standard agreement with employers that clarifies the duties that are entailed in having a RACMA candidate on staff.

Although there is a national process for selection, and the program is considered to be a national one, there is limited movement of candidates between jurisdictions and agencies once they are on the training program. A flexible approach to candidates rotating through different regional programs would also be appropriate; however the complexities and demands on candidates are noted by the Team.

The College's commitment to identifying training opportunities in the public and private sector is commended. Some candidates, however, felt that the training program was geared towards the public sector or area health services and expressed a desire for better inclusion of those training and working in the non-government sector.

In 2006 and 2007, the College invited candidates who passed the oral examination and were awarded fellowship to complete an on-line survey. This survey included questions about all components of the training program. It found that, with a well-organised training program, large urban hospitals could provide all relevant aspects of the curriculum. In the smaller rural hospitals, candidates reported that the available educational experiences were more limited.

In general, candidates were satisfied with the range of educational activities available to them and the enthusiasm of the College and agencies organising and providing them. Several agencies spoke of their sense of commitment to these teaching activities as being part of their desire to pass on the benefits they themselves had received during training.

To this end, the College should adopt a more national approach to the review of logbooks or reports of experience, including the local supervisor certifying where experience has been acquired, and central review of the candidates' experience against a clear statement of requirements.

**Access to appropriate facilities and educational resources in training sites in 2008**

Regular access to the internet and other educational resources, including libraries, is an increasingly important requirement given the flexible learning programs, which will require access to the internet and the College website.

### *8.2.2 2008 Team findings*

The program of educational activities available to candidates varied from jurisdiction to jurisdiction and within regions, depending in part on the relationship established between the College and participating agency, the agency's level of exposure to College priorities and the currency of the clinical training facilities.

Some candidates referred to difficulties in accessing the full range of educational offerings because of their geographical location. Videoconferencing and teleconferencing is available for training; however, there were some technical difficulties from time-to-time when accessing Queensland's training program by other states. These were irritating but not regarded as significant training barriers.

Direct supervision of candidates was variable. In many cases, this appropriately reflected the increasing capability of candidates and the availability of supervisors and preceptors. Some candidates wanted targeted support in some instances, and some that onsite learning resources were not critical, but access to technology to access supports and online educational material was.

**Environment for training and teaching in New Zealand in 2008**

The New Zealand context differs from the Australian one in substantial ways, such as:

- Maori Health
- funder/provider split

- District Health Board system
- funding for training posts.

Historically, New Zealand has not had a model of medical administrators, and in the last three decades has had limited involvement of doctors in management. However, this is changing and there is now an environment of increased enthusiasm for medically trained managers in District Health Boards and support for training. This has materialised in the expectation of ten training posts for the future (there are currently none). The newly formed Medical Training Board was enthusiastic about the College and identified specific roles they felt would be useful in the New Zealand context:

- leadership in health services policy
- bridging gaps between different groups of medical practitioners to create cohesive service delivery
- quality improvement initiatives
- sharing successful innovations between professional colleges
- oversight of the training program for postgraduate years one and two.

There are small numbers of fellows, members and candidates in New Zealand, but they form an enthusiastic group. In the major centres they have formed active learning groups with regular meetings, arranged speakers and considerable interaction between candidates and preceptors. The situation in the rural areas is less supportive of candidates (and possibly fellows), with limited interaction with preceptors or ability to participate in regular meetings.

The small size, collegiality and enthusiasm of the New Zealand preceptors was seen as a strength, but the limited number of preceptors meant some candidates had no preceptor in their region. The experience of candidates was variable, depending on their job and/or their location. Some of the candidates in private and rural areas indicated that they felt somewhat cut off from their preceptors and educational opportunities.

The candidates would have liked a different format for workshops, such as a one or two day network, that would allow the more distant candidates to attend.

2008 Commendations

K The College's commitment to identifying training opportunities in the public and private sector, and the enthusiasm of the supervisors in providing training opportunities for medical administrators.

L The promising environment for training in New Zealand, with enthusiastic preceptors, increasing numbers of candidates and indications of financial support from the Ministry.

*2008 Recommendations*

23 Advocate at an international, national, state and territory level with health departments for funded training positions, training infrastructure support, and specialist recognition for award purposes is to be considered a high priority.

24 Increase the specificity of its policy documentation for accreditation.

| | |
|---|---|
| 25 | Assume a key role in the development of medical administrative leadership in a wide variety of settings. |
| 26 | Address the issue of access to educational support for rural candidates. A workshop program suitable to the needs of New Zealand candidates and approaches to improve preceptor meetings with rural candidates should be considered. |

### 8.3 RACMA censors, preceptors, supervisors, and executive coaches in 2012

The College has retained the supervision structure for individual candidates of preceptors, who are senior College fellows who provide advice and education support, and day-to-day supervisors of candidates who are generally the candidate's work supervisors and may not be College fellows. It has continued to strengthen the relationship between supervisors and preceptors, and has formalised the role of the preceptor in representing the College in dealings with the workplace-based supervisor, recognising the preceptor's understanding of the College processes and the training program requirements.

Since 2008, the College has created the new role of Jurisdictional Coordinator of Training. These Coordinators have important relationships with candidates and preceptors in selection, monitoring candidates' progress, and supporting their learning and examination preparation.

Candidates in the accelerated pathway are supported by an executive coach, who is a RACMA fellow trained as a coach by the College, who facilitates the candidate's reflective learning, including assisting them to develop a training plan, and providing guidance on the case study. College guidelines indicate the executive coach should not be directly responsible for the day-to-day administrative activity of the candidate and should not be employed within the same institution as the candidate.

Preceptors are appointed by recommendation of the local Jurisdictional Coordinator to the Education and Training Committee, and Censors are selected and appointed by the Board on the recommendation of the Education and Training Committee, after an "expression of interest" process. Supervisors are generally appointed by virtue of their position as a line-manager in the candidate's place of work. The College verifies this role at the time of accrediting the training post.

Education and training support for supervisors and preceptors has been considerably developed. Since 2010 the College has conducted three Executive Coaching workshops for fellows who are willing to assist a candidate progressing through the accelerated pathway of the fellowship training program. The College has also implemented a formal College Faculty Education program to provide a structured training program for supervisors, preceptors and censors. This incorporates face-to-face workshops and online webinars, which are supplemented by a supervisors' handbook.

Evaluation of faculty performance is facilitated by the annual survey of candidates in addition to opportunities for candidates to provide feedback in the context of their six monthly candidate training reports.

### *8.3.1 2012 Team findings*

Since 2008, the College has strengthened its oversight of training. The new role of Jurisdictional Coordinator of Training has been particularly important.

Candidates continue to value highly their support and supervision, and recognise the role of the College preceptors as a strength of their training. Candidates in the accelerated pathway were particularly supportive of the value of the role of the executive coach.

The College has clearly defined the responsibilities of its supervisors. Those interviewed were clear about their role and responsibilities. The Team did note that the recent College survey of supervisors indicated that 85 per cent of the respondents reported that they had not been provided the supervisor handbook. The faculty education program appears excellent, and is to be commended. The 2011 supervisor survey did raise some concern, as less than half (48 per cent) reported being invited to participate in RACMA training programs. Of the respondents, 74 per cent indicated they would like to participate if afforded the opportunity. Thirty per cent responded that their knowledge of RACMA assessment activities was poor. The webinar series has been well received, though it would seem that some non-FRACMA supervisors have not been able to access this excellent resource. The College's survey of supervisors shows a significant increase in the number of supervisors who are fellows (70 per cent) reflecting commitment to the College. The need for setting clear learning objectives for placements was identified as an opportunity for improvement.

The faculty education program is commended, but the College is encouraged to ensure that the program (including the webinar series) is available to all supervisors, including those who are not fellows of the College. Reports on the progress of the delivery of the faculty education program will be required in subsequent reports to the AMC.

The College has made good progress in evaluation of supervisor and assessor performance.

Recommendations 27, 28, 29 and 30 from 2008 have been met.

2012 Commendations

N The development of a comprehensive faculty education program.

O The opportunities for feedback from candidates regarding supervisor performance, by means of the candidate survey and candidate training reports.

*2012 Recommendations for improvement*

JJ Ensure that all aspects of the faculty education program relevant to workplace supervisors are available to all supervisors, including those who are not fellows of the College. (Standard 8.1.1)

## 8.4 Clinical and other educational resources in 2012

Since 2008 the College has developed and implemented a workplace accreditation process. The accreditation policy is closely aligned with the RACMA Medical Leadership and Management Curriculum, and guides an assessment of the workplace in terms of physical

resources, management structure and philosophy, the learning/teaching environment, availability of suitable supervision/preceptors, as well as the executive position of the individual candidate. There are facility standards and minimum standards for first year/junior trainee positions and for middle level and senior trainees.

The College conducted a pilot program of site visits to health service organisations in 2010 and 2011, with site visits in Victoria, Western Australia and New Zealand. The policy, regulation and process were reviewed after this pilot.

A three-member RACMA accreditation panel completes the accreditation and reports to the Education and Training Committee. The panel members include the local Jurisdictional Coordinator of Training, and external Jurisdictional Coordinator and a member of the RACMA office. Accreditation is normally for a period of four years.

The College has worked effectively as a binational training body in negotiating support for training positions, and this is supported by advocacy at the level of the Jurisdictional Committees and the New Zealand National Committee. Additional training positions within state health departments and in private health providers have been established. The Specialist Training Program funded by the Australian Government has been successfully utilised for some of these positions.

In New Zealand, the College has advocated for financially supported training posts in medical administration, noting that a Health Workforce New Zealand model for funding training posts has identified medical administration as a craft group in need.

The College has addressed the need for additional support for rural candidates through the development of a Peer Review Case Based Discussion Group for Rural Medical Managers, funded by the Australian Government Department of Health and Ageing. The monthly webinar series on management and leadership topics enables candidates in rural areas and in New Zealand to join in discussions regardless of location.

### *8.4.1 2012 Team findings*

The formalisation of the accreditation process is still at an early stage. Jurisdictional committees with experience of the new process found it clear and viewed the changes as worthwhile. The challenge of accrediting training posts is highlighted by the significant differences between registrar training posts, and substantive medical administration positions. Both of these broad groups of positions may be accredited for candidates on the standard pathway to RACMA fellowship, and accreditation procedures need to adequately address both situations. Aligning the accreditation criteria to the RACMA Medical Leadership and Management Curriculum makes it possible for potential gaps in learning opportunities to be identified and appropriately addressed.

The College has identified other challenges to sustaining a program of accreditation visits including the staff and fellows needed for panel membership, and the need to balance the value gained from such a process with the cost associated with implementation.

The Team commends the College on the progress made with respect to accreditation processes, and looks forward to further reports on the implementation of the process in annual progress reports.

The College's work in negotiating support for additional training positions is commended. Development of positive relationships with health jurisdictions and private health service providers to build training capacity and meet the training requirements of an expanding medical workforce will continue to be a priority for the College.

The Team considers that recommendations 23, 24, 25 and 26 from 2008 have been met.

2012 Commendations

P The development of accreditation procedures aligned with the curriculum and consistent with AMC standards.

Q Collaboration with jurisdictions and private health care providers to achieve additional training positions for candidates by means of the Specialist Training Program and other sources of funding.

*2012 Recommendations for improvement*

KK Continue implementation and evaluation of new accreditation procedures, including an assurance that all positions accredited for training have been assessed in accordance with the newly developed policy. (Standard 8.2.2)

# 9 Continuing professional development

The accreditation standards concerning continuing professional development are as follows:

- The education provider's professional development programs are based on self-directed learning. The programs assist participants to maintain and develop knowledge, skills and attitudes essential for meeting the changing needs of patients and the health care delivery system, and for responding to scientific developments in medicine as well as changing societal expectations.
- The education provider determines the formal structure of the CPD program in consultation with stakeholders, taking account of the requirements of relevant authorities such as medical boards.
- The process and criteria for assessing and recognising CPD providers and/or the individual CPD activities are based on educational quality, the use of appropriate educational methods and resources, and take into consideration feedback from participants.
- The education provider documents the recognised CPD activities of participants in a systematic and transparent way, and monitors participation.
- The education provider has mechanisms to allow doctors who are not its fellows to access relevant continuing professional development and other educational opportunities.
- The education provider has processes to counsel fellows who do not participate in ongoing professional development programs.

## 9.1 The RACMA Continuing Education Program (CEP) in 2008

The College was one of the first Australasian specialty colleges to introduce a Continuing Education Program when it did so in the early 1990s. CEP is conducted as a three-year cycle.

Fellows and members are provided with information about the CEP on joining the College, and through the College *Continuing Education Programme Manual,* which is reviewed annually. CEP may be undertaken individually or as part of a learning group. Learning groups usually comprise two to ten fellows. Members of the CEP learning group assist and support each other in the development of individual CEP contracts and the undertaking of development activities.

The role of the CEP Committee is outlined in Section 3. The Committee addresses policy development and procedures to guide CEP development and implementation, to establish curriculum and competency frameworks, to monitor key indicators and to routinely evaluate the program and its procedures.

The National Director Continuing Education Program/Recertification is a member of Council and of the Council Executive, and has overall responsibility for the objectives of the CEP, for policy development and curriculum components in relation to CEP. The National Director Continuing Education Program/Recertification provides high level advice to Council in relation to CEP, and provides Council with routine reports regarding progress on key matters relating to CEP. This office bearer is also a member of the Board of Education and Training. The state, territory and New Zealand committees appoint a local fellow as CEP Coordinator. The coordinator facilitates access to, and involvement of, fellows and members in the CEP

within their jurisdiction. CEP coordinators liaise with local fellows and members for the development and endorsement of CEP learning contracts. CEP coordinators provide advice to fellows and members about professional development activities. They also support the National Director Continuing Education Program/Recertification in policy development about the CEP.

The National Secretariat supports these officers, provides administrative support to the CEP Committee, and maintains a database of fellow and member CEP participation and certification. It also liaises with fellows and members and maintains website information about the CEP and promotes courses and workshops that may be of interest to fellows and members.

The College CEP process comprises the following steps:

1 Determination of personal learning needs.

2 Development of a CEP learning contract (plan). A CEP contract is an agreement, and may be between the individual and their CEP group, or in the case of individual contracts, between the individual and the local CEP Coordinator, outlining CEP learning objectives for the following three-year recertification period.

3 A commitment of 150 hours to the CEP contract over three years, or an average of 50 hours per year. A guide is provided to fellows and members about the types of activities that may be acceptable in the CEP Contract.

4 The participant undertakes an annual review of progress with the CEP learning contract, which is endorsed either by the CEP learning group members, or in the case of an individual contract, by the local CEP coordinator.

5 Every three years the College National Director Continuing Education/Recertification certifies completion of CEP on the recommendation of the local CEP Coordinator and a new CEP cycle is initiated.

The College has developed templates to assist fellows and members in undertaking and recording CEP activities. These templates have been used as part of a manual system for documenting professional development and CEP participation. The College is now moving to an online environment for the CEP.

**CEP framework and activities in 2008**

In 2007, the College introduced a CEP Competency Domain Framework and CEP curriculum to define the relationships between the College's competencies and the educational framework for continuing education, and to facilitate rapid access to knowledge areas common and necessary for medical management across the broad spectrum of the roles and responsibilities of medical managers.

The CEP Domain Framework clusters competencies in each of the CanMEDS domains into groups. Each group then has a list of knowledge, skills and behaviours that are reasonably specific and relevant.

The College organises a number of CEP activities annually, including the Annual Scientific Meeting (Conference). The state, territory and New Zealand Committees also provide professional development activities in the form of lectures, journals and meetings where participation of fellows and members is encouraged. State/territory committees usually have a

scientific meeting co-coordinator who provides information about appropriate professional development activities being run in each jurisdiction.

A schedule of relevant conferences is regularly advertised in the RACMA journal *The Quarterly* and on the College website. Reminders of key conferences and professional activities are also published in the monthly RACMA *Notes*.

The RACMA Mentoring Program is part of the College's CEP. It was introduced in 2002 as part of the Colleges Strategic Plan, following a survey of new fellows that indicated support for such a program.

The Mentoring Program aims to provide career development support for new fellows by establishing a one-to-one relationship with an experienced fellow whose professional knowledge and management skills will assist career development and provide the opportunity for new fellows to meet their ongoing learning objectives.

The objective of the Mentoring Program is to provide new fellows with the opportunity to access support from experienced colleagues in progressing their careers. A mentor is an experienced fellow, who has agreed to provide their time and expertise to participate in the Mentoring Program. It is proposed to evaluate the Mentoring Program by obtaining feedback from participating new fellows and their mentors; and to undertake a formal review of outcomes and directions in 2008-2009, when two groups have been part of this phase of the Mentoring Program.

**CEP participation requirements in 2008**

The RACMA Council decided in 2004 that it would move to make CEP mandatory by 2007. In August 2007, Council approved the Policy on Mandatory Participation in the Continuing Education Program.

The new policy specifies the grounds on which exemption from participation in CEP may be granted and the process for seeking exemption. This applies to life fellows; honorary fellows; and fellows and members who are fully retired, and in the case of periods of protracted leave. These applications are considered by the Council, with recommendations from the National Director Continuing Education/Recertification.

More than 50 per cent of RACMA fellows and members are also fellows of other medical colleges. Fellows and members who participate in other medical colleges' continuing education programs may include activities relevant to medical management in their RACMA learning contract. Therefore conjoint fellows may be able to satisfy RACMA requirements entirely through active participation in other college programs. Conjoint fellows are required to provide a copy of certification issued by the other college, and evidence that the activities and objectives of their continuing education program are relevant to the development and maintenance of medical management competencies.

The College CEP is available to all College fellows and members. RACMA provide separate *Management for Clinicians* programs specifically designed for clinical staff of other colleges and professional disciplines.

College policy indicates that fellows and members who do not maintain CEP participation, other than those with approved exemptions, will be considered not to be in good standing

with the College. This will exclude them from acting as supervisors, preceptors or censors; serving on the College Council or committees; representing the College on national bodies or in other functions; and using their College post-nominals in any way.

The College has proposed to publish annually on the public section of its website a list of fellows and members actively participating in the College's CEP from January 2009.

**CEP participation rates in 2008**

The CEP Committee monitors participation rates. Fellows' participation rates in the CEP have increased steadily over the last three years and were 63 per cent in July 2007. Participation rates for members of the College have also increased from 5 per cent in 2004, and were at 49 per cent in July 2007. New Zealand has a high compliance with CEP, as this is a registration requirement of the Medical Council New Zealand.

An annual audit of 5 per cent of CEP participants has been conducted in the past, whereby auditees were required to produce documentary evidence to support their certification. In 2008 the annual audit will increase to 10 per cent of fellows and members.

**Evaluation of the Continuing Education Program in 2008**

The National Director Continuing Education/Recertification monitors CEP-related policies.

The criteria used for evaluation are varied and include College participation rates, fellow and member satisfaction levels, self-reflection on learning outcomes, and concordance with learning contracts.

The most recent evaluation of the CEP Program was undertaken in early 2007 under the auspices of the CEP Committee. The survey has pointed to some policy review and practice actions. These have been recommended to Council and include:

- implementation of a CEP electronic recording environment (for pilot in early 2008)
- development of procedures and structures (as appropriate) to recognise professional development in another College
- reorganisation of the College website to make information about CEP more accessible (commenced)
- implementation of a process to communicate information about CEP activities recognised by the College and promoted through the website (commenced)
- in 2007, the orientation session for new fellows was re-instituted at the national conference
- a policy for mandatory CEP.

The new web-based system for CEP activities will help the CEP Coordinators, the National Director Continuing Education/Recertification and the National Secretariat undertake their roles of approval and certification.

### *9.1.1 2008 Team findings*

RACMA is to be commended on its strong history and leadership in the introduction of a continuing education program.

The work of the CEP Coordinator is recognised as critical to the operation, in particular the good functioning of the CEP learning contracts, their regular review and tracking progress to certification. These roles are likely to become increasingly active and require substantial support from the College.

The Team was impressed by the effort and enthusiasm put into development and early use of the learning plan approach. The College has invested considerable energy in explaining adult learning styles, how to assess competencies, identify learning goals, etc. Given the emphasis placed on self-reflection in the candidates, this program complements this philosophy nicely.

The Team noted that the College's guidance on the activities which will satisfy the CEP requirements does not include audit and peer-review activities. The College could specify components of CEP to ensure the range of activities includes those which promote peer review, audit and self-reflection. To satisfy New Zealand requirements, they should include reference to cultural competence.

RACMA has adopted the CanMEDS competencies as a basis for its CEP domain framework and CEP curriculum. This is a positive development, as is the commitment to continuous review of its relevance in reflecting contemporary medical administration practice, as well as the views of the wider community.

The CEP mentoring program would appear to be a worthy venture, however the uptake is poor. The reasons for this should be explored.

The Team commends the recent adoption of a policy of compulsory participation in CEP, and the strengthening of College policy and processes to support this decision. The low participation rates will present a significant challenge to implementing compulsory CEP. In 2007, the College completed a survey of College fellows and members as part of the evaluation of the CEP program. The results of the survey suggested that while fellows and members may be meeting their CEP obligations, not all were subsequently requesting documentary evidence of certification from the College. The College indicates that there are now a number of strategies underway to enhance participation in CEP activities, including publication of the outcomes of the survey, streamlining of College documentation around the certification process, and creation of an electronic CEP environment.

The Team commends the College's regular evaluation of the CEP program and in particular the 2007 CEP survey. It has made a useful contribution to CEP development. Plans to continue and repeat this process are to be encouraged. The CEP program could benefit from regular review by consumers through peak bodies such as the Consumers Health Forum.

The group CEP process is popular with fellows and is commended. The College should consider ways to document individual participation in each group so that it still ensures valid and adequate individual CEP participation.

### 9.2 Retraining and remediation in 2008

At present there are no formal processes for the retraining of fellows whose standards of practice are of concern to peers or employers, or who require retraining after a prolonged period of absence from practice. The Council indicated that it is delineating policies and procedures relating to retraining and performance management and plans to have draft policies completed in 2008.

2008 Commendations

V The College's leadership in professional development programs and its *Continuing Education Programme Manual.*

W Adoption of the CanMEDS competencies as a basis for its CEP domain framework and CEP curriculum, and the commitment to continually re-evaluate its relevance in reflecting contemporary medical administration practice as well as the views of the wider community.

X The significant investment of members' time in developing electronic information technology to support the CEP program.

Y The adoption of a policy mandating participation in the CEP program and the increased level of audit of CEP returns.

*2008 Recommendations*

42 Report to the AMC on how it will manage the move to compulsory CEP given the current low participation rates.

43 Continue and repeat the CEP survey.

44 Explore the reasons for the poor uptake of the CEP mentoring program.

45 Consider a CEP program that includes elements that will promote self-reflection, such as peer review and audit. The program should include activities to promote cultural competence, with the need for certain standards to be met.

46 Consider ways to document individual participation in each CEP group so that it ensures valid and adequate individual CEP participation. The process of monitoring the contract should be reconsidered to avoid the potential for a pair of fellows signing off on each other's contract.

47 Progress its current review of the retraining and remediation of its fellows who are underperforming.

48 Include consumer involvement in CEP program reviews.

### 9.3 The RACMA Continuing Education Program (CEP) in 2012

The CEP program is governed by the Continuing Education Program Committee and the jurisdictional CEP Coordinators. The Continuing Education Program Committee reports to the Education and Training Committee, which in turn reports to the Board.

In 2011 the College published the *Continuing Education Program Manual* based on the curriculum document, *Medical Leadership and Management.* The program's activities relate to two overarching CEP Standards – Standard 1: Peer review and self-audit and Standard 2: CEP activity. The latter comprises four types of activities: Clinical Governance, Quality Improvement, Clinical Risk Management; Maintenance of Knowledge and Skills; Teaching and Examination; and Research and Publication.

The College also established the Maintenance of Professional Standards Program in 2011 for medical managers who are not College members to engage in continuing professional development.

The College is developing a range of tools for the CEP peer review and self-audit standard. The tools include a pilot study of 360 degree feedback which focuses on the participant's leadership and management competency. Participants nominate 15 peers to be involved in providing feedback and a mentor who will be responsible for providing one-on-one feedback of the review results. Participants and peers then engage in a confidential on-line survey with the participant receiving a de-identified report of the feedback. The mentor will assist the participant in developing a performance plan based on the peer feedback. At least one activity must be undertaken during each triennium.

Evidence of cultural competency and Indigenous health training has become a requirement for all fellows from 2012 and a learning resource is available online.

The College has set up and implemented the National Management and Leadership Peer Review program, a joint initiative of the Committee of Presidents of Medical Colleges and the Australian Government Department of Health and Ageing. This program has established a network of RACMA and clinician managers who attend a bimonthly webinar to present and discuss their own workplace related cases with peers. The Peer Review Learning Sets comprise around 15 to 20 managers, two facilitators and the RACMA Curriculum and Training Coordinator. Three learning sets have been established. Each case is a de-identified work-based management or leadership issue that is presented by one of the managers and discussed. These webinars have been well-received by the participants and the College intends to apply for further funding to enable them to continue.

As about 60 per cent of College members are also members of other medical colleges, they may participate in another college's CPD program. Such members may gain 40 per cent (20 points) of the required annual points from the completion of another college's CPD program. RACMA and the Hong Kong College of Community Medicine recognise each other's CPD programs.

Fellows are encouraged to upload evidence of their activities to the e-CEP platform and the College is working towards participants providing evidence on-line for all completed activities. This allows the College to readily audit participation. The respective jurisdictional CEP Coordinator follows up those who are not participating and those who are not meeting the program's requirements. Continued non-compliance is referred to the CEP Chair and then the Board and may lead to removal of membership.

The College carries out program review and evaluation by a periodic online survey of CEP stakeholders.

### *9.3.1 2012 Team findings*

There has been major development of the CEP since the 2008 accreditation and the program has been successfully blueprinted against the curriculum.

The Team commends the College on the wide range of initiatives related to CPD, including the three-year CEP strategic plan, the e-CEP platform, inclusion of cultural competence and indigenous health, peer review and self-audit. The Team was impressed with the range of

resources available on the College website and the strong focus of the CEP on continuous quality improvement.

Specific Medical Council of New Zealand requirements of New Zealand doctors with vocational (specialist) registration include peer review, clinical audit and cultural competence as well as continuing medical education. Whilst the CEP largely meets these requirements, the College needs to ensure that New Zealand fellows are aware of the annual (rather than triennial) requirement of at least ten hours for peer review. Development and audit of personal learning plans is a professional development activity listed under the Maintenance of Knowledge and Skills component of the CEP activity standard. Although not in the CEP peer review and self-audit standard, this could be deemed an annual peer review activity for New Zealand fellows. The College needs to discuss with the Medical Council of New Zealand how a non-medical specialty would best meet the annual audit requirement.

The Team commends the College on the significant improvement in participation rate in the CEP since 2008. All fellows are enrolled and 97 per cent participate. About 90 per cent achieve full compliance.

In 2008, the AMC recommended that the College involve consumers, as stakeholders, in CEP review. Based on the College's progress reports, the AMC had recommended that the College reconsider what was a narrow definition of its consumers and asked that the College show that it had considered its relationship with the wider community and had established an appropriate consumer base.

In its submission for the 2012 assessment, the College outlined its early steps to consider opportunities for integrating consumer perspectives into the activities of the College, including the CEP. These developments are welcome.

## 9.4 Retraining and remediation in 2012

The College has developed a policy and procedure for retraining following protracted leave, self-identification of need or a regional health board, medical board or council requirement. The process is overseen by the Chair of the CEP Committee. Under the policy, if a retraining program is necessary, the fellow and their nominated executive coach and supervisor develop a training plan. The executive coach, Jurisdictional Coordinator of Training and supervisor complete an In-training Assessment Report in the middle of the retraining period and, at the end of the retraining period, recommend either presentation to the Reinstatement Panel or an extended period of retraining. The Reinstatement Panel, comprised of three senior Fellows, asks structured questions based on the RACMA competencies, and a case based discussion question. The panel make a formal recommendation to the CEP Committee and the Board for the fellow's reinstatement or extended retraining.

To date no fellows have undertaken remediation and/or retraining.

### *9.4.1 2012 Team findings*

The Team noted the retraining and remediation policy and procedure and supports its proposed review after use, as well as periodically.

The Team considers recommendations 42, 43, 44, 45, 46 and 47 from 2008 have been met. Recommendation 48 remains to be met, and is recommendation 13 in 2012.

2012 Commendations

R The successful blueprinting of the continuing education program against the curriculum.

S The range of continuing education resources available on the College website and the strong focus of the continuing education program on continuous quality improvement.

T The significant improvement in the number of fellows participating in the continuing education program.

*2012 Conditions to satisfy accreditation standards*

12 Work with the Medical Council of New Zealand to ensure that New Zealand Fellows are aware of the annual, rather than triennial, requirement of at least ten hours for peer review, and that the continuing education program includes a professional development activity that meets the Medical Council of New Zealand's requirement for an annual audit activity. (Standard 9.1)

13 Include consumer involvement in continuing education program reviews. (Standard 9.1)

## Appendix One Members of the RACMA Assessment Team 2008

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## Appendix Two Members of the RACMA Assessment Team 2012

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**Associate Professor Deborah Read** BA *Cant.* MBChB DComH *Otago* MCCM *(NZ),* FAFPHM (RACP), FNZCPHM
Public Health Medicine Consultant
Associate Professor at the Centre for Public Health Research, Massey University

**Ms Theanne Walters**
Deputy Chief Executive Officer
Australian Medical Council

## Appendix Three List of Submissions on the RACMA Education and Training Programs 2008 and 2012

**2008**

ACT Health

Australian and New Zealand College of Anaesthetists

Australian Indigenous Doctors' Association

Bond University

Chronic Illness Alliance

Deakin University

Department of Health and Community Services, Northern Territory

Department of Health and Human Services, Tasmania

Department of Health Western Australia

Department of Health, South Australia

Health Consumers' Council of Western Australia

Medical Board of Queensland

Medical Board South Australia

Medical Practitioners Board of Victoria

Monash University

New Zealand Ministry of Health

NSW Department of Health

Royal Australian and New Zealand College of Ophthalmologists

Royal Australian and New Zealand College of Psychiatrists

Royal Australian and New Zealand College of Radiologists

Royal College of Pathologists of Australasia

The Royal Australasian College of Physicians

**2012**

Australian Medical Association, Council of Doctors in Training

Consumers Health Forum of Australia

Department of Health, Victoria

Department of Health and Human Services, Tasmania

Health Consumers' Council

Health Workforce Australia

Monash University

NSW Department of Health

Queensland Health

Royal Australasian College of Surgeons

The Australasian College of Dermatologists

The Royal Australian College of General Practitioners

The Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Psychiatrists

## Appendix Four Summary of the Team's Program of Meetings 2008

**WESTERN AUSTRALIA**

**Monday 9 June**
Dr Szu Lynn Chan, Dr Omar Khorshid (AMC Assessor)

| *Location* | *Meeting* |
|---|---|
| Department of Health | Medical Administration Candidates |
| | Medical Administration Preceptors |

**WELLINGTON, NEW ZEALAND**

**Tuesday 10 June**
Associate Professor Jennifer Weller, Ms Theanne Walters

| *Location* | *Meeting* |
|---|---|
| The Royal New Zealand College of GPs | NZ State Censor for RACMA<br>Senior Advisor - Service Development for Child Youth and Family Chairman - Health Information Standards Organisation |
| | Medical Administration Supervisors |
| | Medical Administration Preceptor |
| | Medical Administration Candidates |
| | Medical Training Board |

**NEW SOUTH WALES**

**Wednesday 11 June**
Professor Andrew Coats, Dr Szu-Lynn Chan, Ms Simone Bartrop

| *Location* | *Meeting* |
|---|---|
| Royal North Shore Hospital | Medical Director |
| | Medical Administration Supervisors |
| | Medical Administration Preceptors |
| | Medical Administration Candidates |
| NSW Health | A/Director Workforce Development and Leadership |

**QUEENSLAND**

**Wednesday 11 June**
Dr Cam Bennett, Associate Professor Andrew Smith

| *Location* | *Meeting* |
|---|---|
| Royal Brisbane and Women's Hospital | A/Director Medical Workforce Advice and Coordination, Queensland Health |
| | Medical Directors |
| | Queensland State Committee |
| | Medical Administration Supervisors and Preceptors |
| | Medical Administration Candidates |
| | New Fellows |
| | Chair, Board of Studies & State Committee Representatives |

**SOUTH AUSTRALIA**

**Thursday 12 June**
Mr Nino DiSisto, Associate Professor Jennifer Weller

| *Location* | *Meeting* |
|---|---|
| South Australia Health | Chief Medical Officer |
| | Supervisors, Chair of South Australian Board of Studies |
| | Preceptors |
| | Candidates |

**VICTORIA**

**Monday 16 June**
Professor Andrew Coats, Associate Professor Jennifer Weller, Ms Simone Bartrop

| *Location* | *Meeting* |
|---|---|
| Department of Human Services, Victoria | Services and Workforce Planning |
| Hotel | Teleconference with rural hospital candidates |
| | Teleconference with preceptors of rural candidates |

Associate Professor Andrew Smith, Dr Szu-Lynn Chan

| | |
|---|---|
| Southern Health, Monash Medical Centre | Executive Director Medical Service |
| | Supervisors |
| | Preceptors |
| | Candidates |
| | Senior Clinician Managers |
| | Chief Executive Officer of the Monash Medical Centre |

Dr Cam Bennett, Associate Professor Frank Fisher, Mr Nino DiSisto

| *Location* | *Meeting* |
|---|---|
| Peter MacCallum Cancer Centre | Chief Executive Officer |
| | Chief Medical Officer |
| | Supervisors |
| | Preceptors |
| | Candidates |

**Meetings with the RACMA Committees and Staff**

**Monday 16 June 2008**

| **Time** | **Meeting** | **Attendees** |
|---|---|---|
| 2.00pm to 5.00pm | AMC Team Meeting | AMC Team |

**Tuesday 17 June 2008**

| Time | Meeting | Attendees |
|---|---|---|
| 9.30am – 10.30am | Executive of Council | AMC Team<br>Executive of Council |
| 10.45am – 12.30pm | Council | AMC Team<br>Council |
| 1.45pm – 3.15pm | State Committee Officers | AMC Team<br>State Committee Officers plus additional Committee Officers by teleconference |
| 3.30pm – 4.30pm | Secretariat Staff (Chief Executive, Business Support, CEP/Web Support) | AMC Team<br>RACMA Secretariat Staff |
| 4.30pm – 5.00pm | Accreditation support and Quality Co-ordinator | AMC Team<br>Dr Ahern, Dr Appleton, Chief Executive |

**Wednesday 18 June 2008**

| Time | Meeting | Attendees |
|---|---|---|
| 9.00am -10.00am | The College's Fellowship Training Program; Assessment and Examination; Environment for Training; Issues Relating to Candidates | AMC Team<br>Censor in Chief |
| 10.15am – 12:30pm | As above plus OTS, BOS of Qld (Brisbane), NSW (Sydney), VIC (Melb), SA (Adelaide), NZ (Wellington) | AMC Team<br>BOTCE inc BOS, Censors, Education Consultant |
| 1.45 pm -3.15pm | Continued from before lunch (see above) | AMC Team<br>BOTCE including BOS, Censors, Education Consultant |
| 3.30pm – 5.00pm | Continuing Education Committee | AMC Team<br>Continuing Education Committee |
| 5.00pm -6.00pm | AMC Team debrief | AMC Team |

**Thursday 19 June 2008**

| Time | Meeting | Attendees |
|---|---|---|
| 9.00am – 10am | Candidate Representative on Council | AMC Team<br>Candidate Representative on Council |
| 10.00am – 11.00am | Expanded Settings for Specialist Training program | AMC Team<br>Dr Gruner, Steering Committee |
| 11.15pm – 12.30pm | Other matters | |
| 1.45pm – 3.45pm | AMC Team prepares preliminary findings | AMC Team |
| 4.00pm -5.00pm | AMC Team presents preliminary findings and provides opportunity for College comment | AMC Team |

## Appendix Five Summary of the Team's Program of Meetings 2012

**WESTERN AUSTRALIA**

**Monday 2 July 2012**
Professor Michael Kidd, Dr Joshua Francis

| *Location* | *Meeting* |
|---|---|
| Department of Health, Western Australia | RACMA Candidates |
| | RACMA Preceptors |

**WELLINGTON, NEW ZEALAND**

**Thursday 5 July 2012**
Associate Professor Deborah Read, Ms Susan Yorke (MCNZ Representative)

| *Location* | *Meeting* |
|---|---|
| Health Workforce New Zealand | Director |
| Accident Compensation Corporation (ACC) | RACMA NZ Jurisdictional Co-ordinator of Training |

**CANBERRA**

**Tuesday 10 July 2012**
Mr Nino DiSisto, Ms Jane Porter, Ms Theanne Walters

| *Location* | *Meeting* |
|---|---|
| Australian Medical Council | Consumers Health Forum<br>Executive Director and Senior Policy Manager |

**Meetings with the RACMA Committees and Staff**

**Tuesday 17 July 2012**

| Time | Meeting | Attendees |
|---|---|---|
| 12:00pm – 1:30pm | College Board | AMC Team<br>College Board |
| 2:00pm – 3:15pm | RACMA Board | AMC Team<br>RACMA Board |
| 3:30pm – 4:15pm | Assessment and Examination | AMC Team<br>Dr Lyn Lee and Board of Censors |
| 4:15pm – 5:30pm | Candidate Advisory Committee | AMC Team (group 1)<br>Drs Leah Barrett-Beck & Alistair Mah |
| | Continuing Education Committee | AMC Team (group 2)<br>Dr Bernie Street and CEP Committee Members |

**Wednesday 18 July 2012**

| Time | Meeting | Attendees |
|---|---|---|
| 9:00am – 10:00am | Chairs, Jurisdictional Committees & Jurisdictional Coordinators of Training | AMC Team<br>Drs Dines, Ayre, Morris & McArdle |
| 10:15am – 11:00am | Environment for Training – Education and Training & Credentialing Committees | AMC Team<br>Drs Lee Gruner, Tony Austin, Karen Owen |
| 11:00am – 12:00pm | MiniMex | AMC Team (group 1)<br>Drs Pantle & Owen |
| | Standard Pathway Candidates | AMC Team (group 2)<br>12 – 14 Current SP Candidates |
| 1:00pm – 2:00pm | Training Committee | AMC Team<br>Drs O'Sullivan & Karen Owen |
| 2:00pm – 3:00pm | New Fellows | AMC Team (group 1)<br>New Fellows |
| | Executive Coaches | AMC Team (group 2)<br>Drs Rankin & Walsh |

**Wednesday 18 July 2012 (continued)**

| Time | Meeting | Attendees |
|---|---|---|
| 3:15pm – 4:00pm | Preceptors | AMC Team (group 1)<br>Drs Trye, Daly, Asby |
| | Supervisors | AMC Team (group 2)<br>Drs Hill, Kelly, Ayre, Sandford |
| 4:00pm – 5:00pm | Accelerated Pathways Candidates | AMC Team (group 1)<br>Accelerated Pathways Candidates |
| | College Staff | AMC Team (group 2)<br>College Staff |

**Thursday 19 July 2012**

| Time | Meeting | Attendees |
|---|---|---|
| 9:00am – 10:00am | Health Departments (teleconference) | AMC Team<br>Department of Health VIC, QLD Health & NSW Health representatives |
| 10:30am – 1:00pm | AMC Team prepares preliminary statement of findings | AMC Team |
| 2:00pm – 3:00pm | AMC Team presents preliminary statement of findings to RACMA board and provides opportunity for College comment | AMC Team |