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

SPECIALIST EDUCATION ACCREDITATION COMMITTEE
REPORT TO THE
AUSTRALIAN MEDICAL COUNCIL

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EXECUTIVE SUMMARY

In June 2008, an AMC Assessment Team assessed the, training and professional development programs of the Royal Australasian College of Medical Administrators (RACMA). RACMA is the last established Specialist Medical College to undergo the AMC's specialist accreditation program which has been in place since 2002.

The AMC Team wishes to thank the fellows, candidates and the members of the College secretariat for their hospitality and assistance during this accreditation. The interactions between the Team and the College were collegial, and provided opportunities for each group to learn from the other's experiences and expertise.

This Executive Summary provides a short summary of the main findings organised according to strengths and areas that require further development. It also contains a full list of the commendations and recommendations that have been made in the body of the report, and the accreditation decision.

The main findings concerning the strengths of the College's education and training include:

1. The College is a professional, well-run organisation, which is well supported by its Chief Executive Officer and small secretariat.
2. The College has committed to reviewing its constitution, and its policies, procedures and processes.
3. The College is committed to identifying training opportunities in the public and private sector for medical administrators.
4. The College has taken actions to strengthen the relationship between supervisors and preceptors.
5. The College has demonstrated leadership, by being one of the first Australasian colleges to introduce a professional development program, and through its annual review of its *Continuing Education Programme Manual.*
6. The College has adopted the CanMEDS competencies as a basis for its CEP domain framework and curriculum, and is committed to re-evaluate continuously the relevance in reflecting contemporary medical administration practice as well as the views of the wider community.

The main findings in relation to areas requiring further development are as follows:

1. The College needs to complete its response to the constitutional review, and introduce mechanisms to ensure consistency across jurisdictions in regard to the role, independence of, and standards applied to the state and territory boards of study.
2. The College should articulate the goals of training more clearly.
3. The College should further develop competencies into a curriculum map and implement the curriculum in all areas of the training program and assessments.
4. The College should further develop ongoing feedback processes for candidates and make greater effort to overcome training gaps for rural candidates.
5. The College should review its procedures for unsatisfactory candidate performance, remedial work and reassessment.
6. The College needs to develop a systematic process for the selection and training of examiners and censors.
7. The College should further develop formal feedback mechanisms for preceptor performance.

8. The College should form a candidate committee and ensure there is a candidate representative on education committees.

9. The College needs to make greater use of data and feedback in the development of monitoring and evaluation procedures.

10. The College needs to explore further the poor uptake of the CEP mentoring program and review the remediation and retraining of underperforming fellows.

A full list of the commendations and recommendations follows, in the order in which they appear in the Report.

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.

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

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 master degree programs which reduce costs, enhance educational rigour (provided courses are assessed and only good quality courses are accepted) and increase the diversity of input into the training of candidates. The Team acknowledges 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 master degree. The AMC will want to see progress in this direction in subsequent reviews.

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

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

J. The annual assessment through preceptor and supervisor reports.

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

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

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

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

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.

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.

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

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

W. The College's adoption of the CanMEDS competencies as a basis for its CEP domain framework and CEP curriculum, and the commitment to re-evaluate continuously their 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.

Recommendations

That the RACMA:

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

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 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 membership and the wider health community, the College's view of the role of the medical administrator.

7. Consider strengthening its national secretariat.

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.

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.

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

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

15. Ensure that 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.

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.

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.

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

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.

22. Review of 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; and

- reviewing and strengthening processes for providing constructive feedback to candidates who are required to re-submit their case studies.

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 as 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.

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.

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

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 State/Territory/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 offers secretarial support for the new committee.

35. Consider playing a role in facilitating communication amongst candidates nationally and/or internationally through its website, e.g. establishing a candidate online forum, 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. Conduct an annual survey of all candidates (regarding quality of workplace experience, levels of supervision, training and teaching) in addition to the New Fellow Survey.

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 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

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; and
    - streamline and regularise feedback processes by the use of templates.

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 others' 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.

Council decision on accreditation

The AMC Guidelines for Accreditation provide four options for the AMC in making its decision on accreditation:

(a) Accreditation for six years subject to satisfactory annual reports from the college during the period of accreditation, with the possibility of the AMC extending the accreditation by a further four years subject to a satisfactory annual report in the fifth year of accreditation.

(b) Accreditation for six years with conditions on the accreditation subject to satisfactory annual reports from the college during the period of accreditation, with the possibility of the AMC extending the accreditation by a further four years subject to a satisfactory annual report in the fifth year of accreditation.

(c) Accreditation for shorter periods of time with conditions, where significant deficiencies are identified. A shorter period of accreditation may also be granted where the college is making major changes to its education and training programs, and the AMC wishes to review the implementation of plans.

(d) Accreditation may be refused where the AMC considers that the deficiencies are so serious as to warrant that action.

The Specialist Education Accreditation Committee recommends:

(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:

a. 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 annual 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; and
- progress on how the College is managing the transition to compulsory CEP, and the review of participation rates, retraining and remediation of fellows.

1 INTRODUCTION: THE AMC ACCREDITATION PROCESS

The Australian Medical Council (AMC) is a national standards body for medical education and training. One of its functions is to advise and make recommendations to the State and Territory medical boards on the accreditation of Australian and Australasian providers of specialist medical training and of their specialist medical training and professional development programs.

1.1 Background to establishment of the process for accreditation of specialist medical education and training programs

The AMC's accreditation process aims to provide external assurance of the quality of specialist medical education, based on explicit educational standards. It is a voluntary process aimed at quality improvement.

The AMC implemented the review process in response to an invitation from the Commonwealth 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 (CPMC), which was established to consider the Minister's request, 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
- enhancement of 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 medical specialties, the AMC should review and accredit the training programs of the existing providers of specialist medical education and training, the specialist medical colleges. It was agreed that the review process should encompass both specialist medical education and training programs and the continuing professional development programs that the colleges provide to assist their fellows to maintain their standards of professional practice.

Separate working parties developed the three elements of the model. An AMC consultative committee developed a document comprising procedures for reviewing specialist medical training programs and draft educational guidelines against which programs could be reviewed. Following extensive consultation, the AMC endorsed a revised document in July 2000.

In order to test the process, the AMC conducted trial reviews during 2000 and 2001 with funding from the Commonwealth Department of Health and Ageing. These trialled the processes and guidelines by reviewing the programs of the Royal Australian and New Zealand College of Radiologists (RANZCR) and the Royal Australasian College of Surgeons (RACS).

Following the success of these trials, the AMC implemented the new accreditation process in November 2001. It established a Specialist Education Accreditation Committee (SEAC) to oversee the accreditation 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. It confirmed the Guidelines for Accreditation, *Accreditation of Specialist Medical Education and Training and Professional Development Programs: Standards and Procedures*, in July 2002.

1.2 Description of the AMC review process

Historically, specialist medical colleges have coordinated the training, education and examination of medical specialists in Australia, with training in a particular area of specialist medical practice being provided by one national specialist medical college.

Typically, the specialist medical colleges have had as their mission the definition and promotion of high standards of medical practice and patient care in their specialty area, achieved through:

- setting standards of training, medical practice and professionalism
- ensuring that trainees are prepared for specialist medical practice and equipped to respond to evolution in medical practice
- promoting investigation and medical research
- promoting medical knowledge and encouraging medical specialists to continue their professional development
- public education and health education
- contributing to debates about healthcare, and wider health and social issues
- collaborating with other medical bodies nationally and internationally
- promoting health policy that supports good care and responsible decisions.

In developing its new model for recognising medical specialties and reviewing specialist medical training programs, the AMC noted the possibility of different approaches to the provision of specialist medical training in the future, including the possibility of bodies other than specialist medical colleges providing training, and the possibility of more than one provider of training in any specialist discipline.

Thus, the AMC Guidelines for Accreditation do not prescribe any particular model of specialist training.

The Guidelines do, however, identify key features of successful specialist/vocational training programs. The AMC believes that specialist/vocational medical practice requires completion of a comprehensive program of advanced training and assessment including completion of:

- a broad education program in basic medical sciences and clinical skills, with objective assessment of proficiency
- supervised practical training in accredited training programs that emphasise graduated practical experience and development of a knowledge-base in the science and practice of the relevant specialty
- the requirements for fellowship of the relevant college/training organisation, including a range of structured objective assessments and satisfactory supervisors' reports.

The structured assessments conducted during specialist training, and the progressive increase in experience and level of responsibility, are integrally related so that assessments cannot be undertaken in isolation from training.

The Guidelines for Accreditation also outline the roles and responsibilities of the body that awards the qualification certifying completion of a program of appropriate specialist medical training. In addition, they indicate the roles expected of training organisations in assessing the equivalence of overseas-trained specialists, and in providing and accrediting continuing professional development programs.

These key features of training programs and essential roles of training organisations are listed in the Accreditation Standards, which are reproduced at Appendix 1.

The Guidelines for Accreditation describe a standard process that the AMC uses to review education and training processes and programs, including continuing professional development programs.

The AMC believes that the accreditation process should:

1. assess whether the education, training and professional development programs:
    - are relevant to the objectives and outcomes determined by the training organisation
    - are appropriate in terms of modern educational methods and clinical practice
    - include appropriate assessment methods that test the trainee's knowledge, clinical skills, professional qualities and expertise for safe and competent practice of the specialty
2. encourage further improvements and developments in the programs being accredited and so enhance their educational quality
3. provide an opportunity for the organisation being accredited to review and to assess its own program(s). The collegiate nature of accreditation should facilitate discussion and interaction with colleagues from other disciplines to benefit from their experience
4. assure the community that a doctor who has successfully completed an accredited specialist education and training program is able to practise as a specialist in that area and is being assisted to maintain and enhance her/his knowledge, competence and performance
5. provide the basis for medical boards and the Health Insurance Commission (HIC) to grant the legal requirements for practice in the relevant specialty
6. be focused on the achievement of objectives, ongoing development of academic standards, public safety expectations, and good outputs and outcomes rather than on detailed specification of curriculum content relevant to the specialty or discipline.

The accreditation review is conducted as follows:

- The college prepares an accreditation submission, responding to questions in the Guidelines for Accreditation.
- The AMC appoints an assessment team, after seeking the college's views on the expertise required.
- The team considers the college's submission, identifies major issues to be addressed and decides on the meetings, site visits and other information required for the review.
- The team provides feedback to the college, and the college and the AMC Secretariat plan the review.
- The AMC seeks submissions on the college's programs from stakeholder groups.
- The team completes its review and prepares a detailed report.
- The Specialist Education Accreditation Committee considers the team's report and makes a recommendation on accreditation to the Council.

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

On the advice of the Specialist Education Accreditation Committee, the November 2007 Council 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 Team are listed in Appendix 2.

The review process has entailed the following steps:

- 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 Team's preliminary assessment of the submission, the additional information required by the Team, and on the Team's plans for visits to accredited training laboratories and for meetings with College committees
- 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 held between 9 and 16 June 2008.

Since most of the specialist medical colleges span Australia and New Zealand, the Medical Council of New Zealand (MCNZ) is an important contributor to the AMC process. With advice from the MCNZ, the AMC is seeking to ensure that colleges' accreditation submissions also address the MCNZ's requirements. AMC teams that visit New Zealand routinely meet Ministry of Health representatives, and are accompanied by an observer from the MCNZ.

1.4 Appreciation

The Team is grateful to the College staff and fellows who prepared the accreditation submission and managed the preparations for the review. It acknowledges with thanks the support of the College fellows in Australia and New Zealand who coordinated the visits to individual units and hospitals, and the assistance of those who hosted visits from Team members.

The groups interviewed by the Team had been briefed well, and the Team acknowledges the work of College staff in providing these briefings. The Team is grateful to all those who contributed to the review by attending meetings and / or by responding to the Team's surveys.

A list of the organisations that made a submission to the Team is at Appendix 4. A summary of the Team's program of meetings and visits is provided in Appendix 5.

2 ROYAL AUSTRALASIAN COLLEGE OF MEDICAL ADMINISTRATORS

2.1 Organisational structure and governance

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 master's 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. Currently, it does not require additional formal training or qualifications but does require a willingness to participate in RACMA's continuing education program.

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*.

2.2 Governance and organisational structure

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 and the implementation of College policy and the administration of 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 about the appropriateness of training positions; coordinates training programs and develops standards for accreditation of training positions; reviews candidate's training and progress reports; and counsel 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. The Chairs of the Boards of Studies 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 6 of this report.

Management of the College is provided by a small National Secretariat, led by the Chief Executive, Dr Karen Owen.

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.

Team's 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 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 would wish 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 to the 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.

The Team noticed the 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 that 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 recommend 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.

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.

Recommendations

That RACMA:

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.

2.3 Current challenges

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.

Whilst medical administration is recognised as a speciality 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 exists as a subspecialty of 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.

Team's findings

Through a number of commissioned external reports and its own internal structures, the College has clearly identified the key challenges that it faces and the strengths that it can draw on to address these challenges. The Team considers it is an essential step in the evolution of the College to make progress without delay in these areas. The AMC will expect to see progress made in a number of areas by the time of its next review, and to see evidence that the capacity exists to address the challenges raised by the external reports.

In doing this, the Team considers it is essential for the College to develop compelling arguments for the need for medical administration as a specialty and for the important contribution of well-trained medical administrators in complex modern health care systems to be appreciated by their natural allies and stakeholders. The Team is convinced of the value of the College and the speciality, 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 of the value it adds, and the Team remains concerned that the College is not adequately communicating a succinct statement of what medical administration is as a speciality and the key value trained medical administrators make to modern health care provision. This is an essential 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 and 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 current 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 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.

The Team commends the College on its strategic plan 2006-2009 and looks forward to hearing of the progress of its implementation, and a review of the achievements to date. The Team noted that the College is two years into its three-year plan and the Team will be interested to hear of the progress being made towards generating a successor strategic plan for the years 2009-2012.

The Team commends the College and its Chief Executive on the vision enunciated in the RACMA strategic plan and on the implementation milestones that were 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.

Recommendations

That RACMA:

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 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.*

7. *Consider strengthening its national secretariat.*

3 EDUCATION AND TRAINING IN MEDICAL ADMINISTRATION

3.1 AMC accreditation standards concerning the program of education and training

The AMC accreditation standards on education and training require that:

- The College has determined the goals for each of its education and training programs. The goals are based on the nature of the discipline and its role in the delivery of health care, and are related to community need.
- For each of its training programs, the College has a curriculum that enables trainees to achieve the goals of the training program.
- The College curriculum specifies the educational objectives of each component, 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.
- Completion of training is certified by the College by provision of a diploma or other formal award.
- The College has processes to determine the broad roles of practitioners in the discipline and these roles are addressed by the objectives of training programs.

3.2 The goals of education and training

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 achieve a 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 competencies of:

- 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.

3.3 The curriculum

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.

Team's 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 e.g. '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 in the sections 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 the curriculum specification process. 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.

Candidate feedback requested greater consultation and input into the training program redesign.

Commendation

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

Recommendations

That RACMA:

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.*

11. Consider incorporating formal training in direct consumer communication.

3.4 Structure, duration and sequencing of training

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 master's 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 1 and 3, 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 master's degree program usually over a three to four year period. The College requires that the master's 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.

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

- A two-day Induction Workshop early in year 1 which 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 to prepare for the oral examination, which covers amongst other issues: 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.

Team's 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 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 positions in rural hospitals, and this was seen as an increasing opportunity for posts. The Team noted that 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 that 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 for 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 master degree programs which are essential for medical administration.

The candidates' academic studies are provided through the university master 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 master's 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 master 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. 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 master 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.

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 master 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. The Team acknowledges 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 master degree. The AMC will want to see progress in this direction in subsequent reviews.

Recommendations

That RACMA:

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

training program.

13. *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.*

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

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.*

3.5 Recognition of prior learning (RPL)

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 an Accelerated Pathway to Fellowship with 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.

Team's findings

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.

Commendation

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

Recommendation

That RACMA:

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.

3.6 Research in training

The College has defined the competencies of Scholar, 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 master's degree.

Team's 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 speciality. 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.

Commendation

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

Recommendation

That RACMA:

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

4 ASSESSMENT AND EXAMINATION

4.1 AMC accreditation standards on assessment and examination

The AMC accreditation standards on assessment and examination require that:

- The College implements a systematic program of formative and summative assessments that is demonstrated to be reliable and valid.
- The assessment program reflects comprehensively the educational objectives of the training program.
- The College has processes for the early identification of trainees who are under-performing and for determining programs of remedial work.

4.2 Overall assessment and examination policies

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 (BOTCE) and then delegated to the College Censors.

Team's 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.

4.3 Formative and in-training assessment

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 e.g. 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.

4.4 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.

Team's findings

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.

4.5 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 1 to 3 indicating little competence, 4 to 7 indicating competent, and 8 to10 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.

Team's findings

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 that should 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.

4.6 Summative assessment

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 minutes 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 (MPF) 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 MPF. Continuing candidates in 2008 have the option to complete a case study instead of the MPF.

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 MPF will comprise reflective reports and written case studies by the candidate, derived from their work experiences in the three years of candidacy. The Folio 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 MPF 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 MPF.

Team's findings

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. The assessment of 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 MPF 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 MPF, nor how consistency will be achieved. In addition, it was not clear if the aims of the MPF were well understood by candidates and preceptors. Some believed that the MPF 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 portfolio, possibly by the use of a library of examples and other methods.

4.7 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.

Team's findings

The oral examination format has developed over many years. The College is currently 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.

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.

There are no formal processes of preceptor education in terms of performance feedback from candidates. 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.

4.8 Procedures for performance feedback and review

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 off
- 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 advised 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 with the candidate to provide some guidance and direction to assist with further preparation for the subsequent 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 presentation of the case study 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 are given the opportunity for a supplementary oral examination on the same day, as previously described. Candidates who fail the final oral examination are able to 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.

4.9 Identifying unsatisfactory performance

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 and 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.

There is a need for more formal preceptor education in terms of performance feedback. 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. Standardisation of the feedback process would be beneficial for candidates, preceptors and Censors.

4.10 Dismissal of candidates from training

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 currently under review.

4.11 Remedial training

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.

4.12 Dispute Resolution

Disputes about supervision and assessment are managed through the appeals process, which as mentioned, is under review.

Commendation

J The annual assessment through preceptor and supervisor report.

Recommendations

That RACMA:

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

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.

22. Review of 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 ENVIRONMENT FOR TRAINING AND TEACHING

5.1 AMC standards on accreditation of training posts and institutions

The AMC requires that:

- The College specifies the clinical experience, infrastructure, educational programs and support required of an accredited training institution/training position.
- The College implements clear processes to determine whether training institutions and training positions meet these requirements.
- The College's accreditation standards are publicly available.

5.2 College accreditation processes

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

RACMA 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 identified organisational and candidate objects which must be met.

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.

RACMA 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, RACMA 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 RACMA 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, RACMA began to recognise *individual training plans* as suitable for training.

5.3 Structured education programs

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 the need to undertake 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.

Team's 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 that it has not encountered any 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 BoTCE taking appropriate action. The Team expects that the College will 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 currently considerable variation in candidate training experience at different workplaces, and variation in the teaching of core and elective units in different master's 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. Currently 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, currently 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 sign-off by the local supervisor of where experience has been acquired, and central review of the candidates' experience against a clear statement of requirements.

5.4 Access to appropriate facilities and educational resources in hospitals/training sites

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.

Team's 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 availability of supervisors and preceptors. Some candidates felt that targeted support would be beneficial in some instances and that onsite learning resources access was not critical, but access to technology to access supports and online marital educational material was.

5.6 Interactions with health departments

State health departments have a formal well-established communication process with the College, and departments are 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.

Team's 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 training in root cause analysis would be beneficial and 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 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 currently split between the Commonwealth and states.

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.

5.7 Environment for training and teaching in New Zealand

The New Zealand context differs in substantial ways, in particular:

- 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 1 and 2.

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 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.

Commendations

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

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

Recommendations

That RACMA:

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.

6 CENSORS, PRECEPTORS AND SUPERVISORS

6.1 AMC accreditation standards on supervision and mentoring

The AMC accreditation standards on education and training require that:

- The College has processes for selecting and training supervisors and trainers.
- The College has processes for ensuring that trainees receive regular feedback from supervisors and trainers, and for obtaining confidential reports from trainees on the quality of their supervision, training and clinical experience.
- The College has a systematic process for selecting assessors in written, oral and performance-based assessment and examination who have demonstrated relevant capabilities. Selection of assessors takes account of an overall balance in gender, cultural background, nature of practice and its location.
- The College implements training programs designed to foster sound and consistent assessment methods.
- The College assists all trainees in identifying a suitable mentor. The mentor is not, and is highly unlikely ever to be, a supervisor, assessor or trainer for the trainee.

6.2 Defined roles

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 BoTCE
- 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 BoTCE and assist and support the work of the Censor-in-Chief. The censor assesses candidates to ensure that they meet the standards set in 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 BoTCE 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 BoTCE. 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 re-accredited 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 throughout their 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. However, 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 undertaking 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 training program undertaken by a candidate, and assist the candidate with progress towards attainment of medical management education standards by:
    - assessment of the candidate's suitability for a medical management career at the end of the first year of training and to prepare 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 August 31 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
    - responsibility for 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.

6.3 Training for supervisors and preceptors

The College has not provided specific training for supervisors. The College 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, a new Supervisor Induction Kit has been prepared for all new supervisors.

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.

6.4 Mentoring

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 out 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, and those who relocate their substantive positions during the training period and those who are 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.

Team's findings

The preceptorship program is a strength of the RACMA 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 have 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 current 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 it was clear that 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. Currently, 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. The insights of consumers could be more explicitly sought in training courses for preceptors.

Concerns have been raised by candidates that sometime 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 the very busy duties of their work. A contract for preceptors is to be introduced; it is hoped this will improve the situation in this area.

In regard to mentoring, 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.

Commendations

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

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

Recommendations

That RACMA:

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.

7 ISSUES RELATING TO CANDIDATES

7.1 AMC accreditation standards on trainee issues

The AMC accreditation standards require that the specialist medical college:

- selects trainees into training programs based on the principles in the 1998 report, 'Trainee Selection in Australian Medical Colleges' by the Medical Training Review Panel;
- has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training;
- has mechanisms to inform trainees about the activities of its decision-making committees, in addition to communication by the trainee organisation or trainee representatives; and
- provides clear and easily accessible information to prospective and existing trainees about the training program, costs and requirements, and any proposed changes.

7.2 Number of candidates entering medical administration training

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.

Commendation

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

Recommendation

That RACMA:

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

7.3 Process for selection to medical administration training

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

- the award of 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.

Evidence of the above requirements must be supplied, 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 (as detailed on the applicant information guide available from the College).

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 successful applicants are notified by the Censor-in-Chief or Secretariat 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.

Team's 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. The application process 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. Unlike other colleges, 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 the 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. Currently 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.

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.

Recommendations

That RACMA:

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 State/Territory/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 offers secretarial support for the new committee.*

35. *Consider playing a role in facilitating communication amongst candidates nationally and/or internationally through its website, e.g. 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.*

7.4 Candidate involvement in College affairs

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, 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 additions 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.

Team's findings

The Team acknowledged that 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 of the local committees. 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.

It was felt by candidates that it is 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 IT support to conduct their meetings and maintain communication lines.

The Team suggested that provision be made on State Committee meeting agendas for the regular inclusion of 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 Zealand.

As candidates are the ultimate consumers of the training program and represent the future membership 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 the governance of the College 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 the 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. Currently, 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 candidates who had just entered the Training Program had the foresight to view their preparation for the fellowship examination as a continuing task that they sought to commence at the beginning of their 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 RACMA website, improvements can still be made. Based on data collected by the College, only a minority of candidates was 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 BoTCE. 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 BoTCE recommends and reviews the curriculum, and the Boards of Studies are involved with the development of standards for accreditation of training positions, the inclusion of candidate members is strongly advocated by the Team.

Commendation

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

Recommendation

That RACMA:

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.

7.5 College mechanisms to support candidates

Candidates are generally satisfied with the timeliness of College communications. They were grateful of 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 Dispute resolution and appeals process

The AMC accreditation standards require that:

- the College has processes to address confidentially problems with training supervision and requirements:
- the College has clear, impartial pathways for timely resolution of disputes between trainees and supervisors or trainees and the college
- the College has appeals processes that allow trainees to seek impartial review of training-related processes or decisions, and makes its appeals policies publicly available
- the College has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

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 preceptor/candidate relationship to be unsatisfactory, for personal or training reasons, is able to approach the Chair of the local Board of Studies to seek re-assignment of a preceptor. Candidates disputing the assessment of their case study are required to contact the Censor-in-Chief, who will initiate a re-assessment process.

For candidates wishing to appeal their Final Examination result or process, *Guidelines for Appeal under RACMA Examination Procedures* exists. This document is supplied to all candidates and is also available on the RACMA website. An appeal must be lodged in writing with the Chief Executive within fourteen days of the examination result being notified in writing. The Appeals Committee in this case consists of a fellow of the College to be 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 candidacy is ceased by

the Censor-in-Chief, on the recommendation of the relevant Chair of Board of Studies, the candidate has a right of 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 will hand down their decision within one month of this meeting.

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

Team's 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*.

7.7 Flexibility in training

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 cognizant 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 perceived support from the College to allow flexible training was a key strength and attraction of the training program.

Team's 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.

8 ASSESSMENT OF OVERSEAS-TRAINED SPECIALISTS FOR AUSTRALIAN PRACTICE

8.1 AMC accreditation standards

The AMC accreditation standards on assessment of overseas-trained specialists require that the processes for assessing the availability of overseas-trained specialists for practice in Australia are in accordance with the principles outlined by the Joint Standing Committee on the Assessment of Overseas Trained Specialists (JSCOTS) of the AMC and the Committee of Presidents of Medical Colleges (CPMC).

8.2 Description of RACMA's assessment process

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 12 months and two years. The Council authorises a change from provisional to vocational scope of practice when the doctor has satisfactorily complete 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 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*.

8.3 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.

It is noted that no mention of the use of referees is made in the College submission to the AMC. While 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 Team recognised that the very small number of applications from overseas-trained specialists has meant that there have been some difficulties in complying with AMC guidelines. Therefore, the Team recommended that RACMA note the guidelines especially in regard to the possibility of perceived bias, and that it consider training Censors to be involved with assessment of overseas-trained specialists in avoiding such difficulties.

The Team recommended that the College 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. Given the complex social framework within which referees are chosen and used, it is recommended that a template for examination of referees be devised.

8.4 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 internal 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.

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.

Recommendations

That RACMA:

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.

9 MONITORING AND EVALUATION

9.1 AMC standards concerning monitoring and evaluation

The AMC accreditation standards require that the specialist medical college:

- maintains records on the outputs of the training program
- develops methods to measure outcomes of training and to collect qualitative information on outcomes
- has processes for the regular evaluation and review of its training programs, with opportunities for stakeholder input.

9.2 Outputs and outcomes of training

Since 1990, outputs recorded of the College training program indicate the following:

- Most candidates complete the program within a 3 to 6-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 both 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.

Pass Rates

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 clearly relate to a lack of preparation on the part of the candidate, there remains a concern shared by candidates and the Team 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 Board of Studies Chairs to identify the contributory factors.

Withdrawals

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 council of the College.

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.

9.3 Processes for evaluation and review of the training program

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.

Team's findings

The College's accreditation submission lists a number of ways in which the training program is evaluated. 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 program 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 would recommend 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 programme. Consideration of an external survey of candidates who have recently withdrawn, and an analysis of compounded statistics over time is 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 IMGs
- 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 normally 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.

Commendation

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

Recommendation

That RACMA:

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.*

10 THE RACMA CONTINUING EDUCATION PROGRAM

10.1 AMC standards concerning continuing professional development programs

The AMC accreditation standards require that the specialist medical college:

- has professional development programs that assist its members in maintaining their knowledge, skills and performance so they can deliver adequate and safe medical care
- monitors participation in all areas in which the specialist is currently practising and has processes to counsel fellows who do not participate in such programs when they are not compulsory
- has processes in place for retraining and remediation of its fellows who are underperforming.

10.2 The RACMA Continuing Education Program (CEP)

The College was one of the first Australasian specialty colleges to introduce a CEP 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 College has designated key roles in relation to the CEP. These are outlined below.

The role of the CEP Committee is outlined in Section 2. 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.

10.3 CEP framework and activities

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 committees usually have a scientific meeting co-coordinator who provides information to their state committee 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.

10.4 CEP participation requirements

The RACMA Council decided in 2004 that it would move to 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 percent of RACMA fellows and members may also be 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 current 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 that from January 2009, it will publish annually on the public section of its website a list of fellows and members actively participating in the College's CEP.

10.5 CEP participation rates

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

An annual audit of 5 percent 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 percent of fellows and members.

10.6 Evaluation of the Continuing Education Program

CEP-related policies are monitored by the National Director Continuing Education/Recertification.

The criteria used for evaluation are varied and include College participation rates; fellow and member satisfaction levels; self reflections on learning outcomes; 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 undertaken in another College by conjoint fellows or members, and overseas members (commenced)
- 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.

Team's 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 their candidates, this program complements this philosophy nicely.

The Team noted that the College's guidance on the activities which will satisfy the CEP requirements do 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 which has occurred to support this decision. The current low participation rates will present a significant challenge to implementing the impending move to 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.

10.8 Retraining

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 currently delineating policies and procedures relating to retraining and performance management and plans to have draft policies completed in 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.

Recommendations

That RACMA:

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 others' 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.

APPENDIX 1

Standards for Accreditation of Specialist Medical Education and Training and Professional Development Programs

Goals and Objectives of Specialist Education and Training and Professional Development

Specialist education and training:

- enables the trainees to understand the scientific basis of the discipline and to learn through exposure to a broad range of clinical experience in the relevant specialty;
- enables the trainees to appreciate the issues associated with the delivery of safe, high quality and cost effective health care within the Australian health system, to understand that system, and to be prepared for the broader roles of medical specialists in working with and taking a leadership role within the community on matters relating to health;
- produces medical practitioners able to undertake unsupervised comprehensive medical practice in the relevant specialty (including general practice);
- includes a process of assessment that tests whether the trainees have acquired the requisite knowledge, skills and professional qualities to practise in the specialty at an appropriate standard;
- prepares specialists (including general practitioners) to be able to assess and maintain their own competency and performance through continuing professional education, maintenance of skills and the development of new skills.

Accreditation Standards

The Processes of Specialist Education and Training

The goals of education and training

The training organisation has determined the goals for each of its education and training programs. These goals are based on the nature of the discipline and its role in the delivery of health care and are related to community need.

The curriculum

For each of its training programs, the training organisation has a curriculum that enables trainees to achieve the goals of the training program.

The curriculum specifies the educational objectives for each component, 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.

Completion of training must be certified by a diploma or other formal award.

The training organisation has processes to determine the broad roles of practitioners in the discipline. These roles are addressed by the objectives of training programs.

Assessment and examination

The training organisation implements a systematic program of formative and summative assessments which it has demonstrated to be valid and reliable.

The assessment program reflects comprehensively the educational objectives of the training program.

The training organisation has processes for the early identification of trainees who are under-performing and for determining programs of remedial work.

Accreditation of hospitals/training positions

The training organisation specifies the clinical experience, infrastructure and educational support required of the accredited hospital/training position and implements clear processes to determine whether these requirements are met.

The training organisation's accreditation requirements cover: clinical experience, structured educational programs, infrastructure supports such as 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 accreditation standards of the training organisation are publicly available.

Supervisors, assessors, trainers and mentors

The training organisation has processes for selecting and training supervisors and trainers.

The training organisation has processes for ensuring that trainees receive regular feedback from supervisors and trainers and for obtaining confidential reports from trainees on the quality of their supervision, training and clinical experience.

The training organisation has a systematic process for selecting assessors in written, oral and performance-based assessment and examination who have demonstrated relevant capabilities. Selection of assessors takes account of an overall balance in gender, cultural background, nature of practice and its location.

The training organisation implements training programs designed to foster sound and consistent assessment methods.

The training organisation assists all trainees in identifying a suitable mentor who is not and highly unlikely ever to be a supervisor, assessor or trainer for the trainee.

Trainees

Selection of trainees into training programs is based on the principles in the 1998 report, 'Selection into Specialist Training Programs' by the Medical Training Review Panel.

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

The college 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 college provides clear and easily accessible information to prospective and existing trainees about the training program, costs and requirements, and any proposed changes.

The college provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

The college has processes to address confidentially problems with training supervision and requirements.

The college has clear impartial pathways for timely resolution of disputes between trainees and supervisors or trainees and the college.

The college has appeals processes that allow trainees to seek impartial review of training-related processes or decisions, and makes its appeals policies publicly available.

The college has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

Assessment of overseas-trained specialists

The processes for assessing the suitability of overseas-trained specialists for practise in Australia 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.

Outputs and outcomes of training

The training organisation maintains records on the outputs of its training program, is developing methods to measure outcomes of training and is collecting qualitative information on outcomes.

Evaluation of the program

The training organisation has processes for the regular evaluation and review of its training programs.

Supervisors, trainees, health care administrators, other health care professionals and consumers contribute to these processes.

Professional Development Programs

The training organisation has professional development programs that assist its members in maintaining their knowledge, skills and performance so they can deliver adequate and safe medical care.

The training organisation monitors participation in all areas in which the specialist is currently practising, and has processes to counsel fellows who do not participate in such programs when they are not compulsory.

Retraining

The training organisation has processes in place for retraining and remediation of its fellows who are under performing.

APPENDIX 2

Members of the Medical Administration Assessment Team

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Specialist Anesthetist, Auckland City Hospital

Dr Szu-Lynn Chan MBBS *W Aust*
Joined team as Senior Registrar, Anaesthesia and Pain Medicine, Royal Perth Hospital
Trainee from the Australian and New Zealand College of Anaesthetists
Dr Szu-Lynn Chan is now a fellow of the Australian and New Zealand College of Anaesthetists (21 July 2008)
Consultant anaesthetist at Fremantle Hospital, Western Australia

Ms Theanne Walters (Secretary)
Deputy Chief Executive Officer
Australian Medical Council

Ms Simone Bartrop
Specialist Accreditation Officer
Australian Medical Council

APPENDIX 3

Assessment Team's Statement of Preliminary Findings

Preamble

On behalf of the assessment team I would like to thank Associate Professor Gavin Frost, President of the College, Dr Karen Owen, Chief Executive Officer and College Fellows, candidates and staff for the detailed preparation and for the generous hospitality that has been extended to us. We have all enjoyed our site visits and the frank and collegial discussion here in the College.

The preparation for this accreditation has allowed the College to reflect on a range of educational and training issues. This has led to significant changes in education and assessment, and the governance of the College's educational activities. Many of these initiatives are still at an early stage, but the Team considers the College has achieved much in a short space of time.

This statement outlines the Team's preliminary findings. It summarises key strengths identified by the Team and issues to be addressed. Over the next two months, the Team will prepare a full report on its assessment, which expands on this statement. The AMC will provide a copy of the draft to the College for its comment. The report will then be submitted to the AMC's Specialist Education Accreditation Committee, which will make a recommendation to Council on accreditation.

THE COLLEGE

RACMA conducts training in Australia and New Zealand. It has a number of significant complementary relationships, particularly with ACHSE and the Hong Kong College of Community Medicine, although their training roles are different to those of RACMA and there is no analogous overseas college against which the Team could benchmark RACMA training.

The Team commends the recent DLA Phillips Fox review of the College constitution, governance and mission. The Team hopes the College would be in a position to complete its response to this important review in the near future.

Many issues raised in the Phillips Fox review are consistent with issues identified by the AMC Team. One we would specifically identify is the need for the College to address the role, responsibilities and representation of the Member category.

In the context of this review, the Team would encourage the College to adopt a proactive role in engaging with health services and state and national health departments. Feedback to the AMC Team during this review indicated support for RACMA 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.

The Team noted the current statement of purpose, which appears somewhat inward-looking, is at variance with the three-year strategic plan which sets higher goals. The Team would encourage the College to engage the broader community and health consumers as it develops its mission and refines its purpose.

RACMA's documentation indicates that RACMA 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.

This review has confirmed the magnitude of the changes being introduced by the College in its training and assessment processes. In a time of change, lines of communication with fellows in general, those who fill key training roles such as censors, preceptors and supervisors, and the candidates, need to be strengthened and regularised.

In a small college, individual fellows carry large loads and develop considerable expertise and knowledge of College processes. In recent times the College has invested significant energy in documenting the knowledge of key individuals and formalising its processes for making key training decisions. This is commended, and the Team encourages the College to continue these activities.

The College is well served by a very small 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. If the College is to continue to move forward, the secretariat will need additional resources.

EDUCATION AND TRAINING IN MEDICAL ADMINISTRATION

Training leading to the award of the fellowship of RACMA is a three-year program. The College has defined the components of training as academic studies in an approved masters program, an approved period of supervised practice, and attendance at two compulsory workshops.

Training is on the whole, self-directed, with candidates expected to seek out opportunities for learning. The new competencies framework, which is influenced by the CanMEDS framework, is regarded by candidates, supervisors and preceptors as providing a clear structure and making it easier to identify gaps in training. The College is to be commended for the development of the new competency framework. The Team would encourage the College to monitor these competencies and consider developing more formal processes to ensure each candidate has access to appropriate opportunities.

The Team has received very positive feedback from candidates and recently qualified Fellows on the induction and pre-fellowship workshops. The College is congratulated for the development of these labour intensive courses.

In New Zealand and each Australian state and territory, the College Board of Studies manages the delivery of training locally. 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. This ranges from a full workshop program and regular weekly or monthly meetings to minimal participation in formal teaching. There are additional problems for rural candidates who are more isolated and may be unable to attend meetings in metropolitan centres. Candidates were keen to have a more formal framework to the teaching and made various suggestions about workshop frequency and timing.

The Team recommends the College review the educational program in consultation with candidates, possibly increasing the use of videoconferencing and online educational packages. There needs to be ongoing processes for obtaining regular feedback from candidates on components of the training program.

A majority of the College's candidates enter training with recognition of prior learning and the College's commitment to RPL is commended. The way in which decisions concerning RPL are made needs to be formalised.

ASSESSMENT AND EXAMINATION

The College has documented the procedures for the assessment and examination of candidates. Many of these procedures have only recently been introduced and a process of evaluation is underway. The Team considers that it would now be appropriate for the College to give high priority to formalising its processes for standards setting, for assessor and examiner training, and for evaluating the reliability and validity of its assessment methods with input from a professional educationalist.

The College does not have an involvement in the maintenance or assessment of standards of any of the masters degree courses which are recommended to candidates. There are opportunities for College board of studies to contribute locally to the development of relevant units of study within these courses.

The College has recently incorporated the case study within a Management Practice Folio. There is still some confusion about the aims of this activity, the ongoing requirement for a case study report, and whether the documents presented by candidates should be based on their everyday work experience or prepared specifically for the folio.

The Team considered the methodology of preceptor and supervisor reports to be an excellent initiative. 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 they were scored to confirm that on completion of the required reports the Candidate would be eligible to sit the final examination. The Team would encourage the College to respond publicly to the feedback from the preceptors, supervisors and candidates on these reports.

The Team's discussions with candidates elicited a number of criticisms of the examination. College officers are encouraged to consider and address this feedback as a way of improving the quality of the assessment processes.

The College has not yet progressed to an analysis of its exam methodology. While the Team recognises that small numbers make such analysis difficult, the Team believes such analysis is necessary to ensure that there is transparency, consistency and reliability of the examination process and consideration of a specific remediation opportunity.

A specific issue concerning the structure of the oral examination is the impossibility of quarantining candidates. The Team has concerns that this will add to the likelihood of complaints concerning failures in the process.

ENVIRONMENT FOR TRAINING AND TEACHING

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.

It is recognised that the training program has two pathways: one for registrar candidates in rotational programs, and one for those candidates in designated positions who have recognised prior learning. As the majority of candidates enter through the RPL process, and this is centralised through the Censor in Chief, generally consistency is addressed. There was, however, general agreement that funded candidate positions in the future (and as exist in some of the jurisdictions) is a critical success factor.

As a corollary to this, RACMA 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 process for accreditation of training posts appears to entail an individual approach to each post/candidate/supervisor proposal, which means it appears difficult to create guidelines. Some candidates felt their post was too narrow. Dis-accreditation 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 recommends that the College increase the specificity of its policy documentation for accreditation. The Team encourages the College to use its authority as an accrediting body to ensure standards are met. The specification of the curriculum offers 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.

The funding of registrar positions by negotiations with funders appears vital to the future of the College.

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.

SUPERVISORS, PRECEPTORS, ASSESSORS

The Team commends the contribution of College Fellows to training, supervision and assessment activities.

The College has defined two key supervisory positions: preceptors, who are senior College Fellows, who provide advice and education support; and supervisors who undertake day-to-day supervision of candidates and are generally the candidate's work supervisor. Preceptors have a detailed understanding of the College processes and the training program requirements. This structure is a key strength of the College's training system.

The Team commends moves to strengthen the relationship between supervisors and preceptors. The preceptor system has its strength in providing an improved structure to the program and, often because of the seniority of the preceptor, increased funding for training positions. Preceptors contribute greatly to exam preparation and provision of support to candidates.

The supervisor / preceptor relationship with the candidate is seen as crucial to improving the feedback and often was a very strong relationship with monthly meetings with preceptors, and scrutiny of experience. However, there was some variability in experience, with some preceptors having infrequent meetings and one candidate having no assigned preceptor for almost one year of training.

Many candidates would like more feedback on their performance. The requirement for a single report from the preceptor at the end of the first year may not be sufficient for some candidates. The College should ensure that there are mechanisms for regular constructive feedback to candidates. This may require training of supervisors and preceptors in giving feedback, and review of the report templates. Supervisors are not necessarily Fellows of RACMA or medical graduates, and may require more input from preceptors.

Concerns have been raised by candidates that occasionally preceptors and supervisors are unclear of the goals of the training program and may be difficult to engage with for a variety of reasons, including the very busy duties of their work. A contract for preceptors is to be introduced, and this, it is hoped, will improve the situation in this area.

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

Use of the formal opportunities for candidates to provide feedback on preceptor performance could be improved. In general, preceptors indicated support for such a process. Preceptor feedback is not formally structured and they wish for a formal evaluation process.

In recent times the College has developed a supervisors' handbook. The College runs annual preceptor workshops, which preceptors must attend at least every three years. These initiatives were praised by supervisors and preceptors. Gaining adequate attendance at preceptor workshops has been difficult. The College is congratulated for developing an on- line package to overcome this.

There is no formal structure for mentoring. There is a major difficulty in that the College has only a small number of fellows and those who are interested in education are already intimately involved. This makes a conventional mentoring structure difficult to achieve. The College could consider encouraging more of its fellows to take part.

ISSUES RELATING TO CANDIDATES

In most jurisdictions, the College has a very limited role in selection of the candidates; this is mainly being undertaken by employers. The Team encourages the College to seek opportunities to engage more proactively with employers in these processes.

In general, College candidates met by the Team were very pleased to be on the College's training program, and praised the commitment and support of their preceptors and supervisors. There was also praise for the support provided by College staff.

Candidates indicated that the College's communication processes have improved significantly in the last twelve months, and also indicated that there has been good communication about the changes being made to the College training program. However, candidates feel that this good communication needs to be supplemented by better information about their individual situation and with better mechanisms for candidate communication within the College.

Other mechanisms for communication between candidates include the possibility of greater promotion of the candidate forum on the College website being encouraged.

For the last three years the College has had candidate representative on the College Council. This move is commended. In the Team's discussions with state committees, it appeared that there were candidate members of these groups. However, it was not clear that there are mechanisms for communication between these candidates, and these candidates and the candidate representative on

Council. It is also not clear if "candidate issues" is a standing item on the agenda for Board meetings. The College is encouraged to formalise these mechanisms.

ASSESSMENT OF OVERSEAS TRAINED SPECIALISTS FOR AUSTRALIAN PRACTICE

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 high priority to formalise elements of the process, and the Team recommends the College 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.

In 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 working of the Australian and New Zealand health system. 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.

MONITORING AND EVALUATION

The College's accreditation submission lists a number of ways in which the training program is evaluated.

As the College continues to review its training processes, it needs data to inform change. 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 encourages the College to develop such methodology. The College needs prospective and formal evaluation plans which can be reported and used to drive quality improvement. The AMC will expect the College to provide further information on its evaluation plans and results in the future.

The Team commends the College for plans for a candidate database, as well as the newly introduced survey of candidates on the completion of their probationary period and the survey of new fellows. The Team also commends the move to a requirement for participation in CEP programs and the increased level of audit of CEP participation.

The Team would encourage the College to consider seeking feedback on the training process from unsuccessful candidates. Feedback should be formally invited from candidates on their experience of supervision.

The Team would also encourage the College to consider providing feedback to supervisors and preceptors as a way of facilitating their professional development.

CONTINUING EDUCATION PROGRAM

RACMA is to be commended on its strong history and lead in professional development programs as an early adopter of a continuing education program. Similarly, it should be commended for its adoption of a policy of compulsory participation in CEP.

The implementation of this standard and subsequent audit of outcomes will be the basis of subsequent review.

It is noted that 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 continually re-evaluate its relevance in reflecting contemporary medical administration practice as well as the views of the wider community.

It is noted that the current low participation rates will present a significant challenge to implementing the impending move to compulsory CEP. However, RACMA is to be commended for the significant investment of members' time in developing electronic information technology to enable this transition.

The 2007 CEP survey was a successful venture and made a useful contribution to CEP development. Plans to continue and repeat this process are to be encouraged.

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

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 should enjoy substantial support from the College.

The College could specify components of CEP to ensure a range of activities including those to promote peer review, audit and self-reflection.

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.

SUMMARY

In conclusion, the Team commends the College on its progress, and looks forward to reports on further achievements over the period of accreditation that will be determined by the AMC. We wish you well and thank you again for your hospitality.

APPENDIX 4

List of Submissions on the RACMA Training Program and Continuing Education Programme

Ms Linda Blair, Strategic Workforce Project Officer, People and Organisational Learning, Department of Health and Community Services, Northern Territory.

Mr Mark Cormack, Chief Executive, ACT Health.

Professor Brendan Crotty, Head, School of Medicine, Faculty of Health, Medicine, Nursing and Behavioural Sciences, Deakin University.

Professor Chris Del Mar, Dean, Faculty of Health Sciences and Medicine, Bond University.

Mr David Dixon, Assistant Director, Workforce Development and Leadership, NSW Department of Health.

Dr Peter Flett, Acting Director General, Department of Health Western Australia.

Mr Bob Guest, Chief Executive Officer, The Royal Australian and New Zealand College of Ophthalmologists.

Mr Joe Hooper, Registrar, Medical Board South Australia.

Professor Ken Kirkby, President, The Royal Australian and New Zealand College of Psychiatrists.

Ms Michele Kosky, Executive Director, Health Consumers' Council of Western Australia.

Dr Mel Miller, Chief Executive Officer, The Royal Australasian College of Physicians.

Mr Romlie Mokak, Chief Executive Officer, The Australian Indigenous Doctors' Association.

Mr Richard Mullaly, Chief Executive Officer, Medical Practitioners Board of Victoria.

Ms Kaye Pulsford, Executive Officer, Medical Board of Queensland.

Dr Mike Richards, Chief Executive officer, Australian and New Zealand College of Anaesthetists.

Mr David Roberts, Secretary, Department of Health and Human Services, Tasmania.

Dr Tony Sherbon, Chief Executive, Department of Health, South Australia.

Mr Don Swinbourne, Chief Executive Officer, The Royal Australian and New Zealand College of Radiologists.

Ms Christine Walker, Executive Officer, Chronic Illness Alliance.

Dr Tamsin Waterhouse, Acting Chief Executive Officer, Royal College of Pathologists of Australasia.

Professor Steve Wesselingh, Dean, Monash University.

Dr Janice Wilson, Acting Deputy Director-General, Health and Disability Systems Strategy, Ministry of Health, Wellington, New Zealand.

APPENDIX 5

A Summary of the Assessment Team's Accreditation Program of Meetings

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
	Senior Advisor - Service Development for Child Youth and Family Chairman - Health Information Standards Organisation
	Medical Administration Supervisors
	Medical Administration Preceptor
	Medical Administration Candidates

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 (Including 15 minute Afternoon Tea)	AMC Accreditation Team

Tuesday 17 June 2008

Time	Meeting	Attendees
9.30am – 10.30am	Executive of Council	AMC Accreditation Team Executive of Council
10.45am – 12.30pm	Council	AMC Accreditation Team Council
1.45pm – 3.15pm	State Committee Officers	AMC Accreditation Team Available State Committee Officers plus additional Committee Officers by teleconference. Committee Chairs to consider.
3.30pm – 4.30pm	Secretariat Staff (Chief Executive, Business Support, CEP/Web Support)	AMC Accreditation Team RACMA Secretariat Staff
4.30pm – 5.00pm	Accreditation support and Quality Co-ordinator	AMC Accreditation Team 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 Accreditation Team Censor in Chief
10.15am – 12:30pm	As above plus OTS Important to have BOS of states where site visits to be made i.e. Qld (Brisbane), NSW (Sydney), VIC (Melb), SA (Adelaide), NZ (Wellington)	AMC Accreditation Team BOTCE inc BOS, Censors, Education Consultant
1.45 pm - 3.15pm	Continued from before lunch (see above	AMC Accreditation Team BOTCE including BOS, Censors, Education Consultant
3.30pm – 5.00pm	Continuing Education Committee	AMC Accreditation Team Continuing Education Committee
5.00pm - 6.00pm	AMC Team debrief	AMC Accreditation Team

Thursday 19 June 2008

Time	Meeting	Attendees
9.00am – 10am	Candidate Representative on Council	AMC Accreditation Team Candidate Representative on Council Should we also ask Harvey Lander?
10.00am – 11.00am	Expanded Settings for Specialist Training program	AMC Accreditation Team Dr Gruner, Steering Committee
11.15pm – 12.30pm	Other matters	
1.45pm – 3.45pm	AMC Team prepares preliminary findings	AMC Accreditation Team
4.00pm - 5.00pm	AMC Team presents preliminary findings and provides opportunity for College comment	AMC Accreditation Team Open