Trainee Selection in Australian Medical Colleges

January 1998

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JANUARY 1998

ISBN 0 642 367175

Publications Production Unit (Public Affairs, Parliamentary and Access Branch)
Commonwealth Department of Health and Family Services
Publication number 2291

MEDICAL TRAINING REVIEW PANEL

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Commonwealth Department of
Health and
Family Services

The Hon Dr Michael Wooldridge, MP
Minister for Health and Family Services
Parliament House
Canberra ACT 2600

Dear Dr Wooldridge

On behalf of the Medical Training Review Panel I am pleased to submit the national study of the current procedures for the selection of trainees in Australian medical colleges.

The medical colleges have a major responsibility to ensure that a high standard of medical care is available for future generations of Australians. It is proper for medical colleges to determine the standards of achievement required before applicants are selected for training. However, there is an obligation upon medical colleges to ensure that those selection standards are applied in a transparent and consistent manner.

In response to the continuing concerns expressed by some medical graduates that the college's selection process are not suitably transparent, the Medical Training Review Panel agreed to engage a consultant to investigate and report on this issue.

The Panel engaged Dr Peter J. Brennan and Company who produced the report entitled '*Trainee Selection in Australian Medical Colleges*'.

The findings and the recommendations have been endorsed by the Medical Training Review Panel.

This report is submitted to you in accordance with the Panel's Terms of Reference.

Yours sincerely

R. W. Wells
Chairman
Medical Training Review Panel
23April 1998

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ACKNOWLEDGEMENTS

The Project Team wish to put on record the co-operation of the Australian Medical Colleges in the conduct of this review. They frequently made their Office bearers, paid officials and premises available at short notice.

The Australian Medical Association was a member of the Steering Committee but also facilitated many of the consultations and made their premises, around the country available to the Consultants.

Dr Jack Sparrow was required, on several occasions, to exercise his considerable skills in mediation and negotiation. This he did with his usual proficiency.

Chris Lyon, as the Commonwealth Project Officer was able to hold the project together with good humour and genuine commitment.

Finally, to all the men and women in the health industry who gave fully of their time, knowledge and expertise we are indebted to you.

Dr Peter Brennan
Team Leader
14/11/97

A DISSENTING STATEMENT FROM ONE MEMBER OF THE CONSULTING TEAM

One member of the team dissented from the recommendation that an avenue be made available for an external appeal.

Appendix F presents the minority view in relation to appeals.

ABBREVIATIONS USED IN THE TEXT

ACD	Australian College of Dermatologists
ACEM	Australian College for Emergency Medicine
ACP	Australian College of Paediatrician
ACRM	Australian College of Rehabilitation Medicine
AFOM	Australian Faculty of Occupational Medicine
AFPHM	Australian Faculty of Public Health Medicine
AFRM	Australian Faculty of Rehabilitative Medicine
AMA	Australian Medical Association
AMWAC	Australian Medical Workforce Advisory Committee
ANZCA	Australian and New Zealand College of Anaesthetists
AOA	Australian Orthopaedic Association
ASMOF	Australian Salaried Medical Officers Association
BOS	Board of Orthopaedic Surgery
CEO	Chief Executive Officer
CPMC	Committee of Presidents of Medical Colleges
GP	General Practice (Practitioners)
HR	Human Resources
HRM	Human Resource Management
MCQ	Multiple Choice Questions
MTRP	Medical Training Review Panel
OSCA	Objective Scored Clinical Assessment
PGY1	Postgraduate Year 1
PGY3	Postgraduate Year 3
PSA	Public Service Association
RACGP	Royal Australian College of General Practitioners
RACMA	Royal Australian College of Medical Administrators
RACO	Royal Australian College of Ophthalmologists

RACOG	Royal Australian College of Obstetricians and Gynaecologists
RACP	Royal Australasian College of Physicians
RACR	Royal Australian College of Radiologists
RACS	Royal Australasian College of Surgeons
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCPA	Royal College of Pathologists of Australia
SAC	Specialist Advisory Committee (of the RACP)

Section 1 – Executive Summary

The Health Insurance Amendment Act (No. 2) 1996 requires medical practitioners to complete a recognised postgraduate medical training program to be eligible to provide services which attract medical benefits.

The Commonwealth Minister for Health and Family Services established the Medical Training Review Panel (MTRP) to monitor the implementation of particular measures in the Act.

One of these tasks is

> '*to keep under review the transparency of arrangements for selection of graduates into training places and for review of selection decisions, including complaints processes'*.

Postgraduate training in medicine is almost exclusively in the hands of the learned Colleges.

By and large the system has been of enormous benefit to this Country. We have a standard of medical practice which is second to none in the world.

The Colleges have a major responsibility to ensure that this high standard of medical care is available to future generations of Australians. The key to achieving this objective is the selection of the best possible candidates for specialty training.

In recent times people have questioned the role of the Colleges, and suggested that their unwritten objective is to protect the market position and financial security of their members and that they no longer reflect the aspirations of a new generation of doctors.

The Colleges for their part have responded constructively to these criticisms. Many of them have undertaken wide-reaching reviews of their processes including selection of trainees.

Of more concern at least to this review is a perception held by some young medical graduates that the Colleges' selection processes are not fair. This project was designed to identify and describe existing policies and practices of the Colleges, and to determine the extent to which these policies are put into effect at the State and Regional levels.

The views of the profession, particularly recent graduates and those currently undertaking postgraduate training, were canvassed in an attempt to determine the extent and nature of the expressed concerns.

Finally, a framework has been developed for a best practice approach to the selection of trainees. This framework is presented as a set of principles and a description of the processes which would enable these principles to be put into effect.

Information was gathered from the profession, the industry, the Colleges and the broader community using a number of techniques including:

- a Questionnaire to all Colleges, Faculties and Boards;
- a call for public submissions;
- set days of public consultation in capital cities and provincial centres;
- one-on-one consultations on request; and
- a second round of consultations with College representatives to discuss the draft framework.

The conclusions of the study are that there is little evidence to support allegations of systematic malpractice by the Colleges.

There is no doubt that some individuals feel aggrieved, and it is equally true that some of them have had unpleasant and unrewarding encounters with the College system.

However there is abundant evidence that the Colleges have made significant advances in recent years in a number of areas, particularly in relation to their Human Resource Management (HRM) practices.

As is the case in most areas of human endeavour, the action of a few often brings down the standing of many men and women of high intellect and good intent.

For their part the Colleges must accept that they have an image problem. This problem is not just in the eyes of the younger members of the profession but also the broader community.

It is probable however, that the reason for the poor perception of College selection processes may be due to the discrepancies between national policies which are mostly first rate, and every day practices.

Some disciplines have enthusiastically embraced modern HR practices, others are coming along more slowly.

Regrettably some individual College members pay lip service to the new policies but are openly critical of them. Such behaviour does a lot of harm. Those of this persuasion are entitled to their views but are best kept away from selection processes.

The consultations revealed two issues that were of concern to so many people that they deserve special mention.

Foremost in this category is the nexus between employment (largely a function of hospitals), and training (largely the Colleges).

For some disciplines, the internal medicine specialties in particular, the hospitals are responsible for selection and appointment. The Colleges having no involvement in either workforce planning or human resource management. At the other extreme, the surgical disciplines for example, the hospitals have almost no say in either selection for training or employment. Both of these alternatives invite controversy and litigation.

It is the strong belief of this review that neither extreme is acceptable, and that partnership models, with joint appointments is the only workable approach.

The second most common set of issues raised was in relation to women. Nationally women represent 45% of graduating medical students and the trend is towards gender balance.

This change in the gender balance has fundamentally changed the culture of the medical workforce. Most Colleges have developed appropriate policies in relation to the training of women in medical specialties.

Women responding to this review were overwhelmingly of the view that there is a large gap between rhetoric and reality in relation to women in the medical workforce. This review believes that the MTRP can lead the way by facilitating a series of national workshops to come to grips with the practical issues of hospital staffing and specialised training that will flow from the changing gender profile in the profession.

Other recurrent themes from the consultations are described in Section 7 of the report but are of less significance than the two issues referred to above.

The review looked to the national and International literature in an attempt to draw on the experiences of other researchers and other countries.

Basically, the literature is not very helpful. The studies that have been done are either not directly applicable or have serious shortcomings. The major problem is the high pass-rates in postgraduate exams. Because most are passing, the indicators usually examined prove to be non-discriminatory.

The inferences that can be drawn from the literature are that:

- Structured interviews and scored assessments are likely to produce a better result.
- Training of selectors is probably the most crucial factor.

- Clinical proficiency and selection skills are not necessarily positively correlated.
- The opinions of peers and senior trainees may be of more value than generally recognised.
- Clinical and practical assessments need to be highly structured if they are to be meaningful.

The principles developed are described in detail in Section 9 and a tabulated summary is presented at the end of that Section. A summary of the proposed framework is presented below.

The Recommended Framework for Selection of Trainees is:

- **A clear statement of principles underpinning selection**
  - the aim to select the best possible candidates;
  - the objective of producing the best possible practitioners;
  - for the process to be legal; and
  - for the process to be accountable.
- **Eligibility criteria**
  - there should be a clear statement of eligibility to apply for and be selected for training.
- **Advertising**
  - there is to be a national awareness of opportunity for all eligible candidates.
- **Limits to the numbers of training positions**
  - if there is a quota, it should be explicit and openly declared; and
  - limits relating to other factors such as the number of training positions should also be disclosed.
- **Applications for training positions**
  - applications should be written in a standardised proforma.
- **References**
  - referees' reports should be written in a standardised proforma with a view to achieving;
    - objectivity
    - comparability
    - quantification.

- **The selection committee**
  - the group who make the final decision should have the confidence of the candidate, the profession and the community;
  - the size of the Committee should be proportional to the task;
  - they should be prepared to be held accountable for their decisions;
  - they should be prepared for their processes and decisions to be reviewed in other forums;
  - the selection process should be;
    - valid
    - reliable
    - feasible
    - evaluation should be built into the process.
- **Selection criteria**
  - the selection criteria should be documented and published;
  - the selection criteria must be objective and quantifiable to the greatest possible extent.
- **Conduct of the interview**
  - the interview should be objective and free of bias.
- **Selection**
  - the selection should be based on the published criteria and the principles of the College concerned; and
  - the process should be capable of standing external scrutiny.
- **Ranking**
  - selection committees should score and rank candidates using the tools described.
- **Documentation**
  - a record of proceedings should be kept which is sufficient to enable non-participants in the original selection to accurately re-construct processes and decisions; and
  - adequate documentation enables external scrutiny, audit and evaluation of the selection process.

- **Feedback**
  - candidates should be given an honest and frank appraisal of their standing in the eyes of those conducting the selection process.
- **Evaluation of the selection process**
  - there should be a formal, regular, inclusive review of the selection process.
- **Appeals**
  - there should be a formal process for appealing decisions;
  - applicants and candidates should;
    - have the right to have decisions reviewed;
    - have the right to appeal externally if they disagree with the original decision and its internal review;
    - not fear any future bias if they choose to either seek review or appeal;
    - be required to bear the cost of external review if the appeal is unsuccessful;
  - colleges;
    - should have confidence in their processes and recognise that appeals are part of an accountable system; and
    - should be prepared to meet the cost of appeals where their processes are found wanting.

The implementation of these issues may be contentious. The main body of the report identifies the fact that the successful 'implementation' of the framework will require the hospitals and Colleges to work together.

As a first step, this review recommends that the framework is referred to individual Colleges and to State and Territory Health Authorities for a formal response and afterwards to the CPMC for their adoption. The preferred outcome would be for CPMC to decide that compliance with the principles would be a condition of affiliation with the CPMC.

The report also spells out the processes which could give effect to the principles. The review is aware that these are not the only ways in which the principles could be implemented. They are meant to be illustrative. The review is encouraged by the fact that most Colleges and Boards consulted on the framework are not only supportive of the principles but also welcome the section on processes as a guide to the course of action they will need to pursue.

The section on appeals is contentious. Some Colleges do not agree that an external process is essential. Community observers outside the College system are concerned that the

recommendation that external appeals be conducted under the auspices of the proposed Academy of Medicine does not go far enough.

The recommendations of this report are meant to be a ‘middle of the road’ approach which guarantees natural justice for applicants and candidates but maintains for the profession an acceptable level of autonomy and self-determination.

The review suggests that there is a need for Colleges, hospitals and other potential employers to collect uniform data on the selection processes. These statistics should be made available to all interested parties and accessible by the public. This information will facilitate workforce planning and inform potential applicants of training opportunities

CPMC has scheduled a workshop on appeals. The recommendations of this report in relation to appeals, hopefully with the endorsement of the MTRP, should be put before that workshop.

This Consultancy believes that the MTRP could use its standing and influence to progress two issues:

- The nexus between employers and Colleges and the extent to which they should jointly appoint candidates to training programs and jobs.

- The practical implications of the feminisation of the medical workforce and the steps necessary to implement the well-intentioned policies of the Colleges relating to women, employment and vocational training.

- Finally the Consultancy believes that Colleges should address the inconsistencies in accreditation for identical positions in hospitals.

Section 2 – Recommendations

1. The Medical Training Review Panel (MTRP) should endorse the selection framework outlined in this report.

2. In the first instance, the MTRP should refer the report to each College, State and Territory Health Department for a formal response. Subsequently, the MTRP should refer the framework to CPMC with the recommendation that it be adopted by that body and that compliance with the principles and conformity with a uniform reporting system by individual Colleges be a condition of affiliation with CPMC.

3. MTRP should refer the report to individual Colleges and State and Territory Health Departments for a formal response.

4. Depending on the content of those responses MTRP should consider convening a national workshop involving employers, Colleges and candidates to discuss their respective roles in relation to selection, and develop the conclusions of this report that a joint approach to selection and appointment is by far the most preferable approach and address specific issues raised in this report such as unaccredited posts.

5. MTRP should convene a workshop to address the issues raised by many women responding to this review in relation to facilitating the participation of women in training programs in a way that the College policies envisage but that the employers are finding hard to provide. The Project Team agree with the decision to defer this recommendation until the extent and impact of AMWAC's review of women in the medical workforce is known.

6. Colleges should address the current inconsistency of accreditation for identical positions in hospitals.

7. Colleges, hospitals and other potential employers should collect and disseminate uniform data on their respective selection processes. This information could then be used as a workforce planning tool as well as identifying opportunities for trainees.

Section 3 – Introduction

Australia is a young country. Our small population is spread across a vast land. We enjoy a high standard of living. An important part of these standards that Australians tend to take for granted is quality health care. Our traditions in medicine have their origins in the United Kingdom. These traditions are based on the Collegiate system in which medical practitioners enjoy a high level of autonomy in terms of regulation and self-discipline.

The Collegiate system has served Australia well. Our standards of medical practice and medical ethics are second to none in the world. The selection of medical graduates for vocational training is a serious responsibility. It is important not to lose sight of the prime objective to provide Australians with first rate medical care and to achieve this goal by selecting the best possible candidates for training.

Our health care system however, is subject to the same pressures as those of other developed countries. Community expectations, fuelled by technological advances, have outstripped the growth in public funded services at the same time as more and more Australians abandon private health insurance and rely on tax-payer funded services.

Commonwealth Government outlays on medical services are uncapped and have grown at a rate far greater than underlying inflation for more than a decade.

The Commonwealth's major policy response has been to restrict access to tax-payer funded medical benefits payments to doctors who are vocationally trained by one of the learned Colleges.

Some observers see this approach as a 'softer' option than tackling the real issue which is the number of medical practitioners being registered each year.

Net growth in the number of medical practitioners is determined not only by new Australian graduates but also by migration of overseas doctors.

The decision to limit access to publicly funded rebates to vocationally trained doctors was highly contentious and there was a backlash around the country, particularly from young doctors.

The young doctors feel let down in that the 'rules' have been changed since they made their career decision. Further they believe senior members of the medical profession made no attempt to protect their junior colleagues from these events and did not answer their call for the profession to unite against the changes.

The legislation necessary to give effect to the Commonwealth Government's policy intent (*The Health Insurance Amendment Act, No. 2, 1996*) had to pass a hostile upper house.

The minority parties in the Senate consulted widely on the proposed arrangement and as part of the passage of the legislation sought, and were given, a number of assurances.

A major requirement was that the Commonwealth Minister should monitor the impact of the legislation and report to the Parliament. The Medical Training Review Panel (MTRP) was established to oversee the implementation of the legislation and to assess its impact.

MTRP is required *inter alia* to review the processes by which medical graduates are admitted to the College Training systems.

The argument is relatively straight forward. Young medical graduates believe that if they are to be required to undertake vocational training through the College system it is not unreasonable that they, and the broader community be assured that selection to College training programs is demonstrably fair and that the processes are transparent.

Australian Medical Colleges have inherited centuries of tradition. The ceremonial College life, for many, adds to its attraction and mystique. For others the Colleges resemble 'closed societies' with unwritten rules and a veil of secrecy.

It is this secrecy that invites suspicion from not only the broader community but also from young members of the profession.

The Colleges have recognised these trends and responded for the most part, enthusiastically. It is true that some members of Colleges have not accepted or have rejected broader societal change but they are in the minority.

Nevertheless there is a significant gap between the perception of Colleges and the major changes that have occurred in the Colleges.

The existing College selection processes and those recommended in this review are based on the belief that members of the profession and the particular discipline are best able to identify those most suitable for specialist training.

This project is specifically required to review the existing policies of the Colleges, identify the gap between practice and policy and to recommend a best practice framework in relation to selection. The Steering Committee requires that special attention is given to the concerns of young doctors and medical students. The terms of reference are reproduced in Appendix A.

The review has attempted to look at these issues from the broader perspective of the Australian Health Care system. Restrictions on the number of specialists who can be trained in a

particular discipline have been represented by some as the Colleges trying to protect self interest. There is no doubt that a few individuals have been disadvantaged by the College selection systems.

It would appear that the sweeping generalisations of secrecy, bias and incompetence have no foundation in fact. There is genuine concern held by senior people in the profession that undefended allegations may threaten a system which is of enormous advantage to this country.

This review strives for balance. We must not waste an opportunity to put right any practices which are inappropriate. Equally importantly, this review addresses perceptions and identifies where the system can better project an image that will inspire the confidence of the profession and the general community. In the long run a process which is astute, diligent and accountable will carry the day.

Section 4 – Conduct of the Review

The Medical Training Review Panel appointed a Committee to oversee the project. This Committee is chaired by Dr Jack Sparrow, the Chief Medical Officer from Tasmania, and comprises:

Prof David Scott	RACS
Dr Richard Smallwood	RACP
Prof. Peter Thursby	AMA
Dr Tony Lawler	AMA
A/Prof Geoff Duggin	ASMOF
Dr Frank Simonson	PSA NSW
Dr Richard Nowotny	RACGP
Ms Ruth Parslow	Commonwealth

The original Commonwealth Project Officer was Ms Therese Manson, she was replaced after approximately one month by Mr Chris Lyon.

The Project Team invited tenders from a selected group of Consultants. The tender was awarded to a consortium under the auspices of Dr Peter J Brennan & Co Pty Ltd. The team was:

Dr Peter Brennan	Team Leader
Mr David Theile AO	
Dr Brian Williams AM	
Mr Lee Ridoutt	
Mr Robert Anderson Mr Ken Ramsay	Partners in the Sydney Office of Lawyers, Deacons Graham and James
Ms Paula Haslehurst	Administrative/Research Officer

The Steering Committee met on five occasions with the Project Team. Two of these were face to face, and a third was by teleconference.

The terms of reference for the project are included in the report as Appendix A.

The distinct phases of the project were:

- Circulation of a Questionnaire to Colleges, Faculties and Surgical Boards.
- A call for written submissions.
- Face to face consultations in all capital cities and some provincial centres.
- An analysis by the lawyers of the legal and legislative framework particularly in relation to anti-discrimination and trade practices law in the various jurisdictions.
- A workshop for the Project Team to formulate a draft national framework for selection.
- A second round of consultations aimed predominantly at the Colleges to discuss the draft framework with them.

THE QUESTIONNAIRE

The Questionnaire was drafted by the Consultants and after refinement following consultation with the Steering Committee, was circulated to the Colleges, Faculties and Boards. The Questionnaire itself is reproduced at Appendix B, with the list of recipients of the Questionnaire at Appendix C.

A conscious decision not to include the Specialist Advisory Committees (SAC's) of the RACP was made. These SAC's supervise advanced training in the sub-disciplines of internal medicine but are not involved in the selection of trainees, or appointment to training positions.

All but one of the recipients of the Questionnaire responded on the first round.

Most of the Colleges also provided extensive supporting information in the form of policy statements, manuals and selection guidelines.

The base data from the Questionnaire responses been aggregated and are presented as a series of spreadsheets in Appendix D. As these spreadsheets are complex and difficult to interpret on casual inspection, a College by College description of each of the processes is presented in Section 6 of this report.

An advertisement was placed in the national Press on the weekend of September 13th to 14th. The advertisement is reproduced in Appendix E.

THE FIRST ROUND OF CONSULTATIONS

The advertisement invited interested parties to meet with the Consultants. Consultations were held in all capital cities and in Launceston and Newcastle.

Forty five written submission were received.

In reports such as this it is customary to list the names of people consulted, and those making written submissions. The Steering Committee has determined that, for this review, this course of action would not be appropriate.

The Steering Committee have been provided with a summary of each consultation and each written submission.

It is impossible to present much of this information without identifying the individual and organisation concerned. Whilst many respondents were not in the least bit concerned about being identified, others were adamant that their participation in the process should remain confidential and anonymous.

In Section 7 of the report the issues most frequently raised with the Consultants are discussed in some detail.

THE DRAFT FRAMEWORK

Following the consultations and analysis of written submission a draft best practice framework was developed by the Consultants and submitted to the Steering Committee.

A SECOND ROUND OF CONSULTATION

After modification of the draft framework a second round of consultations were conducted. These consultations involved College officials, particularly those involved with selection and training.

Further fine-tuning of the framework was undertaken. The final product is the framework which is presented in Section 9.

LITERATURE REVIEW

Members of the Project team searched the relevant literature to assess the experience of other countries in the selection of vocational trainees.

The primary focus was on the medical literature, complemented by a review of appropriate publications in both legal and human resource journals.

The literature review is included in the text of this report (Section 5).

Section 5 – Literature Review: Selection of Trainees

INTRODUCTION

Much of the literature on the selection of trainees for specialist medical practice is based on opinion. The opinions are given by 'experts' (expert by virtue of their academic and research attention to the selection processes) or by those of accepted wisdom by virtue of elevated position in the profession. Opinion is given on a varying mixture of 'gut feeling' and observation and with varying depths of critical analysis.

Only a small proportion of authors commenting on trainee selection have based their conclusions on empirical research. Even then, research has tended to focus on a narrow set of parameters and a limited scope for outcomes. In the following sections, the review focuses on and favours the literature based on analysis rather than opinion.

The literature reported relates to two main areas of selection:

- the aims and criteria of selection; and
- the processes and mechanisms of selection.

AIMS OF SELECTION

Common sense suggests that the ultimate aims of selection are to obtain the most competent practitioners. Surprisingly though, this basic aim is left implicit in the majority of papers. Papp, Polk & Richardson (1997) for example, speak of 'professional success' as the aim of selection, but measure success only as a trainee, and assume that successful professional practice will follow.

The aims of selection are declared more explicitly by others. For instance, Martin (1996) states 'we wish to select the brightest and best; those who will ultimately develop into the best practitioners'. Similarly, Hirst, Rotem, Arnold & Moss (1995) state specifically for urology that 'the aim of the training programme is to attain and maintain standards of excellence of urological practice. In other words to produce the best quality urologist possible.' Gough (1988) reflects the same interest in selecting those who will enhance the profession once practising.

Gonnella, Hojat, Erdmann & Veloski (1993) go further to emphasise the multi-dimensional nature of physician competence underpinning selection and training. Gonnella, Veloski, Xu & Hojat (1992) gather those multiple dimensions into major physician roles such as clinician, patient educator and resource manager. They state (Gonnella et al., 1992) the aim of selection is 'to produce practitioners who can translate their knowledge into performance, recognise their limitations, learn from their mistakes and keep up with advances in science and technology and ultimately provide high quality care at reasonable cost to patients'.

The aims expressed by Gonnella et al articulate the sentiments in general in the medical literature, whether explicit or implicit, which always appears to be directed towards the production of a good practitioner for the benefit of patients. By way of contrast, the non-medical literature tends to have a somewhat different emphasis. For instance, Holdsworth (1987) notes 'the aim of recruitment and selection is to get the right people into the right job for the benefit of the employer and employee'. Notions of the employer and the employee are rarely canvassed in the medical literature (the constructs of 'profession' and 'quality of patient care' are more prevalent), although in Australia the majority of selections for specialist training are conducted by hospitals for specific salaried positions.

SPECIFIC SELECTION CRITERIA

Although the ultimate aim of selection (and training) is almost always implied to be the quality of the resulting practitioner, the difficulty of measuring this is frequently conceded (Lazar et al., 1980; Taylor & Albo, 1993; Renschler & Fuchs, 1993). Martin (1996) notes that assessing success as a practitioner *per se* is 'clouded by difficulty of defining a competent practitioner and the measurements of clinical competence'. To select for attributes associated with a competent practitioner prior even to training is even more difficult.

Many writers therefore have abandoned attempts to relate selection criteria to competent practice, and have instead reviewed success as a trainee, which may be assessed by in-training examinations, completion examinations or by in-training assessments. The American medical literature abounds with criteria assessments looking at both examinations (in-training and completion) and in training mentor assessments.

There are some notable exceptions to this approach, where a genuine attempt has been made to develop selection criteria from an analysis of the competent or 'ideal' practitioner (eg Van de Loo, 1988; Taylor & Albo, 1993).A process for establishing selection criteria advocated by Van de Loo (1988) is:

- interviews with practitioners and trainees (individually);
- literature survey;
- day seminar of selected practitioners; and
- psychologist observation of practitioners at work.

The personality component of these 'ideals' looms large but Van de Loo (1988) and Greenburg, Doyle & McClure (1994) say there is no one prototype. Abbott (1983) defines personality differences between various specialists and Horne & Heuston (1985) showed personality differences between some specialist groups and the population generally. Quadrio (1991) discusses the same possibilities, but wonders whether this might not be more a product of a (dysfunctional) medical profession culture.

The findings of a range of authors adopting this approach (to identify selection criteria by working 'backwards' from a definition of competent practice) are remarkably similar. They can be summarised by reference to Thorndike's (1986) taxonomy of cognitive, psychomotor and affective domain learning and knowledge (see Table 1).

Table 1: Summary of selection criteria suggested in the literature

Knowledge categories	Selection criteria suggested by author/s			
	Spencer (1976)	Hojat et al (1988)	Van de Loo (1988)	Papp et al (1997)
Cognitive	Cognitive – intelligence – knowledge of surgery & current literature – judgement & elective decision making	Cognitive – knowledge	Intelligence – Verbal – Spatial – Numerical	Knowledge
Psychomotor skills	Dexterity – operative ability & technique	Cognitive – skills – technical ability	Operative skill – dexterity – psychomotor ability – attention & concentration	Technical skill
Affective	Personality – relation to colleagues & nurses – decisions under stress – drive, stamina & work habits	Non cognitive – interpersonal skills – attitude – personal qualities	Stability & organisation – stress tolerance – common sense – organisation & planning ability Work attitude	Maturity & individual judgement

Several other authors (Lazar, et al., 1980; Gonnella et al, 1993; Hirst et al, 1995; Martin, 1996) have suggested selection criteria based on an analysis of competent practitioners, but all the suggested criteria can be accommodated within the broad taxonomy of knowledge, skills and people or personal qualities.

ATTRIBUTE MEASUREMENT

It is one thing to specify criteria, and another to be able to measure those criteria sufficiently well to inform selection processes. It is possible to identify three main strands of measurement recommended in the literature:

- academic assessment
- technical assessment
- non cognitive factors

Academic measures

A number of papers have supported a positive prediction of medical school performance for specialist training performance (Erlandson, et al, 1982; Arnold & Willoughby, 1993; Case & Swanson, 1993; Fincher et al., 1993; Markert, 1993). For selection to Australian surgical training, Martin (1996) has suggested other academic criteria for assessment in addition to the medical degree, including Part I results, number of attempts at Part I, and number of publications. In the American medical literature, the academic component of the selection criteria is dominated by medical school performance. The criteria can be further subdivided into the basic sciences and their results, clinical knowledge examinations and clinical case examinations including OSCA.

Gonnella, et al. (1993) used meta-analysis techniques to review a number of studies that were basically looking at the ability for medical school achievements to predict success in residency programs. A consistent pattern in each study was that top achievers in medical school were more likely to be rated in the top group in residency. The trend for low achievers to be consistent at the two stages also existed but was not as strong as the upper achieving area. There was a less sharp discrimination in the long tail of the prediction continuum than in the upper end. Overall the associations were statistically significant. In two studies (Case & Swanson, 1993 and Hojat et al., 1993), the association extended beyond the in-training examination and through to completion exams.

Several papers offer contrary conclusions with respect to academic criteria as predictors of practitioner competence (Kron, et al., 1985; Taylor & Albo, 1993; Brown et al., 1993). Scheuneman et al., (1984) found no correlation between rating at entry to medical schools and specialist trainee performance. Tutton (1997) offers a possible explanation for this. In a study of entrants to Monash University medical school, he found a high positive correlation between entry criteria based on high school academic performance and exam performance in cognitive aspects of medicine (eg biochemistry and physiology). However, there was a negative correlation between these same criteria and personality traits that seem desirable in medical practitioners.

For those already selected into training Borlase, Bartle & Moore (1985) found good correlation between in-service examination results and final examination resultsæbut no correlation of either of these with clinical performance assessments. Similarly Lazar et al. (1980) found no correlation of in-training examination results with evaluations of clinical competence. It seems likely that while pre-selection examination performance and post-selection examination performance correlate well (both of which have significant objectivity), neither has a relationship with the ultimate aim (to produce a competent practitioner).

Technical measurement

More specific selection of patient-based clinical performance from the overall medical school results gives greater correlation with specialist trainee performance (DaRosa & Folse, 1991; Hojat, et al., 1993; Vu et al., 1993).

No pre-selection measures of components of technical ability have been validated yet as predicting ultimate surgical skill, but assessments are proceeding. For instance, Winckle, Reznick, Cohen & Taylor (1994) have established validity for the Structured Technical Skills Assessment Form (STSAF), by which multiple expert observers use a proforma rating sheet. This however is still an in-training tool rather than being used for selection into training.

Sub-criteria regarding technical ability (of a competent practitioner) are postulated to include both innate and learned factors. Some writers (eg Scheuneman, et al., 1984; Kaufmann, 1987; Murdoch et al., 1994) argue that the innate factors can be measured by the pre-selection assessment of spatial ability. Scheuneman et al. (1984) writes that technical skill as required in operative surgery is dependent on:

- complex visiospatial organisation;
- stress tolerance; and
- psychomotor ability (manual dexterity).

Non cognitive factors

Non-cognitive predictors have significant correlation with progress through training (Hojat et al, 1988), although the predictive power seems to relate most to those aspects of training which could be classified ‘humanistic’ (Tutton, 1997). This might include clinical practice, calling as it does significantly on interpersonal skills.

Assessments of personality and character are not easily made (Papp et al., 1997) but are not infrequently the cause for training programme dismissal (Irby & Milam, 1989). Brown, Rosinski & Altman (1993) found problems during training were mostly personal and motivational. Anwar, Bosk & Greenburg (1981) asked training programme directors ‘what

would cause dismissal?'. The most agreed failings were - irresponsibility, clinical incompetence, dishonesty, negligent patient care, moral ethical violations and personality problems.

Apart from being the main cause of dismissal from training, almost all writers believe that non-cognitive contribution to training performance is crucial, and a primary determinant of the rating of trainees throughout the range of performance. Greenburg, Doyle & McClure (1994) for instance found that surgeons and residents rating 35 non cognitive criteria obtained a high level of agreement on the importance of the following:

- admits errors
- well disciplined
- considers all facts
- highly motivated
- consistent
- decisive
- good team person
- flexible
- positive

The main concerns with non cognitive factors are the factors actually selected as criteria (and the relative weights assigned to different criteria) and the subjectivity of their assessment.

The feminist literature, while acknowledging the desirability of adopting non cognitive measures for selection (and thus giving credibility to possible alternative non competitive styles of learning and practice) worries about the selection criteria that might actually emerge from a male dominated medical practice culture. Quadrio (1991) for instance asserts the 'tough' male paradigm values most stoicism, machoism and workaholism, which if used as a basis for determining non cognitive ability will continue to select out many women (and men) from specialist training. Similar fears have been expressed by Turner, Tippett & Raphael (1994) and Shannon (1997).

On the issue of the subjectivity of assessment, Holdsworth (1987) refers to the bad image of personality questionnaires in the past and says that they 'fall short of complete reliability'. He does however discuss improving validity by reducing the number of assessed dimensions and ensuring occupational relevance of parameters. Martin (1996) however, states that personality testing should be 'view(ed) with extreme caution'.

SELECTION PROCESS

Process elements

The selection process has a number of elements, which range from the setting of selection criteria through to appealing selection decisions.

The sequence suggested by Martin (1996) is:

- define criteria (preferably by a rational and validated method);
- application, evaluated by standard assessment;
- preliminary ranking (by application, referees reports, in-training reports and informal discussions) to select for interview;
- interview;
- standard;
- extra material to application; and
- ranking by average of all rankings of the selection committee.

Hirst et al. (1995) suggests a similar process:

- develop criteria to select the most suitable applicants;
- Australia-wide consideration of applicants;
- give the applicants a list of criteria;
- structured resume on a standard format; and
- referees reports on a format emphasising;
  - personality
  - communication
  - leadership potential
  - verbal advice additionally encouraged.

Like Martin above and Van der Loo (1988), Hirst et al. advocate commencing the process by identify optimal skills for the ideal 'urologist'.

According to Sherry, Mobbs & Henderson (1996) the rational steps outlined above as part of a selection process are often not adopted in practice. Sherry et al. compared new trainees' beliefs about what is important in selection, and what they believed was actually used for their selection. In general they thought that the influence of leading surgeons and major hospitals on the selection process was too great. They thought that medical school performance and surgical expertise were given insufficient weight, as well as paper writing and presentation (but this was not statistically significant).

Reliability

After determination of the selection criteria it will be the assessment of overall clinical ability and the non-cognitive factors that will be most difficult to give objective validity. Reliability may be endangered by inter-rater variability, lack of reliability within the rating scale, rater bias and a 'halo' effect (Lazar, et al., 1980; Hojat, et al.; Martin, 1996).

Ways of improving reliability of written material include standardisation of applications (Keeman & Lagaaz, 1988; Hirst et al., 1995), standardisation of referee reports (Streiner, 1985; Scheuneman et al., 1994), multiple assessments (Borlase, et al., 1985; Streiner, 1985) and mentor, referee and assessor education (Waxman, 1996). Anwar et al. (1981) have suggested that the best assessors of junior medical staff are their 'registrars' rather than the more removed senior consultant staff.

The addition of external assessors has been advocated or at least suggested by several authors (eg Keeman & Lagaaz, 1988; Hirst et al., 1995). In the selection of students for medical school at Monash University, Tutton (1997) has demonstrated the potential gains from using lay external assessors as part of the selection process, with little loss to inter-rater reliability.

The interview

Most writers are of the opinion that the interview is an essential selection tool (eg Powis, Neame, Bristow & Murphy (1988). Some criticise it as having low reliability (Holdsworth, 1987), some cast doubt on its effectiveness (Papp et al., 1997), but others (Ward, 1995) are emphatic in espousing its benefit. It is widely accepted that structuring of the interview will increase its reliability (Edwards, Johnson & Molidor, 1990; Martin, 1996), but there is little evidence in support of this view in the literature. Certainly unstructured interviews have been shown to pose significant problems, as a potential source of social bias and as a means of cultural reproduction (Tutton, 1994).

A structured interview fulfils four criteria (Edwards, Johnson & Molidor, 1990; Martin, 1996):

- content relevant to the job;
- questions standardised;
- interview rankings anchored by training; and
- panel conducts interviews.

For the interview itself, Waxman (1996) and Keeman & Lagaaz (1988) advocates:

- Objective, structured processes, with pre-determined questions.
- Small interview panels, possibly no more than five. If the selection panel is larger, a sub group can always form to convene the interview Committee, which can then provide data to the broader panel.
- 40 minutes per candidate.
- Psychologist from previous stage available for advice.
- Only 2 of the interview panel should ask the questions, the others observe.

The gender balance of interview panels is an important principle of EEO and other legislation affecting selection processes. Quadrio (1991) has indicated this is a crucial requirement of selection processes, even when females are not candidates.

Section 6 – Existing Practices of Australian Medical Colleges - A Commentary based on the Questionnaire Responses

This Section describes existing Human Resource management and selection practices. The profile for each College is based on the information provided by them in their responses to the Questionnaire and additional information provided.

For most Colleges, the information provided in the Questionnaire was checked at the time of the second round of consultations.

The reader needs to exercise some caution in relation to the information provided in this section. A significant number of Colleges were actively reviewing their policies at the time of the review.

In addition to the 'Colleges', the three Faculties of the RACP have been examined, as have the Surgical Boards under the overall umbrella of the RACS.

The Specialty Advisory Committees (SAC's) of the RACP were not separately considered as they have no role in selection.

AUSTRALIAN COLLEGE FOR EMERGENCY MEDICINE (ACEM)

At this stage of their development ACEM does not have a selection policy.

Currently any registered medical practitioner can join the training program by:

- completing the registration form;
- providing appropriate documentation of medical registration, medical defence and good standing with a medical board;
- paying the prescribed fee; and
- obtaining refereed reports on a standard form for prior terms if they seek retrospective accreditation.

The College hopes to have a selection policy in place by December 1997 and are intending to use the outcome of this project to guide the development of their policy.

AMWAC has recently reviewed the emergency medicine workforce and recommended a short-term expansion of training positions followed by a decline to a new base-line, early in the next century.

This review received very few comments on ACEM. Their 'open-door' policy is well received by many young graduates.

Senior GP's and career medical officers are urging alternative pathways to specialised practice in emergency medicine and accelerated entry for experienced practitioners.

THE AUSTRALASIAN FACULTY OF OCCUPATIONAL MEDICINE (AFOM)

The AFOM was first inaugurated in 1984 as the Australian College of Occupational Medicine. In 1993 the College was dissolved, and in 1994 the Faculty, within the corporate structure of the RACP, was created.

The Human Resource management policies and practices of the Faculty are very good. One presumes that their involvement and affinity with the workplace makes them sensitive to the needs of their own candidates.

The publication *'The Training of Occupational Physicians'* is recommended to readers who wish to pursue these issues.

Eligibility for Training

To be admitted to the training program a candidate must have:

- a registered medical qualification in either Australia or New Zealand;
- 3 years clinical experience;
- a capacity to complete training within eight years;
- arranged for supervision in a way acceptable to the Regional Censor (ie Australia or New Zealand);
- have a written plan for achieving the Faculties goals and requirements; and
- be prepared to comply with the Faculty rules, procedures and fees schedules.

Progress of Candidates

On admission, progress is monitored against a set of developmental goals which are both academic and experiential. There is a final examination which assesses the candidate against the competencies to which he or she has had access since the day of admission.

Features of the Program

- The definition of an Occupational Physician and the Mission Statement of the Faculty are clearly set out.
- The aim of the training program and the required competencies are available for all to see, study and debate (soon to be on a web site).
- The criteria for entry are explicit and objective.
- Progress against the required competencies where possible is scored. A candidate is required to accrue a minimum of 400 points.
- The academic components are undertaken through the tertiary education sector.
- There is a very clear and precise appeals process for both admissions and progressions.
- An objective checklist is given for both planning and assessing progress.
- The manual provides specifically for:
  - Remote Area Training;
  - temporary suspension of training; and
  - part-time training.
- Clear statements set out the roles and responsibilities of both students and supervisors.

Summary

No adverse comments were received by this review in relation to the AFOM. The AFOM admission and progress criteria are transparent, flexible, documented, objective, quantifiable, appealable and based on competencies. The clarity of the documentation is very good.

THE AUSTRALASIAN FACULTY OF PUBLIC HEALTH MEDICINE (AFPHM)

The AFPHM is one of the three faculties of the RACP. It has attracted doctors working in diverse areas. They have in common a focus on population health.

The diversity has resulted in a slow evolution of an 'identifiable' training program. Their late arrival has not necessarily been a disadvantage and many of their practices are educationally and managerially sound.

There is a current debate about the importance of primary care to public health and vice versa.

Eligibility for Admission

The AFPHM operates more as an 'advanced training' faculty than do the other Colleges and Faculties aligned with the RACP. It is pitched at medical practitioners further along their career path. The eligibility criteria are:

- registered in Australia (or New Zealand);
- 3 years postgraduate medical experience; and
- completion of at least the coursework for a masters degree in Public Health or a similar accepted degree.

Admission

- Admission equates to advanced trainee status in other Colleges. It does not relate to any particular position or institution.
- The principles underpinning selection have not been laid down.
- Admission is available at any time.
- All who meet the criteria are admitted.
- There is no quota.
- The criteria are well publicised and binding on all regional committees.
- There is no interview.

Two respondents to the review suggested that the Faculty of Public Health Medicine does not take an active interest in the welfare of their trainees and that they are left to fend for themselves.

Summary

The Faculty focuses on the individual, not posts or institutions. The admission criteria are sufficiently objective that a selection panel is not required in a judgmental sense.

'Automatic' admission to advanced training to a (relatively) unpopular discipline is easy to manage but the principle does not translate to disciplines that are already in oversupply, or where oversupply would not be in the public interest.

THE AUSTRALIAN COLLEGE OF DERMATOLOGISTS (ACD)

Dermatology is the most enigmatic speciality. There is a widespread perception amongst the profession, and in the broader community, that there are not sufficient Dermatologists. For their part, the College is continually frustrated by the fact that Dermatology training posts are an easy target for hospital managers under financial constraints. The College has made numerous representations to State and Federal Health Ministers along these lines.

The Dermatology Training Program

- Candidates are eligible for admission to the ACD program if they have more than two years general medicine and have passed the Part I exam.
- Coordination is via State coordination committees.
- Candidates must be appointed to accredited positions in accredited hospitals.
- The College strongly claims that a quota is effectively imposed by State Government funding. In reality no State still funds 'established positions'. Hospitals are now funded either globally or on output.
- Many aspiring dermatologists need to wait 2-3 years to obtain a vocational training position.
- Victoria and NSW have developed selection processes which are in line with those proposed in this report. Other States have a way to go.

Commentary

The College of Dermatologists has legitimate concerns about its capacity to train the next generation of dermatologists. It is true that public sector funding for Registrar positions in dermatology have all but disappeared.

The discipline has become one that is largely conducted in the ambulatory sector and financed through the 'fee-for-service' system.

The College has its HR management under review. The two most populous states have developed acceptable practices.

Notwithstanding these comments, this review believes that the traditional public hospital training post approach may no longer be appropriate to dermatology. The paradigm has changed and new approaches must be found. AMWAC is currently reviewing Dermatology and no doubt, many of the issues put to this review will be addressed by their Working Party

THE AUSTRALIAN COLLEGE OF PAEDIATRICS (ACP)

The ACP training evolved from the College of Physicians. They have a two tiered system. Basic training is undertaken in an accredited hospital, and Advanced training by approval of a proposed program.

The processes which are the subject of this review do not involve the College and are under the auspices of the hospitals. The result is that their questionnaire response is a series of 'don't know' and 'not applicable'.

Eligibility

- Registrable MB BS.
- One year experience in general medicine and surgery.

Admission

In theory there is no limit to the number being admitted to training. In reality, this means that service requirements and available funding are the determinants. Admission requirements are:

- Appointment to an accredited hospital becomes the sole criteria for admission.
- Trainees can be disqualified from the program by:
  - failure of exams;

  - unsatisfactory clinical performance; and
  - failure to be appointed to an approved post or training program.
- Such recommendations ultimately go to the Board of Censors.
- This process is appealable in line with the RACP guidelines.
- 85-95% of those admitted to the program complete their fellowship.

Commentary

Colleges such as the ACP who choose to devolve the selection of candidates and all the associated HR and legal requirements to accredited institutions must be prepared to either:

- audit the institution's performance in these areas; or,
- as a condition of accreditation, be involved in the basic principles under which appointment is to be made.

This may best be achieved by requiring the training institutions to certify their compliance with the principles laid down by this review.

In the eyes of many respondents there is considerable confusion about the respective roles of specialist paediatricians and primary care practitioners.

Some respondents expressed concern about the availability of advanced training posts in their chosen sub-speciality. The imminent review of Paediatrics by AMWAC will address some of these concerns.

THE AUSTRALIAN FACULTY OF REHABILITATION MEDICINE (AFRM)

The Australian Faculty of Rehabilitation Medicine had its origins in the Australian College of Rehabilitation Medicine (ACRM) which was formed in 1980. The ACRM had grown out of the Australian Association of Physical and Rehabilitation Medicine

The Faculty has developed a comprehensive training manual. This manual sets out the requirements for both Basic and Advanced training.

The AFRM is more like the parent body (RACP) than the other two faculties.

The Faculty has embraced the new era of competency based assessment related to a detailed curriculum. The policy manual has detailed statements in the areas of training; the roles and

responsibilities of supervisors; the level and category of feedback that a trainee can expect; proforma supervisor reports; a policy statement on sexual harassment; and a policy on problem trainees.

The Faculty has followed the RACP approach of leaving appointment issues including selection panels, conduct of interviews, formulation of questions, weighting and scoring of responses to the employers.

No adverse comments were received in relation to rehabilitation medicine.

THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS (ANZCA)

ANZCA is the College responsible for training in Anaesthesia. ANZCA has a Faculty of Intensive Care as part of its corporate structure. The Faculty completed a separate questionnaire which is detailed elsewhere in this report.

ANZCA's responses to the questionnaire were given with little explanation.

Eligibility

MB BS and two years general post graduation.

Admission

- Admission as a trainee is dependent on the candidate being appointed to an accredited position in an accredited hospital.
- The number of these posts is said to be determined by:
  - teaching workload;
  - capacity for supervision; and
  - hospital funding.
- The questionnaire indicated that there are a set of principles underpinning selection and training.
- The principles are not published but said to be available on request.
- A written application is required along with three referee reports which are not accessible by the candidate.

- Not all applicants are interviewed.
- Shortlisting is carried out by Hospital Directors of Anaesthesia reviewing the written applications.
- Selection panels are convened by the employers and comprise the Directors of hospital departments.
- There is no College policy relating to selection criteria, conduct of the interviews, appeals or advice to unsuccessful candidates. However these are being developed and are likely to be based on the findings of this review.

Progress Through College

- Trainees cannot progress beyond the second year of training until they have passed the Primary Examination.
- Exclusion from the program can be related to:
  - failure in exams;
  - poor clinical performance; and
  - failure to be re-appointed to clinical posts.
- There is a mechanism for appealing removal from the program.

Commentary

ANZCA clearly falls into the category where the HR function is predominantly left to the employers. In reality this is the local Directors of Anaesthetic departments who are closely aligned with the College.

The only significant complaint in relation to the selection and training of Anaesthetists was the large number of 'non-accredited' posts in some institutions. Trainees and applicants did not see that these positions were any different from accredited ones and many believe that the posts should not be excluded from acceptable training.

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS - FACULTY OF INTENSIVE CARE

The Faculty of Intensive Care is part of the corporate entity of the College of Anaesthetists. Their origin reflects the fact that, most Australian intensivists come from anaesthetic backgrounds.

The faculty co-operates with the RACP through a joint Specialist Advisory Committee (SAC) to offer a combined qualification.

Intensive Care training is based on nationally determined requirements but dependent on appointment to accredited posts in accredited institutions.

As is the case for other disciplines operating under this model, the HR function is related to the policies of the employing hospitals and independent of the Faculty. This is not to say that individual hospital do not have the highest standards of HR management nor that individual Intensivists are not scrupulous in ensuring that appointments to their units based on merit alone. However, the fact remains that the Faculty is not directly accountable for the selection of trainees.

The difference between the Faculty of Intensive Care and other disciplines operating under this model is, that for intensive care, supply of training positions significantly exceeds demand.

THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS (RACGP)

The RACGP is culturally different from most of the other Colleges.

One must acknowledge the enormous task that faces the RACGP. They are required to process some 700 applicants and award 400 training places. Their skills and diplomacy will be tested to a far greater extent than is the case for other Colleges.

Young graduates have no option but to accept the political decisions relating to vocational training and the rationing of training places. However they will wish to be assured of absolute fairness and impartiality.

For these reasons the College's selection processes will need to be based on 'bankable' HR practices.

Eligibility Criteria

'Full and unconditional medical registration in the Australian State or territory by the commencement of active training in that state/region;

Hold Australian citizenship, or permanent residents status in Australia, or New Zealand citizenship by the closing date for applications for the intake in which the application is made;

Agreement to payment of the Registrar Membership Fee;

Satisfactory completion of the enrolment process;

Intention to complete the requirements of training (including circumstance which will permit completion of training);

Not enrolled in another training program or intending to train in another program (as demonstrated by enrolment for another program's examination).

Ability to commence active training in a required training unit (H, B, S,) within three months of the commencement of the training year (or half year in the case of mid-year enrolment).

That professional services provided in general practice training placements when enrolled with the Training Program will attract Medicare benefits. Overseas trained doctors (including New Zealand doctors) and, overseas doctors trained in Australia may not satisfy this criterion.'

Appointments

- The appointments are nationally co-ordinated.
- The number of positions is linked to a Commonwealth quota.
- In 1997, 75% of applicants were admitted.
- In 1998 this number is expected to be 55%.
- The principles that underpin selection are widely disseminated.
- A written application is required as is the nomination of two referees whose reports are accessible by the candidate.
- All applicants are interviewed.
- Written criteria are laid down and are binding an all states.
- For the most part the criteria are objective and scored
- An affirmative weighting is given for rurality.
- Conduct of the interview is subject to national policy, structured and responses are scored.
- The panel is provided with detailed instructional and educational material.
- There are policies on questions and topics which may not be referred to.

- There are no 'independent' members of the panel ie. outside of general practice.
- A formal appeals mechanism exists.

Commentary

The RACGP faces an enormous selection challenge. Many respondents to this review sought to comment on the RACGP selection and training process. A separate section has been devoted to the comments on the RACGP in Section 7.

THE ROYAL AUSTRALIAN COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS (RACOG)

The RACOG was formerly one of the Colleges with a traditional approach to training. They focused on the acquisition of technical knowledge and practical skills while leaving all aspects of recruitment, selection and human resource management up to the employers.

They have recently developed a national policy in relation to

'…the interview and selection of trainees'

which is binding on State Committees and hospitals. The policy is an important advance. It is seen as a trailblazer for Colleges that rely on appointments to accredited posts or accredited rotations.

Eligibility

- Medical registration.

Admission

- Admission to the RACOG training program is dependent on appointment to an accredited post or an accredited rotation.
- The number of positions is limited and is said to be determined by hospitals, State Committees and training co-ordinators.
- The number of posts is limited by available clinical experience and supervision.
- Selection committees are convened jointly by the employers and the College.
- The selection committees operate within a national policy framework.

Progress of the Candidate

- Candidates can be removed from the program for:
  - failure in exams;
  - unsatisfactory clinical performance; and
  - failure to be re-appointed to a training post.
- The decision to disqualify a candidate is referred to council for decision by the Training and Accreditation Committee.
- A decision by Council to disqualify a candidate is appealable.
- 95% of candidates complete the program.

The College in its document 'RACOG guidelines for the Interview and Selection of Trainees' has developed a set of national guidelines for selection. The policy begins with a strong anti-discriminatory statement which would be applicable to all Colleges. It covers; race, gender, marital status, pregnancy, religion, age, domestic arrangements and personal issues. It guarantees the privacy of the applicant and demands that questions must reflect the requirements of the position and nothing else. The policy goes on to cover:

- size and composition of the panel;
- referees reports;
- process for shortlisting, conduct of the interview, objective criteria, questions and/or applications which are not acceptable;
- areas for which questions should be derived;
- a Standardised Assessment Survey for completion by the candidate; and
- a proforma referees report.

One may quibble with the detail but the RACOG has demonstrated that:

- A national Policy can overlay a devolved appointments system.
- A Clinical College can operate within a framework that picks up most issues in contemporary HR practices.

Commentary

The RACOG has made an enormous effort to 'get their house in order'. There are still some opacities in relation to the numbers of training posts and how these are determined. In the framework proposed in subsequent sections many features of the RACOG approach are picked up.

THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS (RACP)

The RACP is a large College which covers general medicine and all the sub-disciplines of internal medicine (Cardiology, Neurology). It has three Faculties as part of its body corporate (Occupational Medicine, Rehabilitation Medicine and Public Health). Theses faculties are each the subject of separate analysis in this report.

Physician Training has to be considered in two phases; Basic Training and; Advanced Training.

The College questionnaire response specifically addresses Basic Training. The responsibility for the selection of basic trainees is assumed to lie with accredited hospitals.

A Brief Outline of Basic Training

The essential criteria are a registered medical degree with one year postgraduate experience and appointment to a training program in an accredited hospital. It is the institution which is accredited, not the position.

At the end of the first year candidates are required to register. They may complete the FRACP examination after or during the third year of registered training.

All human resource issues are determined by the employing hospital. The College has no policy on:

- numbers entering training
- selection criteria
- selection panels
- referees reports
- access to reports
- weighting of criteria
- affirmative criteria

The College does not record the number of medical graduates who apply for, and are rejected for basic training

Commentary

This long standing approach from the College has enabled College officials to say with certainty that they do not have a quota nor do they involve themselves in workforce planning issues.

It would seem that two changes could be made relatively easily:

- Accredited hospitals could be required to report to the College on the numbers who applied, the number of applicants accepted and a categorised statement of reasons for rejection.

- Also, as has been suggested for other Colleges who rely on the employers, it is strongly recommended that the College require a certification of HR practices as part of accreditation.

Advanced Training

Advanced training is usually of three years duration with a minimum of two years core training in the selected discipline. The training is under the supervision of a Specialty Advisory Committee (SAC). The SAC's approve, prospectively and annually, a candidates proposed training program. In theory this is not necessarily limited to an accredited post but in reality these posts (or 95% of them) are in the same hospitals that are accredited for basic training.

Commentary

The College of Physicians has not sought to involve itself in workforce issues in the past and, as a result, is unable to comment on or report on the HR practices to which their candidates and aspirants are exposed.

The Australian Medical Workforce Advisory Committee (AMWAC) is now beginning to examine the internal medicine disciplines. If, as most observers would predict, AMWAC finds an oversupply in some of these disciplines (Cardiology for example), the College will have to involve itself in workforce planning.

Such an involvement will necessarily involve greater intervention in the Hospitals' training programs.

If this is the case and training positions are to be national it can be argued that HR practices will need to be addressed.

Preliminary discussion with senior College officials and office bearers suggest that they are aware of these problems and not unsympathetic to the approaches suggested here.

THE ROYAL AUSTRALASIAN COLLEGE OF RADIOLOGISTS (RACR)

Eligibility

To train as a radiologist the basic requirement is a medical degree acceptable in either Australia or New Zealand and the completion of an intern year.

The number of positions is limited and is said to be determined by the willingness of State Governments and institutions to fund training positions and the capacity of the institution to supervise trainees.

Admission

As is the case for other disciplines reported in these pages, the personnel practices are largely determined by the employers. Specifically:

- The College does not know the total number of applicants and the percentage admitted.
- There is said to be a set of principles underpinning selection but that these are determined at the local level and are not available.
- A written application is required with 2-3 referees. These reports however, are not accessible by the candidate.
- Not all applicants are interviewed.
- The shortlisting is usually carried out by local Directors of departments - no details were given of how this task is carried out.
- Selection criteria are determined locally.
- The College has not considered making the principles and criteria available to either the candidate or the public.
- There is no national policy on the conduct of the interview, structure of the panel or admissibility of questions.
- The panel is covened by the employers.

- There are no data available on what feedback is given to candidates - this is determined locally.
- There is no avenue for appeals to the College because decisions are made by employers.
- Failure to be re-appointed locally is the process for removal of a candidate from the training program.

It is likely that the RACR will need to take on board some of the findings of this review and as a very minimum require some feedback from accredited institutions and HR policy to be applied to accredited posts. Several concerns were expressed to the review by doctors unable to obtain advanced training positions. In one case a candidate with the first part exam was passed over for candidates who did not have it.

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS (RACS)

The RACS co-ordinates surgical training in nine surgical specialties:

- General Surgery
- Cardiothoracic Surgery
- Neurosurgery
- Orthopaedic Surgery
- Otolaryngology
- Paediatric Surgery
- Plastic and Reconstructive
- Urology
- Vascular Surgery

Advanced training is conducted by Speciality Surgical Boards in each of the specialties. The Boards are either national or State, depending on the number of trainees in that discipline. Basic surgical training is common to all the specialties.

A comprehensive response was made to the questionnaire by the RACS with ten attachments providing policy documents, application forms, assessment forms. As well, each of the Surgical boards completed a questionnaire on behalf of their discipline.

This section of the report considers eligibility and entry to Basic training; completion of Basic training; and the generic aspects of Advanced training. The discipline specific responses will be considered in a section for each Board.

Eligibility for Basic Training

- MB BS, registrable in Australian and New Zealand.
- One year postgraduate experience (internship).

Entry to Basic Training

- Appointment to a hospital post accepted for Basic Surgical Training.
  - In practice this means university teaching hospitals (two years).
  - Major urban hospital with adequate teaching and supervision capacity (2 years).
  - Country Base Hospitals (or equivalent) - one year.
- Advertising, selection criteria, conduct of the interview and structure of the interview are solely determined by individual hospital policy.
- There is no limit to the number of trainees (other than the posts available in approved hospitals).
- They are required to register as trainees prior to taking the multiple choice exam.

Completion of Basic Surgical Training

- Two years in approved posts of which three months should be in an emergency department.
- Completion of a four phase examination comprising:
  - MCQ exams;
  - an interview;
  - mentor assessment; and
  - an objective structured clinical assessment.

Advanced Training

The College at the corporate level has a clear set of *'Guidelines for Selection of RACS Advanced Trainees'*.

The purpose of the document is to

'…provide guidelines for selection for Advanced trainees so that applicants, members of the Selection committees, Fellows of the College and the public may be aware of the College processes.'

A summary of the issues the document covers is given below.

- Eligibility criteria:
  - Part I or exemption.
- A philosophy underpinning selection:
  - Specifically mentions academia, rurality, equity, public expectations, public information in relation to the process of, and criteria for, selection; and the philosophy of selection by ranking.
- Appeals:
  - The guidelines provide the applicants the right of appeal on the grounds of;
    - error in process of law;
    - that a decision was against the weight of evidence; and
    - additional information that may have led to a different decision.
- Selection committees:
  - to include employees;
  - to include State registering authorities;
  - not more than six selection panel members; and
  - does not mention an independent member.
- Selection process:
  - chairman to reject those that do not meet essential criteria; and
  - authorises panels to investigate the candidate by approaching persons 'qualified to know'.
- The interview:
  - A strong statement to begin with;

    '*All candidates who meet the absolute requirements for advanced training as set out in the Guide should be interviewed'*

the statement is then, ambiguously, watered down by the qualification

'…unless the advertisement allows further culling based on desirable attributes'

- It requires all panel members to have copies of the guidelines.
- Questions and/or skill assessments to be standardised.
- The whole Committee is to meet with each candidate - but one on one interviewing is acceptable for specific issues.
- Applicants must be given an opportunity to comment on all negative aspects of referees reports but confidentiality (of the referee) is to be reserved.
- Voting is to be by secret ballot.
- Each member may use a personal system for ranking the importance of the selection criteria.
- Notification is within one week and in writing.

- Advice to unsuccessful candidates:
  - to be interviewed by Chair or deputy;
  - major deficiencies are to be explained;
  - not to discuss answers to individual questions; and
  - those unlikely to improve their ranking are to be notified.

Finally the document gives Five Generic Selection Criteria with about fifteen sub categories and indicates how they are to be measured.

Commentary

The College has made enormous advances in updating its HR practices. The questionnaire responses from the Surgical Board suggest that compliance across all disciplines is variable.

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS - BOARD OF GENERAL SURGERY

General Surgery is co-ordinated at a State/regional level. It is a large program

Eligibility

Surgical Primary Package.

Admission to Training

- The number of annual appointments is subject to a quota which is reviewed annually.
- The numbers required for the next decade has also been reviewed in conjunction with AMWAC.
- At the moment 50% of applicants are accepted.

Commentary

The various regional Boards of General Surgery have enthusiastically embraced the RACS guidelines. Very few adverse comments were received.

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS - BOARD OF NEUROSURGERY

Training in Neurosurgery is co-ordinated nationally. Appointment is dependent on candidates securing an accredited post and in an accredited position.

Eligibility

Primary exam of RACS.

Appointment to Training

- The number of people appointed is linked to the available training positions but that number is not transparent.
- 30-50% of applicants are successful in gaining entry.
- There is a set of principles underpinning selection (presumably RACS).
- The remainder of selection, interview, appeals etc appears to closely follow RACS guidelines.
- Feedback to unsuccessful candidates is recorded as informal.

Commentary

The Board of Neurosurgery is, by and large, following the RACS guidelines.

The protocols are fairly new and, under a new Chair, changing very quickly.

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS - BOARD OF ORTHOPAEDIC SURGERY (BOS) AND AOA JOINT SUBMISSION

The AOA was incorporated in 1997. The BOS is part of the corporate structure of RACS. There is a strong national focus in the coordination of this program.

Eligibility

Primary package of Part I.

Admission to Training

- There is a limit to position numbers.
- The limit is determined by

  '*individual State Boards of Studies on advice from the Federal Training and Membership Committee and Workforce Committee of AOA.'*
- Orthopaedic Surgery was reviewed by AMWAC in 1996.
- 50% of applicants are admitted.
- Principles underpinning selection are said to be 'being developed'.
- A written application is required nominating three referees. The reports of these referees are available to the candidates.
- Selection criteria, conduct of interviews, assessing applicants, questions at interviews, feedback to candidates and conduct of appeals all follow closely the RACS guidelines.

Commentary

The AOA/BOS has been the target of criticism in the past. The Orthopaedic Surgeons have done an enormous amount of work to upgrade their processes and policies. The AOA and BOS have indicated that they strongly endorse this project and will be anxious to develop its findings.

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS - BOARD OF OTOLARYNGOLOGY (ENT)

The Board of Otolaryngology co-ordinates a national appointment system to posts in ENT.

Eligibility

RACS Primary Package.

Appointments to Training

- No quota is applied and the limit to the number of appointments is the 'government funding' of training positions.
- 45% of applicants are admitted.
- Not all applicants are interviewed, shortlisting is carried out by State and Regional Training Committees.
- There are no selection criteria laid down nationally.
- The interview is free wheeling, the candidates are not asked the same questions and the responses are not scored.
- The panel is given the RACS guidelines document.
- Unsuccessful candidates are advised in accordance with RACS policy.

Progress

- Removal from the program is solely related to clinical performance and is in accordance with RACS guidelines.
- 99% of accepted trainees graduate from the program.

Commentary

The Otolaryngology Board is obviously using some aspects of the RACS policy but not others. Follow-up revealed greater compliance than was indicated in the Questionnaire. The Board representative indicated agreement with the draft framework and a willingness to implement it.

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS - BOARD OF PAEDIATRIC SURGERY

Paediatric Surgery is one of the smallest of all medical and surgical disciplines.

Eligibility

Primary package of RACS and either Full Fellowship in another discipline or two years advanced training in another discipline.

Appointments

- Quota determined by the 'Manpower Subcommittee' of the Board.
- Selection processes are clearly laid down.
- An objective assessment is used, including scoring of all responses.
- Questions responses are marked individually by panel members (RACS guidelines).
- CV is scored.
- All applicants are asked the same questions.
- Selection is not dependent on a particular post, but on admission to the program.
- All successful and unsuccessful candidates are re-interviewed and later given written advice.
- Appeals are conducted in accordance with RACS guidelines.

Commentary

Paediatric Surgery has not only adopted the RACS guidelines but taken them further. They have broken the nexus between hospital appointment and appointment to the program.

Perhaps it is the relatively small numbers they are dealing with that has required them to be meticulous or it could be the very high rejection rate which requires them to be seen to be absolutely fair.

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS - BOARD OF PLASTIC AND RECONSTRUCTIVE SURGERY

Although the Board currently selects trainees at a State level the process is evolving into a national selection program.

Eligibility

- Completion of Surgical Primary process (see RACS section).
- One year general surgery post primary.

Admission to Training

- There is a quota on the number of trainees admitted which is determined by the Board and reviewed annually (Has not been reviewed by AMWAC).
- 25% of applicants are admitted to training.
- Referees reports are said to be accessible by the candidate.
- All applicants who satisfy the essential criteria are interviewed.
- Selection criteria were formulated as of April 1997 and will be used for the first time in 1998.
- The RACS guidelines for the interview are followed.
- Appeals are according to RACS guidelines.
- Removal from the program is according to the RACS guidelines.

Commentary

Plastic Surgery has obviously made an effort to update its procedures to make the processes in their own words ‘more fair and more transparent’.

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS - BOARD OF UROLOGY/UROLOGICAL SOCIETY OF AUSTRALIA

It is generally acknowledged in the industry that the USA is at the forefront of HR practice

Eligibility

Primary Package; One year (minimum) of accredited general surgical experience.

Admission

The number of positions is linked to funded training positions. The number of these positions has recently been reviewed by AMWAC.

- The principles in the RACS guidelines have been endorsed by the Board of Urology.
- In addition to a CV, a proforma of required information is supplied to candidates.
- A standardised referees report format is also provided to enable scoring and ranking.
- Interviews are held in each State with a standardised interview and scoring sheet. All applicants are graded and ranked.
- The Board then considers all applicants at a national level.
- Feedback to candidates, appeals and possible removal from the program are all conducted in accordance with RACS guidelines.

Commentary

The Urologists have taken the RACS guidelines and operationalised them. There are many features of the policies and procedures adopted by the Urologists that could be regarded as best practice.

THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS VASCULAR SURGERY DIVISION

Vascular Surgery has only recently become distinct from the Board of General Surgery. Admission requires FRACS fellowship in General Surgery. There is a quota which has recently been reviewed by AMWAC. 30-50% of applicants are successful.

The Division has a long way to go to meet the RACS guidelines. At present they are developing:

- principles
- selection criteria
- a policy on interviews

Commentary

The formation of a separate identity for Vascular Surgery is evolving. It is an appropriate time for them to implement sound HR practices. The RACS corporate guidelines have been adopted.

THE ROYAL AUSTRALIAN COLLEGE OF MEDICAL ADMINISTRATORS (RACMA)

RACMA is the College devoted to the promotion of sound management of the health system. It covers both full-time medical managers who would normally enrol in the Fellowship

Program, and a second tier of membership which is aimed at clinicians with an administrative component to their job eg. Hospital/University/Government Department Clinical Managers.

Fellowship Candidate Admission

Admission to the Fellowship program involves:

- A registered MB BS.
- 3 years of clinical training (hospital or community).
- Enrolment in a Masters course accredited by the College.
- Acceptance by the Board of Studies of either previous or proposed management experience for a period of less than three years.
- An interim recommendation of acceptance from an interview from the State Board of Studies.
- Ratification of this recommendation by the national Board of Studies (Censor in-chief plus all State and Territory Board Chairs).

Summary

The RACMA program has some innovative features. Education and training are separated and accreditation goes to the educational component and approval to the experiential component. It can be argued that this model lends itself to management and Public Health and possibly some other disciplines but is less applicable to clinical specialties.

In reality RACMA does not select but has a process to certify that the candidate meet the eligibility criteria.

THE ROYAL AUSTRALIAN COLLEGE OF OPHTHALMOLOGISTS (RACO)

The training program of RACO is under review. Their existing practice is fairly standard.

Eligibility

- Registration, plus two years of general medical and surgical training plus the Part I exam are required for admission.
- Training programs and positions within those programs are accredited by RACO.
- The quota is said to be determined by the level of funding provided by State and Territory Governments but is more realistically determined by the funding priorities of individual hospital managements.
- It is noted that the AMWAC has recently recommended a modest increase in training places across the country.
- It is further noted that only 50% of applicants are successful in obtaining admission to the program (of those admitted 95% complete it, suggesting that admission is the major barrier for those aspiring to train in Ophthalmology).

Admission

- Selection criteria, panel composition, conduct of the interview, instructions to panel members, shortlisting for interviews, feedback to candidates and conduct of appeals is left up to the employers usually represented by heads of the eye departments.
- The questionnaire responses themselves indicate policies in relation to these issues vary from program to program.
- Failure to be re-appointed by the institutions leads to disqualification from the program.

Summary

RACO has up until now followed the common model of accredited training programs and/or posts but leaves all the human resources management issues up to the employers. This decision produces variable results as indicated on the questionnaires responses.

The questionnaire responses concludes with the comment,

'We are currently reviewing our selection requirements and processes.'

The second round of consultations revealed that RACO itself is very committed to revamping their processes and indeed, have asked that they be part of this process and amongst the first to implement this framework.

Several respondents to this review highlighted the factionalism within NSW. Some trainees considered this disruption to be to their detriment. The College is well aware of the problems.

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS (RANZCP)

Admission to, and progress through the various requirements of the RANZCP is complex. The requirements are fully set out in a forty page document.

After two compulsory post graduate years in general medicine, the program covers five stages.

YEAR 0:	*Graduation*
YR 1&2:	*Two years as a medical officer.*
YEAR 3:	*Approved trainee – probationary.* *Assessment of first year.*
YR 4&5:	*Clinical rotations and demonstration of competence in general medicine.*
YEAR 6:	*Section 1 examination.* *Further clinical rotations.*
YEAR 7:	*Elective year.* *Section Two exam. – dissertation.* *Viva examination.*

This review is confined to admission and to training. The first year assessment, and admission to clinical rotation phase, should come under scrutiny as they are barriers to progress.

Eligibility

The initial (provisional year) depends on:

- two years general rotation;
- acceptance by Regional Committees of the Training Board to the College Training Board; and
- securement of an accredited post in an accredited hospital (the candidates responsibility).

Despite the detailed national Policy framework the College has developed, it seems that Regional Training Committees have considerable autonomy and flexibility. The questionnaire responses provided by the College indicate that:

- Principles for recruitment and training are being developed.
- Access to referees reports are generally not available to candidates.
- Not all eligible applicants are interviewed.
- The shortlisting is performed by Regional Selection Committees.
- The mechanism by which this is done 'varies from State to State'.
- Selection criteria are not laid down.
- There is no national policy on conduct of the interview.
- The interview is not structured.
- Scoring of responses is up to State/regional committees.
- There are no policies as to what questions can be asked.
- No feedback is given to successful candidates and only to unsuccessful candidates 'as requested'.
- An appeals process does not exist but is being 'developed'.
- The processes of State/regional committees are not nationally consistent.

It is noted that a number of responses in the questionnaire included the annotation 'under development'. It is hoped that the models developed in this project will be taken on board by the College as part of their review.

THE ROYAL COLLEGE OF PATHOLOGISTS OF AUSTRALASIA (RCPA)

The College of Pathologists trains both laboratory based disciplines and, in collaboration with the Royal Australasian College of Physicians, joint programs in Haematology and Immunology.

Eligibility

To qualify for admission a registered medical degree is required and a minimum of twelve months general clinical experience.

Admission

Admission to College training is secured by winning a position in a laboratory accredited by RCPA.

There are no other selection criteria and it is said that 100% of applicants who meet these criteria are admitted. What is not given, and by inference unknown, is the number of medical graduates who apply for a post in an accredited laboratory.

- There are no principles underpinning training.
- Referee reports are not sought.
- There are no selection criteria (other than essential criteria).
- The interview is conducted by one person (a State Councillor) – 'Getting to know you'.
- There are no rules or policies for the interview – it is freewheeling.
- There are no provisions for appeals – but if 100% are admitted one can presume this has not been an issue.
- The process may vary from laboratory to laboratory.
- The College has no input.
- Failure to be re-appointed to the laboratory post leads to disqualification from the program as does 'poor' performance.

Commentary

The Pathologists' approach has the attraction of simplicity, however it seems that the HR issues are clearly in the hands of employers and that the College has little role in either workforce planning or, meeting the expectations/demands of young graduates.

It may be that, in the past, that available posts out-stripped demand. With vocational training opportunities becoming more restricted this situation is not likely to continue.

Section 7 – Key Issues Arising from the Consultations and Written Submissions

BACKGROUND

This introduction to the issues raised in the verbal and written submissions should not be seen as critical of any group, nor for that matter, is it meant to question the decisions taken by the Federal Minister and the National Government.

There is however, a medico-political context which if not stated and acknowledged, would make interpretation of the issues described in this, and subsequent sections of this review extremely difficult.

Young medical graduates are angry. Their anger is non-specific. The so-called provider number legislation is the focus of their concern but was probably the last straw in a long list of issues. Declining health budgets, fewer opportunities in private practice and an industry demonstrably in turmoil have all contributed to make an elite group of young Australians question the wisdom of their decision to study medicine. Their anger is directed not only at the Federal Government, but also at senior members of the profession who, in their eyes, have let down the next generation of medical practitioners. Rightly or wrongly their anger is directed specifically, at some of the medical institutions and the RACGP, in particular.

The phenomenon of 'urban myths' is a factor in this debate. The doctors-in-training groups faithfully retell stories that are obviously two-to-three times removed from their source. This review did not have the resources or the authority to investigate many of these claims. However a pattern which suggests very strong networks amongst young doctors is evident. The original source of the anecdote is often hard to identify.

For these reasons our conclusion that allegations of systematic contrivance to regulate the workforce in the interests of members of the profession, cannot be substantiated will no doubt concern some readers of this report.

The Colleges for their part, must accept that their image in some sections of the industry is due to excessive secretiveness and a reluctance on the part of some College members to embrace concepts of transparency and accountability.

The issues which emerged with sufficient frequency to warrant special mention in this section are:

- the gap between written policy and practice;
- the perceptions of the profession;
- the nexus between hospitals and Colleges in relation to selection;
- national, State and regional approaches to selection;
- training of selectors and interviewers;
- issues relating to women in training;
- issues relating to basic training;
- RACS;
- physician training;
- the perception of the RACGP selection process;
- appeals processes;
- standardised early postgraduate years; and
- opacity.

THE DIVERGENCE OF POLICY AND PRACTICE

The terms of reference require the Consultants to both, evaluate the policies of the Colleges and, assess the extent to which practices at State and regional levels reflect these practices.

Many respondents, in both written and verbal submissions, indicated that it was the implementation rather than the policies which lead to the breakdown of the system.

Respondents particularly singled out some Surgical Boards and the RACGP. The concerns centred on the use of selectors who apparently did not know, or chose to disregard, their College's policy. For the RACGP, frequent responses were that the committees 'are using criteria other than those stated', and 'are selecting in their own image'.

At the very least, the Colleges have a marketing problem. Vehement denial by College officers does nothing to assuage perceptions.

For the College of Surgeons, the ten surgical boards, which each diversify into numerous State and regional boards, present a logistical challenge. What the critics appear to miss however, is the fluidity of these policies. Enormous changes have been, and continue to be, put in place. The people driving the changes are as amazed and frustrated by avoidable 'hitches' as are the candidates.

Criticisms, particularly from those within the profession, often refer to practices which have long since changed. One can only assume that these messages were delivered in good faith and the Colleges now must ask themselves how well they have marketed their new approaches.

The lessons to be learned in this section are that:

- Policies, no matter how sound, are only as good as their implementation strategy.
- Marketing of new approaches will be necessary to convince a fairly sceptical constituency of a genuine commitment to transparency and accountability.
- The majority of Colleges have people at the top who know and understand the issues addressed in this report. They should be supported for they face a formidable task.

THE PERCEPTION OF THE PROFESSION

Some respondents from within the profession put forward unflattering views of College selection processes.

Two different areas of concern are identifiable. Some senior specialists had anecdotes to give to the project. When pushed, it became obvious that many of these proved to be from several years ago.

Recent graduates tend to recount episodes of what happened to a friend or, a friend of a friend. Over the course of the Consultancy it became obvious that many of these examples could be traced to a handful of well known cases and were not everyday occurrences. For example, it may be that there is an instance of a person who chaired a selection Committee also participating in the appeals process but it is NOT as some would have it, the norm, or anywhere near it.

Likewise it is not part of the written (or even unwritten policy) of the RACGP that those who have been associated with other programs will be disadvantaged in consideration for GP training schemes.

In an environment characterised by distrust and rumour even fabrication flourishes. Senior figures may have spent too much energy trying to 'stamp-out' the untruths and half truths instead of promoting reality.

HOSPITALS AND COLLEGES – WHO DOES WHAT?

The nexus between employment and hospitals on the one hand, and training and the Colleges on the other, was a constant theme of the consultations.

Many respondents had difficulty in determining when they were applying for employment, when they were being considered for training or when an interview or application was for both. Questions such as:

- If I am not re-appointed at the hospital will I be ejected from the training program?
- If I do not continue with the program (or am removed) will I lose my job?
- How will I be judged each year or how will I serve my employer or how will I progress in the program?
- Why is there no College involvement in my application to be admitted to basic physician training?
- Why is there no hospital representative on my application for a post suitable for advanced surgical training?

No doubt aficionados of the current system can answer these questions. To the uninitiated they are bewildering and the answer often depends on the person to whom the question is addressed.

Several respondents pointed out that selection by either;

1. the hospital alone
2. the College alone
3. one with token representation of the other

is not acceptable and creates at best, ambiguity, and at worst conflict. The Consultancy agrees with those who claim that joint selection based on an attempt to meet the legitimate goals of both parties is the preferred solution.

NATIONAL STATE AND REGIONAL APPROACHES TO SELECTION

Australia is a small country. Our history and founding fathers have left us with a complex system of Federation. In medicine, as in other walks of life the arbitrary divisions we call States and Territories exhibit subtle variations in approach and philosophy to professional practice.

Some respondents have argued that the American Boards system of a national selection with candidates criss-crossing the country would be appropriate for Australia. Others caution that not only would the cost be prohibitive, but that the cultural differences and parochialism would make this approach difficult under Australian conditions.

In practice the number of trainees and entrants to training tend to dictate the approach. Paediatric Surgery is national; General Surgery of necessity is devolved to the regional level.

Standardisation and comparability of devolved processes are probably more important than single national systems.

Several Colleges are attempting to produce standardised scorings which would enable national rankings to be constructed. The RACGP does this. Several respondents remain to be convinced of the validity of direct comparisons of scores in say Victoria as opposed to Western Australia.

The rank within a jurisdiction may be valid. Respondents believe that there are systematic errors produced by 'harshness' or 'softness' of scoring within each program.

The Urologists have suggested an interesting compromise. They acknowledge that in any one year the aspirants to Urology in for example, Queensland, may be very good and in Victoria average. In the interests of national standards these variations should be acknowledged. They have proposed a scheme whereby State Committees would offer, say, two thirds of their positions to local candidates. Candidates who are suitable for training and might otherwise have been appointed to the final one third of positions are put into a national pool and re-ranked.

Such a scheme has the advantage of each jurisdiction retaining its best and brightest whilst ensuring an even spread of talent and an overall focus on standards.

TRAINING OF SELECTORS AND INTERVIEWERS

Fortunately, very few people still hold the belief that selection of applicants for either employment or training is based on nepotism.

The case for formal training of panel members is compelling. Respondents to this review, and indeed, the literature emphasise the fact that it would be hard to justify the use of non-trained people in selection of trainees.

The RACS and RACGP have invested considerable resources in this area. Colleges that rely on others to carry out the function may have reason for concern in that the level of commitment from employers may not match that of the Colleges involved in direct selection.

Training programs for selectors need to acknowledge that some, even eminent clinicians, are not suited to the process. Equally important, is the concept of performance appraisal of selectors by their peers and objectively through assessment of panels on which they have served.,

The Consultants concur with the opinion expressed by many respondents that training of selectors is perhaps the single most important step in gaining the confidence of the profession, the industry and the community in these processes.

ISSUES RELATING TO WOMEN IN TRAINING

Most respondents to the review addressed issues relating to gender. There is no doubt that the number of women graduating in medicine is, and will continue to have, a profound effect on the workforce and the culture of the workplace.

Medical women responding to this review were quick to highlight the fact that the employment and training environment is not keeping pace with the feminisation of the workplace.

Most Colleges have introduced policies in relation to part-time and discontinuous training. The most common complaint was that despite these well-intentioned policies, hospitals have not, and possibly cannot, provide the flexibility required. Opportunities for part-time training and job sharing arrangements are few and far between.

Issues relating to continuity of care, volume of work, surgical experience present enormous challenges for women, particularly those training in surgery.

Many female surgical trainees expressed the view that despite the rhetoric a lot more needs to be done to acknowledge the realities of the changing gender profile of the medical workforce in this country.

It may be that College representatives, women from the various doctors-in-training groups around the country and medical managers need to conduct a workshop to get beneath the rhetoric and examine the real practicalities of training for women.

Various respondents to the review raised issues that one would have hoped had disappeared from our hospitals. Examples including inappropriate questioning of family circumstances, perceptions that some work was not suitable for women as well as, overt and covert harassment were all mentioned.

The simple reality is that these practices are not only unprofessional but illegal. The best practice framework outlined later in this report should minimise these events. This review however, takes the view that this sort of behaviour is totally unacceptable and should be treated the same way as any other unethical or illegal act.

A disturbing trend noted by the review was concern from male graduates that affirmative action was disadvantaging them both in terms of available training opportunities and disproportionate workloads. If affirmative action is in place it must be explicit; it must be the subject of broad debate and continuous review.

Within the next generation women will dominate the medical workforce. Employers and Colleges need to come to grips with this reality and not simply assume that the past, male dominated (both numerically and culturally) system, will somehow adapt to the new order.

BASIC TRAINING

Basic training impacts on this review in two ways:

- Selection to a basic training program or position.
- Completion of basic training as an essential pre-requisite for selection to advanced training.

The major focus for this review is selection for advanced training, however, many respondents were also keen to talk about basic training.

Selection and re-appointment to Basic training for both medical and surgical disciplines is almost exclusively the domain of the hospitals. Graduates apply for jobs that are either suitable or accredited to obtain the appropriate experience.

Both the College of Physicians and the College of Surgeons have realised that they need to be far more involved in basic training. The College of Physicians from next year will register 2nd year basic trainees. The surgeons have a special group reviewing the Colleges level of involvement in the Part I training.

The most common complaint was that the Basic or Part I exams are too hard. Many respondents pointed out that it is inexplicable that the 'cream' of Australia's intelligence have such great difficulty in passing these exams. The allegation is that the exam is used for workforce planning and that pass marks are set to some preconceived notion of the numbers that should be trained. The Consultants did not find any evidence to support these assertions. It must be said, however, that the perception is widely held. If the Colleges are to win the confidence of the younger members of the profession it is these sorts of issues that must be addressed.

Of perhaps more concern, is the challenge from a number of educationalists to the validity of the multiple choice papers that characterise the first part exams for most Colleges. The validity of these MCQ papers must be kept under review. This consultancy is not equipped to evaluate these assertions. The assertions originate from people with significant standing in medical education Both training and assessment should keep pace with developments in education theory and practice.

The other issue raised is that of alternate entry for senior clinicians. Two arguments are advanced. Firstly, that years of experience should substitute for Part I examinations and secondly, that for those who have been away from serious study, particularly in basic sciences, it is almost impossible to pass the multiple choice examinations.

RACS

Complaints and concerns about the College selection and training systems have traditionally been directed at the Surgical disciplines. In the past some of these criticisms may have been deserved.

This review can put these ghosts to rest. The surgical disciplines have put in enormous efforts to update and upgrade their practices. Stories relating to private schools and rugby clubs were retold to the review but there was not one worthy of acknowledgement.

The men and women who now lead the surgical disciplines within the RACS are committed individuals. At least two of them claimed that they themselves had been disadvantaged by practices of a bygone era and were determined to change the image of surgical training.

Things have changed in Surgery, very much for the better.

The Surgical Boards can play their part by ensuring that the views of the minority who cling to the old order are not given either prominence or credence.

PHYSICIAN TRAINING

Most of the submissions in relation to Physician training focused on the involvement or non-involvement of the RACP in selection of its trainees and in workforce planning. The College does not involve itself nor does it attempt to restrict, other than by the accreditation process, the numbers in training.

Some respondents interpreted the College distancing itself from HR issues as indifference to its trainees.

Most people readily accept the view that as a minimum, the College of Physicians and other Colleges that leave all selection and appointment to employers, should require the hospitals to certify that they comply with the principles outlined in this framework. As is discussed elsewhere, some of the detail may vary in relation to process, but this review and most of the people consulted, believe that compliance with the principles of the framework should be a condition of accreditation of hospitals and other training institutions.

Most observers believe that the College of Physicians will ultimately have no choice but to involve itself in workforce planning and selection of advanced trainees.

The selection of basic trainees is of second order importance. Most respondents were comfortable with the notion of the employers continuing to have prime responsibility for selection of basic trainees.

PERCEPTIONS IN RELATION TO THE RACGP

The RACGP is by far the largest program. This year they selected some 400 trainees from over 700 applicants - a major undertaking by any measure. The College is justifiably proud of its selection policies and the application of those policies.

There is however widespread concern about the program. The cause for some of the dissatisfaction is readily apparent, but other concerns are more difficult to pin down.

Many applicants and trainees are upset about the requirements for a rural attachment as part of their training. The complaint comes in various forms. Some say the application of the requirement is inflexible in relation to married couples particularly when young children are involved. Others complain of the lack of choice in terms of location and training of the rural rotation.

These complaints are understandable.

There is a national policy direction to encourage doctors and GP's in particular, into rural practice. The prevailing wisdom is that exposure of young graduates and trainees to rural practice and lifestyle is an important determinant of possible future rural practice. The fact that many young doctors resent this imposition does not invalidate the policy direction. It may be that the application is relatively inflexible as a consequence of the large numbers involved.

The second most common comment in relation to the RACGP is the widely held view that the College will not accept anyone who has been in another program, or applied for other training programs.

Many respondents are absolutely convinced that this is College Policy. This review accepts that it is not. Unfortunately four or five years ago some policy statements were made along these lines and the story lives on. It is likely that some College staff inadvertently perpetuate the myth with repeated statements that General Practice is not a default option for failed specialists.

Of more concern is the frequent accusation that criteria other than those stated are being used. Many young doctors fervently believe that there are unwritten criteria relating to social class, family background, schools and universities. There is no evidence to support these allegations, but, at the very least, the College has a significant marketing problem.

These concerns have been raised with senior officers of the College during the second round of consultations. By their nature, reviews such as this tend to attract people who are disgruntled or who have criticisms to make. It is likely that the views presented to the review are not representative. They are common enough for the College to consider some detailed market research to determine exactly where their message is breaking down and the exact nature of the fairly 'free-floating' concern that young graduates have.

The Consultants stressed that no material of any substance was produced to corroborate the various allegations. It may well be that perception and image is the problem even so it cannot be shrugged off.

APPEALS

Most of the responses from young graduates and their representative organisations raised the issues of appeals. The general sentiments are:

- dissatisfaction with 'internal' processes;
- fear of bias against them even if successful; and
- 'old boy' networks not likely to find against their Colleagues.

There is a general belief that it is not worth appealing (even though College statistics do not support this conclusion).

Aggrieved doctors are being advised to pursue avenues (tribunals and courts) outside the College system. Many individuals and organisations called for a tribunal at arms length from the Colleges. Most would want to see such as tribunal remain within the medical profession rather than go to either a judicial or statutory body.

For their part the Colleges remain ambivalent. They have strong views that the best people to select the next generation of specialists are the members of that discipline. The College leaders recognise that this needs to be done within an open accountable framework in which an appeal is not seen as threatening to the integrity or professionalism of those involved. It would be fair to say that this realisation is not universal at 'rank and file' level.

The Consultants believe that the proposals advanced later in this report meet both objectives. The independence of the profession is preserved, while ensuring a final appeal at arms length from the individual College.

THE EARLY POSTGRADUATE YEARS

The MTRP is conducting a review of this issue in parallel with this study. There is considerable overlap with issues relating to selection.

The varying periods of general medicine and surgical training required by different Colleges (1 to 4 years) creates anomalies and perverse incentives. Young graduates are under ever unnecessary pressure to make earlier and earlier career decisions. There is evidence that pragmatism is determining choices rather than higher order motives.

This project understands that the review of early postgraduate years is recommending standardisation on PGY1 - PGY3 as pre-vocational training years. From the perspective of this project this approach is supported. Several anomalies and unreasonable pressure on graduates would be eliminated if this proposal was implemented.

OPACITY

This final issue is of concern across the spectrum, both within and outside the profession. There is a belief that the Colleges behave as secret societies; that decisions are made behind closed doors; that the rules are determined by a select few; that the published material does not necessarily reflect the 'real' situation; and that the interests of existing members are paramount.

It is doubtful if this construct was ever true. It certainly is not now. However the views are widely held, even by members of the profession.

The Colleges must open their processes, policies and procedures to external scrutiny. There is nothing to hide. Therefore if the collegiate system of medicine is to prosper into the next century the veil must be lifted.

SUMMARY

Most Colleges have significantly changed their practices in relation to Human Resource management, and selection, in particular. These changes are fairly recent and even many College members are not familiar with the extent of the changes. The next generation of doctors have expressed a range of concerns. Some of these concerns are well founded, others have all the characteristics of the 'urban myth'. In this section the common themes have been addressed.

It would be a mistake to dismiss these themes on the basis that the respondents were ill-informed or not up to date or vexatious. They are widely held and demand attention. If senior members of the profession cannot convince young doctors of the *bona fides* of the Collegiate system, there is little hope of convincing the wider community.

Section 8 – Legal Considerations

The principal legal considerations concerning trainee selection by Australian Medical Colleges arise because the Colleges and their members and relevant Hospitals and other institutions are now subject to both the Trade Practices Act and discrimination legislation of the various States and Territories and the Commonwealth. The rules of natural justice also apply to the selection process and to appeals resulting from that process.

TRADE PRACTICES ACT

As far as the Trade Practices Act is concerned specific attention needs to be paid by the Colleges, Hospitals and other relevant institutions (and their selection committees) to conduct which the legislation either prohibits absolutely or prohibits if it is anti-competitive.

The purpose of the Trade Practices Act is to generate and encourage competition in the market place for the benefit of those providing and acquiring goods and services - in the present instance medical and surgical services. Because a competitive and efficient market is seen as so important, conduct which interferes with or prevents competitive behaviour is regarded very seriously and the sanctions against such conduct are severe. In the case of corporations which includes the Colleges, Hospitals and other institutions the maximum fine is $10,000,000 and for individuals the maximum fine is $500,000.

One of the types of conduct which is prohibited outright that is irrespective of its effect on competition is a primary boycott. A primary boycott will arise where competitors enter a contract, arrangement or understanding which contains a provision that has the purpose of preventing, restricting or limiting the supply of or acquisition of goods or services by particular persons or classes of persons.

Depending upon how the relevant market is defined members of particular Colleges will be in competition in trade practices terms with respect to the provision of their medical/surgical services. It is arguable that if members of selection committees limit the number of applicants accepted into training programmes for improper reasons such as controlling the number of specialists in a particular discipline that conduct would contravene the relevant provisions of the Trade Practices Act (Section 4D).

Also if a College had market power in the sense that it controlled the number of medical practitioners practising in a particular specialty by determining who is admitted to a training programme it would be illegal if the College used that power for the purpose of preventing the entry of a person (an applicant) into any market or deterring a person (an applicant) from engaging in competitive conduct in any market (Section 46).

Lastly the Trade Practices Act prohibits Colleges and their members, Hospitals or other institutions from entering into or giving effect to a contract or arrangement or arriving at an understanding which will have the effect or likely effect of substantially lessening competition in the relevant market (Section 45).

One or more of the provisions of the Trade Practices Act set out above would be relevant in practice if a group of specialist medical practitioners such as the Council or Selection Committee of a College acted with 'the purpose' of excluding others who, by gaining the relevant qualifications, are their actual or potential competitors. A 'substantial purpose', even if not the sole purpose, of conduct is sufficient to infringe the relevant provisions of the Trade Practices Act.

If there is no qualification other than a medical degree plus experience or some other objective qualification then every person possessing these qualifications should be admitted to training. If there is, in addition, an interview or some more subjective evaluation, it is important that this not be used as an informal exclusion criteria. Therefore, it is important that the interview or other subjective evaluation be able to be 'objectivised' as to quality and standards and defended if necessary.

This means that all applicants should be treated in a similar way. For example, in an interview they should each be asked the same questions and be given the same opportunities to answer. The interview should also be of approximately the same duration for each applicant.

A particular problem occurs in the case of a requirement to obtain a particular position in a hospital as a condition of entry into training. Training places may be limited because of governmental funding restraints over which the relevant College has no control.

We believe that a Court would approach the question of whether the appointment to an approved training position in a hospital was anti-competitive by firstly asking the question whether hospital service is, in fact, a necessary part of the required training or whether this requirement is being used to limit entry. This would, of course, be a question of evidence. Perhaps some specialties have been traditionally hospital driven but this may not have been, or may not now be, necessary. For example, Dermatology, we gather, has been traditionally hospital based but now is searching for other qualification requirements (see page 54). This may be appropriate for Dermatology but it is difficult to see how Emergency Medicine could, for example, give rise to a specialist qualification without substantial hospital service as a pre-requisite. It is, of course, 'horses for courses' but the entry requirements which are the least restrictive ones are what should be aimed for.

If a hospital appointment is, for good and proper reason, a necessary genuine pre-requisite for specialist training and membership of a College and adequate places are not funded by the Government then a College is not liable in competition law for that which it cannot control. A College in denying entry to an approved training programme in these circumstances, does not

have an exclusionary purpose. Its purpose is to maintain appropriate standards. Its inability to accept applicants is because of reasons beyond its control i.e. inadequate Government funding of hospital positions. As stated, this comment applies only if hospital service is a necessary genuine pre-requisite to competent training and the 'hospital service' requirement is itself not being used to limit numbers rather than to maintain standards. The College involved would have to be able to justify its position in this regard. This is because it may well be the case that a disappointed applicant or the Australian Competition & Consumer Commission (ACCC) will seek, as a first step, to demonstrate that the standards imposed were not relevant to quality of knowledge and training but were primarily set to limit competitive entry.

There are a substantial number of cases on this issue in the United States of America in particular. There are few in Australia, and what adjudications there have been have been largely ACCC Authorization Decisions or decisions of the prior Trade Practices Commission on either Clearance or Authorization Applications. This is largely because the professions until recently have enjoyed constitutional immunity from the Trade Practise Act because they comprised individuals practising Intra-State. As mentioned above this constitutional immunity has now been removed. Perhaps it is all summed up in the *United States Federal Trade Commission Guidelines* (in our view broadly applicable in Australia) which state (reading College for Trade Association).

> 'The law is well established that whenever membership in a trade association is a vital competitive factor for a business then *arbitrary or discriminatory* refusal of membership to a qualified applicant or *arbitrary or discriminatory* dismissal from membership constitutes an unfair method of competition … Dismissal from membership (and, we interpolate also denial of admission to membership) should be allowed only for failure to comply *with specific, non-discriminatory, objective criteria* which adhere closely to the requirements of the law.'
>
> [83 FTC 1849 - US Federal Trade Commission Guidelines].

It is, of course, a question of fact in each case as to what is 'arbitrary' or 'discriminatory'.

Where there are quotas on the number of applicants accepted into training it is essential in order to comply with the relevant provisions of the Trade Practices Act that there be a proper reason for the quota. For instance, if the quota is necessary to preserve or maintain the standard or quality of training it will not be illegal in competition law terms. On the other hand if the quota exists to limit the number of applicants accepted into training to lessen or prevent competition in the relevant specialty it will be illegal in competition law terms.

Where there are 'subjective' elements in the selection process like interviews all applicants should be subjected to a similar format and duration of interview.

Where there are certain factors such as research experience which are highly regarded by the particular College applicants should be advised at an early stage.

The selection process must be fair, transparent and open to all appropriately qualified applicants irrespective of gender, race, creed or sexual preference.

DISCRIMINATION LEGISLATION

Introduction

Attached is a schedule of discrimination legislation which applies to Australian Medical Colleges when they select trainees or confer, renew or extend accreditation.

The schedule provides a brief overview of the purpose of the discrimination legislation and its application to the Colleges.

Qualifying Bodies

Most of discrimination legislation applies to the Medical Colleges because they are 'qualifying bodies'. Each piece of legislation defines 'qualifying bodies' in a similar manner. For example, the *Anti-Discrimination Act* 1977 (NSW) (the ADA), makes it unlawful for an authority or body which is empowered to confer, renew or extend an authorisation or qualification that is needed for or facilitates:

1. the practice of a profession,
2. the carrying on of a trade, or
3. the engaging in of an occupation,

to discriminate on the ground of race, sex, marital status, physical or intellectual impairment, homosexuality, age, transgender, in any of the following ways:

- by refusing or failing to confer, renew or extend the authorisation or qualification;
- in the terms on which it is prepared to confer the authorisation or qualification or to renew or extend the authorisation or qualification; or
- by withdrawing the authorisation or qualification or varying the terms or conditions upon which it is held.

The ADA provides that conferring, renewing or extending an authorisation or qualification includes:

- the conferring, renewing, extending, granting, awarding, approving, issuing or accepting of a recognition, registration, enrolment, approval or certification by an authority or body; or
- the admission of a person to membership of such an authority or body.

Discrimination - direct and indirect

Under the various pieces of discrimination legislation, discrimination may be direct or indirect. For example, under the ADA a Medical College discriminates against a person on the basis of that person's sex if the Medical College discriminates against a person on the ground of the person's sex or a characteristic that appertains generally to persons of that sex or a characteristic that is generally imputed to persons of that sex, or the sex of a relative or associate of the person, if the Medical College:

- *Direct Discrimination*

  treats the person less favourably than in the same circumstances or in circumstances which are not materially different, it treats or would treat a person of the opposite sex or who does not have such a relative or associate of that sex; or

- *Indirect Discrimination*

  requires the person to comply with a requirement or condition with which a substantially higher proportion of persons of the opposite sex, or who do not have such a relative or associate of that sex, comply or are able to comply, being a requirement which is not reasonable having regard to the circumstances of the case and with which the person does not or is not able to comply.

It is unlawful for a Medical College to discriminate (as defined above) against the person on the ground of the employee's sex by, for example, refusing or failing to confer, renew or extend an authorisation or qualification that is needed for or facilities a doctor practising as a specialist.

If an act is done by a Medical College for two or more reasons, and one of the reasons consists of unlawful discrimination against a person (whether or not it is the dominant or a substantial reason for doing the act), then the act is taken to be done for the reason which consists of unlawful discrimination.

CONCLUSION

Colleges, Hospitals and other relevant institutions (and their selection committees) must be aware of their responsibilities and obligations under these laws. The proper level of awareness can be achieved by participating in seminars and by having ready access to specialist legal advice.

The Consultancy has noted that many Colleges are well advanced in this regard.

Table 2: Schedule of discrimination legislation (including regulations made under such legislation) applicable to Australian Medical Colleges

Name of Act	Purpose of Act	Application to Colleges
Affirmative Action (Equal Employment Opportunity for Women) Act 1986 (Cth)	The promotion of equal opportunity for women in employment.	Not unless the College employs at least 100 employees.
Disability Discrimination Act 1992 (Cth)	The elimination of discrimination against persons on the grounds of disability, among other things.	Yes. The Act deals with discrimination by qualifying bodies.
Human Rights and Equal Opportunity Commission Act 1986 (Cth)	Allows, among other things, the Human Rights and Equal Opportunity Commission to enquire into acts and practices which may be contrary to human rights.	Yes. The actions of a College may be the subject of an enquiry by the Human Rights and Equal Opportunity Commission.
Racial Discrimination Act 1975 (Cth)	Prohibits discrimination based on race, colour, descent or national or ethnic origin.	Yes. The Act makes it unlawful for a person to do any act involving a distinction, restriction, based on race, colour, descent or national or ethnic origin which has the effect of impairing a person's exercise of a human right or fundamental freedom in any field of public life.
Sex Discrimination Act 1984 (Cth)	Prohibits discrimination on the ground of sex, marital status, pregnancy or potential pregnancy or family responsibilities and sexual harassment.	Yes. The Act deals with discrimination by qualifying bodies.
Anti-Discrimination Act 1977 (NSW)	The elimination of discrimination against persons on the grounds of race, sex, transgender, marital status, disability, homosexuality and age in certain circumstances.	Yes. The Act deals with discrimination by qualifying bodies.

Name of Act	Purpose of Act	Application to Colleges
Equal Opportunity Act 1995 (Vic)	The promotion of equal opportunity and the elimination of discrimination on the grounds of, among other things, age, impairment, marital status, political belief, pregnancy, race, sex or religious belief.	Yes. The Act deals with discrimination by qualifying bodies.
Anti-Discrimination Act 1991 (Qld)	Promotes equality of opportunity by protecting persons from unfair discrimination on certain grounds including sex, marital status, pregnancy, race, age impairment in certain areas of activity and from sexual harassment and certain objectionable conduct.	Yes. The Act deals with discrimination by qualifying bodies.
Equal Opportunity Act 1984 (SA)	The elimination of discrimination against persons on the grounds including sex, sexuality, marital status or pregnancy, race, age and impairment.	Yes. The Act deals with discrimination by qualifying bodies.
Equal Opportunity Act 1984 (WA)	Promotes equality of opportunity and provides remedies in respect of discrimination on grounds including sex, martial status, pregnancy, family responsibility or family status, race, religious or political conviction, impairment, or age or involving sexual or racial harassment.	Yes. The Act deals with discrimination by qualifying bodies.
Spent Convictions Act 1988 (WA)	Deals with discrimination on the ground of spent convictions including in the areas of employment and work.	Yes. The Act deals with discrimination by qualifying bodies.

Name of Act	Purpose of Act	Application to Colleges
Sex Discrimination Act 1994 (Tas)	Prohibits discrimination on the ground of gender, marital status, pregnancy, parental status and family responsibilities and other specified conduct and provides for the investigation and consideration of, and enquiry into, complaints in relation to discrimination and prohibited conduct.	Yes. Prohibits discrimination in relation to, among other things, registration or recognition by qualifying bodies.
Discrimination Act 1991 (ACT)	Prohibits discrimination on grounds including sex, marital status, pregnancy, race, age and religious or political conviction.	Yes. The Act deals with discrimination by qualifying bodies.
Anti-Discrimination Act 1992 (NT)	Promotes equality of opportunity by protecting persons from unfair discrimination on grounds including race, sex, age, marital status, pregnancy and impairment in certain areas of activity and from sexual harassment and certain associated objectionable conduct and provides remedies for persons discriminated against.	Yes. The Act deals with discrimination by qualifying bodies.

Section 9 – A Best Practice Framework for Trainee Selection to Australian Medical Colleges

In this section the information collected from the various stages of this review is collated to formulate a 'best practice' framework

Each major issue is discussed in the text and the information is presented in tabular form at the end of the section.

WHY A BEST PRACTICE FRAMEWORK?

Although this review has concluded that there is no evidence to substantiate allegations of systematic malpractice by the Colleges, there is still a perception in some quarters that processes are not open, and that the Colleges have not embraced modern human resource practices.

The principles outlined below should, if adopted by all Colleges, dispel the unease that concerns young medical graduates. Compliance with the framework will enable Colleges to select the best possible candidates for specialty training and inspire the confidence of applicants, the Profession and the general community in the selection process.

Further, adherence to a best practice framework will provide a degree of consistency across the disciplines in their approach to selection.

Finally, the anticipated increase in appeals, disputes and litigation by candidates and trainees as a result of the 'provider number legislation', demands that selection processes are accountable and defensible.

STATEMENT OF PRINCIPLES

There should be a clear statement of principles which underpin the selection process.

The first step in establishing a transparent and accountable framework is for there to be a statement of principles on which selection and training is based.

Some Colleges already have comprehensive statements. The RACS document *'Guidelines for Selection of Advanced Trainees'* has a section under the heading *'Philosophy'* which addresses

the range of issues as does the *'Statements of Principle' in the College of Occupational Medicine Handbook.*

Various Colleges have already made statements in relation to gender and rurality. It would be appropriate to state these as principles particularly, if an affirmative weighting is to be applied during the selection process. Some disciplines give an affirmative weighting to applicants with research experience, others have determined that a prescribed period of training in a rural setting is mandatory. These principles are perfectly legitimate. Problems only arise when certain principles that impact on selection, are not declared or are only known to a select few.

In determining these principles the Colleges should try to involve as many people from that discipline as is feasible. (The Urology Society of Australia found this to be a valuable exercise.) The principles should be used in the generation of the criteria on which selection is based, and there should be an identifiable link between the two.

The Consultants acknowledge that the principles need to be based on what is practical and achievable. For example, a single national selection process may be the ultimate objective, but for many disciplines the cost and time involved could not be justified.

Finally it is considered important that the principles, along with other key policy issues discussed, be published in a way that makes them easily accessible.

ELIGIBILITY CRITERIA

T*here should be a clear statement of eligibility to apply for, and be selected for, training*

Several submissions to the review highlighted ambiguities. For example, in at least one College it is not obvious if the first part examination is an essential criteria, or for that matter whether candidates with the Part One are given preference over those who have not passed it.

Another example concerns the amount of general medical and surgical experience required for admission to vocational training. Many submissions to this review questioned the length of general clinical experience and/or suggested that the period be standardised.

It is not the place of this review to question the requirements of the various Colleges. It is worth reporting however that a distortion is being introduced by the fact that the requirements differ. Recent graduates are applying to the first discipline they become eligible for, not because of any desire to pursue that discipline but to provide a 'safety-net' if they fail to secure subsequent training positions in the discipline they really want.

ADVERTISING

There should be national awareness of opportunity for all eligible candidates.

Most training programs and/or positions are advertised in the national Press and in the appropriate Medical Journals. It is acknowledged that advertising is expensive and unrealistic requirements would place a burden on many Colleges and Hospitals.

Colleges that rank candidates deemed to be suitable for vocational training but not ranked highly enough to meet the quota can save on advertising by filling casual vacancies from this pool of previously assessed candidates. It would not be appropriate however, for this mechanism to replace the annual recruitment cycle.

The advertisement should be placed early in the recruitment cycle to enable the candidate to obtain supporting material and complete the required documentation. The advertisement should either contain the selection criteria or state where they can be obtained.

During the consultation phase several discussions covering possible national coordination of the annual recruitment program were held. Such a process may evolve over time. Two short term goals have been identified:

- The publication of a consolidated College information manual/prospectus. This concept is further developed later in the report.

- The establishment of a nationally consistent timetable for the recruitment cycle.

LIMITS TO THE NUMBER OF TRAINING POSITIONS

Quotas, if applicable, and limits relating to other factors, such as the number of training positions, should be explicit and openly declared.

It is not appropriate for this review to debate the role of the Colleges in workforce planning.

The current involvement of the Colleges in Workforce Planning can be considered in three broad categories.

1. Where there is a quota or limit to the number of training positions and these positions are keenly contested e.g. most of the surgical disciplines.
2. Where, (a), there is no quota in a workforce planning sense, but numbers are limited, usually by the availability of training positions and (b), the positions are very popular and demand exceeds supply e.g. many disciplines in internal medicine and Paediatrics and dermatology.

3. Where the available training positions exceeds demand and positions are not filled. e.g. rehabilitation medicine and geriatrics.

Colleges in the first category and to some extent in the second, are frequently accused of unduly restricting training opportunities for less than honourable motives. The Australian Medical Workforce Advisory Committee (AMWAC) is, with the co-operation of the Colleges, systematically reviewing the workforce requirements on a discipline by discipline basis. About one third of the discipline specific reviews have been completed over the past two years. The entire cycle will take about five years.

Where a quota or limit exists it should be openly declared. The mechanism by which the quota or limit is arrived at should be widely known as should the mechanisms by which it is given effect.

The frequency of review of the quota should be declared as should its impact. For example, as part of this review it has been found that many Colleges do not know how many people apply for and are rejected for basic training. Where a College makes the selection directly this information is known, however this is often not the case for selections conducted by accredited institutions. These institutions should be required to provide basic statistics such as the number of applications, the percentage who met eligibility requirements, the percentage not interviewed and the percentage ultimately appointed. Publication of such material will:

- contribute to public accountability;
- facilitate the College's understanding of its own workforce;
- quantify the demand for training in that speciality; and
- assist medical graduates in identifying programs where competition may be less intense.

REFERENCES

Referees' reports should be Proforma with a view to achieving, objectivity, comparability and quantification

Of all the issues canvassed during this review for both the Colleges themselves and for the employees this area was the most contentious. There is general, but not unanimous agreement that:

- Appointments to training programs and training positions should require referees reports.
- Referees' reports should follow a standardise proforma with a view to achieving objectivity, comparability and quantification. Most respondents felt that free form references were time consuming, difficult to process, could not be scored and often so vague as to be useless.

The contentious issues are:

- open vs closed system;
- contacting persons other than those nominated by the candidate;
- the sheer volume of work required (by teaching hospitals in particular); and
- confronting the candidate with adverse comments made by referees.

The first issue is that of confidentiality. One argument goes that unless a referee is prepared to have his or her comments seen by the candidate the process is of little value and cannot be relied on. Proponents of this approach argue that the reports could be subpoenaed in any legal proceeding and therefore should not be considered confidential in any case. An opposing view shared more by the Colleges than the employers is the belief that practitioners will only be forthright if confidentiality is likely to be maintained.

Concerns of the Hospitals

The employers are more concerned at the sheer volume of work required when they have literally hundreds of applications to process. Some candidates apply to most of the hospitals and often for several different jobs.

The response in many cases, has been to not seek references for candidates they know (largely their own staff) and instead rely on their in-house appraisal systems.

One teaching hospital Medical Director pointed out that for popular advanced training positions they may receive as many as 100 applications for the two to three posts available.

This issue also highlights a dilemma for this review. Clearly the intention is to develop a framework for Colleges to *select* their *trainees.* The reality is that many Colleges defer to the hospitals for all selection.

Teaching hospitals all have a Human Resource Department which have developed their own processes which, although not studied by this review, are known to be a blend of idealism and pragmatism.

The framework identified as best practice in this review would be a significant burden for teaching hospitals and unlikely to be implemented. This is not because they do not support the principles, but merely because of the logistics.

This different approach and philosophy likely to be taken by employers is significant. The implications will be considered in more detail in the chapter relating to implementation.

In Queensland, applications are processed centrally by the Workforce Section of Queensland Health thus eliminating the double/triple/quadruple handling of applications. In that State however, for many positions, the applications are fewer than the available positions.

Handling the Referees Reports

In developing this national framework the review concludes that it is not possible to decide on either an open or closed reference system. It will evolve over time; most likely in favour of an open system.

Each College should document and publish the methods it uses to handle referees reports.

The policy adopted by the College of Surgeons is commended to other Colleges. This policy requires that candidates are made aware of adverse comments in referees reports. They are not told who made the comment, nor do they know for that matter, whether it came from more than one referee.

To meet the principle of procedural fairness the Consultants would recommend that the candidate is put on notice that the issue will be raised at the interview. The period given should be sufficient to enable the candidate to adequately prepare a response. It is not reasonable that adverse comments be 'sprung' on the candidate on the day of the interview.

The final concern was that Colleges have a process for validating reports which do not fall into line with comments by other referees or the overall profile of the applicant. It is well known that some doctors are 'hard' assessors whilst others are at the other extreme. An understanding of individual approaches can be vital to the overall assessment of a candidate.

The consultancy generated considerable debate on the legitimacy of Colleges exploring, usually by telephone contact, information on the candidate from persons other than the nominated referee. Most respondents to the review indicated that this was their normal practice and that they did not perceive any problem with the approach.

The review considers that it is normal practice and that a lot of information can be cross checked in this way. However there are problems. Two serious examples were cited by respondents. In one, a candidate was dismayed to find that a senior clinician, with whom he had had personal conflict was contacted without his knowledge or permission. In a second and more serious scenario, a senior person who had made 'inappropriate personal advances' to the candidate was contacted by the College again without knowledge or consent. Both cases highlight difficulties.

As a minimum the consultancy believes that the application proforma should contain advice that College representatives may seek to contact former supervisors and colleagues of the candidate.

The candidate should be given the option to authorise across the board access to professional colleagues or request that any contact, other than with nominated referees, should be discussed with the candidate.

Some Human Resource consultants often give candidates the chance to identify colleagues with whom they have experienced conflict and whose opinions may need to be interpreted in that light.

This is a difficult area. Experienced selectors learn to 'navigate' their way through these complexities. Inexperienced and untrained players can make mistakes, often with profound consequences for both parties.

The safe approach is to involve the candidate. A telephone call along the lines of 'Would you have any objections to me talking to the people you worked with at your last hospital' is rarely rejected. If it is, future conflict can be avoided.

THE SELECTION COMMITTEE

The Committee should have the confidence of the candidate, the profession and the community. It should be prepared to be held accountable for their decisions with the size of the Committee proportional to the task. They should be prepared for their processes and decisions to be reviewed in other forums. The selection process should be valid, reliable and feasible with evaluation built into the process.

It is important that a distinction is drawn between the selection Committee and the interview panel. In some people's minds these are one and the same, and indeed, in many cases they are but not necessarily so.

The selection Committee is the group that can, and should, reflect the range of Stakeholders. Diversity in this group should be considered a strength.

Problems have arisen when a large group, as many as 20 or 30 is constituted as an interview panel. This practice is unacceptable on the grounds of both fairness, and efficiency.

It is perfectly reasonable for selection committees to delegate tasks. For example one group can assess the application pro-forma, another can assess and 'chase-up' referees and another can be the interview panel.

It is preferable that these all be subsets of the selection Committee. Difficulties can and have occurred when people assessing parts of the application do not sit around the 'final selection' table.

Composition of the Committee

The composition of the Committee and its processes should be tailored to inspire the confidence of the candidate, the profession and the community. This principle need not, and should not, conflict with the primary objective of selecting the best possible candidate.

At least one member of the Committee should be 'independent' of the discipline involved. This can be achieved by including a medical practitioner from another discipline or, preferably in the eyes of many, a person from outside the medical profession. This person adds to the integrity of the process.

An alternative to this approach is a non-participating observer being appointed to overview all aspects of the selection process including the interview. This model ('the White Knight' as it is referred to) is often used when it is known in advance that, for whatever reason, the selection may be contentious.

The gender balance of the selection Committee and particularly the interview panel (if they differ) must be addressed for both propriety and legality. All panels should have at least one person from each gender. As a 'rule of thumb', the balance of the panel should reflect the gender balance of the applicants.

Several hospital managers, while indicating that they agree with this principle, have pointed out that the changing profile of the medical workforce makes this requirement difficult to meet. The majority of medical students and recent medical graduates are women. This is not true of more senior positions.

The balance will obviously change over time, but for the moment achieving gender balance for selection committees places an enormous burden on a handful of senior medical women.

Training of Selection Panel Members

One clear message from the literature, reinforced by the experiences of several Colleges, is that formal training for selection panel members enhances the performance of the panel and minimises complaints and appeals.

As part of the training process some practitioners will be found not suitable. Professional and clerical eminence is not always a predictor of the skill required for selection.

Conflict of Interest

Many respondents to the review have raised issues, and sought guidance, in relation to conflict of interest and exclusion of certain people from panels. Obviously when family or personal friends are involved the doctor should not participate in the selection process.

Lesser degrees of potential conflict e.g. ones own registrar or where a mentorship relationship exists, should be declared. The other panel members may request non-participation in the grading of that particular candidate.

It has been pointed out, however, that disqualification of practitioners who have worked with one or more of the candidates would often prohibit the formation of any Committee, particularly in the smaller cities.

The appropriate course of action is to refer back to the principles and ensure the selection process has the confidence of the stakeholders, including the community.

SELECTION CRITERIA

The selection criteria should be documented and published. To the greatest extent possible they should be objective and quantifiable.

The criteria should address academic achievements and capacity as well as previous and potential clinical performance.

There is some confusion in relation to criteria concerning personal attributes. The guiding principle is that the personal attributes assessed must clearly relate to the practice of the discipline. The personal attributes suitable for practice of the disciplines should be part of the statement of principles and the criteria derived from that statement. This is already in evidence for some of the Colleges and Surgical Boards.

An attempt to establish these characteristics, for example interpersonal and communication skills does not justify questions relating to marital status, sexual preference, parenthood which would, in any case be illegal under the various anti-discrimination acts.

The scores to be applied to each criterion should be documented and known to candidates, for example, the relative value of research experience, as opposed to clinical experience as opposed to academic achievements

The use of affirmative criteria is, for many respondents, a source of concern. In their responses to the questionnaire the Colleges identified three areas of affirmative criteria. These are gender, rurality and research experience.

It is not for this review to argue the relative merits of these criteria, however it is vital that if these criteria are being used that they be declared and known to all candidates.

Several respondents claimed that women were being given preference in some disciplines, but that this has not been disclosed.

There is a perception held by a number of young graduates that criteria other than those published are used by some Colleges. This perception is often created by comments made in the debriefing of unsuccessful candidates. In attempting to explain the decision, criteria other than those published are introduced. The conduct of these interviews requires as much skill and training as does the original selection.

CONDUCT OF THE INTERVIEW

The interview should be objective and free of bias

The candidate should be given every opportunity to demonstrate his or her suitability for the position.

Courtesy should be extended to the candidate in terms of adequate notice of the date and time of the interview, the names of affiliations of interview panel members and an introduction to them prior to commencement.

Distraction of the candidate by mobile phones and other interruptions should be avoided.

The questions should be set and asked of all candidates. Responses should be scored. The questions should be derived from, and explore, the selection criteria and should not introduce new criteria.

In addition to the set questions, others that amplify the criteria can be pursued. It is prudent however, to maintain a consistent approach to all candidates.

Many HR practitioners recommend that, on the day, panel members should have in front of them a one page summary of issues which may threaten the integrity or legality of the selection process.

As mentioned earlier, if adverse comments from referee reports are to be raised the candidate should be given reasonable notice of the issue.

The interview should be of the same duration for each candidate. It is customary and good practice to allow time for the candidate to restate their claim for the position and comment on any aspect of the selection process.

SELECTION

The selection process should be based on the published criteria and the principles of the College concerned whilst also being capable of standing up to external scrutiny.

As should be clear from previous sections, selection refers to the total process and not just the interview.

The selection of trainees should be based on the published criteria and the principles which underpin that discipline and its training program.

The essential tools for any selection process are considered to be:

- an application form, preferably proforma;
- referees reports, again proforma; and
- an interview.

These three components should be objective and scored. Some Colleges have weighted these three components e.g. 50% application, 30% referees and 20% interview. However it is considered preferable that the weights be given to the criteria, and that the criteria be explored, and scored, from any or all three of the 'tools'.

Irrespective of the method of scoring, the process should be capable of withstanding external scrutiny.

Applicants who do not meet the eligibility criteria can be automatically excluded. This task is frequently delegated to the Chairperson of the Committee. Other Committee members should be given the opportunity to query any exclusion. The Committee as a whole should endorse the action of the Chair or group that excluded these candidates.

All candidates that meet the essential or eligibility criteria should be interviewed and the reports sought from their referees. If this is not logistically possible the process of shortlisting should be transparent and objective. If shortlisting is to be used the number of candidates interviewed should be approximately twice the number of places available.

Some teaching hospitals have adopted the practice of only contacting referees for recommended candidates. This may be appropriate when large numbers of people are being considered for junior positions. For selection of advanced training however it is considered necessary that all three components (application, references and interview) are used.

Various other selection tools were put forward by respondents including:

- OSCA
- clinical scenarios
- professional portfolios
- psychometric testing

Some of these tools are better suited to assessment of progress through the training program than they are to original selection.

The literature on the use of psychometric testing for selection is equivocal. For undergraduate selection there is evidence to support the use of such testing, but there is not much evidence to support testing for postgraduate training.

RANKING

The Selection Committee should score and rank candidates using the tools presented earlier.

It is preferable that members rank candidates individually and that a composite ranking be achieved by aggregation.

The panel should then arrive at a final ranking after a general discussion. Candidates whose rank order was not uniform across scorers need special consideration and even further review.

The number of trainees in each discipline dictates, to a large extent, the level at which rankings are aggregated. Small disciplines such as Paediatric Surgery have a truly national process and ranking.

For other disciplines, particularly the larger ones e.g. General Surgery, the ranking is at the State or even regional level. Some have tried to standardise the process to the point where State and regional selection Committees can generate standardised scores to produce a national ranking of candidates. Without cross-over of assessment the comparability of State scorings must be questioned.

The RACGP 'selection process' is interesting in this respect. All applicants (over 700 in 1997) are aggregated from State and regional panels into a national rank order. Places are then allocated, State program by State program, from the national ranking, in accordance with predetermined State quotas and the applicants' stated preference(s) for location of training, until all places in the program are filled. This could mean that an applicant for South Australia (which fills early) may be ranked, say, 200 and be unsuccessful in gaining a place whilst number 700 may get a place if they gave North Queensland (which usually fills late) as one of their preferences,

The RACGP 'selection' is in fact a national ranking and matching process. The College deems all eligible applicants suitable for training and has no predetermined score above which applicants are successful in gaining a place in the training program.

In the light of this knowledge it is easier to understand why there is significant regional variation in satisfaction/dissatisfaction with selection for the RACGP Training Program, with South Australia having proportionately the largest numbers failing to gain a place (due to the

relatively high number of local graduates and the relatively small quota) and therefore the highest level dissatisfaction.

The Urologists are considering a mixed State and national ranking in which the top, say, third, of candidates in each State would automatically go into the local program. The middle third would then enter a national allocation for remaining places.

DOCUMENTATION

Adequate documentation enables external scrutiny, audit and evaluation of the selection process. It should enable accurate reconstruction of the original detail and process.

For some Colleges a belief has grown up that all documentation should be destroyed on the completion of the process.

Presumably the idea is that paperwork that no longer exists cannot be accessed even on subpoena. Such action is not justifiable on a number of grounds:

- It implies a resistance to external scrutiny and accountability.
- It may prevent candidates and applicants seeking justice if they have genuinely been wronged.
- It may seriously impede the conduct of appeals.
- It prevents a meaningful audit of processes.
- In future years, evaluation of selection processes particularly in relation to future performance of trainees will be difficult, if not impossible if original documents have been destroyed.

Application forms, referees reports, notes on telephone contacts and the selection Committee's scoring for each criterion should all be kept. For successful applicants, as a minimum, the paperwork should be kept until they have completed the program. Unsuccessful applicants may make repeated applications over a number of years. Although each application should stand alone and not be biased by previous assessments, in the event of a subsequent appeal earlier documentation may be extremely valuable.

Each College will need to develop its own policy in the light of their appointment and training processes.

The destruction of documents is to be avoided until there is some certainty they will not be required and that they will not be needed for audit or evaluation.

Notes made by individual panel members as an *aide - memoire* need not be kept.

FEEDBACK

The principle to be followed is that candidates should be given or at least offered a frank appraisal of their standing in the eyes of those conducting the selection process.

This is a very difficult area and the evidence put before the review suggests that it is not always done well.

Some of the important points are:

- honesty and simplicity are the best approaches;
- candidates whose applications are unlikely to improve to the required standard should be told that this is the case;
- a single person, preferably the Chair of the Committee should, as far as practicable, deal with all the briefings; and
- candidates who are deemed to meet required standards but are not ranked highly enough to meet the quota should be informed and where appropriate, advised of the possibility of filling a casual vacancy during that year.

On the other side of the coin there are some practices to be avoided:

- the debrief should not become a ‘coaching session’;
- discussion of responses to specific panel questions;
- indicating that a particular selector(s) were doubtful;
- indicating that they ‘should be right next time’;
- trying to ‘soften the blow’ by avoiding direct criticism;
- introducing criteria or variables other than the published ones may well lead to appeals that are difficult to defend;
- any suggestion that the carrier of the message does not support the majority view; and
- advising people that they should not apply again as opposed to advising them that the panel do not think it is likely they can improve to the required standard.

EVALUATION

The principle is that there should be a formal, regular inclusive review of the process.

Many Colleges over the last three to four years have put in enormous effort to upgrade or revamp their selection processes. Unfortunately, for some the effort stops at the completion of the review or even worse, slides backwards when committed individuals move on to other roles in their College.

The principles of continuous quality improvement are as applicable to HR practice as they are to clinical medicine. There needs to be a continuous loop of evaluation, feedback, modification

Unfortunately the only reliable measurement or indicator presently available is completion of the program. The reality is that most students admitted to medical school are capable of graduating and most of those are capable of completing any graduate program.

Thus completion of training is a fairly blunt instrument and a poor discriminator. Unfortunately there is no one reliable measure of what is a good, bad, average or excellent specialist. Colleges will need to work on the development of these indicators. In the meantime indirect measures of outcome and process indicators can be used. Some possibilities are:

- the frequency and content of complaints;
- the frequency of appeals;
- the outcome of appeals;
- the commentary of tribunals, appeals committees or judges on the appeals;
- the decisions, performance and compliance of State and Regional Committees with a national policy;
- completion of advanced training;
- completion in minimal period;
- dismissal rates;
- dropout rates;
- gender and ethnic profile of trainees and graduates; and
- the proportions practicing in suburban, provincial, rural and remote settings.

The result of these ongoing evaluations should be on the public record. A broad debate in the College, the profession and the community should be encouraged.

APPEALS

There should be a formal process for reviewing/appealing decisions in relation to selection. Applicants should have the right to appeal externally without fear of bias and be required to bear the cost of the appeal if it is unsuccessful (Colleges to bear the cost if it is successful).

A three-tiered system is proposed giving both an internal review and external appeal.

The steps to activate the appeals process would be:

- In the first instance the most senior person responsible for selection and training (e.g.Censor-in-chief, Chairman - national Training Board) should review the decision of the selection process.

- If that person does not find fault with the process or the decision, the President of the College should empanel three people who were not involved in the original decision, one of whom should be independent of the College, to determine if:
  - the process followed College policy;
  - the process was legal;
  - all the available material was considered; and
  - additional material is available, which if available at the time, may have led to a different outcome.

If the panel finds that the candidate did not receive natural justice nor were the rules of the procedural fairness followed they could recommend to council that the decision be overturned or that a new selection panel reconsider the case.

For the internal review legal council would not be permitted and the candidate should be required to establish their own grounds. The cost of the internal review would be borne by the College irrespective of the outcome.

External review

It is recommended that an appeals tribunal be established. If the proposed Academy of Medicine does go ahead it would be an appropriate vehicle for the external review process. If the Academy does not eventuate other options for establishing an appeals process will need to be pursued. The authors agree with the conclusion by MTRP that the CPMC as currently structured, would have difficulty carrying out this function.

It would have an independent Chair and a panel of members drawn from the spectrum of disciplines. Panel members would be senior members of their profession but not currently and probably not recently associated with the administration of their College. They would hear the appeal *de novo.* Applicants would have the right to legal representation.

Initiation of the appeal would involve the lodgement of a substantial fee determined from time to time by CPMC. The fee may be refundable in full or part to successful applicants at the discretion of the tribunal.

The College concerned would be required to meet the cost of the appeal in the event of the tribunal determining that its processes were found to be at fault.

The Chair would be required to determine that there are reasonable grounds for the tribunal to proceed. The decision to proceed would be at the absolute discretion of the Chair. The tribunal would not hear an appeal if they deemed it to be frivolous or if they thought the applicant vexatious.

The tribunal would not be fettered in the recommendations it could make to the College. Appeals on matters of law would be to the Federal Court.

Table 3: Best Practice Framework

Issue	Principle	Process
A clear statement of principles underpinning selection	• Select the best possible candidates • Produce the best possible practitioners	• The enunciation of principles should be presented in a way that inspires confidence in the medical profession and the broader community.
	• For the process to be legal	• The principles for each discipline should be published and promoted. • The interests of both the employers and training institutions must be acknowledged and respected.
	• For the process to be accountable	• Efficiency of processes must be taken into account and accompanied by an acknowledgement that resources that can be devoted to a selection are limited.
Eligibility criteria	• There should be a clear statement of eligibility to apply for and be selected for training	• The statement of eligibility should be available to all.
Advertising	• There is to be a national awareness of opportunity for all eligible candidates.	• Advertising should be designed to reach the target group. This may involve: – national and State press – regional press – Medical journals – the Internet • A nationally consistent timetable and some degree of national coordination should evolve over time.

Issue	Principle	Process
Limits to the numbers of training positions	• If there is a quota, it should be explicit and openly declared • Limits relating to other factors such as the number of training positions should also be disclosed.	• The mechanisms by which the quota or limit is arrived at should be widely known and publicly available. • The mechanisms by which it is given effect should be openly declared. • The frequency of review of the quota should be declared • The impact of the quota should be published e.g. the number of applicants and the percentage appointed.
Applications for training positions	• Applications should be written and proforma	• The Proforma should: – establish eligibility – describe experience – document qualifications – give research experience and publications – provide the opportunity for the candidate to make a clear statement of claim against the selection criteria – nominate referees
References	• Referees' reports should be Proforma with a view to achieving: – objectivity – comparability – quantification	• It should be clearly stated how referees reports are handled and used. • Candidates should have the opportunity to respond to adverse comments made by referees. • There should be a process to vet apparently inconsistent comments by referees • The number of referees reports called for should acknowledge the preferred degree of diversity of information on the one hand and efficiency on the other.

Issue	Principle	Process
The Selection Committee	• The group who make the final decision should have the confidence of the candidate, the profession and the community. • The size of the Committee should be proportional to the task • They should be prepared to be held accountable for those decisions. • They should be prepared for their processes and decisions to be reviewed in other forums. • The selection process should be: – valid – reliable – feasible • Evaluation should be built into the process	• The Committee should have a common composition for all candidates • The size of the selection Committee needs to take into account the delicate balance between the needs of the legitimate key stakeholders and efficiency without intimidating the candidate. • If the number of legitimate stakeholders is large an interview panel or panels can be convened as a subset of the selection Committee. • The mix of the panel should be equitable with respect to gender, the discipline and the employers. • 'Independent' members of the panel from within or without the profession are supported and are considered to add value and integrity to the process. • Formal induction and training of panel members is essential. • Selection of panel members is necessary. Some competent clinicians are not suited to participating in these processes.
Selection criteria	• The selection criteria should be documented and published. • The selection criteria must be objective and quantifiable to the greatest possible extent.	• The criteria should be derived from the principles referred to earlier. They need to be developed through a deliberative process both within the discipline and with related stakeholders. • The criteria should address: – academic qualities – clinical performance – personal attributes (e.g. communication skills, interpersonal skills) • Affirmative criteria (eg. gender, rurality) should be explicit and declared.

Issue	Principle	Process
Conduct of the interview	• The interview should be objective and free of bias.	• The questions should be set. • The same questions should be asked of each candidate. • Responses should be scored wherever practicable. • The interviews should be of the same duration. • There should be an opportunity for the candidate to ask questions and express satisfaction or otherwise with the process.
Selection	• The selection should be based on the published criteria and the principles of the College concerned. • The process should be capable of withstanding external scrutiny	• The essential tools are: – application – referees – interview • These should be objective, scored and weighted. • Optional tools could include: – OSCA – professional portfolios – clinical scenarios – psychometric testing • All candidates who meet essential criteria should be interviewed. • If this is not possible logistically, the criteria by which candidates are excluded from the ‘short-list’ should be clearly stated.
Ranking	• Selection committees should score and rank candidates using the tools described.	• It is preferable for panel members to rank individually and for the panel to create a composite numerical ranking. • A discussion should be conducted to finalise rank order.

Issue	Principle	Process
Documentation	• A record of proceedings should be kept which is sufficient to enable non-participants in the original selection to accurately re-construct processes and decisions. • Adequate documentation enables external scrutiny, audit and evaluation of the selection process.	• Applications, referees reports and scoring sheets should be kept. • Notes made of telephone and other interviews regarding the applicant should be kept. • Any advice, including debriefing, given to the candidate should be recorded. • The documents should be kept for as long as they may be useful for giving effect to the principles established under this heading.
Feedback	• Candidates should be given an honest and frank appraisal of their standing in the eyes of those conducting the selection process.	• Unsuccessful candidates should be offered an interview and/or counselling. • For the purposes of determining the appropriate counselling unsuccessful candidates should be categorised e.g. – suitable for training but not ranked highly enough to meet the quota/number of available positions. – not suitable but a reasonable expectation of improvement to a level which could win a place in subsequent selections – not suitable and unlikely to improve to the required standard • The process of limiting the number of attempts is not supported. • A candidate not falling into the ‘suitable for training’ category after two attempts should be advised of unsuitability

Issue	Principle	Process
Evaluation of the selection process	• There should be a formal, regular, inclusive review of the selection process.	• The frequency and content of complaints, appeals and their outcomes should be monitored. • The performance and compliance of devolved selection processes (State, regional) should be audited • Sample interviews of successful applicants should be undertaken. • Variables such as the following should be continuously monitored: – completion rate – completion rate in the minimum period – dropout rates – dismissal rates – gender – ethnic background – practice in rural areas

Issue	Principle	Process
Appeals	• There should be a formal process for appealing decisions. • Applicants and candidates should: – Have the right to have decisions reviewed. – Have the right to appeal externally if they disagree with the original decision and its internal review. – Not fear any future bias if they choose to either seek review or appeal. – Be required to bear the cost of external review if the appeal is unsuccessful. • Colleges: – should have confidence in their processes and recognise that appeals are part of an accountable system. – should be prepared to meet the cost of appeals where their processes are found wanting.	• A three tiered process is required: 1. To the most senior person responsible for selection in the College (Chairman national Training Board, Censor in Chief). 2. To an internal review by a panel convened by the President of the College to review procedural fairness, legality and propriety of the original process. 3. To a tribunal constituted under the auspices of CPMC which is independently chaired and selected from a panel of eminent medical practitioners who are not currently or recently associated with the administration of any College – The tribunal would hear the case *de novo*. – The parties would be entitled to legal advocacy. – Matters of law would be subject to appeal to the Federal Court. • If the proposed Academy of Medicine goes ahead it would be an appropriate vehicle for the external appeals process.

Section 10 – Implementation Issues

OWNERSHIP OF THE REPORT

This report was commissioned by the Medical Training Review Panel. By definition it is their decisions which will determine its fate. The Project Team strongly urges the MTRP to transfer ownership of this report to the Committee of Presidents of Medical Colleges. There are several reasons for recommending this course of action.

- Compliance with the framework is the real objective. Championing by CPMC is the most probable pathway for that objective to be met.
- Evolution of College policies is more likely to occur if the impetus comes from within the College system.
- Imposition of these recommendations by bureaucratic policy or political processes may well meet insurmountable rank and file resistance.
- CPMC can give effect to the report by making compliance with the principles of this best practice framework a condition of affiliation.

THE COLLEGE/HOSPITAL RELATIONSHIP

As discussed earlier in this report the hospitals are the employers of most vocational trainees (excluding RACGP).

Some Colleges, RACP and ACP in particular, depend on the hospitals to select, appoint, and manage their trainees. The relationship has been symbiotic. The hospitals currently have two concerns.

- Firstly, the practice of Colleges, the Surgical Boards in particular, selecting the candidates and later informing the hospitals of the person who will be their registrar for the next year is not acceptable to some CEO's. This practice has been the subject of a Supreme Court case in one jurisdiction.
- Teaching hospitals are also concerned that the workload associated with selecting both junior medical staff and advanced trainees is becoming a major burden. They fear that the recommendations of this report will exacerbate the situation. The hospitals do not dispute the validity of these principles. They are, however, concerned with the logistics. The requirements to constitute panels with independent members, to find sufficient female

selectors, the chasing up of thousands of referee reports and counselling hundreds of unsuccessful applicants is perhaps an unrealistic expectation in the prevailing financial climate.

It is obvious that the parties need to come together. The current practices whereby either:

- a hospital makes an appointment and because the institution and/or the post is accredited the appointee is automatically enrolled in a training program; or

- the College/Board makes an appointment either by itself, or with token employer representation;

are both perceived as having deficiencies by hospitals. These sentiments are shared by this review.

If the current practices for selection to vocational training are to survive in this country, and the Project Team would strongly argue that they should, a genuine partnership needs to be forged.

Such a partnership between Colleges and training institutions would be based on mutual respect and understanding of each others needs.

For basic trainees it is reasonable to assume that the hospitals will continue to be the employers and responsible for selection they will also take on responsibility for guidance and supervision of their trainees.

The recommendations of this report focus predominantly on vocational training which is the core business of the Colleges. The problems that arise can, in many cases, be traced back to misunderstandings between employers and Colleges.

MTRP may well be the catalyst to break down these barriers. A national Workshop of College representatives, teaching hospital managers and organisation representing doctors-in-training could easily forge a partnership based on the recommendations in this report.

One thing is certain, neither the hospitals nor the Colleges can do it alone. Currently, the selection and management of basic trainees and advanced trainees in non-procedural disciplines, is predominantly in the hospitals ‘court’. Advanced training in surgical disciplines is largely the province of the Colleges. This review recommends greater shared responsibility for both categories.

FUTURE TRENDS

The position adopted in relation to a stronger partnership in the previous section will be strengthened by the recent move of the Australian Medical Workforce Advisory Committee into the medical disciplines.

The College of Physicians and its related disciplines have maintained that they are not involved in workforce planning and that their role is in training, in certification of skills and competency and maintenance of standards.

National workforce planning studies in the disciplines of internal medicine may require the RACP to go down similar paths to the College of Surgeons. The Physicians can, and will, learn from the experience of the Surgical Boards. The end result is likely to be an Australian medical workforce that has a concise structure and balance. Posts in oversupplied areas will be transferred to specialties that have been neglected in the past and to disciplines and activities that are emerging e.g. genetics and molecular biology, ambulatory care, hospital in the home, occupational health and geriatrics.

As our construct of 'teaching hospitals' changes in favour of ambulatory and community based care, so will the patterns of training and the demand for specialist skills.

Clinicians trained to assess, diagnose, initiate treatment and follow-up sick patients without reliance on a hospital bed are already in demand in most parts of the world.

The challenge is for our institutions both Hospitals and Colleges to go forward together.

SUPPORT OF COLLEGES

After endorsement of the draft framework the Colleges, Faculties and Boards were offered a further consultation with the Project Team Director. The purpose of this second consultation was to:

- validate the original responses to the questionnaire;
- to personally brief the Colleges on progress with the College;
- to discuss the draft framework; and
- to discuss implementation issues.

This offer was enthusiastically received by the College representatives and contact was made with all but three of the original respondents. Some concern was expressed however, that full implementation may incur significant additional expense. This review believes that, as is now the case for most of the tertiary education sector, the candidate should bear the cost of the selection process.

There is widespread endorsement of the proposed approach and many indicated that they would embrace the draft framework immediately.

Acceptance at 'rank and file' level may be more difficult but most indicated that they saw their role as championing these changes in their own Colleges.

WHERE TO FROM HERE?

Many key organisations have indicated a desire to take this issue furtherand to do it quickly. To date three Colleges have indicated that they will, before the end of the year, act on the draft framework and are seeking input from this project and/or the MTRP to assist them.

The Chairperson of CPMC is keen to progress the issue quickly as it will obviously become involved in the debate on the future of CPMC and the possibility of the emergence of an Australian Academy of Medicine and Surgery,

The Consulting Team would urge immediate adoption of this framework and referral to CPMC. This framework is but a cog in a large series of interrelated wheels.

Bibliography for Section Five

Abbott L.C, *A study of humanism in family physicians.*, J. Fam. Prac. 1983; 16: 1141–6

Anwar R.A.H., Bosk C., Greenburg A.G, *Resident evaluation: Is it, can it, should it be objective?*, J Surg. Res. 1981; 30: 27–41

Arnold L., Willoughby T.L., *The empirical association between student and resident physician performance*., Acad. Med. 1993; 68: S35–40

Borlase B.C., Bartle E.J., Moore E.E., *Does the in-service training examination correlate with clinical performance in surgery?* ,Curr. Surg. 1985; 42: 290–2

Brown E., Rosinski E.F., Altman D.F., *Comparing medical school graduates who perform poorly in residency with graduates who perform well.*, Acad. Med. 1993; 68: 806–8

Case S.M., Swanson D.B., *Validity of the NBME Part I and Part II scores for selection of residents in orthopaedic surgery, dermatology and preventive medicine.*, Acad. Med. 1993; 68: S51–6

Da Rosa D.A., Folse R., *Evaluation of a system designed to enhance resident selection process.*, Surgery 1991; 109: 715–21

Edwards J.C., Johnson E.K., Molidor J.B., *The interview in the admission process.*, Ac. Med. 1990; 65: 167–77

Erlandson E.F., Calhoun J.G., Barrack F.M., *Resident selection criteria compared with performance*., Surgery 1982; 92: 270–5

Fincher R.E., Lewis L.A., Kuske T.T., *Relationship of interns' performances to their self assessments of their preparedness for internship and to their academic performances in medical school*, Acad. Med. 1993; 68: S47–50

Gibbons R.D., Baker R.J., Skinner D.B., *Field articulation testing; a predictor of technical skills in surgical residents.*, J. Surg. Res. 1986; 41: 53–7

Gonnella J.S., Hojat M., Erdmann J.B., Veloski J.J., *Epilogue: What have we learned, and where do we go from here?*, Ac. Med. 1993; 68: S79–87

Gonnella J.S., Veloski J.J., Xu G., Hojat M., *The Challenges in Measuring outcomes.*, Paper presented at the 50th Anniversary Conference of the Liaison Committee on Medical Education. Chicago, Illinois, 1992,

Gough M., *Personality assessment techniques and aptitude testing as aids to the selection of surgical trainees.*, Annals R.C.S.Eng. 1988; 70: 265–6

Greenburg A.G., Doyle J., McClure D.K., *Letter of recommendation for surgical residencies: what they say and what they mean*., J. Surg Res. 1994; 56(2): 192–8

Hirst G., Rotem A., Arnold T., Moss D., *Report of a workshop to review urological training in Australasia*., Aust. N.Z. J. Surg. 1995; 65: 273–7

Hojat M., Borenstein B.D., Veloski J.J., *Cognitive and non-cognitive factors in predicting the clinical performance of medical school graduates.*, J. Med. Educ. 1988; 63: 323–325

Hojat M., Gonnella J.S., Veloski J.J., Erdman J.B., *Is the glass half full or half empty? A re-examination of the associations between assessment measures during medical school and clinical competence after graduation*., Acad. Med. 1993; 68: 569–76

Hojat M., Robeson M., Damjanov I., Veloski J.J., Zebzen C., *Performance in Medical School as a function of psycholosocial characteristics.*, Paper at Centennial Convention American Psychological Association, Washington D.C. 1992

Holdsworth R.F., *Objective assessment – the state of the art.*, Annals R.C.S.Eng. 1987; 70: 266–70

Horne D., Heuston J.T., *The personality of hand surgeons.*, J.Hand.Surg. 1985; 10: 5–7

Irby D.M., Milam S., *The legal context for evaluating and dismissing medical students and residents,* Ac. Med. 1989; 64: 639–43

Jensen A.R.G., *Artefact or reality.*, J. Vocational Behav. 1986; 29: 301–31

Kaufmann H.H., *Teaching surgeons to operate: principles of psychomotor skills training.*, Acta Neurochir. 1987; 87: 1–7

Keeman J.N., Lagaaz M.B., *Candidate selection for surgical training in the Netherlands.*, Ann. R.C.S.Eng. 1988; 70: 275–7

Kron I.L., Kuser D.L., Nolan S.P., *Can success in surgical residency be predicted from pre-residency evaluation?*, Ann. Surg. 1985; 202: 694–5

Lazar H.L., DeLand E.C., Thompkins R.K., *Clinical performance versus in-training examination as measures of surgical competence.*, Surgery 1980; 87: 357–62

Markert R.J., *The relationship of academic measures in medical school to performance after graduation.*, Acad. Med. 1993; 68: S31–4

Martin J. A. , *Trainee selection for General Surgery.*, Aust. N.Z. J. Surg. 1996; 66: 428–30

Murdoch J.R., Bainbridge S.G., Fisher S.G., Webster M.H.C., *Can a simple test of visuo-motor skill predict the performance of micro-surgeons?*, J. R. Coll. Surg. Edin. 1994; 39: 150–2

Papp K.K., Polk H.C., Richardson J., *The relationship between criteria used to select residents and performance during residency.*, Am. J. Surg. 1997; 173: 326–9

Powis, D., Neame, R., Bristow, T. & Murphy, L., *The Objective Structured Interview for Medical Student Selection.*, British Medical Journal, 1988; 296: 765–68.

Quadrio, C., *Women in Australian & NZ medicine: The Fat Lady Sings.*, ANZ J of Psychiatry, 1991; 25: 95–110.

Scheuneman A.L., Pickleman J., Hesslein R., Freeark R.J., *Neuro-psychological predictors of operative skill among general surgery residents.*, Surg. 1984; 96: 288–95

Scheuneman A.L., Carley J.P., Baker W.H., *Residency evaluations – are they worth the effort?*, Arch. Surg. 1994; 129: 1069–73

Schwartz R.W., Barclay J.R., Harrell P.L., Murphy A.E., Jarecky R.K., Donnelly M.B., *Defining the surgical personality: A preliminary study.*, Surgery 1982; 92: 368–72

Shannon, K., *The Hidden Agenda - Culture of the Medical Profession.*, Prepared at the Request of GP Training review Group 1997.

Sherry E., Mobbs R., Henderson A., *Becoming an orthopaedic surgeon: Background of trainees and their opinions of selection criteria for orthopaedic training.*, Aust. N.Z. J. Surg. 1996; 66: 473–7

Spearman C.E., *The Ability of Man.*, New York : Macmillan, 1927

Spencer F C, *Deductive reasoning in the lifelong continuing education of a cardiovascular surgeon.*, Arch. Surg. 1976; 111: 1177–83

Streiner D.L., *Global rating scales in Neufeld V., Norman G. (eds). Assessment of Clinical Cometence Vol.7*, New York: Springer Pub.Co. 1985: 118–41

Taylor C.W., Albo D., *Measuring and predicting the performances of practicing physicians: An overview of two decades of research at University of Utah.*, Acad. Med. 1993; 68: S65–7

Thorndike R.L., *The role of general ability in prediction* J. Vocational Behav. 1986; 29: 332–9

Turner, J., Tippett, V. & Raphael, B, *Women in Medicine – Socialisation, Stereotypes and Self Perception.*, ANZ J of Psychiatry 1994; 28: 129–135.

Tutton, P., *The development of a semi-structured interview system to be used as an adjunct to secondary school performance for the selection of medical students.*, Aust. J Education, 1994, 38 (3): 219–232

Tutton, P., *The selection interview*, J Higher Education Policy & M'ment, 1997; 19 (1): 27–33

Van de Loo R.P.J.M., *Selection of surgical trainees in the Netherlands.*, Annals R.C.S.Eng. 1988; 70: 277–9

Vu N.V., Distlehorst L.H., Verhulst S.J., Colliver J.A., *Clinical performance – based test sensitivity and specificity in predicting first-year residency performance.*, Acad. Med. 1993; 68: 541–5

Ward P.H., *The selection and training of students and residents*, Laryngoscope 1995; 105: 893–5

Waxman B.P., *Selecting advanced trainees; can we do it better?*, Aust. N.Z. J. Surg. 1996; 66: 427

Winckle C.P., Reznick R.K., Cohen R., Taylor B., *Reliability and construct validity of a structured technical skill assessment form.*, Am.J.Surg. 1994; 167: 423–7

Appendix A – Terms of Reference

1. To survey, summarise and analyse the selection criteria, selection decision processes, review of selection decision criteria and review of selection decision processes provided by each of the Medical Colleges. Analysis of this material will require the successful consultant to consider matters such as:

    a. the manner and extent to which actual criteria and processes depart from the formal criteria and processes proclaimed by the Medical Colleges;

    b. the manner and extent to which the working life of junior medical practitioners is inappropriately hampered by activity related to these criteria and processes; and

    c. the manner and extent to which the current criteria and processes reflect both the letter and the spirit of Equal Employment Opportunity legislation, the *Trade Practices Act 1974*, Corporations Law, relevant industrial legislation and any other relevant legislation.

2. To identify, develop and assess a model set of arrangements for selection decisions and review of such decisions which would be considered an appropriate benchmark for Medical Colleges. Identification, development and assessment of such arrangements will require the successful consultant to consider matters such as:

    a. content, format and level of specificity which is appropriate for use as a benchmarking tool;

    b. whether the model set of arrangements reflect accepted Equal Employment Opportunity principles and concepts; principles of natural justice (regardless of whether these emanate from the common law or legislation); and other like principles;

    c. the legislative framework within which any such set of arrangements must be implemented, including Equal Employment Opportunity legislation, the *Trade Practices Act 1974*, Corporations Law, relevant industrial legislation and any other relevant legislation; and

    d. likely acceptance by key stakeholders of the model set of arrangements proposed.

3. To consult widely on the proposed model set of arrangements with key stakeholders and summarise their views.

Appendix B – The Questionnaire

Medical Training Review Panel
Training Programs Questionnaire

Please indicate your response by checking the appropriate box

This response is made on behalf of: _____
(The name of your College/Faculty/Society)

1. What is the legal status of your College, Faculty or Society?
(eg. incorporated company, incorporated association)

_____

Could you please provide copies of documents relating to the governance of your organisation. eg. Constitution, Articles of Association, By-Laws

2. Describe the eligibility requirements for admission to your training programme.

_____

_____

_____

3. Is your programme predominantly coordinated at the

- National level? ☐
- State level? ☐
- Regional level? ☐
- Hospital level? ☐

4. Is admission to the training programme dependent on appointment to

- An accredited hospital? ☐
- An accredited position? ☐
- Both? ☐
- Neither? ☐

5. Where are the positions in your training programmes advertised?

_____

_____

_____

_____

6. Is this an annual recruitment cycle?

- Yes ☐
- No ☐

Other, please specify. _____

_____

7. Is there a limit or quota to the number of people who can be appointed?

- Yes ☐
- No ☐

If you answered Yes to Question 7 please complete Questions 8 to 10, otherwise please go to Question 11.

8. Who determines this quota and how often is it reviewed?

_____

_____

_____

_____

9. How is the quota implemented?

- By the number of available training positions ☐
- By the number of accredited institutions ☐
- By the numbers inducted to the program ☐

10. What is the limiting factor to the total number of trainees?

_____

_____

11. Roughly what percentage of applicants are successful in obtaining admission to your program? _____

12. Is there a set of principles which underpin selection to your program?
(principles as opposed to selection criteria referred to in Questions 19 to 23)

- Yes ☐ *If Yes, please enclose them with your response.*
- No ☐
- Currently being developed ☐

13a. If you answered Yes to Q12, are these principles documented and made available?

- By publication? ☐
- On request? ☐
- To the general public? ☐
- No ☐

13b. If you answered No to Q12, would your College/Society be prepared to develop a set of principles for appointment to your training programme?

- Yes ☐
- No ☐

The Selection Process

14. Is there a requirement for a written application? *Yes* ☐ *No* ☐

15. Are referees required? *Yes* ☐ *No* ☐
If Yes, please specify number required

		Yes	*No*
16.	Are these referee reports accessible by the candidate?	☐	☐

		Yes	*No*
17.	Are all applicants interviewed?	☐	☐

If No, please indicate who is responsible for this process and how the shortlisting is carried out.

Who: _____

How: _____

_____

_____

_____

		Yes	*No*
18.	Are weightings given to the different components of the application?	☐	☐

ie. written application, interviews, referees

The Selection Criteria

		Yes	*No*
19.	Are your selection criteria laid down?	☐	☐

If yes, where? _____

_____

_____

_____

Could you please attach the criteria to your response.

		Not applicable	*Yes*	*No*
20.	Are these criteria binding on all States, Regions and Hospitals?	☐	☐	☐

		Yes	*No*
21.	Are the criteria given weightings?	☐	☐
	If Yes, are these		
	• *Quantitative?*	☐	☐
	• *Qualitative?*	☐	☐

Please attach any information which will help us interpret your criteria and the way they are applied.

		Yes	*No*
22.	Are there any 'affirmative' weightings?	☐	☐

eg. in relation to age, rurality, ethnicity, language skills

If Yes, please specify. _____

_____

_____

_____

23. Does your College have a policy on whether the principles and selection criteria should be available to

	Yes	*No*
• the candidates?	☐	☐
• the general public?	☐	☐

Please provide details if you wish.

_____

_____

_____

_____

The Interview

		Yes	*No*
24.	Is there a national policy on the conduct of the interview?	☐	☐

		Yes	*No*
25.	Is the interview		
	• structured?	☐	☐
	• freewheeling?	☐	☐
26.	Are all the candidates asked the same questions?	☐	☐
27.	Are the responses to the questions scored?	☐	☐
28.	Are the panel given instructions prior to the commencement of interviews?	☐	☐
	If Yes, are these written?	☐	☐

Please provide details of the instructions either written or unwritten.

		Yes	*No*
29.	Is there a national policy on the conduct of the interview in relation to what may or may not be asked?	☐	☐

If Yes, please provide details as an attachment.

The Selection Panel

		Yes	*No*
30.	Is the Panel convened by the		
	• the College?	☐	☐
	• the Employers?	☐	☐
	• jointly?	☐	☐

31. Is the Panel

- national? ☐
- State? ☐
- regional? ☐
- Hospital? ☐

Other, please specify. _____

_____

_____

_____

32. What is the composition of the selection panel? _____

_____

_____

_____

_____

Feedback to Candidates

33. What advice is given to
Successful Candidates? _____

_____

_____

_____

Unsuccessful Candidates? _____

_____

_____

_____

Appeals

34. Are the decisions of the Selection Panel appealable? *Yes* ☐ *No* ☐

If Yes, what are the criteria. _____

_____

_____

_____

Please attach any information relevant to the appeals process.

35. Is the composition of the Appeals Panel specified? *Yes* ☐ *No* ☐

If Yes, please specify. _____

_____

_____

_____

36. Are there Procedural Rules for the Appeals Panel? *Yes* ☐ *No* ☐

If Yes, please specify and/or provide attachment. _____

_____

_____

_____

37. Are the processes outlined above nationally consistent? *Yes* ☐ *No* ☐

If there are significant State, regional and/or Hospital variations please specify or attach details. _____

_____

_____

_____

Other Considerations

38. Once selected, what processes might result in a candidate being disqualified from the training program

	Yes	*No*
• Barrier Examinations?	☐	☐
• Unsatisfactory performance (clinically)?	☐	☐
• Failure to be reappointed to training institution/post by employing authority?	☐	☐

39. Are there formal processes for candidates to be removed from the training program? *Yes* ☐ *No* ☐

If Yes, please provide details. _____

_____

_____

_____

If No, could you describe the informal process? _____

_____

_____

_____

40 Is there a mechanism for appealing the decisions made regarding the removal of candidates? *Yes* ☐ *No* ☐

41. Approximately what percentage of trainees accepted by the program complete their Fellowship? _____

42. When were the policies you have outlined in response to this questionnaire last reviewed? _____

_____

_____

_____

43. Is there a policy or protocol for regular review of these processes? _____

_____

_____

_____

_____

44. Have you any other comments in relation to trainee selection that has not been covered by this Questionnaire? _____

_____

_____

_____

45. Would your College/Faculty/Society wish to further consult members of this project

	Yes	*No*
• in relation to this preliminary Questionnaire?	☐	☐
• in the relation to our analysis and draft recommendations?	☐	☐

If Yes, please provide the following details:

Contact Person _____

Contact Telephone _____

Thankyou for taking the time to complete this Questionnaire.

Please return to:

Dr Peter Brennan
PO Box 120
DARLINGTON WA 6070

Appendix C – The Recipients of the Questionnaire

Professor Phillips	Professor GD Phillips The President Australian and New Zealand College of Anaesthetists 630 St Kilda Road MELBOURNE VIC 3004
Dr Brunello	Dr Lawrence Brunello The President Royal Australian College of Obstetricians and Gynaecologists College House 254 Albert Street EAST MELBOURNE VIC 3002
Dr Alan Duncan	Dr Alan Duncan Board of Intensive Care Specialists C/- PMH Box D184 GPO PERTH WA 6001
Associate Professor Lipton	Associate Professor Lipton The President Royal Australian and New Zealand College of Psychiatrists 309 Latrobe Street MELBOURNE VIC 3000
Dr Chakera	Dr Chakera The President Royal Australasian College of Radiologists Level 9, 51 Druitt Street SYDNEY NSW 2000
Dr Baggoley	Dr Baggoley The President Australasian College for Emergency Medicine 17 Grattan Street CARLTON VIC 3053

Professor Smallwood	Professor Smallwood The President Royal Australian College of Physicians 145 Macquarie Street SYDNEY NSW 2000
Mr McRae	Mr Colin McRae The President Royal Australasian College of Surgeons College of Surgeons Gardens Spring Street MELBOURNE VIC 3000
Dr Joseph	Dr Peter Joseph The President Royal Australian College of General Practitioners 52 Parramatta Road FOREST LODGE NSW 2037
Dr Raik	Dr Eva Raik The President Royal College of Pathologists of Australia 207 Albion Street SURRY HILLS NSW 2010
Dr Jones	Dr Jones The President Royal Australian College of Medical Administrators 35 Drummond Street CARLTON VIC 3053
Dr Frank Martin	Dr Frank Martin President Royal Australian College of Opthamologists 27 Commonwealth Street SYDNEY NSW 2010
Professor Phelan	Professor Phelan The President Australian College of Paediatrics PO Box 30 PARKVILLE VIC 3052

Professor Watson	Professor Watson The President Australasian Faculty of Public Health Medicine 145 Macquarie Street SYDNEY NSW 200
Dr Stone	Dr Stone The President Australasian Faculty of Rehabilitation Medicine 145 Macquarie Street SYDNEY NSW 2000
Dr Gardner	Dr Gardner The President Australasian Faculty of Occupational Medicine 145 Macquarie Street SYDNEY NSW 2000
Mr J Tatoulls	Mr J Tatoulls Chairman, Board of Cardiothoracic Surgery Suite 28, Private Medical Centre Royal Melbourne Hospital PARKVILLE VIC 3050
Professor Gough	Professor Gough Chairman, Board of General Surgery Royal Australasian College of Surgeons 50 Water Street SPING HILL QLD 4004
Mr M Besser	Mr M Besser Chairman, Board of Neurosurgery Suite 418, RPAH Medical Centre 100 Carillon Avenue NEWTOWN NSW 2042
Mr Tregonning	Mr Tregonning Chairman, Board of Orthopaedic Surgery Ground Floor, Mercy Specialist Centre 100 Mountain Road EPSOM AUCKLAND NEW ZEALAND

Mr Ryan	Mr Ryan Chairman, Board of Otolaryngology 532 Doncaster Road DONCASTER VIC 3108
Mr K Stokes	Mr K Stokes Chairman, Board of Paediatric Surgery Children's Specialist Centre Royal Children's Hospital Flemington Road PARKVILLE VIC 3052
Mr Katsaros	Mr Katsaros Chairman, Board of Plastic and Reconstructive Surgery 174 Ward Street NORTH ADELAIDE SA 6008
Mr RJ Millard	Mr RJ Millard Chairman, Board of Urology The Prince Henry Hospital Anzac Parade LITTLE BAY NSW 2036
Professor Faris	Professor Faris Chairman, Board of Vascular Surgery Department of Surgery The Geelong Hospital GEELONG VIC 3220
Mr Goldberg	Mr Goldberg Chairman, Joint Board in Ophthalmology C/- RACO 27 Commonwealth Street SYDNEY NSW 2010
Dr William Land	Dr William Land President Australasian College of Dermatologists PO Box B65 BORONIA PARK NSW 2111

Appendix D – Questionnaire Responses Raw Data – Spreadsheets

College Introduction	Legal Status	Additional Eligibility Requirement for Admission – Note all require a recognised MB BS and medical registration in the State or Territory of training	Level of Program Co-ordination
Anaesthetics	Co.	2 yrs Gen.	NS & H
Obstetricians & Gynaecologists	Co.		NS & H
Dermatology	Co.	Part I, 2 yrs Gen.	S
Psychiatry	Co.	2 yrs Gen Training.	NS & H
Radiology	Co.	1 yr Gen.	S & H
Emergency Medicine	Co.		H
Physicians	Co.	Basic-1 yr Gen. Advanced-3 yr Basic, Part I.	N
Surgeons	Co.	2 yrs Basic Surg., Primary, Mentor Rpt.	N & S - Varies in Specialities
GP's	Co.	Eight Criteria	N
Pathology	Co.	1 yr Gen., Work in Accred. Lab	N
Medical Administrators	Co.	3 yrs Clinical	N
Ophthalmology	Co.	Part 1, 2 yrs Gen.	N & R
Paediatrics	Co.	1 yr Gen.	N
Faculties			
Public Health	RACP	3 yrs Gen., Coursework for MPH.	S
Rehabilitation	RACP	Adv Training-Part I, +3 yrs.	N
Occupational Medicine	RACP	Seven Criteria	N

College	Introduction	Legal Status	Additional Eligibility Requirement for Admission – Note all require a recognised MB BS and medical registration in the State or Territory of training	Level of Program Co-ordination
Surgical Boards				
Cardiothoracic Surgery		RACS		
General Surgery		RACS	Completion of Part I.	S
ENT		RACS	Part 1.	N
Paediatric Surgery		RACS	FRACS Part I.	N
Plastic		RACS	1 Yr Surgical, Primary.	S but will become N
Urology		RACS	Part I or Exemption, 1 yr Gen. Surgeon Training.	N
Vascular		RACS	FRACS in Gen. Surgery.	N
Orthopaedics		Co. AOA RAC	Part I, FRACS.	N
Neurosurgery		RACS.	Part 1, RACS.	N
Intensive Care		Co	2 yrs experience.	N & H

Codes

N: National
S: State
R: Regional
H: Hospital

College	Appointment linked to Hospitals or Posts	Where are positions advertised	Recruitment cycle	Is there a quota Y/N?	Who determines the quota?
Anaesthetics	B	Local & National Press.	A	Y	College Accredits Posts.
Obstetricians & Gynaecologists	B	National Press, Hosps.	A	Y	Hosps, State C'tees, Co-ordinators
Dermatology	B	National & State Press.	A	Y	State Funding of Hosps.
Psychiatry	B	Local & National Press.	A	N[1]	Govt. Funding.
Radiology	B	Local & National Press.	A	Y	Funding.
Emergency Medicine	N	Hosps. Advertise.	R	N	N/A
Physicians	H	Hosps. Advertise.	R	N	N/A
Surgeons	N	RACS, National Press.	A	Y	RACS, Boards, Workforce Planning
GP's	N (neither)	National, Local, RACP news.	A	Y	Commonwealth
Pathology	H. Accredited Lab.	National Press & Med. Jnls.	A	N	N/A
Medical Administrators	P	N/A	R	N	N/A
Ophthalmology	P	State Press.	A	Y	State Govts., AMWAC.
Paediatrics	H	Hosps. Decide.	A	N	State Govts., AMWAC.
Faculties					
Public Health	N	Do not Advertise.	R	N	N/A
Rehabilitation	N	Hosps. Advertise.	A	N	N/A
Occupational Medicine	N	Do not Advertise.	R	N	N/A
Surgical Boards					
Cardiothoracic Surgery					

College	Appointment linked to Hospitals or Posts	Where are positions advertised	Recruitment cycle	Is there a quota Y/N?	Who determines the quota?
General Surgery	B	MJA & RACS Bulletin	A	Y	Board General Surgery
ENT	P	MJA.	A	N(?)	Board (?)
Paediatric Surgery	B	National Press, MJA.	A	Y	Manpower C'tee. of Paed. Surg. Board
Plastic	B	MJA, RACS Pubs.	A	Y	Board Plastic Surg.
Urology	B	National Press, RACS.	A	Y	Posts/Board.
Vascular	P	RACS	A	Y	Board Vasc. Surg.
Orthopaedics	P	Journals	A	Y	State Boards & advice of Nat. C'tee
Neurosurgery	B	National Press, RACS	A	Y	Accred. Posts.
Intensive Care	B	National & State Press	A	Y	Faculty

Codes

H: Accredited Hospital
P: Accredited Post
B: Both
N: Neither

A: Annual
R: Random

College	How often is the quota reviewed?	What is the limiting factor to number of trainees?	% of applicants admitted?
Anaesthetics	7 yrs	Workload, Available funds, Supervision	Don't Know
Obstetricians & Gynaecologists	?	Posts & quality of Training	Don't Know
Dermatology	?	Funding	Most but can take 2-3 yrs
Psychiatry			80%
Radiology		Funding	Don't know
Emergency Medicine	N/A	N/A	?
Physicians	N/A	N/A	N/A
Surgeons	?	Pos.	Varies 30%–80%
GP's	Annual	Quota	1997–75% 1998–55%[2]
Pathology	N/A	N/A	~100%
Medical Administrators	N/A	N/A	90–100%
Ophthalmology	Recent	Posts	50%
Paediatrics	Annual	Posts but flexible	~100%
Faculties			
Public Health	N/A	N/A	All who meet criteria
Rehabilitation	N/A	N/A	Basic–100% Adv–80%
Occupational Medicine	N/A	N/A	95%
Surgical Boards			
Cardiothoracic Surgery			
General Surgery	Every year	Training posts	50%
ENT		Funding	45%

College	How often is the quota reviewed?	What is the limiting factor to number of trainees?	% of applicants admitted?
Paediatric Surgery	6/12	Std of applicants, Workforce requirement	20%–25%
Plastic	Every year	Posts	25%
Urology	Annual	Govt. funding of posts	50%
Vascular	Every year	Training posts	30%–50%
Orthopaedics	?	Posts, Surgeon/Pop. ratio	50%
Neurosurgery	?	Posts	30%–50%
Intensive Care	7 yrs	Demand for trainees	100%

College	Is there a set of Selection Principles	Are these Principles avasilable?	If no, Willing?
Anaesthetics	Yes but not provided	R	N/A
Obstetricians & Gynaecologists	Yes but not provided [3]	R	?
Dermatology	Being developed	N/A	Y
Psychiatry	Being developed	N/A	N/A
Radiology	Yes but not national	No	Y
Emergency Medicine	Being developed	N/A	N/A
Physicians	No	N/A	?
Surgeons	Yes & documented	G	N/A
GP's	Tes	G	N/A
Pathology	No	N/A	Y +/-
Medical Administrators	No	N/A	N/A
Ophthalmology	Being developed	N/A	Y
Paediatrics	No	N/A	Y
Faculties			
Public Health	No	N/A	Y
Rehabilitation	No	N/A	N
Occupational Medicine	Comprehensive doc	G	N/A
Surgical Boards			
Cardiothoracic Surgery			
General Surgery	No (but RACS?)	N/A	?
ENT	No	N/A	N
Paediatric Surgery	Being developed	N/A	Y
Plastic	No (but RACS would say yes)	N/A	Y

College	Is there a set of Selection Principles	Are these Principles avasilable?	If no, Willing?
Urology	Yes as per RACS	G	N/A
Vascular	No (but RACS Yes)	N/A	?
Orthopaedics	Being developed	N/A	?
Neurosurgery	Yes	On request	On request
Intensive Care	No	N/A	Y

Codes

G: Generally Available
R: Restricted Circulation

College	The Selection Process	Is there a written application?	Are referees required?	Are the referee reports accesible	Are all candidates interviewed?
Anaesthetics		Y	Y, 2	N	N
Obstetricians & Gynaecologists		Y	Y	N	N
Dermatology		Y	Y, 3	Y	N
Psychiatry		Y	Y	N	N
Radiology		Y	Y, 2–3	N	N
Emergency Medicine		Being developed	Being developed	Being developed	Being developed
Physicians		Det. by Empl. Hospital	Det. by Empl. Hospital	Det. by Empl. Hospital	Det. bt Empl. Hospital
Surgeons		Y	Y	Y	Individual Boards Y & N See below
GP's		Y	Y, 2	Y	Y
Pathology		Y	N	N/A	Y
Medical Administrators		Y	N	N/A	Y
Ophthalmology		Y	Y, 2	Y	N
Paediatrics		Det. by Empl. Hospital	Det. by Empl. Hospital	Det. by Empl. Hospital	Det. bt Empl. Hospital
Faculties					
Public Health		Y	N	N/A	N
Rehabilitation		Y	Y, 2	Y	N
Occupational Medicine		Y	N	N/A	N
Surgical Boards					
Cardiothoracic Surgery					
General Surgery		Y	Y, 3	N	Y[4]

College	The Selection Process	Is there a written application?	Are referees required?	Are the referee reports accesible	Are all candidates interviewed?
ENT		Y	Y,3	Y	N
Paediatric Surgery		Y	Y, 3	Y[15]	Y
Plastic		Y	Y, 3	Y	Y
Urology		Y	Y	N	Y
Vascular		Y	Y, 2	N	Y
Orthopaedics		Y	Y, 3	Y	Y
Neurosurgery		Y	Y	Y	Y
Intensive Care		Y	Y, 3	N	N

Codes

Y=Yes and no. given when known
N=No

College	Who & how are candidates shortlisted?	Weigtings to various components of the application?
Anaesthetics	Directors of Hospital Depts, from application	Y
Obstetricians & Gynaecologists	Selection C'tees, from applications	N
Dermatology	Hospital, Independent 'Round table'	Y
Psychiatry	Regional selection commitee	Y
Radiology	Varies, Dept. Directors	Y
Emergency Medicine	Being developed	Being developed
Physicians	Det. by Empl. Hospital	Det. by Empl. Hospital
Surgeons	Individual Boards – Y & N – See below	Y & N
GP's	N/A	Y
Pathology	N/A	N
Medical Administrators	N/A	N
Ophthalmology	Selection Commitee & Referees	Y
Paediatrics	Det. by Empl. Hospital	Det. by Empl. Hospital
Faculties		
Public Health	Regional Committees	N
Rehabilitation	Board of Censors	N
Occupational Medicine	Written correspondence, Telephone calls	N
Surgical Boards		
Cardiothoracic Surgery		
General Surgery	N/A	N
ENT	Regional Training Committees	Y
Paediatric Surgery	N/A	Y

College	Who & how are candidates shortlisted?	Weigtings to various components of the application?
Plastic	If they meet criteria	N
Urology	N/A	Y
Vasular	N/A	N
Orthopaedics	N/A	N
Neurosurgery	N/A	Y
Intensive Care	Hospital Directors, Review of Applicants	Y

College	The Selection Criteria	Are the Selection Criteria laid down	Where	Are they binding on all States, Regions & Hospitals
Anaesthetics		N	N/A	N/A
Obstetricians & Gynaecologists		N	N/A	N/A
Dermatology		No – Being developed	N/A	N/A
Psychiatry		N	N/A	N/A
Radiology		Y – but varies across states	?	N
Emergency Medicine		Being developed	Being developed	Being developed
Physicians		N – Selection by Accred Hospitals	Selection by Accred Hospitals	Selection by Accred Hospitals
Surgeons		Y	College Document	Y
GP's		Y	Guide book	Y
Pathology		N	N/A	N/A
Medical Administrators		Y	Handbook	Y
Ophthalmology		Y[6]	N/A	N/A
Paediatrics		Selection by Accred Hospitals	Selection by Accred Hospitals	Selection by Accred Hospitals
Faculties				
Public Health		Y	Handbook	Y
Rehabilitation		Y	Manual	Y
Occupational Medicine		Y	N	N/A
Surgical Boards				
Cardiothoracic Surgery				
General Surgery		N	N/A	N/A
ENT		N	N/A	N/A

College	The Selection Criteria	Are the Selection Criteria laid down	Where	Are they binding on all States, Regions & Hospitals
Paediatric Surgery		Y	RACS	Y
Plastic		Y	RACS Manual	Y
Urology		Y	RACS document	Y
Vascular		N	N/A	N/A
Orthopaedics		Y	RACS Doc	N
Neurosurgery		Y	Board	Y
Intensive Care		N	N/A	N/A

College	Are the criteria given weightings?	Are they any affirmative weightings?	Is there a policy on availability of criteria?
Anaesthetics	N	N	N
Obstetricians & Gynaecologists	N	N	N
Dermatology	Y – Qualitative	Being developed	N
Psychiatry	N/A	N/A	N/A
Radiology	Varies	Don't know	Not considered
Emergency Medicine	Being developed	Being developed	Being developed
Physicians	Selection by Accredited Hospitals	Selection by Accredited Hospitals	Selection by Accredited Hospitals
Surgeons	Varies see Boards	N	Y
GP's	(Quant) Y	Y – Rurality	Y
Pathology	N/A	N/A	N/A
Medical Administrators	N	N	Y
Ophthalmology	Varies	Y – Rurality, Gender	Y
Paediatrics	Selection by Accredited Hospitals	Selection by Accredited Hospitals	Selection by Accredited Hospitals
Faculties			
Public Health	N	N	Y
Rehabilitation	N	N	N
Occupational Medicine	N	N	Y
Surgical Boards			
Cardiothoracic Surgery			
General Surgery	?	N	N
ENT	N/A	N/A	N
Paediatric Surgery	Y – Qual	Y – If already hold FRACS	Y

College	Are the criteria given weightings?	Are they any affirmative weightings?	Is there a policy on availability of criteria?
Plastic	N	N	Y
Urology	Quantitative	N	N
Vascular	N/A	N/A	N
Orthopaedics	N	+/-	Y
Neurosurgery	Y – Quant. & Qual.	No	N/A
Intensive Care	N/A	No	No

College	Where available?	The Interview	Is there a policy on the interview	Structured interview Y/N?
Anaesthetics	N/A		N	F
Obstetricians & Gynaecologists	N/A		Y	S
Dermatology			N	S
Psychiatry	N/A		N	Varies
Radiology	Not considered		N	Varies State to State
Emergency Medicine	Being developed		Being developed	Being developed
Physicians	Selection by Accred Hospitals		Selection by Accred Hospitals	Selection by Accred Hospitals
Surgeons	Yes; Candidate not public		Y[9]	S
GP's	Yes; Candidate & Public		Y	S
Pathology	N/A		N	F
Medical Administrators	Candidates not public		N	F
Ophthalmology	Candidates & Public[6]		N	Y
Paediatrics	See Footnote 5		Selection by Hospitals	Selection by Hospitals
Faculties				
Public Health	Candidates & Publuc		N	N/A
Rehabilitation	N/A		Not Applicable	Not Applicable
Occupational Medicine	Public document soon on WEB		Not Applicable No Interview	Not Applicable No Interview
Surgical Boards				
Cardiothoracic Surgery				
General Surgery	N/A		Y	S
ENT	Comment but illegible		Y	Part S

College	Where available?	The Interview	Is there a policy on the interview	Structured interview Y/N?
Paediatric Surgery	Candidates not Public		Y	S
Plastic	Candidates & Public		Y	S
Urology	N/A		Y	S
Vascular	N/A		N	F
Orthopaedics	Candidates & Public		Y	S
Neurosurgery	N/A		Y	S
Intensive Care	No		N	Hospital determined

Codes

S = Structured
F = Free Wheeling

College	Are all candidates asked the same questions?	Are the responses scored?	Are the panel given instructions prior to the interview?
Anaesthetics	N	N	Y, W
Obstetricians & Gynaecologists	Y	N	Y, W
Dermatology	Y	N – Being developed	Being developed
Psychiatry	Varies	Varies	Varies
Radiology	Varies	Varies	Varies
Emergency Medicine	Being developed	Being developed	Being developed
Physicians	Selection by Accred Hospitals	Selection by Accred Hospitals	Selection by Accred Hospitals
Surgeons	Y	Y	Y, W
GP's	Y	Y	Y, W
Pathology	N	N	N
Medical Administrators	N	N	N
Ophthalmology	Y	Varies	Varies
Paediatrics	Selection by Hospitals	Selection by Hospitals	Selection by Hospitals
Faculties			
Public Health	N/A	N/A	N/A
Rehabilitation	Not applicable	Not applicable	Not applicable
Occupational Medicine	Not applicable No interview	Not applicable No interview	Not applicable No interview
Surgical Boards			
Cardiothoracic Surgery			
General Surgery	Y	Y	Y
ENT	N	N	Y, W
Paediatric Surgery	Y	Y	Y, W

College	Are all candidates asked the same questions?	Are the responses scored?	Are the panel given instructions prior to the interview?
Plastic	Y	Y	Y, W
Urology	Y	Y	Y, W
Vascular	Y	N	Y, V
Orthopaedics	Y	Y	Y, W
Neurosurgery	Y	Y	Y/?
Intensive Care	N/A	N/A	N/A

Codes

W = Written
V = Verbal
D = Being Developed

College	Is there a policy on whay questions may be asked?	The selection panel	Selection panel convened by?	Panel Nat/State/Local?
Anaesthetics	N		E	S & H
Obstetricians & Gynaecologists	Y		J	S & H
Dermatology	Being developed		J	S
Psychiatry	N		J	R
Radiology	N		E	S,R,H (varies)
Emergency Medicine	Being developed		Being developed	Being developed
Physicians	Selection by Accred Hospitals		E	H
Surgeons	Y		C	S & R
GP's	Y		C	S
Pathology	See Footnote 7		N/A	N/A
Medical Administrators	N		C	S
Ophthalmology	N		E	S & R
Paediatrics	Selection by Hospitals		E	H
Faculties				
Public Health	N		C	N
Rehabilitation	Not Applicable		N/A	N/A
Occupational Medicine	Not Applicable No Interview		C	N
Surgical Boards				
Cardiothoracic Surgery				
General Surgery	Under development[8]		C	S
ENT	N		C	S
Paediatric Surgery	Y		C	N

College	Is there a policy on whay questions may be asked?	The selection panel	Selection panel convened by?	Panel Nat/State/Local?
Plastic	Y		C +/- E	S
Urology	Y		C	S
Vascular	Y		C	N
Orthopaedics	Y, RACS		J	S
Neurosurgery	Y, RACS		C	S
Intensive Care	No		E	H

Codes

C = College
E = Employers
J = Jointly

N = National
S = State
R = Regional
H = Hospital

College	Composition of the panel?	Feedback to successful candidates?	Feedback to unsuccessful candidates?
Anaesthetics	Hosp.	Yes?	No policy
Obstetricians & Gynaecologists	Hosp. & State C'tee	Nil	Nil – format
Dermatology	College, Hosp. & Indep.	Nil	Nil but being developed
Psychiatry	Training C'tee & Hosp.	Nil	'On request'
Radiology	Varies	Decided locally	Decided locally
Emergency Medicine	Being developed	Being developed	Being developed
Physicians	?	N/A	N/A
Surgeons	Board, Reg. Board, Hosp.	N	Offered Counselling
GP's	College staff & GP's	Nil formal	Nil routine, meet with staff on request
Pathology	N/A	N/A	N/A
Medical Administrators	Chair, Board of Studies	Written advice – of success or failure	Written advice – of success or failure
Ophthalmology	Hosp. & Ophth from Hosp	Nil	No formal mechanism
Paediatrics	Hosp.	No policy	No policy
Faculties			
Public Health	Board of Censors	Nil – formal	Nil – formal
Rehabilitation	N/A	N/A	N/A
Occupational Medicine	Board of Censors	Letter & personal contact	Letter & personal contact
Surgical Boards			
Cardiothoracic Surgery			
General Surgery	State C'tee., Surgeons & Supervisors	Nil	Interview with Chair of C'tee.
ENT	Training C'tee,. Hosp. Mgmnt	Nil	

College	Composition of the panel?	Feedback to successful candidates?	Feedback to unsuccessful candidates?
Paediatric Surgery	Board of Paed. Surg	Y[16]	Y[16]
Plastic	College, Hosp. Mgmnt	?	Written advice – not specified
Urology	Training Supervisor	Letter & Phone call	Letter & Phone call
Vascular	Board of Gen. Surgery	No	Counsel, assess performance
Orthopaedics	Supervisors, Hosp.	No	Advice on future
Neurosurgery	Trianing Unit, College Reps.	?	?
Intensive Care	Hospitals	Hospitals	Hospitals

College	Appeals	Is the decision appealable?	Composition of appeals?	Procedural rules?
Anaesthetics		Y	Hosp. not College	N/A
Obstetricians & Gynaecologists		N	N/A	N/A
Dermatology		Y[14]	–	–
Psychiatry		Y[10]	N/A	N
Radiology		N	N/A	N
Emergency Medicine		Being developed	Y	?
Physicians		N/A	N/A	N/A
Surgeons		Y, RACS	Y	Y
GP's		Y – See detailed policy	Y – See detailed policy	Y – See detailed policy
Pathology		N/A	N/A	N/A
Medical Administrators		Y (200)	Y – Censor in chief or Full council	N
Ophthalmology		N	N/A	N
Paediatrics		N/A	N/A	N/A
Faculties				
Public Health		N	N/A	N/A
Rehabilitation		N/A	N/A	Y – Manual
Occupational Medicine		Y	RACP guidelines	Y – RACP
Surgical Boards				
Cardiothoracic Surgery				
General Surgery		Y – RACS	Y – RACS	Y
ENT		Y[11]	N	N
Paediatric Surgery		Y – RACS	Y – RACS	Y – RACS

College	Appeals	Is the decision appealable?	Composition of appeals?	Procedural rules?
Plastic		Y	Y – RACS	Y – RACS
Urology		N	N	N
Vascular			Y – RACS	RACS
Orthopaedics		Y – RACS	RACS	RACS
Neurosurgery		Y – RACS	RACS	RACS
Intensive Care		No – Hospitals process the dec	N/A	N/A

College	Nationally consistent?	Other considerations	Disqualification?	Processes for removal?
Anaesthetics	N/A		EPH	Y – fail exams, performance
Obstetricians & Gynaecologists	N/A		EPH	Y – Accred. C'tee.
Dermatology	–		EPH	Under development
Psychiatry	N		EP	Y (guidelines)
Radiology	Dont' know		EPH	N
Emergency Medicine	?		P	Under development
Physicians	N/A		EPH	N – SAC Interview
Surgeons	Y		P	Y (document provided)
GP's	Y – See detailed policy		Y – See detailed policy	Y – See detailed policy
Pathology	N/A		PH	N – Under development
Medical Administrators	Y		EP	Y – Preceptors Report
Ophthalmology	N		PH	N – Being developed
Paediatrics	N/A		EPH	Y – RACP
Faculties				
Public Health	N/A		PH	N – prospective approval of training
Rehabilitation	Y		EP	Y
Occupational Medicine	Y		P	Y, unfinancial, non-participation
Surgical Boards				
Cardiothoracic Surgery	Y			
General Surgery	Y		PH	Y – RACS

College	Nationally consistent?	Other considerations	Disqualification?	Processes for removal?
ENT	N		P	Y – RACS
Paediatric Surgery			PH	Y – RACS
Plastic	Y		P	Y – RACS guidelines
Urology	N/A		P	Y – RACS
Vascular	Y		PH	Y – Councelling review
Orthopaedics	Y		P	performance (3) National Board (4) RACS
Neurosurgery	Y		P	Y – RACS
Intensive Care	N/A		E,P,H	No

Codes

E = Exams
P = Performance
H = Lose post at Hosp.

College	Appeal for removal?	% complete fellowship?	Policies reviewed?
Anaesthetics	Y	90%	'Progressive' annual
Obstetricians & Gynaecologists	Y	95%	12/12
Dermatology	Y	90%	Under develop.
Psychiatry	Y	80%	Now
Radiology	N	90%	N/A
Emergency Medicine	Y	?[13]	Current
Physicians	Y	?	N/A
Surgeons	Y	99%	Every Year
GP's	Y	See Attachment 'C'	Y, 12/12
Pathology	N – under development	85%	12/12
Medical Administrators	Y	75%	1997
Ophthalmology	Y	99%	Ongoing
Paediatrics	Y	85%–90%	yes but[12]
Faculties			
Public Health	N	>80%	Current (see comment)
Rehabilitation	Y	90%	Continuous
Occupational Medicine	Y	75%	Every 6/12
Surgical Boards			
Cardiothoracic Surgery			
General Surgery	Y	98%	12/12
ENT	Y	99%	12/12
Paediatric Surgery	Y	~100%	1–2 yrs
Plastic	Y	99%	?? m/y
Urology	Y	98%	12/12

College	Appeal for removal?	% complete fellowship?	Policies reviewed?
Vascular	Y	100%	12/12
Orthopaedics	Y	99%	1997
Neurosurgery	Y	99%	1 yr
Intensive Care	Y – ANZCA	90%	1 yr

College	Policy for review?	Further comment on Questionnaire?	Further consult on findings?
Anaesthetics	Y	Y	Y
Obstetricians & Gynaecologists	N	?	Y
Dermatology	Under develop	Y	Y
Psychiatry	Y	Y	Y
Radiology	N	Y	Y
Emergency Medicine	?	N	Y
Physicians	N/A	Y	Y
Surgeons	Y	N	Y
GP's	Y – Very detailed	N	Y
Pathology	Y	N	N
Medical Administrators	N	N	Y
Ophthalmology	Y – Biannual	N	Y
Paediatrics	?		
Faculties			
Public Health	N	Y	Y
Rehabilitation	N	N	Y
Occupational Medicine	Y	N	Y
Surgical Boards			
Cardiothoracic Surgery			
General Surgery	Y	?	?
ENT	Y	Y	Y
Paediatric Surgery	Y	N	Y
Plastic	Y	Y	Y
Urology	Y	?	Y

College	Policy for review?	Further comment on Questionnaire?	Further consult on findings?
Vascular	N	N	Y
Orthopaedics	Y – Board & censor	Y	Y
Neurosurgery	Board meetings	?	Y
Intensive Care	+/-	Y	Y

College	Contact Person	Other comments
Anaesthetics	Prof G D Phillips, (03) 9510 6299	–
Obstetricians & Gynaecologists	Dr Eleanor Long and Ms Elaine Halley (03) 9417 1699	–
Dermatology	David Wong, (02) 9879 6177	
Psychiatry	Peter Burnett, (03) 9342 2800	–
Radiology	Michael Sage, (08) 8204 4405	–
Emergency Medicine	Paul Mark, 0411 725 042	–
Physicians	Peggy Tomlins (02) 9256 5422 or Don Swinbourne (02) 9256 5499	
Surgeons	R G Bennett (03) 9249 1200	No
GP's	Richard Novotomy (03) 9214 1420	No
Pathology	–	'Selection' related to job by a recognised employer
Medical Administrators	Stephen Krul (03) 9663 5347	No
Ophthalmology	Ms M Dunn (02) 9267 7006	Processes are currently under review
Paediatrics		See accompanying letter (Attachment 'C')
Faculties		
Public Health	Dennis Calvert 042 213463	Interaction of Primary Care and GP under review
Rehabilitation	Dr Stephen Buckley (02) 9256 5402	Faculty training is totally unrelated to hospital appt.
Occupational Medicine	Ms Elaine Siggins (02) 9256 5481	No
Surgical Boards		
Cardiothoracic Surgery		
General Surgery	?	–
ENT	L M Ryan (03) 9848 6611	No

College	Contact Person	Other comments
Paediatric Surgery	Keith Stokes (03) 9347 5724	
Plastic	James Katsaros (08) 8239 0115	Constantly under review; and more fair and transparent
Urology	Richard Millard (02) 9382 5980	–
Vascular	Faris (03) 5226 7899	–
Orthopaedics	Michael Fogarty (03) 9509 7233	Closer links of Basic and Advanced training to be developed
Neurosurgery	Alan Kaye RMH	–
Intensive Care	Alan Duncan (03) 9350 2861 (08) 9340 8506	

FOOTNOTES

1. Re - Psychiatry - This is the first time anyone has mentioned Government Funding and the influence this has on training positions - could be very important.
2. Of major significance. This drop is presumably the result of the so-called provider no. legislation under which this project is established.
3. The 'Principles' from RACOG were more selection criteria and processes.
4. General Surgery - Shortlisting is to be done in future by the State Selection Committees on the basis of written application including CV, 3 referees reports and mentor reports.
5. College of Paediatricians believes that the principles and Criteria for selection should be made available to candidates and the public and are prepared to work to that end
6. Ophthalmologists - Criteria set by each training program. Now developing national guidelines which will be available to candidates and public and will be binding on training programs.
7. The response from the College of pathology was 'The interview is with one person only (State Councillor) and is merely a 'getting to know you' interview.
8. General Surgery - No policy or questions that can or cannot be asked but they are under development.
9. The umbrella response from the RACS gives the national policy but in doing so indicates that their policy is 'not ?? enforced by all boards' but increasingly this is the case.
10. Psychiatry - appeals mechanism 'being developed'.
11. ENT - 'We have accepted that there is a right to appeal but we have not publicised that belief'.
12. Paediatrics - Appeals. 'those under the control of the College are under review'.
13. 'Candidates voluntary withdraw - 37 of 699 in 1997.
14. Dermatology - appeals - 'under development'.
15. Paediatric Surgery - 'Yes' to referee reports being available qualified by the statement 'Contents of the reports available.
16. Paediatric Surgery - Successful Candidates - 2nd interview with same Board designed to welcome and brief candidate and receive feedback on the process. Unsuccessful - same procedure plus counselled on likelihood of future success and given this information in writing.

Appendix E – National Advertisement

MEDICAL TRAINING REVIEW PANEL

Trainee Selection in Australian Medical Colleges

A team of consultants, led by Dr Peter Brennan, is currently developing a model set of arrangements for the selection of medical practitioners into training programs and training posts accredited by Medical Colleges. In addition to the Medical Colleges, the team is also seeking input from individual doctors, medical and industrial organisations, and other interested medical stakeholders.

The team will also be visiting capital cities to undertake face-to-face interviews. The anonymity of individual respondents will be respected.

Consultations have been scheduled for major centres as shown below. The consultants will attempt to meet all requests for personal consultation. The days shown are the most convenient but we can negotiate a mutually convenient time in most centres.

Tuesday 30th September, Hobart
Friday 3rd October, Launceston
Tuesday 7th October, Adelaide and Canberra
Wednesday 8th October, Melbourne
Thursday 9th October, Sydney
Friday 10th October, Brisbane
Monday 13th October, Perth

REGIONAL CENTRES AND DARWIN:
By arrangement.

A briefing paper which outlines the project and gives an overview of progress to date is available. The paper also suggests specific issues respondents may wish to address.

To organise an appointment with the consultants, or obtain a copy of the briefing paper, please contact Dr Peter Brennan on telephone number 0419 589 052 or Mr David Theile through his rooms on (07) 3831 0106, or Dr Jack Sparrow, Chair of the Steering Committee on (03) 6233 3297. It will greatly facilitate arrangements if requests can be received by not later than Friday 26 September.

Written submission should be sent to the address below by no later than Monday 13 October 1997.

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PO Box 120
DARLINGTON WA 6070
Dr Peter J Brennan & Co Pty Ltd
Management Consultants to the Health Industry
91 Darlington Road
Darlington, WA, 6070

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Appendix F – A dissenting statement by Mr David Theile in relation to appeals

DAVID E. THEILE A.O.
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ALEXANDRA,
201 WICKHAM TERRACE
BRISBANE , 4000

DAVID THEILE PTY LTD
ACN 010 726 815

13th November 1997

Professor Jack Sparrow
Chairman
Steering Committee
Trainee Selection - Medical Training Review Panel
Chief Medical Officer
Department of Community and Health Services
GPO Box 125B
HOBART 7001

Dear Professor Sparrow

Whilst I wholeheartedly support all other parts of the consultancy's submission on "Trainee Selection" I feel compelled to submit a minority statement on the matter of Appeals.

I find what is proposed on Appeals to be unacceptable in the following fundamental elements:-

1. It is proposed that access to Appeal and continuation through multiple appeal steps is simply dependent on a difference of opinion by the applicant.

   Virtually every candidate for a position believes that he or she should achieve that position and therefore all who fail are likely to be in disagreement with the selection outcome. If all are immediately free to contest that decision, the selection process will have no stamp of authority and the whole process will likely be swamped and destroyed by repeated and protracted contests.

   Access to the appeals process must only be on substantive grounds which present some evidence that there has been an error of law or process, a denial of natural justice or a decision demonstrably against the weight of evidence. The appellant must present grounds which prima facie demonstrate that error may well have occurred.

.....2

2. A declaration of a three-tiered system is fundamentally wrong. No confidence in the first tier is generated by such a proposal and indeed it is noted that the reason for proceeding from Step 1 to Step 2 is if the adjudicator on Step 1 finds that there is no error or misjudgment! There appears to be an implied mistrust of the earlier steps and significant impetus to proceed through all steps (at least an impetus from low confidence countered only by prospect of a financial penalty - a recipe for even greater suspicion).

   Each step in this appeals process will be very taxing, requiring delving consideration by multiple people - and all because someone does not agree with the outcome of the decision.

3. The idea that an external review is superior to an internal review with respect to astuteness and fairness is I believe highly contestable.

   Firstly, decisions are always best made by the people best informed on the subject of the decision. Those who understand the requirements for a specialty best, will make the most astute judgements.

   External appeal panels involve people of lesser specifically relevant expertise. External review implies lack of confidence in and authority of the specialist body which has rightfully the intellectual and administrative control of the specialty.

   This belief has been expressed by judges in the courts (The judge in the case Williams versus the AFL) and by judges in academic addresses (Mr Justice Winneke).

   That the appeal is fair and not swayed by self-interest can be assured by the involvement in the appeal panel of people who are independent of the selecting body (college or institution) and well versed in the relevant law and process.

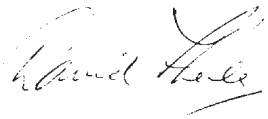
   All of the processes advocated by this review of trainee selection are directed towards improving the quality of selection and should therefore be producing justified confidence in the relevant institutions. It is inappropriate to place in amongst such a constructive build-up, such unjustified challenges to the authority of professional bodies and to so impugn their integrity.

4. The Committee of Presidents of Medical Colleges does not have sufficient stability of its membership or sufficient administrative structure and permanence to enable it to take on the wise supervision of what will be a very taxing process in terms of immediate response and ongoing handling of documentation of many multi-layered proceedings.

   It is perhaps felt that the CPMC may be able to significantly increase its management substance in the future to enable it to accommodate this, but why pass on the responsibility to it in expectation of its future capabilities, when most colleges have established and stable management and capability.

5. I don't believe that the assignment of costs and the prospect of those should be a mechanism by which the usage of the appeals process is influenced or controlled. Confidence in the appeals process should be generated by its honesty and effectiveness on the fundamental issues.

On the attached sheet is my version of "Appeals" for the BEST PRACTICE FRAMEWORK.



BEST PRACTICE FRAMEWORK

APPEALS

PRINCIPLE

- There should be a formal process for appealing decisions.
- The grounds for appeal should be substantive and should be declared.
- The terms and format for appeals should be declared.
- The principles of "natural justice" should be observed.

PROCESS

- The declared grounds for appeal could include
  - Error of law or process
  - Denial of natural justice (such as consideration of irrelevant or false evidence, bias or pre-judgement).
  - Decision against the weight of evidence.
- The application to appeal will be received and considered by a defined individual or group of the selection authority (College or institution) but independent of the selection committee. They will determine whether there are presented grounds for revisiting the selection.
- The committee hearing an appeal should not include participants in the original selection. The people of the committee should be well informed in the required processes of the selection and of the appeal and should be guided by some person or persons experienced or knowledgable in the relevant process and law in a broader context.
- The appeals committee should include people with expertise relevant to the selection and also people independent of the selecting authority (College or institution).
- The appellant has the right to appear before the appeal committee.
- The appeal committee should consider all material from the specific selection process, should receive a submission from the selection committee in response to the specific terms of the appeal and should question a representative of the selection committee.
- The courses of action open to an appeals committee should be declared, such as
  - to dismiss the appeal
  - to require the selection committee to reconsider in the light of advice to that committee
  - to require a new selection committee reconsider
  - to over rule that selection committee