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Introduction

The Royal Australasian College of Medical Administrators (RACMA) was founded with the aim of promoting and advancing the study of health services management by medical practitioners. The College had 279 founding Fellows and currently has approximately 900 Fellows, Members and Candidates (trainees) throughout Australia and New Zealand. The College is formally affiliated with the Hong Kong College of Community Medicine.

The College was established on 19 September 1963, when the Medical Superintendents' Association of Victoria resolved that:

> "a Professional Association dealing with the specialty of medical administration be formed."

It was further resolved on 17 October 1963 that:

> "The objects of the proposed College shall be:
>
> i. To ensure that the best principles of administration are conjoined to those of medicine for the public good.
> ii. To foster research, postgraduate study and courses of instruction which are designed to achieve the first object.
> iii. To encourage interchange of ideas and the dissemination of knowledge regarding medical administration.
> iv. To co-operate with other professional and statutory bodies in matters related to those objects.
> v. To promote and safeguard the professional interests of members.

A College Steering Committee was convened from 1964 to 1966, and the Australian College of Medical Administrators was formed and incorporated under the Companies Act of Victoria on 21st March 1967.

In 1979 Her Majesty Queen Elizabeth II approved the granting of the prefix 'Royal' and in 1980 the College was recognised by the National Specialist Qualification Advisory Committee (NASQAC), allowing Fellowship to be a nationally recognised specialist qualification.

In August 1998 the College changed its name to the Royal Australasian College of Medical Administrators in acknowledgement of the incorporation of New Zealand, and the Articles of Association were converted to a Constitution on 27 August 2002. (Attachment 1)

The Royal Australasian College of Medical Administrators (RACMA) has a comprehensive website for communication with Fellows, Members, Candidates and other visitors: www.racma.edu.au

The Australian Medical Council (AMC) recently reviewed the RACMA and that outcome was to grant AMC accreditation until 2012.

This submission to the Medical Council of New Zealand is prepared for re-accreditation. RACMA acknowledges the Medical Council of New Zealand's advice that there is some overlap between the Council's requirements and the AMC's requirements, but that there are also differences. The RACMA New

Zealand Committee has provided input to the development of this submission. The following documents are also submitted to be read in conjunction with this submission:

RACMA (February 2008), *Accreditation Submission to the Australian Medical Council, The Education and Training Programs of The Royal Australasian College of Medical Administrators.* (Attachment 8)

AMC (November 2008), *Accreditation Report: The Education and Training Programs of The Royal Australasian College of Medical Administrators.* (Attachment 9)

RACMA (September 2009), *Annual Report to the Australian Medical Council 2009 (with permission from the AMC)* (Attachment 10)

Please note that the RACMA 2009 Annual Report to the AMC was prepared specifically for the AMC's consideration and specifically follows the annual report format required by the AMC. This report is yet to be considered by the AMC Working Party to Review Specialist Medical Colleges on 30 September, and then the Working Party's report will be considered by the Specialist Education Accreditation Committee on 22 October. The Report is submitted with this re-accreditation submission to enable the Medical Council of New Zealand to see the progress made by the College to address the recommendations in the AMC Report, November 2008.

Dr Karen Owen
Chief Executive

1. Clearly identify with empirical evidence how the vocational scope of practice of medical administration fulfils a recognised health need and contributes to improved medical care and/or public health

The Medical Administration scope of practice contributes directly to fulfilling health care needs and to the improvement of medical care through the application of knowledge of both medicine and business principles and practices to the management of continually evolving and increasingly complex health care services.

The definition of medical administration most frequently used is, "administration or management utilising the medical and clinical knowledge, skill and judgment of a registered medical practitioner, and capable of affecting the health and safety of the public or any person. This may include administering or managing a hospital or other health service, or developing health operational policy, or planning or purchasing health services. Medical administration does not involve diagnosing or treating patients."[1]

Most evidence of this contribution exists in the form of qualitative case studies[2] analysing the performance of medically qualified health service executives (working as chief executives, directors of medical services or department heads) involved in a broad range of activities that are crucial to sustainable health care delivery and have a direct and immediate effect on the quality and safety of patient care in Australian and New Zealand hospitals.

Medical administrators are specialists in charge of specific business units, clinical departments or services, and may progress to manage an entire facility or health system. They must be competent to deal with evolving integrated health care delivery systems, technological innovations, an increasingly complex regulatory environment, restructuring of work, and an increased focus on preventive care. They aim to improve efficiency in health care facilities and the quality of the health care provided. Increasingly, medical administrators work in organisations in which they must optimise efficiency of a variety of related services, for example those ranging from inpatient care to ambulatory and community care.

Medical administrators establish and implement organisation and system-wide policies, objectives, and procedures for their health services, evaluate personnel and work, develop reports and budgets, and coordinate activities with other managers. Some experienced medical administrators become consultants or professors of health services management or advisors to Ministers and leaders of health authorities. The training for medical administration assists transition from clinician to manager.

RACMA has a total membership of 794, which includes 456 Fellows, 241 Members and 97 Candidates. In New Zealand there are 22 Fellows, 5 Members and 12 Candidates. While RACMA has 22 Fellows in New Zealand, only 16 are vocationally registered in Medical Administration, nine of which hold dual Fellowship

[1] Medical Council of New Zealand, Definition of Vocational Scopes www.mcnz.org.nz

[2] Mountford, J., & Webb, C. (2009). When clinicians lead. *The McKinsey Quarterly* , 1-8.

(four hold Fellowship of the New Zealand College of Public Health Medicine, two are Fellows of Royal New Zealand College of General Practitioners, two are Fellows of the Royal Australasian College of Physicians, and one of Accident and Medical Practice).

Current candidates include Fellows from Royal Australian and New Zealand College of Obstetrics and Gynaecology, Royal Australian and New Zealand College of Psychiatry, Royal Australasian College of Physicians, Australian and New Zealand College of Anaesthetists, Australian College of Emergency Medicine and the Royal New Zealand College of General Practitioners.

Medical Administration was first recognised as a vocational branch of medicine in New Zealand in 2001.

2. Provide evidence to support the vocational scope of Medical Administration remaining a separate discipline. This should be based on major developments in medical science or health care delivery, or public health, identifying societies and journals devoted to the branch.

It is the clinical skills and knowledge inherent in medical training that separate medical leaders from health service executives. In making day to day decisions in health management, the medical leader is applying their clinical knowledge to assess the impact, risk and clinical outcome of decisions to ensure that services are tailored to effectively achieve high quality health outcomes.

The undergraduate medical training program in New Zealand does not prepare a doctor to undertake leadership roles. Where a doctor undertakes a role as medical leader without adequate training and experience, there is a high risk that it will result in compromised patient care and reduced healthcare outcomes.

In other scopes of practice, doctors receive little or no training in health law, health economics, health care financing, health care organisation, human resource management or change management. These skills must be learnt if the doctor is to become a competent manager.

In order to demonstrate the achievement of competence, the Royal Australasian College of Medical Administrators determines that a registered medical practitioner must satisfactorily complete:

- Approved supervised medical administrative experience of a minimum standard of three years full time, or equivalent.
- Academic studies involving the award of an approved masters program at a recognised Australian or New Zealand university or equivalent. The masters program should cover the following subjects:
    - Health Law
    - Health Economics
    - Health Care Systems
    - Financial Management in health
    - Epidemiology and Statistics
    - In addition at least two management-related subjects should be completed

In August 2005, RACMA undertook a medical management workforce study *Factors Affecting Recruitment and Retention of Medical Managers in Australian Hospitals*. The purpose of which was to support the development of an evidence-based workforce strategy to underpin the provision of a sustainable medical management workforce. The report discussed major system changes that have impacted on medical administrator work in the past decade, including:

- Less emphasis on line management of clinical services, including diagnostic and allied health departments, particularly in large hospitals. This is due to the trend to appoint and pay practicing clinicians as part-time managers.
- Appointing clerical administrative staff as Junior Medical Staff Managers with responsibility for junior medical staff recruitment and rostering. Medical administrators are still responsible for the

oversight of junior medical staff appointments and conditions but the time spent on this has decreased markedly over the last two decades.

- Increased focus on quality and risk management and financial management. Medical managers have acquired a new body of quality and risk management knowledge and skills and in many health services hold a key role in these areas.
- Complex hospital funding systems and the focus on health budgets mean that medical administrators require financial management expertise, to contribute to improving financial outcomes and to advise others particularly in relation to changing models of care and planning for clinical services.
- Medical managers require reasonable knowledge of legal matters such as medico-legal processes and employment law.
- Clinical governance, including performance management, credentialing, professional development and risk management, has grown from a small part of the medical administrator's responsibility into a major component.
- Increasing time is required for workforce recruitment, retention and planning. This is a result of medical staff shortages, changing motivations of medical staff such as increased expectations of work/life balance, safe working hours, changing award conditions and the impact of increased use of technology in both patient care and health services management.

This report demonstrated that changes in the health system, particularly over the past decade, have caused medical administrators' roles to evolve. The changes relate to the focus on particular tasks rather than the evolution of completely new tasks. RACMA has responded to these changes by broadening the core competencies framework in the Candidate training program, in the review of the Masters programmes by developing specific core and recommended elective units.

The report also provided overall findings about the medical administrator workforce including:

- The shortage of medical administrators is due to a decreasing number of training positions and an increasing movement out of formal medical administration positions into a variety of other available options. This has led to a mismatch of demand and supply.
- The difficulty of attracting new candidates and the difficulty of formally promoting the specialty as a result of inability to predict the number of training positions that may be available from year to year.
- The problems with retaining experienced medical administrators due to a lack of understanding of what motivates them to continue in a position and a lack of flexibility in the conditions of employment.
- The changing role of the medical administrator related more to a changing emphasis on particular roles and tasks than an absolute change in roles or tasks.
- The changing emphasis on competencies required by the medical administrator with the attendant need to change the emphasis of both training and continuing professional development.
- Clarification of the value provided both to health service organisations and the health system itself by medical administrators and thus an improved ability to ensure medical administrator training and development is appropriately focused.
- The lack of clarity around key medical administrator roles to assist health services to employ the right person with the right skills for the right roles and thus assist in employment of other staff for those roles where professional medical administration is not essential.

- The importance of medical administrator influence in driving, facilitating and supporting change in the health system as well as in health service organisations.
- The lack of clarity around the differences in competencies and roles between clinician managers (part-time administrators with a large clinical load) and medical administrators.
- The need for an overall workforce strategy for the medical administration workforce agreed to by governments, RACMA and other key stakeholders.

Although this study was undertaken in relation to the workforce in Australian hospitals these same issues apply and the same concerns are apparent in New Zealand.

There are many journals with a medical management focus, some of which are dedicated to medical administration, including *Clinical Leader*, the twice yearly refereed journal of the British Association of Medical Managers (BAMM). The association is working with the GMC to have Medical Management accepted as a specialist branch of medicine in the UK, based on the standards in its *Fit to Lead* program.3

The American College of Physician Executives has a *Physician Executive Journal* which is a bi-monthly publication.

RACMA publishes *The Quarterly*, a journal which is distributed throughout Australasia and several overseas countries with approximately 900 subscribers.

There is an Australian College of Health Service Executives (ACHSE) which conducts professional development activities and provides membership services such as the Health Planning and Management Library, and a Graduate Health Management Program for people working in management in health services. The New Zealand Institute of Health Management (NZIHM) is a branch of the Australian College of Health Service Executives, and provides a wide variety of information services to keep its members abreast of current developments and thinking in Health Services Management. RACMA has successfully held joint conferences with NZIHM in New Zealand and ACHSE in Australia where some sessions are of common interest and the rest of the program is carried out in separate streams to meet the needs of the two professions.

[3] http://www.bamm.co.uk

3. Provide details of the defined body of knowledge and practice specifically identifiable with the vocational scope of Medical Administration.

Refer to the Royal Australasian College of Medical Administrators' Submission to the Australian Medical Council, *"The Education and Training Programs of The Royal Australasian College of Medical Administrators",* Chapter 3, Goals of the Education and Training Program. Also refer to the College competencies framework in Chapter 4, p 47-50.

Details of the defined body of knowledge and practice specifically identifiable with the vocational scope of Medical Administration is addressed in the response to Question 2.

RACMA has a framework of competencies (these are fully defined in Question 5 and attached Attachment 3) to define the body of knowledge and practice in medical administration. This framework is based on the seven CanMEDS roles of Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Health Advocate. This framework has guided the education and training curriculum following Council adoption in 2006. They are currently under review as part of the Curriculum Project and it is anticipated that a higher level of specificity will be determined for each of the Roles. As well, a move to outcomes statements is being discussed for the higher order skills and behaviours required in medical management.

4. Provide details of the branch of the Royal Australasian College of Medical Administrators' (RACMA) structure and personnel that set and maintain requirements for training, assessment, and recertification, and advise the Medical Council on matters of vocational registration. Include details of any affiliation that exists with other groups that deliver similar or related care or services.

Refer to the Royal Australasian College of Medical Administrators' Submission to the Australian Medical Council, *"The Education and Training Programs of The Royal Australasian College of Medical Administrators",* Chapter 1, Structure and Organisation of the College pp 1 -22 and Chapter 9, Supervisors, Assessors, Trainers and Mentors, pp 120 - 129

The following summary is prepared from the above document:

Governance

Council

The Council is comprised of three Fellows from each of New South Wales and Victoria, two Fellows from each of Western Australia, South Australia, Queensland and New Zealand, one Fellow from each of the Australian Capital Territory, the Northern Territory and Tasmania, one Candidate (trainee) representative, the Immediate Past-President, the Censor-in-Chief, and the National Director Continuing Education/Recertification.

The 2009 Annual General Meeting will be considering significant constitutional change. The revised constitution will recognise the principles of good governance including the introduction of a smaller Board of Directors (10 members), the introduction of an independent director and formal representation at the Board by Candidates and Members.

Council Executive

The Council Executive is responsible for business outside of formal Council meetings. It is made up of College Office bearers including the President, Vice-President, Immediate Past-President, Honorary Secretary, Honorary Treasurer, Censor-in-Chief and the National Director Continuing Education/Recertification.

Finance Committee

The Finance Committee is to advise Council on financial and audit matters. It is made up of the Honorary Treasurer (Chair), President, two senior Council members and the Chief Executive.

Board of Training and Continuing Education Committee

The Board of Training and Continuing Education Committee is responsible for: recommending changes to the curriculum, examination of candidates, recommendation for Fellowship, recommendation of continuing professional development criteria and other educational functions as required.

Curriculum Steering Committee

The Curriculum Steering Committee advises Council on the development of RACMA's curriculum. It liaises with the Board of Training and Continuing Development and the Continuing Education Program Committee

and is responsible to: review the competencies including a framework of goals and outcomes to guide the education and training programmes, document the core content and learning activities in the curriculum, develop an appropriate structure for delivery of the curriculum, document assessment approaches, and provide ongoing evaluation.

National Scientific Program Committee

The role of the National Scientific Program Committee is to plan the scientific content and structure for RACMA's annual scientific meeting.

New Zealand, State and Territory Committees

The New Zealand, State and Territory Committees are responsible for their Board of Studies, the implementation of policy and the administration of affairs at a local level.

New Zealand Committee

The New Zealand Committee advises Council on: education and training matters, strategic policy development, workforce issues in New Zealand, cultural competence, and other matters relating to the practice of medical administration in New Zealand.

The New Zealand Committee is responsible for matters pertaining to the Branch Advisory Body in New Zealand including providing advice on vocational registration.

The current New Zealand Office Bearers are:

- Chair, Dr Andre Nel
- Immediate Past Chair, Dr Bernard Brenner
- Secretary, Dr Wilson Young
- Treasurer, Dr Kevin Morris
- Chair Board of Studies, Dr David Rankin
- Continuing Education Program Coordinator, Dr Bob Boyd
- Committee member, Dr Dell Hood
- Candidate representative, Dr Tim Kerruish

Boards of Studies

The Boards of Studies are appointed by the New Zealand, State and Territory Committees.

The New Zealand Board of Studies is responsible for: oversight of candidate progress, provision of preceptors and review of reports, assist with examination preparation, advise on accreditation of training positions, counsel candidates who are not progressing well, and report to the Censor-in-Chief on any training matters.

The tasks of the Board of Studies in New Zealand are undertaken by the New Zealand Committee.

Continuing Education Programme Committee

This committee is chaired by the National Director for Continuing Education/Recertification and its members are the state, territory and New Zealand Continuing Education Program Coordinators. These local CEP Coordinators support and verify participation in ongoing professional development by Fellows and Members.

The CEP committee:

- develops policy and procedures for CEP development and implementation

- establishes curriculum and competency frameworks
- monitors key indicators
- evaluates the continuing education program and its procedures.

The committee meets at least five times per year.

Information on the above committees can be found on the College web site at www.racma.edu.au

Preceptors and Supervisors

The primary objective of Preceptors is to provide advice and education to support the formal training program and to report annually on the overall progress of Candidates. The Preceptor has a key role in liaising with the Candidate's Supervisor to monitor the Candidate's progress, provide information about RACMA education and training policies and programmes and to progress any training issues.

The role of the Supervisor is to understand the core competencies and skills prescribed by RACMA to be acquired during the minimum of three years of full time medical administrative experience. The Supervisor oversees a Candidate's day-to-day work. The Supervisor may or may not be medically qualified and may or may not be a Fellow.

Further information on the preceptor and supervisor roles is in Question 5 Section 9.

The Preceptor Co-ordinator

The Preceptor Co-ordinator is a new position created in 2008. The Preceptor Co-ordinator supports and advises the Censor-in-Chief and is responsible to liaise with Preceptors, oversee the appointment and training of Preceptors and the in-training assessment of candidates. The in-training assessment is encompassed in the annual Supervisor/Preceptor Report which is prepared for each Candidate.

Secretariat

Management of the College is provided by the National Secretariat, led by the Chief Executive based in Australia.

The New Zealand branch has a secretariat based in Wellington which provides administrative and support services to the New Zealand Committee including matters relating to the operation of RACMA as a Branch Advisory Body in New Zealand.

Affiliations

The USA and UK have formal organisations that provide and support education for doctors in management, but neither has chosen to develop medical administration using the medical specialty College model. In the UK this has been considered by BAMM, but a decision was made not to do this, because of the limitations imposed by the rules and regulations of being a College.

RACMA's President is an active member of the Committee of Presidents of Medical Colleges (CPMC), ensuring that RACMA is aligned with the practices of other recognised Australasian medical Colleges.

A training program in medical administration exists in Hong Kong, which is based on the RACMA training program (see below). Most recently, senior managers in Singapore, Indonesia and South Africa have approached the College about its Fellowship training program, and discussions continue about the support RACMA can give to establish training in these countries.

5. Provide details of the Royal Australasian College of Medical Administrators' training program.

Refer to the Royal Australasian College of Medical Administrators' Submission to the Australian Medical Council, *"The Education and Training Programs of The Royal Australasian College of Medical Administrators",* Chapters 3 – 13.

5.1 The program's consistency with the defined body of knowledge and practice and including attitudes, behaviours and skills referred to in criteria 3 and the goals and objectives referred to in criteria 4.

The overall objective of the Candidate Training Program is to develop a competent Medical Administrator to carry out such functions as:

- Plan health care services,
- Define the scope of services that can safely be provided in particular clinical settings,
- Ascertain the appropriate credentials of medical professionals who are likely to be competent to provide those services, and
- Recruit medical professionals and have a significant role in the creation of professional relationships between employing/contracting health services and medical professionals that foster retention and ongoing delivery of quality health care.

These functions include:

- the financing, operation and management of health services and their legal obligations,
- medical staff management including influencing and engaging doctors and other business stakeholders, clinician learning and performance management,
- leadership and clinical governance including systems and processes to ensure safety and quality of organisational care, credentialing,
- innovation, systems design and implementation of new services and technology,
- health policy making and deployment, planning and innovating,
- strategic thinking and analysis,
- patient and health/medical services advocacy, and
- ethical decision-making and appropriateness of care and treatment.

The Training Program consists of:

formal academic studies at a New Zealand or an Australian university in a Masters degree (or equivalent) including RACMA prescribed core papers,

minimum of three years full-time, or equivalent, supervised medical management experience in a workplace that has been accredited by RACMA as a training post,

Participation in a two-day Induction Workshop in year 1 which introduces Candidates to the training program at the beginning of the Candidacy and management training period,

- Participation in a four-day Pre-Fellowship Workshop in the final year to prepare for the Final Oral Examination, including oral presentation and assessment of the Reflective Case Study,

- Participation in the Preceptorship program and submission of three annual in-training assessments,
- Participation in a Writers Workshop (currently optional),
- Submission of a Management Practice Folio,
- Submission of a written Reflective Case Study, and
- Successful completion of the annual Final Oral Examination involving at least four viva examinations to establish the Candidate's knowledge and expertise in the area of health services management.

This training program structure is designed to provide for the progressive development of the knowledge, behaviours and skills embedded in the competency framework.

The Competency Framework is built upon the CanMEDS structure and defines seven domains of competencies:

1. Medical Expert
2. Communicator
3. Collaborator
4. Manager
5. Health Advocate
6. Scholar
7. Professional

Competencies Framework

Each domain of the Competencies Framework is described by a number of competencies, classified according to the broad elements of: knowledge, skills, behavior, and attitudes in the table below.

The Medical Expert domain describes the specialist competencies that are unique to the medical administrator. Competency development in the other domains enables doctors to develop the more generic knowledge and skills associated with their roles as medical managers.

Role	Competencies	Education/Training	Assessment
Medical Expert	Demonstrates intelligent leadership	Leadership unit of Masters	Preceptor and Supervisor Reports Final Oral Examination
	Able to influence medical staff behaviour	RACMA workshops Masters Change management projects (work experience)	Preceptor & Supervisor Reports Management Practice Folio Final Oral Examination
	Able to devise and implement appropriate clinical governance systems	Masters Work experience Short courses	Preceptor & Supervisor Reports Management Practice Folio Final Oral Examination
	Able to manage health care provision for all patients (clients) of a health system	Health Systems unit of Masters Work experience in complex health services	Preceptor & Supervisor Reports Final Oral Examination

Communicator	Able to distil and convey complex information to diverse groups	RACMA education sessions Communication course, media training, public speaking	Management Practice Folio Preceptor & Supervisor Reports Final Oral Examination
	Demonstrate an understanding of effective communication methodologies and pathways	RACMA education sessions Communication course	Preceptor & Supervisor Reports Presentation at 4-day workshop
	Able to communicate up, down and across the organisation and internally and externally	Communication course, media training, public speaking	Preceptor & Supervisor Reports Management Practice Folio Final Oral Examination
Collaborator	Demonstrate an ability to listen to all sides of an issue and move forward with action	Masters units e.g. health law, ethics, conflict resolution	Preceptor & Supervisor Reports Management Practice Folio Final Oral Examination
	Able to manage the interfaces in health systems	Work experience Masters units	Management Practice Folio Preceptor & Supervisor Reports Final Oral Examination
Manager	Demonstrate business contingency management	Masters units Work-based projects	Management Practice Folio Preceptor & Supervisor Reports Final Oral Examination
	Demonstrate ability to 'think on your feet' within real world timelines	Reflection on experience in the workplace	Management Practice Folio Preceptor & Supervisor Reports Final Oral Examination
	Demonstrate a co-ordinated systems approach to all management tasks	Masters units Project work Reflection on experience in the workplace	Preceptor & Supervisor Reports
Health Advocate	Ability to influence policy and practice to optimise health outcomes	Masters unit Reflection on experience in Government Health or Community Services Department	Preceptor & Supervisor Reports Management Practice Folio Presentation at 4-day workshop
	Provide advocacy for patients, populations, staff and organisations	Reflection on service development experience Master unit	Preceptor & Supervisor Reports Management Practice Folio
Scholar	Demonstrates a commitment to education and research to continuously improve knowledge and skills	Attend courses that increase knowledge and skills on a regular basis	Preceptor & Supervisor Reports Management Practice Folio Reflective Case Study
	Demonstrates use of academic rigour in furthering knowledge	Short courses on evidence-based medicine or other relevant topics	Management Practice Folio Final Oral Examination

	Demonstrates ability to apply research skills to management tasks	Masters unit Reflection on experience	Management Practice Folio Final Oral Examination
Professional	Demonstrates behaviour that is always within the value systems of RACMA	Values provided at commencement of training and via web. Supervisor and Preceptor reinforce.	Reports from Preceptor & Supervisor
	Demonstrates behaviour that shows use of self-knowledge	Use of psychometric screening as part of self knowledge process	Reports from Preceptor & Supervisor Management Practice Folio Entry interview
	Demonstrates 'patient first' behaviour	Reflection of experience in workplace	Reports from Preceptor & Supervisor Management Practice Folio Reflective Case Study Entry interview
	Demonstrates awareness of ethical issues in managerial and clinical decision-making	Reflection of experience in workplace	Reports from Preceptor & Supervisor Management Practice Folio Reflective Case Study Final Oral Examination

Aims of the Training Components

Assessment of the Candidate derives from the competencies and the integrated program of learning strategies and training experiences provided. All medical management experiences, workshops, Preceptor and Supervisor reports aim to integrate training to maximise the Candidate's learning and capacity to demonstrate the competencies. The following table provides a summary of the specific aims of the different training components.

Training Structure	**Main Aim**
Clinical Pre-requisite	To ensure currency with the clinical environment and credibility.
Formal academic study	To provide theoretical knowledge.
Medical management experience (apprenticeship)	To gain experience in an appropriate management setting, build foundations and establish skills in management based on observation, instruction and practical experience.
Workshops	To convey the purpose and opportunities of the training program. To assist with defining expectations of training content and assessment. To network and be exposed to experienced Fellows. To provide selective course content.
Case Study	To encourage reflection for building self-knowledge and constructing new knowledge, based on a project in which the Candidate was involved.
Preceptorship	To ensure that the competencies are being achieved and to discuss approaches to enhance learning and achieve future competencies. To ensure that continued learning can be demonstrated with goals set and met on a regular basis.
Final Oral Examination	To evaluate overall achievement of competencies and attainment of minimum required standards to proceed to Fellowship.

Learning Strategies

Candidates acquire key competencies through the general management units within their university Masters degree, working as a part of a health management team in the workplace, staying abreast of developments in the broad spectrum of health care, and the refinement of verbal and written skills during their training.

Exposure to senior Fellows and experts in the health management field during the training program helps to contextualise formal theoretical studies and practical workplace experiences. Each of the two compulsory workshops enable Candidates to communicate with senior Fellows. Discussion and debate assists reflection and construction of learning about the management process while placing Candidates' own experience in the broader context of the health system and the community.

Candidates will participate in two compulsory workshops during their candidacy; namely the Induction Workshop for new Candidates, and the Pre-Fellowship Examination Workshop. There is an additional optional Writers Workshop, which candidates are encouraged to attend.

The components of training are formatively assessed throughout Candidacy via university examination, assessment processes, and the RACMA workshop presentation. Summative assessment in the form of a viva exit examination requires that the Candidate satisfies the examiners that they are able to practice safely, effectively and unsupervised within the area of medical administration.

The Final Oral Examination assesses the Candidates' knowledge, application and attitude based on responses to scenarios derived from current issues that are likely to face medical administrators. Ethical issues are significant in the practice of medical administration and are the major theme in a number of questions in each component.

5.2 Educational objectives and competency requirements, including educational prescriptions

Refer to the Royal Australasian College of Medical Administrators' Submission to the Australian Medical Council, *"The Education and Training Programs of The Royal Australasian College of Medical Administrators",* Chapters 4 and 5.

The regular requirement for self-reflection and self-determination of learning needs is a driving force in the ongoing education of medical managers. In addition there is a focus throughout the training program on group involvement in setting and meeting learning objectives.

The Medical Expert domain of the Competencies Framework encompasses an in-depth understanding and skills of health systems management, including:

- the financing, operation and management of health services and their legal obligations,
- medical staff management including influencing and engaging doctors and other business stakeholders, clinician learning and performance management,
- leadership and clinical governance including systems and processes to ensure safety and quality of organisational care, credentialing,
- innovation, systems design and implementation of new services and technology,
- health policy making and deployment, planning and innovating,
- strategic thinking and analysis,
- patient and health/medical services advocacy, and
- ethical decision-making and appropriateness of care and treatment.

Elements of the Training Program

Throughout the training program, attention is given to the gradual attainment of the core competencies. The program does not separate the training components into basic or advanced and the curriculum does not identify learning outcomes according to the year of training. This is because of the variation in experiences of Candidates and the flexibility encouraged. Most learning outcomes are measured in terms of competency achievement but others are the outcome of reflective practice over time.

The academic and experiential components of the training program are usually completed concurrently, to provide integrated theory and practice. The assessment components are completed at regular intervals to monitor the progressive development of knowledge and skills.

Formal Academic Studies

Completion of the required university Masters degree program usually occurs over a three to four year period. Academic studies can be completed by distance or on-campus mode, full or part-time. There is a strong preference for studies to be completed as course work. The requirements are more flexible for those approved under the Accelerated Pathway and each application is assessed on its merits by the Censor-in Chief.

The training program prescribes core content areas of formal university study to be undertaken. Candidates select their preferred Masters degree program in consultation with their Chair of Board of Studies, Preceptor and the Censor-in-Chief to be sure that they satisfy requirements before enrolment.

Core papers for the Masters degree component of the training program are:

- Health care systems,
- Health law,
- Health economics,
- Financial management in health,
- Epidemiology and statistics, plus
- Two appropriate management units.

Units covering core content are generally supplemented by elective units that offer the opportunity for Candidates to further explore areas of interest to a greater breadth and depth.

Appropriate Management units may include:

- Public health,
- Quality and safety,
- Medical ethics,
- Governance,
- Leadership,
- Organisation, and
- Human relations or Industrial relations.

Some of the papers offered in the Diploma in Aviation Medicine program and the Master of Science in Occupational Medicine program are recognised as partially satisfying requirements.

Supervised Medical Management Experience

Candidates must undertake a minimum of three years full-time, or equivalent, supervised medical management experience in a workplace that has been accredited by RACMA as a training post.

All Candidates have Supervisors and Preceptors. Supervisors are usually immediate line managers so that Candidates have direct or one-on-one contact on a regular (weekly) basis. Supervisors sign off Candidate progress annually. An induction kit is available to better inform Supervisors of their responsibilities.

Candidates are allocated a Preceptor immediately after Council approves their application to be a Candidate. This allocation is a responsibility of the Chair of the Board of Studies who attempts to match a Preceptor with the Candidate so that an effective coaching relationship will be constructed. Contact with Preceptors occurs at least bi-annually.

RACMA ensures that the required competencies are achieved through review between the Candidate, Supervisor and Preceptor and documented in the Preceptor Reports. Competencies are assessed using the Management Practice Folio.

The Supervisor must complete three in-training assessments in conjunction with the Preceptor, during the period of the Candidate's training. These assessments require the Supervisor to specify the training activities, core competencies achieved and experiences that the Candidate has been involved in over the previous year.

The ratings achieved by the Candidate against each of the roles and competencies are recorded in the training profile in the education data base. The Candidate is required to prepare a Management Practice Folio that will provide examples of workplace experiences.

The in-training assessments are reviewed by the Candidate's Preceptor. There may be variation in Candidate training experiences at different training sites. The Preceptor and Candidate plan areas in which the Candidate requires further experience within the existing or an alternative workplace to achieve the competencies. The Candidate then develops a training plan to address significant gaps in competency development. The Preceptor Co-coordinator reviews all Preceptor Reports.

The Preceptor is also required to communicate with the Candidate's Supervisor to ensure that the Supervisor understands and supports the workplace requirements of the training program.

Suggested Workplace Activities that Satisfy Key Competencies

Competency Domain	**Competency**	**Suggested Workplace Activities**
Medical Expert	Demonstrates intelligent leadership	Chair relevant organisational committees (e.g. medical advisory committee) and lead service business and quality planning processes Manage crises Manage a major change process
	Demonstrates ability to engage and work with medical staff	Medical staff management is one of the key roles of a medical manager. All Candidates should, where possible, participate in: • SMS & JMS credentials committee & appointment processes • Performance management of a SMS/JMS • Education and training of medical staff especially JMS.
	Devises and implements appropriate clinical governance systems	Actively participate in an organisational quality committee, preferably the peak executive or Board quality committee Be involved in Coronial reports and/or investigations, FOIs, insurer notifications, medico-legal reports, subpoenas. Actively participate in an organisational quality committee, preferably the peak executive or Board quality committee. Be involved in one or more of: • Clinical Risk Management training/activity • Review of a clinical incident • Quality improvement activity.
	Manages health care provision for all patients/ clients of a health system	Experiences in Operational activities such as: • Unit/Divisional operational committees • Service development • Service review • Planning activities – strategic, business, operational, quality. • Other committees, e.g. Infection Control, Medical Advisory, Blood Transfusion.

Communicator	Demonstrates ability to distil and convey complex information to diverse groups	Experiences in Operational activities such as: • Unit/Divisional operational committees • Service development • Service review • Planning activities – strategic, business, operational, quality • Other committees, e.g. Infection Control, Medical Advisory, Blood Transfusion.
	Demonstrates an understanding of effective communication methodologies, pathways	Chair meetings, facilitate interaction between clinicians and managers. Formal communication with Minister/Head of Government Department Formal and informal communication with heads of Departments, senior clinicians, non clinical staff, community representatives.
	Communicates up, down and across the organisation and internally and externally	Medical staff management is one of the key roles of a medical manager. Where possible, participate in: • SMS credentials committee • SMS appointment processes • JMS appointment processes • IMG appointment processes • Performance management of a SMS/JMS • Education and training of medical staff especially JMS.
Collaborator	Demonstrates an ability to listen to all sides of an issue and move forward with action	Preparation of business case that involves multiple stakeholders. Planning of new service or facility.
	Manages the interfaces in health systems	Development of political alliances to ensure success of initiatives. Develops communication systems, for example to inform LMOs and community services about patient discharges.
	Works constructively with patients/clients from different cultural backgrounds	Managing a complex complaint.
Manager	Demonstrates business contingency management	Where possible, the Candidate should have the opportunity to manage an individual or unit.
	Demonstrate ability to 'think on your feet', analysing, determining options and acting within real world timelines	Managing a crisis. Managing a recurring problem. Dealing with a complex group of people.
	Demonstrates ability to manage disasters/crises	Managing a crisis, involvement in disaster management planning or critical incident management.

	Manages the implementation of new processes and technologies in the health system	Preparation of a business case. Participation in a New Technology Committee or introduction of a new technology process.
	Demonstrates ability to provide culturally appropriate health care to all patients/clients	Awareness of and/or participation in cultural committees and other processes that allow for cultural diversity to be recognised within the organisation. Provide for cultural needs of major groups in local community and develops models to meet these needs, e.g. prayer mats for Muslims, outdoor space for Aboriginal relatives to grieve, decisions about service design.
	Demonstrates a coordinated systems approach to all management tasks	Participation in a relevant project dealing with systems issues. Facilitation of a process improvement team and description of process and outcomes. Facilitation of accreditation processes and. description of learning. Managing a work unit. Reviewing a monthly unit/divisional budget. Participation in a unit/divisional annual budget building process.
Health Advocate	Influences policy and practice to optimise health outcomes	Involvement in Policy and Procedure development. Preparing submissions, policy advice. Working with a media advisor on an issue.
	Provides advocacy for patients, populations, staff and organisations	Working with a media advisor on an issue. Presenting the case for alternative viewpoint. Recognising and where possible supporting the public advocacy role of clinicians in organisation. Acting as an advocate for medical staff where appropriate.
Scholar	Demonstrates a commitment to education and research to continuously improve knowledge and skills	Actively participate in an organisational quality committee, preferably the peak executive or Board quality committee. Participate in individual and organisation-sponsored continuing professional education. Attend skill development workshops, courses and is current with relevant literature. Be involved in one or more of: • Clinical Risk Management training/activity • Review of a clinical incident. • Undertake/lead a quality improvement activity.
	Demonstrates use of academic rigour in furthering knowledge	Use literature evidence, knowledge of current practice, and advice from local and international experts in everyday practices. Conduct investigations, research and publish articles in refereed journals. Present at conferences. Demonstration of principles of Evidence Based Medicine in Case Study/Management Practice Folio.
	Demonstrates ability to apply research skills to management tasks	Application of evidence based decision making.
Professional	Demonstrates behaviour that is always within the value systems	Identify values and ethical issues and how these impact on work. Completion of Management Practice Folio

	Demonstrates behaviour that shows use of self knowledge	Demonstrate reflective analysis in oral and written form. Modify behaviour following reflection. Encourage reflective interpretation in others. Completion of Management Practice Folio
	Demonstrates 'patient first' behaviour	Implement strategies to Enhance patient care within the work environment. Use of patient feedback and community input in decision making.
	Demonstrates awareness of ethical issues in managerial and clinical decision making	Reflection on non research ethical decision making using a real life Case Study. Completion of Management Practice Folio

The Final Oral Examination presents Candidates with a set of medical management scenarios based on real life issues. Candidates are supported to prepare for these examinations by the conduct of trial examinations. Trial examinations are held in Queensland and Victoria and Candidates often attend both programmes. The Final Oral Examination is designed to integrate all components of the training program and assess the Candidates' capacity to respond to the types of issues that will beset them as medical managers.

Workshops

Fellows and other experts deliver the following components of the training program:

- Two Workshops and an optional Writers Workshop, and
- Preceptorship and submission of Preceptor Reports (in-training assessments).

Attendance at the two workshops is mandatory for Candidates.

The Induction Workshop is for new Candidates and provides an introduction to the specialty of medical administration, an overview of the Candidacy program, and an opportunity for networking and sharing initial experiences with other Candidates. Examples of discussion topics are: roles of Preceptor, Supervisor and Candidate during the training period, Competencies Framework, introduction to the case study process, presentation skills, transformational leadership, dealing with difficult doctors, communication skills workshop, risk and quality, health financing in the public and private sectors, working with your Preceptor and Supervisor, preparing for the Final Oral Examination. This workshop is designed to present material in the areas of the key competencies expected of Candidates.

The Pre-Fellowship Workshop is held for Candidates who plan to sit the Final Oral Examination that year. At this workshop, Candidates are required to give an oral presentation (currently based on their written Reflective Case Study) which is assessed by pairs of Censors. The workshop also includes presentations on topics of relevance in current health services management. The Candidates undertake trial oral examinations and receive feedback from the examiners. Workshops are reviewed annually and variations made to the program based on Candidate feedback, and the evolving needs of the sector.

The Pre-Fellowship workshop covers the following areas: examination processes, competencies, presentation skills, disaster medicine, preparation for the Final Oral Examination, Health Manager's toolkit, issues in healthcare, health and the law, workshop Coaching Clinicians, presenting the case study, working with the media, review of learning outcomes and developing a personal action plan.

Accelerated Pathway to Fellowship

RACMA Council is continuing to review its *Accelerated Pathway to Fellowship* for senior medical managers. These people may be Fellows of other medical colleges, already possess formal qualifications at Masters degree level and have 5-10 years medical management experience.

Such Candidates will have more discretion about their formal course of external study and may have up to two years of previous management time recognised under RACMA's Recognition of Prior Learning (RPL) process. If successful, a Candidate may receive a reduction in the length of supervised medical management and preceptorship required but will need to complete the same assessment program as for other Candidates. For these senior Candidates assessment will include:

- Attendance at the two workshops,
- Two satisfactory Preceptor reports,
- Abridged Management Practice Folio,
- Satisfactory pass of a Reflective Case Study, and
- Pass the Final Oral Examination.

Educational Resources for Support of Candidates

Educational materials are provided at the two compulsory Candidate workshops, and via the Candidate Corner on the RACMA website. Some of the resources on the RACMA website include: RACMA Handbook (Attachment 2), topic reading lists, web references to current resources, online video conferences (Qld), University library/search engines for electronic journals, and *The Quarterly*.

The Queensland State Committee provides presentations and discussion forums via a videoconference which can be accessed by all Candidates. Information from these sessions is also available on CD.

Other activities and materials include:

- Participation in group tutorials and study groups for Candidates preparing to sit their examinations.
- Assistance in forming study groups and provision of a trial examination.
- RACMA Annual Scientific Meeting.
- RACMA's journal *The Quarterly*, which provides regular articles on trends in medical management.
- The RACMA website, which has updates on issues of topical interest and web links to appropriate sites.
- The *RACMA Handbook*, which is updated each year and provides details of the structure of RACMA and its education program.
- A *Candidate Assessment Guide* (Attachment 4).

5.3 Admission requirements to the vocational educational program.

Refer to the Royal Australasian College of Medical Administrators' Submission to the Australian Medical Council, *"The Education and Training Programs of The Royal Australasian College of Medical Administrators",* Chapters 8 and 10, p 131 ff.

The application process complies with the legislative requirements of the jurisdiction within which it operates, in particular equal opportunity of employment and anti-discrimination legislation. The process adheres to the principles of natural justice.

The application process is fair and objective, giving applicants the best possible assessment of their suitability within the constraints of time and resources. Applicants have recourse to an appropriate appeals process.

Eligibility for Acceptance of Application

To be eligible to apply for acceptance into the training program, evidence of the following requirements must be supplied:

- The award of a medical degree from a recognised Australian or New Zealand university, or equivalent,
- Current medical registration in Australia or New Zealand and being in good standing with the registration body,
- Clinical experience of at least three years in an Australian or New Zealand health system, or one that is comparable, and
- Access to supervised medical management experience over the period of the training program as evidenced by a substantive position in health services management .

RACMA does not limit the numbers of positions available for the training of medical managers. It is important that high-calibre individuals are attracted to the scope of practice.

Application Process

The application process requires that applications be submitted on the required form and accompanied by the appropriate fee, with the provision of contact details for at least two referees.
Note: Refer to the RACMA New Zealand Registrar Dataset (Attachment 11)

Selection Process

The employer or Supervisor and a senior RACMA Fellow, who may be the Chair of the New Zealand Board of Studies, may be involved in the selection process

Applications and all supporting documentation is reviewed by the Censor-in-Chief who considers the applicant's clinical and management experience, including whether or not the administrative experience is suitable for recognition. Where it is not clear if the applicant has met the requirements of three years clinical training, it is the responsibility of the applicant to provide evidence from the relevant training institution(s) that this has been completed.

The Censor-in-Chief may ask the New Zealand Chair of the Board of Studies to interview an applicant to provide advice on the appropriateness of Candidacy.

Where an applicant holds an appropriate substantive position in a health services organisation, the applicant is required to submit evidence that the employer supports the application. The employing organisation is required to agree to participate in the process for recognition as a training organisation.

The Censor-in-Chief makes a recommendation to Council about the suitability of all applicants.

Selection Criteria

The selection criteria are transparent and objective. They cover a range of attributes and measures of suitability for medical administration, which may include some, or all, of the following:

- Interest in medical management and evident commitment to the pursuit of a career in medical management as a scope of practice.
- Referees' reports that support the application for medical management training. Where conflicting reports are received, the Censor-in-Chief may choose to seek an additional reference, or allow the applicant to respond to any adverse comments made.
- Possession of the personal attributes of flexibility, insight and resilience.
- Completion of an appropriate aptitude assessment and/or evidence of satisfactory referees' reports for medical management training.
- Good communication skills. The application form should be structured in such a way as to allow reasonable assessment of written communication skills. Where appropriate, an interview is conducted and communication skills are further assessed.
- Tests of analytical skills may be carried out at interview.
- Provision of evidence of presentations at either internal (hospital) or external (symposia) meetings, or publications in peer reviewed journals.
- Evidence of experience, where an applicant seeks recognition of prior learning (RPL), together with the names of three referees.

Recognition of Prior Learning

An applicant may request that recognition be given for substantial periods of relevant prior experience. Recognition may reduce the length of time required by a Candidate to meet the medical management training experience requirement. The maximum period of recognition is two years. Only those applicants who meet the criteria for extensive administrative experience as laid out in the RACMA *Handbook* are eligible for the maximum period of recognition. Where these criteria have not been met, recognition of prior administrative experience is not commonly awarded, but each case is considered on its merits. A decision about recognition is made by Council on the recommendation of the Censor-in-Chief.

Acceptance of Application

The Council's approval of the application is based on merit, the nature of which is derived from the application and referees.

Documentation of the Process

The Censor-in-Chief documents his/her assessment of the applicant. The documentation includes the amount of RPL awarded the need for specific extra core units to be completed and any other assessment to

be carried out by the Candidate's Preceptor. This documentation is provided to the Chair of the Board of Studies in the relevant state and to the Preceptor selected for the Candidate.

Feedback

Applicants who are selected as suitable Candidates are notified by the Censor-in-Chief or Secretariat in writing immediately after the Council decision. Successful applicants receive a *RACMA Candidate Induction Folder*.

Applicants who are not selected into the training program are notified as soon as possible following consideration of their application, with the Censor-in-Chief, or the Chair of the Board of Studies, providing feedback as to reasons for their inability to meet the criteria.

Appeals

Applicants who are not selected into the training program have the right to request review of the application decision through a formal review process organised by the Censor-in-Chief. The review process includes a formal interview of the applicant by the Chair of the New Zealand Board of Studies who reports to the Censor-in-Chief about the suitability of the applicant. Seeking a review does not disadvantage the applicant in any future decisions.

Evaluation

RACMA evaluates the effect of its application process and its policies on subsequent achievements in education and training by formal annual review of Candidates' performance by the Supervisor and Preceptor, reviewing Preceptors' feedback in the annual Preceptor's Report, monitoring pass rates, and undertaking psychological profiling of potential Candidates to assist in determining suitability for a career in medical management.

5.4 A timetable for the competency and learning objectives

The program can be completed in a minimum standard period of three years full time. It is possible to undertake the Training Program six years part time. The six years allows for interruption and part time training period. Extensions of time must be approved by Council on recommendation from the Censor-in-Chief.

Completion of the required university Masters degree program usually occurs over a three to four year period. Academic studies can be completed by distance or on-campus mode, full or part-time. There is a strong preference for studies to be completed as course work. The requirements are more flexible for those approved under the Accelerated Pathway and each application is assessed on its merits by the Censor-in Chief.

Candidates must undertake a minimum of three years full-time, or equivalent, supervised medical management experience in a workplace that has been accredited by RACMA as a training post.

A typical timetable is set out below:

Year	Date for Completion	Description
One		RACMA recognised university degree (Masters) or single units as prescribed
		12 months supervised medical management experience in recognised training post
		2-Day Induction Workshop
	Monthly	Participation in Training Programmes
	June	Preceptor/Supervisor Report
		Management Practice Folio (100 pts total, max 60 per year), comprising:
	1 September	Letter to the Editor (compulsory task, 20 pts)
	30 December	Other Management Practice Folio Tasks
Two		12 months supervised medical management experience in recognised training post
		Other Management Practice Folio Tasks (various points, see guidelines) complete 100 pts
	Monthly	Training Programmes for Candidates
		Writing Workshop
	June	Preceptor/Supervisor Report
	1 December	Reflective Case Study
Three		Complete RACMA recognised university degree (Masters) or single units as prescribed to complete
		12 months supervised medical management experience in RACMA recognised training post
	Monthly	Training Programs for Candidates
	February	Preceptor/Supervisor Report
		4-day workshop, including: • Presentation of Case Study • Trial Examination • Lectures/expert speakers
	August	Final Oral Examination

5.5 Clinical or public health experience and performance requirements for completion of the program

The requirements for completion of the training program are outlined in 5.2. Candidates are required to successfully complete all components of the Training Program.

5.6 Methods of assessment

Refer to the Royal Australasian College of Medical Administrators' Submission to the Australian Medical Council, *"The Education and Training Programs of The Royal Australasian College of Medical Administrators",* Chapters 7 and 11.

The following is a summary of these chapters and includes current details as some details relating to the assessment instruments in the submission to the AMC have since changed.

The following table shows the major components of the training program and the type of assessment applied.

Major Components of the Training Program and Type of Assessment

Component	Program	Assessment
1	Supervised medical management experience in a recognised workplace training program	Workplace organisation and training recognised by RACMA. In-training assessment through the Supervisor/ Preceptor reports.
2	University Masters degree program requirements	University assessments recognised by RACMA.
3	Satisfactory completion of RACMA program requirements	College formative and summative assessments e.g. Management Practice Folio, College Workshops, Reflective Case Study, Fellowship Examination

Summative assessment applies in the Fellowship examination

Formative assessment

This section describes the components of the program to which formative assessment applies.

University Masters Degree
The College identifies core subject requirements that must be included in the university Masters degree that is required to be undertaken before completion of the fellowship training program. The College accepts the university assessments and conferral on completion of all components of the course.

Management Practice Folio (MPF)
The purpose of the MPF is to assist Candidates to develop superior writing and reflective skills, so that they learn from their own experiences. The MPF was introduced for all Candidates attending the two-day workshop in 2008 and any new Candidate commencing since 2008. (Attachment 5)

The Folio comprises reflective reports and written papers by the Candidate, derived from their work experiences in the three years of Candidacy. Currently these may include:

- Published journal articles based on work experiences
- Reflective evaluations of workplace experience
- Letters to the editor of respected publications and related to relevant issues in the Candidate's workplace or health services system
- Business case for the introduction of technology or new service delivery in the workplace
- A medico-legal case analysis undertaken in the workplace
- A Case Study on a health service management issue encountered or project undertaken
- A Business Plan developed in the workplace
- An audit of governance or quality improvement activities and health care outcomes from the workplace
- Others as appropriate.

The folio of works selected by the Candidate must be completed to the satisfaction of the College. Preceptors and Supervisors are asked to assist and support Candidates to gain the relevant experience to undertake this work.

Written folio pieces are evaluated by Censors who write comment for the Candidates. This assists to improve subsequent pieces of work and to identify any Candidate who may be experiencing difficulty. Preceptors and Chairs of Boards of Studies are kept informed about Candidate progress so that individual learning plans can be modified.

Reflective Case Study

The Reflective Case Study is submitted in the year before the Candidate sits the Fellowship examination.

The reflective case study will be:

- Contextualised and relate to an event/s, situation/s that have impacted on the candidate's work and have caused him or her to learn more about themselves, and/ or about becoming a professional medical manager and/ or improving the way that they work in the context of the RACMA competencies for a medical administrator.

- A reflective self analysis/critique of the personal journey located within the context and the events/ situations alluded to.

- An explication of what the candidate has learned about themselves in the context using the framework of the RACMA competencies and how they have changed their behaviour and/ or thinking as a result.

Candidates may attend a Reflective Writing Workshop that is designed to introduce Candidates to the reflective writing style.

The final reflective case study will be:

- Between 2500 and 3000 words (excluding references).
- Appropriately referenced to relevant literature.
- Submitted to the candidate's preceptor who will sign off on the case study and submit it to the Secretariat. No case study will be accepted direct from the candidate.

- Assessed according to the criteria in these guidelines.
- Appropriately related to the RACMA competencies to demonstrate how the candidate has attained and enhanced these as part of a learning process during candidacy.

The Reflective Case Study is assessed both as a written piece and during an oral presentation by the Candidate. Both modes must be rated satisfactory for the Candidate to pass overall, as it is considered important that a Candidate possesses both written and presentation skills to work effectively as a medical manager.

RACMA induction and pre-fellowship examination workshops
The RACMA formative assessment includes participation in two RACMA workshops. While Candidate participation in the workshops is not formally assessed, the Pre-Fellowship Examination Workshop is the forum for oral presentation of the Reflective Case Study.

Supervisor/Preceptor Reports
The Candidate works with their Supervisor and Preceptor to monitor their progress towards achieving the required competencies. This progress is documented on the Preceptor/Supervisor reports.

Annual self evaluation and discussion with the Supervisor and Preceptor encourages reflection and helps the Candidate to receive feedback about performance, monitor progress and plan objectives for the following period. These assessments are used to identify future experiences in medical management that will help the Candidate achieve the required core competencies.

Completion of the Reports provides an opportunity for any concerns about the suitability of a Candidate for the training program to be raised early. While the Candidate is not formally assessed through the Reports, three completed reports are required for the Candidate to be permitted to sit the oral examination. This is reduced to two for Candidates on the accelerated pathway.

The Candidate's Supervisor must complete three in-training assessments in conjunction with the Preceptor during the period of training.

Trial Viva Examinations

Trial viva examinations are conducted by the New Zealand Board of Studies prior to the Final Oral Examination. The Chief Executive advises the New Zealand Board of Studies of the names of New Zealand Candidates for the Final Oral Examination. The Board of Studies contacts individual Candidates to advise them of the details for trial examinations.

Application for Final Oral Examination

Eligible candidates are required to make application in writing, including an examination fee, to the Chief Executive.

Final Oral Examination

The Final Oral Examination is held in August each year.

Candidates are required to have successfully completed all elements of the study and training program before they are eligible to present for the Final Oral Examination, including the provision of satisfactory Preceptor reports to cover their period of supervised management experience training. Candidates may sit the Final Oral Examination prior to completing all their supervised management experience training if

approved by the Censor in Chief, but will only receive their Fellowship once all training requirements are completed.

Candidates are assessed on their general skills, abilities, knowledge and experience as professional medical managers, using examination question material as the basis of discussion between Candidates and Censors.

The Censors assess the following areas:

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

Each Candidate is assessed independently by four pairs of Censors, for twenty minutes with each pair. Candidates are given a case to read 20 minutes before they present to the examiners. Candidates are expected to elucidate the specific and generic management issues in the case and discuss them logically with the Censors. Presentation is an important aspect of a Candidate's assessment.

To ensure validity and reliability, the potential issues to be recognised and the minimum responses expected from Candidates to achieve a pass assessment have been discussed and agreed upon jointly by the Censors beforehand.

Example examination questions and the method of assessment are available to Candidates and the New Zealand Boards of Studies to enable Candidates to familiarise themselves with the examination style.

All Candidates are notified of the results of the Final Oral Examination at the end of the day on which they are examined. Where a Candidate has not passed but meets the guidelines for a supplementary Final Oral Examination, this will offered and held later in the same day.

The examination provides a robust assessment of knowledge, skills and attitude. The 2009 examination had a 66% (8 of 12) pass rate.

5.7 Dealing with poor performance

The first year of Candidacy is a probationary year in which the Candidate's suitability for training is assessed. Suitability is evaluated through regular meetings between the Candidate and their Supervisor and Preceptor in the first year, as well as an evaluation by the Chair of the Board of Studies, which includes:

- a meeting between the Candidate and the Chair of the Board of Studies,
- a review of the Preceptor/Supervisor Reports for the first year of Candidacy by the Preceptor Co-ordinator,
- a review of the Candidate's academic transcript for the year, and
- possible discussions between the Chair of the Board of Studies and the Candidate's Supervisor and Preceptor where continuing Candidacy is at risk.

The Chair of the Board of Studies then discusses with the Censor-in-Chief any Candidate whose performance is considered unsatisfactory. A discussion is then held with the Candidate as to whether he/she should continue in the training program. This may result in:

- The Candidate undergoing a further probationary period in a different workplace, or
- The Candidate not being recommended for continuation of training in another workplace. Usually a workplace is unwilling to take on a Candidate under these circumstances and the Candidate exits from the training program.

There is a review process for Candidates whose performance is considered unsatisfactory. Remedial training may be provided, if sought by the Candidate.

Candidates may be required to rework their written Reflective Case Study following assessment by the Censor for Case Studies. Candidates who fail the presentation of the Reflective Case Study may proceed to the Final Oral Examination later that year but must successfully present the Case Study at the four-day Pre-Fellowship Workshop the following year before they can be admitted to Fellowship.

Candidates who do not pass the Final Oral Examination are given the opportunity for a supplementary Final Oral Examination on the same day, as previously described. Candidates who fail this examination are able to apply to re-sit the examination the following year. There are no limits on the number of times that a Candidate may sit the Final Oral Examination.

Remedial Training

If the Candidate seeks remedial training this may be provided by: successfully undertaking an additional year of training, repeating the introductory workshop, additional coaching and trial examination (for up to five attempts), and/or the allocation of a new Preceptor.

Dismissal of Candidates from Training

The reasons for dismissal from the Training Program are defined in the *Constitution of RACMA,* detailed below.

Any Fellow, Candidate or Member shall ipso facto cease to be a Fellow, Candidate of Member of the College if that Fellow, Candidate or Member:

vi. is found guilty of unprofessional conduct by a medical disciplinary tribunal in Australia, New Zealand or elsewhere

vii. is found guilty of an indictable offence

viii. ceases to be eligible for Membership as provided by the Constitution

ix. is expelled from the College in the manner hereinafter provided (Rule 118)

x. resigns the Fellowship, Candidacy or Membership by notice in writing left at or sent by post to the office; or

xi. has failed for a period of more than two years to pay any monies due by that Fellow, Candidate or Member to the College.

Where Candidacy has been ceased by the Censor-in-Chief, on the recommendation of the Chair of the New Zealand Board of Studies, the Candidate has a right of appeal.

5.8 Educational quality audit and evaluation process

Refer to the Royal Australasian College of Medical Administrators' Submission to the Australian Medical Council, *"The Education and Training Programs of The Royal Australasian College of Medical Administrators",* Chapters 12 and 13.

5.9 Organisational structure and decision making process of the education provider, including review mechanisms for the trainee

Refer to the Royal Australasian College of Medical Administrators' Submission to the Australian Medical Council, *"The Education and Training Programs of The Royal Australasian College of Medical Administrators",* Chapters 1, 12 and 13.

The governing body overseeing the education and examination program is the Board of Training and Continuing Education. The functions of the Board of Training and Continuing Education are to:

- Recommend to Council for approval the curriculum and other requirements that Candidates must meet to be considered for election to Fellowship,
- Examine Candidates seeking admission to Fellowship and to report the results of such examination to Council,
- Recommend to Council the criteria that should be approved whereby Fellows and Members can demonstrate continuing professional development, and
- Undertake such other functions as may from time to time be required by Council.

The Chairs of the New Zealand Board of Studies is a member of the Board of Training and Continuing Education.

New Zealand Board of Studies

The New Zealand Board of Studies is appointed by Council on the recommendation of the Censor-in-Chief following advice from the New Zealand Committee. The term of office of the Chair of the Board of Studies is three years.

The role of the New Zealand Board of Studies is described under Question 4 of this document.

The key roles with responsibility for the training and assessment of Candidates are: Censor-in-Chief, Censors, Preceptors and Supervisors.

Censor-in-Chief

The Censor-in-Chief is appointed by Council and is responsible for:

- Chairing the Board of Education and Training to ensure that it exercises its responsibilities under the *Constitution*,
- Supervising the educational and examination program,
- The maintenance of educational standards for award of Fellowship and Continuing Education and demonstration continuing professional development,
- Developing the program of study in association with individual Censors,
- Conducting examinations.
- Recommending applications for Candidacy and Membership to Council,
- Determining eligibility for admission to training programmes via acceptance of applications from Candidates,

- Conducting Recognition of Prior Learning processes to determine eligibility of Candidates for exemptions within the training programmes, and
- Ensuring that each Candidate has a recognised training plan.

Censors

Censors are RACMA Fellows of at least five years' standing, unless exceptional qualifications and experiences apply. Censors are appointed for a period of five years. New Censors attend a professional development workshop run by the Censor-in-Chief and every three years Censors must attend a reaccreditation workshop to continue in their role. Censors are members of the Board of Training and Continuing Education.

The Censor assesses Candidates to ensure that they meet the standards set in the training program. Censors assess and provide advice to the Censor-in-Chief on the performance of Candidates' written work and Final Oral Examinations. Censors also support the Censor-in-Chief and the Education Coordinator in developing and improving the education and assessment processes of the training program. Censors must monitor the external environment to keep abreast of current educational best practice. Censors participate in an annual peer review process that is open and transparent.

The key accountabilities of Censors are to assist the Censor-in-Chief and Chairs of the Board of Training and Continuing Education with the maintenance, improvement and design of assessment processes in the training program, to evaluate Candidate progress, and to provide broader advice on behalf of RACMA on the maintenance of professional standards through representing RACMA in appropriate forums.

Process for Appointing Supervisors

The day-to-day supervision is performed by a Supervisor, who may or may not be a Fellow. Supervisors are normally senior managers employed in organisations where Candidates hold substantive positions. RACMA, through the Chairs of the appropriate Board of Studies, provides all Candidates with a Preceptor who is a senior Fellow, but who does not normally supervise the day-to-day work experience of the Candidate.

Supervisor

Each Candidate has a Supervisor who is normally in a substantive position within the Candidate's organisation, as the Candidate's line manager. RACMA does not prescribe the supervisor's role but expects them to assume the additional responsibilities of coaching a Candidate. The Supervisor oversees a Candidate's day-to-day work. The Supervisor may or may not be medically qualified and may or may not be a Fellow.

The role of the Supervisor is to understand the core competencies and skills prescribed by RACMA to be acquired during the minimum of three years of full time medical administrative experience. In almost all cases the RACMA Candidate is in a substantive position reporting to a line manager who becomes their Supervisor for the workplace component of the training program.

Preceptor

A Preceptor is a RACMA Fellow of at least three years' standing, who is actively engaged in the field of medical administration. Preceptors are appointed by recommendation of the Chair of the New Zealand Board of Studies to the Board of Training and Continuing Education. Each Preceptor may oversee two Candidates at any time. New Preceptors must attend one of the annual workshops run by the Censor-in-

Chief and every three years Preceptors must be reaccredited to continue in their role by attending a further workshop. Preceptors may have up to three, 3-year terms. RACMA provides each Candidate with a Preceptor for the duration of the Training Program. The Preceptor is responsible for coaching, mentoring and evaluation of the Candidate.

The Preceptor is responsible for liaising annually with the Candidate's workplace supervisor. Preceptors educate Supervisors on the competencies that Candidates need to attain, negotiate an appropriate job description to ensure this occurs and to obtain information on the Candidate's work experience and progress.

The primary objective of Preceptors is to provide advice and education to support the formal training program and to report annually on the overall progress of Candidates. The Chair of the Board of Studies allocates Preceptors to Candidates. However, Candidates can be involved in selecting their Preceptor.

The Preceptor works with the Censor-in-Chief, the Chairs of the New Zealand Board of Studies and other Preceptors. In addition, the Preceptor has a key role in liaising with the Candidate's Supervisor to monitor the Candidate's progress, provide information about RACMA education and training policies and programmes and to progress any training issues. The Preceptor is involved in undertaking workplace evaluation together with the Candidate and their Supervisor, to assure that the workplace is able to provide the Candidate with the necessary access to resources and support to undertake the program.

Regular evaluation of the role of the Preceptor is provided through Candidate Surveys.

Preceptor Co-ordinator

The Preceptor Co-ordinator is a new position created in 2008. The Preceptor Co-ordinator supports and advises the Censor-in-Chief and is responsible to liaise with Preceptors, oversee the appointment and training of Preceptors and the in-training assessment of candidates. The in-training assessment is encompassed in the annual Supervisor/Preceptor Report which is prepared for each Candidate.

Commencing in 2008 all Candidates' competency scores are entered in to the College data base to enable tracking of progress towards attainment of the required competency standards in the College's competency framework. Gaps identified in a candidate's performance are reported to the Censor in Chief and the Board of Training and Continuing Education. This information is used to inform modifications to the Candidates' learning plans and in College workshop design and instruction.

Appeals Process

The Appeal process is available on the website. The Examination Appeal process includes: *Guidelines for Appeal under RACMA Examination Procedures* which are included in the *Candidate Assessment Guide* (Attachment 4) and Policy: *Examination Candidates in Need of Consideration for Illness, Accident, Disability or Compassionate Grounds*, as well as the Policy: *Review of Decisions of Council and its Committees.*

Candidate Advisory Committee

Council established the Candidate Advisory Committee in February 2009 to be a representative body for Candidates of the Royal Australasian College of Medical Administrators (RACMA) from all Australian States and New Zealand. It has as its key terms of reference to:

a) Consider and review any issues relevant to Candidates;

b) Provide advice to the Candidate Representative on Council;

c) Provide advice and/or recommendations to the Secretariat and Council on matters relating to Candidates through the Candidate Representative on Council;

d) Be available for consultation on administrative, educational, constitutional, policy, accreditation or any other matter relating to Candidates;

e) Liaise with internal and external bodies in matters relating to Candidate training and other issues where authorized by Council;

f) Provide information for the Candidate's Corner section of the RACMA website to ensure it is relevant and current for Candidates;

g) Ensure that the interests of Candidates are promoted within the College; and

h) Represent the collective views of Candidates and provide advocacy for Candidates.

The Committee is chaired by the Candidate nominee/representative on Council and has so far met twice.

6. Provide details of the Royal Australasian College of Medical Administrators' nationally recognisable qualification/s for inclusion in the vocational register

The qualification of RACMA is Fellowship of RACMA. This is conferred by Council and recognised by the post nominal FRACMA.

7. Identify existing vocational scopes whose scopes of practice or training are similar, or whose scopes of practice overlap. Identify this overlap.

There are no other existing scopes of practice or training that are similar to Medical Administration. There may be some small areas of overlap with the Public Health Medicine scope of practice such as organisation of services.

Medical administration is administration or management utilising the medical and clinical knowledge, skill, and judgement of a registered medical practitioner, and capable of affecting the health and safety of the public or any person. This may include administering or managing a hospital or other health service, or developing health operational policy, or planning or purchasing health services. Medical administration does not involve diagnosing or treating patients.

Public health medicine is the epidemiological analysis of medicine concerned with the health and health care of populations and population groups. It involves the assessment of health and health care needs, the development of policy and strategy, the promotion of health, the control and prevention of disease, and the organisation of services.

8 Identify formal components of the training and recertification programmes that demonstrate an understanding and respect of cultural competence.

Recently Council has considered a proposal to adopt a Statement of the Role of Medical Administrators in Managing Cultural Competent Health Care Services as detailed below. There is to be a College wide consultation on this draft statement and maybe the development of a professional standard.

As senior health service executives, medical administrators contribute to the development and management of culturally competent health care organisations/services. To fulfil this role, medical administrators will need to:

- understand key concepts and stages in developing organisational cultural competence,
- reflect on their organisation's cultural identity,
- evaluate its developmental needs,
- ensure that all medical staff receive cultural orientation and competency training,
- ensure equality of opportunity in employment, training and promotion,
- monitor the ethnic composition of the medical workforce to ensure that it reflects its patients'/clients' demographic profile,
- provide organisational support for culturally competent service provision by:
    1. fostering a culture of openness and respect for cultural diversity,
    2. challenging systemic cultural bias within health care services where this will have a negative impact on patient care,
    3. implementing organisational policies and procedures that support culturally competent service provision,
    4. implementing models of care that address the needs of different patient groups incorporating (in their design) an understanding and respect for patients' cultural beliefs, values and practices which may influence their perceptions of health, illness and disease, their treatment preferences and their interactions with medical professionals and the health care system,
    5. ensuring that the appropriate patient information, signage and other communication aids, such as translators, are available to help patients understand their health conditions and treatment options,
    6. seeking advice from ethnic community representatives and other ethno-community organisations,
    7. collecting demographic information about the service users including their ethnic and linguistic background and evaluating the treatment outcomes for different ethnic and linguistic groups, and
    8. seeking feedback on the organisation's performance from patients and staff.

- formally audit their organisation's cultural competence across four dimensions:
    1. a health care organisation's relationship with its community,
    2. the administration and management's relationship with staff,
    3. inter-staff relationships at all levels, and
    4. the patient-health care provider encounter.

The above statement has been prepared taking into account the:

- New Zealand *Health Practitioners Competence Assurance Act* 2003 (which can be found at http://www.moh.govt.nz/hpca),

- MCNZ Statement on Cultural Competence, and
- international frameworks for the establishment and assessment of culturally competent organisations such as that outlined by The Lewin Group, and
- a range of organisational competence audit tolls such as that developed and used by the NSW Department of Ageing, Disability and Home Care.

Working groups within the Curriculum Project are responsible to articulate more closely sets of cultural competencies for Maori and Aboriginal and Torres Strait Islanders. When this framework has been documented it will be used to better inform inclusion of appropriate training activities in the training workshops, and in-training assessment reports for Candidates. This work will also make more transparent the requirements for Fellows in the recertification program.

9. Provide details of the Royal Australasian College of Medical Administrators' recertification program. This should include the content of the program that verifies that individual practitioners practise competently.

Refer to the Royal Australasian College of Medical Administrators' Submission to the Australian Medical Council, *"The Education and Training Programs of The Royal Australasian College of Medical Administrators",* Chapters 14 and 15.

The RACMA Continuing Education Program (CEP) enables Fellows to maintain their continuing professional development as a full time medical administrator or clinician manager, taking into account their current employment, career aspirations, and perceived strengths and weaknesses.

The CEP focuses on individual responsibility for the development of learning plans and commitment to ongoing professional development.

Fellows and Members must meet the CEP requirements for ongoing certification. See Attachments 6: *RACMA CEP Curriculum* & 7: *RACMA CEP Manual 2009*.

The website now provides the major access for recording of CEP activities. It was felt that this access was important for easy and accurate recording and reporting processes.

Underlying principles

The design of the CEP is based on the following principles:

- Fellows and Members are responsible for their own learning,
- individual learning needs and styles differ and participants start from different bases,
- Fellows and Members have different needs and opportunities in their jobs,
- individual Fellows and Members have different career plans,
- CEP groups are a form of peer review and learning, and assist promotion of collegiate culture, and
- individuals commit to a learning plan, with regular review.

Quality assurance

RACMA CEP maintains quality assurance through a system of reviews by state CEP Coordinators, annual statements of completion, triennial certificates when requested, and annual audits for compliance.

Minimum requirements

CEP requires a minimum of 50 points/hours per annum (or 150 points/hours per triennium) of participation in the appropriate CEP activities preferably aligned with the curriculum and Competencies Framework. The process involves creating a learning plan, completing a log of activities to fulfill the learning plan and then periodically reviewing progress against the learning plan, with revision of educational goals as required.

Program Audit Process

RACMA audits 20 per cent of Fellows and 20 per cent of Members annually. The purpose is for Council to be assured that members are meeting their obligations under the mandatory CEP policy and to be informed about trends and priorities in members' professional development selections.

Fellows and Members must meet the CEP requirements for ongoing certification. To ensure compliance 20 per cent of those without a current CEP Certificate (2006 – 2008) will be audited. This excludes those who have been audited in the previous five years and those who are participating in the electronic CEP.

CEP activities

A range of CEP activities can be undertaken individually or as part of a learning group or a combination of both. Individual activities include:

- attendance at meetings/conferences/ lectures,
- professional reading,
- preparing and presenting education, including publication of same,
- RACMA activities, and
- research.

CEP learning groups have been the traditional form of learning for RACMA Fellows and Members.

Peer review, journal clubs and other discussion forums can also be used to meet CEP requirements.

Fellows and Members who participate in continuing professional development programmes of other colleges may meet some of their RACMA CEP requirements depending on the nature of the activities. The process involves submitting the log of activities undertaken with the other medical college(s) to RACMA, preferably with the RACMA relevant activities highlighted for review, consideration and advice.

Governance

Continuing Education Program Committee

The CEP Committee, which meets at least five times per year, is part of the RACMA committee structure, and includes the National Director (chairman) and the local CEP Coordinator in New Zealand. The CEP Committee addresses policy development and procedures to guide CEP development and implementation, to establish curriculum and competency frameworks, to monitor key indicators and to routinely evaluate the program and its procedures.

The key roles in relation to governance of the RACMA Continuing Education Program are described below.

National Director Continuing Education/Recertification

The National Director Continuing Education Program/Recertification is a member of Council and the Council Executive. He/she has overall responsibility of the CEP, including the objectives, development of policy, curriculum components. The National Director Continuing Education Program/Recertification provides advice to Council in relation to CEP, and provides Council with routine reports regarding progress on key matters relating to CEP. He/she is also a member of the Board of Education and Training.

CEP Coordinators

The New Zealand Committee has a CEP Coordinator, who is a Fellow and a member of the New Zealand Committee. The CEP Coordinator facilitates access to and involvement of Fellows and Members in the CEP in New Zealand. He/she liaises with New Zealand Fellows and Members for the development and endorsement of CEP learning contracts and provides advice and supports the National Director Continuing Education Program/Recertification in policy development.

9.1 Audit

This recertification category has been modified to apply to medical administration (which does not include the care of patients). Accepted activities in this category are:

- supervising and mentoring a Candidate or Fellow or Member,
- participation as a Censor,
- quality and clinical governance activities,
- research,
- preparing and presenting lectures and seminars,
- formal presentations at conferences or meetings,
- publication of papers,
- books or book chapter,
- reviewer of articles for scientific journals or medical publications, and
- RACMA pamphlet/publication authorship and/or review.

9.2 Peer Review

This category of recertification activities is directly applicable to medical administration. Accepted activities are Journal Club and other group meetings where Fellows present and discuss their work seeking constructive feedback from their peers, developing, reviewing and revising learning plans.

A personal learning plan includes:

- analysis of personal strengths and weaknesses,
- the competencies required for both current and future positions,
- and the deficits between current and the desired capacity.

Often a learning plan may form part of an employer's annual performance appraisal, and this can be adapted for the purposes of the CEP. The minimum data required for a learning plan includes: educational goals, planned activities to achieve goals, and a timeline. Ideally the goals should be aligned with the RACMA Competency Framework and most particularly the roles therein i.e. Medical Expert, Collaborator, Manager, Communicator.

After an annual review of the learning plan and activities, the goals can be revised. The option for triennial review will also remain available, with RACMA providing a signed CEP Certificate of Participation on request, following sign off by the CEP Coordinator (this is called a formal review). The formal review of the learning plan is usually the basis for the next triennial learning plan.

9.3 Continuing medical education

This category of recertification activities is directly applicable to medical administration. Accepted activities are: RACMA approved/medical administrator related conferences, lectures, seminars, workshops, and attendance at RACMA international, national and State/Territory formal meetings and teleconferences and educational activities, professional reading in texts, journals and electronic media, and Self Assessment Courses.

9.4 An understanding and respect of cultural competence.

This category of recertification activities is directly applicable to medical administration.

As described in Question 8 Council has commenced a consultation within the College on a proposal to adopt a Statement of the Role of Medical Administrators in Managing Cultural Competent Health Care Services as detailed below.

Working groups within the Curriculum Project are responsible to articulate more closely sets of cultural competencies for Maori and Aboriginal and Torres Strait Islanders. When this framework has been documented it will be used to better inform inclusion of appropriate training activities in the training workshops, and in-training assessment reports for Candidates. This work will also make more transparent the requirements for Fellows in the recertification program.

Some of the activities that are being considered will focus on development of cultural competence and are:

- Attendance at conferences focused on Māori, Pacific or Asian health
- Māori language courses

10. Define the following key elements of the recertification program:

10.1 The categories of practitioner and the number of practitioners undertaking their recertification program.

Fellowship of RACMA is contingent upon participation in the CEP. Participation in the CEP is essential to be in good standing with RACMA. Exemption for leave purposes may be granted on a case by case basis.

Of the current 22 Fellows in New Zealand, 12 are currently participating in CEP. Three of the five Members (who are not vocationally registered and therefore not required to participate in CEP) are currently undertaking CEP. Overall RACMA has 51% participation rate in CEP across Australasia.

Many of the Fellows who are not involved in RACMA CEP are Fellows of other colleges and are understood to be completing their CEP requirements with that College.

10.2 Any categories of practitioner that are not enrolled in recertification programs.

Members are expected, but not required, to participate in the CEP. Members may not be considered to be in good standing or act in any Collegial or education role if they are not participating in the CEP.

Life and Honorary Fellows, and fully retired Fellows and Members are automatically granted exemption from participation in the CEP.

10.3 Whether the recertification program is available for practitioners registered within a vocational scope of practice who are non-members and if so, in what form.

The CEP is available to all Fellows of other medical colleges by the person joining RACMA as a Member (MRACMA).

10.4 Whether the BAB has the ability to identify poor performance on the part of a member and, if so, how this is done?

Refer to the Royal Australasian College of Medical Administrators' Submission to the Australian Medical Council, *"The Education and Training Programs of The Royal Australasian College of Medical Administrators",* Chapter 15.

Most recently the College has revised its Constitution and this will be considered at the AGM in September 2009. The new Constitution will strengthen the governance framework for managing continuing professional development of members as follows:

Continuing education

The Board, with the advice of the Education and Training Committee, may from time to time adopt and promulgate to Fellows and Associate Fellows binding standards defining the amount and type of continuing education in which Fellows and Associate Fellows must participate as a condition of ongoing Membership in those classes.

Periodic demonstration of continuing competence

The Board may require Fellows and/or Associate Fellows to periodically demonstrate continuing competence as a condition of their continuing Membership in those classes, providing the Board's requirements are described in a regulation or policy which:

- *subject to clause xxx, applies equally to all Members within a designated Membership class; and*
- *is approved by at least three-quarters of the Fellows present, in person or by proxy, at a general meeting.*

The Board's regulation or policy for demonstrating continuing competence may include the following requirements:

- *Subject to clause xxx, a requirement for periodic recertification by the College of the competence of each Fellow or Associate Fellow as a condition of their ongoing Membership in that class.*
- *Provision for the College to assess and provide a report on the current competence and performance as a specialist medical administrator of any Fellow or Associate Fellow at the request of a specific regulatory or employing authority or other entity recognised by the Board, but only with the explicit consent of the Fellow or Associate Fellow.*

The College must assist any Fellow or Associate Fellow who fails to demonstrate continuing competence in accordance with the Board's regulation or policy to regain competence by providing reasonable educational and professional support, at reasonable cost to the Fellow.

The revised Constitution will be promulgated through new policy and regulations. Generally RACMA considers that if a concern is raised regarding a Fellow it is to be reported to the medical registration board. It considers that it is employers' responsibility to address performance issues with those Fellows under their employment.

Increasingly the College is being asked by external organizations during their credentialing processes for confirmation from the College that a FRACMA has current CEP and is in good standing with the College.

10.5 The procedures that can be put in place to assist the poorly performing doctor.

A requirement for this has not arisen however the process would be for the National Director Continuing Education/Recertification and the Censor-in-Chief to collaborate to devise an appropriate retraining and support program.

FRACMA in the College's Queensland jurisdiction have developed a program for senior medical staff in employment with Queensland Health and the College is monitoring the performance of the program.

10.6 The steps to be taken if a doctor fails to respond to this assistance.

Since the issue has not arisen there is currently no formal process to address this issue. Refer to 10.5.

10.7 Does the BAB collect information on whether their doctors have an external systems audit and/or a system of peer assessment visits or practice system visits or credentialing?

RACMA does not currently collect information on whether its Fellows undergo external systems audits. The New Zealand Committee is developing a proposal for peer assessment visits / practice visits. RACMA recognises that a number of its New Zealand Fellows and Members are employed in hospitals and institutions and are required to participate in credentialing in the department in which they work or the clinical specialty in which they have conjoint vocational registration.

11 Provide details of the hours per year that members are required to spend on recertification activities.

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

12 Provide details of the process that is in place for evaluating whether medical practitioners participating in the program are meeting the requirements.

Evaluation is undertaken in relation to the individual, the program policy and its implementation.

Individual: This evaluation is undertaken continuously by the Fellow or Member as they monitor and review their CEP Learning Contract. An annual review is expected to be undertaken and a review at the 3-yearly contract completion is submitted to the CEP Coordinator as part of the recertification process. An individual may also be randomly selected to participate in the College's annual audit of CEP participation.

CEP Policy: CEP-related policies are monitored by the National Director Continuing Education/Recertification. There is a three-year policy review period, which can be brought forward if circumstances require.

Continuing Education Program implementation: The CEP is monitored by the CEP Coordinators throughout the year and participation rates are reported to Council at least annually. The program is reviewed periodically.

A CEP Evaluation Survey is undertaken by requesting feedback from Fellows and Members on aspects of the CEP. The feedback is used to evaluate and review the program. Fellow and Member satisfaction levels are derived from formal surveys conducted on average every two years. Anecdotal comment is also received by CEP Coordinators and the National Director Continuing Education/Recertification.

The *CEP Handbook* is updated annually, which enables inclusion of new policy and practice decisions taken by Council on recommendation from the CEP Committee.

Since the first quarter of 2009, CEP can now be accessed electronically by all Fellows and Members via the RACMA website. This on-line facility (eCEP) provides the participating Fellow or Member to:

- prepare a Learning Plan in conjunction with peers in a learning group or in association with the CEP Coordinator;
- submit the plan for approval by the coordinator
- log all activities and supporting evidence (as they occur)
- prepare an annual report;
- amend the Learning Plan as often as necessary, and
- at the end of the 3 year contract period, submit a request for a certificate of participation, based on the material logged during the period of the contract.

The eCEP allows RACMA to collate 'real-time' records of participation rates and receive feedback on the program, which are discussed at each CEP Committee meeting. In the first year, while participation is voluntary, the CEP Coordinators have a role in encouraging Fellows and Members to join the eCEP process and continue their participation.

Criteria for Evaluation

The criteria used for evaluation are varied and include:

- participation rates,
- Fellow and Member satisfaction levels,
- self reflections on learning outcomes, and
- concordance with learning contracts.

Participation rates are derived from data collected about CEP certification. Fellows and Members advise of their participation at the end of each three-year cycle, and this information is maintained on the RACMA database.

Attachments to this Document

1. RACMA Constitution July 2009
2. RACMA Handbook 2009
3. Competencies Framework January 2008
4. 2009 Candidate Assessment Guide
5. Management Practice Folio Guidelines
6. Continuing Education Program Curriculum
7. Abridged RACMA CEP Manual June 2009
8. RACMA (Feb 2008) Accreditation Submission to the Australian Medical Council
9. AMC (Nov 2008) Accreditation Report
10. RACMA (Sept 2009) Annual Report to the AMC
11. RACMA New Zealand Registrar Dataset
12. Mountford, J., & Webb, C. (2009). *When clinicians lead.* The McKinsey Quarterly, 1-8.