Review of Paediatric Clinical Examination in Australia and Aotearoa New Zealand

Conducted by the Paediatric Clinical Examination Review Expert Advisory Group appointed by the Royal Australasian College of Physicians.

6 November 2024

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Paediatric Clinical Examination Review Expert Advisory Group Members

Maria Dew KC, Barrister, Aotearoa New Zealand, Independent Chair

Dr James Anderson, Trainee Representative Member, Aotearoa New Zealand

Dr Davina Buntsma, Paediatric Consultant, Board Director, Australia

Dr Stephen Inns, Consultant, Gastroenterologist, Board Director, Aotearoa New Zealand

Professor Maree O'Keefe, Fellow, Paediatric Consultant, Australia

Honorary Professor Deborah O'Mara, Independent Assessment Expert, The University of Sydney, Australia

Dr Melanie Yeoh, Fellow, General Paediatrics and Neonatal and Perinatal Medicine, Australia.

A brief resume for each of the Advisory Group members is attached at Appendix A.

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1. Executive Summary

1.1 In October 2023, the Royal Australasian College of Physicians (RACP or the College) established the Paediatric Clinical Examination Expert Advisory Group (Advisory Group) under a Terms of Reference dated 27 October 2023.[1]

1.2 The Advisory Group was formed after a formal complaint was made to the College by the New Zealand Resident Doctors Association (NZRDA) on 13 April 2023. The complaint was made on behalf of thirty (30) anonymous complainants, regarding the Paediatric Divisional Clinical Examination in Australia and Aotearoa New Zealand (the clinical exam), including concerns about racism and unconscious bias by examiners.

1.3 The 2023 complaint from the NZRDA, was preceded by a large number of earlier anonymous complaints to the College by Paediatric trainees, in relation to the 2021 clinical exam. There were unfortunate delays in dealing with these earlier complaints within the College, which resulted in the further complaint made in 2023, through the NZRDA.

1.4 This Review presents information on candidate concerns that can, at times, make uncomfortable reading for many within the College, the profession and for past and present candidates. However, without examining these concerns in such an open manner, they cannot be properly understood, explained and resolved.

1.5 The purpose of this Review is twofold; to acknowledge the concerns raised and to undertake a comprehensive evaluation of the clinical examination to determine if there were any structural, design, delivery or assessment issues, which adversely impact the clinical examination in 2021 and more generally.

1.6 The Advisory Group has found that there are justifiable concerns about the 2021 clinical examination, and the examination more generally. This has resulted in the following recommendations:

[1] Terms of Reference, Appendix B.

- The clinical examination process, and rationale for assessment of candidates, need to be better communicated to candidates.

- There are material aspects of the clinical examination that are sound, but they are no longer regarded as the gold standard, so the format of the clinical examination should be amended to better reflect contemporary practice.

- The training and support for examiners needs to have additional resourcing provided by the College, to improve consistency across both Australia and Aotearoa New Zealand. This training should include a compulsory unconscious bias and cultural awareness module provided annually by a specialist external consultancy.

- The College should invest greater personnel and financial support to ensure that Aotearoa New Zealand Paediatric candidates are assessed on the same basis, as those in Australia.

- The College should focus greater attention and support for examiners, to improve the diversity of the examiner panels.

- The data collection and assessment related to candidates, examiners and the examination results, needs to be improved to ensure the College is able to measure and communicate trends related to diversity and inclusion goals and risks associated with bias. The assessment of this data also needs to be more broadly communicated to the examiners and candidates to improve transparency.

- The examination complaints process needs to be simplified, better communicated and more responsive to candidates.

- The various Examination, Training, Education and Complaint Committees structure should be simplified and have clearly demarcated roles and responsibilities, to avoid confusion and duplication.

1.7 The Advisory Group commends the candidates, examiners and the College, for their participation in this Review. We have been fortunate to have the benefit of

a full view of the clinical examination from all key participant groups and been provided with all the documents requested from the College, so far as they exist.

1.8 It is a significant undertaking for all parties to provide their contributions voluntarily, to assist the Review. Without this co-operation, the Advisory Group would have not been able to gain the insights it has. We wish to acknowledge these valuable contributions to this Review.

2. Terms of Reference

2.1 Under the Terms of Reference, the Advisory Group that has conducted this Review has been made up of the following parties:

- Two members of the Board of the College, nominated by the Board: Dr Davina Buntsma, Australia, and Dr Stephen Inns, Aotearoa New Zealand.
- Two Fellows nominated by the Board with significant experience in physician examinations and who have not served on the Board or the College Education Committee within the last 5 years: Professor Maree O'Keefe and Dr Melanie Yeoh, both of Australia.
- At least one Trainee or Recently Fellowed Member: Dr James Anderson, Aotearoa New Zealand.
- Two third party (non-Fellow) persons with expertise or significant experience related to the matters under investigation and who have not served on or advised the College: Honorary Professor Deborah O'Mara, Australia, and the Chair of the Advisory Group, Maria Dew KC, Aotearoa New Zealand.

2.2 The Review has been asked to address four key issues under the Terms of Reference:

(a) Whether the structure, design, delivery and assessment of the 2021 clinical examination in Australia and Aotearoa New Zealand adversely impacted the effective conduct and outcome of that examination.

(b) The long case and short case structure of the 2021 clinical examination and the means for appealing examination outcomes.

(c) The training for examiners on unconscious bias, also considering small trainee groups and other factors where the identity of the candidates may be ascertained.

(d) Whether the implementation of the examination structure, design or delivery of the 2021 clinical exam, resulted in unconscious or inadvertent bias against groups of candidates on a racial basis.

2.3 The Advisory Group has met on-line monthly, between November 2023 and September 2024, with additional meetings as required. The Advisory Group has interviewed relevant parties, reviewed documents provided or requested from the College, and considered research and other reports related to clinical examination design and assessment. The documents and literature reviewed are listed in Appendices C and D of this Report.

2.4 In total, fifteen individuals were interviewed over the period of the Review, including:

- Two anonymous complainants from Aotearoa New Zealand. Others were invited to come forward but declined to do so.

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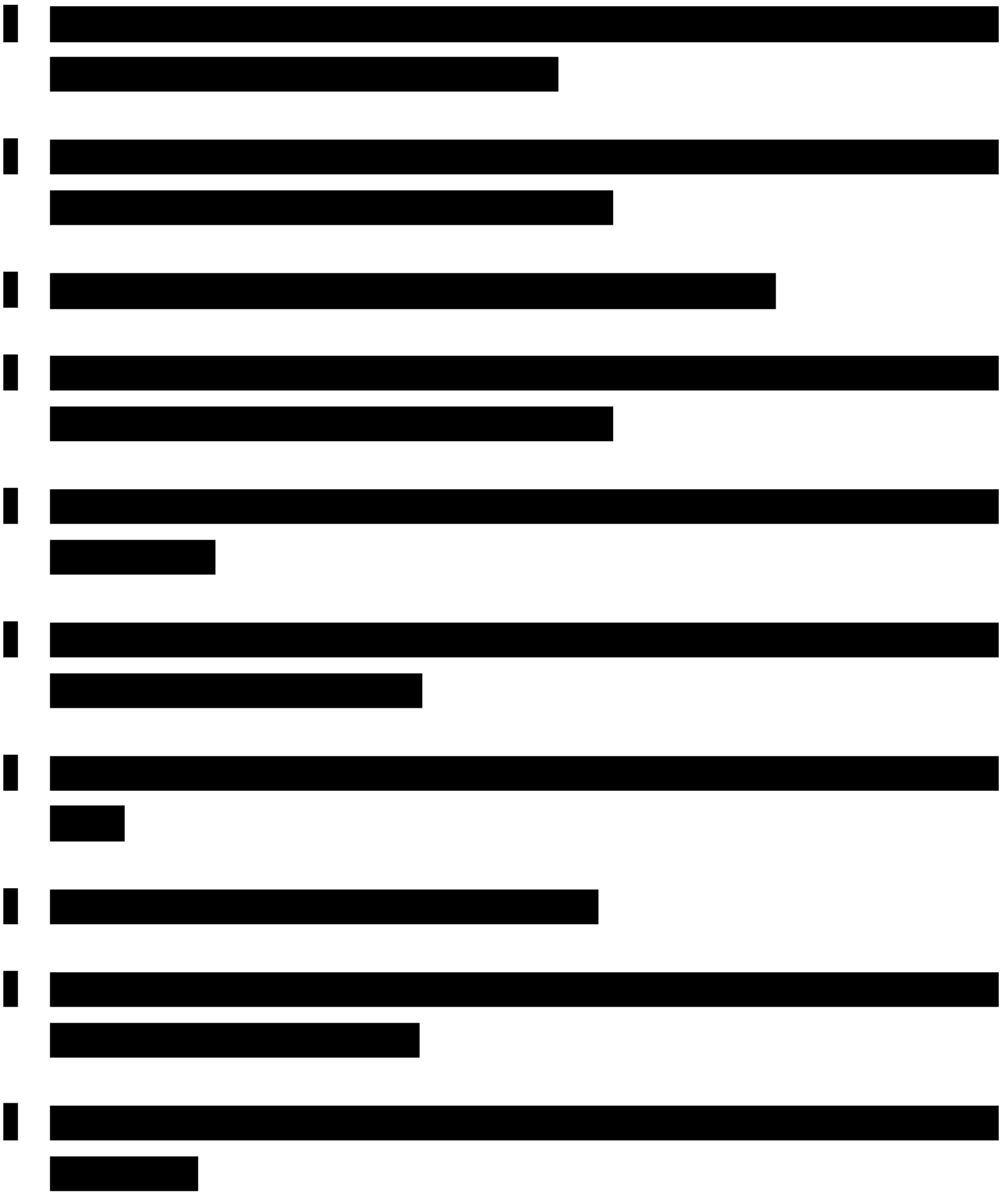

2.5 The Advisory Group has also consulted with several key participants on aspects of the draft report to confirm the accuracy of information collated in this Report.

2.6 The College's complaints management process does not fall within the scope of the Advisory Group's Terms of Reference.[2] However, we have made comments on the complaints management policy and process, given it features as a part of the complaints raised in this Review.

[2] The RACP complaints management process has been the subject of a previous RACP internal review in 2021 and is part of a further review by the College in 2024.

3. Summary of Complaints

3.1 Between February 2021 and April 2023, it is estimated that more than forty written complaints were made to the College by Paediatric trainees from Aotearoa New Zealand and Australia, in relation to the structure, delivery and outcomes of the 2021 clinical exam.

2021 | fifteen complainants

3.2 The first complaint was made by an Aotearoa New Zealand Paediatric Trainee Representative, in relation to the 2021 Clinical Examination, held between 28 – 30 May 2021.[3] The complaint was directed to the Aotearoa New Zealand Trainees' Committee. It was made on behalf of fifteen anonymous trainees, predominantly based in Wellington, who each provided attached statements raising concerns with the examination. The complaint explained that these trainees did not feel comfortable disclosing their names.

3.3 Of the fifteen trainee statements, eleven came from trainees who passed the clinical examination, while four came from trainees who failed. Three of the statements came from trainees who sat the clinical examination in 2019, while the remainder came from those who sat the examination in May 2021.

3.4 The trainees' statements contained recurring concerns:

(a) concerns over a perceived lack of consistency and fairness across the exams;

(b) concerns about lack of transparency in the marking system for the clinical exam;

(c) concerns with the structure and format of the short case exam as a form of assessment; and

[3] 2021 Anonymous trainees' complaint, Appendix C, 2.1.1.

(d) The impact of the clinical examination on the health and wellbeing of trainees.

3.5 The complaint did not raise concerns about racism or discrimination based on ethnicity.

3.6 The Aotearoa New Zealand Trainees' Committee referred the complaint to the RACP General Manager of Education, Learning and Assessment. The complaint was responded to on 17 June 2021.[4]

3.7 The General Manager responded substantively to the key concerns raised in the complaint and advised that the complaint had been provided to the Divisional Clinical Examinations Committees, College Assessment Committee and College Education Committee. The General Manager advised that the College Assessment Committee had been asked to provide a written response to the College Education Committee about the concerns raised in the complaint and that the College Board had also been made aware of the complaint. The General Manager stated that this would ensure that the feedback contained in the complaint would inform future improvements to the clinical examination.

2022 | thirty complainants

3.8 In April 2023, the NZDRA re-lodged a complaint made in February 2022 by a group of thirty Aotearoa New Zealand paediatric trainees who wished to remain anonymous.[5] The complaint does not refer to the 2021 exam expressly but references the exam more generally.

3.9 The 2022 complaint was originally made by the trainees directly to the College's Aotearoa New Zealand Trainees' Committee in relation to the clinical examination. However, the complaint was lost or not progressed by the Trainees' Committee. The Chair of the Aotearoa New Zealand Trainees' Committee commented that the Committee was unprepared to receive the complaint and did not know how to

[4] RACP response to 2021 Anonymous Trainees' complaint, Appendix C, 2.1.1.2.
[5] 2022 Anonymous Trainees' complaint, Appendix C, 1.1

progress the complaint.[6] As the 2022 complaint was not progressed, the NZDRA re-lodged the complaint with the President of the College in April 2023.

3.10 The complaint raised concerns about "pervasive systemic issues with the exam." The key concerns raised were lack of standardisation across the long and short case exams, unclear marking criteria, pre-existing relationships between some examiners and candidates, lack of feedback in relation to areas for improvement, and a view that the appeals process is unfair.

3.11 This Review has not been able to confirm the degree of any overlap between the 2022 complainants and those authors of statements contained in the first complaint made in early 2021.

2022-2023 | ten complainants

3.12 Between December 2022 and February 2023, ten (10) anonymous complaints or submissions regarding the clinical exam were submitted to the College through its 'Contact Us' web portal. The majority were made by New Zealand complainants. These complaints about the clinical examination are summarised below [7]:

(a) 5 December 2022 (NZ): complaint about conduct of examiner; concerns raised about bias, racism, lack of transparency, and lack of standardisation.

(b) 13 December 2022 (NZ): complaint of racial bias in favour of white, cis-gender candidates, structural racism, and lack of standardisation.

(c) 13 December 2022: complaint of racist behaviour from examiners, lack of examiner diversity, and criticism of exam complaints process.

(d) 14 December 2022 (NZ): supporting call for investigation into the clinical examination.

(e) 14 December 2022: supporting call for investigation.

[6] Chair, Aotearoa New Zealand Trainees' Committee (Paediatrics).
[7] The country of origin is shown as (NZ) for Aotearoa New Zealand, if known. Otherwise, it is unclear from the complaint where it originated from.

(f) 14 December 2022 (NZ): supporting call for investigation and complaint of discriminatory marking and lack of 'cultural consideration.'

(g) 14 December 2022 (NZ): supporting call for investigation and complaint of bullying by examiners.

(h) 9 February 2023 (NZ): complaint identifying systemic issues including unfair advantage for certain candidates due to prior working relationships with examiners; and in some instances, prior knowledge of patient cases that were the subject of the examination.

(i) 12 February 2023 (NZ): complaint of systemic and overt racism, including racist comments made towards candidates from ethnic minorities by Caucasian examiners.

(j) 16 February 2023 (NZ): complaint of bias by an Aotearoa New Zealand examiner and fear of speaking out against examiners, due to retaliation.

April 2023 | New Zealand Resident Doctors Association complaint

3.13 On 13 April 2023, Dr Deborah Powell, National Secretary of the NZRDA wrote to the College summarising and reiterating complaints previously raised by paediatric trainees in Aotearoa New Zealand.

3.14 It is unclear to what extent these series of complaints represent the same or overlapping groups of complainants. However, there has been a growing concern amongst Aotearoa New Zealand candidates about the clinical examination.

Complainants interviewed

3.15 Two complainants came forward to this Review and were interviewed on the basis that their names would not be identified in this report. They were both trainees based in Aotearoa New Zealand, one male and one female. They had both taken part in the 2021 clinical examination.

Complainant 1

3.16 This complainant was aware of the 2022 complaint by a group of anonymous trainees but was not involved in that complaint. The complainant reported that

issues with the clinical exam are, in their view, not isolated to the 2021 examination. They considered that the issues are primarily structural in nature and that the exam format was out of date.

3.17 They believed the lack of standardisation across the patient cases created unfairness for candidates. The complainant reported that, to their knowledge, the College is not involved in the selection of patient cases. Selection of cases is undertaken by the local organiser (a volunteer consultant paediatrician), who selects cases by approaching families throughout the year, prior to the exam. The complainant explained that one candidate could have a highly complex patient, while another candidate could have a patient with only a heart murmur. However, both candidates would be assessed on the same criteria, without any apparent adjustment for the relative complexity of the patients.

3.18 The complainant also considered that there were inconsistencies in the exam results, which caused them to doubt the reliability and robustness of the examination process. The complainant reported that all candidates at the Rotorua and Dunedin centre for the 2022 clinical examination were from Auckland. The Dunedin centre had one Auckland based examiner, who recused themselves based on their knowing the candidates well. The majority of examiners at the Rotorua centre were from Auckland, so recusal was not possible. The complainant noted that:

- all candidates sitting the examination in Rotorua passed; and
- only half of the candidates sitting the examination in Dunedin passed.

3.19 The complainant queried the consistency of the examination process across the two centres, noting that all 2022 examiners were from Auckland and may have had pre-existing relationship with the Auckland candidates. They told the Review that there was no process for appealing examination results, other than for extenuating circumstances.

3.20 A further concern was that candidates only formally received their examination results and feedback 2 to 3 months after the date of the exam. Due to the passage of time, it was unlikely that examiners would remember candidates they had assessed. This made it difficult for candidates to appeal their results.

3.21 While formal communication of exam results and feedback from the College took some months, the complainant was aware that some candidates, with pre-existing relationships with examiners, had received congratulatory messages from examiners on the same day as the exam. The complainant told the Review that a fellow candidate had received a congratulatory text message on the day of the exam from an examiner who was known to the candidate, but who did not examine them.

3.22 The complainant noted that the fees for sitting the one-day exam were approximately $4,000 NZD. They queried how this was justified given what they understood to be the low cost to the College of facilitating the exam given the use of volunteer examiners and patients.

3.23 The complainant said that the examination format does not accommodate candidates with medical conditions or disabilities that may affect their performance in a time-pressured environment. The complainant suffered from severe anxiety, which impaired their performance in the exam. However, they had apparently performed well in practice, based on feedback. They considered it unfair that there was no dispensation process or other accommodations made by the College to assist candidates who may be disadvantaged by the exam format.

3.24 The complainant suggested that recording the examinations and having them independently assessed by an external moderator could mitigate some of the concerns However, they still remained concerned at what they considered outdated format which they did not believe was an evidenced-based method of assessing clinical standards.

3.25 The complainant reported that that there is no process for appealing exam results.

Complainant 2

3.26 This complainant was part of the 2022 written complaint to the College. The complainant told the Review that it was common for candidates in Aotearoa New Zealand to have previously worked with their examiners during their training. The complainant considered that candidates who had pre-existing relationships with examiners could be unfairly advantaged or disadvantaged, based on how well liked they were by the examiner.

3.27 The complainant noted that some examiners will recuse themselves if they know the candidate, however, this recusal process is ad hoc and inconsistent.

3.28 A further issue was that candidates resitting the examination were in some cases assessed by the same examiners who had failed them previously. They raised doubts about the ability of examiners to remain objective when reassessing candidates.

3.29 The lack of standardisation across patient cases and in the marking process, was a central concern for this complainant. They commented that "the long case complexity can be huge and can result in different marks with different examiners." During the short-case exam, they explained that one candidate could be assigned a patient who has an abdominal scar, whereas another candidate may have a patient who requires a neurology exam, which is far more complex.

3.30 The complainant also raised concerns about the conduct of some examiners which included eye-rolling, expressing disinterest, dismissiveness, and cutting off candidates when presenting their treatment plan. They felt that examiners have a lot of power, and the absence of video recordings means that there is a lack of accountability for examiners.

3.31 The complainant believed was racial bias in favour of Caucasian candidates. They considered that the College has not put in place processes to ensure that the examination is culturally safe. A key issue is the lack of ethnic diversity amongst examiners. The complainant recalled that in the 2021 examination in Aotearoa New Zealand, three out of seven candidates sitting the exam failed in one region, and all three were non-white.

Key themes across all complaints

3.32 The complaints made to the College concern both the structure and delivery of the clinical examination across several years. The key themes of the complaints are discussed below.

Theme 1: Lack of standardisation across the clinical exams

3.33 The majority of complaints reported that there is significant variation in:

- the complexity of real-life patient cases which are the subject of examination; and

- the approach and standards of examiners.

3.34 The key concern raised in nearly all complaints was that the level of complexity across patient cases varied widely, and there was no scaling or calibration built into the marking criteria to mitigate this variability. According to one complainant, "One well-prepared candidate may get multiple difficult cases and fail, whereas another less well-prepared candidate will get straightforward cases and pass."[8]

3.35 An example of the significant variability in the complexity of patient cases from the 2021 short case clinical examination was included in an anonymous statement attached to that complaint:[9]

> *An actual example from the latest clinical short case exam is below. In brackets are candidates' commonly held opinions with regards to case complexity.*
>
> | | |
> |---|---|
> | *Candidate One:* | *Aortic stenosis (low complexity)*
Interstitial lung disease (low complexity)
Peripheral neuropathy (low complexity)
Acromegaly (low complexity) |
> | *Candidate Two:* | *Congenital heart murmur (high complexity)*
Interstitial lung disease (low complexity)
Neuro eye disease – unclear diagnosis (high complexity)
Hereditary spastic paraparesis (moderate complexity) |

3.36 Passing the clinical examination was reported to be dependent on a combination of receiving favourable real-life patient cases and the varying standards of the examiners undertaking the examination.

3.37 An example of the variation between the approaches of examiners during the 2021 examination was provided by one complainant in relation to the rheumatology exam. The complainant explained that it was widely understood that candidates would be permitted to comment on their findings on an as-you-go basis throughout the rheumatology exam. However, it transpired that some candidates within the complainant's cohort were permitted to do this, while others were not.[10]

[8] 2021 Anonymous Trainees' complaint, Appendix C, 2.1.1.
[9] 2021 Anonymous Trainess' complaint, Candidate 2, Appendix C, 2.1.1.
[10] 2021 Anonymous Trainees' complaint, Candidate 8, Appendix C, 2.1.1

3.38 Several complainants also expressed concern that examiners are not subject to independent oversight or external moderation. In some cases, it was noted that examiners had pre-existing relationships with trainees. It was noted that there is a small pool of examiners and it is not uncommon for trainee candidates to have previously worked directly with their examiner while on rotation, or as part of preparation for the clinical examination.

3.39 The 2022 anonymous trainees' complaint reports that some candidates had pre-knowledge of the patient cases on which they were to be examined.[11] This was cited as another area where some candidates were placed at an advantage over other candidates.

3.40 Multiple complaints noted that the examinations are not recorded, which prevents external moderation and makes it difficult to appeal exam results.

3.41 Complainants reported:

"Overall, the RACP clinical examinations seem highly subjective and whether you pass or fail appears to depend greatly on the examination centre and stream within which you are placed."

"While a clinical examination using actual patients is always going to be prone to some variability, my colleagues and I experienced wide variation in patient case difficulty, along with highly varied examiner approaches."

"The lack of standardisation both in the cases and marking seems most unfair – one candidate may get a straightforward case while a candidate in another stream may encounter more difficult or rare cases."

"There is a common understanding amongst physicians that failing the clinical exam is not a judge of how good a doctor you are, but 'what you get on the day.'"

"The most upsetting aspect of my exam experience is the realisation that one's success in passing these exams relies heavily on chance."

[11] 2022 Anonymous Trainees' complaint, page 9, Appendix C 1.1.

"For years this exam has been described as highly dependent on luck by previous candidates and it is generally understood that it does not accurately reflect a candidate's clinical abilities."

"The feeling of many of us is it is more a test of good luck and a candidate's 'performance' skills. With little exception, the main difference between a candidate who passes and a candidate who fails appears to be luck on the day."

Theme 2: Lack of transparency in marking system

3.42 The majority of complaints raised concerns about the transparency of the marking and assessment process.

3.43 These complaints were concerned that the pass/fail standards for each case are set by the examiners allocated to each examination and there does not appear to be external moderation of the examination. This has created significant variation in the standards expected of candidates.

3.44 Several complaints reported that while the College provides candidates with a marking rubric, in practice many examiners do not follow the format of this rubric. One complaint explained that the videos on the College's website in relation to the short-case examination indicated that examiners would provide candidates with an agreed list of what is required to pass each station, and following the examination, candidates would be marked and receive feedback in the format of the examiner's short case summary form. The complainant stated that they had not received either of the documents referred to on the College website.[12]

3.45 Complainants also reported that the feedback they received from examiners was rudimentary and vague and did not make it clear what was required to pass each station. The February 2022 complaint noted that candidates who fail stations are often only provided with one or two generic comments as feedback. In one instance a candidate simply received the comment "dangerous doctor."[13]

3.46 The complaints included the following comments:

[12] 2021 Anonymous Trainees' complaint, Candidate 15, Appendix C, 2.1.1.
[13] 2022 Anonymous Trainees complaint, page 7, Appendix C, 1.1.

"One gets the impression that there is little consistency in the standard of marking. Some examiners mark harshly or have very specific standards, whereas others will be more generous."

"...the examiners vary significantly in the standard they deem appropriate for a pass and in many cases even after receiving our individual feedback, the pass standard is not made explicit.

"Compared to examinations from other clinical specialities where the marking schedule and pass requirement are clearly delineated, this examination seems very subjective."

Theme 3: Criticism of exam structure and content as outdated

3.47 The majority of complainants were critical of the format and content of the examination. Most considered that the exam did not reflect the reality of clinical work. A common view expressed was that the examination has fallen out of step with the type of clinical skillset now required by paediatricians.

3.48 It was reported that the exam assessed antiquated clinical practices which were of "questionable clinical relevance" and "very limited diagnostic accuracy". Two complaints noted that the cardiovascular exam assessed the ability of candidates to elicit clinical signs of severe heart valve disease. However, in modern clinical practice, echocardiography had replaced use of clinical signs in determining the need for valve surgery.

3.49 Candidates were asked to make clinical diagnoses under intense time pressure without first having conversed with or built rapport with the patient, which does not reflect the reality of clinical practice. One complaint stated:

"The artificial environment where you are given the task of examining a patient without any knowledge of their medical history, or without the ability to ask questions, does not reflect our working reality. It feels like a staged performance..."

3.50 Complainants also raised concerns that during the examination candidates are expected to turn away from the patient to present their clinical diagnoses to the examiner. This was described as a "deviation from a patient-centred approach" and "symbolic of an earlier era of paternalistic medicine." Another complainant

felt that standing with their back to the patient while presenting their diagnosis was "degrading" for the patient.

3.51 Multiple complaints reported that the manner of the examination is outdated, overly formal, and out of touch with the modern hospital environment. Two complainants reported that there was an expectation that candidates should wear business suits, carry a leather briefcase, and use formal language throughout the examination. One complainant commented: "This examination seems to be mistaking formality for professionalism, and with each year that goes past it becomes more out of step with how doctors practice medicine."

3.52 The complaints contained the following comments which were critical of the exam's format, content, and manner of delivery:

"...I feel that the skill set required to pass these examinations overlaps only a small degree with the skill set required to be a good doctor."

"Part of the problem is that the examination scenario is so removed from reality – almost never in our clinical lives are we going to examine a patient without being allowed to converse with them and under such intense time pressure."

"The short case exam feels outdated... I always felt uncomfortable during training of the short case, where were actively encouraged to turn our backs on the patient and talk about them. The process is degrading to patients."

"The examination format does not accurately reflect our daily practice of medicine..."

"The clinical exam in its current format however, is far removed from the 'real-life' competencies that registrars require when admitting and managing patients."

"The expectation that an examination candidate will examine a patient and then turn their back on the patient and explicitly ignore and not engage with the patient for the duration of the discussion is symbolic of an earlier era of paternalistic medicine, which thankfully has been expunged from medical culture over many years, but unfortunately lives on in the clinical examination."

Theme 4: Concerns about racism and bias

3.53 Several complaints raised issues of systemic racism and alleged racist conduct by examiners. This includes four (4) complaints received through the "Contact Us" web portal and in the February 2022 complaint by Aotearoa New Zealand trainees. The 2021 complaint did not raise concerns about racism.

3.54 The February 2022 complaint provides anecdotal data gathered by the complainants from some trainees that sat the 2021 Aotearoa New Zealand clinical examination. This data suggests that:

(a) the current examination panel is over 90% Caucasian.

(b) the overall chance of passing the exam on the first attempt for a non-Caucasian candidate is 40%, compared with 93% for a Caucasian candidate (based on the last 5 years of Auckland Clinical Examinations).

3.55 The Advisory Group asked the New Zealand Residents Doctors Association for the detail of this data to verify this statement. Unfortunately, neither the complainants nor the College have been able to produce this to the Review. The College does not collect any record of the ethnicity of candidates. However, the College acknowledges that it does need to improve the diversity of the examiner panel.

3.56 Two complainants reported that they had raised concerns about racism with senior paediatricians, and the College, but their complaints were dealt with dismissively. One complainant recalled that they were told to "remember that "you're in New Zealand now and maybe dress and act like a New Zealander." This was a sentiment supported by the Chair of the Māori Health Committee in his statement to the Advisory Group.

3.57 The complaints also included:

"Through my training, I have had concerns that the examination process is not fair and heavily biased in favour of white-presenting cis-gender candidates such as myself. My study group comprised excellent doctors and time after time our colleagues of colour were failing in disproportionately high numbers."

"The Caucasian viewpoint on issues such as marital discord, family dynamics, end of life care are seen as the predominant and "right" answer by the Caucasian majority examiners - further disadvantaging candidates who do not share these views."

"To pass the examination you must think and act like a Caucasian and have Caucasian values, especially in the social setting."

"I have seen many colleagues of minorities struggle while their junior, less experienced, less knowledgeable Caucasian colleagues sail through this hurdle – it is designed this way."

Theme 5: Cost of Examination and lack of support

3.58 Some complaints reported that the cost of the examination at $4000 NZD per candidate, was excessive given that candidates did not, in their view, receive much visible support from the College before, during or after the examination, and the examiners, patients, and exam centre co-ordinators, are unpaid volunteers.

Concluding remarks on complaints

3.59 Our Advisory Group consider it is important to set out the detail of the complaints, made over the period 2021 to 2023. It shows the extent of discontent particularly from within the Aotearoa New Zealand examination cohort, that has existed over a three-year period.

3.60 Complainants in any profession where their career progression is at stake, will generally not make written complaints lightly. The extent of the complaints evidences a lack of effective communication with candidates about the rationale for key aspects of the clinical examination structure and delivery.

3.61 Whether there are also good reasons for changes to the structure and delivery of the clinical examination, has been examined later in this report.

4. Review of 2021 Clinical Examination

Overview

4.1 The clinical examination for Paediatrics and Child Health consists of examination on two long cases and four short cases. This format has been used for over two decades in post graduate medical training. The same format is used for the Adult Medicine division of the College.

4.2 The long and short case examination structure is commonly employed in medical education worldwide. While opinions on the efficacy of long and short case examinations differ, the long case is generally considered to be a valid representation of the complexity of clinical diagnosis and management. The inclusion of short cases adds to the reliability of the overall examination and provides an opportunity for candidates to demonstrate clinical skills.

4.3 The clinical examination is undertaken in a single day, once annually.[14] There are two examination cycles: morning and afternoon. In each cycle, the candidate is examined on one long case patient and two short case patients.

4.4 In one cycle, the long case will be seen before the short cases, while in the other cycle, the long case will follow the short cases. The candidates will be examined during both cycles by up to 12 examiners. Each case will be scored independently by each examiner in a pair, before a consensus score is determined between the pair. The consensus score is the result in each case.

4.5 Each case is guided by real patient scenarios. Patients are selected by the Local Examiner Organiser (LEO) at each exam site following guidelines coordinated by the RACP and Examination Executive. No scenarios are pre-prepared, and no content blueprint is created as each candidate is given a different set of patient scenarios.

4.6 Examiners use a predetermined rubric and scoring guide that allocates scores from 1 to 6 based on the objectives of the clinical examination. This scoring guide is available to all candidates on the College website. Prior to the examination,

[14] The exception to this was in Australia during COVID-19 in 2021.

examiners undergo calibration as a group as part of the standard setting. Prior to the examination, the two examiners assess the patient together and agree on what is required by candidates to meet the passing standard. During the examination, the examiners mark the student separately and then after the examination, they discuss their assessments and agree on the final marking.

4.7 Information on the examination is provided on the College website, by direct emailing the "Instructions to Candidate" document to candidates, and through the practice examinations each candidate is encouraged to complete. Candidates are allowed to sit the examination a maximum of five times over five years before training in the specialty cannot be continued.

4.8 In 2019, to enhance the equivalence of results and consistency, a new scoring system was developed from the Review of the Divisional Clinical Examination scoring rubric (CLEAR) and introduced for the RACP clinical examinations. The changes included improvements to the rubric scoresheets and use of the score combination grid to determine outcomes.

4.9 A computerised system of entering final marks was also implemented in 2019 to enhance reliability and turnaround time, as well as the accuracy of recording results. The marks for each examiner are entered, included the agreed mark as combined by examiners for each candidate. As part of this redesign, the process of documenting and addressing procedural issues was enhanced with the modification of the scoresheets and introduction of a new Incident Report form.

4.10 The CLEAR initiative was designed to clarify the purpose of the examination, promote fairness and consistency of scoring guide use, and form a better approach to determine pass/fail outcomes. Evaluation of this initiative was conducted for the Adult Medicine clinical examination in 2020, but an evaluation was not completed for the Paediatric clinical examination.

4.11 In more recent years, the Objective Standardised Clinical Examination (OSCE) has been used by some RACP divisions as an alternative to the long and short examinations. This has not been considered suitable for use in Paediatrics to date.

Long case assessment

4.12 The purpose of the long case is to test clinical examination skills with an emphasis on accuracy and completeness of history taking and the physical examination, synthesis and prioritisation of clinical problems, understanding the impact of the illness on the patient and the family, and the development and discussion of an appropriate management plan.

4.13 Before candidates see the long case patient, the examiners assess each patient and develop the problem list, discussion points, and management and diagnostic issues which will be used for marking the candidates. The examiners determine the key clinical issues they would expect the candidate to identify and discuss, and the expected satisfactory standard of performance for the case.

4.14 Candidates are allotted 60 minutes to take a patient's history, examine the patient, and develop a patient management plan. They then have 10 minutes to prepare their discussion points. Following that, candidates move to the examiners' room where they spend 25 minutes discussing the patient with their allocated examiners. Lengthy case presentations may be interrupted by an examiner, to prompt the candidate regarding case timing. Examiners will assess whether candidates display the skills relevant to the standard in the time allowed. This assessment is based on the criteria set out in the Examination Rubric which is the uniform template given to all examiners.[15]

Short case assessment

4.15 The purpose of the short case is to assess a candidate's clinical examination skills. Prior to the assessment of the candidate, examiners individually examine the patient, independently document signs, and compare notes. Examiners then discuss and agree on the minimum findings required to pass, investigations to be shown and the expected level of interpreting those investigations.

4.16 Before entering the short case room, candidates are given two minutes to read a written introduction to the case (the "stem"). This introduction is written by the

[15] Rubric for Clinical Examination Appendix C, 9. 19.1.

examiners and contains the patient's name, the relevant body system and, sometimes, the dominant clinical problem.

4.17 Each short case examination lasts 15 minutes. The exam is designed to assess the following skills: interaction with the patient and their family, technique and accuracy of physical examination, interpretation and synthesis of physical findings, and investigations/management.

4.18 As part of the assessment candidates may be asked to comment on relevant diagnostic tests and/or nominate appropriate investigations. Examiners will assess whether the candidate based on the criteria set out in Rubric template. This is the same Rubric that is used for the long case assessment.[16]

College evidence on the 2021 examination

4.19 The Chair of the Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand, provided the following information about the 2021 examination in Australia:

(a) The 2021 Clinical Exam structure in Australia was "modular" in nature. This required long cases to be completed virtually via MS Teams. The short cases were held several months later when COVID cases had declined, and face-to-face medical reviews could be held.

(b) In 2021, trainees had further time to prepare for the short cases (approximately 6 months compared with 2 months in the traditional format). This may have contributed to the higher pass rate that Australia received in 2021. The short case examination process is often criticised by trainees and some Fellows of the College, as being "artificial" given limited patient history is provided. It was noted that, in practice, a trainee would never approach a clinical interaction without additional information.

(c) The Australian 2021 long cases were virtual in nature. While this virtual format did not provide the opportunity for formal examination of patients, much of the work in paediatrics is based on observation and a significant amount of clinical information could be gleaned by observing the patient on

[16] Rubric for Clinical Examination Appendix C, 9. 19.1.

screen. The virtual format was also felt to be very useful by trainees as it was convenient for them to do cases from home. Survey feedback from trainees in 2022 was that they would have preferred virtual long cases.

(d) Feedback from local examiners and organisers has been that the 2021 clinical examinations were an extraordinarily stressful exercise and required significant extra hours of work and preparation without adequate remuneration. In the three years following the 2021 exam, there has been significant disengagement with College activities by experienced clinicians and examiners. Previous good will from senior physicians, which led to the assumption that they would take responsibility for helping with exam preparation and mentoring of trainees, has reduced.

(e) The benefits to the Fellows of the College who act as local and national examiners are "immeasurable." The clinical examination ensures ongoing continuing medical education and engagement with peers in different states and specialties.

(f) The National Examining Panel members uniformly support the format of the clinical examination, and the long case remains integral to that structure. The process of effective history taking and being able to combine this with focused clinical examination is the core of paediatric assessment. The importance of formulation of specific management issues and development of an effective plan for these complex medical and psychosocial cases, ensures that trainees are equipped to practice paediatrics when they complete their advanced training.

4.20 There were views expressed by other senior members of the Clinical Examination Committee that the short form case was somewhat artificial and could be improved. They also said improvements could be made to the electronic scoring platform. However, given that the exam involves real patients and the logistical challenges this involved, they considered the exam process is as good as it can be.

4.21 There was concern expressed that if the exam was restructured to be based on programmatic assessment – a series of assessments done in the workplace rather than a single assessment day – this would be "a wholesale change" from the

current exam structure. An additional concern was that restructuring the exam in this way may risk candidates passing the exam who do not meet the standard that the College expects. However, it was acknowledged that programmatic assessment may be a better method for the short case exam.

4.22 Interviews were also held with the Aotearoa New Zealand Chair and two Deputy Chairs of the Paediatric Education and Clinical Examination Subcommittees. They acknowledged that the short cases are not as practical as the long cases, where a candidate assesses the patient and produces their own patient plan. Overall, they considered that both long and short cases are working well, noting that because of the clinical examination, preparation skills significantly improve, with better presentation, assessment and patient plans for long case exams, and better examination skills for short case exams. The view was that they also reflect day to day practice well.

4.23 The Aotearoa New Zealand Chairs noted that as the Aotearoa New Zealand clinical examinations are held over one weekend, under significant time pressure, it is difficult for the examiners to complete all tasks expected of them within the timeframe.[17] They also advised that if candidates could prepare for long and short cases separately, it would be easier for candidates. However, it would create a logistical problem for examiners, and it would be a challenge to obtain resources to run the two exams separately. They noted it was unlikely there would be enough examiners in Aotearoa New Zealand to separate the exams in this way.

4.24 The Chair of the RACP Māori Health Committee did not consider that a structural change to the examination was required. They were of the view that the exam structure was sound, particularly the long case exam. However, they considered that cultural bias training for examiners was needed.

4.25 The Chair of the Aotearoa New Zealand Trainees Committee took a different view. They considered that more significant change was required and pointed to other Colleges that have moved away from the traditional long and short case exams and replaced them with standardised station examinations in an OSCE.

[17] Chair, Paediatric Division Education Subcommittee, Aotearoa New Zealand.

2021 clinical examination data

4.26 This Review has gathered all available data on the 2021 clinical examination held in Australia (1 September to 14 December 2021 and 19 February to 18 March 2022), and in Aotearoa New Zealand (28 – 30 May 2021).

4.27 The examination period in Australia extended over some six weeks in total, whereas in New Zealand the examination dates were condensed over three days.

Data Table for 2021 Examination

	Australia	Aotearoa New Zealand
Candidates	296	38
Examiners	238 (51 Senior)	25 (13 Senior)
Patients	435	80
Locations	42	5
Pass Rate	86% (255 candidates)	76% (29 candidates)

4.28 The 2020 pass rate in Aotearoa New Zealand was similar to 2021, with the pass rate being 76.2%. On the face of the pass rate in Aotearoa New Zealand, there was nothing exceptional about the 2021 clinical examination. However, the complaints in 2021 mirror similar concerns about the clinical examination in previous and subsequent years. The complaints are not directly related to pass rates in 2021 but are part of an accumulation of concerns.

4.29 The pass rate difference between Aotearoa New Zealand and Australia, has been identified in this Review as differing across 2020 and 2021. The Australian pass rate in earlier years had been closer to the mid 70% pass rate seen in Aotearoa New Zealand, until 2021.

4.30 The increase in the pass rate in Australia over COVID-19 years, appears to relate to the introduction of a modular format in Australia 2021 due to COVID-19

restrictions, which did not apply in New Zealand. This allowed Australian candidates to be assessed online and over two periods in 2021.

4.31 However, this was a one-off change due to COVID-19 and it is not possible to attribute the change in pass rates to this one factor. Pass rates do fluctuate over time for the adult and the paediatric exams by country and by state for Australia.

4.32 A post-examination survey questionnaire was sent to 194 candidates who sat the 2021 Clinical Examination.[18] There were 19 Aotearoa New Zealand respondents. The results of the survey for Aotearoa respondents included:

(a) "Overall, I was satisfied with the examination process":

- 37% (8 respondents) – Agree
- 37% (8 respondents) – Somewhat agree
- 16% (3 respondents) - Somewhat disagree
- 11% (2 respondents) – Disagree

(b) "The examination was able to assess my competency as a basic trainee":

- 21% (4 respondents) – Agree
- 37% (7 respondents) – Somewhat agree
- 16% (3 respondents) – Somewhat disagree
- 26% (5 respondents) – Disagree

(c) "The examiners' behaviour gave me fair opportunity to demonstrate my competence during the examination":

- 68% (13 respondents) – Agree
- 11% (2 respondents) – Somewhat agree
- 11% (2 respondents) - Somewhat disagree
- 11% (2 respondents) – Disagree

(d) "The cases were suitable to allow me to demonstrate my competency during the examination":

- 32% (6 respondents) – Agree
- 37% (7 respondents) – Somewhat agree

[18] Results from post-examination survey of candidates, Appendix C, 5.1.1.

- 16% (3 respondents) - Somewhat disagree
- 16% (3 respondents) - Disagree

4.33 In 2021, there were 227 incidents reported by examiners on the day of the examination across Australia and Aotearoa New Zealand.[19] Unfortunately, this data is not broken down into separate incident reports for each country.

4.34 The 2021 report shows an overall increase in the number of incidents reported compared with the 2020 examination:

(a) In 2021, there were 214 incident reports or procedural issues relating to the hospital or examiners only. This is compared with 172 incidents in 2020.

(b) In 2021, there were 7 incidents of Special Consideration reported by both candidates and examiners (compared with 6 in 2020), and 6 incidents of Special Consideration reported by candidates only (compared with 5 in 2020).

(c) In 2021, there were 24.2% of incidents reported as "significant". This is compared with 14.2% in 2020.

(d) In 2021, 87.7% of all incidents reported were in relation to the long case exam, compared with 84.7% in 2020.

Examiners calibration training day

4.35 The College National Examination Panel (NEP) consists of experienced examiners from both countries. The NEP holds an annual calibration session in Sydney or Melbourne.

4.36 Typically, two national examiners from Aotearoa New Zealand travel to Australia to attend this session.[20] The examiners then share their knowledge from the Australian calibration day with the Aotearoa New Zealand national examiners.

4.37 The Chair of the Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand, reported that all Australian examiners attend the national

[19] Incident Reports/Procedural Issues, Appendix C, 5.1.
[20] Chair, Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand.

calibration day in Australia. NEP members also run local calibration day sessions for all local examiners prior to the examination dates.

4.38 All Aotearoa New Zealand examiners attend their own local calibration sessions. The calibration training is facilitated by the Chair of the Aotearoa New Zealand Clinical Exam Committee.[21]

4.39 Attendance at local calibration sessions is mandatory for all examiners. In these three-hour sessions, the group is provided with one long and one short case video to review and apply the scoring rubric. The aim is to reach a group consensus on what would be required for a minimum pass in each case. The examiners then compare their score to the NEP score as a further point of reference. Limited analysis is performed across cases as each case is different.

4.40 The afternoon session of the calibration day is allocated to calibrating short and long cases assessment using real patients. Examiners observe a short case and long case assessment, with each examiner scoring the candidate using the exam rubric. The examiners then discuss in a group whether the mock candidate has passed and vote on a consensus score.

4.41 The Advisory Group was told by managers from the College's Education, Learning and Assessment team that calibration training sessions are held to improve inter-rater reliability and consistency from year to year. Pass rates are analysed per hospital, per state, per country and overall. Duplicate data capture is used to verify data. There is only analysis of examiner severity overall or by geographic area. More detailed analysis of individual examiners or cases cannot be conducted due to the small number of candidates seeing each case and/or examiner. Case complexity is assumed to be equal by the College and the cases selected are intended to represent what a candidate would generally encounter on the ward. There is currently no requirement to classify or record case complexity.

4.42 The analysis conducted by the College is provided annually to Examiner Committees, but not to candidates or Trainee Committees. The overall pass rates are published on the College website.

[21] Chair, Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand.

The 2021 Calibration training

4.43 Due to the timing of the clinical examination in Aotearoa New Zealand, which are held before the calibration training day in Australia, videos and NEP scores from the Australia calibration session from the previous year are used. The Chair of the Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand, explained that this process ensures that examiners are aware of the standard of assessment to be applied.

4.44 The Chair of the Paediatric Division of the Education Committee for Aotearoa New Zealand (NZPDEC) said they do not follow the same calibration process as Australia. She noted that the NZPDEC is not fully involved in the calibration process.

4.45 In 2021, the Aotearoa New Zealand Calibration Training Day was held in May 2021 in person, with 25 Aotearoa New Zealand examiners attending. It was led by the Aotearoa New Zealand Chairs of the Clinical Examination Committee. No Australian national examiners attended.

4.46 The 2021 Australian National Calibration Training Day was held on 26 August 2021, via an online meeting. Two Aotearoa New Zealand examiners attended.

4.47 All 2021 calibration training sessions, across both Australia and Aotearoa New Zealand, were based on the 2020 Australian national calibration video that was provided to both Australian and Aotearoa New Zealand examiners.

4.48 In 2023 and 2024, two Aotearoa New Zealand examiners attended each Australian national calibration day. This was a resumption of the usual pre COVID-19 practice.

Candidate preparation

4.49 Resources to support candidates in preparation for the exam are provided on the College website and the RACP Online Learning Platform. Candidates are encouraged to complete practice examinations, prior to the examination. Candidates otherwise rely on their local hospital consultants and Trainee

Committee representatives to assist them with preparation and testing prior to the examination.

4.50 The College resources published on the RACP Online Learning Platform include:

(a) A webinar series on how to prepare for and approach the clinical exams;

(b) The Divisional Examination Readiness Course that provides information and tips on the clinical examination, how to complete short and long cases, study strategies and guides on forming study groups, links to externally organised examination preparation programs, demonstration videos of short and long cases including examiner discussions and examples of marking sheets; and

(c) The College Learning Series, which is a curated online educational resource covering a wide range of clinical topics.

Conflict management for examinations

4.51 In relation to management of conflicts on the examination day, the Aotearoa New Zealand Chairs of the Clinical Examination Committees reported:

(a) The examiners review the list of candidates and advise which candidates they do not wish to examine because they have worked with, supervised, previously examined or otherwise know the candidate.

(b) Given the small number of examiners in Aotearoa New Zealand, it is likely that a candidate will see an examiner they know.

(c) Despite best efforts, there are not enough examiners for the number of candidates in Aotearoa New Zealand. There is an option for Aotearoa candidates to go to Australia to sit the exam, but this is not funded by the College. There is also an option for Australian examiners to come to Aotearoa New Zealand. This was going to be adopted for the 2024 examination, recognising the small number of examiners in Aotearoa.

4.52 Conflicts were not reported as a concern in Australia. This Review was told that conflicts rarely arise in Australian RACP paediatric examinations, due to

examiners being flown inter-State to assess candidates and candidates being assessed at hospitals they have not worked at.

Standard setting for examiners

4.53 The College considers that there are appropriate safeguards to ensure candidates are meeting expected standards in clinical examinations, via the use of calibration and two experienced clinicians as examiners who must reach agreement on the outcome.

4.54 The Review was told that following the examinations, the respective Examination Committees discuss outlying cases and all failing cases, to ensure that the final decision is supported. Any intervening factors such as a patient leaving the examination or other major interruptions are discussed at this meeting, though not necessarily documented.

4.55 Research has verified the increased reliability of clinical examinations when more than one examiner is involved. Over the course of the examination, candidates are assessed by a total of 12 examiners (6 examiners per assessment day).

4.56 However, the Review was left in some doubt about the extent of the post examination review and whether it occurs consistently or in a way that can impact a candidate score in the examination just undertaken. There is no written record of the post-examination discussion in Aotearoa New Zealand or Australia from the 2021 Examination or in other years.

4.57 The RACP Accreditation submission to the Australian Medical Council dated 19 February 2024, provides information about calibration of the written clinical examination. The submission states that the new rubric introduced for both the long case and short case was intended *"to improve the accuracy of examiner ratings and set a passing standard that can compensate for outlier performance on long and short cases"*[22]. Most of the submission regarding standard setting pertains to the written examination rather than the clinical examination. The RACP has not yet had its accreditation confirmed for the current period. This is due later in 2024.

[22] RACP Submission to Australian Medical Council 2024, Appendix C., 17.3.

4.58 The Chair of the Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand, reported that there is no process by which examiners record the complexity of the patient case. They said it was difficult to assess the level of complexity of different patient cases and that non-complex cases can be harder for examiners to assess and examiners may ask candidates how they would respond to hypothetical scenarios.

Unconscious bias

4.59 In 2022, unconscious bias training was provided for the first time to examiners at the National Examination Panel, which met in Melbourne. This was a 30 minute session delivered by a member of the College. One Aotearoa New Zealand examiner was in attendance and gave a summary of this training at the 2022 local examiner training in Aotearoa.

4.60 The Chairs of both the Australia and Aotearoa New Zealand Trainees Committees held the view that if you are an ethnic minority candidate, you are more likely to fail the clinical examination. They both told this Review that they gave pragmatic and frank advice to candidates from ethnic minority backgrounds, that if they want to pass the exam, they *"need a western mind set"*. The Chairs explained that the fact that they felt it necessary to give this advice was evidence to them, that they were reacting to existing unconscious bias displayed by examiners.

4.61 The Chair of the Māori Health Committee stated that as a senior Māori physician, he has advised Māori trainees to adopt a 'talk like them, walk like them' approach in relation to the examiners, which he considered increased the likelihood of a trainee being graded higher in the exam. He stated *"It would be nice not to have to feel that we need to behave in a different way to not be negatively biased against..."* The Chair suggested that it would be helpful to have a Māori examiner examining Māori trainees or at least a support person of Māori descent in the room, and for the College to pay travel costs of a support person for candidates when they travel from rural hospitals.

4.62 The Advisory Group noted that the patients involved in clinical exams are often not Māori or Pasifika, therefore candidates who excel in dealing with Māori or

Pasifika tamariki, will not get the opportunity to demonstrate this strength in the examination.

4.63 The Chair of the Australian Trainees Committee reported that trainees from both Aotearoa and Australia have contacted the Committee with concerns about unconscious bias by examiners. He considered that both Australian and Aotearoa trainees are affected by unconscious bias in the clinical examinations.

4.64 These Chairs also reported a concern that the College has not focused sufficiently on addressing unconscious bias in the clinical examinations. The lack of any ethnicity or diversity data was, in their view, evidence of the lack of focus on the risk of racial bias in clinical examinations. Currently, only the gender of candidates is collected by the College. The Chairs of the Australian Trainee Committee expressed a further concern about the equity of examinations, given regional variation in pass rates, for example, with regional and remote trainees.

4.65 In contrast, another senior Chair believed that whilst some in the trainee community may feel marginalised by the examination process, the majority were supportive. [23] This Chair did not believe that the format of the 2021 examination resulted in unconscious bias by examiners towards candidates.

4.66 This Review has highlighted a stark contrast in views about the existence of structural or cultural bias, within the Committee Chairs group. This may well reflect a wider contrast in views within the College. This will require work by the College to ensure that there is a sound understanding of the existence of this bias.

4.67 The recent findings of the JAMA Network Investigation, *Māori Medical Student and Physician exposure to racism, discrimination, harassment and bullying*, July 2024, confirm the experience of racism and bias by Māori medical students and put this beyond doubt for ethnic minority professionals within the health profession.

[23] The Advisory Group notes that the majority support for a proposition or the status quo, is generally not sufficient when discussing the experience of minority groups.

Psychometric analysis for bias

4.68 The College psychometrician monitors the pass rates of candidates by training region and number of attempts. However, the demographics of candidates are not collected or assessed.[24]

4.69 Historically, "Hawk/Dove" analyses of examiner scores were conducted. However, it is not clear how this was done as the Advisory Group have not been provided with this information. The process of confirmation of results is not clear, as no process guidelines or psychometric results have been provided to this Review, despite our request for this information. We acknowledge the change of staff over the period of the Review has likely affected the organisational knowledge of the history of examination and record keeping.

4.70 The College's psychometrician reported that unconscious bias is possible in any exam format, where there is human interaction within an exam. They considered there were protective processes put in place in the clinical exam, to minimise this risk. These protective factors include calibration sessions for examiners, the use of multiple examiners and multiple cases for each candidate's exam (six cases with 2 examiners in each). It is recognised that some examiners may score lower or higher than others, amongst a range of possible examiner behaviours that relate to how they assess performance against the rating scale. The goal is to mitigate the impact through training of examiners and by conducting multiple assessments. However, it was acknowledged that bias can be difficult to quantify, or to determine its cause.

4.71 The College acknowledges it has not undertaken any analyses of pass rates of trainees from indigenous or other ethnic backgrounds. This because of current College policies towards collecting data on ethnicity and concerns to respect indigenous data. However, there has been an assessment made of region variation in pass rates by the College psychometricians.

4.72 The Advisory Group has considered whether any statistical or psychometric data analysis would be possible to determine the presence or nature of examiner bias

[24] Manager, Assessment Services, Education Learning & Assessment; and Manager, Training Services, Education Learning & Assessment, Australia and Aotearoa New Zealand.

in the 2021 clinical examination. The Chairs of the Aotearoa New Zealand Clinical Examination Subcommittee (Paediatrics) told the Advisory Group that the College does not currently hold statistics on the pass rates of trainees broken down by ethnicity or by any category. However, the collection of these statistics in 2025 is under discussion within the College.[25]

4.73 Psychometric analyses cannot be conducted on long and short case exams, as this analysis requires large samples of similar standardised assessments or stations with common links of candidates and examiners. Psychometric analysis is suitable for OSCE style examinations and sometimes MiniCEx, but not on long and short form clinical examinations.

Examiner diversity

4.74 Concerns have been raised by complainants about lack of cultural diversity within the National Examiner Panel (NEP). This was a recurring theme and was raised as a significant risk for unconscious bias towards candidates of diverse backgrounds.

4.75 The diversity of NEP members is stated, by the College, to be one of the considerations when making appointments to the NEP.[26]

4.76 Anecdotal reports from candidates, in the review interviews and the written complaints by candidates, highlight the lack of diversity amongst examiners. The distribution of examiners being predominantly of Anglo-Saxon background was the principal concern. The candidates reported that when this issue was raised by trainees with their mentors and supervisors, they were met with unsupportive responses.

4.77 There is currently no College data collected which records the cultural or linguistic background of examination candidates or examiners. Equally, the College does not collect data about a candidate's primary medical qualifications, ethnicity, and indigeneity when registering for the divisional examinations.[27] If

[25] Chair, Aotearoa New Zealand Clinical Examination Subcommittee (Paediatrics); and Deputy Chair, Aotearoa New Zealand Clinical Exam Subcommittee (Paediatrics).
[26] National Examining Panel Membership (racp.edu.au).
[27] International medical graduates undertaking specialist assessment are not required to complete the divisional examinations.

this data is not collected it is not possible to measure the progress of the commitment to diversity.

4.78 The Advisory Group was told that it is a constant challenge to get examiners across specialties with a mix of genders and ethnic backgrounds. The Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand, reported that when recruiting examiners, gender and ethnicity diversity are relevant considerations. The estimate made is that clinical examiners are 40-50% Caucasian and 50-60% other ethnicities, with a mix of genders with an increasingly female pool. In New Zealand the pool of examiners is equal between male and female examiners.[28]

4.79 The College's data provided to this Review records the ethnic breakdown of examiners of the Paediatrics Divisional Clinical Examination in Aotearoa New Zealand from 2021 to 2023. This indicates that 3% of examiners self-identified as Māori.[29] There remains a lack of representation on the examiner panel from International Medical Graduates (IMG). The challenge in Aotearoa New Zealand for ethnic diversity was particularly noted, given the size of the examiner pool and the conflict for examiners who have already worked the candidates.[30]

4.80 A senior examiner and former Chair of the Aotearoa New Zealand Paediatric Clinical Examination Subcommittee, believes *"the recruitment of an examiner panel that is closer to reflecting the diversity of the candidates....will be helpful to improve confidence in the examination process".* The diverse backgrounds of the Australian and Aotearoa New Zealand medical communities should be mirrored by the examiner panel.

4.81 Some steps have been taken by the College to increase the inclusivity of different cultures and backgrounds. These include:

[28] Deputy Chair, Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand; Chair, Paediatric Education Committee, Aotearoa New Zealand; and Chair, Aotearoa New Zealand Clinical Examination Subcommittee (Paediatrics).
[29] Training Services, Education Learning & Assessment, Australia and Aotearoa New Zealand. However, this figure only represents those who voluntarily disclosed their ethnicity and there may be additional examiners of Māori descent who chose not to self-identify.
[30] Chair, Aotearoa New Zealand Clinical Examination Subcommittee (Paediatrics).

(a) The development of the Membership Diversity Advisory Group (MDAG) in 2021;

(b) An online survey in 2023 was distributed to RACP members to assist in identifying member identities and experiences (circulated via the Australasian Faculty of Rehabilitation Medicine; and

(c) The Cross College Exam Review Advisory Group (CCERAG) was formed in 2024 to undertake a review and make recommendations to the College Education Committee (CEC). One of their functions is to make recommendations to the CEC that ensure that issues related to equity, diversity and cultural safety are addressed. There is reference to the Diversity Lead Representative Working Group in the CCERAG Term of Reference document, but further information about the progress of this group is not available.

Selection and recruitment of examiners

4.82 The Chair of the Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand, states that examiners need to be at least twelve months into Fellowship. Often members with an interest in education will self-nominate. A lot of General Paediatricians will volunteer, however, not many specialists nominate themselves for appointment as an examiner.

4.83 The appointment process was highly informal. It typically starts with a call for physicians to put their names forward. They attend as an observer at clinical examinations and then are appointed as an examiner. New examiners are put with experienced examiners when first assigned.

4.84 In practice, very few offer to be an examiner, but are shoulder tapped and requested. The Aotearoa New Zealand Examination Subcommittee is actively recruiting for examiners as it is difficult to find examiners. It was acknowledged that this process of recruitment was not ideal. In Aotearoa New Zealand, there are 19 examiners and 52 candidates in Paediatrics due to be examined in 2024. The College is short eight examiners for the number of Aotearoa candidates expected in 2024.

4.85 The Advisory Group was told there are difficulties recruiting examiners in New Zealand for the following reasons:

(a) It is a voluntary position and can be a stressful for examiners;

(b) The time commitment over a weekend in New Zealand;

(c) The exam in May clashes with a major overseas conference;

(d) Hospitals are increasingly reluctant to conduct exams on a weekday. This limits the number of examiners and patients available; and

(e) Adverse publicity from the current complaints.

4.86 Due to the small examiner pool in Aotearoa, many candidates will already know the examiners in some capacity. If candidates are concerned about their pre-existing relationship with an examiner, a candidate conflict form can be completed. Additionally, given that there are two examiners for each candidate, the examiner that does not know the candidate should take the lead in conducting the exam.

4.87 The College acknowledges that it is best for candidates to be assessed by examiners who do not know them. However, given the size of Aotearoa it is difficult to find examiners who do not already know the candidates. Typically, two Aotearoa National Examiners will fly to Australia and two Australian examiners will fly to Aotearoa for the exams. However, this did not occur in 2021 or 2022 due to COVID19 and flight restrictions.

Feedback to candidates

4.88 A digital score sheet is used by examiners to provide feedback to candidates. If any concerns or issues are raised by candidates during the examination, examiners are required to record this in the digital score sheet.

4.89 The College Training Services Manager advised the Review that there is a proforma template to assist examiners when providing feedback on each long case and short case. The Chair of the Aotearoa New Zealand Clinical Examination Subcommittee said the digital score sheet and revised rubric, which was

introduced in 2019, is preferable as it is legible, and the free text comments are more specific for the candidate.

4.90 When a candidate fails an exam, or is marginal, examiners try to provide balanced feedback that is honest and objective to inform a candidate they have failed. The Chair of the Aotearoa New Zealand Clinical Examination Committee acknowledged that there had been some concern about the harshness of examiner feedback in circumstances where the candidate had failed.

4.91 All candidates will receive individual feedback. However, the quality of this feedback will depend on the individual examiner's training and time pressure on the day of the examination. The feedback is not provided on the day of the clinical examination, given the examination load to be completed on the day. All identifying patient information is removed, and the case summaries are not provided to candidates. The candidates are reminded not to discuss this information outside of their feedback meeting, as this would be in breach of the Academic Integrity in Training Policy. The feedback sheets cannot be reproduced or distributed.

4.92 Results are not able to be discussed by the candidate with the College over the phone or by email. The College website notes that the Reconsideration, Review and Appeals Process does not apply to the outcome or results.

4.93 The Divisional Examination Subcommittees receive pass/fail results immediately after results are released to candidates. They also receive pass/fail outcomes for candidates within their region. There is some variation in feedback for successful and unsuccessful candidates, which is noted below.

4.94 In Australia, if a candidate is unsuccessful in the clinical examination, they will receive a personalised letter with confirmation of result and score within four weeks of receiving their result. This letter includes the contact details of the NEP they will need to contact to receive their feedback. The Assessment Services team is able to arrange feedback sessions with a NEP of the candidate's preference.

4.95 In Aotearoa New Zealand, if a candidate is unsuccessful, they will receive a letter confirming their result and they must schedule a feedback session with a supervisor or senior examiner. They can invite a support person to attend. An

output of the performance and interpretation of how their outcomes is determined using the score combination grid is also provided.

4.96 On completion of the feedback sessions with the allocated Senior Examining Panel (SEP) member, the candidate can retain copies of the feedback sheet. Case summaries that contain confidential patient information will not be provided to candidates.

4.97 A self-reflection sheet is also sent out for candidates to complete before their feedback session with the NEP.[31] Candidates are provided with details on how to contact the RACP Training Support Unit, if they wish to seek support in preparation for their next exam attempt.

Feedback for examiners

4.98 A potential vulnerability of any clinical examination is that examiners differ in their relative leniency or stringency. Traditionally this is known as the 'hawk-dove' effect. Hawks tending to fail more candidates because they display overly high standards, whereas doves tend to pass more candidates.

4.99 This Review has been informed that the College undertook Hawk-Dove analysis for all examiners, as per Australian Medical Council requirements, in 2017. However, it is not clear this analysis has been undertaken or provided to examiners since that time or in 2021. The College has not been able to provide any written evidence this analysis was undertaken in 2021 or currently.

4.100 This vulnerability in clinical examinations is well recognised. In 2006, a study of this effect was undertaken in the United Kingdom.[32] The results of the study reported that about 87% of main effect variance was due to candidate differences, 1% due to station differences, and 12% due to differences between examiners in leniency-stringency. Examination scores were adjusted for examiner stringency, and it was shown that for the present pass mark, the outcome for 95.9% of candidates would be unchanged using adjusted marks. However, 2.6% of

[31] Appendix C, 12.1.
[32] BMC Med Educ, *Assessment of examiner leniency and stringency ("hawk – dove effect") in the MRCP (UK) clinical examination using multi-facet Rasch Modelling*, McManus, Thompson and Mallon, 2006.

candidates would have passed, even though they had failed based on raw marks, and 1.5% of candidates would have failed, despite passing based on raw marks.

4.101 The College could consider conducting a similar analysis on the paediatric clinical examination data.

Cost of examination for candidates

4.102 Some complainants raised concerns about the costs of the examination and questioned the value they saw from the College for this fee.

4.103 The Advisory Group asked for a detailed breakdown of the costs that make up the fee. This has been provided but only to a limited extent. The Review was advised by the College that the 2024 Clinical Examination fees were AUD $3221.00 and NZD $3704.15. The 2024 spending breakdown of RACP Basic Training Fees reports that funds were allocated to exam development, exam calibration sessions and exam administration.

4.104 The College notes that the examination fees are lower than other peer Colleges but that the training fees were toward the upper end of the range, due to the complexity of the RACP training pathways.

Examination governance

4.105 During this Review, the Advisory Group identified a complex web of College Education, Training, CPD, Examination and Assessment committees, particularly for small specialties such as Paediatrics.[33]

4.106 The Advisory Group was left concerned about the risk of this structure to role clarity and duplication of responsibilities across the committees. The Advisory Group considered that this complex structure was likely to spread resources more thinly across the various committees, particularly in Aotearoa New Zealand and regional Australia where there are fewer clinicians.

4.107 The complex structure of committees appears to have contributed to a lack of clarity for individual committees in relation to progressing complaints received,

[33] RACP Education Committee Organisational Structure Chart May 2024, Appendix C, 15.2.

as well as complicating complaint pathways for candidates. Candidates reported that they are unsure which committees are tasked to deal with complaints.

4.108 The key committees and their roles are explained below. The potential for duplication and disconnection are evident from these descriptions.

Paediatric Clinical Examination Committee Australia and Aotearoa (PCECA)

4.109 The PCECA is responsible for overseeing the clinical examination. This is an extensive pro bono time commitment for members of the PCECA. The role of the PCECA is wide ranging and includes approving correspondence that goes out by management, ensuring that there are enough examiners, dealing with exam complaints, authorising the results at the end of the exam period and managing any issues that have occurred during the exam. The PCECA also runs the calibration session for examiners. The PCECA reports to the Paediatrics & Child Health Division Assessment Committee.

Aotearoa New Zealand Clinical Examination Subcommittee

4.110 This committee is a subcommittee of the PCECA, but appears to operate largely independently in relation to its calibration training and sourcing of examiners.

Aotearoa New Zealand Paediatrics & Child Health Division Education Committee (NZPDEC)

4.111 The NZPDEC does not have a direct role in overseeing clinical exams. However, some committee members are examiners. The committee covers basic training and governance for paediatric education and hears any appeals and complaints for the advanced training committees. However, the NZPDEC does not hear complaints about the examinations. The NZPDEC is also responsible for sourcing examiners in Aotearoa. A PCECA representative normally sits on the NZPDEC, but there has not been a PCECA representative on the NZPDEC since 2023. The NZPDEC comprises 12 pro bono members, with a maximum term of six years.

College Trainees Committee (CTC)

4.112 The CTC is the College's peak representative body of all trainees and their interests, across Australia and Aotearoa New Zealand. The committee comprises

representatives from each of the regional trainees' committees. The CTC's purpose is to advocate on behalf of trainees in matters relating to their selection, training, assessment, supervision and overall education experience, and to make recommendations regarding policy that relates to any training matter. The CTC liaises with regional trainees' committees and their representatives, including the Aotearoa New Zealand Trainees' Committee.

Aotearoa New Zealand Trainees' Committee

4.113 This is the regional trainees' committee for Aotearoa New Zealand. The committee works in conjunction with the CTC. The Chair of the Aotearoa Trainees' Committee sits on the CTC. The purpose of this committee is to represent and advocate for Aotearoa trainees within the College on matters affecting selection, training assessment, supervision and overall education experience.

4.114 The Aotearoa Trainees' Committee has a particular responsibility to support initiatives that will assist Fellows and trainees to develop cultural competence. This incorporates tikanga Māori values of manaakitanga (hospitality, kindness and support), whanaungatanga (relationships, sense of family connection) and mōhiotanga (knowledge, understanding, insight).

5. Literature review on high stakes clinical assessment and training

Overview

5.1 Any professional licensing assessment, like the RACP Basic Training Clinical Examination, is considered high stakes, as it determines eligibility for progression to advanced training in a medical specialty.

5.2 The Advisory Group undertook a literature review of high stakes examinations so that this report could provide up-to-date information relevant to current best practice for post graduate training assessment, the long and short case assessment method and bias in clinical assessments.

5.3 This literature review was conducted through Medline using OVID and Google Scholar by the independent assessment expert member of the panel, Hon. Professor Deborah O'Mara.

5.4 A similar literature review was conducted by Professor Elizabeth Farmer as part of the Australian College of Emergency Medicine (AECM) *Expert Advisory Group on Discrimination: Final Report to the ACEM Board* October 2017. The key points from the ACEM review have been included where appropriate.

5.5 A review of other clinical assessment techniques used by other Colleges, such as the mini-CEx, Direct Observation of Procedural Skills (DOPS) or the Objective Structured Clinical Examination (OSCE), was outside the scope of this literature review.

Best practice for post-graduate training assessment

5.6 It is widely accepted that best practice for single assessments should meet the principles of good assessment, as agreed by the 2018 Ottawa Conference on Assessment[34]:

Table 1. Framework for good assessment: single assessments.

1. *Validity or Coherence: The results of an assessment are appropriate for a particular purpose as demonstrated by a coherent body of evidence.*

2. *Reproducibility, Reliability, or Consistency: The results of the assessment would be the same if repeated under similar circumstances.*

3. *Equivalence: The same assessment yields equivalent scores or decisions when administered across different institutions or cycles of testing.*

4. *Feasibility: The assessment is practical, realistic, and sensible, given the circumstances and context.*

[34] Source: Norcini et al (2018) Medical Teacher 1103.

5. *Educational Effect: The assessment motivates those who take it to prepare in a fashion that has educational benefit.*

6. *Catalytic effect: The assessment provides results and feedback in a fashion that motivates all stakeholders to create, enhance, and support education; it drives future learning forward and improves overall program quality.*

7. *Acceptability: Stakeholders find the assessment process and results to be credible.*

5.7 These principles of good assessment recognise that multiple assessment tools or a system of assessment is preferable to reliance on a single assessment, especially for a high stakes decision. They also provide a framework for good systems of assessment, as they should be coherent, continuous, comprehensive, feasible, purpose driven, acceptable and transparent. This research recognises that in medical education, there is a need to assess "difficult to measure" competencies important in clinical practice.

5.8 The most recent development in good practice assessment has been Programmatic Assessment (PA) which promotes longitudinal continuous assessment with multiple assessments, including rich feedback to augment it as assessment as well as learning.

5.9 PA has been promoted by (Schuwirth & Van der Vleuten, 2011) with more recent guiding principles developed at the 2020 Ottawa Conference on Assessment, in part due to PA's growing popularity (Heeneman et al., 2021). PA has been implemented to varying degrees in both undergraduate and postgraduate medical training, particularly for the final three years of specialty training. [35]

[35] Loosveld et al., 2023; Ross et al., 2023; Torre et al., 2022

The long case as an assessment method

5.10 While the long case has been used in medical education for many decades, in the early 2000's there were several articles published regarding its validity and reliability. The articles questioned whether the long case would continue as an assessment tool, in part reflecting a trend for it to be discontinued in North America, while it continued to be used in the United Kingdom and Europe. [36]

5.11 The fact that the long case does not lend itself to detailed psychometric analysis such as Rasch modelling, as an OSCE does, accounts for some of the criticism of this assessment method. In particular, it cannot be broken down into easily measurable units for analysis. Rather, it is a more holistic measurement. However, Norcini criteria for good assessment still apply.[37]

5.12 Some studies maintain that because the long case attempts to mirror clinical practice, assessing "know how", that this is evidence of validity, incorporating a synthesis of clinical skills, i.e. history taking, examination, differential diagnosis and management.[38] This is primarily why the long case is still utilised, despite earlier predictions that it would be phased out.[39]

5.13 It is due to low inter-examiner reliability for a high stakes decision, based on one case, that Norcini (2001) is not in support of the long case. Reliability is viewed as a necessary, but not sufficient condition, for validity in these studies, though more recently reliability is viewed more as evidence for validity.[40]

5.14 Suggestions for improving the reliability of the long case have been put forward, including direct observation, rather than just a case presentation and testing across more cases. [41] However, the authors of this article also acknowledged this proposal requires more research.

[36] Norcini, 2002.
[37] Wass & Van Der Vleuten, 2004; Tey et al., 2020.
[38] Wass et al., 2001, Wass & Van Der Vleuten, 2004.
[39] Norman, 2002.
[40] Cook et al 2015.
[41] Wass and Van der Vlueten, 2004.

5.15 A study of RACP long cases conducted in 2005 and 2006, looked to identify the source of variation, finding 38% was explained by candidate ability in 2006 and 33% in 2005. [42] At the time of the study, the RACP candidate sat two long cases and four short cases. This study estimated that assessment time would need to be increased to 4-5 hours to improve its reliability. The research concluded that the examination is, as a whole, made more reliable by the inclusion of four short cases with two long cases.

5.16 There is also recognition and evidence that anxiety affects long case performance negatively. [43] Stresses experienced by dental students have been outlined by (Paul et al., 2022) who recommend greater calibration of both examiners and cases and enhancing student preparation and expectations.

5.17 A comparison of OSCE and long case performance led to a recommendation to observe the history taking component of the long case separately, to improve its validity (Wass & Jolly, 2001).

5.18 In summary, most previous studies of the long case were conducted 20 years ago. However, this assessment technique continues to be used in medical education throughout the world in medical schools and in postgraduate medical training. While there is general recognition of its face validity in approximating practice, there is also recognition that a high stakes decision on one long case alone does not have sufficient reliability. More recent literature has focused on alternative clinical examinations such as workplace-based assessments (WBAs)and OSCEs, which may be more appropriate for small specialties.

The short case as an assessment method

5.19 Very few studies discuss the short case. Rather a substantial section of literature has been focused on the Mini-CEx. This is not unlike a short case but is generally specific to one clinical skill such as history taking, examination, diagnosis, management and usually is conducted opportunistically on a ward. These are

[42] Wilkinson et al., 2008.
[43] Guraya et al., 2018.

growing in popularity, particularly as part of a programmatic system of assessment.

5.20 A study in 1998, demonstrated that long and short cases for undergraduate surgery training provide essential complimentary information to knowledge assessment. Trainees also perceived them as "relevant appraisal of their clinical skills". They recognise the importance of the short cases to be used as the use of a single long case is insufficient to assess clinical performance. [44]

5.21 A further study in 2001, provides evidence to support the use of short cases to identify problem solving skills relative to factual knowledge questions. [45]

5.22 In 2008, a later study found that less variation in short case scores was due to candidate ability (for example, 15% for 2006 and 9% for 2005) relative to the long cases. Rather, a large proportion of variation in short case scores was due to the interaction between the candidate and the case; (56% 2005 and 58% 2006). Case by examiner explained the next highest variation; (11% 2005 and 10% 2006). The case on its own was not found to be the major source of variation or indeed examiners. Rather, the interaction with the examiner and particularly with the candidate did account for differences in performance. The authors concluded that the RACP examiner training and calibration is reinforced by these results, as is the case selection, despite anecdotal comments about bias and/or differences in complexity. [46]

5.23 In summary, there is a paucity of literature about short cases, particularly in the postgraduate medical training context. Workplace based assessments (WBAs), particularly Mini-CEx are more commonly discussed in the literature. The alternative of an OSCE, with specific stations on history and examination, are also discussed and are an option to consider for best practice.

[44] Hardy 1998.
[45] Schuwirth et al., 2001.
[46] Wilkinson et al 2008.

Bias in clinical assessments

5.24 This Review has not found any previous studies of clinical high stakes examinations that have investigated actual or potential bias in long case or short case medical examinations, based on ethnicity.

5.25 There are several studies that have examined racial bias, in terms of OSCE results for clerkships in the United States of America.[47] These studies include large numbers of identified sub-groups including black and/or Hispanic cohorts, but rarely include indigenous groups due to sample size. The focus of the studies is the socio-cultural, education and political history of the United States and therefore this Review has been cautious about implications for Australasia.

5.26 In a United Kingdom study of basic physician training OSCE, one examiner was identified as having ethnicity bias.[48] OSCE data lends itself to psychometric analyses which can investigate such patterns due to the high number of candidates completing the same "station" which includes the same patient or patient actor. This is not the case for the long and short form case structure used by the RACP.

5.27 Most studies on implicit racial bias in healthcare, focus on the bias by health professional towards patients. In 2017, a systematic review found that healthcare professionals have the same levels of implicit bias as the general population.[49]

5.28 A more recent JAMA Network Open Report "*Māori Medical Student and Physician Exposure to Racism, Discrimination, Harassment and Bullying,* Cormark, Gooder and others (2024), confirms concerning levels of reported racism experienced by Māori medical students and physicians. While this study did not specifically investigate experiences in clinical examinations, the high level of reported racism experienced in training and workplace settings, makes it likely that the experience also relates to clinical assessments. There is no reason to conclude that the

[47] O'Sullivan et al., 2023.
[48] McManus et al., 2013.
[49] FitzGerald & Hurst, 2017.

examination setting would be immune from the same experiences in other aspects of the workplace.

5.29 In the AECM review of its clinical examinations, the review group used international medical graduates (IMG) as a proxy for ethnicity because the College did not collect ethnicity data. The AECM Report confirms that IMG consistently perform lower than local candidates in high stakes examinations, in a wide range of settings. The report concludes that "*the causes of differential attainment remain unclear and while some effects of examiner and candidate interaction have been determined, they appear relatively small in comparison to the size of the disparity in results between groups of local graduates and international graduates*".

5.30 Variation and perceived lack of fairness in a dental long case in Aotearoa New Zealand, has been outlined with student complaints being similar to those voiced in the anonymous complaint to the College. [50] The data is based on 22 semi-structured interviews and survey results. The key themes were stress (before and after the long case), concerns about fairness, (low inter-rater reliability, variability or luck in terms of examiners and the case), confusion (ambiguity, lack of support).

Conclusions on literature review

5.31 There are few studies in the literature with direct relevance to the Terms of Reference for this Review. This is in part due to the move to Programmatic Assessment and/or the adoption of the OSCE in post graduate training.

5.32 There are no recent research studies involving the long case or the short case that have been published in peer reviewed medical education journals, except for a recent study of the dental program in Aotearoa New Zealand, where the three issues raised by students are similar to those raised in regard to paediatrics: stress, fairness and confusion.

[50] Paul et al., 2022

5.33 The long and short case examination is no longer regarded as the gold standard as it has been in the past, though it is still considered valid and reliable. The short case exams do not represent contemporary practice and require review and improvement. There have also been other complaints about bias in long case exams which is recorded in the literature.

5.34 In 2024, the College has commenced a Cross College Review of Examinations to better reflect current assessment philosophy and practice in both written and clinical assessment. [51] This is appropriate and timely.

6. Review of training for examiners

Examiner training material

6.1 Current examiner training has been described as a calibration exercise where a video of a candidate completing an examination, is viewed by examiners. The examiner training then involves scoring the candidate in this video, followed by discussion of the scoring as a training team.

6.2 The Advisory Group was able to view examples of calibration videotapes from 2022. However, there were none available for the 2021 training.

6.3 The Chair of the Aotearoa New Zealand Clinical Examination Subcommittee reported that in Aotearoa there is no specific training that examiners are required to complete. The only requirement is that they must have been a medical officer for at least two years. During the 2021 clinical examination period, no expert training for examiners was offered on unconscious bias.

6.4 In 2023, unconscious bias training was provided for the first-time as part of calibration in Australia only. Some Aotearoa examiners attended this training session in Australia.[52] The Chair of the College's Trainees' Committee (Australia)

[51] As outlined in the RACP accreditation submission to the Australian Medical Council 2024, Appendix C, 17.3.
[52] Chair, Aotearoa New Zealand Clinical Examination Subcommittee (Paediatrics).

considered that the unconscious bias training presentation was too short and more in-depth unconscious bias training was required.[53]

6.5 The training session was a 30 minute session facilitated by Associate Professor Robert Roseby, a respiratory and general paediatrician. A copy of the unconscious bias training module for 2023 was produced to the Review.[54]

6.6 As at June 2024, the Chair of the Māori Health Committee was not aware of any cultural bias training provided to examiners by the College.

6.7 While this 2023 training was an important starting point for the College, it was not sufficient. It should be delivered by an external provider with specialist knowledge of the unconscious bias training and longer in presentation time.

Training information not available

6.8 The Advisory Group has requested but not been able to be provided with any documents setting out guidelines for examiners regarding examination behaviours and expectations for the 2021 examinations or any other years. It appears that each calibration group moderates itself as to expected standards.

6.9 Similarly, this Review has not been provided with any reports or metrics on examiners, relating to the 2021 clinical examination.

6.10 The Advisory Group has also not been provided with any evidence of objective recording or other forms of quality assurance, such as independent observation of examiner behaviours or performance.

6.11 No written information has been provided speaking to any process for guidance for examiners, as to appropriate prompting or questioning of candidates during the examination.

6.12 There also appears to be very limited 'hands on' involvement by College staff in local examination organisation. The Advisory Group has not been provided with information for local organisers, on expectations to enable consistent procedures.

[53] Chair, College Trainees' Committee, Australia and Aotearoa New Zealand.
[54] Unconscious Bias Training PowerPoint Slides and Video, Appendix C, 10.1 and 10.2.

7. Appealing examination outcomes

Overview

7.1 One of the key complaints raised by the NZRDA and complainants, was that the College did not provide an adequate procedure to review or appeal examination outcomes.

7.2 At present, candidates who are unhappy with any aspect of the examination process or outcome are directed to three College policy documents:

(a) Special Consideration for Assessment Policy (effective 2 December 2022).

(b) Reconsideration, Review and Appeals By-law (approved October 2011, Updated as at June 2022).

(c) Complaint Management Policy.

7.3 Under the existing policy framework, candidates cannot appeal substantive exam results.[55] However, candidates can apply for Special Consideration in relation to technical or procedural issues arising during the assessment process.[56]

7.4 In summary, the policy framework provides four options for candidates to raise concerns with the assessment process[57]:

(a) Apply for Special Consideration in relation to the assessment process (no fee applicable).

(b) Application for Reconsideration of a Decision (no fee applicable).

(c) An Application for Review of a Reconsideration Decision (fee applicable).

[55] This is because the definition of a "Decision" that can be reconsidered, reviewed or appealed under the Reconsideration, Review and Appeals By-law expressly excludes *"the outcome of results of the assessment of written or clinical examinations or research projects."*
[56] Reconsideration, Review and Appeals By-law, Appendix C, 9.13.
[57] Chair, Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand.

(d) Application to Appeal a Review Decision (fee applicable).

7.5 The College rationale for not allowing exam results to be appealed, is that College exams are not recorded or videotaped in clinical examinations.

7.6 The Advisory Group was informed that some comparable clinical exams held by other Colleges, including the Australasian College for Emergency Medicine, record exams after obtaining appropriate consents from patients.[58]

7.7 Those interviewed by the Advisory Group demonstrated a variable level of familiarity with the College policies and processes. No one interviewed could describe a clear pathway for candidates to complain about unfair treatment.

7.8 Candidates interviewed by the Advisory Group had not found the available policies to have been useful. They are not held in one single accessible information portal. It was also reported that specified timeframes within the policy framework, such as the 5-day period in which to request special consideration, are too short.

7.9 Currently the College policies and procedures for candidates do not provide for any initial informal exploration of concerns raised.

Special Consideration for Assessment Policy

7.10 This policy document is found on the College website under the Trainees' webpage.[59] It sets out the process for considering the "*particular circumstances affecting a trainee and the special provisions or arrangements available to alleviate the impact of those circumstances*".[60]

7.11 The policy states that candidates can apply for special consideration regarding technical or procedural issues not resolved during the exam, or temporary impairment in a discontinued exam. The application must be made within 5 days of the date of the exam and prior to the release of the exam results.

7.12 In circumstances where special consideration is granted, the policy states that examination marks are final and cannot be adjusted. Instead, the outcome of a

[58] Chair, College Trainees' Committee, Australia and Aotearoa New Zealand.
[59] Special Consideration for Assessment Policy, Appendix C, 9.16.
[60] https://www.racp.edu.au/trainees/education-policies-and-governance/education-policies.

successful application for special consideration could include the College refunding the examination fee or allowing the candidate to sit a supplementary exam.

7.13 The Advisory Group was told Special Consideration applications are initially reviewed by College staff, and if the application is complex it is forwarded to the Exam Chairs for review.[61]

7.14 The Chair of the Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand (PCECA) reported the College has a clear policy that is signed by trainees when they apply to sit the clinical examination. Following the exam, a results meeting is held in which the special consideration policy is considered along with the candidate's marks for each case. The details of each case are assessed by the Clinical Exam Committee and deemed either significant or insignificant. The Committee will determine whether the candidate is eligible for a supplementary examination in the same year, or whether they may designate the examination as a non-attempt and permit a refund of the examination fee.[62]

7.15 The PCECA reported that if a candidate asks for special consideration, the exam results are reviewed and the candidate is reassessed, to determine a reasonable solution. Consideration is given to anything that has happened on the day. A candidate may request to re-sit the exam or to be reassessed. The Chair and Deputy Chair will review these requests, except if the candidate is known to either of them, in which case they will be replaced.[63]

7.16 The Deputy Chair advised that the PCECA do receive grievance and unfair treatment complaints. In those situations, the PCECA look across the whole day of exams and review the comments and feedback that the candidate has received. If it appears that the candidate was disadvantaged on that day for one single exam, the PCECA may give them special consideration or an opportunity to re-sit the exam. If the candidate's performance is consistent throughout the multiple exams held on the examination day, which are each assessed by a different examiner, it is more likely that the trainee may not be suitable for special consideration. The

[61] Manager, Assessment Services, Education Learning & Assessment; and Manager, Training Services, Education Learning & Assessment.
[62] Chair, Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand.
[63] Deputy Chair, Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand.

Deputy Chair noted that he was not sure whether there is a policy that prescribes this reassessment process.[64]

7.17 In 2021, there were two applications for special consideration across Australia and Aotearoa New Zealand. The applications were received several months after the exam and no procedural incidents were raised by either of the examiners. The College received the candidates' applications and sent them to the examiners to review. A response was provided to the candidates. Both applicants alleged that the examination could not be properly conducted because the child was uncooperative. Neither examiner made a written record of the incident. This was unusual as normally examiners record procedural incidents or small details which may impact the exam on the same day as the exam, so that details of the incident can be referred to later.

7.18 The number of Reconsiderations, Reviews and Appeals in Aotearoa New Zealand compared with Australia for the period 2021 – 2023 were provided by the College:

Reconsiderations

Year	Australia or International	Aotearoa New Zealand	Total
2021	104	19	123
2022	73	2	75
2023	102	13	115

[64] Deputy Chair, Paediatric Clinical Examination Committee, Australia and Aotearoa New Zealand.

Reviews

Year	Australia or International	Aotearoa New Zealand	Total
2021	15	1	16
2022	5	1	6
2023	15	2	17

Appeals

Year	Australia or International	Aotearoa New Zealand	Total
2021	2	0	2
2022	0	0	0
2023	4	0	4

7.19 The Chair and Deputy Chairs of the Aotearoa New Zealand Clinical Examination Subcommittee (Paediatrics), discussed the process for addressing complaints received:

(a) An examination completion meeting is held one to two weeks after the exam (after the five-day timeframe for requesting special consideration) to discuss any issues arising during the exam.

(b) During the exam process, all incidents are documented at the time of the exam by the examiners, and the examiners explain what actions were taken. For example, a candidate was given extra time because a patient had to go to the bathroom.

(c) Results are discussed and the list of incidents raised in the examination are reviewed. If a candidate has not passed, after reviewing the documented incidents, the results may change or, if warranted, the candidate may be offered the opportunity to re-sit the exam. The lead examiner on the day

will reiterate anything that may be considered as a potential incident and all things are taken into account when determining the final mark.

Trainees' perspective

7.20 The Chair of the College Trainees' Committee, Australia, reported that most trainees do not realise there is a special consideration process. He explained that navigating the special consideration process can be complicated due to the short timeframe candidates have to raise complaints, and trainees feel isolated in navigating this process.

Reconsideration, Review and Appeals process

7.21 The Reconsideration Review and Appeals Process By-law sets out the process for the reassessment of specified "Decisions" made by College bodies.

7.22 The definition of "Decision" includes decisions relating to assessment, supervision and progress of trainees and special consideration decisions. However, the definition excludes the outcome or results of the assessment of written or clinical examinations or research projects. [65]

7.23 The three stages of the College's internal process for the reassessment of specified decisions are:

(a) Reconsideration: by the same College Body that made the Decision;

(b) Review: by the Reviewing Body, which is the College Body that oversees the College Body that made the Decision. The Reviewing Body must not include a member who participated in the Reconsideration Decision; and

(c) Appeal: to an Appeals Committee appointed by the Board. The Appeals Committee must not include a member who participated in the Review Decision.

7.24 An application for Reconsideration, Review, or Appeal must be received within 28 days of the applicant receiving the Decision that is the subject of the application. Each stage involves a review 'on the merits', in which the decision maker is

[65] Reconsideration, Review and Appeals By-law, Appendix C, 9.13.

required to reassess all the facts and circumstances relating to the decision, including any additional material, and make a new decision.

7.25 The policy sets out the decision-making process for the College Body. In summary:

(a) The College Body must have regard to any information or materials provided to it in relation to the original decision, any submissions or other materials provided by the applicant as part of the application for Reconsideration, Review or Appeal, and any other information obtained by the College Body which is relevant to the application.

(b) If the College Body intends to consider information which has not been provided to the applicant, the information must be provided to the applicant (unless procedural fairness does not require it) and the applicant provided with a reasonable time to respond to that information before a decision is made.

(c) The applicant does not have a right to attend any meeting of the College Body considering the application, or to make oral submissions (with the exception of the Appeals Committee which has the discretion to hear oral submissions and has done so on certain occasions).

7.26 If the candidate is dissatisfied with a Reconsideration Decision, they my then apply for the decision to be reviewed or appealed. The Reviewing Body or Appeals Committee:

(a) may not make a decision that the College Body that made the original decision could not have made;

(b) may not take into account evidence of further training and experience obtained by the applicant since making the application for Review of Appeal; and

(c) must give the applicant written notice of its decision within a reasonable timeframe.

7.27 There was a range of College views about the effectiveness of the process.

7.28 Some of the Chairs of Committees interviewed reported that there is reasonable knowledge of the processes available within the College. In particular, it was explained that candidates are asked to sign a document which outlines the process for appeals, before entering the exam room.

7.29 Other Chairs acknowledged that asking for this to be signed on the day of the exam is not ideal and that the limited timeframes for complaints or reviews reduced the effectiveness of the options available. The recording of examinations, which is given as the reason that substantive challenges are so limited, could be resolved by recording examinations in some way, as in other Colleges. This was raised by some Chairs as an option. They also considered that the College needs to have a clearer and more streamlined way for trainees to seek assistance and for the College to receive complaints and feedback from trainees.[66]

Conclusions on Reconsideration, Review and Appeals Process

7.30 The Reconsideration, Review and Appeals By-law provides *'an internal process for the reassessment of specified decisions made by College Bodies'.* It applies to all activities within the College, including membership matters. However, it lacks sufficient relevance to matters relating to examinations and assessments.

7.31 If a candidate raises a matter under the By-law, it is not easy for candidates or representatives to discern which is the relevant College Body to conduct the Reconsideration or Review. For example, it could be argued that the examiners of the long and short case assessments are in effect the relevant College Body under the By-law, as they are the original decision-makers in respect of the assessments.

7.32 Equally, the Paediatric and Child Health Division Education Committee (PDEC) is charged, under its terms of reference, to *"ensure all forms of assessment are conducted fairly, efficiently, in a transparent manner, and in accordance with standards".*

7.33 Further, the PDEC has an Assessment subcommittee with responsibility to "*oversee the process by which decisions are made about individual trainees as they relate to assessment".* The subcommittee is required to report to the PDEC on occasion. The

[66] Chair, College Trainees' Committee, Australia and Aotearoa New Zealand.

PDEC can make exception reports to the College Assessment Committee *"to address emergent or risk management issues"* or to the Basic Training Committee *"on matters relating to assessment."* The PDEC also has a Basic Training (sub) Committee to *"oversee the Paediatric and Child Health Division Basic Training Program across Australia and New Zealand".*

7.34 It is unclear which College Body is ultimately responsible for the certification of clinical examination results.

Complaint Management Policy

7.35 The purpose of this policy is to set out a process for making complaints and for staff to respond to and process complaints. According to the Policy's overview, it is the policy for management of trainees' complaints, as it *'applies where a person... makes a complaint about a decision the RACP has or has not made'.*

7.36 This policy excludes a complaint of *'matters dealt with under the Reconsideration, Review and Appeals Process Bylaw'.* It states that such complaints *'will be forwarded to the relevant team in the RACP for action ... and will be recorded in, but not be managed under, the complaint management system'.*

RACP Whistleblower Policy

7.37 The Whistleblower Policy is not a policy used to challenge exam or training results. The policy covers misconduct or conduct including for example, systemic misconduct. Complaints under this policy are confidential and may be anonymous. The Policy has been effective since March 2022 and was due for review in March 2024.

7.38 The stated purpose of the Policy is to encourage the reporting of improper conduct that that may cause harm to individuals or the College, and to ensure that individuals who make reports can do safely, securely, and with confidence that they will be protected and supported.

7.39 The Policy applies to "Protected Disclosures" made by any "Workplace Participant", including fellows and trainees, acting in good faith and who have reasonable grounds to believe or suspect the occurrence of "Improper Conduct",

as defined in the Policy. This covers a wide range of conduct from criminal offending to bullying.

7.40 The Policy sets out a range of options by which Workplace Participants can raise their concerns. This includes options to report matters internally by contacting the College's Whistleblower Protection Officers (WPO), and externally through KPMG's FairCall service. Both internal and external reporting mechanisms allow for anonymous reporting.

RACP Code of Conduct

7.41 The RACP Code of Conduct is not a policy used to challenge exam or training results. However, complaints may be made under that policy by members or College employees against directors or other members.

7.42 The Code requires that Directors and Members must comply with their legal and statutory duties as officers of the College and its College Bodies, including:

(a) using their position at the College and the College's resources in a responsible manner;

(b) acting in good faith and in the best interests of the College as a whole;

(c) acting with due care and diligence and for a proper purpose;

(d) avoiding conflicts of interest or duty.

7.43 The Code requires Directors and Members to adhere to behavioural standards including:

(a) act honestly;

(b) treat all other persons fairly and with dignity, courtesy and respect;

(c) not use offensive language or behaviour in the workplace;

(d) not engage in any form of unlawful discrimination;

(e) not engage in any form of bullying or harassment or physical or verbal conduct, which a reasonable person would deem to be unwelcome, offensive, humiliating, or intimidating.

7.44 Complaints are confidential and are dealt with by the President and the Board where required. Complaints can also be made anonymously.

8. Conclusions

8.1 The Expert Advisory Group sets out its conclusions, in answer to the Terms of Reference.

TOR (A): Whether there are factors that adversely impacted the 2021 clinical examination in Australia or Aotearoa New Zealand?

8.2 This Review has concluded that dissatisfaction with the delivery of the examination in 2021, was worsened by the increased pressure on the health system due to COVID-19 as experienced across both countries.

8.3 However, we are also satisfied that there were existing concerns with the structure and delivery of the clinical examination by candidates, which had existed for some years prior, and which do not arise from the pressures of COVID-19.

8.4 The candidate complaints principally come from Aotearoa New Zealand candidates. There is no material evidence that candidates in Australia have complained about the 2021 clinical examination. This Review has principally reviewed the 2021 clinical examination for Aotearoa New Zealand, as it represented the typical format for past and current years and there was limited information provided on the 2021 modified version used in Australia in that year only.

8.5 The conclusions we have drawn, and recommendations made, are applicable for both countries. There should not be any material difference in the structure, delivery or assessment of the examination in either country.

8.6 The following factors have been identified as adversely impacting the 2021 examination. Many of these factors are not unique to the 2021 examination, but represent ongoing and systemic challenges for the College:

(a) There is variability in clinical case selection influenced by patient availability and the local examination organiser understanding of their role.

(b) There is variability in examiner expectation for candidate performance, influenced by lack of specific guidance for examiners as to expectations.

(c) There is inadequate monitoring of individual examiner performance or Quality Assurance activities to monitor for risks or evidence of bias.

(d) There are inadequate processes for timely management of candidate complaints. Existing complaint pathways and policies are not readily communicated, visible or well understood by candidates or clinicians, working within the College. There are also too many formal and informal pathways for complaint, including unclear accountabilities within existing complaint policies. Finally, there has been a lack of response to complaints made which has created the perception that the College is reluctant to engage with complaints.

8.7 This Review also identified aspects of the clinical examinations which may have cause adverse impacts on candidates, in both countries, namely;

(a) The variation in feedback and absence of feedback training for examiners; and

(b) The lack of recording of examination data and information, which could enhance post examination analysis including ethnicity, disability and demographic characteristics of examiners and candidates and case complexity.

8.8 In addition, some aspects of the clinical examinations requiring attention are specific to Aotearoa New Zealand, namely:

(a) The small examiner pool and population of paediatricians, which is a small specialty;

(b) The small number of assessment sites, i.e. teaching hospitals;

(c) The higher likelihood of candidates and examiners having worked together;

(d) The difference in calibration training; and

(e) The failure to provide any unconscious bias training to examiners in Aotearoa New Zealand.

8.9 In relation to the New Zealand 2021 examination process, the examination was conducted in the same in person format as in previous years, and had a similar pass rate to previous years in the region of 76%.

8.10 In Australia, the 2021 examination was conducted in a significantly different format with the use of Zoom and a much longer time between long and short cases, enabling longer preparation. The 2021 pass rates in Australia were 88% which was significantly higher than the pass rate in 2020 of 75%. The change in the Australian examination format and timing appears to have advantaged Australian candidates, as the increase in the pass rate was material when compared with previous years.

TOR (B): The long and short case structure and the appeals process

8.11 This Review has concluded that the long and short case structure remains valid and is a viable high stakes clinical examination structure. However, it is no longer regarded as a gold standard for clinical examinations. It is therefore timely that the College has commenced a review of all clinical examination structures in 2024, to determine a best practice model or models.

8.12 The long and short case structure for clinical examinations requires effective training and support for examiners to reduce the risks of variability and bias, which are inherent within this examination structure.

8.13 The Advisory Group found more widespread support for the long case primarily due to its face validity for replicating the everyday work of paediatricians. More

varied options were found for the short case which is viewed by some candidates and examiners as superficial. Overall, the structure of the 2021 clinical examination in New Zealand with two long cases and four short cases meets the Norcini et al's (2018) criteria of good assessment, being valid and reliable. Notably the examination structure has the following positive features:

(a) equivalence due to the use of rubric marking and examiner training;

(b) being feasible in its practicality and acceptable to most stakeholders; and

(c) promoting educational effort i.e. practice. However, the catalytic effect of feedback driving learning is not strong and could be improved.

8.14 The variation in case complexity was a key issue for complainants in Aotearoa New Zealand in 2021, for both the long and short cases. The hospital system restrictions on clinical time and training as well as the difficulties in a relatively smaller population, appear to be additional adverse factors affecting candidates in New Zealand more than in Australia.

8.15 The structure and process for appealing examination outcomes is inadequate and requires revision. This Review concludes there is a lack of transparency, information and avenues for timely appeal of examination results. This applies equally to both countries.

TOR (C): Review of training for examiners on unconscious bias

8.16 There is no evidence of any unconscious bias training delivered to examiners in 2021.

8.17 Unconscious bias training was only introduced for examiners in Australia in 2023 and was not delivered formally to examiners in Aotearoa New Zealand until 2024. Two senior examiners from Aotearoa attended the 2023 Australian training and gave an informal summary to the Aotearoa examiners at their calibration day.

8.18 The examiners in Aotearoa New Zealand are conscious of the conflicts and pre-existing knowledge concerns that arise with relatively small Paediatric candidate and examiner groups. However, there has been difficulty in obtaining sufficient

examiners, such that it is not possible to avoid being assessed by at least one or more examiners who the candidate has known or have worked with.

8.19 The conflict concern could be reduced if a larger pool of Australian examiners were available to travel to Aotearoa New Zealand or candidates could travel to Australia. In Australia, the College pays for paediatricians to assess in locations other than their home state. These solutions require consideration by the College for Aotearoa New Zealand, to reduce the risk of conflict and bias.

TOR (D): Whether the 2021 examination resulted in bias against some candidates, based on race?

8.20 The Advisory Group is not able to make any assessment of individual candidates' complaints of racism, as these complainants declined to come forward to this Review.

8.21 However, based on the evidence presented from participants and the acceptance of structural bias in the health sector more generally, we are satisfied that unconscious bias including racism, did likely exist in the clinical examination processes in both Australia and New Zealand in 2021 and in other years.

8.22 The Advisory Group accepts the evidence of the Chair of the Māori Health Committee and the Chairs of the Trainee Committees, that unconscious bias including structural and unconscious racism has existed in the clinical examinations in 2021 and in other years. The recent findings of the JAMA Network Investigation, *Māori Medical Student and Physician Exposure to racism, discrimination, harassment and bullying*, July 2024, highlight that there is a significant exposure to racism within the health sector for Māori students and medical professionals.

8.23 The lack of unconscious bias training in 2021 will also, in our assessment, have increased the risk of bias in the examiner pool. This Review has highlighted there are conflicting views held by College Chairs about the existence of structural or cultural bias within the clinical examination. This will require work by the College to ensure that there is a sound understanding of the existence of bias and structural racism that exists in the health profession. The inconsistent acknowledgement that this exists is not assisted by the lack of training.

8.24 Finally, it is notable that the College does not currently collect any data on ethnicity or disability status of candidates either in an examination setting or otherwise. This is preventing the College from being able to evaluate its performance on equity goals or any assessment of bias.

8.25 The absence of this focus on gathering and assessing such date is itself a key indicator of structural bias towards the concerns of the majority.

9. Recommendations

9.1 The Terms of Reference ask the Expert Advisory Group to make recommendations as a part of this report. The following recommendations are made to ensure that the clinical examination process is meeting the needs of candidates and the College.

Recommendation 1: Key principles to be adopted: The first recommendation is that the College adopt four key principles when considering its examination and appeals structure:[67]

> Transparently Fair: It is widely accepted that organisations providing services that benefit the public should be open, transparent and fair about their process. Providing information, in an accessible way, about all relevant process that are fair, and seen to be so, can reduce uncertainty for individuals, assist in managing expectations and creating greater accountability.
>
> Responsive: This ensures that matters are dealt with as quickly as possible and escalated where appropriate. Proportionate and appropriate processes are built on a commitment to timeliness.
>
> Accountable: The College and its various committees and staff must clearly understand their roles and responsibilities, in relation to the examination structure, delivery and outcomes. Greater public reporting

[67] These four principles are derived from those recommended by the Australian National Health Practitioner Ombudsman Report, *Processes for progress,* dated October 2023.

to candidates and related associations and representative bodies, on process, monitoring and evaluation, will also ensure accountability.

People focused: Specialist clinical examination is a high stakes examination process affecting both the candidate, patient volunteers, examiners and the broader community who will ultimately be receiving healthcare from successful candidates. A people focused approach will ensure that processes are respectful and accessible, considering of the diversity of candidates, patient volunteers and examiners.

We consider the use of guiding principles to be a valuable underpinning for the remaining recommendations below. This first recommendation follows the recent findings of the National Health Practitioner Ombudsman Report dated October 2023, *Processes for progress, Part one: A roadmap for greater transparency and accountability in specialist medical site accreditation.* The Ombudsman's Report should be considered alongside this Report.

Recommendation 2: Publication of this Report: We recommend that the College publish this report to all interested parties. This will ensure that the principles of transparency and accountability are evident to past and current candidates and the national Resident Doctors Associations. It will also allow the Examination Committees and examiners to be fully informed of the nature of the complaints and the outcome of this Review. The College should commit to a publishing an update in 12 months' time, detailing the recommendations that have been accepted and implemented.

Recommendation 3: Candidate Information and Q&A Sessions: The College should provide regular and comprehensive in person or live online presentation of information for examination candidates. This should occur both before and after the clinical examination, to ensure that candidates are well informed of the clinical examination and assessment process, the complaints and challenge processes and the overall results and trends. These presentations should allow for candidates to ask questions and provide feedback for the College, both before and after the clinical examination each year.

Training recommendations

Recommendation 4: Training for Examiners: All Aotearoa New Zealand clinical examiners should, be offered and if possible, attend the pre-examination training and calibration days in Australia or have them delivered in person in Aotearoa New Zealand. This will ensure that all examiners obtain a consistent level of training which is repeated annually. This training should include expert providers delivery of unconscious bias and cultural training annually.

Recommendation 5: Unconscious Bias Training and Cultural Awareness Training: This training should be commissioned and developed for the College by external consultants who are expert in the field of this training, considering the differing indigenous contexts for Australia and Aotearoa New Zealand. This training should be compulsory for all examiners and delivered consistently and annually across all Examiner Calibration Training Days.

Recommendation 6: Manuals for Examiners: The College should prepare and distribute an up-to-date Clinical Examination Manual for Examiners, as part of the training to confirm the training, best practice standards and procedures and conflict and conduct requirements for examiners. This manual should also be made available to the Aotearoa New Zealand and Australian Resident Doctors Associations and Trainee Committees, for transparency.

Recommendation 7: Training for College Chairs: It is recommended that mandatory training is introduced for all College Chairs to ensure there is a common and agreed understanding of the existence of structural or cultural bias within the clinical examination and College more generally. The recent findings of the JAMA Network Investigation, *Māori Medical Student and Physician Exposure to racism, discrimination, harassment and bullying*, July 2024, put the need for understanding beyond doubt.

Examination recommendations

Recommendation 8: College Examination Moderators to attend in Aotearoa New Zealand: In each examination centre in both Australia and Aotearoa New Zealand, there should be a senior examination moderator from the College present to ensure quality assurance standards are being meet consistently across both countries. It is recommended that a minimum of ten examiners from Australia should assist in clinical examinations in Aotearoa New Zealand, in line with the support offered by the College to Tasmania and South Australia, and that New Zealand examiners attend examinations in Australia to ensure improved knowledge and consistency of Australasian standards.

The College should also advocate with Health New Zealand, to achieve a more flexible assessment period similar to Australia, which will support improved examiner diversity.

Recommendation 9: Examiners Conflicts of Interest Policy and Register: This conflicts policy should be documented and approved as a written College policy to ensure that all examiners declare if they have an existing working or personal relationship with an examination candidate. Each examiner should be required to complete a conflict-of-interest form as part of their induction. The examiners should not be part of the examination panel for that candidate. A written Register of Interests should be prepared ahead of the examination, to ensure planning to avoid conflicts and be visible for all parties at each examination centre.

Recommendation 10: Case complexity: It is recommended that the Clinical Examination marking sheet include a recording of the complexity of each case so that it can be considered in discussing failing candidates in the Examination Committee. This record will then be available in the case of any reviews or appeals.

Recommendation 11: Clinical examination changes to be considered: The Cross College Review of Examinations should consider video or audio recording of the clinical examinations in each centre, so that if there is a challenge to a clinical examination, it can be dealt with based on the recorded examination. The College

could consider a trial of this technique for small specialties such as Paediatrics in smaller examination locations such as Aotearoa New Zealand and Tasmania.

It is also recommended that the College Review consider a change to the short case format to include a broader range of clinical skills, with similarities to a MiniCEx. The College should review benchmarking assessment against the clinical assessments conducted by other specialist colleges.

It is recommended that the College allocate additional budgetary resources for sending candidates who have previously failed and/or a random selection of candidates to Australia for their examination.

Practice and Work Based Assessments should be considered in special considerations, if candidate health or other circumstances justify this approach.

Recommendation 12: Improved feedback to candidates: The College should improve the quantity and quality of feedback to candidates, from both the long and short case components of the Clinical Examination. Part of the calibration and training of examiners should include the provision of constructive feedback. Improvements in this area may go a long way to explaining to candidates a negative result and providing them feedback, to focus on in improving their clinical skills for a future attempt at the examination. Feedback for successful candidates is also required to assist them develop during their advanced traineeship.

College process improvements

Recommendation 13: Ethnicity, gender and medical qualification data: The College should establish a system to gather the ethnic, gender and country of origin of medical qualification data of both examiners and candidates, so that the College is able to track and report on the diversity of candidates as compared with only aggregate pass and failure rates. This will ensure that the College is able to set benchmarks, goals and measure for diversity and inclusion improvements and enable more analyses to be conducted for quality assurance purposes. For quality

assurance purposes, this data should be publicly reported including to College Trainees and relevant Resident Doctors Associations.

Recommendation 14: College Committee structure to be simplified: This Review has identified that the structure of College Committees is complex and appears to have overlapping and unclear roles and responsibilities. The number of Committees should be reduced to avoid overlap and role confusion. The Committees should ensure they each have clear written Terms of Reference and that these are made available on the College website. The names of the Committees should be sufficiently distinctive to allow easy demarcation for all College members.

Recommendation 15: Complaints process to include ability to seek review of examination outcome: The College should amend its complaints policy to include the ability to challenge the examination outcome, where there is an allegation of bias, discrimination or a decision that is otherwise outside the reasonable range of findings available to an examiner panel. These are natural justice grounds of challenge that should be available to a candidate, beyond the current grounds for complaint which relate to special or extenuating circumstances that relate to the candidate.

It is recommended that members of the College Trainee Committees are involved in the redesign of the complaints process.

Recommendation 16: Complaints process to be simplified: This Review has found that there are multiple pathways for complaints to be received by the College. However, these pathways are not well understood by the Committees or candidates. The pathway for complaint should be simplified with one senior College manager and office, responsible for receiving and administering the progress of all complaints. The determination of the complaint will still be delegated for determination by an appropriate Committee, but this should be one Complaints Committee with members trained to receive and deal with complaints, support by the College administration to ensure they are progressed promptly.

Recommendation 17: Clinical Examination Fee: The College should annually provide all candidates, the National Resident Doctors Associations and Trainee Committees, with a detailed explanation of the way in which their fee is used to meet the costs of the examination and administration within the College. Consideration may be given to reduced fee for second and subsequent examinations, where candidates are required to take the examination again in subsequent years and have financial circumstances that warrant consideration.

Recommendation 18: Apology by College to 2021 complainants for failure to deal with complainants in a timely manner. It is recommended that the College offer an apology to the anonymous complainants, via the New Zealand Resident Doctors Association and the College Trainee Committees, acknowledging the unacceptable delay in response to the complainants raised. The apology may also offer a facilitated discussion for any anonymous complainants who wish to come forward to discuss the recommendations in this Report.

Appendices

Appendix A – Resumes for Advisory Group members

Maria Dew KC, Chair of the Advisory Group

Maria Dew is a senior barrister practising from Britomart Chambers in Auckland, Aotearoa New Zealand. Maria's practice has focused principally on employment law, professional misconduct health law and human rights. In the last decade, she has also been appointed to conduct independent reviews and investigations including in the health, justice and legal sectors, and for sports, media and banking organisations. Maria also sat as a Deputy Chair of the Health Practitioners Disciplinary Tribunal for nine years and is a past President of the New Zealand Bar Association | Ngā Ahorangi Motuhake o te Ture.

Dr Stephen Inns

Dr Inns is a Consultant Gastroenterologist in Wellington, Aotearoa NZ, with extensive experience in clinical practice and medical education. He served as the RACP Aotearoa NZ President and Board member from 2022 to 2024. Stephen is a senior examiner for the RACP and was a member of the Aotearoa NZ Clinical Exam Committee from 2013 to 2022. He is also a senior lecturer at the University of Otago, Wellington, where he teaches and examines in the MBChB course.

Professor Maree O'Keefe

Professor O'Keefe is a general paediatrician and clinical professor at the University of Adelaide. She is deputy chair of the Australian Health Practitioner Regulation Agency Accreditation Committee, and a senior examiner and clinical examinations chair with the Australian Medical Council. She has recently completed a four-year term on the RACP Governance Committee and is a past chair of the College Paediatric and Child Health Division Education Committee.

She sat for many years on the South Australian Health Practitioner Tribunal and has provided advice as an independent consultant to Australian and New Zealand professional accreditation councils. She is a Principal Fellow with the Higher Education Academy (UK) and a graduate of the Australian Institute of Company Directors.

Dr Melanie Yeoh

Dr Yeoh is a general paediatrician and neonatologist currently working at the Perth Children's Hospital in Western Australia (WA). She completed her Bachelor of Medicine through the University of Newcastle. Dr Yeoh completed her training in New South Wales, WA, Northern Territory and Victoria. She is an active WA Child and Adolescent

Health Services Human Research Ethics Committee member and supports the BMJ as a reviewer. Dr Yeoh holds roles in medical education and clinician development as a Clinical Examiner and Tutor at the University of Western Australia, with previous roles at the University of Melbourne, and as a RACP Clinical Examination Tutor. She will be a local examiner in 2025 for the RACP Clinical Examination. Within the RACP, Dr Yeoh is an Advanced Training Supervisor and member of the College Learning Series Editorial Group, having been a member of the WA and Vic-Tas Trainees ' Committees.

Dr Deborah O'Mara

Dr O'Mara is a recently retired Professor of Medical Education and a nationally and internationally recognised expert in medical education assessment, selection and psychometrics. She was an integral part of the leadership team in the University of Sydney Medical program. In 2017, the Assessment Unit which Dr O'Mara led was recognised with the Association for Medical Education in Europe (AMEE) Aspire for Excellence in Assessment Award. Earlier in her academic career, Dr O'Mara was a tutor focusing on assessment in education at Macquarie University while she worked on her doctorate in education (conferred 1991).

Since retiring from the University of Sydney in early January 2023, Dr O'Mara was awarded the title of Honorary Professor, Sydney Medical School, Faculty of Medicine and Health and became a graduate of the Australian Institute for Company Directors (GAICD). In the last 12 months she has been appointed to two organisations as an independent member; Royal Australian College of General Practice (RACGP) Education and Workforce Committee and Academic Board of New Medical Education Australia Pty Ltd.

Dr O'Mara has also had a significant research consultancy career for a cross-section of commercial and not-for-profit clients. Through her consultancy company, DOMensions Consulting Pty Ltd, she advised on maximising the use of in-house data for marketing and strategic decision-making.

Dr James Anderson

Dr Anderson is a registered medical practitioner, qualifying BMSc (Hons) in Applied Orthopaedic Technology in 2012, MBChB in 2014 from the University of Dundee (Scotland). Dr Anderson completed his first 2 years of postgraduate general medical rotations in Scotland. On moving to New Zealand, Dr Anderson, passed his Royal Australasian College of Physicians Paediatric Divisional Written and Clinical examinations in 2021. Since that time has worked in the Dunedin Hospital for 5 years and is currently a junior paediatric fellow working in Wellington Hospital, where he has worked for the past 3 years.

Dr Anderson sits on the Aotearoa New Zealand Royal Australasian College of Physicians trainees committee as a representative of paediatric trainees. This committee is one of the interfaces between the college and trainees for consultation, feedback and change management.

Dr Anderson is the President of the New Zealand Resident Doctors Association, a role which he has held for the past 3 years. Dr Anderson is also the Chair of the Board of Trustees for the New Zealand Resident Doctors Association Education Trust, a trust established to further provide financial support for the furtherance and protection of the education or training of RMOs in all aspects of medical practice in Aotearoa New Zealand.

Dr Davina Buntsma

Dr Buntsma is a recent Fellow in General and Adolescent Paediatrics currently working in Adolescent Medicine and Refugee & Immigrant Health at the Royal Children's Hospital in Melbourne. She completed her Bachelor of Medicine and a postgraduate certificate in Clinical Education through the University of Melbourne. Dr Buntsma has completed paediatric training in Victoria, New South Wales and the Northern Territory.

Dr Buntsma's clinical education experience includes roles as a Clinical Teaching Fellow and Examiner at the University of Melbourne as well as four years as a trainee representative on the RACP College Education Committee. She completed surveyor training in hospital site accreditation and has participated in site accreditation visits. As a Paediatric Chief Registrar in 2021, Dr Buntsma has recent experience coordinating and supporting paediatric trainees through the clinical examination.

Dr Buntsma was appointed to the Paediatric Clinical Examination Review Expert Advisory Group in her role as Trainee Board Director on the RACP Board (2022- May 2024). Prior to this, she has served as Chair of the RACP College Trainees' Committee (2018-2022) and has held trainee representative roles on the Fellowship Committee, as well as NSW-ACT and Victorian-Tasmanian Regional Trainees' Committees.

Appendix B – Terms of Reference

Appendix C – List of Documents reviewed

Appendix D – List of Literature reviewed