

Selection into Training Quality Assurance and Improvement Initiative

Discovery Phase Report | Advanced Training

October 2025

Purpose of this document

This report describes the current state for recruitment, selection and entry into the RACP's Advanced Training programs. It provides a foundation for later phases of the Selection into Training Quality Assurance and Improvement Initiative. The report aims to strike a balance between providing sufficient representative detail for Advanced Training programs in each jurisdiction and synthesising key commonalities and distinctions. The report does not include exhaustive detail.



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Executive Summary

Background

In July 2024, the CEC approved the “Selection into Training Quality Assurance and Improvement” initiative to develop an evidence-informed and stakeholder-guided strategy to support the quality assurance and quality improvement of selection and entry into Basic and Advanced Training programs in Australia and Aotearoa New Zealand. This initiative was developed in response to regulatory expectations from the Australian Medical Council (AMC), feedback from trainees, supervisors, and educational leaders, and increasing external interest in the relationship between physician training and workforce planning.

Methodology

The project has three phases:

1. **Discovery** - Understanding current selection practices.
2. **Evaluation** - Assessing these practices against RACP standards and identifying improvement opportunities.
3. **Response** - Implementing recommendations.

The discovery phase was guided by a set of structured questions, and for the complex environment of entry into Advanced Training a conceptual framework including ‘systems evaluation theory’ SET (Renger, 2015) was incorporated to assist in describing and evaluating the current state of diverse approaches through a common frame of reference. Multiple sources and lines of inquiry are synthesised into the findings presented in this report. Stakeholder identification and engagement were undertaken alongside a desktop review of available information about entry and selection processes for each Advanced Training (hereafter collectively referred to as “AT”) programs across jurisdictions. In addition, twelve focus groups with those conducting recruitment and selection, and three with trainee representatives, were facilitated by an RACP staff member. Recruitment to focus groups was designed to sample a range of jurisdictions over a spread of AT specialties to confirm desktop findings and explore the local context.

Findings across all programs were synthesised into this report, with additional detail provided where appropriate to illustrate how selection and entry into training operate in different contexts.

Findings

Findings from the Discovery phase process for entry into AT are described according to components of the SET framework. This process identified the range of *subsystems* that interact in the selection and recruitment of trainees to AT programs and the *control boundaries* that influence how subsystems interact and may operate differently in different contexts to influence selection and recruitment outcomes. After thematic analyses, for clarity and ease of interpretation, the mechanisms by which selection into training operates are described in layers titled ‘models’ as an organising principle to accommodate the multiple combinations of specialties * jurisdictions that form the selection and entry into RACP AT programs landscape. Models are described on a continuum of centralisation apparent in the

processes and the factors that influence the level of centralisation.

Regardless of the model used, selection processes typically follow recruitment processes combining CV review, written statements, referee reports, and structured interviews (often formed by panels). Models that exhibit greater centralisation and relatedly greater emphasis on a *training pathway* rather than a specific job role tend to emphasise motivation and capability for training and specialty career. Common factors include evidence of clinical competence, communication skills, professionalism, teamwork, cultural safety, and motivation for physician training. There are differences between specialties in terms of emphasis.

Limitations

It was not feasible through this discovery process to provide an exhaustive report of all specialty by program selection processes, in part because information publicly available about selection into training processes can be transient and transactional, designed for the recruitment period. In addition, this report has been produced with limited opportunities to member check interpretations of focus group data collected made by the authors.

A key aim of this work was to provide a demographically stratified quantitative report focused on the supply, demand and success rates of entry into training. However, this was not feasible at this stage due to differing protocols and retention practices used across jurisdictions for data management, and a longer than anticipated lead time for sourcing this data. Mapping this data will remain a *focus for future collaboration across the RACP and jurisdictions*.

Conclusion and next steps

The findings in this report demonstrate the common and divergent factors affecting approaches to recruitment and selection into AT programs. The discovery phase has collected a great deal of dispersed and internalised information about goals, rationale, structure and process related to how specialties as professions and custodians of entry into training for professions aim to attract, recruit and train ATs in the context of their local jurisdictional employment and workforce demands and constraints. Significant tensions are describable in the relationship between the goals of selecting for a program of training and those of fulfilling workforce needs in health systems. This can result in scenarios where these goals conflict and produce an outcome of a registrar working in an AT position to fulfil workforce needs, but their selection into training program status may render certification of training fulfilment for such time problematic. Attributes assessed through selection in AT are similar to those in BT but with greater depth and focus on motivation and capability for individual specialty job profiles. Clinical competence is more aligned to specific work experience for specialties where BT is not a requirement (e.g. most Faculty and Chapter programs) and highly competitive specialty programs tend to seek more information relating to academic performance or research output either as indicators of specialty-specific attributes or as a discriminatory signal between candidates in tight selection fields.

The report also notes that AT selection is part of a broader medical training system, with reciprocal influences that interact at the boundaries of prevocational, BT, and AT stages, specialty and jurisdiction. These interactions and influences will be framed into the SET evaluative lenses of *efficiency* and *effectiveness* of system and subsystem processes in the Evaluation Phase report along the continuum of entry and progression in physician training.

Background to the initiative

In July 2024, the RACP's College Education Committee approved an initiative to map local trainee selection procedures and identify opportunities for collaboration, support and improvement. This accords with the Australian Medical Council's (AMC) expectations for the RACP to have greater involvement in the quality assurance and improvement of selection into training. The initiative spans Basic and Advanced Training programs in Australia and Aotearoa New Zealand.

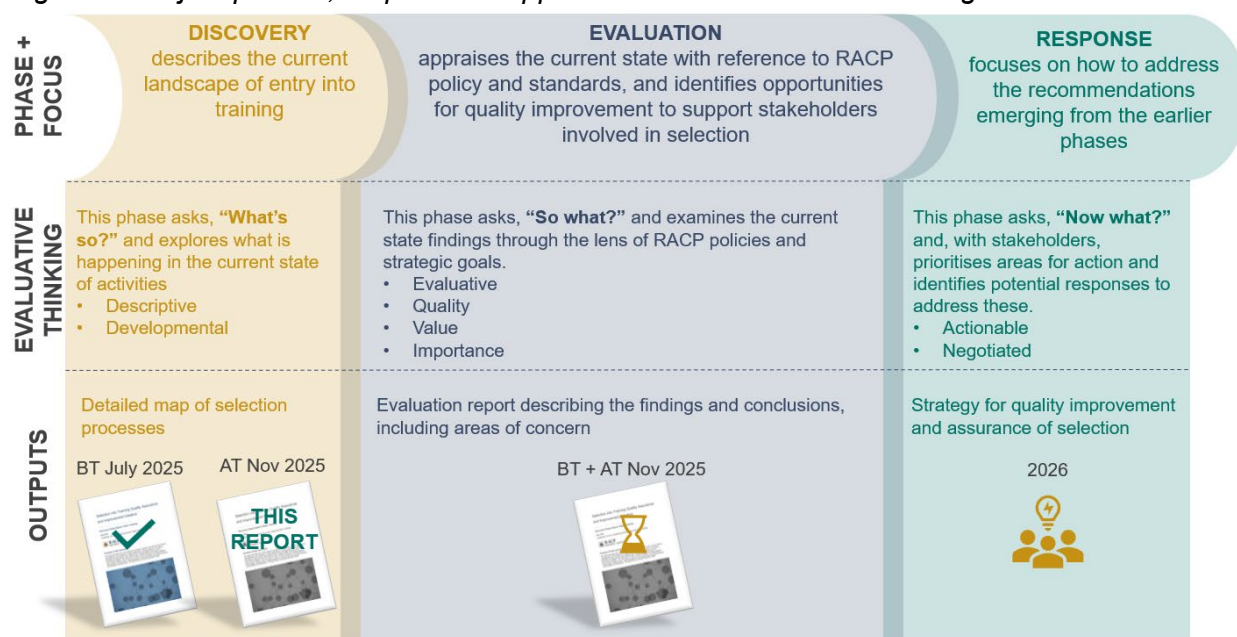
This initiative responds to:

- Feedback from leaders, supervisors, and applicants seeking greater support during selection and entry into training.
- Regulatory expectations for monitoring selection processes and outcomes. (e.g. AMC)
- National reforms (e.g. National Framework for Prevocational Medical Training)
- Increasing interest and inquiry into the relationship between workforce and physician training by external agencies, e.g. the Australian National Medical Workforce Strategy, NSW Special Commission of Inquiry into Healthcare Funding.

Ultimately, the work will result in the development of an evidence- and stakeholder-informed strategy for the quality assurance and quality improvement of selection into physician training.

The work is guided by the 'three phases of evaluative thinking' (Davidson, 2012). This model frames the questions that are asked at each phase and guides the interpretation of the evidence gathered to answer these questions.

Figure 1: Project phases, outputs and application of the evaluative thinking model



Thus far the initiative has delivered a [BT Discovery Phase Report](#) (July 2025) and this AT Discovery Phase Report is the second output. A combined BT and AT Evaluation Report is also being delivered as a companion document in November 2025. In 2026, a group of stakeholders will be convened to use these materials as the foundation for development of an evidence- and stakeholder informed strategy for the quality assurance and improvement of selection into physician training.

Governance

The Discovery and Evaluation phases, i.e. Phases 1 and 2 will be carried out by College teams, working in collaboration with stakeholders, under the auspices of the CEC.

The Response Plan Phase, i.e. Phase 3, will likely be guided by a Working Group / Advisory Group/ Steering Committee composed of members and other stakeholders. However, that approach will be determined at the conclusion of Phase 2 when more information is known about the nature of the issues.

Scope

In Scope

- Entry into Basic and Advanced Training programs in Australia and Aotearoa New Zealand
- Application, selection and entry (and recruitment where this is intertwined) into:
 - Basic Physician Training programs
 - Advanced Training Programs, inclusive of Chapter and Faculty programs
- Australian and Aotearoa New Zealand contexts, inclusive of current and emerging factors that may influence the context.

Out of Scope

- Access to jobs/further training opportunities after completion of training.
- Complex pipelining of medical workforce with reference to training program outputs and community needs.

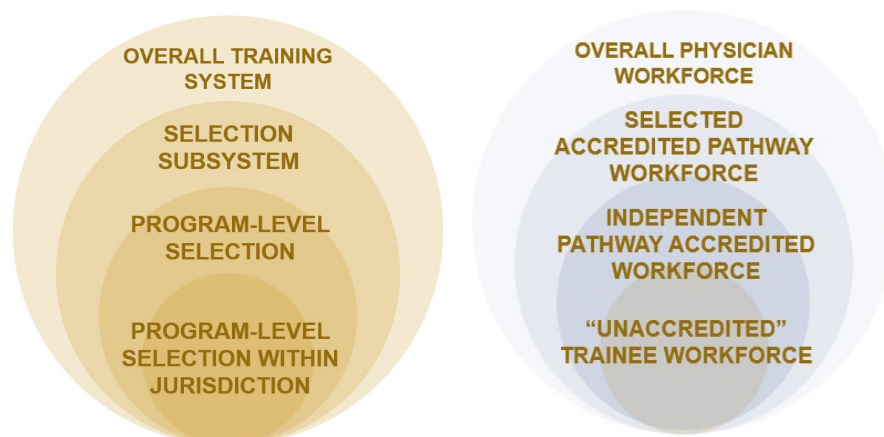
Conceptual framework

As the project shifted focus to Advanced Training (AT) programs, the conceptual framework was expanded to support both the Discovery Phase of AT and the Evaluation Phase across all programs. This change responded to growing complexity due to the number of AT programs and varied governance structures for trainee recruitment.

To manage this complexity, Systems Evaluation Theory (SET) (Renger, 2015) was applied to AT program data. SET offers a structured way to interpret findings at a system level, helping to identify themes and relationships across the training landscape. It also guides the upcoming Response Phase, where insights will be translated into practical recommendations.

Selection into AT programs and recruitment of physician workforce involves multiple layers as shown in Figure 2.

Figure 2: Conceptualisation of selection and outcomes of recruitment as subsystems of the overall training system, per System Evaluation Theory



RACP training is therefore treated as a complex system with a purpose, with selection into training a subsystem within it. SET was used to describe and evaluate its subsystems and feedback loops, focusing on the efficiency and effectiveness of selection at the AT program level, with interjurisdictional consistency as a key consideration.

The following sections explain how SET was applied in this project.

Systems Evaluation Theory (SET)

SET is a structured way to understand and assess complex programs by looking at how different parts work together to achieve outcomes. Instead of evaluating components in isolation, SET focuses on the system's overall purpose, its parts, boundaries, and feedback loops.

Each system is described through:

- **Inputs:** resources and conditions entering the system
- **Processes:** interactions between parts
- **Outputs:** immediate results
- **Outcomes:** broader impacts
- **Boundaries:** where stakeholders or organisations interact
- **Feedback loops:** mechanisms for learning and improvement

In this project, SET is used to describe how selection into physician training operates as a program of distributed subsystems across specialties and jurisdictions. It highlights how information, authority, and accountability flow between the College, health services, and applicants.

SET was chosen because many organisations are involved in trainee recruitment, selection, and employment. It also allows consideration of related systems that significantly influence the structure, processes and performance of selection activities, such as RACP accreditation or jurisdictional health structures like Networks and funding.

Importantly, SET uses feedback loops to identify areas for improvement, especially for entities like the College that may not directly control selection processes but can influence them. Additionally, feedback loops in this project are considered as how a system responds

to external influences at the boundaries in a process to achieve its own goals. These responses could include strategies employed by some specialties to manage the different timelines of recruitment offers in other specialty selection systems to mitigate the likelihood of having their own job offers rejected.

SET evaluation occurs in three broad steps:

1. **Describe the system** - identify its purpose, subsystems, boundaries, and feedback mechanisms.
2. **Evaluate the system's efficiency and effectiveness** - determine whether the parts work together as intended and whether the system achieves its purpose.
3. **Use the system's feedback to adapt or improve** - identify leverage points where action can enhance performance or alignment.

The Response Phase reflects SET's adaptive learning function—turning insights into strategic action.

This approach aligns with this project's design, as depicted in Figure 3 which maps the SET steps to the project design, outlining the relevant SET focus questions and actions to each of the three project phases.

Figure 3: SET steps mapped to project phases

PROJECT PHASES	DISCOVERY	EVALUATION	RESPONSE
	describes the current landscape of entry into training	appraises the current state with reference to RACP policy and standards, and identifies opportunities for quality improvement to support stakeholders involved in selection	focuses on how to address the recommendations emerging from the earlier phases
	1. Describe the system Define the system's purpose, parts, boundaries, subsystems, and feedback loops.	2. Evaluate Efficiency and Effectiveness Assess whether system parts interact efficiently (process coherence) and effectively (achievement of purpose).	3. Apply Feedback for System Learning and Improvement Use system feedback loops to strengthen performance, address tensions, and enhance alignment.
	FOCUS QUESTIONS What is the system? Who and what are its components? How do subsystems (jurisdictions) interact?	FOCUS QUESTIONS Are the system's processes smooth, equitable, and aligned with College policy? Where are the tensions or inefficiencies	FOCUS QUESTIONS How can the College respond via strategic action that will create feedback loops into systems/subsystems to improve coherence, fairness, and capability?
ACTIONS	Mapping components of training that influence entry and selection. Mapping how each specialty operates across jurisdictions and identifying boundaries between the College and health services	Evaluating variation in recruitment processes, number of interviews, and alignment with Selection into Training principles.	Developing a response plan/framework so the College can influence system conditions via policy, accreditation, or advocacy.

Defining a system in the context of RACP training programs

Prior to characterising elements of the system, it is important to define components parts in the RACP context. Table 1 outlines the component parts of the training system. These definitions will be used in subsequent sections to describe the results using a common framework.

Table 1: Components of the RACP training system

Component	Definition	Conceptual Application in the RACP Training System
Purpose	The reason the system exists; what it is designed to achieve.	To develop physicians through structured, accredited training pathways.
Inputs	The resources, conditions, and elements required for the system to operate.	Trainees, supervisors, curricula, accredited settings, governance structures, and jurisdictional support. Funding for positions.
Processes	The activities and interactions that transform inputs into outputs.	Selection into training and/or recruitment to positions, supervision, learning activities, assessment, accreditation, and program administration.
Outputs	The immediate products or results generated by system processes.	Trained physicians, assessment completions, accredited posts filled, and progression outcomes.
Boundaries	The limits that define what is inside or outside the system.	The interface between College educational functions and jurisdictional employment systems.
Feedback Loops	The mechanisms through which information about performance is used to adjust or improve the system.	Accreditation review processes, training evaluation, stakeholder consultation, and data reporting. Use of funding for positions.
System Efficiency	The degree to which the system uses resources effectively to achieve its goals with minimal waste.	Relationship between accreditation capacity, available posts, and jurisdictional recruitment processes.
System Effectiveness	The extent to which the system achieves its intended purpose or outcomes.	High validity of selection outcomes (e.g. fair, alignment of candidate and program selection goals), Alignment of training outcomes with curriculum standards, workforce needs, and College policy.
Emergent Properties	New patterns or behaviours that arise from interactions within the system and cannot be explained by individual parts alone.	Variation in training pathways, competition for posts, and distributional trends across jurisdictions.

Methodology for AT Discovery Phase



Work in this Phase asks, “**What’s so?**” and sought to explore the processes, experiences and outcomes of selection into RACP training programs.

Data collection

- Desktop review of available material on selection/entry/recruitment to AT.
- Identification and engagement of positions and groups involved in selection processes.
- Qualitative data from engagements (eg surveys, focus groups) with stakeholders.

Stakeholder engagement

A stakeholder scan was conducted to identify key groups involved in AT selection across specialties and jurisdictions. Due to the wide range of stakeholders, a convenience sampling approach was used to gather indicative qualitative data, rather than aiming for full coverage.

The main stakeholder groups identified were:

- Advanced Training Committees
- RACP-affiliated Specialty Societies
- AT Supervisors/Heads of Departments
- Advanced Trainees
- Other individuals directly involved in selection

We used snowball sampling to identify additional relevant stakeholders and sent one reminder email to encourage participation.

Engagement methods included:

- **Advanced Training Committee members** received a survey and project summary and were asked to share their understanding of AT selection and suggest other relevant stakeholders.
- **Specialty Societies** were selected using stratified sampling based on their reported involvement in selection. They were contacted via the RACP Model of Collaboration pathway.
- **AT Supervisors** were chosen based on specialty, location, and gender. 100 were invited to participate and encouraged to share the invitation within their departments.
- **State and Territory Trainees’ Committees** were contacted with help from the College Trainees’ Committee. They were invited to focus groups or offered a project team visit to an existing meeting.
- **Other stakeholders** were identified through desktop research or referrals via snowball sampling.

Desktop review

Desktop research was conducted to gather publicly available, specific information about selection and entry into AT programs, and develop an understanding of broad trends in the current landscape of selection into AT across and within jurisdictions and specialties. Internet searches were used to gather information about how to apply to Advanced Training Programs by Specialty and in each jurisdiction. Research focused on identifying key stakeholders, processes, governance (organising principles), the timelines and instruments used for recruitment and selection, and which criteria and/or attributes were used in recruitment and selection processes. This information was gathered from the public facing websites of jurisdictions, health services, RACP-affiliated specialty societies, and other key groups involved in selection, such as prevocational medical councils. Meta data was compiled in spreadsheets to populate, where possible, key variables for each specialty/jurisdiction permutation. Detailed content from information sessions, job descriptions or facilitating organisations or collaborations (e.g. PMCV ATSM Match) were downloaded for thematic analysis.

Analysis of data

Focus Groups and Surveys

Focus Groups were used to gather insights on how selection into AT works, and how effective and efficient the processes are. Groups were organised into specialty “waves” based on structure and information needs:

- Participants from Paediatrics and Child Health and Adult Medicine Divisions were grouped separately
- Divisional specialties were split into three waves based on how much information was available from earlier research.
- Faculty and Chapter programs formed a separate wave due to their varied entry pathways.
- Specialty Societies and AT Supervisors made up the final two waves.

Where possible, participants from the same specialty and different jurisdictions were grouped together. When scheduling didn’t allow this, individual interviews were conducted and analysed using the same methods.

Analysis steps were:

1. A traditional detailed qualitative analysis of an initial focus group using a deductive approach, whereby the hypothesis was tested using the focus group guiding questions. Responses were coded based on guiding questions to create a Codebook of themes.
2. Expedited analyses of later focus groups using keyword searches based on the Codebook, summarising content. Microsoft Copilot was used to transcribe interviews and focus groups and generate summaries which were manually checked and adjusted by project staff.
3. A second full analysis of a randomly selected group to verify and refine the Codebook.

The hypothesis we were testing for in the coding was that structural, procedural, and human factors influence:

1. The likelihood of AT candidates gaining a training position.
2. Trainees' choice of pathway and opportunity to complete it; and
3. Program or employer decisions about selection

These factors are thought to include how different governance models and arrangements assess candidate attributes and shape candidate experiences across progression and completion.

The Framework - themes developed to saturation

The following themes were developed based on the results of the initial deep qualitative analysis using *a priori* coding of the initial focus group

- **This report:** Models of selection and recruitment - centralised via networks versus trainee-initiated health-service-based.
- **Evaluation report (BT and AT):**
- Efficiency - are the processes of selecting candidates working the way they should for all stakeholders.
- Effectiveness
 - Opportunity for specialty training and workforce need. i.e. availability – factors that influence ensuring accredited training positions are filled with trainees and whether trainees can attain a training position of choice to fulfill requirements.
 - Effectiveness - is the 'system' selecting the right* candidates for the relevant training program? *'Right' being those who will be most likely to cope/thrive/complete the program, whilst also meeting the demands of the registrar role in the context in which they are training?
 - Progression – successful trainees, meeting service/societal needs, quality - other impacts of program design and HR law – attract, recruit, retain, progress, exit

Triangulation of data

Data from desktop review and focus groups plus surveys were triangulated through cross checking of information about selection and entry processes across specialties and jurisdictions and combined in thematic analyses.

Outputs

- Descriptive report of the selection processes for physician training programs using SET framework and themes of selection models. (This report)
- Identification of key stakeholders and their roles in the selection processes. (This report)
- Identification of common and locally unique contextual factors, challenges and opportunities for stakeholders. (Evaluation Phase report).

Results

Participants and data retrieved

Data retrieved

Table 2 summarises the information gathered from desktop reviews, focus groups and survey data. The desktop review revealed varying levels of detail, from comprehensive webinars featuring Network and Specialty representatives discussing program opportunities and locations, to individual job advertisements for AT Registrar roles on hospital and recruitment websites. Some selection details were also found on third-party websites hosted by collaborations or intermediaries in the process such as the PMCV.

Forty-eight people took part in twelve focus groups of those involved in designing and delivering selection or training. Participants included physicians and administrators involved in selection and program delivery. Participants were highly engaged, especially in learning how selection and entry into AT programs differ across specialties and regions. Three focus groups were also held with College Trainee Committee representatives.

Table 2: Identification by specialty and jurisdiction where information about selection and entry into AT programs was collected.

Program Level	Specialty	NZ	ACT	NS W	QLD	VIC	SA	WA	TAS	NT
PCH Division	General Paediatrics*	F		F	F	F	F	F	F	
	Community Child Health									
	Neonatal–Perinatal Medicine	D		D	D	D	D	D		
Adult Medicine Division	Cardiology	D			D	D.F	D		F	
	Clinical Genetics	D				D	D			
	Clinical Haematology	D		D	D		D	D		
	Clinical Immunology & Allergy									
	Clinical Pharmacology									
	Dermatology (NZ only)									
	Endocrinology	D			D	D. F				
	Gastroenterology	D		D	D	D.F	D	D	D	
	General Medicine	D.F		D	D.F	D	D	D. F	F	
	Geriatric Medicine	D			D	D	D	D	F	F
	Infectious Diseases	D		D	D	D	D	D	D	
	Medical Oncology	D		D	D	D	D	D		
	Nephrology	D		D	D	D	D	D	D	
	Neurology	D	D	D	D	D	D.F	D	D	D
	Palliative Medicine**	D.F		D.F	D.F	D	D	D	D	
	Respiratory & Sleep Medicine	D		D.F	D	D	D	D.F	D.F	
	Rheumatology	D		D	D.F	D	D. F	D	D	
Faculties	Occupational & Environmental Medicine				F					

Program Level	Specialty	NZ	ACT	NS W	QLD	VIC	SA	WA	TAS	NT
Chapters	Paediatric Rehabilitation Medicine									
	Public Health Medicine					F	F			
	Rehabilitation Medicine	D.F		F	F	D	F			
	Addiction Medicine			F	F					
	Sexual Health Medicine			F		F				
Joint	Endocrinology and Chemical Pathology									
	Haematology									
	Immunology & Allergy	D		D	F	D	D	D		
	Infectious Diseases & Microbiology									
	Paediatric Emergency Medicine									
Legend	D.F = Focus Group or Interview and Desktop review		F = Focus Group or Interview				D = Desktop review			

* Information about sub specialty paediatric training programs was discussed in these focus groups.

** Palliative Medicine is also a Chapter training program

Overview of system and subsystem structure

As outlined in the [Conceptual Framework](#) section of this report, in System Evaluation Theory (SET), Selection into Advanced Training is conceptualised as a subsystem of the broader Advanced Training system due to the influence that other activities such as accreditation of training positions, training requirements and training certification that also operate as subsystems in the full training system influence selection and entry processes into Advanced Training. Table 3 describes in SET terminology the relationship between the Advanced Training holistic system and the Selection into Advanced Training subsystem, with examples.

Table 3: SET applied to AT holistic system and the Selection into AT subsystem

SET Component	Advanced Training System (Whole System)	Selection into Advanced Training (Subsystem)
Purpose	To produce competent physicians capable of independent specialist practice, through supervised, accredited workplace-based learning that meets community and workforce needs across Australia and Aotearoa NZ.	To identify and appoint suitable doctors to accredited roles that provide access to RACP Advanced Training.
Inputs	- Eligible trainees (completed Basic Training) - Accredited positions for AT and accredited settings for BT (set by RACP Accreditation Program) - Supervisors, curricula, governance frameworks - Jurisdictional employment systems and budgets	- Accredited positions for AT (set by RACP Accreditation Program) - College eligibility criteria, AT program eligibility or selection criteria, and policy frameworks. - Advertised job descriptions (Registrar / Senior Registrar / SRMO / Fellow). - Applicant pool that meets eligibility requirements. - Selection committees/bodies and matching processes

SET Component	Advanced Training System (Whole System)	Selection into Advanced Training (Subsystem)
Processes	- RACP Accreditation Program (subsystem): assesses and approves training settings and posts to ensure appropriate supervision, case mix, and training scope. - Curriculum-based teaching, workplace assessment, and progression reviews. - College monitoring and site reaccreditation cycles.	- Local governance framework (DoTs/HoDs, selection committees). - Eligibility checks as entry - Application → shortlisting → interview → ranking → (possibly matching) → offer. - In some contexts, 'pre-meets' are encouraged in others prohibited. - College certification of training as accredited and site accreditation before enrolment.
Outputs	- Trainees appointed into accredited posts delivering service + education. - Data on training capacity (number of accredited posts) and distribution of trainees. - Workforce supply of registrars progressing to Fellowship.	- Ranked and appointed candidates into available accredited posts. - Doctors in registrar or equivalent /more senior roles registered with College for training approval and oversight.
Boundaries	Accreditation defines system boundaries—only accredited posts/hospitals can host AT or BT trainees. - Interface between College (education/accreditation) and Health Departments (employment/funding).	Operates within jurisdictional employment frameworks but must also fall inside College - accredited boundaries for eligibility ("Registrar in accredited training setting"). Temporal boundaries: timing of selection and/or recruitment campaigns
Feedback Loops	Accreditation reviews and College site visits inform training capacity adjustments.	Accreditation of training position(s) and duration of accreditation.
System Efficiency	Efficiency depends on alignment between accredited capacity and funded employment positions. Duplicate approval or unfilled posts reduce efficiency.	The efficiency of selection depends on matching candidates to available accredited posts and avoiding redundant applications/interviews.
System Effectiveness	Effectiveness is achieved when accredited posts deliver quality training and meet workforce needs. Requires continuous capacity monitoring and accreditation alignment.	Effective selection fairly identifies trainees ready to enter appropriate accredited roles with clear scope and supervision, and who have the capacity and opportunity to complete the training program. Selection processes and outcomes are transparent and communicated.
Emergent Properties	A binational education–employment ecosystem that adapts to changing workforce and training demand through accreditation cycles, policy updates, and jurisdictional coordination.	Local selection models produce functionally equivalent outcomes aligned within boundary conditions (accreditation + eligibility rules).

Selection into AT subsystem

Description of the selection into AT programs and recruitment into accredited positions subsystem(s)

The following sections describe the findings related to current situation in the Discovery Phase for selection into Advanced Training programs in Australia and Aotearoa New Zealand. Results include data was available from desktop reviews and focus groups but is not claimed to be exhaustive.

The results are structured using the SET framework. Selection inputs are first described by job roles at the specialty level within each jurisdiction, as most trainees enter AT at the Registrar level. Job seniority titles tend to be consistent within jurisdictions rather than across specialties. Following the job role description other inputs are described including eligibility criteria and participants in the processes.

Section [5. Selection processes](#) explains the selection processes and outcomes. Since models and pathways vary by specialty and jurisdiction, a thematic approach was used to describe selection systems along a spectrum of centralisation. This model helps illustrate consistency in applicant experience, though centralisation is not necessarily preferred or the only pathway to achieve consistency. Recruitment into accredited positions is described as a separate but related subsystem as part of these models, as the functions and outcomes of selection and recruitment do not always align in some specialties, and selection to a program pathway is not always the model for entering an AT program.

[Section 8](#) considers the outputs of selection and a description of how subsystems of selection and accreditation interact (or not) to produce these results. These results are key inputs into the Evaluation Phase reporting which will consider the SET concepts of feedback loops between subsystems and structures that impact the efficiency and effectiveness of selection and entry into training at all levels of training.

Key findings are summarised as themes identifying structural and functional patterns in specialty program selection, with examples provided to show how local factors shape training entry. More detailed information about selection and entry subsystems by specialty and jurisdiction are available in the [Appendices](#) to this report.

The narrative highlights both commonalities and differences in selection processes, without implying that one approach is superior.

Selection inputs

1. RACP guidelines about selection and entry to Advanced Training

RACP guidelines and policy regarding include criteria that prospective Advanced Trainees must demonstrate for entry to training and the Standards and Principles that must be addressed by those conducting selection activities, as outlined below.

1.1 RACP Selection into Advanced Training criteria

The RACP specifies within training handbooks that prospective Advanced Trainees should demonstrate:

- a commitment and capability to pursue a career within the specialty.
- The ability to plan and manage their learning.
- The ability and willingness to achieve the common learning goals for Advanced Training:
 - Team leadership
 - Supervision and learning
 - The professional behaviours, as outlined in the [Professional Practice Framework](#)

1.2 RACP Selection into Training Policy

The [policy](#) sets out the principles which underpin selection into RACP training programs and standards for the process of selection into training at RACP accredited training settings. The standards listed refer to fairness, validity, reliability, sustainability, collaborative and accountable.

2. Accredited positions for AT (set by RACP Accreditation Program)

2.1 Accredited training positions

RACP training handbooks specify that “Trainees must have secured employment with an accredited setting before applying for Basic or Advanced Training.” The RACP’s accreditation of training settings process is based on an assessment of the extent to which settings provide:

- an appropriate level of supervision
- sufficient clinical experience
- opportunities for continuing education and research
- suitable training infrastructure.

RACP Accredited training positions for each Specialty and jurisdiction are listed on the RACP website: [Advanced Training accredited settings | RACP](#). Although current trainee membership numbers may not exactly correspond, Table 4 shows the current College membership for Fellows and Trainees by specialty as ‘snapshot’ of the volume of training positions and is provided for context to the perspectives considering competition or lack thereof for positions in AT programs. This information was sourced from the College membership reporting system (BI Hub).

Table 4: Current College membership for Fellows and Trainees by specialty

Note: For PII reasons, numbers has been masked with <5 or n.p.(not provided)

Rank	Specialty	# Members	# Fellows	# Trainees
1	General & Acute Care Medicine	3,960	2,578	1,336
2	General Paediatrics	3,660	2,487	1,124
3	Cardiology	2,210	1,962	243
4	Geriatric Medicine	1,932	1,476	437
5	Medical Oncology	1,580	1,303	268
6	Gastroenterology	1,579	1,353	226
7	Respiratory and Sleep Medicine	1,439	1,201	271
8	Endocrinology	1,361	1,117	243
9	Neurology	1,268	1,057	206
10	Haematology	1,097	871	224
11	Nephrology	1,094	910	182
12	Rehabilitation Medicine	1,003	730	273
13	Palliative Medicine	943	661	281
14	Infectious Diseases	834	647	186
15	Public Health Medicine	749	588	161
16	Neonatal and Perinatal Medicine	715	434	272
17	Rheumatology	688	560	128
18	Community Child Health	655	290	357
19	Occupational & Environmental Medicine	473	354	119
20	Paediatric Emergency Medicine	339	207	126
21	Addiction Medicine	329	241	88
22	Nuclear Medicine	236	220	16
23	Clinical Genetics	226	166	56
24	Sexual Health Medicine	214	169	45
25	Infectious Diseases & Microbiology	213	148	65
26	Immunology and Allergy	211	162	49
27	Clinical Immunology and Allergy	186	120	65
28	Clinical Pharmacology	118	96	22
29	Adolescent and Young Adult Medicine	105	51	53
30	Clinical Haematology	95	60	34
31	Dermatology	85	73	12
32	Intensive Care Medicine	72	72	0
33	Endocrinology and Chemical Pathology	13	13	0
34	Child and Adolescent Psychiatry	7	7	0

2.2 Job positions advertised for AT training positions

Table 5 provides a comparison table of job titles that are relevant to the AT programs.

Key findings

- Jobs are predominantly Registrar at entry level, often advertised as “Advanced Trainee”. Exception may occur when a SRMO job has achieved accreditation with RACP due to the nature of job activities and supervision in a particular unit (NSW)
- Job seniority regularly increases with progression through training. Some subspecialty experiences required in later stages of advanced training require trainees to apply for and obtain Fellowship positions. Doctors with existing Fellowship (e.g. FRACP, FRACGP) less likely to seek Registrar level positions.

Table 5: Job titles that are relevant to AT programs

Jurisdiction	Main Job Title(s)	Variants / Exceptions	Specialties where variations observed	Job Title Consistency between Specialties.
Queensland	Registrar (standard for AT positions)	<i>Senior Registrar</i> (used in Neonatal & Perinatal Medicine, Medical Oncology, sometimes General Medicine to denote final-year ATs). <i>Provisional Advanced Trainee</i> (in some network documents; equivalent classification).	General Medicine, Cardiology, Clinical Haematology, Infectious Diseases, Medical Oncology, Nephrology, Neonatal & Perinatal Medicine	Very consistent: all AT positions are Registrar-level, salaried through Queensland Health. Networks manage rotations; title rarely varies by specialty.
Victoria	Registrar	<i>Senior Registrar</i> in a few tertiary centres (Haematology, Neonatal & Perinatal Medicine). <i>Fellow</i> occasionally used post-core years (Endocrinology, Cardiology).	General Medicine, Cardiology, Haematology, Endocrinology, Gastroenterology, Neonatal & Perinatal Medicine, Nephrology	Mostly consistent across specialties; local hospitals choose whether to label senior AT posts as Senior Registrar or Fellow. All positions fall under “Registrar” employment band.
New South Wales / ACT	Registrar	<i>Senior Resident Medical Officer (SRMO)</i> sometimes used for early AT or dual-purpose posts (esp. Clinical Immunology, small subspecialties). DoT must confirm SRMO posts meet RACP accreditation standards for AT.	Clinical Immunology & Allergy, some General Medicine subspecialties	Slightly inconsistent titles: functionally equivalent to Registrar but with local award differences; relies on College sign-off to validate for AT.
South Australia	Registrar	<i>Senior Registrar</i> in Haematology, Infectious Diseases <i>Advanced Trainee Registrar</i> wording common in SA Health documents	Clinical Haematology, Infectious Diseases, General Medicine	Uniformly Registrar-level; minor title variations for seniority.

Jurisdiction	Main Job Title(s)	Variants / Exceptions	Specialties where variations observed	Job Title Consistency between Specialties.
Western Australia	Registrar	Advanced Trainee Registrar occasionally used	General Medicine	Consistent with national pattern; no SRMO roles identified.
Tasmania	Registrar	<i>Senior Registrar</i> and <i>Registrar</i> (Neonatal & Perinatal Medicine)	Neonatal & Perinatal Medicine, General Medicine	Clear internal hierarchy but all classified under Registrar employment award.
Aotearoa New Zealand	Registrar	<i>Senior Registrar</i> in large Districts for sub-specialty rotations	Cardiology, General Medicine, Haematology (contextual references only)	Consistent; titles mirror Australian usage.
Northern Territory	Registrar	–	–	–
Binational (ANZAN Neurology)	Core Neurology Registrar (program term rather than payroll title)	Employment titles vary by jurisdiction (Registrar or Senior Registrar), but entry occurs after selection onto the training program.	Neurology (ANZAN)	Unique structure: program entry precedes employment allocation.
All	Fellow or Advanced Trainee (depending on specialty and entry)	Employment titles may include Senior Medical Officer (already Fellowed)	Public Health, Sexual Health, Addiction Medicine, Palliative Care, Occupational and Environmental Medicine	Significant proportion of trainees are already Fellowed in another specialty (e.g. General Practice) so

3. Eligibility criteria

3.1 Eligibility for Divisional AT programs

Eligibility to apply for AT positions in divisional programs, as well as Paediatric Rehabilitation Medicine, across Australian jurisdictions and Aotearoa New Zealand is consistently based on two primary criteria:

1. General medical registration.
2. Completion of RACP Basic Training, including Divisional Written and Clinical Examinations.

All jurisdictions require applicants to hold general/general scope of practice registration:

- Australia: Applicants must hold general registration with the Australian Health Practitioner Regulation Agency (Ahpra).
- Aotearoa New Zealand: Applicants must hold general scope of practice registration with Te Kaunihera Rata o Aotearoa | the Medical Council of New Zealand (MCNZ).

Accordingly, International Medical Graduates (IMGs) are eligible to apply if they hold general/general scope of practice registration with Ahpra or MCNZ at the time of application.

3.2 Eligibility for Faculty and Chapter AT programs

While the foundational eligibility requirements (per RACP eligibility statement) are broadly similar across Faculty and Chapter programs, there are nuanced differences in minimum Basic Training, requirements, employment prerequisites, and specialty-specific processes.

3.2.1 Chapter programs

Chapters Applicants have two avenues for entry eligibility. The first is through the RACP Basic Training pathway, as described above for divisional programs. The second is directly into Advanced Training after being awarded Fellowship of another Australasian medical college.

3.2.2 Faculty programs

In addition to general medical registration, Faculty programs have the following eligibility criteria:

- **Public Health Medicine**
 - Three years full-time equivalent (FTE) of postgraduate clinical experience. Entry prior to 2026 requires only two years of this experience to be clinical
 - A Master of Public Health (MPH): Completion of an MPH is mandatory. The degree must meet a “mapping exercise” that ensures coverage of key subject areas.
- **General Rehabilitation Medicine (Adult)**
 - Two years FTE of supervised postgraduate general clinical experience in a health-related field training within the last 5 years
 - From 2025, applicants must have completed an advanced life support course within the last 3 years.

- **Occupational and Environmental Medicine**

- Agreement with an occupational and environmental medicine Fellow (FAFOEM) to be the Educational Supervisor and have this approved by the regional Training Program Director
- At least three years FTE of postgraduate general clinical experience
- At least one year's experience working in a position with adequate exposure to occupational medicine
- Appropriate postgraduate course at diploma level or higher in occupational and environmental health or a related field (from new curriculum commencement)
- One reference from a previous employer or direct supervisor from the past 3 years which addresses the desired entry attributes.

Doctors may also enter directly to Stage B of training. Stage B eligibility includes the above requirements, have completed an Advanced Life Support course, and fulfil at least one of the following criteria:

- Completion of Stage A of training
- Completion of RACP Basic Training, including Clinical and Written Examinations
- Completion of the Australasian Faculty of Rehabilitation Medicine Training Program Modules 1 and 2
- Hold Fellowship of the Royal Australian College of General Practitioners (RACGP), the Royal New Zealand College of General Practitioners (RNZCGP), or the Australian College of Rural and Remote Medicine (ACRRM).

4. 'Actors' and resources

4.1 Local governance framework and entities

The selection process for AT typically involves a combination of Specialty Group Coordinators, Heads of Department (HoDs), administrative personnel, and, in some cases, external representatives or specialty societies. Additionally, PMCV (Victoria), fulfils a coordination and 'interface' role including centralised CV platform and algorithm-based matching of health service to applicant preference and outcomes communication (PMCV Allocation and Placement Service AT "Match"). Other jurisdictions, like WA, NT, and TAS have their own structures involving health departments and hospitals and coordinate the selection and training of ATs. The composition and structure of the selection panels vary by jurisdiction and specialty.

4.2 Resources

Funding for selection processes varies from no dedicated resourcing beyond what is required in job roles of specialty staff involved in recruitment and selection (with considerable volunteer time included), to dedicated funding from health departments for centralised processes. The only dedicated funding streams for selection discoverable at this point were the QLD Health General Medicine model and support for PMCV through the Victorian Department of Health.

5. Selection processes

5.1 Models of selection processes

Descriptions of selection processes in this section combines the range of inputs (e.g. governance entities, criteria) and processes (e.g. shortlisting, interviewing, ranking and offers) are themed into “models” of selection. The types of models identified can then be described as how these interact with the boundaries that selection processes need to operate within for example, jurisdictional health department structure, demand or supply for positions, timing of recruitment processes. Boundaries and their level of rigidity or porosity influence the efficiency and effectiveness of selection processes and will be described further in the evaluation sections of this report.

5.2 Paediatrics and Child Health

5.2.1 General Paediatrics

Table 6 (page 25) lists the selection and entry into Paediatric AT programs discoverable by desktop research and focus group discussions. Across most jurisdictions, entry into general paediatrics advanced training is more structured and coordinated than paediatric subspecialty training. Several jurisdictions have developed statewide or network-based models to ensure equitable access and alignment with workforce needs.

- Queensland and South Australia employ coordinated statewide systems, involving structured interviews, CV reviews, and centralized oversight. These models aim to match trainees to rotations that fulfill curriculum requirements and address service delivery needs.
- New South Wales uses a collaborative model across major hospitals, with structured interviews and increasing use of scoring frameworks to improve transparency.
- Victoria: VPAT (Victorian Paediatric Advanced Training) group is a collaborative arrangement for recruitment to the majority paediatric registrar and some Fellow positions in Victoria. The collaboration aims to increase the efficiency of the recruitment process by supporting a one application to multiple jobs process, with a matching to one job offer. It is not a training network.
- Tasmania and Western Australia rely on informal or self-directed models, with Tasmania focusing on retention through multi-year contracts and mentorship, while WA allows trainees to self-navigate without formal oversight.
- Aotearoa New Zealand does not have a formal selection process; trainees typically continue into Advanced Training after completion of Basic Training and employment to a Registrar level position.

5.2.2 Hybrid Paediatric Network Model

Specialties within paediatrics (e.g., Neonatal–Perinatal Medicine) often operate through state or regional paediatric training networks, with processes linked to broader paediatric workforce and education structures.

Common features:

- Managed jointly by paediatric networks and health departments
- Shared shortlisting and panel processes across multiple hospitals

- Close integration with general paediatric training pathways.

Examples

- Queensland, South Australia, Western Australia- Neonatal–Perinatal Medicine selected through state paediatric networks.

5.2.3 Other paediatric subspecialties

Training for subspecialty paediatrics training is generally less structured, more competitive, and fragmented across jurisdictions.

- In Queensland, some subspecialties like neonatal/perinatal medicine have centralised, multi-year programs, but most others are hospital-based and require annual applications, often with limited positions.
- New South Wales and Victoria show significant fragmentation. Subspecialty posts are often self-funded, single-year, and lack centralised coordination, making access inconsistent and competitive.
- Western Australia and South Australia offer limited subspecialty opportunities, often requiring trainees to seek rotations interstate or overseas.
- Tasmania has very limited subspecialty infrastructure, with selection driven by workforce needs and funding availability.
- In Aotearoa/New Zealand, subspecialty training is centralised at Starship Hospital, with access based on seniority and availability, creating bottlenecks and competition between basic and advanced trainees.

Key themes for Paediatrics and Child Health

Entry into General Paediatrics training is increasingly structured, with efforts to align training with workforce needs and curriculum requirements.

Entry into subspecialty paediatric training programs is relatively fragmented, competitive, and often dependent on local service capacity and funding.

Table 63: Selection and entry into Paediatrics AT programs discoverable by desktop research and focus group discussions

Selection Model		
Jurisdiction	General Paediatrics	Subspecialty Paediatrics
New South Wales	Statewide collaborative selection across major hospitals. Structured interviews and CV review.	Fragmented and self-funded. Often single-year posts with limited oversight. Selection varies by hospital.
Queensland	Structured network-based and hospital-based pathways. Centralised coordination for general paediatrics.	Hospital-based, competitive, year-by-year applications. Neonatal/perinatal medicine has a centralised 3-year network.
South Australia	Statewide coordinated selection across hospitals and rural sites. Consultant-supported recruitment.	Subspecialty access is limited and often informal. Selection depends on service needs and availability.
Tasmania	Informal, retention-focused. Offers 2–3 year contracts to retain trainees.	Very limited subspecialty options. Selection driven by workforce needs and STP* funding availability.
Victoria	Centralised recruitment application platform coordinated by VPAT; hospitals rank applicants independently. No formal AT selection.	Subspecialty posts are secured through job applications. No centralised subspecialty coordination.
Western Australia	No formal selection; trainees self-navigate and apply for roles independently.	Competitive and limited. Many trainees must go interstate or overseas. No centralised process.
Aotearoa New Zealand	No formal selection; trainees progress based on employment and seniority.	Highly limited access; centralised at Starship Hospital. Allocation based on availability and seniority.

*STP = Specialist Training Program

5.3 Adult Medicine

5.3.1 Binational or nationally coordinated specialty model

Specialties with shared governance across Australia and Aotearoa New Zealand use national coordination to ensure uniform selection criteria and timing. Jurisdictions conduct interviews locally, but the process and scoring are standardised nationally.

Common features:

- National oversight of eligibility, timing, and scoring processes.
- State subpanels report to a central coordinating body.
- Shared templates and consistent assessment frameworks.

Examples:

- Neurology- Managed by the Australian and New Zealand Association of Neurologists (ANZAN), with national criteria and state subpanels.
- Aotearoa New Zealand- Advanced Training programs often coordinated nationally through District Health Board (DHB) recruitment.

5.3.2 Statewide or Network-Based Model

A coordinated model where a single application process covers multiple health services or training sites within a jurisdiction. Shortlisting and interviews are managed centrally or by a network panel, and successful applicants are allocated to sites within that structure.

Common features:

- One application and one interview process for multiple positions.
- Panels include representatives from multiple hospitals or a statewide network.
- Health departments or specialty training networks often facilitate coordination.

Examples:

- Queensland- Many specialties, including Cardiology, Gastroenterology, General Medicine Nephrology, and Infectious Diseases, use Queensland Health statewide selection processes.
- New South Wales - a number of specialties that are included in the annual 'JMO recruitment campaign', using a centralised application platform (one application) but may include several interviews per hospital or network depending on specialty.
- South Australia- Selection for General Medicine, Cardiology, and Neonatal–Perinatal Medicine, Rehabilitation Medicine occurs through SA Health networks and MET panels.
- Western Australia: Nephrology, Gastroenterology, and Cardiology are managed through state-based specialty networks.

5.3.3 Health Service–Led Model (Local Hospital or Network Process)

Each hospital or local network conducts its own recruitment independently. Applications, shortlisting, and interviews are handled by local committees, often using College-recommended tools and criteria but without a centralised process.

Common features:

- Separate applications to each hospital.
- Locally constituted interview panels.
- Local employment decisions aligned to workforce needs.

Examples:

- New South Wales- General Medicine and most subspecialties operate through hospital or Local Health District–led processes.
- Tasmania, Northern Territory, ACT- Recruitment conducted directly by individual hospitals or small regional networks.
- Victoria (non-PMCV managed specialties)- General Medicine, Clinical Haematology, Immunology & Allergy.

5.3.4 PMCV Match Interface Model (Victoria)

Used for a defined group of specialties in Victoria through the Postgraduate Medical Council of Victoria (PMCV) ATSM Match. The PMCV match does not conduct selection. It aligns key dates, standardises CV format, and performs a post-selection preference matching process between applicants and health services after interviews are completed.

Common features:

- Applicants submit a standardised CV template via PMCV (some specialties include extra survey-based tools).
- Combination of statewide vs health service interviews.
- May be statewide panel for shortlisting and interviews.
- Final matching allocates applicants to health service based on mutual preferences once rankings are complete.
- PMCV Primarily a coordination and administrative interface.

Examples:

- Victoria- Cardiology, Clinical Genetics, Endocrinology, Gastroenterology, Geriatric Medicine, Infectious Diseases, Medical Oncology, Nephrology, Respiratory & Sleep Medicine, Rheumatology (2025 ATSM match list).

5.3.5 Small-Scale or Single-Centre Model

Used for small programs with limited positions, often available at one or two tertiary hospitals per jurisdiction. The same individuals responsible for training also manage recruitment.

Common features:

- Direct application to the training sites
- Informal coordination between states due to small applicant numbers.
- Simple, collegial decision-making processes.

Examples:

- Immunology & Allergy- Typically recruited through single tertiary hospitals (e.g., RPAH in NSW, RMH in VIC, Royal Brisbane in QLD)

5.3.6 Joint training programs

Joint selection processes occur in specialties that require both clinical and laboratory training, where the RACP and the Royal College of Pathologists of Australasia (RCPA) share oversight of training.

Joint processes occur for selection into Haematology and Immunology & Allergy, with occasional overlap in Endocrinology and Chemical Pathology, where joint training pathways are recognised.

In these specialties, recruitment is coordinated through a single process that serves both colleges. Applicants submit a single application through the relevant health service or statewide network. Interview panels include representatives from both colleges, typically including RACP and RCPA supervisors or program directors.

The interview format and assessment criteria are structured to capture both clinical and

diagnostic competencies. Documentation often uses shared templates for referee reports and curriculum vitae, ensuring consistent evidence across both colleges. Eligibility is verified for both colleges before appointment, and offers are conditional upon joint training approval.

While recruitment governance sits primarily with health services or state networks, the two colleges collaborate through shared specialty committees and joint-accreditation processes. Training supervisors report to both Colleges, and joint accreditation visits may occur where sites provide both clinical and laboratory components of training.

Across jurisdictions, the configuration of joint selection reflects the local size and organisation of the specialty:

- In larger states, such as Queensland and New South Wales, selection is usually statewide with RACP and RCPA members sitting on the same panel.
- In Victoria, selection is typically hospital-based but conducted through departments accredited by both colleges (e.g., Royal Melbourne, Alfred, Monash).
- In South Australia and Western Australia, joint state panels or cross-represented hospital committees are used.
- In Aotearoa New Zealand, recruitment for joint RACP–RCPA programs follows a national coordination model, with joint eligibility review and shared recognition of training sites.

Table 7 on page 29 illustrates the spectrum of application pathways to Specialty programs and jurisdictions as a ‘heatmap’ indicating levels of centralisation. Table 8 on page 30 describes the methods of processing application as a similar ‘heatmap’.

Table 74: Application Submission Pathways, by specialty and jurisdiction.

Application Submission Pathways									
Specialty	Aotearoa NZ	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Addiction Medicine									
Adolescent and Young Adult Medicine									
Cardiology									
Clinical Genetics									
Clinical Haematology									
Clinical Immunology and Allergy									
Clinical Pharmacology									
Community Child Health									
Dermatology									
Endocrinology									
Gastroenterology									
General and Acute Care Medicine									
General Paediatrics									
Geriatric Medicine									
Infectious Diseases									
Medical Oncology									
Neonatal and Perinatal Medicine									
Nephrology									
Neurology									
Nuclear Medicine									
Occupational and Environmental Medicine									
Paediatric Emergency Medicine									
Paediatric Rehabilitation Medicine									
Palliative Medicine									
Public Health Medicine									
Rehabilitation Medicine									
Respiratory and Sleep Medicine									
Rheumatology									
Sexual Health Medicine									
Legend	Centralised application	Application direct to Local Health Network		Application direct to service		Information unavailable		NA No program	

Table 8: Methods of Processing applications, by specialty and jurisdiction.

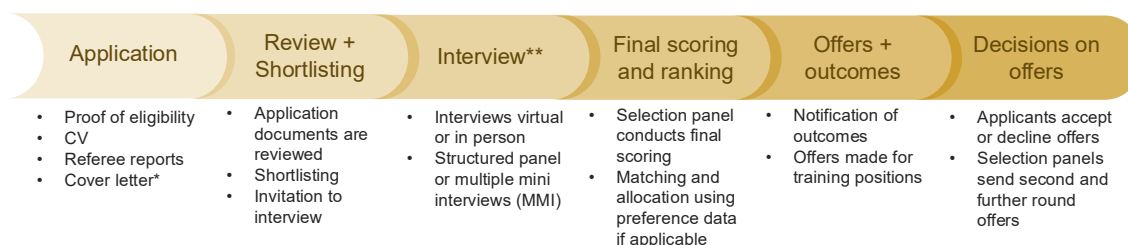
Methods of Processing of Applications									
Specialty	Aotearoa NZ	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Addiction Medicine									
Adolescent and Young Adult Medicine									
Cardiology									
Clinical Genetics									
Clinical Haematology									
Clinical Immunology and Allergy									
Clinical Pharmacology									
Community Child Health									
Dermatology									
Endocrinology									
Gastroenterology									
General and Acute Care Medicine									
General Paediatrics									
Geriatric Medicine									
Infectious Diseases									
Medical Oncology									
Neonatal and Perinatal Medicine									
Nephrology									
Neurology									
Nuclear Medicine									
Occupational and Environmental Medicine									
Paediatric Emergency Medicine									
Paediatric Rehabilitation Medicine									
Palliative Medicine									
Public Health Medicine									
Rehabilitation Medicine									
Respiratory and Sleep Medicine									
Rheumatology									
Sexual Health Medicine									
Legend	Centralised MATCH process		Local decisions		Information unavailable			NA No program	

5.4 Processes and tools used in selection/recruitment

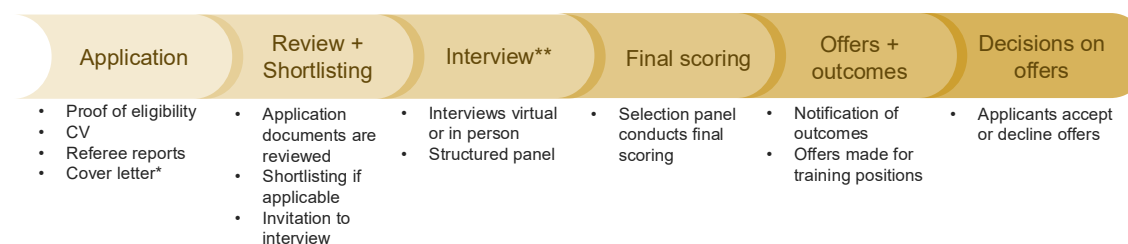
Figure 4 illustrates two common processes applied for selection into AT programs: centralised process including a match allocation and a direct to service process. The selection processes vary within and between specialties and jurisdictions, but share common features of multi-step assessment, merit-based evaluation, and alignment with local employment structures. Significant differences in the processes for selection relate to the degree of centralisation ‘the model’ of the process, as described earlier in this report, including whether applicants are being selected into a pathway of training or individually securing employment in a position that can be accredited towards training time in their chosen Specialty. [Appendix 2: Components of application and selection into training per Specialty across jurisdictions](#) provides more detail of specialty by jurisdiction models of selection.

Figure 4 5: Typical process for recruitment and entry into training

Example of centralised MATCH process



Example of direct to service process



*Not all jurisdictions/specialties include a Cover letter in scoring.

** Informal “pre-meets” are encouraged in some specialties/jurisdictions, and prohibited in others

5.5 Attributes targeted in selection process and indicators

Specialty selection processes for AT consistently target a blend of genuine motivation for training and career, foundational attributes such as clinical competence, professionalism, communication, and teamwork - qualities essential for safe practice and collaborative learning, capability to meet the demands of training and work, and alignment with the values and community health priorities of the health service or network. For general medicine, a range of motivations to secure a training place were noted to occur, for example, for some a desire to work as a generalist and for others as a component or stepping stone to a different specialty as dual training or recognition of prior learning. These different profiles are factored into the selection processes of some jurisdictions, specifically observed for selection into General Medicine in Queensland. Additionally, there are variations as to the role of academic performance in predicting suitable trainees or for targeting clinicians who have and are likely to continue to produce specialty-specific research outputs.

However, significant variation exists in how additional attributes are weighted. Research-

intensive specialties like cardiology and gastroenterology emphasise academic excellence, scholarly output, and formal scoring of exam performance. In contrast, generalist and community-facing specialties such as general medicine, geriatrics, and rheumatology place greater value on service-oriented qualities, including rural experience, teaching, interpersonal effectiveness, and alignment with workforce needs. A summary and key examples of the targeted attributes and indicators are grouped into themes and discussed below.

5.5.1 Motivation and commitment to specialty training and career

Definition: Clear interest in the specialty, long-term commitment, and alignment with workforce needs.

A key theme across all specialty selection processes revealed in focus group discussions is commitment to a career in the specialty. For some specialties the eligibility requirements serve as an indicator of motivation to work in the specialty and sufficient knowledge of the demands of the specialty-specific job roles. (e.g. Diploma in Occupational and Environmental Medicine, time working in relevant job roles and Masters qualification, completion of PCH Basic Training). For others this may be indicated by activities listed in a candidate's CV that the selection panel value as representative of key features of the specialty work profile. For example, academic and research engagement are related to specific career roles for gastroenterology and cardiology in Victoria, whilst general medicine and geriatric specialties favour activities related to quality assurance/improvement and in some contexts evidence of commitment to regional communities where these professions are critically needed.

NB: Specialty examples listed below may be specific to a jurisdiction.

How it's assessed:

- Specialty-specific audits, research, or clinical exposure
- Repeat applications and persistence
- Interview responses about career goals and specialty fit
- Rural experience or willingness to relocate.

Specialty examples:

- Rheumatology: prioritises rural experience and private practice readiness.
- Addiction Medicine: motivation often linked to personal or community impact and experience.
- Paediatrics: actively seeks trainees committed to regional service.

5.5.2. Clinical competence and specialty readiness

Definition: The ability to manage relevant clinical scenarios safely and effectively, and to demonstrate preparedness for specialty-specific training.

How it's assessed:

- Completion of Basic Training requirements
- Specialty-relevant experience (e.g., rotations, audits, research)

- Structured interviews with clinical scenarios testing judgment, prioritisation, and reasoning
- Specialty-aligned motivation (e.g., respiratory candidates completing pleural ultrasound courses).

Specialty examples:

- Geriatrics: comprehensive geriatric assessment scenarios used in interviews
- Respiratory: resuscitation/life-support skills at advanced trainee level; competence in common ward procedures
- Sleep Medicine: procedural exposure/skills (e.g., bronchoscopy/pleural procedures; NIV; reporting polysomnography; managing sleep/respiratory failure).

5.5.3 Communication and teamwork

Definition: The ability to collaborate effectively with patients, peers, and multidisciplinary teams, and contribute positively to clinical environments.

How it's assessed:

- Referee reports and director evaluations
- Interview questions targeting conflict resolution, empathy, and collaboration
- Evidence of teaching, mentoring, or leadership roles
- Feedback from peers and supervisors.

Specialty examples:

- General Medicine: assessed via referee reports and MMI interviews
- Rheumatology: structured CV includes education and teamwork contributions
- Paediatrics: communication issues flagged as common challenges.

5.5.4. Professionalism and ethics

Definition: Integrity, accountability, ethical decision-making, and adherence to professional standards.

How it's assessed:

- Interview scenarios involving ethical dilemmas or professionalism challenges
- Review of performance concerns (e.g., trainees on IPAPs)
- Referee comments on reliability, honesty, and conduct
- Self-awareness and reflective practice.

Specialty examples:

- Respiratory Medicine: clinical scenarios include ethical and legal reasoning and decision-making.
- Immunology: interview questions probe ethical reasoning and specialty commitment

- Neurology (ANZAN): structured questions assess handling of uncertainty and conflict.

5.5.5 Academic excellence and research capability

Definition: Aptitude and desire to contribute to evidence base through research and scholarship.

How it's assessed:

- Cardiology: CV scoring of higher degrees (e.g. PhD), publication output, Divisional Examination scores
- Gastroenterology: structured evidence submission including Divisional Examination scores and self-assessment submitted through a REDCap survey.

5.5.6 Service oriented clinical attributes

Definition: Aptitude and desire to support safe, collaborative, adaptable clinical care in patient community context.

How it's assessed:

- Geriatrics: scenario-based interview questions dealing with patient with delirium, professional behaviour during interview and previous engagement with geriatric medicine
- General Medicine: CV and interview focus on regional workforce experience and intention (particularly QLD)
- Rheumatology: rural experience and education contributions.

5.6 Criteria and evidence used to measure attributes and/or determine selection outcomes

Across jurisdictions and specialties, selection criteria consistently assess applicants on attributes using structured criteria and methods. The specific weighting and assessment methods vary locally but include common instruments.

5.6.1 Curriculum Vitae (CV)

- Used to assess clinical experience, employment history, research outputs, academic achievements, leadership or volunteering experiences, teaching, and research contributions.
- Most specialties apply structured scoring rubrics across multiple domains, such as local employment, and relevant rotations, research outputs, some include rural experience indicators, volunteering activities.

“Pre-Meets” or “Meet and greets” are used variably. These are intended as familiarisation with local training settings for preferencing not selection onto a Training Program *per se*.

5.6.2 Cover Letter/Written Statements or Structured Selection Questions

- Structured responses to selection criteria are commonly used to elicit applicants' motivation and capability for training, in the local context, whether that be a particular location, for a particular specialty, or to join a particular health service.

- REDCap Survey (may include details of Divisional Examination performance and 'self-assessment', e.g. Cardiology Victoria.)

5.6.3 Referee Reports

- Referee reports typically assess clinical skills, professionalism, communication, reliability, and teamwork. Potential identification of professionalism issues.

5.6.4 Interviews

- Interview formats vary across selection programs with increasing use of multiple mini-interviews (MMIs) or similarly structured approaches, using scenario-based questions, clinical prioritisation tasks, assessments of cultural safety and ethical reasoning.
- Interviews commonly assess:
 - Communication
 - Professionalism
 - Clinical reasoning and decision making in conditions of uncertainty (e.g. prominent in less-procedural specialties such as Neurology).
 - Commitment to training in the specialty
 - Cultural awareness and safety.

Interview panels are frequently comprised in centralised selection processes of statewide representatives of different training settings. Procedures are in place to manage any local conflicts of interest and extreme scoring from individual interviewers before candidate final scores and rankings are produced.

5.7 Steps where candidates may be screened out or shortlisted

Across jurisdictions, screening and shortlisting steps occur at multiple points in the AT selection process, although the level of competition and therefore shortlisting and successful appointment vary by location and specialty. Common steps include:

5.7.1 Eligibility Screening: standard first step in application process, notably the completion of prerequisites (eg Masters degree in public health for Public Health Medicine training) constitutes the only specialty-level assessment of suitability.

5.7.2 Shortlisting for Interview: this follows eligibility screening, and typically involves:

- Review of written selection responses, or where mandatory self-assessment is included
- CV scoring
- Differential use of Referee Reports: may be part of shortlisting or not scored depending on local training context.

5.7.3 Post-Interview Ranking and Final Offers: Candidates may be excluded after the interview if:

- They do not meet performance standards
- They are ranked too low to receive an offer in competitive selection processes.

Key Insights

For some specialty programs, e.g. General Medicine, the eligibility screen is the primary exclusion point (and rare). However, in high-demand programs, further funnelling of applications occurs at shortlisting for interview and post-interview ranking stages. Ranking suitable applicants for limited position numbers is a greater need than screening out highly unsuitable candidates.

6. Timing and Timelines

6.1. Duration of selection process

Across jurisdictions, the recruitment/selection process for all specialties typically spans 7 to 12 weeks, depending on the recruitment structure and the sequencing of application, interview, and offer phases.

6.2. Examples of milestone dates in the selection processes.

Figure 5 (overpage) illustrates the jurisdictional and specialty differences in the timing of annual recruitment campaigns. Date ranges are only shown where the start and end date of the recruitment round could be reliably determined. Some specialties and jurisdictions, such as Public Health Medicine, Occupational and Environmental Medicine, and Sexual Health Medicine, do not have an advertised selection timeline as they do not have an annual recruitment campaign and instead advertise jobs as they become available.

7. Equity and parity approaches embedded in selection processes.

Most domains considered under equity and parity in selection into Advanced Training are aligned to those identified in the Discovery Phase for Basic Training, given these tend to be embedded in jurisdictional health department recruitment systems. The following list is not exhaustive.

NT: NT Health employs 'special measures for recruitment', where eligible Aboriginal applicants who meet essential criteria are assessed first. If a suitable Aboriginal applicant is selected, other applicants are not considered further.

QLD: Selection processes are to comply with Queensland Health equal opportunity policies.

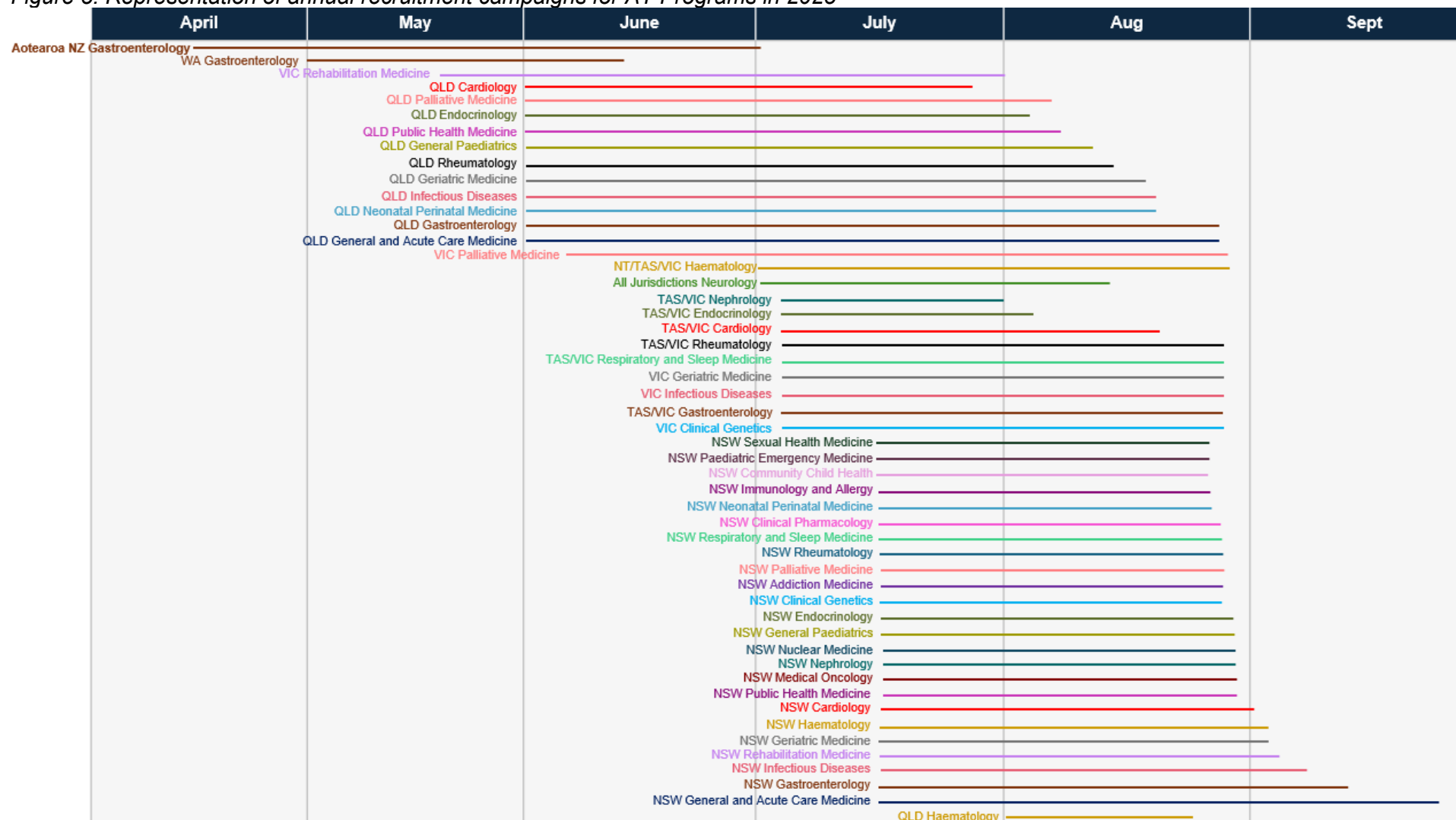
Flexible working arrangements were not universally identifiable through the Discovery process; however, it was noted part time roles are more common at advanced training level positions. The following examples were identified:

VIC: Mentioned in job advertisements and in focus groups discussions.

QLD: Limited part-time and job-share training positions are available, but these are **not part of the standard application process**. Preferences for flexible work are submitted later in the training allocation process and are considered during network placements.

Aotearoa NZ: **Part-time registrar positions** are available. Specific job advertisements, such as those for Southland Hospital, note interest in candidates seeking flexible arrangements.

Figure 5: Representation of annual recruitment campaigns for AT Programs in 2025



8. Information regarding selection and entry into AT programs

Apart from the ANZAN website describing the selection process into Neurology AT there is no centralised location where candidates can find permanently hosted information about selection processes into a specialty program across all jurisdictions. Application guides and scheduled information sessions are the primary mechanism training programs share information about required attributes criteria and application processes and scoring data in centralised selection processes. These guides and sessions are variable in frequency and are more prevalent in centralised selection recruitment models at the jurisdictional level. Smaller 'direct to service' entry into AT programs by recruitment do not tend to provide publicly available information about program structure or 'pathways' and are primarily indicated through job advertisements when these occur.

Typically for any program a large amount of information being released just prior to and during annual recruitment campaign periods or as individual jobs are advertised.

Examples:

QLD: Application guides describe selection criteria and interview scoring methods. While exact scoring rubrics used by panels are not publicly shared, applicants are advised of the assessed attributes and required documentation.

Interacting subsystem(s) relevant to selection into AT programs

This section describes the relevant subsystems and boundary limits that influence how these subsystems interact during selection and entry into AT programs. This section also includes examples of how these subsystems interact with different outcomes and tensions across the range of models of selection described earlier in this report.

Table 9 describes the key subsystems that interact during selection and entry into training programs, their functions, activities and control boundaries. Table 10 describes the system boundaries that drive how the subsystems interact by setting limits that shape how each subsystem fulfils its function. There are more boundaries than subsystems because limiting influences include contextual factors such as timing of selection and recruitment processes.

The information in the two tables combined describes where authority, timing, and information are shared between subsystems and ultimately stakeholders.

The implications of how and to what extent these characteristics combine to produce efficient and effective outcomes for selection and entry into training will be considered further in the Evaluation Phase of this initiative.

Table 9: Key subsystems that interact during selection into AT, their functions, activities and control boundaries.

Subsystem	Core Function (Purpose)	Typical Activities	Examples of Primary Controller(s)	Primary Boundary Type
Selection Subsystem	To determine professional and educational suitability for training (merit,	Eligibility checks, CV and referee review, interview, ranking, referee verification.	College, specialty committees, state selection panels (e.g., ANZAN,	Professional boundary (who decides suitability); may extend beyond employment system.

Subsystem	Core Function (Purpose)	Typical Activities	Examples of Primary Controller(s)	Primary Boundary Type
	readiness, fit for specialty).		PMCV specialty panels).	
Recruitment Subsystem	To appoint individuals into funded and accredited roles that satisfy workforce and service needs.	Job advertisement, HR screening, interview, contract offer, onboarding.	Jurisdictional HR systems (e.g. NSW Health eRecruit, QLD Health RMO campaign, hospital HR).	Employment boundary (who can be hired; FTE/funding limits)
Accreditation Subsystem	To ensure training positions and environments meet educational and supervision standards.	Site accreditation, program review, setting of training capacity.	RACP accreditation program, health department interface.	Quality assurance boundary (what counts as a training position)
Eligibility / Enrolment Subsystem	To confirm that employment and selection outcomes meet College entry criteria.	RACP enrolment verification, documentation of appointment to accredited post.	RACP Advanced Training Committees.	Regulatory boundary (linking selection/recruitment to training enrolment)

Table 10: Key boundaries in selection to AT programs and subsystems with primary controls

Boundary Type	Description in selection and entry into AT programs	Subsystem with Primary Control
Professional Boundary	Defines where professional and educational standards are applied to determine who is suitable for training.	Selection subsystem (College, specialty panels)
Employment Boundary	Marks where jurisdictional HR rules, contracts, and funding determine who can be employed.	Recruitment subsystem (health services, jurisdictions)
Accreditation Boundary	Defines which positions and settings meet the College's training and supervision standards.	Accreditation subsystem (RACP TPAP)
Temporal Boundary	Sets the timeframes for each annual selection and recruitment cycle and when feedback can occur.	Jointly controlled by Selection + Recruitment subsystems
Jurisdictional Boundary	Differentiates state or territory systems, policies, and governance arrangements.	External governance environment (jurisdictions; not directly College-controlled)
Control Boundary	Determines who has decision-making authority within or across subsystems.	Shared control across Selection, Recruitment, and Accreditation subsystems

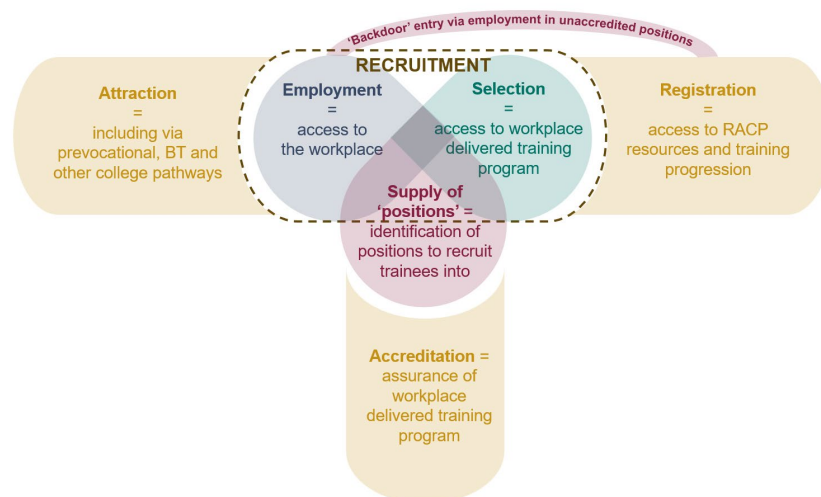
Boundary Type	Description in selection and entry into AT programs	Subsystem with Primary Control
Feedback Boundary	Defines where data about selection outcomes and approaches flow back into the system to support improvement.	Could not be identified
Equity Boundary	Determines who can access opportunities and how fairness is ensured across jurisdictions or employment models.	Selection subsystem, with influence from Recruitment (through access and timing)
Information Boundary	Controls how data move between College, jurisdictions, and employers.	Could not be identified
Funding Boundary	Limits training capacity based on funded FTE and service budgets.	Recruitment subsystem (jurisdictional workforce planning)

Examples of subsystem interaction by recruitment/ selection model

Except for selection onto the Neurology training program, doctors wishing to join an AT program need to secure employment in an accredited training position. Securing this position is in some contexts be integrated within a selection process conducted by members of the Specialty, for example General Medicine (Queensland), Cardiology, Gastroenterology (Victoria). In other contexts, including most of the 'small scale single centre model' and most of the direct to service recruitment processes, there is no overarching selection into training separate from a candidate demonstrating suitability for the accredited job. Figure 6 summarises the relationships between these functions.

In SET terms, selection and employment/recruitment function as **structurally coupled subsystems**: usually functionally interdependent but *sometimes* distinct in purpose when decisions are made about recruitment outside of a selection process. Selection and recruitment share boundaries with other controlling boundaries - eligibility, timing of selection and recruitment processes, and accreditation of training positions by the College.

Figure 6: The functional relationship between accreditation, employment and selection subsystems in recruitment functions



Examples of recruitment and selection boundaries

There are two key subsystems at play in entry to AT- recruitment into accredited positions and selection into the training program. The boundaries of these subsystems interact in varying ways depending on the model of recruitment/selection as outlined in the following three examples.

Figure 7: Key subsystems at play in entry to AT - recruitment and selection



Example A: Selection first then recruitment or allocation to a matched accredited position

For example, in the ANZAN Neurology process selection into the training program precedes allocation (at a jurisdictional level) to 'core' training positions that are intended to act as the first two years of training. Trainees that are not selected onto the training program but have secured employment in an acceptable 'non-core' position can then seek to have this training time certification towards their Neurology training time if selected in later years or may find training time rejected by ATC if outside the selection process.

Figure 8: Sequential selection then recruitment



Example B: Simultaneous selection and recruitment

Selection into general medicine training occurs simultaneously with recruitment to positions. The selection criteria for training are embedded in the centralised recruitment process.

Figure 9: Simultaneous selection and recruitment



Example C: No selection only recruitment

For direct-to-service applications for (accredited) positions there is no selection into training

but securing employment in an accredited position means that the trainee can seek to have the time in the position as contributing to their training program requirements. In these instances, there is typically no planned 'pathway' of training experiences that are matched to curricula. These are characterised at best as 'choose your own adventure' (e.g. Public Health Medicine, Infectious Diseases) or in some cases as 'you're on your own'.

Figure 10: No selection only recruitment



Outputs

The next component to describe per System Evaluation Theory are the system outputs, which are defined as the immediate products or results generated by system processes. In the selection into AT subsystem, the outputs can be considered a combination of:

1. Doctors who are deemed eligible to register for an AT program via a formal third-party selection process with
 - a. a training pathway and length of training contract, or
 - b. a partial length of training contract.
2. Doctors who are deemed eligible to register for an AT program by virtue of being appointed to a suitable employment position for a set period of training time
3. Doctors who have not been appointed to a suitable position and therefore are ineligible to register for an AT program.

Feedback Loops

Feedback loops observed in the Discovery Phase relate predominantly to how subsystems use information from the processes that occur within the subsystem and others that interact with them for learning and to adjust strategy and processes where necessary to achieve aims or work around barriers.

In SET terms, "learning" refers to the system's (or subsystem's) ability to detect, interpret, and respond to information about its own performance in meeting its purpose or local goals.

Feedback loops provide the mechanism through which this occurs, but they do not guarantee improvement.

Where control is porous or incentives are misaligned, feedback may produce defensive or maladaptive learning - reinforcing behaviours that preserve local stability at the expense of the system's overall purpose. The role of feedback loops and how these are operating in different contexts will be discussed in Evaluation Phase Report.

Conclusion

This report provides a description of the commonalities and divergences of recruitment/selection into RACP AT programs. It presents a summary of inputs, processes and how variations in contexts in turn influence variations in recruitment and selection practices, structures, and outcomes.

Key insights that can be taken from this descriptive exercise include:

1. Models vary in terms of centralisation and are often related to the level of structure or determinable pathway in a particular specialty AT program.
2. There are areas of commonality in selection across specialties, such as eligibility requirements and the importance of identifying a commitment and suitability to specialty training per program but also variations in emphasis placed on attributes and skills relating to research intensives specialties compared to more personalised community care in others.
3. Selection processes typically combine CV review, written statements, referee reports, and structured interviews (often MMIs), focusing on clinical competence, communication skills, professionalism, teamwork, cultural safety, and motivation for physician training.
4. Equity and diversity approaches are consistent to those discovered in Basic Training as they are embedded in local health department policy framework. The exception is a greater emphasis and desire expressed by several focus group attendees to be able to offer part time training opportunities, particularly considering a growing proportion of women in training (greater than 50% in some specialties) and increasing age of medical graduates.

The discovery phase has collected a great deal of dispersed and internalised information about goals, rationale, structure and process related to how specialties as professions and custodians of entry into training for professions aim to attract, recruit and train ATs in the context of their local jurisdictional employment and workforce demands and constraints. Significant tensions are describable in the relationship between the goals of selecting for a program of training and those of fulfilling workforce needs in health systems. This can result in scenarios where these goals conflict and produce an outcome of a registrar working in an AT position to fulfil workforce needs, but their selection into training program status may render certification of training fulfilment for such time problematic.

In working to gather insights for inclusion in this report, it was also obvious that training recruitment and selection is most certainly a stage in a training pathway in a range of specialties, but for some AT programs the concept of selection into a planned pathway dissipates and access to opportunities to complete training is dependent on a series of recruitment successes.

The next report in this work is the Evaluation Phase report for both Basic and Advanced Training. The findings of both Discovery reports and the conclusions and recommendations of the Evaluation Phase report will inform the Response Phase of this project commencing in early 2026.

Limitations

It was not feasible through this discovery process to provide an exhaustive report of all specialty by program selection processes, in part because information publicly available about selection into training processes can be transient and transactional designed for the recruitment period. In addition, this report has been produced with limited opportunities to member check interpretations of focus group data collected made by the authors.

A key aim of this work was to provide a demographically stratified quantitative report focused on the supply, demand and success rates of entry into training. However, this was not feasible at this stage due to differing protocols and retention practices used across jurisdictions for data management, and a longer than anticipated lead time for sourcing this data. Mapping this data will remain a *focus for future collaboration across the RACP and jurisdictions*.

Appendices

Appendix 1: Role terminology: Doctors in AT positions by jurisdiction

Table 11: Role terminology training doctors by jurisdiction

Jurisdiction	Employment Titles in Use	Typical PGY / Experience Range	RACP Training Stage(s) Covered	Employment / Award Source	Notes on Title Use and Distinction
Australian Capital Territory (ACT Health)	Resident Medical Officer → Registrar → Senior Registrar / Fellow	PGY 2 – 8 +	Basic & Advanced Training	ACT Public Sector Medical Officers Agreement (aligned to NSW Award)	Uses NSW title taxonomy; “Registrar” = AT entry; “Senior Registrar” = final year / post-AT; recruited locally via Canberra Health Services.
New South Wales (JMO Campaign)	Intern → Resident → SRMO → Registrar → Senior Registrar → Provisional Fellow	PGY 1 – 8 +	Pre-Basic, Basic, Advanced Training	NSW Health Public Hospital Medical Officers Award	“SRMO” persists as pre-BT step; “Registrar” = AT minimum; “Senior Registrar” = late AT; title variability across LHDs.
Northern Territory	Resident → Registrar → Advanced Trainee	PGY 2 – 6 +	Basic & Advanced Training	NT Public Sector Medical Officers EA	Small workforce; all ATs employed as Registrars; no SRMO tier.
Queensland (RMO Campaign)	Resident → Registrar → Advanced Trainee → Provisional Fellow	PGY 1 – 7 +	Basic & Advanced Training	Queensland Health RMO and Registrar Award	“Registrar” = AT entry; “Provisional Fellow” = final / post-AT; consistent statewide titles.
South Australia (SA Health / LHN)	Resident → Registrar → Senior Registrar	PGY 2 – 7 +	Basic & Advanced Training	SA Health Medical Officers (Enterprise) Agreement	“Registrar” = AT minimum; “Senior Registrar” = final AT / post-FRACP; recruitment local to LHN.
Tasmania (Health Service)	Resident → Registrar → Senior Registrar / Fellow	PGY 2 – 7 +	Basic & Advanced Training	Tasmanian Health Service EA	Titles mirror VIC; “Registrar” = AT minimum.

Jurisdiction	Employment Titles in Use	Typical PGY / Experience Range	RACP Training Stage(s) Covered	Employment / Award Source	Notes on Title Use and Distinction
Victoria (PMCV)	Resident → Registrar → Advanced Trainee → Senior Registrar / Fellow	PGY 1 – 7 +	Basic & Advanced Training	Victorian Public Health Medical Officers Agreement / PMCV match	“Registrar” = AT minimum; “Advanced Trainee” & “Senior Registrar” mark progression; uniform College alignment.
Western Australia (MedJobsWA)	Resident → Service Registrar → Registrar → Senior Registrar	PGY 2 – 8 +	Pre-Basic, Basic, Advanced Training	WA Health System Medical Practitioners Award	“Service Registrar” = non-training; “Registrar” = BT/AT; “Senior Registrar” = final AT / post-training.
Aotearoa New Zealand (Te Whatu Ora)	House Officer → Registrar → Senior Registrar / Fellow	PGY 1 – 7 +	Basic & Advanced Training (both under “Registrar”)	National MECA (Resident Doctors Assoc + Te Whatu Ora)	All ATs are Registrars, but not all Registrars are ATs; stage distinction via RACP status & MECA pay step.

Appendix 2: Components of application and selection into training per Specialty across jurisdictions

Table 12: Overview of coordination of recruitment and selection process by Specialty and jurisdiction Adult Medicine (for Specialties and jurisdictions for which information could be reliably accessed).

Specialty	NSW	QLD	VIC	SA	WA	TAS	NT	ACT	Aotearoa NZ
Addiction Medicine	Included in NSW Annual Recruitment campaign	Service based recruitment.							
Cardiology	Central statewide process through NSW Annual Recruitment Campaign	Central statewide process through Cardiology network.	PMCV ATSM match (interface only): aligns dates, CV template, and post-selection matching; hospitals conduct own interviews.	SA Health statewide panel for advanced cardiology training.	WA state-based cardiology network selection.	Direct hospital application process.	Managed regionally; limited positions.	ACT Health panel for local positions.	National Cardiology Training Network process across DHBs.
Clinical Genetics	Tertiary hospital-based recruitment.	Hospital-based selection (e.g., RBWH).	PMCV ATSM match (interface only): coordinated timeline and CV format; independent hospital interviews.	Hospital or network-level recruitment.	Local hospital-level selection.	Small-scale direct process.	Regional collaboration.	ACT Health process.	National coordination through DHBs.
Clinical Haematology	Joint RACP–RCPA panels at tertiary hospitals.	Statewide coordinated selection via QLD Health with RCPA involvement.	Hospital-based recruitment; not included in PMCV.	SA Health or hospital-level selection panels with dual College representation.	WA Health statewide specialty panel.	Local tertiary hospital selection.	Coordinated regionally; linked with SA panels.	ACT Health local recruitment.	Nationally coordinated dual College process.
Endocrinology	Central statewide process through NSW	Statewide or network recruitment under QLD Health.	PMCV ATSM match (interface only): aligned dates; hospital-	SA Health statewide specialty panel.	Hospital or network-level recruitment.	Local hospital recruitment.	Regional collaboration.	ACT Health selection panel.	National DHB coordination.

Specialty	NSW	QLD	VIC	SA	WA	TAS	NT	ACT	Aotearoa NZ
	Annual Recruitment Campaign		based interviews and ranking.						
Gastroenterology	Central statewide process through NSW Annual Recruitment Campaign	Statewide process through Gastroenterology training network.	PMCV ATSM match (interface only): coordinated timelines; hospital-level shortlisting and interviews.	SA Health statewide process through specialty network.	WA GI network; single application and coordinated interviews.	Direct hospital recruitment.	Regional process through local hospitals.	ACT Health hospital process.	Nationally coordinated through DHB Gastroenterology networks.
General and Acute Care Medicine	Local hospital or LHD recruitment; multiple independent panels.	Statewide network-based process via Queensland Health portal.	Local hospital-led recruitment; not part of PMCV match.	Statewide selection through SA Health network panel.	Network-based process; one application per network.	Direct hospital recruitment for limited positions.	Small-scale local recruitment; some interstate collaboration.	ACT Health direct hospital recruitment.	Nationally coordinated through regional DHB recruitment.
Geriatric Medicine	Local hospital or LHD-led selection.	Statewide or regional process under QLD Health.	PMCV ATSM match (interface only): post-selection preference matching; interviews at hospital level.	Statewide network selection panel.	Regional or statewide selection network.	Local hospital recruitment.	Small regional process.	ACT Health process.	National geriatric training selection process.
Immunology & Allergy	Single tertiary hospital recruitment (e.g., RPAH).	Single tertiary site (e.g., Royal Brisbane).	Conducted locally by tertiary departments; not part of PMCV.	Managed by Flinders Medical Centre.	Managed by tertiary immunopathology departments (e.g., Fiona Stanley).	Small number; direct hospital recruitment.	Collaborates regionally with larger states.	ACT Health tertiary hospital process.	National network with coordinated intake.
Infectious Diseases	Central statewide process through NSW Annual	Statewide process via QLD Health, often linked with General Medicine.	PMCV ATSM match (interface only): alignment of dates and CV format;	SA Health statewide selection panel.	WA Infectious Diseases network selection process.	Local hospital-based recruitment.	Regional collaboration with larger jurisdictions.	ACT Health hospital process.	National ID network selection through DHBs.

Specialty	NSW	QLD	VIC	SA	WA	TAS	NT	ACT	Aotearoa NZ
	Recruitment Campaign.		independent hospital selection.						
Medical Oncology	Central statewide process through NSW Annual Recruitment Campaign	Statewide coordination through QLD Health Cancer Services.	PMCV ATSM match (interface only): coordinated timelines; hospital-based interviews.	SA Health oncology network selection.	WA oncology network panel.	Direct hospital recruitment.	Regional collaboration.	ACT Health process.	National oncology training network coordination.
Nephrology	Central statewide process through NSW Annual Recruitment Campaign	Statewide coordinated renal selection via QLD Health.	PMCV ATSM match (interface only): aligned timing and CV format; local interviews.	SA Health renal specialty panel.	WA renal network statewide process.	Local hospital recruitment.	Regional coordination; small programs.	ACT Health recruitment.	Nationally coordinated renal network process.
Neurology	State panel under national ANZAN coordination.	State panel under ANZAN coordination.	State subpanel under ANZAN coordination; PMCV not used.	State panel reporting to ANZAN.	State panel under ANZAN coordination.	Small hospital-based process linked to ANZAN.	Regional links to ANZAN processes.	ACT Health panel under ANZAN guidance.	National ANZAN process across NZ DHBs.
Occupational and Environmental Medicine		Direct to service (once eligibility requirements met)							
Palliative Medicine	Central statewide process through NSW Annual Recruitment Campaign	Statewide coordinated program (QPMTP) under Queensland Health: one application, central ranking, and allocation.	Statewide coordinated program (VPMT) managed by St Vincent's Health; centralised interviews, allocation across sites; employment issued locally.	Hospital or regional network-based process through SA Health Palliative Care units.	Local hospital-led recruitment via MedJobsWA; separate applications to each service.	Small local hospital recruitment process.	Regional or cross-border collaboration with larger jurisdictions.	ACT Health hospital-based recruitment.	Nationally coordinated through RACP NZ Palliative Medicine Working Group and DHBs.

Specialty	NSW	QLD	VIC	SA	WA	TAS	NT	ACT	Aotearoa NZ
Rehabilitation Medicine	Hospital or network-based recruitment; coordination through local AFRM committees and health services.	Hospital-based or HHS-level selection; no central match; local applications to accredited sites.	Two-stage hybrid model coordinated by RMTV: applicants apply directly to hospitals (Stage 1) and submit ranked preferences to RMTV (Stage 2). RMTV conducts statewide matching via virtual allocation meeting; employment issued by matched health services.	Hospital or statewide network-based selection under SA Health and AFRM SA Branch; independent hospital interviews.	Local hospital recruitment via MedJobsWA; no central coordination; selection aligned to AFRM standards.	Local hospital selection with oversight from AFRM TAS representative; occasional participation in VIC information sessions.	Small-scale local recruitment through regional health services.	ACT Health recruitment panels; independent applications to accredited sites.	Nationally coordinated across DHBs through the NZ Rehabilitation Medicine Training Committee; single annual intake.
Respiratory & Sleep Medicine	Hospital or regional network recruitment with local interviews.	Statewide coordinated intake through QLD Health RMO campaign; one application and interview; allocation via statewide committee.	PMCV match (interface only): central interview and matching process across all VIC/TAS sites; hospitals rank preferences; guarantees 24 months respiratory core training.	Network-based recruitment across LHNs (CALHN, SALHN, NALHN); local interviews; linked respiratory and sleep training positions.	Hospital-based recruitment through MedJobsWA; no coordinated match or ranking process.	Included in VIC/TAS PMCV interface; part of same match framework.	Regional collaboration; local hospital appointments.	ACT Health hospital-based recruitment.	Nationally coordinated through NZ Respiratory & Sleep Medicine Committee (RACP) with DHB allocation.
Rheumatology	Hospital or regional selection.	Statewide process under QLD Health.	PMCV ATSM match (interface only): aligned timing and CV format; interviews at hospital level.	SA Health specialty panel.	WA statewide rheumatology network.	Direct hospital recruitment.	Regional process.	ACT Health process.	National rheumatology selection process.

Specialty	NSW	QLD	VIC	SA	WA	TAS	NT	ACT	Aotearoa NZ
Sexual Health Medicine	Through NSW JMO annual recruitment campaign (post BT) or if Fellowed via recruitment to service.	Statewide coordinated process through QLD Health RMO campaign recruitment directly by QLD health facilities.	Service-based recruitment; not included in PMCV						

Appendix 3: Examples of RACP-RCPA joint selection processes

Specialty	Nature of Joint Process	Jurisdictional Example	Panel Composition / Structure	Application Pathway
Clinical Haematology	Fully joint RACP–RCPA process for all dual trainees	QLD Health Haematology Network; SA MET Panel; major tertiary hospitals in NSW, VIC, WA	Joint interview panels with RACP and RCPC supervisors; shared eligibility verification	Single application through health service or state network; dual registration before appointment
Immunology & Allergy	Partially joint process (clinical + laboratory immunology)	Royal Melbourne Hospital, Royal Brisbane Hospital, RPAH, Flinders	Combined clinical and pathology interview panel; overlapping supervision	Application via tertiary hospital; eligibility confirmed by both Colleges
Chemical Pathology with Endocrinology or Metabolic Medicine	Occasional dual training coordination	Tertiary metabolic and endocrine units in VIC and NSW	RCPC lead with RACP input from endocrinology supervisors	Separate applications; linked training plan approved by both Colleges
Clinical Genetics / Genetic Pathology	Parallel selection with departmental integrations	NSW Health tertiary genetics services	Distinct but aligned clinical and laboratory panels; shared oversight by head of department	Separate College applications; coordinated local selection process
Aotearoa New Zealand Dual Programs	National coordination of joint College eligibility	Haematology and Immunology national panels	Binational RACP–RCPC	DHB-led process with College membership on national selection confirmation of dual eligibility committees