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Selection into Training Quality Assurance and Improvement Initiative

Discovery Phase Report | Basic Training

July 2025

Purpose of this document

This report describes the current state for recruitment, selection and entry into the RACP's Adult Medicine and Paediatrics & Child Health Basic 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 Basic Training programs in each jurisdiction and synthesising key commonalities and distinctions. The report does not include exhaustive detail.

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 will be delivered in three phases. The first is a **discovery phase**, aimed at understanding the current landscape of entry into training. This is followed by an **evaluation phase**, which considers the current state with reference to RACP policy and standards, and identifies opportunities for quality improvement to support stakeholders involved in selection. The final **response phase** will focus on how to implement recommendations emerging from the earlier phases.

The discovery phase was guided by a set of structured questions, with responses 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 Basic Physician Training (hereafter collectively referred to as “BT”) program across jurisdictions. Where possible, RACP staff met with key stakeholders and those involved in selection delivery 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 Basic Physician training highlights **variation in entry pathways, selection methods, contract structures, and equity approaches across jurisdictions**, while also identifying several **areas of commonality**, such as **eligibility requirements and the importance of a commitment to the differentiating aspects of physician training to service positions** in early training and to a future role as a physician committed to local health service needs and ongoing education of the physician training workforce.

The primary pathway for entry into Basic Training (BT) is through annual jurisdiction-wide recruitment campaigns for clinical positions suited to doctors with postgraduate experience, most commonly PGY2 or above, although entry points and position titles vary across regions. Employment structures differ, for example, some jurisdictions offering rolling annual contracts and others providing length-of-training contracts, while Aotearoa New Zealand generally offers permanent roles.

Training numbers are locally determined, based on accredited capacity to offer adequate clinical experience, workforce demand, and supervision availability. Eligibility requirements are broadly consistent, requiring general medical registration and a minimum postgraduate year, though some jurisdictions prefer applicants with specific clinical experience.

Equity and diversity approaches differ, with, for example, formal affirmative action pathways in New South Wales, Queensland and the Northern Territory, targeted rural programs in Western Australia and Victoria, and more informal diversity commitments in other areas. 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.

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 and approaches to recruitment and selection into BT programs. The discovery phase has revealed how local context, particularly recruitment structures and demand for BT positions shapes practices, structures and outcomes. While most trainees enter through annual jurisdiction-wide recruitment campaigns, employment structures vary – ranging from rolling contracts to length of training or even ongoing permanent roles.

Attributes assessed through selection focus on clinical competence, professional behaviours and motivation and maturity for physician training. Selection methods consistently include an eligibility check, written application including curriculum vitae and responses to selection criteria, reference checks and a structured interview process.

The report also notes that Basic Training selection is part of a broader medical training pipeline, with reciprocal influences between prevocational, Basic, and Advanced Training stages. The next phase of this work will map current recruitment practices against RACP's Selection into Basic Training criteria and policy, and engage stakeholders to identify strengths, improvement areas, and opportunities for quality enhancement.

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: Application of the three phases of the evaluative thinking model to this work

			
	DISCOVERY		**RESPONSE PLAN**
	Current state description	Evaluation of findings	Develop strategic response to address findings
Focus	This phase asks, **"What's so?"** and explores what is happening in the current state of activities.	This phase asks, **"So what?"** and examines the current state findings through the lens of RACP policies and strategic goals.	This phase asks**, "Now what?"** and, with stakeholders, prioritises areas for action and identifies potential responses to address these.
Output	Detailed map of the selection processes for physician training programs	Evaluation report describing the findings and conclusions, including areas of concern	Strategy for quality improvement and assurance of selection

Governance

The Discovery 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.
    - Entry into Advanced Training Programs.

Background to this report

This report describes the findings of **Discovery Phase 1: current situation** for entry into Basic Training Programs for Adult Medicine and Paediatrics & Child Health in Australia and Aotearoa New Zealand, collectively referred to in the rest of this report as “BT”, or described in full when referring to a particular Basic Training Program for a specific jurisdiction, for example, “BT Adult Medicine Queensland”. A separate **Discovery Phase 1: current situation** report will be produced for entry into Advanced Training Programs, to be delivered to the CEC in quarter 4 of 2025. The report is intended to provide a foundation for later phases of the Selection into Training Quality Assurance and Improvement Initiative.

RACP guidelines about selection and entry to Basic training

The discovery phase work for Basic Training is framed by the RACP criteria that prospective Basic Trainees must demonstrate for entry to training and the Standards and Principles that must be addressed by those conducting selection activities.

RACP Selection into Basic Training criteria

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

- The capacity and commitment to pursue a career as a physician or paediatrician.
- The ability to plan and manage their learning.
- The ability and willingness to achieve the Basic Training Competencies, particularly those associated with the RACP Professional Practice Framework:
  - Communication
  - Cultural safety
  - Ethics and professional behaviour
  - Leadership, management, and teamwork.

Figure 2: The RACP Professional Practice Framework

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 are:

- Valid
- Reliable
- Transparent
- Procedurally fair
- Evidence-based
- Sustainable
- Collaborative
- Accountable

Methodology for current state description

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

The aim of the Discovery Phase 1 work is to produce sufficient knowledge of selection practices for RACP training programs, the contextual factors influencing these practices and the concerns of stakeholders to conduct an evidence-based evaluation of current practices through the lens of relevant RACP policies and strategic priorities.

Key questions

We used several key questions to guide Phase 1 of the Discovery Phase to work towards our current state description. The questions were organised in the following groups:

D1: Applicants and positions

D2: Stakeholder involvement

D3: Processes

D4: Timelines

D5: Communication

D6: Resource allocation

Methodology

In this phase, we sought to:

- Conduct a comprehensive scoping review of physician training selection processes.
- Collect quantitative aggregated data of applicant numbers and outcomes for each stage in the selection processes*.
- Interview key stakeholders, including training program directors (Directors of Physician Training (DPEs), Network DPEs/equivalent, Advanced Training Committees, jurisdictional workforce managers or equivalent roles), selection committee members, and trainees.
- Analyse the data to identify trends, issues, and contextual factors.

Data collection

- Desktop review of available material on selection/entry/recruitment to Basic Training
- Identification and engagement of positions and groups involved in selection processes.
- Qualitative data from engagements (eg interviews, meetings) with stakeholders
- Quantitative data supplied by stakeholders from jurisdictional selection activities*

Analysis of data

- Thematic review and synthesis of findings into description, commonalities and differences within jurisdiction and Division stratification for BT.

Outputs

- Descriptive report of the selection processes for physician training programs.
- Quantitative analysis of application numbers and outcomes.*
- Identification of key stakeholders and their roles in the selection processes.
- Identification of common and locally unique contextual factors, challenges and opportunities for stakeholders.

**Detailed quantitative mapping was not feasible at this stage due to differing protocols and retention practices used across jurisdictions for data management, and due to the longer than anticipated lead time for sourcing this data that was not compatible with project timelines. Mapping this data will remain a focus for future collaboration across the RACP and jurisdictions.*

Results

Results in this section are presented in the overarching themes of the Discovery Questions and are presented narratively as key themes with high level key findings summarised. For each section, exemplars are included to highlight contextual differences in how entry into training is organised in response to local factors. Narrative reporting is intended to demonstrate similarities and differences in entry and selection processes and does not suggest either is better or worse than the other. To conserve the length of this report coverage for questions for all programs is grouped in tables by Division or and jurisdiction as the key levels of distinction.

1. Applicants and positions

1A. What are the positions that applicants apply for?

The primary pathway to Basic Training programs is via jurisdiction-wide annual RMO recruitment campaigns which run between May and September.

The positions advertised through recruitment campaigns are predominantly targeted at junior doctors with two to four years of postgraduate clinical experience. This is reflected in the job seniority level of advertised positions. Job roles may or may not be labelled as "Basic Physician Trainee", but all carry a job seniority grading considering clinical experience related to 'postgraduate year'. Job role titles reflect the local employment hierarchies and training system arrangements.

Table 1 and Table 2 provides a comparison table of job titles related to RACP Foundation Phase (BPT 1).

Key findings

- **Position titles and entry points vary across jurisdictions** but consistently reflect applicant seniority and readiness for training.
- **State-based employment models dominate** the recruitment and selection landscape, with selection to BT programs contingent upon securing an appropriate clinical position.

- **Whilst applicants seeking to enter BT would not apply to an unaccredited role as a formal BT entry point,** appointment to such positions may be an outcome of the selection process in some jurisdictions for doctors who are considered suitable for training but were not ranked highly enough to secure one of the limited accredited positions on offer or considered to need more relevant clinical exposure before appointment to BT. This is not always the case, e.g. in Tasmania, all positions are training positions.
- **Jurisdictional flexibility exists** regarding entry level: applicants with greater experience may access junior or more senior hospital grade positions at commencement BT, particularly in Tasmania and Queensland.
- **Variability in centralisation of recruitment processes**, in some contexts (for example, Queensland Adult Medicine Basic Training), applicants submit a single application that is assessed simultaneously for positions at one of several preferenced training locations. In South Australia, applicants to Adult Medicine BT Networks may preference General Practice training in addition to each local Basic Physician Training Network. Conversely, for some jurisdictions, prospective trainees must apply separately to every health service where they are interested in training. For example, this model is used within the Victorian Adult Medicine Basic Training Program, which also requires a central application to the PMCV Allocation and Placement Service Match.

Table 1: Summary of Entry Positions by Jurisdiction: Adult Medicine Basic Training

Jurisdiction	Positions Applicants Apply For	Entity
ACT (Canberra Health Services)	SRMO (PGY3+), BPT Registrar (PGY4+), accredited positions only	Canberra Health Services (BPT Network)
NSW	Basic Physician Trainee (Registrar) via NSW JMO Campaign	Eleven BPT Networks: • Concord • Nepean • East Coast • Hunter and New England • Illawarra • Liverpool • Northern Sydney Coastal • Royal Prince Alfred • St George • St Vincents' South West • Westmead
NT	Basic Physician Trainee (PGY2+) Top End Health Service, RMO Central Australia Health Service.	Top End Health Service (Darwin Hospital) Central Australia Health Service (Alice Springs Hospital)
QLD	Senior House Officer (SHO), Medical Registrar via QLD Health RMO Campaign	Five BPT Rotations (hospital BPT training networks): • Coastal • Far North • North Queensland • Northside • Southside
SA	RMO (PGY2), Service Medical Registrar (SMR PGY3+) via SA MET Campaign	Three Local Health Networks: • Central Adelaide • Northern Adelaide • Southern Adelaide
TAS	RMO-level BPT positions via statewide campaign; Registrar positions (PGY4+) via General Medicine at Royal Hobart Hospital	Health Service: • Royal Hobart Hospital • North West Hospital
VIC	Hospital Medical Officer (HMO) BPT 1 positions (commonly titled Basic Physician Trainee)	Health Services (within Consortia) Sixteen Health Services
WA	RMO, Service Medical Registrar (SMR) – applicants select either based on eligibility	Four Training Networks: • South (Fiona Stanley Hospital) • East (Perth Hospital) • North (Sir Charles Gairdner Hospital) • Rural (Five regional)
Aotearoa NZ	SHO, Medical Registrar – typically after PGY2 with core medical rotations	One Network: • Northern Network (four hospitals) Fifteen Health Services

Table 2: Summary of Entry Positions by Jurisdiction: Paediatrics and Child Health

Jurisdiction	Positions Applicants Apply For	Entity
ACT (Canberra Health Services)	BPT Registrar (PGY4+), accredited positions only	Canberra Hospital incorporated in the Greater Eastern Paediatric Physician Training Network (NSW)
NSW	Paediatric Physician Basic Trainee (Registrar) via NSW JMO Campaign	Three Networks: • Greater Eastern (Sydney Children's Hospital plus 19 health services/hospitals) • Northern (John Hunter Children's Hospital plus 9 health services/hospitals) • Western (The Children's Hospital at Westmead plus 15 health services/hospitals)
NT	N/A*	-
QLD	Senior House Officer (SHO), Medical Registrar via QLD Health RMO Campaign	Queensland Basic Paediatric Training Network. Three Rotations: • Queensland Children's Hospital • Townsville Children's Hospital • Gold Coast University Hospital
SA	RMO (PGY2), Service Medical Registrar (SMR PGY3+) via SA MET Campaign	One state-wide Network incorporating: • Women's and Children's Hospital • Lyell McEwin Hospital • Flinders Medical Centre
TAS	RMO-level BPT positions via statewide campaign; Registrar positions (PGY4+) via General Medicine at Royal Hobart Hospital	Statewide process that covers three hospitals: • Royal Hobart Hospital • Launceston General Hospital • North West Regional Hospital
VIC	JRMO level positions commence at Royal Children's Hospital; SRMO positions to commence at Monash Medical Centre.	The Victorian Basic Paediatric Training Consortium (VBPTC) coordinates applications to: • Royal Children's Hospital: JRMO • Monash Medical Centre: SRMO
WA	RMO or Registrar at Perth Children's; Paediatric/Neonatal Registrar at Fiona Stanley Hospital.	Health Service : • Perth Children's Hospital (PCH), • Fiona Stanley Hospital (FSH).
Aotearoa NZ	SHO, Medical Registrar – typically after PGY2 with core medical rotations	One Network: Northern Network (four hospitals) Fifteen Health Services

**Darwin Hospital is incorporated in the Greater Eastern Paediatric Physician Training Network (NSW)/Townsville Children's Hospital Network Rotation. Women's and Children's Hospital (SA) to Alice Springs Hospital (secondment).*

1B. What is the relationship between recruitment and selection?

Most jurisdictions combine the dual functions of recruitment to the job position and selection into the training program in a single process. However, in Western Australia, the campaign follows a sequential approach, where candidates must first secure employment before applying for BT. This sequential model separates employment from training program selection. Conversely, in Aotearoa New Zealand, potential trainees can register directly with the RACP for training once recruited to a suitable job role, effectively bypassing a formal selection into the training program. Figure 3 summarises the relationships between these functions.

Figure 3: The relationship between employment and selection in recruitment functions

1C. What is the relationship between recruitment and training

In all jurisdictions, employment is the primary pathway to training access.

Trainees must first or simultaneously secure an employment contract to be eligible for or to maintain BT enrolment.

- In some jurisdictions (e.g., ACT, NSW, QLD), employment directly specifies the requirement to maintain active registration with the RACP throughout the duration of training.
- The **employment contract structure typically mirrors the training progression**, with annual renewals or rolling multi-year agreements that align with training stages. Some jurisdictions offer length of training contracts with possible extensions to a fourth year if required to meet program requirements. (e.g. NSW BPT).

This employment-training integration supports local workforce planning while embedding BT participation within the responsibilities of the job.

1D. Basic Trainee employment structures

Table 3 describes the link between employer and contract in the context of Adult Medicine BT in each jurisdiction. Table 4 describes the link between employer and contract in the context of Paediatrics and Child Health BT in each jurisdiction.

Table 3: Employers and contract structures by jurisdiction, for Adult Medicine

		Employer	Contract Length
ACT		Canberra Health Services (CHS)	Rolling 12-month contracts with annual reapplication
NSW		BPT Network	Length of training contract (3 years). Employment letters issued by the network.
NT		Health Service (TEHS or CAHS)	Fixed-term contracts up to 2 years; positions available across multiple hospitals.
QLD		Health Service within the Rotation	Annual contracts, typically two 6-month contracts or one 12-month contract, aligning with training programs.
SA		Local Health Networks (LHNs)	3 year contract from BPT 1, additional annual contract negotiated if required.
TAS		Health Service within the Rotation	24-month rolling contracts aimed at promoting retention within Tasmanian Health.
VIC		Individual Health Services	Generally, 12-month fixed-term contracts with automatic renewal subject to performance; Bendigo rural pathway offers a 3-year contract.
WA		Main Hospital of the Network	12 month contracts with annual reapplication.
WA RPTP		WA Country Health Service (WACHS)	Employment contracts need to be annually secured network operates for training purposes.
Aotearoa New Zealand		Te Whatu Ora | Health New Zealand	Permanent ongoing contracts for the duration of training. Single Employer Contract Agreement (SECA).

Table 4: Employers and contract structures by jurisdiction, for Paediatrics & Child Health

	Employer		Contract Length
ACT		Canberra Health Services (CHS)	Rolling 12-month contracts with annual reapplication
NSW		BPT Network	Length of training contract (3 years). Employment letters issued by the network.
NT		Health Service (TEHS or CAHS)	Fixed-term contracts up to 2 years; positions available across multiple hospitals.
QLD		Health Service within the Rotation	12-month contracts renewed subject to annual performance review.
SA		Local Health Networks	3-year length of training contract with the Womens and Children's Health Network.
TAS		Health Service within the Rotation	24-month rolling contracts aimed at promoting retention within Tasmanian Health.
VIC		Individual Health Services	Generally 12-month fixed-term contracts with automatic renewal subject to performance
			Bendigo rural pathway offers a 3-year contract.
WA		Main Hospital of the Network	12-month contracts with annual reapplication.
Aotearoa New Zealand		Te Whatu Ora | Health New Zealand	Permanent ongoing contracts for the duration of training (SECA)

1E. How are training numbers or positions available determined?

Training numbers for Basic Training are **locally determined**. The number of positions available each year is primarily determined by a combination of training capacity, workforce demand, supervision availability, and accreditation requirements. Although the specific processes vary by location, several common themes underpin how training numbers are set.

Capacity to train- supervision and accreditation constraints

- Across all jurisdictions, the **capacity to train** is the fundamental driver of position availability. This capacity is defined by:
    - The number of accredited training sites and rotations.
    - Availability of specialty and non-specialty terms required over the three-year training period. For example, limited Network **neonatal positions can create fluctuations in numbers that can enter NSW Paediatric and Child BT.**
    - Access to adequate supervision and clinical resources to support trainee development.

Workforce demand and service delivery needs

- **Workforce planning and service delivery requirements** also strongly influence the intake for BTs with a general desire from health services to recruit to the BT workforce to maximum (and sometimes beyond) training capacity. This can create tension between meeting workforce demand and maintaining adequate training support.

Flexibility and hierarchical allocation

- In some contexts, for example, the Northern Network (Auckland Doctors) in **Aotearoa New Zealand**, training numbers are also influenced by a hierarchical allocation model where **Advanced Training positions are prioritised** due to their more rigid training requirements, and BT numbers are adjusted accordingly. Similarly in this Network some sites may have capacity to train **"10% more than allocated"** if supervisory resources allow, creating built-in flexibility to accommodate service and trainee needs.
- In **Victoria, for Adult Medicine**, individual health services set their training capacity independently. Some services may fully recruit to their BPT 1 allocations through internal processes before participating in the PMCV Match, meaning that **some positions may not be entered into the centralised Match if fully filled early.**
- Some jurisdictions, such as NSW and QLD, operate more structured rotational and network-based allocation systems, whereas others, like Tasmania and Victoria, rely more heavily on localised workforce and service factors.

1F. Who is eligible to apply to Basic Training?

Eligibility to apply for BT positions across Australian jurisdictions and Aotearoa New Zealand is consistently based on two primary criteria:

1. General medical registration.
2. Minimum postgraduate clinical experience.

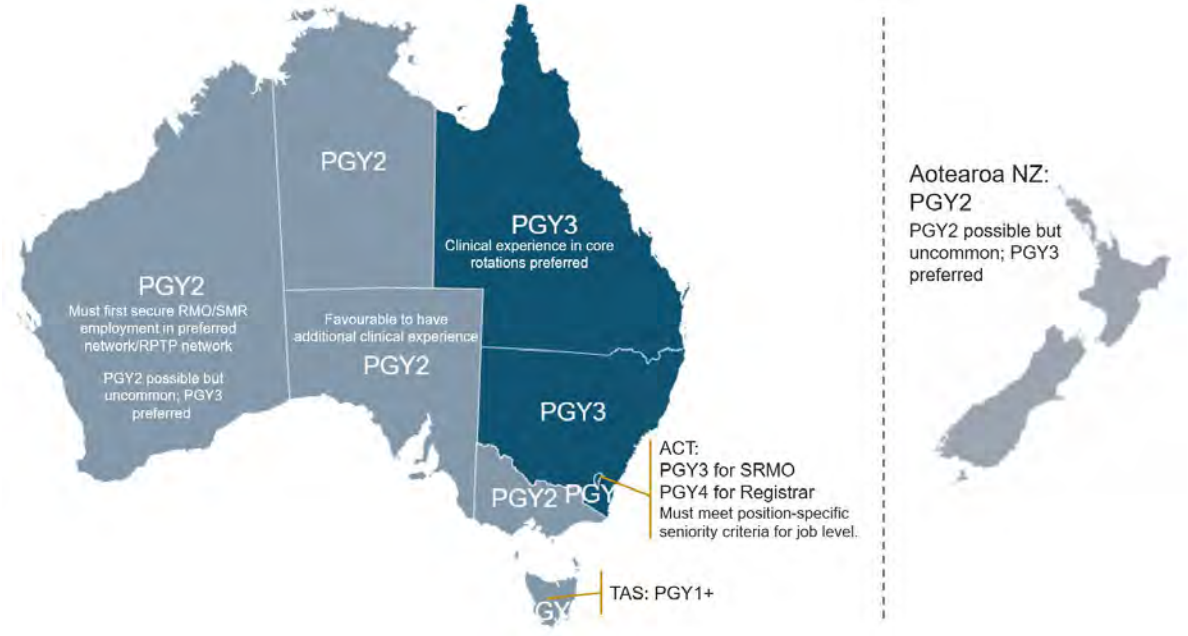
While the foundational eligibility requirements (per RACP eligibility statement) are broadly similar across regions, there are nuanced differences in minimum postgraduate year (PGY) requirements, employment prerequisites, and jurisdiction-specific processes.

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.

Figure 4 shows the variation in clinical experience via postgraduate year (PGY) recruitment.

Figure 4: Minimum PGY experience at point of commencing accredited training position



Key insights

- **Baseline requirement:** All jurisdictions require general registration and at least PGY1 completion.
- **Flexibility:** Some regions (e.g., SA, TAS, VIC, Aotearoa NZ) accept PGY1 applicants, provided they will commence BPT in PGY2, although the likelihood of selection into BT may still vary with clinical experience in some.
- **Local employment linkage:** WA requires securing local employment before BT application; other jurisdictions separate employment from training application but often run concurrently. **WA Rural Physician Training Program (WA RPTP)** requires applicants to hold or have applied for a 12-month clinical contract at an accredited rural WACHS site.

Role of clinical experience: Two profiles for clinical experience are represented through PGY year emerge concerning entry into BT. One is where **PGY year level relates to the job function of the trainee, rather than entry into the training program,** with training opportunities organised to experience. The other supports a **minimum level of clinical experience threshold before entry into BT,** through specific rotations and/or PGY level. Requirements related to job roles:

- Clinical exposure for relevant rotations is a selection advantage, particularly in QLD and SA.
- In the **ACT**, Senior Resident Medical Officer (SRMO) roles require applicants to be PGY2+, while Basic Physician Trainee (Registrar) roles require PGY3+ at the time of application.

- Additional Experience Considerations:
    - Experience as a natural advantage: for example, in SA and in the Northern Network in Aotearoa New Zealand, where applications from PGY1 doctors are accepted, the selection process tends to favour applicants with additional clinical experience, such as a general training year.

Specific clinical experience in paediatrics and child health, whilst not mandatory is advantageous as a demonstration of commitment to paediatrics as a career, but also assists local training providers in allocating relevant training rotations for BT 1.

1G. Equity and parity approaches

Across jurisdictions, **equity and parity approaches vary in formality, application, and strength.** Some systems have embedded affirmative action policies, while others rely on informal commitments to diversity without structured pathways.

- **ACT:** applies a standing recruitment decision that prioritises the recruitment of Aboriginal and Torres Strait Islander doctors. While the standard application form includes an identification question, this primarily triggers discussions about culturally appropriate support and mentorship rather than a modified selection pathway.
- **NSW:** NSW Paediatric and Child Health BT recruitment includes advertised **targeted positions for an Aboriginal and/or Torres Strait Islander entrants.** Eligible applicants are offered first preference positions
- **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: QLD Health has an Aboriginal and Torres Strait Islander Basic Physician Training Affirmative Pathway** for Adult Medicine and Paediatric Training Programs. All eligible applicants are shortlisted for interview and prioritised for first preference allocation. All applicants are invited to reflect on cultural safety in their submissions. Selection processes are to comply with Queensland Health equal opportunity policies.
- **SA:** There is an active commitment to increasing Indigenous representation in the physician workforce, with **additional consideration given to Aboriginal and Torres Strait Islander applicants.**
- **TAS:** Tasmania does not have formal equity-identified positions. Aboriginal candidates would be strongly supported if they applied, but there is **no structured affirmative action pathway.** Diversity is considered in a general sense, particularly for IMGs, who are a significant part of the workforce.
- **VIC:** Equity approaches vary by health service. Monash Health explicitly guarantees **interviews for Aboriginal and Torres Strait Islander applicants** who meet essential criteria and offers positions if the applicant demonstrates capability to perform the role.
- **WA**: recruitment processes explicitly encourage applications from Aboriginal people, culturally and linguistically diverse applicants, LGBTQIA+ individuals, and people with disabilities. No identified positions or priority offers were noted.

- **Aotearoa NZ:** does not offer identified or targeted positions, but if Māori or Pacific Peoples meet minimum selection thresholds (reference scores, clinical experience), they are prioritised for offers. The scoring process is otherwise standardised across all applicants.

Flexible Working Options

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 in Basic Training were identified:

- **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.
- **South Australia:** Part time (0.5 FTE) Adult Medicine BT positions may be offered, but rotation types offered may be restricted due to rostering limitations.

Rural Pathways

- **Western Australia Adult Medicine Country Health Services Network (WACHS):** Commenced in 2025, application is through a separate campaign from the metropolitan-based RMO recruitment that occurs several weeks earlier in the year. Applicants must already have or have applied to an RMO position in a country health service, and be able to demonstrate a connection to the rural context through previous employment and a commitment to a rural physician career.
- **Victoria Basic Paediatric Physician Training: Extended Rural Stream (ERS):** Commenced in 2022 and targets junior doctors who aim to become rural paediatricians. Applications are processed as part of the centralised JRMO recruitment campaign and indicate preference for one of three (location based) extended rural streams. ERMS positions are allocated before metropolitan or prevocational preferences.

2. Stakeholder involvement

2A. Who is involved in the selection process and what are their roles?

The selection process for BT typically involves a combination of Directors and/or Network Directors of Physician Education (DPEs/NDEs), other senior physicians, Advanced Trainees, administrative personnel, and, in some cases, external representatives. Additionally, HETI (NSW), PMCV (Victoria), and SA MET (South Australia) fulfil coordination roles ranging from support to arrange interviews to algorithm-based matching of health service to applicant preference and outcomes communication (PMCV Allocation and Placement Service BT “Match”). Other jurisdictions, like WA, NT, and TAS have their own structures involving health departments and hospitals, and coordinate the selection and training of BTs.

Network coordination of selection processes is prevalent in selection into Paediatrics & Child Health Basic Training programs.

The composition and structure of the selection panels vary by jurisdiction.

2B. How are different stakeholder needs and perspectives considered?

Stakeholder engagement varies in formality across jurisdictions but is consistently present in recruitment design and selection panel composition.

- **ACT:** Stakeholders, including network partners contribute during recruitment planning. Mentorship and cultural safety are discussed for Indigenous applicants. Future alignment with RACP accreditation standards is considered when evaluating rotation proposals and trainee numbers across the Network Cultural safety, mentorship for Indigenous applicants, and the interests of the local medical school (ANU) are key considerations. The selection process is sensitive to gender balance, cultural safety, and the needs of locally trained candidates.
- **QLD:** Each rotation adapts the selection process to local site-specific needs while ensuring statewide consistency. Selection panels are diverse, including both clinical and managerial representation. Regional training needs and local workforce distribution are considered in both Adult Medicine and Paediatrics and Child Health training programs.
- **TAS:** Stakeholder input is more informal, focusing on retention of local trainees, support for International Medical Graduates (IMGs), and workforce sustainability. Although diversity is valued, no formal structures or processes ensure diverse stakeholder input.
- **VIC:** Each health service independently considers local workforce needs in the selection process. PMCV collaborates with health services and the Department of Health to ensure the matching system aligns with broader training and workforce planning priorities.

2C. How does the selection process reflect local community health needs?

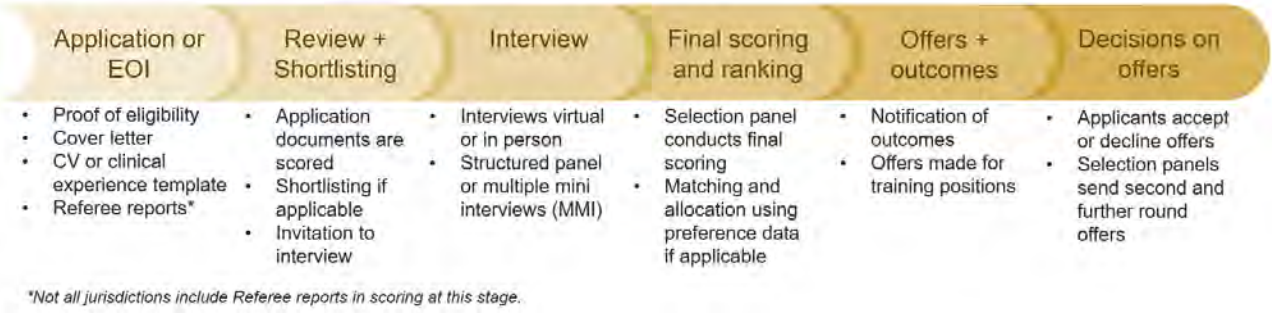
- **Selection panels are typically multi-disciplinary,** led by DPEs, senior clinicians, and local administrators.
- **Local community health needs are considered** at program and local level, paediatrics and regional/rural priorities.
- **Informal local workforce retention strategies** were referenced particularly in smaller regional settings.

3. Understanding the current processes

3a. What are the current selection processes?

The selection processes vary within and between programs and jurisdictions but share common features of multi-step assessment, merit-based evaluation, and alignment with local employment structures.

Figure 5: Typical process for recruitment and entry into training



Significant differences in the processes for selection relate to:

- The degree of centralisation of the process
- Sequential vs concurrent nature of recruitment and selection.

Factors that influence the processes also include how industrial awards relate the purpose of training to the conditions of employment (and vice versa) and the level of demand for training positions at the local level.

Case study examples of local characteristics of entry into training are illustrated in Figures 6 to 9 below. Table 5 provides a comprehensive summary of these features for all jurisdictions.

Figure 6: Tasmanian recruitment and selection process features

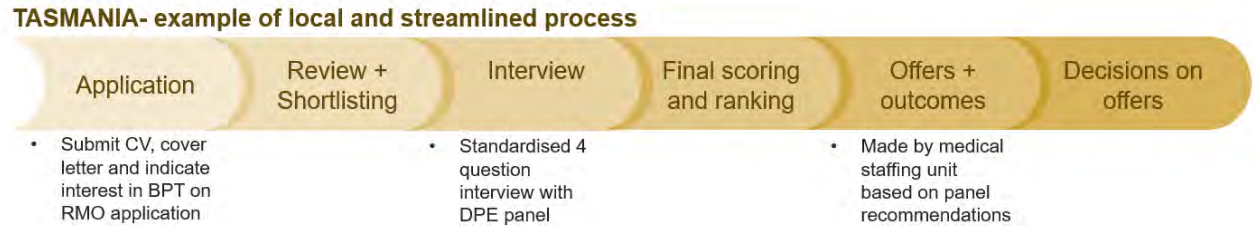


Figure 7: Victorian recruitment and selection process features

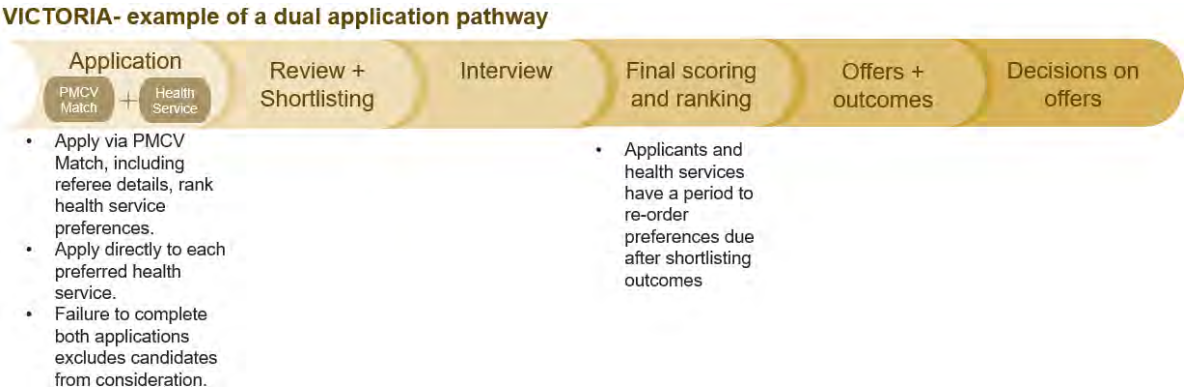


Figure 8: Western Australian recruitment and selection process features

Figure 9: Queensland recruitment and selection process features

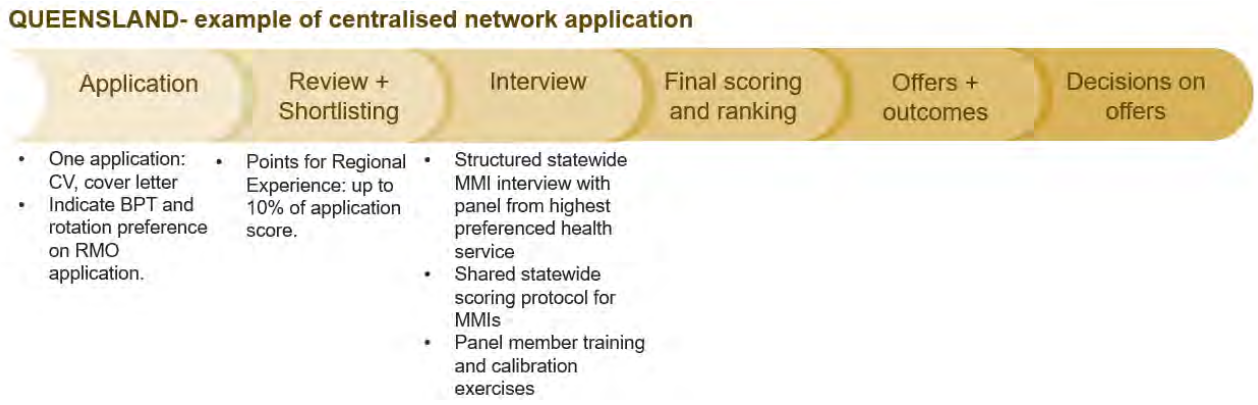


Table 5: Characteristics of recruitment and selection characteristics, by jurisdiction

	Match/ preference allocation	Apply to	Selection decision	Entities involved	Outcome options
ACT	No	ACT Physician Training Network	ACT Physician Training Team	Network	Binary- Offer of training position or No offer
NSW	Yes	BPT Network (separate applications required)		LHDs, BPT Networks	Binary- One offer of employment from the highest matched preference or No offer
				HETI (support and administration)	
NT	No	Health Service			Binary- Offer of training position or No offer
QLD	Yes	Statewide BPT Network	Statewide Network including Rotation reps.	Statewide BPT Network	Three options- Accredited position; Unaccredited position; No offer.
SA	Yes	Program and Network	Statewide panel (1	BPT selection panel SA Met	Second round offers- One offer of highest matched preference. If

	Match/ preference allocation	Apply to	Selection decision	Entities involved	Outcome options
			interview per program)		no match, invited to participate in “late vacancy management process”.
VIC	Yes	Health service		Health Services	Second round offers- One offer of highest matched preference. If no match, may be referred to health services with unmatched positions. May apply for non training positions.
				PMCV	
TAS	No	Health service	Health Service BPT selection panel	Health Service	Employment not affected- applicants usually already employed in RMO positions so if unsuccessful continue in that role.
WA	No	Relevant BPT Network for the hospital through annual RMO campaign		Health Service	
Aotearoa NZ	No	Health Service	DPEs and Medicine Vocational Training Committee.	Health Service	
		Auckland Network		Network	

3B. What attributes are targeted in the selection process?

Figure 10: 'Word cloud' visualisation of core attributes for selection into BT

Across jurisdictions and selection frameworks, the selection process for BT consistently targets a blend of genuine motivation for physician or paediatrics training and career, clinical competence, professional behaviours, interpersonal skills, capability to meet the demands of training and work, and alignment with the values and community health priorities of the health service or network applied to. The targeted attributes can be grouped into four overarching themes:

1. **Motivation and alignment with physician training**
    - Genuine motivation for a career in physician training or paediatrics and child health physician training and a commitment to lifelong learning.
    - Alignment with the **education, research, and healthcare values of the employing health service.**
    - Leadership potential, quality improvement engagement, and willingness to contribute to medical education and research.
2. **Clinical competence and readiness**
    - Applicants are expected to demonstrate proven clinical knowledge and competence appropriate to their postgraduate year (PGY2 or above). This does not imply high levels of medical expertise in the chosen career path – rather, safe practice along with "trainability".
    - Safe and effective patient management.
    - Competence in common ward-based procedural skills and the ability to make sound clinical decisions under pressure.
3. **Communication and teamwork**
    - Strong communication skills are universally valued, particularly the ability to communicate respectfully, empathetically, and effectively with patients, families, and healthcare teams.

- Teamwork, collaboration, and the capacity to support and supervise junior colleagues are critical selection criteria.
- Applicants must be able to engage constructively with others to ensure positive patient outcomes.

4. **Professionalism, ethics, and cultural competence**
    - Ethical behaviour, professional integrity, and maturity in handling responsibility are key attributes.
    - Awareness of health equity and public health issues in the context in which applicants seek to work. This is a core attribute considered especially in applications to Paediatrics & Child Health training programs.

3C. What criteria are used to measure the attributes and/or determine who is selected for training?

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

Curriculum Vitae (CV)

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

CVs and cover letters are an opportunity for applicants to demonstrate motivation and suitability for BT.

Cover Letter/Written Statements or Structured Selection Questions

- Written statements and structured responses to selection criteria are commonly used to elicit applicants' motivation for physician training, in the local context, whether that be a particular location, for paediatrics when applicable, or to join a particular health service.

Referee Reports

- Referee reports typically assess clinical skills, professionalism, communication, reliability, and teamwork. In Aotearoa NZ, the National RMO Reference Form is used across hospitals to ensure consistency in scoring and assessment.

Interviews

- Interviews are universally weighted highly, typically 60% of selection scoring and cover a range of attributes.
- 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

- Commitment to physician training
- Cultural awareness and safety.

3D. How are these criteria determined, and by whom?

Across all jurisdictions, **selection criteria are developed locally** by physician training committees, local health services/equivalent, or clinical leadership teams and in some cases at the **Network training level.**

Selection criteria are **aligned with RACP's expectations for entry into Basic Training,** particularly regarding motivation to pursue a career as a physician or paediatrician, and professional behaviours.

Local workforce contexts and desired skills of the recruiting body are represented in the criteria for selection.

3E. What are the steps where candidates may be screened or shortlisted out of the process?

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

1. **Eligibility Screening**: in most jurisdictions there is an initial screening step based on eligibility criteria, such as:
   - General medical registration
   - Postgraduate year minimum (typically PGY1 completion)
   - Relevant clinical experience (if required)
2. **Shortlisting for Interview:** this follows eligibility screening, and typically involves:
   - Review of written selection responses
   - CV scoring
   - Differential use of Referee Reports: may be part of shortlisting or not scored depending on local training context.

   Examples of shortlisting (or not) include:
   - **ACT:** Shortlisting is relatively inclusive; almost all eligible applicants are interviewed.
   - **Queensland:** Shortlisting is more competitive and considers the completeness, quality, and relevance of the application.
   - **South Australia:** Most candidates who express clear motivation in their cover letter are interviewed.
   - **Victoria:** Applicants may not be shortlisted by their preferred health services. If this occurs, candidates may have an opportunity to adjust their PMCV match preferences or add new options.
   - **Aotearoa New Zealand:** example from the Northern Network : health services rank candidates based on their assessments, including discrepant referee reports, and low-ranked applicants may not receive offers.

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 jurisdictions
- Final offers may reflect different outcomes that relate to the structure of the local employing entity. e.g. applicants considered suitable for training but ranked below the quota for capacity to train may be offered an 'unaccredited training position".

Key Insights

- Across most jurisdictions, **the eligibility screen is the primary exclusion point.** 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.**

4. Timing and Timelines

4A. How long does the selection process typically take?

Across jurisdictions, the recruitment/selection process for both Adult Medicine and Paediatrics and Child Health typically spans **7 to 12 weeks**, depending on the jurisdiction's recruitment structure and the sequencing of application, interview, and offer phases.

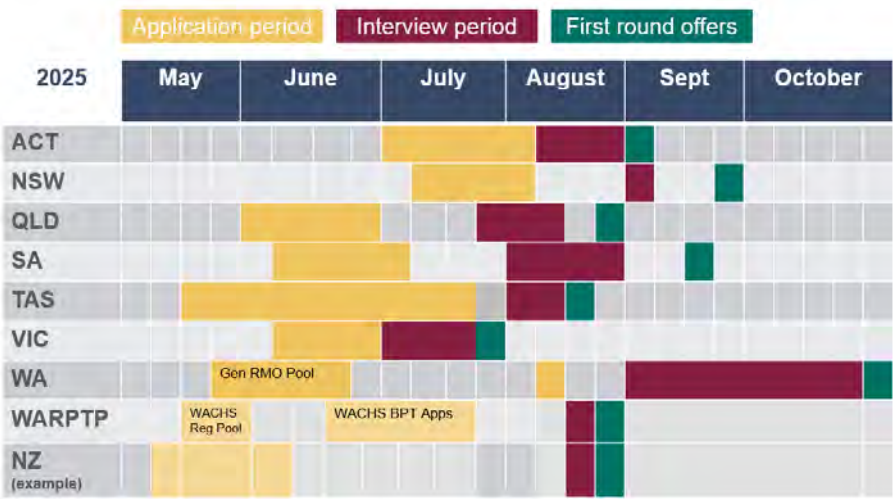
Table 6: Selection Process Duration

Region	Duration Estimate	Notes
ACT	~7 weeks	Applications open in early July; offers released by early September.
NSW	~7–9 weeks	Main recruitment round applications open mid-July and offers commence late August to mid-September.
QLD	~10–12 weeks	Applications open in early June; offers are released by late August to early September.
SA	~12–16 weeks	Expression of Interest opens in early June; offers are released from mid-September to early October.
TAS	Variable	Aligns with the annual RMO recruitment campaign timeline; flexible to accommodate mid-year offers and late applications, particularly for International Medical Graduates.
VIC	~7–8 weeks	PMCV BPT1 Match process runs from early June to early August.
WA	~10–12 weeks	RMOs and Service Medical Registrars (SMRs), June to August, BPT August to September.
NT	Variable	BPT recruitment typically from July-August, although recruitment can be a continuing need.
Aotearoa NZ	~12 weeks	Applications open May – 'National Offer Day' August 18, 2025.

4B. What are examples of milestone dates in the selection process?

Figure 11 illustrates the jurisdictional differences in the timing of annual recruitment campaigns. Although date ranges are shown for first round offers only, most jurisdictions will have multiple rounds and/or a late vacancy management process, as a proportion of first round offers are declined, sometimes due to applicants securing a preferred position in a different jurisdiction.

Figure 11: Representation of annual recruitment campaigns for BT Programs in 2025



5. Communication

5A. What information is available to applicants about selection and entry into BT Programs?

Application guides and scheduled information sessions are the primary mechanism training programs share information about required attributes criteria and application processes and scoring data. These guides and sessions are typically refreshed annually, with a large amount of information being released just prior to and during annual recruitment campaign periods or as individual jobs are advertised:

Examples:

- **ACT:** Applicants are informed via application documentation and interview briefings about how application materials and interview scores are used to rank candidates.
- **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.
- **SA:** Feedback mechanisms are available upon request for unsuccessful candidates. However, no in-person feedback or appeals regarding ranking positions are entertained. Procedural fairness provisions allow appeals based only on process errors.

6. Resource Allocation

Local physician training teams are the key resource in designing, coordinating, scoring and decision making in selection into BT programs. All interviewees noted selection is a **resource intensive process.** Staff of medical education units, vocational training committees and workforce units are key resources and contributors as relevant to

the local context. Jurisdiction based entities provide support to the process through a range of functions:

- HETI (NSW): supports the organisation and administration of a central interview location, and document collation for annual recruitment campaign.
- PMCV (Victoria): hosts the allocation and placement digital platform where applicants register and submit key documentation, including proof of eligibility, referee report collation and health services preference ranking. PMCV **verifies applicant eligibility, conducts algorithmic based matching** of health services to applicant preferences, and **communicates outcomes** to applicants and health services.
- SA Met (South Australia) coordinates a centralised Expression of Interest process on behalf of the South Australian, Department for Health and Wellbeing and South Australian Local Health Networks (LHNs). SA Met conducts **eligibility checks, matches applicants to positions** by considering both the applicants' preferences and the Selection Panels' rankings and **communicates outcomes.**

Conclusion

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

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

1. The primary pathway for entry into Basic Training is through annual jurisdiction-wide recruitment campaigns for clinical positions suited to doctors with postgraduate experience, most commonly PGY2 or above, although entry points and position titles vary across regions.
2. Employment structures for Basic Training differ, for example, some jurisdictions offering rolling annual contracts and others providing length-of-training contracts, while Aotearoa New Zealand generally offers permanent roles.
3. There are areas of commonality, such as eligibility requirements and the importance of identifying a commitment to physician training and differentiating aspects of physician training and service positions.
4. Training numbers are locally determined, based on accredited capacity to offer adequate professional experience, service demand, and supervision availability. Eligibility requirements are broadly consistent, requiring general medical registration and a minimum postgraduate year, though some jurisdictions prefer applicants with specific clinical experience.
5. 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.
6. Equity and diversity approaches differ, with, for example, formal affirmative action pathways in Queensland and the Northern Territory, targeted rural programs in Western Australia and Victoria, and more informal diversity commitments in other areas.

The next stage in this work is to consider the current state of Basic Training recruitment/ selection practices through the lens of the RACP's Selection into Basic Training criteria and the RACP's Selection into Training Policy and to further explore with stakeholders their perceptions of the strengths, areas for development and opportunities for further quality improvement regarding selection practices.

In working to gather insights for inclusion in this report, it was also obvious that training recruitment and selection is most certainly a pipeline, with prevocational practices influencing Basic Training, and Basic Training practices also influencing Advanced Training. The relationship between these activities will be further explored in the Discovery process for Advanced Training recruitment and selection.

Appendix 1

Table 7: Role terminology training doctors by jurisdiction

PGY Year	PGY1	PGY2	PGY3	PGY4+
VIC	Intern (HMO1)	Hospital Medical Officer (HMO2)	Hospital Medical Officer (HMO3)	Registrar
NSW	Intern	Resident Medical Officer (RMO)	Registrar (BPT)	Registrar
QLD	Intern (RMO)	Junior House Officer (JHO) (RMO)	Senior House Officer (SHO) (RMO) or Registrar (BPT)	Registrar (Trainee) or Principal House Officer (PHO)
WA	Intern	Resident	Resident	Registrar
SA	Intern	Resident Medical Officer (RMO)	Resident Medical Officer (RMO)	Registrar
TAS	Intern	Resident Medical Officer (RMO)	Resident Medical Officer (RMO)	Registrar
NT	Intern	Resident Medical Officer (RMO)	Resident Medical Officer (RMO)	Registrar
ACT	Intern	Resident Medical Officer (RMO)	Senior Resident Medical Officer (SRMO)	Registrar
Aotearoa NZ	House Officer (PGY1)	House Officer (PGY2)	Senior House Officer (PGY3)	Registrar

Appendix 2: Components of application and selection into training.

Table 8: Components of the recruitment and selection process, Adult Medicine

Jurisdiction	CV	Cover Letter	Referee Reports	Interview	Other/Notes
ACT	Yes	Yes	Yes	Yes	Selection generally non-competitive so process often used to benchmark for AT application.
NSW	Yes	Yes	Yes	Yes	Networks use common position description and selection criteria.
NT	Yes	Yes	Yes	Yes	Interest and motivation for working in remote Australia
QLD	15%	Written statements 20%	5%	60%	Planning form, clinical experience template
SA	10%	10%	30%	60%	Scenario-based interview structure, pre-interview EOI scoring
TAS	30%	10%	Not required for local candidates, not scored	60%	Standardised interview questions

Jurisdiction	CV	Cover Letter	Referee Reports	Interview	Other/Notes
VIC	Yes	Yes	Yes	Yes	Direct health service applications, local criteria
WA	Yes	Yes	Yes	Yes	Scoring provided for the rural program, assumption is susbset apply to metropolitan networks.
Aotearoa NZ	Structured template used.		Used via National RMO Reference Form,	Used, the process varies by DHB,	DHBs use shared CV template, local selection

Table 6: Components of the recruitment and selection process, Paediatrics and Child Health

Jurisdiction	CV	Cover Letter	Referee Reports	Interview	Other/Notes
ACT	TBD	TBD	TBD	TBD	
NSW	Yes 10%	Responses to selection criteria 10%	Yes 40%	Yes 30% panel.	Skills stations: 10% Verbal – patient handover Charting – e.g. IV fluids Management of a difficult non clinical scenario. Questions provided before session.
NT	-	-	-	-	-
QLD	Paediatric Specific CV	Yes	Yes	60% 7 MMI stations	• CV, cover letter referee reports combined weighting: 40% • Clinical experience template included- mostly for planning.
SA	Yes	Yes	Yes	Yes 3 stations • Clinical expertise (Paediatrics - focused scenario) • Teamwork and communication with patients • Approach to quality improvement and safe practice	Professionalism behaviours are considered throughout the interview process.
TAS	Yes	Yes	Yes & RHH Paediatric	Yes: • Communication skills	• Purposefully don't seek trainees with

Jurisdiction	CV	Cover Letter	Referee Reports	Interview	Other/Notes
			Trainee Data Sheet	• Keen/open to learning "someone we can train". • Ability to reflect	lots of experience in paediatrics or completed research • Interview questions are provided to candidates 10 minutes in advance to allow for preparation
VIC	Yes 18%	Yes 18%	Yes 4%	Yes 60% Online 6 station MMI	Single application to consortium (VBPTC)
WA	Yes 20%	Yes 20%	No, but previous supervisors listed in CV	Yes 60% 5 station MMI	Clinical experience worksheet and last 2 term assessments submitted with CV.
Aotearoa NZ	Structured template used, weight not specified	Not specified	Used via National RMO Reference Form, significant	Used, process varies by DHB, weighting not specified	DHBs use shared CV template, local selection