RACMA
ROYAL AUSTRALASIAN COLLEGE
of Medical Administrators

Q1. 2019

THE QUARTERLY

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It is published quarterly and distributed throughout Australia and New Zealand to approximately 1000 College Fellows,Associate Fellows, Affiliates, Trainees and Candidates, as well as selected libraries and other medical colleges.

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The Royal Australasian College of Medical Administrators
The College was founded in 1967 as the Australian College of Medical Administrators and attained its Royal Prefix in 1979.

In August, 1998 when links with New Zealand were formally established, the College changed its name to The Royal Australasian College of Medical Administrators.

The College when first established had the aim of promoting and advancing the study of health services administration by medical practitioners.

Profound changes in health administration have occurred since that time, but the need for competent well-trained health sector managers has not diminished.

The College works to achieve its aims through a rigorous university-based training course, supervised posts in medical administration and postgraduate education programmes for Fellows, Associate Fellows, Candidates and Trainees.

Front cover

In this edition we celebrate International Women's Day by highlighting the work of five RACMA female Fellows, discussing their views on women in medical leadership and where the focus should be in attracting future leaders of the College.

Pictured left to right: Dr Iwona Stolarek (RACMA Vice President), Dr Jennifer Alexander (RACMA first female President), Dr Sidney Chandrasiri (Director Medical Services, Epworth Freemasons and Group Director, Academic & Medical Services Epworth HealthCare), Air Vice-Marshall Tracy Smart (Commander Joint Health and Surgeon General of the Australian Defence Force) and Dr Mellissa Naidoo (Director of Medical Services at Greenslopes Private Hospital, Queensland).

From the President

Welcome to 2019 – what a busy first quarter it has been. The new Board has hit the ground running and I have been meeting many key stakeholders across the healthcare industry.

Two of the most recent key meetings, in terms of increasing the awareness of the College and engaging on some key issues facing our profession, were with the Federal Minister for Health Greg Hunt and the AMA.

The meeting with Minister Hunt was very positive. He was very aware of what RACMA did and the important role our members play in health system leadership and governance. He is very interested in exploring stronger collaborations with RACMA and the federal department in key areas such as research. We welcomed this opportunity.

The AMA forum with several other Colleges was very valuable to be part of as there were presentations from several key medical leaders. Dr Anne Tonkin, the newly appointed Chair Medical Board of Australia, provided an overview of implementation of the Professional Performance Framework and the forthcoming National Training Survey, which will be undertaken this year. Dr Brendan Murphy, Australian Government Chief Medical Officer, spoke about the Government's plans regarding the National Medical Workforce. Ms Jaelea Skehan, Director of Everymind, presented an overview of the draft National Framework for Tackling Mental Ill-health in Doctors and Medical Students. While AMA President, Dr Tony Bartone, provided an update on recent and current activities by Government and peak bodies regarding Out of Pocket Costs and the AMA's work on Informed Financial Consent.

We have also met with State Ministers for Health in Tasmania, Queensland and the ACT to promote the College and its training and impact in their jurisdictions

Leadership in quality and safety, risk and workforce planning was on the agenda when I met with the Clinical Excellence Commission in NSW. I believe our College Fellows are in an ideal position to provide leadership in this space.

We are not far away from releasing the final AMC Accreditation Report to all members. As most of you are aware the initial feedback was very positive. When we release the report, we will explain how we will be working together to implement the AMC's conditions and recommendations. The conditions will serve as a strong guidance as we continue to improve as a College. I'd like to acknowledge the significant effort and time many of our specialist leaders have contributed to the whole accreditation process, particularly Dr Lyn Lee and Associate Professor Pooshan Navanthe for all their work.

With this in mind, the year ahead presents as an exciting prospect and I am looking forward to the College taking the lead on setting the standard for excellence in medical management across Australasia.

Finally, I am pleased to recommend to you all that you read and promulgate the College's position statement on Doctors' Wellbeing. It can be found on the RACMA website.

Associate Professor Alan Sandford AM
President

Censor-in-Chief Update

The College is facing an exciting challenge moving down the pathway of implementing programmatic learning and assessment. This is a requirement for all Colleges of the Australian Medical Council (AMC), and is based on contemporary medical education practice. The recent AMC Review of the College confirmed that our process of summative assessments of research presentations and the RACMA Oral examinations are sound.

Nevertheless, the College and the Board of Censors (BOC) is committed to the need for continual reflection and improvement. This includes an ongoing program of review and clarification of our Curriculum, as well as identifying a schedule of regular formative programmatic assessments throughout the training program, which is aligned with intended outcomes and supports the development of our trainees. The BOC also has an ongoing program of review to improve the validity and integrity of our summative assessments.

As previously flagged to candidates, in 2020 the format of the RACMA Oral Examination will change with removal of the current two choice questions, resulting in four compulsory questions. Feedback from Candidates supports this change. In the trial examinations in 2019, the BOC will be piloting this format. Please note, for Candidates undertaking the RACMA oral examination in 2019, there will be no change in the current format, which involves two choice questions.

Finally, I would like to acknowledge the great contribution of Dr Tony Austin to the College and to the Board of Censors. Tony is retiring and has relinquished his positions in the College. I have personally valued Tony's advice and support, and I am sure all of his colleagues and trainees who have interacted with Tony will wish him well and thank him for his work supporting our candidates, the College and the Board of Censors over many years.

Dr Peter Lowthian
Censor-in-Chief

Education & Training Committee Update

The ETC hit the ground running for 2019 after the Fellowship Training Program (FTP) workshop in Sydney in January.

In addition to the ETC, a number of JCT representatives from across NSW, Queensland, Tasmania, Victoria and New Zealand spent two days in discussion and debate. Also present were our Vice President, immediate past President and immediate past Vice President. The time was spent in dissecting the FTP and making improvements to better suit the needs and capacity of Candidates, Supervisors and Preceptors, and to ensure we continue to attract and develop exceptional Fellows in the specialty of medical administration so healthcare across Australasia remains superior.

Extensive discussion took place around the length of the program and the type of training and assessment undertaken within the program each year. The group also examined whether the College's training and assessments were producing quality, competent and consistent graduates.

ACEM Director of Education and Training Lyn Johnson provided a breakdown of Programmatic Assessment models which prompted discussion around whether this type of assessment will drive learning and produce quality graduates. Appropriate summative and formative assessments were explored, as was the impact on workload for supervisors, preceptors and the national office.

The workshop reviewed the roles and responsibilities of the Dean, Censor in Chief, Supervisors, Preceptors and Jurisdictions as well as FTP entry requirement processes and pathways, including RPL Accreditation.

A number of outcomes were developed. These have been approved by the Board and an action plan will be developed for implementation.

Summary of outcomes

1.Develop a clear statement on the outcomes of the FTP (What does a Fellow look like?).

2.Consider whether we need to limit intake of Candidates of both novice and experienced candidates.

3.Review Recognition of Prior Learning process to improve governance and rigour and ensure that we provide RPL for competencies and activities not in terms of years.

4. The FTP program to move to a four-year program for new Candidates commencing in January 2021.

5. Develop Work Based Assessments with a mandate to ensure all assessment activities are successfully completed prior to oral exam being undertaken by the candidate. Develop a list of WBAs that are core (and therefore mandatory) before the summative assessment (oral exam). Six ITRs (however named) and a minimum of 30 core WBAs required for Fellowship (unless exempted by RPL).

6. All Candidates to be provided with a customised training program.

7. A review of accredited Masters programs to be conducted in line with the AMC outcomes.

8. Process for providing feedback to participants for trial exams to be undertaken.

9. Change title of Supervisor to Training Supervisor and all must undergo F2F training for induction and online for follow-up 5 yearly. Training will commence at the 2019 Annual Meeting.

10. Mandatory for Training Supervisors to be Fellows and to be allocated by the Jurisdictional Coordinator of Training.

11. Development and implementation of standardised Position Description, Training Program and Evaluation Process for Workplace Supervisor, Training Supervisor, and Preceptor.

12. Candidates to have the same Preceptor for entire period of Candidacy.

13. All Preceptors must complete Supervisor Training and Mentor Training.

14. That all roles within the College Office to be clarified as well as roles of Committees and Sub Committees.

15. Decisions regarding Candidates' training and progression to be made by a delegated authority/authorities. This delegation and process needs to be established.

16. Review of resourcing requirements to support the FTP including both College Office and Jurisdictional Coordinators of Training to be conducted.

17. A role such as Dean of Education remain in place to oversee governance of the FTP.

18. A change management plan be developed outlining clear timelines and actions including identified stakeholders. This plan will also include a proposed consultation process and risk register.

19. Aim to launch programmatic assessment as above from intake of 2021.

Associate Professor Pooshan Navathe
Chair, ETC and RACMA Board Member

Continuing Professional Development Update

Monthly Webinars

The RACMA Member Webinar Series provides a range of webinars exclusively available to RACMA members, with participation contributing towards Continuing Professional Development (CPD) hours. These webinars are facilitated by our senior Fellows as well as a range of guest speakers. The webinars comprise of a diverse range of topics within contemporary medical leadership and management, presented by influential leaders in Australasian medical administration, governance, health care and health services research.

Upcoming webinars include:

- 24 April, 2019: Artificial Intelligence & future impact. Presented by Professor Erwin Loh FRACMA.
- 29 May, 2019: Doctor suicide/Mental Health. Presented by Dr Geoff Toogood AFRACMA.
- 4 July, 2019: Mindfulness for well-being and peak performance. Presented by Professor Craig Hassed.

A summary of topics for 2019 as well as past webinar records can be found at: **www.racma.edu.au/page/resources/webinars/racma-monthly-webinar-series**

REMINDER - cut off date for 2018 points registration 31 March 2019

Review and endorsements will be undertaken during April/May and Certificates will be available to download in your MyRACMA portal once approved. We will email all members to advise when certificates are available to access.

Click **https://my.racma.edu.au** to login. If you do not know your MyRACMA User ID and/or password, please contact us at cpd@racma.edu.au

Jurisdictional Groups

Contact your jurisdiction to see what they have going on. For contact details visit **https://www.racma.edu.au/our-team**

Remember that you don't have to do all activities through RACMA and that activities held through other Colleges or external providers can be recorded if they relate to leadership and management activities.

CPD Logo

When you see this logo it indicates it is a RACMA activity and will indicate how many hours can be claimed. Your attendance will be recorded on your behalf for any activities with this logo.

Refresh

We are currently conducting a review of MyRACMA, handbook, website, Quick Reference Guides and templates. An update will be sent to all Fellows and Associate Fellows once the review is complete and the new version of the CPD Handbook is available.

CPD Policies

Requests for exemptions – If you wish to apply for exemption from 2018 or 2019 CPD, please complete the online application form which can be found at **https://www.racma.edu.au/page/members/cpd/apply-for-exemption** For more information on exemption criteria, please go to the Compliance and Exemption policy at **https://www.racma.edu.au/page/about-us/governance/college-policies/continuing-education-program-exemptions**

Other recently updated CPD policies are:

- Annual Audit of Participation in CPD located at **https://www.racma.edu.au/page/about-us/governance/college-policies/annual-audit-of-participation-in-cep**
- Participation in CPD located at **https://racma.edu.au/page/about-us/governance/college-policies/participation-in-continuing-professional-development-cpd**

Professional Development Training Calendar

The 2019 programs offered provide training options designed for Medical Administrators to develop your potential and expand your knowledge and skills. From masterclasses to introductory courses, these tailored workshops are specifically contextualised for clinicians to provide training from subject matter experts to develop your career. The program for the next four months is on the following pages or you can explore all your professional development options by accessing the full 2019 calendar at **https://www.racma.edu.au/content/Document/PD/2019_RACMA_PD.pdf**

2019 College Professional Development Calendar

ADELAIDE

DATE	WORKSHOP	TIME	PRICING	BOOKING LINK
Friday 14 June	Crisis Management	9 – 5pm	$945 – Member $1,095 – Non Member	https://www.trybooking.com/403868
Monday 28 & Tuesday 29 October	Operations & business excellence for medical leaders	9 – 5pm	$1,695 – Member $1,840 – Non Member	https://www.trybooking.com/404313

BRISBANE

DATE	WORKSHOP	TIME	PRICING	BOOKING LINK
Saturday 8 June	When Doctors Lead – Rethinking Leadership	8 – 4pm	$965 – Member $1,140 – Non Member	https://www.trybooking.com/404348
Friday 9 August	Preparing a Compelling Business Case	9 – 5pm	$980 – Member $1,130 - Non Member	https://www.trybooking.com/406129

MELBOURNE

DATE	WORKSHOP	TIME	PRICING	BOOKING LINK
Friday 10 May	Presenting with Confidence	9 – 5pm	$1,125 – Member $1,145 – Non Member	https://www.trybooking.com/403852
Friday 26 July	Mastering Transformational Change	9 – 5pm	$945 – Member $1,095 - Non Member	https://www.trybooking.com/406122
Monday 19 & Tuesday 20 August	Decision Making for Medical Leaders	9 – 5pm	$1,695 – Member $1,840 – Non member	https://www.trybooking.com/403875
Saturday 12 October	Collaborative Communication	9 – 5pm	$745 – Member $890 – Non Member	https://www.trybooking.com/407692

NEW ZEALAND - Auckland

DATE	WORKSHOP	TIME	PRICING	BOOKING LINK
Saturday 3 August	Mastering Transformational Change	9 – 5pm	$945 – Member $1,095 - Non Member	https://www.trybooking.com/406126

NEW ZEALAND - Wellington

DATE	WORKSHOP	TIME	PRICING	BOOKING LINK
Monday 14 & Tuesday 15 October	Decision Making for Medical Leaders	9 – 5pm	$1,695 – Member $1,840 – Non Member	https://www.trybooking.com/403885

PERTH

DATE	WORKSHOP	TIME	PRICING	BOOKING LINK
Monday 16 & Tuesday 17 September	Decision Making for Medical Leaders	9 – 5pm	$1,695 – Member $1,840 – Non member	https://www.trybooking.com/403880

SYDNEY

DATE	WORKSHOP	TIME	PRICING	BOOKING LINK
Saturday 11 May	Conflict Resolution	9 – 5pm	$745 – Member $895 - Non Member	https://www.trybooking.com/406392
Friday 28 June	Influencing for impact	9 – 5pm	$980 – Member $1,130 – Non Member	https://www.trybooking.com/406404
Saturday 7 September	Finance Fundamentals	9 – 5pm	$745 – Member $890 – Non Member	https://www.trybooking.com/404672
Friday 25 October	Presenting with Confidence	9 – 5pm	$1,125 – Member $1,145 – Non Member	https://www.trybooking.com/403857
Thursday 14 November	Writing with Clarity	9 – 5pm	$960 – Member $1,110 – Non Member	https://www.trybooking.com/406138

TASMANIA - Hobart

DATE	WORKSHOP	TIME	PRICING	BOOKING LINK
Saturday 17 August	Effective Interviewing	9 – 5pm	$745 – Member $890 – Non Member	https://www.trybooking.com/406396

TASMANIA - Launceston

DATE	WORKSHOP	TIME	PRICING	BOOKING LINK
Saturday 2 November	Finance Fundamentals	9 – 5pm	$745 – Member $890 – Non Member	https://www.trybooking.com/404678

TOWNSVILLE

DATE	WORKSHOP	TIME	PRICING	BOOKING LINK
Saturday 10 August	Managing Budgets & Financial Plans	9 – 5pm	$745 – Member $890 – Non Member	https://www.trybooking.com/404669

College Update

2019 Conference

Discover the latest technology and robotics research shaping the world of medical management and leadership at the 2019 RACMA Annual Conference.

Medical Leadership in the New Age – Futurism, Artificial Intelligence, Agility is the theme for this year's Conference, to be held at the Hilton in Adelaide on October 2-4.

Planning has commenced for the Conference program and RACMA welcomes our members to be involved in their Conference. Take the opportunity to contact Conference Program Co-ordinator Dr Jo Jenson - jjenson@racma.edu.au with suggestions for speakers or Abstract submissions. The program will feature the College AGM, Conferment Ceremony, faculty workshops and the welcome reception and conference dinner.

You can register your interest and take advantage of early bird discounts by visiting the RACMA website or clicking **HERE**

Specialist Training Program (STP) gathering momentum

RACMA's Specialist Training Program (STP) continues to go from strength to strength, thanks to funding and support from the Federal Government's Department of Health.

A three-year Standard Funding Agreement between the Department of Health and the College was executed in 2018, which has enabled the College to offer funding to an increasing number of health settings over this period. The STP seeks to extend vocational training for specialist registrars into settings outside traditional metropolitan teaching hospitals, including regional, rural and remote, and private facilities.

Under the new Agreement, the College must meet its Specialist Training Program Key Performance Indicators of funding 11 rural, regional or remote settings and six private settings by the end 2020. The College has been working hard towards meeting these targets and looks set to achieve the goal in the time frame.

Under the same Agreement, funding for training posts under the Integrated Rural Training Pipeline (IRTP) has been extended to nine posts (from eight) for 2019 and 2020. Experiences in these posts enable a specialist trainee to complete at least two thirds of their Fellowship Training in a rural region. These training posts receive a contribution towards the Candidate's salary as well as rural support loading, assisting in meeting additional costs which are incurred to support a speciality trainee in these locations.

Likewise, the Training More Specialist Doctors in Tasmania program continues to be funded under this Agreement. In 2019 and 2020 funding is available for three training posts as well as a Supervision component, which supports the training and retention of specialist doctors in the Tasmanian public health system.

In 2018 the College was also granted extra STP Support Projects funding to develop and deliver educational support projects for the purpose of supporting the success and sustainability of delivering training in rural and private health care settings. The funding lasts for the duration of the new three-year Standard Funding Agreement and the College has commenced delivery of these.

2019 Supervisor & Candidate Rural Workshop 31 May - 1 June, Albury

RACMA is hosting a two-day workshop designed to provide an opportunity for Candidates and Supervisors to develop strong, cross-jurisdictional rural health networks and enhance the quality of training and support.

DAY 1, Supervisor workshop - This will include an overview of workplace assessment as well as a facilitated session dedicated to Managing Difficult Conversations and Constructive Feedback.

DAY 2, Candidate workshop - This will include a panel discussion on Rural Career Planning and Progression and a facilitated session on Crisis Management. 2019 Victorian Young Australian of the Year, Dr Skye Kinder, will be the lunch time guest speaker.

All participating Supervisors and Candidates are also invited to the workshop dinner, which will be hosted by RACMA President Associate Professor Alan Sandford AM. Guest speaker for the evening is Air Vice-Marshall Tracy Smart - Commander Joint Health and Surgeon General of the Australian Defence Force. For the full workshop program or to register please click **HERE.**

The workshop, which is funded by the Federal Department of Health under the Specialist Training Program's (STP) Support Projects, will be held at the Mantra Albury, 524 Smollett Street, Albury. For more information email Rebecca Hateley - rhateley@racma.edu.au

Third Year Candidates Workshop a success

The Advanced Medical Management Workshop in February looked at healthcare finance and resource management appropriate for medical managers and provided Candidates with the insight and understanding of the theory and practical tools underpinning financial governance in health.

Candidates were given an extra insight into how to interpret a hospital financial budget and provide an informed and sensible analysis for management action. The workshop also covered recognising the significance of health law and medico-legal issues as well as the importance of and the difference between State and Federal legislation, regulatory bodies and relevant policies and guidelines.

Other sessions helped to raise awareness and provided opportunities to examine the roles of medical managers in preparing for and providing a response to emergency situations. Candidates were also guided through issues around employment, governance and management of a medical workforce.

Attendees were also given assistance in developing a plan for preparing and being ready for oral exams, which included:

- Censors' advice, tips and information required to prepare for the exam.
- Tips and wisdom on exam preparation, best practices, tools for exam preparation.
- How to use the jurisdictional exams prior to the exam.
- What to do differently/more effectively.
- What skills and mindfulness Candidates need to perform better.
- Exam case study scenarios to practice.
- Presentation hints for the exam day.

Upcoming Candidate Workshops & Exams

The Workforce Management and Engagement Workshop for second year Candidates is on 21 & 22 June at Pullman Melbourne on the Park.

The 2019 RACMA Oral Examinations for final year Candidates are scheduled to be held at the AMC National Training Centre (AMC – NTC), Melbourne, on 3 & 4 August, while the Trial Oral Exams for second year Candidates will be held on 19 & 20 October at the AMC – NTC, Melbourne.

Faculty Education Program

The College is again offering RACMA Faculty a Training and Education program via webinars, teleconferences and workshops on topics addressing emerging issues around supervision and the Fellowship Training Program (FTP) for Censors, Supervisors, Preceptors, Executive Coaches and Faculty Trainers.

The program aims to:

- Develop understanding of the Medical Leadership and Management Curriculum Competency Framework and the Assessment Framework of the FTP
- Build expertise to support training activities including assessment methods, evaluation and feedback .
- Enhance engagement from Supervisors, Preceptors, Censors, Jurisdictional Coordinators of Training (JCTs).
- Provide introduction on the Programmatic and Workplace-based observation and assessment, and new tools to assess performance of Candidates in the workplace and their progress through competency development in the FTP .

The first webinar in February, which was presented by College Dean of Education Dr Lyn Lee, covered the RACMA Curriculum.

April's webinar "Giving and Receiving Feedback", will be presented by Professor Lambert Schuwirth, Professor of Medical Education and Director Prideaux Research Centre, Finders University South Australia. While May's topic "Support with Exam Preparation" will be presented by Dr Lyn Lee and Dr Peter Lowthian (RACMA Censor in Chief).

The webinars offer the opportunity to gain CPD points. For the full program please visit www.racma.edu.au/page/resources/faculty-education-program

Medical Careers Conference - Queensland

Medical leadership and RACMA's training programs were the topic of conversation with a number of medical students at a recent conference in Queensland.

RACMA women driving a diverse approach to medical leadership

In recognition of International Women's day earlier this month, RACMA is proud to celebrate its female Fellows – many of whom are influential medical leaders in the Australasian healthcare system. While the College has come a long way in 50 years when we had three female Foundation Fellows among a group of 168, The Quarterly discovered the equality debate has now moved beyond the gender binary for RACMA. A cross-section of female Fellows share their views on women in medical administration and leadership. Despite there being a way to go to see more female leaders at the Board table, they believe the focus should widen to diversity, visibility, voice and role modelling.

The face of female medical leadership is changing and RACMA's women Fellows are leading the charge, whether they see themselves playing this role or not. Increasingly, they are formulating pivotal strategies and solutions and influencing top-level decisions.

"I think we are changing as women leaders," RACMA Vice President Dr Iwona Stolarek said.

"We're finding our voices better, as well, there are more of us in the work place. I think previously the lack of visibility and voice reflected a time when women couldn't be true to themselves to succeed in a very male dominated world. When I was at medical school 25% were women and that puts a different slant on things. Now there's well over 50 per cent. But I think it is more than the binary male-female equality debate now. How do we look beyond gender definitions to the values, behaviours, skills and experiences we bring?"

If anyone knows what change looks like when it comes to women in leadership, it is Air Vice-Marshall (AVM) Tracy Smart - Commander Joint Health and Surgeon General of the Australian Defence Force. In her career within the Australian Defence Force (ADF), which spans 34 years, she has often found herself to be one of the first women to hold a number of positions.

AVM Smart was the first female Commanding Officer of the Institute of Aviation Medicine and was the third female to be promoted to the rank of Air Commodore, which is a one-star rank.

"Now we have 10 or more at that rank and there is another female Air Vice-Marshall like me, while the Army has four or five female Major Generals, for the first time. That's the really big change we are seeing now and it's exciting," AVM Smart said.

"We are still a minority at senior leadership meetings, but it's changing. In the health sector of the military we have more women on a percentage basis than the rest of the defence force.

"I look at the impressive young women coming through the system and we are absolutely on the right track, it will just take time. We are in really good hands. It has changed and will continue to change and we have nothing but support from senior leadership."

In her current role, AVM Smart is in charge of Joint Health Command (JHC), which provides health care to ADF members and ensures the health preparedness of ADF personnel for operations and deployable elements of JHC for deployment in support of operations.

"I think women, from the health perspective, bring the human side," AVM Smart said.

"That's what I think I bring to the table. It's not all numbers. I try to be consultative and I try to get other people involved and make sure everybody is aligned in the decision.

"In the end, we are going to be driven by what workforce we have that wants to do the job and does the job well versus what some random statistic talks about."

Dr Mellissa Naidoo is Director of Medical Services at Greenslopes Private Hospital, Queensland. She is passionate about women in leadership and diversity, advocating for gender balance in college conferences and developing an annual symposium for women in medicine.

"Women are powerful agents of change and advocacy and bring unique perspectives and insights," she said.

"We need to acknowledge women's achievements, forge positive visibility and embrace flexible training and job opportunities to attract and retain women in medical administration. I recently created a flexible training role and as many men as women applied – it's not just women who are held back by cultural and structural barriers, although the impact is disproportionately greater for women."

Wind the clock back three decades to when many would argue this passion and drive for female leadership in medical administration was ignited. In 1994, Dr Jennifer Alexander became the first female President of RACMA after being on the Council for more than a decade. In that year, 18 females were conferred as Fellows, the highest number in the history of RACMA. Between 1968 and 1994, 63 females were admitted to the Fellowship, but between 1994 and 2017 this number more than doubled with 156 females conferred.

"In those days the President was appointed by the Council from the Council members when there was a 'succession plan'. One of those in line was unable to take up the President's role for, I think, health reasons and so the line got 'jiggled' about," Dr Alexander said.

"I think that this coincided with the Council members becoming aware that it was important to attract more women into RACMA and that the time was right for RACMA to have its first female President. So in that sense I was in the 'right place at the right time', but I had no hesitation in taking on the role," she said.

Dr Alexander made quick work of making sure she was in the role because of her merits and expertise. As President, she did the

Left: RACMA first female President Dr Jennifer Alexander
Below: RACMA Vice President Dr Iwona Stolarek

foundation work to bring New Zealand into the College and change the name to "Australasian" in line with many other of the bi-national colleges.

"I had been in many board rooms dealing with many senior men, so I was used to that environment whatever it meant. I stood my ground. I'm not a person that is easily intimidated," Dr Alexander said.

"People have always described me as a strategic person. I have always had a belief that the leadership and management of an organisation is as important as the quality of the technical skills of the people that work in the organisation. It's like an orchestra – you can have all these talented players but if the conductor doesn't bring them together in a meaningful way then they are just a group of people playing their own instruments.

"I believe that leaders have a great impact on the overall success, or otherwise, of an organisation. Strong leadership is needed if an organisation is to achieve its full potential."

In her 30-plus years in medical administration, Dr Alexander held various roles, including chief executive and medical director. Her passion for leadership continues today through her portfolio of non-executive director roles with various organisations, including the University of NSW, Relationships Australia and Mindgardens Neuroscience Network and as an independent member of the Audit and Risk Committee of the NSW State Emergency Service and the Barangaroo Delivery Authority.

About 33% of current RACMA members are women, a number which has been growing steadily over the past three decades. However, new Fellow Dr Sidney Chandrasiri believes there is still a way to go in creating conditions conducive for women to feel comfortable and accepted to take on more influential roles in medical leadership.

Director Medical Services, Epworth Freemasons and Group Director, Academic & Medical Services Epworth HealthCare, Dr Chandrasiri said recognition of this was only the starting point of enabling an increasing number of women to play influential leadership roles.

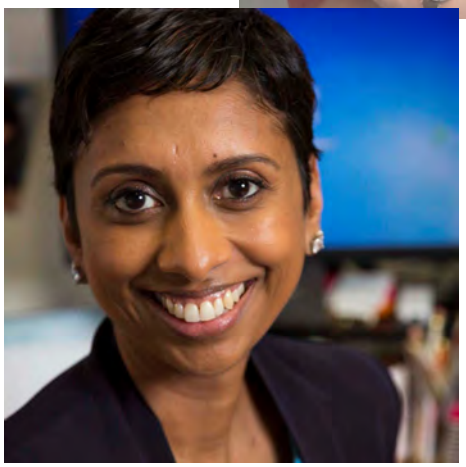
"It is important for there to be more recognition, more acceptance and active sponsoring of women into influential medical administration roles, not just because they are women, but because they possess unique skills and individual attributes that set them apart from their male (or female) counterparts," she said.

"A somewhat contentious and sobering realisation that we need to be aware of is that younger women embarking on leadership journeys are often facing more competition and thereby fewer opportunities, not by men in leadership positions, but by other women in leadership positions who genuinely do not want to see other women succeeding.

"There is also a great degree of inherent (conscious or unconscious) bias that many women leaders currently face, from other senior leaders both in their organisations or those in their industries, in being promoted or in being perceived as equal to their male counterparts in the field of medical leadership."

Above: Air Vice-Marshall Tracy Smart Commander Joint Health and Surgeon General of the Australian Defence Force

Right: Dr Sidney Chandrasiri Director Medical Services, Epworth Freemasons and Group Director, Academic & Medical Services Epworth HealthCare



Above: Dr Mellissa Naidoo, Director of Medical Services at Greenslopes Private Hospital, Queensland

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RACMA women driving a diverse approach to medical leadership

AVM Smart said medical colleges were starting to realise it was one thing to increase the number of women joining but another to have key leadership positions available for them.

"I don't think some of the colleges have set the right conditions in place to be able to encourage that to happen. I think the whole medical profession is struggling with this same issue – the same issue Defence has been working on for a number of years," she said.

The opportunity is there for RACMA to take the lead for all other medical colleges in Australasia and play a pivotal role in supporting women into medical administration and leadership roles.

"All colleges have to consider how to be more inclusive of women and our college is no exception," Dr Naidoo said.

"At the RACMA Conference a couple of years ago, a group of medical students presented a poster 'Where are the females?' highlighting the lack of women in medical leadership positions. Where there were women, they tended to be in supporting or deputy roles. That's interesting to consider – as early as medical school, women are given implicit messages about what leadership roles they can aspire to. It prompts us to think about not just the percentage of women in the College, but the kind of roles they are holding and what opportunities exist."

Dr Stolarek is the Medical Director, Health Quality & Safety Commission New Zealand, where there is a strong focus on increasing the Māori workforce. She firmly believes workplaces need to reflect the diversity of communities and the wider population.

"How do we ensure the voices around the table reflect the diversity of our communities and population, which can only be good for health and solutions?" she said.

"How do we make a work model, or models of work in leadership and health that allows flexibility not only for women but everyone?

"The next generation are thinking differently about work and want more balance. So, we need to be thinking not so much in that binary gender mindset, but how do we make work and the model flexible and adaptable for everyone's needs. It's about how we keep everyone contributing for as long as they want and are able to."

AVM Smart agrees.

"Involving more cultural groups at a leadership level could potentially break or reduce the risk of group think, in terms of everybody thinking the same," AVM Smart said.

Dr Naidoo also believes RACMA, and other colleges, should be aiming for leadership diversity to harness the depth of talent pool available to the industry.

"Women make up over 50 per cent of medical school graduates and have done so for some time now, contradicting the traditional pipeline theory. Rather it is likely that cultural, systemic and gender barriers influence the proportion of women in medical administration and leadership roles," Dr Naidoo said.

"Gender equity is one part of a broader diversity issue in medical leadership and we have to consider what other talent we are missing out on."

"We need to address systemic barriers and bias that make it difficult for women and other underrepresented groups to progress. As a college of medical leaders we are well placed to drive this and influence culture. We can start with college commitment and clear policy and strategy on diversity and inclusion to underpin all activities. Removing barriers to inclusion ultimately benefits everyone."

From Dr Alexander's point of view, it is important not to assume having a greater number of Fellows from diverse backgrounds, including gender, will automatically lead to greater diversity within the leaderships positions within the College.

"There is quite of lot of evidence that the 'pipeline' theory does not work as there are different barriers impacting on access to the leadership roles," Dr Alexander said.

"To get greater diversity in leadership positions, these other barriers must be identified and addressed."

According to Dr Chandrasiri, the character and integrity of the individual in a leadership role is what defines its importance as opposed to any gender or race label that is assigned.

"However, it would be naive to think we are not still a considerable distance away from arriving at that point of recognising true leadership qualities and being able to overlook gender labels," she said.

“Within our current societal fabric, the only path to get to that point is to tirelessly promote the importance of women continuing to be sponsored into medical leadership roles.”

You can’t be what you can’t see and women leaders are important as role models to encourage women to enter and remain in medical administration.

"When I first started training in medical administration there weren’t many female or diverse role models, but like leadership paradigms, this is changing,” Dr Naidoo said..

“I’ve since learnt a lot from having diverse role models and seeing that leadership can take a variety of forms and you can lead effectively in different ways.”

“I’ve had both male and female mentors and sponsors over my career and they have really made a huge difference to me, so I’m very grateful to them. Having diverse role models was essential to my continuing down this career path.”

Dr Alexander said it was most important that there are diverse role models in all areas of work, including medical administration.

“So, it is important that we continue to attract female graduates into medical administration, it is also important that we attract medical administration graduates from different ethnic and cultural backgrounds,” she said.

Role modelling is also integral to interaction, attitudes and behaviours. Dr Stolarek says the widespread ripple impact of role modelling is not always recognised or thought about by all clinicians.

“Our behaviours are noted and followed by our medical team and others and whatever we role model, is the standard of behaviour we are telling everyone unconsciously is acceptable,” she said.

“We don’t pay enough attention to the importance of this. We can learn from good role modelling and bad role modelling and shape who we want to be by seeing good practice.”

Regardless of the level of authority, qualifications and roles, few individuals can inspire others to achieve great heights and strive to be better human beings, Dr Chandrasiri believes.

“The role models I respect and consider important are those who are truly genuine and demonstrate respect and integrity,” she said.

“Those who have an inherent sense of calm, justice and kindness for others; these are the people that makes good role models.”

This group of highly-driven women may be too modest to see themselves as role models to many, but it is no surprise they are often approached for guidance, support and advice from trainees, new entrants and even peers who want to emulate their successful paths. Each have something different and valuable to offer.

AVM Smart believes role modelling good behaviour, authenticity and passion are key.

“Know yourself and be yourself - regardless of how high up in the organisation you go you still have to be true to yourself, because people can sniff out people who aren’t authentic,” she said.

“Authenticity is important in terms of being able to transmit passion. I also believe in listening to your gut feeling and experience and ensuring you are making the right decision from that point of view. The other thing is I like to think I haven’t asked anybody else to do something I wouldn’t do myself.”

For Dr Chandrasiri, it is harnessing your determination to navigate certain barriers and hurdles successfully.

“Master the art of resilience, of tenacity and of passion, and cultivate an unwavering determination to achieve whatever you set out to achieve.”

Dr Naidoo sees her role as encouraging the best and the brightest people to consider medical administration as a specialty and an option.

“We need diverse medical leaders if we are to collectively improve the health system and the organisations we work in and ultimately patient experiences and outcomes,” Dr Naidoo said.

“Having open and honest conversations around what our jobs look like is important because they are demanding roles. I think when you are a woman and are at the intersection of having a family it is more challenging, but it doesn’t mean that you can’t do it with supportive structures in place. You can make a difference and help forge a path for others.”

And the message from Dr Stolarek is straight forward – get involved.

“It’s easy enough to critique the system and we can all do that, but to get involved and try and influence the change is hard work,” she said.

“If we don’t take part we are not going to see that change and it’s really important that people who have a passion and want to make a difference are part of our College and advocating within other colleges.

“I believe each time you step into another leadership position, you get a view of a more distant horizon and that bigger picture and a greater insight into the complexity of the system and not necessarily always coming away with the answers but more ideas of how to influence.”

Fellow Q&A Profiles

Taffy Jones

MBBS AHA FRACMA

- Past RACMA President

To those new to the College, you would be hard pressed to find a more passionate person about healthcare and Medical Administration than Taffy Jones. He has dedicated most of his working life to improving patient care. Taffy was the recipient of the 2005 AMA Victoria Gold Medal for his outstanding service to the medical profession in Victoria and his leadership and dedication to the Victorian Doctors Health Program (VDHP).

In 2008, he was awarded an AM for his service to medicine, particularly in health services management, accreditation and standards of patient care, and in 2009 the Australian Council on Healthcare Standards honoured Taffy with their highest award 'for outstanding achievement in the promotion of quality and safety in healthcare services'. Here's a snippet behind the reason why Taffy continues to advocate for quality medical administration, quality patient care and better conditions for doctors, despite being retired.

What drew you to pursue the path of medical leadership/medical administration?

I went into Medical Administration in 1975. I had been a GP for 10 years, working in the Riverina, on the Bellarine Peninsula and in other rural areas. I woke up one morning and thought I can't keep doing this for another 40 years and considered what else I could do. I think for me it was being able to have a positive influence on the bigger picture of health care which is why I chose Medical Administration. It was about being an advocate for the patients and safe patient care as well as looking out for the welfare of doctors.

What lead you to undertake the Fellowship training program of RACMA?

A position came up as Deputy DMS at Geelong Hospital and I got it. Becoming a medical administrator meant two years of further study, mainly in law and accounting, but I needed the accreditation. I studied through the University of NSW and did the RACMA exams through there. It was a very busy and interesting time with work, study and bringing up a young family. I was then a Medical Administrator at the Alfred and the Austin.

What attracted you to take up the role of President of RACMA?

I was asked if I would step into the role and so I thought I would give it a go. I had already held positions on other Boards so I appreciated the role. It gave me further insight into the value of the College and the work that went into running such an organisation. I had an outstanding assistant at the time who helped me navigate through the role. I think it is good to be involved in organisations which support the industry you work in as they take a lot of man power to exist and support the next generation of trainees coming through.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?

The reason why Medical Administrators are extremely important is because they have the knowledge and know-how of looking after patients properly. But we also know what it is like to be a doctor and the pressures which come with the role. Having the background in medicine means you have the respect of your peers and it helps when you need to sort out conflicts between doctors or doctors and patients. As a Medical Director I kept doing clinical work through my career, running staff clinics at the hospitals where I worked. It was a great way of getting to know a lot of people and maintaining credibility with the doctors, nurses and allied staff.

Medical Administrators also have a key responsibility for keeping the wider community and the healthcare system connected, which is vital to the overall health of our population. When I worked at Geelong we re-started hospital open days and introduced a new community healthcare course to encourage people over 50 to become more self-reliant about their health. And we tried to make the hospital a less scary place for kids by taking groups of pre-schoolers around the children's wards during "children's week". I believe when it comes to really important decisions in life, someone else makes them for you, especially when it comes to healthcare – so it is up to medical administrators to be at the top of their game to make sure our care is of the highest quality.

What are the challenges you can see that RACMA, and the field of Medical Administration in general, will face in the future?

Getting the right calibre of people involved in the College is a must. It is key to ensure the College remains relevant and viable to the field of Medical Administration. To do this you need to attract the right people and grow the number of incoming Candidates and in turn the number of Fellows. The promotion and marketing of the College and its training needs to be rectified. The College needs to improve the way it sells its value proposition.

I also believe one of the important issues for RACMA moving forward will be the physical and mental health of clinicians. I believe RACMA has a direct responsibility for the workload of trainees and should play a key role in advocating for a better work-life balance.

What are the main changes you have seen in Medical Administration and within RACMA since you first became involved in the field and the College?

Now the focus and emphasis are on finance matters rather than patient matters. I think that economic rationalists have a lot to answer for. It is difficult for Medical Administrators when the bottom line has become so important and is placed ahead of patient care and safety. In my day, patients came first, and we found the resources to manage them.

What advice would you give a Medical Administrator staring out now?

The best advice I have for Medical Administrators is that you must be an advocate for the patients and for safe patient care. Speak up for them and ensure high standards. A Medical Administrator is sometimes not liked by politicians and clinicians, but our job is to ensure that safe, high quality patient care is not compromised by political or other pressures. It is also important to maintain your clinical skills – doctors gain more respect in the Medical Administration field as they understand the clinical problems. Lastly – listen. It is important to listen to what others have to say, don't talk at people.

I have a quote from comic writer Leo Rosten hanging on my office wall:

"There is a myth to which many of us are addicted that the purpose of life is to be happy. I know of nothing more demeaning than this narcotic pursuit of fun. Where was it ever written that life can always be easy or completely free of conflict or of pain? The purpose of life is not to be happy but to matter – to be productive, to be useful, to have it make some difference that we lived at all."

That is what I have tried to do and to be a good Medical Administrator it is critical to be purposeful.

Dr Stephen Ayre

MBBS (QLD) MHA (UNSW) FRACMA

- Queensland and Northern Territory Jurisdictional Chair

- Chief Executive - Metro South, Queensland Health

What drew you to pursue the path of medical leadership/ medical administration?

I really enjoyed clinical work with individual patients and the satisfaction that could be taken from that. I had some early exposure to acting roles outside my normal clinical role and this opened my eyes to being able to influence the health of whole groups of patients. This inspired me to progress further along my medical admin pathway.

What lead you to undertake the Fellowship training program of RACMA?

I was working in a medical administration role and it was obvious to me that I needed to have further tertiary qualifications to maximise my chance of success. A mentor suggested the College program and I became a member then progressed to candidate where I commenced my Master's studies through the University of NSW.

What attracted you to take up the role of a State/Jurisdiction Chair member of RACMA?

I like leadership roles that make a difference. The Qld Committee is a dynamic group and has been providing a leading edge in Medical Administration Training. I have been on the Committee on and off since the late 1990s except for a period of time when I worked in Tasmania. I became a preceptor in the mid-2000s and picked up the Jurisdictional Coordinator of Training role then becoming State Chair more recently.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?

Medical Administrators are crucial to good governance in the Australian system. They assist in bridging the gap between medical clinicians and administration being able to often interpret for both groups. Their particular skills in change management, safety and quality and more recently the digital health environment allow them to appropriately steward the resources of the system to optimise care and ultimately improve the health of our communities.

What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?

There are many challenges for RACMA but importantly it is being contemporary with agility to train and support future and current Fellows now and in to the future.

Is there a particular achievement of RACMA/your jurisdiction you are most proud of to date in your current role with RACMA?

I have to say that I am most proud of the collegial support for our Candidates, Associates and Fellows. A strong focus on this supports the growth of our networks and encourages the next generation of Medical Administrators.

Fellow Q&A Profiles

Dr Tony Sara

BSC MBA MBBS FRACMA

– New South Wales Jurisdictional Chair

– Director Clinical Information Systems SESAHS, Prince of Wales Hospital

What lead you to pursue the path of medical leadership/ medical administration?

At university I got involved with the Medical Society, and the University of Sydney Union, which is a student organisation or services-based organisation, it's not a political organisation. After a few years of that, I started to understand that I had some flair in organisational activities in changing directions of organisations, of 'making things better'.

So I realised I wanted to make a difference by treating a significantly larger volume of patients at a higher level as opposed to treating single patients as a hands-on clinician. I did an MBA, did all the other degrees that I've done over the years, and it seemed to me that I had an aptitude to resolve problems, solve issues, make things better, and that's what I've done, in a sense, ever since.

What lead you to undertake the Fellowship training program of RACMA?

I was encouraged to apply by George Bearham and Tim Smyth to fulfil my aim of making a difference at a higher level in the healthcare system.

What attracted you to take up the role of a State/Jurisdiction Chair member of RACMA?

There were two reasons. Firstly, everyone else had resigned and left the committee and there were only two of us left. So in the beginning it was because no-one else wanted the job. Secondly, it became clear to me that we as a college needed to take a far higher profile in the health system and in the profession in NSW if we were to have the effect we notionally and allegedly wanted to have; both for patients and for our successful existence as a college.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?

It is a parochial view, but one that I have seen very often, both as a medical manager and also as a union official, that specialist medical managers do a far better, more effective job, than lay managers, nurses-turned-managers, and non-specialist medical managers, in terms of the "hard and difficult cases".

What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?

The first challenge is to remain relevant; to continue to demonstrate that our skill set is second to none, and to put what we do and what we stand for, into the medical and public space. The second is going to be how best to address the lack of economies of scale of the office, our Fellows and the training program, as compared to the much larger colleges as we move to the more onerous processes of programmatic assessment.

Is there a particular achievement of RACMA/your jurisdiction you are most proud of to date in your current role with RACMA?

We have had a number of notable achievements. One was retaining a direct nominee to the Medical Council of NSW, following high-level lobbying when the Ministry of Health proposal was that one nominee be chosen from nominees from three of the smaller colleges. A second was dissolving an unincorporated association of medical managers donating its funds to the College as a directed donation for the NSW Committee.

Dr Jayanthi Jayakaran

MBBS FRACMA

- South Australia Jurisdictional Chair
- Director Medical Services, Barossa Hills Fleurieu Country Health SA

What drew you to pursue the path of medical leadership/ medical administration?

Like many others, it was by chance and a good one indeed. I was pursuing training in neuropsychiatry in Singapore and also had a special interest in Public Health. I moved to Adelaide subsequently due to family reasons and as an international medical graduate had the opportunity to experience several speciality rotations including medical administration. The Medical Administration rotation was a new rotation and was an opportunity afforded to me by the then Director Medical Services. I went in with an open mind and never looked back.

What lead you to undertake the Fellowship training program of RACMA?

Having had the privilege and experience of working in different healthcare systems and public health perhaps laid the foundation for a mental framework of a systems approach to problem solving and horizon scanning of trends of what works and does not from a health care system perspective.

Certainly having great mentors was a draw. My special interests in health practitioner performance and regulation as well as service planning drew to me undergo formal fellowship training. The need to have formal learning and attain specialist qualification in Medical Administration was paramount to commence the journey as a credible medical leader.

What attracted you to take up the role of a State/ Jurisdiction Chair member of RACMA?

As the newest Fellow at the time of the South Australian Committee's recommencement after a period of hiatus, it was an opportunity to contribute where possible in raising the profile of Medical Administrators within the State. The ongoing engagement with other clinical faculties as well as administrators has certainly been valuable in advocacy and reinstating our integral role not only as medical leaders within hospitals but in other domains pertaining to Health Informatics, AI in Health, strategic service planning and so on. Personally the most important reason was to advocate for increasing training positions, capacity and professional opportunities for our faculty.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?

Absolutely integral, especially in the advocacy role and in the engagement of health system stakeholders, including the political arena.

Equipped with management and leadership skills, qualified administrators, Fellows and members are well placed to support health systems where there is increasing demand on our specialist colleagues and health professionals to deliver safe, quality and efficient care within finite services. With future directions in technology, health informatics and regulatory domains medical administrators will continue to play an important role.

What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?

With any domains or profession, the need to reinvent and reposition would be key to maintaining relevance and value add as a medical leader/ administrator. The need to deliver safe, quality and cost effect services within resources is a constant challenge. Keeping up with the dynamic changes, being up to date and adaptive as a Medical Administrator in this mercurial environment is a need of the hour.

Is there a particular achievement of RACMA/your jurisdiction you are most proud of to date in your current role with RACMA?

It has been a really fruitful two years in getting our local faculty and Associate Fellows together. The networking has been valuable and the local CPD events have been well received. The biggest achievement would be the growing number of candidates at present which is a reflection of a successful collaborative effort between the College and the local faculty.

Fellow Q&A Profiles

Dr Tony Robins

MBBS MBA (UWA), GradCert Lead&CC (ACU), FRACGP, FRACMA

– RACMA West Australian Jurisdictional Chair
– Executive Director of Medical Services, WA Country Health Service

What drew you to pursue the path of medical leadership/ medical administration?

As a Fellow of RACGP, I often became frustrated around delays and access issues for the patients I referred to State hospital facilities. 15 years into my clinical career, I decided to "jump the fence" and get on the inside to try and facilitate better access and service for patients inside large healthcare organisations. My career ambition has been to make it easier, safer and an overalll better experience for people traversing our complex health system.

What lead you to undertake the Fellowship training program of RACMA?

I quickly learned that just as in clinical medicine there is a requirement to receive formal training and mentored experience to provide contemporary and high quality care, which the same principle applies in the speciality of medical administration. While holding Fellowship of RACMA is a benchmark credential in its own right, I sleep more soundly at night knowing I have been equipped to better predict and mitigate the pitfalls and traps that daily challenge us in these roles.

What attracted you to take up the role of a State/Jurisdiction Chair member of RACMA?

I was initially asked to take on the role and while I had not initially considered it, now I have been in the role for 6 months, I have become excited around the possibilities of where the role may be able to work with other jurisdictional committee members and the broader membership and College to identify and try some innovative thinking. I see opportunity to continue the traditions of the past while also testing some boundaries for the future.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?

Unlike other medical colleges, RACMA has competition. There are many examples of medical administrators who do not hold FRACMA, but who may have completed tertiary studies or completed leadership or management as part of another college program, so FRACMAs need to demonstrate their worth and gain the confidence and support of their bosses. Just because we have a FRACMA does not mean we are the only option to lead and manage health care, so the importance in my mind, comes down to how we leverage our unique skill set to add enormous value for patients, colleagues and health systems. It is through our capability and the way we employ our skills that informs our value (importance) and I like to think it is this "Je ne sais quoi" that sets us apart and will encourage employers to mandate FRACMA.

What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?

There are many, but two include the rapid pace of change within the health system and the digitisation of health care. FRACMAs will need to be at the cutting edge of health care delivery to remain highly valued into the future. To remain the medical leaders of choice, we will need to stay on the horizon of this change and be part of new and innovative solutions. If we are not in that space (pun intended) then others will be. We may not have a right to be the health leaders of choice into the future just because we have a FRACMA. As in any market place, we will need to continually evolve and stay relevant to remain valued and sought after.

Is there a particular achievement of RACMA/your jurisdiction you are most proud of to date in your current role with RACMA?

We are putting in place better governance for trainees to ensure they get quality supervision and training and we are advocating for our jurisdiction to ensure we are heard in Melbourne.

Dr Christina Wilkinson

MBBS, MBA, MBEth, FRACMA

- RACMA ACT Jurisdictional Chair
- Director Prevocational Education & Training, The Canberra Hospital

What drew you to pursue the path of medical leadership/ medical administration?

Whilst working in a clinical role in regional Australia I became interested in health as a large and complex system, governance structures required to support provision of high-quality care, health policy, and challenges of access to health care. The role of the medical administrator and the ability to have a positive impact on populations and communities really interested me and I was keen to develop the skills to work in this field.

What lead you to undertake the Fellowship training program of RACMA?

A RACMA training position was advertised in Western Australia at the time of my increasing interest in medical administration. After investigating RACMA and having a conversation with Dr Andy Robertson, it was clear that the training program would support me to develop the skills and knowledge for a career in medical leadership/administration. I had a great experience during my training with opportunities to work in the Department of Health, tertiary teaching hospitals and a secondment to the private not-for-profit sector.

What attracted you to take up the role of a State/ Jurisdiction Chair member of RACMA?

Back in 2016, the ACT Branch officer bearers left their roles for various reasons and one of the longstanding ACT Fellows encouraged me to take on the role of chair. The branch was in need of re-invigoration and it was a good opportunity for me to engage with other RACMA Fellows in the ACT.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?

The increasing emphasis on provision of safe, high-value care and harm reduction requires understanding of health systems and the ability to connect stakeholders such as frontline staff and policy makers. In this complex system, the focus of the RACMA training program domains gives Fellows a unique perspective to contribute to high quality health care and therefore qualified administrators are an essential component of the system.

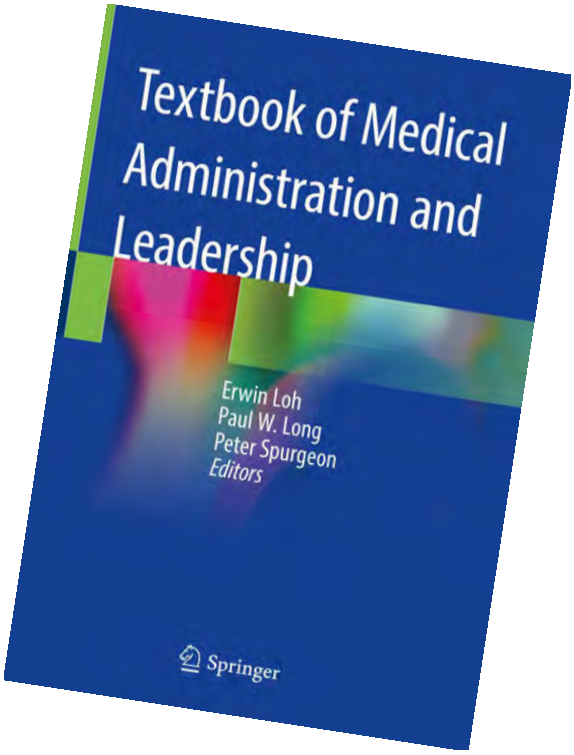
What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?

RACMA and medical administration face the same major challenges that the whole health system faces such as increasing demand for services, the rise of chronic disease and health inequity in an environment of limited resources and financial constraint. Another challenge is to keep up with and be responsive to development of new technologies and considering innovative models of care. Culture in the medical profession has received ongoing scrutiny and needs to be addressed as it has a impact on staff wellbeing and clinical outcomes. The challenge for the College in the evolving health care environment is to position itself as a leader and increase its ability to influence government policy.

Is there a particular achievement of RACMA/your jurisdiction you are most proud of to date in your current role with RACMA?

As Chair of the ACT Branch I am proud that over the past few years the branch has developed into a cohesive and supportive group of regular attendees. The high level of trust we have developed has resulted in many interesting, thought provoking presentations and discussions at our monthly meetings.
I support the work that the RACMA is undertaking to raise the profile of the College as a leader in health policy. I look forward to supporting this strategic direction by participating in the Policy and Advocacy Committee in my role as ACT Jurisdictional Chair.

Long awaited first Medical Administration and Leadership text arrives



After more than four years in the making, the field of Medical Administration and leadership has its first dedicated textbook. Co-edited by Professor Erwin Loh, Paul Long and Professor Peter Spurgeon, the Textbook of Medical Administration and Leadership is the brainchild of Professor Loh who, among many, identified a gap when he was a trainee.

"I went looking for a text to study for my exams and there wasn't one," he said.

"In other specialities that's what they have to use for study or for references. We have text books which look at health services management and leadership but they apply to both clinical and non-clinical management and don't hit the mark with our very specific speciality.

"The scope of practice is quite broad but it is niche in the sense that you have to be an expert in the topic."

With the aim of the text to both support trainees and be a reference for Fellows and non-Fellows, it reflects exactly what medical managers do "on the job". Hence, it was not difficult for Professor Loh to decide on the content, who said notes had been "passed down from trainee to trainee for many years arranged around the specific subject areas."

There are 16 chapters and some of the key topics covered include:

- health systems and policy
- health law
- private health and insurance
- health disaster planning
- population and public health
- health information and technology
- health economics and financial management

The majority of the chapters have been written by RACMA Fellows. At the time of the books inception, Professor Loh was Victorian Jurisdictional Co-ordinator of Training and took the opportunity to contact those subject experts he knew, to guage their interest in contributing to the book.

"They were quite enthusiastic to be involved, so much so they are keen to collaborate for the next one," Professor Loh said.

RACMA Fellows who have authored the chapters are:

- Professor Johannes Stoelwinder
- Associate Professor Caroline Clarke
- Dr Susannah Ahern
- Dr Jason Goh
- Dr Heather Wellington
- Dr Alison Dwyer
- Dr David Rankin
- Dr Andrew Robertson
- Associate Professor Alastair P. Mah
- Dr Bennie Ng
- Dr Anjali Dhulia
- Dr John Ramsay Ferguson
- Dr Peter Lowthian
- Dr Monica Trujillo
- Associate Professor Eleanor Flynn

RACMA Candidate Nic Woods co-authored a chapter, while Professor Loh, Mr Long and Professor Spurgeon also worked on chapters.

Professor Loh said the text book had been arranged to reflect knowledge domains.

“We did this intentionally as they are the specific domains you need to know. We have covered everything you need to know in theory as well as how you then apply it in practice,” Professor Loh said.

As easy as it was to decide on content and find authors, selling the concept was another story, which is the reason behind the lengthy turnaround from the genesis to publishing.

“Initially it was me as a single editor and I approached Springer but they weren’t interested,” Professor Loh said.

“I then went to three other publishers with no luck, so I enlisted the help of Paul and Peter. Paul was instrumental in helping do a lot of co-ordination with the authors and ensuring the proofing was right. Then we went back to Springer and they came on board two years later.

“It was frustrating, but it was all worth it in the end. It’s been a great achievement.”

According to Professor Loh there are two reasons why this is the first text of its kind. Firstly, because the scope of practice is quite wide and varied making it difficult to bring all the knowledge into one text.

Secondly, academic consultants and Fellows in this speciality are not as common as other medical specialties, so there was no one in the right position to do it.

“Our specialty, unlike other medical specialities, is not completely restricted to us,” Professor Loh said.

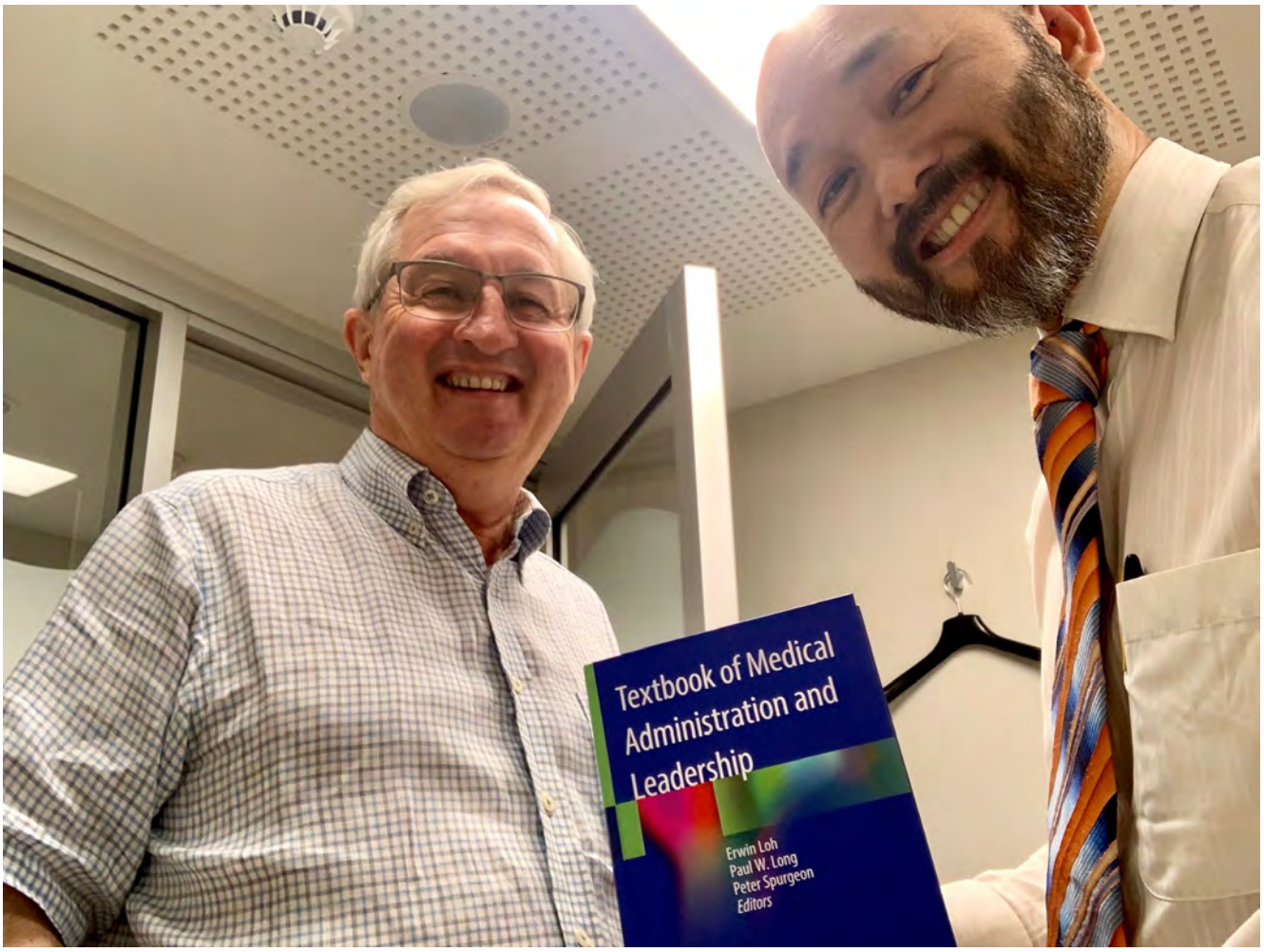
“Yes, Chief Medical Officers' roles have to be doctors, but you don’t have to be a doctor to run hospitals, you can come from a corporate business. So, a lot of the people who do the research we look at, aren’t doctors or Fellows.

“People who are attracted to the specialty turn out to be people who aren’t researchers. They are people who want to be leaders and managers., not academics.”

And plans are already in place for a research study of this text. Once a critical mass has been using it, an evaluation will be carried out to find out if there are any gaps.

But it doesn’t stop there. If Professor Loh has anything to do with it, this textbook is just the first of many for the Medical Administration Specialty. As a start he is proposing a more generic text book for all clinicians, not just doctors.

To order your copy visit **https://www.springer.com/gp/book/9789811054532**



Dr Stuart Paige, CMO at St Vincent’s Private Hospital in Toowoomba, shows off one of the first hard copies of the textbook to Professor Loh.

Voluntary Assisted Dying: A practical approach for Victorian Health Services

By Dr Sidney Chandrasiri MBBS MHM FCHSM FRACMA CHIA and
Associate Professor Luis Prado MBBS FRACMA FRACGP FCHSM FISQua FAAQHC FACHE FACMQ GradDipSpMed CHIA

Healthcare institutions in Victoria, both private and public, are presently engaged in deep deliberations over a most controversial and highly sensitive matter, Voluntary Assisted Dying (VAD).

On the 29th day of November in 2017, the Victorian Parliament took an unprecedented step in passing a key piece of legislation, the Voluntary Assisted Dying Act 2017. This has continued to trigger ferocious debate, declarations of extreme viewpoints and at times divisive dialogue amongst health care providers. The guiding principles upon which this new legislation is based, such as patient autonomy, informed decision making, minimising suffering and open discussions about death and dying, has created a dynamic interplay of multiple ethical, moral and legal considerations that will require careful navigation and leadership by Medical Administrators and healthcare organisations.

This legalisation of access to voluntary assisted dying is poised to create a substantial shift in both the governance and practise of medicine, whether medical leaders agree with its premise or not, and the ripple effects of their decisions and responses to this matter will continue to permeate for a long time to come.

With a suite of safeguards and several layers of protections, the Voluntary Assisted Dying Act 2017 is aimed at providing a framework for and regulating access to voluntary assisted dying to specific groups of people, to choose the manner and timing of their death. The Act establishes strict eligibility criteria, steps through a detailed request and assessment process, establishes the Voluntary Assisted Dying Review Board and sets up a permit system which authorises the prescribing and dispensing of Voluntary Assisted Dying medication.

Eligibility is restricted to adult Australian citizens (or permanent citizens) over 18 years of age, residing in Victoria for at least 12 months, with decision-making capacity and having been diagnosed with an incurable, advanced and progressive disease illness or medical condition that is causing suffering that cannot be relieved in a manner the person considers tolerable, and which is expected to cause death within weeks or months (not exceeding 6 months, and not exceeding 12 months for neurodegenerative conditions).

The Voluntary Assisted Dying Review Board that has been established for assessing each individual request, coordinates the assessment process in collaboration with a 'coordinating medical practitioner' and, if approved, provides a VAD permit to the patient on behalf of the Department of Health and Human Services (DHHS). The VAD permit takes the form of a 'self-administration permit' and/or "practitioner administration permit". A self-administration permit authorises the person to obtain, possess, store and self-administer a VAD substance, whilst a practitioner administration permit authorises the coordinating medical practitioner to prescribe, supply and in the presence of a witness, administer the VAD substance in the event the requesting person is physically incapable of self-administering or digesting the substance. A single state-wide pharmacy service has been established to provide access to a range of these suitable medications across Victoria, for secure storage, dispensing and destruction of unused medications.

The operational aspects of the Act alone present multiple complexities for medical practitioners, health services and medical administrators. Consider the scenario for example, of a patient with end-stage Motor Neuron Disease admitted with Aspiration Pneumonia, who advises the hospital staff that they have obtained a *Voluntary Assisted Dying Permit*, have the drug in their possession and wishes to self-administer the drug during this admission. Multiple questions immediately arise: Will the hospital allow this to take place? Who will hold the drug, the patient or 'the hospital'? Will the drug be recorded in the medication chart?

Will the administration of the drug be witnessed by staff? To what extent will the family be allowed to witness/partake in the administration of the drug? These are difficult questions

requiring well-thought out responses, that all health services, regardless of their position on VAD, must be prepared to face.

The Act allows conscientious objectors to choose not to participate in any manner in the VAD pathway, with protections for health practitioners and paramedics who act in good faith, including not providing life-sustaining treatment if they believe the person has not specifically requested it and they believe the person has accessed VAD. Coupled with this are also a range of offences that are outlined in the legislation, including offences to induce a request or self-administration, falsify records or make a false statement, and to provide or administer VAD medication without a permit, with penalties ranging from five years to life imprisonment.

Given the complexity and scale of systemic and process infrastructure that is required in implementing the VAD framework, and with the deadline for commencement of the Act fast approaching, health services in Victoria must soon decide their level of participation in VAD. Regardless of whether a health service chooses to provide VAD, Medical Administrators must prepare their organisations and plan for its commencement. This includes a range of considerations, from educating and engaging clinical staff in preparedness to respond to questions from patients and families, supporting staff in managing requests for information about VAD, and considerations of infrastructure in terms of people and resources required for providing VAD or actively referring patients to alternative facilities. Another significant consideration is the interaction with and impact of palliative care services that are provided as a result of an organisation's position on VAD.

There is potential for a wide array of clinical governance responses in any considerations of providing or restricting access to VAD. Consider the situation of a patient who is unable to self-administer a VAD substance and who possesses the permit for their '*coordinating medical practitioner*' to administer the drug. Presuming this practitioner is not accredited at the organisation, will this require emergency or temporary accreditation to be granted to the practitioner to administer the drug? How will the institution manage the impact and reaction to such appointments from its existing medical workforce? What degree of accountability will the institution hold in managing any unintended adverse clinical outcomes on the part of these temporarily appointed practitioners? How will the institution maintain a balance between upholding patient and doctor autonomy, with organisational duty of care? This law comes into effect on 19 June 2019, a critical point in time when health services and health care providers simply will not be able to afford to be indifferent, effectively choose to "ignore", or to be unprepared for these types of scenarios.

In discussing a suggested framework for a possible way forward that Medical Administrators in Victoria can consider, it is relevant to note that VAD is currently lawful in several states and countries, with Washington DC being the most recent state to legislate prior to Victoria in 2017. In Belgium and Netherlands, there are provisions enabling people under 18 years to access assisted dying. In Australia, assisted dying was legalised in the Northern Territory between 1995 and 1996, Western Australia's Joint Select Committee on End of Life Choices recommended its introduction in August 2018 and South Australia is poised to consider assisted dying laws in the next few years. The lessons that would have been learnt in each of these contexts, the challenges that individual health services/networks would have faced in the implementation

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Voluntary Assisted Dying: A practical approach for Victorian Health Services

and any unanticipated consequences as a result of assisted dying models should be sought and analysed.

Governing the participation of health services (in any shape or form) in the provision and/or referral for VAD, will, for many medical administrators and health practitioners be a highly emotive, deeply personal and potentially religious choice. Notwithstanding the provision in the Act that allows for conscientious objection, it is important to be self-reflective and transparent in the early declaration and managing of any inherent and/or unconscious bias (where possible) in advising and leading others through this issue. The 'conscientious objectors' themselves will need to be supported and empowered, to ensure that they are not inadvertently marginalised.

Medical Administrators must be aware of the impact on equality of access to VAD and the choices they make as leaders of health organisations, will afford patient communities. There may well be significant negative impact on patients' right of access to a service that will soon be lawful for all in Victoria, simply based on the geographical maldistribution of institutions that do or do not choose to provide the service. The impact, particularly on those living in remote areas, where there is already a scarcity of healthcare providers and referral services, is likely to be amplified, further widening existing gaps in healthcare equality.

Another aspect of equitable access, is that of the requirement in the Act that prohibits healthcare practitioners from initiating any discussions with patients of VAD. This will be particularly significant in socio-economically disadvantaged communities, migrant patient groups, disadvantaged ethnic minority groups and/or those with lower health and/or English literacy. A low level of awareness and understanding of the assisted dying service and patients' rights in this regard, may also limit their ability to provide full informed consent in choosing any alternative medical procedures and treatments for terminal illness management. Ensuring equality of access across healthcare institutions whilst allowing supported conscientious objection by health care practitioners is critical. Managing changes in doctor-patient relationships, promoting autonomy and informed consent for patients and their families, are also key considerations.

Given the time imperative that currently exists for organisations to declare a position on the matter of VAD, Medical Administrators will be required to advise and guide their Executive and Boards in assessing the impact and decision-making of the legislation. There are two key sequential decision points that organisations need to consider. The first decision point is "Does the health service support patients decision making and patient choices in VAD?" If the answer is "no", there is no further consideration to be had as the organisation's position is absolute in that it will neither provide nor refer patients to VAD services.

If the answer to this ethical decision point is "yes", the organisation can then proceed to the second decision point, "Does the health service actively participate in the provision of VAD?" Whilst this raises practical and feasibility concerns for the health service, there are significant ethical aspects at this point that cannot be overlooked.

If the answers to both these questions is "yes", then the organisation will need to consider actively providing VAD services to patients. If the answer is "yes" to the first point, and "no" to the second, then the institution has the option of not providing VAD but in actively participating in referring patients to alternative healthcare organisations that do provide a VAD service.

In conceptualising a model for VAD service delivery at the health service level, provision of both inpatient and/or outpatient (community) VAD services will require an alignment to individual patient's clinical circumstances or preferences. Diagram 1 represents the modelling of an inpatient VAD patient journey.

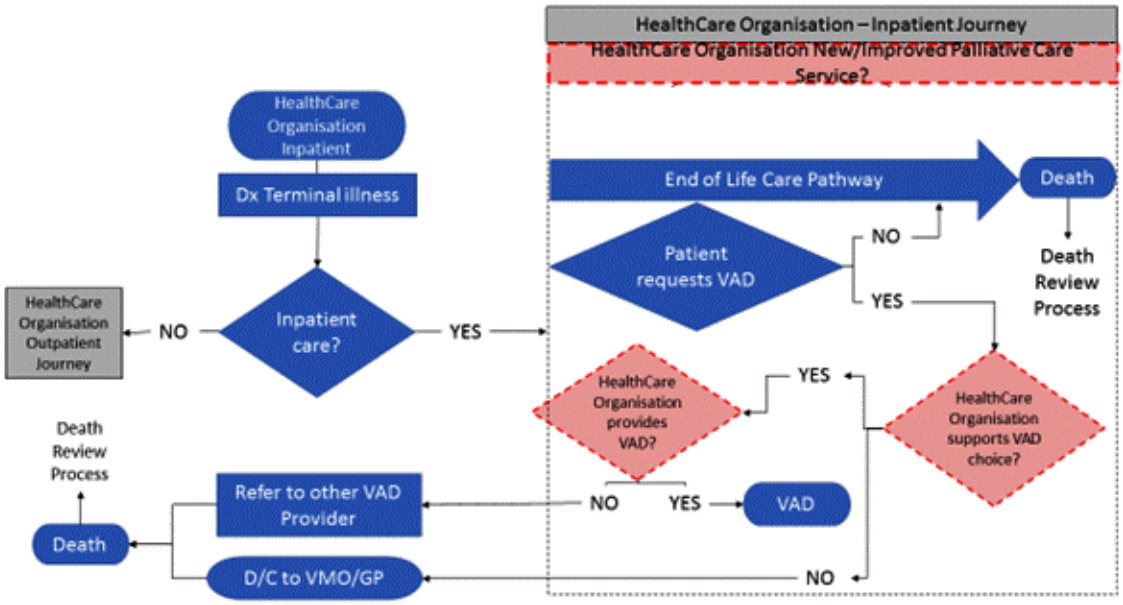


Diagram 1: Inpatient VAD Patient Journey Model

(Assuming patient has obtained a VAD permit)

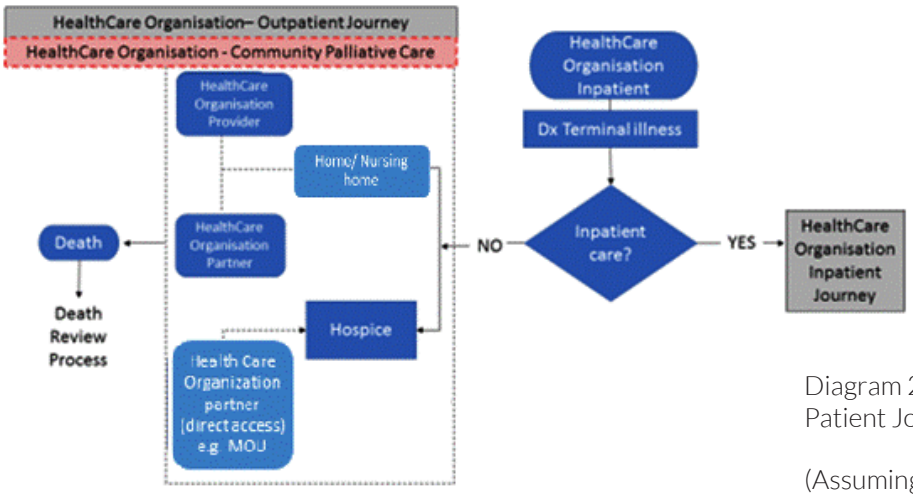


Diagram 2: Outpatient VAD Patient Journey Model

(Assuming patient has obtained a VAD permit)

If the patient does not need, does not want and/or the health service does not offer inpatient VAD care, the patient may choose to receive VAD services at a nursing home, hospice or in their own home. In this context, the organisation must consider the impact of providing this on an "outreach" basis, or partnering with an external provider to provide the VAD service on an outpatient basis. This scenario is represented in Diagram 2.

The first two models (for inpatient and outpatient care) presume an internal referral source (that the patient requesting VAD is a current patient of the health service).

Diagram 3 represents a model for considering the organisation's position on VAD provision in response to an external referral source. Other health services, general practitioners, specialist medical practitioners (in private practice) and other community services may request VAD access. Nonetheless, adhering to the two key decision making points, the resulting patient journey model remains consistent and in line with the principles described above.

The fundamental aspect of palliative care service availability and provision also warrants due consideration in this context. For many clinicians in order for a VAD service to be provided, it needs to be supported by a comprehensive palliative care service. Access to inpatient, liaison and/or community palliative care at each health organisation will need to be comprehensively mapped and any adjustments made in alignment with any implementation and consideration plans for VAD.

Acknowledging the simplified representation of the possible scenarios to be considered, the framework presented here may be useful for Medical Administrators in engaging their medical and executive staff when assessing the impact of VAD legislation in Victoria. Adopting this approach of mapping VAD implementation considerations in the patient journey, may further assist in determining the position each organisation will ultimately take in this complex issue.

Victorian Medical Administrations must lead their organisations during what will be one of the key historical turning points of healthcare provision in this state. The engagement of clinicians and the focus on patients and their families will be critical. Regardless of personal view and perspectives, Medical Administrators' leadership is paramount.

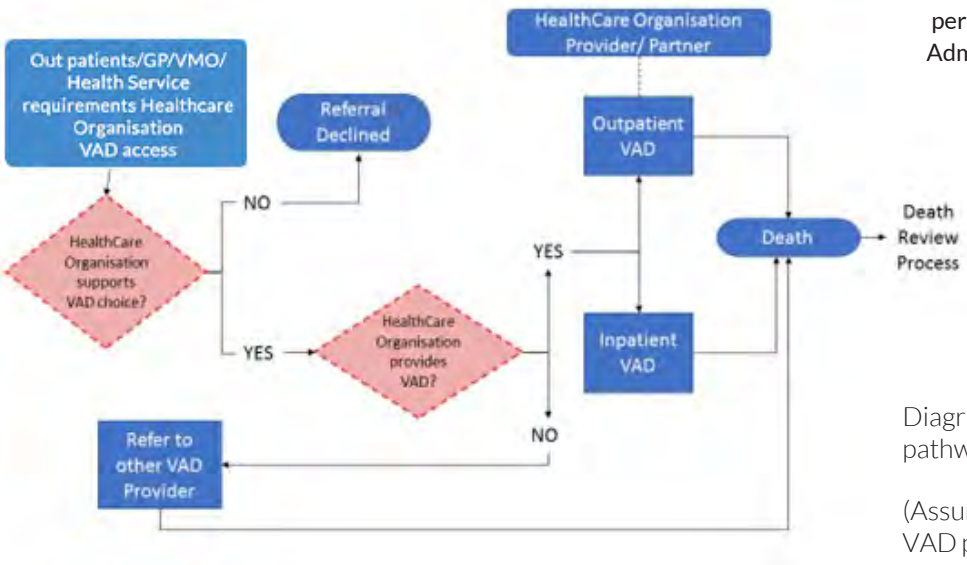
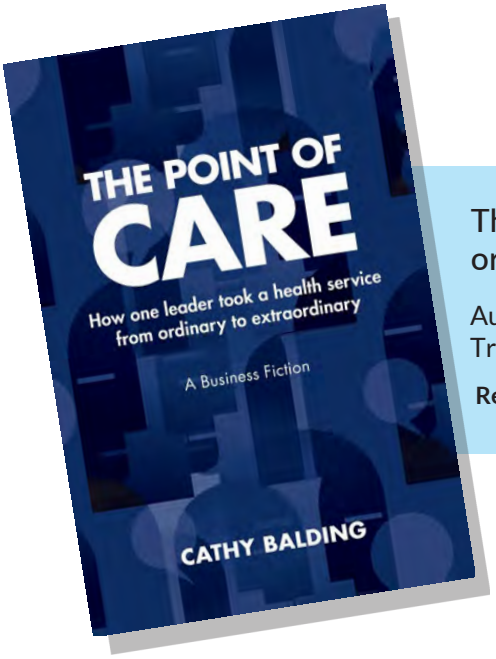


Diagram 3: External Referral pathway for VAD Modelling

(Assuming patient has obtained a VAD permit)



The Point of Care – How one leader took a health service from ordinary to extraordinary

Author: Cathy Balding. Director of Qualityworks and Adjunct Professor at La Trobe University

Review by Dr David Rankin

The Point of Care is a Business Fiction – relating the story of how Carol Mathewson, the newly appointed Chief Executive managed to turn around the performance of Kinsley Valley Health Service (KVHS).

The previous CEO had overseen the opening of a new wing at the hospital which has absorbed much of the attention and efforts of the executive team.

Carol is faced with the latest department report which shows KVHS is the poorest performing health service in both customer and staff satisfaction.

The book opens with the first executive team meeting, demonstrating the fragmentation and infighting that reflected the general hospital culture. By lunch time the long-standing Director of Medical Services has resigned, and it is apparent that the Quality and Risk Executive Director is not up to the job.

Originally trained as a physiotherapist, Carol is now approaching fifty and is recently separated. She was excited about returning to Kinsley Valley as it is where she grew up. The move has enabled her to care for her elderly mother after her father recently passed away.

Carol sets about working with her team to identify quality, define how it can be measured and the steps that are required to make KVHS a quality focused organisation. "Great Care" becomes the theme of the book and is clearly modelled on the author's Strategic Quality Systems Model.

I was charmed by the portrayal of Nancy - the Board Chair, as an unassuming, yet incisive community leader who has clear insights into the internal dynamics of the organisation. Her skills in managing the department are delightful. Nancy gives Carol some sage advice yet provides rock solid support and encouragement throughout the book.

The local media clearly has an internal source of disruptive reports and festers community angst against KVHS. They appear to be actively undermining Carol's efforts to turn staff morale around.

The book focuses on the work of the executive team - in setting a vision, educating staff and sponsoring change projects. The book is supported by a relatively short list of 21 references. The various models used by the team are outlined in the appendix including tools such as the Strategic Quality Systems Model, tips for leading great care, quality success mindset and Turbo Charge Model Overview.

When Anne (the long serving, highly respected DMS) resigns she is replaced by Jeff, the chair of the Senior Medical Staff Committee. Jeff is an emergency physician with an MBA and PhD who has "nearly finished his medical administration training."

Jeff's ability to engage the medical staff and effect culture changes seems almost magical. While there is a range of nurse and allied health initiatives, there is little discussion or exploration of process for engaging medical staff.

I enjoyed the way the book develops the various characters, from Anton, the CFO who annoyingly habitually clicks his pen, to Elena, the Chief Nursing Officer and Executive Director of Clinical Services who never warms to Carol. Elena ends up being accused of leaking information which creates emotional tension and a major challenge for Carol.

At 224 pages, I found the book kept my interest, though there were several sections where it was a challenge to determine the focus. This was particularly the case with the parable that Chen, the guest University lecturer introduces in one of the training days.

It would have been helpful if the chapters and subsections could have been titled to enable easy reference back to the various learning points and helpful guides.

By the end of the book I had been challenged to think about a range of issues in health management in new ways and found myself eagerly waiting to hear the latest department league table results.

I would recommend this book to any health administrator as a way of gaining new insights into particular turn-around models and reflecting on your own model of quality.

Obituary

Dr Michael Glover

Michael Robert Glover was born in Brisbane in 1953 to Noel Stanley and Helen Glover. He was the eldest of four children –Alice, Rebecca and Timothy. Michael grew up on a farm outside of Texas, southwest of Brisbane, where his father (known as Stan) was the only doctor for the town. His mother ran a piggery on the farm, which Michael helped run.

Like many children living in the country, then and now, Michael went to boarding school – in his case Toowoomba Grammar School. After completing high school at Toowoomba Grammar, Michael followed in his father's footsteps and qualified to study medicine at the University of Queensland. He initially stayed at St John's College on campus, before moving to student share housing.

While still a student, Michael was assisting with a lady who was in premature labour, with the object being to stop the premature labour. He unexpectedly was the only attendant in the room with her when the baby was delivered. When the midwife arrived shortly after, Michael was standing beside the mother, holding her baby (reasonably healthy) upended by the feet. The midwife asked how he knew what to do? Michael replied, "it was just like delivering a pig." Clearly his experience on the pig farm growing up served him well.

Michael met his first wife Cathy when they were put into a hospital group together, in their fourth year of medicine. In 1977, Michael began working as a resident at the Royal Brisbane Hospital, he then went on to work in the Nambour, Mt Isa, Normanton, Cairns and Beaudesert hospitals.

It was at Beaudesert where he took on a diverse range of roles including orthopaedics, obstetrics, general surgery and stepped into the field of medical administration as Medical Superintendent. During this role he became a member of RACMA in the early 1990s.

Despite a bid to retire in 2002, when Michael and his second wife, Karen, moved to Kyogle to live on their farm Hillview - they bought a medical practice in town. Over time they grew the practice to employ other doctors and moved to a larger location.

As he always had throughout his career, Michael worked very hard in his medical practice, and was often on call. He also continued to be the visiting doctor at Palen Creek Correctional Centre for a period after leaving Beaudesert Hospital.

But it was Hillview which was the realisation of a long-held dream of Michael's; he loved the farm very much where he enjoyed spending a lot of time with his family.

Michael is fondly remembered as a smart, complex and compassionate man who had a wicked sense of humour but was committed to his work and his children. He has four children – Jen, Rob, Tom and Phoebe, a stepson Zarnie and five grandchildren – Emily, Michael, Harry, Margot and Annie.

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