RACMA
ROYAL AUSTRALASIAN COLLEGE
of Medical Administrators

The Quarterly
#2

2019

> Rural and Regional medical leadership in the spotlight

Quarterly 2

quarterly

The Quarterly is the journal of The Royal Australasian College of Medical Administrators (RACMA). It is published quarterly and distributed throughout Australia and New Zealand to approximately 1000 College Fellows,Associate Fellows, Affiliates and Candidates, as well as selected libraries and other medical colleges.

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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.

RACMA is a specialist medical college that provides education, training, knowledge and advice in medical management. Recognised by the Australian and New Zealand Medical Councils, it delivers programs to medical managers and other medical practitioners who are training for or occupying Specialist Leadership or Administration positions. It is the only recognised way you can become a Fellow in the Speciality of Medical Administration.

From the President

The Board recently undertook a very productive two-day strategic planning workshop which involved important discussion around the future direction of the College. Some of the outcomes include:
• The development of an investment strategy to work out the right asset mix and reserves level for the College.
• Some constitutional changes we will be proposing to you to consider and determine at our AGM in Adelaide.
• The appointment of two new external directors to the Board – I am delighted to announce Gillian Biscoe and Kiri Rikihana are joining the Board.

The College has been extremely busy over the past few months ensuring our expertise and voice is sought and considered from key decision makers. We are working to develop a more prominent profile and awareness with respect of RACMA continuing to grow.

An important part of this strategy of awareness has been the submission of several responses to various consultations which impact Medical Administration and the evolving health system generally, in addition to representation and input at key National meetings.

As you are aware, the Medical Board of Australia has officially endorsed RACMA's Fellowship Program as an Approved Program of Study until 2025. The full Accreditation report prepared by the AMC is up on our website and can be viewed HERE. If you haven't already, I encourage you to read the full report and take great pride in this outcome for your College.

The calibre of our members has once again been highlighted with a number of colleagues awarded Queen's Birthday Honours this year. This recognition is a great personal and professional achievement. It demonstrates the key role our medical leaders play in improving the health outcomes of all Australians. It also highlights how critical quality Medical Administration, and the service our members provide, are to the wider community and armed forces. RACMA members to receive Queen's Birthday Honours include:
• Professor Christine Julie Kilpatrick FRACMA - OFFICER (AO) IN THE GENERAL DIVISION
• Air Vice-Marshal Tracy Lee Smart FRACMA - OFFICER (AO) IN THE MILITARY DIVISION
• Brigadier Michael Charles Reade AFRACMA - MEMBER (AM) IN THE MILITARY DIVISION
• Associate Professor Michael John Murray AFRACMA - MEMBER (AM) IN THE GENERAL DIVISION

I would like to acknowledge those Candidates preparing to sit for their upcoming Oral Examinations next month and wish them well in their endeavours. The work and support of Supervisors, Preceptors and the Jurisdictional Committees in preparing Candidates cannot be underestimated. Examinations require the commitment and work of the Censors, Censor in Chief and the RACMA team and I thank them and acknowledge their dedication to this important work.

At a recent Australian Medical Council meeting the term "non-clinical" was used. This is often used when referring to our work. I took the opportunity to correct this to what I believe is a more appropriate phrase - "indirect clinical" work. We as Specialist Medical Leaders are indeed clinicians and our work I believe is incorrectly described as non-clinical. The group and officials acknowledged this anomaly and agreed that indirect clinical was more appropriate. I am hoping we may gradually correct this misconception, which by association undervalues our clinical leadership work.

Finally, I look forward to seeing you all in Adelaide at the RACMA Conference in October when we admit our new Fellows and Associate Fellows. I encourage you to attend this key event on the College calendar as it is the perfect opportunity to network with colleagues, reconnect with peers and engage in some robust discussion around medical leadership in the future and artificial intelligence.

Associate Professor Alan Sandford AM
President

Dean of Education Update

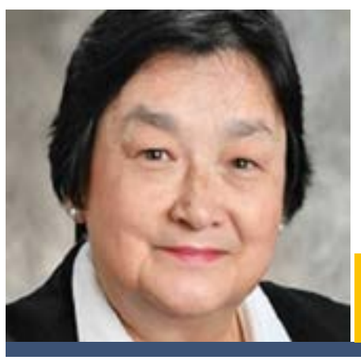
Well, by now you will all have heard that we were successful in retaining Accreditation with the Australian Medical Council, until 2025, for providing a Fellowship Training Program which equips doctors in Australia and New Zealand to be registered, specialist, executive medical leaders, medical human resource managers and medical governance overseers! We are now on our way to embedding our proposed shifts in workplace learning in order to demonstrate the consistency in our approach across all settings.

For many Supervisors and Candidates, 2019 will be another year of documenting, piloting and evaluating new rubrics and methods of learning as we continue to develop our program of formative assessment in the workplace in the Medical Management Practice Domain. As many of you are aware, we have had a schedule of intermittent written assignments, based on workplace activity, being sent to the College Office for feedback commentary from experienced Fellows. We are transitioning this year to that feedback being provided by supervisors and experienced health system leaders in your own workplace settings.

From 2019 all Candidates are expected to complete an In-Training Performance Report every six months. For some Supervisors and Candidates this is a new activity and the College is providing update webinars as this transition takes place.

The IRTP has four components: the log of educative activities (courses, workshops, webinars) and training activities (workplace tasks) undertaken; the outcomes of workplace assessments (proposed minimum of 5) that have been recorded; the candidate and supervisor views on the learning outcomes related to the RACMA Competencies; and the statement of overall performance against expectations of the term.

The frequency with which possible workplace activities are recorded by existing candidates, and your comments on the usefulness of the draft rubrics will be helpful in shaping future decisions by the Education and Training Committee, so please feel free to provide feedback.



Dr Lynette Lee
Dean of Education

College News

New External Directors chosen

Gillian Biscoe AM and Kiri Rikihana join the College Board filling the roles of External Directors.

Gillian was awarded the Order of Australia (AM) in 2016 for her work for and advice to state, national and international organisations in the health sector, and was awarded the Sidney Sax Medal in 2010 for her outstanding services to the Australian health sector.

A consultant in more than 40 countries, her previous senior executive positions include:

- Assistant Secretary in the Australian Federal Health and Community Services Department;
- Chief Executive of the then Royal Canberra Hospital;
- Head ACT Health Department and Tasmanian Health & Community Services Department; and
- Deputy Director General in New Zealand's Ministry of Health.

Gillian has been the chair or member of numerous boards and committees from the National Health and Medical Research Council to the Australian Health Ministers Advisory Council. She is currently Chair of the WHO Western Pacific Region Technical Advisory Group on Universal Health Coverage.

Kiri is the Group Manager of the Mortality Review Committee Secretariat at the Health Quality & Safety Commission of New Zealand and will be Australian and New Zealand College of Anaesthetists' (ANZCA)General Manager (NZ) in August.

Kiri is a lawyer by training and continues to hold a practicing certificate with the New Zealand Law Society.

Kiri began work in the health sector straight from University. In her 20-plus years in health, Kiri has worked in policy, project management and senior management and held various roles within the Ministry of Health.

She has served as a Māori and community representative on the Nelson Marlborough District Health Board, the Optometrists and Dispensing Opticians Board of New Zealand and the Chiropractic Board of New Zealand. Kiri is the current Chair of the Interagency Health Equity hub *Te iti me te rahi* - a forum to consider Māori health advancement and health equity.

2019 Health Informatics Conference - RACMA Member Exclusive 25% Discount

Hear about the latest in digital health research and global trends at this year's Health Informatics Society of Australia HIC Conference, 12-14 August. The program includes artificial intelligence, precision medicine and genomics, cybersecurity, quality and safety and clinical informatics. Keynote speakers include Nobel Laureate and neurosurgeon Dr Ruth Mitchell, Global strategist on digital health Lucien Engelen from Netherlands and CNIO and Managing Partner of Gevity Consulting, Dr Margaret Kennedy from Canada.

For more information visit www.hisa.org.au/hic/program/. To receive the discounted rates, register for a day pass at www.hisa.org.au/hic/register/ and use code VHIC19.

Rural Supervisors and Candidates meet in Albury

The College recently delivered a very successful Rural Supervisor and Candidate workshop in Albury. Sessions centred around workplace observation and feedback, difficult conversations and constructive feedback, career planning and progression and crisis management.

Initial feedback from both Supervisors and Candidates indicated the sessions were beneficial and offered relevant, quality information.

The two day event offered attendees the opportunity to network, share ideas and strengthen relationships across different regions in each state.

Class of 2019

First year RACMA Candidates at their first workshop in Melbourne recently. This is the biggest intake of Candidates in one year in the College's history with 50 commencing the Fellowship Training Program this year. *Please note not all Candidates are present in this photo.

Board get to know future Fellows

Second year Candidates took the opportunity to discuss medical leadership with the College Board in Melbourne recently when a workshop and Board meeting coincided.

2019 RACMA Award Nominations Open

Candidates...

Nominate your Supervisor or Preceptor for the

Supervisor of the Year Award or the

Preceptor of the Year Award

This is your opportunity to tell the College who has had a positive impact on you as you progress through your training. These awards recognise the outstanding support, education, guidance, mentoring and advocacy RACMA Supervisors and Preceptors provide to Candidates as part of the Fellowship Training Program.

To view the Regulation for the **Supervisor of the Year Award,** click HERE. **Candidates must complete the nomination form,** which can be downloaded from the same page under item 7.

To view the Regulation for the **Preceptor of the Year Award,** click HERE. **Candidates must complete the nomination form,** which can be downloaded from the same page under item 7.

Nominations are closing soon and should be emailed to
nominations@racma.edu.au

The successful recipients of each category will be announced at the RACMA Conference in October.
For more information email nominations@racma.edu.au

Acknowledging outstanding achievements & contribution of our members

2019 Conference drawing close

MEDICAL LEADERSHIP IN THE NEW AGE

FUTURISM | ARTIFICIAL INTELLIGENCE | AGILITY
2-4 OCTOBER | HILTON ADELAIDE

Join hundreds of like-minded colleagues and peers from Asia, New Zealand, Australia and beyond at this year's RACMA Conference to learn more about the latest technology and robotics research shaping the world of medical management and leadership.

A number of local and international experts in medicine, research, medical law and robotics, will examine approaches to Medical Management in the new world, AI and Futurism and the ethics surrounding AI in medicine and medical administration.

Speakers lined up for this year's Conference include:

- Dr William Haseltine - International keynote
- Alix Dunn - International keynote
- Professor Jose Miola - International keynote
- Dr Nic Woods
- Dr Avnesh Ratnanesan
- Associate Professor Bernadette Richards
- Dr Johan Verjans
- Mary Freer
- Professor Robert Sparrow
- Professor Des Gorman
- Professor Erwin Loh
- Dr Sergio Diez Alvarez

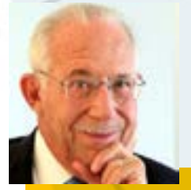
Earlybird registrations close 11 August, 2019. Full Registration costs (which includes attendance to all sessions, the Welcome Reception and Conference Dinner) are as follows:

- Earlybird Member - $1,320 AUD
- Earlybird non-Member - $1,520 AUD
- RACMA Candidate - $900 AUD
- Young Doctor - $450 AUD

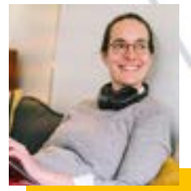
Day Registration costs (includes attendance to all sessions on the selected day. Does not include any social functions) are as follows:

- Earlybird Member - $770 AUD
- Earlybird non-Member - $870 AUD

To Register please CLICK HERE. For more information visit www.racma.edu.au/page/conference/2019-conference or if you have any questions regarding this year's Conference please contact Dr Jo Jenson by email on jjenson@racma.edu.au or by phoning 61 3 9824 4699.



Dr William Haseltine



Alix Dunne

Prof Jose Miola

Dr Nic Woods

Conference program highlights

Wednesday 2 October	**Workshop** - How to Manage and Improve the Patient Experience in your organisation (Dr Avnesh Ratnanesan) **Workshop** - Emerging Technologies, healthcare and the law; Rights, roles and responsibilities (Associate Professor Bernadette Richards) **Site tours** - Tonsley Park Facility Royal Adelaide Hospital Social tours - Ultimate Adelaide and Hahndorf Taste the Barossa Tour Adelaide City Tour with River Cruise RACMA AGM Conferment Ceremony & Langford Oration delivered by Villis Marshall Welcome reception
Thursday 3 October	Official conference opening Official ASM Opening Address International Keynote Speaker Panel Presentation – Futurism and AI Abstract Presentations Panel Presentation – AI: The good, bad and ugly Conference Dinner
Friday 4 October	International Keynote Speaker Margaret Tobin Challenge presentations Margaret Tobin Award presentation Panel Presentation – Agility & Where Medical Administration fits in the new world Panel discussion – Robo2000 to manage hospitals in 2030
Saturday 5 October	**Social Tours**- Ultimate Adelaide and Hahndorf, Taste the Barossa Tour, Adelaide City Tour with River Cruise. Sprout Cooking School **RACMA Supervisor workshop** - for current RACMA Supervisors and those Fellows interested in becoming a Supervisor in the future.

Queen's Birthday Honours

Making the most of every opportunity

Professor Christine Kilpatrick AO FRACMA, Chief Executive of the Royal Melbourne Hospital, has never shied away from a challenge.

"The way I look at it is I've been given lots of opportunities over the years and I've always taken them," Prof Kilpatrick said.

"I think it's all about doing things a little outside of what your day to day job might otherwise be. I've been lucky to be offered the opportunities I have, lucky to be able to take them on and lucky to have a family who have supported me."

Prof Kilpatrick received the Queen's Birthday Honour award of Officer (AO) in the General Division for distinguished service to medicine through senior administrative roles, to the promotion of quality in health care, and to neurology.

"It was a lovely surprise," Prof Kilpatrick said.

"It is a great honour and humbling at the same time receiving such recognition for what I see as my day to day job. I always say you do your job and do your best."

Prior to her current role, Prof Kilpatrick was the Chief Executive of the Royal Children's Hospital in Melbourne for nine years and over the past 15 years has been involved in some key improvements and changes to Victoria's health care systems.

"In 2004 I was appointed chair of the then Victorian Quality Council and had the privilege of leading a team which put together a safety and quality improvement framework for Victorian health services," she said.

"That framework really set the scene for quality in Victoria, which was pretty unstructured at that time. And we've come a long, long way since then."

Prof Kilpatrick was also at the helm of The Children's Hospital when electronic records were introduced, which she said was a very important initiative.

Initially a neurologist, Professor Kilpatrick turned to Medical Administration in the early 2000s after enjoying a part time management role at the Royal Melbourne Hospital. That later led to her becoming the hospital's Chief Medical Officer.

"I realised I had to do one thing or the other," she said.

"I did my RACMA training and an MBA because I realised it was hard to go from being a neurologist to running a hospital. But that was my goal once I had a taste of management; I thought hold on, I want to be CEO next.

"So that was what I did, and I have had no regrets. It has given me a different career; a second career in my lifetime, which is a good thing and I was very lucky to have that."

Striving for the best physical and mental health care for Defence Force

Ensuring the Australian Defence Force has a comprehensive, seamless and holistic approach to health care for its current and former members has long been the end game for Air Vice-Marshal Tracy Smart AO FRACMA and the Joint Health Command (JHC) team.

In recognition of her exceptional leadership and service to the Australian Defence Force in the fields of medical and health services, including her key role in making major improvements in mental health services for current and former Defence Force members, AVM Smart was bestowed a Queen's Birthday Honour award of Officer (AO) in the Military Division.

Although surprised with the elevation from Member of the Office of Australia (AM) to AO, AVM Smart said she was very pleased JHC's work around championing mental health issues had been recognised.

"This is as much about the whole team as it is about me," she said.

"We have worked very hard to educate and focus our members on taking a holistic view. Our mental health strategy slogan is 'Fit to fight, fit to work, fit for life'. From the time they come in, but even beyond service now, we are responsible to set them up for success and we are responsible to ensure that they transition seamlessly into the civilian health system. It is about how we can help them take a bit of self-care and individual responsibility while they are serving so it's more natural for them when they leave the Defence Force.

"I'm really pleased to see this has been recognised because I do think we have come a long way over the last few years and it has been said to me that we do have the best holistic and multi-disciplinary mental health services in Australia."

The statistics prove AVM Smart's strategy works. The suicide rate in the Australian Defence Force is 51 per cent lower than the general population.

"An important part of the piece has been reducing the stigma associated with mental health problems," AVM Smart said.

"We have placed an emphasis on ensuring our people recognise they need to ask for help early instead of waiting, so we can help. What has been important over the past few years is to change the culture both internal to Health Command with the whole of life approach but also the culture in the Defence Force outside of Health Command to ensure they understand we are there for them to keep them fit for life rather than stopping them doing things. We are still on that journey, but I think that has been one of the big changes we've been able to make – to destigmatise the mental health side and encourage people to come forward and get help when they need it.

"We all focus too much on the here and now; I think because the people who join the Defence Force are so committed to the bigger picture and to serving something bigger than themselves, it is easy to forget about themselves in a way."

The recognition has also delivered a definite sense of pride for AVM Smart, who said historically doctors had not always been recognised in the same way as operators in the military.

"I think in a way I'm proud of this because it really signifies that health is on the map in Defence and what we are doing is highly valued by the senior sirs," she said.

"It shows that they value the work we have been doing and value that we are doing it for their people."

Queen's Birthday Honours

Total commitment to a cause

For three decades, Associate Professor Michael Murray AM AFRACMA has dedicated his career to improving health outcomes for the elderly and developing world class continence support services.

In that time, he has continuously served on several boards. Associate Professor Murray is President of the National Ageing Research Institute and President of the Continence Foundation of Australia. He has also been a member on the board of Benetas, Lynden Aged Care Association and for 25 years was on the board of the Australian Association of Gerontology. The unwavering commitment of the head of Austin Health's Geriatric Medicine was rewarded with a Queen's Birthday Honour award of Member (AM) in the General Division for significant service to geriatric medicine as a clinician and educator.

"It was truly a lovely surprise because I had no idea I had been nominated," Associate Professor Murray said.

"It is a great honour."

Associate Professor Murray played a key role with the Continence Foundation of Australia to deliver crucial models of care for continence support, which provide funding for eligible people for continence aids and equipment. He also helped secure $30 million of government supported funding for research into continence.

"We now have services in every state of Australia, which has led to the most robust continence awareness in the world," he said.

"The flow on affects have been very positive."

Associate Professor Murray also worked with the National Ageing Research Institute to build and expand services and research around elder abuse and translating research into practice.

Associate Professor Murray became and Associate Fellow of the College in 2017 and found it extremely beneficial and advantageous.

"I thought it was brilliant and I'm only sorry I didn't do it 10 years ago," he said.

"I've encouraged many others to do it. Not that long ago we had no idea about clinical governance and quality – quality was almost a dirty word. It is delivered by clinicians for clinicians, which is great to integrate clinical expertise into management. It really gives you a smattering of all the things you need to perform your job or enable good performance within a unit."

Teamwork key to success

If anyone knows how to lead a team to make things happen, it is Brigadier Michael Reade AM AFRACMA, Defence Professor of Military Medicine and Surgery at the University of Queensland and Joint Health Command of the Australian Defence Force.

He led the Australian Regular Army's field hospital through the Trauma Verification process of the Royal Australasian College of Surgeons (RACS) - the first mobile, deployable military field hospital in the world to be accredited as a Trauma Centre.

"The RACS Trauma Verification process was a catalyst for us to improve many aspects of the way our hospital functions, but most importantly it demonstrated to both Defence and to the Australian public that we wished to hold ourselves to the highest possible standards and we embraced external scrutiny," Brigadier Reade said.

Brigadier Reade was also integral in building the academic trauma research program between the Defence Force and the University of Queensland, with the close collaboration of several institutions including the Australian and New Zealand Intensive Care Society (ANZICS) Clinical Trials Group and the Australian Red Cross Blood Service.

"An example of this research is our frozen platelet trial, now funded by the NHMRC (National Health and Medical Research Council), which I hope will make platelets for transfusion available to bleeding patients in both military hospitals and also in rural civilian hospitals ," he said.

Brigadier Reade's outstanding leadership and team qualities and commitment to strive for superior healthcare for Australians was rewarded with a Queen's Birthday Honour. He was awarded Member of the Office of Australia (AM) in the Military Division for exceptional performance of duty as the Director of Clinical Services of the 2nd General Health Battalion and Professor for Military Medicine and

Surgery."I was thrilled to receive the award as I hold it in such high regard, and I am honoured to join colleagues from whom I have learned so much from over the years," he said.

"But I equally recognise whatever I have achieved has been as part of a team of outstanding people and the award denotes their achievements as much as mine."Everything I have learnt in the Army has centred on building and leading effective teams. The notion of an authoritative leader dictating commands to be followed without question is a long way from modern military leadership. True, sometimes direction is needed, but it is only effective if given to a team that has already built skills, trust and interdependence."

It was the AFRACMA Leadership for Clinicians training which Brigadier Reade believes helped him better understand continuous quality improvement, formal governance systems, strategy and change management.

"I think the course provided an opportunity to tailor study to what I needed it to be," he said.

"The AFRACMA is a demonstration of commitment to professional medical administration that I'm sure has helped me to progress within the Australian Defence Force."

He undertook the training in 2015 when appointed the Director of Clinical Services of the 2nd General Health Battalion, the Regular Army's field hospital. Soon after appointment, he led the deployment of a subunit of this hospital to Iraq – the first Australian military hospital to be established overseas for many years. He completed most of the AFRACMA tele-learning modules via secure military satellite uplink. He has since been appointed the Assiwwstant Surgeon General – Army, responsible for advice on the technical regulation of the Army's specialist workforce and for capability development.

Growing pains of attracting and retaining a strong medical workforce in rural and regional areas

There's a lot to be said for making a career in a rural or regional health service – the lifestyle, the opportunities to implement sophisticated system changes and being an integral part of a community. Ask those Fellows based in rural and regional Australia and New Zealand, and they wouldn't have it any other way. They don't deny the job can be difficult, but it is no more challenging than if working in a metropolitan setting and there are many successes which their city counterparts could learn from. Then begs the question why the longstanding issue of attracting and retaining medical professionals in rural and regional health services remains a significant hurdle? A number of Fellows shared their insights into working in rural and regional Australia and New Zealand, as well as their opinions and ideas around addressing the perennial workforce problem.

After growing up in Sydney, RACMA Rural Advisory Group Chair Dr Joe McGirr arrived in Wagga as a junior doctor on rotation from St Vincent's hospital in Sydney in the 1980s. And from there he made his life and a successful career in the regional NSW town. He ran the Wagga hospital's emergency department before moving into Medical Administration and holding roles of Executive Director Medical Services (Greater Southern Area Health Service), Director Clinical Operations (Greater Southern Area Health Service), Chief Executive Officer (Greater Murray Area Health Service) and Associate Dean, Rural, University of Notre Dame Australia.

"It is a great experience living in a rural or regional community," Dr McGirr said.

"You get a range of support from a whole lot of people so that's good. There is a broader range of opportunities and experience available to tap into. I have been able to work not just clinically but also in management, with the university and even politics.

"Rural and regional health services have a stronger connection to community and strong loyalty from the community and I think there is the potential to do some good work at the population health level as well."

Needless to say Dr McGirr is passionate about working in a rural and regional health service. And in his current role as the Independent Member of Parliament for the NSW seat of Wagga Wagga, he will continue to champion the advancement and improvement of rural and regional medical workforce and health services. Dr McGirr said many rural and regional health services continued to struggle attracting and retaining doctors and medical leaders, despite some improvements in recent years.

"Rural hospitals just don't have the same numbers of doctors as metropolitan hospitals and I think it is because they are underfunded for what they do," he said.

"Fewer medical staff means less flexibility around numbers of workforce from a management perspective. Where you have less choice, you have issues of critical mass and you often struggle to maintain basic rosters. And the fewer doctors also leads to issues around isolation of practitioners. There is also a greater level of responsibility particularly in hospital practice. So, when you are required to make decisions without immediate, professional medical assistance and a sounding board, that can become quite stressful. The isolation also presents real issues around peer review and keeping abreast of current practice. And on the flip side, because they are so critical to service provision doctors are in a very powerful position in their community if they are the only doctor.

"Fly in - fly out services pose their own set of problems – the cost, quality and the loss of social capital of not having long term health professionals living in the communities. There are challenges specific to road and farm trauma and mental health provision in rural areas. On top of this the community looks to the local health professionals to provide leadership, adding another layer of pressure."

A number of recurring factors which continue to drive the workforce supply problem have been identified by several RACMA Fellows. These include urban drift, maldistribution, professional isolation and concerns regarding career progression.

Remote Vocational Training Scheme (RVTS) Chief Executive Dr Patrick Giddings acknowledges the reasons are valid but is unsure why anyone wouldn't, at the very least, trial working in a country setting.

"I have spent 30 years in Albury-Wodonga, and it is fulfilling and exciting to work in a rural or regional health service," he said.

"There is so much untapped potential for working in rural and remote Australia and you can have a really interesting and challenging role where you can make a difference, especially at the medical administration level. There is an increasing need for expertise in medical leadership, medical management and clinical governance across rural hospitals."

He's not alone. Darling Downs Health Executive Director Medical Services Martin Byrne oversees 26 health services and loves living and working in small rural communities.

"The thing I love about small rural communities is that you are part of the community," he said.

"You get to know the community; our patients' children go to school with our children, our patients are our neighbours, our shop keepers, priests and other things in the town. So, you not only build relationships with them as patients, but you also build relationships with them as a community. And in my job, I get to be part of the health care of each of the 26 communities while trying to advance the health care of the Darling Downs region."

New Zealand Mid Central District Health Board Chief Medical Officer Dr Kenneth Clark couldn't agree more.

"There are many advantages to working in a rural setting and being involved with the community," he said.

"Unfortunately, groups of the population don't see it or don't even give it a chance. I can't see us ever being able to fully solve medical recruitment in rural settings, the question is how do we best manage the problem? It's a constant never-ending burden. No sooner do you feel as though you are getting recruitment to where you would like it that you have people leaving and gaps forming again. But it's even more than that. Are you comfortable with the calibre of people employed or their suitability? And even the best locums in the world are locums – they are not necessarily committed to the service long term.

"I think it sometimes means that people who ideally should be getting care or treatment of varying kinds, sometimes just don't receive it or their treatment is delayed."

Dr Giddings believes another key problem with workforce supply in rural and regional health services is maldistribution.

"We are spending significant resources training more medical students than we have had before; three times more than five or six years ago," he said.

"The real challenge is to be able to harness that investment and translate that into the right people with the right skills working in the right places and that remains the single greatest challenge we are facing at the moment."

For all the drivers behind the attraction and retention issue, there have been just as many (if not more) government, health industry and community initiatives put in place across Australia and New Zealand.

One which has been successful in Australia is the RVTS led by Dr Giddings. Since the scheme was piloted in 1999, more than 250 rural towns across Australia have been serviced and more than 350 doctors have successfully gone through the program and achieved their general practice qualifications.

"What we can say from that is providing educational training and support is a great retention strategy for doctors working in rural and remote settings," Dr Giddings said.

"I believe education and training are a significant part of the solution to ensure ongoing adequate medical workforce supply.

"We know that professional isolation is one of the barriers for doctors working in rural and remote areas and the need to feel like you have career progression. These days we can provide that training and support from a distance through video conferencing and webinars and have virtual networks of people across the country so the professional isolation needn't be the case."

Dr Giddings also says increased recognition is needed for the unique skillset required to work in a rural or regional setting.

"The Australian College of Rural and Remote Medicine and the establishment of a Rural Health Commissioner has been integral to address the special needs and develop a national rural generalist pathway moving away from rural GPs," he said.

"It is about recognising rural and regional health services require people with strong generalist skills rather than the subspecialties that we are moving more and more towards in our medical training in the metropolitan areas."

Dr Clark said it has been a long held belief that if some form of training at any stage of the medical training continuum was spent in a rural or regional setting, medical professionals were more likely to go back and settle or spend time working in such settings.

"There are many examples which could provide possible solutions to encourage this, including compulsory rural placements and post graduate rural

From previous page

Attracting & retaining rural medical workforce

rotations formalised by our Colleges within vocational training programs, beyond the rotations at intern and undergraduate level that already exist," he said.

"Weighted selection of students with rural or provincial backgrounds accepted into city universities could also work. People who have grown up in a rural area are more likely to go back and live in that environment."

The Australian Federal Government has developed the 'Stronger Rural Health Strategy'. A key intiative of this is the Murray-Darling Medical Schools Network, which will establish medical school sites in Wagga Wagga (University of NSW), Dubbo (University of Sydney), Orange (Charles Sturt University in partnership with Western Sydney University), Bendigo and Mildura (Monash University) and Shepparton (University of Melbourne) with a pathway for undergraduate students from La Trobe University in Bendigo and Wodonga. The new schools, which are expected to have their first intakes in 2021, will enable medical students to stay in their communities while they study and train to become a doctor, increasing their likelihood of staying and working in rural areas. The network will provide an end-to-end approach to rural training to improve the future distribution of the medical workforce.

Dr McGirr said a further step was needed to change the dynamic of how the whole health system operates across rural, regional and metropolitan regions.

"If you really want to solve the medical workforce supply problem in rural and regional areas, you have to make the centre of control in the regional areas," he said.

"So you reverse the power dynamic. The regional areas must encourage medical student training locally, organise the training for their doctors, specialists and rural generalists; and it must be based in local, rural areas so people get rotated to the city rather than the way it is now. Until you locate the control in the regions you won't fix this and all you will get is this model of remote support from the metros. It discourages doctors from coming out here and encourages all cases to go to the cities for treatment and cements an attitude that rural is second class.

"But we still have a way to go to get to that point."

Dr McGirr said it would take a combined effort from state and federal governments, the medical colleges and the universities to make this happen.

In New Zealand, Dr Clark believes further extension of some current models of rural health care is needed, which would help stem the issue around the lack of medical workforce supply.

"I think the extension of some of the work we are doing in appropriate use of nurse practitioners and other practitioners working with extended scopes in allied health, needs further thought and development," he said.

"But you still need a core of medical staff. Perhaps as well, true movement towards addressing equity issues may prove to be a key driver and enabler for improving recruitment and retention."

Dr Clark said the perception rural-based doctors couldn't reach the heights of their city counterparts was wrong.

"We have to break that myth," he said.

STRONGER RURAL HEALTH STRATEGY

$550 MILLION FEDERAL INVESTMENT

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- **3000 EXTRA DOCTORS IN RURAL AUSTRALIA**
- **3000 ADDITIONAL NURSES IN RURAL AUSTRALIA**
- **$95.4 MILLION FOR MURRAY-DARLING MEDICAL SCHOOLS NETWORK**

SOURCE: Federal Department of Health. For a full breakdown on the strategy and investment visit https://www.health.gov.au/resources/corporate-plan-2018-2019/our-performance/stronger-rural-health-strategy

"If you really want to solve the medical workforce supply problem in rural and regional areas, you have to make the centre of control in the regional areas"

- Dr Joe McGirr

"With good role modelling, highlighting some of the careers and some of the things people in those settings are doing very well, we can very easily show that you can achieve anything no matter where you are located."

You only need to look at what Darling Downs Health has achieved. Their medical leadership team is testament to the greatness and opportunities which can be accomplished in rural health services.

"One of the big things was improving the clinical governance of the organisation and implementing a clinical governance team, so rather than having a different procedure for the management of anaphylaxis in one hospital to another, for example, we now have standardisation across the organization which improves patient safety," Dr Byrne said.

"As an organisation we've also worked hard to reduce our long waits for specialist patients and for surgical procedures and we were one of the first organisations in Queensland that has zero long waits.

"A couple of things that were integral to that was the executive, the board, the senior leadership had a vision and made a commitment to do it. The second thing is then you have to develop a process to do it. We ran a whole lot of extra clinics and looked at all of our other opportunities in our communities - private hospitals, general practice, external providers and how we could best utilise them to get the long waits down. We had lots of clinician driven initiatives, where clinicians would come up with different ideas - doing twilight lists, doing Saturday clinics, redesigning our triaging system, coming up with an easier way for general practice and primary care to refer patients into the system, so when they came through the system they were ready to be seen and ready to be assessed.

"We worked a lot with our general practice to work out how to get the referral process working so that when they referred patients, we could see them in the appropriate time. Then I think we had tenacity to continue to do it. It is our fifth year in a row where we have had no long waits. It's been an all of organisation achievement led by RACMA Fellows Dr Peter Bristow and Dr Peter Gillies.

"Most recently we have introduced an increased focus on patient and staff safety. We've used the cognitive institute program 'Speaking Up For Safety', promoting professional accountability. The idea is we support our clinicians and non-clinicians to work safely in the organisation, to have patient safety in the forefront of every conversation and to then have a system where if things aren't going as safely as they could be, to rapidly identify the problem and respond. We are in the midst of creating a safety vision for the organisation, which is essentially going to be aiming towards a no patient harm vision.

"It may sound ambitious, but we managed to achieve zero long waits so there is no reason we can't get our patient safety incidence to zero."

Above: RACMA Rural Advisory Group Chair Dr Joe McGirr

REGIONAL CASE STUDY: The Quarterly interviewed Bendigo Health Chief Medical Officer and Executive Director of Clinical Governance, Dr Humsha Naidoo, as part of this edition's theme looking at Medical Administration in rural and regional areas. Dr Naidoo highlights a positive system change for Bendigo Health implemented after a key learning from the Institute of Healthcare's International Forum this year.

New leadership concept to implement change successfully adopted at Bendigo Health

Bendigo Health are taking a new approach to change management after the Chief Medical Officer and Executive Director of Clinical Governance, Dr Humsha Naidoo recently attended the Institute for Healthcare Improvement's (IHI) International Forum on Quality and Safety in Healthcare in Glasgow.

The new approach is related to the concept of "Agency" which is defined as the ability of an individual or group to choose to act with purpose. Agency includes the Power (the ability to act with purpose) and Courage (the emotional resources to choose to act) to create change successfully in various settings within the health care system. This is particularly relevant to hospitals which are commonly described as complex adaptive systems and where change management is challenging for the leadership team.

Dr Naidoo was the catalyst for Bendigo Health to apply this concept to the annual staff influenza vaccination program to ensure all staff, visitors, students, volunteers and contract staff would be vaccinated against the Influenza virus. The approach was key for Bendigo Health to meet their organisation's vision of Excellent Care, Every Person, Every Time.

Scotland's National Clinical Director Healthcare Quality and Strategy, Professor Jason Leitch, and IHI President and CEO, Derek Feeley, explained the concept at the forum, which is central to the IHI Whitepaper - 'Psychology of Change Framework' (Hilton K, Anderson A. IHI Psychology of Change Framework to Advance and Sustain Improvement. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018).

They believe the four key steps to unlocking the Agency concept are:

1. Purpose and courage
2. Supportive culture
3. Method for change (toolkit, data – technical and relational ie you have to co-produce with colleagues)
4. Widening horizons (learning and teaching)

"By using this concept of Agency we are trying to achieve unprecedented levels of staff engagement in order to secure those improvements in quality and safety we know go with unprecedented levels of engagement," Mr Feeley said.

"The most important way to engage staff is to create Agency."

The following five components are highlighted in the IHI 'The Psychology of Change' whitepaper as pivotal to activate people's Agency:

1. Unleash intrinsic motivation – sense of purpose and meaning.
2. The notion that a change or new process should be co-designed and people driven – recognizing the most important words in the model for improvement is WE – what is the change WE are trying to accomplish?
3. Co-produce in authentic relationship – continue to work together to secure the improvements we want to see.
4. Distribution of power – new way to look at this and how distributed through our system and power becomes a function of relationship not of position.
5. Adapt in action – testing and improving of our theory; activation.

The latest report from the Victorian Sentinel Practice Influenza Network (VIC SPIN) for July 2019 indicates the number of notified cases of laboratory confirmed Influenza was over nine times higher than at the same time in 2018. In 2019 there have been more than 13,000 confirmed cases of influenza and 50 influenza associated deaths in Victoria, comprising three children, three adults and 44 elderly people.

Due to this unusual increase and severity in Influenza activity in 2019, it was decided a key change management project at Bendigo Health would be to increase the rate of Influenza vaccination coverage for staff.

Dr Naidoo implemented the above five components to activate staff agency throughout the hospital in relation to improving the Influenza vaccination coverage rate for the 2019 season.

The key performance indicator set by the Victorian Department of Health and Human Services for hospitals is that 84 per cent of staff should have Influenza vaccination. However, Dr Naidoo set the target at 90 per cent Influenza vaccination coverage across Bendigo Health's hospital staff - and she is fairly optimistic this target will be reached at the end of the program in August.

"The high target instilled a sense of purpose and meaning for everyone across the hospital," Dr Naidoo said.

"A workshop was held with key stakeholders and the notion that this process would be co-designed and people-driven was emphasised to engage staff across the organisation. The purpose of the workshop was to explore new ideas and innovative approaches from the key stakeholders themselves and to emphasise that this was change that WE are trying to achieve together rather than just the Infection Control Team.

"A supportive culture from the hospital Board, Executive team and managers across the organisation was created to support this initiative with great determination and vigor from all staff."

The policy on Influenza vaccination was reviewed and strengthened to support managers across the organisation. The accountability and follow up of staff who refused vaccination but did not have a medical certificate to support the refusal of vaccination was strengthened. The data systems were reviewed to ensure that reporting to managers occurred seamlessly and regularly so that follow up with staff that were not vaccinated was done quickly and systematically.

The key message throughout the Influenza vaccination program was about reducing the risks to our patients, the staff themselves, other staff, families and visitors by ensuring that all staff had received Influenza vaccination across the hospital, Dr Naidoo said.

"Agency is about the energy and focus you put into engaging people to work towards solving problems and creating change that results in better quality and safety of care that we can deliver to our communities," she said.

"Staff Influenza vaccination has been a challenging issue for us in the past and it was imperative that we adopted a different approach this year to improve our coverage rates to secure an improvement in quality and safety that we all know goes with high levels of engagement from all staff.

"I think this is a great example of the application of learnings from an international quality and safety conference to a local change management project and achieving great outcomes in a regional hospital in Victoria."

Dr Naidoo believes that the concept of Agency in relation to any change management project in the health system should be part of the College's Fellowship Training Program and is a useful concept that should be part of the tool-kit of Medical Administrators across Australia and New Zealand.

"I think it will be integral to achieving successful outcomes in implementing change in any healthcare setting in the future," Dr Naidoo said.

"It is about implementing a culture of achieving goals together, working in a project as a team until you get it right; being persistent, proactive, positive and always trying to achieve the end goal of better quality and safety of patients within the healthcare system.

"We need to be more focused on the strengths of our people and be open in identifying and highlighting those strengths to individuals, it encourages a level of emotional engagement which leads to a sense of purpose and meaning which increases performance, and in turn better quality and safety of our healthcare systems."

In the shoes of a regional medical leader

REGIONAL CASE STUDY: The Quarterly interviewed Darling Downs Health Executive Director Medical Services Dr Martin Byrne as part of this edition's theme looking at Medical Administration in rural and regional areas. Dr Byrne takes us through the positives and opportunities involved with working in a regional/rural healthcare setting.

When Martin Byrne starts his workdays at the Toowoomba Hospital, he is most likely to end up covering hundreds of kilometers and finishing the day at a different hospital. But he wouldn't have it any other way because he loves being part of a community and playing a key role to advance the healthcare of several small towns.

The Darling Downs Health Executive Director Medical Services oversees 26 hospitals – it is the largest of Queensland's 16 Hospital and Health Services when it comes to facilities. The hospitals in the Darling Downs are split across three levels of care – tertiary with specialist services, activity-based funded hospitals which carry out some surgical procedures, maternity and mental health services and there are the small hospitals classed as primary providers offering some day surgery, inpatient and maternity services.

As a Medical Administrator and Leader, Dr Byrne has to be highly adaptable, moving across many different hospitals and health care services.

"One of the big differences we have from the metro centres is we have to work with the different models of employment and different models of care in each of the hospitals and the levels of risk and patient acuity in each of the hospitals," he said.

This means there is no shortage of variety for the EDMS.

"Because we have so many facilities and so many differences in those facilities, I find myself switching from how an intern is performing in a big hospital to how a GP is going to bill someone in a private hospital or how are we going to cover a hospital when someone gets sick urgently and there is only one doctor in town – if a doctor gets sick it is a crisis over night in a rural town as opposed to a big hospital where you just shuffle things around," Dr Byrne said.

"For example, in one day I went to some meetings at Toowomba Hospital and was involved in some decisions around operational processes, recruitment issues, selection processes and then in the afternoon I went to Warwick and met with some doctors there around change management in the Warwick Hospital. Then we had a tele-link into Dalby hospital that's having some staffing issues and then had to meet about one of our small hospitals where there are some performance issues with one of our doctors. In one day I covered four or five different facilities and all of the issues which come with them."

In a regional health service like Darling Downs the advantage of someone like Dr Byrne is building the links between all the different facilities.

"One of the biggest problems that can happen in multi-facility regions or health services is often the siloing," Dr Byrne said.

"We know in 2019 that healthcare is fluid, that the sharing of resources happens across health services and that there are needs to move patients around and move resources around from time to time to get the best outcomes for patients. We don't have cardiologists in our small communities, so when someone has heart problems we want to get them to a cardiologist and one of the big advantages of having an EDMS position across the region is you start to break down those silos, you start to bring communities together because through our medical leadership we can have a visibility across the whole system and work to break down the barriers between them.

"I think the beauty is we can have a patient centric view across multi sites and be able to help smooth that patient flow. If you just had individual supers in each town it is difficult for them to have the bigger picture view and break that down."

While the role manages Queensland's biggest health service, it's not a difficult role for Dr Byrne.

"I sometimes miss the day of being a GP when you see one patient at a time but on the whole I much prefer having the 'what can I do for our community?' 'What can I do to ensure the healthcare we are providing for our community is the best it can be?' 'What can we then do to improve the health of our community both in general practice and then into the hospital system?'

"I like having an executive role where you get to be the leading team for the whole organisation, you have to know the balance sheets and make sure you are employing people and providing a safe working environment.

"I have a great team and great support from my peers. We have really strong medical leadership in the darling downs with a number of RACMA Fellows."

Unlike being in a metropolitan health service where you have everything at your fingertips, regional and rural health services survive and succeed with less resourcing, meaning you have to be practical person in Dr Byrnes role.

"You just have to get on and do things," he said.

"We don't have huge committees of people. You can't delegate jobs off to other people because there are not a lot of other people out there to do it. We have a fairly small clinical governance and patient safety team compared to other organisations and so we just have to be more reactive and able to do it. We don't have the resources that maybe metro's do and because we are so diverse across our multiple sites, resourcing gets even more diluted. Doing these regional jobs you have to be able to turn it into a practical reality. You don't have the luxury of time or people to be able to consider situations at length.

"And I think you really succeed in regional and rural systems by being a generalist. If you look around in QLD in particular, a lot of our EDMS's and medical leaders in regional and rural centres are generalist doctors."

Dr Byrne finds it very rewarding to work with other clinicians and witness firsthand the excellent care they provide.

"It's exciting to be at the forefront of developing new and emerging technologies and new treatment," he said.

"Looking at the ways we manage patients. In our hospital today, the way we manage a hip replacement for example is vastly different to the way it was just two or three years ago which is completely different to what it was 10 years ago. So even just a straight forward operation that has been around for a long time continues to evolve and improve and we change and increase our ways to manage these.

"And being part of seeing patients getting good outcomes; less time in hospitals, less disability from a procedure -it's great."

Abstract

Objectives: To investigate the economic viability of locum specialists in NSW compared to staff specialists and VMOs; and to discuss non-economic costs of locum doctors.

Design: NSW state awards were used to calculate daily costs for employing locums, staff specialists and VMOs respectively. Costs were compared to ascertain the most cost-efficient employment type.

Main outcome measures: Daily cost to healthcare organisations for similarly senior medical officers. Average cost for a 'mid-level consultant' was taken as the average between a non-senior and senior position.

Results: Locums are the most cost-efficient employment type for a day's work, in all seniority levels and average cost, except when compared to a non-senior VMO. On average, locums cost health organisations $33.00 less than a VMO and $415.87 less than a staff specialist for a day's work. The average cost for a day's work for a locum is $2,460.00, VMO is $2,493.00 and Staff Specialist is $2,875.87.

Conclusion: Locums are economically viable as an employment type. However, they have significant non-economic cost to the health organisation in terms of increased length of stay, high turnover of staff resulting in fall in healthcare quality, decreased clinical efficiency and lack of engagement for quality improvement and teaching and training. Each health organisation should carefully consider how this valuable resource should be utilised within their own context. However, as this review demonstrates, cost should not be a prohibitive factor for locum specialists.

Are locums cost effective? A review

Dr Junyi Shi, Medical Administration Registrar, Wagga Wagga Base Hospital, NSW.
Dr Lenert Bruce AFRACMA, Clinical Director: Department of Anaesthesia, Wagga Wagga Base Hospital, NSW

Introduction

Locums specialists are generally seen as expensive, and senior executives have always frowned on the use of locums from an economic standpoint, preferring employed permanent staff based on lower cost (Jennison 2013). Indeed, in the UK, there has been a recent capping of the hourly rate of locum doctors (Murray 2017). In addition, utilisation of temporary locum doctors has a myriad of operational issues, including clinical efficiency, workplace culture, teaching, onboarding etc. These issues will need to be balanced with the interests of the health organisation and requirements for provision of clinical services. This article investigates the economic viability of locum specialists.

Methods

The annual cost of NSW staff specialists and VMOs were calculated from the respective NSW state award (the **Award**, referenced in bibliography), in addition to the relevant determination. Locum payment figures were sourced from online advertisements. Figures were compared for 1st year staff specialists, senior staff specialists, visiting medical officers (VMOs) and senior VMOs. A midrange (average) was calculated to better compare with the costs of hiring a locum to staff for a single day.

Fee-for-service VMOs were excluded from this review because of the high variability of claiming depending on the amount and type of work. On-call was excluded for the purposes of comparability and high variability of on-call frequency and workload. This is further reviewed in the discussion section.

The following rules were used to underpin this review:

- All figures were calculated with all leave and allowances taken and paid within a non-leap year.
- GPs were excluded from this review as they do not routinely feature within large regional and metro hospitals.
- Pathologist and radiologists were excluded because they operate under a different award.
- No private practice arrangements were taken into consideration due to highly variable nature.
- Assumes no shift work. More in discussion section.
- Assumes staff specialist and VMO lives locally.
- Assumes locums does not live locally and requires flights (from the nearest capital city), transport and accommodation.
- Assumes no public holidays (for ease of calculation).
- No managerial duties.
- No salary packing.
- Full time employment.
- Superannuation has been included because these figures are part of health organisation spending.

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Table 1. Variables used in the calculations of costs with their justification.

Variable and Value	Justification
Working week – 40 hours, 4 days by 10 hours.	This was the most common arrangement for staff specialists in NSW.
Weekly rate – annual salary/ 52.17857.	As dictated by the Award.
Hourly rate – 1/40th of weekly rate.	As dictated by the Award.
Special allowance – 17.4% of salary.	As dictated by the Award.
Non-clinical shift – 1 in every 4 working days.	Time for non-clinical work, including administration, teaching etc.
Private practice allowance level 1 – 17.4% of salary	As dictated by the Award. Level 1 has no private practice arrangement, but an allowance to compensate.
Training, Education and Study Leave (TESL) allowance - $35,000 per annum for 18/19 financial year.	As dictated by Funding entitlement bulletin.
Annual leave loading – $10,611.33, 7.4% of Clerk Grade 12, 4 weeks salary.	As dictated by the Award.
52 weeks per annum.	Non leap year.
12.6 weeks of leave per annum.	Annual leave 5 weeks. Sick leave 10 days. FACS leave 3 days. TESL leave 25 days.
Superannuation – 9.5% of salary.	As dictated by legislation.
VMO background cost – $25.20/hr.	As dictated by the Award. Rate of anaesthetist and physician used because surgeons generally use fee-for-service.
Locum expenditures.	Estimation.
Locum rates - $2,000 per day.	This is the most frequent advertised rate for non-shift work specialists with variable on-call requirements.

Table 2. Breakdown of Staff Specialist annual cost for 1st year and senior staff specialists.

*Note that the annual total is paid over 52 weeks, but the staff only works for three-quarters of 39.4 weeks. As such, the daily rate is calculated as indicated.

Staff Specialist Cost Breakdown	Year 1	Senior
Annual salary	$166,493.00	$224,937.00
Special allowance (17.4% of salary)	$28,969.78	$39,139.04
Private practice allowance, Level 1 (20% salary including special allowance)	$39,092.56	$52,815.21
Annual leave, 5 weeks (Included in salary)	$0.00	$0.00
Annual leave loading (17.5% of Clerk Grade 12, 4 weeks salary)	$10,611.33	$10,611.33
Sick leave, 10 days (Included in salary)	$0.00	$0.00
FACS leave, 3 days (Included in salary)	$0.00	$0.00
TESL leave, 25 days (Included in salary)	$0.00	$0.00
TESL allowance (Funding entitlement bulletin)	$35,000.00	$35,000.00
Superannuation (9.5% salary)	$15,816.84	$21,369.02
Annual Total		
(Paid for 52 weeks, but works 39.4 weeks and only 3 of 4 shifts are clinical)	$295,983.50	$383,871.59
Daily rate that is worked (Total/39.4/3)	$2,504.09	$3,247.64
Average (Mid-level specialist)		$2,875.87

Table 2 demonstrates the annual cost of a staff specialist according to figures set out in the Award. Including superannuation, a Year 1 Staff Specialist costs $295,983.50 and a Senior Staff Specialist costs $383,871.59. Broken down, a Year 1 Staff Specialist costs $2,504.09 and Senior Staff Specialist costs $3,247.64 per day, taking into consideration of that they only work 39.4 weeks and each 4th shift is non-clinical. The average cost for a Staff Specialist is $2,875.87 per day.

Table 3. Breakdown of VMO annual cost for specialist and senior specialist VMOs. Note that the daily rate was calculated from annual total because superannuation has been included.

Sessional VMO Cost Breakdown	Specialist	Senior Specialist
Hourly rate (/hr)	$198.15	$212.65
Background cost rate (/hr)	$25.20	$25.20
Annual income (40hr week, 52 weeks)	$412,152.00	$442,312.00
Background costs (40hr week, 52 weeks x background rate)	$52,596.00	$52,416.00
All leave	$0.00	$0.00
Superannuation (9.5% annual income)	$39,154.44	$42,019.64
Annual Total		
(52 weeks)	$503,902.44	$536,747.64
Daily rate (total/52.17857/4)	$2,414.32	$2,571.69
Average (Mid-level VMO)		$2,493.00

Table 3 demonstrates the annual cost of a VMO according to figures set out in the Award. A Specialist costs $503,902.44 and Senior Specialist costs $536,747.64 per annum (if working all 52 weeks). This is equivalent to $2,414.32 per day for a Specialist and $2,571.69 for a Senior Specialist. The average cost for a VMO is $2,493.00 per day.

Table 4. Breakdown of locum cost.

Locum Cost	
Daily rate	$2,000.00
Accommodation	$120.00
Car	$50.00
Airfares	$100.00
Superannuation (9.5% salary)	$190.00
Total (daily rate)	$2,460.00

Table 4 shows the cost for a locum. The locum expenditures were estimated to be a reasonable level of expense per day. A locum costs $2,460 per day.

Table 5. Daily cost of the three types of specialists and locum savings per day compared to Staff Specialists and VMOs. Locums were only more expensive compared to non-senior VMOs.

Daily Cost	1s yr/ non Senior	Senior	Average
Staff Specialist	$2,504.09	$3,247.64	$2,875.87
VMO	$2,414.32	$2,571.69	$2,493.00
Locum	$2,460.00	$2,460.00	$2,460.00
Locum saving VS Staff Specialist	$44.09	$787.64	$415.87
Locum saving VS VMO	-$45.68	$111.69	$33.00

Table 5 shows the cost difference between the three employment types and the cost saving/loss from employing a locum. It is clear that locums are more economical than permanent staff only except in the case of non-senior VMOs. It is also clear that staff specialists are the least economical, supported by having the highest daily cost across each criteria.

See following pages for analysis and conclusion

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Are locums cost effective?

Discussion

Reasons behind variables

Shift work and on-call were not taken into consideration. Each Award allocates further loading for after-hours work which would elevate the cost of Staff Specialists and VMOs. This will further support that locums are cost efficient. Locum on-call is variable but generally expected within locum rates. Therefore, taking into consideration of on-call, locums would be even further economically efficient as they do not have further loading on their base daily rate.

Staff Specialists are provided non-clinical days to attend to administration, teaching activities etc. They do not provide a clinical service during this day but is still paid for it.

Private practice within public hospitals are up to the discretion of each individual physician. The Award provides the opportunity for the physician to select a level that is suitable for their private earnings. As this is variable, Level 1 with no private practice arrangement, was selected for ease of comparison. The hospital will be able to access the private billings of Staff Specialists to offset cots, but the same will hold true for locums. It therefore does not alter the relative cost effectiveness of locums.

Locum expenditures were estimated. The geographical location of the hospital and access to public transportation will significant change the airfares and care figures. Most hospitals have fleet cars and corporate travel partners, which allow them to access rates which are not available to the public. As such, an estimation based on rates available to the public is utilised.

Analysis

Locums are cheaper than 1st year staff specialists and significantly cheaper than senior staff specialists. On average, employing a locum would provide a saving of $415.87 for each day worked. The average calculation is useful in this particular case because it is unlikely a health organisation will have a significant amount of 1st year specialists for locums to cover. As such, one would expect more mid-range or senior staff specialists to be covered by locums.

Locums are on par with employing VMOs. Locums are more expensive than non-senior VMOs, but less so than senior-VMOs. Given that the base pay does not change between each year of VMO (but only changes between senior and non-senior), the average calculation is less valid and helpful because the VMOs are either senior or not, and there is no range of escalating pay grades. The differences in pay rates between locum and VMO are quite small, given that it's for a whole day's work and that hospital budgets are in the hundreds of millions. Senior executive efforts are better spent elsewhere for budget savings as the costs saving between locums and VMOs are on the scale of rounding errors.

In raw economical terms, locums are comparable to cost to VMOs and significantly cheaper than Staff Specialists. This assumes that experience is comparable. However, there are many non-economic issues with using temporary staff.

'Cost' of locums

Locums generally do not provide a 'continuity of care' as they are only present in the health organisation for a short period of time. However, in certain units such as the emergency department, staff generally do not become involved in the complete patient journey within the facility. However, they will be able to form a therapeutic relationship if the patient has chronic needs requiring frequent representations. Anaesthesia is also a craft group well suited to locum practitioners.

Given their limited continuity of care, there is evidence to support that the 30-day mortality of locum physicians are not significantly different from their non-locum counterparts (Blumenthal 2017), and even associated with lower levels of adverse events and fewer medication errors (Murray 2017). However, locum physicians are associated with a higher length of stay, higher spending, but significantly lower 30-day readmissions (Blumenthal 2017). The reasons for this could be multi-factorial, but a more cautious approach to treatment could be a significant driver of the differences in practice.

Locums are not necessarily able to produce the same 'work' as their non-locum peers. The turnover of medical officers has a negative impact on service delivery, especially for organisations reliant on locums to provide a substantial portion of their services. There is ample evidence to support high staff turnover is linked to a fall in healthcare quality and efficiency (Busbridge 2015). These inefficiencies stem from many issues, least of which is that orientation for locum doctors are either inadequate or non-existent in some organisations (Jennison 2013, Theodoulou 2018). This leads to inefficient workflow, whereby a locum doctor can take much longer to undertake simple tasks like documentation and procedures because they do not have logins to computers or access to stock rooms. In addition, not all information is available at time of advertisement (eg. exact units to be covered by locum shift) which can lead to employment of doctors who are 'unfit for purpose' (Theodoulou 2018). As such, one method to increase the clinical efficiency of locums is to provide increased support for orientation and induction and ensure correct access to resources within the organisation.

Teaching and training of junior doctors is not something that is routinely required in a locum contract. As such, health organisations relying on locums to sustain their workforce faces issues with upskilling and career progression of junior doctors, which in turn impacts their ability to attract further junior doctors.

Locums do not routinely participate in quality improvement and culture building given their short time with the health organisation. In addition, their engagement with improvement strategies are likely to be low as they have no vested interest in improving their work environment. Locums perceive a high degree of freedom in their medical decision-making which takes place outside organisational constrains (Salloch 2018), and likely to be a primary driver in the motivation in the popularity of locums. For locums to be reach their full potential, they need to engage with organisational quality improvement as they have a wealth of experience from working at many different health organisations.

Conclusion

The usage of locum has drawn much criticism for being "expensive". This review indicates that locums are significant cheaper than staff specialists and comparable to VMOs. With the addition of shift work on-call, locums would stand head and shoulders above both other positions types from an economic stand point. However, the drawbacks of temporary medical officers include lack of continuity of care, teaching and training for junior medical officers and low engagement. As such, locums provide an excellent stop gap measure in medical workforce gaps. Each health organisation should carefully consider how this valuable resource should be utilised within their own context. However, as this review demonstrates, cost should not be a prohibitive factor for locum specialists.

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Member Q&A

1. What drew you to pursue the path of medical leadership/medical administration?
After completing my resident medical officer placements, my initial career was as a medical officer in the Royal Australian Navy. As I became more senior in the organisation, the roles were increasingly focused on managing health resources and leading the health personnel involved in its delivery, which I found both challenging and rewarding. By the time I left the Navy full-time in 2003, I had responsibility for managing all of the on-base non-operational health care nationally, which enabled me to further develop my expertise in these areas. There was also a good synergy between my health management and my public health medicine specialisation, which I have been able to put to good advantage in my various roles with the W.A. Department of Health.

2. What lead you to undertake the Fellowship training program of RACMA?
As I progressed through the ranks in the Navy, the roles open to me required enhanced medical administration and leadership expertise and skills. I had undertaken public medicine training initially, which assisted in developing some of these skills, and some general management and leadership training with Defence, but there were significant gaps in my training and experience that I felt could only be addressed by formal academic study and a dedicated specialist program. A Masters in Health Management and the RACMA training met those requirements.

3. How would you describe the importance of RACMA to the future of medical administration and leadership in Australasia?
RACMA has, and must maintain, a key role in ensuring that there is a steady stream of highly proficient, capable and competent medical administrators to undertake important medical administration and leadership roles, both in clinical medicine and the broader health hierarchy. Without this training, the medical community risks relinquishing these roles completely to other health professionals or to under-trained and poorly prepared medical practitioners, who may struggle in the role. With regards to the former, I have heard the aphorism that 'doctors should not be managers or leaders' in both Defence and the civilian health community. While not all doctors aspire to these roles, an important cohort do, and RACMA has an important role in training and developing people for these roles. With the latter, there have been well-documented incidents, both nationally and internationally, where under-prepared medical practitioners have failed, sometimes spectacularly, in these roles.

4. How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
Health care management and leadership continues to evolve across the Australasian health care system, both in public and private health. Highly professional managers and leaders are appropriately stepping up into these roles from both health care professions, including nursing and allied health, and other professions, including those with legal, financial and information technology backgrounds. RACMA trained medical practitioners bring unique clinical, administrative, management and medical cultural perspectives, which complement those of other members of the leadership team. Without such professional and respected input, the medical community risks distancing itself from key decision-making, that will impact on the profession both now and into the future. While medical administrators are sometimes the brunt of criticism by medical clinicians, the solution is not to de-medicalise the health management roles, but to work to ensure that the best qualified and trained medical administrators are available to perform the function. As Joni Mitchell notes, sometimes 'you don't know what you have lost until it is gone'.

5. What lead you to take up your current medical administration/leadership role? How different is it to being in the traditional healthcare management system (hospitals)?
As a dual specialist in public health medicine and medical administration, the opportunity to work in both fields was my ideal role. As with many clinical specialists, most public health physicians have not had extensive medical training and the opportunity to further develop medical management and leadership within a public health setting was very satisfying. My current role captures both the challenges and rewards of leading a team of 215 health and science professionals to produce highly beneficial public health outcomes, while performing the public health regulatory and legislative role as the Chief Health Officer, which ensures public health is protected across the state.

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

The main challenges will be:
- relevance, to both the medical profession and the broader health community;
- currency, to ensure that training and professional development meets the emerging challenges of modern medicine, management and industry;
- collaboration across the broad health spectrum, as a key leadership team member ;
- change, to facilitate Fellows and Members having the necessary skills to manage the changes from new technologies, organisational structures, extended and new scopes of practice, and changing lifestyles;
- evolving general management and leadership practices; and
- politics, which may both advance and hinder good medical practice and its management.

RACMA will continue to have an important role in steering and supporting medical administrators through these challenges.

Dr Andy Robertson CSC, PSM, MBBS MPH MHSM FAFPHM FRACMA Hon DSc

Chief Health Officer
Assistant Director General
Public and Aboriginal
Health Division |
Department of Health

Member Q&A

Associate Professor Rosemary Aldrich BA Communication, B Med (Hons), MPH, PhD, FAFPHM, FRACMA

Chief Medical Officer,
Ballarat Health Services

1. What drew you to pursue the path of medical leadership/medical administration?
I had trained in public health medicine while continuing to work in clinical medicine and was attracted to roles which combined the principles of public health medicine (including health improvement for many and making safe an environment beyond an individual's capacity to control) and clinical medicine and patient care (which I had always very much enjoyed).

2. What lead you to undertake the Fellowship training program of RACMA?
My first position after being awarded my public health fellowship was as a DMS at a 160-bed district hospital. Later after working in research management and undertaking a PhD I landed as a senior staff specialist in clinical governance in Newcastle NSW, with a role which covered more than 40 hospitals in an area half the size of Victoria. I was encouraged to pursue the RACMA executive pathway by two FRACMAs I respected, and moved to a DMS role in a tertiary hospital before taking the exam. In my current role as Chief Medical Officer at Ballarat Health Services I am credentialed in both medical administration and leadership and as a public health physician, and my role straddles health system leadership and management and public health.

3. How would you describe the importance of RACMA to the future of medical administration and leadership in Australasia?
I think medical leadership is critical to improving health care in Australia, through making a unique contribution which combines health system understanding, capacity for responsiveness, and detailed clinical knowledge. In other countries the peak bodies for medical leadership are rapidly filling the gap in having doctors training doctors to be leaders whatever their medical discipline, and I think RACMA has increasing opportunity to become even more key in rigorous medical leadership training from the most junior to the most senior levels of medical practice

4. How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
I think a RACMA qualification does train a Fellow or Associate Fellow in a unique set of skills, as with any other medical specialist qualification. In addition as our peers and colleagues see the value of having an expert who understands the health system working to support them to care for our patients and community I think there is a growing appreciation of how FRACMAs or AFRACMAs can work with all to make it more straightforward for doctors to do their job well.

5. What led you to take up your current medical administration/leadership role? What are the major differences and challenges for medical administration/leadership within a rural hospital/healthcare setting compared to metropolitan hospital/healthcare systems?
I am half rural and half Victorian by birth, although had never lived anywhere smaller than Newcastle before moving to Ballarat. A key thing I missed about my role in clinical governance was getting on the road and visiting the smaller and more distant of the hospitals in my patch, supporting the nurses, doctors and allied health professionals in those locations to do their best and work through their challenges, making sure no-one was left out or left behind. I had enormous respect for the role those rural hospitals had in their communities, and was very grateful for the generous welcome I received wherever I went. As my children grew into adults I looked around and visited a number of centres where I thought I might like to work; not too far from an international airport and warm summers with cool nights and cold winters were also somethings I sought. The Ballarat role came up, fitted the bill perfectly, and I feel very very fortunate to be doing the job I do (and by the way it snowed here in late May this year).

Having moved from metropolitan NSW to regional Victoria I noted some differences. These were less to do with the practice of our craft: clinicians everywhere need personal and professional support and I do here what I have done elsewhere. The great blessing has been the calibre of the senior and junior medical officers and the many other professionals working at Ballarat Health Services. The most noticeable difference has been a health system structure unlike anywhere else in Australia. It is essential to work collaboratively across health services boundaries with my Grampians region executive medical leader counterparts to address the current stark disparities in health outcomes between metropolitan Melbourne and the rest of Victoria.

6. What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?
One challenge is to be known as the peak training organisation for medical leaders and managers. Notwithstanding the 50 years of strong College traditions, I am of the personal view that "Medical Administration" is a dated term for what we do. We are medical leaders and we train people to be medical leaders, and I believe the name of our peak body needs to better describe that role in the health system.

Member Q&A

Ian Hosegood
MBBS, FRACGP, DAvmed, PGDipOEM, FRACMA

Director Medical Services
QANTAS

1. What drew you to pursue the path of medical leadership/medical administration?
As a product of the accelerated pathway to fellowship for me, Fellowship followed an established career in Medical Leadership. My initial post-graduate years were spent in the Australian Defence Force where, as an Officer, leadership training is a core competency and has as high a value placed on it as technical skills. I think this is where I realised that I enjoyed not only clinical governance and improving patient care but also being able to make systemic changes that potentially impacted the health and safety of a population. It was also where I became hooked on working in a multidisciplinary team to get great outcomes and build an 'espirit de corps'.

2. What led you to undertake the Fellowship training program of RACMA?
I recognised that the CPD I was partaking in was very much focussed on clinical currency with no development in the areas where I was increasingly spending my time i.e. leadership, management and administration. I wanted to be part of a collegiate group where others were facing similar challenges that I was around corporate and clinical governance. I also wanted to formalise my 'on the jo' experience as a leader through anevidence-based approach.

3. How would you describe the importance of RACMA to the future of medical administration and leadership in Australasia?
When we look at the challenges facing the Health system over the coming decade, it is an incredibly daunting list of priorities that needs to be considered. Whether it is the explosion of medical technology costs, the issues of inequality of care, the ageing population, the need for improved research or the public-private balance, there is a need for clinical leaders who also understand economic realities and ability to prosecute a strategy. In that light, RACMAs role is incredibly important in leading the conversation and producing the individuals who can make difference.

4. What led you to take up your current medical administration/leadership role? How different is it to being in the traditional healthcare management system (hospitals)?
I haven't worked in a hospital since I completed my residency. I have essentially enjoyed a serendipitous and exciting career pathway that was entirely unplanned. It was my time in the Air Force that made it clear to me that I loved the intersection of Health with human performance in industry and in particular Aviation. My career has included medical leadership roles in Australia and Overseas with Defence, the Airlines (Emirates and Qantas), the Aviation regulator (CASA) and also in the not-for-profit sector (with the Royal Flying Doctor Service). It's been an incredible ride so far and what I love is that for most of my roles medicine is not the primary function of the organisations I have worked for, but rather is an enabler and supporter of the goals of those organisations. When I did the RACMA program I was concerned that the Hospital focus may be too far removed from what I did day to day but in fact I found that the principles were essentially identical.

5. What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?
I think the primary challenges are ensuring we continue to enhance relevance and respect for our role in healthcare. Administration can be a challenging and sometimes thankless function which is inherently rewarding but can sometimes lack the recognition and validation it deserves. We want to attract the best to this field as this is where the biggest difference can be made. To achieve that, I think we need to work on the 'aesthetics' of the field as well as the substance.

Member Q&A

Darrell Duncan
MB BS, FRACMA, FCHSM, GDipHI, MHA, MPH, MClin Epid, GAICD

Director Medical Services, Department of Defence - Health Programs Pans and Assurance

1. What drew you to pursue the path of medical leadership/medical administration?
Combining a career in medicine and a career in the Defence Force leads to an interest in leadership and management. My early career in Army not only included responsibility for direct patient care but also for the leadership and management of various sized teams that might include other doctors but also included registered nurses and Army 'medics'. As time went one I found I received great intrinsic rewards when activities I had planned for others to implement such as training days worked out well and when my team produced good outcomes in part because of my management and leadership (but more because I have been fortunate enough to work with some great people). Thus my pursuit of a medical leadership path was in part a push down that path by the vagaries of life in the Army and a pull towards the attraction of making things happen on larger scales than an individual patient.

2. What lead you to undertake the Fellowship training program of RACMA?
In part the changes to the Defence Force salary structure that meant a Fellowship was financially rewarding as well as necessary for career progress but also because I figured that I should learn the theory and make sure my practice was at a contemporary standard. When I undertook the training I had completed my full time military service (still serving as a reserve member) and was working in various administrative roles in the public sector and observed colleagues who were Fellows and those who were not. It seemed to me that the Fellows had a more complete view of their roles and the management of a "system of systems" than the non Fellows.

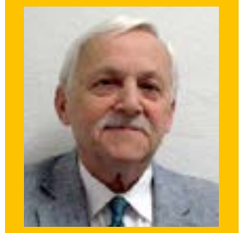
3. How would you describe the importance of RACMA to the future of medical administration and leadership in Australasia?
I recall a presentation made by a General that pointed out to the audience of budding leaders looking to take over Command roles that our stewardship of the organisations we were to Command for the future was equally if not more important than what happened during our time in Command. I think a similar thinking is one of the elements that makes the professional approach to medical leadership espoused by the College vitally important. If we do not have an eye to the future, think about the challenges (both obvious but also what might happen) we will be 'overtaken by events' and developments in the health system and society and be left behind. If we do not apply our skills and understanding to how the future develops important insights will be missed as other disciplines/ Colleges/ craft groups do not apply our perspectives to the issues.

4. How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
The skills that Fellows have in systems thinking and organisations are critical to the future. Very few of the other specialist disciplines think beyond individual patients or their own speciality area. A successful medical administrator looks takes a broader perspective and looks at the impact on all aspects of the health system. The RACMA training program, both as a candidate but also the ongoing learning as a Fellow or Associate Fellow, is focused on thinking about the broad health system and these skills will be essential to ensure a balanced approach to the development of health systems.

5. What lead you to take up your current medical administration/leadership role? How different is it to being in the traditional healthcare management system (hospitals)?
I was working as contractor to Defence in an administrative role and there were a range of discussions occurring about how to bring some elements of the organisation into a more contemporary structure. I realised to a degree that my contribution meant my contracted role was going to disappear to I applied for and was appointed to the Commonwealth Public Service. My current role requires someone with significant experience in the Defence Force health services, in part someone who can remember what policies existed 20 or more years ago. Clearly I am biased but I think providing health care to Defence members is a great opportunity for evidence based care that is free of some of the 'traditional' pressures in the public hospital setting around access and funding. Defence is responsible for providing the whole range of health care from pre-hospital care through to high end specialist care. To be a health administrator in that environment means exposure to all levels of the system with a need to identify optimum models of care and what is and is not good practice. Arguably, the main difference between Defence and the management of a hospital is the Defence Health System belongs to an organisation where the purpose is not health care. We enable operational capability that the Government of the day can use to meet the national interest so healthcare in Defence is important and politically charged but it is not the prime output of the system we belong to. That creates both opportunities and challenges

6. What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?
One of the main challenges at the moment is to know what the future holds so we can prepare for it. The corollary is that the challenges RACMA and medical administration will face in the future is how to provide stewardship to a system that is no longer as closed as it was and will be informed by technologies and capabilities that do not exist yet but that will almost certainly be developed by industries not currently associated with health care to any degree. Gene therapy and individually tailored treatment approaches is one that springs to mind at the moment but also what services will be required from traditional hospitals or points of service and what will be possible by remote technologies or other methods of delivery. The College is working on a strategy in terms of digital health and I wonder what strategy will be needed next.

Member Q&A



Ross Duncan
MBBS FRACMA MHP AFCHSM MAICD

Executive Director Medical Services, North East Health, Wangaratta

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

I was influenced towards a career in medical administration as I had a reputation as an organiser, I was unimpressed with management at the Austin Hospital at the time (It was only in later years I realised how wrong I had been and that medical administration was difficult and demanding). However, the strongest influence occurred because I was conscripted into the Army and serendipitously worked for the Director of Clinical Services Colonel Keith Fleming. A brilliant leader and inspiring administrator. I was subsequently approached by the then Chief Executive of Wangaratta Base Hospital (WDBH) Michael Kirk to take on the role of Medical Superintendent. Again an outstanding Chief Executive who has remained a friend and mentor throughout my career.

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

In my early years at WDBH I started to meet other medical administrators and learnt of the establishment of the College. The senior members of the College were highly influential in healthcare across Australia and it became clear to me that I should work to become a Fellow. The training program was not as extensive or rigorous as it is today and I was advised to undertake the Master of Health Planning Course at the UNSW. I did the MHP under a scholarship from the Victorian Department of Health. One of the lecturers in the MHP was Stephen Duckett. I made lasting friends during that course and built a professional network that has been valuable to this day. I was admitted to Fellowship in 1979.

3. How would you describe the importance of RACMA to the future of medical administration and leadership in Australasia?

I sincerely hope that the College is able to continue to enhance its role as an educational powerhouse for all doctors in Australasia so that the medical profession is better able to provide inspirational leadership and develop the management expertise needed to transform the health system which is changing rapidly and increasing in complexity.

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

Essential. The Australasian Heath System would struggle if there were not highly trained medical leaders in modern management, systems thinking, improvement science and medical informatics who had the capacity to lead future innovation, continuously improve processes of clinical care and administration and had the knowledge and skills to redesign clinical and management processes to improve patient care outcomes and better manage cost.

5. What lead you to take up your current medical administration/leadership role? What are the major difference and challenges for medical administration/leadership within a rural hospital/healthcare setting compared to metropolitan hospital/healthcare systems?

I had returned to Australia in 2010 and the quickest way to get back into medical administration was to undertake locum DMS and EDMS roles. Most of these just happened to be in regional or rural settings mainly in Queensland, NSW and Western Australia. I enjoyed the work and

saw a lot of Australia and came to realise how diverse health care was not just between states but often within states. The major differences between rural/regional and metropolitan health systems for a DMS or EDMS is the isolation and often requirement to travel extensively. There is also a realisation that there are not a lot of other people around to help you. Recruitment of medical staff both senior and junior can be very difficult in Rural areas. In the last ten years governments have not made recruitment any easier. Also a number of excellent doctors refuse offers in rural and regional areas because the partner does not wish to leave the "City". It also can be difficult for a rural DMS to maintain continuing education as leaving a rural or regional hospital with no DMS can be stressful for all concerned. I believe also that it is considerably harder for doctors training with RACMA in rural areas to achieve the standards required for the FRACMA exams.

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

General Issues:

1. Rapidity of change in healthcare, and especially around knowledge, technology, community expectations.

2. Adapting to the ballooning cost increases in healthcare (Learning to improve clinical outcomes and reduce costs significantly)

3. Building a learning organisation which is collaborative, patient centered and driven by data and teamwork.

4. The urgent need to develop sophisticated integrated medical record systems which are capable of using effective data analytics, machine learning, and artificial intelligence. This is essential to help us manage complexity and develop methodologies to continuously improve clinical outcomes and the patient experience.

RACMA issues:

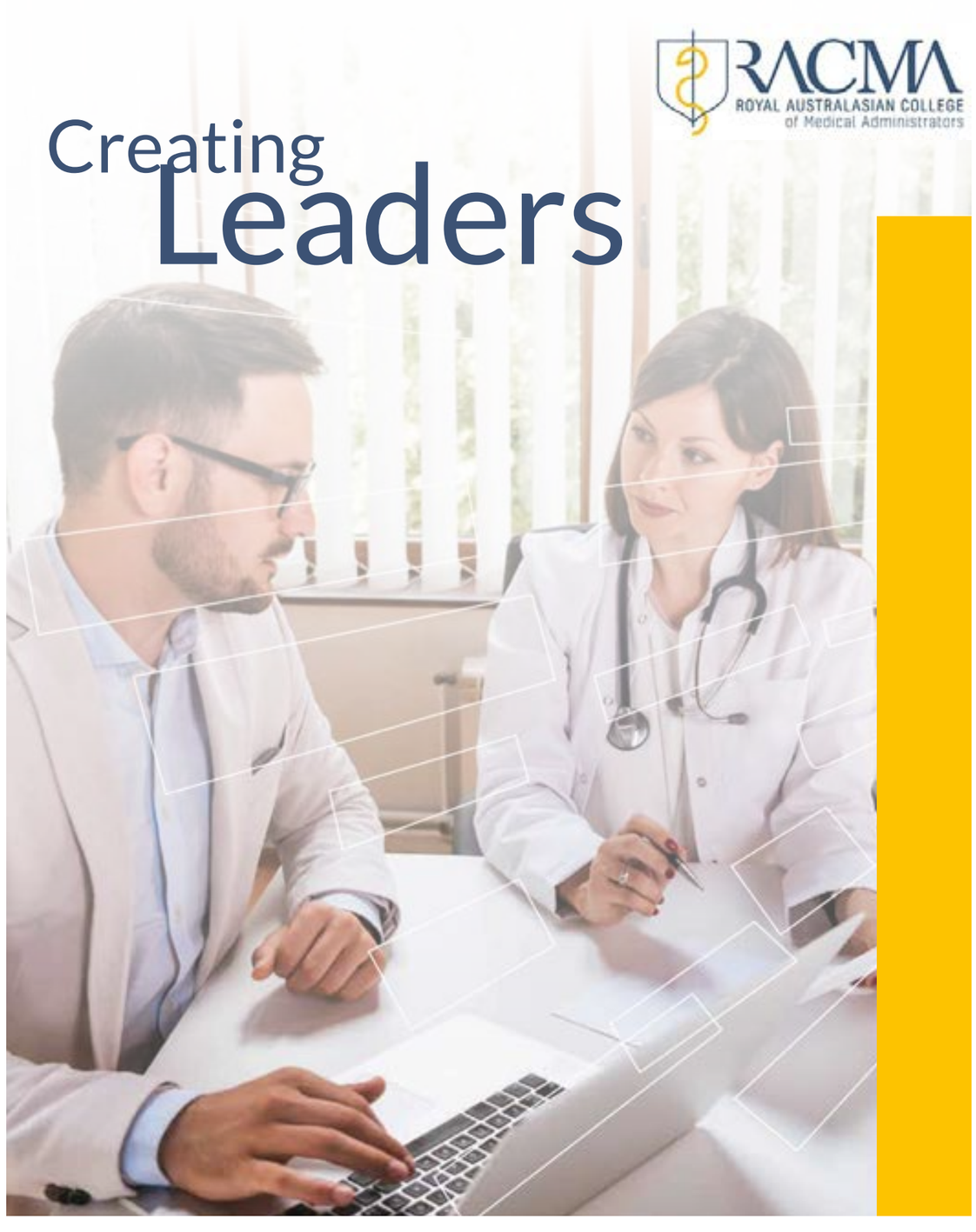
1. Maintaining an influential position in Australian Healthcare. We see the President of the AMA meeting the Minister of Health regularly. Hopefully the President of RACMA can achieve similar recognition.

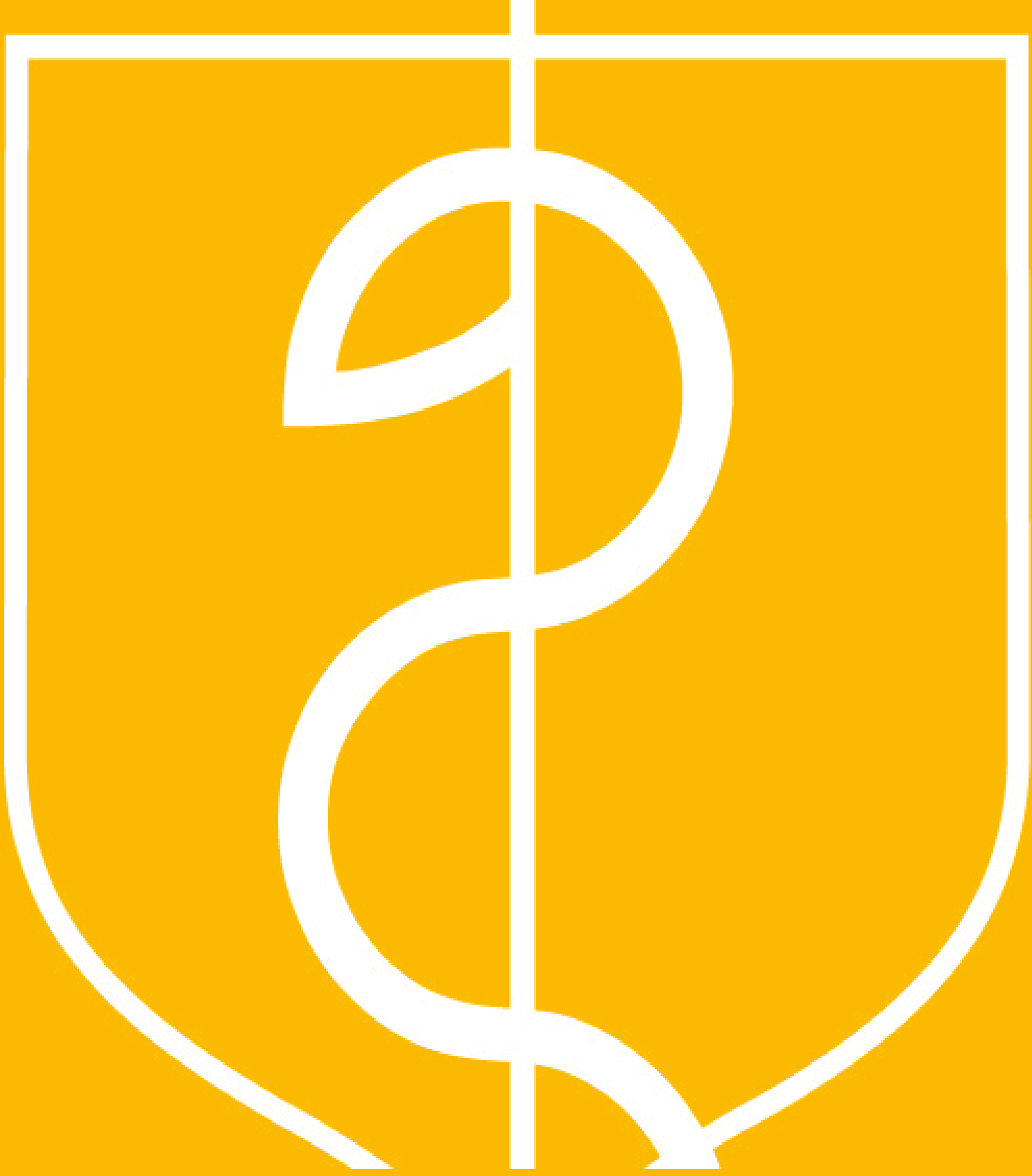
2. There will be a need to continually evaluate and adapt the College educational programs. There is increasing competition for the leadership and management dollar not just in Australia but internationally. There are trends to facilitate access to international management and skills programs at modest costs via the internet.

3. The costs of belonging to RACMA and participating in CPD are in my view a barrier to bringing doctors under the influence of RACMA.

4. Serious consideration needs to be given to helping medical administrators deal with the stress associated with DMS type jobs and issues around burnout. Hopefully the College can influence health departments to improve administrative support in hospitals and other settings in which medical administrators find themselves.

5. Improved training of medical administrators and departmental directors to manage behaviour and deal with conflict more effectively.





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