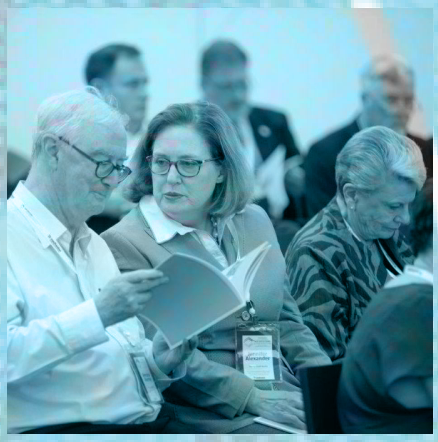

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THE QUARTERLY

Cover images:
RACMA Conference 2017

Contents

RACMA ROYAL AUSTRALASIAN COLLEGE of Medical Administrators

The Quarterly is the journal of The Royal Australasian College of Medical Administrators

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

Publisher
The Royal Australasian College of Medical Administrators
A.C.N. 004 688 215
Suite 1/20 Cato Street Hawthorn East Vic 3123
Telephone 03 9824 4699 Facsimile 03 9824 6806
Email: info@racma.edu.au
Website: http:/www.racma.edu.au

Honorary Editor
Dr Andrew Robertson
C/- The Royal Australasian College of Medical Administrators

The Quarterly is prepared by staff of the RACMA Secretariat.
ISSN 1325-7579
ROYM 13986

Design and Production
PI Creative – Printing Intelligence
51 Park Street South Melbourne T: 03 820 5311 E: info@printell.com.au

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

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

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

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

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

From the President

I would encourage you to be involved in your College! As we perform in our roles as Medical Administrators, we are in a unique position to see both the clinical application of medicine and governance of medicine at local, regional, jurisdictional, national and international spheres of influence.

RACMA members can influence the health and welfare of Australians and New Zealanders in a very positive and meaningful way. The College Strategic Plan 2017-2020 RACMA states that *"The College role is to enhance the health of the nation by advancing to excellence the medical administration profession"*. Forming part of the College response, we have instituted working groups in the areas of Indigenous Health, Diversity & Inclusion and Clinical Infomatics.

We recognise as a College and as Medical Administrators, that where there is a lack of diversity, or discrimination against people due to their gender, ethnicity, indigeneity, sexual orientation and identity, age, disability or religion, there are consequences with serious health, social and economic consequences for affected individuals, their families and communities. Discrimination is costly to business, government, communities, health services and ultimately, individuals.

Clinical Infomatics is a focus area and the working group will be invaluable as we explore this burgeoning area and the rapid pace of change. The College has an important role to play in influencing and providing leadership in this disruptive and innovative clinical space.

These working groups will play a pivotal role in ensuring the College responds appropriately to these critical issues and provides thought leadership to the sector. I would urge you to contact the College office to discuss how you can contribute to these important initiatives.

The Board and Jurisdictional Committee Chairs met in March at the new College premises. The contribution by the Jurisdictional Committee Chairs was invaluable for the Board and I thank all those who attended for their ongoing commitment to our College. This was a worthwhile opportunity for the Board to engage at a deeper level on the challenges confronting our jurisdictional groups. Additionally, College staff presented to the group on key activities, including the Fellowship Training Program, Learning & Teaching Centre and Information Technology etc.

The Dean of Education presented a comprehensive update on the Fellowship Training Program and the Australian Medical Council RACMA Accreditation progress, more of which is contained in the Deans Report. The Board will meet face to face in June for a two-day intensive meeting, where the focus will be firmly on progressing our Strategic objectives and measuring our progress to date.

The Board are planning on an official opening of the new College premises in June and there will be more information on this event at a later date.

The 2018 RACMA & Hong Kong College of Community Medicine Conference is being held in Hong Kong on the 5th – 8th September and the program is setting the scene for an interesting and dynamic few days. I would encourage you all to attend and support this important College initiative.

> The College role is to enhance the health of the nation by advancing to excellence the medical administration profession.
> RACMA Strategic Plan 2017-2020

Prof Michael Cleary PSM
President

Education and Training Committee (ETC) Update

I am pleased to advise that the ETC has four new members. They are, Dr Peter Lowthian, Dr Andrew Johnson, Dr Lynnette Knowles and Ms Glenda McLean.

Dr Peter Lowthian will be taking up a new role on the ETC as the Lead Fellow for the Personal and Professional Leadership Domain. Peter is the Executive Director of Medical Services at Cabrini Health, Melbourne, Victoria.

Dr Andrew Johnson has taken on the role of Chair of the Curriculum Review Committee. Andrew is the Executive Director of Medical Services at the Townsville Health Service District, Queensland.

Dr Lynette Knowles is the Chair of Candidate Advisory Committee (CAC). The CAC chair is now formally a member of the ETC, thereby formalising the new reporting structure for CAC to the ETC. Dr Lynnette Knowles' membership on CAC creates a direct line of communication for Candidates to the ETC. Lynnette is a Medical Administrator Registrar at Metro North HHS, Caboolture Hospital, Brisbane, Queensland.

Ms Glenda McLean is our Community Representative and comes with a strong background in senior Community and local Government roles. Glenda is an organisational consultant with extensive experience in public and hospital sectors, corporate service, education and training, governance program development, psychology and human resources. Glenda is based in Mt Isa, Queensland.

The ETC is working towards achieving a modern and responsive Fellowship Training Program to meet the challenges of providing a relevant and dynamic training program for Medical Administrators into the future. We have collected feedback from Candidates, and have an action plan to rectify and improve some of the issues. Many members are also involved in the preperation for the AMC accreditation. We are working to provide appropriate support to our supervisors and preceptors by preparing rubrics, templates and supervisor training courses, with a face to face workshop being planned for 5th September during the RACMA Annual Conference. More about this in coming months.

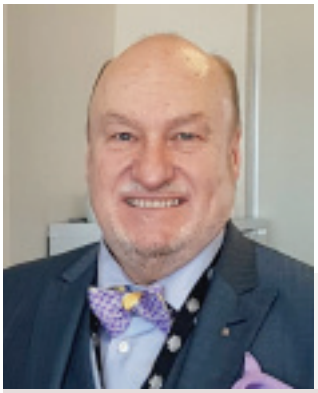
I am delighted to work with such a committed and educationally aware group of medical professionals, and am always happy to recieve feedback on the program from candidates, fellows, Associate Fellows, and college staff. I invite you to do this by emailing me at ETCChair@racma.edu.au.

A/Prof Pooshan Navathe
Chair, ETC and RACMA Board Member

Censor-in-Chief Update

2018 sees the Board of Censors (BoC) and other key College groups continuing the work commenced last year on the further development and refinement of the RACMA Programmatic Learning and Workplace based Assessment process.

We are ensuring we have contemporary processes for multi-modal medical assessment and evaluation.



This process is a collaborative process and is seeking to deliver a 'fit for purpose' model that meets AMC Standards and contemporary education platforms for the College. Other key activities of the BoC for the year include a review of the examination process; fostering appropriate assessment environments for assessments; a review of Declarations of Interest guidelines amongst many other equally important tasks and items.

As Censor-in-Chief, I have the pleasure of working with a committed group of Fellows of the College. We have record numbers of Candidates undergoing Fellowship and I would encourage anyone who may be interested in becoming a Censor, to contact me via the College. The role is interesting and rewarding and for younger Fellows, you will be provided with appropriate training and guidance.

A/Prof Alan Sandford AM
RACMA Censor-in-Chief

A/Prof Alan Sandford AM
RACMA Censor-in-Chief

Dean of Education Update

In 2008, the College was first granted Accreditation with the Australian Medical Council, to be the higher education body whose training program met the standards required for medical officers to be granted 'Specialist' registration in medical administration across Australia and New Zealand. In committing to maintaining accreditation, the College has been making changes.

The Board identified its overarching functional Policy when, in 2011, it published its 'new' Curriculum for Medical Leadership and Management, which identified eight role competencies for the graduate Fellow of RACMA. Each of these competencies had several learning objectives in the areas of specialist knowledge acquisition, skill honing and personal and professional leadership development.

There was an expectation that Candidates would progress from year to year, learning in successively complex tasks. The key assessment of learning activity in the Curriculum was the College's exit Oral Examination.

Over the ensuing decade the College has introduced accelerated pathways to attainment of Fellowship; accreditation of Master's degrees; accreditation of training posts; formative and summative activities in health service research; numerous assignments marked at the College level; and a College Trial Examination.

There has been a steady increase in the number of Candidates. The Fellowship Training Program currently has 140 Candidates in our Fellowship Training Program, thirty per cent of whom are registrars in medical administration.

The Fellowship Training Program is transitioning from its progression learning model to an integrated one and has a programmatic approach to learning and assessment in each of its four domains:

- Health system science;
- Medical management practice;
- Research training; and
- Personal and professional leadership development.

This approach has shifted the status of the Oral Examination from that of an exit examination to that of a component of the assessment activities of the Medical Management Practice domain; and, also in the same domain, scheduling of frequent exposure to experiential learning in the workplace has greater priority than in previous years.

More attention is being paid to Fellowship Faculty awareness-raising about formative assessment; and to teaching about rigour in summative assessment methods.

2018 is our Re-Accreditation year with the Australian Medical Council. We are interested in hearing from you about anything else that you think could be improved in terms of the Fellowship Training Program, so that we can be responding to your needs and presenting a solid claim for continuing to be the right training body!

Dr Lynette Lee
Dean of Education

RACMA & Hong Kong College of Community Medicine 2018 Conference

5-8 September

Venue
The Jockey Club
Hong Kong
Academy of Medicine Building

Schedule

6th September
World Federation of Medical Managers Forum/Pre-Conference Workshops

7-8 September
Joint RACMA-HKCCM Annual Conference

8 September
HKCCM Fellow Conferement Ceremony cum joint Langford and Ek Yeoh Oration

5 September
Hospital Visits:
a) Hku-Shenzhen Hospital
b) HK Childrens Hospital

Joint
RACMA & HKCCM Conference

Hong Kong
5-8 SEP 2018
Change
Disruption.
Innovation.
Transformation.

Letters to the Editor

Dear Editor,

This letter is addressed to you but my intended audience is every colleague who is a FRACMA, AFRACMA, nearly a FRACMA/AFRACMA and any NOIMADs* who may be reading. I'm unsettled, and hopefully through this subtle form of catharsis, I may become less unnerved. I'm unsettled because medical administrators (terrible title, but more on this later) should have done something about medical workforce planning umpteen years ago. We shouldn't be commenting here – we should have been leading the charge. Let's talk about the harsh reality and politics that govern it. Make no mistake, the future of the medical workforce in Australia is in grave danger of imploding, unless we do something bold, quickly.

Doctors are sexy. Half the TV shows are about them, notwithstanding an unrealistic premise, the general public are obsessed with disease and anyone that helps fight it. Politicians are therefore interested in doctors as they move hearts and minds of their electorates so they are interested in how doctor schools are planned for, and how doctors are allocated around the country. According to the WHO[1], 2.5 doctors per 1,000 inhabitants are needed to provide adequate clinical care. Australia has 3.6 doctors per 1,000 people[2] and is ranked 10th in the Organisation for Economic Co-ordination and Development (OECD). It is thus reasonable to say that we have enough doctors, and we are ranked 6th highest in the OECD[3] for producing medical graduates – higher than the United Kingdom when in 2015, 20,000 doctors marched in protest of harsh enterprise agreements due to the exorbitant costs of the unnecessarily high volume of doctors. Our time is coming as we doubled the annual amount of medical graduates from 2006 to 2012 (from ~1,500 to ~3,000) without a corresponding doubling of our population. Planning or lack thereof.

Why is this happening? Firstly, let's blame the ludicrous political cycle. Politicians build roads, hospitals and medical schools as if they're playing a game of monopoly. Their primary goal is to enchant locals that benefit the most, hopefully to vote them into power again. No foresight, no guts to do the right thing, to play the long-game. One elegant example of pork-barreling is when John Howard built a medical school in Western Sydney to buy popularity in the strong Labor region. Did the people need another few hundred doctors a year? Absolutely not. Enough doctors to go around, but fundamental infrastructure was needed to get doctors to work in those regions – not sexy, too long-term. Now these poor doctors have to scavenge around for jobs that don't exist like another thousand of their colleagues.

This is the very unfortunate side-effect of bad practice. Our best and brightest simply can't get jobs and nobody seems to be alarmed. The 'tsunami' of medical graduates has come, gone and the flood waters have washed away any job prospects for our vulnerable new colleagues with expensive fellowships, major debts and other social stressors. They usually scrounge around for a hint of EFT here and a touch of EFT there – usually in some backwaters an hour away from home and their primary place of employment. But hey, we all have to eat. New fellows will take a job anywhere and gone are the days when a PhD or papers in nature got you a gig at the local big teaching tertiary. These days, they are being coerced into the neglected areas not by good intentions but under duress. We should design a system where doctors are less maldistributed, not let it happen by purposeless osmosis. Where is our compassion? This is appalling planning on the government's part but our College should not sit on their hands – as the supposed custodians of the health system, we must stand up and for our medical fraternity and for the community who will suffer when our unsustainable health system falls in a heap.

Let's call a momentary truce on our government friends. How about us medical leaders and managers? A potential solution for decades has been a brave attempt to discuss succession planning with our clinical leaders. Nobody seems to have the courage to tell the Professor of Surgery or Medicine – having been incumbents for 20-30 years and past their peak – that it's time to find a successor. We're all too scared of offending the old guard. We're simply too conservative in Australia, and the AMA is partly to blame. The best leadership is one of renewal, one of succession for the fresher new ideas to come through the ranks. The Romans worked this out 2,300 years ago but we still have not worked it out in Australian hospitals. We need limited tenures and limited renewals, perhaps two x 5 year blocks. Otherwise, how are they different to self-serving dictators? I don't propose making it as short and pointless as the political cycle but a transparent limit must be in sight. This way, our young colleagues will see light at the end of tunnel and real job prospects, not crumbs cruelly laid out by their forebears.

The AMA is also to blame. They were once a key advocacy body speaking out about public health, innovative ways to improve the health system and a staunch supporter of safe standards for junior doctors. They have evolved into a covert political party, perpetually in opposition. I now only hear them opposing matters – sometimes with a very one-sided stance – and they

References:

* NO Idea what Medical Administrators Do
1. World Health Organization, World Health Report, 2006.
2. Organisation for Economic Co-ordination and Development – Data 2018. https://data.oecd.org/healthres/doctors.htm
3. Ibid.

jack up doctors' wages so much that they will single-handedly break our public health system. In Victoria, a 9% rise in wages in 2018 on the background of contracting health spending and an ageing patient population, will be the start of the end. If the AMA did care about its members and the system, they would be prudent during these uncertain times. Recently in Montreal Canada, doctors refused the pay rise from their medical union and instead 'donated' the funding to the public health system and nurses – that's what you call social responsibility and valour.

Australians also have very little imagination with regards to innovative workforce strategies. We have the likes of the Grattan Institute who publish erudite articles and sensible proposals, always to fall on government's deaf ears. I will never advocate for the radical physician assistants as it does nothing to curb the increasing glut of doctor graduates, but why don't we look across the Tasman to learn from our far more imaginative Kiwi cousins. In New Zealand, for over a decade they have employed final year medical students for a nominal amount to work as 'quasi-interns'. The students love it as they get 'ring-side' exposure, their young doctors love it as they get substantial assistance and the administrators love it as they save money – win, win, win. Apart from a colleague of mine who is launching this locally, I know of no other foray at drastically remodeling our medical workforce. Why don't we hear about any other radical innovations? Too conservative, too polite, too short-term.

Last but not least, the solution. Firstly, our title must change but what's in a name? We are not administrators, we are leaders and managers, custodians and arbiters. We are system innovators. But we are not administrators as no matter how you bake it, it still reeks of bureaucracy and paper shuffling and aficionados of the status quo with a rigidity that hampers change. A rose by any other name would smell as sweet? No. Otherwise why have our American and British counterparts spent millions re-branding to include 'leadership' prominently in their new College titles? Why is the word 'administration' hardly featured in our training material where as leadership and management are ubiquitous, as they should be. A change in name won't change everything but it is the start of a fresh chapter in our proud history. A new relevant and more accurate name will invigorate spirits and help the public start understanding why we're even here.

If we want to change the system, we need to be at the table with the system owners, the government, as medical system leaders. If we do care about the clinical outcomes of patients, let's start by fixing our medical workforce and the demand-supply crisis that has insidiously crept up on us. If we want to improve healthcare, let's strongly influence the planning of medical schools and stop specialty Colleges playing chess with graduates. If we want to win, let's fight in the ring, not spectate, when the AMA want to roll the die and seal our ill-fate. If we truly want to change the system, let's be bold and not afraid of change, let's embrace it and start with our College name.

Candidly,
Dr Ann Onoyd
FRACMA

College Update

The College has moved to the new College premises at Suite 1, 20 Cato Street, Hawthorn East, Melbourne and settled in well. The new premises were the location for the recent March Board & Jurisdictional Committee Chairs Meeting.

We are looking forward to welcoming you to our new location on your next visit to the College and Melbourne.

Fellowship Training Program

The Board of Censors is meeting on the 4th & 5th May in Melbourne. A call for Expressions of Interest for all categories of Censor has been issued to all Fellows. The call closes on the 11th May 2018. Contact the College if you have any questions or would like to be considered.

The College is preparing for the College Trial Exams 28th and 29th July 2018, to be held at the AMC National Test Centre, Melbourne. Applications will open next month.

The College is conducting a Faculty Training Workshop in Hong Kong on the 5th September 2018, during the RACMA & Hong Kong College of Community Medicine 2018 Conference. Numbers for this workshop are limited and it is filling fast. If you are interested in attending this workshop, and you have not yet indicated your interest, please contact the College for more details.

Specialist Training Program:

RACMA continues to be actively engaged in the Specialist Training Program (STP) which is funded through the Australian Governments Department of Health. RACMA has been a recipient of STP funding since 2011 and we currently have the FTE of 28 training posts in one of three streams:

- Specialist Training Program
- Integrated Rural Training Pipeline
- Training More Specialist Doctors in Tasmania

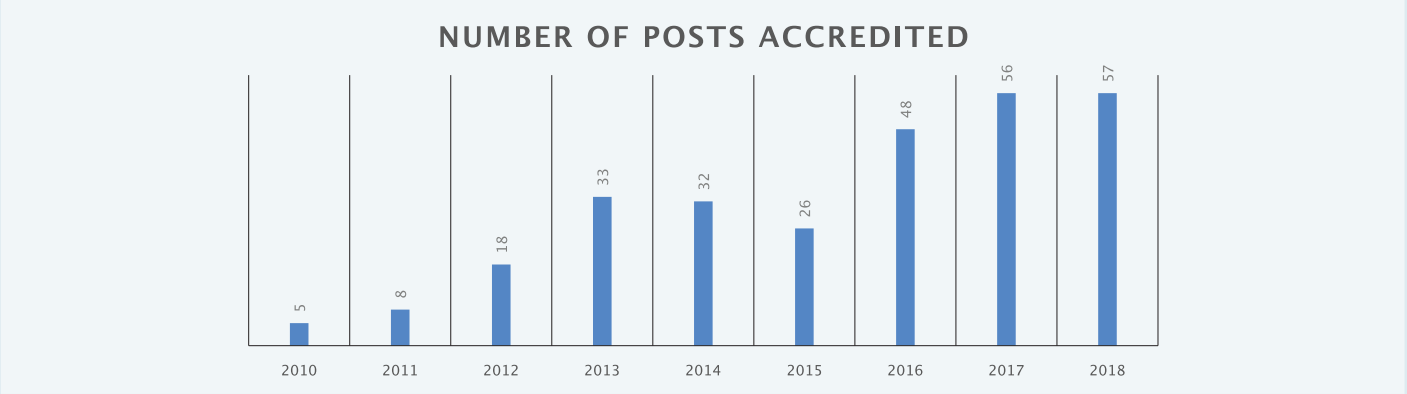
The current funding round is through to 2020. The STP program has five outcome parameters and they are:

PARAMETER	
1	Parameter 1–Contribute to enhancing the capacity of the health care sector to train the future medical specialist workforce.
2	Parameter 2 –Contribute to increasing the capacity of specialist training being undertaken in non-traditional settings.
3	Parameter 3 –Contribute to enhancing availability of the specialist workforce in areas of unmet community need including rural and remote locations.
4	Parameter 4 –Ensure specialist training experience is of high quality for participating specialist registrars.
5	Parameter 5 –Enhance Indigenous health outcomes through increasing opportunities and training experiences for Aboriginal and Torres Strait Islander people seeking to become medical specialists.

The College continues to work closely with the Department to deliver the desired outcomes with the STP program.

Accreditation of RACMA Training Posts:

2018 has seen the largest number of accreditation site visits of RACMA Training Posts since its inception in 2010. We are in the process of accrediting the 57 training posts across Australia and New Zealand. This has kept our Site Accreditors and College staff very busy and if you are interested in participating in future Accreditation Post reviews please contact the College for more information via accreditation@racma.edu.au.



Continuing Professional Development Update

Management for Clinicians in New Zealand. Mary Hunter facilitated this successful CPD event in Auckland.

MyRACMA

The Committee is in the process of preparing for the launch of MyRACMA. The launch is scheduled for June 2018 and look out for updates on progress! The updates will provide more information relating to the launch of the new platform and how to best use it for your CPD records.

CPD Compliance Certificates

You will receive your CPD Compliance Certificates over the coming weeks. Please contact the College if you have any questions on this process. With the introduction of the MyRACMA the process for recording your CPD activities will be streamlined.

CPD Points

The College schedules tailored workshops and activities throughout the year that have CPD points attributed. For more information on our CPD offerings please contact the College or go to www.racma.edu.au.

Sydney Professional Development Workshop

Team Skills to Survive Workplace Behaviour session (photo courtesy of Lynette Lee, FRACMA).

A series of professional development workshops were held in Sydney on Thursday 5 and Friday 6 April at the Novotel Darling Harbour hotel. The sessions were well received from those who participated in the following programs:

- Audit and Peer Review for Managers and Leaders
- Clinical Governance Crisis Management
- Developing a compelling business case
- Essential Negotiation Know How
- Mastering Transformational Change Presenting with Impact (Incorporating Media Training)
- Review of the practice visit process for RACMA Fellows and AFRACMAs
- Stakeholder Engagement Team Skills to Survive Workplace Behaviour

Feedback from the Sydney Workshop included the comments:

1. Engaging, concise and relevant workshops with opportunities to engage with colleagues facing similar challenges.
2. The workshops were relevant and presented in a way that mixed theoretical and hands on learning.
3. The session was a very valuable learning opportunity with a facilitator of exceptional standard.

Team Skills to Survive Workplace Behaviour session (photo courtesy of Lynette Lee, FRACMA).

Continuing Professional Development Update

The Leadership for Clinicians Program attendees keenly working through some case studies.

RACMA conducted a Leadership for Clinicians Module 1 program in Brisbane in April, facilitated by Dr Liz Mullins, FRACMA. All places in the 2018 Leadership for Clinicians Programs are fully subscribed.

The 2019 program dates are listed on the website (www.racma.edu.au).

Dr Gino Pecoraro, FRANZCOG, delivered the Leadership for Clinicians dinner address on the topic of 'Politics of Medicine'. This was greatly enjoyed by attendees and we thank Dr Pecoraro for this time.

Private Infrastructure Clinical Supervision Program (PICS)

RACMA has been contracted by the DoH, since 2011, to administer Private Infrastructure Clinical Supervision funds in the STP for all posts in all Colleges. This contract is closing at the end of May 2018.

RACMA will continue to receive funding under the PICS program to support our own activities for RACMA registrars employed in private settings:

- To support the development of specialist training arrangements beyond traditional teaching hospitals in expanded private settings;
- To ensure that additional supervisor support will provide for improved training, opportunities and experiences available to medical specialist trainees;
- To allow registrar access to all clinical support information; and
- To establish processes to enable greater efficiencies in administration;
- Workforce to better train specialists.

College Engagement Activity Update

The Chief Executive, Melanie Saba, travelled to New Zealand to participate in stakeholder meetings and to meet with the New Zealand Jurisdictional Committee. Meetings were held with the New Zealand Council of Medical Colleges, Health Quality and Safety Commission and Health Workforce New Zealand. These meetings were a great opportunity to see first hand what is happening in the New Zealand health sector, including the challenges and opportunities.

Melanie also travelled to Hong Kong to meet with our partners in the joint RACMA & Hong Kong College of Community Medicine 2018 Conference.

RACMA has participated in jurisdictional or national meetings, some of which are listed below:

- Fairy Floss Day at Gosford Hospital (Doctor Wellbeing event)
- RANZCOG National Woman's Health Summit
- AMA National Workforce Summit
- Medical Workforce Planning Advisory Group (Victorian DHHS)
- Opioid Stewardship
- Doctor Wellbeing

The College has responded to requests for participation and/or submissions on the following:

- Queensland Law Reform Commission Review of Termination of Pregnancy Laws
- Victorian Fellows to participate in a consultation process for Complaints Handling for the Victorian Health Complaints Commission
- Panel members for the Queensland Minister of Health's Health Ombudsman Panel of Assessors

The RACMA Board has established a Policy and Advocacy Committee with key working groups in the areas of Indigenous Health and Diversity. An EoI has been distributed to members via email, but if you missed it, and are interested in participating, please contact Meg Milne, mmilne@racma.edu.au for more information.

Doing more of the same isn't an option: challenging times provide opportunity.

Adj. Prof. Belinda Moyes

The health system both here in Australia and in many countries overseas is struggling to deliver efficient and effective service and care as a consequence of growing and increasingly complex demand, poor system connectivity and outdated system architecture. The workforce also struggles to keep up, working in institutions and environments that are fundamentally inefficient and not necessarily fit for purpose which in turn negatively impacts multi-disciplinary team work and safe care.

Is our workforce fit for purpose given the challenges ahead, is the way we work efficient and effective, do health professionals have the skills required to manage in a different environment and for different ways of working?

Our environment is changing rapidly and there is great opportunity to do things differently. The way we have worked, and work now, will need to shift. The system must work in a much more connected way if we are to improve the health outcomes of Australians. System navigation, working in partnership with consumers and patients to improve health literacy and empowering them to manage risk factors for poor health and build skills in self-management and using digital technology much more are all skills and capabilities that are required of health professionals to effectively manage the huge burden of chronic disease that confronts us.

Yet generally speaking, we keep doing things the same way even though there is evidence to the contrary. Consumers have different expectations and want more of a role in their care. Technology is changing how we do things, data and information is telling us that some long standing practices and procedures add little, if any, value and budget pressures are driving greater accountability and forcing benefit:cost analysis. This increasingly pressured environment exposes many underlying system inefficiencies.

I think that there is a lack of recognition of the fundamental importance of investment in good organisational governance and structures that positively engage employees and clinicians, drive accountability and foster positive respectful leadership and cultures to ensure safe care and positive outcomes for patients and consumers. Directors of Medical Services /Chief Medical Officers have a key role to play in terms of strategic organisational and professional leadership in this current environment.

have spent a significant part of my career on workforce issues and looking at shortages. For as long as I can recall there has always been talk of health workforce shortages and impending alarm and realistically there probably always will be. My view is that there will never be enough, and it is really a question of what people are doing and why that needs to be addressed. There are identified workforce shortages across a range of sectors and locations, particularly in rural and outer metropolitan areas, high turnover rates in some sectors, unknown future impacts of large scale system reforms in disability services, and forecasts of large demand for workforce growth in these areas. Shortages are influenced by locations, specialisations and sectors that health professionals want, or are willing, to work in, and the supports and training structures that are in place to facilitate them to do so.

Demand for workforce time will keep growing so it is really important that we look really closely at what the health workforce is doing now and what we could do differently. Our challenge is to be proactive and not distracted. One thing we can do is to value people and pay attention to the work environment. It's easier to say we need more rather than tackle some of the leadership and cultural issues we have in our professions and organisations that influence attraction and retention.

Retention is a key issue in the health sector as is an ageing workforce. There is no doubt that health services need to continually work at attracting and keeping good staff. We know that those organisations that focus on people and have respectful, caring and accountable cultures are much more likely to attract and retain staff and indeed have better outcomes for patients and consumers. Rural areas have specific challenges and we do need to develop better support frameworks for training and improve connectivity between health services. We have failed at incentivizing rural opportunities because the support or training framework isn't are either not there or mature however I know there is positive work progressing and I also have great faith in Emeritus Professor Paul Worley in his new role as National Rural Health Commissioner and his work on pathways. Working in the rural environment is incredibly rewarding work.

We are burning people out and frustrating them with inefficient systems and routines. We need to look very closely at how we work and invest in process tools, more meaningful data and tailored information, communication, structures and authorising environments that support and enable timely and safe work. Health professionals with well-developed engagement skills who can work constructively and respectfully in teams and partnerships and collaborations in organisations and across sectors for the benefit of patients and consumers is crucial.

There are many practices and routines that require review not only from a patient risk point of view but from an efficiency

perspective. I recently listened to an ABC podcast with Norman Swan about the insertion of cannula's in ED patients and how the Royal Brisbane & Women's Hospital had significantly reduced cannulation. There are many things that we are not all addressing in our day to day work. Further examples include the ordering of unnecessary imaging diagnostics and pathology. Organisation-wide inefficiencies such as these require good co-ordination and connected clinical leadership across the entity and or region. This is a key leadership role for the DMS/CMO.

At the end of the day, whether we want to hear it or not, we are wasting valuable resources, doing unnecessary, low value work with a by-product of harm as well. Doing more of the same isn't an option for the community, the workforce or the system.

Connected leadership in the midst of busyness, and at times chaos, is critical now and more so into the future. A key role for the CMO/DMS is to lead work to reduce unnecessary interventions, low value care.

Clinical Governance is often seen, and considered to be, separate from general organisational governance but the fundamentals are the same and I consider an integrated model is the best approach as clinical endeavour is the core function of health services. Whilst ultimate responsibility sits with the Board and the Executive, clinical governance often sits with the CMO, or the Quality & Safety Directorate, or other administrative areas in health entities. It is however a critical component of governance generally and must be considered within this context not separately. Governance including clinical governance is a critical issue for health services and getting it right creates a good solid framework for safe quality care delivery.

Organisational structures are quite rightly less top heavy these days. Devolved clinical structures and accountability to Clinical Directors in health services challenges the historic accountability of DMS/CMO roles and calls for shared leadership. Distributed leadership calls for less directional top down ways of working and more collaboration. Clinical governance is everyone's business. DMS/CMO roles need to adapt.

Defining the role and the value proposition of the CMO/DMS is important particularly in the current environment where we have so much to do from a clinical leadership perspective in the health sector. A quick search of current jobs and position descriptions of CMO's otherwise called DMS, DCS and Exec DMS reveals a huge variety of skills and experience required for the role and it varies depending on the rural or metropolitan context : mentoring, clinical governance, patient safety, contributing to initiatives that reduce unwarranted clinical variation and deliver better value care, medico-legal advice, quality improvement, medical workforce strategy, teaching and education, credentialing and research are all included. One could argue that others are accountable for these areas of endeavour as well and devolved organisational structures challenge traditional areas of responsibility and administrative hierarchy. One size won't fit all and nor should it but defining the contribution rather than the responsibility is the challenge.

Doing more of the same isn't an option: challenging times provide opportunity.

CMO/DMS leadership should include working collaboratively with the Nursing, Midwifery and Allied Health Chiefs to engage the collective clinical community in terms of supporting and promoting innovation and the adoption of "next" practice.

Managing clinical governance in rural areas is a key challenge and rural partnerships and alliances are important – formalising these is even more critical from an accountability perspective. In rural services the challenge is critical clinical mass and the need to be connected. The DMS/CMO role should be concerned with networking and bringing clinicians and others together across regions to ensure good governance around practice and safe care, to streamline referral processes in that region and truly support and mentor clinical staff, to use best practice and reduce clinical variation and unnecessary intervention. This is where the DMS/CMO together with Nursing and Allied Health leaders are key as they should model collaborative and respectful team work and look at things from a system and organisation-wide perspective.

The current environment provides opportunity to focus this key leadership role on:

- Challenging bed-based models of care and pathways and lead and stimulate different thinking, working with clinicians, patients and consumers and GP's/ PHN's and other providers to effect this;
- Leading with other professional leaders in multi-disciplinary ways of working with patients;
- Addressing professional culture and working with clinicians to provide a safe working environment for junior staff and
- Advancing technology and its use – rostering, clinical care.

Medical administrators should lead in fostering a culture of enquiry and renewal of clinical practice. Innovation is much more likely to percolate and flourish in an environment where there is an enquiring culture or spirit. We must all work together in a more proactive and strategic way rather than be constantly buffeted about by the prevailing issue of the day.

I commend a paper to you: *Caring to Change. How compassionate leadership can stimulate innovation in health care.* The Kings Fund, May 2017, West, M., Eckert, R., Collins, B. & Chowla, R. It is well worth the read.

Adj. Prof. Belinda Moyes
Strategic Adviser, National Health Workforce Reform,
Department of Health & Human Services, Victoria

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Strategic Adviser, National Health Workforce Reform
Department of Health & Human Services, Victoria

Belinda is an experienced health professional, CEO and Board Director in the Australian health sector with a proven track record of achievement. She has had a broad variety of roles with extensive policy, strategic and operational leadership experience in public, private and government including leading a national taskforce.

Belinda's clinical background was in Nursing with post graduate studies in Infectious Diseases and Midwifery. She is tertiary qualified at the UNSW in Health Administration and Health Planning and has completed the Australia and New Zealand School of Government (ANZSOG) Executive Fellows Program. She is a Fellow of the Australasian College of Health Service Management, a Member of the Australian Institute of Company Directors and currently holds an Adjunct Professor appointment with Deakin University. Her Biography has been included in Who's Who of Australian Women since 2006.

Her experience includes leading significant change in several large organisations and community consultation in rural and remote areas. She has initiated and led cross sector partnerships that have resulted in improved collaboration and communication between primary health and the acute health sectors, improved consumer journeys, improved emergency demand management and outpatient waiting list management as well as improved relationships with consumers and GP's. She has demonstrated success in changing organisational culture and building and maintaining highly effective and productive teams and engaging clinicians to achieve work environments that are respectful where people are empowered and work collaboratively to make a difference and improve outcomes.

Belinda's interests and expertise relate to 3 inter-related areas that are key challenges in the health and human services, aged care and disability sectors now, and into the future, in terms of effort, investment and outcomes: governance, leadership and culture, and partnerships and collaboration

Medical Administration 2016 Factsheet

Medical administration is administration or management utilising the medical and clinical knowledge, skill, and judgement of a registered medical practitioner. This may include administering or managing a hospital or other health services, or developing health operational policy, planning or purchasing of health services. A minimum of three years full-time training through the Royal Australian College of Medical Administration is required to specialise in this area.

Workforce

In 2016, there were 277 medical administrators employed in Australia, of whom 20.2% worked in the private sector. The majority (72.9%) of specialists in this field who completed the 2016 National Health Workforce Survey indicated their principal role in medicine was an administrator. While 20% (57) indicated that their main role was as a clinician.

Demographics of workforce

In 2016, males represented 66.8% of medical administrators and had an average age of 58.4 years and average hours of 26.5 hours per week. Females represented 33.2% of the workforce and were on average 2 years younger and worked 9.2 fewer hours per week than male medical administrators. The total average hours for the medical administrator's workforce were 24.5 hours per week.

Distribution of workforce

In 2016, most medical administrators (80.9%) were located in a major city or a location considered as MMM1 under the Modified Monash Model classification system. Further information on the Modified Monash Model is available at doctorconnect.gov.au.

Over 32% of medical administrators indicated their principal place of practice was in New South Wales and over 27% indicated it was in Queensland.

The Northern Territory had the highest ratio of medical administrators in 2016 with 2.0 per 100,000 population. By contrast, South Australia had the lowest ratio with 0.8 per 100,000 population. The average for Australia was 1.1 clinician per 100,000 population.

New fellows

The overall number of new fellows from the Royal Australasian College of Medical Administrators decreased by 7.7% between 2013 (13) and 2015 (12). During this period, there were no overseas trained new fellows.

Vocational training

The number of trainees remained steady each year between 2013 and 2016, at 107 and 110 respectively. Between 2013 and 2016, female trainees increased by 9.3% and male trainees decreased by 1.6%.

Vocational intentions

In 2016, there were 30 Hospital Non-Specialists (HNS) who indicated their intention to undertake vocational training in medical administration. Over 46% were aged between 30-39 years and over 36% were aged 40 years or older. A HNS is a medical practitioner employed in a salaried position mainly in a hospital. They do not hold a specialist qualification and are not training to obtain one. They include career medical officers, hospital medical officers, interns, principal house officers, resident medical officers and registrars.

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6 National Medical Training Advisory Network (NMTAN) – Prevocational Doctor Factsheet Methodology Paper.

Leading Leadership Diversity

Dr M Naidoo

The importance of diversity in leadership and decision-making roles is an increasing focus of attention. Diversity of thought, experiences and perspectives provides tangible benefits, including innovation, risk mitigation, better problem solving, improved customer service and higher employee engagement and retention. More than just 'doing the right thing', diverse leadership is recognised in business as a strategic priority providing competitive advantage. Board diversity is seen as essential to good governance and organisational performance. Increasing diversity and building an inclusive culture is just as important in healthcare.

Healthcare organisations need to engage increasingly diverse workforces, meet diverse consumer/community needs and expectations and employ new and innovative approaches to challenges in healthcare. To effectively achieve this requires leadership diversity and senior leaders setting an inclusive "tone from the top". When leadership teams are diverse (i.e. they include men, women, a variety of age, racial, and ethnic groups, and individuals with a range of professional experiences) the organisational strategies, policies and norms that cascade down are likely to be broader-reaching, balanced, and more comprehensive. Alternatively, if one group predominates in leadership, the organisation is more vulnerable to a narrow perspective that reflects the values of that demographic group alone.[1]

Despite evidence that diverse leadership teams outperform those that lack diversity, these gaps persist and this is particularly apparent in terms of gender diversity. It is now recognised that despite attempts to develop talent and increase diversity through mentoring, women still rarely make it to the top of their organisations.[2] This is no different in medicine. Despite women comprising more than 50% of medical school graduates,[3] visibility of female medical leaders and numbers of medical women in leadership positions is far from representative as highlighted by Navani, Tomar & Foo[4] in their poster presentation at the RACMA Annual Scientific Meeting.

Recently I attended Harvard to explore leadership diversity as part of their Women Executives in Healthcare program. There I learnt about gender barriers to career development and progression, the impact of unconscious bias on organisations and the role sponsorship can play addressing inequality and advancing more women through the pipeline to senior leadership.

So what is meant by 'sponsorship'? Sponsorship is the process whereby senior leaders provide emerging leaders with active, targeted, deliberate support aligned with career progression needs. We know it more commonly as giving someone an opportunity to show 'they've got what it takes' or colloquially 'see whether they'll sink or swim'. To be clear, although the term may be unfamiliar, the concept is not new, it occurs everyday, often unconsciously, but importantly, is unequally applied to men and women.

Unlike mentors who are consulted privately about professional issues and decisions, sponsors take the relationship into the public domain, providing endorsement and visibility within the workplace for their proteges. A 'sponsor' is usually a senior leader in the organisation that invests his or her own leadership capital in you ie. puts their own reputation on the line, to recommend you for a key opportunity. In contrast to mentorship, It's a two-way relationship built on trust, requiring outstanding performance in return and has been shown to objectively increase career outcomes.[5]

However, there is a natural tendency for leaders to sponsor, promote and provide opportunities to those who 'think' and 'behave' like them and fit entrenched views of what leadership 'looks' like. This tendency influences recruitment, development and promotion and can yield new senior leaders who mirror the traits and biases of the existing leaders thereby creating a pervasive cycle of disadvantage and narrowing the talent field.[6] It is this unconscious bias (known as second generation bias[7]) that contributes to the persistent underrepresentation of women in leadership roles. Unconscious bias affects our behavior, creating barriers to inclusion, performance, engagement, and, ultimately, innovation. Our judgements about leadership may be particularly susceptible to such bias. We might not necessarily feel it's effects, but many of those around us do.

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7. First generation gender bias refers to the deliberate or intentional exclusion of women, in contrast, second generation gender bias or gender stereotyping refers to the implicit and unintentional bias that appear neutral or non-sexist but discriminate against or opress women and can have the same outcomes as first generation bias.

For example:

- Lack of diversity in senior roles means fewer diverse role models. You can't be what you can't see.
- Gendered career paths and gendered work discourage diversity in leadership roles.
- Entrenched organizational structures and work practices and how work is valued can perpetuate existing senior leadership characteristics and bias who gets promoted.
- Women's lower access to networks and sponsors impacts access to developmental opportunities and career progression.
- Women are viewed differently than men for the same behaviours creating a 'double-bind' that can undermine their leadership and influence.
- Women from culturally diverse backgrounds may experience 'double whammy' effect of being both a woman and from a cultural minority.

Women have been advised to 'lean in' to overcome these barriers but despite best efforts to do so many still feel unable to access opportunities to broaden skills, contribution and visibility to progress their careers.[8] Paradoxically perceptions of leadership and fit are often more influential than actual performance and studies show developmental opportunities tend to be directed to men.[9] Men are also more likely to receive sponsorship, placing women at a disadvantage in terms of career progression.[10] Simply put, regardless of demonstrated ability, men are much more likely to be given chances to show 'they've got what it takes' which then leads on to further developmental and career opportunities. Similarly as a result of prevailing masculine and Anglo-Celtic leadership norms, women from culturally and ethnically diverse backgrounds can experience bias in multiple dimensions and further disadvantage.[11]

Gender equity is part of a broader diversity issue in medical leadership. Sponsorship as a tool, used effectively and deliberately, can help overcome unconscious bias for women and other disadvantaged groups,[12] and help develop diverse medical leaders for the future by providing:

1. Public endorsement - sponsors lend their leadership capital to build trust and a leadership profile.
2. Leadership development - sponsors offer high profile, stretch assignments that enable growth and opportunities to demonstrate potential.
3. Recognition - sponsors help overcome structural biases and leadership constructs which contribute to lack of visibility (eg. women are less likely to be publicly recognised and rewarded for leadership).
4. Enhanced social capital - sponsors provide strategic introductions to high-level internal and external contacts and influential connections for career advancement.

I've reflected on what I've gained from this form of sponsorship. Whilst I've had several mentors over the course of my career, it was being put forward for high-profile challenging, stretch assignments outside of the expectations of my day to day role that changed my career trajectory. Personally, it allowed me to step outside my comfort zone and translate skills to new areas for which I had previous little experience, growing my capability and confidence. Professionally it gave me visibility and raised my profile leading to further opportunities to demonstrate what I could do.

Whilst it wasn't promotion that I sought, the public endorsement, development, recognition and social capital I've gained through being sponsored provided opportunity for me personally and created value for the organisation where I worked. Sponsorship begets sponsorship – as a result of greater visibility, I've been sought for external opportunities (eg. board positions), creating networks of new sponsors and leading to additional opportunities to develop broader skills, further enhancing the leadership value I bring back to the workplace. My growing leadership capital has also enabled me to sponsor others in turn. Research shows sponsors benefit too - they advance further and faster by investing in future talent, becoming better leaders themselves and creating a pipeline for their organisations.[13]

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Leading Leadership Diversity

As medical administrators, how can we use sponsorship strategically to grow hidden talent and build diversity? We should be actively looking for people around us professionally and opportunities to sponsor them - this could be as straightforward as putting them forward to chair a high-profile committee or lead a challenging but high-visibility project. We should look beyond our direct reporting lines to colleagues within the wider profession, and in healthcare more generally, who could benefit from such sponsorship. We should also encourage them in opportunities for development outside of traditional CPD activities that can further broaden leadership potential and networks eg. AICD, Harvard, board roles.

Knowing organisations perform better when there is diversity in decision-making and leadership roles, as leaders within our own healthcare organisations, we should nurture leadership diversity. We have a responsibility to make additional efforts to identify potential leaders from underrepresented, minority and disadvantaged groups and provide equal opportunity for their development. We should be aware of our own biases in recruiting, developing, promoting, rewarding and recognising staff and the impact on diversity, inclusion, culture and performance. We should actively identify and sponsor emerging leaders that represent the diversity of our workforce, providing leadership opportunities for career development. Those who have been sponsored should acknowledge their sponsors and pay it forward. As a college of medical leaders, this should form part of a more comprehensive RACMA diversity and inclusion strategy.

Sponsors and mentors serve different functions and both are needed.[14] However, sponsorship can practically help overcome barriers related to unconscious bias.[15] Whilst sponsorship does need to be earned and performance returned, it can be made more transparent and accessible to a broader range of high-potential employees to build diversity, particularly for women and minorities who are underrepresented in leadership. As leaders within the medical profession we are well-placed to actively support this and other strategies to increase diversity in medical leadership and enable a more inclusive culture within healthcare.

This article was developed from content originally presented at 2017 RACMA Annual Scientific Meeting as part of a joint presentation and I acknowledge my fellow presenters, mentors and sponsors.

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Queensland Rural Generalist Program (QRGP) Leadership for Clinicians delegates graduate

RACMA is one of a few medical colleges in the world accredited to offer professional training for medical practitioners working in the specialty field of Medical Administration. The development of the Leadership for Clinicians Program for the Queensland Rural Generalist Pathway (QRGP) was developed in collaboration and consultation with the QRGP, Australian College of Rural and Remote Medicine (ACRRM) and Royal Australian College of General Practitioners (RACGP). The program was contextualized for Queensland medical practitioners in rural and regional settings to develop their leadership and management capabilities.

Such settings are typically characterised by small hospitals, supported by independent and visiting specialist practitioners, GPs and generalists working in clinical teams. These practitioners need to address the challenges associated with providing primary care as well as timely access to specialist and hospital emergency services, workforce performance matters linked to recruitment and retention, professional isolation, and community integration. Therefore, this unique collaboration between RACMA, RACGP, QRGP, ACRRM and RACGP will equip doctors who undertake this unique training program with the medical leadership and management skills that will assist them to impact on health outcomes in rural Queensland.

The graduation ceremony was held on Friday 23 February 2018. This date was chosen to coincide with the conclusion of the second day of module 1 for the 2018 intake who have been sponsored by the Queensland Rural Generalist Pathway. The rationale for holding the event at this time was to provide the graduating cohort with the opportunity to network with the 2018 commencing cohort. The ceremony was attended by graduating doctors, the 2018 cohort, members of other medical colleges, and senior health officials from within Queensland Health.

The graduates, their guests, RACMA fellows together with other invited guests, were delighted to have the opportunity to hear Australia's first National Rural Health Commissioner speak on the importance of medical leadership and the role of the Rural Health Commissioner. We are pleased to advise that as a result of this funding initiative by QRGP, one of the indigenous graduates has been motivated to take the important step of enrolling into RACMAs Fellowship Training Program. He will be mentored by Associate Professor Alan Sandford and is very much looking forward to further developing his clinical and leadership skills over the next 3 years.

Professor Worley spoke about failures of clinical governance and highlighted instances in institutions overseas and in Australia. He suggested such events were caused by good people who were trying their best but the system was failing. The reviews of each of these clinical governance failures was a failure of leadership that was outlined as the root cause. Professor Worley completed his MBA focussing on organisational culture and what occurs in organisations that can make good people fail. Professor Worley reflected on at that time in his career he had good people in his team but they weren't always getting it right. He reflected on leadership and stated that in many ways leadership is as much about learning about yourself as it is about learning about others. It is as much about learning to manage yourself as it is about learning to manage others. That's what learning to be a leader is. You are constantly learning more about yourself so that you can understand others. So that you can manage the instant reactions you have that will stop you from being able to make good decisions. That will prevent you from being wise, you may be knowledgeable, but you want to be wise. He highlighted a quote by Alexander the Great "I am not afraid of an army of lions led by sheep; I am afraid of an army of sheep led by a lion". Professor Worley used this quote in the context of having the courage to lead.

Courage involves looking inside yourself at times and being prepared to sit with ambiguity, to sit with the grey that often is there. He hoped to encourage those participating in the Leadership for Clinicians program to continue to realise that you have more to learn about yourself, about the process of leadership and not to be afraid that learning about leadership may mean that you don't do as much clinical work anymore.

Professor Worley concluded by reinforcing that communities need leaders, they need great clinicians and the principal of rural generalism is that most communities in rural Australia need people who can be bothered We need practitioners that can have general practice and emergency and other specialist skills. Why – because that is going to benefit our rural and remote communities.

The event concluded with the graduates receiving the Associate Fellowship certificates, presented to them by the RACMA President, Professor Michael Cleary.

The Migrant and Refugee Women's Health Partnership -

RACMA is a key part of this collaborative initiative

RACMA is represented on the Migrant and Refugee Women's Health Partnership (MRWHP) by Dr Susan Sdrinis and Dr Georgia Karabatsos. Other specialist colleges and government agencies are also members of the Partnership, which is auspiced by RANZCOG.

The MRWHP was launched in November 2016 and is a national initiative bringing together health practitioners and community organisations to address systemic barriers experienced by migrant and refugee women in accessing healthcare. Its goal is to work collaboratively to enable the implementation of good practice models in culturally appropriate care across health care settings. Driving the direction of the Partnership is a Working Group that brings together stakeholders with expertise in clinical education, standard setting and health service provision across the continuum.

The MRHHP's objectives are-

1. Identifying good policy and practice that support cultural capability in healthcare.
2. Promoting cultural consideration in healthcare and developing recommended standards.
3. Supporting practitioners and healthcare services through tools and resources.
4. Working collaboratively to enhance targeted communication and outreach in health literacy and health promotion.
5. Informing broader health and social policy debate and contributing to evidence development and research.

Delivering care that meets the needs of women in a culturally diverse Australia requires clinicians who understand the impact of cultural determinants on women's health and who can provide culturally competent care. Clinicians need to consider a number of key factors when caring for women from migrant and refugee backgrounds. Culture influences women's expectations for care, health beliefs and behaviours, and should be considered in the context of health literacy and provision of care, particularly when addressing sensitive health topics such as sexual and reproductive health.

Existing research demonstrates that migrant and refugee women face greater challenges in accessing health care. Settlement is an overwhelming process, and women often overlook their own health issues. Their health care needs are often complicated by pre migration experiences. They underutilise preventative health services and are over-represented in using acute and crisis services. Health promotion and prevention strategies may not be as effective in reaching women from migrant and refugee backgrounds as they could be.

Individual context and experiences, including pre-migration health experiences, also impact greatly on women's health literacy and systems knowledge, with vastly different levels of knowledge and capacity to navigate the health care system across the great diversity of migrant and refugee women. They often lack the English proficiency and/or health literacy to provide the practitioner with relevant information and the confidence necessary to be active participants in the process, so clinicians need to consider how to communicate

and engage effectively with migrant and refugee women. The development of trust and collaboration-based relationships between clinicians and migrant and refugee women will assist in creating an environment where women feel comfortable and are encouraged to ask questions to improve their health literacy.

The Partnership applies a holistic approach. For clinicians, the aim is to embed cultural competency in clinical education, training and practice. For migrant and refugee women health care consumers, the Partnership aims to enhance systemic health and wellbeing literacy strategies.

The Partnership has published a number of papers and submissions –

- Overview of Cultural Competence in Professional Education, Training and Standard Setting for Clinicians (August 2017)
- Consultation Report on Strategies to Promote Culturally Appropriate Care and Consumer Health Literacy (May 2107)
- Submission to the Review of Antenatal Care Guidelines (June 2017)
- Submission to the Public Consultation on Revised Code of Conduct for Nurses (March 2017)
- Submission to the Public Consultation on Revised Code of Conduct for Midwives (March 2017)
- Submission to the review of Australia's health system performance information and reporting Frameworks: Public Consultation (February 2017)
- Submission to the development of the 5th Edition RACGP Standards for General Practice (February 2017).

Dedicated Sub-Working Groups have also been established to address specific issues and projects of the Partnership. These Subgroups comprise the Refugee Women's Health Subgroup, the Effective Communication Subgroup and the Effective Communication and working with Interpreters Standards Subgroup.

In addition, a subgroup of members has met with the Australian Commission on Safety and Quality in Healthcare (ACSQHC) with respect to reviewing the Partnering with Consumers Standard in Version 2 of the National Standards[1] (due for implementation in January 2019) to ensure that the perspectives and needs of refugee and migrant women are considered as part of the accreditation process. For RACMA Fellows and Associate Fellows who are health service administrators, this has been an important contribution to the work of the Partnership.

For more information about the work of the Partnership, please visit www.culturaldiversityhealth.org.au.

Authors:

Dr Susan Sdrinis, FRACMA
Director, Medical Services – Governance
Alfred Health Melbourne Victoria

Dr Georgia Karabatsos, AFRACMA

Ms Gulnara Abbasova, MRWHP Executive Officer

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Recent case law on unfair dismissals in health –

As a practising lawyer, I try my best to keep up to date with recent legal developments, and as a specialist medical administrator with responsibility for a few thousand employees, I am always interested in law as it relates to human resources and workforce management. The performance review and management of staff is a key accountability for doctors like us in senior management roles, and an understanding of basic industrial relations and employment law is essential to ensure we comply with best practice and our legal obligations.

The cases I will share all come from around the past 12 months, and involve clinical staff working in different health settings that have had their employment terminated. The first few cases involve nurses, but the facts and findings are potentially applicable to all clinicians. I'll start with four cases where the tribunal found in favour of the employees. The common theme in all of them is a lack of procedural fairness and natural justice.

In Michael Renton v Bendigo Health Care Group [2016] FWC 9089, a nurse working in the aged psychiatric unit posted a "sexually explicit" video to Facebook in which he "tagged" two other work colleagues with a statement suggesting that the two co-workers were the people in the video. At around the same time, the nurse also left five blobs of Sorbolene cream on one of the co-worker's desk, suggesting it was something sexually-related as well. Bendigo Health terminated the nurse's employment, and the nurse challenged this at the Fair Work Commission. The Commission agreed that the matter was serious, and required a swift and strong response from Bendigo Health, but concluded that the "dismissal of Mr Renton was harsh" and found that he was unfairly dismissed, awarding him just over $2000 in compensation. This case illustrates the high threshold courts and tribunals have in relation to summary dismissals, and the need to provide employees with procedural fairness. This case also warns us about the perils of using social media in the context of work.

In *White v State of Queensland (Central Queensland Hospital and Health Service) [2017] QIRC 41*, a patient made a complaint against a nurse stating that he felt the nurse was "fiddling with the drainage tubes in the groin area for a bit longer than he felt was necessary". The nurse was summarily dismissed, and the matter was heard in the Queensland Industrial Relations Commission. The Commissioner felt that there was inadequate investigation of the matter, and that the health service had considered past allegations that were unrelated and unsubstantiated. The Commissioner concluded that the dismissal was harsh, unjust or unreasonable and that he was unfairly dismissed. The health service was ordered to reinstate the nurse. This case shows us the importance of a proper investigation prior to disciplinary action, and to ensure that past matters that are unrelated are not considered when making decisions.

In *Dorris Maharaj v Northern Health [2017] FWC 2997*, an ICU nurse was involved in a car accident in May 2015 on the way to work, and fractured her C5 vertebrae requiring two weeks of inpatient rehabilitation. She subsequently developed secondary psychiatric symptoms as a result of the car accident requiring psychological treatment. She recovered from this in August 2016. The Director of Human Resources wrote a letter to the nurse in September 2016 terminating her employment "effective immediately" because she had been absent from the workplace for a significant period of time, and remained unfit to return to her preinjury duties and hours. The matter was heard at the Fair Work Commission, and the Commission concluded that the

decision to terminate was unreasonable, and that the nurse was unfairly dismissed. The Commission found that the employer had not undertaken "the most basic investigation" to find out if the nurse could have returned to her pre-injury duties on a graduated return to work plan. This case reflects the fact that staff members who are unwell cannot be terminated simply because they are sick and cannot return to full duties immediately. An investigation or assessment is required, and a proper return-to-work plan needs to be considered first.

In *Ms Shahin Tavassoli v Bupa Aged Care Mosman [2017] FWC 3200*, an assistant nurse working in an aged care residential facility was filmed by a colleague to be singing in a disrespectful way at a resident, laughing and joking at the death of two residents, and ignoring resident's buzzers requesting help. The employer raised concerns with the nurse, but did not provide her with any specific allegations in writing and refused to show her the video recording. The nurse subsequently resigned, and brought the matter to the Fair Work Commission, claiming she was constructively dismissed. The Commission found that her dismissal was harsh, unfair and unjust, and ordered that she be reinstated. This case brings up the importance of following due process in disciplinary matters such as these – ensuring that a proper investigation occurs, allegations are presented in writing and that there is an opportunity for the employee to respond. This case also shows us that just because an employee resigns doesn't meant that the resignation was voluntary, and that there was no termination of employment – courts may still find it to be constructive dismissal.

The next couple of cases are ones where the tribunal has found in favour of the employer. In *Scott Vassella and Ambulance Service of NSW [2017] NSWIRComm 1018*, an insurance claims manager went on sick leave because of stress from alleged work-related mismanagement and was approved for workers compensation. While on sick leave, the manager obtained a job as a full-time manager at another organisation on a contractual basis – the manager did not tell his original employer of this secondary employment, who found out about this after three months, and terminated his employment. The manager filed an unfair dismissal claim at the NSW Industrial Relations Commission, which was dismissed. The Commission found that getting a second full-time job is evidence that he had abandoned his first one. This case is particular pertinent for doctors, who frequently work for different employers at the same time. It is important to ensure that the different jobs do not conflict with each other and breach the employment contracts of the employers.

In *Sarvestani v State of Queensland (Metro South Hospital and Health Service) [2017] QIRC 085*, an ICU nurse was assisting a colleague in restraining an agitated patient coming out of sedation who was attempting to remove his tracheostomy tube. When the nurse released the patient's arm, the patient struck the nurse in the abdomen. The nurse then punched the patient on the left side of his face. The nurse's employment was terminated by the health service, and the nurse applied for reinstatement to the Queensland Industrial Relations Commission. The nurse acknowledged that what he did was inexcusable and out of character, and provided medical opinion to show that there was a limited likelihood of reoffending. Despite these mitigating factors, the Commission found that his conduct warranted "in its own right" termination of employment, and that the penalty was not disproportionate based on the gravity of the conduct – the serious assault occurred in a public hospital. As such, the application for reinstatement was dismissed. This case shows that serious assault by a clinician against a patient may be grounds for termination.

As these recent cases show, tribunals will find in favour of employees and conclude that there is unfair dismissal if due process is not followed. We need to ensure that we appropriately investigate the issue, provide the employee with the allegations in writing, offer the employee opportunities to respond, and ensure that the disciplinary action is at the right level. I hope these cases have been interesting, and I look forward to sharing other medicolegal cases with you in future.

Prof Erwin Loh

THE ACSEP *DOCTOR DASH* 2018

Some years ago now beyondblue published alarming results, following a world-first survey of thousands of Australian doctors and medical students. The full report can be downloaded here https://www.beyondblue.org.au/media/media-releases/media-releases/action-to-improve-the-mental-health-of-australian-doctors-and-medical-students and the major findings are also highlighted.

As a College, we want to show the power of exercise in dealing with such issues for not only our own members, but members of all specialist medical colleges. The event aims to bring together the medical community as a whole to:

- Promote the benefits of sport and exercise in the prevention and treatment of mental illness – along with other common and often serious medical conditions, such as arthritis, heart disease, obesity, diabetes and many cancers.
- Raise awareness for beyondblue and their specific doctors' mental health program.
- Increase awareness of the issues affecting the mental health of doctors, medical students, nurses and allied health professionals and work to destigmatise mental illness.
- Reduce barriers to, and encourage, help-seeking behaviour within the medical community.

AIDA Conference 2018

AIDA CONFERENCE 2018
Vision into Action

26–28 September, Crown Perth, WA

AIDA's 2018 conference will be held in Perth from Wednesday, 26 until Friday, 28 September 2018. This year's conference theme is *'Vision into Action'* - Building on the foundations of our membership, history and diversity, AIDA is shaping a future where we continue to innovate, lead and stay strong in culture. It's an exciting time of change and opportunity in Indigenous health.

The AIDA conference supports our members and the health sector by creating an inspiring networking space that engages sector experts, key decision makers, Indigenous medical students and doctors to join in an Indigenous health focused academic and scientific program.

AIDA recognises and respects that the pathway to achieving equitable and culturally-safe healthcare for Indigenous Australians is dynamic and complex. Through unity, leadership and collaboration, we create a future where our vision translates into measurable and significantly improved health outcomes for our communities. Now is the time to put that vision into action.

Register now

Visit the official AIDA Conference 2018 website to:

- register for the conference
- submit an abstract
- apply for funding support
- nominate an outstanding AIDA member for the 2018 AIDA Awards

www.aida.org.au/conference

2018 DR DASH *FUN RUN*

Proudly presented by the ACSEP in conjunction with beyondblue, the event has been designed to promote the benefits of exercise and to raise money and awareness for the mental health of doctors, medical students, nurses and allied health professionals.

AUSTRALASIAN COLLEGE OF SPORT AND EXERCISE PHYSICIANS

Proudly supporting beyondblue

27 MAY 2018
THE ROYAL BOTANIC GARDENS RUNNING TRACK – 'THE TAN'

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THE COURSE WILL INCLUDE 4KM AND 8KM OPTIONS, AND LOT'S OF SMILING FACES AT THE FINISH LINE.

TO REGISTER PLEASE VISIT:
https://www.eventbrite.com.au/e/the-doctor-dash-tickets-41852811887

The mental and physical health of doctors, medical students, nurses and allied health professionals in Australia is an ongoing concern within the medical profession and community. Research from beyondblue has highlighted the high rates of suicide, depression, anxiety, substance use and self-medication throughout the profession. To actively promote mental wellness ACSEP has teamed up with beyondblue to create a family friendly event, designed for doctors, medical students, nurses, practice managers, associated allied health professionals along with their family and friends.

FREE INTERPRETING SERVICE ACCESS FOR MEDICAL PRACTITIONERS

General Practitioners and approved Medical Specialists can access the Free Interpreting Service through TIS National, when delivering Medicare rebateable services in private practice to anyone with a Medicare card. Nursing and practice support staff working with practitioners registered with TIS National can also access the service using the same client code. Interpreters in over 160 languages and dialects are available 24 hours a day, every day of the year. Once registered for the Free Interpreting Service medical practitioners get access to the Doctors Priority Line, which gives priority access to interpreters over other callers.

Working with professional interpreters is essential to ensuring medical practitioners are able to communicate effectively with their patients and are protected from professional risk. This is particularly important when seeking consent, in crisis situations, dealing with complex issues and assessing patient competence.

Research by the Australian National University Medical School provides examples of significant physical and psychological harm resulting from not using a professional interpreter. There is also significant professional risk for practitioners not able to communicate effectively with their patient, particularly in regards to; understanding symptoms, prescribing medication or treatment and/or obtaining informed consent.

To access this free service complete the client registration form. For more information contact TIS National Language Policy Liaison team on tis.lpl@border.gov.au or by calling **1300 575 847**.

Doctors and medical students across Australia now have access to an expanded network of doctors' health advisory and referral services. Confidential advice and support is available in every state and territory on the following help-lines.

New South Wales and the Australian Capital Territory	02 9437 6552
Victoria and Tasmania	03 9495 6011
South Australia and the Northern Territory	08 8366 0250
Queensland	07 3833 4352
Western Australia	08 9321 3098

A national program for doctors' health advisory and referral services

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This national network of services is coordinated by Doctors' Health Services Pty Ltd, a wholly-owned subsidiary of the Australian Medical Association, with funding from the Medical Board of Australia.

Visit www.drs4drs.com.au for more information

Suite 1/20 Cato Street
Hawthorn East Victoria 3123 Australia
T +61 3 9824 4699
F +61 3 9824 6806
info@racma.edu.au
racma.edu.au
abn 39 004 688 215