RACMA
ROYAL AUSTRALASIAN COLLEGE of Medical Administrators

The Quarterly

#3
2019

> Medical Leadership in the New Age

Quarterly 3

quarterly

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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.

COVER: Internationally renowned author, scientist and business leader Dr William Haseltine dissected medical leadership at the 2019 Conference in Adelaide.

From the President

It was fantastic to see so many colleagues, peers and dedicated medical leaders come together at this year's Conference. I enjoyed being part of the conversations which challenged industry ideas and practices around Medical Leadership in the New Age, artificial intelligence, futurism and agility.

We all know the world of medicine is being faced with a changing workforce impacted by technological advancements. This in itself makes being a Leader increasingly challenging. Every day, new discoveries are being made, and while existing technologies are being used to streamline the efficiency of healthcare operations, emerging robotic technologies are being harnessed to enable breakthroughs in medical care. Thus, accommodating as Leaders for robots to play a bigger part in diagnosis, safer less invasive surgery, shorter waiting times, reduced infection rates, and increased long-term survival rates for everyone is now part of our domain. And that is definitely something to be excited about.

We gathered together with a common goal in mind - to strengthen and advance medical leadership across Australasia to ensure quality health care is delivered to all. Many of us came away enlivened, inspired and stimulated. I was heartened by the camaraderie and power of our leadership fraternity which shone through.

While we had plenty of scope to cogitate with colleagues and experts, we need to ensure the discussions, research and motivation do not stop there. Let's keep this collegiate approach to robotics and Medical Leadership front and centre of our daily operations. If we don't stay ahead of the developments which impact the way we run our healthcare systems, we run the risk of diminishing the quality and safety of what we deliver.

I would like to acknowledge the Program and Steering Committees for all their efforts in organising this year's conference. A lot of hard work and countless hours goes into making sure an event like this is a success. The content and calibre of speakers were of high quality and I have received nothing but positive feedback indicating it was one of the best conferences to date.

We also admitted 19 Fellows and 98 Associate Fellows to the College in Adelaide at the annual Conferment Ceremony, the culmination of hard work and commitment. As you go forth and take on leadership roles across the whole health system, I urge you to stay motivated and committed to push the boundaries to ensure the long-term sustainability and success of delivering consistent and superior healthcare. I wish each of you every success as you enter the next chapter of your careers qualified in a medical leadership role.

The College bestowed Honorary Fellowship to Professor Clifford Hughes AO - for outstanding commitment to champion, nationally and internationally, the crucial role medical leadership plays in delivering high quality safe patient care. An extraordinary Leader who was proud to join or Fellowship as we are proud to have him a part of our College.

Lastly, you will all be aware of the Australian Government's push to repeal the Medevac Law. The Presidents of 11 of our peak medical specialty colleges, including myself, recently issued a joint statement asking the Australian Parliament to maintain the Medevac legislation and the Independent Health Advice Panel (IHAP) process. The statement can be found on the RACMA website by clicking HERE. The Royal Australasian College of Physicians is leading the campaign and you can show your support via social media using the handle #savemedevac.

Associate Professor Alan Sandford AM
President

College News

College represented at UK Conference

The views and expertise of RACMA Fellows were heard by more than 700 medical leaders from across the world at the recent Leaders in Healthcare Conference in Birmingham.

RACMA's Leadership for Clinicians Program was also in the spotlight at the UK's foremost Healthcare Leadership Conference.

The College was invited to submit a poster, which was titled Mind the Gap - bridging the gap in Leadership Education for Clinical Leaders. The poster provided an overview of the evolution of the College's Associate Fellowship and what the program offers.

RACMA Finance and Audit Committee Chair Professor Erwin Loh presented his research "Rise of the Robots – the Ethical and Medicolegal Challenges of AI in Health" and was also part of an expert panel discussion looking at 2020 Vision: Novel Perspectives and New Understandings in Global Medical Leadership Research. Professor Loh also delivered a presentation looking at the "Art and Science of Managing Up and Effective Fellowship".

RACMA Fellow Rosemary Aldrich, who is Chief Medical Officer of Ballarat Health Services, presented on the theme: Creating a Compassionate Culture through Communication. RACMA Fellow Professor George Braitberg (Executive Director Quality Safety and Improvement Melbourne Health and Professor of Emergency Medicine University of Melbourne) submitted a poster titled Safe Timely Effective Person Centred Care – STEP. The poster summarised how STEP was developed to personalise clinical governance to assist front line care givers and consumers to understand how Melbourne Health monitors and improves the care they provide.

Above: RACMA Chief Executive Melanie Saba (centre) with Fellows Dr Rosemary Aldrich and Professor George Braitberg AM.

Save the date: 2020 Conference

RACMA will be a supporting partner for the 2020 International Forum on Quality and Safety in Healthcare at the Sydney Convention Centre. The RACMA 2020 Conference will run on 28 and 29 September and the International Forum will take place across 30 September to 2 October with benefits to RACMA members from this sponsorship. Stay tuned for more information.

New and familiar faces elected to RACMA Board

Dr Mellissa Naidoo is the new FRACMA Director on the College Board, while Fellows Dr Helen Parsons CSC and Dr Luis Prado were re-elected. They join our recently appointed new external directors Gillian Biscoe AM and Ms Kiri Rikihana.

Dr Naidoo has more than 10 years' experience in senior leadership roles in Medical Administration in both the private and public sectors. She is a graduate of the Australian Institute of Company Directors and an experienced board member. Dr Naidoo has also spent more than nine years on the Queensland Jurisdictional Committee in various roles including Candidate Representative, Treasurer and New Fellow Representative. She is a Preceptor, Supervisor and Censor and has been a member of the RACMA ASM Program/Steering committees for the past three years.

President Associate Professor Alan Sandford AM acknowledged outgoing FRACMA Director Dr Kevin Morris for his valuable contribution and service to the College. Dr Morris has completed his tenure on the RACMA Board.

Constitution amendments passed at AGM

Three of the proposed College Constitutional Amendments by the Board were supported by voting Fellows at this year's AGM, which was well-attended before the Conference in Adelaide.

The first amendment passed inserts a new paragraph into the Objects of the College set out in clause 4 to address Indigenous Health Commitment. The amendment follows a condition from the Australian Medical Council as part of the College's accreditation this year.

In clause 4.2, the following sub-clause will be inserted:

- 4.2.5A - To address health equity, and in particular health equity for Aboriginal and Torres Strait Island peoples of Australia and Maori of New Zealand.

Voting Fellows also approved the amendment to clause 5.16.5 in relation to Associate Fellows. This amendment provides for the use of separate titles and post nominals by Associate Fellows who are admitted to membership of the College on the basis of recognition of overseas (i.e. non-Australian or New Zealand) medical-practitioner registration.

The third amendment supported adjusts Clause 9.3 - Non-payment of Membership Fees. The amendment reduces the grace period of unpaid fees from 11 months to three months.

Medical Leadership in the New Age

There are many ways Artificial Intelligence can be leveraged to improve hospital efficiency and patient care … Think about adopting technology to move away from hospital-centric healthcare … If AI is going to be introduced in health, the risk must be borne by hospitals, not patients.

These are just a few of the key take home messages from this year's Annual Conference which focused on the impact of AI, futurism and agility for Medical Leadership in the New Age.

A delegation of more than 300 medical leaders from Australasia and the world gathered in Adelaide last month to dissect the opportunities, challenges, positives, negatives and legal issues associated with new technology and medical leadership.

Marita Cheng AM is the founder and CEO of aubot (formerly 2Mar Robotics), which makes a telepresence robot, and was one of the key presenters at the 2019 Conference. The 2012 Young Australian of the Year has transferred her engineering expertise into developing robotics which help take care of everyday tasks for ill children, people with a disability and the elderly.

Ms Cheng believes there are many opportunities for AI within healthcare currently being worked on for diagnosis, supply tracking, forecasting for hospital demand and monitoring for post-operative or chronically ill patients.

"With diagnoses there are so many companies out there working on different projects and that all requires a lot of data, but also requires a lot of time in order to verify that the results are good and that the research is valid," Ms Cheng said.

"But outside of that, I think there are a lot of ways in which AI can be used in order to help hospitals run more efficiently, such as in keeping track of supplies to improve the efficiency in service levels of its medical consumables supply chain.

"There's the example of the Queensland Government used CSIRO's patient administration prediction tool to forecast the demand of hospital beds, staff resources and elective surgery in order to try to cut patient waiting times at 27 major hospitals across the state. The software analyses historical data to predict with over 90 per cent accuracy how many patients would present at emergency departments and when."

Ms Cheng explained AI technology had also been used for reducing readmissions in a rural Health District in New South Wales. The district was experiencing high rates of unplanned hospital readmissions, which required enormous financial and staffing resources to manage.

"The hospital sought an AI solution to detect which patients were at high risk of readmission," she said.

"By integrating a decade of medical records to create an AI-powered machine learning model that considered patient characteristics such as demographics, case histories and treatment results, the health service was able to identify with 70 per cent accuracy patients who had an unexpected readmission within 28 days. So, things like that mean that doctors make real-time decisions that improve care quality. "

In her experience, Ms Cheng recommended to trial any AI technology on a small scale to find out if it works for the intended use.

"I think it's a matter of reaching out to companies doing this kind of work, forming a relationship with them, having them get to know your use case so they can develop something that works for you," she said.

"Some of the technologies are still in the early days and so practitioners like yourselves need to be open and willing to work with the scientists and the engineers who are working on implementing them.

"I encourage all of you to keep thinking about the ways your hospitals could be more efficient and also make better use of your staff's time by leveraging technology in order to offer a better healthcare solution to your patients."

Internationally renowned author, scientist, business leader, and philanthropist, Dr William Haseltine is well known for his pioneering work on cancer, HIV/AIDS, and genomics. But it his new book, World Class, which has everyone in the world of medical administration and leadership talking. The number one new release looks at how New York University Langone Health went from mediocrity to global leadership in less than a decade.

Dr Haseltine held the audience captive with his sage advice on successful leadership in an ever-evolving world of medicine.

"I urge you to think about how healthcare should be distributed," Dr Haseltine said.

"Think beyond a hospital-centric system. Don't build the biggest hospitals, build a hospital which can be the centre or hub of a distributed network where the care can eventually move to a person's home.

"As populations age you don't want to have to treat them in hospitals or out patients, you want to treat them in clinics or at home to the extent you can distribute healthcare where it should be.

"We can do this with different technologies today. For example, technology allows you to change where and how you perform your surgeries."

Dr Haseltine noted working in the medical world was one of the most complicated parts of our society with its political, economical and social implications. In order to cope with this, he said medical leaders needed to be the best they could be.

"Be the best you can be in your circumstance and then hope that the circumstances will change because you can take advantage of change," Dr Haseltine said.

"What does it take for leadership change? First it takes a desire in adversity. Second it takes the framing organisation - whether a board or government – deciding to make that change and allowing it to be possible.

"All too often people put all the responsibility for that kind of change on the CEO, but the CEO is helpless unless the framework in which that CEO works is positive and the bigger the change that has to be made the more that framing has to protect that change agent."

An optimistic leader with a clear vision, who is respected internally and externally, are also key to the success of an organisation according to Dr Haseltine.

"I'm not sure you have to always be feared, but you surely have to be respected," he said.

"Respected for your personal qualities and the respect you give to others."

> "I urge you to think about how healthcare should be distributed."
>
> - Dr William Haseltine

As the development and adoption of various AI technology increases across all areas of medicine, who should be held accountable for decisions made or informed by AI? What are the challenges that the law faces if an AI entity fails to diagnose an illness, maybe provides a false positive? Is the law fit for purpose as it is?

These were just some of the questions raised by the University of Leicester's Professor of Medical Law, Jose Miola. Professor Miola's work includes many journal articles which have been cited by courts in the UK, Australia and Singapore. Professor Miola is assistant editor of the Medical Law Review and will be its joint editor from 2020. He also sits on the editorial board of the journal Clinical Ethics and is a member of the Wellcome Trust's Social Science and Bioethics Interview Committee

Starting with the question of blame, the short answer is that much will depend on how the AI entity is deployed, the amount of human oversight and control and the level of sophistication of the AI entity, according to Professor Miola.

"Israeli criminal lawyer Gabriel Hallevy has had a go at creating a typology of blame for AI entities and he divides it into three: the perpetration via another liability model and the natural probable consequence liability model where we can still blame a human, and then a direct liability model where it's appropriate to blame the AI entity," he said.

"If AI is going to be introduced in health, the risk must be borne by

The good, bad and ugly of AI - from an ethical, legal and corporate perspective

"The question should not be about how we embrace AI, but how do we improve access to quality healthcare and can AI be part of the solution? ... using AI systems in health-care sees medicine as information rather than medicine as care."

Professor Robert Sparrow
Adjunct Professor
Monash Bioethics Centre

"Because AI is happening so quickly, there isn't the regulation and framework to support it ... We are living in a world of potential - how can we future proof the law so it is not inhibitive?
If something goes wrong with AI, who is responsible? What are we trying to regulate - the rate of introduction of AI, the role or the responsibility?"

Dr Bernadette Richards
Associate Professor of Law and Associate Dean (Research)
University of Adelaide

"Disruption in healthcare will not come from healthcare, it will come from other industries.
How do we use AI to improve patient care experience?"

Dr Avnesh Ratnanesan
CEO of Energesse

"AI is an innovation which moves so fast. What is useful now, won't be the same in weeks. We need to invent a culture of innovation for AI, be open-minded and flexible."

Dr Paulina Chow
Psychiatrist, award-winning researcher
Hong Kong

Continued from previous page

Medical Leadership in the New Age

hospitals, not patients. This is, in particular, if patients are physically injured. The question is not so much whether this will be done; it is how the courts will do it.

"One argument has been to actually give agency to AI entities. If you give agency to the AI entity, and it's acting in the course of its employment, the hospital could be vicariously liable and you protect patients that way. That helps you with blame but it doesn't help you with fault. Giving agency to the AI entity does not solve the problem of black box medicine.

"The second option we can derive from Mildred Solomon, from the Hastings Center in New York, is that AI entities must have human oversight. My view is that what is likely is that the courts will adopt this as a legal requirement. In other words, they can't assess whether the AI entity is at fault, so instead, they will ask was it reasonable to deploy the AI entity and was there sufficient oversight?

"That may not be the most comfortable thing for a group of Medical Administrators to hear."

This year's line-up of speakers and presenters has attracted overwhelming positive feedback and has been lauded by attendees as one of the best ion the College's history.

Conference Program Committee Chair Dr Mau Wee and Conference Steering Committee South Australian member Dr Jayanthi Jayakaran said the speaker composition was very considered in order to provide different perspectives and approaches to robotics and futurism outside of Medical Administration.

"We thought the best way to form opinions, new ideas and strategies about how Medical Administrators can be agile in the new world, is for us to understand what other people think about AI and technology and how it is used," Dr Wee said.

"So we decided to invite experts in medical law and ethics, corporate business, NGO's, as well as hearing from an entrepreneur start up. And from there it is about how we insert ourselves in the conversation from now on.

"Some of us get bogged down in our day to day work and we have a very narrow view of new technology and experience with new technology. I think a Conference like this give us the opportunity to broaden our horizons because you learn from other people's experiences which can be very different to what we have been through. At the end of the day it is a learning journey for all of us."

Dr Jayakaran said both attendees and speakers remained engaged with each other for the entire Conference.

"The RACMA Conference is always a key opportunity for medical leaders to network, re-connect with old colleagues and make new connections," she said.

"There was much to learn and gain from this Conference for us all. It certainly gives us a lot to think about and investigate to adopt in our own workplaces.

"And it is a great opportunity to host the College Conference. We take away a lot of positives and the support and feedback from our peers was very encouraging. It proves that it is more than being a member of an organisation, we are part of a special community."

Delagates were treated to five exceptional presentations in the Margaret Tobin Challenge, named in honour of Dr Tobin's contribution to RACMA and her passion in developing leadership in the field of mental health. This year's award went to Dr Rajdeep Ubeja for his presentation on the terror of the ease in interfering with medical imaging. Other Challenge entrants were:

- Dr Paul Lane from Townsville Hospital Health Service, who looked at Medical Leadership in the New Age;
- Dr Brendan Graham from Epworth Healthcare Melbourne, who discussed the Rise of the Robots - "Futurism";
- Dr Ruth Kearon, Director Health Workforce Planning Unit, Tasmanian Department of Health, who delivered her presentation on Health Workforce 2040; Shaping our workforce now and into the future; and
- Dr Samir Heble from Greylands Hospital Perth, who asked the question Will Machine replace Man?

There were nine abstract presentations which covered off a broad range of topics from clinical informatics to fatigue risk management and leading from the inside. Cabrini Health Clinical Informatics Director, Dr David Rankin, was judged the best for this year's Conference for his presentation on the adventures and perils of engaging clinicians in data reporting.

There were 10 posters submitted to the Conference, with Royal North Shore Hospital Deputy DMS Dr Kevin Luong taking the honours for Best Poster. Dr Luong's poster depicted Quantifying junior medical officer unrostered overtime using electronic medical record activity.

What do the experts say about Futurism and AI?

"Computers will change from passive order takers to generative and intuitive partners... AI should enable doctors to have more patient contact."

Dr Johan Verjans
Cardiologist
Royal Adelaide Hospital & SAHMRI

"Partnerships between technology companies and health providers are key. A project in Seattle is crunching a trillion data points a year, looking at the different T cell receptor markers and genomic patterns and how these might correlate to different diseases as an early marker."

Dr Nic Woods
Chief Medical Officer
Microsoft

"Think outside the box with AI and technology in medicine...unusual collaborations can bring the best outcomes."

Christopher Kommatas
Head of Strategic Partnerships & Innovation
Health Roundtable

RACMA President Associate Professor Alan Sandford AM officially opening the Conference.

There were no spare seats for the Conference key speakers.

Keynote Speaker Marita Cheng AM (cente) with Conference Program Committee Chair Dr Mau Wee (left) and Conference Steering Committee South Australian member Dr Jayanthi Jayakaran.

International keynote speaker Dr William Haseltine.

Key presenter Dr Jose Miola.

AI panel experts Christopher Kommatas (back left) , Dr Johan Verjans (back right) and Dr Nic Woods Dr Nic Woods (bottom right) with Moderator Professor Erwin Loh.

Conference audience members remained enagaged at all questions times.

RACMA staff members from left: Angela Chan, Daniel Fogarty, Soundra Subramanian, Melanie Saba, Toula Panagopoulos, Felicity Gallagher and Debbie Greenberger.

Conferment 2019

The College admitted 19 Fellows and 98 Associate Fellows at the 2019 Conferment Ceremony in Adelaide last month.

College President Associate Professor Alan Sandford AM congratulated the newly elected Fellows, acknowledging their commitment and hard work.

"You should all be very proud," he said.

"As Specialist Medical Leaders we are the custodians of clinical quality, safety and system integrity. We are uniquely placed, in the constantly evolving health systems of modern times, to be leaders and partners in bridging the gaps between delivering quality clinical care and managing the resources available to provide that care.

"Medical workforce planning is "having the right people with the right skills in the right place at the right time" - a major imperative for clinical safety and appropriately overseen by the specialist clinicians that are RACMA Fellows. This is why it is critical that appropriately qualified, experienced and credentialed Medical Specialists are appointed and lead in our health system throughout Australasia."

This year, the College bestowed Honorary Fellowship to Professor Clifford Hughes AO for outstanding commitment to champion, nationally and internationally, the crucial role medical leadership plays in delivering high quality safe patient care.

Professor Hughes AO was the inaugural CEO of the NSW Clinical Excellence Commission where he led system wide improvement to the quality and safety of patient care across the NSW public hospital system, a role he held from 2004 until 2015.

A former Cardiothoracic surgeon and Member of the Australian Council for Quality and Safety in Health Care, he has demonstrated national and international leadership in clinical governance, a cornerstone of modern Medical Administration.

Professor Hughes has been chairman or member of numerous state and federal committees associated with quality, safety and research in clinical practice for health care services. He has also held various positions in the Royal Australasian College of Surgeons.

The immediate Past President of the International Society for Quality in Health Care (ISQua) has served on four editorial boards and has published widely in books, journals and conference proceedings on cardiothoracic surgery, quality and safety. He has a passion for patient-based care, better incident management, quality improvement programmes and the development of clinical leaders.

Professor Hughes challenged College Fellows and leaders to become people who have verve - to have intellectual dynamism.

"On the basis of what we know, we are doing something to change the world," he said.

"That is why RACMA is here, that is why I am greatly honoured and humbled to be part of this great Fellowship."

Professor Hughes highlighted the critical role leadership and collaboration play in decreasing the vulnerability of all those involved in healthcare.

"If we have vulnerable patients and vulnerable staff, there's a fairly good chance we have vulnerable organisations who are struggling to find the resources they need to deliver the care we would like to have if it were us," he said.

"That's where leadership and cross discipline collaboration becomes so vitally important and if we can work together as administrators, as clinicians, as politicians and volunteers even, we can change the way things work. If we don't our entire community is vulnerable.

"I would like to suggest to you one of our challenges is to make our hospitals look and act and think and feel like a village. Let's start to care for other people. When we see someone who is struggling, we need to put our hand up and take the load upon themselves and if we do that we develop a whole new vision of what healthcare will look like: people caring for people, while we treat disease."

The Conferment ceremony also honoured a number of Fellows with the annual College Awards. The RACMA College Medallion was awarded to Dr Peter Renshaw and Dr Ian Rewell, Dr Singithi (Sidney) Chandrasiri received the New Fellow Achievement Award, Dr Jon Hodge was named Supervisor of the Year and Preceptor of the Year was awarded to Professor Andrew Johnson.

Chair of the Australian Commission on Safety and Quality in Health Care, Professor Villis Marshall AC delivered the 2019 Langford Oration. Professor Marshall AC has extensive experience providing healthcare services, managing public hospitals, and improving safety and quality.

He has had significant clinical experience as a urologist, and as Clinical Director (Surgical Specialties Service) for the Royal Adelaide Hospital and Clinical Professor of Surgery at the University of Adelaide.

Professor Marshall has previously served as General Manager at Royal Adelaide Hospital, Senior Specialist in Urology and Director of Surgery at Repatriation General Hospital, and Professor and Chair of Surgical and Specialty Services at Flinders Medical Centre.

Professor Marshall AC detailed a number of critical issues and areas impacting quality and safe healthcare, including safe hours for junior doctors, bullying and sexual harassment, culture, antimicrobial resistance and hospital accreditation.

"I think we have to accept that hospital Boards, the senior administrator and clinical leads are the key to ensuring good corporate governance in turn leads to good culture," Professor Marshall said.

"This is potentially the most important of the accreditation standards. At times it is possible to feel that a hospital does have a good culture, as often it is easy to feel the culture is not good in a hospital.

"Some years ago I visited St Thomas' Hospital in London and I was particularly impressed by how staff and patients interacted in a positive way. I asked the senior, what were the key strategies? And much to my surprise was informed that changes to a positive culture resulted from all senior managers, clinical administrative, including finance, spending a day a week out of their offices on the wards talking to the staff and to the patients.

"And I have to say I think this is one of the things that we really have to think about. Often management has become isolated, at least in the perception of the staff. We have to be seen because we have to be seen as both part of the problem and part of the cure of the problem. I think they almost uniformly felt that they better understood the issues facing the staff and the patients. And I think that's so important that we don't always appreciate the sorts of issues that are facing the staff and also of course the patients."

While Professor Marshall started the Langford Oration by saying we could improve healthcare with the knowledge we already have, he ended by pointing out the industry is facing an era of medical knowledge explosion which has not been put through any sort of rigorous test.

"It's been estimated that the doubling time for medical knowledge in 1950 was 50 years. In 1980 it was seven years. In 2010 it was 3.5 years. In 2020 it's going to be 0.2 years or 73 days. Medical knowledge is doubling as we sit here almost," he said.

"So how does our learning take cognisance of this? Do we have to use artificial intelligence? How do we separate the wheat from the chaff? Because now there's such an explosion you can get your articles published without good peer review. And even if you did have good peer review, how could you find enough peers to do this properly?

"… knowledge is expanding faster than our ability to assimilate it effectively… And so I put up the challenge to you - how do we deal with this new explosion of information which is not like anything we have ever experienced before?"

Members of the Offocial Party L to R: A/Prof Pooshan Navathe, Dr Peter Lowthian, Prof Villis Marshall AC and A/Prof Alan Sandford AM

Langford Orator Professor Villis Marshall AC

Dr Iwona Stolarek delivered the Conferment Welcome

Honorary Fellow Professor Clifford Hughes AO

College President A/Prof Alan Sandford AM with Prof Villis Marshall AC, Prof Clifford Hughes AO and Mr Tony Sparnon from RACS

2019 Graduates

Fellows

Georga Cooke
Catharina DeMuelenaere
John Eastwood
Daryl-Anne Elias
Christian Ghan
Patrick Giddings
Andrew Hallahan
Helen Harris
Dhanvee Kandadai
Lynette Knowles
Deepan Krishnasivam
Kevin Gia Dat Luong
Ranjit Paul
Elaine Pretorius
Vineet Sarode
Krishnaswamy Sundarajan
Christopher Tan
Vikas Wadhwa
Peter Watson

Associate Fellows

Zoe Adey-Wakeling
John Ah-Chan
Aman Anand
Dharampal Anand
Stephen Arthur
Nicholas Baker
Leanne Bennett
Tanya Boast
Cam Buchanan
Paul Butel
Nicholas Cairns
Brendan Carrigan
Anna Carswell
Sara Cash
Rick Catterwell
Stanley Cheung
Paul Chuah
Damian Claydon-Platt
Ruben Cohen-Hallaleh
Simon Collins
Adam Coltzau
Brooke Davies
Prue Dawson
Apo Demirkol
Raja Devanathan
Nina Dhondy
Steven Diamond
Sara Flint
Jessica Gaughan
Krishnendu Ghosh
Atul Goel
Rob Gray
Daniel Halliday
Sara Handley
Michelle Hannan
Andre Hardidge
James Harris
Liz Hawkins
Irina Hollington
Derek Holroy
Gary Hopgood
Kim Humphrey
Muhammad Ihsan
Shaikh Javaid
Richard Kane
Harsh Kanhere
Mrudula Kanhere
Barbara King
Alison Kinnane
Michael Lam
Alice Lee
Helen Lunt
Stuart Millar
Maaike Moller
Mark Monaghan
Emily Moody
Pieter Nel
Van Nguyen
Debra O'Brien
Cullen O'Gorman
Wilson Ong
Jun Parker
Alison Parr
Laila Parvaresh
Nicola Patching
Geoff Pearce
Trong Pham
Graeme Pickford
Rachel Preece
Francois Pretorius
David Prisk
Lana Prout*
Vidya Ramnath
Pankaj Relan
Tom Rozen
Matt Ryan
Shaun Ryan
Matt Sabin
Wendy Scheil
Nilesh Shah
Bennett Sheridan
Amul Sibal
Simon Smith
David Steward
David Sturgess
Gavin Sullivan
Debra Tennett
David Tralaggan
Danny Tucker
Sally Ure
Mohammed Usman
Mayooran Veerasingham
Clare Walker
Andre Wannenburg
Sue Wass
Dave Wood
Justina Wu
Andre Yeates

Vale Lana Prout MBBS (Hons) BMedSc (Hons) GCHPE MPH DCH DAvMed(UK) MHM MIPH FRACGP AFRACMA

The College would like to pass on our thoughts and sympathy to family, friends and colleagues of Royal Australian Airforce Squadron Leader Dr Lana Prout. Dr Prout was admitted to the College as an Associate Fellow at the Conferment Ceremony in Adelaide, and passed away suddenly shortly after.

New Fellows

2019 RACMA Award Honour Roll

Serving College on Many Levels Earns Veteran Administrator RACMA Medallion

There aren't many College roles Dr Ian Rewell hasn't tackled in his 30-plus years in Medical Administration.

Dr Rewell became a Fellow of the College in 1985 and has been involved in the College as:

- NSW Jurisdictional Committee member
- Board of Censors member
- College Supervisor
- College Preceptor
- Site Accreditation Panel member
- Chairman of Assessment of Specialist International Medical Graduates in Medical Administration

For his outstanding service to the College at state and national level and continual commitment to Medical Administration and Leadership, Dr Rewell received a coveted College Medallion.

"It was a big surprise to receive the College Medallion," Dr Rewell said.

"But it is nice to be recognised. It's work I enjoy and love and want to keep doing. There are a great bunch of people working with the College, which makes it really enjoyable to be a Censor and an Accreditor."

For Dr Rewell, being a Censor is contributing to the future of the College.

"I am passing on the knowledge that I have gained over 30 years to people who are just starting in their career in Medical Administration and making sure whatever mistakes I made aren't repeated," he said.

From his first Medical Administrator role in 1981 as Area Medical Superintendent for the Young Hospital Group, Dr Rewell has dedicated his career to the field. From 1984 – 2016 he held consecutive executive medical positions in the South Eastern Sydney and Illawarra Local Health Districts directing clinical strategy, clinical performance and medical resource governance.

Since 1989 Dr Rewell has developed his professional reputation for surveying roles in the Australian Council on Healthcare Standards and ACHS International, the Postgraduate Medical Council of NSW and the NSW Health Education and Training Institute. He was a Council Member of the Australian Medical Officers' Federation (ASMOF) representing Medical Administrators from 2002 to 2014.

Dr Rewell has the qualifications of Associate Fellow of the Australian College of Health Service Executives and Fellow of the Australian Institute of Management. He has been acknowledged for his teaching capacity with conjoint Associate Professor titles in the faculties of Medicine of both the UNSW and the University of Wollongong.

Holding various roles within the College has given Dr Rewell a holistic view and deeper appreciation of how the College operates.

"The work that has gone into the Board of Censors over the time I have been there has really been very professional and lead to significant improvements to how we conduct the exams and all the other testing we do in the research domains and the oral exams," he said.

"I think there has been a lot of work put into being fair to the Candidates while maximising their chances of passing at the same time."

Dr Rewell said there was an increasing number of young doctors choosing Medical Administration as a primary career choice, as well as the senior clinicians who choose it as a second fellowship.

"I have never seen the College more vibrant," he said.

"I think it is becoming a more popular career choice because doctors have seen they can make a difference to the overall healthcare system from being a Medical Administrator rather than a practicing clinician.

"I think they see that medicine and healthcare overall is becoming more complex and more challenging and to impact on the system and make changes to it, being in Medical Administration is a very advantageous position to be in.

For Dr Rewell it is the area of medical workforce which has kept him hooked since becoming a Fellow.

"You are no doubt aware of the current focus on junior medical officer wellbeing, safe working hours and the unfortunate number of suicides we have from junior medical officers," he said.

"I think working with junior medical officers in my current role with HETI is one of the most interesting areas."

Dr Rewell has witnessed some significant changes to Medical Administration since the 1980s, particularly the introduction of Medicare and the tightening of hospital budgets.

"I lived through the doctors dispute and the introduction of Medicare completely changed the face of what was up until then the Honorary medical officers system so we had a whole new entity called visiting medical officer that we had to come to grips with," Dr Rewell said.

"The introduction of revenue budgets forcing hospitals to make ever increasing amounts of revenue has led to a much busier system with elective surgery, emergency departments, increasing population and an increasing ageing population."

So does Dr Rewell believe we are any closer to another monumental change in mandating FRACMA and AFRACMA to hold any medical leadership roles across healthcare services in Australasia?

"It would be nice to think so, in NSW it is largely left to the discretion of individual local health districts," he said.

"I think personally it should be. It's not difficult to do at all."

Long-time Censor and Staunch Medical Administration Advocate Honoured

Despite accidentally stepping into Medical Administration after he was thrown in the deep end as a Registrar, Dr Peter Renshaw has dedicated his career to preparing Candidates for Fellowship.

Dr Renshaw was awarded a College Medallion for significant contribution to the College Board of Censors, to the training of College Fellows and to Medical Administration as a specialty in Tasmania.

"I was definitely stunned and also very grateful."

Dr Renshaw has been Director of Clinical Services at Tasmania Health – Northern, since 1987 and became a Fellow of the College in 1997. He is a firm believer you cannot do the job of a Medical Administrator without having a solid clinical background.

"It's not only important for dealing with your colleagues but more importantly when you are dealing with members of the public, patients and their families," Dr Renshaw said.

"One of my favourite parts of the role is dealing with the complaints and concerns of patients. I have always maintained an active involvement and a direct involvement in the complaint's management service. When it is done well, you can see how helpful it is for people who either don't understand what happened to them or are angry that something has apparently gone wrong.

"I love dealing with people in that context so you can say 'ok, if you were me what would you recommend that I do to help fix the system'. It is a cliché, but I like partnering with consumers. I love that engagement where you can share ideas about how to make the system better."

Shortly after he gained Fellowship, Dr Renshaw joined the Tasmanian Jurisdiction Committee. Over the past 20 years he has held various positions on the Committee. At a national level, Dr Renshaw has been a longstanding Censor since 2010 and as the Lead Censor for Examination Questions since 2012.

The role as Lead Censor for Examination Questions is a pivotal one for the Board of Censors. Dr Renshaw is responsible for providing the suites of examination questions for the Oral Examination and for the College Trial Examination. Dr Renshaw collects questions from Members of the Board of Censors, refines them and ensures each has an appropriate scoring rubric. He then works with the Censor-in-Chief and the Dean to guarantee the final proposed group of questions is matched across the days of the examination and has an appropriate scope for the examination of the Medical Management Practice domain of the Curriculum.

His continued commitment is driven by the support of his colleagues and the reward of being an examiner.

"The group of Censors have been a really cohesive, friendly, engaging, supportive group," Dr Renshaw said.

"The whole idea of making the exam as fair and as practical as possible has been very rewarding. I think overall, we have been successful in making a good practical exam that tests your ability to 'think on your feet'.

One thing I didn't want was simply regurgitated book knowledge but a candidate who can cope with unexpected twists and turns using the tools their RACMA training has provided.

"The scenarios we provide are as real to life as possible. Sometimes they are very left field and that has caused some angst among candidates. But that is the point: situations you've never encountered before are what you get in medical admin very regularly and you need to have the tools to deconstruct the problem and put together a solution."

On top of introducing a more realistic approach to the questions, Dr Renshaw has also changed the exam structure from choice questions to compulsory questions, which is more in line with other college exams.

"We have also made it a rule that if you are going to remain a censor you have to submit one or two questions a year so all the censors are involved now in writing the questions; they don't just come in and examine but are actively involved in creating the exam," he said.

Dr Renshaw has also been a solid support for several trainees as a Supervisor and as a Preceptor. Since 2014 he has been on numerous panels in other states for the College Accreditation Review Committee. Dr Renshaw has also been consistently active in the medical politics of advocacy for Medical Administration as a specialty.

One of his passions has been pursuing a mandate for FRACMAs and AFRACMAs to fill Medical Administration roles.

"In my role as an accreditor when I visit hospitals all around Australia, I see on the statements of duties for medical managers 'must have FRACMA or equivalent or be working towards'," Dr Renshaw said.

"That has always stopped me as being particularly naïve because when you see ads for, say, specialist orthopaedic surgeons, they do not state 'must be a qualified orthopaedic specialist or be working towards your qualification.' It really is a nonsense. It needs to be a must to have your FRACMA or AFRACMA at least to be appointed to any leadership positions in healthcare."

Dr Renshaw believes it is a health service responsibility rather than a government responsibility to make this happen.

"The College needs to continue to lobby hard. Health services need to ask themselves do we want trained specialists in medical administration?" he said.

"Then it is the responsibility of the College to make sure the supply of competent, practical specialist Medical Administrators is such, that health services don't have to look for back-up solutions when they can't get a FRACMA.

"But I think we are some years away from achieving this goal."

2019 RACMA Award Honour Roll

Supervisor's Reward for Positive, Practical & Non-prescriptive Guidance

Recognising Candidates are not a homogenous group and avoiding being too prescriptive when guiding them are key to being a good Supervisor, according to Dr Jon Hodge.

"Like Fellows, registrars aren't a homogenous group, so it is nice picking up the different personalities and characteristics because they are always going to have something to give," he said.

"We are not training people to be DMS's and EDMS's, we are training people across a whole spectrum of Medical Administration and medical leadership.

"We need to be cognisant of that so we are teaching them a basic skill set that can be applied across a range of settings. That is the valuable piece from the perspective of a Supervisor that we aren't expecting them to go down a certain career path."

A simple but solid philosophy which has rewarded Dr Hodge with 2019 Supervisor of the Year Award.

A Supervisor for two and a half years, Dr Hodge has been instrumental in creating a RACMA hub in North Queensland. According to his nomination, Dr Hodge has effectively mastered the supervision of three Candidates, at least two other aspirants and another Candidate for whom he is Preceptor. This has been sustainably achieved by promoting Candidate accountability for engaging in learning opportunities, up-skilling by Dr Hodge himself in how to practice effective supervision and his positive attitude.

The Townsville Hospital and Health Services Director of Medical Services – Workforce was very surprised with the honour.

"I really enjoy being a Supervisor," he said.

"It is a nice way to give back to juniors coming through by passing knowledge on to them. Being a Supervisor means you have to keep up to date and abreast of changes in governance and workforce because that's what the registrars ask you. And we have always recognised that that is part of being a Supervisor.

"We are seeing some amazing talent coming through which is exciting to be part of."

Dr Hodge draws on his military and Medical Administration experience to provide effective feedback and he is an active proponent for improving doctor welfare in the organisation, emphasising the importance of a balance of learning, working and living without getting cognitively overloaded.

Dr Hodge said the award was testament to high quality supervision being available in a regional setting.

"It is rewarding being a Supervisor in a regional setting," he said.

"We continue to have this thought that if you want high quality supervision and high quality training you should be in a metro setting. We need to look a bit broader than metropolitan settings for rotations. There is an important role that regional settings have to play.

"In terms of working with other specialty colleges, we want to encourage other specialists to come to rural and regional areas. Are we as a College being pro-active in that space where we are telling other colleges to send their registrars to rural/regional places and if we aren't doing the same then are we being consistent? We can hold our heads up high we are and I am keen to continue to do it."

Unwavering Support for Colleagues Critically Important to Preceptor of the Year

Being available to support his colleagues is a core personal priority for Townsville Hospital and Health Service Executive Director Medical Services Professor Andrew Johnson.

Early in his career he almost burnt out through difficult circumstances and not having a formal structure around him.

"I see that having that capacity to call on someone when times are difficult and having someone keep an eye on you is incredibly important," Professor Johnson said.

"I didn't realise how important it was to ask for help until it was almost too late."

Professor Johnson has been a Preceptor, Supervisor and coach for close to 20 years.

"As a Preceptor you are a consistent thread, there for someone to come back to and to provide support, making sure that the candidates are getting the training opportunities they need," he said.

Last month, Professor Johnson was named 2019 Preceptor of the Year for his commitment and enthusiasm to Medical Administration. He was nominated for being an excellent mentor and role model, extremely informative and encouraging and providing invaluable advice.

"I was really surprised to receive the award and I am really honoured, although I've never doubted that the effort you put in these roles is appreciated", he said.

Professor Johnson believes the opportunity to work with other people and help them fulfil their destinies is a real privilege.

"I have had the genuine privilege of working with a whole bunch of really amazing people over the years. Whether as Preceptor, Coach or Supervisor it has always been a rewarding experience" he said.

"Having the opportunity to interact with Candidates and provide a positive influence means you get to bask in their reflected glory when they do wonderful things."

But the need for support doesn't go away after training is completed, Professor Johnson said.

"The starting point is your relationship with your Preceptor and Supervisor, but it is really preparation for what you need to continue doing," he said.

"One of the great challenges for us is you get your ticket and walk out the door and you are a FRACMA, but if you don't continue to have those relationships where you have someone you can go to when you have a problem, it can become very difficult for you. They are very lonely jobs sometimes.

"We need each other as a collegiate group and senior people need to work together to keep each other safe. In Queensland we have made it a major focus for us as a group of FRACMAs. When we have new people start, one part of the introduction is 'please phone a friend', don't let yourself get into a difficult spot."

To be a successful Preceptor, Professor Johnson said it is key to be available, flexible and empathetic.

"A flexibility to flip between coaching and mentoring and a recognition that your job isn't to solve others' problems but to help them through it," he said.

"I think there is an evolution coming for the role of Preceptors and Supervisors. There will be a change in the expectations of what we need to do as Supervisors and Preceptors going forward into the programmatic assessment model, and they will only become more important still."

2019 RACMA Award Honour Roll

New Fellow's Drive and Contribution to College Recognised

Soon after gaining her Fellowship last year, Dr Sidney Chandrasiri was appointed as the Jurisdictional Co-ordinator of Training in Victoria. Within the first year of this appointment, she has transformed the training and support program for Victorian Candidates, significantly increasing its profile and engagement of both Candidates and Fellows in Victoria.

So, it is little wonder the 2019 New Fellow Achievement was awarded to Dr Chandrasiri for exceptional dedication and vision to improve the training experience for Victorian Candidates and drive to contribute to the College on many levels.

Her specific achievements to note include:

• Leading an inaugural "meet and greet" event in February 2019 for Candidates, Supervisors and Preceptors which will become a regular event after its success.

• Estbalishing a monthly journal club, initially aimed at Candidates but now strongly promoted for, and supported by, Fellows as well.

• Reinvigorating the tutorial program for Candidates in Victoria leading to increased attendance rates either in person or by video conference.

• Organising and leading state trial exams in 2018 and 2019 including writing suitable exam questions.

Outside of her JCT role, Dr Chandrasiri is also Supervisor to two RACMA Registrars and was asked to observe the College's formal examinations to gain experience to become a Censor in the future.

"My goal was to raise the standards of training in Victoria and to inspire my peers to join me in realising that vision," Dr Chandrasiri said.

"I would now like to take a step back and allow my colleagues the opportunity to also lead in this space, and I plan to do this by actively sponsoring other new Fellows to join me as co-JCTs in establishing a structure that will continue to build on these improvements. I plan to launch a Victorian "JCT Faculty" the details of which I hope to announce at the start of 2020, which will strengthen the system of training coordination in Victoria into the future.

"There is a great deal of untapped potential and enthusiasm from many of my colleagues who are also new Fellows, to contribute to the College and I hope to inspire them to take up and improve on the work that I've started."

Dr Chandrasiri moved to Victoria from New South Wales several years ago primarily for RACMA specialist training.

"This was a significant turning point in my life and wasn't an easy task," she said.

"So I always wanted to create similar opportunities for others if I was able to. I believe very strongly in giving back to others and if I can help even one person achieve their career ambitions in even a small way, it's a very rewarding experience for me.

"I am passionate about the future of our College, our members and our Candidates, because at the end of the day we are uniquely placed to powerfully influence not just healthcare delivery in this county, but also to create the highest calibre network of individuals who can lead the future of our industry."

Epworth Healthcare's Group Director, Academic and Medical Services who also holds the Chief Medical Officer position at Alexandra District Health, said receiving the award was both unexpected and humbling.

"It was an absolutely phenomenal feeling to be told that the work that you've done has created value and been of benefit to others," Dr Chandrasiri said.

"I am very grateful to the Victorian Jurisdictional Committee for their support and encouragement in the initiatives, and my two RACMA registrars, Dr Jane Lovell and Dr Brendan Graham, whose diligent and tireless work behind the scenes is what has made it all possible.

"It is the highest honour to receive acknowledgement for your work by your peers, as they uphold the standards of our profession and often are the toughest critics in our industry."

Manipulating medical imaging examined by Margaret Tobin Challenge Award winner

When RACMA Candidate Dr Rajdeep Ubeja first found out that people were able to tamper with Medical Imaging in real-time, he was shocked. So, he took the opportunity to spread the word to his peers through the College's Margaret Tobin Challenge.

"I think as an industry we're quite static and sometimes need reminding that we're going to be forced to adapt at an increasing pace."

It was the Sydney Local Health District Medical Informatics Officer's presentation on the Terror of using of AI to manipulate Medical Imaging which impressed this year's Margaret Tobin Challenge Award judges to win the 2019 title.

"I remember watching last year's presentations in Hong Kong […] there was a certain buzz to the session that I really enjoyed and thought I'd like to be part of," Dr Ubeja said.

"I'm humbled because there were so many great presentations. I look forward to working alongside the other trainees as Medical Administrators of the future."

There were five presentations in total for this year's Challenge Award, the other entrants were:

- Dr Paul Lane from Townsville Hospital Health Service who looked at Medical Leadership in the New Age
- Dr Brendan Graham from Epworth Healthcare Melbourne discussed The rise of the robots "Futurism"
- Dr Ruth Kearon, Director Health Workforce Planning Unit, Tasmanian Department of Health delivered her presentation on Health Workforce 2040; Shaping our workforce now and into the future
- Dr Samir Heble Greylands Hospital Perth asked the question Will Machine replace Man?

Judges Associate Professor Pooshan Navathe, Dr Peter Lowthian and Dr Liz Mullins said the standard of all the presentations was of a high quality.

Dr Ubeja has always enjoyed complex problem solving and systems-level thinking, which he believes are fundamental to Medical Administration, and was drawn to the field because of the numerous career opportunities it presents.

"I'm new to the College but I'm constantly amazed at the breadth of careers that Fellows have pursued with their skills as specialist Medical Administrators," he said.

"Whilst at present I'm very much enjoying developing my skills in a personal interest area of digital health I look forward to what new and exciting opportunities lay ahead."

Having a keen interest in digital health and informatics, Dr Ubeja believes AI will have a big impact on Medical Administration in the future.

"I think as the field grows and evolves there will be greater conflicts between safety and efficiency and I think medical administrators are well placed to take an active role in decision making," he said.

Fierce Competition: Margaret Tobin Challenge Award winner Dr Rajdeep Ubeja (centre) with entrants (from left to right) Dr Samir Heble, Dr Paul Lane, Dr Brendan Graham and Dr Ruth Kearon.

Engaging Clinicians in Data Reporting to Improve Performance

Often, when doctors receive data, they glance at it and put it to one side. Data that is presented is often extracted and formatted in a way that management feels is important without engaging the doctor recipients to ensure it is meaningful, relevant and of interest.

So, how do you best provide doctors with data in a way that encourages reflection and changes their individual behavior?

Cabrini Health Clinical Informatics Director Dr David Rankin and a dedicated group of doctors are working on creating a culture where every clinician reflects on their performance and strives for good practice.

"The key to this culture change underpins robust clinical governance," Dr Rankin said.

"Data is at the heart of clinical governance and RACMA is the champion owner of clinical governance so RACMA Fellows should be driving the whole clinical data performance reporting agenda."

Dr Rankin examined the advantages and challenges of data collection and reporting at this year's Conference in Adelaide. His abstract presentation, Engaging Clinicians in Data Reporting - the Adventures and Perils, was judged the best.

At Cabrini Health, Dr Rankin and his team have been working with craft groups to develop meaningful reports and then distributing them in a way that focuses the doctor's attention.

His presentation outlined the process, which involved:

- Commitment from Craft Group Lead
- Selection of procedures of interest
- Identify MBS codes (surgery) or ICD codes (medicine)
- Agree a set of clinical indicators (from a standardised selection with limited craft group customisation)
- Agree timeframes for preparation and distribution - quarterly, semi-annual, annual or multi-year
- Prepare Group report and circulate to craft group leader
- Distribute Individual reports
- Presentation and discussion at craft group level

"When the members of the craft groups came together as a group, they are curious about how they are performing as a group," Dr Rankin said.

"But this method also provides comparative information on how they are performing as an individual so they can defend or support their individual position with the privileged setting of their peer group. And that process seems to be working well.

"I think we've reached a tipping point with 10 groups engaged where the medical executive are talking about it and saying how important it is."

Dr Rankin said there were many challenges involved in reaching widespread adoption. These include:

- Developing a culture of collaboration
- Benchmarking and organisational performance are currently a "management" issue
- Defining acceptable, recognised clinical indicators
- Creating a core indicator set
- Visualisation and presentation of data
- Communication and distribution
- Individual &/or group engagement
- Transparency and knowledge dissemination

"The idea of normalising the clinical indicators across the organisation means if we say to a surgical group your length of stay is long. We present the same information to the nurses so they can work collaboratively together and present the same info to the board and the Board says we have to work on length of stay," Dr Rankin said.

"So you have a consistent and cohesive strategy right through the organisation."

A new research project has been established with up to six PhD students. It is led by Sydney University with other partners including Monash University, Royal Australasian College of Physicians, Royal Australasian College of Surgeons, Cabrini Health, St John of God and Sydney Adventist Hospital.

"We found very little literature on how to identify appropriate clinical indicators, how to adjust the data and then how to best present comparative performance reports to doctors," Dr Rankin said.

"So we are excited about this project."

Dr Rankin believes it is inevitable that data about an individual surgeon's or physician's performance will eventually become public.

"There's a big national push for transparency and accountability and empowering patients to make informed choice," he said. "This is fundamental to creating a market in healthcare where patients have the information they require to make informed choices."

"It's really important that medical leaders drive the engagement of doctors around data and reporting, rather than some rogue organisation going out and starting to make data public that may not be meaningful and may not be valid. Unfortunately, that would create harm."

RACMA Members Go Great Gatsby at Conference Gala Dinner

Member Q&A

Dr David Rankin
MBCHB MPH MHA
DipObstet FRACMA

Clinical Informatics
Director, Cabrini Health

RACMA Censor
RACMA Past President

1. What drew you to pursue the path of medical leadership/medical administration?
After graduating from medicine in New Zealand, my wife and I moved to a rural town in Victoria where I took up a position in general practice. The local private hospital was struggling financially and was attempting to expand its services. I became interested in how the hospital was being run and somehow ended up as Director of Medical Services. For me, general practice operated within very short time frames with most problems resolving over a few days or weeks. I was looking for bigger challenges that were more complex and required creative and challenging solutions. The hospital brought in a retired FRAMCA with many years experience to develop a clear strategy for the health service and to assist it attain accreditation. He apparently saw potential in my interest in administration and leant me one of Peter Drucker's books on being an effective executive. I found it fascinating as it opened up a whole new world of management, leadership and strategic planning.

2. What lead you to undertake the Fellowship training program of RACMA?
My new mentor and I subsequently had a number of discussions about the role of management and the need to attains skills and competencies if I was to influence the outcome of clinical practice. As a senior FRACMA, he really saw the only pathway to credibility being through completing an MBA and RACMA training. My wife is an American and she was keen for our two pre-school children to spend more time with her recently widowed father. So, we made the decision to move back to Los Angeles where I completed my MHA and MPH. I subsequently attained a management internship in a large private hospital in downtown Los Angeles. At the end of the internship, I was invited to return to Australia as a steppingstone to taking up a position as CEO of a private surgical hospital in Auckland. On returning, I enrolled as a RACMA candidate and was fortunate to have Lee Gruner as my preceptor.

3. What attracted you to take up your role as a Censor with RACMA?
The year I passed my Fellowship was the first year that RACMA used case-based scenarios in the examination. I expressed frustration to the college that many of the examination questions were biased towards Australian health services and may be disadvantaging New Zealanders. As New Zealand branch president, I had a passion for ensuring RACMA was an Australasian college open to both Australian and New Zealand candidates.

4. Has the role of Censor evolved since you first started? What attributes and skills do you believe are key to being a quality Censor?
The College has matured enormously since I became a Fellow in 1995. At the time RACMA employed just two staff and had very little in the way of policies, procedures, training material or support. The use of scenario-based questions was brand new and the assessment framework was emerging. Scoring and results determination were quite basic. The work that the college has invested over the past 20 years in formalising the policy and procedures has ensured the robustness of the training and examination process. While I think it is relatively straight forward to determine if a candidate has been successful in answering the examination questions, the challenge is to communicate the reasons for your decision and provide constructive feedback to the borderline candidate so they can apply the learnings and successfully pass the examination the following year. It is also a challenge to provide reassurance and support to the candidate while concentrating on evaluating their answers and accurately recording your findings. I try to continually remember that the candidate in front of me is a person, that they are nervous, and it is probably the first time they have been in this situation.

5. How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
Quality in healthcare is founded on robust clinical governance. Clinical governance is about ensuring every medical staff member reflects on their practice and is continually re-evaluating their decision making, patient engagement and techniques in light of best practice. Creating this culture requires a leader with credibility and trust supported by robust clinical data. These are the unique skills that make up the armamentarium of the FRACMA.

6. What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?
I am fascinated by the impact that digitisation will have on health service delivery. With the increasing availability of robust clinical data, the determination of quality and comparative performance will become democratised and transparent. As decision making moves into the realm of AI, medical practitioners will increasing become the communicators and skilled advisors to the informed patient. Healthcare will become a functional market with all that implies for demand management and purchaser discretion.
Transition to this new world will require very skilled medical leaders who can ensure the sustained delivery of quality healthcare during what will likely see significant political battles before we attain a new equilibrium.

This will be an exciting, but challenging transition.

Member Q&A

Dr Caroline Clarke
BM DM FRACP FRACMA
GAICD

Executive Director Medical Services,
Royal Victorian Eye and Ear Hospital

RACMA Censor

1. What drew you to pursue the path of medical leadership/medical administration?
I trained as a paediatrician, first in the UK and then moved to Australia in 1989 where I completed my training, specialising in paediatric endocrinology. I took up a consultant position as Head of Adolescent Medicine at Monash Medical Centre in Victoria, whilst continuing to practice in paediatric endocrinology. After a few years I started to become more involved in the management of the paediatric service at Monash, resulting in me becoming Program Medical Director for the Children's Program in 2000 and for the combined Women's and Children's Program in 2001. I have always enjoyed the opportunity to influence the way services are delivered in hospitals, making sure patients and families are at the centre of safe, high quality health care delivery. I took the plunge in 2005 and moved from a very part time medical leadership and management role into a full time role as Chief Medical Officer/ Executive Director, Medical Services at the Royal Children's Hospital in Melbourne and a few years later moved on to a similar role just down the road at the Eye & Ear Hospital. I have been fortunate that working in a largely ambulatory speciality I have had the opportunity to continue part time work in paediatric diabetes. I would certainly not suggest that all FRACMAs should be practising clinically but personally I find it serves to remind me what life is like working at the coalface, plus I still find the interaction with my patients and their families very rewarding.

2. What lead you to undertake the Fellowship training program of RACMA?
I was part of the first cohort who undertook the Executive Pathway for fellowship (then known as the Accelerated Pathway) leading to me becoming a FRACMA in 2010. At the time I was already in a substantive CMO position, however I felt it was an opportunity to ensure that I had knowledge and skills across the full range of competencies and had a good working knowledge of other health environments having predominantly worked in the acute public sector. Going back to take an exam after many years was very daunting (a feeling shared by most of my peers at the time) but I am really pleased that I did this and it helped me fill a few "gaps" such as private sector and aged care where I hadn't worked.

3. What attracted you to take up your role as a Censor with RACMA?
Earlier in my career I had been actively involved in the Royal Australasian College of Physicians both as a member of their Board of Censors and as Deputy Chair of the Committee for Exams. I was interested to engage in similar roles with RACMA as this is now my primary college. I saw this as an opportunity to bring some of my experience and learnings from my RCPA role, plus those as a recent fellow of RACMA. More recently I have been a member of a number of Specialist College Accreditation panel's for the Australian Medical Council which gives me a closer view of the work and improvements other Colleges are undertaking which is also useful for my contribution as a Censor. I am very pleased that I put my hand up to be considered for this role which I am really enjoying and hopefully making a positive contribution!

4. Has the role of Censor evolved since you first started? What attributes and skills do you believe are key to being a quality Censor?
My observation over the past 3 years is that the role of Censor has continued to evolve in a positive way under the leadership of the immediate past Censor-in-Chief, Alan Sandford, and the current incumbent Peter Lowthian who have both been inspiring in their role. Progress over this time has included more opportunities for peer review including robust calibration sessions for the trial and actual exams. The Censors have contributed actively to recent developments and improvements in the curriculum and training matters as well as providing input into formal college policy around training and assessment. For me the required attributes and skills include excellent communication skills, collegiality, commitment, flexible thinking and willingness to engage in constructive feedback (for self and others). Censors bring a range of expertise from their diverse working environments, and we can all learn from each other.

5. How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
They have a critical role to play. Our fellows and members have an enormous number of cumulative years of experience working in leadership and management roles across a range of health environments in the private and public sectors, in metropolitan and rural areas. We have a level of credibility with our medical peers which cannot be substituted. As well as providing significant leadership to all aspects of clinical governance the College has an opportunity to provide advice and support to other colleges who are developing leadership roles and competencies for their fellows and members.

6. What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?
RACMA needs to ensure that it is in a position of continual renewal, keeping abreast of changes to funding, legislation, service delivery, challenges in clinical governance and the changing workforce requirements. One recent example of the changing environment is the digital transformation that many health services are undergoing: this means that as medical administrators we need to take a leadership role in this space and ensure that our processes, for example clinic governance, reflect the new environment. Personally I have recently moved into a part-time role as Chief Medical Information Officer at the Eye & Ear Hospital. I am no technical expert but my role is very much to ensure that clinician expectations are met whilst ensuring that quality of care is improved and the benefits of these new systems realised.
RACMA is a relatively small college and must ensure that its importance and the role and standing of its fellows is fully understood by others including other professional colleges and health services. We need to ensure that our training and education programs are agile to ensure our fellows and associated fellows are always equipped for the current environment.

Member Q&A

Dr Colin Feekery
MBBS (QLD) FRACMA
MHA (NSW)

Executive Director Medical Services, Eastern Health

RACMA Censor

1. What drew you to pursue the path of medical leadership/medical administration?
This is a question I have often asked myself. When I was a clinician I confess that I did not think kindly about administrators. It was only when I was delegated the task of running a medico-legal unit and establishing a clinical ethics service that I began to appreciate the complexities of management and the challenges of leadership.

What has sustained me in this career is more prosaic; I like things neat and tidy. It's a fatuous reason for becoming an administrator but nothing satisfies me more than seeing a complete complement of staff bedded down in a gap-free roster; or having a coherent policy written, accepted, understood and in-place; or chairing a meeting which results in actions completed and implemented. Bliss.....

2. What lead you to undertake the Fellowship training program of RACMA?
I came to RACMA reverse wise. I did a management degree, then became a medical manager and subsequently came to appreciate that there was a whole body of colleagues who belonged to this RACMA "thingy". I knew Alan Sandford from my paediatric days. It was he who kept preaching the benefits of doing the exams and joining the elect. Once committed I couldn't afford to fail! How could I return to work as a Chief Medical Officer having failed the theory?! So, in a study group comprising four very senior administrators I learnt the theory and much more about medical administration. The "old guard" were fortunate to be joined by a competent trainee registrar Anjali Dhulia, who patiently corrected our idiosyncratic approaches and taught us exam technique.

3. What attracted you to take up your role as a Censor with RACMA?
The reason is that I wanted to "give back" to those who had so generously given to me. The college and our profession can only prosper when we give of our time and ourselves.

4. Has the role of Censor evolved since you first started? What attributes and skills do you believe are key to being a quality Censor?
I have changed and so has the College. The College has become increasingly professional in how it trains, assesses and qualifies its trainers and trainees. This was evidenced by the recent review by the Australian Medical Council who were fulsome in their praise. Observing my fellow Censors, they reflect what is best in our profession. They impress as being motivated to do good, are self-critical and despite being leaders in their jobs are team players in their censor's role. I cannot talk for others, but I do take my duties very seriously; I listen attentively, I think carefully and I try to assess objectively, using agreed upon rubrics.

5. How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
The evidence is accruing; doctors engaged in the management of health services translates to better patient outcomes, better use of resources and increased staff satisfaction. It's a no brainer; how we engage, train and empower clinicians is the challenge.

6. What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?
There are many future challenges which we are going to confront. Too many to list, so i will confine myself to one. Our society's current obsession with orthodoxy. Our electronic world has enabled a dictatorship of the many. Everywhere I look, i see that those who are not in step with the many are derided. The number of taboo subjects are becoming legion and those who question are quickly culled. I hope that our college continues to provide a venue for questioning and debate; a haven where science governed by common sense trumps the mediocrity of the middle ground. While i don't always love "ratbags" they do hold a mirror up to ourselves. So long live those who are out-of-step! Their "ratbaggery" may just be worth listening to.

Member Q&A

Professor Gavin Frost
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FAFPHM FHKCCM (Hon)

School of Medicine, Sydney

RACMA Censor
RACMA Past Censor-in-Chief
RACMA Past President

1. What drew you to pursue the path of medical leadership/medical administration?
I trained at Sydney University and the great Sydney Hospital Clinical School. After several years of general medicine, and with an interest in hypertension and renal disease, I assisted in establishing as cardiovascular risk screening program in 1976.Subsequently support from the Kiwanis Club of Sydney and the then Community Health and AntiTB Association allowed us to open a mobile screening service as well.

I realised I was quite innumerate, and with a NSW Health Department scholarship in obtained an MPH. I heal dual positions of Deputy Medical Superintendent and Director of Community Medicine and greatly appreciated to opportunity to be at the interface of medicine and health service management.

2. What lead you to undertake the Fellowship training program of RACMA?
A lecturer suggested I apply to RACMA because of my health management interests and I duly obtained fellowship after examination. In the late 1970s the training was self-directed with frequent learning groups to attend. The examination (held on both floors of the College Building in Drummond Street Carlton) consisted of 5 vivas. A number of colleagues achieved fellowship around the same time.

3. What attracted you to take up your role as a Censor with RACMA?
The opportunity, apart from contributing to the assessment of future colleagues as Fellows, to assist with the development of the assessment functions, and ensure the reflection of the curriculum in the assessment.

4. Has the role of Censor evolved since you first started? What attributes and skills do you believe are key to being a quality Censor?
The commitment of censors to their task has always been a great inspiration to me. The role is now more complex, subject to close peer review and moderation and still just as rewarding. Just as the assessments evolve, so must the role of the censor.

5. How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
The Australasian health system is an extraordinarily complex system with multiple opportunities for patients/clients to fall between the gaps -more so in Australia than New Zealand. With a clear focus on patient outcomes the qualified medical administrator is in a unique position to implement control over many aspects of the care system to ensure best results at the lowest reasonable costs.

6. What are the challenges you can see that RACMA, and the field of medical administration in general, will face in the future?
Ever increasing demands for services generated by advances in technologies and population expectations and population ageing will continue to be experienced into the foreseeable future. Medical administrators are uniquely placed to contribute by policy development, technology assessment and system review and improvement.

Developing a System of Organised Trauma Care in the Era of Tasmanian State Health Reform

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Abstract

Regionalised trauma systems have evolved over 50 years to address the clinical, operational and strategic challenges injury presents as a major public health problem. All trauma systems have general features that are associated with significant outcome benefits, whilst continuing to evolve in response to changes in presentation and practice.

Accreditation of trauma services, conducted in Australia by the Royal Australasian College of Surgeons through its Trauma Verification program (with participation and support of the Australasian Trauma Society and the colleges responsible for Emergency Medicine, Intensive Care Medicine, and Anaesthesia) provides a mechanism to shape individual services according to bi-national best practice and expert assessment.

Tasmania is a small island state that is the last regional jurisdiction in Australia to seek to implement a regionalised trauma system, as part of an overarching state-health reform process. The new Royal Hobart Hospital (RHH) trauma service represents the transition of a progenitor State-wide Trauma Service as part of this reform process.

Further development will require modeling its structure and processes, service delivery and model of care against established national trauma benchmarks described through RACS Trauma Verification, tailored to local implementation and needs.

Background

Tasmania is a small island state to the south of the Australian mainland with a highly distributed population of over 520 000. Main population centres are in the south (Hobart), north (Launceston) and north-west (Burnie, Devonport), each with corresponding public hospitals and co-located pre-hospital services. Fixed-wing retrieval capability is based in Launceston, and a helicopter emergency medical service based in Hobart shares platforms provided through the Tasmanian Police Service also providing search and rescue services for the state. Outside these areas, the highly distributed population is serviced by small rural hospitals and limited ambulance services, with either solo or volunteer paramedic staffing. A system of organised trauma care has been proposed to address the public health problem of injury for the state as part of a state health reform process, and to bring Tasmania into line with national counterparts.

Injuries are acknowledged as a leading cause of death between 15 and 45 years of age. They present significant burdens to individuals, health services, and communities in terms of lives lost, quality of life reduced, physical dependence, and financial cost. Injury presents both consequences for both acute care and long-term survivorship, and so represents a major public health problem in Australia and around the world [1, 2] . Care of the severely injured benefits from an organized system of trauma care that ideally gets "the right patient the right care in the right place at the right time", to avoid preventable death or harm, and optimize patient outcomes for high quality functional survival on return to their families and communities [3- 7]. Optimally structured trauma systems share common themes and have been associated with significant mortality reductions and better functional outcomes [8-16]. (BOX 1)

Australian trauma services were originally modelled on USA services, themselves modelled on their military experiences in Korea and Vietnam but responding to the civilian public health problem of road trauma in the 1960s and 1970s, with a classically described trimodal distribution of immediate, early and late deaths [20- 23]. At the outset, surgeons would go on to accept responsibility for clinical leadership, direction and advocacy in a field dominated by their knowledge, skills and approaches to early and definitive care.

Since then technological advances including computerized tomography, ultrasound and interventional radiology provide more options for non-surgical care and non-operative management. Specialist fields of emergency medicine and critical care medicine emerged to provide greater levels of resuscitative and supportive care, including the pre-hospital and inter-hospital environment. Pre-hospital care has benefitted from major advances in paramedic training, knowledge and skills. The distribution of deaths following trauma in various jurisdictions has likely changed as a function of these influences [24-27].

Sadly, improved road and vehicle design, legislation, policing and road safety initiatives and injury prevention programs have failed to eliminate transport-related injuries as a leading cause of severe injury presentations and death. Data from the Towards Zero Tasmanian Road Safety Strategy 2017-2026 indicates that as of 2015, "serious casualties" remained stable at around 300 per annum, and the annual population road trauma death rate at 7.03 per 100,000 was above the national average (5.13) and second highest in Australia at the time [28, 29]. Superimposed on this is the rise of low energy injuries due to falls in the elderly with superimposed frailty and/or comorbidity, with a disproportionately higher mortality risk [29].

Tasmanian experiences of health reform

On 26 July 2014 the Tasmanian Minister for Health announced One State, One Health System, Better Outcomes (One Health System (OHS)) state health reform, through which trauma service development can be described across five eras:

- Clinical Advisory Group (CAG) era: late 2014 to mid-2016.
- State-wide Services: 01 July 2016 to 29 May 2017
- Transition to local governance: mid 2017 to early 2018
- Establishment of RHH Department of Trauma Services: Early 2018 to July 2019
- RHH Department of Trauma Services development following verification: July 2019 to present

Clinical Advisory Group (CAG) era: late 2014 to mid-2016

A key component of the health reform process was the amalgamation of three regional Tasmanian Health Organisations (North, North West and South) into a single Tasmanian Health Service.

Consultation began in August 2014 with an Issues Paper, followed by a Green Paper in December 2014. Clinical Advisory Groups (CAGs) were commissioned by the DHHS to provide expert advice and facilitate state-wide clinical engagement. Ultimately 19 CAGs would be established to facilitate statewide consultation and draft role delineation frameworks and clinical service profiles using Queensland's Department of Health Clinical Services Capability Framework, completed and outlined in the resulting White Paper mid-2015 [30]. The RHH was determined to be the highest-level trauma service in Tasmania (level 6), acknowledging its role as a state-wide referral centre for major trauma.

Trauma services were unique in this process, not being the amalgamation of existing services, but an ambitious attempt to establish a new service without a finalised governance structure for the proposed health service. The Tasmanian Health Service (THS) commenced operation on 1 July 2015 as a separate legal entity under the Tasmanian Health Organisation Act, with consultation regarding a governance structure having just commenced in April 2015.

By mid-2016, a new substantively appointed CEO directed the evolution of the 'design phase' CAGs into an operational state(-wide) services by submitting business cases for their state-wide services. In the setting of time and resource constraints, a small scale proto- service for trauma, the State-wide Trauma Service (STS), was proposed to continue to develop the state-wide trauma system.

State-wide Services: 01 July 2016 to 29 May 2017

The second half of 2016 saw the appointment of a part-time director, and a permanent full-time clinical nurse consultant to the new service, which commenced its program of projects, stakeholder engagement, and submissions for workforce, capability development, and better trauma governance and operations. However, state-wide services were effectively dissolved in favour of a devolved local governance model announced on 29 May 2017. This would ultimately be finalised with the Tasmanian Health Service Act on 1 July 2018 splitting the state once again into three regional health organisations, now designated THS-North, -North-West and -South. The future of trauma services was again very unclear.

Transition to local governance: mid 2017 to early 2018

The STS entered a period of flux within the THS. It had been relegated to carrying on in an advisory role, but without formal links to the THS or any hospital executive or operational departments. Hospital trauma services listed on local governance organizational charts had no provision

Developing a System of Organised Trauma Care in the Era of Tasmanian State Health Reform

BOX 1: FEATURES OF OPTIMAL TRAUMA SYSTEMS

- A geographically demarcated regional area of sovereignty, conferring responsibility and accountability for clinical care standards using evidence-based approaches, with processes for operational oversight, clinical governance, leadership and strategic direction
- Pre-hospital and retrieval services providing high level responses to scene and interfacility transport of the severely injured, so linking injury scene and trauma centres
- A network of accredited trauma hospitals (trauma centres) in this region, each with designated roles according to acknowledged capability to provide corresponding levels of early, definitive, and/or subacute care for the full spectrum of injured patients
- Inclusive coordinating arrangements matching pre- and inter-hospital responses and trauma centre destinations to injury severity, patient and logistic factors in order to:
  - ensure timely early care; and
  - maximise the number of severely patients receiving expeditious definitive care in major trauma centres
- Continuity of care through acute and sub-acute hospital phases, integrated across different centres, multiple service providers and craft groups, providing:
  - Early care including resuscitation;
  - Assessment and prioritisation including trauma imaging;
  - Definitive care including operative or non-operative management, interventional radiology and supportive perioperative and critical care services; and
  - Rehabilitative care with links to primary health and community
- Quality improvement systems that encompass data collection and reporting on activity, acuity, performance, and outcomes
- Programs for trauma research and education
- Sustainable organisational arrangements, staffing, funding, resourcing, and housing

made for their funding or establishment. Local executives were rapidly being established, and by 1 July 2018 the THS CEO would be stood down and the Governing Council terminated, in favour of a small state level executive and three new regional hospital executives responsible for hospital governance structures including streams and constituent services. The STS took up an opportunity to transition as the Department of Trauma Services within the RHH Surgery and Perioperative Services stream, retaining state-wide advisory responsibilities, but now tasked to develop and implement clinical service delivery and trauma quality improvement programs at the local level, focused on three projects:

- Resumption of the Tasmanian State Trauma Registry project
- Development of a trauma case management model of care at RHH
- Royal Australasian College of Surgeons (RACS) trauma verification [31]. Trauma Verification was identified as a highly effective opportunity to drive and shape local capability development, and Tasmania conspicuous as being perhaps the last jurisdiction bi-nationally to seek verification [31].

Establishment of RHH Department of Trauma Services: Early 2018 to present

After reappointing a new clinical nurse consultant, the RHH trauma service pursued the three strategic priorities through the course of late 2018 and into 2019. RACS trauma verification consultation was conducted 28 February and 01 March 2019, and the report submitted to the RHH 01 July 2019.

RHH Department of Trauma Services development following verification: July 2019 to present

The organisational response to the RACS Verification Consultation report has not been issued at time of writing. The challenge for the RHH, the THS and the Department of Health will be to support the transition of trauma services from a limited "relocated statewide service" to a fully integrated clinical service at the state's major referral centre, fulfilling all requirements for RACS verification criteria as a level 1 trauma centre.

Conclusion

The RHH deserves to be supported to lead an inclusive, highly coordinated, well governed system of clinical services and care for the severely injured that is:

- safe, effective and timely;
- well-regarded and highly valued by patients, families, carers, community, and clinicians; and
- well supported by the state's funding bodies.

It is certainly time for Tasmania to join the bi-national trauma community. The response to verification consultation report will be vital in shaping this process.

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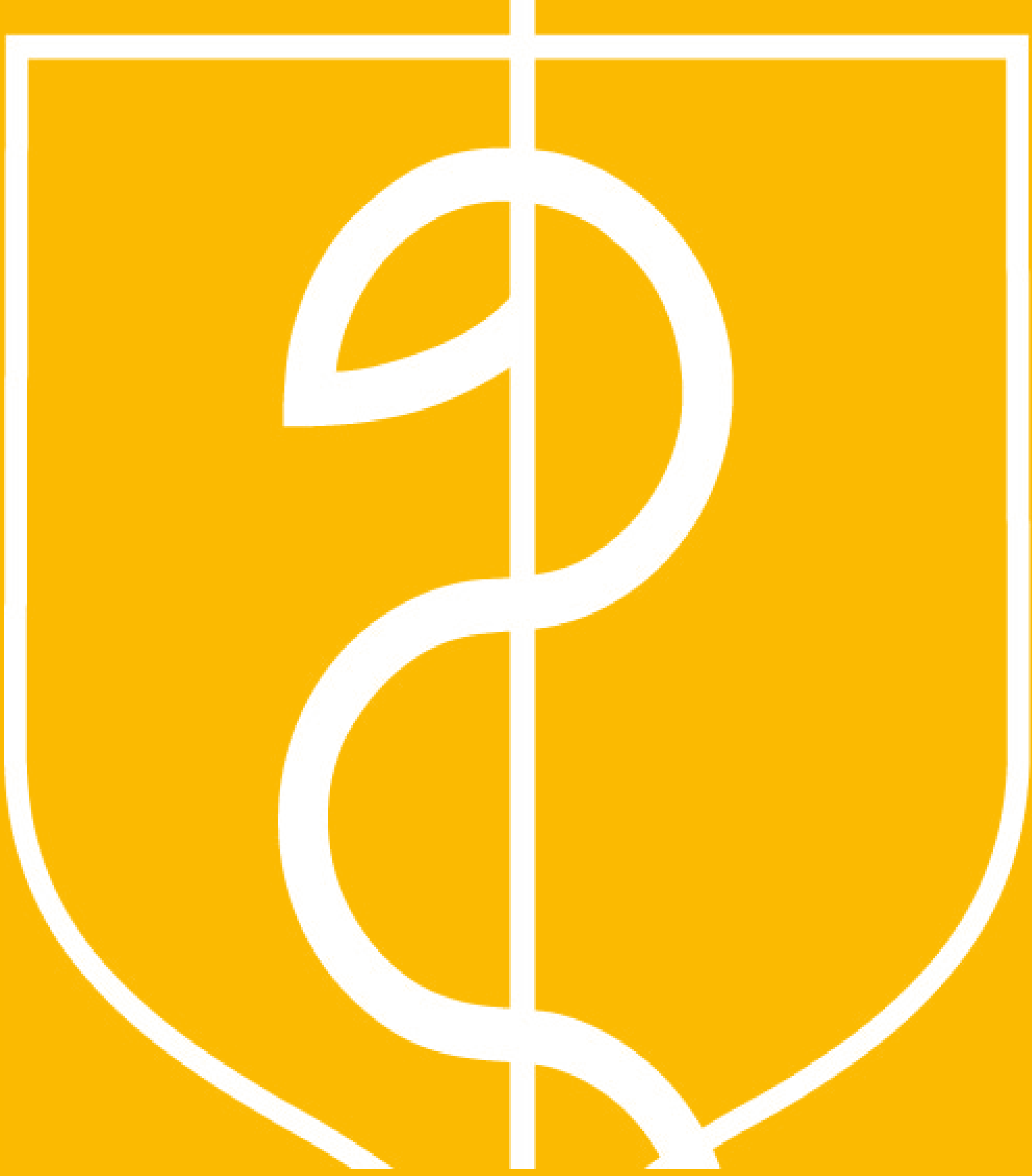

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