RACMA
ROYAL AUSTRALASIAN COLLEGE of Medical Administrators

The Quarterly #4

2019

> College increasing presence, voice & influence

Quarterly 4

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

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The College was founded in 1967 as the Australian College of Medical Administrators and attained its Royal Prefix in 1979. In August, 1998 when links with New Zealand were formally established, the College changed its name to The Royal Australasian College of Medical Administrators.

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

From the President

As we come to the end of another very busy and fruitful year for the College, I would like to take this opportunity thank everyone for their hard work and commitment to our College.

To our Censors, Supervisors, Preceptors, site Accreditors and those members involved in the various RACMA committees – if it wasn't for your ongoing commitment, the College would not be able to achieve and succeed as we do for a College of our size. I would also like to acknowledge the extraordinary work our Jurisdictional Committees undertake.

We have had an incredibly successful year, in particular I would like to note the record number of first year Candidates and Leadership for Clinicians participants, the AMC Accreditation outcome and the conference in Adelaide.

Extra support for the Jurisdictional Committees commenced in the second half of this year to administratively assist their activities and we will look at broadening the support to other areas.

I was delighted to refresh the Memorandum of Understanding with the Hong Kong College of Community Medicine and am excited by our strategic partnership with the International Forum on Quality and Safety in Healthcare for next year's conference in Sydney. RACMA's conference runs from 28-29 September 2020 and the International Forum will take place from 30 September to 2 October 2020.

We continue to improve the College's presence and visibility by building a profile in the policy and advocacy space. RACMA was engaged in a number of roundtables, consultations and high-level meetings across the country to expand its footprint in regard to advocacy work. The work of Dr Helen Parsons and the Policy and Advocacy Committee she Chairs needs to be noted.

The College's key leaders will continue to advocate the role of RACMA at jurisdictional, state, national and international fora, particularly in the area of workforce planning and the support of First Nation's peoples. The clinical governance, medical leadership and advocacy domains we represent and support are also a constant critical obligation.

I would like to acknowledge our Chief Executive Melanie Saba and her tireless team for their continued dedication to the College and its members. None of the success achieved this year can occur without a hardworking and dedicated team.

However we cannot rest on our laurels!

We will continue our efforts to maintain a strong level of engagement and consultation with all members to ensure we remain attentive to your needs. I encourage you to be involved in College consultation work and respond to any Expressions of Interest that arise.

Lastly, I wish everyone all the best for a safe, healthy and happy festive season and look forward to a productive 2020 for Medical Leadership and RACMA.

Associate Professor Alan Sandford AM
President

Dean of Education Update

2019 has been an interesting year of updating the Medical Management Practice Domain of the College Curriculum.

Firstly we have continued to refine our Learning Objectives in the Domain competencies (Medical Expert, Medical Manager and Communication) and have focussed on clinical governance and digital health.

Our other main activity this year has been raising awareness amongst supervisors and candidates of our preparations for our transitioning from centralised marking of written management assignments to scheduled assessment of learning tasks in the workplace i.e. programmatic workplace-based assessment, for learning.

In the Research Training Domain we have begun to see the fruits of the 2018 Research Training review. We now have four options for the evidence-informed project:

- a curiosity-driven health service research project;
- a substantial investigation for a quality improvement management task, using a scholarly approach;
- a systematic analysis of literature, using a standardised protocol, relevant to a health service/medical management task; or
- a bio-ethical disputation of an issue arising in the training workplace.

It has been pleasing to see that the challenge for the fourth option has been taken up by several candidates already and some interesting questions are being investigated!

We could not have achieved these changes in our curriculum renewal without the commitment of expertise and time of interested Fellows and the involvement of our Candidate Representatives on our committees, especially the Chairman of the Candidate Advisory Committee, Dr Bahare Moradi.

We have also been ably supported again this year by our Chief Executive Ms Melanie Saba and we have welcomed Ms Angela Chan, our new Director of Education, with open arms!

Thank you to you all.

Dr Lynette Lee
Dean of Education

College News

RACMA 2020 Sydney

As was announced in Adelaide, the 2020 Conference will lead into the 2020 International Forum on Quality and Safety in Healthcare, of which RACMA will be a partner. As a partner, RACMA has secured a 30 per cent discount for our members for the International Forum.

Registrations for the RACMA Conference will open early next year. Members will also be able to register for the International Forum on Quality and Safety in Healthcare at the same time and can access the 30 per cent discount. The partnership provides members the opportunity to submit the one poster for both events.

The call for Abstracts for the College Conference will open early next year. Stay tuned for a registration link and more information on the RACMA website in the New Year.

The Conference will be held at the Sydney Convention Centre, Darling Harbour, on Monday 28 and Tuesday 29 September 2020 and the International Forum will take place from Wednesday 30 September to Friday 2 October. 2020

If you have any questions or require more information please contact College Conference Co-ordinator Paula Wilkinson on 03 9824 4699 or racmaconference@racma.edu.au.

2020 FTP dates

The 2020 oral examinations and workshops for first, second and third-year Candidates have been locked in.

Oral Examinations
Date: Saturday 1 August & Sunday 2 August 2020
Location: AMC National Test Centre, Melbourne

Trial Oral Examinations
Date: Friday 4 December, Saturday 5 December & Sunday 6 December 2020
Location: AMC National Test Centre, Melbourne

First Year Candidates Workshops
Date: Thursday 26 March to Saturday 28 March (inclusive) 2020
Location: Melbourne Holiday Inn, Tullamarine Airport

Second Year Candidates Workshops
Date: Friday 12 June to Saturday 13 June (inclusive) 2020
Location: Melbourne Holiday Inn, Tullamarine Airport

Third Year Candidates Workshop
Date: Wednesday 19 February to Saturday 22* February (inclusive) 2020
Location: Melbourne Holiday Inn, Tullamarine Airport

* Research oral presentations will take place on Saturday 22 February 2020.

Workshop registration information will be emailed closer to the time of each workshop. If you have any questions please email ftpadmin@racma.edu.au or phone FTP Services Co-ordinator Jessica Coombes on (03) 9088 7959.

MCNZ Regulation Updates

The Medical Council of New Zealand has recently revisited its Statement on informed consent. This statement sets out the standards of good medical practice when discussing options for treatment and obtaining consent from patients. It will support patients to understand what they can expect from their doctors when discussing options for their treatment.

The key points about informed consent are:

- Every time treatment is provided, a doctor must have permission to provide that treatment - 'informed consent'. Without informed consent, the treatment may be unlawful. To help the patient decide whether they want a treatment, they first need to be given information, such as the risks and benefits.
- Obtaining consent is a process of shared decision-making where a doctor helps the patient understand their medical condition and the options for treating (or not treating) that condition. For the full statement visit https://www.mcnz.org.nz/informedconsent/

The Council has also released strengthened Recertification requirements for vocationally-registered doctors in New Zealand that build on existing systems and emphasise the value of the activities, particularly those related to review and reflections of practice.

Responsibility for determining what is appropriate for each vocational scope falls to the recertification programme provider. Accredited recertification programme providers are expected to work towards these requirements, with implementation by 1 July 2022.

Have Your Say

The College is surveying members to find out more about their preferences for Professional Development. You will have received the survey link via email. The survey will take approximately 5 to 10 minutes to complete and the information provided will be used to assist in planning future Professional Development activities offered by the College.

The survey closes Friday 24 January 2020. If you have any questions please email Angela Chan - achan@racma.edu.au

or Debbie Greenberger - dgreenberger@racma.edu.au

Member ID

From the beginning of 2020, all member communications will include your five-digit member identification in the top left hand corner. This will make it easier for members to find their ID when trying to access MyRACMA or when seeking help from the College for any reason.

Please note the RACMA office will close at 12pm 24 December and reopen on 2 January 2020.

Continuing Professional Development Update

Register 2019 CPD Requirements

Members are being reminded annual Continuing Professional Development (CPD) requirements need to be completed by 31 March 2020.

It is important to note CPD activities for RACMA are relevant to your scope of practice as a Medical Administrator and include a professional development plan (PDP), which is mandatory for all Fellows and Associate Fellows.

There are quick reference guides (QRGs) available on the website which can be found on the website at https://racma.edu.au/members/cpd/myracma/. These QRGs include:

- how to enter an activity;
- how to update your personal details; and
- how to enter a PDP.

Minimum CPD compliance requirements for Australian and New Zealand Fellows and Associate Fellows can be found on the website at https://racma.edu.au/members/cpd/cpd-handbook/. The CPD handbook is under review and until this is completed, the 2017-2018 handbook remains current.

If you wish to review a summary of your 2019 CPD activities, login to MyRACMA and you will be directed to your CPD Dashboard, which provides a total of hours against each category. You can download a summary by clicking on "My ePortfolio" and selecting "Summary".

It is crucial to maintain your CPD compliance for both membership of the College and registration with the Medical Board of Australia or Medical Council of New Zealand.

Please email cpd@racma.edu.au if you have any queries regarding your CPD compliance requirements.

Professional Development Plans (PDP)

PDP's are mandatory as they can guide a doctor's future CPD and educational activities throughout their career. It ensures a focus on those activities that will provide most benefit to a particular doctor, based on identified development needs, the identification and integration of professional and personal (non-work) objectives.

PDPs are most effective when they incorporate specific goals that are achievable, time-based and appropriate to the doctor's actual work and the setting they work in. The PDP is a working document that is revisited and updated regularly to reflect areas still to be addressed, and where things have been achieved. The PDP can be developed either before or after CPD activities and an annual conversation have been completed, thereby using data gathered to inform future learning and activities.

CPD funding for rural and remote Australian Fellows

Grants worth up to $10,000 are available to eligible RACMA Fellows based in rural and remote Australia to cover training costs, travel and accommodation for CPD.

The funding is part of the Federal Government's Support for Rural Specialists in Australia (SRSA) program. Specialists who live and work in areas determined using the Modified Monash Model system categories MM2 to MM7 are eligible to apply for the grants.

CPD activities must be completed between 1 April 2020 and 30 April 2021. RACMA offers a range of Professional Development workshops across Australia, which support your CPD compliance requirements. For more information on RACMA professional development opportunities email cpd@racma.edu.au.

Applications close Friday 31 January 2020 and successful applicants will be notified in March 2020. To find out more about the grants, including the online application form and guidelines, visit https://ruralspecialist.org.au/funding/round-5/

Exemption

You can apply for exemption for 2019 based on:

- Bereavement of an immediate family member
- Extended family/personal leave
- Health reasons
- Extended absence from professional duties
- Other special circumstances.

The policy can be found on the RACMA website by clicking HERE and the online form can be found at https://racma.edu.au/members/cpd/apply-for-exemption/

RACMA 360-degree Survey

A newly developed 360-degree survey was recently launched after being generated in consultation with a focus group comprised of College Fellows and Associate Fellows. The customised, online, peer-review questionnaire is designed for members and non-members to evaluate a person's interpersonal, management and leadership behaviours.

Aligned with RACMA's Medical Leadership and Management Curriculum Framework, the survey's 31 questions fall within the eight competencies of the RACMA framework of Medical Leadership, Medical Expert, Communicator, Health Advocate, Scholar, Professional, Collaborator and Manager.

A report is provided to each participant detailing their results and two webinars have been developed to support participants to understand the benefits of the survey and how to get the most out of the report.

Participants will also have access to Mark Bramwell, who worked with RACMA to develop the survey. Mark can provide a one on one debrief session for a nominal fee. The debrief session assists in interpreting and understanding the report as well as identifying self-development strategies.

Completion of the survey will attract 10 CPD hours under the category of 'Peer Review'.

More information on how to apply and pay for access to the survey can be found at https://racma.edu.au/members/cpd/360-degree-survey/. Alternatively, queries regarding the survey can be directed to cpd@racma.edu.au.

College Asserting Presence in Industry Advocacy

A group of dedicated members have been working hard behind the scenes to strengthen the College's voice and become a formidable presence within healthcare advocacy. And it has been happening at a rapid rate in the last 12 months. This year alone, the College has completed close to 30 submissions for policy consultations across Australia and New Zealand, including the Royal Commission into Aged Care Quality and Safety.

As the Board continues to build a stronger profile for the College, advocacy has been identified as a key priority to achieve greater visibility, influence and recognition. After a hiatus of about three years, the RACMA Policy and Advocacy Committee (PAC) has been reinvigorated. A number of sub committees have been established under the PAC to focus on areas crucial to the College creating a footprint in Medical Administration and the healthcare industry in general. These sub committees are:

- Medical Workforce Planning for Medical Administration Working Group
- Rural Policy Advisory Group
- Diversity and Inclusion Working Group
- Indigenous Health Working Group (member appointment still in progress)

RACMA Policy and Advisory Committee

Helen Parsons CSC (Chair, New South Wales)
Paul Cavicchia (secretariat)
Alison Dwyer (Victoria)
Antony Sara (New South Wales)
Bahare Moradi (New South Wales)
Donald Mackie (Queensland)
Grant Phelps (Victoria)
Iwona Stolarek (New Zealand)
Jayanthi Jayakaran (South Australia)
Joe McGirr (New South Wales)
Kate Tindall (ACT)
Maryann Ferreux (New South Wales)
Mellissa Naidoo (Queensland)
Peter Thomas (New South Wales)
Peter Renshaw (Tasmania)
Tony Robbins (West Australia)
Virginia Hope (New Zealand)

The driving force behind the PAC is RACMA Board Director Dr Helen Parsons, CSC District Director Medical Services at Nepean Blue Mountains LHD. The PAC Chair has worked in rural and urban health service settings in the public sector, correctional health services, Immigration and Defence. Dr Parsons has dedicated her career to working in and advocating for communities in need, so it is little wonder she jumped at the chance to be Chair of the PAC.

"I thought it was a very important area in which the College needed to develop its presence," Dr Parsons said.

"Our College Fellows and members occupy very influential positions across Australia and New Zealand and I felt, in many ways, that influence is under recognised. I thought we needed to take advantage of the opportunities presented by the positions our Fellows hold.

"We are in a very good position to provide informed, expert commentary and advice on all aspects of Medical Administration to ensure our healthcare settings offer quality, effective and efficient care."

However, it is not that simple. In Dr Parsons' experience, many other medical colleges do not recognise the role RACMA can play in providing leadership and management training and in leadership and policy advocacy in the health system.

"There are quite a number of doctors, and they are often quite senior doctors, who have never heard of RACMA," she said.

"We have a lot of work to do. I'd like to see the College identify the key players within all levels of the health sector across Australia and New Zealand as well as external stakeholders and influencers. The key then is to develop relationships with these stakeholders. In doing this, we will become a trusted body which is the first to be approached for advice on specialist leadership and management issues, and on health systems leadership and advocacy, rather than participating in ad hoc submissions as we are now."

Within its work plan, the PAC is focusing on three key areas – medical workforce planning for Medical Administration, community/consumer engagement and governance of new technology.

Dr Parsons said next to being health system leaders in clinical governance, medical workforce planning was a major priority for Medical Administrators

"The issues are around having sufficient numbers of well trained and qualified Medical Administrators across Australia and New Zealand, and ensuring appropriate distribution across the health sector," she said.

"We have recently set up the Medical Workforce Planning Working Group to identify the gaps and develop a plan to tackle the issue moving forward."

When it comes to community and consumer engagement, there are two aspects to focus on according to Dr Parsons. Stakeholders, including other medical colleges, and the actual community.

2019 RACMA Advocacy Consultation Submissions Summary

The Medical Board of Australia: Public Consultation on clearer regulation of medical practitioners who provide complementary and unconventional medicine and emerging treatments
The Royal Australian and New Zealand College of Radiologists (RANZCR): Ethical Principles for Artificial Intelligence in Medicine
The Australian Digital Health Survey Agency; the Australian Federal Government: Better connections: Your health, your say survey
Australian Health Practitioner Regulation Agency (AHPRA): Consultation on the definition of Cultural safety. This public consultation is released by the National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group) in partnership with the National Health Leadership Forum (NHLF)
Everymind: Tackling mental ill-health in doctors and medical students
New Zealand Ministry of Health: Therapeutics Products Bill Consultation. RACMA response with the Council of Medical Colleges in New Zealand
Medical Board of Australia: Good Practice guidelines for the specialist international medical graduate assessment process
Medical Council of New Zealand: Cultural competence and best practices when providing care to Maori patients and their whanau.
Australian Commission on Safety and Quality in Health Care: Australia's national to the Third World Health Organisation (WHO) Global Patient Safety Challenge - Medication without harm
Medical Board of Australia: Strengthened Continuing Professional Development for Medical Practitioners
Medical Council of New Zealand: Statement on the maintenance and retention of patient records
The NSW Health Consent Manual
Department of Health and Human Services, Victoria Government: Rural and Regional Medical Director role outline
Victorian Auditor- General Office (VAGO): To determine the relative efficiency and economy of Victorian metropolitan acute public hospitals
Australian Medical Association (AMA) Queensland: Doctors with disabilities
NSW Government, Health: HealtheNet and My Health Record for NSW Health Clinicians
Australian Health Practitioner Regulation Agency (AHPRA): Guidelines for Mandatory Notifications
The Royal Australian College of General Practitioners (RACGP): Standards for residential aged care facilities (the Standards)
The Australasian College for Emergency Medicine (ACEM): A review of the FACEM Training Program and associated system of training site accreditation
The Royal Commission into Aged Care into Quality and Safety

"We have some considerable work to do in this space, which I see as a key to our success in the advocacy space in the future," she said.

"We will carry out a benchmarking project to look at what the other colleges and other similar organisations have done in this space, and what has worked and what hasn't."

Discussions surrounding the governance of the introduction of new technologies in healthcare, such as Artificial Intelligence, are still in their infancy for the PAC. Work will ramp up next year once RACMA completes its Digital Health statement and competencies and the PAC complete some benchmarking work, which will all be used to inform the Committee's strategy for this key focus area.

Reflecting on the past year and the sheer volume of work completed by the PAC, Dr Parsons said there were a number of major achievements to acknowledge.

"We now have a system to firstly decide

FROM PREVIOUS PAGE

College Asserting Presence in Industry Advocacy

ABOVE: PAC Chair Helen Parsons CSC

if we should comment on a proposed consultation and secondly, whether we canvas comments from the PAC members or the wider College community," she said.

"We attracted a very strong group of College members with excellent expertise, interest and background in aged care who worked to put together a comprehensive submission for the Royal Commission into Aged Care.

"We formed the Diversity and Inclusion Working Group who will develop a Diversity Inclusion Framework and action plan - I see this as a much needed and very exciting way forward for the College to get that going.

"The Rural Advisory Group now reporting to PAC, has been renamed as the Rural Policy Advisory Group, and will have a focus on policy and advocacy which is very exciting, and they have gone out for further EOIs for that committee. And we are very close to forming the Indigenous Health Working Group."

The formation of the sub-committees under the PAC through an Expression of Interest process has proven successful in finding members with amazing skills and expertise and engaging with a wider group.

"I am quite buoyed by the interest in the EOIs and the calibre of people coming onto the committees and groups," Dr Parsons said.

"We have a wealth of knowledge and expertise in the College membership, and many members want to be engaged in this policy and advocacy space. We train highly skilled medical leaders for the health industry – we need to make sure our voice is heard, and we are sitting at the table when significant policy and strategic issues are being discussed in Australia and New Zealand.

"The wider we go to get more College members involved, the more the word will spread about RACMA and our advocacy work. It's a pretty exciting time for RACMA."

PAC SUB-COMMITTEE MEMBERS

Medical Workforce Planning Working Group (MWPWG)

- Alison Dwyer (Chair, Victoria)
- Antony Sara (New South Wales)
- Bahare Modari (New South Wales)
- Campbell Miller (Victoria)
- Daniel Garcia (Victoria)
- Donald Mackie (Queensland)
- Eugene Chee Keen Wong (Queensland)
- Helen Vickery (Queensland)
- James Houston (Queensland)
- John Elcock (Victoria)
- Jonathan Hodge (Queensland)
- Lachlan Gordon (New South Wales)
- Natalie Klees (New South Wales)
- Nicolas Smoll (Victoria)
- Peter Renshaw (Tasmania)
- Peter Thomas (New South Wales)

Diversity and Inclusion Working Group (DIWG)

- Mellissa Naidoo (Co-Chair, Queensland)
- Mary Ann Ferreux (Co-Chair, New South Wales)
- Anil Nair (New Zealand)
- Asha Chitrarasu (South Australia)
- Catharina de Muelenaere (New South Wales)
- Emma Crampin (West Australia)
- Lloyd McCann (New Zealand)
- Lynette Knowles (Queensland)
- Scott Ma (South Australia)

Rural Policy Advisory Group (RPAG)

- Joe McGirr (Chair, New South Wales)
- Hwee Sin Chong (Queensland)
- Kelvin Billinghurst (West Australia)
- Mau Wee (South Australia)
- Robert Pegram (Victoria)
- Sara Watson (Northern Territory)
- Sue Page (Queensland)

2019 PAC key advocacy submissions

The Royal Commission into Aged Care Quality and Safety

The Royal Commission authority conducted an inquiry into the quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken.

An Aged Care Working Group was formed to address the Royal Commission's Terms of Reference.

The RACMA response paper submission themes and areas of concern for Royal Commission noting were as follows:

- Choosing Aged Care facilities
- Corporate and Clinical Governance
- Transparency
- Risk Register
- Complaints Structure
- Workforce Planning
- Nursing and Medical Care
- Regulation & Licensing of Aged Care workers
- Cuisine & Diet
- Oral Health
- Using Technology to improve Quality of Care
- Transition from Hospital care to Aged Care facilities
- Rural & Remote Health
- Education
- End of Life Decisions
- Elder Abuse

RACMA also identified to the Royal Commission the major shortfalls and patient care issues in the Aged Care sector.

RACMA consultation provided key recommendations and solutions as medical leaders and administrators for best practice and optimal patient care.

EVERYMIND, National Medical Framework addressing the mental health and wellbeing of doctors and medical students.

The draft Medical Framework is a high-level document setting a reform agenda positioning the wellbeing of the medical profession as a national priority. The goal of the framework is to provide a platform for national leadership that is focussed on preventing mental ill-health, preventing suicide and supporting good mental health for doctors and medical students. It outlines a shared commitment between the medical profession and key stakeholders in the sector, including Commonwealth, state and territory health departments and hospitals; non-government organisations; regulatory agencies; the university sector; medical colleges and training providers; and specialist services.

RACMA advocated the necessary actions that needed to be implemented to achieve wellbeing of doctors and medical students from a medical leadership perspective and best practice.

The Royal Australasian and New Zealand College of Radiologists (RANZCR) Ethical Principles for AI in Medicine

The development of professional and practice standards regarding the research and deployment of machine learning (ML) systems and artificial intelligence (AI) tools in medicine, specifically with regards to clinical radiology and radiation oncology. These tools should at all times reflect the needs of patients, their care and their safety, and they should respect the clinical teams that care for them.

These principles are intended to complement existing medical ethical frameworks, which are insufficient for the emerging use of machine learning and artificial intelligence in medicine.

In order to bridge this gap, RANZCR has developed an additional eight ethical principles to guide the following:

- development of standards of practice for research in AI tools;
- development of standards of practice for deployment of AI tools in medicine;
- upskilling of radiologists and radiation oncologists in ML and AI; and
- ethical use of ML and AI in medicine.

The RACMA submission provided recommendations for modifications to the standards within clinical governance and leadership for AI and patient care.

FACEM Training Program Review

This paper outlined proposed modifications to the:

- Structure and content of the ACEM Curriculum Framework;
- Structure and requirements of the FACEM Training Program; and
- System of accrediting Emergency Departments for FACEM training, including limitations on time trainees may spend at any one accredited site, and the delineation (MR, UD or RR) of Emergency Departments.

RACMA recommendations provided feedback to an ACEM-accredited Special Skills placement approved for Training Stage 4, which included RACMA-accredited Medical Administration posts. Specifically advocating education and training in the fields of clinical management, governance and leadership.

Member Q&A

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

I have always enjoyed my clinical work in Intensive Care Medicine. I get lot of satisfaction with the individual patient care. I got early exposure to Medical Administration with my role as a supervisor of training in Lyell McEwin Hospital. I have been involved for the recruitment and performance management of ICU registrars. This inspired me to progress further in my medical administration pathway.

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

I have been working in a role of Medical Administration for some time. My role as a Medical Administrator has happened concurrently with my other role as a clinician in Intensive Care Unit. I have worked intermittently as an acting Director in ICU in Lyell McEwin Hospital along with my other role as a supervisor of training. I also get lot of exposure to medical administration in private health system in my role as a co-director of ICU at Western Hospital, South Australia. In doing those roles, I felt the need of further qualifications in medical administration to gain more knowledge and skills to perform my day to day work smoothly.

The program continues to attract an increasing number of clinicians, why do you believe this is happening? What are the strengths of the training?

AFRACMA program has become very popular amongst clinicians. I feel there are many reasons for that. Lot of clinicians like to increase their knowledge and skills by taking the medical administration pathway. It helps clinicians to take higher roles and make a difference in the healthcare system. It helps clinician to have more job opportunities in a different role in the health system.

What aspects of the training have strengthened your skills to succeed in your current role?

There are many aspects of training have strengthened my skills to succeed in my current role. Webinars and meetings have helped me to improve communications skills in the difficult situations. The training has improved my skills to manage a trainee in difficulties. It has strengthened my dialogues with other medical administrators and clinicians.

How would you describe the importance of both RACMA and qualified Medical Administrators to the Australasian health care system?

I feel qualified medical administrators are key people in the Australian health care system for the good governance. They have immense credibility with their excellent skills, knowledge and passion to do the role of a Medical Administrator. They can earn lot of respect from other clinicians and make a big difference in the health care industry to provide safe and high-quality care to all Australians.

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

There are many challenges in the field of medical administration. We need to utilise our resources optimally in Australian health care system. We need to utilise our skills for the benefit of Australian Population as we are the advocate for patients and safe care. There are many challenges to train junior colleagues to make administrators for the future. To develop ongoing CPD program and to keep it updates is also important challenge for the future.

Dr. Milind Sanap
FCICM, JFICM, AFRACMA, EDIC (Eur), MBBS, MD (Ind)

Senior Consultant
Intensive Care Medicine,
Supervisor of ICU Training at Lyell McEwin Hospital, South Australia

Clinical Senior Lecturer, Adelaide University
Co-Director: ICU, Western Hospital, Henley Beach, South Australia
VMO, Calvary North Adelaide Hospital, North Adelaide,, South Australia

Member Q&A

What drew you to pursue the path of medical leadership/medical administration?
During my clinical and non-clinical training years, I encountered various modalities of leadership and management. When working as a junior medical registrar I witnessed and was affected by daily struggles of rostering and resource allocation. Through, my public health training, the necessity of learning how to lead and manage a team was highlighted to me as a part of my future role as a Fellow. I also witnessed successes and struggles of the teams because of their effective or non-effective leadership. Hence, I decided to get organised for the future and learn about leadership and Medical Administration.

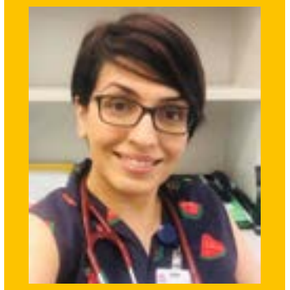
What lead you to undertake the Associate Fellowship training program of RACMA?
As there was no formal training provided in both of the fellowship pathways that I was involved, I gave myself a chance of attending the "Management for Clinicians" course in 2017 and applied for the Associate Fellowship program. Little did I know I would be accepted into the program near my second fellowship exam in Public Health Medicine. I attended the six-month program while studying for the Public Health Medicine exam. It was a big surprise to find out I won the Sue Moray Medal of Faculty of Public Health Medicine for the best grade in the exam. I believe a bit of hard work and the leadership course of how to manage a busy life of a medical mother, training and work (which was polished during the course) was all needed.

The program continues to attract an increasing number of clinicians, why do you believe this is happening? What are the strengths of the training?
As a medical practitioner who has been working both in non-clinical and clinical roles, I believe it has become more evident that we, as clinicians, are required to actively be involved in leadership and management roles after experiencing that our needs may not be have been addressed adequately. Clinicians are the main part of any leadership or management plans implemented in clinical grounds and their involvement at managerial level is felt and is essential for addressing the main clinical ground issues for providing best quality of care. I believe the AFRACMA program will provide the knowledge and expertise needed to be involved in leadership roles.

What aspects of the training have strengthened your skills to succeed in your current role?
My current role as an advanced trainee in addiction medicine, enables me to lead small teams on a daily basis. As a junior leader, I needed to understand and appreciate the role of a leader in a team, the type of leader I am and where my senior leaders are coming from. I was challenged many times during my clinical years of practice about concepts and patterns of communication and decisions made by supervisors, managers of the units and executive directors. The AFRACMA course helped me understand the various styles and forms of leafership and communication I might encounter in my career and also gave me the ability to carry out a leadership role I may hold in the future in my area of interest.

How would you describe the importance of both RACMA and qualified Medical Administrators to the Australasian health care system?
I believe Australian health care system would greatly benefit from clinicians who are trained for leadership and management. The training and skills gained during the Leadership for Clinicians program will enable a Fellow to practice both in clinical grounds and leadership positions. The Australasian health care system is a complicated maze. For a clinician to know how to navigate the system and have strong budget and resource management knowledge, for example, is crucial.

What are the challenges you can see that RACMA, and the field of Medical Administration in general, will face in the future?
There is a fine line between balancing the provision of the best quality of care for patients and budget and resource management. In the future, as resources become more scarce with health care organisations managed on activity-based funding, patient outcomes may deteriorate. The other challenge is as more health care services become aware of the importance of a sustainable system and reducing the carbon foot print, supporting and approving the funds for the resources to achieve this goal are important.
The available options for transforming a non-sustainable health care practice into an environmentally friendly one may not seem cost effective in the short term, and may even look controversial for health care directors or leaders in the future.



Dr Laila Parvaresh
MD, MPH, AFRACMA, FAFPHM

Addiction Medicine Advanced Trainee (RACP pathway)

South Eastern Sydney Local Health District- The Langton Centre- Prince of Wales Hospital

Member Q&A

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

I have been through most of my career, and still am, a rural-remote procedural GP and have worked in the Northern Territory, Central Queensland, Cape York and the Torres Strait. I've had the privilege to see and experience the health system quite broadly and from a number of angles. I've also had the opportunity to meet a wide range of people in communities that we as health care professionals seek to serve.

I think it was a natural progression for me as someone with an interest in serving many people with my career, to also want to work on improving the health system that so often determines the quality of care people receive. My experiences have made me want to make the system more healing for patients and healthier for staff. Whilst I got a lot of satisfaction from being a clinician, I felt I could offer value through positive influence in the system and being "top cover" for my colleagues.

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

I've always been a believer that natural talent only gets you so far. Effectiveness comes from channelling good practice, which usually must be actively learned. There isn't a lot of training in leadership and management for clinicians. I certainly didn't feel well equipped for this by my medical school and clinical fellowship training. Thankfully, being a generalist clinician helped train me to be comfortable with uncertainty and to problem solve. Whilst common sense is a great asset, I recognised I still lacked the technical competencies that are essential to succeed as a medical leader and manager. The Associate Fellowship was a great way to gain some foundational knowledge and skills, as well as to interact and learn from like-minded colleagues.

3. The program continues to attract an increasing number of clinicians, why do you believe this is happening? What are the strengths of the training?

The AFRACMA is extremely flexible and directly relevant to the work that clinicians do on the ground. It isn't onerous and many clinicians I know have completed it. Whether or not medical leadership and management is going to be their career path or not, I believe most clinicians could benefit from the principles they will learn through the AFRACMA.

4. What aspects of the training have strengthened your skills to succeed in your current role?

Alongside other training I have undertaken, the AFRACMA strengthened my self-awareness, helped me to put on a leadership lens and use a system thinking approach to solving clinical and non-clinical problems. Leadership and management isn't always intuitive, at least not for me, and the formal training I've undertaken, including the AFRACMA, has really helped to accelerate my personal growth as a leader and manager.

5. How would you describe the importance of both RACMA and qualified Medical Administrators to the Australasian health care system?

The Australian health care system has a relatively small number of doctors in leadership positions, particularly when you compare us internationally. Medical Administration was not really seen as a legitimate specialty field when I was a medical student. (Perhaps it was something to do if you couldn't find success in clinical practice.)

I think that perception is beginning to change and RACMA's visibility and credibility is growing. Doctors provide a lot of value to health care organisations and hold a perspective on the system than non-clinicians and other non-medical clinicians sometimes can't. There's a lived experience and inherent knowledge of the calling and deep responsibility that doctors uniquely have. All clinicians are to be patient advocates, and doctors are especially well positioned to advocate for their patients in a powerful way.

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

Whilst comparatively speaking RACMA is a small college in terms of membership, I think it should be leading the way in fostering a caring, compassionate, patient-centred and staff-centred culture in health care. I believe staff wellbeing is intrinsically linked with patient wellbeing. Health care providers can't provide the care patients deserve unless they feel safe, valued and trusted. Leadership sets the culture and RACMA is the college of medical leaders. Hence, we should hold ourselves responsible and accountable for whatever culture exists in healthcare.

We also need a more adaptable and resilient medical workforce to meet the needs of a changing society. Society is now always connected, always on, but we can't expect that health care providers be always switched on. RACMA needs to figure out how to lead in a world of changing paradigms, that is becoming virtualised, where cost constraints are increasingly being felt, and in which the health care workforce experiences unsustainable pressure.

We need courageous, compassionate and principled leadership in health care. Attracting enough of the right people to choose Medical Leadership as a vocation will be an ongoing challenge knowing how much my colleagues love and value practising clinical medicine.

Dr Eugene Wong
MBBS FACRRM FRACGP FARGP AFRACMA JCCA MIPH GCCS
Current RACMA Candidate

Director of Medical Services, Central Highlands and Woorabinda - Central Queensland Hospital and Health Service

Member Q&A

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

I entered medicine with the desire to make a difference for patients and it is this that keeps me coming back to work day after day. Subsequently I discovered that I also enjoy the opportunity to have an impact within my institution and within my college, to make a difference at a hospital and population level, for both patients and practitioners.

I have a habit of saying yes to opportunities and then working out the logistics afterward. This put me on a path very early in my career as a specialist anaesthetist as Supervisor of Training for ANZCA. Subsequently I was seconded to the NZ National Committee of ANZCA and took on a leadership role as deputy and then acting National Education Officer for the college. I was a member of the MCNZ Education Committee for a few years too, which gave me a broader overview of training and ongoing medical education for the full spectrum of medical students through to specialists. Subsequently I was offered the role of Deputy Director in my department and held this for 6 years until I became the Director last year.

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

It took me 6 years to become an anaesthetist and I think leadership requires formal training too. The opportunity to step up to being Director has occurred at a relatively early stage in my career, and although I had the benefit of being mentored into the role as deputy for six years, I felt it would improve my leadership ability if I held a formal qualification in this area.

3. The program continues to attract an increasing number of clinicians, why do you believe this is happening? What are the strengths of the training?

I think there is a growing perception that medical leadership is not a skill that we are born with, along with an appreciation that it is also not necessarily well taught in our primary specialties.

The strength of the AFRACMA is in the provision of an overview of the incredibly complex system within which we all operate, and a taster of the skills that you need to develop to succeed as a leader. Having had an opportunity to be an apprentice and learn many of these skills on the job already, I have found most value in access to CPD activities for fellows and networking with like-minded peers.

4. What aspects of the training have strengthened your skills to succeed in your current role?

My weakness was understanding financial spreadsheets and I found the opportunity to learn about these valuable – at least I can understand what the accountant is talking about now, although admittedly his thick Russian accent remains a challenge.

It is often useful to contemplate the different characteristics that make us all such complex beings. I know myself well (an anaesthetist who's a conscientious introvert; who would have thought), but it is useful to reflect on the communication strategies you might employ when interacting with and motivating different personality types. Doctors are highly intelligent, altruistic and motivated individuals, and one of the challenges is directing that energy and enthusiasm in a productive way.

5. How would you describe the importance of both RACMA and qualified Medical Administrators to the Australasian health care system?

It is crucial that we have Medical Administrators with an understanding of the complex health system in which we work, who have the ability to build relationships both within and between teams, and who have an understanding of strategic planning and health informatics. This will enable us to contribute to the ongoing provision of safe and quality care for our patients, whilst promoting innovation and quality improvement – and addressing inequity where it exists. This sits alongside the provision of excellent training opportunities, nurturing the next generation of medical practitioners and leaders, and providing a safe and rewarding environment for our peers and trainees to practise in.

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

The relentless pressure to achieve a higher quality and volume of work, with less and less resource – whilst patients have increasingly optimistic expectations of the care that we deliver, particularly with advances in medical technology and pharmaceuticals. Helping our patients and our colleagues to understand and come to terms with the reality of resource constraint is a constant challenge. It is becoming increasingly important to align patient expectations with realistic goals of care, along with the avoidance of futile treatment.

Dr Sally Ure
BHB, MBChB, Dip Obs Med Gyn, FANZCA, AFRACMA

Clinical Director, Department of Anaesthesia and Pain Management, Wellington Regional Hospital
Deputy Chair, NZ National Committee, ANZCA

Member Q&A

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

From an early stage, I wanted to contribute to solutions rather than constantly complaining. As a medical student, I was the president of the medical society and contributed to committees within the medical school. I continued my involvement after graduation through various organisations, including South Australian Medical Education and Training and the Australian and New Zealand College of Anaesthetists.

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

As an anaesthetist, you learn that you are a small, but potentially influential, cog in the machine. I interact with so many aspects of the healthcare system in my clinical role, but I felt that I was ineffective (and sometimes ignored) when I wanted to contribute to making the system better, not only for our patients but for the staff.

3. The program continues to attract an increasing number of clinicians, why do you believe this is happening? What are the strengths of the training?

We have entered an era where healthcare is increasingly being treated as a commercial entity and clinicians are becoming more disempowered in the ever-increasing bureaucracy that creatively uses the term "clinician engagement" without actually speaking to those at the coalface. As an attempt to retain influence, we are forced to learn how to navigate the politics and economics of healthcare as a matter of self-preservation.

The Associate Fellowship training program was a way for me to harness my interest into a structured program, leading to membership of an organisation that fosters my needs as an aspiring medical leader.

4. What aspects of the training have strengthened your skills to succeed in your current role?

I enjoyed the interactions with other clinicians through the learning sets and workshops. The sharing of ideas and development of networks means that I don't feel so alone.

5. How would you describe the importance of both RACMA and qualified Medical Administrators to the Australasian health care system?

RACMA and its members are in a unique position to influence policy at local and national levels. Our understanding of the healthcare system, and innate drive to deliver safe and high-quality care to our patients and community mean that we can provide a balanced perspective to the table.

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

We have many talented, accomplished doctors amongst the membership, but I feel that we are leaving the emerging leaders behind. There still remains an "us and them" perception when it comes to frontline clinicians' perspective of medical administration. RACMA has an opportunity to build on its brand to attract doctors to its programs and become more influential. RACMA should also be working with other specialist medical colleges to advocate on issues facing the community at large.

Sustainability is the biggest challenge that we all face. Climate change is and will continue to be a risk to our population's health. As contributors to 7% of Australia's total carbon footprint, we have a role to play to not only mitigate our impact, but also prepare for its consequences.

While it is so easy to say that delivering healthcare in a resource-limited environment is a challenge, the reality is that we live in a rich country where the quality of healthcare is determined by your socio-economic background. Inequity of healthcare is rampant and RACMA should be at the forefront in correcting this, particularly for rural/remote communities and indigenous populations in Australia and New Zealand.

Use of information and communication technology remains a big risk with healthcare systems prematurely implementing digital health systems with little/no clinician engagement. RACMA has an opportunity to define digital health governance and advocate for meaningful clinician engagement.

Our healthcare system is only as strong as its weakest link. Doctors wellbeing is paramount to patient outcomes. RACMA and its members can engage more in this area by supporting other college's activities in this area, as well as leading by example in their workplaces.

Dr Scott C Y Ma
BMedSc BMBS FANZCA
AFRACMA GAICD

Consultant Paediatric Anaesthetist - Women's and Children's Hospital, Adelaide

Member Q&A

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

Destiny. During my interview for Medical School in 1982, I was asked "how is studying mathematics instead of biology going to help you with a career in medicine?" I dug a deep hole with my answer, which was rapidly filled in by admitting that, despite using such big words as demographics, epidemiology, statistics and health infrastructure planning, I really didn't know what I was talking about. At the turn of the century, I was able to answer that question. After 14 years dabbling in anaesthetics, general practice, intensive care and biotechnology, I had realised that clinical medicine was a glove that didn't quite fit, and I resigned from my intensive care role. Our General Manager asked me to help the hospital come to grips with activity based funding. That's when I discovered how to answer the question put to me as an eighteen year old. In 1982, I could have said that clinical information and hospital funding were going to be linked in a rather complex way, and that we would need clinicians with a love of numbers to help navigate that system, to keep our hospitals solvent.

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

I joined the College as a member in 2002, and received my AFRACMA in 2010. It was simply the most appropriate College to join, and has provided much greater value than I initially anticipated.

3. The program continues to attract an increasing number of clinicians, why do you believe this is happening? What are the strengths of the training?

The short answer is that clinical leaders, particularly in the public sector, see the need to improve their management and leadership skills. It's becoming increasingly important to understand the administrative environment, and how to communicate to best effect with non-clinical decision makers.

Another factor would have to include the exponential growth in oversight of clinical care by multiple agencies. For example, towards the end of last century, if surgery had resulted in death, a conversation with the family may have been the end of the process. There would have been considerable discretion regarding whether the coroner should be involved, and there might have been a morbidity and mortality meeting. In today's world, there will be a report to the coroner, likely a request for more information or internal investigation recommended by a state health employed practitioner, possibly a referral to the state ombudsman who might refer the matter to AHPRA, and an ongoing process with the practitioner's medical defense organisation. That is in addition to the complex internal hospital mortality review processes. It's important for clinicians to understand this environment, and how best to navigate it.

4. What aspects of the training have strengthened your skills to succeed in your current role?

RACMA has given me a better understanding of communication skills, how I think and learn, clinical governance, the regulatory environment, how to do, and not to do change management, the importance of measuring what we do, and above all, RACMA has given me the opportunity to work with some fabulous people. I highly recommend serving on RACMA committees and working groups, not only will your contribution be appreciated, there are always good people involved with a wealth of experience that they are willing to share.

5. How would you describe the importance of both RACMA and qualified Medical Administrators to the Australasian health care system?

Qualified Medical Administrators have a lot to offer. By first training and working as doctors, we have a unique perspective of what is required to support frontline services, and the stresses and strains that frontline staff experience; we can understand what clinicians are asking for, and why. We understand the value of multi-disciplinary teamwork. Amanda H. Goodall's 2011 study found "that hospitals positioned higher in the US News and World Report's "Best Hospitals" ranking are led disproportionately by physicians." From my own experience, the value of qualified medical administrators is felt most acutely when the position of DMS is removed, a disturbing trend in some sectors of our private health system. The sigh of relief is palpable when the position is reinstated. This is not to undervalue managers who come from a business background. I am often impressed by the depth of understanding of our healthcare system by a manager with no clinical experience. The truth is we need multidisciplinary management at every level of the organisation with at least medical, nursing and business working together.

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

It's us. It's always been us, and always will be. We, the humans, are the biggest challenge. Humans think, communicate, understand, prioritise, and act in different ways. Finding a common purpose, a common set of priorities, and the willingness to respect and work with a diverse group of people, with diverse motivations has never been easy. Throw into the environment the rapid pace of technological development, rising costs, increasing expectations of the people we care for, a renewed focus on patient centered healthcare, and the evolution of ever more complex models of funding, aiming to put a lid on healthcare expenditure, it's going to get even more complex. From my own narrow perspective of quality assurance and activity based funding, we all need need to better understand how to deliver good quality healthcare, how to find the resources we need, to use those resources wisely, and to be able to measure and communicate the value of what we do to those holding the purse strings.

Dr David Quigley
MBBS DAUK PGDipSc
AFRACMA MAICD

Managing Director – Medmin
Non-Executive Director - Comlink

Creating Leaders

OPINION

MoneyBall and Modern Medicine

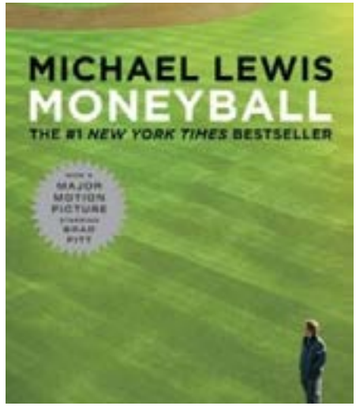
Past President and Cabrini Health Clinical Informatics Director, Dr David Rankin **MBCHB MPH MHA DipObstet FRACMA** raises ideas about using similar statistic reporting methods for evaluating clinical performance, specialist recruitment and retention in Australian Medical Administration as has been adopted in selecting players in the American Baseball League.

MoneyBall is a wakeup call to modern medicine. Michael Lewis's 2003 book outlines how Billy Bean, the General Manager of the Oakland A's football team radically transformed baseball. I unfortunately missed the implications for healthcare when I watched the 2011 movie starring Brad Pitt, however reading the book over the past few weeks provided me with a clarion call to Medical Administrators.

Billy Beane worked with Paul DePodesta – a Harvard statistic graduate, to change the way baseball players were evaluated and recruited. Rather than relying on trusted aging scouts who relied on observing potential recruits play, Paul and Billy evaluated their outcomes using the extensive statistics collected by an array of amateur and professional data loggers.

They observed that players with dysmorphic physique, disabilities and challenging personalities were often high performers in specific aspects of the game, yet seldom chosen for professional league baseball, and therefore came at a significant discount price. Many of these overlooked players had lost confidence in being selected for the major league.

By selecting players for their data proven skills, Billy Beane, with just $44m in funding, was able to take his team to the playoffs, winning over teams that had budgets of over $125m.



The book raises some fundamental challenges to our traditional assumptions about how to identify a successful young player, how to measure success and how to systematically track outcomes.

If healthcare adopted the Moneyball formula we would have a radically different strategy to evaluating clinical performance, specialist recruitment and retention.

In particular:

- Every specialist (and their medical administrator) would know their personal statistics, how they compare with their team players and how their team compares with the competition:
  - their patient's average length of stay (batting average)
  - their mortality rate (outs)
  - their average theatre times (pitching strikes)
  - their rates of 28-day readmission (fouls), ICU admission (walks) and return to theatre (bunting)
  - their patient experience scores (popularity)
  - their hospital financial performance and how they personally contribute to the overall team outcomes
- Data collection would commence as interns (high school) and continue through registrar training (minor league) and throughout their professional career.
- Young players would be continually competing to enhance their patient's outcomes so they would come to the attention of major league hospitals and be selected on performance, rather than reputation, references or which scouts they know.
- Credentialing and appointment committees would focus on specialist performance statistics and work to develop programs to assist the struggling specialist lift their game.
- Each specialist's unique skills and contribution would be identified, and they would be deployed to match the patient, anaesthetist and weather conditions on the day.
- Waste (fouls, walks and strikes) would be clearly defined, measured and actively eliminated.
- Poor performers would know their performance statistics on a daily and seasonal basis. As their performance fades, they would retire gracefully, move to minor leagues, move into management or seek coaching to prolong their contribution.
- High performing specialists would be actively traded between hospitals who were all competing to win the world series .
- There would be a massive professional and amateur data collection system that tracked and reported statistics on every specialist in both public and private healthcare.
- Metrics would be continually refined to accurately predict future performance.
- Every interested person in Australia and New Zealand would have access to statistics on all the specialists in the country.

Moneyball provides a real challenge to medicine in Australia and New Zealand. Data collection, reporting and transparency has started. We are facing radical reform, moving from opinion-based performance assessment (accreditation) to data driven evaluation of outcomes. Every specialist needs to have access to and take ownership of their statistics. There needs to be transparency of validated measures of both individual and team-based performance.

Medical Administrators must be the agents to facilitate this evolution to data driven healthcare, otherwise the disruptive change will be brutal, uncoordinated and destructive. There is a risk that without our leadership, teams will become defensive, performance will deteriorate and revenue will evaporate as patients no longer attend our games.

Leavers in WA: Mass Gatherings and the role of the Medical Administrator

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Introduction

The Medical Administrator has an integral role in the planning, response and recovery for mass gathering events(1). Collaborative planning with stakeholders such as event organizers, police, ambulance services, and local health facilities is imperative to identify potential public health hazards and understand limitations of local resource capacity (1). Understanding limitations provides insight into event specific requirements such that risk to participants, staff and the local community is mitigated (1, 2).

Framing planning through the consideration of psychosocial, biomedical, and environmental domains will enable administrators to better estimate the response required for the specific event(3). The psychosocial domain considers the collective culture of an event, and how this may impact on individual behaviours. The biomedical domain considers the age of the attendees, as well as potential for substance use, and the environmental domain considers the weather, location, and venue factors(3). This paper examines these domains in the context of lessons learned from the past 15 years of school leavers celebrations in Dunsborough, Western Australia.

Psychosocial Domain

'Leavers' is a term used for secondary school students who have completed their final exams or school year. 'Leavers festivals' or 'Schoolies festivals' are thought to have originated in 1979 on the Gold Coast in Queensland, where final year school students descend each year after the completion of secondary school (4). These festivals now exist around Australia as well as internationally, including Dunsborough in the south-west of Western Australia, Victor Harbor in South Australia, and Bali, Indonesia (4). These congregations of large numbers of students for brief time periods mimic mass gathering events and often occur in established rural communities (5).

Since the late 1990's, Dunsborough has been growing in popularity for school Leavers festivities(6). This has resulted in an increased demand for health and law-enforcement services for alcohol and other drug related behaviour, such as hospitalisations, property damage, and disorderly conduct(6). In response to this, in the year 2000, a campaign led by local service agencies and businesses called for a more coordinated effort that minimised impacts on the community but still maintained enjoyment for the school Leavers(6). In 2001, this expanded to incorporate some state government agencies offering support, as well as other youth agencies and sporting clubs(6).

However, despite these efforts, local capacity and demands on services became progressively more exhausted as Dunsborough increased in popularity (7). In 2004, over 4000 young people congregated in Lions Park in the centre of Dunsborough, leading to multiple nights of 'gang-style violence'(7). These events catalysed the State government to intervene, instituting a five point plan for a state-wide approach to Leavers from 2005(7, 8). This plan focused on the rights and responsibilities of both Leavers and locals, ensuring improved safety from greater police presence, harm minimisation strategies, support to local communities, and better co-ordination between Government and non-government agencies(8).

For the last 15 years, the Office of Crime Prevention (a subsidiary of the WA police) has been responsible for the primary coordination of Leavers festivities, with the core strategy being 'management by event'(9) The rationale to manage Leavers as an 'event' is based on the premise that young people are less likely to engage in antisocial behaviour if they are entertained (7).

Environmental Domain

The central strategy for Dunsborough Leavers was to set up a Leavers zone ('the Zone') away from the central business district (CBD) (7). The Zone not only diverted leavers away from the CBD, but it also facilitated contained entertainment and enabled stakeholders, such as medical support, to maximise their exposure to the participants(6). The presence of medical support within the zone averts possible presentations to the local health services, with an estimated 600 presentations prevented in 2018 treated within the medical area of the Zone(10).

In addition, by containing the celebrations and diverting them away from the CBD, the clean-up costs to the Shire of Busselton almost halved by 48% from $22,710 in 2004 to $11,875 in 2005(7). In 2018, the Zone was located in the City of Busselton local government area, 10 kilometres from the Dunsborough community(10).

Along with the establishment of the Zone, event organisers sell wristbands that enable Leavers to have access to transport to and from the Zone, participate in other activities such as the Meelup Beach Day, and offer discounts to participating local businesses, and are provided with free ambulance services (7, 10). This allows for organisers to provide expectations around the length of festivities, minimises the risk of drink driving to and from event sites, and measure the number of expected participants from sales(7). The sale of these wristbands contributes to the cost of the event(7). In 2018, 8,454 wristbands were sold to attend the Dunsborough Leavers celebrations(10).

In 2005 there were approximately 5,000 Leavers in the Dunsborough area, and it was estimated that this brought $1,080,915 of new expenditure into the local community(7).

"Leavers are known to engage in alcohol and risk-taking behaviour, and indeed the participation in excessive alcohol use during Leavers week has been described as a 'rite-of-passage'."

Biomedical Domain

Leavers are known to engage in alcohol and risk-taking behaviour, and indeed the participation in excessive alcohol use during Leavers week has been described as a 'rite-of-passage' (11, 12). Given this perception amongst Leavers, excessive alcohol use is considered to be socially and culturally normalised during this event(13). Acknowledging this, many health promotion campaigns for Leavers specifically target this perception. Additionally, approximately half of school leavers are under the age of 18, such that there are legal implications for facilitating drinking in this underage cohort (11).

It is known that many Leavers plan their alcohol intake to maximise consumption within a fixed budget (14). With this in mind, each year the South West Liquor Accord proactively develops strategies to reduce harmful consumption of alcohol in the Leavers cohort(14). For example, local alcohol retailers raise the cost of minimally priced alcohol products, remove options to 'click and buy' alcohol, and participate in voluntary enforcement of maximum purchasing quantities.

In addition, the Royal Lifesaving Society of Western Australia runs a 'Don't Drink and Drown' beach day, allowing for messages of the dangers of alcohol and aquatic activities to reach the target audience(11).

Enkel et al (2017) recently compared the intended and actual alcohol consumption for Leavers in Dunsborough, finding that 90% of Leavers surveyed (n=549), intended to consume alcohol during Leavers festivities. Enkel et al (2017) also found that while the intention for Leavers was to drink 8-9 standard drinks, the actual drinking patterns revealed an average of 5-6 standard drinks per day. This is in contrast to a similar evaluation for the 2007 Leavers cohort at Rottnest Island, where the actual consumption of alcohol was 15.8 standard drinks per day. This reduction in actual standard drinks per day over a 10 year period provides evidence that the health promotion messages and strategies utilised in Dunsborough may be effective in reducing quantities of alcohol consumed.

FROM PREVIOUS PAGE

Leavers in WA: Mass Gatherings and the Role of the Medical Administrator

Conclusion

Leavers celebrations in Dunsborough can be considered through the biomedical, psychosocial, environmental domains of a mass gathering event. This assists the Medical Administrator to assess the resource capacity and limitations of the event, and mitigate risks inherent in hosting transient mass gathering events in a rural community. Under the Office of Crime Prevention, managing leavers as an event has enabled targeted intervention strategies to be applied directly to the Leavers participants. In addition, the economic benefits to the community, as well as the better definition of Leavers expectations by both participants and the community have been able to contain the celebrations. This allows for participants, stakeholders and agencies to better respond to this event within the rural community. This multi-stakeholder approach provides a blueprint for other prolonged mass gathering events where participants at high risk of alcohol and other drug related harm.

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Tackling the Fear of Notifications – One Practitioner's Experience

'If there's one thing I could do differently about that whole process, I would go and talk to someone right at the beginning' – these are the words from a medical practitioner in a new video from the Australian Health Practitioner Regulation Agency (AHPRA) and National Boards.

The video, is a firsthand account of a practitioner's experience of what it is like to be the subject of a notification with the regulator.

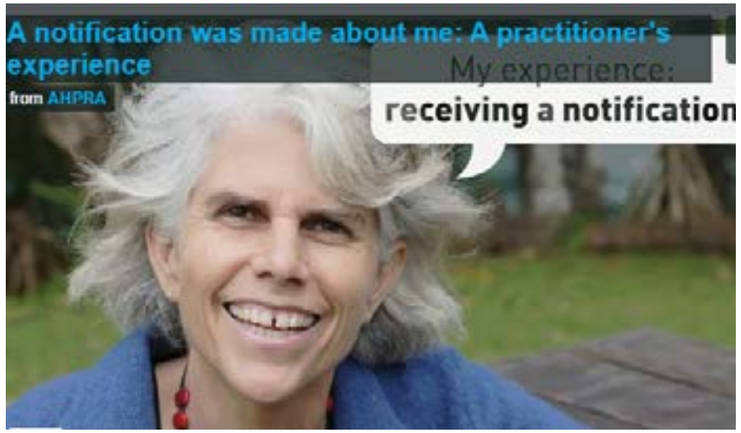
'Practitioners have told us that notifications are stressful for them and their families', said AHPRA CEO Mr Martin Fletcher. 'We are listening to what practitioners are telling us to develop resources such as this video.'

AHPRA has gathered feedback from notifiers and practitioners about what it is like to go through the notifications process. After over 80 interviews and more than 5000 survey responses, a small number of consistent themes have emerged as important factors for notifiers and practitioners.

'The need for support described by this practitioner speaks to all 16 regulated professions whether they are an optometrist, chiropractor or dental practitioner,' said Mr Ian Bluntish Co-Chair of the Forum of National Registration and Accreditation Scheme Chairs.

Medical Board of Australia Chair, Dr Anne Tonkin said that the video reminds practitioners that getting good support early on can make a big difference.

'For practitioners, we hear again and again about the fear they feel when they receive a letter from AHPRA. Yes, a letter can mean someone has raised a concern about their practice, but it doesn't mean that their career is over. Many health practitioners may at some stage have a concern raised about them to AHPRA, their employer or another health complaints organisation.



ABOVE: A far north Queensland GP shares her experience and advice with AHPRA for other medical practitioners.

'We understand this can be a daunting experience. We encourage all practitioners to seek the support they need to be healthy at all times—and this is particularly important during a notification,' she said.

Australia Medical Association (AMA) President, Dr Tony Bartone, says that doctors' health is a priority for the AMA and the profession. Notifications can be a difficult and potentially confronting time and have the ability to significantly impact the health of the doctor.

'This new AHPRA video is an excellent resource to encourage doctors to be open and honest about their experience during a notification process. It's especially important to talk about your health, and to share your concerns with fellow doctors, family, or friends,' Dr Bartone said.

'Doctors need to understand that many of our colleagues may receive a notification. It is not something to be embarrassed or ashamed about. It should not stop anyone from asking for help.

'Many doctors feel angry, anxious, even depressed through a notification process. This video shows that they are not alone.

'I encourage any doctor who needs support during a notification process to seek the help they need,' Dr Bartone said.

Registered health practitioners and their support networks will be encouraged to use this new resource when they are involved in the notifications process.

For more information and to view the video visit https://www.ahpra.gov.au/Notifications/A-notification-has-been-made/Understanding-your-experience.aspx

Advance Care Planning in a Large National Catholic Not-for-Profit Private and Public Health Service

Dr Lisa McDonald, Group Mission Leader, St Vincent's Health Australia
Professor Erwin Loh, Group Chief Medical Officer, St Vincent's Health Australia

There are many decisions and choices to be made during the course of a chronic illness and progressively deteriorating health. Determining a course of care presents patients and clinicians with decisions about treatment and alternatives that become more frequent and complex as health fails. Supporting frail, elderly or irreversibly unwell patients and their families, through these choices, especially towards the end of life, is a key expression of the mission and values of St Vincent's Health Australia (SVHA) and is present in our organisation's End of Life (EOL) Care framework.

Founded by the Sisters of Charity, SVHA has been providing compassionate, high quality health and aged care to the Australian community since 1857. It is Australia's largest not-for-profit health service, with 39 facilities across the country in Victoria, New South Wales and Queensland, comprising six public hospitals, 10 private hospitals, 20 aged care facilities, three co-located research institutes, and one co-located partner facility.

The Catholic approach emphasises the importance of the ongoing conversation arising from a form where a person has recorded their wishes to be the most important aspect of Advance Care Planning (ACP). In the Catholic vision of care, developing and implementing a successful future health care plan depends on good, long-term communication between the health care professional, the person and the person's representative, family and friends. Particularly when the choices for the future are unclear and answers uncertain, the Catholic approach emphasises the importance of the person identifying, and communicating their values in advance to, their substitute decision-maker so that the decision-maker is informed if a time were to come when the person was unable to make their own decisions.

Dialogue is not always easy, however when it is thorough and productive it can result in planning for future health care in a way that provides comfort and certainty for patients, families and staff. This may involve appointing a medical treatment decision maker as well as recording personal values and the goals of treatment on a form that can help guide representatives and staff in the conversation. When implementing a future health care plan, health care professionals must comply with their personal, professional and institutional ethical responsibilities, while ensuring that they provide appropriate care.

What is Advance Care Planning?

ACP is the process of planning for future health whereby a person's values, beliefs and preferences are made known so they can guide clinical decision making at a future time when that person cannot make or communicate their decisions due to lack of capacity[1].

It is important to recognise three things:

1. ACP is moving in the direction of being a part of usual care, understanding a person's wishes and goals for their care and embedding it across a person's care pathway, rather than being seen as limited to an occasion when a decision needs to be made to continue or withdraw a specific treatment. In general, the process is moving towards Advance Care Directives (ACD)'s being legally binding in each state and territory.

2. SVHA does not yet have a standardised approach to ACP across the country, though we do have some examples of excellent practice, some places where early steps have been made, and other facilities that are yet to commence their journey. This is reflective of ACP more generally in the community. It is not yet at the forefront of people's mind, so uptake is low.

3. There are different legislations regarding ACP in the states where we operate our ministries. Legalisation also dictates the standardisation of forms for each state.

[1] Terminology associated with the work of ACP is wide and varied. It is not uncommon to encounter any of these acronyms in the community or in our services.

ST VINCENT'S HEALTH AUSTRALIA

What are the different legislations in the three states in which we serve?

VICTORIA

The Medical Treatment Planning and Decisions Act 2016 (VIC) was introduced in Victoria on 12 March 2016. This provides a clear legal framework for the recognition of ACD's in Victoria. The Victorian Civil and Administrative Tribunal (VCAT) make guardianship and administration decisions within Victoria. In an ACD, you can write either or both:

- an instructional directive (eg. a refusal of treatment certificate) with legally binding instructions about future medical treatment you consent to or refuse; and/or
- a values directive (eg. a statement of choices or wishes) which documents your values and preferences for your medical treatment decision maker to consider when making decisions for you.

The Victorian Department of Health and Human Services (DHHS) has created a standard form which allows people to:

- make an ACD;
- appoint a Medical Treatment Decision Maker (MTDM); and
- appoint a support person.

NEW SOUTH WALES (NSW)

Advance Care Directives are legally enforceable in NSW. Although NSW does not have specific legislation on advance care directives, the Supreme Court has said that valid advance care directives must be respected (as an extension to a person's right to determine their own medical treatment). In addition, Advance Care Plans, like advance care directives, can capture a competent person's wishes about treatment and care at end of life. Where an advance care plan documents the known wishes of a competent person, they should be considered in the same way, according to common law standards, as an advance care directive. Where advance care planning has never been able to include the person's wishes due to lack of capacity, the advance care plan should be consulted as part of determining treatment and care decisions that are in the best interests of the patient. There is not a standardised template for advance care plans or advance care directives in NSW.

QUEENSLAND

The Powers of Attorney Act 1998 and parts of the Guardianship and Administration Act 2000 (QLD) regulates Advance Health Directives in Queensland. Advance Health Directive is the formal document recognised by the legislation. This directive allows the person to consent to or refuse medical treatment. Queensland also allows for informal ACPs such as statement of choices, however these are non-binding and fall under common law.

How does ACP appear in the National Standards?

Advance Care Planning is embedded in the National Safety and Quality Healthcare Standards V2. ACP now falls under the Comprehensive Care standard, criteria 5.9 and 5.17.

In the previous version of the National Standards, ACP fell under 'recognising and responding to physiological deterioration', which was only applicable to acute care. This is reflective of the move toward embedding ACP into the routine goals of care.

The move for it to be listed under comprehensive care shows the intention

FROM PREVIOUS PAGE

Advance Care Planning in a Large National Catholic Not-for-Profit Private and Public Health Service

to have it more widely understood and addressed in all health settings. The criteria of 5.9 and 5.17 are reasonable actions for a well-established ACP program.

In relation to Aged Care, within the accreditation standards, introduced on 1 July 2019, there are explicit expectations set within these standards to ensure a process to address Advance Care Planning is offered and discussed with all new residents. Standard 1. 3(b) requires 'assessment and planning that identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes'.

How are we currently measuring it?

Mortality review is a process in which the circumstances surrounding the care of a patient who died during hospitalisation are systematically examined. Whilst not standardised, screening of all deaths occurs across each division. The RiskMan consolidation project aims to standardise this process to ensure that assessment of end-of-life care, including presence and adherence to advanced care directives is reviewed as part of this process.

The Measurement and Reporting System (MARS) is SVHA's bed-side audit tool. The current questions in the SVHA bed-side audit come under Standard 2 Partnering with Consumers. These are:

1. Do you have an Advanced Care Directive?

If the patient answers no, no more questions are asked. However, if patients ask what an advanced care directive is they are given the local facility information sheets and assisted with more information by appropriate senior staff.

2. If they answer yes, the following question is asked: Did you bring in your advance care directive with you?

If they answer no, a conversation should be had with the person and if they agree they are asked to source it or we assist them to source a copy and alert their medical team and senior staff.

3. If they answer Yes to the above question they are asked the following question: Have you, your family and/ or carer been involved in an Advanced Care Directive conversation with your medical doctor? [2]

If the answer is no, the medical team is alerted and again a conversation should be had with the patient and their families etc.

What are the challenges?

- There is a lack of standard terminology.
- Staff find it very difficult to have these conversations and most do not see it as their responsibility to be aware of people' ACD's and substitute decision maker.
- This is not something the community are very well aware of, so people are not asking for it yet. Staff are sensitive that asking people about an ACP in this environment can create angst.
- It should be done in the community when you are healthy and well.
- Most people in the community do not have one.
- There are different models of ACP in different facilities. Some places have a person or a team solely responsible for these conversations, others prefer to upskill all staff and for it to be a part of usual care. Nurses in GP practices may often have this role.

Conclusion

SVHA is considering the preparation of a national set of guidelines on ACP reflective of our Catholic position, and seeking an appropriate umbrella term aligned to the National Safety and Quality Health Service Standards and the Aged Care Quality Standards. There is also work to progress with standardisation of terminology across SVHA, mindful of state legislations. We are also reviewing current education packages in place with the view to update and share these nationally. There is a plan to host a yearly forum sharing examples of best practice across our services.

Lastly, we are considering a special project around ACP for vulnerable populations, which is a focus of our mission.

[2] With each state legislation in place we really should be asking "Has your nominated substitute decision maker been involved in an Advanced Care Directive conversation with your medical doctor?"

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