The Quarterly #1

2020

> The faces behind RACMA

Quarterly 4

quarterly

PAGE 4 — President's Report
Associate Professor Alan Sandford AM reflects on the College's response to COVID-19.

PAGE 6 — The faces behind RACMA
This edition puts the spotlight on some of the staff who work in the RACMA office.

PAGE 11 — Member Profiles
Find out more about some of the College's key leaders.

PAGE 18 — St Vincent's Health Medical Leadership feature
St Vincent's Health Australia Group Chief Medical Officer, Professor Erwin Loh and colleagues detail systems and processes in place dealing with ethics and Medical Leadership.

PAGE 24 — Improving Research Ethics and Governance in a Large Metropolitan Academic Health Service
Monash Health's Deborah Dell and St Vincent's Health Australia's Professor Erwin Loh report on Monash Health's comprehensive organisational-wide change management process to reform research ethics and governance processes.

PAGE 32 — The catch 22 of Australia's Junior Doctor Issue: Is it time for a balanced perspective?
Dr Sidney Chandrasiri (Group Director, Academic & Medical Services Epworth HealthCare) and Dr Laura Mogie (Registrar in Medical Services & Leadership Epworth HealthCare) discuss the welllbeing and workload of junior doctors.

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.

2019 Office Bearers

President: A/Prof Alan Sandford AM
Vice President: Dr Iwona Stolarek
Chair Education & Training Committee: A/Prof Pooshan Navathe
Chair Finance & Audit Committee: Prof Erwin Loh
Censor-in-Chief: Dr Peter Lowthian
Chair Continuing Education Program Committee: Dr Elizabeth Mullins
Chief Executive: Ms Melanie Saba

From the President

From the President

The expertise and leadership of our specialist Medical Administrators and trained Medical Leaders across Australasia have really come to the fore after facing numerous challenges to our healthcare system in 2020 - from the erupting Volcano in New Zealand, to the devastating bushfires across Australia and now the COVID-19 pandemic.

On behalf of the College Board I would like to thank our Members for their valuable leadership. You are all playing key roles in the management of the COVID-19 pandemic in order to maintain the quality and safety of our healthcare system - now and into the future, however that may look.

From the outset of the COVID-19 pandemic, the College's leaders and staff have put in a tremendous amount of work to ensure a seamless delivery of service to Members. As the health crisis changed daily, our staff and contributing Members worked tirelessly to modify the delivery of RACMA's education, training and professional development. We appreciate the patience and support from our Candidates and participants in the 2020 Leadership for Clinicians program.

Whilst very mindful of the pressure our Candidates are under managing COVID-19 at their workplaces, we felt it imperative they had the opportunity to continue to progress through the program to ensure continuity and security of the trainees.

The importance of having Medical Administrators, and Medical Administration Candidates, in healthcare settings has been made clear through the pandemic. Across our training sites, Candidates have demonstrated the valuable contribution they make to planning and managing the implementation of health service responses to COVID-19.

However, given the nature of the delivery of the Leadership for Clinicians program coupled with the challenges associated with COVID-19 faced by participants, the RACMA Board decided to reschedule all Leadership for Clinicians programs that commenced at the start of the year or were scheduled during 2020. The program has been postponed to 2021 - participants were refunded fees and will be given priority to enrol in the 2021 program.

Throughout this pandemic we as a College have steadfastly supported the efforts and direction of our bi-national Chief Medical Officers. We received some great exposure for the College and the value of our Medical Leadership fraternity through the live webinar with the Deputy Chief Medical Officer of Australia Dr Nick Coatsworth, in which he engaged and complimented our College members. We have also regularly maintained contact with New Zealand's Chief Medical Officer, one of our Fellows, Dr Andrew Simpson.

The superior leadership practices of our members are increasingly capturing attention at the coalface. The RACMA office continues to field numerous enquiries about enrolling in the Fellowship Training Program and the Leadership for Clinicians program. Medical professionals are witnessing firsthand the value of our education and training, led by Fellows. It is our training programs which teach our Fellows and Associate Fellows how to implement sophisticated and highly functional systems, using policies, standards and protocols to positively influence the health of our communities.

While we were already a tight-knit College, the crisis has strengthened our fraternity further through the weekly, online Member Forums which I implemented early in the pandemic. The initiative has provided Members the opportunity to stay connected with peers, while being able to share insights and learnings to support each other. I think it has been imperative for our mental health and wellbeing that we all have a safe, peer environment to express what we are experiencing and share knowledge and support among understanding colleagues.

The Member online platform's success only comes from the generosity of our Members sharing their stories. It is providing a great avenue for colleagues and peers to learn from each other. It reinforces how important it is to share information and ideas to maintain leadership, innovation and, importantly, hope in times of adversity.

Hence, I believe it is essential to keep the communication lines open beyond COVID-19, and I will explore avenues to continue the forums into the future.

As I have mentioned in my member email updates, we all recognise our healthcare systems will never operate the same again. It is our responsibility as Medical Leaders to start planning for tomorrow and the new emerging world in healthcare. We must embrace the opportunity to implement change for a more robust system in the future. I am drawn to the powerful quotes attributed to those in history:

"Out of adversity comes opportunity." ~Benjamin Franklin

"Never let a good crisis go to waste." ~ Winston Churchill

One of the best ways to make system improvements is to learn from experience. We should not let this opportunity merely pass us by as we endure, we cannot! Our workforce configurations and work-practices have needed to be adapted. We should resist the tendency to "snap back" to business as usual. It will never be that way again.

There have been suggestions from Members that we look at a "reverse" approach to drive adoption of our

Associate Professor Alan Sandford AM
President

FROM PREVIOUS PAGE

practices and learnings. It is indeed food for thought to utilise the public, our "customers" and our patients to support and guide adaptive change in behaviour of our health culture. We have the perfect opportunity to tap into the wider community's newly adopted habits of distancing, hygiene and personal protection habits while they are still engaged.

We have adapted many approaches for preparedness and delivery of healthcare in this crisis. The benefits and shortfalls of telehealth adaptation is one of many areas we need to explore and develop. The focus on our acute and primary care interface both in rural and urban settings is also worthy of development and change.

I urge all Members to share their experiences and learnings with the College to ensure we develop meaningful documents to influence and guide both jurisdictional and national leaders and shape healthcare developments and reforms.

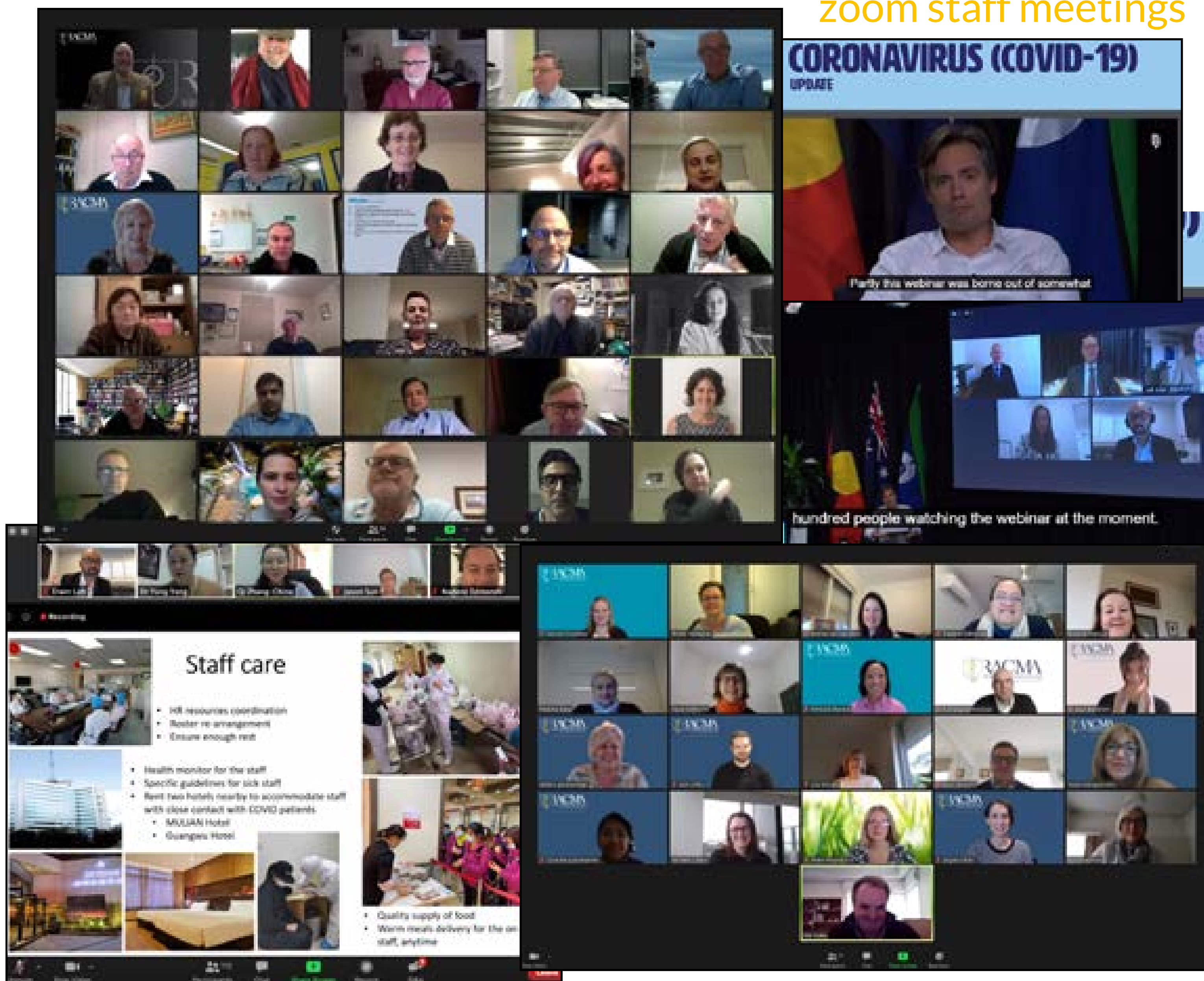
It is essential we are clear about how we take these learnings and experiences and use them to adjust and become more adaptable and resilient as we emerge into the future world of healthcare and indeed society. Please email your learnings and experiences through to covid19@racma.edu.au.

What life through COVID-19 looks like for the College

online member forums

Live webinars

zoom staff meetings



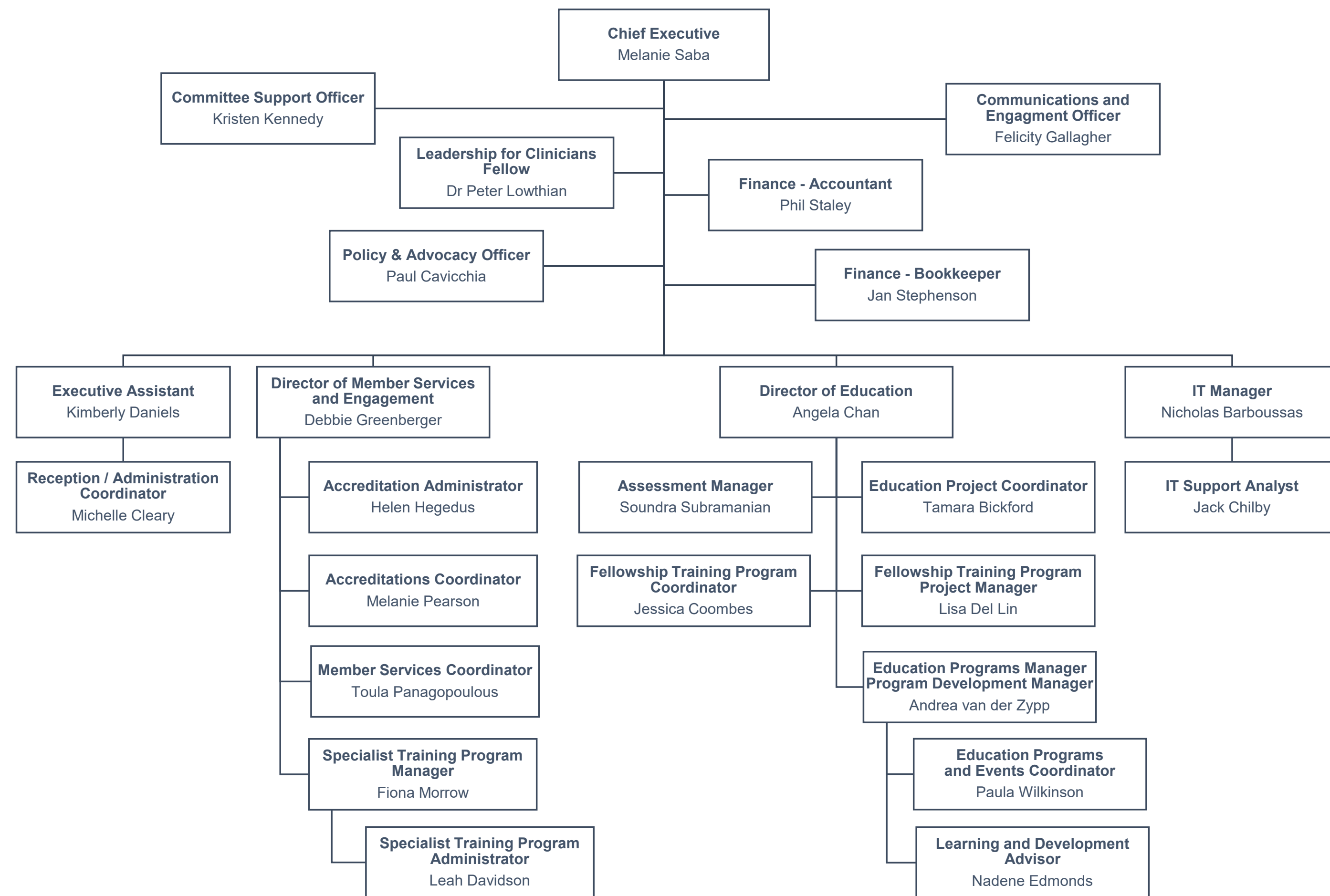
THE faces BEHIND

The College has continued to work on improving our support and services to our members- both those who have completed your qualifications and are Fellows or Associate Fellows and to support those who are training with the College in both the Fellowship and Leadership in Clinicians program.

The College has been extremely fortunate to recruit some great people to join the team and to offer new opportunities to current members of the team in a structure that is focused on three key areas- Members Service and Engagement, Education and College Services, to support the work of the College and its members. The College has expanded its work in policy and advocacy, support for the jurisdictional committees and working to improve is online services.

We know that members often say they have not met some of the team and are not sure about where the areas of responsibilities lie. I am pleased to introduce some of the team to you and their areas of responsibilities and we look forward to continuing to work with you and to support the College.

RACMA ORGANISATIONAL CHART



Melanie Saba, Chief Executive

Melanie Saba joined RACMA as Chief Executive in 2017 after seven years as Chief Executive of the Victorian Institute of Teaching. Melanie boasts a career in critical care nursing, nursing education, regulation for nursing, psychology and teaching professions.

As the Chief Executive of RACMA, Melanie works with the RACMA Board and team to deliver services to Candidates and Members and to promote the specialty of Medical Administration. She works closely with the President and College Board to ensure the College improves the education and training of medical practitioners occupying roles and positions in health services leadership and management.

The Chief Executive is also responsible for maintaining and developing relationships with key government health officials, medical leaders and influencers across the wider healthcare industry. In maintaining these relationships, the Chief Executive has a key role in ensuring RACMA will be valued by its members, and recognised internationally, as the Australasian medical college that provides specialist education, leadership, advice and expertise in Medical Management that promotes safe and effective healthcare.

Angela Chan, Director of Education

Angela Chan commenced at RACMA in May 2019. She has more than five years' experience in Specialist Medical Colleges and was previously Deputy Director of Education and Training at RANZCOG.

Angela has previously worked as a radiographer in public and private healthcare and as an academic at RMIT University. Her qualifications include:

- BAppSc (Medical Radiations)
- GradDipEd (Secondary)
- Cert IV (Assessment and Workplace Training)
- MEd (Education Leadership and Management)

At RACMA, Angela oversees the College education and training programs including the Fellowship Training Program, Leadership for Clinicians and professional development activities. She leads a team of seven in the Education Division, which provides support for a number of RACMA Committees including:

- Education and Training committee
- Academic Board
- Board of Censors

For all queries relating to the Fellowship Training Program email: ftpadmin@racma.edu.au

THE faces BEHIND RACMA

Debbie Greenberger, Director Member Services & Engagement

Debbie Greenberger has worked across the adult education sector and public service for most of her career in roles supporting education development, stakeholder engagement and software implementations. She has held key roles with Victoria Police, Melbourne University, Deakin University and Chisholm Institute

Prior to commencing with RACMA Debbie was the regional manager of membership and professional development for a professional body with more than 150,000 members globally. In 2018, she completed a Masters in Business Administration.

At RACMA Debbie oversees the Member Services & Engagement Division which comprises:

- Membership
- CPD governance
- Applications
- Site Accreditations
- Specialist Training Program funded posts

The divisional team consists of five support staff. As manager of this division, Debbie is responsible for meeting strategic obligations with a specific focus on operational efficiencies. She works closely with members as well as internal and external stakeholders to achieve continuous improvement outcomes.

For any membership enquiries email: membership@racma.edu.au

Nicholas Barboussas, IT Manager

Nicholas joined RACMA in January 2020, after 13 years with the Victorian Institute of Teaching, where he was Business Systems Manager and Infrastructure Manager. He brings more than 20 years' experience in IT.

He is working on building a proactive, long-term strategy to not only eliminate any existing moving targets but to get ahead of potential problems which could arise in the future.

Nicholas is implementing a customer service approach through a centralised Service Desk. This will provide members and the RACMA team with a progress report of their issue from start to finish. The IT team provides support to all members experiencing issues with MyRACMA, Canvas, Webinars and the RACMA website.

Nicholas will look for opportunities for RACMA to be more efficient and effective across all areas of information technology and its use to ensure continuing service improvement.

For any IT-related queries email: support@racma.edu.au

Kristen Kennedy, Jurisdictional Committee Support Officer

This is a newly created position for the College in order to strengthen RACMA's connection with its Jurisdictional Committees and ensure a continuity across all projects and communication with the committees and the College.

Kristen Kennedy brings strong people, communication and organisation skills from her previous roles in recruitment. More recently she has also carried out volunteer work with local, school and charitable committees, in integral roles such as Secretary, Event Coordinator, General Committee and Committee President.

Kristen directly supports the Chair and Secretary of each Jurisdictional Committee in the planning, communication, agenda preparation and minute taking of scheduled Committee meetings. She follows up agenda items to ensure the outcomes of meetings are monitored. Kristen can facilitate linking Committee Members with the right contacts within the College to fast track assistance they may require performing their roles.

Kristen is best contacted via email: kkennedy@racma.edu.au

Felicity Gallagher, Communications and Engagement Adviser

Felicity joined the College in 2018 with extensive experience as a journalist, Victorian Government Communications Adviser and Agricultural Industry Media Manager. A communication specialist with a commitment to high-quality writing, planning, research and stakeholder engagement.

At RACMA, Felicity delivers all key messages, statements and news to members, maintains the College's social media presence, edits and designs website content and edits and produces the Quarterly, RACMA Annual Report and various Jurisdictional Committee newsletters. She is developing a relationship with other specialist college communications managers and key industry and government bodies to leverage various communications opportunities.

Felicity is best contacted via email: fgallagher@racma.edu.au

Member Q&A

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

I've always been interested in problem solving and improving systems. I wanted to make a difference and while I enjoyed clinical medicine, I saw medical administration as a way to influence patient care and health outcomes on a bigger scale.

What led you to undertake the Fellowship Training Program of RACMA?

As a junior doctor I knew very little about the college and medical administration as a career path but was encouraged by colleagues to give it a try. I found I enjoyed the breadth and challenge of medical administration and had great role models who showed me the value of fellowship.

What attracted you to take up the role of a Board member of RACMA?

I'd been involved in the Queensland Jurisdictional Committee for many years and found it very rewarding. I was attracted to the board by the opportunity to contribute to RACMA at a strategic level and help shape the college's future direction.

What do you hope to achieve in your role on the Board of RACMA? Or is there a particular area/issue you would like to focus on?

I hope to help strengthen and grow our professional profile amongst other colleges, clinicians and the broader health sector. I'd like to see us cultivate and harness the diversity of our membership as well as ensure we engage all members in positioning RACMA for the future.

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

We have a pivotal role in cultivating medical leadership - not just within our college but also amongst our peers and others – and in demonstrating the value of doctors as leaders within the healthcare system. Management and leadership skills and change management capability is essential to not only achieving high quality care and sustainable service delivery, but the uptake and integration of innovation needed to address current and future healthcare challenges.

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

How do we continually evolve and expand our role as Medical Administrators in response to the rapidly changing healthcare landscape, whilst adding value and ensuring our professional identity?
AI and emerging technologies, changing healthcare goals and disruptive models of delivery, increased workforce mobility and global migration of products and services all bring new challenges for medical administration. The changing scope and breadth of medical administration in training and maintaining a robust health management workforce, with the right skills and flexibility to fulfil diverse roles of the future is a key challenge.

Dr Mellissaa Naidoo
BSc BMBS MHM FRACMA FCHSM GAICD CHIA

Chief Medical Officer &
Head of Clinical Innovation

nib Health Funds

RACMA Board Member

Member Q&A

Dr Bill Appleton
MBBS (Hons), FRACMA,
Dip Comp Sci

Tribunal Member,
Administrative Appeals
Tribunal

RACMA Returning Officer

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

Recognition of the pivotal importance of management in health services, in part because of the high expense in providing health services, but more importantly because of the contribution that good organisation can make to the quality of health service provision, and the high significance of health in our lives.

What led you to undertake the Fellowship Training Program of RACMA?

The desire to be formally trained for the role of a medical manager and leader.

What attracted you to take up your role as Returning Officer for RACMA? Have you learned anything through the role or benefited by carrying out the responsibility?

I was invited by the College to become the returning officer. The role constantly reminds me of how important maintaining the integrity of electoral processes is to our organisation.

How important is it for members of Colleges like RACMA to be actively involved through various roles like yours or on College Committees?

A small College needs all hands on deck, and involvement in College affairs benefits us by extending our professional networking, and in furthering our professional development through involvement in activities outside our ordinary work role.

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

College members cannot only make an important contribution to health care, but also provide other valuable roles in society. For example, in my current role as a Medical Member of the Administrative Appeals Tribunal, I am required to make legal decisions on whether individuals with illness are, or are not, eligible for payment of disability support pension. I believe there is no better preparation for developing the skills required to critically review the supporting medical documentation, to conduct an impartial hearing, and to write a decision based on clinical and legal reasoning, than the training and skills provided by the College training programs.

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

The College has largely, but not exclusively, developed from members with management roles in hospitals and health departments. I foresee a broader role for medical leadership in the future, incorporating both private and public sectors, community and institutional settings, and research and development activities for the continuing development of health programs. The College will need to continue to evolve to adapt to this greater diversity.

Member Q&A

Alistair Mah
MBBS, BMedSc, MHSM, MBA, FRACMA, FCHSM, FHKCHSE, GAICD

Senior Manager, Patient Safety & Risk Management,

Hong Kong Hospital Authority

Clinical Associate Professor, Deakin University

RACMA Conference Steering Committee

What drew you to pursue the path of medical leadership/medical administration?
Initially I thought of doing Emergency Medicine, but even the most efficient specialist would be treating an individual at a time. I was interested in influencing the health outcomes for larger populations and that meant influencing policies, whether at hospital or State/territory wide levels. I always joke that since my father is a doctor and my mother was the Director of Quality at a university, I've just ended up as a combination of both!

What led you to undertake the Fellowship Training Program of RACMA?
Once I decided to venture into management, I wanted to know whether there was any training and how I could take the first step. I spoke to quite a few people, including the DMS of the health service I was at, who is a FRACMA, and she pointed me in this direction. That year I actually made quite a few random calls to Directors of Medical Services around Melbourne to introduce myself and see if there were any job openings! It was an interesting job hunting experience and I would visit people even though I knew there weren't any positions immediately available at that health service. I was very fortunate to be one of the first STP Candidates in Victoria, and was given an opportunity at St Vincent's and Mercy Private Hospital in Melbourne. I had two really good mentors there whom I still keep in contact with, and that was the start of a fantastic journey with the College.

What attracted you to take up your role with Conference Steering Committee? Have you learned anything through the role or benefited by carrying out the responsibility?
It is important that members of our College continually improve through understanding and practicing what is at the forefront of evidence-based management. Conceptually it is no different to practicing evidence-based medicine. So when I was on the Victorian Committee, I got involved in Conference Program Committees. Then in 2018 there was a joint conference in Hong Kong with the Hong Kong College of Community Medicine, and I was asked to Co-Chair the Conference Steering Committee, as perhaps I understood the local culture a little better, and was also involved in the previous 2010 joint conference. Those who know me know that I can be quite straightforward, and these roles definitely taught me how to hone my diplomatic skills, as you are working with very intelligent individuals from a variety of backgrounds, and it is important to try and pick up non-verbal cues that someone's expectations are not being met. It is not always easy and it is a responsibility I have cherished.

How important is it for members of Colleges like RACMA to be actively involved through various roles like yours or on College Committees?
To me, our 'College' is a collective name for its members, and it represents their common goals and values, whether it is for our society or individual members. Over the last decade I have seen the College mature, and this relies on all our members chipping in through various channels, and often not being or wanting to be recognised specifically. You can see a lot of Fellows giving back to the College now through various pro bono work, and this represents the spirit that we want to cultivate especially amongst our candidates or newer members. RACMA especially is a small college in terms of numbers, meaning that it is critical members contribute more frequently if we want to influence the wider health agenda. There are now opportunities not just to contribute to education and training, but also in health policy and position papers too. I would strongly encourage our members to be involved in their area of interest.

How would you describe the importance of both RACMA and qualified Medical Administrators to the Australasian health care system?
Our College is small, yet its members often hold influential positions that shape the health outcomes of various communities. Would you not want people in these positions to have good leadership and management skills, just as you would want your surgeon to have good surgical skills? Many of us would have the experience of working for a boss who is less than ideal, or may have seen things done in a way that is counter-intuitive. We can all agree that being a FRACMA does not guarantee good leadership or management skills, and we all know that there is a large number of fantastic leaders and managers who have nothing to do with our College. However the value of RACMA is that we actively develop doctors to demonstrate the values, competencies and skills we believe make a good leader and manager, based on current evidence. Hopefully through the actions of our members demonstrating these values and behaviours, we influence other managers in our health system positively and over time this becomes the culture (yes I am very naïve this way!)

What are the challenges you can see that RACMA, and the field of Medical Administration in general, will face in the future?
The next step for RACMA would be to position itself to influence more health and social policies nationally, and the College is at a level of maturity where we can be more progressive in this area. While this requires support from the Secretariat, it also relies on members contributing their time and expertise. Australia and New Zealand are very fortunate to have such a structured foundation for peers to support each other, and to train and develop medical leaders. This is rare even amongst developed countries. Over the last 5 years, I have had the opportunity to advise and work in other countries that do not have the same level of support we enjoy, and it is quite obvious that some are calling out for assistance. As the world is getting more and more connected, I do firmly believe that RACMA has a role to play in developing medical leadership internationally.

Member Q&A

Dr Debbie Holdsworth
BHB, MBChB, FRACMA

Director Funding, Waitematā and Auckland District Health Boards

Acting Chief Operating Officer Waitematā District Health Board

New Zealand Co-Juridictional Coordinator of Training

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

Serendipity. At a crossroads having decided to not to pursue physician training, I was offered a job following an off-the-cuff comment to an old university colleague that 'I would take a job outside medicine like a flash'. At the time I was recently married to a non-medic and working 'office hours' for a year held a certain appeal. I took the role working as the lead clinician on an Information Systems project and discovered a passion and aptitude for systems. Needless to say my plan to return to clinical medicine after 12 months went out the window as I continued to accept new opportunities as they arose and effectively underwent general management training through a wide range of management roles across the health system.

What led you to undertake RACMA's Fellowship Training Program?

I first considered RACMA training back in the late '90s and recently discovered the manually typed 1999 RACMA handbook on file. At the time, being a FRACMA didn't really have any currency in NZ and public health training, which I was also considering, seemed to hold more relevance. The possibility of RACMA stayed on my 'maybe someday' to-do list. Eventually the changes to medical council requirements for general registrants caught up with me and the same colleague who changed the course of my career and provided my collegial oversight finally gave me a nudge. At the time I was considering whether to keep up my Annual Practising Certificate as my job didn't require it although it was considered an advantage. In the intervening 15 years, a number of respected NZ Chief Medical Officers had since gained their fellowship which was the impetus for me to apply. I considered myself very lucky to be accepted on the medical executive pathway which was an option at the time. I did struggle to balance study with a busy fulltime role and vulnerability as an adult learner. It was however a rewarding journey and in hindsight I gained a lot more than I was expecting from it:

- It provided the legitimacy to my medical degree I was seeking - I did feel I was a manager pretending to be a doctor when everyone else was a doctor learning to be a manager. I overcompensated in my exam prep and learnt a very important lesson when a censor very kindly said to me, 'you are clearly a very experienced clinician – you need to learn how to manage and take charge'. Let's just say my performance reviews over the years have never identified this as an issue!
- Despite significant management experience at the time, the training was incredibly useful. I still find the structured approach to a 'RACMA scenario' useful in my day to day work, a sentiment echoed by a number of my RACMA colleagues
- It required a lot of self-reflection and I learnt to ask for help which ultimately led to a late diagnosis of dyslexia. Rather than a curse, it has unlocked strategies to a lifetime of struggles I wish I had been aware of long time ago.
- Finally, it has opened up a whole new set of peer colleagues to connect with.

What attracted you to take up your role as New Zealand Co-JCT? How have you benefited by carrying out the responsibility?

I have recently learnt the term 'voluntold'. Shortly after being accepted for fellowship, I attended a curriculum review workshop in Sydney and found myself introduced as the new NZ JCT by the outgoing NZ JCT. To be fair I had said we needed to grow NZ membership and the exam needed to be seen less as a barrier. I am very appreciative of the help I received from a couple of Australian FRACMAs who took pity on me and were generous in providing resources that helped me have my 'aha moment'. I had figured my contribution back would be helping future candidates get through the exam. Working with candidates has grounded me in first principles and provided an ongoing continuous refresher. I have also really enjoyed and appreciated the ongoing contact with other JCTs through the seemingly never-ending committees. The predominant pathway to fellowship in NZ is through a standard pathway with RPLE and while there are a number of differences between us and our colleagues across the Tasman, the constant contact provides an ongoing reality check that we are more alike than we are different.

What are some of the key achievements to note/changes you have implemented in your role as JCT?

My goal was to remove the barrier of the exam so pretty pleased to see the NZ pass rate significantly increase over the past three years. There is now an established pattern that those who have recently

Member Q&A

FROM PREVIOUS PAGE

passed to support current candidates. We also have sufficient interest from local Fellows to run a practice exam. The biggest positive change has been driven by others – all of the changes required to shift the training program to programmatic assessment has resulted in a far more structured approach to oversight of candidate progression and accreditation of posts which has been really beneficial. I am also very appreciative of the effort of my co-JCT Mary Seddon who has provided the impetus for formalising our recruitment and selection of registrar candidates for when we do have vacant posts and to create a more formal rotation through Auckland based positions.

How important is it for members of Colleges like RACMA to be actively involved through various roles on committees?

The work is predominantly volunteer and given how busy we are all, the more members to share the load, the better. While I have made light of being voluntold, as the candidate rep on our jurisdictional committee at the time NZ hosted the annual scientific meeting, I saw how we stand on the shoulders of those before us and observed the lion's share of work fell to a small number of individuals. The outgoing JCT was well overdue for a break after several years of service. In taking on a role it would be good to have the confidence there are others to hand on the baton. In NZ, we now share the JCT role to make it more manageable both from a workload and timetable perspective. While we have relatively small numbers of candidates relative to other jurisdictions, the number of meetings, which is not insignificant, is the same and given the time difference they aren't always easy to get to.

I'm also of the view that our future progress and success is dependent on diversity of thought which comes from widespread participation.

I can also attest to it being a great way to network and a good source of CPD points!

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

Clinical leadership is essential to our healthcare system and requires appropriately qualified specialist medical leaders. Unlike most other disciplines which train and work within a narrow focus, RACMA Fellows are trained to be leaders and systems thinkers, to challenge the current status quo and to work on system improvement. Demand is only going to increasingly outstrip available resources, requiring prioritisation decisions to be taken from a broader perspective and based on whole of system impact. RACMA Fellows have an important leadership role in these conversations.

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

The most significant challenge RACMA faces is retaining relevancy, both within in the medical profession and the wider health system, to be seen as system leaders and the peak training organisation for medical leaders and managers. We are facing increasingly disruptive times with rapidly changing technology, notably digital and genomic, potential health system structural change, changing workforce and scopes of practice along with the impact of climate change. Retaining currency requires agility to adapt our scope, training and professional development in light of these changes. I would also like to see RACMA accept the challenge of eliminating unacceptable inequities in our health system.

Member Q&A

Dr Pankaj Banga
FRACMA FRACGP FARGP
Grad Dip Rural MHM MHL

Director of Medical Services, Wagga Wagga Health Service and Sector 2 Murrumbidgee Local Health District

Murrumbidgee Local Health District, NSW Health

NSW Co-Jurisdictional Coordinator of Training

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

I used to work as a rural procedural GP in Queensland Health, where I would often complain about the system and make suggestions to improve services. My employer encouraged me to take up the sector Director of Medical Services position, which I did. That introduced me to medical administration/ medical leadership. I got a chance to stop complaining and start doing, and I liked the opportunity that a medical leadership position provides to make a positive difference to life in communities.

What led you to undertake the Fellowship Training Program of RACMA?

After starting work as Director of Medical Services, I realised that in my day to day work there were things about which I would have liked some formal training. I had been a doctor/ GP for 18 years before that, and was used to the concepts of learning and best practice. But here I was a Director of Medical Services without any formal training for the job. That is when I came across RACMA and the medical administration fellowship program. Within six months of becoming Director Medical Services, I joined RACMA and commenced in the fellowship training program. I changed jobs midway during my fellowship training and relocated to NSW, but RACMA processes facilitated seamless support and helped me to finish my training whilst continuing to work as Director of Medical Services in NSW Health.

What attracted you to take up your role as Jurisdictional Co-ordinator of Training? How have you benefited by carrying out the responsibility?

I am passionate about learning and teaching. I did my graduation and specialisation in the 1990s. Since 2006 and till 2020 I have been continuously doing formal training myself along with work. Initially I completed all education programs that the College of GPs could offer, and then FRACMA. After that I went on to do a masters in health law. Colleges have made, what I am today. As a gesture of thanks, for more than a decade I have held academic positions with various medical schools and contributed to RACGP/ ACRRM/ RACMA.

My reason for taking up the JCT position is the feeling of gratitude for RACMA. JCT position is a way in which I think I can give back to my College, by helping RACMA Candidates in NSW achieve their best learning outcomes.

What are some of the key achievements to note/changes you have implemented in your role as JCT?

It is still early days for me as the JCT. I am doing site visits, both in NSW and interstate and learning about the job. Once I get a handle on the position, I would then make changes as required.

How important is it for members of Colleges like RACMA to be actively involved through various roles like yours or on College Committees etc?

This is how the system works. Colleges make a positive contribution to the lives of their Fellows, and the Fellows then help with the work of the Colleges to pass on their learning and experience to the next generation.

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

It is similar to any other speciality. For example, people would not and should not go to an untrained non-specialist for having their surgery done, and health services would not appoint a non-specialist as a Surgeon.

Medical administration is a medical speciality and RACMA is the specialist medical college which trains medical administrators. Fellows of RACMA are appropriately trained and are in the best position for medical leadership roles in the Australian healthcare system, for the system to perform efficiently and safely and for the system to achieve the best health outcomes for our communities.

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

The biggest challenge that I think for the health system in the near future is the spiralling cost of continuing to provide quality services. The other big challenge, which has been around for some time but has become more acute recently, is how do we continue to provide even the basic health services in rural and remote areas. Innovative thinking and new technology will help find solutions to these issues, but effective leadership will be required to manoeuvre the health system through these difficult times. Providing leadership is where the role of RACMA and its fellows will be, and I am confident that we as the RACMA community will be able to live up to the challenge.

Member Q&A

Dr Leonard Brennan, AM
MBBS GDFM FRACMA

Principal Medical Adviser

Department of Foreign Affairs and Trade

ACT Jurisdictional Coordinator of Training

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

Part of my attraction to joining the Army whilst studying medicine, was the opportunity to be an officer and assume leadership roles. Throughout the 30 plus years I spent in the full time Army, most of my most rewarding experiences were leading military health teams.

What led you to undertake the Fellowship Training Program of RACMA?

The FRACMA was a natural progression having initially focused on general practice and tropical medicine. It prepared me will for a number of deployments where I was running small trauma hospitals in remote and austere conditions.

What attracted you to take up your role as Jurisdictional Co-ordinator of Training? How have you benefited by carrying out the responsibility?

The ACT is a very small jurisdiction and when my predecessor moved interstate I decided to offer to pick up the role.

I wasn't fully aware of the importance of the role and how it interacted with head office when I assumed the position. It has provided a great opportunity to better understand the operations of the College and the training program in particular. I find I am now much better connected within the ACT and more broadly around the country.

What are some of the key achievements to note/changes you have implemented in your role as JCT?

I have been heavily involved in site accreditation visits and ensuring that candidates are well supported by their work place. The oral exams have been challenging for ACT candidates but I have worked with my colleagues to run regular practice exams to assist candidate preparation.

How important is it for members of Colleges like RACMA to be actively involved through various roles like yours or on committees etc?

A College lives or dies by the engagement of its members. It is important that members share the time burden associated with College participation in order to get the most for the total membership. It can be surprisingly rewarding to see your contribution make a difference and shape the College's future.

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

All health care system face significant challenges, with many competing priorities and some would say, vested interests. RACMA members have the skills and knowledge to bring some cohesion to system. The expertise they bring to optimising services, whilst championing clinical governance has the potential to improve the health of many Australians.

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

The demands of an aging population and the associated proportionate decrease in the supporting workforce will place growing demands on the health care system. The key challenge will be mobilising support to increase the funding "pie" which will require medical administrators to demonstrate that we have made the system as efficient as practicable.

ST VINCENT'S HEALTH AUSTRALIA

ETHOS - an ETHical Operating System for a healthy culture in Health

Catherine Jones, Group Manager, Strategy and Projects, SVHA
Professor Erwin Loh, Group Chief Medical Officer, SVHA

The Ethos program aims to build a culture of safety and respect: a review and evaluation of the implementation of a complex program in a complex organisation.

Why are we doing it?

External scrutiny of the health sector has indicated it is failing to respond effectively to entrenched cultures and behaviours that put the well-being and safety of staff and patients at risk. The pressures of modern healthcare often reduce complex, deeply personal, care-giving relationships into a series of demanding tasks performed under severe time and financial constraints. Under these circumstances, the resulting stress staff feel, can manifest as disruptive behaviour which undermines a culture of safety and reliability. In healthcare, we have long given ourselves a 'free pass' for disruptive behaviours because of the life and death nature of our work[1].

The cumulative effects of dysfunctional interactions can reduce discretionary safety behaviours such as speaking up for example if a patient is deteriorating, or an error is about to occur. Part of the problem with addressing poor behaviour and entrenched cultures in a sector as heavily hierarchical as healthcare is that staff often feel ill-equipped or unsafe to speak up when they witness or experience behaviour that undermines patient or staff safety[2].

It is now well established that poor behaviours are linked to clinical harm to our patients and impacts patients' experience of care[3]. There is evidence that clinical teams perform worse when exposed to rudeness[4] and that surgeons who have more patient complaints, also have worse clinical outcomes[5].

Healthcare is largely failing in its legal obligation to create a safe workplace. As a Catholic health and aged care provider, St Vincent's Health Australia's philosophy and mission is deeply rooted in our values. We are committed to a positive culture where all staff and patients feel welcome, valued, and safe.

What are we doing?

St Vincent's Health Australia launched the Ethos program in July 2017 to help build on a culture of safety and respect (Box 1). The program is now in place at two public and five private hospitals and will be implemented in two additional private hospitals by February 2020. St Vincent's Health Australia is not alone in adopting a professional accountability program to promote a positive culture. Similar programs are being implemented in an expanding number of health service organisations across Australia and there

is considerable interest within the sector in such programs. The St Vincent's Ethos ProgramTM has been cited in recommendations in recent reports as a model for consideration by other health services; most recently by the Independent Review into Workplace Culture within ACT Public Health Services[6], and the AMA submission to the National Inquiry into Sexual Harassment in Australian Workplaces, the Australian Human Rights Commission (AHRC)[7].

The review & evaluation process

In March 2019, St Vincent's Health Australia commissioned an independent review of the Ethos program at St Vincent's Hospital Melbourne and St Vincent's Private Hospital Melbourne. The program had been implemented for nearly two years so it was a timely opportunity to explore which elements of the program were working well, and which elements could be improved and how.

The review attracted a significant response from employees at both hospitals and included:

- 63 face-to-face interviews, representing most professional groups. Senior and junior medical staff represented approximately 60% of interviewees, followed by nursing, allied health, Aboriginal health and other employee groups;
- 21 written submissions via email;
- 10 telephone interviews; and
- attendance at two Ethos program related meetings.

The key finding of the review was that the overall objectives and intentions of the Ethos program were well supported by all professional groups. The review made 18 recommendations that were grouped into eight themes. Each theme was addressed, and improvements were designed and implemented through the work of a multidisciplinary working group.

1. Continue to build "speaking up" capability and develop a culture of feedback literacy throughout all levels of the SVHA

The Ethos program is centrally concerned with speaking up and creating a culture of safety and respect. The program will continue to promote the range of options to assist speaking up for example, using graded assertiveness tools or seeking advice from colleagues and managers to enable individuals to address issues. The online Ethos Messaging System enables speaking up when an individual feels unable or unsafe to address an issue directly.

"I wonder whether junior doctors do feel empowered to speak out if they have been bullied by a more senior doctor?"

The program will continue to develop key resources to improve feedback literacy at all levels of the organisation. This includes promoting a culture of safety where feedback is invited and acknowledged as part of daily practice and staff are skilled at both giving and receiving feedback. The Ethos program provides an opportunity to affirm St Vincent's values and expectations through informal and confidential peer-led conversations and feedback. Informal feedback aims to create awareness of how we are perceived in the workplace and to strengthen our ability to maintain the high standards of care for which St Vincent's Hospitals are known.

Description of the Ethos Program

The St Vincent's Ethos ProgramTM aims to create an environment where all staff and patients feel welcome, valued and safe. The Ethos program allows us to:

- **recognise staff who exhibit exemplary behaviour and are exceptional role models;**
- **remove barriers to speaking up and make it easier and safer for people to do so; and**
- **provide feedback to staff whose behaviour undermines a culture of safety and check on the welfare of staff whose behaviour suggests they may be experiencing stress or burnout.**

The Ethos program includes:

- **an Ethos pathway and a peer led early intervention process to provide a consistent and transparent approach to addressing conduct that is inconsistent with our values;**
- **options to speak up including an online Ethos messaging system which provides a safe confidential avenue to speak up when addressing an issue directly is not an option; and**
- **a package of capability building and training to equip leaders and staff with the skills they need to role model and teach safe behaviour.**

FROM PREVIOUS PAGE

ETHOS - an ETHical Operating System for a healthy culture in Health

2. Continue to encourage the collection and use of positive feedback ("Feedback for Recognition") as part of SVHA culture

"Feedback for Recognition" is greatly valued. The number of positive workplace experiences raised through the Ethos program was a major benefit of the initiative. It was recognised as a strong driver of building on a culture of safety and respect and that this aspect of the program should continue to be encouraged.

"There is a lot of goodwill in healthcare, we need to focus on thanking our staff and celebrating our achievements. Ethos can do this. We need much more communication about this."

Managers have a specific "Feedback for Recognition" conversation guide to assist these conversations. Feedback for Recognition is a powerful learning tool to reinforce high standards of practice. The Ethos program will continue to look for opportunities to use Feedback for Recognition to promote the great work we do as an organisation.

3. Change the language associated with the Ethos program to better reflect the intention of the program

Some of the terminology used in the Ethos program did not align with its intent, for example, the use of the terms 'positive reports' and 'negative reports' implied a process that was more formal than intended and could sometimes feel punitive (Table 1). The language has been reviewed to ensure it reflects the true purpose of the program, which is to reward and recognise role models and provide feedback to staff whose behaviour undermines a culture of safety and also a welfare check for staff whose behaviour suggests they may be experiencing stress or burnout.

Table 1. Changes to Ethos program terminology

Former Language	Improved Language
Ethos Reporting Tool	Ethos Messaging System
Report	Submission
Positive Report	Feedback for Recognition*
Negative Report	Feedback for Reflection*
The Ethos Accountability Pathway	The Ethos Pathway

*Feedback for Recognition: recognises staff who exhibit positive behavior and are exceptional role models.
*Feedback for Reflection: creates awareness of behaviour in the workplace and provides an opportunity for self-reflection. This type of feedback may include discussion about standards of conduct, a welfare check, options for support, coaching and development.

4. Increase transparency of the program in terms of the roles, functions and processes

The roles functions and processes associated with the Ethos program needed to be more transparent and better understood by staff. The Ethos program policy and procedure were reviewed to provide a clear explanation of all processes and roles associated with the program. Clarification was provided that the Ethos program did not conflict with any existing grievance or disciplinary processes. Staff were provided with information about the full range of options available to them if they experience behaviour that undermines a culture of safety and respect. It was emphasised that speaking up at the time of the incident is the preferred option. Further, it was clarified that receiving informal feedback through the Ethos program is always confidential and has no impact on future career opportunities.
Concerns had been raised about women being unfairly targeted by the Ethos program.
"We need to look at the number of women in senior medical positions in particular Heads of Unit or craft group leads"
"There is often a repeated dynamic between female medical staff and female nurses which makes female medical staff feel unfairly targeted for behaviour which would be overlooked in male medical staff".
"They [female medical staff] have to moderate their behaviour in a way that male medical staff don't."

Patterns related to gender were analysed based on 309 submissions to the Ethos Messaging System. The key findings were:

- there were no statistically significant differences between submissions made about female compared with male doctors;
- nurses were more likely to be the subject of a submission than doctors; and;
- male nurses were more likely to be the subject of a submission than female nurses.

The Ethos Messenger role was reviewed to improve the ability of Ethos Messengers to provide high quality "Feedback for Reflection". Ethos Messengers have increased the emphasis on checking on the welfare of recipients of "Feedback for Reflection". As well, the number of 'check in' points has increased with the addition of an offer to check in with recipients 48 hours post the conversation.
"More support should be provided to individuals who are distressed."
The Ethos Messenger conversation was broadened to include identification of system failures that may have led to increased levels of stress or that may have left staff venerable to conflict. System failures will be logged, analysed and prioritised and will be the target of improvement initiatives.

5. Increase transparency about how information from the Ethos Messaging system is used

There was a need to increase the transparency around how information from the Ethos Messaging system was used and to clarify that:

- the Ethos Messaging System is not part of any HR personal management system;
- submissions made to the Ethos Messaging System are informal, do not form part of an employee record, cannot influence an individual's future career prospects, cannot be used in performance management and cannot be used in any formal disciplinary process; and
- the Ethos Messaging System is governed by the highest level of security standards.

Where to from here?

The Ethos program is a complex program being implemented into complex organisations. It was timely to review the program to see what was working well and what could be improved. One of the aims of the Ethos program is to provide (sometimes challenging) feedback to staff about how their behaviour has been perceived. The independent review of the Ethos program provided (sometimes challenging) feedback about how the program was performing and its perceived intentions. The review provided a perfect opportunity to model a positive response to feedback and reflect on how improvements could be made.

The Ethos Program will continue to be evaluated as part of a longitudinal investigation in partnership with the Australian Institute for Health Innovation (AIHI) at Macquarie University, with whom St Vincent's Health Australia share a NHMRC partnership grant to evaluate the program. The evaluation; "Creating a culture of respect: a controlled mixed methods study of the effectiveness of a behavioural accountability intervention to reduce unprofessional behaviours" will allow a longitudinal in-depth evaluation of the Ethos program which will be the first evaluation of its kind.

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SAVING the planet while improving the BOTTOM LINE – the role of HEALTHCARE LEADERS in addressing the climate crisis

David Bryant, Executive Director, People & Culture, SVHA
Professor Erwin Loh, Group Chief Medical Officer, SVHA

Climate change is an emerging crisis, with potentially significant negative impacts on population health, and it is important for specialist medical administrators to understand how health systems can adapt to mitigate these outcomes.

Research tells us that people will increasingly experience adverse health effects from climate change, with increased mortality and morbidity due to heat waves and fires, increased risk of food- and water-borne illnesses, and malnutrition due to food scarcity . In addition, respiratory and allergic disorders, heat-related disorders, collective violence, and mental health problems will all likely increase due to climate change . There is even a belief that the threat from climate change is so great that it could undermine the last 50 years of gains in development and global health .

The health system needs to transform itself to prepare for these impacts, and doctors, particularly those in leadership roles, must lead these changes. One of the ways health organisations can help mitigate some of the predicted outcomes is to transition from fossil-fuel dependence to renewable energy sources. Healthcare is one of the worst culprits for carbon emissions – internationally and in Australia – and the sector needs to take more responsibility for its actions. The global healthcare sector's environmental footprint is equivalent to 4.4 percent of global net emissions or the annual greenhouse gas emissions from 514 coal-fired power plants . In Australia, the carbon footprint attributed to healthcare is 7 percent of Australia's total. That's the equivalent of the carbon emissions of the entire population of South Australia. Hospitals are responsible for almost half (44 percent) of these emissions .

Clinicians take oaths to 'first, do no harm', and it is time that Australia's healthcare organisations started taking that oath seriously when it comes to its environmental impact as well. To that end, St Vincent's Health Australia (SVHA) – Australia's largest not-for-profit provider of health and aged care services – has announced it is expanding its efforts to reduce its greenhouse gas emissions and has challenged other major operators in the sector to lift their game.

> *The health system needs to transform itself to prepare for these impacts, and doctors, particularly those in leadership roles, must lead these changes.*

St Vincent's Health, which is best known for its public and private hospitals in Sydney, Melbourne and Brisbane, has pursued a range of measures since 2015-16 that has seen its total energy use drop by 8 percent and greenhouse gas emissions cut from 118,109 tonnes of CO2e in 2015-16 to 108,638 in 2018-19 – the equivalent of removing 4,242 cars from Australian roads for one year - despite opening a private hospital, undertaking a major redevelopment and extension of another private hospital and five aged care facilities over the period.

The organisation has achieved this by installing approximately 13,000 solar panels across 19 hospitals and aged care facilities, with another five recently completed (55 buildings altogether). The clean energy produced by the solar panels across its facilities is enough to power the equivalent of 3,000 houses for one year (year on year for 25 years). In addition, it has replaced just over 33,000 incandescent and fluorescent lighting with LED alternatives, introduced a 'plug-smart' system to improve the energy efficiency of lighting and other electrical equipment, and trialled a program to reduce the energy needed to drive the air conditioning systems at St Vincent's Hospital Sydney, which has reduced the cooling energy consumption by 30 percent and delivered a utility cost reduction of $128,590.

As a healthcare organisation founded to provide care to the vulnerable and marginalised, St Vincent's recognises that low income Australians will be hardest hit by climate change, and to not reduce its carbon output would be a direct contradiction of its mission. But SVHA's actions also make significant financial sense. Electricity and gas prices have skyrocketed in Australia over the past five years – power prices have increased by close to 120 percent since 2008 – and the more St Vincent's saves on power and gas bills, the more it can put into its frontline services.

In terms of the financial impact of these changes, the organisation is achieving savings in the area of around $880,000 each year in solar technology alone, and will do so for another 25 years, which is the general lifespan of the technology. In fact, the estimated total savings for making these changes – across solar, lighting, energy-saving devices, and air conditioning – is more than $34 million over the next 25 years.

The current bushfire crisis has reminded us all of the grave risks of climate change. Australia's health sector has to recognise its very significant contribution to the problem and must get serious about addressing it.

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Improving Research Ethics and Governance in a Large Metropolitan Academic Health Service

Deborah Dell, Manager, Research Support Services, Monash Health
Professor Erwin Loh, Group Chief Medical Officer, SVHA

Introduction

Research ethics and governance processes in health services can be unnecessarily complex and costly, including low risk health services research, and requires reform[1]. A recent study in England found that a low risk study needed 89 individuals to approve it and concluded that ethics and governance approvals are burdensome for historical reasons, with opportunities to improve their efficiency[2]. Despite the move to centralised ethics review systems, their benefits have not been realised due to duplicative, inflexible research governance processes[3].

The authors of this article undertook a comprehensive organisational-wide change management process to reform research ethics and governance processes at Monash Health, a large multi-site metropolitan academic health service in Victoria, over the period of two years, which led to significant improvements in research governance efficiencies and researcher experience. This paper summarises the steps taken to carry out this reform.

Research Governance Structure Reform

Research governance and leadership

As part of engaging clinician scientists and academics, and to set up a research governance structure that is led by practicing and respected researchers, the Chief Medical Officer, who was one of the authors at the time, established a peak research governance body, called the Monash Health Research Council, which is the leading group driving research strategy and research governance policies across the health service.

Research strategy

The Chief Medical Officer facilitated 5 Research Consultation Forums held on 24 May 2018, 13 June 2018, 26 June 2018, 09 August 2018 and 3 September 2018. The forums were the first steps towards development of a Monash Health Research Strategy, which formed the backbone and foundation for the reforms proposed and implemented. The following recommendations arose from the forums:

- Draft Strategic Intent – with the overarching vision being to develop and support a culture of research excellence;
- Draft Organisational Chart for Research Operations and Governance – with the purpose being to support and expedite research across the organisation; and
- Suggested Clinical Trials Operations Group – to ensure clinical trials processes are led by expert clinical triallists.

Accountability framework

There was an establishment of a research-specific Authority Delegation Schedule to ensure there is accountability for each step of the research governance process, detailing each staff member's responsibilities with respect to all aspect of ethics and governance, including the review of responses to the HREC conditions of approval, applications for Site Authorisation/Governance approval, post-approval amendments, safety reports and annual reports. Obligations were also placed on researchers, as the end-users of the research governance system, with the establishment of Good Clinical Practice requirements for all researchers involved in interventional research, to ensure that the highest standards of research excellence are complied with.

Research partnerships

In addition, the health service entered into shared financial arrangements with its closest university partner in order to maximise Research Infrastructure funding available to the health service, to further support investment in research. Also, the health service improved its engagement in the initiatives of the regional academic health science centre it was a part of, by strengthening links with its research partners, and entering into a shared platform for ethics review for the private health services within that consortium.

Research Governance Process Reform

The health service implemented a new Site Specific Authorisation Coordinator position, specifically dedicated to Site Authorisation/Governance of applications that have been reviewed by another accredited Human Research Ethics Committee. In addition, a preferred Research Agreement Template listing, including Investigator and Collaborative Group templates, was also introduced, together with a Research Contract Checklist to facilitate expedited review of research contracts and indemnities. Commitment from supporting departments for timeframes for providing approval/non approval of new study requests was obtained. Lastly, and importantly, the health service introduced an annual submission date for progress reports of 30 April each year, which standardised this compliance process across the board.

Research Ethics Reform

The following strategies were used to reform and improve the research ethics process at the health service.

Quality Assurance

The health service implemented an expedited Quality Assurance Process for activities exempt from Human Research Ethics Review. The two-part process involved a clinician checklist, and if all answers are a yes, then a very brief application consisting of names and positions of staff involved, along with a description of the activity. The checklist and application is reviewed within 3 days by Human Research Ethics Committee Manager, and a letter of ethics exemption is then provided. A Patient Information and Consent Form, specifically for Case Reports, was also introduced.

Low Risk Review

The health service established a Virtual Low Risk Panel, which provided feedback within 10 days of submission. The Low Risk Panel consisted of two Co-Chairs and a pool of members who are required to meet the following Key Performance Indicators.

- Current evidence of Good Clinical Research Practice Training;
- Willingness to engage in professional development opportunities relevant to Human Research Ethics Committee members;
- Adequate review of proposals evidenced by knowledge of the research proposals for review including the formulation of questions/comments; and
- Availability for communication with researchers and the staff of the Research Support Services unit.

The Low Risk Panel members were sourced from clinical departments who regularly submit research applications for consideration. A Memorandum of Understanding was updated with all clinical research units to encompass mutual acceptance of all types of research, with the caveat that all types of applications would require completion on the National Ethics Application Form/Human Research Ethics Application, in order to be accepted across jurisdictions as there is no uniform low risk form across different jurisdictions. Lastly, it was agreed that completion of a Human Research Ethics Form for a Low Risk study was required.

Human Research Ethics Committee Review

Active engagement by the health service's Human Research Ethics Committee with other committees from other health networks commenced, in order to develop consistent approaches to issues such as the adoption of the State health department's preferred templates on the understanding that there may be modifications required, dependent on the nature of the study,

FROM PREVIOUS PAGE

Improving Research Ethics and Governance in a Large Metropolitan Academic Health Service

the consideration of waiver of consent applications, the use of independent reviewers in first time in human research, the development of a new Human Research Ethics Committee Member induction process to be held twice a year, and the facilitation of an annual Victorian Chairs and Executive Officer's Professional Development program to ensure ongoing professional development and networking.

Work was also undertaken to increase the membership of the Human Research Ethics Committee and the health service entered into more flexible membership arrangements to retain members, including job-sharing arrangements for members so that they can share the one position on the committee, access to professional development opportunities at no cost, the provision of honorariums to lay members to assist with out of pocket expenses such as transport or childcare, and increasing the pool of members, so that the workload would be more evenly distributed.

The health service also introduced an open-door policy with regard to observers, enabling personnel from internally and externally to the health service to observe meetings, making them more transparent and subject to scrutiny at any time. There was also a move to a totally electronic submission system, enabling Human Research Ethics Committee members to receive applications at least 12 days ahead of the meeting. Lastly, the Research Support Services team members was given a key performance target of ensuring minutes and feedback to researchers are provided within 3 working days of the Human Research Ethics Committee meeting.

Conclusion

As a result of these comprehensive changes to research governance and ethics processes, the experience of both front-end researchers as well as back-end research support staff increased. Timeliness at all key milestones of the research process also improved, and the overall quality and quantity of research projects improved. Reform to current research approval processes need to occur across the health system, so that clinical research can continue to be supported and excel, for the betterment of our patients and the community.

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Ethical Decision Making in Health Leadership and Management

health leadership

Professor Erwin Loh, Group Chief Medical Officer, SVHA

Ethical decision making is an important topic for people in medical management and leadership because one of the key roles of leaders and managers is to make decisions. The more senior you are, the more impact your decisions have on people and on operational services, so it is important to have a framework to ensure that decision-making is ethical.

Ethics can be defined as the principles relating to right and wrong conduct. The concept of right and wrong can be difficult because what is right to one person might be wrong to another, and sometimes, the issue may not be as black or white as one might like. Everyone faces decision-making problems daily and a lot of these have an ethical element to them. Sometimes the decisions are easy and can be made straight away; other times they are not as straightforward, and require considered deliberation and thoughtfulness.

Medical ethics is primarily based on the Hippocratic oath; the foundational domains of medical ethics are autonomy, beneficence (doing good), non maleficence (do no harm), and justice. As a profession, we have taken these principles as carry out our clinical practice. Bioethics (ethics applied to biology) is a broader concept than medical ethics, and is an interdisciplinary field of the moral dimensions of the decision making in health care and life sciences.

The difference between morals, ethics and law

Human behaviour needs to be governed for society to function as a whole. There are common principles within all cultures that govern our behaviour as we act and interact with others. As individuals, we have morals, which can be defined as the principles and rules by which we run our personal behaviour. These rules are based on our own values, which may be influenced and shaped by our upbringing, cultural background, and/or religious faith. These rules form the boundaries that dictate what we believe are the right things to do, and the lines that we will definitely not cross. Morals that are collectively shared by a group or society becomes the foundation of ethics.

Where does ethics fit with law? Sitting above ethics (or group morals) and personal morals, we have laws, which are official behaviours dictated by principles governing a society that are sanctioned by government and by society itself. Laws are needed, because without them there may not be clear boundaries as to what we are expected or allowed to do. In addition, if those laws are breached, there may be consequences. For the purposes of this discussion, we can conceptualise ethics as sitting between personal, individual morals, and the legal framework that the individual is located in.

Nevertheless, an action may not be considered by an individual to be moral or ethical even if is legal (or not illegal). A good example that has been used by Dr Martin Luther King Jr is that everything Hitler did in Germany was legal according to their laws. As such, just because something is legal does not necessarily mean it is ethical. Likewise, at a personal level we have to consider the concept that something ethical may not necessarily be moral for an individual. We all have to work out where we sit within the ethical/moral framework in the context of our society's laws.

Behaviours that are both illegal and unethical are usually easy to identify, such as corruption, theft or fraud. Clearly these actions both against the law and are unethical. However, there are some issue that may not be lawful, but for some groups, be considered ethical. A recent example in Australia of this situation is the issue of laws being put in place to prohibit doctors who have treated asylum seekers from raising concerns to third parties. In this case, what is perceived as whistle blowing has been made illegal, but could still be potentially ethical. There may actually be an ethical obligation on an individual, on top of the individual's own moral obligation, to break the law to report wrongdoing. There may also be actions that may be perfectly legal, but potentially unethical. An example of this are laws that allow companies to produce waste up to a ceratin level, which may still have a negative environmental impact and still be potentially unethical.

FROM PREVIOUS PAGE

Ethical Decision Making in Health Leadership & Management

Theories of Ethics

There are many different kinds of ethical theories, but we can distil them down into two broad categories, deontological and teleological. Deontological ethical theories are rule-based, while teleological theories are consequence-based. Figure 1 below explains this succinctly, in that deontological ethics is concerned with the action first, with the outcome being secondary, while teleological ethics would argue that the ends justify the means, and is based on consequentialism. The classical deontological theory is Kantian ethics, while the two main teleological theories are Virtue ethics and Utilitarianism. We will discuss each of these in turn.

Kantian ethics is a deontological approach that has an ethical decision making foundation that is rule based and concerned with the right action. Rules are made based on past experiences that happiness is generally increased if such rules are followed. An example is the rule "do no harm". Immanuel Kant came up with the idea of the categorical imperative, which is based on a supreme principle of morality. People should act according to rules, such as duties and rights, that are universally valid and should be universally embraced. An example of a universally valid rule is that all human life is sacrosanct, and conversely, everyone has a right to life. As such, whatever the circumstances, it is never ethical to sacrifice a human life. This theory holds that every individual have a duty to a higher universal moral law that applies to everyone. There are perfect duties, which are negative duties of justice, that are based on things we never do, such as the duty to not kill, which are always true. There are also imperfect duties, which are positive duties of virtue, that are based on things we can sometimes do, such as the duty to help the needy, as long as they do not conflict with the perfect duties.

Virtue ethics is a teleological approach that is based on personal character (and not on actions or rules) and on "being good", also known as Aristotelianism. This theory is based on a classical school of philosophy from the Socratic period inspired by the works of Aristotle. In short, for an individual to be ethical, or "virtuous", that person must perform virtuous activities (and not just avoid performing negative ones). Individuals must have core values that make them a good character that leads to positive relationships. This framework is based on the belief that individuals are rational moral agents and that virtue comes from the exercise of reason. This theory also espouses the idea of the "golden mean", which describes the ideal positive balanced state in the middle of two negative extremes, for example, the virtue of courage between the vices of cowardice and foolhardiness. This approach is also similar to leadership theories that explore the paradox of leadership.

Utilitarianism, another teleological approach, has an ethical decision making foundation that is primarily based on consequences and outcomes. An action is right (good and ethical) if it causes more happiness or prevents pain, and wrong if it decreases total happiness, regardless of whether the action is intrinsically right or wrong. Definitions of happiness include advantage, benefit, goods or pleasure. John Stuart Mill and Jeremy Bentham were well-known proponents of this theoretical framework. Utilitarianism is a classical ethical foundation and framework that a lot of managers, including in health, use, because it is based on the principle of utility, or the principle of greatest happiness and greater good. It shares some similarities with economic theories that are prevalent in Western healthcare systems. In essence, decisions are ethical if they are made to benefit the greater good, rather than the minority. The point of utilitarianism is that you are theoretically removing personal values or morals from your decision-making process, and using a logical, rational, objective process to arrive at the decision. From this point of view, the health manager can utilise a business case with cost benefits analyses to help make a decision that is ethically defensible.

FIGURE 1. Deontological vs Teleological ethics

Figure 2 below summarises the three theories discussed in a flowchart. The fourth ethical theory referred to in the figure, egoism, has not been discussed, but it refers to the theory that individuals as free moral agents should do what is in their own self-interest as opposed to the greater good, and that such actions are ethical.

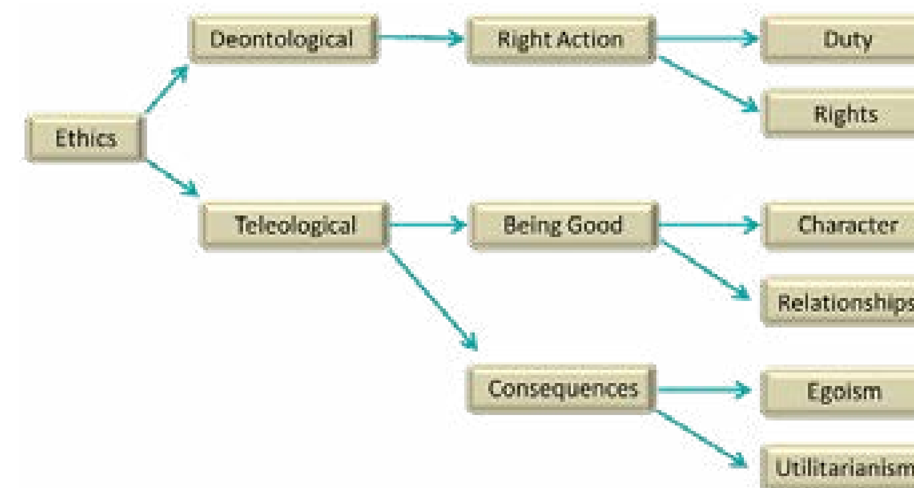

Figure 2. Ethical theory flowchart

Limitations of the ethical theories

Each of the ethical theories have their own limitations. Kantianism assumes that everyone who is rational will subscribe to the same set of rules based on universally applicable moral principles that cannot be breached. The problem with this belief is that such universal absolutes are unqualified and overly simplistic in complex systems such as healthcare, especially when there are limited resources that need to be applied over a large population.

In addition, Aristotelianism also has its own problems. One of the main problem with virtue ethics is that it is based on individual morals and values, and these may differ between cultures and societies. Virtue may also evolve over time and therefore this theory may be morally relativist. In addition, health leaders may be expected to refrain from making decisions based on their own morals and values, as they may differ with that of the organisation or wider society.

In relation to the Utilitarianism approach, there is no universal agreement in defining what a positive or negative outcome is, and who should be the final arbiter of the definition. What may be good for one person may not be good for another. There is also difficulty in calculating non-monetary value that may be subjective when undertaking a cost-benefit analysis to determine the greater good. The other shortcoming of Utilitarianism is that it does not consider the individual and is a dispassionate, even compassionless framework, because actions that benefit the majority may be at the expense of the minority or individual. This lack of apparent compassion has been a criticism of the modern healthcare system, which focusses on managing the largest population as efficiently as possible with limited resources.

A dual-process theory of moral judgement

From a practical point of view, most people utilise both deontological as well teleological approaches when making decisions, even if they are quick and easy ones. Neurocognitive studies have shown that different parts of the brain are more amenable to different ethical approaches. When faced with a moral dilemma, the first thing that happens is that an individual's higher brain starts going through a utilitarian moral reasoning process, balancing out in a rational manner the costs and benefits of the different options. Then the non utilitarian emotional Kantian response kicks in – even though the majority may enjoy the greater good, is it right that a decision may negatively impact an individual or minority. Even though the rational mind may want to avoid personal judgements and morals, a person's own virtues will also be influential, even if it is subconscious.

The process can be broken up into the following parts:

- Recognise the dilemma, analyse it and get the facts. Sometimes analysis has to be done by a committee, for example, the clinical ethics committee of the hospital.
- Select an ethical theory. Broadly speaking, there are only two broad approaches, deontological (looking at the rules) or teleological (focussing on the outcomes).
- Do the first level of analysis, which is usually a utilitarian type approach, for example, using a cost benefit analysis.
- Undertake a second level of analysis using a Kantian approach, looking for any universal principles and moral duties or rights.
- Ensure the decision being contemplated is not only ethical, but also legal under current legislation and common law.
- Make the decision.

In an ideal world, ethical decisions that we make have only winners, with no losers. In reality, decisions that made usually have winners and losers, and it

FROM PREVIOUS PAGE

Ethical Decision Making in Health Leadership & Management

becomes a question of how much. As health leaders we can use both utilitarian and Kantian thinking to work our way towards an ethical decision. The question "Is that unfair?" is utilitarian, while "If I take this decision will I feel badly about it, even though it's for the greater good?" is Kantian. The ethics of a pragmatic decision can be tested by considering whether or not you are going to be ashamed to tell your family, friends and co-workers, and if you would be embarrassed if the decision was reported in the press. Can you live with yourself and be happy that it is the right ethical decision, even though it is a hard decision and someone is losing out?

Let us now explore some case studies based on real-life scenarios.

Case Studies in Ethics

Case 1

Therapeutics committees in hospitals and health services have to deal with the issue of high cost drugs. This theoretical case revolves around a high-cost drug for a rare condition. The drug has passed the Therapeutic Goods Administration (TGA) process but it is still not on the Pharmaceutical Benefits Scheme (PBS), and therefore it has to be funded from the hospital high-cost drug budget, which has almost reached its spending limit. There is a proposal to spend the $400,000.00 remaining in the budget on the drug for a year for one patient who will die if it is not given. This proposal is competing with one for the same amount of money to fund a drug trial in a subset of diabetic patients. The study drug has the potential to improve quality of life, prevent complications and increase survival, and may have a positive impact on 100 people. The moral dilemma is whether the money should be spent on preventing one person from dying, or potentially prolonging life expectancy for a group of 100 people.

Points to consider when making the decision include: how does spending the money in either scenario do the greatest good for most people (the utilitarian approach)? How do you calculate the cost benefit of preventing one death compared with the potential for prolonging a number of lives for a period? Should the consideration be funding a proposal that provides the greatest good for the people who pay into the system, rather than the general population? There is always the option of breaking the budget and spending on both proposals.

The reality is that there would be a presentation to the therapeutic committee but they may not drill down into too much detail. They make the assessment on the basis of the treating doctor's assessment, and most of the time the health service will say yes to proposals for high-cost drug spending and be willing to sometimes break the budget.

Case 2

The head of Paediatric Nephrology has referred the case of a nine year old boy with congenital kidney disease and intractable hypertension resistant to pharmacological treatment to the clinical ethics committee. The child has complications of long term hypertension including deteriorating eyesight and headaches, and also has multiple side effects from polypharmacy. The Head of Paediatric Nephrology wants the child to have renal sympathetic ablation, an operation that has been done in adults for intractable essential hypertension, but has never been done in secondary hypertension or children. There are no trials demonstrating efficacy of the procedure in children, but the thought is that it may work. As well as the standard risks of bleeding and other complications of angiography and the potential for death, the major risk in children is that the renal artery itself in a child is physically small. However, the only other option is to continue with medical management, which will lead to renal failure, bilateral nephrectomy and peritoneal dialysis, or renal transplant, a procedure that also has long-term issues. The child's parents want renal sympathetic ablation, and the child agrees with doing the procedure, so there are no issues around consent. There is a specialist paediatric angiographer and a competent paediatric surgeon available who have the skills to do the procedure. The clinicians understand that they don't know what the potential outcome could be but they believe it is the right thing to do, and the worst possible outcome – that the child dies – is no worse that the outcome of the natural course of the disease. There are no issues with the cost of the surgery. How would you, as party of the ethics committee, make the decision? Is this procedure ethical?

When considering this case, it is important to consider whether the risk of the disease outweighs the risk of the ablation. In this instance, the clinical ethics committee had initially said no, but after they met with the parents they changed their decision to yes. The reason for the initial "no" decision was that they were very worried about the fact that the surgery had never been done in children, and that it would be unethical to do research on a child. After the change in decision, the procedure was done and was highly successful, and the child now has normal blood pressure.

Case 3

You are the Chief Medical Officer of your hospital. You receive a letter from a small hospital in Fiji thanking you for the kind donation of medical equipment from your health service. You find this unusual because you know nothing about a donation. You investigate further and you find out that some of your staff have not been disposing one-use only devices, expired bandages and other medical equipment that are no longer deemed to be able to be used at your health service, but have been packaging them and posting them directly to a sister hospital in Fiji that hospital staff, including the hospital surgeons, have been supporting. They have been using your hospital resources to do this and the hospital is covering the cost of postage. When questioned about this, they indicated that they did it because the equipment was going to be thrown away anyway, but now it is being used to save lives in Fiji.

The ethical issues here are whether there is potential to do harm to others through the use of expired equipment, and whether or not it is appropriate for the equipment to be used in Fiji if it is not good enough to be used in your hospital. Balancing this however, is the consideration of whether substandard treatment is better than no treatment at all. If you do not give the hospital in Fiji expired products that you no longer want to use, they are not going to have anything. We can also consider whether expiry dates are meaningful and whether an expired dressing is better than nothing. Then there is the issue of informed consent - the hospital in Fiji needs to know this is discarded equipment that they use at their own risk.

In the end, the hospital involved felt it was ethical to provide the equipment but did not want to be the agent to do it, because hospitals are not designed to be charitable organisations that have expertise in providing equipment overseas. The hospital partnered with an NGO that had a system in place, and channelled its expired equipment to them. The NGO decided what was safe and distributed the equioment to the places that required them. The hospital also needed to improve the clinical governance of such donations to ensure that there were no such surprises in the future.

Case 4

As the Chief Medical Officer of your hospital you have received a letter from the local government in Fiji thanking you for life changing surgery performed on a child in the region. You find this unusual because you know nothing about any surgery. On investigation, you find that some of your plastic surgeons have been flying to Fiji during their leave to do aid work, including surgery. They've also organised a few of the children to be flown back to your hospital for more complex surgery. The costs of the flight and accommodation are covered by donations and NGOs, and the surgeons are donating their time. However, the costs of your staff, resources, and the stay in paediatric intensive care are not recoverable. You discover that your public affairs department knows about this and are very supportive because it is great public relations. They show you multiple newspaper articles about the fact that your surgeons are going and bringing children back to your hospital. However, you know that the elective waiting list for plastic surgery is blowing out and your hospital budget is under stress.

Professor Loh talks RACMA Candidates through his case studies

Ethical issues to consider include whether or not it is fair that overseas children are getting hospital care when the local children are on a waiting list and there is potential for their surgery to be delayed, whether Australian public tax payer funds should be used for non-residents, and whether or not the surgeons should be undertaking duties that are not within their job descriptions without prior approval.

There are no issues with surgeons using their own time to do overseas aid. The issue to consider is that of bringing the complex cases into the Australian public health system, with no means of recovering the extra costs. There is no easy answer to resolving this ethical issue and people are often divided on whether such charitable works should be performed locally. The hospital involved developed a policy where there was an agreed arbitrary number of such surgeries that would be approved each year, with an independent expert panel set up to assess and prioritise the cases.

Case 5

You are the Chief Medical Officer of your hospital and your Head of Medicine, a Professor has indicated that he has got a great deal for you. He knows of an experienced neurologist from India, a Professor, who has passed all his Australian Medical Council (AMC) exams and is credentialed, but needs to complete the required hours of college supervised practice before he gets his fellowship of the local physician medical specialist college. While the medicine program in your hospital has no extra EFT and no budget for new positions, this Professor is willing to work for your health service for free for 12 months. The Head of Medicine sees this as a win/win situation, because this Professor is highly qualified and the clinic needs more neurologists. The Professor is happy to sign any waiver, declaration, or contract, but under the college rules he needs to be practicing neurology full time and be looking after patients.

The question here is whether or not it is ethical for such person to work for free, even if they want to, because they would only be doing so because they have no real choice in the matter. While this man did have a choice in coming to Australia, it would be unethical for a hospital to take advantage of the opportunity. The hospital involved in this case addressed the issue by categorising the Professor as a Fellow, paid on the junior medical staff award, and provide him some sessions on that basis.

Conclusions

The single most important factor in ethical decision making in organisations is the commitment by its leaders to ethics in both their talk and behaviour. As health leaders, we set the standard in our organisation, so we need to make sure that our decisions are always seen as values-based with the decision-making process is clear and transparent, which are ethical based on sound ethical frameworks.

The catch-22 of Australia's Junior Doctor Issue: Is it time for a balanced perspective?

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"Exactly 30 years ago, as an intern, I tried to kill myself. If I had not been interrupted, I would have died. Luckily for me, that didn't happen. Now I find myself a College President", wrote Professor Steve Robson, former President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

As we read this confronting statement in the article titled "Learn from me, by Steve Robson", against the backdrop of a spate of junior doctor suicides in the last few years, the recent hospitalisation of the NSW surgical trainee, the current legal action launched by junior doctors against a Victorian hospital and the pending class action on behalf of doctors-in-training against the NSW government – we are both alarmed and frustrated about this troubling issue.

Junior doctor working hours are often the primary focus when discussions regarding junior doctor wellbeing arise. Doctors in Training, in particular, are faced with significant competing demands on their time. Increased clinical responsibilities, supervision of junior colleagues, on-call commitments and the ever present pressure of looming exams, place Doctors in Training in a unique position. These formative years are often seen by consultant colleagues as a rite of passage.

No doubt we have all recently read accounts of unfair rostering practices, claims of excessive on-call, and unreasonable workload expectations that has pushed doctors to the point of exhaustion, even requiring hospitalisation. There are numerous studies and statistics echoing much the same concerns. According to the AMA NSW 2018 Hospital Health Check survey, more than 42% of junior doctors reported working from 10 to 25 hours of unrostered overtime a fortnight. Another 2016 survey of 914 junior doctors by the Australian Medical Association found more than two thirds of the respondents had experienced high levels of stress at work. It further identified female junior doctors were more likely to be at risk of burnout (73% vs 65%), compassion fatigue (59% vs 48%), and had lower levels of job satisfaction compared to males (75% vs 65%). More than half of the respondents reported that their workload had been excessive and 41% believed that their workload compromised patient safety. The 2015 Expert Advisory Group Report to the Royal Australasian College of Surgeons was further instrumental in uncovering an entrenched culture of discrimination, bullying and harassment across all surgical specialties, with disturbing accounts of detailed individual incidents, indicative of the same cycle of ongoing concerns year after year. Unfortunately these issues are still happening across our health services today.

Over the years, there have been numerous headline news articles, inquiry reports and multiple surveys, all painting essentially the same grim picture of a dire situation. Since the spotlight has been turned on these issues in the last few years, it's evident that multiple initiatives and well-intentioned efforts have been actioned. A significant amount of effort, publicity, and industry outcry has seen unprecedented attempts to rectify the situation. So much so that it could be said the "#junior_doctor_issue" could well be on the verge of snowballing into even a political movement.

Despite having received this level of intense focus, specialty colleges and medical associations are still required to advocate for mandated protected training time of medical trainees through site accreditation visits. Hospital leaders are required to micromanage processes for escalation of concerns. Memorandums of understanding are required to be signed between colleges and health services in reassurances of commitments to tackle bullying, discrimination and sexual harassment. The NSW Health JMO Wellbeing and Support Plan Programs to the tune of $3 million need to be implemented, ranging from exercise programs, on-site nutritionist employment models, meditation and mindfulness sessions, to stress and resilience building workshops. Increasingly novel approaches are needing to be progressed; smartphone apps for tracking overtime hours in real-time, national surveys of junior doctor wellbeing at each and every possible touch point in the training continuum, and even the trialling of sleeping pods to provide rest periods whilst working.

With all this, why then do claims of junior doctor anxiety, depression and disempowerment, continue to pervade the healthcare industry, year after year and generation after generation? Why is it that as an elite professional industry we are being told that we have failed to get it right, time after time?

Could it be because this problem is lacking a balanced perspective? Could it be that we may not have explored all possible causative factors in this situation? Have we examined dimensions such as work ethic, cultural implications of personal responsibility, and differing expectations intrinsic to a new generation of doctors? Could it also be that we have implemented program after program in a flurry of reactionary response without adequately evaluating their impact or effectiveness? Are we even capable of distancing ourselves long enough from the emotive aspects of this issue to consider these questions? Perhaps it is difficult, but if we are to ensure the wellbeing of Australian junior doctors, we must.

Firstly, it must be realised that current sentiment around this issue has resulted in it being viewed from a rather unilateral perspective. Populist thinking (justifiably in most cases) has meant that the only acceptable viewpoint is one of sympathy and of ardent advocacy for the junior doctor plight. Whilst this is admirable and expected, the concern with taking such a view-point is that it leaves us blind to what might be other key causative factors that could in fact lead us down the path to real solutions.

Consider for example, the perspective of other stakeholders in this situation -particularly supervisors and senior clinicians, with regard to just one aspect related to junior doctors. What should otherwise be a relatively straightforward task of giving honest and constructive feedback to trainees, has now turned into an anxiety provoking ordeal for some of these senior clinicians. Anecdotal evidence gathered through private and frank discussions, appears to reveal that there now exists a high degree of apprehension for giving honest feedback, sometimes to the point of even downright fear. This has been stated by many senior doctors to be due to an increased likelihood of being falsely or even vexatiously accused of "bullying" or "victimising" their junior colleagues. Needless to say, the provision of honest and open feedback is an important element in the professional development of all trainees, therefore deterrence away from that, will only be to the detriment of the trainees themselves.

As an unintended consequence of our recent heightened sensitivity to junior doctor welfare, it seems we have inadvertently created a culture that is reluctant to performance manage under-performing trainees. In other words, a "catch-22" situation. In the bid to improve junior doctor welfare, the medical profession has inadvertently been pushed into a corner that is reflective of the idiom, "damned if you do and damned if you don't".

Thankfully, while these incidents may be infrequent, and possibly isolated to a few junior doctors, the simple fact that many supervisors feel they cannot openly and honestly discuss this aspect of the JMO dilemma in a public forum, because of the current public sentiment, is a more significant concern.

Concerns have also been raised regarding the negative consequences reduced training hours may have for both patient safety and the quality of training provided. Increased numbers of clinical handovers within a given time period have the potential to reduce patient safety and diminished working hours result in less trainee contact with senior clinicians and patients alike. Experience gained through exposure to a large volume of patients is crucial to developing trainees' own clinical acumen. Striking the right balance between safe working hours and maintaining a safe healthcare service, which includes appropriately trained and experienced specialists, is our challenge.

Another interesting and rather curious aspect arises if we compare some of these concerns with junior doctors' international counterparts. As an example, junior doctors have recently been headline news in India. Concerns of India's junior doctors have been about a very fundamental need. That of the basic human right to security and protection from physical violence! Doctors recently surveyed at a tertiary hospital in Delhi, India, reported that the main source of stress for junior doctors was a fear of violence from carers, with more than 62% of doctors reporting they were unable to safely perform their job. Notwithstanding these two contexts are worlds apart, and not to minimise the situation in Australia, it is an interesting comparison to make.

Medicine in the developed world is one of the few highly skilled vocations where trainees are paid a higher than average salary, not just to work but also to train and to develop their skills. Even for senior doctors in the Victorian public sector, annual CME entitlements approximates up to tens of thousands of dollars. Junior doctors are also entitled to not insignificant monetary support, paid leave provisions and mandatory paid and protected training time, amongst a suite of other benefits. As a whole, most people would agree that it is a privilege to be a doctor, particularly a doctor in the western world.

There is also the added honourable and intangible privilege of having the means to alleviate human suffering and disease, by working in this profession. If we contrast this with almost any other vocation that bears any amount of responsibility for person-centred service delivery, whether it is the aviation industry, hospitality, law enforcement or even public transport, it would be difficult for us to recognise an equivalent amount of privilege and benefit. Safe working hours for police officers, guaranteed annual wage increases based on years of experience for wait staff, or significant investment in fatigue management for bus drivers for example, are aspects that pale in comparison to what is provided to doctors in the medical industry. Therefore, in finding a solution to

FROM PREVIOUS PAGE

The catch-22 of Australia's Junior Doctor Issue: Is it time for a balanced perspective?

catch-22

balanced perspective

our junior doctor issues, it is important for us to not lose this perspective, that at the end of the day, being a doctor is a privilege.

Taking one step back and adopting a balanced, and even global perspective to the junior doctor issue in Australia, would be of great assistance to us in taking a mature and considered approach when putting in place any solutions.

If we fail to take a balanced and comprehensive perspective to the current junior doctor dilemma, other junior medical officer cohorts may also be placed at potential risk in the near future, such as private hospital junior doctors, unaccredited trainees and locum/casually employed junior doctors. This is partly due to the private-public chasm that exists in Australia's health sector when it comes to junior doctor entitlements. Unlike 30 years ago when Professor Robson was an intern, private health services are now increasingly involved in the teaching of medical students and the training of junior doctors. The 2017 Australian Private Hospital Association (APHA) report on 'Education and Training in the Private Sector' estimated the private hospital investment in clinical workforce training has increased by almost 250% in the last decade. This trend is likely to increase, as private hospitals continue to grow both in bed numbers and in service complexity. This would mean we would see a much greater throughput of junior doctors across the private health sector in the coming years.

Private hospitals, particularly in Victoria, are not signatories to state-based enterprise bargaining agreements. This has unfortunately resulted in a chaotic blend of individual employments contracts, departmental or specialty-based enterprise bargaining agreements and subjective interpretations of "aligning the private with pubic entitlements" being the foundations upon which junior doctors are currently employed in the private sector. Notwithstanding some of these private hospital arrangements yield far, far greater financial benefit to individual junior doctors than their public counterparts, this lack of standardisation in accountability between private and public health services, could put more junior doctors at risk by generating a greater divide than we currently appreciate. Whilst the public hospital junior doctors who at least have theoretical protection of their entitlements via state-based awards, and accredited trainees have advocacy support via specialty colleges, the remaining categories of junior doctors, regrettably do not seem to receive the same degree of advocacy or industry concern as their mainstream counterparts.

So perhaps a way towards a potential solution lies in reconsidering and even re-configuring the Australian medical training structure in its entirety. Perhaps we should look at a unified and consolidated national or state-based body to assume responsibility for the welfare of all training medical officers. Maybe we first need to establish a commission to review this issue from a more comprehensive perspective, providing advice that is evidence-based and informed through rigorous analysis of international comparisons. Both public and private health contexts, as well as the junior doctors themselves, need to be held to the same standards and to an equal level of accountability. Perhaps people smarter are already considering these, and even better approaches. Regardless of whether we adopt these postulates or not, what we certainly cannot continue to do is to layer on siloed individualistic program after program, in a reactionary madness, because the issue is now topical.

In fact, perhaps another way forward might be found in viewing the junior doctor situation as a similar issue to others that have plagued the Australian health care industry of late. Perhaps we can learn from and adapt the thematic improvements that have been implemented in response to those. The Djerriwarrh Health Service' baby deaths scandal in 2015, for example, prompted wide-spread recommendations for standardised regulations and consistent accountability between all public and private health services in Victoria. The 2010 Davies Inquiry into the Bundaberg Hospital debacle, in relation to issues raised with hospital surgeon at the time Dr Jayant Patel, established a nationally consistent medical practitioner registration scheme. The Oakden review into allegations of elder abuse in 2017 has now paved the way for consistent aged care standards across all care providers at a national level.

A common theme that arises by analysing the basis of these recommendations is that a consistent and standardised set of rules, regulations and expectations need to be applied, and it has to be applied to all stakeholders, regardless of differing persuasions. As part of this approach, firstly each and every stakeholder group involved needs to feel free to speak truthfully about all aspects of the issue, regardless of the contentiousness or political correctness of their views. In addition, they need to be provided a platform that encourages the open and frank vocalisation of opposing thoughts, without fear of recrimination or backlash. Only then will we be able to assume the appropriate degree of perspective that this issue may need.

Whilst there may not be a simple solution to this genuine problem and there are many other aspects not covered in this opinion piece, fundamentally we need to not shy away from being open-minded enough to take a balanced perspective to this issue. Even if it means considering perspectives that may be unpopular. Despite what they may be, we should create a platform of tolerance and inclusiveness for all views to be heard and acknowledged. Without openly reflecting on these aspects, we might not be able to develop sustainable ways of tackling the current crisis of junior doctor bullying, harassment and discrimination, or in ensuring their entitlements are met. We need to take a considered perspective and a balanced approach to ensuring the welfare of junior medical trainees.

More importantly, we must be bold in not simply remaining silent in the face of what may be overwhelming public narrative that risks swaying our industry towards unilateral perspectives, on this or on any other issue. This is particularly an imperative when developing policy and regulation, and in ensuring an issue is viewed from objective and multiple vantage points.

If we are to protect the lives and wellbeing of future generations of Australian doctors, we must learn to overcome being swayed by populist sentiment, and to free our industry from forever being entwined in never-ending "catch-22" situations. Doing this will ensure that each and every junior doctor who faces challenge or difficulty will have the best foundation the medical industry can provide, for them to be protected, to help them to overcome and to watch them succeed, and perhaps even to go on to become future College Presidents.

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