RACMA
ROYAL AUSTRALASIAN COLLEGE
of Medical Administrators

Changing Workplace Culture in the Health System

Quarterly Journal
Q2 2021

Contents

RACMA ROYAL AUSTRALASIAN COLLEGE of Medical Administrators

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

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.

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 1,000 College Fellows,Associate Fellows, Affiliates and Candidates, as well as selected libraries and other medical colleges.

The Quarterly is prepared by staff of the RACMA Secretariat.

Connect with Us

ISSN 1325-7579
ROYM 13986

Honorary Editor:
Dr Andrew Robertson

Publisher:
The Royal Australasian College of Medical Administrators
1/20 Cato St Hawthorn East VIC 3123
Australia
ABN 004 688 215

Tel: 03 9824 4699
Email: quarterly@racma.edu.au
Online: racma.edu.au

From the President

As COVID-19 continues to position itself as a health issue at the forefront of our healthcare system, I would like to acknowledge our Medical Leaders and Members for their swift responses to the rapidly changing environments within their jurisdictions.

I applaud those who have upheld our healthcare system integrity and ensured the ongoing delivery of quality and effective healthcare for overall patient safety amid all of this. I firmly believe the key to maintaining the superior standard across our healthcare services is the professional guardianship and guidance of our workforce and workplace environments.

We are fortunate to have an increasingly diverse and agile workforce across Australasia and as Medical Leaders it is our duty and opportunity to recognise and harness this ensuring it is genuinely reflected at the system leadership level.

Diversity makes us stronger, improves productivity and workplace culture and has a positive impact on patient care if it is utilised to the full potential it has to offer. This reminds me of something I was taught a long time ago — The law of requisite variety states in each physical system, is that part of the system with the greatest flexibility of behaviour will control the system. This is a Neuro-Linguistic Programming (NLP) concept also expressed in cybernetics.

In embracing and leveraging diverse perspectives with flexibility, we as leaders can also encourage new initiatives, ideas, innovations and collaboration. These are the key ingredients to create more efficient and effective operations and generate the momentum to be at the cutting edge of Medical Leadership.

As a College we are working to hone our strategies to aid our membership base in the promotion of diverse and inclusive cultures across all workplaces. You would have seen the release of the RACMA Diversity, Inclusion and Equity position statement which was put together by the College Diversity and Inclusion Working Group. RACMA is committed to achieving diversity across the College, enhancing cultural competency in our members, and improving our ability to provide inclusive Medical Leadership across the health system. If you haven't already, please take the time to read the statement and I encourage you to embrace it. I also encourage broader Member input and participation in this significant area of work moving forward.

Medical Leaders need to examine any unconscious, conscious and systemic biases, which may undermine efforts to enhance diversity, inclusion, and equity. This includes the use of everyday verbal, non-verbal, intentional, or non- intentional messages which can devalue the perspectives, experiences, and/or feelings of individuals or groups.

Which brings me to the importance of us as Medical Leaders to lead by example and the power of role modelling best behaviour. Let's consider how we set the tone of our organisations and the expectations for employees.

There will always be different expectations of what is acceptable, just as there will always be differences of opinion. Always consider that airing those differences insensitively in front of other colleagues and patients is not acceptable nor is it beneficial. We need to value and consider our differences on all levels.

When we are inclusive and treat each other with respect, it incites kindness. At one of the recent Member Forums we welcomed Professor. Catherine Crock AM & Associate Professor David Brewster who discussed the significance of kindness, friendliness and civility in the workplace. It is timely now as our healthcare system continues to be strained as a result of COVID-19, we show kindness, tolerance, compassion and forgiveness for those under stress. Read more from Professor Crock AM and Associate Professor Brewster on page 16.

I have reiterated several times in our Member Forums how proud I am of our collegiate fraternity and the support we continue to provide each other. And collegiality only improves with kindness.

It is crucial in our positions of influence, we insist our team members across all departments and positions remember consistent, quality and safe healthcare is not the result of an individual's work; It takes teamwork and cooperation — and no one person, nor their role, is more important than another's.

The wellbeing of the whole medical workforce is crucial to deliver quality healthcare and as medical leaders it is up to us to nurture our workforce together.

Our workplaces would benefit greatly if we adopted the 90-10 principle — 10 percent of life is made up of what happens to us and 90 percent of life is decided by how you react. Reacting to situations, events and colleagues with kindness and understanding creates a ripple effect. It impacts the general level of positivity, boosts our mood and it's contagious as the good feelings it promotes make people likely to 'pay it forward'.

By definition, kindness implies the recognition of being of the same nature as others, being of a kind, in kinship. It suggests people are motivated by that recognition to cooperate, to be generous and thoughtful. Perhaps then systems will flourish if, as a whole, we are driven by a sense of kinship with our colleagues.

Professor Alan Sandford AM
President

Censor-in-Chief Report

Thank you all — Looking back and to the future

The work of our Trainees and Fellows

The last eighteen months has been a difficult period for our Trainees and Fellows.

COVID-related prolonged and then intermittent lockdowns, uncertainty, issues with the AstraZeneca vaccine and the delayed vaccine rollout, and political disagreements have affected the general community and the medical community with resultant increased levels of anxiety and uncertainty. For our colleagues there have been additional new areas of work to embrace and master.

Throughout this period and in this environment, our Fellows and Trainees have supported and delivered essential work in our hospitals and health services. Your quiet leadership in so many ways has been wonderful to observe. We will all have a role to play in the "coping with COVID future". Medical Leadership has never been more important.

Preparing for the 2021 Oral Examinations

The education team at the College have also been extremely busy — establishing systems for remote delivery of assessment, training Censors and Candidates in the use of the technology, and running National and State trial examinations to provide the same experience as the Zoom platform for the Oral Examinations.

The 2021 MMPD Oral Examinations will be conducted over two periods (2nd and 3rd August and 11th, 12th and 14th October) in response to requests from some trainees for additional time following the Trial Examination which was delayed because of COVID lockdowns. The results will be provided to the Candidates a few days after each of the two periods.

This is requiring the preparation of 48 scenarios (to allow for additional contingency days) — which is huge amount of work for the Censors who provide and review the scenarios.

Information sessions have been provided for the Candidates planning to sit this year, both in terms of preparing for the Examination and also in the technology which will be used. Many Fellows have also been involved in assisting the Candidates' preparation.

What does 2022 look like?

It is too soon to be sure what the situation will be in 2022. We hope that we will be able to conduct more College activities in a face-to-face format, although it will be different and "blended" formats are likely to be the way of the future. I am sure that most of us are looking forward to opening up, and being able to at least travel freely within Australia and to renew direct contacts with colleagues.

I would like to express my appreciation to our great Trainees, Fellows, Censors and all of the education staff of the College. Their work has been amazing during this period.

Dr Peter Lowthian
Censor-in-Chief

College Update

College Continuing Professional Development

CPD Audits and Sign Off for 2020

In line with the exemption applied to CPD for 2020 by the Medical Board of Australia and the Medical Council of New Zealand, the following applies for your CPD record for 2020.

For Members who have completed the minimum CPD requirements (50 hours for FRACMAs and 25 hours for AFRACMAs) your CPD record has been audited as per normal. Anybody who has achieved compliance can download their CPD Certificate of Compliance from their MyRACMA portal. Instructions on how to access the certificate can be found at the bottom of the FAQ page.

For those who have completed some CPD but did not meet the minimum requirements, you will have been sent a Certificate of Participation via email. If you have not received this, please contact us.

No action will be taken for non-compliance for the 2020 CPD reporting period.

Professional Development Plans (PDPs)

PDPs are an annual mandatory requirement to support compliance for RACMA CPD. Completion of PDPs by members continues to be an issue with many members not completing one which means they cannot be signed off as compliant even if minimum hours have been achieved.

We would like to ensure that Members are cognisant of the importance of submitting a quality PDP for their CPD record. There are instructions to support you on how to complete a PDP on the RACMA website which can be found here. There is also information provided in the CPD Handbook which you can access directly here.

Applying for Exemption for 2021

Members may be considered for exemption from CPD for a maximum period of 12 months under the following circumstances:

- Parental Leave
- Bereavement of immediate family member
- Personal illness/health reasons

Please refer to the policy on CPD exemptions which can be found here.

To apply for an exemption please complete the online application form which you can access here.

RACMA Board Nominations Now Open

Nominations are being sought for the following five positions:

- President (must be a Fellow) for a three-year term.
  Click here for the position description.
- Vice President (must be a Fellow) for a three-year term.
  Click here for the position description.
- Chair of Finance and Audit Committee (must be a Fellow) for a three-year term.
  Click here for the Terms of Reference for the Finance and Audit Committee.
- Board Director from the Associate Fellow membership category for a three-year term.
  Click here for the position description.
- Board Director from the Fellow membership category for a three-year term.
  Click here for the position description.

For more information, including eligibility criteria and the nomination forms, please click here.

Please email Melanie Saba, Chief Executive with any questions regarding this process at msaba@racma.edu.au.

Key Dates

Friday 27 August 2021	Nominations for Board Elections Close
Friday 10 September 2021	Voting Opens (if more than one nomination in each category)
Monday 27 September 2021	Voting Closes

Save the Date

This year, the RACMA Annual General Meeting (AGM) will coincide with the College Graduation Ceremony and a Member and Candidate Symposium.

The combined event will be held over two days — 23-24 October 2021.

Stay tuned for more information.

RACMA Conference

Planning is underway for RACMA 2022, which will be held in Tasmania.

It is hoped this Conference will be held face-to-face. The exact date is yet to be confirmed, but the College is aiming for September or October.

The last Conference held in Tasmania was in 2006, when a joint National Congress was hosted with the Australian College of Health Service Executives, which is now the Australasian College of Health Service Management (ACHSM).

The RACMA Board has also locked in New Zealand as the host jurisdiction for RACMA 2023.

Stay tuned for more details at https://racma.edu.au/conference/

Leadership for Clinicians Full Scholarship for AIDA Member

Together, RACMA and AIDA are committed to developing Medical Leaders and Managers among the Indigenous medical community. For the first time, RACMA has offered a full scholarship to an AIDA Member for its Leadership for Clinicians (LFC) Program from August to November this year.

Dr Marshall Watson, a Noongar Man from the south-west of Western Australia, was the chosen recipient. A psychiatrist dual-trained in child and adolescent and forensic psychiatry, Dr Watson currently lives and works in Adelaide in private practice. In addition to his clinical work, he is also an associate research fellow with the Telethon Kids Institute in Western Australia, and a chief investigator with the Indigenous Mental Health Intervention Program (IMHIP) Youth Project through the University of Queensland, which looks at addressing the clinical and cultural needs of Indigenous young people in custody.

After several years of clinical experience, Dr Watson's career has made an evolving transition into leadership and management through his clinical work, committee experience, and being an expert witness. As a junior consultant Dr Watson had the opportunity to help drive the development of an evidence-based therapeutic service to address the needs of young people within the criminal justice system. He believes you tend to move more into a leadership and management sphere with service development as you grow as a clinician.

"One of the things I'm particularly passionate about is service development and delivery particularly how it relates to meeting the needs of Indigenous people and how both the cultural and clinical needs of Indigenous people i.e. clients and staff can be met," Dr Watson.

"I firmly believe that leadership and management from an Indigenous perspective is around issues such as knowledge exchange, adaptive leadership and supporting people to help them grow within their disciplines."

Dr Watson believes the LFC Program will help to further consolidate his knowledge base around leadership and management as he looks to pursue more roles throughout his career within this sphere in Indigenous health.

"My initial goal is to build a foundation around the work I have done with service development so far," he said.

"I am curious to see how indigenous ways of thinking can be incorporated into medical management and leadership and vice versa.

"One of my interests is around cultural safety and security within clinical practice but also within leadership. Not only making services culturally competent but also seeing that decision-making at a higher level is culturally responsive and considered to meet the needs of Indigenous Australians who do present with unique clinical and cultural needs within health services."

Dr Watson also envisages using the learnings from the LFC Program within his research and roles on the RANZCP Aboriginal and Torres Strait Islander Mental Health subcommittee and the Child and Adolescent Forensic Psychiatry subcommittee.

The role of trained Medical Leaders in Indigenous health is incredibly important according to Dr Watson, as doctors are trained as clinicians rather than Medical Leaders despite at times being placed in leadership positions without a specific framework or knowledge base.

"For Indigenous health there are various levels of complexity across multiple disciplines at the primary, secondary and tertiary health levels," Dr Watson said.

"I think it is time we saw the development of Indigenous Medical Leaders in mainstream services, as well as strengthening the higher-level system development and healthcare delivery, from both an Indigenous and non-Indigenous perspective, for all Australians.

"I think Indigenous people can bring a very different way of thinking around leadership and management, drawing upon family, kinship and cultural ways to how we work with each other and within mainstream services."

Dr Watson said the real challenge for Medical Leadership in Indigenous Health was around gradually introducing Indigenous trainees and young consultants into areas of leadership to avoid extra burden being placed on them and risk losing them from the specialty altogether.

"Our Indigenous colleagues have worked hard to overcome various levels of adversity to go through University, working as junior doctors, training programs and junior consultants, so in the first instance they need to have a chance to consolidate their knowledge," he said.

"Additionally, our doctors are cultural people as well and it is always a balance between navigating clinical and cultural needs for the patients, families and services that we work within."

Advancing Medical Leadership & Management through UK Partnership

The increased global need for qualified and experienced Medical Leaders in the past 18 months has also seen cross-collaboration between international healthcare organisations gain momentum.

The opportunity has not been lost on RACMA. With the winding down of the World Federation of Medical Managers, RACMA and the Faculty of Medical Leadership and Management (FMLM) looked to strengthen and formalise their partnership, culminating in the signing of an MoU in 2019.

The connection came about through the shared vision of setting the standard for excellence in Medical Leadership and Management and increasing the number of medical practitioners in leadership and management roles because of their experience and appreciation of medicine at the coalface.

An example of the two agencies' developing alignment to advance research into Medical Leadership and Management is the agreement for the BMJ Leader to become the scientific journal of RACMA. As the FMLM's official journal dedicated to Medical Leadership and Management, all RACMA Members now benefit by having full access to the BMJ Leader.

Many RACMA Members are familiar with the FMLM and regularly attend their annual conferences. In the past, RACMA Members have featured as presenters, while the College submitted a Poster at the 2019 conference showcasing the Leadership for Clinicians Program.

Together the two organisations aim to nurture a wider spirit of collegiality and increase the network of like-minded professionals to share insights and solutions to similar healthcare governance challenges and discuss new management innovations.

RACMA Chief Executive Melanie Saba and FMLM Chief Executive Peter Lees are keen to increase the exchange of learnings and research, as well as create opportunities for each organisation's members to engage in realistic discussions.

"I think there is much to be gained from the significant synergies between both organisations," Ms Saba said.

"We are also in a position to take advantage of the increased interest in Medical Leadership as a result of the COVID-19 pandemic. We will be exploring every opportunity to bring our members and leaders together on a regular basis to advance Medical Leadership in both countries."

Mr Lees agrees both FMLM and RACMA can learn a lot from each other.

"It's about addressing what works and what doesn't work," Mr Lees said.

"I think what is particularly exciting is your model is very different to us and I think we haven't yet compared and contrasted that. That leads me onto the research agenda which we are putting a lot of effort into because there is research which shows if you have good leadership, outcomes are better even to the point of mortality.

"It is important for us to be exposed to different approaches to the same challenges so we're not just getting a UK perspective. I think this could be the beginning of some quite serious comparisons with other countries as well."

MOVING FORWARD

As the affiliation between RACMA and FMLM develops, The Quarterly will explore the Faculty's framework and strategy to keep Members informed and increase their awareness of future opportunities, learning and exchanges.

The end goal between the two organisations remains firmly aligned despite the basis of RACMA and FMLM differing. Medical Leadership is not a recognised medical speciality in the UK, hence the FMLM does not deliver training and education to become a recognised specialist in the field. Instead, it acts as more of a professional body for Medical Leaders and Managers, focusing on professionalisation, research and individual and organisational leadership development.

FMLM, established in 2011 by all the UK medical royal colleges and faculties and endorsed by the Academy of Medical Royal Colleges, is the UK professional home for medical leadership. Their primary objective is to raise the standard of patient care by improving Medical Leadership. In 2019 it became an independent charity with a 'trading arm' the sole purpose of which is to support the charity and its aims and objectives.

FMLM currently has 2600 Members. Its three areas of focus are:

- Professionalisation
  - The Leadership and Management Standards for Medical Professionals
  - Fellowship at three levels based on the standards
  - Accreditation of development programmes against the standards
- Research
  - Numerous external research projects
  - Dissemination through BMJ Leader and the annual conference, Leaders in Healthcare
- Individual and organisational leadership development (FMLM Applied)
  - Increasingly offering evidence-based guidance as to how this might be most effectively achieved
  - Design and delivery of leadership development programmes and support for current and aspiring medical leaders and multi-professional teams
  - Nationals and regional multi-professional Clinical Fellows Schemes which are growing rapidly at the moment — 91 English Fellows this coming academic year (and 300+ alumni)

"For several years now, we at the Faculty of Medical Leadership and Management (FMLM) have been building a professional body; setting standards, issuing guidance, developing our fellowship, running events and increasingly moving into supporting people and organisations under pressure," Mr Lees said.

"I think we are gaining in recognition at the moment, but it's something we're constantly vigilant about."

Mr Lees, who was awarded an MBE in the Queen's Birthday Honours List for services to Medical Leadership, said there was evidence which indicated doctors make good chief executives.

"Evidence also says if you have three or four doctors on hospital boards, then quality goes up and I think we've ignored that end far too much," he said.

"We need more doctors in management and leadership roles in the UK. Our healthcare boards do not have enough clinical expertise when that's the core business.

"I think we have to get leadership and management on the agenda much earlier. I would argue to become a good doctor, you have to be a good leader and manager."

To learn more about the FMLM, their strategy and programs, visit https://www.fmlm.ac.uk/

In Quarterly 3 2021, a follow-up article will explore how RACMA and FMLM are working to set standards in Medical Leadership and Management and FMLM's strategy for healthcare leadership research.

Leaders in Healthcare Call for Abstracts

RACMA Members are invited to showcase their new, innovative solutions to healthcare's more persistent problems in an ePoster for the 2021 Leaders in Healthcare Conference. Leaders in Healthcare, delivered by the Faculty of Medical Leadership and Management and BMJ, takes place online and in-person at the Barbican Centre in London, on 8-11 November.

All posters will be displayed as ePosters and will be hosted online. The ePoster display will be a valuable opportunity to share your achievements, learnings and experiences across healthcare leadership and management, with colleagues and experts internationally. Presenters can also submit a short video presentation to accompany their poster.

The six ePoster topics you can submit to are:

- Developing effective leadership
- Leadership lessons from around the world
- Leading across systems and organisation
- Understanding leadership through
- Leadership of the pandemic
- Leadership for greater diversity and inclusion

For more information on the process, templates and to submit your poster and abstract, please click here.

Gender Equity: I'm Not Biased, so What's the Big Issue?

Medical Administrators have a crucial role to play in bridging the gender gap at the leadership level of Australia's healthcare system — consciously and sub-consciously.

On the world stage we have seen some monumental gains on the road to gender equity across sport, politics, and workplaces. But for all these advances, a silent undertow continues to stifle true gender parity, particularly in Australia.

According to the 2020 World Economic Forum's Gender Gap Index, Australia is currently ranked 44, down from 15th in 2006. On a positive note, New Zealand is ranked six on this index.

Why, then, is Australia in this position?

President of the Australian Federation of Medical Women (AFMW) and well-known gender equity commentator, Associate Professor Magdalena Simonis, believes we are faced with breaking down generations of enculturation. The General Practitioner of 30 years says this has created a sub-conscious bias in the majority of the Australian population without the majority of people even realising.

"Culture is inherited, and it takes a long time to change," Associate Professor Simonis said.

"If we wait for culture to change, we are going to be waiting another 100 years."

While the ongoing subconscious conversation cannot be controlled, behaviour is much easier to be governed, Associate Professor Simonis says.

"It is the conscious, external conversations we can be correcting in the workplaces," she said.

"This is where the Take a Stand Program is critical in workplaces. It is a positive bystander program that promotes safe, productive and respectful workplaces. The bystander responsibility is really important because it ensures everyone feels confident and reassured to call out inappropriate behaviour.

"All employees must be meaningfully engaged for gender equality to be effective."

According to Associate Professor Simonis, the healthcare sector is poised to ignite a widespread shift in gender imbalance given the far-reaching trust in doctors and nurses and the positive influence they carry beyond the hospital.

However, Associate Professor Simonis said it is of key importance to bridge the gender gap at the decision-making, leadership level with real, strategic targets and goals with equitable outcomes. Hence, the crucial role of Medical Administrators.

"Firstly, there needs to be an evaluation of where the workplace is on the gender equity scale and how it measures in terms of representation of gender in leadership," she said.

"You might have 90 per cent gender equity across all employees, but yet all the leadership is male. Change happens at the leadership level and it is where culture is best demonstrated.

"We know change doesn't necessarily happen overnight, but it is important to make the decision for a new vision and take people on the journey."

In 2003, Norway introduced a law on 40:40:20 for company boards. In short, the 40:40:20 ratio is about aiming for diversity of gender in workplace leadership, be it senior leadership teams or on the Board. It refers to 40% men, 40% women, 20% of any gender.

This movement is now gaining momentum as global organisations and corporations adopt the practice. Associate Professor Simonis said it was time the 40:40:20 rule was implemented across the board in Australia, particularly in the healthcare system.

"It is a very good model we should be using," she said.

"Even though some women, or even people from different backgrounds, might not have leadership experience, they have the voice. The voice and the perspective are just as important.

"And if we don't include that voice in our decision making, those minorities and groups will always be left behind, which is what's been happening traditionally."

Associate Professor Simonis suggested organisations could introduce the co-optation strategy as another step towards achieving gender equity.

"We have board tenures we need to stick to, but why can't we give board members the opportunity to mentor someone new half-way through their tenure and have a co-opted person on the board?" she said.

"This provides plenty of time and opportunity to train and prepare the new member for equitable board participation.

"It's not about disabling or destabilising existing leaders. It is creating an achievable and smooth transition plan."

As healthcare is a service-focused industry, Associate Professor Simonis believes the governance structures should shift from the current corporate orientation to ensure fair representation of the people they serve.

"I think that's the connection that we're probably missing," she said.

"If we marry the gender equity issue with the people that we serve, it puts the focus on the job at hand and the outcome for the patients. Even people who believe that the gender equity issue no longer exists for women, still care about positive health outcomes in the community.

"It also puts the real onus on the leaders and the organisation as a whole rather than making individuals feel like they have to make the change on their own. That's what it should be about: making organisational change to achieve the outcomes and better serve the population, as gender equity benefits all of society."

Positive steps are continuing to be taken on various fronts, with the Victorian Government setting the bar for others to follow. In March this year, the Gender Equality Act 2020 came into effect, which aims to improve workplace gender equality in the Victorian public sector, universities and local councils. The provision of education and enforcement of compliance to the Act is overseen by the Gender Equality Commissioner, Dr Niki Vincent.

"This will promote gender equity training in schools and organisations, so that the processes that support conscious and subconscious enculturation of society around the primary role of women being carers and nurturers based upon their biology, is corrected," Associate Professor Simonis said.

"Expanding knowledge and creating impetus in this space requires effort and encouragement at all levels of society. Supporting the people who are making the changes and improvements is just as crucial as accepting and adopting the changes.

"By the very nature of our choice of profession, doctors want to feel like we are making a positive difference. So, let's make sure the decision-makers feel good about what they are doing by normalising this transition."

Associate Professor Simonis said a good way to start this was to create Gender Equity Working Groups within every organisation. This group would be responsible for overseeing the process and providing guidance to the leadership, using tools now available.

"This will ensure a consistent process and measure change or lack thereof which can be quantified and reported on," she said.

"The flow-on effect of installing a Gender Equity Working Group, demonstrates a commitment to the overall goal of gender equity — consciously and sub-consciously.

"The roadmaps for change have now been created and we just have to follow them. There are simply no excuses for not acting on this now."

Magdalena Simonis is involved on a number of boards and committees including:

- Board Member — Women's Health Victoria
- Safer Families Centre of Research Excellence — Department of General Practice University of Melbourne, Associate Professor
- RACGP Expert Committee Quality Care
- Co-Chair, Scientific and Research Subcommittee — Medical Women's International Association
- President — Australian Federation of Medical Women

Useful Resources for Gender Equity in the Workplace

RACMA Diversity, Inclusion & Equity Statement

https://racma.edu.au/about-us/governance/position-statements/2021-position-statements/diversity-inclusion-equity/

RACMA is committed to achieving diversity across the College, enhancing cultural competency in our Members, and improving our ability to provide inclusive Medical Leadership across the health system.

Creating Healthcare Cultures of Safety and Respect Conference

RACMA-led panel: "Merit: Challenging the Status Quo."

This Conference was a joint collaboration between RACMA, St Vincent's Health, RACS and Macquarie University. The panel explored interventions and approaches for change.

Workplace Gender Equality Agency

https://www.wgea.gov.au/newsroom/gender-equality-in-australia-a-guide-to-gender-equality-in-2020

The Workplace Gender Equality Agency is an Australian Government statutory agency with a vision for women and men to be equally represented, valued and rewarded in the workplace. It:

- Promotes and improves workplace gender equality
- Administers the Workplace Gender Equality Act 2012 (Act)

Victorian Government Gender Equality Act 2020

https://www.genderequalitycommission.vic.gov.au/about-gender-equality-act-2020

The Gender Equality Act 2020 will improve workplace gender equality in the Victorian public sector, universities and local councils. The Act commenced on 31 March 2021.

The Act promotes gender equality by:

- Requiring the Victorian public sector, local councils and universities to take positive action towards achieving workplace gender equality
- Requiring these organisations to consider and promote gender equality in their policies, programs and services
- Establishing the Public Sector Gender Equality Commissioner

Women's Health Victoria

Accredited Gender Equity Training Project

https://whv.org.au/our-focus/gender-equity

Women's Health Victoria is dedicated to improving the health and wellbeing of all Victorian women. It delivers a range of online and interactive training for individuals and workplaces, all with a focus on improving the lives of women through addressing gender inequality in the workplace and building individual and collective capability to contribute to the prevention of violence against women.

Take a Stand Program

https://whv.org.au/training/take-a-stand-program

Take a Stand is an award-winning program that supports workplaces to prevent and respond to domestic violence, by taking a stand against sexism and promoting a respectful and safe workplace for all. The first of its kind in Australia, Take a Stand continues to lead the way as a workplace bystander program to prevent domestic violence and other forms of violence against women.

40:40:20 Gender Rule

Women on Boards

https://www.womenonboards.net/en-au/resources/wob-advocacy/40-40-20

Women on Boards has been working since 2006 to address gender inequity in the boardroom and across leadership roles with an aim to have 40% of these roles occupied by women by 2025. It is a recognised leader in the ecosystem of organisations and networks promoting and supporting women; dedicated to breaking down barriers to entry into leadership and onto boards.

Male Champions of Change

https://championsofchangecoalition.org/wp-content/uploads/2019/11/MCC-40-40-40-Talent-Processes-Toolkit-2019_Web_Final.pdf

Male Champions of Change is a coalition of CEOs, secretaries of government departments, non-executive directors and community leaders. Established in 2010, by then Australian Sex Discrimination Commissioner Elizabeth Broderick, its mission is to step up beside women to help achieve a significant and sustainable increase in the representation of women in leadership.

"Unless we actively and intentionally include women, the system will unintentionally exclude them."
Elizabeth Broderick AO Founder, Male Champions of Change

Lessons learnt from managing a multi-hospital pandemic response: A leadership challenge with a silver lining

Erwin Loh, Anna Boltong, Victoria Jones, Anna McFadgen, Angela Nolan, Janine Loader

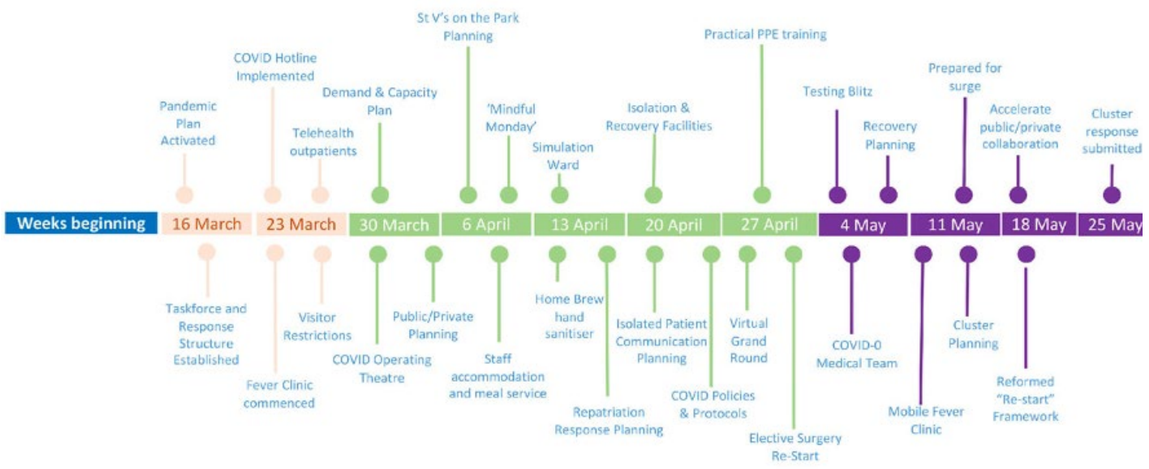
Background

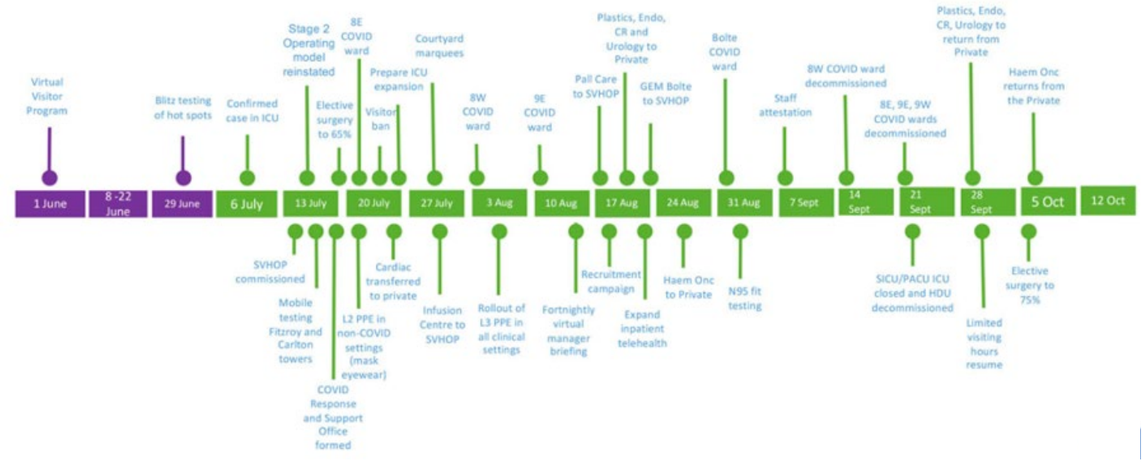
St Vincent's Health Australia (SVHA) is the nation's largest not-for-profit health and aged care provider. SVHA operates six public hospitals, 10 private hospitals and 20 aged care facilities in Queensland, New South Wales and Victoria. Along with three co-located research institutes — the Victor Chang Cardiac Research Institute, the Garvan Institute of Medical Research, and St Vincent's Institute of Medical Research — the organisation works in close partnership with other research bodies, universities, and health care providers

Core and enduring to the Mission of SVHA and the founding Sisters of Charity is continuous learning and improvement. As Sister Mary Aikenhead, the founder, said "Even when you are the best, you desire to do more, to go beyond'. Whilst the COVID-19 pandemic has created many challenges for our organisation and has tested the limits of our resolve, it is imperative that we reflect on our journey, make improvements for the future based on these experiences, and share the learnings from these experiences so that, together, we can improve and ensure the future success and sustainability of our organisation and of our Mission.

Between March and October 2020, Victoria experienced two waves of COVID-19 demand, with the second wave being significantly greater than the first, and severely impacting the Victorian health and aged care sectors. St Vincent's Hospital Melbourne (SVHM) and St Vincent's Private Hospital Melbourne (SVPHM) worked in tandem to respond to Victoria's second COVID wave when it engulfed the community in 2020.

Figure 1. The SVHM and SVPHM COVID journey





Following the de-escalation phase of Wave 2, a comprehensive lessons learnt process was undertaken, led by the SVHM Strategy & Planning and Quality, Safety & Risk Teams. This paper outlines the method used, the findings, and the lessons learnt.

Methods

Fifteen structured focus group style sessions were facilitated throughout October 2020 and data was captured from more than 120 participants from across both SVHM and SVPHM. The scope of the review included COVID-19 Planning and governance models, operational response, communication methodologies, infection prevention processes and structures, patient and outbreak management, workforce modelling and people management, logistic and environmental responses.

Table 1. Focus groups undertaken

Date	Discipline or working group	# invitees	# attendees
28/9/20	Integrated Care General Manager Group	9	6
28/9/20	Workforce Working Group	12	11
30/9/20	Operational Taskforce	17	17
1/10/20	Healthcare Worker (HCW) & Patient Transmission Taskforce	9	9
5/10/20	Capability & Safety Task Force	21	14
7/10/20	Personal Protective Equipment (PPE) Group	7	7
7/10/20	Infection Control	18	10
7/10/20	Clinical General Managers	23	13
8/10/20	Communications Working Group	16	9
15/10/20	Nurse Unit Managers (NUMs)	120	19
20/10/20	Allied Health Heads of Units (HOUs)	21	14
21/10/20	SVHM/SVPHM Collaboration	Unknown	7
Various in October	Feedback received from individuals	–	7
Total numbers		**273**	**143**

Employees provided feedback in relation to "what worked well" and "what didn't work well" during SVHM's COVID-19 pandemic response. Feedback was also provided by individuals that did not attend a workshop. Information gathered from these groups were collated, analysed and organised into themes. Content analysis was undertaken to identify themes.

Results

A total of 15 focus groups were conducted (total of n=273 participants). Themed data pertained to duplication, process alignment, escalation, communication and reporting. Data was synthesised into 'stop', 'start' and 'keep' categories.

Lessons learnt feedback regarding Governance is the focus of this paper, as summarised below. The COVID-19 incident response operational manual for residential aged care facilities covers the activities across four phases, delineated by specific trigger events as described in the graphic below:

Table 2. What Worked Well

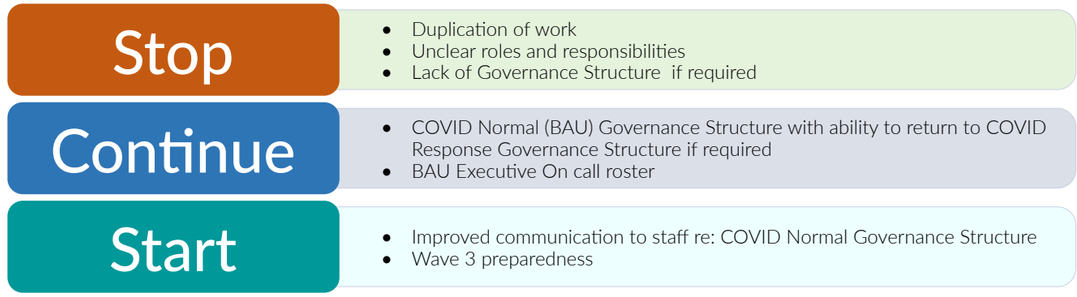
Scope	Feedback
Overall COVID-19 Governance Structure/ Taskforce model	• Provided structure for key response groups to respond to ongoing Victorian Department of Health and Human Services (DHHS) guideline changes. • Provided avenue for clear and efficient process development — "great change management culture throughout SVHM". • Model worked well, focused on key areas and supported communication follow through. • Timing and volume of meetings adjusted in accordance of requirements. • Rapid decision to implement COVID Incident Command (CIC) structure whilst maintaining usage of embedded operating systems. • Ability to 'fast track' new process implementation with support from working groups. • Service integration between SVHM and SVPHM. • Strong leadership helped staff feel supported. • Documentation and governance controls.
Communication's Working Group	• Communications working group membership was good — broad spectrum of attendance from relevant key stakeholders enabling breadth of input. • Structure was short and to the point — limited time wasting. • COVID intranet acted as source of truth and all staff knew this was the case. • Daily SitRep Report provided key information and statistics to managers and staff.
Operational Taskforce	• Daily operational meeting — great for escalating any issues, barriers and communicating demand. • Balance of Business-as-Usual (BAU) and COVID response work was managed well and staff felt supported.
Infection Control	• Timely response to ongoing DHHS guideline changes. • Provided links to DHHS and state advisory groups re: infection control matters. • Provided opportunity for forward planning re: Infection Control and PPE.
Supply, Logistics & Support services	• Bought previously 'siloed' groups together. • Decisions made quickly and communicated to operational managers resulting in timely progression of actions in relation to procurement issues and environmental planning.
Workforce	• Consolidation of all workforce groups in one place made communication, barrier analysis and decision making easier and visible between teams.

Table 3. What Didn't Work Well

Scope	Feedback
Overall COVID-19 Governance Structure/ Taskforce model Please note that the majority of feedback re: what did not work well was applicable for all workstreams.	• Lack of clarity regarding the initial COVID Response Governance structure resulting lack of understanding regarding response preparation and implementation. • No Terms of Reference for Working Groups resulting in confusion about the remit of the response groups and some duplication in effort. • Slow to implement change at times — not pandemic speed. Many decisions needed to be taken 'off-line' and took time to get decisions made. • Communication of working group information back to clinical staff was variable in effectiveness. • PPE Advisory group scope was too broad. • No structure in place to review and resolve conflicting information e.g. DHHS PPE (not current practice initially) — Too many directives with conflicting directions regarding PPE and Infection Control. • Lack of clarity regarding PPE advisory group remit and relationship to Executive decision making. • Infection Control, Infectious Diseases and Microbiology initially not part of decision making within COVID response structure. • Missing some key stakeholders e.g. Theatre representation and front line staff. • Hierarchical structure needs to be overcome when agile decision making is required. Staff on the ground (or nominated staff) need to be able to make decisions.

Table 4. Potential Opportunities

Working Group Structure	Governance
• Develop Terms of Reference for all working groups to support clearer role and responsibility definition and reduce duplication of work. • Review working group members as part of Wave 3 preparation to ensure appropriate stakeholder involvement.	• Increase visibility of COVID-19 Response Structure to support reduction in staff anxiety and confusion. • Improve communication between various working groups and committee to provide consistent approach to planning and decision making.



Discussion

The lessons learnt relating to governance summarised in this paper provides:

- An overview of the Victorian experience
- An overview of the response journey for SVHA's Victorian public and private hospital networks, SVHM and SVPHM
- High level lessons learnt relating to governance and how these lessons are being integrated into planning and preparedness for any future waves.

The lessons learnt encapsulated in this paper have formed the basis of several improvements across planning, governance, operations and workforce domains at SVHM and SVPHM, with activity to implement these improvements well underway. Additionally, these lessons are reflected in the SVHH and SVPHM COVID Response Preparedness Plan, recently updated to support any future COVID-19 response.

Rapid response requirements necessitated large scale changes to clinical care, workforce, logistics, planning and governance, and partnership work to ensure infection prevention and control efforts supported optimal clinical care and patient and staff wellbeing. Leadership challenges during this period were reflected upon as an opportunity for improvement.

Conclusion

The COVID-19 Lessons Learnt exercise undertaken at SVHA by SVHM and SVPHM provided an opportunity for the whole national organisation to reflect on the experiences and learnings of the COVID-19 response to date and to ensure what these learnings are captured and further developed, to optimally position our organisation and our people to respond to any future wave. These lessons and planning can be shared across SVHA divisions nationally, as well as with other health services, to ensure as a health system we are prepared and ready to meet the demands of our communities in the COVID-19 context.

Kindness the Key to Leading by Example

As improving workplace culture at the coalface of healthcare continues to prove challenging, bullying, harassment, equality, and mental wellbeing have dominated the discussion to date. Now the time has come for Medical Leaders and Managers to flip the focus and hone in on kindness and its role in creating cohesive work environments.

Influential Medical Leaders Professor Catherine Crock AM, co-founder of the Gathering of Kindness, and Associate Professor David Brewster, Deputy Director of Intensive Care at Cabrini and Clinical Dean at Monash University, believe a considerate effort needs to be made amongst the fraternity of Medical Leaders and Administrators if real culture change is to occur.

Well known for their advocacy and research on improving collegiality through kindness, the pair believe Medical Leaders hold crucial roles and influence to instil widespread behaviours of kindness across the healthcare system.

However, Professor Crock said there was often a disconnect between the executive and leaders in healthcare services and the people working on the frontline.

"I think it's absolutely critical Medical Leaders use their influential roles to promote the right sort of culture," Professor Crock said.

"I think often they seem to have a hands-off approach and they don't get closely involved on the ground. But it is becoming more and more evident that if you have your leaders involved, supportive, and modelling you'll make more progress with your culture."

Professor Crock said part of the problem, which was highlighted by the COVID pandemic, was staff felt a lack of care, value, kindness, and respect.

"You can cope better if you know the people above you are going to bend over backwards to get you the things you need to do your job and are ensuring you are looking after yourself, for example providing space and time for staff to debrief and recover," she said.

"Because you get to a stage where you can't give much more if the system is not giving you the space to look after yourself and your team. I think a lot of executives and leaders can be quite absent in that conversation. We know they're in their offices making very important decisions to keep the whole machine going, but if they neglect being connected to the experience of their staff, their workforce will suffer."

Associate Professor Brewster said it was key that healthcare leaders and managers displayed good behavior as well as "celebrating and championing good behaviour and kindness".

"Nowadays, medical leaders are perceived to be such important people within the hospitals which means they can have a tremendously positive impact," Associate Professor Brewster said.

"But there's always been a punitive approach to work and behavior at the healthcare executive level. For example, if a goal isn't achieved the focus is about the punishment and then the successes or the positives are missed because of that focus.

"When the administrators are seen to be celebrating the good in clinicians, it helps create a much better relationship. So, if administrators are celebrating the acts of kindness they are seeing, that inspires and encourages more kindness and similar behaviours.

Professor Crock said as humans we thrive on encouragement and feeling safe. However, many healthcare workers on various levels are working under a culture of fear, she says.

"We're working in a culture of fear where you think you're going to get into trouble for not doing well enough, or making a mistake," Professor Crock said.

"Imagine if you take that fear away and you free people up to bring their whole self and their creativity to work knowing they will be appreciated and their managers are acknowledging their work, the whole system rapidly begins to thrive.

"Healthcare has been a system that up until now, has valued your academic performance and your ability to get everything right and it's been a threatening environment to show your vulnerability and to show that you might not have all the answers.

"I think leaders should be modeling kindness and encouraging this behaviour, talking about it, rewarding it and making sure we measure and value kind treatment among colleagues as one of the things we really care about."

Professor Crock said signs of a harmonious workplace is where staff are engaged, productive, and creative. Where people are enjoying each other's company, their work and they feel safe to speak up about any issues.

Medical Administrators need to "use the multiple markers of staff wellness they have at hand as a metric to measure progress of improved culture over time", according to Associate Professor Brewster. This should also be combined with the introduction of Key Performance Indicators (KPIs) around the behavioural performance of the leaders themselves, he said.

"Our Medical Leaders are much more influential than they were 20 years ago. They can strive to have KPI's around their own performance and how kind their hospital performs with respect to culture, that can be used as a marker of success," Associate Professor Brewster said.

"And also, what is a KPI for kindness? What are we using? Is it an audit of our hand-over behavior? Is it an audit of work satisfaction, stress, burnout, and wellbeing?

"It's not just about the staff failing at being kind to each other. It's also the management level failing to create a culture of kindness. I think it would be refreshing to make this measure of how the hospitals are tracking."

The responsibility and accountability to behave in a certain way and demonstrate the right way forward to staff sits firmly on the shoulders of Medical Leaders, Associate Professor Brewster says.

"If those senior staff are taking the culture in the right direction, it's going to make it so much easier for everyone else to follow and to change the culture across all levels," he said.

"I remember rounds as a junior doctor where the senior staff would berate the junior staff at the bedside and that was our way of learning. Then that behavior became mimicked by the junior staff as they moved into senior roles.

"I think there is also silo behaviours between different clinician groups as well as management and clinicians, and this is a long standing problem in certain hospitals. It is an 'us against them' mentality, tribal behavior which no one has ever broken down. The existence of the behaviour continues to be acknowledged, yet no one ever challenges that it should not be there.

"The continuing negative language has a big impact. The constant negative interactions between departments creates even more fear and anxiety, and we just need to break all of that down and have an environment where every interaction is a positive one where people feel safe to perform at their best."

Associate Professor Brewster said healthcare was moving into an environment of shared leadership and interprofessional teams, however junior doctors are continually taught to concentrate on individual performance.

"The culture of always being ranked and competitive when we are in training is a big contributor to the lack of collegiate behaviour," Associate Professor Brewster said.

"Rather than working as a team or working towards goals together where we are assessed together, we're always seen as individuals and having to be better than the person next to us. I think it is this type of competitive environment which leads us to constantly put each other down.

"In an industry which works within a hierarchical system, it is fraught with individuals focused on individual gain and individual notoriety. Unfortunately, they are the ones who seem to succeed, which doesn't create a culture where kindness can flourish."

Associate Professor Brewster said everyone inherently wanted to be kind, but somewhere along the way unkindness had been celebrated and seen to be more successful.

"With the leadership and guidance of Medical Administrators and executives we need to turn that around," he said.

"If kindness is not seen to be beneficial then people won't do it."

Useful Links

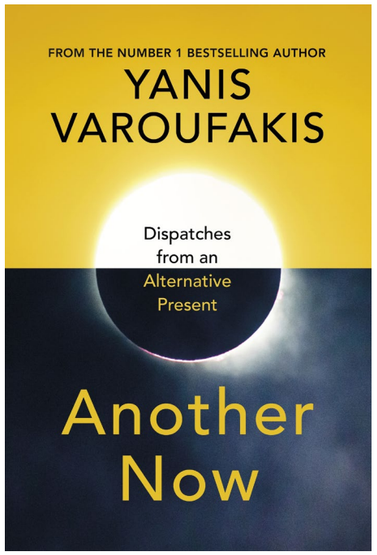
- Gathering of Kindness
- COVID-19: a chance to embed kindness in our health care
- Adding kindness at handover to improve our collegiality: the K-ISBAR tool
- Hush Foundation
- When rudeness in teams turns deadly | Chris Turner TEDxExeter

Professor Crock *has worked closely with patients and families to redesign services and improve quality and safety. She is Chair of the Hush Foundation which transforms healthcare culture through the arts. Hush has collaborated with playwright Alan Hopgood AM to develop plays which are performed in hospitals and Aged Care to raise awareness of patient centred care, communication and patient safety issues. She cofounded the Gathering of Kindness, a movement promoting a kind health system. Catherine is also a Professor at Deakin University, Centre for Social and Early Emotional Development.*

Associate Professor Brewster *is currently the Deputy Director of Intensive Care at Cabrini, as well as Head of ICU Research, Clinical Dean for the Monash University Clinical School and a practicing anaesthetist. He is an advocate for student well-being and has published in the MJA on improving collegiality through kindness in the workplace. David is an internationally recognised expert on airway management in intensive care and anaesthesia. He was the National lead for Australia and NZ for the INTUBE study (recently published in JAMA and funded through an ESICM grant). In 2020, David was the lead author of the national guidelines for airway management for COVID-19 patients.*

Book Review

Reviewed by:
Dr Nick O'Connor MBBS MM MHA FRANZCP FRACMA GAICD FHETI
Clinical Lead Mental Health Patient Safety Program
Clinical Excellence Commission
Clinical Lead Mental Health COVID-19 Community of Practice
NSW Ministry of Health



Why would a medical college be interested in a novel that proposes a different economic order? This reviewer has form: having previously reviewed a book about economics in the RACMA Quarterly 2013[1]. That book followed the global financial crisis and warned of the health and mental health damage of austerity economics. In 2020 another crisis, COVID-19, has revealed the social and health impacts of the structural inequities in our society and the neo-liberal capitalist system.

Yanis Varoufakis is a Greek-Australian mathematician, economist, politician and author. Another Now is a novel set in the future of 2035 where due to a forking of worlds in 2010 there are two 'nows'. In "Our Now" live our three protagonists: Costa, a brilliant Graeco-German digital engineer, Eva, an investment banker turned dry academic economist, and Iris, a feisty social anthropologist and political activist. Through a technological time-tunnel built by Costa, the three are able to communicate and travel to "Another Now" where they encounter the society that diverged from Our Now in 2010, and their alter egos in that world: Kosti, Eve and Siris.

The three characters are from different social and intellectual universes. The author uses these different personalities, world views and skill-sets to analyze the failings of our world (as readers know it) and to interrogate another social and economic polity where markets, money, banks and property ownership are done differently and for the common good.

Perhaps, as is suggested in the book, "science fiction is the archaeology of the future". If so, we may have much to learn from Another Now about moving to a world of more equitable health and well-being.

[1] Stuckler D Basu S. The Body Economic. Why Austerity Kills. London: Allen Lane; 2013.

International Forum on QUALITY & SAFETY in HEALTHCARE AUSTRALASIA

Don't Miss International Forum on Quality and Safety in Healthcare

RACMA Honorary Fellow and New Zealand Director-General of Health and Ministry of Health Chief Executive Dr Ashley Bloomfield has been announced as one of the keynote speakers for the 2021 International Forum on Quality and Safety in Healthcare Australasia, 8-10 September.

'Reconnect and Rebuild' is the theme for Australasia 2021, which includes the wellbeing of health and care staff, equity, patient partnerships and the future of quality improvement in the new reality for healthcare systems around the world.

Other keynote speakers to be announced include Kedar Mate, MD, President and Chief Executive Officer at the Institute for Healthcare Improvement (IHI), and Janet Anderson, Commissioner of Australia's Aged Care Quality and Safety Commission.

The conference program streams are:
- Safety
- Quality Cost, Value
- Population and Public Health
- Person and Family Centred Care
- Improvement Methods
- Building Capability and Leadership

Some of the key discussions to be explored throughout the sessions include:
- How can we support the wellbeing and recovery of our health and care workforce post-COVID?
- How can we learn from innovation in times of crisis, and what does QI look like in the new normal?
- How can we build fairer systems to tackle inequalities in healthcare access and outcomes?
- What does patient partnership, involvement and leadership look like in the post-COVID world?

Early bird registrations close 11 August and as RACMA is part of the Partner network, Members can save 20%. To book, click here and:
- Select Attendee Type: Supporting Partner
- Enter your verification code: Rekindle2021

For more information including the full program, visit https://internationalforum.bmj.com/australasia/

Member Q&A

What drew you to pursue the path of Medical Leadership/Medical Administration?

I always had an interest in governance of hospital processes and the health system as a whole. From working in the system as an unaccredited registrar, I was acutely aware of the gaps in our training system, and the difficulties in getting key organisations to work together towards a solution. These gaps impact not only on the wellbeing of the doctor but also the provision of a high standard of care for our patients. I want to create change in this space and in using my own experience, help shape a safer training environment for doctors.

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

The RACMA Fellowship Training Program gives me the opportunity to gain an in depth understanding of the health system as a whole and all the external factors that influence its direction. The Fellowship Training Program gives me an opportunity to build on the skills required to improve the status quo, namely, strong leadership, communication, and advocacy skills.

What attracted you to take up your role as Candidate Representative on your Jurisdictional Committee?
How important do you see the role of Candidate Representative?

Coming from an unaccredited background, I strongly believe in ensuring there is trainee representation within institutions and that those representatives are strong advocates for their peers. It is critical that those who are directly affected by decisions made by the College have an avenue to provide feedback and that there is transparency within the College governance to ensure trust in the institution.

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

Representation is vital to creating an environment for equitable decision making. The decisions made by the College that influence the direction of the Fellowship Training Program has significant direct impact on the lives of trainees both professionally and personally, but also have a unique impact on the workplaces in which we are placed. It is important that the College committees have a variety of members so that decisions achieve the greatest good for the stakeholders that matter most.

What are some key attributes of a quality and strong Medical Administrator/Medical Leader?

Without quoting our curriculum in full, I do believe that strong communication skills, adaptive leadership styles and advocacy all contribute to an effective Medical Leader/Administrator. These skills allow our profession to build relationships, create change, and unify a team. In this way, a leader is able to shape the future of the organisation or system they are driving and effect the cultural changes necessary to ensure continued growth.

Dr Isabelle Kapterian
B MedSc MBBS MS (Surgical Anatomy)

Medical Services Coordinator — Sydney Adventist Hospital
New South Wales Jurisdictional Committee Candidate Representative

What drew you to pursue the path of Medical Leadership/Medical Administration?

Within the first six months of internship I realised I was drawn to the systems and structures behind the practice of clinical medicine. I took some time to explore different areas of clinical practice but none called to me in the same way. I like the variety and creativity required of Medical Administration, and particularly the opportunity to effect change on a large scale.

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

I remember looking at the curriculum and finding everything interesting! I think it's fantastic to be able to formally learn the skills and knowledge to bridge the gap between medicine and management.

What attracted you to take up your role as Candidate Representative on your Jurisdictional Committee?
How important do you see the role of Candidate Representative?

I was approached by the JCT and previous Candidate Representative. It seemed like a great opportunity to develop the jurisdictional support for Candidates, which in a small jurisdiction is crucial.

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

Being involved in the Committee gives you greater insights to what is happening in the RACMA community and gives you avenues to contribute.

What are some key attributes of a quality and strong Medical Administrator/Medical Leader?

Good communication skills, the ability to form and lead a team, and a sensible approach to problem-solving are necessities. There are some personal attributes that I have noted in the most effective Medical Leaders I have seen: they are authentic, act with integrity and have a firm ethical base.

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

I think qualified Medical Administrators are crucial, though too often under-recognised. They are able to bridge the disparate languages and ways-of-thinking of managers and doctors and bring a unique insight into the strategic direction of healthcare in Australasia.

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

A particular challenge for the College is to define its role in digital healthcare, which is currently not a substantial part of the curriculum and is only going to continue to grow and evolve — and the skills needed to navigate this area are niche. In general, I think we will continue to see increasingly challenging strategic decision-making driven by the ever evolving (and expensive) scientific advances jarring with ongoing economic pressure.

Dr Veronica Corrigan
MBBS

Medical Administration Registrar — Counties Manukau District Health Board
New Zealand Jurisdictional Committee Candidate Representative

Member Q&A

What drew you to pursue the path of Medical Leadership/Medical Administration?
It is a mix of natural tendencies to be a leader and wanting to make system level changes. Drawing from my background in surgery, I saw some similarities in setting up systems that work well and then improving them with trial and application.

What led you to undertake the Fellowship Training Program of RACMA?
I wanted to gain the formal qualifications as I think the RACMA Fellowship Training Program will equip me to harness my natural abilities while providing me the knowledge and skills needed to be a Medical Leader. It will give me the recognition needed to pursue roles in Medical Leadership.

What attracted you to take up your role as Candidate Representative on your Jurisdictional Committee? How important do you see the role of Candidate Representative?
After being a trainee for a year, in what is perhaps one of the hardest times to be a trainee with the ongoing pandemic, I started to see pockets of isolation, lack of clarity in roles, and for first year trainees, a training year that was not the "normal" year. As I started to navigate training, and became slightly more comfortable, I remembered those early days and thought if I could share some of my challenges, key coping strategies and learning strategies, it might help other trainees. But I also wanted to develop and learn from the other Candidates as part of this role. I think the Candidate Representative is key to trainees feeling connected, and to know that this is someone who has a shared goal for training and development of Candidates.

How important is it for members of colleges like RACMA to be actively involved through various roles like yours on college committees?
It is very important for members of colleges to be involved as it shows commitment to their chosen craft group. Nothing in medicine is static and similarly in Medical Leadership. Keeping abreast of College activities and contributing actively ensures ongoing learning, engagement and ultimately a collective avenue to further the strategic direction of that speciality.

What are some key attributes of a quality and strong Medical Administrator/Medical Leader?
At this early stage in my training, I often think 90% of what I do is communicate. So, I think honing, developing, and learning great communication is a key attribute. I also think honesty is key in building relationships and showing people that you are in it with them. I suspect I will add others or change my view on things as I continue to develop as a leader.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
The Australian Health care system is beginning to recognise the importance of having formally trained Medical Administrators fulfilling key Medical Leadership roles. I think the global pandemic has highlighted the importance of having people who are fit for purpose and trained specifically in Medical Leadership and Management.

What are the challenges and/or opportunities you can see that RACMA, and the field of Medical Administration in general, will face in the future?
From a trainee perspective, as the trainee cohort grows the risk is lack of senior positions or Fellow jobs in the field. However, it is an opportune time to build a culture of wanting key leadership roles in medicine to be filled by trained RACMA Fellows.

Dr Shemanandhini (Shema) Haima
MBBS

Medical Administration Registrar — Gold Coast Hospital and Health Service
Queensland Jurisdictional Committee Candidate Representative

Dr Pradeep Mishra
MBBS CCT AFRACMA MSc (Diabetes) PGDip (Endocrinol)

Director of Medical Services, Executive Manager Medical & Health Services — Anyinginyi Health Aboriginal Corporation, Tennant Creek, Northern Territory
Northern Territory Jurisdiction Candidate Representative

What drew you to pursue the path of Medical Leadership/Medical Administration?
Right from my days of vocational training in General Practice in the United Kingdom, I was attracted to Healthcare Management. Following my move to Australia there were more opportunities to finally embark on a career in Medical Administration. I had the opportunity to undertake training in health economics, finance, and learn principles in healthcare management. Completing the Leadership for Clinicians leading to the Associate Fellowship in 2019 cemented my resolve to start my Medical Leadership journey in a full-time role in one of the remote towns of Central Australia.

What led you to undertake the Fellowship Training Program of RACMA?
The interactions with peers and RACMA Fellows whilst undertaking the Leadership for Clinicians was a major catalyst for me. The RACMA Fellowship Training Program provides a solid foundation in the core competencies, contemporary knowledge, skills and expertise that is required of a medical leader in today's challenging times. Prior to applying for the FTP, I was fortunate enough to be able to speak to some highly experienced FRACMAs from Queensland and Victoria who were able to highlight both the challenges and rewards of this career path.

What attracted you to take up your role as Candidate Representative on your Jurisdictional Committee? How important do you see the role of Candidate Representative?
Since my days of being a Vocational GP trainee in the UK, I have strongly advocated for trainees both at a regional and national level (BMA). As one of the few RACMA trainees based in Northern Territory, I was made aware of the opportunity of joint representation on the Jurisdictional Committee recently. Following a chat with the outgoing Candidate Representative, I wanted to contribute to furthering the voice of trainees in all fora and promote the good work of the College. The role offers the opportunity to further interact with peers and remain abreast of contemporary issues faced by members in the jurisdiction and sharing knowledge through communities of practice.

How important is it for members of colleges like RACMA to be actively involved through various roles like yours on college committees?
I believe representation on various committees including the Jurisdictional Candidate Representation, offer both personal and professional development opportunities to Members. It also serves as a platform to bring additional skills into the mix allowing for an exchange of ideas and knowledge across the board. My experience of interaction with peers on the committee has been extremely positive and encouraging.

What are some key attributes of a quality and strong Medical Administrator/Medical Leader?
The most important attribute as a Medical Administrator and leader is to lead by example. In addition to taking responsibility for important leadership and strategic goals, being humble and an excellent communicator who can transcend organisational hierarchy and engage at all levels is a key function of the role. Understanding your own emotions, leadership style and 'the fit' or impact on the organisational climate is essential in comprehending how and why we do what we do as well as when to adapt our approach.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
The role of the Medical Administrator unfortunately remains poorly understood and undervalued even amongst our medical peers. Formal training through RACMA offers to make the role, and its incumbent, professional through setting standards and certification. The need for competent and high-quality Medical Leadership in today's uncertain times is more than ever and is key to driving the quality of healthcare in which Members play a significant role. The Australasian health care system stands to benefit from qualified leaders who are able to inspire and promote excellence whilst driving innovation and continuous improvement in healthcare.

What are the challenges and/or opportunities you can see that RACMA, and the field of Medical Administration in general, will face in the future?
With exemplar leadership during the pandemic from some of our highly experienced Members, RACMA has the opportunity to overcome the challenges of attracting more doctors into the profession. The current year has seen unprecedented numbers of trainees join the FTP in the QLD/NT Jurisdiction which presents both an opportunity and challenge for the College to adapt itself in a virtual environment. As a Candidate and Medical Leader in the Aboriginal Medical Services environment, I believe there are opportunities for the College to offer alternative training environment exposure and help in 'Closing the Gap' through provision of sustainable quality leadership.

Member Q&A

What drew you to pursue the path of Medical Leadership/Medical Administration?
Medical Administration is really about patient care, and the fact that if done well, we can benefit patients at a much larger scale than just one person at a time. We are the guardians of the system, which helps our clinicians to provide the best care possible.

What led you to undertake the Fellowship Training Program of RACMA?
Many reasons. One of which is the disillusionment of seeing the same person in ED over and over again. After the fourth admission in one year, I had to question myself if anything that we are doing for the patient was going to produce any positive outcome. I decided that I wanted to be able to influence the health of people in the bigger picture and not just as a 'last line of defence' when deterioration has already set in.

What attracted you to take up your role as Candidate Representative on your Jurisdictional Committee? How important do you see the role of Candidate Representative?
I was keen to be involved with the College and I think the Candidate role is a key role to make sure that the concerns of the Candidates are heard. Our training program is unique in its diversity, but also means that there is complexity with the experiences and supervision that each type of position offers. The Candidate Representative is part of the support system for the Candidates to ensure their training and wellbeing are looked after.

How important is it for members of colleges like RACMA to be actively involved through various roles like yours on college committees?
Very important. For a small college, the proportion of Members involved in College activity is higher than other larger colleges. However, there is still much to be done and having a broad range of perceptions influencing the College is a strength that we can leverage. It is about giving back to the College and the Candidates to help raise the next generation of Medical Administrators.

What are some key attributes of a quality and strong Medical Administrator/Medical Leader?
There are many, most of which are covered off by the training program's curriculum. For me, it's about resilience. At some point in time, we will be faced with making an unpopular decision and we have to strive on regardless of the nay-sayers. To do this, we require the support of our peers and superiors, backed up by the literature evidence and expert opinions.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
We are unique. Unlike other medical interest lobby groups, our Members have an understanding of the limitations of the system. This means we can best improve the system in pragmatic ways which will help maintain the fine balance between competing tensions.

What are the challenges and/or opportunities you can see that RACMA, and the field of Medical Administration in general, will face in the future?
The pace of progress is fast, which means there will be new challenges that Medical Administration will be tasked to meet. Take the digital health care revolution that has seen Australia adopt the electronic medical record in a short period of time that has given rise to the Chief Medical Informatics Officer role that was not prevalent before. These challenges are also opportunities that we need to meet with equal amounts of enthusiasm and caution; for if we do not take the lead, who will?

Dr Junyi Shi
MBBS MHA

Medical Administration Registrar — Monash Health
Victoria Jurisdictional Committee Candidate Representative (Metro)

What drew you to pursue the path of Medical Leadership/Medical Administration?
I happened upon a Masters of Medical Science by research opportunity which touched on many aspects of quality, safety, clinician engagement, the health system as a whole — and didn't want to stop after a year!

What led you to undertake the Fellowship Training Program of RACMA?
I first heard about RACMA during career counselling while I waited for General Registration in order to continue physician training after moving to Australia. Speaking with RACMA Fellows and trainees inspired me to try my luck and apply to be a Medical Administration Registrar. My first day as a RACMA trainee was the very day Victoria declared a State of Emergency due to COVID-19!

What attracted you to take up your role as Candidate Representative on your Jurisdictional Committee? How important do you see the role of Candidate Representative?
Candidate Representatives are an important link between trainees and the College at both jurisdictional level and as part of the Candidate Advisory Committee. I was nominated for the role, and was pleased to take on an interesting new challenge.

How important is it for members of colleges like RACMA to be actively involved through various roles like yours on college committees?
It's been a great opportunity to get to know all the Victorian Candidates better, as well as 'meeting' trainees from further afield. I would encourage others to take on an active role like this if you're able — the chance to support others and understand more about the College is so worthwhile.

What are some key attributes of a quality and strong Medical Administrator/Medical Leader?
Someone who can keep calm, stay humble, play well with others, and do as they would be done by.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
RACMA training enables us to bring medical experience and training to management, and a management perspective to medicine. Medical Managers bridge a perceived gap between clinicians and bureaucracy as healthcare grows increasingly more complex.

What are the challenges and/or opportunities you can see that RACMA, and the field of Medical Administration in general, will face in the future?
I look forward to growing recognition and awareness of FRACMA and AFRACMA as we face future challenges together beside our clinical and non-clinical colleagues. We will all have roles to play in the future of healthcare — the ongoing digital health revolution, future pandemic responses and beyond.

Dr Serin Cooper Maidlow
BMBS MMedSci

Registrar Medical Leadership, Management & Administration — Ballarat Health Services
Victoria Jurisdictional Committee Candidate Representative (Rural and Regional)

Member Q&A

What drew you to pursue the path of Medical Leadership/Medical Administration?
My career path hasn't been the most straightforward. I didn't wake up one morning and decide I wanted to be a healthcare administrator and leader. After several years of rotating through different surgical and medical terms, I was set on entering RANZCOG training. However, I soon felt I needed a change in pace after life's wakeup call on my third on-call shift in a row and a complicated birth at 4am in a country hospital. The head of department at the time, who is a wonderful mentor and brilliant leader, saw in me characteristics suitable for Medical Leadership, and whilst other consultants insisted, I continue with clinical medicine, with her support and encouragement I decided to pursue a career in Medical Administration.

What led you to undertake the Fellowship Training Program of RACMA?
I was always intrigued by the business of health management, I was attracted to the dynamic nature of the work, the ability to initiate change and see it through, and how each day brings about its own unique set of challenges. However, a career outside of clinical medicine felt very foreign and daunting to me. And so, I took it upon myself to do extensive research and arranged to meet and speak to several Medical Administrators, all of whom spoke highly of the RACMA Fellowship Training Program.

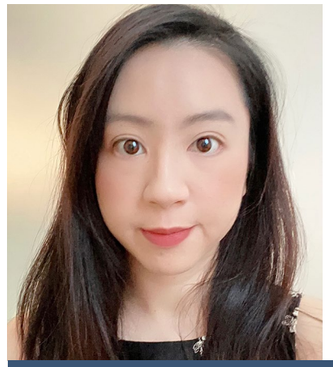
What attracted you to take up your role as Candidate Representative on your Jurisdictional Committee? How important do you see the role of Candidate Representative?
I felt it was an excellent opportunity to be better heard, and to promote the interests of the College as well as advocate for my fellow trainees. I believe the Candidate Representative role is very important in ensuring that all matters relating to Candidates are acknowledged and actioned to ensure a satisfactory and holistic training experience.

How important is it for members of colleges like RACMA to be actively involved through various roles like yours on college committees?
Nothing can be achieved just by being an observer or a back-seat driver. If we want to keep being well-informed of the latest developments and to contribute effectively and bring about concrete changes, we need to be actively involved. Additionally, it's a great way to meet and network with trainees and to converse with and learn from well-respected Fellows.

What are some key attributes of a quality and strong Medical Administrator/Medical Leader?
The complexities of the healthcare sector with its many moving parts is undergoing an unprecedented level of disruptive change. Operations need to be flexible enough to continue functioning in the event of natural disasters, cybersecurity breaches and even pandemics. As such, healthcare leaders may need to learn to do less planning and more adapting. This includes cultivating a desire to learn, agile thinking and innovation to better adapt to unexpected circumstances, and the ability to critically analyse our automatic almost instinctive thoughts and behaviours (mental scripts) towards external stimuli.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?
Without proper healthcare management training and education, clinicians may lack business acumen in the use of limited resources, and so hospitals and health systems may be at risk of under performing and becoming inefficient. The benefits of training clinicians to lead and manage teams and facilities in such a high stakes industry cannot be understated and RACMA plays an integral part in ensuring that Candidates are well-equipped to be future leaders and managers.

What are the challenges and/or opportunities you can see that RACMA, and the field of Medical Administration in general, will face in the future?
The current healthcare improvement paradigm is antiquated and continues to adopt top-down practices, which implies a healthcare system that is linear, thus completely disregarding the system's complexity and its multiple interacting agents. Medical Administrators are faced with the challenge of designing and implementing new and effective strategies/frameworks, paving the way for the next generation of healthcare.



Dr Melissa Maluda
BMED

Senior Registrar - Medical Administration — WA Country Health Service
West Australia Jurisdictional Committee Candidate Representative

Dr Rajdeep Ubeja
MBBS MHPol FRACGP AICGG

Medical Administration Trainee — St Vincent's Hospital Sydney
Candidate Advisory Committee (CAC) Chair

What drew you to pursue the path of Medical Leadership/Medical Administration?
It is an often overlooked and unappreciated privilege to live in a healthy, happy society. On the surface many health system decisions seem obviously flawed but once you start to transpose broader contextual factors and drivers for change the picture becomes increasingly opaque. I have always been fascinated by health policy and systems although I was first introduced to the value of health system interventions as a medical student undertaking an elective in Patient Safety and Quality at the Armstrong Institute at Johns Hopkins University. This experience really opened my eyes to the sort of impact clinicians could make outside direct patient care.

What led you to undertake the Fellowship Training Program of RACMA?
The idea of undertaking RACMA training was first suggested to me by one of our inspiring Fellows back when I was a junior doctor. I attended the College conference in Hong Kong back in 2018 and was blown away by the incredibly diverse roles our Fellows are working in across the world. I have since found Medical Administration a great fit for my interests and skill set and am excited about where my career may lead moving forward.

What attracted you to take up your role as Candidate Advisory Committee Chair? How important do you see the role of CAC Chair?
I am strong believer in the role of trainee voices in medical organisations. Although we may be a small college our trainees' group is made up of a wonderfully diverse group of individuals who are current and future Medical Leaders. I am humbled to be able to serve our 2021 cohort alongside an incredibly talented and passionate group of state representatives.

We must remember delivering speciality training is at the centre of what RACMA exists to achieve. Accordingly, the role of the CAC is vital in ensuring Candidate views are incorporated in all College activities. Having discussed the role of trainee representation with the chairs of equivalent committees at other medical colleges I think RACMA performs well in this respect, although like with anything in life there is always room for improvement, and I hope our committee will be able to deliver some tangible benefits for our trainees.

How important is it for members of colleges like RACMA to be actively involved through various roles like yours on college committees?
The strength of any member-based organisation are its members. It's important to recognise that medical colleges are heavily reliant on volunteer contributions. Whilst of course I believe it is beneficial for all RACMA Members to be involved, I understand why this is a difficult proposition for many trying to live a balanced life. Accordingly, I think it is vital the College provides Members regular opportunities to provide input through a variety of different channels. I think the introduction of open Member forums have been a fantastic addition and something I hope will continue for many years to come.

What are some key attributes of a quality and strong Medical Administrator/Medical Leader?
A learning mindset
A willingness to collaborate
An appreciation of diversity
Humility

What are the challenges you can see that RACMA, and the field of Medical Administration in general, will face in the future?
The importance of high-quality specialist Medical Leadership has been front and centre during the current COVID-19 pandemic. The ongoing challenge for RACMA remains achieving universal recognition of the value our Fellows add to all tiers of the health sector.

RACMA
ROYAL AUSTRALASIAN COLLEGE
of Medical Administrators

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