Royal Australasian College of Medical Administrators

THE QUARTERLY

Q4 2021

RACMA
ROYAL AUSTRALASIAN COLLEGE
of Medical Administrators

Contents

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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.

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.

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From the President

It is hard to believe we are at the end of another year – one which has again challenged many of us in our leadership roles in various ways. It is a true testament to the calibre of Members who have been outstanding, at the coal face and behind the scenes, rapidly implementing new strategies, standards and policies to combat the crisis.

Looking back at the year, the College and its staff have had another busy year rolling out various programs and projects to grow and support the whole membership.

I acknowledge all the time and effort which went into delivering many practice examination sessions to prepare Candidates for the Oral Examinations, which were again successfully carried out online.

This year saw the online delivery of the Leadership for Clinicians program, spanning 16 weeks. It should be recognised the mammoth task which was required to co-ordinate and support the facilitators and 200 participants across eight cohorts. Applications for the 2022 program have opened and participant demand continues to rise.

The College also hosted its first ever virtual Conference, attracting more than 500 registrations - the largest number of attendees we have ever seen.

And not to mention the numerous site accreditations, College IT system and platform updates and the ongoing advocacy work including the submission to the Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability.

I would like to take this opportunity to express the Board's gratitude to the RACMA Office for their continued work and dedication. The ratio of staff to Members does not compare to some of our counterparts, yet their tireless efforts to support the Members has led to these outstanding achievements.

As the College Board transitions to a new phase, with new faces, I am excited for what the next three years holds for RACMA as I take on the role of President. Our aim is to increase RACMA's visibility, presence and influence in healthcare decision-making and ensure we are always involved or consulted and regarded as authoritative voices.

I have always been greatly impressed with the diversity of experience and talent of our Members, and their willingness to engage and contribute to the College and their colleagues. I will be focusing on building a closer connection with each of the Jurisdictional Committees and engaging more with Members.

While the year is drawing to a close, the College is not winding down by any means.

After launching the 2021-2024 Strategic Plan this year, the Board is very keen to get to work on actioning the key priorities.

Work is well under way to action the key priority "To Deliver High-Quality Member Services & Support". The Member Services and Engagement Division have a number of new team members, including Lead Fellow Dr David Rankin whose first piece of work is analysing the RACMA 2021 Workforce Survey results. Members would have received the notifications to participate in the Survey and I thank those who provided their feedback. We had a strong response to the survey which gathered vital data to support the role of the College in its planning and advocacy role in Australia and New Zealand. The survey results will also provide a profile of who our Members are to give the College an informed understanding of the Medical Administration workforce. A report is currently being finalised for the Board, which will then be shared with the whole membership.

On the topic of workforce, the College Medical Workforce Planning Working Group (MWPWG) is piloting a Peer Support Group Program. It is encouraging to see this major piece of work take shape to provide a structured peer support to professionally isolated Members across all jurisdictions. Meetings will be conducted monthly over the six months of the pilot to provide a forum for participants to discuss topics they are not able to due to their professional isolation. A full story on the Pilot Program is on Page 20.

Another important area of work to ramp up in 2022 is the review of the Constitution. The College has been consulting with Members to ensure the Constitution is contemporary, complies with relevant legislative requirements, allows the College to be agile and reflects sound governance. Over the last 12 months, meetings have been held with Jurisdictional and other College committees to obtain feedback on key issues moving forward.

Off the back of this, the Constitution Working Group released the first Consultation Paper to Members detailing the updated Objects and Purposes of the College. I encourage Members to provide feedback via this LINK and thank the Working Group for their efforts to date.

On behalf of the Board, I thank our Chief Executive Melanie Saba, who finishes with RACMA on 13 January 2022. Melanie has taken up the Branch Director role with the Victorian Branch of The Pharmacy Guild of Australia and we wish her all the best. For the past four years, Melanie has provided a significant contribution and her guidance has left a strong legacy for the College to build upon. The Board is progressing the recruitment process, and the College office will mantain the momentum of all organisational activities to ensure a smooth transition when the next College Chief Executive is appointed.

I would also like to take this opportunity to thank the Members for your commitment to our College, and more broadly our healthcare system.

Thank you to my colleagues on the RACMA Board, the Secretariat, Dean, Censor in Chief, the College Office, our Censors, Supervisors, Preceptors, site Accreditors, Jurisdictional Chairs and those Members involved in the various RACMA committees. Everyone should be proud of what has been achieved in 2021, given the extra workload COVID-19 produced for many and its impact on ourselves and colleagues.

I wish everyone all the best for a safe, healthy and happy holiday season and look forward to another productive year for Medical Leadership and RACMA in 2022.

Dr Helen Parsons CSC
President

Seasons Greetings and a Happy New Year

On behalf of the Board and team at RACMA, I wish you and your family a happy, safe and restful holiday period. Thank you for your leadership and dedication throughout another challenging year. We look forward to reconnecting in 2022.

Please note the RACMA office will close 5pm, Friday 17th December 2021, and reopen on Tuesday 4th January 2022.

ETC Chair Report

In 2019, the FTP Renewal Project was established to develop and implement a renewed Fellowship Training Program (FTP). The project will culminate in a renewed FTP which is expected to be implemented in 2023/2024.

The renewed program will:

- continue to deliver a specialist training program that meets AMC and MCNZ standards
- be based on contemporary evidence for 'best practice' models in medical education
- demonstrate a greater commitment to cultural competence and safety, in particular for Aboriginal, Torres Strait Islander and Māori peoples
- include more emphasis on clinical governance and digital health
- continue to train future Fellows to meet the challenges of their roles within rapidly changing health systems

FTP Renewal Project: Phase One
Phase One of the Renewal Project saw a suite of materials prepared to provide Members with information about the Project. In late 2020 the concepts were presented as part of the Phase 1 Member Consultation. Feedback from the Phase 1 Consultation has been factored into the continued development of the renewed program.

FTP Renewal Project: Phase Two
The Fellowship Training Program (FTP) Renewal Project members have continued with development of the renewed program, factoring in feedback from the Phase 1 consultation. Progress has included development of a proposed structure of the renewed FTP.

It is proposed that the renewed program should be four years and comprise two stages. The proposed stages are currently being referred to as 'Foundation' and 'Advanced'.

It is proposed that both the Foundation and Advanced stages will each contain four training periods at equivalent of 1.0 FTE. During each training period, Candidates will complete required education activities, workplace activities, and assessments.

Phase Two Consultation
A consultation document has been developed to detail the proposed Foundation and Advanced stages of training. This document contains written explanations and visual aids that provide a detailed overview of the proposed renewed FTP structure and its various components.

In this Phase 2 Member Consultation feedback will be invited, via a survey, regarding the following concepts:

- the Fellowship Training Program (FTP) proposed structure.
- the proposed RACMA Education Activities for the renewed Fellowship Training Program.
- the proposed Workplace-based Assessment Tasks for Foundational Stage of training.
- the proposed Workplace-based Assessment Tasks for Advanced Stage of training.

The FTP Renewal Project Team, working with the Education and Training Committee, will use Member feedback to refine the concepts. The Consultation document will be made available to Members before the end of 2021. Members will have an opportunity to read the paper in preparation for question-and-answer sessions and a consultation survey which will open in late January 2022.

The FTP Renewal Team look forward to engaging with Members to receive and implement feedback as we continue to shape the renewed Fellowship Training Program.

Associate Professor Pooshan Navathe
Chair Education and Training Committee

RACMA Constitution Review

Consultation Paper #1 - The Objects and Purpose of the College

The College has been consulting with Members on a review of the RACMA Constitution to ensure it is contemporaneous, complies with relevant legislative requirements, is sufficiently flexible to allow the College to be agile in the future to changes in the environment, and reflects sound governance.

A working group was formed after an expression of interest and is chaired by members of the RACMA Board. Over the last 12 months, meetings have been held with Jurisdictional and other College committees to obtain feedback on the current constitution and to hear what members believe are the key issues going forward.

A discussion paper, which seeks feedback on the Objects and Purposes of the College as outlined in the Constitution, has been developed by the working group and endorsed for consultation with Members by the RACMA Board.

The paper is the first of a series to be developed for Members. The Objects and Purposes of the College form the basis of the Constitution and are how the College describes its business and the activities it undertakes.

The working group have aimed to keep the Objects as broad as possible, so that they not only capture the current activities of the College but allow for the College to expand or refocus its activities in response to any changes in the environment in which the College operates.

To consider the changes and the proposed new version, click the below links:

- Current Objects and Purpose Statement
- Proposed new Objects and Purpose Statement

The College is seeking feedback on:

1. Do you support the proposed new Objects and Purpose statement for RACMA? If not, can you provide feedback on why?

2. Is there anything more that you believe needs to be added to the proposed Objects and Purpose?

Click here to provide your feedback.

Feedback on Consultation Paper #1 is sought by Friday January 7, 2022.

Once all the feedback has been collated, the working group will consider the information and make recommendations to the RACMA Board.

To keep up to date with the review process visit the RACMA website or if you have any questions, please email info@racma.edu.au.

Vale Dr Jennifer King MBBS MBA FRACMA FAICD

The College would like to acknowledge the recent passing of Dr Jennifer King, who was a Fellow of RACMA for more than 20 years. Dr King will be missed by many friends and colleagues within the College community.

Introducing RACMA's new Board Members

The RACMA Board entered a new era at the AGM in October when it welcomed the fourth female President in the College's history. A new Vice President was also elected, along with two new faces filling Director positions.

The new RACMA Board now comprises:

- Professor Erwin Loh - Vice President
- Professor Alan Sandford AM - Chair Finance Audit Committee
- Associate Professor Pooshan Navathe - Chair Education and Training Committee
- Dr Helen McArdle - Director (FRACMA membership category)
- Dr Mellissa Naidoo - Director (FRACMA membership category)
- Associate Professor Luis Prado - Director (FRACMA membership category
- Dr Angela Williams - Director (AFRACMA membership category)
- Dr Allison Turnock - Director (Candidate membership category)
- Ms Gillian Biscoe - Director (independent member)
- Ms Kiri Rikihana - Director (independent member)

Dr Helen Parsons CSC

President

Helen becomes the President after being a Board Director since 2016 (she was re-elected in 2019). She has been a highly active Member of RACMA carrying out a number of roles including, Chair Policy and Advocacy Committee, Preceptor, Candidate Coach, and a member of the Board of Censors. She is currently the District Director Medical Workforce at Nepean Blue Mountains LHD.

What motivated you to become the President?

My experience of fellowship training and of supporting college candidates in their training has highlighted to me the immense value of the College's training program to healthcare leaders and health systems across our jurisdictions. The College's membership is unique in that we have medical leaders from across jurisdictions, areas of expertise, roles, experience and specialties, and many are also willing and enthusiastic to provide their expertise to contribute to the aims of the College, to the training of future healthcare leaders and the health system more generally.

I have been very fortunate to also have been previously elected by the membership as a College Board Director and in that role have chaired the Policy and Advocacy Committee. This experience has shown me the influence that the College is able to have on a broader strategic and policy level within the healthcare system, and in my role as President, I am keen to increase that profile and influence, as well as supporting the ongoing development of our training for medical leaders to ensure that it meets their needs and that of a rapidly changing environment. Our ultimate goal as medical leaders is to provide the highest quality clinical care and to improve the health of people in the communities we serve.

What skills, expertise and personal attributes do you bring to the Presidency?

The diversity of experience as a medical leader across the rural and metropolitan public health sector, Immigration, Corrections and the military, combined with the opportunities the College has given me in supporting candidates, in policy advocacy, and in supporting the direction of the College as a Board member has driven a strong commitment and passion for formal leadership training for medical leaders at all levels in our healthcare systems. I have seen the difference this training has made to individuals, the organisations they lead, the health system and the communities these medical leaders serve.

What do you see as being the key role of the President? What do you believe are the key attributes a College President should hold/focus on?

Driving the strategic direction of the College, ensuring appropriate governance of the organisation, building networks and relationships with key stakeholders, strongly supporting the development of medical leaders, and providing opportunities for them to engage with each other in the College and to participate and contribute more broadly across the health system are the key areas of my focus as President. As College President I am very clear about my responsibilities as a leader of a member organisation, and my accountability to the members and organisation for achieving the College's strategic goals.

What challenges and opportunities do you see Medical Leadership and RACMA facing in the next three years of your term?

The current pandemic has shown the significant contribution of medical leaders at all levels of our health system and highlighted to many clinicians the value of formal medical leadership training. The pandemic response has been a combined effort by everyone associated with the health system across specialties, disciplines, health sectors, jurisdictions, governments, media, a wide variety of agencies and organisations, and the community. We have seen global cooperation on an unprecedented scale. The pandemic has also highlighted vast social and health inequities even in our own countries. These need to be addressed with urgency. Change and our responses have been rapid with novel models of care and large-scale health care operations with supporting infrastructure launched. Medical leaders have had to be extremely adaptable, resilient and resourceful, as well as being able to engage a wide variety of stakeholders across diverse organisations.

The future challenges and opportunities for medical leaders are to build on the relationships and innovative models of care developed across specialties, disciplines and sectors during the response so that healthcare can be truly integrated across the continuum of care. Building sustainable and effective relationships with the communities that we serve is vital. We also need the ability, resourcefulness and resilience to face other significant challenges impacting on our societies and environment in the years ahead. Our College training and the support that we give medical leaders has to keep pace with these changes and challenges.

Over the next three years implementation of the College's Reconciliation Action Plan and the Māori Action Plan, our work in Diversity and Inclusion, our advocacy for equitable health care access and outcomes in regional, rural and remote communities and our work as Lead Partner with Monash University in the Women in Leadership Research Project are exciting opportunities for the College.

What is your vision for the College throughout the next 3 years – areas of focus? Changes?

The College's Strategic plan, 2021–2024, outlines what the College Board, members and staff wish to achieve in the next three years. RACMA is unique globally as the only specialty College providing formal leadership and management education and training to medical leaders. We want to continue to build on our leading reputation in the field, continue to develop innovative training and delivery systems, increase our engagement with emerging medical leaders in our health systems and provide them with formal and relevant training, as well as improving the support we provide College members in their professional roles and their personal development. We also want to encourage greater collegiality and engagement of members with each other and the College and to enable medical leaders to advocate and influence at all levels of healthcare leadership and delivery.

Professor Edwin Loh

Vice President

Erwin takes on the role of Vice President after carrying out the position of Chair Finance and Audit Committee since 2017 (he was re-elected in 2020). He is currently national Chief Medical Officer and Group General Manager Clinical Governance for St Vincent's Health Australia.

What motivated you to become the Vice President?

I have been involved in College governance matters since I was a Candidate Representative on the RACMA Board many years ago, and I am a great believer in Members being involved in supporting the vision and mission of our College. I was part of the Executive Board of RACMA as Chair of the Finance and Audit Committee over the past four years, and felt that I still have more to offer. I decided to nominate for the role of Vice President so I can continue to contribute to the College.

What skills, expertise and personal attributes do you bring to the role?

I hope to bring my passion and strong conviction to see our College continue to lead in all aspects of medical leadership, clinical governance and health policy.

What do you see as being the key role of the Vice President?

In my mind, the Vice President serves to support the President, the Executive Board and the College, and share the load in governance, decision-making and policy setting on behalf of the membership.

What challenges and opportunities do you see Medical Leadership and RACMA facing in the next three years of your term?

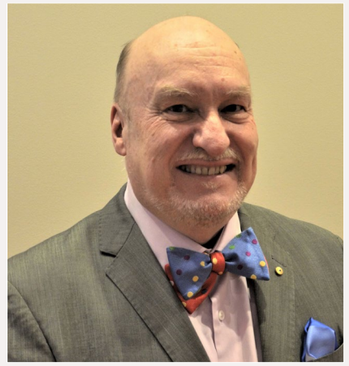
The pandemic has shown us how effective Medical Leadership can make a positive difference to the health system during a crisis. The challenge and opportunity for RACMA is to be able to show how Members of our College, who have been credentialled to lead through our training programs, can continue to add value as leaders in the health system moving forward, as we transition back to a new normal.

What is your vision for the College throughout the next 3 years – areas of focus? Changes?

My vision for the College is encapsulated in its 2021-2024 key priorities, which is to see it strengthen its reputation as the leading Medical Leadership and Management education and training provider for all doctors, and be the respected and expert voice in decision-making and policy formulation at all levels of healthcare leadership and delivery. I would also like to see the credentials and scope of practice of our Fellows as specialist Medical Administrators better defined, recognised, respected and remunerated moving forward. I will work closely with the President on these matters and more.

Professor Alan Sandford AM

Chair Finance Audit Comittee



Having completed his Presidency term this year, Alan continues his involvement with the Board taking on the Chair Finance and Audit Committee position for the first time. Alan is currently the Director of Medical Academic Development – Regional Medical Pathway, Central Queensland & Wide Bay Hospital and Health Services.

What motivated you to become the Chair Finance and Audit?

The financial security and integrity of any organisation is critical to its future success. Having previously been a member of the Finance and Audit committee, I felt I had the experience required to fulfil this role in addition to being part of the ongoing board executive after completing my term as President this year.

What skills, expertise and personal attributes do you bring to the role?

My experience as President and as a previous member of the Finance and Audit committee enables me to demonstrate my contribution to the successful growth of the College, as a Member committed to the success and integrity of RACMA.

What do you see as being the key role of the Chair Finance and Audit?

To maintain the financial integrity and well-being of the College and enable the financial execution of the strategic objectives as set by the Board.

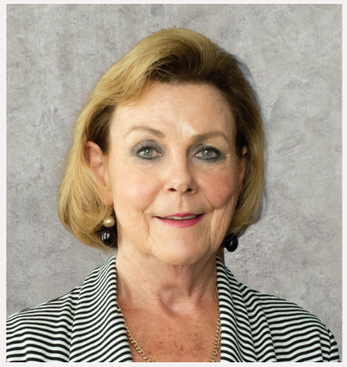
What challenges and opportunities do you see Medical Leadership and RACMA facing in the next three years of your term?

There are many existing and no doubt further emerging challenges within the healthcare sector which will require skilled medical leadership aimed at fulfilling our role as "custodians of clinical quality, safety and system integrity". The current Pandemic and the ramifications will continue to challenge the system for some years to come. One of the corollaries of these recent challenging health events highlights the key role of the skilled and empowered Medical Leader in maintaining system integrity. The RACMA Leadership for Clinician's course has become acknowledged as an excellent way in which clinician leaders within our broad healthcare system are enabled to step up as skilled and empowered Medical Leaders. Such leaders are then able to work alongside their specialist colleagues, being our fellowship. Together we can meet the challenges and further develop a better healthcare system for Australia and New Zealand.

What areas of importance for Medical Leadership/Administration do you believe the Board needs to focus on throughout the next three years?

To further grow our membership, College profile and influence within the broader healthcare system and also within the community. As RACMA membership grows in the various categories, so too does the need to update and develop a suite of ongoing professional support and development. The College needs to further develop and maintain a system of ongoing professional development, which is responsive to the changing healthcare needs within our broad system and meets the requirements of the regulators.

Another key area of importance is the further refresh of our curriculum, along with critical review and development of our assessment methods in keeping with contemporary practice and regulator requirements.



Dr Helen McArdle

Director (FRACMA membership category)

New to the RACMA Board, Helen is a Locum Medical Administrator and the current AMA Tasmania President. She has been a Fellow for more than 30 years and actively involved in RACMA as a Preceptor and as the Jurisdictional Coordinator of Training for Tasmania. Helen is also a member of the AMA Federal Council and a Fellow of the Australian Institute of Company Directors.

What motivated you to join the RACMA Board?

The reason for joining the Board is twofold:

1. I have been actively involved in RACMA for many years initially as the Tasmania Jurisdiction CPD Coordinator and subsequently as the Jurisdictional Coordinator of Training. As these are more operational roles, I wanted to be more involved in the governance of the College given it has expanded significantly over the last few years both in size and in profile.

2. I come from one of the smaller jurisdictions within the College, Tasmania, and feel it is important the smaller jurisdictions are recognised appropriately and have their views and needs met.

What skills, expertise and personal attributes do you bring to the role of Board Director?

I am an experienced board director, having served on a number of local and national boards in the roles of chair, deputy chair and chair of audit and risk committees.

I have completed the AICD Company Directors Course and the Mastering the Boardroom Course and have been elected to be a Fellow of AICD. From a personal perspective I am diligent and take board roles very seriously. I enjoy working with other directors and enjoy innovation and change.

What do you see as being the key role of a RACMA Board Director?

The key role, as I see it, is the governance of the College. As a RACMA Board Director it is essential to avoid conflicts of interest and to ensure the Company can meet its duties under the Corporations Act. The Board is responsible for selecting the Chief Executive and ensuring the financial viability of the College. Strategy is very important to ensure the College can meet its objectives and continue to grow.

What challenges and opportunities do you see Medical Leadership and RACMA facing in the next three years of your term?

I am very excited about the role of RACMA in the next few years. As I mentioned above RACMA has grown significantly in both size and profile over recent years. This is both positive and negative. There is always the risk of getting too big and losing focus so further expansion needs to be carefully considered. Another challenge is that we largely rely on volunteers, often only a small group. As we expand further this may not be viable and we may need to look at other alternatives.

What areas of importance for Medical Leadership/Administration do you believe the Board needs to focus on throughout the next three years?

Probably the main issue we should focus on in the next three years is the old chestnut of why it is not essential to have a FRACMA to be appointed as a Medical Leader. A surgeon cannot be a surgeon without a FRACS. I think we should also be much more active in advocacy and should explore partnerships with other organisations such as the AMA. We should engage much more with politicians both at a local and national level. Another area would be working with our immediate neighbours, Pacific Islands, to improve healthcare and Medical Leadership.

Dr Angela Williams

Director (AFRACMA membership category)

New to the RACMA Board, Angela is a Consultant Forensic Physician with the Victorian Institute of Forensic Medicine. She became an Associate Fellow in 2019 and since then has been a member of the Victorian Jurisdictional Committee and RACMA's Constitutional Review Working Group.

What motivated you to join the RACMA Board?

The opportunity to work with a great group of people to achieve the Board's strategic goals, which ultimately support safe and effective healthcare – a strong belief of mine.

What skills, expertise and personal attributes do you bring to the role of Board Director?

I have more than 20 years of experience in Clinical Forensic Medicine. As a Forensic Physician, I spend a lot of time thinking about human rights, managing sensitive issues, adapting to the needs of diverse and vulnerable populations, and promoting health and culture change in local, national, and international contexts. In 2019, I became an AFRACMA and since then have been a member of the Victorian Jurisdictional Committee and participated on the Constitutional Review Working Group. I connect to good governance with experience as a board member with Eastern Health and TripleZero(000), and a tribunal member with Football Victoria and the Victorian Civil Administrative Tribunal.

Contributing to boards and tribunals as a medical practitioner is incredibly rewarding. Where I have seen strong Medical Administrators and Medical Leaders in action, they all share the key attributes of:

- authenticity (of self and organisation)
- honesty (addressing issues and reporting)
- openness (ethical listening and cultures of reporting)
- kindness (inwards and outward)

What do you see as being the key role of a RACMA Board Director?

There are the fiduciary duties of oversight, monitoring, strategy and planning. But just as important is the leadership of culture, empowering quality and standards, and keeping an eye on the future and improvements. I also believe being able to bring others along for the journey, and enabling people to shine, always seems to bring success and outcomes.

What challenges and opportunities do you see Medical Leadership and RACMA facing in the next three years of your term?

We are living in evolving times. For today it seems like looking after the leaders themselves is a big issue. I think it is critical we manage the compounding exhaustion exacerbated by the Pandemic, whilst maintaining motivation and empowering people. Otherwise, we face an even more uncertain future if our Medical Leaders and Medical Administrators cannot lead.

What areas of importance for Medical Leadership/Administration do you believe the Board needs to focus on throughout the next three years?

Three fundamental actions to target for the College and its Members are:

- ensuring connection
- avoiding complacency
- challenging norms

The College recognises Professor Alan Sandford for his contribution to the College as President for the past three years, and Professor Erwin Loh for his service as Chair Finance and Audit Committee over the past five years.

The College also thanks our outgoing office bearers:

- Dr Iwona Stolarek for her support as Vice President for the past three years
- Dr Vinay Rane for his role as Director from the AFRACMA membership category
- Dr Liz Mullins for her service to RACMA as Chair Continuing Education Program Committee for the past six years

Introducing New Staff Members

Fiona Norsworthy

Member Engagement Officer

Fiona joined the College in September 2021 with extensive client relationship management experience while ensuring a high level of customer satisfaction.

At RACMA, Fiona provides support to the Member Services & Engagement Director and the College members. This involves providing continuing professional development support to members and maintaining College records and membership data. Fiona also assists with the Continuing Education Program Committee, the Medical Workforce Planning Working Group and provides support with external membership events and College graduation.

Phoebe Lee

Accreditation Officer

Phoebe joined the College in September 2021 with years of extensive experience in Supplementary Education and Management. In her previous role, as a Chief Operations Officer, she helped develop a single business from conception to a multi-award-winning franchise. She is trained as a specialist Phonographix Educator. Phoebe graduated from the University of Bedfordshire, England with a degree in Media Studies and English Literature.

At RACMA, Phoebe assists with jurisdiction communications, provides direct support to Candidates and Health settings, reviews applications for Accreditations. Scheduling site visits and assists with the Fellowship Training Program Applications. In addition, she focuses on building and maintaining rapport with internal and external stakeholders from RACMA Fellows and Health settings to College trainees and committees.

Shreya Masters

Accreditation Officer

Shreya joined the college in October 2021 and has 9+ years' experience working in membership and education support services.

At RACMA Shreya is responsible for administering the training post accreditation process. This involves responding to general enquiries, reviewing applications, support preliminary reviews, schedule training post accreditations, and provide secretariate support to the accreditation panel. To ensure a seamless process, Shreya initiates interaction with health settings to provide them with a high level of support while they go through the process of obtaining an accredited post.

College enhancing its investment in Member engagement

RACMA has appointed the expertise of a Lead Fellow to strengthen the work of the Member Services and Engagement Division and further develop its responsiveness and support for Members.

The College has grown enormously in the past decade and with that growth has come recognition and potential influence, making it an opportune time to re-evaluate the services the College offers to Members.

"It is key to interpret what it is the Members are trying to say and what the College could do differently, and conversely what is the College trying to say and how can it best say that in a way that gains traction with Members," Member Services and Engagement Division Lead Fellow Dr David Rankin said.

"The role provides both huge opportunities and real challenges - bridging the gap between what Members want from the College and what the College can provide."

Working closely with the Chief Executive and Director of Member Services and Engagement, the Lead Fellow will contribute to achieving key strategic goals and priorities of the division by providing subject matter expertise. Key responsibilities of the role include:

- assisting in review of applications for membership of the College, including applications for the Fellowship Training Program and Specialist International Medical Graduate
- assisting in accreditation of training post process where possible and the continual review of College policies and processes
- writing assessment outcomes and briefing papers for College Committees and the RACMA Board
- working closely with the Director of MS&E to support delivery of key strategic objectives and outcomes including reviewing policies and member value proposition
- contribute to activities that support growing membership and as a College representative at external events
- work collaboratively with RACMA office bearers and committees to support continuous improvement within the College.

Dr Rankin has been a College Member for 35 years and has always been a strong advocate for RACMA. He brings experience in a mixture of public and private hospital settings, government departments, health insurance and private practice across Australia and New Zealand.

"The Member Services and Engagement team will be working to establish and maintain clear communication lines with all College Members to validate the value the College provides," Dr Rankin said.

"It is important for Members to understand and appreciate the value the College adds to their professional lives."

In his first three months in the role, Dr Rankin has started work on reviewing the RPLE program and analysing the results from the 2021 RACMA Workforce Survey.

"At the moment the RPLE evaluations determines how long a candidate will need to prepare for the examination, rather than what activities they need to experience to round out their knowledge and understanding of Medical Administration" Dr Rankin said.

"We need to make the skills of a Fellow much more explicit and then set those as a benchmark or a criteria for determining whether or not the Candidate or the RPLE applicant has gaps which need to be addressed in order to have the knowledge and experience to be a competent medical administrator."

Introducing a framework for College resources and developing a clear definition of a Medical Administrator, will also be a focus for the Member Services and Engagement Division.

"The College has a range of resources but currently it is not clear how a Medical Administrator can identify their knowledge gaps and what resources with the College will then help meet those gaps, which requires a proper catalogue of the resources the College has developed over the years," he said.

"It is very important we create a clear scope of practice for a Medical Administrator so we can be explicit in the value the College brings to Australia and also support CPD requirements for both Australia and New Zealand.

"A Medical Leader should be leading clinical governance, but what does that really mean? They should also be able to benchmark clinical performance, undertake a root cause analysis, engage with a coroner, lead an incident investigation and have a conversation with a clinician about how they can improve their performance. They're the fundamental activities that every RACMA Fellow should be able to undertake. But we haven't identified those activities and without identifying them explicitly and clearly, we haven't been able to demonstrate the value RACMA brings."

For the College to grow its membership and increase engagement, Dr Rankin believes RACMA needs to be the acknowledged leader in Medical Administration, which includes health sector reforms across Australasia.

2021 RACMA Workforce Survey

The RACMA biannual Medical Workforce Survey attracted 230 responses this year and the College thanks those Members who participated and provided valuable feedback, which will help prepare information to support the role of the College in its planning and advocacy role in Australia and New Zealand. The survey explored a range of topics and issues which will be evaluated in the final report provided to the Board in March 2022 to inform and support any identified key strategic objectives. These include:

- Issues for Medical Administration
- Challenges for the College
- Why Medical Administrators choose their roles and positions
- Member engagement with RACMA
- Organisational responsibilities for Members
- The metrics that should be used to determine the demand for Medical Administrators
- A profile of Fellows and all College Members

Interim 2021 Workforce Survey results

Geographical spread

	Metropolitan	Regional	Remote	Rural
FRACMA	72	19	1	6
Candidate	6	4		3
AFRACMA	33	20	3	5
Affiliate		1		
Total	121	44	4	14

Year Since Attaining RACMA Membership Category

	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40+
FRACMA	16	20	14	9	9	7	10	6	7
Candidate	22	1						12	
AFRACMA	50	7	2		1	2			
Affiliate	2			1					
Total	90	28	16	9	10	9	10	6	7

Current Role

	CEO	Exec	DMS	Clinical Director	Senior Advisor	Academic	Consultant	Trainee
FRACMA	7	34	25	2	5	5	20	
Candidate		3	7	1				12
AFRACMA		5	14	21	2	2	15	2
Affiliate				1				
Total	7	42	46	25	7	7	35	14

Changes afoot for Continuing Professional Development

As RACMA prepares for the introduction of new CPD registration standards in Australia and New Zealand, CPD for the College is also evolving, with a new face driving the transformation.

Dr Greg Watters has recently taken over as the Chair of RACMA's Continuing Education Program Committee (CEPC) after being the NSW CPD Coordinator since 2018. While he brings more than a decade of experience in Medical Administration to the role, his interest in CPD came from his years in clinical practice as a urologist.

"I certainly saw issues with clinicians who were not keeping up to date with their clinical practice," he said.

"But that was a long time ago and since then CPD has become increasingly important as part of the self-regulation of medical practice. I have always been interested to know how people maintained their recency and currency.

"Being on the CEPC over the past three years has given me a real insight into our Members regarding their CPD. It has been interesting to talk to the members because, while most undertake CPD activities, there are occasions when they do not document them with the college. This can become an issue because certification of CPD is a requirement of medical registration."

Now a locum DMS, Dr Watters is already putting plans into action for the next three to five years and believes the College needs to take a more hands on approach to CPD.

"I think as a College one of our key roles is to provide Fellows and Associate Fellows with plenty of different CPD opportunities to make the process easy," Dr Watters said.

"We can facilitate our Members meeting their requirements, not because the Medical Board of Australia and Medical Council of New Zealand want it, but because the Members want to do it. There are ways of making their practice more worthwhile and more transparent and easier to show they are current and have recency."

Dr Watters said the College needed to increase engagement with each of the jurisdictions.

"The CPD coordinators are our ambassadors for their own jurisdictions," he said.

"They can influence Members more than the College can from a central point as they have an existing connection we need to tap into."

MBA's revised CPD registration standard

To date the main source of CPD for FRACMAs and AFRACMAs has been through education and teaching. While College Members have maintained a strong compliance rate, the Medical Board of Australia (MBA) and Medical Council of New Zealand's (MCNZ) revised CPD registration standards will make this challenging, according to Dr Watters.

Colleges have until January 2023 to update their CPD frameworks to align with the new MBA standards, while the MCNZ changes need to be implemented by 1 July 2022.

"The challenge is coming in that the mandatory CPD required for registration will require documented auditing of one's practice and peer review." Dr Watters said.

"Peer review is difficult for Fellows because many are in isolated practice as most hospitals have only one DMS. In addition, Medical Administration does not involve direct patient care, and it can be difficult to nominate things that we can audit within our practice.

"Finding a way for our Fellows to actually meet those requirements is where the challenge is. The College of Psychiatrists has quite a lot of people who don't have clinical practice and they have developed ways around this so we will talk with colleagues there and other colleges to see what they are doing in this situation."

In Australia under the changes, doctors will do 50 hours CPD each year, made up of:

- 25 hours active CPD - **reviewing performance** and **measuring outcomes** (doctors decide the best mix for these activities to suit their practice, with five hours minimum of each type)
- 12.5 hours **traditional learning or educational activities** – reading, lectures, conferences
- 12.5 hours – doctors choose across the three types of CPD.

Detailed information regarding the changes for Australian practitioners can be found on the Medical Board of Australia's website.

For Fellows registered in the **New Zealand** the new requirements are:

- Reviewing and reflecting on practice
- Measuring and improving outcomes
- Educational activities

In addition to the thress categories above, these activities must be underpinned by:

- Annual conversation
- Professional Development Plan
- Cultural safety and focus on health equity

A summary of the Medical Council of New Zealand re-registration standards can be found here.

Dr Watters said there were some distinct differences between Australia and New Zealand.

"The Medical Council of New Zealand has not asked for a mandatory number of hours for each category and in New Zealand it is mandatory to have a visit of practice between doctors, which is one of the things we need to try and facilitate. The College of Psychiatrists facilitates that well, so there are a few lessons to be learned there.

"New Zealand makes the distinction that CPD must be both culturally safe and to think about inclusion in your practice. The MBA hasn't made that a particular issue, but I believe it is an important issue."

Dr Watters said there had been some initial resistance to the announced changes, however the College is embarking on a widespread consultation to ensure all Fellows and Associate Fellows would be informed, prepared and ready for implementation.

"Change is coming, and resistance is futile," he said.

"We will have to adapt, and the College will be facilitating the adaption.

"There has been a lot of thought about it already and people are very inventive and have good ideas. There are ways of doing peer review which we need to explore and formalise a bit more and ways of doing practice review.

"At the moment we are collecting ideas and while a lot can be done easily and quickly, others need more resources. We are looking at running a workshop in the New Year to collect ideas and start to formalise them."

If you have any questions regarding College CPD or the new changes please email cpd@racma.edu.au

Dr Greg Watters - New Chair of CEPC

Fellows & Associate Fellows - Remember to complete your CPD for 2021

Mandatory completion of CPD has returned in 2021 following the Medical Board of Australia and the Medical Council of New Zealand approved exemption for 2020 due to the difficulties posed by COVID-19. There is less than two weeks left for Fellows and Associate Fellows to complete CPD requirements for this year, with the deadline of 31 December to have completed the required hours of CPD activities. FRACMAs and AFRACMAs have until 31 March to record CPD activities. Click HERE for more information here.

Please note changes to recording of CPD for attendance at 2022 Wednesday President Member Forums

During 2021 the College recorded Members' attendance at the Weekly Forum as a CPD activity. When the President's Member Forums recommence in February 2022, the College will no longer be entering attendance at these forums as a CPD activity on behalf of members as evidence in the form of a reflective statement is required. Members may continue to record attendance at these forums as a CPD activity but must enter the activity themselves in their MyRACMA record ensuring there is a reflective statement included. Any queries should be directed to cpd@racma.edu.au

Making Inroads to Provide Tangible Support for Isolated Members

RACMA is Piloting a Peer Support Program in a bid to address the critical challenge of professional isolation for College leaders.

As a Medical Administrator, by the nature of the various roles, RACMA Members are leaders of the medical profession within their organisations, or senior advisors to Chief Executives, Boards or senior government departments. These roles carry a significant privilege, strategic and professional autonomy but also significant professional burden. It is a role which often requires balancing complex clinical and corporate judgements, and shouldering the outcome of those difficult decisions. Being at the "top of the tree" can be lonely.

"By the nature of our roles, who we are and what we do, many RACMA Members feel a sense of professional isolation. This can occur particularly for those colleagues who are rurally and regionally isolated, but also for those sole Medical Administrators in any organisation," Medical Workforce Planning Working Group (MWPWG) Chair Adjunct Clinical Associate Professor Alison Dwyer said.

"You are the ultimate decision maker for a lot of really tricky things in the organization, and that emotionally can be really hard. The decisions you make affect patients or clinical staff, and often involve balancing complex ethical, clinical, or legal decisions. Frequently there's no other senior peers in the organisation you can seek advice from, or talk through the options. So, it does feel very isolating. To be able to have a strong network of colleagues that you're able to bounce ideas off and feel like you're not alone is actually really important."

In 2019, the MWPWG was established after the Policy and Advisory Committee realised work needed to be done to support the Medical Administration workforce. There have always been very clear pathways for Candidates in the Fellowship Training Program to learn with peers, and for FRACMAs and AFRACMAs to strengthen their knowledge via Continuing Professional Development activities. However, a gap was quickly identified for collegiate support for Members to do their role well.

A work plan was developed to assess the current challenges within Medical Administration, and the recurring theme was the concept of professional isolation, either individually, socially or geographically. Professional isolation in the workplace is a well-recognised risk factor to professional wellbeing. It can occur irrespective of workplace location.

Research by the MWPWG found key literature identifies three types of isolation that in turn lead to decreased knowledge sharing, lowered intention to work in rural areas and a change of career choice. The three types of identified isolation are social isolation, structural isolation, and professional isolation.

Hence, the Pilot Peer Support Program was created.

"The Peer Support Program is quite different to other programs. It's not a College training program, it's not a Candidate pathway to become a Fellow and it's not a CPD event to enhance your content knowledge on a topic," Adj. Clin. A/Prof. Dwyer said.

"It was a tangible and achievable concept we could use to offer real value to Members and colleagues.

"We wanted to explore the College's role in facilitating new Fellows or geographically disparate Fellows to connect together. The concept of a community of practice, but more around a peer support process. It is about peers supporting each other in their day-to-day work."

In developing the Peer Support Program, the MWPWG spent much time articulating the specific needs to address the identified gap, ensuring the program has a very defined purpose and have set clear expectations for participants and facilitators.

The Peer Support Program comprises three, geographically linked, facilitated groups who will each meet for six sessions over six months. The groups, which have had their first meeting are:

- New South Wales and New Zealand - Dr Grant Rogers, Director Of Medical Services, Tweed Byron and Murwillumbah Hospitals at Northern NSW Local Health District
- Queensland and Northern Territory - facilitated by Professor Andrew Johnson, Medical Director Clinical Leadership and Collaboration Townsville Hospital and Health Service
- Victoria and Tasmania - facilitated by Dr Lee Hamley, Alfred Health Chief Medical Officer

To be a facilitator, more than five years' experience post Fellowship is preferred. Facilitators are expected to:

- monitor and reduce any potential conflicts of interest that may arise throughout the group
- coordinate any evaluation activity within the group as required.

Participants are be expected to participate in:

- problem solving and brain storming
- confidential and collegiate discussions
- peer support collaboration and consultation
- reflective practice – learning how to improve on their own practice.
- networking opportunities

"Actively engaged participants are critical to the effective functioning of the group," Adj. Clin. A/Prof. Dwyer said.

"This is new for us as Medical Administrators, and we are optimistic for the added value this will provide for our college members. We are also exploring the concept through a research framework with the aim to give back to the broader leadership literature on the role of peer support to reduce professional isolation.

"It is a very exciting step for the College. I can see us starting with something small which has the potential for a whole raft of programs and resources."

Who Medical Administrators are as a profession and the value of Medical Leaders has always been a passion for Adj. Clin. A/Prof. Dwyer's, ever since she undertook her first Master's research defining the roles, attributes and career paths of Medical Administrators.

"It's not just the tasks that you do, and what are the attributes that you bring to the role that make you a successful Medical Administrator," Adj. Clin. A/Prof. Dwyer said."It's then about understanding how we can actually support Medical Administrators professionally in their roles, particularly when it's really hard.

"What my research study of Directors of Medical Services showed is not only are there certain skills you need as a Medical Administrator, but there is a career path churn. In fact, the individuals usually stay in the roles three to five years, and then they burn out. So, having longevity in the career path is really hard."

It's no surprise then, Adj. Clin. A/Prof. Dwyer and the MWPWG are already thinking about the next step beyond the Peer Support Pilot Program. Dr Dwyer sees value in the College define the needs and gaps of the Medical Administration workforce across Australia and New Zealand and how they will be addressed.

"We are keen to explore the future workforce planning for our Medical Administration profession. We can see value in defining the principles around the health sector requirements for medical administrators, perhaps even the number of medical administrators required for our different health services, depending on the size of the health services, the complexity of the service and the number of Medical Administrators needed," she said.

"Its trying to understand the demand for Medical Administrators and what our current workforce looks like. At the moment, I am concerned we don't have enough Medical Administrators for the future, and we also have an aging workforce. So, my question is, what is the next workforce required for Medical Administration across Australia and New Zealand over the next 10 to 15 years?

"It's a really complex piece, and will probably take a good 12-month period to define the principles, comparing against our current state of our workforce, and then determine our gaps and next steps. Its conceptually very exciting for us as a profession."

The expressions of interest remain open to join the Pilot Peer Support Groups. For more information and to submit an EOI visit the RACMA website.

Adjunct Clinical Associate Professor Alison Dwyer

Medical Workforce Planning Working Group Members

Adj. Clin. A/Prof. Alison Dwyer (Chair)
Dr Tony Sara
Dr Campbell Miller
Dr Don Mackie
Dr Eugene Wong
A/Prof James Houston
Dr John Elcock
A/Prof Jon Hodge
Dr Peter Renshaw
Dr Peter Thomas
Dr Vicki Tse
Dr Andy Simpsom

COVID-19; Looking Forward - Ballarat Health Service

Toward the end of 2020, Dr Serin Cooper Maidlow, Registrar in Medical Leadership, Management and Administration at Ballarat Health Services, was tasked with developing a COVID-19 organisational recovery plan. Upon taking stock and thinking about the approach, Dr Cooper Maidlow and her colleague Sharon Sykes, Improvement and Innovation Advisor, began to see that amid the challenges and difficulties of dealing with the pandemic in Victoria, there were some great initiatives and collaborations shining through.

“We needed to hear how different areas of our organisation adjusted to healthcare provisions during Victoria’s second wave of COVID-19, and what people thought we could do better next time,” Dr Cooper Maidlow said.

“But we also wanted to know about great ideas and initiatives and start to harness the new developments and spirit of co-operation into our thinking, both about preparedness for future outbreaks, and our day-to-day work.”

The Method

More than 20 semi-structured group discussions were set up with more than 80 participants - including executive directors, clinical and operational directors; departmental leads and managers and key team members. A survey designed by the Royal Children’s Hospital was used to structure the sessions.

“These discussion sessions were just a real privilege to lead,” Dr Cooper Maidlow said.

“It was actually the first time many people involved had been asked what aspects of the health service’s acute pandemic response they, or staff in their teams, had found difficult or challenging. It was also the first time they had the opportunity to tell us what they thought our focus looking forward into the near future should be.

“We got a lot of very honest answers, and many groups used the session almost as a debrief. It was wonderful to hear about a whole range of innovations, ventures and projects happening all over the organisation.”

The Model

After these sessions, whiteboards were used to do thematic analysis, working towards building a ‘Looking Forward’ model.

It soon became apparent that a ‘road map’ with a single path to a new normal wouldn’t be adequate.

“What we ended up developing was more of a flexible model with three ‘modes’ designed to work in parallel with the Victorian Health Services Guidance and Response risk rating,” Dr Cooper Maidlow said.

- Response - focussing on urgent issues
- Readiness - focussing on evaluation and planning
- Recovered - which prioritised long term sustainability

"We wanted to reflect what we heard from people in our organisation about balancing the need to stand ready to respond to further COVID-19 outbreaks, with the desire to build on the innovation and capability that grew out of these necessary changes,” she said.

The Messages

"It was clear just how widespread the desire for an organisational leadership figurehead was, and how much people wanted visible leaders - which was often very difficult when people in these leadership positions had to be working from home,” Dr Cooper Maidlow said.

“Another related theme concerned information dissemination, and how we communicate across the organisation.

“COVID-19 has meant getting used to information and updates coming thick and fast, and people wanted communications to be transparent, timely and tailored to the staff group they were intended for.”

There was also a strong desire for the health service to issue organisation-wide guidance to offer some uniformity to managers on some topics nobody had had to navigate previously, such as working from home, the use of telehealth, and online meetings.

“Many felt interdepartmental working relationships, collegiality and a more co-operative organisational culture developed under the pressure of the second wave of COVID-19,” Dr Cooper Maidlow said.

Some improvements made based on this feedback were small changes which made a big difference, such as:

- opening COVID-19 meetings to a wider attendance
- facilitating more awareness around the important decisions taken at the COVID-19 planning meetings
- changing the day Staff Updates were published to avoid the last minute scenario on a Friday, which left managers fewer people to escalate to answer questions and queries over the weekend.

"Some improvements were more significant, such as CEO-hosted ‘All Staff Briefing’ webcasts, building back that visible leadership that was missed so much,” she said.

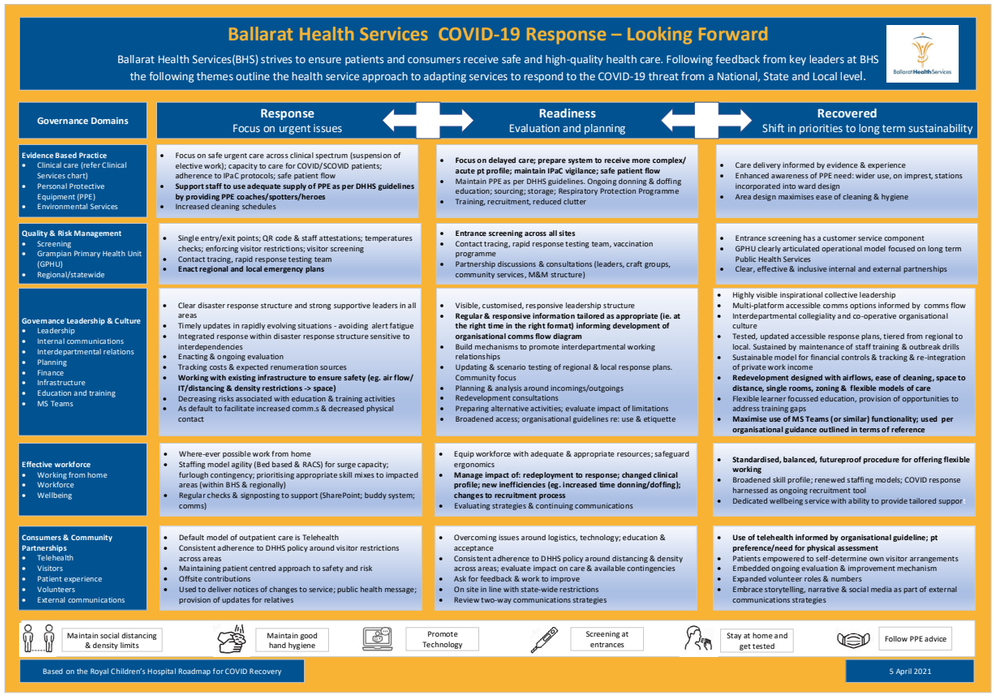
And More...

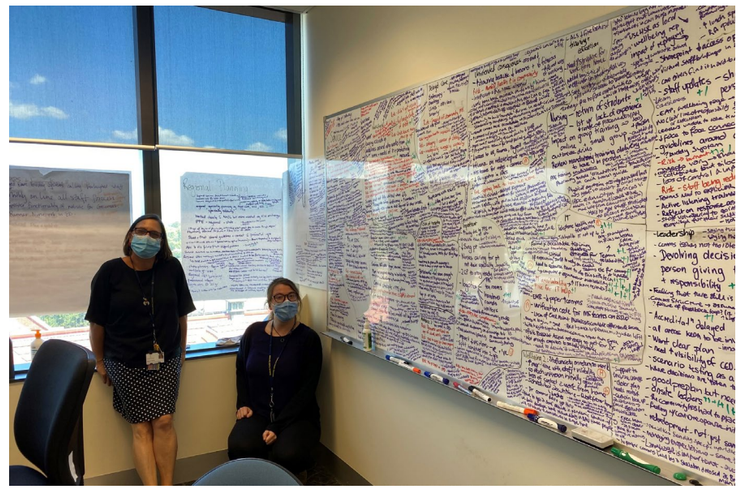
In the past three to four months, Ballarat Health joined the Victorian state wide streaming system, accepting transfers of COVID-19 positive patients from elsewhere as part of the state response to increasing cases of the Delta variant.

“We were asked, as the team behind the Looking Forward project, to lead the hospital’s COVID Taskforce,” Dr Cooper Maidlow said.

“We used our work on the ‘Response’ mode of the Looking Forward model as a springboard to assist a range of different areas of the health service with urgent planning and risk mitigation strategies to meet the challenges of Victoria’s third wave of COVID-19.”

Dr Cooper Maidlow is a second year Candidate in the Fellowship Training Program. If you have any questions regarding Looking Forward please email *scmaidlow@doctors.org.uk*





Dr Serin Cooper Maidlow and Sharon Sykes carrying out their thematic analysis of group discussion sessions to develop the Looking Forward model.

Through the eyes of a new Fellow

Bernard Nicholson Award winner, Dr Jeremy Wellwood reflects on his time as a Candidate and his approach to RACMA Oral Examinations

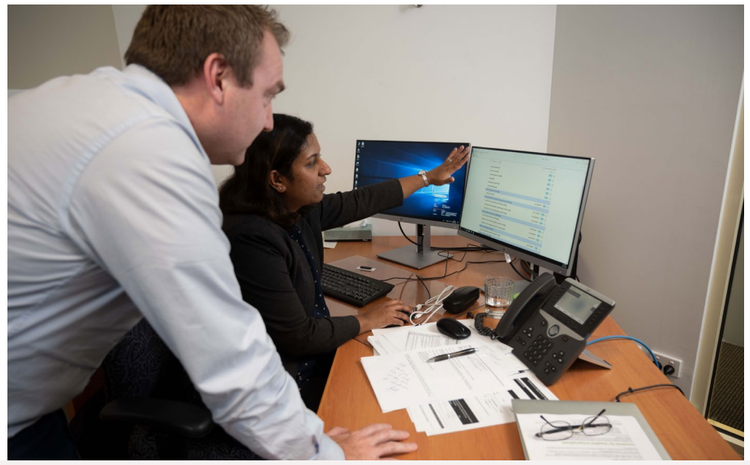
In August 2018, I found myself suddenly acting in a senior medical leadership position. As a Haematologist, I had spent many years as a busy Clinician and Pathologist finding myself more and more drawn into management and leadership opportunities. While I had always been a reasonably confident clinician and communicator, being thrust into a purely administrative role was a real learning curve for me. I decided that if I was actually going to take on this new career direction, I needed to commit to learning rather than just assuming I knew everything. So, I signed up to RACMA training which I commenced in February 2019.

Due to recognition of my prior learning, I spent the next 2 years undertaking the fellowship training program including the Research Training domain and starting my Master of Health Management in parallel. I will admit it was very hard to fit it all in with the challenge of a very busy full-time job (which is the equivalent of a Health Service Chief Medical Officer position). Initially I was terrified of doing the masters having not done an assignment since medical school- but after my teenage children showed me how to reference, I was cooking with gas. Being a University student again took a while to get used to.

It was hard to keep up with the weekly reading (a losing battle at times) and doing two subjects concurrently in retrospect was probably too much for me. Overall, I enjoyed the learning and found I was able to consolidate my knowledge and create structure around my thinking. The workshops (which I got through prior to lockdowns) were a great opportunity to gather information and meet new colleagues working in different roles and States.

I enjoyed forcing myself to read about ethics, law, and health economics. Call me weird, but I also enjoyed reading important State legislation which helped me greatly in my day-to-day work providing advice to others on issues such as Consent or HR etc. Overall, my training has taught me to listen twice when dealing with emergent issues rather than jumping to solution mode. Learning my limitations and when to ask for help was critical. Along the way I met many wonderful colleagues who were ever so willing to share experiences and potential solutions to challenges that crop up.

Winning the annual Bernard Nicholson award in 2020 was very unexpected but a great honour considering the company I was going through my training with. I can honestly say I was learning to improve my skills with the passing of an exam as a secondary thought. I figured that if I knew enough to get through my day then the exam should take care of itself. I recommend developing a group of peers to discuss cases with at an early stage. This is a crucial supplement to the more formal trial exam preparation that was very generously provided in my jurisdiction.



> “the structured approach to answering questions was a discipline I built into the way I tackled everyday challenges...

The oral exam preparation was a busy period but again, the structured approach to answering questions was a discipline I built into the way I tackled everyday challenges- whether they were HR, Patient safety, Legal or Disaster management. I suggest start using the oral exam response structure from the outset such that the exam is not just something you prepare for 6-12 months out but rather a useful way to address everyday challenges. Practicing exams is an important part of that process and I suggest that seeking out people who work in settings less familiar to you is particularly helpful. I knew I had gaps in my learning and so I sought out Fellows of the college that could give me a better understanding of issues relating to Rural and First Nations Health and Private Medical Administration. I was always impressed with how generous people were in giving of their time and wisdom. This same culture of seeking advice and support remains important to me now and can be a key to maintaining sanity when curly questions come your way (and they will!).

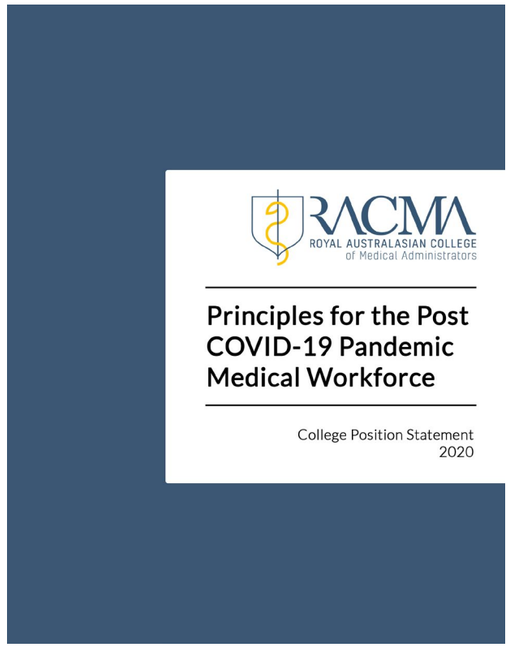
Having gained my fellowship this year (once the Masters was knocked over) I remain in my substantive role and am still the Jeremy I was at the start- but I feel a much better Leader and Administrator for the time I spent in RACMA training. I will admit I lost a fair amount of work life balance along the way – something that I am in process of resurrecting (along with my golf handicap). The Fellows of RACMA were very welcoming to me and even though I had only recently transitioned from my clinical background, I found that it was not hard to develop relationships and become accepted into the RACMA club locally.

One thing that is clear to me, particularly through the experiences of the COVID-19 Pandemic, excellence in Medical Leadership and Management is needed now more than ever.

My advice - don’t overthink things or feel you have to memorise things- just progressively use your learning to help you in the role you are in and remember that the ability to develop rich professional relationships and humbly learn from others is more important than any title or text book.

Dr Jeremy Wellwood MBBS, FRACMA, FRACP, FRCPA, MHLM

Executive Director, Medical Services, Clinical Governance and Research,
Gold Coast Health and Hospital Service



RACMA's post Pandemic medical Principles under the global leadership spotlight

For the first time RACMA hosted a panel session at the recent Leaders in Healthcare – the premier conference focused on supporting medical and healthcare leadership globally.

Produced by the Faculty of Medical Leadership and Management and BMJ, it is the only international conference of its size to connect junior, senior, and future leaders and managers from around the world - furthering their learning and discussing the current and future challenges and opportunities in healthcare leadership.

The RACMA session at the 2021 Leaders in Healthcare "The post Pandemic medical workforce - a new future? Lessons learnt from Australia and New Zealand", was based upon the College's Principles for the Post-COVID-19 Pandemic Medical Workforce document.

Facilitated by RACMA Chief Executive Melanie Saba, the panel included:

- Dr Helen Parsons CSC – RACMA President and District Director Medical Workforce at Nepean Blue Mountains LHD
- Professor Erwin Loh – RACMA Vice President and national Chief Medical Officer and Group General Manager Clinical Governance for St Vincent's Health Australia
- Professor Alan Sandford AM – RACMA Chair Finance and Audit Committee and Director of Medical Academic Development – Regional Medical Pathway, Central Queensland & Wide Bay Hospital and Health Services
- Dr Debbie Holdsworth – New Zealand Jurisdictional Committee Coordinator of Training and Executive Director Funding Auckland and Waitemata District Health Boards

Here are some of their insights and reflections on the lessons learnt through the COVID-19 Pandemic across their various roles and health services.

The impact of no doctors travelling to and from overseas destinations on the quality of our specialty training and the value placed on overseas experience going forward.

Dr Parsons: There are impacts for the individuals themselves in that if a specialist is looking for career advancement, going overseas to do research for a PHD and having a year-long fellowship in a prestigious organisation is highly regarded for career development. Missing different perspectives from overseas and bringing those different perspectives back into our health care systems will also have a negative impact.

Professor Loh: For certain skills you may have to go overseas because you don't have the expertise, volume or case mix locally. You may not see certain conditions in Australia that you may see in a third world country where you learn different skills. During this current pandemic, the concern is less about getting overseas experience and more about the limited experience people are getting internally due to lockdowns and restrictions to elective surgery.

Dr Holdsworth: COVID-19 has demonstrated that medical professionals form very strong networks through overseas experience and these relationships last throughout their career. We would see that this remains a very important aspect of training and the loss of the opportunity to practice overseas is likely to have a significant impact on our health system, especially at tertiary level in New Zealand.

Professor Sandford: For us as a College, compared to proceduralists with restrictions on surgery and significant disruption to the experiential learning of the trainees in those colleges, our fraternity has become very closely networked. The specialty of Medical Administration experienced quite significant learnings and growth as we were thrust into the forefront of the overall health sector.

Is there an emphasis we need to place on post pandemic workforce for First Nations people medicine/medical specialists?

Dr Parsons: Part of the answer to that is about us fostering health careers in all clinical and non-clinical professions in health in Indigenous communities. I don't necessarily have the answer how to do that, but I think we have to grow our own in our own local communities across all professions in health and grow them from high school with local programs.

Dr Holdsworth: Māori doctors are under-represented in the New Zealand medical workforce overall. There are positive developments at both undergraduate and graduate levels with the proportion of student and graduates now reflecting the population. Key success factors have been Māori leadership, mentorship, peer support, comprehensive support with study programs and the transitions between school, university and work. The number of Māori specialist trainees across colleges is however low. You have to start with strategic intent and we are beginning to see this. There also needs to be a focus on improving health equity and equipping doctors for cultural safety through their training, so they are examining their own biases and encouraging reflective practice. Training experiences can be influenced by supervisors and with small numbers, it is more than likely to be from a Pakehā western perspective and may not be helpful. Another significant issue is the concept of cultural loading. If you are one of a few Māori trainees, you can carry additional expectations to perform extra duties, often unpaid, such as providing a Māori view or acting as a Māori representation on various committees.

Innovations from COVID-19 we must maintain and develop for the future.

Dr Parsons: I think one of the big ones is care in the home/hospital in the home. I think we need to keep that in place particularly with chronic disease, which comes back to preventable hospital admissions. With the increased demand from an aging population, we cannot continue to meet the demand and the reality is the community want care in the home. I think we need to focus on telemedicine/telehealth aspects and monitoring in the home. The other area which is important to keep in place is access to the national My Health Record in the acute care and residential aged care sectors.

Professor Loh: Virtual care is the future of health. We need to move care beyond hospital walls because we can't keep building hospitals. Not only because we won't have enough hospital beds due to the aging population and rise of chronic disease, but also because it is not environmentally sustainable - physical hospitals are one of the biggest emitters of carbon. We need to be innovative about how we keep the elderly in the community and how we use technology to support them. The other thing we have found during the pandemic is the better coordination of care between the public and private system, and between primary care and hospitals. We have seen an improvement in the way the different health professions have cooperated to work together. I also think the data recording systems and analytics platforms we have developed during the pandemic have matured significantly. We have improved the way we use statistics and monitor our patients. The pandemic has accelerated new technologies, for example, around the MRNA platform that produced for the vaccine, which can be used for other diseases.

It is now 2040, we are now looking at COVID-39. You are commencing workforce planning for the expected effects coming into your healthcare systems and countries. What did you learn through COVID-19 and what will do differently to manage this?

Professor Loh: The first thing is don't panic. Take a deep breath. Trust in the science, the experts and the effectiveness of public health measures. Then ensure better coordination across jurisdictions, between federal and state, public and private. Be on the forefront of getting the right information out. Unfortunately, once misinformation takes hold it is hard to break that so we need to be better at combatting that.

Dr Holdsworth: It would be the 200th anniversary of our Treaty of Waitangi so I would expect we have made significant progress in terms of achieving equity for Māori, that our workforce represents our population, and we have vibrant Māori healthcare providers. I agree with a focus on better communication and would add the importance of staff wellbeing plans which are now in prominence – we have never thought about staff wellbeing the way we do now.

Dr Parsons: I would expect to have strong integrated care across all sectors in health already set up, to avoid wasting time.

Professor Sandford: I would hope we don't have a system that is wasteful. I hope we have redesigned a whole range of things, become more efficient, expanded scopes of practice, distributed the load as well as focusing on kindness and self-care because that's what we do - we are all about care.

Evaluation of a ward-based system of care in acute geriatric wards to improve doctors-in-training wellbeing and staff experience

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Abstract

Acute geriatric rotation is a busy term for doctors-in-training with workload and stress exacerbated by increasing numbers of complex geriatric admissions. Traditional care in this setting utilises a team-based system, where medical teams care for patients across the geriatric wards; this may contribute to the workload and stress experienced by staff. In the current pilot study, we evaluated the impact of a ward-based system care model, whereby medical teams are assigned to specific geriatric wards, on doctors-in-training' wellbeing and staff experience. A ward-based system was conducted from June to October 2020. Doctors-in-training completed an online survey to rate their experience during the ward-based system. Geriatricians and ward staff were similarly asked to compare ward- and team-based systems. Total overtime claimed by doctors-in-training during this period and the year 2019 was also collected. Nineteen of twenty-five (76.0%) doctors-in-training, 8/12 geriatricians (66.7%), and 22/65 (33.8%) ward staff responded. Eleven (57.9%) doctors-in-training felt the workload was excessive and patients' care was compromised, secondary to the excessive workload. Twelve (63.2%) experienced a high level of stress. Nevertheless, the vast majority (89.5%, n=17) of doctors-in-training agreed that the ward-based system provided adequate supervision and a positive working experience. Most geriatricians (82.5%, n=7) and ward staff (77.3%, n=17) agreed the ward-based system improved communications and inter-professional relationships between staff. Differences in doctors-in-training overtime between care models was not significant (p-value>0.05). These preliminary results suggest a ward-based system could improve doctors-in-training' well-being and staff's experience through improved communication and a supportive environment conducive to positive interprofessional relationships.

Introduction

The Agency of Clinical Innovation recommends that an acute geriatric unit is staffed by a multidisciplinary team (MDT) composed of medical teams and allied health teams (social workers, physiotherapists, occupational therapists, speech pathologists, dieticians, pharmacists, and nursing staff).[1] The MDT provides optimal care to the elderly through comprehensive geriatric assessment (CGA). Performing CGA during hospital admission leads to more patients remaining in their own home in the next 3 to 12 months.[2] Conducting CGA is important and requires effective multidisciplinary meetings.[3] In Australia, multidisciplinary team care is standard in most in-patient acute geriatric services.[4] Nevertheless, there are few studies looking at health care service provision in acute geriatric units in Australia.

Nepean Hospital is part of the Nepean Blue Mountains Local Health District (NBMLHD). It is a tertiary teaching hospital with 520 beds. Acute Geriatric Medicine has 54 beds in two acute geriatric wards. By 2036, the projection for the aging population in the district is 134% growth.[5] Thus, geriatric medicine and geriatric care is a priority for the NBMLHD. The acute geriatric service at Nepean Hospital has always practiced a team-based model of care. This service includes an Aged Care Rapid Assessment Unit (ACRAU team) based in the Emergency Department (ED) and three medical teams who look after patients in two wards. Each medical team has three geriatricians, an Advanced Trainee (AT) or a basic physician trainee (BPT) and two junior medical officers (JMOs). The number of patients varies between each team depending on the number of patients admitted during the on-call day. The medical teams attend MDT meetings on both wards.

With an ageing population, hospital admissions increase and patients' acuities and complexities are higher. These changes result in a significant increase in workload across the sector contributing to higher stress levels amongst health care workers. In this study, we focus on the experience and wellbeing of doctors-in-training.

A survey conducted by the Australia Medical Association revealed 54% of doctors-in-training reported excessive workload and 70% of them experienced high levels of stress at work.[6] On average, doctors-in-training in Australia work 50.1 hours a week.[7] Increased workload and long working hours are some of the key psychological stressors among doctors-in-training.[8,9] Based on the 2018 NSW Health Survey, only 32% of JMOs agreed that Nepean Hospital monitored workload and managed workload surges effectively.[10] Feedback from JMOs indicated factors that contributed to the increased workload and stress in the team-based system included (i) 'safari ward rounds', whereby the medical teams moved across the wards to conduct their ward round and; (ii) attending MDT meetings on different wards. Hence, we piloted a change of the system of care from a team-based system to a ward-based system. In the ward-based system, medical teams managed patients in the appointed geriatric ward. We anticipated that a ward-based system would minimize the movements of medical staff between wards and the number of MDT meetings. The primary objective of this study was thus to describe the impact of a ward-based system on doctors-in-training' wellbeing and staff experience using a survey method.

Metrhods

Description of Ward-Based System

The ward-based system was piloted from June 2020 to October 2020 in both acute geriatric wards. Patients were managed by the medical teams that are based in the appointed geriatric ward. Each ward had two registrars and three JMOs. The doctors-in-training were allocated to bed numbers. The medical teams only participated in MDT on the ward they were based on. The role of the ACRAU team based in ED, system and frequency of the MDT meetings, educational meetings, consultant ward round and supervision, frequency of after-hour shifts, and other aspects of patient management remained unchanged.

Survey of Doctors-in-training wellbeing and staff experiences during implementation of the ward-based system

An online survey of doctors-in-training, geriatricians, and ward staff was conducted from June 2020 to October 2020 when the ward-based system was implemented. All participants were contacted via email and provided a link to respond to the survey through Survey Monkey. The participants were allowed to provide additional comments on the survey. Participation was voluntary and anonymous.

All 25 doctors-in-training including registrars, residents, and interns who were on Acute Geriatric term during this period were asked to complete a survey which consists of 10 questions (Supplementary Table 1) during the last week of their Geriatric term. They were asked to rate their opinion of the ward-based system using a 5-point Likert scale. The survey assessed five domains related to wellbeing including workload, level of stress, supervision, overtime, and experience during the Geriatric term. The survey was developed based on previous studies focusing on doctors' wellbeing.[6,10]

All 12 geriatricians and 65 ward staff including nursing staff and allied health staff were also invited to complete the survey (Supplementary Table 2 and 3) before the ward-based system ended. These staff were asked to compare the ward-based and team-based systems on a 5-point Likert scale in the domains of patient care, communications, and supervision for doctors-in-training.

Ethical approval for this study was obtained from the NBMLHD Human Research Ethics Committee (Approval reference number: 2020/ETH02278).

Impact of the ward-based system on Doctors-in-training overtime

As a secondary objective of this study, the overtime claimed by doctors-in-training from June 2019 to October 2019 (team-based) and June 2020 to October 2020 (ward-based) was examined following its provision from the JMO office.

Data Analysis

Descriptive statistics were calculated for the survey results on doctors-in-training' wellbeing and staff experience when the ward-based system was conducted. The difference in overtime rates between the team and ward care types was assessed using independent samples Mann-Whitney U test.

Results

Doctors-in-training experience during ward-based system implementation

Nineteen of twenty-five (76%) doctors-in-training completed the survey. Results are summarised in Figure 1A-C. Eleven (57.8%) doctors-in-training felt the workload was excessive and patients' care was compromised secondary to the excessive workload. Twelve (63.2%) experienced high levels of stress at work. Thirteen (68.4%) doctors-in-training worked overtime to finish their work. Despite the busy clinical workload, seventeen (89.5%) doctors-in-training agreed that they had a positive experience and adequate supervision on the ward. Thirteen (81.3%) doctors-in-training agreed that they had efficient communication with the other staff. Fifteen (78.9%) doctors-in-training were able to attend teaching sessions. Fourteen (73.7%) doctors-in-training had time for self-education while 15 (93.8%) were able to attend ward case conferences. There was no additional comment provided by the participants.

Experience of geriatricians and ward staff during ward-based system implementation

The results of the surveys completed by geriatricians are presented in Figure 2. Eight of the 12 (66.7%) geriatricians completed the survey. Four (50%) geriatricians perceived that the ward-based system provided better patient care in comparison to the team-based system. Seven (87.5%) geriatricians agreed that the ward-based system improved communication among the staff. All geriatricians reported that the ward-based system improved doctors-in-training' workload and time management. Only one (12.5%) geriatrician reported that the ward-based system impaired the supervision of BPTs and the relationship between consultants and trainees. There was no additional comment provided by the participants.

Twenty-two out of 65 (33.8%) ward staff completed the survey with the results presented in Figure 3. Seventeen (77.3%) staff agreed that the ward-based system improved communication between the staff and medical teams, and they spent less time paging the medical teams. Sixteen (72.7%) staff perceived that patient care was delivered more efficiently. Eighteen (81.9%) staff agreed that medical teams were present at the MDT meetings, however, only 12 (54.6%) staff agreed that medical teams were on time for the meetings. No additional comments were provided by the participants.

Figure 1. Doctors-in-training responses to questions regarding workload and stress levels (A), overtime, supervision and experience on the wards (B), and communication with staff and learning opportunities (C).

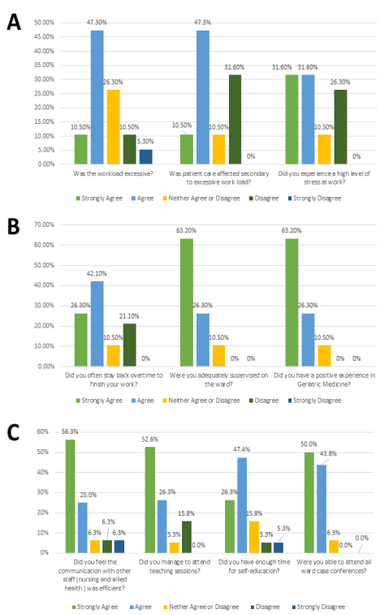


Figure 2. Geriatricians' responses to questions comparing the ward-based and team-based systems.

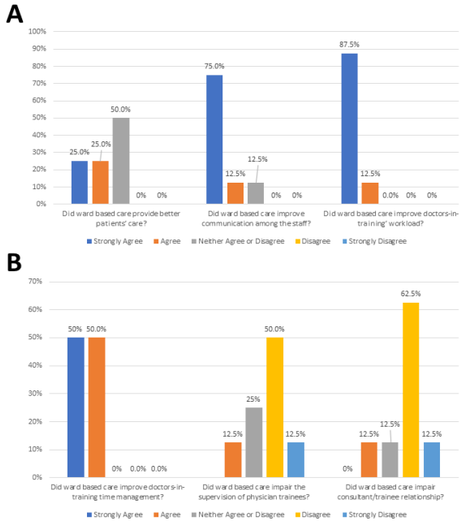
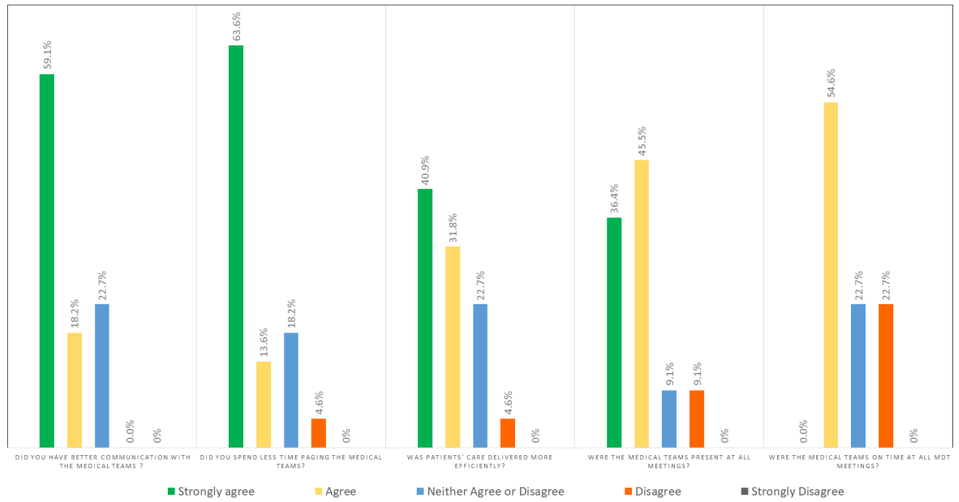


Figure 3. Response from the ward staff when asked to compare ward-based system and team-based system.



Overtime claimed by Doctors-in-training

The total overtime claimed by doctors-in-training when the ward-based system was used was 17.1 hours less in comparison to when the team-based system was employed (273.5 hours versus 256.4 hours). This difference was not statistically significant (p-value>0.05).

Discussion

To our knowledge, this is the first study to explore the experience of staff on a new ward-based structure of care in the geriatric wards. The primary focus of our study was the wellbeing of the doctors-in-training and their experience during an acute geriatric rotation.

Our study showed that more than half of the doctors-in-training reported excessive workload and high levels of stress with some doctors-in-training perceiving that this compromised patient care. Despite the unfavourable reports on workload and stress level, the overwhelming response from the doctors-in-training of their experience during the term was positive. This could be due to adequate supervision, good inter-professional relationships with staff, and learning opportunities.[3,11,12] Indeed, studies have shown positive work relationships and adequate support from senior colleagues improve doctors-in-training' satisfaction,[13] and reduce risks of burnout.[14] The geriatricians who have been present through the change of model of care believed that there was an improvement in doctors-in-training' workload and time management. This is consistent with the result of a similar study conducted overseas.[15] Although the ward-based system did not result in a significant reduction in total overtime claimed by the doctors-in-training, it suggests a possible strategy to support the wellbeing of doctors-in-training through better supervision and potential mentoring program within the department.[16] Staff experiences were overwhelmingly positive in all categories. Perceived communication among all staff was more efficient in the presence of a ward-based team, leading to a reduction in the number of pages the medical teams received which can disrupt patient care and increase physician fatigue.[17] Effective communication not only lays the foundation to building team collaboration but improves patient outcomes.[18]

It should be noted that the introduction of the ward-based system occurred during the ongoing COVID-19 pandemic and the necessary protocols for infective precautions could have affected the delivery of care to patients and contributed to the above results amongst doctors-in-training. Patients with suspected COVID-19 were transferred to non-geriatric wards initially, adding time to ward rounds secondary to movement to multiple wards and the requirement of personal protective equipment. JMOs also had more workload as they were required to perform venepunctures for patients with suspected COVID-19 instead of a phlebotomist. The ongoing COVID-19 pandemic is also thus likely to impact on un-rostered overtime. Sixty percent of the JMOs at our centre worked more than 6 hours of overtime fortnightly and were concerned about clinical errors and safety due to fatigue.[19] This finding indicates that organisational interventions are required to address systemic rostering and workforce issues that are not just confined to the departmental level. We acknowledged that the impact of the COVID-19 pandemic on psychological stress and training[20,21] could be significant confounders in our study that were not measured. Hence, further studies are needed to further evaluate doctors-in-training' wellbeing on the acute geriatric term. It is also worth noting, however, that the implementation of the ward-based system during the COVID-19 pandemic also improved team collaboration, supervision, and patient safety.[22] This model of care could potentially be conducted in the acute hospital in the era of COVID-19 as it reduces staff movement.

In terms of patients themselves, Reeves et al demonstrated that patients had high satisfaction with a ward-based system but the lack of continuity of care was identified as an issue due to bed moves.[23] Intra-hospital transfers increased risks of delirium[24], falls[25] and hospital-acquired infections[26] which can prolong hospital admission. To ensure continuity of care of patients, we minimised bed moves except for patients who required single rooms for end-of-life pathway or infection control.

There are several limitations to this preliminary study. Firstly, we only had a small pool of participants that were available for the survey. Only nineteen out of 25 (76%) doctors-in-training, eight out of 12 geriatricians (66.7%), and 22/65 (33.8%) ward staff responded to the survey. In addition, none of the participants provided additional comments on the survey. These extra comments may have helped to explore the responses in greater depth. Furthermore, as the survey questions were not validated, the quality of the survey may be affected. Hence, the survey result could not be extrapolated to all staff. The experience of doctors-in-training was descriptive in nature and no comparison to the team-based group was available, as the doctors had rotated to another network. Hence, we were unable to perform any qualitative analysis on their experience during geriatric term. Further qualitative studies could be conducted to compare the experience of doctors-in-training in a different model of care in the geriatric unit.

Bias is another major limitation. Response bias occurred as most of the doctors-in-training worked with the principal investigator. There is also recollection bias as some of the doctors-in-training responded to the survey after they started a new rotation. In addition, when the geriatricians and ward staff responded to the survey, a period of 19 weeks had passed since the model of care had changed from team-based to ward-based system.

This study nevertheless provided an insight into doctors-in-training' wellbeing when they were completing geriatric term. The adoption of a ward-based system could improve doctors-in-training' well-being and staff's experience through improved communication and a supportive environment that is conducive to positive interprofessional relationships. The ward-based model achieved this outcome despite no change in workload, perceived stress level and un-rostered overtime worked. The study highlights the need for future qualitative studies to evaluate the benefits of the model of care on wellbeing and career satisfaction of doctors-in-training during acute geriatric term.

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Competing Interests

The authors declare no conflicts of interest.

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