RACMA
2013 Annual Scientific Meeting
Featured Articles from 2013 Issues
Annual Reports
**The Quarterly Continual Publication Schedule**

The Editorial, Presidents Report, and CEO Matters will be published quarterly. Other articles will be on a continual publication schedule. All articles submitted by the end of each month will be published online during the following month if accepted. In December there will be a hard copy edition, containing feature articles that must be submitted by Friday the 14th of November, 2014.

“Medical Administration is administration or management utilising the medical and clinical knowledge, skill, and judgement of a registered medical practitioner, and capable of affecting the health and safety of the public or any person. This may include administering or managing a hospital or other health service, or developing health operational policy, or planning or purchasing health services.”
Contents

4 Editorial Dr Andy Robertson
5 From the President Dr Lee Gruner
8 College Matters Dr Karen Owen
9 Why Doctors Move From Clinical Roles Into Health Management A/Prof Erwin Loh
14 The Dying Art of Critical Thinking Dr Lee Gruner
17 The Impact of Bullying in Health Care Mr Kamal Farouque & Mr Enrico Burgio
21 Developing Medical Leaders: Training in Administrative Medicine: Hong Kong Perspective Dr Hong Fung
23 Reflections on the Accelerated Pathway Dr CT Hung
26 RACMA Annual Conference 2013 High Performance in Austere Times
30 Finance and Audit Committee Annual Report Dr Draginja Kasap
33 Education and Training Committee Annual Report Prof Gavin Frost
34 Continuing Education Program Committee Annual Report Dr Bernard Street
36 Candidate Advisory Committee Report Dr Leah Barrett-Beck
37 List of RACMA members
43 Thank You
Editorial: Interesting Times and the 2014 Forecast

As we approach the festive system, it is time to reflect on the year and to look forward to 2014. Unfortunately, as I write, we are all just realising the full impact of Typhoon Haiyan on the Philippines, with major loss of life and injuries in Tacloban City and surrounding areas. Australia has deployed an Australian Medical Assistance Team, complete with 50 bed hospital, into the area, which will assist greatly, but the impacts of this tragedy will be unfortunately felt in the area for years to come. I often reflect how we, in Australia, would cope with such a disaster. The early fires in NSW and the upcoming fire and cyclone season behoves us to ensure our disaster planning and preparations are robust and in place.

For myself, I have decided that I am not overly fond of years with the number 13 in them, but am pretty sure that I am unlikely to see 2113. The year has seen the change of the Commonwealth Government, the ramifications of which will not be fully felt until 2014. Certainly, the paring down of the Commonwealth Department of Health and the review of the PCEHR highlights a significant change of direction. Fiscal tightening in Health Departments continued to be a feature in 2013, with tough health budgets in many jurisdictions. This has been offset by significant investment in Health infrastructure, with the opening of the Gold Coast University Hospital and other hospitals, like Fiona Stanley Hospital in WA, due to open in 2014. 2014 is looking to be a different year. Although health reform and further fiscal belt-tightening will remain key features, the priorities of the new Commonwealth and the various State governments will impact significantly and potentially bring a few surprises.

Moving to The Quarterly journal, we have now completed our third year of the revised format with a mix of online issues and an annual print version of the key articles. From our surveys, this continues to be well-received and we will continue with this format, although we are keen to broaden it out to address the needs of our readers. Some of the themes this year, which have been addressed in a series of excellent and diverse papers, have included health management (Austin T. Managing Upwards; Brand I. Be a Better Manager; Loh E. Why Doctors Move From Clinical Roles Into Health Management), leadership (Gardiner B, Walker R. Leadership in Practice: Career Case Studies; Dickson G. Assessing Leadership Capability; Fung H. Developing Medical Leaders: Training in Administrative Medicine - Hong Kong Perspective), capital planning and funding (Kilpatrick C. Capital Planning and Funding: The Royal Children's Hospital Melbourne), social issues (Farouque K, Burgio E. The Impact of Bullying in Health Care; Farouque K, Burgio E. Social Media At Work - What Does It Mean For You?) and health policy (Baggoley C, Monaghan M. Translation of Policy into Practice), all of which have been key issues over the last 12 months. There have also been some great book reviews and a thoughtful article on critical thinking (Gruner L. The Dying Art of Critical Thinking). In 2014, can I encourage all Fellows, Members and Candidates to consider writing and submitting a paper on those issues that are challenging, bemusing or simply frustrating them. Are you seeing the benefits of enhanced Information and Communication Technology in the clinical setting? How are the health capital projects progressing and are their key lessons to learn? How do you make savings in a time of fiscal restraint? These are just some of the questions that may provide some food for thought and some stimulating articles.

Finally, is there anything further that Fellows, Associate Fellows, Affiliates and our Candidates want from The Quarterly? Should we be providing more on-line training? Should we be moving to shorter articles? We would be very keen to have your feedback on how we need to continue to develop The Quarterly over the coming years.

Dr Andy Robertson
Editor
From the President

Dr Lee Gruner

Over the past year the college has continued to build on our previous successes and I am delighted to share the important successes with the membership. The key areas to include are:

- Growth in membership numbers
- Training programs: both registrar and AFRACMA
- E-learning initiatives
- Input of College faculty
- Input of College staff
- AMC progress report
- World Federation of Medical Managers
- Building relationships
- Policy and Advocacy matters
- Strategic Planning

Growth in membership:
As of the end of June, we have 485 Fellows, 228 AFRACMA, 13 Affiliates, 116 Candidates and Trainees. Total membership is up 7% on this time last year and 13.5% on the same time in 2010 when we undertook our initial forecasts. This is a remarkable turnaround from some years ago and we see this continuing into the foreseeable future.

Training matters:
Growth in the training program continues with increased numbers in NSW, Northern Territory, Western Australia and Tasmania. Three new posts will be funded in Tasmania from 2014 with DoHA funds allocated to the College under the Tasmanian Rescue Package. As a result of the NSW Committee negotiations, HETI support appears more than likely for medical administration training in NSW and this combined with STP funding in NSW, will enable growth of the registrar training program.

Most significant is the very strong likelihood that up to 10 posts will be funded in NZ under the HWNZ model of contributing funds to DHBs. This will be the first time training in medical management will have been funded in NZ. This is a credit to the hard work and persistence of David Rankin, David Sage and Kevin Morris and is a very exciting development.

There has been an overwhelming response to AFRACMA training with almost 60 people enrolling in 2013. In addition the national Management for Clinician courses continue to gain numbers.

E-learning Initiatives
Over the past 12 months the College has continued its move into more “e” type activity. Webinars, e-learning sets, e-modules in indigenous health are taking the College into a new mode of training delivery. There is much further to go and we are becoming aware of the different skill sets required to deliver training in the on-line environment. New STP project monies in 2104 and 2015 will see more progress in this direction.

College Faculty
Our college faculty continues to grow and there has been training in some areas for faculty. We appreciate and commend the time and effort these Fellows continue to put into all of our educational programs, face to face, webinars and learning sets. The webinars and the learning sets as newer initiatives have been highly successful and commended by all parts of the Membership. On behalf of the Board, a heartfelt thanks to all of you who are involved. We could not run our successful programs without your commitment.

Staffing at the College
We have an enthusiastic and highly competent staff of 13 people. These staff are employed in both continuing and contract positions to reflect our project funding. To accommodate this growth the Board agreed to rent additional space which became available in the Milton Road office block. I would personally like to thank all of our staff. They do a sterling job in all areas of college activities.

AMC progress
Following the last years accreditation success, the Board received a very positive report and has just been advised that 50% of the recommendations have been closed out based on evidence supplied in our 2013 Annual Progress report. The next AMC Annual Report will be in March 2014. Key areas where the College continues to focus are: our engagement with external professionals and consumers to evaluate the training programs, developing the rigour, reliability and validity of our assessment processes.
The Education and Training Committee has recently developed its 3 year Action Plan and will pick up on these themes.

There is no doubt the indications are there that colleges are being required to show evidence of compliance to AMC standards. The balance between continuous improvement and compliance must be strenuously defended by colleges. Some colleges, including our CEO (Chair of College CEOS) are making this point to AMC. Despite this the AMC accreditation process continues to stimulate significant professionalising of the RACMA Fellowship training program. A review of the AMC medical colleges’ accreditation standard is planned in the next 12 months and the ETC will be invited to contribute to this review.

World Federation of Medical Managers

On the international level, the WFMM held a stimulating one day conference, with the support of CSPE in Vancouver this year. A number of our Fellows attended. Dr Roger Boyd was re-elected Chair of the WFMM Steering Committee for a further 12 months. The Board earlier this year discussed its continuing support of this initiative for the remainder of the 5 year term of the MOU. After this there will be a review and the Board has requested the Steering Committee to develop plans for sustainability.

Strategic Planning

The Board held a strategic planning session in July and the aim is to increase our PACE. This acronym refers to:

- P Presence
- A Advocacy
- C Courses
- E Expansion

A draft plan has been prepared and over the next few months we intend to consult widely with our membership, to finalise the plan in time for 2014. We hope many of you will be involved in this.

Policy and Advocacy

A policy and advocacy committee was set up earlier this year with a group of interested Fellows and chaired by Vice President Michael Walsh. We see this committee having a large role to play in developing topics in the areas of expertise of our membership and with a resource employed to assist in this process. One of the discussions we need to become involved in relates to medical revalidation.

There was an excellent response rate to the recent survey on what we need to consider in these endeavours. A number of topics were developed from the survey, with a particular focus on the top nominated topics allied with the ability to provide expertise in specific areas. The three areas to be concentrated on are:

- Workforce planning
- KPIs Outcomes and Success Management
- Hospital management and infrastructure

We intend to have a lunch time meeting at the conference to further flesh out these topics and invite interested Members to attend.

Relationships

As a consequence of our PICS contract and the bedding down of our accreditation of training posts program, the College is building new and stronger relationships with specialist training sites around Australia. There are continuing opportunities to build on these relationships. The importance of relationships is also reflected in our strategic plan and our advocacy strategy and these will be a focus over the next 2 years.
Research

The Board has discussed at length how it might sponsor College members and others to engage in research to support our specialty. It is becoming increasingly important to our future that we build our evidence base. Seeing how some of our newest Candidates are engaging in the College’s training program about research highlights to me the significant issues medical administrators grapple with on a daily basis. Having these contributions rigorously explored and published will make a significant contribution to our specialty. This again will require resources. But we believe that this will be money well spent and will also provide extended ways to promote the college and its membership.

“Having these contributions rigorously explored and published will make a significant contribution to our specialty.”

Our 2013 conference begins with two master classes to be delivered by Professor Chris Ham, CEO of the Kings Fund in UK, and Professor Graham Dickson from Royal Rhodes University in Canada. We are fortunate to have such expertise come to our conference and I am aware these master classes have been oversubscribed!

I would like to thank my fellow board members for their intelligent and valued input during the past year and of course our CE Karen for too many things to mention but overall continuing to lead and steer the college in the right direction. In addition, all committee chairs need also to be thanked for their ongoing hard work.

Dr Kasap, Professor Frost and Dr Street will report to you on our successful year from financial, training and CPD perspectives. I thank you all for your continuing contributions to RACMA and I wish you an enjoyable conference.

Dr Lee Gruner
RACMA President

The Future of Health Services – Your View

The 2013 RACMA Workforce Census asked respondents to identify one word (from a list of 47 words) to describe the future of health services in their organisation. 251 people responded.

---

The 2013 RACMA Workforce Census asked respondents to identify one word (from a list of 47 words) to describe the future of health services in their organisation. 251 people responded.
College Matters

A growing number of College members are engaged in supporting College activities while regular feedback from Fellows, Associate Fellows and Candidates continues to help us grow and improve our training programs.

The new Candidate e-learning sets and webinars still attract large numbers to listen to and discuss a range of great topics with excellent presenters.

There is continuing demand for RACMA training with more young doctors applying to enter limited funded training posts at registrar level. It is a sign of more good things to come with new trainees and candidates entering the College in 2014 and new funding to support training initiatives in New Zealand and Tasmania.

The College is progressively developing its partnerships with universities as several long standing masters programs are reviewed taking into account the College’s interest in developing research training as part of the masters studies thus ensuring excellent supervision e.g. UNSW, James Cook, Monash, QUT.

Invitations to the College for FRACMA representative on course advisory committees has been noticeable this year.

Across the jurisdictions members will see new co-ordination of medical; administration training with HETI in NSW and involvement of New Zealand District Health Boards as Health Workforce New Zealand funding becomes available for 5 EFT of training in medical administration. The HKCCM continues to be an excellent and valuable RACMA partner and in 2013 celebrates with the Academy of Medicine its twentieth anniversary. The WFMM keeps RACMA in touch with medical administration specialists and training activities at the global front.

The College is progressively developing its partnerships with universities as several long standing masters programs are reviewed taking into account the College’s interest in developing research training as part of the masters studies thus ensuring excellent supervision e.g. UNSW, James Cook, Monash, QUT.

Assessment Centre in Victoria for College exams. These are state of the art facilities especially designed for examinations and offer the additional services of video for training and evaluation activities.

We thank the following jurisdictions and their members who supported National College activities throughout 2013:

Queensland
September
Annual Scientific Meeting

NSW
March
National Examinations
October
Junior – Doctors Meeting
National Pre Fellowship Workshop

Victoria
February
Medical Leaders Workshop
AFRACMA Leadership Workshop
April
Communications Workshop
November
Management for Clinicians

New Zealand
March 2014
Management for Clinicians

South Australia
Junior Doctors Meeting

Northern Territory
November meeting with the President and CEO

Across the jurisdictions members continue to build the College. We thank you for your support in 2014 and beyond.

Karen Owen
Chief Executive
Clinicians like doctors are useful in management roles because of their credibility and knowledge of healthcare. Only a minority of doctors decide to move into a management career. There are intrinsic and extrinsic decision-making factors. Intrinsic factors are factors that are specific to each individual. Extrinsic factors are factors that are imposed upon and experienced by the individual. Abstract factors also exist expressed as specific career drivers. Doctors have more disincentives to move from clinical practice into management. There are also specific factors for doctors. Medical students who belong to the biosocial group are more likely to move into a management career in the future. Workplace engagement and the presence of role models and mentors have also been found to be important factors. Four major factors are described: personal career drivers, individual interest, presence of role models and mentors, and workplace engagement. A better understanding of such factors will assist employers in the recruitment of doctors into management positions.

**Introduction**

Hospitals in the past have been ‘professional bureaucracies’ [1] when clinicians moved into management positions and retained direct and indirect power and influence [2]. Doctors, as a major professional group, contributed to a hospital’s professional bureaucracy culture [3, 4]. More recently, there has been a move to have non-clinicians in hospital management under a managed professional business model [5], with a move away from clinicians in management, but elements of a professional bureaucracy remained [6, 7]. Despite this move to non-clinician managers, clinicians like doctors are useful in management roles because of their credibility and knowledge of healthcare [8]. Thus, some doctors have remained or moved into middle management of hospitals as clinical directors, forming clinical directorates with nurse directors and business managers [9]. More recently, doctors have also moved back again into senior management roles in hospitals as chief medical or executive officers [10-12].

Why do doctors choose careers in health management? Doctors spend most of their lives in clinical work and occasionally dabble in management, but only a minority decide to move into a management career. [13, 14] Understanding the motivations of doctors who decide to take up the challenge of health management will assist health services in the recruitment, training and retention of such doctors.

**Generic decision-making factors**

There is a need to identify factors that are involved in pushing or pulling doctors into management roles. Doctors’ decision making process in relation to medical career choice is influenced by variables that can be divided into two separate categories: intrinsic and extrinsic [15]. Intrinsic factors are the factors that are specific to each individual such as the person’s age, gender, personality, ethnicity and intellect; there are other intrinsic factors relating to a need for autonomy, mastery and purpose that go beyond the traditional concepts of reward and punishment [16]. In turn, extrinsic factors are the external factors that are imposed upon and experienced by the individual, such as social or family commitments. Besides these intrinsic and extrinsic factors, several sets of more complex constructs exist to explain the decision-making process in career choice. These abstract factors, such as self-perception, self-efficacy and motivation, are expressed as specific career drivers [17]. These career drivers are material rewards (seeking wealth and a high standard of living), power and influence (seeking to be in control of people), search for meaning (seeking to do things which are believed to be valuable for their own sake), expertise (seeking a high level of accomplishment in a specialised field), creativity (seeking to innovate and be identified with original output), affiliation (seeking nourishing relationships with others at work), autonomy (seeking to be independent and able to make key decisions for oneself), security (seeking a solid predictable future) and status (seeking to be recognised, admired and respected by the community at large). Thus, there is no one factor or driver that can predict or determine a person’s ultimate career choice [17], but an interplay between different intrinsic and extrinsic factors forming...
career drivers that guide decision-making. Moreover, despite career choice being an important part of a person’s life, decision-making in this area by most people tends to be opportunistic and haphazard, rather than deliberate and strategic [17]. Table 1 shows how these career drivers relate to a doctor moving from clinical practice into management.

There appear to be more disincentives for doctors to move from clinical practice into management than there are incentives, as the positives and negatives in the last column of Table 1 shows. One major disincentive is the salary differences between senior hospital managers (including chief executive positions) and senior doctors [12]. Doctors also feel that they lack management expertise [18], and there is a strong wish to retain the flexibility of clinical practice [12]. In addition, doctors appear to fear the loss of professional autonomy [19]. Doctors also express concerns about the lack of job security compared with clinical practice, and the high turnover of chief executives and other senior managers in hospitals [12].

On the other hand, the incentives are the opportunities for doctors to make a bigger difference than is possible in clinical work – this difference comes from increased decision-making ability and higher status [12]. Doctors also move into management with the belief that they are able to do a better job than their predecessors in the role. Some were also frustrated having to be second-in-charge. An understanding of career drivers for doctors moving into health management may allow health services to undertake career planning for their own employee clinicians. Appropriate career opportunities could also be crafted, and proper training and personal development offered.

### Specific medical factors

Besides the generic factors above that influence career choice for doctors, specific factors also exist. For example, medical students can be divided into two categories that predict the type of medical subspecialty they end up in [15]. There is a group of medical students who are more interested in the scientific aspects of

### Table 1 Significance of career drivers for doctors moving from clinical role to management

<table>
<thead>
<tr>
<th>Career drivers</th>
<th>Move from clinical role to management</th>
<th>Impact on doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Material rewards</td>
<td>The doctor in most cases gets a salary reduction moving from clinical practice into management.</td>
<td>Negative</td>
</tr>
<tr>
<td>2. Power and influence</td>
<td>There is a perception of increased power and influence in senior management.</td>
<td>Positive</td>
</tr>
<tr>
<td>3. Search for meaning</td>
<td>There is a perception that more can be done for public health in senior management.</td>
<td>Positive</td>
</tr>
<tr>
<td>4. Expertise</td>
<td>Most doctors feel they have a lack of expertise in management.</td>
<td>Negative</td>
</tr>
<tr>
<td>5. Creativity</td>
<td>There is a perception that there is less creativity involved in management and more flexibility with clinical practice.</td>
<td>Negative</td>
</tr>
<tr>
<td>6. Affiliation</td>
<td>There is a perception that there is an increased ability to network with decision makers in senior management.</td>
<td>Positive</td>
</tr>
<tr>
<td>7. Autonomy</td>
<td>Doctors feel that there is a loss of professional autonomy in senior management.</td>
<td>Negative</td>
</tr>
<tr>
<td>8. Security</td>
<td>Because of the high turnover at senior management level, there is a perception of less security.</td>
<td>Negative</td>
</tr>
<tr>
<td>9. Status</td>
<td>There is a perception of a higher status in senior management.</td>
<td>Positive</td>
</tr>
</tbody>
</table>

Source: career drivers adapted from Francis [17] and explanations adapted from Ham et al. [12].
medicine, known as the bioscientific group, and these students tend to gravitate towards surgery, pathology and other similar medical specialties. Another group are students who are more interested in the public and social aspects of medicine, known as the biosocial group, and these students end up as primary care physicians, public health physicians and medical managers.

Furthermore, factors that relate to how engaged the doctors are to their workplace can be considered. The doctor must be engaged in the workplace in order to want to move into management, and three elements have been identified in this engagement: intellectual commitment, emotional attachment and interpersonal outcomes [20]. This engagement goes beyond the appointment of doctors into positions of authority, but there could be other factors that explain why management is a viable career choice for doctors.

Similarly, mentoring and role models have been found to be relevant in fostering medical administration careers [21-23]. Mentoring can be defined as the process by which the mentor’s role shares experience, wisdom and savvy, enabling the mentoree to embark on the task being mentored [24, 25]. Half of doctors surveyed in a study looking at clinical directors indicated that they have chosen their career path because of the influence of a role model or mentor [23]. Similarly, medical students have chosen a particular specialty later in life because of a highly rated supervisor from the same specialty. For example, role models were found to be influential in medical students’ choice of surgical careers [26]. In brief, the presence of positive mentors and role models is a positive predictor of medical career decision-making.

In addition, doctors who move up to management can be divided into different categories based on their attitude to management. There are six different types of clinicians, including doctors, who step into a management role [27]. These categories have been adapted to doctors in particular for this research in Table 2. The first category consists of born managers who see management roles as an opportunity for promotion from their clinical roles, being ambitious and seeking out such stepping up opportunities. Next, ambivalent managers are unsure of management as a definite career, because they have not sought such roles and are doubtful of their own skills in this area. In turn, former managers are clinicians who have experienced management and have decided it was not for them. Then ‘never have been, never will’ clinicians are those that avoid any form of managerial duties because they see this as compromising their own value set. In addition, itinerant managers are clinicians who are able to move in and out of management roles based on expediency and opportunity due to their own changing interests at any one time. Finally, stuck managers are the ones who are unable to change their management roles because of intrinsic and/or external factors beyond their control despite their wish to leave management.

These six categories provide insights into the different motivational factors that influence doctors’ career decision making and provide a useful way of conceptualising the issue. By classifying doctors into a specific category based on their approach to management, the employing hospital may be able to develop an appropriate and customised career plan that will benefit both the individual and the hospital itself.
Another concept to assist in the understanding of the motivations of doctors who move into management is the concept of portfolio careers [28]. Portfolio careers describe careers that are made up of many parts due to the gradual progression of an individual’s interest in activities relating to their core occupation. This progression can represent the evolution of the person’s occupation through deliberate design, or from the capitalisation of opportunities that present themselves at different times. Many doctors who end up in management have portfolio careers, and an understanding of how and why this has occurred will help in understanding how opportunistic career changes could become more deliberate ones [12].

In addition, half of all health services managers take a mobile career path that includes time outside of the health industry [29]. Such flexibility in career pathways has been encouraged by the proliferation of double degree courses offered by universities, such as medicine-arts or medicine-law degrees [30]. For example, the career paths of medical chief executives are various, with some becoming chief executives early in their careers and others being appointed much later [12]. As a result, the training received by medical chief executives may be inconsistent and often involve learning on the job rather than more formal development.

**Summary of factors**

A summary of these factors that contribute to the decision of a doctor to move from clinical practice to management is shown in Figure 3. In general, there are individual factors and workplace factors. Individual factors consist of the career drivers already discussed such as power and influence or status, and individual personal interest. Workplace factors are the role models and mentors that provide positive influence, and workplace engagement. The absence of these positive factors reduces the probability of a doctor moving from clinical practice to management.

**Figure 3** Factors influencing doctors’ decision-making to move from clinical practice to management

<table>
<thead>
<tr>
<th>Category of manager</th>
<th>Relevance to doctors in management in particular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Born managers</td>
<td>These are doctors who have decided on early in their career that management is their goal. Such doctors undertake further postgraduate medical training and sub-specialise in medical administration early in their medical career.</td>
</tr>
<tr>
<td>Ambivalent managers</td>
<td>These are doctors who have drifted into a management role, usually as a clinical director.</td>
</tr>
<tr>
<td>Former managers</td>
<td>These are doctors who have taken on management roles in the past and who have decided to return to clinical practice.</td>
</tr>
<tr>
<td>Never have been, never will be a manager</td>
<td>These are doctors who have decided early on that they will never participate in management roles because that would contravene their personal value set.</td>
</tr>
<tr>
<td>Itinerant managers</td>
<td>These are doctors who are able to move between clinical and management roles easily, without making a commitment to management.</td>
</tr>
<tr>
<td>Stuck managers</td>
<td>These are the doctors who are stuck in management roles but would prefer clinical practice instead.</td>
</tr>
</tbody>
</table>

Source: developed for this research about doctors with categories adapted from Boucher [27].
Conclusion

In conclusion, only a minority of doctors decide to move from clinical practice into a management career. There are generic decision-making factors that apply to most occupations as well as factors that are medical-specific that influence how doctors make such a career move. These four major factors are personal career drivers, individual interest, presence of role models and mentors, and workplace engagement. A better understanding of such factors will assist employers in the recruitment of doctors into management positions.

A/Prof Erwin Loh
RACMA Victorian Coordinator of Training

References
27. Boucher C. To be or not to be... a manager: the career choices of health professionals. Australian Health Review. 2005;29(2):218-25.
The Dying Art of Critical Thinking

I doubt that there would be anyone who has been working over the past two decades who would disagree that we have less time, we expect things faster, get impatient with if we don’t have instantaneous replies to emails and try to accomplish as much as possible in the least possible time. In addition, we rely on technology to fix our problems, collect and collate data and communicate with colleagues and friends. We have less time for thinking, reflecting and building robust relationships based on face to face conversations. We have bred a culture of superficiality based on assumptions that the data that we get is true and accurate, that friends made via Facebook are real friends and that anyone who does not reply immediately is being unhelpful.

What does this have to do with critical thinking and what appears to be a dying art?

Browne and Keeley (2001, p 2) define critical thinking as:

- an awareness of a set of interrelated critical questions
- the ability to ask and answer critical questions at appropriate times
- The desire to actively use the critical questions.

Critical thinking is an active pursuit. This means not passively accepting everything we read and hear, but questioning, evaluating, making judgements, finding connections and categorising. It means being open to other points of view, not being blinded by our own biases and thus making assumptions that are not based on evidence.

In these days “doing things quickly and moving on to the new task” seems to be the new mantra. We have lost the ability to take time, think about what we have seen, heard or read, reflect on things and ask the right questions. We do spend the time needed to do the task, but often have no time to do it thoughtfully and ensure that the answer we have come up with is the right one. After all, the next task and the one after that are waiting to be completed and time is the essence, isn’t it? Well yes and no. This is true for some tasks, but not for others and we need to be able to distinguish the tasks that just need to be done from the issues that require thought and reflection before they can be considered successfully completed.

What are some examples of this and what outcomes do these examples have? In a project I completed recently I required data about costs of work and requested this from a senior executive in a health service. When I analysed the data, it was clear that it was wrong. It seemed to indicate that medical staff at this hospital earned only $25,000 annually. When I questioned this, I was told that “the finance department provided the data so it must be right”. When I indicated that the health service could get into major problems as it paid its medical staff so much below the award, the penny dropped and the finance department was asked to re-examine its data. I did eventually end up with data that made sense. A very similar example occurred with data I requested from another hospital in relation to waiting lists. For years the formula on the Excel spreadsheet had been wrong and the data used by the executive to assess waiting lists had been inaccurate. An analysis of the data indicated that the figures did not make sense and then checking the formula demonstrated why this was so.

In both of these cases, the data was simply accepted as it was regarded to be from a trusted source and therefore correct. What is the use of collecting and collating data if it gives the wrong information? Who in our health services actually critically analyses the data that is provided to ensure that it is right? Who in our health services has the critical thinking competency to be able to do this appropriately?

There are examples of this in clinical care as well. The issue of the deteriorating patient and the lack

“We do spend the time needed to do the task, but often have no time to do it thoughtfully and ensure that the answer we have come up with is the right one.”
of recognition of deterioration at the bedside is something that is lamented by many senior clinicians, both doctors and nurses. Medical and nursing staff are also often overwhelmed with work and focussed on completing tasks. Observations are taken and recorded without thinking about what the observation means. Assumptions are made that because observations seem to be within normal limits that the patient is stable. The thing is “the observation has been done”. There is no time to assess if the observation is normal or if information provided from other sources should also be considered or if the observation requires further action. In some cases significantly abnormal observations are recorded and forgotten. After all, there are other patients waiting to have their observations done and more tasks to complete.

So how does this apply to us in medical management? Because we are also humans and part of this time poor community, we are no different as a group to others. However, we need to be the professionals who are the experts in critical thinking. That is what we are employed to do. That is what we are respected for.

In a project for RACMA some years ago, I interviewed hospital executives who worked with our Fellows. I can clearly remember a Director of Finance describing one of our Fellows and how much they respected this FRACMA’s ability to take on complex information, synthesise it, evaluate it and translate it into the simple terms that he was able to understand and that made sense to him from a financial point of view.

Some years ago, we introduced a data question into our oral examination. The reason for this was to try to build critical thinking and analysis as we discovered that many of our candidates rarely saw any data, let alone analysed and evaluated it. There is nothing like making this a key summative task to ensuring that learning in critical thinking is adopted. As we know in management, what gets measured gets managed and likewise what is measured in an examination gets studied. However the exercise in data analysis is just the tip of the iceberg. The principles need to flow through to the way we do our daily work, solve complex problems and assist in decision making. I am not convinced that just adding a data question has gone far enough to developing this competency.

If our critical thinking skills require honing, we need to make an effort to improve these. A good structure for critical thinking is from Bloom’s Taxonomy. This defines a hierarchical structure as indicated below:

I will freely admit that I only became aware of Bloom’s Taxonomy myself recently as I spoke to a young and highly enthusiastic senior manager in Indonesia. She had been educated in the USA, not in health systems but in education. We had discussed the lack of critical thinking skills in many staff and she indicated that she had started teaching staff in her hospital these skills. “Of course you know Bloom’s taxonomy”, she said. I answered that I didn’t and she gave me a run down. Once I was back in Australia, I started to explore Bloom’s taxonomy for myself. I believe this structure has a lot to offer both in our educational processes and in our examination techniques.

For the candidate, this provides a means of showing how they are progressing from year one to year three. In year one remembering and understanding would be important.

Who in our health services actually critically analyses the data that is provided to ensure that it is right?
as candidates get the knowledge and understanding of how the health system in general and their organisations in particular work. They then begin to apply this knowledge and understanding under supervision. Year two would increase the depth of knowledge and understanding with a further emphasis on application and hopefully the development of analytical skills. These analytical skills should be further developed in year three, when we test these in the case study and the oral examination. This will be added to by the ability to evaluate.

The research project will also aid in the development of analytical and evaluation skills and it is intended that this will improve overall competency in these areas. By the time of the oral, we would expect our candidate to have conscious competence in these areas. Experienced Fellows will be expected to be well into the unconscious competence zone for the whole hierarchy, with high level and innate skills in analysis and evaluation and well into the creating new meaning. This is the experienced medical manager’s key and respected skill. Those of you who have studied reflective thinking will see many parallels here in the hierarchical structure from Stage One “Reflectivity” or describing what happened to stage seven “Theoretical Reflectivity” related to development of our own practical theories.

However, I still believe that this is not enough. I am still concerned that our college tasks and experiences towards Fellowship will still not raise awareness of the overwhelming importance of critical thinking, nor develop the competency to a degree that is expected of us. It is time to teach some of the theory of critical thinking, as this will raise awareness, and, to test our candidates in the development of this, at all stages of their progress towards fellowship. This should be the role of all of us who are involved in educating, supporting and mentoring in these key formative years. If we as professional medical managers lose the skill of critical thinking, we will no longer be able to provide optimal value to health services and health systems and this in my opinion means that our profession will be at risk.

Dr Lee Gruner
RACMA President


---

Call for Papers
Medical leadership: Development and Practice
Special Issue of the Leadership in Health Services journal

In collaboration with Emerald publishing the WFMM is pleased to call for papers for publication in a Special Issue of the Leadership in Health Services journal.

The guest editors are seeking contributions from across the spectrum of medical leadership, covering (but not limited to) the following topics:
- What is medical leadership and what do medical leaders do?
- Is there a unique perspective or world view that informs and shapes how doctors manage and lead?
- Examples of programs used to help physicians learn the capabilities of modern leadership.
- What processes do health systems and health organizations use to ‘create an environment in which excellence in medical leadership will flourish’?
- Should physician-led healthcare settings be differentiated from non-physician-led healthcare settings in terms of patient outcomes?

Guest editors Professor Emeritus Graham Dickson (gdickson@royalroads.ca) and Dr Karen Owen (kowen@racma.edu.au) are interested in both empirical research articles and conceptual pieces. Papers which use either quantitative, qualitative or mixed-method studies are welcome. For further information please see the journal homepage at www.emeraldinsight.com/lhs.htm or contact the guest editors. Submissions must be received by 1st March 2014.
The Impact of Bullying in Health Care

The health care profession has one of the highest levels of bullying in the workplace. Employment law experts Kamal Farouque and Enrico Burgio from Maurice Blackburn outline the scope of the issue, and explain the legal and policy obligations for managers.

Bullying behaviour at work impacts not only an individual victim’s health, it affects workplace morale, can undermine an organisation’s productivity and places a significant burden on the national economy. Workplace bullying exists across all professions and can occur at any level of an organisation. Such is its ubiquitous nature, chances are that if you have not experienced it directly, you will know of someone who has.

The existence of bullying in all facets of the healthcare profession is well documented. In fact, healthcare professionals, irrespective of their field, experience one of the highest levels of bullying. A recent article suggested 23% of the surveyed health care administration staff had experienced bullying in the preceding six months. While rates do vary depending on job classification, 25-50% of medical professionals in Australia have experienced bullying. Importantly, the incidence appears to be higher amongst junior clinical staff, as evidenced by a British study which found that 84% of junior doctors had been subjected to an incident of bullying in the preceding year.

What is workplace bullying?

Bullying is by nature, a shifting, fluid phenomenon; one that manifests itself in myriad of forms and contexts. As such, agreement as to single definition is elusive.

But a recent Report prepared by a Federal Parliamentary Committee into workplace bullying recommended that the Commonwealth Government establish a universal definition of bullying. The proposed definition is, as follows:

Workplace bullying is repeated, unreasonable behaviour directed towards a worker or group of workers, that creates a risk to health and safety.

Putting the federal Parliament’s definition aside, most attempts to define the concept of bullying involve two key elements. First, that it involves behaviour of a repetitive nature; and second, that it has an illegitimate exercise of power over an individual or group of individuals.

Given its shifting nature, the categories of behaviour that might be considered bullying cannot be listed exhaustively. However types of behaviour which might be considered bullying include: threats to professional status; threats to personal standing; isolation; overwork; and destabilisation.

It is, however, important to note the fundamental distinction between bullying, which is inherently undermining and corrosive, and constructive supervision, which is developmental and supportive.

The existence and costs of workplace bullying

The costs associated with bullying in the workplace are varied and significant. Bullying impacts the individual employee, the employer organisation and the economy at large.

On an individual level, bullying can have a profoundly detrimental impact on a victim’s physical and mental health. It can erode dignity, self-esteem and job satisfaction. At an organisational level, bullying may affect workplace morale, compromise productivity as well as commitment to the organisation, increase exposure to litigation and jeopardise an organisation’s reputation.

In terms of economic effects, the Productivity Commission has suggested that the cost of workplace bullying to the Australian economy is between $6 billion and $36 billion each year. Further, the Parliamentary bullying inquiry highlighted the additional burden bullying places on the public sector. For example, individuals whose capacity to work has been compromised by bullying are often dependant on the provision of health and medical services and income support and government benefits.

“...”
The following documented effects of bullying are of particular significance from a management perspective in the healthcare profession:

- **Cost to organisation:** SafeWork Australia put the average cost of compensation claims for bullying harassment in the 2007-08 financial year at $41,700 and 25 weeks absence from work. This is more than double the average cost associated with ‘other claims’, which totalled $13,300 and an average of 7 weeks off work.12

- **Organisational commitment – staff retention:** As noted above, a number of studies suggest bullying alters employee perceptions of an employer, ultimately reducing staff commitment to the organisation.13 This pattern is particularly important to medical administrators concerned with staff retention. Surveys of the nursing profession suggest that organisational commitment is one of the most accurate predictors of staff turnover.14

- **Quality of care:** Factors central to the quality of patient care include effective teamwork and communication and a collaborative work environment. As such the disruptive and corrosive effect of behaviours associated with bullying is magnified in the healthcare sector.15 A dysfunctional team environment will invariably lead to errors and preventable adverse outcomes. As the authors of a recent British study pointed out, “Ultimately if the culture of bullying results in demoralized staff working in a caring profession, it is the patients who will suffer.”16

- **Litigation:** Not only does the presence of bullying in a workplace subject the employer to potential litigation in respect of bullied employees, it also exposes an organisation to actions in negligence on behalf of patients.17 Hence the importance of dealing with bullying in healthcare from a risk management perspective.

**Existing legal framework**

Surprisingly, despite the scale of the phenomenon and the significant costs associated with it, there is no dedicated bullying legislation in Australia.

Nonetheless, currently a victim of bullying in Victoria has the following possibilities in seeking statutory relief:

- **Workers’ Compensation:** Workers’ compensation is the primary remedy for employees who suffer an injury as a result of workplace bullying. Where a claim is accepted, affected employees may be eligible to receive weekly payments, reimbursement of medical expenses and, in certain circumstances, a lump sum payment.18

- **Occupational Health and Safety Legislation:** Victorian legislation requires an employer to provide a workplace that is safe and does not endanger the health of employees.19 Where this provision is breached an employer may be prosecuted by WorkSafe Victoria, however an employee has no actionable right.

- **Bullying and stalking:** An amendment to criminal legislation has broadened the definition of stalking to include some forms of bullying behaviour.20 However, this law is not relevant to the majority of incidents of workplace bullying.

- **Contract of employment:** In certain limited circumstances it may be argued that incidents of bullying breach the contract of employment. For example, this may be the case where a contract of employment, or a workplace policy expressly incorporated into the contract, contains a provision that the employer undertakes to provide a workplace free of bullying. In more limited circumstances,
it may be possible to argue workplace bullying contravenes an implied contractual term of mutual trust and confidence; however the law on this issue is still being developed before the Courts.

• **Anti-discrimination legislation:** Where bullying is directed toward a protected attribute of an employee, such as gender, religion, sexual orientation, marital status or race, the victim may seek a remedy under either Commonwealth or State anti-discrimination legislation.

• **Fair Work Act:** Similarly, where adverse action is taken against an employee on the basis of a protected attribute, it may be possible to bring an action pursuant to section 351 of the *Fair Work Act 2009* (Cth).

• **Industrial instruments:** Finally, where workplace policies are deemed to contain an enforceable promise to address or eliminate workplace bullying and such a provision is breached, a right of action may arise under the *Fair Work Act 2009* (Cth).

### Future reform to anti-bullying laws

The patchwork nature of current anti-bullying laws has resulted in a push for law reform. The Federal Government has recently announced that it will push to enact significant amendments to the *Fair Work Act* to:

• Adopt the Parliamentary Committee’s recommended definition: ‘Bullying, harassment or victimisation means repeated, unreasonable behaviour directed towards a worker or a group of workers that creates a risk to health and safety’.

• Recognise that bullying does not include reasonable management practices including performance management conducted in a reasonable manner.

• Allow employees who have suffered bullying to make a complaint to the Fair Work Commission

• Require the Fair Work Commission to deal with any application as a matter of priority including by listing the matter for consideration within 14 days; and

• Enable the Fair Work Commission to make orders to deal with the complaint and/or to refer to the relevant state WHS regulator

### Recommendations to medical administrators

Medical administrators have an important role in raising awareness of bullying in the healthcare profession. Recognition of the problem at an administrator level, as well as the promotion of policies endorsed by the organisation, are important steps to promoting a safe and healthy workplace, ensuring a functional healthcare team and maintaining acceptable standards of patient care. Getting ahead of the problem is critical.

The following recommendations draw on suggestions set out in the Australian Medical Association Position Statement on Workplace Bullying:

1. A clear statement of “zero tolerance” in relation to bullying behaviours, irrespective of the role or seniority of the perpetrator

2. Adoption of an organisation-wide anti-bullying policy, which:

• Identifies examples of bullying behaviour

• Outlines managers and staff responsibilities

• Provides tiered response strategies aimed at early intervention and informal resolution

• Provides clear and confidential grievance, investigation and disciplinary procedures

• Requires any steps taken in relation to complaints of bullying be documented

• Protects staff who report bullying or cooperate in investigatory processes

3. Implementation, review and monitoring of the policy

4. Provision of training for all staff, clinical and non-clinical, to assist in the recognition and resolution of issues related to bullying

• Training in relation to bullying should be incorporated into the organisation’s induction program, particularly for junior doctors

• Additional training for managers and supervisors which enables them to identify and deal with problem behaviour at an early stage

5. Ensure appropriate support mechanisms, both internal and external, are available to assist victims of bullying

6. Establish structures which encourage patient feedback to be provided to management, thereby providing an additional, external source of surveillance in relation to problem behaviours
Medical administrators have an important role in raising awareness of bullying in the healthcare profession.


6 Workplace Bullying: We Just Want it to Stop. House of Representatives Standing Committee on Education and Employment, October 2012, p.18.


11 Workplace Bullying: We Just Want it to Stop. House of Representatives Standing Committee on Education and Employment, October 2012, p.10.


15 Joint Commission – Issue 40 “Behaviours that Undermine a Culture of Safety”, p.1

16 Bullying: A Growing Workplace Menace, p.24

17 Joint Commission – Issue 40 “Behaviours that Undermine a Culture of Safety”, p.1

18 See Accident Compensation Act 1985 (Vic), s 93, Division 2B & Division 2A.


20 See Crimes Act 1958 (Vic), s 21A.


22 Joint Commission – Issue 40 “Behaviours that Undermine a Culture of Safety”, p.1

Kamal Farouque and Enrico Burgio
Maurice Blackburn

References

Articles:


Australian Medical Association Position Statement “Workplace Bullying and Harassment” 2009


Workplace Bullying: We Just Want it to Stop. House of Representatives Standing Committee on Education and Employment, October 2012, p.10.

Legislation:

Accident Compensation Act 1985 (Vic)

Crimes Act 1958 (Vic)

Fair Work Act 2009 (Cth)

Occupational Health and Safety Act 2004 (Vic)
The Hong Kong Special Administrative Region (HKSAR) of China has a land area of only 1100 sq kilometres, but houses a population of approximately 7 million. It is a financial centre in Asia, and has a per capita GDP of US$32,000. Hong Kong has a birth rate of approximately 12.5%/1000 population, and in 2010 had a maternal mortality rate of 1.1/100,000 population. The infant mortality rate has steadily decreased over the last 28 years from 10/1000 live births to 1.7/1000 live births in 2010. Life expectancy has steadily risen to 80 years in 2010, and 85.9 years for women.

Unlike China, which has a market-driven healthcare system, Hong Kong’s health system is socialised. The HKSAR Department of Health, which is responsible for public health and regulations and oversee private hospitals, is a government department directly under the control of the HKSAR Food and Health Bureau. Direct management of public hospitals and institutions is the responsibility of the Hospital Authority, a statutory body with a dotted reporting line to the Food and Health bureau. The policy secretary responsible for health used to be a senior government official, usually Administrative Officers, under the previous colonial government. Since the return to China, in particular after the SARS epidemic, the health policy secretaries all have a medical background.

Hong Kong’s public healthcare policy can be summarised as:

“No one should be denied adequate healthcare through lack of means.” The system ensures that the public healthcare system can continue to serve those who cannot afford private healthcare services.

Public health services are heavily subsidised, with a fixed subsidy ranging from 85% to 98% (as at 2010/2011), depending on the service. Health service expenditure as a percentage of GDP has risen very little since 1991 (from 4% to 5.3% in 2009), and is marginally greater than that of Singapore (4%), but considerably lower than that of the US (nearly 18%), Japan (8%) and the UK (10). 2009 figures show that Healthcare expenditure is split between public (2.4% of GDP) and private (2.9%) healthcare provision.

Public healthcare, which is highly subsidised by the government, accounts for 90% of hospital inpatient care (approximately 27,000 beds), 30% of outpatient care and all public health provision (2008/2009 data). Private healthcare is mostly self-financed by patients, accounts for 10% of inpatient care (approximately 4000 beds), and 70% of outpatient care (mainly primary healthcare services). At 16.5% of budget in 2011/12, healthcare was the third largest area of public expenditure, exceeded only by social welfare (17.4%) and education (22.5%).

Hong Kong’s public healthcare system faces a number of challenges, including a growing and ageing population, an increased risk of hospitalisation for the elderly (relative risk 4.2 times that of the younger population; 2.6/10 of those aged 65 years and older were hospitalised in general speciality in 2010, compared with 0.6/10 of those younger than 65 years), an escalating disease burden especially for the top 5 diseases (ischaemic heart disease, chronic renal failure, lower respiratory tract infection, cancer and schizophrenia) and treatment complexity (especially for radiology, pathology and ultra-major or major surgery). Most elderly people rely on the public health system for healthcare, as few have private insurance cover. Public health challenges faced in recent times include SARS, Avian flu, Human Swine flu, May 2012 Wenchuan earthquake, melamine-tainted milk products and contaminated drugs. There are challenges in providing service quality and safety in the context of higher community expectation, advances in medical science and an overstretched
medical workforce trying to provide an increasing number of services.

In its reform agenda, the government of Hong Kong wants to reform healthcare financing by promoting voluntary medical insurance. It also would like to enlarge the safety net of public healthcare services through increased public expenditure and an enlarged coverage of the second safety net, and reform the healthcare delivery system through strengthening primary healthcare, the promotion of public-private partnerships and the development of four new private hospitals. In order to address the challenges faced by the healthcare system, the government is driving quality, performance and cost-effectiveness strategies. The government wants to be better able to manage a growing demand for health services by increasing capacity, keeping people healthy and diverting demand. Better service quality and safer services can be achieved through an approach of “do no harm”, promotion of patient-centred care, and the implementation of continuous service improvement programmes. None of this can be achieved without an engaged staff and enhanced workforce capacity, which can be achieved through nurturing a skilled, high-performing workforce.

Medical leadership in Hong Kong is involved in all areas of health, from government stewardship of public health policy to clinical governance. Doctors have taken leading roles in leadership of both public and private hospitals. Medical leadership in hospitals has strengthened clinical governance, while clinical leadership is prominent in ensuring performance quality and risk management. As well as responsibility for performance

quality and risk management, the Hospital Authority is also responsible for the Clinical leadership development programs that turn doctors, senior clinicians, nurses and allied health professionals into clinical leaders.

Universities also have a role in promoting education in public health and health services management in Hong Kong. Both the University of Hong Kong and the Chinese University of Hong Kong have a School of Public Health and Masters programs in public health and health services management. The role of the Hong Kong Academy of Medicine is to oversee standards in specialist training through her subspecialty Colleges, including the Hong Kong College of Community Medicine which developed specialist fellowship training (after completion of the masters program) in three areas: Public Health Medicine, Occupational Medicine and Administrative Medicine.

The purpose of developing specialists in Administrative Medicine is to produce medical specialists able to practice evidence-based medicine; critically appraise complex health administration problems; assess the health care needs of the community; maximize health of the community; manage human and material resources; manage changes in technology; promote good clinical and administrative practices; and understand and promote medical ethics.

Dr Hong Fung
Hong Kong College of Community Medicine

This transcript was prepared by Dr Susan Keam AFRACMA (New Zealand), derived from material presented by Dr Hong Fung at the 2012 WFMM Medical Leaders Forum held on the 26th of April 2012 in San Francisco.
Reflections on the Accelerated Pathway

Introduction
When I was invited to join the RACMA accelerated pathway to Fellowship training program, I knew I would be the first local candidate setting the scene for others. In my consideration to accept the invitation and the challenge, three questions went through my mind, usefulness, time-management and the local support that can be provided for going through the process.

Considerations for joining
Managing healthcare organizations poses special challenges with the manager-physician relationship being one of the notable ones. There are different views about managers with some thinking management is just a common sense job. In my view the common sense is only available to those learned in the trade. Whether one is an accidental or cultivated administrator, the basic premise is ‘get trained for the job’.

Learning is a life long process and specialist medical management training is only an initial step in gathering all the required basic skills. I have a university masters degree in management which has given me theoretical knowledge. Having had a few years of experience as a clinician-manager is not good enough to be a proficient or even competent executive manager and leader. Experience contributes problem-based learning and quality of learning is good in terms of depth. But the breadth of learning depends on the problems one is exposed to, which can be very limited, accidental, un-systematic and leave lots of gaps. To fill the gaps in knowledge and skills and to be proficient in medical management, one has to experience it; like reading a textbook from cover to cover. Having examined the RACMA medical leadership and management competency framework, I believed the accelerated pathway to Fellowship gave me this opportunity to systematically lay the foundation stones of proficiency.

Once the usefulness question had been addressed, my other two questions were straightforward. Time management depends on my own prioritization. Deadlines and time urgency are useful parameters to get things done. Lack of time could be an excuse but not a valid reason. The first issue was not considered significant at the time as there are similarities between the RACMA and the local Hong Kong examination. At the RACMA medical leadership workshop for accelerated pathway candidates, I was invited by other participants to join a telephone-conference study group. This was not taken up later because of time zone differences.

Executive Coach
My first challenge was to work with my executive coach on preparing the reflective writing case study. Hong Kong is geographically small, and we are close to each other. This meant the Executive Coach would be someone that I knew, and someone with whom I might have to share many secrets that might have been hidden deep down emotionally. We required time to get over the initial embarrassment and to accept through mutual understanding and development of trust. I had previously had the privilege of working with an executive coach for two years when moving from a doctor to the executive position. This made me understand the role of an executive coach and so made the idea less confronting; ice-breaking with this accelerated pathway executive coach was easier. Without trust and understanding, the executive coach model will not work. Trust was fundamental to help me ‘dig into my recollections and to reflect’ and write my case study using the reflective writing style.

Reflective case study
The reflective case study proved to be the most difficult part of the entire accelerated pathway training program. The first challenge was that I did not join the reflective writing workshop in Melbourne, Australia, and had to master much of the material through reading and through my executive coach. Like other people, the case study had to go through numerous iterations moving from superficial to deep reflection. As part of the normal adult learning process, it was important to acknowledge the usefulness of reflection and making some ‘sense’ out of it. Otherwise there would be no constructed knowledge and learning for me and the exercise of writing reflectively would serve no useful purpose. This insight and self...
Awareness came from the iterative process of reflection and when the subtle impact of emotion in decision making was acknowledged, coupled with the far reaching impact of an executive’s decision on a big group of people. This insight helped the case study becoming more and more reflexive. I felt the process of reflection was as important as the case study itself.

The time factor was the second challenge. To match the timeline of the Final Examination, there was a deadline for submission of the reflective case study. The initial reflection was slow. Eventually I needed to squeeze in more time and it took me six months in writing the case study.

Preparation for Final Examination

Management in healthcare organizations is about understanding of human nature and the psychology of human behaviors; understanding systems and organizations; and eventually using those tools and skills to steer and change the behaviours of groups of people. The social, cultural contexts are important in deciding the “how” and “what” of these changes. Together with the legal framework, they also define the boundaries for change.

Another challenge was to know the Australian laws, and to have a glimpse of the Australian cultural context. Hong Kong is very westernized and inherited the common law system from United Kingdom. Despite this, there are differences in the local legal climate and most importantly the culture between Hong Kong and Australia. Culture affects how things are done in different places and such differences had already emerged in my reflective article. The article contained practices on maintaining good working relationship (guanxi), harmony and face saving during confrontations which are some of the prevalent Chinese culture and management philosophies4-6. Although face-saving is also described in the western literature7-8, it is less prevalent. It was a challenge for me to write the article so that the cultural context culture could be understood by people outside the system.

Learning the Australian laws was a real challenge. Australia has a very elaborate set of laws to guide and restrict the medical administrators. There are 63 legislations in Australia with relevance to healthcare9, compared to 70 in Hong Kong. Such numbers just showed that it would be impossible for me to know them all in preparation for the examination as time and age were both against me. As I had not joined any study group nor the trial viva sessions, I was used to learning by myself. I prepared seriously for the examination and checked for my gaps by going through all the past questions myself in a simulated examination environment. The examination technique was a bit different from my previous specialty and I could draw reference from the daily practice. For issues that related to the legal systems, further reading was required.

The Final Examination

Having served as an examiner for more than ten years in another clinical specialty and taught so many people through examinations, and having been interviewed so many times in my career, the entire examination process should be very familiar to me and should have taken away the stress factor. However, sitting on the other side of the table felt different and the stress factor was always there, differing only in degree. As a routine psychological preparation, I had to consider all the scenarios that could happen with the examinations, including what if I could not pass. It helped to put away personal dignity and personal pride and focused on the examinations.

What I have learned

It is pertinent to ask what I have learned and gained from the process. How did the Accelerated Pathway add value to my work? In what ways have I been doing things differently?

Superficially I gained some new knowledge through the preparation for the final examination as it forced me to understand and learn all the important topics including the difficult ones, making notes during the process. This exposed some of my previous blind spots but some more are bound to come.

The different approaches in handling issues and yet reaching the same goal were readily appreciated, including the influence of local culture, and local legal framework. The pros and cons of legislations, practice code, good practices or guidelines were also evident.

By far, the most fruitful was the reflection and the reflective writing. As an administrator, a lot of information is obtained through talking to people. Just like a doctor facing a patient, the chief complaint may not be the real purpose of the consultation. One of the biggest challenges for medical administrators is to understand the ‘self’ - the meaning behind the
words, the comments they utter to make a diagnosis of what exactly they want to say. Understanding all the psychological defense mechanisms may help. But the reflective writing helped me to understand more the relationship between rationality and emotionality – these are interacting all the time. It is difficult if not impossible for true rationality to occur, because many a time we are just pseudo-rational. Organisational decision-making can impact a lot of people. Although ‘the organization’ has no emotion, members making up the organization do, and we may not always be able to avoid emotional elements. Emotions however are signals and when we are aware of the impact of emotion, we can sense our way forward into intelligent decision making. I now see that managing emotions is good risk management.

I now have a better understanding of my ‘self’. True listening occurs when one can put his self-dignity away, put away the emotions, intuitive feelings, possible biases and other discolorations with the person. I have also learned to be a better coach and mentor.

While all seemed positive, von Knorring et al1 raised the issue that medical administrators were practicing “medical leadership” rather than management was worth some more reflection.

**Conclusion**

In this day and age, Medical administration is a very challenging job and medical leadership calls for a very versatile person. Transparency and accountability are important considerations as all decisions can have long lasting consequences. The RACMA accelerated pathway training program is a worthwhile experience and it has helped me to be a better executive.

> It pointed out some of the previous blind spots such as the different legal systems. Although the management tools are there all the time and known to us, the challenge is to decide which and how to apply the tools. It is always helpful to learn and know a bit more than we need.

**References**


This year’s Annual Scientific Meeting was entitled High Performance in Austere Times, and was held at the Sofitel Broadbeach, Gold Coast from the 4-6th of September. Around 200 delegates engaged with the exceptional scientific and social program that the National Scientific Program Committee had developed.

**Preconference workshops**

Two pre-conference Leadership Master Classes were delivered on the first day one with Professor Chris Ham, Chief Executive of The Kings Fund and one with Professor Graham Dickson, Founding Director of the Centre for Health Leadership and Research at Royal Rhodes University.

**Welcome Reception**

The welcome reception was held poolside at the Sofitel on a mild Queensland evening where the invited guests were entertained by a jazz musician.

**Margaret Tobin Challenge Award**

Two Candidates competed for the coveted Margaret Tobin Challenge Award at the conference. The presenters and their topics are listed below:

**VIC** Dr Paul Eleftheriou
*Revolutionising Professional Governance in the 21st Century*

**NSW** Dr Barbara Moritz
*The Role of Cake in Promoting Excellence*

Congratulations must be extended to Paul Eleftheriou for taking out the Margaret Tobin Challenge Award and cash prize of $1500.

**Conference key note speakers**

Keynote speakers included:

- Prof Chris Ham CBE, PhD, MPhil, FRCP (Hon), Chief Executive of The King’s Fund
- Prof Chris Baggoley, Chief Medical Officer, Australian Government
- Professor Graham Dickson (PhD), Professor Emeritus, Royal Roads University
- Dr William Ho, Medical Superintendent, St Paul’s Hospital, Hong Kong
- The Honourable Justice Catherine E Holmes, Judge, Queensland Court of Appeal
- Dr Lee Gruner, President, Royal Australasian College of Medical Administrators
- Dr Michael Walsh, Chief Executive, Cabrini Health
- Dr Joanna Flynn AM, Chair, Medical Board of Australia
- Prof David Hayward, Dean, School of Global, Urban and Social Studies, RMIT University
- Prof Jeffrey Braithwaite, BA, MIR (Hons), MBA, DiplLR, PhD, FAIM, FCHS, RACMA Board member, Director, Australian Institute of Health Innovation, University of NSW

**“Around 200 delegates engaged with the exceptional scientific and social program that the National Scientific Program Committee had developed.”**
This year the College conferred 18 new Fellows.

Dr’s Danielle Klar, Grant Howard, Philip George Reasbeck and Tom Gordon Watson received their testamurs in absentia.

Congratulations to the following Fellows that received their testamur at the Gold Coast.

Anjali Dhulia
Bennie Pak Nam Ng
Colin Myers
Hwee Sin Chong

Jayanti Jayakaran
Joe McGirr
Julianne Graham
Mellissa Naidoo

Pamela Gail Robinson
Pooshan Navathe
Rosalind Marcella Crawford
Sayanta Jana

Shuk Han Lee

Conferment Ceremony
Graduating Fellows

This year the College conferred 18 new Fellows.

Dr’s Danielle Klar, Grant Howard, Philip George Reasbeck and Tom Gordon Watson received their testamurs in absentia.

Congratulations to the following Fellows that received their testamur at the Gold Coast.
Dr Joanna Flynn has made an exceptional contribution to the development of the pivotal discipline of general practice as a distinct professional specialty. She graduated equal second, and with prizes in surgery and gynaecology, in the University of Melbourne’s MBBS class of 1975 after which she continued training in general practice and public health.

With experience in North Queensland, Tasmania and rural Victoria, for the past 20 years, she has worked in a West Brunswick practice, where she is a partner. In parallel, she was State Director of the Royal Australian College of General Practitioners (RACGP) Training Program in Victoria, for the ten years until 1998.

Dr Flynn was President of the Medical Practitioners Board of Victoria from 2000 to 2008 having been first appointed to the Board in 1989, President of the Australian Medical Council from 2003 to 2008 and a member of the Board of the Postgraduate Medical Council of Victoria for eight years, and chair in 2007.

She also chaired the Australian Medical Council working party that developed the seminal ‘Good Medical Practice: A Code of Conduct for Doctors in Australia’ in preparation for the introduction of national medical registration.

In June 2009, Joanna Flynn was appointed Chair of the Board of Eastern Health, one of Melbourne’s largest metropolitan health services, and in August 2009, was appointed the Inaugural Chair of the Medical Board of Australia.

She has served as a member of significant accreditation committees and advisory boards and has been a representative of the Australian Medical Council on the Expert Group on Legislation, Australian Health Ministers Advisory Committee, the Commonwealth Medical Training Review Panel and the Australian Medical Workforce Advisory Committee.

Joanna Flynn’s lucid, strongly written and informative editorials and communiqués have been integral in the dissemination of the framework of a new era in the regulation of health professions in Australia. The Australian National Registration and Accreditation Scheme which regulates health practitioners and students, is developing with Joanna Flynn as a key leader to be responsive, adaptive, open, outward facing and engaged with the professions and community. Throughout the development and implementation of this scheme Dr Flynn has been a respected source of advice and guidance.

A Membership of the Order of Australia was awarded to Joanna Flynn in 2011 for her service to medical administration and to the community, particularly in the areas of practice standards, regulation and professional education and as a general practitioner. Her tireless industry for high standards in medical practice and medical regulation throughout Australia brings credit to this University and the Melbourne Medical School.

Conferment Ceremony Graduating Associate Fellows

All of the Associate Fellows except Dr Dilip Dhupelia received their testamurs in absentia.

Congratulations to the following Associate Fellows:
Meredith Elise Arcus
Andrew Humphrey
Carmel Patricia Sheridan
Clayton Kenneth Spencer

Conferment Ceremony Honorary Fellow Dr Joanna Flynn AM

Dr Flynn has made an exceptional contribution to the development of the pivotal discipline of general practice as a distinct professional specialty. She graduated equal second, and with prizes in surgery and gynaecology, in the University of Melbourne’s MBBS class of 1975 after which she continued training in general practice and public health.

With experience in North Queensland, Tasmania and rural Victoria, for the past 20 years, she has worked in a West Brunswick practice, where she is a partner. In parallel, she was State Director of the Royal Australian College of General Practitioners (RACGP) Training Program in Victoria, for ten years until 1998.

Dr Flynn was President of the Medical Practitioners Board of Victoria from 2000 to 2008 having been first appointed to the Board in 1989, President of the Australian Medical Council from 2003 to 2008 and a member of the Board of the Postgraduate Medical Council of Victoria for eight years, and chair in 2007.

She also chaired the Australian Medical Council working party that developed the seminal ‘Good Medical Practice: A Code of Conduct for Doctors in Australia’ in preparation for the introduction of national medical registration.

In June 2009, Joanna Flynn was appointed Chair of the Board of Eastern Health, one of Melbourne’s largest metropolitan health services, and in August 2009, was appointed the Inaugural Chair of the Medical Board of Australia.

She has served as a member of significant accreditation committees and advisory boards and has been a representative of the Australian Medical Council on the Expert Group on Legislation, Australian Health Ministers Advisory Committee, the Commonwealth Medical Training Review Panel and the Australian Medical Workforce Advisory Committee.

Joanna Flynn’s lucid, strongly written and informative editorials and communiqués have been integral in the dissemination of the framework of a new era in the regulation of health professions in Australia. The Australian National Registration and Accreditation Scheme which regulates health practitioners and students, is developing with Joanna Flynn as a key leader to be responsive, adaptive, open, outward facing and engaged with the professions and community. Throughout the development and implementation of this scheme Dr Flynn has been a respected source of advice and guidance.

A Membership of the Order of Australia was awarded to Joanna Flynn in 2011 for her service to medical administration and to the community, particularly in the areas of practice standards, regulation and professional education and as a general practitioner. Her tireless industry for high standards in medical practice and medical regulation throughout Australia brings credit to this University and the Melbourne Medical School.
Gala dinner

The social highlight of the conference program was the Gala Dinner held in the Sofitel’s Grand Ballroom. Guests were serenaded by fellow guests during the RACMA Factor Karaoke, with Honourable mention to the defence forces for their enthusiastic participation.

RACMA Award Winners

College Medallion
Dr Bernie Street

Dr Bernard Street graduated in Medicine from the University of Melbourne in 1978, obtained the Diploma of Geriatric Medicine in 1983, an MBA from the Melbourne Business School in 1993 and the Fellowship of the Royal Australasian College of Medical Administrators (RACMA) in 1997. He is currently A/director of Clinical Services at the Shoalhaven District Memorial Hospital in Nowra, NSW.

Dr Street is committed to clinician engagement and leadership, improving teamwork and empowering patients in the management of their care.

Dr Street is Chair of the Continuing Education Program Committee of RACMA and its National Scientific Program Committee which organises its national conferences. His other love is theatre. He has moderated many “Hypotheticals” at major conferences and is soon to reprise the role of Fr Mularkey from “Once a Catholic” in a local Bendigo production.

Margaret Tobin Challenge Award 2013
Dr Paul Eleftheriou

Bernard Nicholson Award 2013
Dr Joseph McGirr

Langford Oration

The Honourable Justice Catherine E Holmes delivered a stirring and stimulating presentation on hospitals and natural disasters which covered the role of health care during the Queensland Floods. It was followed up by a response from our Vice President Dr Michael Walsh.

Gala dinner

The social highlight of the conference program was the Gala Dinner held in the Sofitel’s Grand Ballroom. Guests were serenaded by fellow guests during the RACMA Factor Karaoke, with Honourable mention to the defence forces for their enthusiastic participation.
I am pleased to table the Annual Report for 2012-2013. With respect to the 2012-13 Financial Report consolidated audited accounts, I am pleased to report that the College’s Auditor, Morton, Watson and Young, has provided an unqualified audit report for the year which was received by the Finance and Audit Committee on 5th August, 2013, and subsequently circulated to the Board and posted on the College website. I trust that you have had the chance to review the report on the website.

The Finance and Audit Committee has continued to meet on a quarterly basis during the year, reporting to the elected Board. Five years ago the then Federal Council of the College reviewed the issues regarding a Financial Strategy 2008-2013. I am pleased to summarise for you the highlights from my annual reports for this five year period as we embark on another five year cycle.

In 2007-08 there was the need to improve Fellowship Training Program as an AMC imperative to achieve accreditation, professional educational staff was recruited, and greater emphasis was being placed on information technology. That year there was an overall loss in the Operating Budget offset by the capital gain from the sale of the Carlton property. Proceeds from the sale were invested in a term deposit before the GFC at an attractive interest rate, which resulted in a high interest yield in 2008-09.

In 2008-09 further work identified a significant decline in numbers of Fellows with an aging membership profile which was cause for concern. However, the College achieved AMC accreditation which was funded by an additional levy on Members.

In February 2010 RACMA launched Accelerated Pathway training program, which doubled the revenue from Candidates fees. In seeking alternative sources of revenue, RACMA entered into a partnership with Phillips Fox in a project for Victoria Health to develop medical leaders. This project extended into the following year. Additional funding was also obtained for RACMA to support its trainees in the Commonwealth Specialist Training Program (STP).

In March 2010 the College purchased its rental premises in Milton Parade. The Board also commissioned a Medical Leadership Feasibility Study by Siggins Miller which highlighted some of the strategic issues facing the College.

In 2010-2011 Commonwealth funding for STP support of RACMA trainees continued. RACMA also submitted as successful tender to manage the Commonwealth Dept. of Health and Aging STP Phase 2 for Private Infrastructure and Supervision (PICS) of trainees across all Colleges’ trainees doubling the size of the secretariat for the duration of the contract. There was increased revenue from the conjoint annual conference in Hong Kong, and membership numbers increased.

In 2011-2012 we were advised by the STP program that the number of RACMA trainees would increase from 6 to 14 positions in 2013 with additional funding. Also there was an extension of the PICS contract through to 2015. RACMA also attracted funding from the Rural Health Continuing Education Program funding for an online Peer Review/360o tool, which sadly didn’t eventuate due to lack of support from Fellows.

The Conjoint conference with ACHS, AHHA and AAQHC proved a financial success.

A further levy was raised for re-accreditation by the AMC, which RACMA again was successful in securing in August this year.

In the last financial year 2012-13 the College’s financial position has improved even further with the ongoing funding from the Commonwealth Dept. of Health and Aging for the Specialist Training Program – 14 RACMA trainees, and the Private Infrastructure and Supervision (PICS) contract. The College had increases

“In 2011-2012 we were advised by the STP program that the number of RACMA trainees would increase from 6 to 14 positions in 2013 with additional funding.”
in College Membership. The operating budget resulted in a modest profit of $202,438 from a Total Income of $1.51M. Management fees earned from projects was $109,553 and Project cost recoveries were $448,014.

The “Management for Clinicians” Program was held three times during the year providing income to NZ, Vic, and NSW. The overall financial performance for 2012-13 resulted in a profit of $629,531 as compared with $602,581 in 2011-2012.

The overall improvement in the College’s Equity position of has gone from $629,532 in 2007-08 to $3,857,799 in 2012-13.

I’ve summarised the changes in the past five years in the following graphs.

**Budget 2013-2014**

As regards the Operating Budget (Core business of Education and Training excluding Project Recoveries and Management Fees) for 2013-14 it is based conservatively at $1.72M, as a balanced budget with a profit estimate of $640.

The AMC Levy is discontinued. Provision has been made for rental accommodation, two examination cycles in November, 2013 and March, 2014, with further support for Faculty education and training to meet accreditation, curriculum, and robust assessment of Candidate and Trainees training outcomes. The Board is committed to the development of an Investment Strategy for the 2013-2018 period. Detailed review will be undertaken with respect to the feasibility of setting up additional financial entities such as that of a Foundation and/or a research arm along with the potential for property investment.
I wish to thank the Members of the Finance and Audit Committee, Drs Michael Walsh, and Kevin Morris and Lee Gruner. I also wish to thank the Chief Executive Dr Karen Owen for her ongoing commitment and efforts on behalf of the College. It is largely due to her efforts that the College is now recognised as a project resource by the Commonwealth. I commend the Annual Financial Report to Fellows and Members for endorsement.

Dr Draginja Kasap
Chair, Finance and Audit Committee

The “Management for Clinicians” Program was held three times during the year providing income to NZ, Vic, and NSW. The overall financial performance for 2012-13 resulted in a profit of $629,531 as compared with $602,581 in 2011-2012.

RACMA: Equity (Specials Funds, Retained Earnings): 2008-2013

RACMA Membership: 1978-2013
The Education and Training Committee has had a successful year. I would first like to acknowledge the chairs of the Training Committee, the Board of Censors and of the CPD committee as major contributors to our work.

Since we regard the education and training of medical managers as the core business of the College the developments in educational offerings, many electronic and available to all at convenience, has been a major step in the right direction. Given the adult learning paradigm to which the College subscribes, it has been a central function of the Committee to ensure that many of the foundational aspects (for example clarification of the concept of a training year, and specificity about period of training) are established and promulgated. In this regard I would particularly acknowledge Dr Leah Barrett-Beck who, as chair of the Candidates’ Advisory Committee has assisted both candidates and the Committee to achieve sensible outcomes in these areas.

The development and promulgation of the Curriculum document 2 years ago, while a major step in the College trajectory, is in many ways the trigger for renewed educational focus for us. Among these and the steps outlined as part of the College Strategic Plan and as this will determine specific actions and working party functions, I would like to highlight two tasks for the next few years. One is to ensure that the College’ processes of assessment provide the right balance of formative (i.e. for the candidate) and summative (i.e. for the College and the protection of the Public) information. One of the most interesting outcomes of the teleconferences we conducted with Associate Fellows was their request for more feedback, more quizzes, and more formative assessment on their progress. The second, is to ensure that our assessments are consistent with current best academic practice, and equally importantly that the items in all our assessments are derived from careful mapping to the curriculum.

As you would by now have guessed, this also means that the curriculum document and its distribution to fellows, preceptors, supervisors and candidates is an ongoing activity, as must be its continuous renewal in light of what we aspire to—nothing short of world’s best practice.

I have greatly enjoyed my time as Chair and offer every support to my successor and colleague Dr Sally Tideman.

Prof Gavin Frost
Chair, Education and Training Committee
Continuing Education Program Committee Annual Report

Highlights

2013 has been another successful year for the CEP Committee. Our CEP participation rates have continued to improve, the eCEP platform is working well, the College is running increased educational activities, the program was positively reviewed by the AMC Accreditors and this year’s Annual Scientific meeting is shaping up to be an outstanding event.

CEP participation

The proportion of RACMA Fellows logging CEP activities in 2012 increased to a best ever 92.3%. This is a 2% increase on last year’s rate and reflects the dedicated efforts of all involved in the highest ever measure. The goal remains 100% in line with the AHPRA Continuing Professional Development Registration Standard and we are striving towards this goal.

Participation Rates for Associate Fellows have increased to 56.6%. This reflects the high level of engagement of AFRACMAs with the College and is a pleasing increase. We encourage all AFRACMAs to participate, acknowledging that in many cases they are participating in a number of CEP programs.

2013 is the third year of the current triennium. Fellows are reminded of the RACMA requirement to engage in a triennial peer review or self-audit/360 degree review activity by the end of the 2013 CEP year (Standard 2).

Audit of Medical Practice definition for NZ Fellows

The Medical Council of New Zealand requires that all doctors participate in 1 audit each year as part of their recertification. The definition of “audit of medical practice” will be:

A systematic, critical analysis of the quality of the doctor’s own practice that is used to improve clinical care and/or health outcomes, or to confirm that current management is consistent with the current available evidence or accepted consensus guidelines.

RACMA is updating Standard 2 of the CEP program to incorporate this definition.

Review of the CEP manual

The current edition was completed in October 2011 and includes the CEP Standards and Activity tables. The next stage of development is to increase the alignment of the activities with the RACMA Curriculum and this will occur in the next 12 months.

CEP Education Activities

In its strategic planning RACMA is exploring ways in which it can design and deliver training activities which are high quality and value for money. The CEP Committee will be working closely with the Education and Training Committee to develop a range of activities of relevance and value to Fellows, Associate Fellows and all doctors involved in medical management.

Management for Clinicians

After very successful programs in 2012 and work refining the administrative framework in early 2013 we are planning our next program in Melbourne in November 2013. I thank all members of our Management for Clinicians faculty and Dr Lee Gruner for generously conducting the faculty training sessions.

RACMA eActivities

These include webinars and learning activities:

- Peer review webinars (Commonwealth funded RHCE program – now concluded). Feedback has been positive and the webinar format is proving a very effective interactive communication channel. These activities are in hiatus while we explore alternative funding.
- Self-audit and peer review (also Commonwealth funded) – has developed a 360 degree peer review tool which is available to members.
- RACMA Interact Webinars. These monthly webinars have covered a range of medical management topics including “Clinical Governance” and “Resilience engineering in Australian Healthcare”.
- RACMA Cultural Competence. This incorporates an eLearning portal focussed around strengthening the indigenous and multicultural competence of all RACMA members.
**CEP Committee:**

**Strategic Goals for 2014-17**

Apart from activities already outlined, initiatives include:

- Continued enhancement of the RACMA eCEP platform
- Exploration of revalidation and its implications for the College.
- Development of a CEP Strategic Plan for 2014-16

**National Scientific Program Committee (NSPC)**

This Committee was established in 2008 as part of a national approach to convening the RACMA Annual Scientific Meetings. Our 2012 Conference was a RACMA focused event at the Perth Conference Centre last September. The theme was “Benefitting from the Boom-Challenges for the Health Care System”. Feedback was excellent and we had over 200 registrants - a boom number of registrants for a RACMA only conference. We are about to embark on the 2013 Conference here on the Gold Coast. This year’s theme is “High Performance in Austere times”. The mining boom has peaked, government revenues are collapsing and the health system is coming under increasing pressure to do more with less. This year’s conference features an outstanding array of prominent international and local speakers including Professor Chris Ham, Chief Executive of the King’s Fund, UK, Professor Chris Baggooley, Chief Medical Officer, Australian Government, Professor Graham Dickson from Canada and Dr William Ho from Hong Kong.

**Acknowledgements**

I would like to thank the members of the RACMA CEP Committee for their energy and enthusiasm, wealth of knowledge and contribution. Thanks also to the members of the National Scientific Program Committee and Leishman Associates, our conference organisers. The expertise and enthusiasm of this group is a key factor in our ability to convene outstanding conferences. Finally, I would like to thank our President Lee Gruner, the Board, our amazing Chief Executive, Dr Karen Owen, and the brilliant team at the National Office, especially Christine Cottrell, RACMA’s Training Projects Coordinator and Mr Dino DeFazio (Information Systems Coordinator) for their wonderful support through the year.

Dr Bernard Street
Chair, CEP Committee

---

"Feedback was excellent and we had over 200 registrants - a boom number of registrants for a RACMA only conference. We are about to embark on the 2013 Conference here on the Gold Coast. This year’s theme is “High Performance in Austere times”. "

Dr Joanna Flynn, Dr Michael Walsh and Prof Chris Ham at the 2013 RACMA Annual Conference
The Candidate Advisory Committee (CAC), with representatives of each of the State and Territories of Australia and New Zealand has continued to meet regularly to represent the voice of all Candidates of The Royal Australasian College of Medical Administrators (RACMA) in 2012 and 2013. The group meets to discuss issues and initiatives raised by candidates in all jurisdictions as well as reviewing information provided by the National RACMA Office and Board Committees providing feedback to ensure the College’s processes and policies take into account the practical and contemporaneous aspects of candidacy.

An important aspect of this function is the representation of CAC members on Jurisdictional Committees. This provides representation of Candidates at the jurisdictional level for matters arising locally but also provides jurisdictional Candidate representatives with a framework on which to draw and develop opinion at the local level to bring to the CAC for further discussion and consequent action.

Over the last twelve months a number of initiatives have been driven by the CAC. Significant changes to the ‘Eligibility to sit the Pre-Fellowship Examination’ policy were reviewed by the CAC and taken to the Education and Training Committee (ETC) for review and action. This has led to the strengthening of this policy representing a fair and equitable system governing this part of the Fellowship training program. This kind of review of policy by the CAC sets the scene for robust discussion and examination of these kinds of policies, which in the longer term assists with the continuous improvement of the training program leading to Fellowship of the College.

Communication with Candidates has also been an issue discussed by the CAC. A clear recommendation was made to the National Office that email remains the most important means by which communication should be made with Candidates. Candidates need to maintain close contact with the College to ensure that all requirements in the Fellowship training program are completed in a timely manner and close liaison of the CAC with the National Office will continue to ensure that communication methods remain contemporary and any issue can be rectified by the development of solutions. This will be increasingly important with the introduction in the future of policies effecting Candidates who do not meet deadlines for the completion of elements of the Fellowship Training Program. The development of regular ‘Ed Notes’ by the National Office has been an important initiative to provide regular electronic communication of recent changes and upcoming events with Candidates.

Governance matters have been an important area of review for the CAC with several significant changes being made to the Terms of Reference of the CAC over the last few months:

- Candidate membership on Board Committees will now be attendees of the CAC in line with formal processes now in place with the National Office to appoint these members by Expression of Interest. This will ensure a clear flow of information from these Committees to the CAC for matters requiring the feedback about candidacy.

- The position of Chair of the CAC will no longer be the Candidate Board Director. This is a crucial move in maintaining the independence of the CAC and also clearly recognises the important governance position of the Candidate Director in decision making and accountability at the Board level. These changes are in keeping with governance requirements of the College as a Company Limited by Guarantee.

As I step down as Chair of the CAC I thank the President Dr Lee Gruner for her support of Candidate matters, Professor Gavin Frost for leading the robust and professional discussions relating to candidacy matters at ETC level over the previous year and the CEO Dr Karen Owen and National Office staff for ensuring the Candidate voice is developed and strengthened.

Dr Leah Barrett-Beck
Chair, Candidate Advisory Committee
List of RACMA Members

Fellows

ACT
Baker, Jennifer Lindsay
Boyd Turner, Mary
Brennan, Leonard Basil
Burnand, Josephine
Curtis, Nicole
Davis, Stephen Clive
De Souza AM, David
Donovan, John
Dumbrell, David Milton
Edmondson, Kenneth William
Elvin, Norman Anthony
Klar, Danielle
Lambert, Rodney
Langsford OBE, William Andrew
MacCarrick, Geraldine
Navathe, Pooshan
O’Leary, Elizabeth Mary
Orchard, Barbara
Palmer AM, David Hugh
Proudfoot, Alexander
Rushbrook CSC, Elizabeth
Smart, Tracy
Walker, Robyn
Wells AM, Ronald Harry Cecil
White, Gordon Eustace E.
Wilkins MBE, Peter Sydney

HK
Chan, Wan Kin
Cheng, Beatrice
Cheng, Man-Yung
Cheung, Wai-lun
Ching, Wai Kuen
Chiu, Lily
Choi, Teresa Man-Yan
Chow, YorkYat Ngok
Choy, Khai Meng
Fong, Ben Yuk Fai
Fung, Hong
Ho, William Shiu Wei
Hung, Chi Tim
Lai, Lawrence Fook-ming
Lam JP, Ping-yan
Lam, Mei Yee

NSW
Alexander, Jennifer Anne
Atkinson, Kathleen
Austin AM, Tony
Baker, Andrew
Bashir AC CVO, Marie
Batten, Tracey
Bearham (Jnr), George
Benjamin, Susanne Jane
Bennett, Andrew Gordon G.
Bennie, Alexander
Best AO, John Barton
Blizard, Claire Maree
Blok, Charles Ronald
Bolevich, Zoran
Boss, Heidi
Boyd, Roger Gregory David
Boyd, Susan
Bull, Robert Russell
Burrows, Donald Leslie
Cable RFD, Ronald Hughes
Campbell, John
Carless, Alan James
Chan, Steevie Siu Wei
Child AM, Donald Stewart
Collie, Jean Patricia
Collins, John Malcolm
Conley, Jeanette
Currow, Elwin George
Curtis, Owen Gregan
Curtis, Paul
De Carvalho, Vasco
Dewdney, John Colin Harris
Donnelly, Roy Douglas John
Doolan, David
Douglas, Paul
Duggan AM, John Malcolm
Duncan, Darrell
Ellis, Vivienne Margot
Finlayson, Peter
Forster, Susan Lesley
Gardiner, Brett
Gobius, Risto Julianus
Golding, Robyn
Golding, Stephen John
Golding, Michael
Graves, Debra
Grunseit, Barbara Anne
Guanlao, Luisito Pangilinan
Haski, Robert Reuben
Hely, Joanna Kathryn
Hill, Kim
Ho, Leong Kit
Hockin OAM, Ralph Lionel
Holland, Howard John
Hooper, Roger Carrington
Hoyle, Philip
Jansen, Peter
Jones, Roslyn
Jump, Marie-Antoinette
Karnaghan, Jo-Anne
Kasap, Draginja
Kilien, Alice Ruth
Kotze, Beth
Lander, Harvey
Latta, Alison
Laughlin, Allan
Lee, Lynette
Mackertich, Martin
McEwin AM, Roderick Gardner
McGirr, Joseph
Miross, Christopher
Miskell, Sharon
Mok, Anne
Montague, Andrew James
Moore, Carmel
Morey AM, Patricia Sue
Murugesan, Ganapathi Asiri
Narayan, Yogendra Prakash
List of RACMA Members continued

NZ

Allen, Patricia (Pim)
Brenner, Bernard
Brown, Ian McLaughlan
Chamberlain, Nick
Clark, Kenneth
Davis, Alan
Feek, Colin
Gollop, Bruce
Gootjes, Peter Robert Findlay
Harpin, Roderick
Holmes, John
Hood, Dell Arlington
Hope, Virginia
Howard, Wayne
Jessamine, Stewart Sinclair
Johnson, Gloria
Kelly, Francesca
Kirwan, Jeffery
Mackie, Donald
Millar, Nigel
Morris, Kevin
Patel, Avind Chhotu
Pike, Pieter
Rasiah, Rebecca
Robinson, Peter
Sage, David
Watson, Tom
Welch, Lorraine
Wilsher, Margaret
Young, Wilson Wai Sang

QLD

Alcock, Annabelle
Alcorn, David
Alexander, Paul
Ashby AM, Richard Huish
Ayre, Stephen
Bell, Brian
Beresford, Bill William
Brennan, Colin Kenneth
Bristow, Peter
Bromwich, Christine Emily
Campbell AM, Charles Bryan
Chern, Inglis Wayne
Chong, Hwee Sin
Cleary, Michael

NT

Arya, Dinesh
Joyce, Brian
Katekar, Leonie
Satthianathan, Vinothini
Watson, Sara Elizabeth
Wilson AM, Pauline

NZ

Coffey, Gregory
Cooper, Barbara Marion
Copland, Geoffrey
Costello, Gerard
Crawford, Rosalind
Daly, Michael
Dines, Amanda
Doheiry AO, Ralph Leonard
Donald AO, Kenneth John
du Preez-Wilkinson, Gabrielle
Du Toit, Mauritius
Dulhunty, Joel
Edwards AC, Lwelwyn Roy
Emmerson, William
Evans, David
Falconer, Anthony
Farmer, Jillann
Fitzgerald, Gerard
Fothergill, John Lewis
Gilhotra, Jagmohan Singh
Gillies, Peter
Ginsberg, Samuel Aaron
Golledge AM, John Gouldhawke
Good, Michael
Graham, Julieanne
Graves, Judith Ann
Herriott, Bruce Arthur
Hills, Michael William
Hodge, Jonathon Vere
Holloway, Alison
Hosegood, Ian
Houston, James Henry
Jaumees, Kay
Jellett, Leon Barry
Jensen, Graeme Roland
Johnson, Andrew
Kennedy OAM, Christopher
Kitchener, Scott James
Kuehnast, Barbara
Le Baccq, Frank
Le Ray, Lance
Margetts, Craig Charles
Martin, Donald
Mattiussi, Mark
McFarlane, Jean Fergus
Menzies, John
Miller, Peter Mcintosh
Mistry, Yogesh

48 The Quarterly RACMA
Myers, Colin
Naidoo, Humsha
Naidoo, Melissa
O’Connor, Alan
O’Donnell, John James
O’Dwyer, Susan
O’Sullivan, Donna
Pakchung, David Norman
Palmer, George Rupert
Parmar, Nilesh
O’Dwyer, Susan
Pearn AM, John
Pegg AM, Stuart Phillip
Polong, Jose
Porter, Robert
Powell, Jacinta
Prado, Luis
Robinson, Pamela
Rowan, Christian
Scanlan, Brian John
Shaw, Alexis Eric
Shearer, Alexander Boardman
Smart, Timothy Francis
Sparrow, John
Stable, Robert
Stuart, Duncan
Swierkowski, Piotr
Taylor, James Ross
Thomson, Dale Leonard
Thomas, David
Trujillo, Monica
Ulrich, Peter Edward Rodney
Wakefield, John
Waller AM RFD, John Powell
Waters, Mark
Waugh, John
Weinstein, Stephen
Young, Jeannette Rosita

SA
Allan, Barbara
Baggoley, Christopher James
Barrington, Dianne
Beal AM RFD, Robert William
Czechowicz, Andrew Stanislaus
Dowie, Donald Alexander
Farmer, Christopher John
Frewin AO, Derek
Fuller, Clarence Oliver
Hall, Robert
Hoff RFD, Lothar Clemens
Jayakaran, Jayanthi
Jelly RFD, Michael Thomas James
Keamey AM, Brendon
Lian-Lloyd, Nes Bie Sian
McCoy AM, William Taylor
Merrett, Susan
Mylius, Raymond Ernest
Rozenbils, Elizabeth Stuart
Satterthwaite, Peter
Scragg OBE, Roy Frederick Rhodes
Swanson, Bruce Albert
Tideman, Sally
Wagner, Christopher Arthur
Wareham, Conrad
Webb, Richenda

TAS
Grimes, Donald
McArdis, Helen
McCann, Paul
Renshaw, Peter John
Ross Alasdair, Diarmid
Sandford, Alan
Sparrow AM, John

VIC
Ahern, Susannah
Appleton, William
Barker, Coralee
Bartlett, Jennifer
Bearham (Snr), George
Bessell, Christine Kaye
Blake, Douglas Harold
Bradford, Peter Stewart
Brand AM, Ian
Breheņys, James Ernest
Brennan, Peter John
Campbell, David
Champness, Leonard Torr
Christie, John Chalmers
Clarke, Caroline
Cole, Brian Ernest
Collopy AM, Brian
Damodaran, Saji Suseela
Davis, Alan Shaw
Devanesen, Sherene
Dhulia, Anjali
Dohrmann, Peter
Duncan, David
Dwyer, Alison
Elcock, John
Feekery, Colin
Ferguson, John
Flower, Clifford James
Flynn, Eleanor
Flynn, Joanna
Fraser, Simon
Funder, John Watson
Gallicchio, John Louis
Garwood, Mark
Graham, Ian
Gray, AO AM Nigel John
Griffin, James John Joseph
Grogan, Robert
Gruener, Lee
Hamley, Lee
Hanning, Brian
Hillis, David
Jones, Michael Robert
Kelly, Catherine
Kelly, William
Kilpatrick, Christine
Krupinski, Jerzy
Leslie, Peter Leonard
Loh, Erwin
Lowthian, Peter
Lubliner, Mark
Mah, Alastair
Majoor, Jennifer
Malon, Robert Geoffrey
Mason, Elizabeth
Mathews, Colin Lindsay
McCleave, Peter John
McDonald, Wayne
Mead, Catherine Louise
Mohr, Malcolm
Mulkins, Elizabeth
Nel, Andre
Ng, Bennie
O’Brien, Peter
Oliver, Brian Houston
Perrignon, Andrew Charles
List of RACMA Members continued

Peyton, Thomas Matthew
Phelps, Grant
Pisasale, Nella Maria
Power, John
Ramsey, Wayne
Rankin, David
Raynayeke, Valentine Joseph
Reasbeck, Philip
Sachdev, Simrat Pal Kuar
Sconw, Paul
Sdrinis, Susan
Shaw, Rosalie Jean
Shepherd AM, Stuart John
Stoelwinder, Johannes Uiltje
Street, Bernard
Sumithran, T Lakshmi
Sunderland, Ian Sydney
Trevaks, AM Gad
Trye, Peter
Tse, Vicki
Wake, Arlene Helen
Walsh, Michael
Warburton, David John
Warton, RFD Robert
Wellington, Clive
Wellington, Heather Louise
Westwood, Geoffrey
Wolff, Alan
Wooldridge, MP, Michael
Yeatman, John Samuel
Zalcberg, John

WA
Bayliss Colin, Terry
Carruthers, Kenneth John
Dunjey, Malcolm Victor
Ellis, Archie Samuel
Flett, Penelope
Forgione, Nicholas Salvatore
Frost, Gavin
Galton-Fenzi, Brian Lionel
Gill, Jagjeet Singh
Jana, Sayanta
Kelly, Shane
King, Jennifer Margaret
Lawrence, Robyn
Lee, Kwang Beng (Norman)

Lipton, George Lucien
Loh, Poh-Kooi
Maclean, Alison
Mahmood, Farhat
McNulty AO, James Columba
Montgomery, Philip
Murphy, Kevin John
Nickel Norma, Rose
Oldham, David
Pelkowitz, Allan
Phillips, Suzanne
Platell, Mark
Quadros, Caetano Francisco D.
Roberts, William Daniel
Robertson, Andrew
Russell-Weisz, David
Salmon, Mark
Smith, Darcy Peter
Williams, Timothy

Associate Fellows

ACT
Angstmann, Tobias
Dickson, Grahame
Gatenby AM, Paul
Griffin, Robert
Hallam, Lavinia Ann
Killer AO, Graeme Thomas
Loc, Jeffrey Chee Leong
Lum, Gary David
Mays, Lawrence John

NSW
Brown, Katherine Margaret
Brydon, Michael Paul
Cheng, Nga Chong
Chung, Stephen
Fiore-Chapman, Jennifer
Gatt, Stephen Paul
Goh, Shyan Lii
Harrison, John Anthony
Ho, Vincent
Kosloff, Lana
Kremer OAM, Edward Phillip
Kwong, Wyman
Lee, Cheok Soon

NZ
Alexander, Dallas
Anand, Muthur
Bailey, Matthew
Belotovski, Alexander
Keam, Susan
Morreau, Johan
Shirley, Alan John
Thompson, Belinda
Wong, Deanne

OSEAS
Al Amri, Badria
Alkindi, Said
Giele, Henk Peter
Kukreja, Anil
Thomas, Adrian Powell
Tienan, Paul Joseph

QLD
Abdi, Ehtesham Askari
Allison, Roger William Gordon
Baqir, Yasir Al-Lawati
Brophy, Conor
Buckland, Stephen
Chand, Dip
Chapman, Kenneth
Dascalu, Jack
Dhupelia, Dilip
Gabbett, Michael Terrence
Humphrey, Andrew Reid
Kumar, Jashnil
Lewin, Morris Walter
Likely, Michael John
Mallett, Andrew
McCrossin, Robert
Menon, Mahesh
Morgan, Clare
Mottarelly, Ian Wayne
Moyle, Robert
Newland, Jill
Nydam, Cornelius (Kees)
Oliver, Nicholas
Pennisi, Robert
Quigley, David Thomas
Rattenbury, Sandra
Reddan, Jill Georgina
Samy, Chinna
Seet, Geoffrey Peng Soon
Stone, Michael
Ueno-Dewhirst, Yusuke
Unwin, Alston Melvyn
Wang, John
Whiteley, Michael
Wilson, John Gilmore
Withers, Stephen
Xabregas, Antonio Avelino
Yee, Kah

VIC
Adesanya, Adesina
Allen, David
Barton, David
Bell, Richard
Bohra, Suresh
Brooks, Anne Marie Vickery
Bryan, Sheila
Burrows AO, Graham
Castle, Robert
Chan, Thomas
Chao, Michael Wan-tien
Chopra, Prem
Conyers, Robert Anthony James
Danvers, Linda
Davies, Glenn
Dewan, Patrick Arthur
Drummond, Roslyn
Fawcett, Rodney Ian
Fielding, John Mathew
Francis, Paul Howard
Jayarathe, Sami
Jensen, Frederick Owen
Judson, Rodney Thomas
Kambourakis, Anthony
Kennelly, Eric
Lakra, Vinay
Lakshmana, Raju
Lo, Emily
Longmore, Peter Graham
Lynch, Rod
Mudalil, Selva Nathan
Newton, John
Omotoso, Jose
Pedagogos, Eugenia
Prince, Henry
Rambaldo, Salvatore
Robertson, Megan
Rosenfeld, Jeffrey Victor
Rozen, Leon
Shearer, Bill Arthur Joseph
Smith, Jacqueline Bernadett
Snell, Anthony Peter John
Steele, Brendan
Sullivan, Danny
Tan, Gim Aik
Toogood, Geoffrey

WA
Andrews, Reginald
Arcus, Meredith
Barratt, Peter Stewart
Davidson, Rowan Morton
Graydon, Robert Harold
Joseph, David John
Keller, Anthony John
King, Benedict Pui-Yan
Langford, Stephen Alan
McLaughlin, Virginia
Rhodes, Helen Christine
Robins, Anthony
Rosman, Johan
Sheridan, Carmel
Stokes AM RFD, Bryant Allan Rigbye
Williamson, Geoffrey Donald

Candidates

SA
Atkinson, Robert Neville
Lethlean, Margaret
Nath, Lakshmi
Penhall, Robert
Shroff, Behzad Daran
Visvanathan, Thavarajah

TAS
Flett, Peter John
Hickman, John Arthur
Lamplugh, Ross
Oakley Browne, Mark
White, Craig

VIC
Adesanya, Adesina
Allen, David
Barton, David
Bell, Richard
Bohra, Suresh
Brooks, Anne Marie Vickery
Bryan, Sheila
Burrows AO, Graham
Castle, Robert
Chan, Thomas
Chao, Michael Wan-tien
Chopra, Prem
Conyers, Robert Anthony James
Danvers, Linda
Davies, Glenn
Dewan, Patrick Arthur
Drummond, Roslyn
Fawcett, Rodney Ian
Fielding, John Mathew
Francis, Paul Howard
Jayarathe, Sami
Jensen, Frederick Owen
Judson, Rodney Thomas
Kambourakis, Anthony
Kennelly, Eric
Lakra, Vinay
Lakshmana, Raju
Lo, Emily
Longmore, Peter Graham
Lynch, Rod
Mudalil, Selva Nathan
Newton, John
Omotoso, Jose
Pedagogos, Eugenia
Prince, Henry
Rambaldo, Salvatore
Robertson, Megan
Rosenfeld, Jeffrey Victor
Rozen, Leon
Shearer, Bill Arthur Joseph
Smith, Jacqueline Bernadett
Snell, Anthony Peter John
Steele, Brendan
Sullivan, Danny
Tan, Gim Aik
Toogood, Geoffrey

VA
Vaughan, Stephen Lawrence
Ward, Michael
Waters, Mary Josephine
Waxman, Bruce
Weeks, Anthony Maxwell
Williams, Daryl
Williams, Richard
Wong, Michael Tak Hing
Woodhouse, Paul Damian
Workman, Barbara

WA
Andrews, Reginald
Arcus, Meredith
Barratt, Peter Stewart
Davidson, Rowan Morton
Graydon, Robert Harold
Joseph, David John
Keller, Anthony John
King, Benedict Pui-Yan
Langford, Stephen Alan
McLaughlin, Virginia
Rhodes, Helen Christine
Robins, Anthony
Rosman, Johan
Sheridan, Carmel
Stokes AM RFD, Bryant Allan Rigbye
Williamson, Geoffrey Donald

Candidates

ACT
Benson, Jo-Anne
Norrie, Peter
Shah, Niral
Sharkey, Sarah Edith

HK
Lee, Albert
Lui, Joseph

NSW
Aldrich, Rosemary
Anderson, Svetlana
Banga, Pankaj
Billinghurst, Kelvin
List of RACMA Members continued

Burke, David
Carroll, Logan
Chandrasiri, Singithi
Chiu, Mary
Datynier, Michael
Dennington, Peta Michelle
Duggan, Anne
Farrow, Glendon
Giddings, Patrick
Goodwin, Samuel
Greenberg, Randall Drew
Harris, Anita Michelle
Harris, Justine
Holdaway, Joanne
Jodlovich, Tommy
King, Michael
Mansoor, Manadath
Menday Lee, Naomi
Messara, Louise
Moritz, Barbara
Nigam, Vivek
Olsen, John Robert
Sinclair, Barbara
Song, Wan Jun
Souvannavong, Deky
Tindall, Katherine
Trevillian, Leigh
Watters, Gregory
West, Elizabeth
White, Andrew

QLD
Barrett-Beck, Leah
Beck, Christopher
Bell, Anthony
Byrne, Martin
Carrahar, Eleri
Choudhary, Anand
Clements, Michael
Cooke, Georgia
Cooper, David
Joshi, Viney
Kingswell, William
Lennox, Denis
Mackinnon, Angus
McLaughlin, Erik
Murdock, Nicola
Nunnink, Leo
O’Neill, Patrick
O’Sullivan, Maree
Papworth, Gregory
Price, Kirsten
Puskarz, Thomas
Skye
Rothwell, Sean
Seierup, Dale Peter
Steel, Graham
Thompson, Peter
Thorn, Sara
Vonau, Marianne
Westacott, Lorraine
Zappala, Christopher

WA
Cheng, Victor
Denholm, Eva
Frazer, Amanda
Hawkins, Philippa
Heble, Samir
Heredia, Daniel
Koay, Audrey
Murphy, Karen
Robins, Anthony
Wilkinson, Christina

Affiliates

ACT
Mohamed, Abdel-Latif

NSW
Chew, Gerald
Cronin, Jodi-Maree
Dalton, Sarah
Searle, Judy

NZ
Earnshaw, Steven
Wilson, Alastair

QLD
Egan, Catherine
Morze, Conrad

VIC
Tse, Ka Chun
Thank You

A special thanks to all the Fellows, Associate Fellows, Candidates, Trainees, Affiliates and Faculties that contributed to the College in 2013.

RACMA would also like to thank the following Conference Sponsors and Exhibitors:

CereNET  Cognitive Institute  Xacom

Mercury  Global Medics