The Quarterly
The Royal Australasian College of Medical Administrators

RACMA
2016 ASM Harm Free Health Care
Do Medical Administrators owe a duty of care to patients for their management decisions?
Annual Reports
Last Row L-R
Dr Pooshan Navathe, Professor John Pearn AM, Dr Dale Seierup, Dr Thomas Gibson,
Dr Elizabeth West, Dr Deborah Holdsworth, Dr Gregory Simmons, Dr Troy Gianduzzo,
Dr Anthony Cidoni, Dr Rajiv Subramanian, Dr Moazzam Zaidi,
Dr Krishnaswamy Sundararajan

Front Row L-R
Associate Professor Lynette Lee, Dr Louise Messara, Dr Humsha Naidoo,
Dr Milind Sanap, Dr Vrushali Sanap, Dr Paul Eleftheriou, Dr Vinay Lakra,
Dr Michael Cleary PSM, Associate Professor Alan Sandford, Professor Hong Fung,
Dr Graham Steel, Dr Susan Inglis, Dr Ha Yun Lee, Dr Susan Nightingale,
Dr Mary Olliver, Dr Daniel Heredia

The Quarterly Continual Publication Schedule
The Editorial, Presidents Report, and College 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 the most popular read feature articles from earlier editions.

“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 Andrew Robertson
5 From the President Professor Michael Cleary
6 College Matters Dr Karen Owen
9 RACMA Annual Conference 2016
13 Do Medical Administrators Owe a Duty of Care to Patients for their Management Decisions? Dr Owen Bradfield & Professor Erwin Loh
15 Using a Leadership Capital Index to Measure the Performance of Medical Managers Dr Singithi Chandrasiri
18 Leadership Practicalities: A Wealth of Experience Dr Lee Gruner
22 Performance Management: Difficult Conversations Associate Professor Alan Sandford
26 2015/16 Finance & Audit Report Dr Humsha Naidoo
27 Education and Training Report Dr Pooshan Navathe
28 Continuing Education Program Report Dr Liz Mullins
29 Board of Censors Annual Report Associate Professor Alan Sandford
30 Successful Launch of RACMA’s Learning and Teaching Centre Ms Cassie Smith
32 Specialist Training Program Update Ms Valerie Ramsperger
34 Candidate Report Dr Sergio Diez Alvarez
36 RACMA Members as at November 2016
44 State/Territory, New Zealand and Hong Kong Committees
Gone to pot?

In a recent newspaper front page, the headlines asked whether Australia had “Gone to Pot?” This highlighted, albeit in a sensational way, that medicinal cannabis was to be rescheduled as a Schedule 8 drug from 01 November 2016. So where are we at with medicinal cannabis and why is it relevant to medical administrators?

Cannabis broadly refers to the constituents of a plant that includes approximately 70 cannabinoids, the most psychoactive of these being tetrahydrocannabinoid (THC). Cannabis is currently listed in Schedule 9 (prohibited) of the National Poisons Standard. On 31 August 2016, the Therapeutic Goods Administration decided to list cannabis-based products in Schedule 8. Non-medicinal use will remain Schedule 9 and continue to be prohibited. This came into force on 01 November. In addition, the Commonwealth Narcotic Drugs Act 1967 was recently amended to allow cultivation of cannabis and manufacture of cannabis-based products for research and medical purposes. The license and permit scheme, to be run by the Commonwealth, also opened on 1 November 2016.

These changes addressed some of the legal impediments to the prescription of medicinal cannabis, but did not resolve some of the broader issues around its prescription and use. The first of these is supply. There is currently no supply, as to date, there have been difficulties sourcing suitable overseas products due to shortages, international laws preventing imports, and prohibitions inside Australia. This is likely to be resolved as both overseas and Australian products become available in 2017. The second issue is use. Once we have a supply of pharmaceutical products, the form of which remains unclear but won’t involve smoking or otherwise taking pure cannabis or cannabis oil, then which patients should be receiving these products? This will become an issue for jurisdictions as expert medical bodies grapple with which authorised medical specialists should be prescribing which product or sub-component for which condition, noting that strength of evidence for benefit is low to moderate at best. The Royal Australian College of General Practitioners (RACGP) Position Statement of October 2016 provides a good overview of medicinal cannabis and summary of the evidence base for various conditions (http://www.racgp.org.au/download/Documents/Policies/Clinical/RACGP-position-on-medical-cannabis.pdf).

As medical administrators, there will be increasing consumer pressure to include these products in hospital drug formularies, particularly as they are likely to be initially expensive. While supply as part of formal research project will help to add to the evidence base for their use, more widespread use will need to be managed very carefully by hospitals and medicines regulators to ensure that costs don’t rapidly outweigh benefits. It will be interesting to review where we are in 2 years and see what lessons have been learned on this journey.

In 2017, I am again looking to Fellows, Members and Candidates to submit papers on those issues that are challenging, confronting, bemusing or simply frustrating them. Feedback on what Fellows, Members and Candidates want from The Quarterly is also welcome, as we continue to develop The Quarterly over the coming years.

Dr Andy Robertson
Editor
From the President

RACMA has made several submissions in the last 12 months, including a submission to the Medical Board of Australia’s Expert Advisory Group on Options for Revalidation in Australia. We were proud to state in our submission that RACMA’s 2017 CPD program is strongly aligned to the approach to CPD outlined in the consultation paper. Our submission does highlight, however, specific areas for consideration for successful implementation of revalidation in Australia, which we are happy to work with the MBA on achieving.

This year, RACMA launched the Learning and Teaching Centre. The Learning and Teaching Centre (LTC) was instigated with the objective of providing high level and quality education for members in partnership with leading national and international universities. This year saw the first forum in May, which was extraordinarily successful, and I must thank all those involved for their work. In 2017, RACMA will be running three LTC professional development forums as well as the Annual Scientific Meeting.

RACMA has furthered its relationships with key stakeholders, including the Department of Health and Ageing in relation to the Specialist Training Program, the Departments of Health in Tasmania, Victoria and Queensland regarding AFRACMA training opportunities, the Council of Presidents of Medical Colleges (CPMC) regarding joint initiatives and advocacy, the Australian and New Zealand Medical Councils regarding accreditation, and the Medical Board of Australia regarding revalidation.

There has been significant work undertaken this year to amend the constitution and implement reforms to enable the College to enhance the mix of skills and expertise on the Board, as RACMA secures its position as providing excellence in medical management.

I acknowledge the incredible work of the College. From the accreditation of training, the training of candidates through to the examination program and CPD, and now health advocacy. This can only be achieved through the hard work and commitment from the members and the national office.

Can I thank formally, Preceptors, Coaches, Supervisors and Censors. A big thanks to Jurisdictional Committees and the wider faculty of trainers and educators. I would also like to thank Board members, the RACMA national office, and the Chief Executive.

I look forward to the year ahead, and seeing the College continue to evolve in its role of setting the standard for excellence in medical management.

Dr Michael Cleary
President
The National Office has engaged with Members these past 12 months for some significant activities – some of which are outlined below.

**Clinical governance**

When a group of senior Fellows met in Sydney mid-year, they came to discuss the significance of the College’s role in clinical governance. Participants were explicit about what they did, what they taught and that RACMA should clearly articulate the key role of its Fellows in stewarding quality and safe systems of care in Australasian health systems.

Participants quickly surfaced definitional issues during discussion about responsibilities and accountabilities within organisations. There emerged strong support to differentiate Boards’ governance and medical administrator responsibilities in oversight and management of systems clinical governance.

RACMA’s Board has accepted a recommendation from this meeting, that the College develop a position statement on clinical governance and a training program to develop Members’ management and technical capability as practitioners within clinical governance systems.

**Talking to Medical Leaders**

As part of an STP funded project, stories about the contributions, challenges, opportunities and careers of senior College Members have been recorded for the first time. These medical leader profiles highlight the attributes of exemplary medical leadership and management in Australian and New Zealand health care. The project will provide for a series of online resources for Candidates in training from 2017.

Interviewees have included:

**Dr Michael Cleary:** On leading change, the implementation of the National Health Reforms in Queensland Health and the importance of consistency, persistence and resilience in challenging times. Michael also discusses authentic leadership, making genuine connections and building trust as important characteristics of any leader in high performance organisations.

**Dr Lee Gruner:** On passion, engagement initiatives in quality and safety and health system change. Lee believes advocacy for the junior medical workforce is essential in today’s health care system.

**Dr Michael Walsh:** On mentors, the practice of reflection to enhance one’s effectiveness and the importance of teams. Michael also talks about his experience with cultural, religious and system differences between health in Australia, the UK and the Middle East. As a big picture thinker, Michael believes that we all need to look outside of health for answers, taking what can be learnt and applied in health from non-health organisations.

**Dr Donna O’Sullivan:** On leadership styles, reflective practice, self-awareness and considers the qualities of good mentors both within and external to health.

**Dr Michael (Taffy) Jones:** On delivering bad news in a good way, experiences with the United Nations and the World Health Organisation and taking action when you see something needs to be done. Taffy also provides advice to today’s medical leaders such as ‘never underestimate the politics of a situation’, ‘be visible to staff’, ‘listen’ and ‘be relatable to people’. Taffy strongly believes that doctors need to support each other and ensure each other’s wellbeing in the doctor’s community.

**Dr Barry Catchlove:** On becoming the first Chief Executive of the Royal Children’s Hospital Melbourne. This time provided an opportunity to lead reform with a total health service restructure. Barry discussed the importance of recognising the need for change and driving change, particularly in the situation of implementing mandatory reporting of child abuse in Victoria and changing the emphasis on prioritising the needs of children, rather than the rights of their parents.

**Dr Chris Baggoley:** On the significance of curiosity; never saying ‘no’ to a new experience, system-wide thinking and incorporating the broader medical environment in one’s thinking such as government, universities and other medical colleges. ‘Circumstances come and go that knock you ‘off-course’ and you’ve got to carry your people with you, they need to trust you and you need to be able to communicate with them that whatever you’re doing has their best interests at heart’.

**Dr Sara Watson:** On the complexities of rural, regional and remote health in
the Northern Territory. The importance of broad consultation, collaboration and multidisciplinary groups in the Northern Territory is pivotal in achieving quality health outcomes. Sara highlights that medical leaders in rural areas must develop a high level of resilience, a high degree of self-insight, have a bigger picture view and be able to maintain focus on the end result.

Dr Ian Brand: On creation of the RACMA Constitution and being one of the original signatories ‘In 1966 we started. At a meeting of the College, I moved that we form a College of Medical Administrators. Ian Howard was the Medical Superintendent at The Alfred at the time; he seconded and the motion was passed. There were 5 Medical Superintendents and 4 distinguished Non-Medical Superintendents, we drafted a constitution, what should be done, and then incorporated the College, we were the nine signatories.’ ‘People now have a better appreciation of the medical administrators.’

Rural and Regional themes in new training programs

The Commonwealth, through the STP program will fund five new RACMA training posts in 2017 as part of the Integrated Rural Pipeline Project (IRTP) initiative. Further to this, the College has been in continuing discussions with Tasmanian, Victorian and Queensland health representatives about training specifically for rural and regional medical leaders. To prepare for these training programs we have teleconferenced with College Members working in these settings to further our understanding of the rural/regional context vis a vis the metropolitan one - the one which most often influences our training. The College will establish a Rural & Regional Advisory Group to develop stronger support strategies for rural health programs and RACMA training.

Research in the Fellowship Training Program

This year we have begun to seen the early results of the College’s training in research program. Several Candidates have now submitted and passed their research based papers on themes as diverse as:

- An analysis of the attitudes of resident medical officers towards futility of care
- The Australian Open disclosure framework – changes at the coalface?
- Do multiple patient bed moves during an in-patient stay result in a higher falls rate?
- Fatigue Risk Assessment for three rural hospitals in QLD. A fatigue Risk Scan using principles of the QLD Health endorsed Fatigue Risk Management System Resource Guide
- Motivators of medical specialists in choosing to work in the public or private health sector
- Medical students’ attitudes, beliefs and experiences of leadership in health: a preliminary study on the teaching of clinical leadership in the undergraduate medical curriculum in Australia and New Zealand
- Is there a substantial difference in local complications of inserted peripheral venous catheters in hospital patients following the substitution of a dedicated intravenous therapy team with a multi-faceted education program?
- Sustainability, Effectiveness and Safety implementing a preoperative Rational Investigation Ordering Process
- To explore Senior Medical Staff (SMS) perception of accreditation processes and its impact on quality and safety in a mental health setting
- A possible methodology for the investigation of the local impact of changes in national health policy.

Branding the College

Many will be aware that the Board is sponsoring a significant project to position and promote the role and contribution of RACMA and its Fellows in the health system. This work will continue into 2017 as the College and its consultants develop a broad communications strategy for the College.

Learning and Teaching Centre: Professional Development Forums

In 2016 we launched a significant College initiative with the May Professional Development Forum in Melbourne. The PD Forums program is designed for Fellows and Associate Fellows with their professional development requirements in mind. All programs delivered at the Forums are College accredited and map back to the RACMA CEP Standard and the Medical Leadership and Management Curriculum Framework. Feedback from the May Forum was very positive; the atmosphere was exciting and inclusive of all categories of membership.

In 2017 we will offer an extended program including masterclasses for
senior Fellows, SkillsLabs for practical skill development and the Professional Practice Review Program offering audit and peer review activities that are relevant to the medical administration specialty.

The 50th year celebrations will umbrella the 2017 Forum program commencing at the February Summer PD Forum, then welcoming international WFMM delegates at the June Winter PD Forum and reaching an exciting crescendo at the October Spring PD Forum and ASM with the 50th celebration dinner at Melbourne’s famous MCG.

The National Office comprises a group of 17 people and provides administrative support services to College Members and other specialist practitioners throughout the year. The table provides one view of this support and includes event organisation, writing and developing programs and administrative services through 2016.

**Dr Karen Owen**  
Chief Executive

<table>
<thead>
<tr>
<th>Meetings</th>
<th>Workshops</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board</td>
<td>5</td>
</tr>
<tr>
<td>Executive Committee</td>
<td>5</td>
</tr>
<tr>
<td>Finance and Audit</td>
<td>4</td>
</tr>
<tr>
<td>Learning &amp; Teaching Centre Advisory Committee</td>
<td>7</td>
</tr>
<tr>
<td>Policy &amp; Advocacy Committee</td>
<td>2</td>
</tr>
<tr>
<td>Education &amp; Training</td>
<td>4</td>
</tr>
<tr>
<td>Board of Censors</td>
<td>2</td>
</tr>
<tr>
<td>CEP Committee</td>
<td>3</td>
</tr>
<tr>
<td>Progression Committee</td>
<td>2</td>
</tr>
<tr>
<td>Accreditation Panel and Teams</td>
<td>43</td>
</tr>
<tr>
<td>RPL Panels</td>
<td>4</td>
</tr>
<tr>
<td>Jurisdictional Committees</td>
<td>6</td>
</tr>
<tr>
<td>AGM</td>
<td>1</td>
</tr>
<tr>
<td>ASM</td>
<td>26</td>
</tr>
<tr>
<td>WFMM</td>
<td>5</td>
</tr>
<tr>
<td>CPMC and CEOs Meetings</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Training</th>
<th>Workshops</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction</td>
<td>1</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
</tr>
<tr>
<td>Pre-Fellowship</td>
<td>1</td>
</tr>
<tr>
<td>National Trial</td>
<td>1</td>
</tr>
<tr>
<td>AFRACMA</td>
<td>3</td>
</tr>
<tr>
<td>M4C</td>
<td>2</td>
</tr>
<tr>
<td>Practical Leadership (Tas)</td>
<td>2</td>
</tr>
<tr>
<td>May PD Forum</td>
<td>12</td>
</tr>
<tr>
<td>Interacts</td>
<td>6</td>
</tr>
<tr>
<td>Learning Sets</td>
<td>46</td>
</tr>
<tr>
<td>Faculty Ed</td>
<td>6</td>
</tr>
<tr>
<td>Graduations</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Projects</th>
<th>Workshops</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum</td>
<td>1 day</td>
</tr>
<tr>
<td>Clinical Governance</td>
<td>2 days</td>
</tr>
<tr>
<td>Branding and Communications</td>
<td>18 telco, and 5 focus groups</td>
</tr>
<tr>
<td>Strategic Planning</td>
<td>6 telco</td>
</tr>
<tr>
<td>Medical Leader Project</td>
<td>52 interviews</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communications</th>
<th>Workshops</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submissions and E-newsletters</td>
<td>30 papers</td>
</tr>
<tr>
<td>The Quarterly</td>
<td>4 issues</td>
</tr>
</tbody>
</table>
This year’s conference, *Harm Free Health Care*, was strongly attended and saw a significant rise in sponsorship compared to previous years.

The conference was held at the Brisbane Convention & Exhibition Centre, 12-14 October 2016.

The conference was held over three days, and included pre-conference workshops, a site visit to Princess Alexandra Hospital – Australia’s first large scale digital hospital, breakfast sessions, panel discussions, the conference dinner, and awards.

Dr Stephen Bergman (AKA Samuel Shem) was the international guest speaker at the 2016 conference. His presentation, Staying Human in Medicine: From the House of God to Spirit of Place, was strongly attended and a highlight of the conference.

There was a significant increase in sponsorship and registrations in 2016 compared to previous years.

There were more than 300 registrations for RACMA 2016, which included complimentary, full and partial registrants for delegates, speakers and sponsor/exhibitors.

Award recipients at this year’s conference include:

- **Honorary Fellow**: Professor Jeffrey Braithwaite
- **College Medallion**: Associate Professor Lynette Lee
- **Margaret Tobin Award**: Dr Sonia Chanchlani
  “Exploring the Impact of a Peer Led Mentoring Program on the Psychosocial Wellbeing of Junior Doctors”
- **Best Oral Presentation**: Dr Rosemary Aldrich
  “Invisible Injuries: Patient Harms We Hear About When We Take the Time to Ask”
- **Best Poster**: Dr Joel Dulhunty
  “Hand hygiene awareness: from the inside looking in”
- **Best Junior Poster**: Dr Lynette Knowles
  “Ward Call: scoping the nocturnal hospital environment and activity”.

RACMA would like to thank the people who contributed towards the success of the Conference.

RACMA would like to particularly thank our sponsors, Avant, Cerner, Medtasker, and Litmus, our supporters, Elsevier, Erromed, and MinterEllison, exhibitors, and the people who worked to organise the conference, including the Conference Steering and Program Committee chaired by Dr Luis Prado, Christine Cottrell from the National Office, and Leishman Associates.
Dr Stephen Ayre, Dr Melissa Naidoo, Dr Luis Prado, Dr Michael Cleary

Samuel Shem MD. Staying Human in Medicine: From the House of God to The Spirit of Place

Dr Steve Hambleton. High Performing Health Systems Engage Patients

Dr Nicola Ward, Dr Brett Gardiner, Ms Georgia Cameron

Dr Monica Trujillo, Dr Luis Prado

Professor Hong Fung

Dr Mary Olliver, Dr Justine Harris

Dr Leonie Katekar and Melissa Fox. The Great Debate: Financial Incentives and Penalties to Drive Better Patient Outcomes
Conferment Ceremony

Fellows

Congratulations to the following Fellows who received their testamurs in absentia:

- Dr Maxwell Alexander
- Dr Martin Byrne
- Dr Logan Carroll

Congratulations to Professor Jeffrey Braithwaite for the award of Honorary Fellow:

Dr Anthony Cidoni
Dr Dale Seierup
Dr Daniel Heredia
Dr Deborah Holdsworth
Dr Elizabeth West
Dr Graham Steel
Dr Gregory Simmons
Dr Ha Yun Lee
Dr Louise Messara
Dr Mary Olliver
Dr Paul Eleftheriou
Dr Susan Nightingale
Dr Thomas Gibson
Dr Vinay Lakra
Associate Fellows

Congratulations to the following Associate Fellows who received their testamurs in absentia:

- Dr Fiona Abell
- Dr Yogendra Agrawal
- Dr Victoria Atkinson
- Dr Lynette Bellamy
- Dr Lisa Brichko
- Dr Leonard Chen
- Dr Asha Chitrarasu
- Dr Steven Earnshaw
- Dr Sally Edmonds
- Dr James Evans
- Dr Louise Flood

- Dr Geetha Giri
- Dr Nicolette Hallin
- A/Prof Nerina Harley
- Dr Jocelyn Howell
- Dr Suhail Imran
- Prof Jane Ingham
- Dr Anthony Jackson
- Dr Sachin Joshi
- Dr Georgia Karabatsos
- Dr Preeti Krishnan
- Dr Yee-May Ling
- Dr Vinodh Madapusi
- Dr Marc Maguire
- Dr Wael Mohamad
- Dr Kiran More

- Dr Sathiaseelan Nair
- Dr Shriram Vaidya Nath
- Dr Jayanthi Ramanathan
- Dr Daniel Roertgen
- Dr Amitesh Roy
- Dr Dominik Rutz
- Dr Nathanael Sheehan
- Dr Mohammad Shuaib
- Dr Romesh Singam
- Dr Amitra Singla
- Dr Andrew Stapleton
- Dr Rebecca Thomas
- Dr Nazeer Ahamad Upanal
- Dr Tom Yap
- Dr Nicola Yuen

Award Winners

College Medallion
A/Prof Lynette Lee

Margaret Tobin Award
Dr Sonia Chanchiani
Do Medical Administrators owe a duty of care to patients for their management decisions?

- Dr Owen Bradfield & Professor Erwin Loh

It is well established that hospitals owe both a common law and contractual duty of care to patients, and are also vicariously liable for breaches by their employees. It is also clear that medical administrators owe contractual obligations to their employers. However, what is not so clear is whether medical administrators also owe a direct duty of care to patients of the hospital. This article briefly examines the four principal cases.

The seminal case is that of Roylance v General Medical Council [2]. Dr John Roylance, CEO of United Bristol Healthcare NHS Trust, was charged with serious professional misconduct by the General Medical Council for failing to investigate complaints from hospital staff about unacceptably high mortality rates for children undergoing cardiac surgery. On appeal to the Privy Council, it was held that a medical administrator had a duty of care towards patients in his hospital system as a medical practitioner, and that this ‘obligations to care for the sick... did not disappear when he took on the [administrative] appointment, but continued to co-exist with it.’

Lord Clyde said that there should be no distinction between medical administrators and other clinicians because the interests and safety of patients are of paramount concern to both.

The first case in Australia to consider Roylance was Fitzgerald v The Medical Board of Queensland [4]. Dr Gerald Fitzgerald was Chief Health Officer of Queensland Health during the time that Dr Jayant Patel worked at Bundaberg Hospital. The Medical Board of Queensland argued before the Queensland Civil and Administrative Tribunal that his failure to properly investigate complaints about Dr Patel amounted to unsatisfactory professional conduct.

The Queen (on the application of Remedy UK Ltd.) v General Medical Council [3] considered the findings in Roylance but came to a different conclusion based on the facts of the case. Sir Liam Donaldson (Chief Medical Officer) and Professor Sarah Thomas (Chair of the Steering Committee) faced allegations of professional misconduct following the failed implementation of a medical vocational application service. However, the High Court disagreed, finding that the ‘making and implementation of government health policy is not a medical function, even where the policies in issue directly relate to doctors and closely affect the medical profession.’ Importantly, it was noted that the actions of Sir Donaldson and Prof Thomas were “wholly divorced” from a clinical setting and “did not even directly” affect patient care. As they were largely carrying out a government function, their medical skills were only “peripherally relevant”.

The medical administrators owed a duty of care to patients in their hospital system as medical practitioners, and that this duty continued to co-exist with any administrative duties they may have. The cases highlight the importance of ensuring that all those involved in the management of a hospital system are aware of their responsibilities to patients and are held accountable for any breaches of duty.
However, the Tribunal found that the material provided to Dr Fitzgerald about Dr Patel by staff at Bundaberg Hospital was inconsistent and sometimes contradictory and that not all concerns were communicated to him as requiring an urgent response. Four experts in medical administration assisting the Tribunal felt that Dr Fitzgerald acted appropriately. No argument was raised that Roylance did not apply to Dr Fitzgerald, but the case failed instead on its merits.

The only other case that considered the application of Roylance in Australia was Keating v Medical Board of Queensland [5]. Dr Darren Keating was Director of Medical Services at Bundaberg Base Hospital during the time that Dr Jayant Patel was operating there. As with Dr Fitzgerald, the Medical Board of Queensland alleged that he had engaged in unprofessional conduct for failing to follow up on complaints and for allegedly misleading others about the true extent of the problem. Unfortunately, the reasons for the Tribunal’s decision remain subject to a suppression order that, to the authors’ knowledge, was not lifted. However, it has been reported elsewhere that a condition was imposed on Dr Keating’s practice that ‘he not practise as a Director of Medical Services, or in any similar administrative position, in any public or private hospital’.

In summary, it would appear to be the law in Australia that registered medical practitioners working as specialist Medical Administrators are subject to the same standards of professional conduct as other registered medical practitioners in circumstances where their management decisions have a direct effect on patient outcomes. Although the case law to date only deals with professional conduct claims, there is no reason to suspect that a common law duty will not be implied into the relationship between Medical Administrator and hospital patient.

Dr Owen Bradfield
Senior Claims Manager, Avant

Professor Erwin Loh
Chief Medical Officer, Monash Health
Clinical Professor, Monash University

References

2. [2000] 1 AC 311
3. [2010] EWHC 1245
4. [2010] QCAT 565
5. [2009] QHPT D3299/08
Using a Leadership Capital Index to measure the performance of Medical Managers

Dr Singithi Chandrasiri

The ultimate goal of RACMA medical managers is to combine our clinical knowledge and administration experience to successfully manage health care organisations in achieving optimal performance of patient safety and quality outcomes while maintaining financial viability of the organisations in which we serve. So, investing in leadership development and upholding a high standard of leadership competence can be said to be the whole objective of our medical management training. This is reflected in the abundance of studies describing what good leadership is and how to achieve it.

However, apart from the current CANMeds model of assessing leadership competency, there is not much evidence in how to actually quantify or measure what good leadership is to any degree of confidence. It is here that perhaps we in the medical management field can benefit from borrowing and adapting the practices of our financial industry counterparts.

We do not need more standards defining the highest ideals of what good leadership and management should look like. What we need is an index or a rating system that can measure the performance of leadership to a more specific, quantifiable and accurate degree. A leadership ratings index will be able to assess the leadership capabilities of the current and future medical management workforce as well as provide a means of standardising their training and education requirements. It will also assist in informing the relevant stakeholders about the real-life readiness of hospitals and healthcare teams in meeting current and future healthcare challenges.

So, if we are to freely adapt from the financial industry’s notion of a ‘Leadership Capital Index’, both individual and organisational domains should be included in the measurement process. Individual qualities that are currently assessed such as character traits, behaviours, and level of emotional intelligence...
should be supplemented by an assessment of a range of more specific factors. These should include an assessment of the extent to which leaders are able to strategise, execute plans, build commitment and contribution from others, as well as an assessment of how consistently they perform in meeting patient/customer expectations. Simultaneously, organisational measures on the other hand should assess the system that these leaders have created to manage clinical governance and operational proficiency and how readily these various processes are being adapted in meeting the specific conditions and challenges that arise in their respective healthcare organisations.

David Ulrich proposes the following 10 leadership factors that should define the two domains of a leadership ratings index when assessing the market value of private commodities:

**Individual:**

1. Personal proficiency: To what extent do leaders demonstrate the personal qualities to be an effective leader (e.g. intellectual, emotional, social, physical, and ethical behaviors)?

2. Strategist: To what extent do leaders articulate a point of view about the future and accordingly adjust the firm’s strategic positioning?

3. Executor: To what extent do leaders make things happen and deliver as promised?

4. People manager: To what extent do leaders build competence, commitment, and contribution of their people today and tomorrow?

5. Leadership differentiator: To what extent do leaders behave consistent with customer expectations?

**Organizational:**

1. Culture capability: To what extent do leaders create a customer-focused culture throughout the organization?

2. Talent management: To what extent do leaders manage the flow of talent into, through, and out of the organization?

3. Performance accountability: to what extent do leaders create performance management practices that reinforce the right behaviors?

4. Information: To what extent do leaders manage information flow throughout the organization (e.g., from top to bottom, bottom to top, and side to side)?

5. Work practices: To what extent do leaders establish organization and governance that deal with the increasing pace of change in today’s business setting?

As medical managers, in our daily dealings with the ‘business’ side of health care, I think we have much to glean from the learnings of our financial industry counterparts.
This leadership capital index is therefore composed of measures of the elements and indicators of the five individual and organisational domain factors. The means by which these 10 measures are rated could be obtained via interviews, observations, formal assessments, surveys and/or reports and tailored to suit the objective – whether it is measured on a numerical or qualitative scale.

This approach then provides us with a rigorous and relevant means of evaluating a leader’s performance, and in our case, a healthcare organisation’s full market value (as an added dataset to the routine KPIs and clinical indicators that are already being monitored in each). In addition to the benefits this provides for an assessment of medical management training, hospital boards and relevant monitoring bodies will have a more comprehensive process for evaluating the quality of leadership within and between organisations. This will help to better inform them of any adjustments or improvements that may need to be made to existing strategic plans and processes.

All of this will in turn then foster constructive competition for better clinical governance between health services and in achieving better patient outcomes. Realising the market value of leadership in this manner could even have a significant impact on other governance processes, risk management approaches, corporate practices, level of social responsibility, and professional reputation of the individual healthcare organisation as a whole. This will then allow for a more definitive and realistic measure of the impact leaders have on the intangible value of an organisation.

It may even impact on achieving cost-benefit efficiencies and contribute to containing national health expenditure. And be of particular benefit in the private sector, where higher ratings will enable a means for a stronger negotiating position in contract negotiations with health funds and doctors. Further, a higher rating will serve to increase the market appeal of private health services leading to attracting more patients, positively impacting medical staff recruitment efforts and provide a means of eliciting additional sources of contributory funding.

So (somewhat) briefly, in “transitioning from the narrow or ‘gut feel’ assessment of leadership capability to an index that can start to predict the impact leaders have on intangible value creation to an organisation, (we can potentially) change the entire game of leadership assessment and development” of our future medical management workforce. It is perhaps then time for us now as medical managers to invest in this brave new concept of a Leadership Capital Index.

References

Leadership practicalities: A wealth of experience

Leadership practicalities: A wealth of experience I think most of us would agree that it is not easy to be a Prime Minister, always in the public eye, always being subject to criticism (both warranted and unwarranted), always subject to expectations (achievable and non-achievable) and having to deal with rude and uncompromising interviewers on a regular basis. Would we like the job? I don’t really think so. If we did, more of us would have gone into politics.

I think most also would agree that over the past decade, our prime ministers seem to have lacked the leadership qualities that we expect from someone in this high office, who is in many ways the face of our country. I do think that each time the new PM has been given a honeymoon period to allow them to hit their straps, but each time seems to have found wanting and the press has turned against them. Perhaps the exception to this was Julia Gillard, who did not appear to have a honeymoon period, perhaps because of the way she was initially anointed. The press in this case was vitriolic from the start.

So here we are with yet another PM where the hopes were high: the end of three word slogans, the end of right wing rigidity and the end of a pugilistic opposition leader type stance. But no, it seems the honeymoon is over and there is a shambolic lack of preparedness to take a stand on issues that will determine Australia’s future. The lack of the sort of decision making needed at this time is almost breathtaking.

So it was more than appropriate to have today’s Age newspaper in Victoria devote a page to the last PM we had who actually displayed some leadership qualities, about his take on leadership. The article is written to commemorate the 20th anniversary of John Howard’s ascension as PM, when he was asked to reflect on the reasons for his longevity. This is not about political parties. There were definitely leader PMs before John Howard, but these have not gone into print in this way in recent times. And sadly, since John Howard in my opinion, we have not had a PM that I would put forward as a leader.

So what did John Howard have to say that caught my attention and had me saying yes: take this to heart Malcolm Turnbull and then perhaps we might get Australia out of the doldrums? Not only this, but take this to heart RACMA membership and you will always do a good job in a leadership position, no matter what environment this is in.

What he has said, is simply really good common sense and certainly worthwhile noting. Here is someone who carried an onerous job successfully for more than a decade and so can certainly provide us with a degree of wisdom. Here are John Howard’s practical secrets to success:

- Never miss a meal
- Make time to think
- Clear the desk
- Keep colleagues happy
- Maintain stability
- Do something.

Never miss a meal

Here JH talks not only about meals but also about his daily walks and short catnaps during the day. To me he is saying “remember to look after yourself”, “you need to maintain your health”, “you need to have a routine.” It is telling that this is the first of the secrets to success as I think it is true for all of us. If you don’t look after yourself effectively, it is impossible to look after your organisation and the people in it. There is nothing like a regular and unbreakable health routine to ensure you are always at the top of your game.

At RACMA we often talk about work-life balance, but this is quintessential work-life balance. It is something that is built into every day and so maintains a core of work-life balance within the working day, not just outside of work.

Make time to think

All leaders are busy everyday with appointments and events lined up, so that is barely a minute to even attend to key bodily functions as they rush from place to place, attend to emails, talk to people, write reports and give talks, in between solving problems and dealing with difficult issues and people. I have

“At RACMA we often talk about work-life balance, but this is quintessential work-life balance.”
no doubt a PM’s life is even busier than this. But JH wisely indicates “you also need time to think and to talk about things to people whose advice you value.”

How simple and yet how significant is this statement. We acknowledge that reflection is an essential part of being a successful leader, yet how many of us routinely put aside time to reflect on the weighty issues that impact on our organisations and lead us to in–depth strategic thinking. Do our discussions with colleagues focus just on the operational or do we foster real in-depth discussions with them to collect and collate all the wisdom that they can bring to analysis and decision making? Do we actually routinely make time for these sorts of discussions rather than trying to do things on the run in our busy, busy days?

There is no doubt in my mind, that unless we do consciously build in personal reflection time and strategic discussion time, these things will simply not happen and all of the incredible brains we have at our disposal in a leadership position in the health arena will not be effectively utilised.

Clear the desk

How many times do we hear this from management gurus? JH says that “if you don’t clear your desk, the routine becomes urgent and difficult.” This is something we all know. It is absolute motherhood, but do we actually do it? A super-busy leader really has no time to look at simple things more than once, make decision what to do with them and get them off the desk. This leaves time to do the really important things. As JH says 10% of what comes across your desk needs more thought so spend your time on the important 10% not the easily dealt with 90%. These are usually the things that you delegate to others. Not doing this leads to enormous frustration for the leader’s team and often a sense of not being valued or supported.

Clearing the desk means that things can get done in a reasonable timeframe, things don’t get put off and the work actually gets done. What JH indicates is that a good system is needed to ensure that clearing the desk is done appropriately and any leader needs to develop their own system that works not just for them but for the people things are delegated to.
Leadership practicalities: A wealth of experience continued

Keep colleagues happy

At first glance this seems like a trite sort of statement, but when JH’s comments are analysed, this is actually about listening to colleagues and understanding that you as the leader are also part of a team. As PM of course, as he points out, you are chosen by the party room “and that is where you get your authority.” This is of course different in organisations where the leader is appointed to a substantive position, not elected. Nevertheless, the maxim holds true. JH indicates that he stayed to the end of party meetings even though many had gone to show that “he was interested in their point of view.” He also visited the dining room to eat with and talk to colleagues. There has been considerable mention of this at other times by various commentators indicating the importance of having the common touch and how different JH has been in relation to his successors in this regard.

This is good example of the use of emotional intelligence, that sociability with a purpose, the being prepared to give people the opportunity to express their views in their environment rather than in the formal environment of the leader’s office, which can be daunting for some.

I am sure that JH did not always take the advice of the party room and this is normal for any leader. However the key is to solicit advice, listen to advice, take it on board and if it doesn’t fit then explain why. This is a key to good teamwork and keeping your colleagues feeling that they are valued.

Maintain stability

JH points to the fact that the top team of PM, Treasurer and Foreign Minister remained the same over almost 12 years, a “record unmatched in Australian history.” While one might argue about how long is too long, the underlying message is clear. When you have experienced people, keep them and make use of their significant experience and contacts so that you can continue to build on what has gone before rather than having to start again.

The health organisations that have had a degree of stability over a longer period seem to have done considerably better than those with continuous turnover. Picture Jonkoping in Sweden and Intermountain Health in the USA, two examples of the best of the best in relation to culture, efficiency and high quality standards of care. Their leadership teams have been very stable over more years than the Howard government, but they have achieved success with a focus on ongoing innovation and renewal, rather than a “more of the same” approach. In this way they continue to build on their successes, always aiming higher and using experience to learn from the past and cement the future.

Do something

JH here talks about courage, another of the key attributes of real leadership. “There are times where you must stand in the middle of the road and dare people to run over you.” On the other hand he states, “There are other issues where the art of good political leadership consists of listening and understanding and comprehending and absorbing and persuading and cajoling and explaining.”

The expectations of a leader are that decisions will be made and implemented, that what people dislike most is indecisiveness, as indecisiveness on the part of a leader means the troops feel directionless and this impacts on morale. Very often doing something that is wrong is better than indecisiveness. (One might say that that pink batts and school halls might have been worse than indecisiveness, however one might also say that the idea was good, but the planning and implementation were so poor in each case, that it wasn’t so much the decision but the poor governance that was the key to failure).

I can hear comments that JH was not a perfect leader, that he and his team may have stayed too long, that he may not always have taken his own advice. I have no doubt there will be some truth in this, but no leader (indeed no human) is perfect. What is important is that someone who has led a very complex organisation for a long period of time and achieved clear successes in a number of areas, does have some words of wisdom to share. I believe these words of wisdom have a degree of authority and relevance to any leadership position.

Building these very simple maxims into the way we do our daily work will make leading easier and more robust not only for us as individuals, but for those that we work with and the organisations within which we work.

Dr Lee Gruner
FRACMA
The RACMA eLibrary is an educational service offered to RACMA members to support their ongoing development of skills and knowledge in Medical Administration.

The RACMA eLibrary is a curation of digital materials predominantly developed by and for College members to support training and continuing professional development.

Identified resources have been mapped and linked to the RACMA Medical Leadership and Management Curriculum role competencies and workplace themes or topics.

Visit the RACMA eLibrary at www.racma.edu.au/elibrary to learn more.

Doctors and medical students across Australia now have access to an expanded network of doctors’ health advisory and referral services. Confidential advice and support is available in every state and territory on the following help-lines.

New South Wales and the Australian Capital Territory 02 9437 6552
Victoria and Tasmania 03 9495 6011
South Australia and the Northern Territory 08 8366 0250
Queensland 07 3833 4352
Western Australia 08 9321 3098

A new national program for doctors’ health advisory and referral services

This national network of services is coordinated by Doctors’ Health Services Pty Ltd, a wholly-owned subsidiary of the Australian Medical Association, with funding from the Medical Board of Australia.

Performance Management: Difficult Conversations

In my role as a Specialist Medical Administrator, there have been many occasions where I’ve had to deal with very difficult conversations, and for anyone either functioning in or moving towards medical management roles, you will have to have those conversations as part of our normal activities. It’s important that as medical managers that we’re able to identify when we’re going into a difficult conversation and that we’re able to manage those conversations. The communication can be particularly trying where it’s a difficult conversation; however, there are a few tips and tools available that makes the process easier.

This session’s learning objectives are to recognise and acknowledge the features of a difficult conversation, and to identify some of the skills and strategies that we can use when confronted with some difficult ploys, which may come into play during such conversations. We will also look at how you manage the circumstances that led to the conversation being difficult in the first place.

There is no doubt that dysfunctionality in an organisation or a situation where a difficult conversation with somebody is needed but does not occur has a profound negative impact on the organisation. As Medical Managers or Specialist Medical Administrators, we’re often in a situation where we are faced with managing a difficult conversation that many others have shied away from because they see it as too hard. It’s here that we, as skilled and experienced managers, can come into our own, because we can demonstrate the “when and how” of difficult conversations.

Learning how to manage difficult conversations, including being adaptable and enterprising during the process, is a very important and essential skill for an experienced medical manager. Such learning can be best achieved through specific training. In the past, when doctors trained under the apprenticeship model, you would often see your boss managing a difficult conversation, and you therefore had exposure to the skills required; however, those days are long gone. The austere times in which we operate often don’t allow us to have Deputies, and it is often much more difficult to have that apprenticeship model. So, we have to identify ways of learning to enhance our skills and our exposure in the area of managing difficult conversations, which is a very important organisational and personnel management skill.

There is a high risk of failure if the conversation is not managed in a careful, skilful, thoughtful way. There is a high level of personal involvement, emotion and opinions associated with the people you are having such conversations with, all of which need to be taken into account.

The five most common types of difficult conversation

- Top of the list in difficult conversations is performance issues. If you’ve got a member of staff that are struggling or not performing in a way that’s expected, then it is important to be able to have those conversations – early.

- Patient complaints are another area where difficult conversations take place, especially when you have a family conference where there is a degree of emotion, dissatisfaction and anger.

- Peer disputes and conflict between clinicians are relatively common and can require diplomacy, particularly when you’ve got conflicts that occur between very senior people.

- In the formal process of open disclosure we already have a very serious adverse event that has involved either a death or serious harm. Emotion and the discussion that you will have with family can often be very difficult and would fall into the difficult conversation category, as do some episodes of clinical disclosure that we undertake on a regular basis.

“...There is a high risk of failure if the conversation is not managed in a careful, skilful, thoughtful way...”
• Delivering bad news can be difficult whether it be to your boss (as in you haven’t met your targets), your department or various members of staff; to CEOs, Boards of Directors, or Director Generals or Departmental Secretaries/ senior Officers; to the media, presentations at tribunals, Coroner’s cases, or the Minister’s office. All these would be described as difficult conversations, and there are a variety of skills that you will need, depending on the type of difficult conversation.

A practical framework for approaching difficult conversations at work

A useful framework for approaching difficult conversations has been developed by Fred Kofman. It’s not the only framework available, but it’s one that I find useful.

• **Listen.** This means carefully listening when you’re speaking to people and when you’re undertaking a difficult conversation.

• **Summarise.** You also need to be careful in the way that you recall the conversation, summarising it to make sure that there’s clarity of understanding in what may be transpiring within the conversation.

• **Ask questions.** You need to ask the appropriate questions when you’re having the conversation. This will assist in clarity and information provision.

• **Express yourself clearly.** It is very important to clearly and non-emotively express yourself, but often that can be very difficult because the topic of the conversation, the environment and the circumstances may be quite emotional and/or emotive. Self-control is clearly important.

• **Be clear about any requests you make, and that the person that you’re speaking with understands what is being asked of them.** Don’t speak in technical or professional jargon that may not be understood. That includes management jargon.

• **Validate, negotiate and, commit.** You need to validate the request, negotiate where necessary, and then commit to a particular cause of action.

It is imperative to “be present” in the conversation, not to be there in any tokenistic way, but to actually fully engage with the individual and in the circumstance. To listen from the inside out, truly taking in what’s going on and listen to the interaction that you may be having with the other individual. There is a need to be very clear and aware of your response depending on what may be transpiring throughout the conversation; this can be difficult and it takes practice! It’s always important to make it clear that the conversation is in the best interests of all concerned, so that the individual you’re having the conversation with, and you as a manager understand what it is that we are doing in our workplaces.

Nine mistakes that people make

Due to the difficult nature of these conversations there are a number of common mistakes people make. Holly Weeks, in her Harvard Business Review article “Failure to communicate: how conversations go wrong and what you can do to right them” identifies nine common mistakes when having difficult conversations. I find these identified errors useful to understand so as to avoid them.

1. **Combat mentality**

Unsurprisingly, one of the most common mistakes that people make is falling quickly into a combat mentality. When a difficult conversation turns toxic, it’s often because we’ve made a key mistake. We’ve fallen into a combat mentality, and allowed the conversation to become a zero win for both parties (i.e. lose/lose, or win/lose). That’s not the way we want the conversation to go. When we let the conversation take on this tenure, particularly in the office setting, everybody looks bad, and everybody loses. The real enemy is not the conversation but the combat mentality. It’s important that we recognise this and don’t fall into that trap.

2. **Oversimplifying the problem**

The second mistake is oversimplifying the problem. This happens for a variety of reasons. These include feeling uncomfortable with the nature of the difficult conversation, and then falling into the trap of trying to oversimplify the problem. Another reason is that we try and tackle several issues at once, and roll up the issues into a mega-problem with a simplified approach. We need to remember that if the subject of the argument was straightforward, the chances are that we wouldn’t be having this conversation – usually, the situation is complicated rather than straightforward.
3. Not bringing enough dignity and respect to the problem

A third mistake is that we don’t bring enough dignity and respect to the problem. We need to respect the person that we’re talking to, and we also need to respect ourselves for having the discussion. We must ensure that we respond in a way that we can later be proud of and that we’re having a discussion with a degree of dignity and respect for the problem.

4. Lashing or shutting down

A fourth mistake is that we lash out or we shut down. In a difficult conversation you’ve got emotion, and emotions arising from fear, anger or embarrassment may be being flung back at you. Defensiveness is also common when people are feeling threatened. In that situation it is easy for us to lash out, and therefore become a lot more aggressive, or alternatively we try and shut things down by smoothing things over, which is a mistake. It’s important that we don’t seesaw through counterproductive roles. Instead we need to move in the middle and state what it is that we really want.

The tough emotions won’t disappear - that’s part of why the conversation is difficult. But with practice we can learn to be more focused on the conversation outcome, in spite of the emotion that may occur within the conversation.

5. Reacting to thwarting ploys

The fifth mistake is that we react to thwarting ploys. In any difficult conversation thwarting ploys may occur. These can range from lying, to threatening, stonewalling or crying. I always have a box of tissues in my office because I have often people cry! Sarcasm, shouting, silence, accusations, and taking offence are all ploys that can derail the difficult conversation.

It’s important to try and move beyond the combating activities to a more effective middle ground. We need to always be aware of when ploys are being used and be able to disarm that ploy by addressing it and not reacting to it negatively. For instance, if the person that you’re talking to stops responding, it may be simple enough to say “I don’t know how to interpret the fact that you’re no longer saying anything, that you’ve become silent”.

6. Getting hooked

The sixth mistake is that we get hooked. We often get hooked into reacting, especially when the person with whom you are having the difficult conversation knows you very well, knows which buttons to press and how to get you hooked and derailed in a conversation. Knowing where your vulnerabilities are is important, and identifying them helps you stay in control as you continue to have your discussion.

7. Rehearsed conversation

A seventh mistake is to rehearse the conversation. The conversation must be free flowing and genuine, and must not come across as contrived. Even though you may have prepared for the conversation, it is important that it doesn’t come across as if you’ve scripted it, because this will hamper and decrease its effectiveness. It may also inflame or anger the other person which becomes highly counterproductive.
8. Making assumptions

The eighth mistake is making assumptions about what the other person’s intention are. Optimists tend to assume that every disagreement is just a misunderstanding between two well-intentioned people. It’s important that in the fog of hard talk, that we don’t forget and start to presume what people’s intentions are. Remember that you and your counterpart with whom you are having the discussion are both dealing with this, and the accompanying ambiguity. If you get stuck, a handy phrase to use is “Look, I realise that as we talk I don’t fully understand what you mean”, and then allow the person to explain to you further, rather than getting stuck on what you think and/or have assumed is meant.

9. Losing sight of the goal

The ninth mistake is losing sight of the goal. Don’t ever lose sight of the goal, don’t be side-tracked. Remain focused on the outcome you hope to achieve, don’t meander or get side-tracked so as to lose the focus.

In summary...

If you’re not the one that’s initiating the conversation, remember your basics, keep clear content, a tone that’s neutral, and be very careful with the phrasing. You can easily be pushed out of these zones, and you’ll be off foot.

Two of the key skills medical managers need to have are courage and diplomacy. Courage in knowing when to have that conversation, that it is time to have that conversation. It’s all too easy to avoid, because it’s going to be difficult, and that’s where courage truly comes in.

Be very mindful of how you’re going to have the conversation and set it up in an appropriate way, thinking carefully about scenario setting. It’s also important to be clear about what the organisational and professional imperatives are and the reasons for the conversation, and reasons why you’re going to have that conversation. Carefully and sensitively select where you’re going to have the conversation. Never fall into the trap of being caught in a corridor or in a public area or in a space where it’s not appropriate to have the conversation.

If you’re confronted by an individual, then it’s important that you manage that situation, by saying “Listen, how about we meet in my office in X minutes”, or “Let’s make a time and a place” so that the meeting venue and timing is appropriate and conducive for the conversation, for you to be composed, and for the individual with whom you’re having the conversation to likewise be composed.

Associate Professor Alan Sandford FRACMA
This year saw a profit of $482,535, from income of $2,472,444 (an increase of 7.9% from the previous year). Total assets as at June 30 2016 were $20.6 million, and total liabilities were $15.1 million. The following tables show the financial performance of the College over the last ten years.

Membership increases, projects and grants management continue to significantly contribute to RACMA’s financial position. This includes funds from the Commonwealth Department of Health and Ageing for the Specialist Training Program, including administration of the Private Infrastructure and Clinical Supervision (PICS) Program.

In 2017, RACMA will continue to further diversify its funding, including pursuing further opportunities with state health departments in the provision of training, expansion of the Learning and Teaching Centre, and the provision of additional fee for service and training.

The Board has committed to funding several strategic projects in 2016/17, including, the development of the strategic plan, developing RACMA’s brand and communication strategy, expansion of the Learning and Teaching Centre, a curriculum delivery review, Minimex, and development of position papers concerning clinical governance.

As the RACMA national office expands, the Board has been considering future accommodation, including the relative benefits of purchasing a property compared to renting additional space to house the College national office.

The auditors, Morton, Watson & Young Audit Pty Ltd have been appointed as the College’s auditor for a further three years, following a process of testing the market for the provision of audit services.

The terms of reference for the Finance and Audit Committee were revised during the year.

Members of the Finance and Audit Committee are Kevin Morris, Max Alexander, Amir Rahimi, Robyn Lawrence, Judith Day (external) and Michael Cleary (ex officio). I would like to thank their contributions over the past 12 months.

Dr Humsha Naidoo
Chair, Finance and Audit Committee

In 2017, RACMA will continue to further diversify its funding, including pursuing further opportunities with state health departments in the provision of training, expansion of the Learning and Teaching Centre, and the provision of additional fee for service training.
In the last 12 months, there has been significant work underway to further develop training so it prepares candidates and trainees in their role as medical managers, increase its relevance to candidates and trainees, and to ensure alignment with the expectations of regulatory bodies.

Last year the College undertook a curriculum review of the delivery of the Fellowship Training Program. A workshop chaired by the Dean of Education, Professor Gavin Frost, was held earlier this year to discuss the outcomes of the review and the implementation. A key initiative is to implement the Medical Management Practice Program and the Workplace Based Coaching and Assessment as part of the induction to Programmatic Assessment into the Fellowship Training Program. The implementation of this initiative is being overseen by a working party, and is expected to enhance the assessment, delivery and outcomes of the Fellowship Training Program.

RACMA’s submission to the 2016 AMC annual report included an update on RACMA’s training and assessment processes in the areas of indigenous health, assessment of international medical graduates, wellbeing and patient safety, and continuing professional development. RACMA has made significant progress in these areas, including: Continued improvement in candidate training in cultural competence; Development of policy concerning IMG to strengthen governance around RACMA’s assessment of comparability for the IMG and to provide programs for those overseas trained specialists who are found to be substantially comparable; Revisions to the CEP standard; and Development and implementation of a policy, processes and training concerning discrimination, harassment, bullying and victimisation. There is further work underway in these areas, and these will continue to be priority areas in 2017.

There is continuing strong participation in RACMA’s training programs. As at November 2016, there were 127 Candidates in the Fellowship Training Program – an increase from the previous year, and 51 Trainees in the AFRACMA training program, with 154 trainees graduating from this program since 2013.

There has been further development concerning the training programs, including tightening the governance and submission requirements concerning the Research Training Program, and customisation of programs to make the training more relevant to doctors training for medical management in different contexts.

Over the last 12 months, the AFRACMA training program has been customised to meet the needs of specific jurisdictions and settings. In September, eight new Associate Fellows graduated from the Tasmanian Practical Leadership Program. Additionally, a training program developed specifically under contract with the Victorian Department of Health and Human Services (DHHS) saw customisation of the AFRACMA program to build capability of rural and regional based Victorian GPs and SMOs moving into Director of Medical Service roles. Successful participants of the program will be eligible for the award of an Associate Fellow. RACMA is working with other jurisdictions to provide similar programs, as these programs build a strong platform for affiliation with RACMA, and provide participants with a potential pathway to Fellowship.

Further to the pilot of the RACMA exams held in May 2015, the College held its National Trial Exams in July 2016 at the AMC National Test Centre, and the RACMA pre-fellowship exams are also being held at the AMC National Test Centre in November.

The work of the Education and Training Committee has been supported by the work of the Board of Censors chaired by the Censor in Chief, Associate Professor Alan Sandford, the Continuing Education Program Committee, chaired by Dr Liz Mullins, and the Committee’s working parties. The Committee has been ably assisted by the RACMA National Office, including the National Education and Training Program Manager, Ms Anna Lyubomirsky, and the Chief Executive, Dr Karen Owen.

Dr Pooshan Navathe
Chair, Education and Training Committee
As Chair of the Continuing Education Program (CEP) Committee, it gives me great pleasure to present this year’s report.

Along with developments in revalidation/recertification in Australia and New Zealand, RACMA has revised its CPD standard and will be providing new professional development programs for members through RACMA’s Learning and Teaching Centre. The 2017 February CPD Forum will also include a new peer review and audit program. This is to support RACMA’s revised CPD standard, which will place greater emphasis on incorporating performance review, and where applicable, the measurement of outcomes, than has been the case with the previous standard. These developments are important in the context of the regulators’ (MBA and MCNZ) revalidation considerations. It is also consistent with the directions of other specialist medical colleges, who are also increasing the specificity of requirements and the rigour required to be demonstrated by Fellows in CEP.

There will be challenges in implementing a standard of CPD that is beyond undertaking education activities, such as attending conferences, lectures, reading and research. Specialist medical administrators are employed in diverse roles, and the scope of practice can differ across the specialty. Further, specialist medical administrators usually work at a level where their work and decisions affect the broader system and hence a whole community rather than an individual patient. There are also some differences in the definition of scope of practice across jurisdictions that will need to be accommodated. While these challenges exist, they are not insurmountable ones.

The Medical Board of Australia’s Expert Advisory Group (EAG) this year released a consultation on Options for Revalidation in Australia. The approach to revalidation in the EAG’s proposal has two distinct components, including: 1) Strengthening Continuing Professional Development to drive practice improvement and better patient healthcare outcomes, and 2) Proactively identifying doctors who are either performing poorly or at risk of performing poorly, assessing their performance, and if necessary, supporting their remediation. RACMA provided a submission to this consultation. The submission can be accessed from RACMA’s website.

The rate of CEP participation this year is down on the previous year. A revitalised CPD program in 2017, strengthened role of CEP coordinations in the jurisdictions, and an increased focus on AFRACMA participation in College CPD, should see CEP participation improving in 2017.

Finally, I would like to thank Mr Dino DeFazio from the RACMA National Office for his support to me and the CEP Committee over the past 12 months.

Dr Liz Mullins
Chair, Continuing Education Program Committee
The past year has seen some key critical developments for the Board of Censors (BOC), including some significant changes to how and where the Censors undertake their fundamental roles. The overall function of the Board of Censors is:

- To advise on the assessment of candidates for Fellowship of the College
- Development of a framework for assessment which maintains a contemporary relevance to the curriculum for training of Specialist Medical Administrators
- Progress a program of formative and summative assessment of trainees progressing through the program, and
- Monitoring and regulating processes of assessment, including training of Censors that ensures standardisation and consistency as they undertake their tasks.

With the exciting and challenging move from the previous exam venues in which the examinations were held, we now conduct the final Pre-Fellowship oral examination within a purpose-built facility – the Australian Medical Council’s National Test Centre located in Melbourne. This purpose-built facility contains state-of-the art technology and purpose-built rooms in which the scenario based oral examinations are undertaken.

The move to the National Test Centre has been a threshold step and is part of a process which the Board of Censors, supported by the RACMA Board, have undertaken to ensure a contemporary approach to our assessments, held under optimal conditions.

The BOC has recently increased the number of Censors with a rigorous program involving the calling for expressions of interest followed by training and induction of Censors through a formalised path. Censors are fully instructed on their role and responsibility. This has allowed the College to have sufficient Censors equipped to undertake the annual task of the pre-Fellowship oral examinations in addition to our other assessment tasks.

The National trial examinations were conducted at the AMC Test Centre using the technology of video recording which will later be used for professional development, candidate feedback and quality assurance purposes for the Censors.

The 2016 pre-Fellowship oral examinations ran well in terms of logistic performance, ease of delivery, monitoring of process and electronic recording of results. This comprises a major step forward for the College in undertaking a component of its assessment process within this purpose-built contemporary facility.

The BOC with the great assistance of the College Secretariat has also undertaken a comprehensive review of its current policies, procedures and guidelines. The ongoing engagement of Censors enables an active program of assessment and candidate development; such activities are undertaken by the Censors on a voluntary basis, mostly performed within their own time. This significant contribution to the College is critical in nature and is deeply appreciated.


delimited

Associate Prof Alan SC Sandford
Censor in Chief

RACMA INTERACT Webinars

The INTERACT Training Program is a series webinars for Candidates and Trainees chaired by senior FRACMA and guest speakers. The INTERACT webinars are open to all RACMA members.

INTERACT Webinars engage with diverse topics within contemporary medical management, presented by influential leaders in Australasian medical administration, governance, health care and health services research.

COMING UP: 22 February 2017
Rural Clinical Governance: A Collaborative Effort

Visit racma.edu.au for more information
Successful launch of RACMA’s Learning and Teaching Centre

Ms Cassie Smith

2016 saw the launch of RACMA’s Learning and Teaching Centre (LTC). The LTC was developed to enable RACMA Fellows and Associate Fellows to access more effective, and relevant continuing professional development programs.

In May this year, medical administration specialists from Australia, New Zealand and Hong Kong met in Melbourne for the inaugural professional development seasonal forums. It has since been followed with this year’s conference in Brisbane. Three professional development seasonal forums will be held in 2017, including February, June and October – all in Melbourne.

As part of the Learning and Teaching Centre, a new and refreshed Management for Clinicians program is being run, with a national faculty engaged to deliver this program. Management for Clinicians will be expanded in 2017, and will seek to expand the offering to include Advanced Management for Clinicians, and Management for Clinician Teams. This training will be available to a broad range of health professionals, including nurses and allied health professionals managing healthcare teams.

The Associate Fellowship Training Program is now known as Leadership for Clinicians. This program provides training to doctors in management. RACMA is working with state health departments to adapt this program to specific and local needs, such as the delivery of this program for general practitioners and medical officers working in rural and regional Victoria. Recipients receive an award of Associate Fellowship on successful completion of the program.

The RACMA Audit and Peer Review Program will be launched at the February 2017 Professional Development Forum in Melbourne. The program called Professional Practice Review Program (PPRP) will offer an audit and peer review program that is relevant to the scope of RACMA Fellows and Associate Fellows. PPRP will offer 3 topics in 2017, including: Open disclosure; SMO performance systems and challenges; Multisource feedback for leadership development. More topics will be developed over time, addressing the need for a suite of programs that reflects the diversity of the specialty. Completion of one PPRP per year meets the annual Audit and Peer Review requirements of the CEP Standard.

In 2017, the CEP standard will require 25 CPD points to be earned through RACMA programs. The Forums and the PPRPs are an excellent way to meet this requirement.

Ms Cassie Smith
Manager, Learning and Teaching Centre
For upcoming events, visit RACMA’s event calendar
http://www.racma.edu.au/

2017 Professional Development Forums
Professional Development for Medical Managers and Leaders

Summer PD Forum
23-25 February 2017
RACV City Club
Melbourne
racmacme.com.au

Winter PD Forum
15-17 June 2017
The Langham
Melbourne
racmacme.com.au

Spring PD Forum & ASM
18-21 October 2017
Melbourne Convention and Exhibition Centre
Dinner at the MCG

Register Now
View Program
Save the Date
The ongoing support by the Department of Health of specialist medical training under the Specialist Training Program (STP) continues to contribute to the significant growth in medical administration training, particularly in expanded settings such as rural and private health, and in the development of medical leadership capabilities.

This year there was a strong uptake of RACMA STP posts, with 83% of posts being in expanded settings. Further, the College is seeing Candidates, having trained in these posts, continuing to work in substantive medical management positions in the same expanded settings upon receiving their Fellowship.

RACMA is responding to an expression of interest to create new reserve lists of posts in expanded settings for funding in 2018 under either the STP or the Integrated Rural Training Pipeline (IRTP) program.

Training more of Australia’s medical workforce in rural areas

Late last year, the Australian Government announced the Integrated Rural Training Pipeline (IRTP) program. Its purpose is to deliver a sustainable, Australian trained future medical workforce for regional, rural and remote communities.

The IRTP is a targeted expansion to the STP providing new rurally based specialist training places with 50 new posts allocated in 2017, and a further 50 new posts to be established in 2018. RACMA was awarded five training posts for 2017.

There is a high need for skilled medical managers in rural areas, and medical managers working in these areas need skills and experience relevant for the setting.

Working in a specialist medical role in a rural health service is different to working in a similar role in an Australian city. A key challenge in providing health care in rural and remote regions is that there are limited resources providing care to a dispersed population, and the distance to specialised care is typically long. Adding to the divergence between settings is that skilled positions in rural health services can be difficult to fill, and population and disease profile are different in rural areas compared to cities.

RACMA strongly endorses the Department’s initiative to support more medical practitioners to train in the rural and regional settings. The experience of the College is the longer these practitioners can be supported in these settings, the more equipped they will be to work in rural areas, and the more likely that the Candidate will develop a connection with the setting and will continue to work in rural settings after their training.

Developing tomorrow’s medical leaders

The Department of Health is also funding the development of an online training program that includes profiling the careers and experiences of RACMA’s medical leaders regarding leadership in health care, with a particular focus on RACMA’s Medical Leader role competency.
Thirty five medical leaders were interviewed, of which seventeen were filmed to capture the qualities of medical leadership in the health care context. A particular emphasis was placed on medical leadership in rural and remote communities.

These audio and visual recordings and transcripts will be embedded within the RACMA Fellowship Training Program as exemplars of medical leadership. They will contribute to the Leadership Program delivery areas, including: Perspectives of Leadership; Relational Leadership; Reflective Practice; Leadership Styles; and Effectiveness as Leaders.

This initiative will see the creation of online resources that will provide flexible access to training and training resources for trainees independent of time and location, and will be important for supporting trainees in rural, regional and remote areas.

It is expected these resources will be ready for the commencement of the 2017 academic year.

Training more doctors in Tasmania in medical management

RACMA has been working with the Department of Health to train more doctors in management. Additional posts have been created in Tasmania to train specialist medical administrators, and a leadership program, Tasmania Practical Leadership Series – Clinician to Manager Program, was delivered across 2015 and concluding in 2016.

Eight doctors have completed the program, and have qualified for Associate Fellowship. Congratulations to Dr Nick Harkness, Dr Kalpurath Krishnakumar, Dr Alasdair MacDonald, Dr Beth Mulligan, Clinical Associate Professor Marcus Skinner, Dr Christopher Wilde, Dr Lennie Woo, and Dr Sandy Zalstein.

The Commonwealth government has extended the Specialist Training Program in 2017 and this includes the Tasmanian professional development program. RACMA is currently developing a new Leadership for Clinicians program for Tasmanian doctors that will commence in 2017. This will ensure that the program remains contemporary and meets the needs of doctors in Tasmania.

Ms Valerie Ramsperger
Manager, Specialist Training Program
I would like to start by thanking all those that supported my nomination in the recent RACMA Board Candidate representative election, I was humbled and honored. I hope to continue to serve as the conduit for the Board’s communication to all the trainees on matters that affect us all through my attendance on the Candidate’s Advisory Committee (CAC).

I want to also thank Mick Kirk for chairing the CAC this year and through its representative structure to provide feedback to Karen Owen and the rest of the Board and staff on matters of concern to trainees.

In CAC this year we addressed several issues of concern, including ensuring a wider representation on CAC of all trainee cohorts including our colleagues in Hong Kong, and the creation of an openly accessible trainee database “Meet your Fellow Candidates” on the RACMA website (https://goo.gl/yiJk5U) to encourage networking within the different jurisdictions among trainees.

Furthermore, CAC was instrumental in an innovative networking opportunity at the RACMA annual conference by hosting a Candidate Open Forum. At the forum several issues were discussed including concerns by some candidates in meeting the financial requirements for training and enhancing the relationship between the Jurisdictional Co-ordinators of Training and Candidates. There has also been a need for clarification of the research component of training and expression of some of the difficulties experienced by trainees in completing this component of training.

On a positive side, the trainees have been very appreciative of the enormous effort in the recently held mock exams for those undertaking examination this year. This is an invaluable training opportunity prior to the exams.

The RACMA Autumn Professional Development Forum was very well received by trainees and fellows and was seen as a valuable addition to the training calendar.

The conference in Brisbane titled Harm Free Health Care was again a fantastic success with all attendees remarking on the high quality of the presentations and workshops.

My time on the Board since my appointment in February has been filled with getting to terms with the strategic and logistic aspects of the college and familiarizing myself with the role as Candidate Representative. This is a great opportunity for my own professional development and I want to thank the members of the Board and the CEO for their warm welcome and support. I aim to inform the board on matters of training and at the same time communicate the board’s decisions to trainees.

In the near future, trainees look forward to a diverse body of trainees represented by the different pathways to fellowship, and a growing influence of the college in advocacy. We all want to contribute towards making the college the peak body of training of leaders and managers in health through the provision of high quality education and supervised training opportunities.

“Leadership and learning are indispensable to each other.”  
– John Fitzgerald Kennedy

Dr Sergio Diez Alvarez  
Candidate Director,  
RACMA Board

---

**RACMA Pre-Fellowship Examinations**

The College extends its congratulations to the following Candidates who passed their oral examination held on 19 – 20 November 2016.

- Dr Kelvin Billinghurst
- Dr Eleri Carrahar
- Dr Jodi Glading
- Dr Randall Greenberg
- Dr Philippa Hawking
- Dr Felicity Jensen
- Prof Sean Keogh
- Dr Michael Kirk
- Dr Pat Sing Tony Ko
- A/Prof Sean Ording-Jespersen
- Dr Lloyd McCann
- Dr Mary Seddon
- Dr Boon Shih Sie
- Dr Vanessa Thornton
- Dr Gregory Watters
Leadership for Clinicians
RACMA Training Program

The Royal Australasian College of Medical Administrators (RACMA) offers a program of medical management and leadership modules to support medical practitioners.

The modules incorporate best practice and take on board the expertise of leaders in the medical fields; consequent workshops will be delivered by a variety of State and national speakers, expert medical educators and RACMA Fellows.

The workshops, webinars and learning sets are designed to give medical practitioners fundamental knowledge and practical skills in medical management and leadership. These are the essentials that can effectively be incorporated into current working practice. Sessions are aimed at enabling individuals to enhance their performance and build working confidence and competence in a safe and confidential setting.

The themes included are aimed at supporting the development of skills in the most challenging areas of medical management and leadership.

The five themes are:
1. Understanding our healthcare system
2. Clinical governance and medico-legal
3. Medical workforce management and engagement
4. Leading strategy and change
5. Financial governance

All themes are explored in the context of medical leadership.

The five themes will be delivered through three modules. The structure of each of the modules will be as follows:

- Two webinars
- Interactive face to face workshop
- Learning set and reflective exercise

Participants will complete an online quiz for successful completion of each module. Assessment is undertaken through participation in all activities.

Register Now
Visit racma.edu.au or contact Kathy Vlahopoulos p 03 9824 4699 e kvlahopoulos@racma.edu.au
### Fellows

#### ACT
Brennan, Leonard Basil
Burnand, Josephine
Curtis, Nicole
Davis, Stephen Clive
De Souza AM, David
Donovan, John
Dumbrell, David Milton
Elvin, Norman Anthony
Klar, Danielle
Lambert, Rodney
MacCarrick, Geraldine
O’Leary, Elizabeth Mary
Orchard, Barbara
Palmer AM, David Hugh
Proudfoot, Alexander
Seidl, Isaac Alexander Gregory
Smart, Tracy
Walker, Robyn
Wells AM, Ronald Harry Cecil
White, Gordon Eustace E.
Wilkins MBE, Peter Sydney
Wilkinson, Christina

#### NSW
Aldrich, Rosemary
Alexander, Jennifer Anne
Atkinson, Kathleen
Austin AM, Tony
Baker, Andrew
Bang, Pankaj
Bashir AC CVO, Professor The Honorable Dame Marie
Batten, Tracey
Benjamin, Susanne Jane
Bennett, Andrew Gordon G.
Bennie, Alexander
Best AO, John Barton
Blizard, Claire Maree
Bolevich, Zoran
Boss, Heidi
Boyd, Roger
Boyd Turner, Mary
Buhl, Robert Russell
Cable RFD, Ronald Hughes
Campbell, John
Carroll, Logan
Chan, Steevie Siu Wei
Collie, Jean
Collins, John Malcolm
Conley, Jeanette
Currow, Elwin George
Curteis, Owen Gregan
Curtis, Paul
Daynner, Michael
De Carvalho, Vasco
Dewdney, John
Donnelly, Roy Douglas John
Doolan, David
Douglas, Paul
Duggan, Anne
Duggan AM, John Malcolm
Duncan, Darrell
Ellis, Vivienne Margot
Finlayson, Peter
Forster, Susan Lesley
Frost, Gavin
Gardiner, Brett
Gobius, Risto Julianus
Goding, Robyn
Golding, Stephen John
Golding, Michael
Graves, Debra
Grunseit, Barbara Anne
Guanalao, Luisito Pangilinan
Harris, Justine
Hely, Joanna Kathryn
Hill, Kim
Ho, Leong Kit
Hockin OAM, Ralph Lionel
Holland, Howard John
Hooper, Roger Carrington
Hoyle, Philip
Hsueh, Wayne
Jones, Roslyn
Karnaghan, Jo-Anne
Killen, Alice Ruth
King, Michael
Kotze, Ethel
Lander, Harvey
Latta, Alison
Laughlin, Allain
Lee, Lynette
Mackertich, Martin
McEwin AM, Roderick Gardner
McGirr, Joseph
Messara, Louise
Miross, Christopher
Miskell, Sharon
Mok, Anne
Montague, Andrew James
Moore, Carmel
Moray AM, Patricia Sue
Moritz, Barbara
Murugesan, Ganapathi Asiri
Narayan, Yogendra Prakash
Navathe, Pooshan
Niall, Paul
Nigam, Vivek
O’Brien, Lisa
O’Connor, Nicholas
Oldham, James
Parsons, Helen
Pegram, Robert
Peters OAM, Harry
Pilowsky, Eva
Pisk, Dennis William
Price, Edward Daniel
Ramesh, Nadarajah
Reeve AC CBE, Thomas Smith
Repin AM, George Dimitri
Rewell, Ian Leslie
Ross, Bronwen Anne
Ruscoe, Warwick John
Sanderson, Russell Bruce
Sanger, Margaret Mary
Sara, Antony
Schedlich, Russ
Sesnan, Terence
Shea, Peter Barry
Shepherd, Webster Graeme
Smith, Denis
Spencer, Ronald Brian
Stewart, Gregory
Thomas, Dale
Tindall, Katherine
Tridgeil, Paul
Vago, Leslie
Ward, Nicola
Wasti, Syed
Waterhouse, Tamsin
Webb, Freda Holland
West, Elizabeth
Wills, James Thomas
Wilson, Roger
Woolard, Thomas John
Wooster, Arthur
Yoong, Helen
Yu AC, John

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

QLD
Alcock, Annabelle
Alcorn, David
Alexander, Paul
Ashby AM, Richard Huish
Ayre, Stephen
Barrett-Beck, Leah
Bell, Brian
Bell, Anthony
Brennan, Colin
Bristow, Peter
Bromwich, Christine Emily
Byrne, Martin
Campbell AM, Charles Bryan
Chong, Hwee Sin
Cleary, Michael
Clements, Michael
Coffey, Gregory
Cooper, Barbara Marion
Costello, Gerard
Crawford, Rosalind
Daly, Michael
Dines, Amanda
Doherty AO, Ralph Leonard
Donald AO, Kenneth John
du Prez-Wilkinson, Gabrielle
Du Toit, Mauritius
Dulhunty, Joel
Edwards AC, Llewellyn Roy
Emmerson, William
Evans, David
Falconer, Anthony
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
Johnson, Andrew
Kelly, Shane
Kennedy OAM, Christopher
King, Jennifer Margaret
Kingswell, William
Kitchener, Scott James
Koh, Yi Mien
Kuehnast, Barbara
Le Bacq, Frank
Le Ray, Lance
Margetts, Craig Charles
Martin, Donald
Mattiusi, Mark
McFarlane, Jean Fergus
Menzies, John
Miller, Peter McIntock
Mistry, Yogesh
Murdock, Nicola
Myers, Colin
Naidoo, Mellissa
O’Donnell, John
O’Dwyer, Susan
O’Sullivan, Donna
Pakchung, David
Palmer, George Rupert
Parmar, Nilesb
Pearn AM, John Hemsley
Pegg AM, Stuart Phillip
Polong, Jose
Porter, Robert
Powell, Jacinta
Prado, Luis
Reasbeck, Philip
Robinson, Pamela
Rogers, Grant
Rowan, Christian
Rushbrook CSC, Elizabeth
Sandford, Alan
Scanlan, Brian John
Seierup, Dale Peter
Shaw, Alexis Eric
Shearer, Alexander Boardman
Smart, Timothy
Steel, Graham
Swierkowski, Piotr
Taylor, James
Thorn, Sara
Trujillo, Monica
Turley, Annette
Ulrich, Peter Edward Rodney
Wakefield, John
Waller AM RFD, John Powell
Waters, Mark
Waugh, John
Weinstein, Stephen
Young, Jeannette Rosita

SA
Baggoley, Christopher James
Beal AM RFD, Robert William
Czechowicz, Andrew Stanislaus
Farmer, Christopher John
Frewin AO, Derek
Jayakaran, Jayanthi
Jelly RFD, Michael Thomas James
Kearney AM, Brendon
Lian-Lloyd, Nes Bie Sian
McCoy AM, William Taylor
Merrett, Susan
O’Connor, Alan
Rozenbilds, Elizabeth Stuart
Satterthwaite, Peter
Scruggs OBE, Roy Frederick Rhodes
Swanson, Bruce Albert
Tideman, Sally
Wagner, Christopher Arthur
Wareham, Conrad
TAS
Grimes, Donald
McArdle, Helen
Pantle, Annette
Renshaw, Peter John
Ross, Alasdair Diarmid
Sparrow AM, John

VIC
Ahern, Susannah
Alexander, Maxwell
Appleton, William
Barker, Coralee
Bartlett, Jennifer
Bearham (Snr), George
Bessell, Christine Kaye
Blake, Douglas Harold
Bradford, Peter Stewart
Brand AM, Ian
Breheny, James Ernest
Brennan, Peter John
Campbell, David
Champness, Leonard Torr
Christie, John
Cidoni, Anthony
Clarke, Caroline
Collopy AM, Brian
Damodaran, Saji Suseela
Davis, Alan Shaw
Devanesen, Sherene
Dhulia, Anjali
Dohrmann, Peter
Duncan, David
Dwyer, Alison
Elcock, John
Eleftheriou, Paul
 Feebery, Colin
Flower, Clifford James
Flynn, Eleanor
Flynn, Joanna
Fraser, Simon
Funder, John Watson
Gallichio, John Louis
Garwood, Mark
Goh, Zhong Qing
Graham, lan
Griffin, James John Joseph
Grogan, Robert
Gruner, Lee
Hamley, Lee
Hanning, Brian
Hillis, David
Jones, Michael Robert
Kambourakis, Anthony
Kelly, Catherine
Kelly, William
Kerr, John
Kilpatrick, Christine
Kirwan, Jeffrey
Lakra, Vinay
Leslie, Peter Leonard
Loh, Erwin
Lowthian, Peter
Lubliner, Mark
Mah, Alastair
Mahmood, Farhat
Major, Jennifer
Malon, Robert Geoffrey
Mason, Elizabeth
Mathews, Colin Lindsay
McCleave, Peter John
McDonald, Wayne
Miller, Campbell
Mohr, Malcolm
Mullins, Elizabeth
Naidoo, Humsha
Nel, Andre
Ng, Bennie
O’Brien, Peter
Oliver, Brian Houston
Perrignon, Andrew Charles
Peyton, Thomas Matthew
Phelps, Grant
Pisasale, Nella Maria
Power, John
Ramsey, Wayne
Rankin, David
Ratnayeke, Valentine Joseph
Sachdev, Simrat Pal Kaur
Scown, Paul
Sdrinis, Susan
Shaw, Rosalie Jean
Shepherd AM, Stuart John
Sloan, Peter
Stoelwinder, Johannes Ulitje

WA
Bayliss, Colin Terry
Carruthers, Kenneth John
Coid, Donald
Dunjey, Malcolm Victor
Flett, Penelope
Forgione, Nicholas Salvatore
Galton-Fenzi, Brian Lionel
Gill, Jagjeet Singh
Heredia, Daniel
Jana, Sayanta
Koay, Audrey
Lawrence, Robyn
Lipton, George Lucien
Loh, Poh-Koon
Maclean, Alison
McNulty A.O., James Columba
Montgomery, Philip
Murphy, Kevin John
Nickel, Norma Rose
Oldham, David
Pelkowitz, Allan
Perry, Gregory
Phillips, Suzanne
Platell, Mark
Quadros, Caetano Francisco D.
Roberts, William Daniel
Robertson, Andrew
Robins, Anthony
Russell-Weisz, David
Sumithran, T Lakshmi
Sunderland, Ian Sydney
Trevaks AM, Gad
Trye, Peter
Wake, Arlene Helen
Walsh, Michael
Warton RFD, Robert
Wellington, Clive
Wellington, Heather Louise
Westwood, Geoffrey
Wolff, Alan
Yeaman, John
Zalcberg, John

Street, Bernard
Sunithra, T Lakshmi
Sunderland, Ian Sydney
Trevaks AM, Gad
Trye, Peter
Wake, Arlene Helen
Walsh, Michael
Warton RFD, Robert
Wellington, Clive
Wellington, Heather Louise
Westwood, Geoffrey
Wolff, Alan
Yeaman, John
Zalcberg, John

The Quarterly RACMA
Salmon, Mark
Smith, Darcy Peter
Williams, Timothy

New Zealand
Allen, Patricia (Pim)
Bensemann, Clive
Brenner, Bernard
Brown, Ian McLaughlan
Chamberlain, Nick
Clark, Kenneth
Davis, Alan
Gibson, Thomas
Gootjes, Peter Robert Findlay
Harpin, Roderick
Holdsworth, Deborah
Holmes, John
Hood, Dell Arlington
Hope, Virginia
Howard, Wayne
Jansen, Peter
Jessamine, Stewart Sinclair
Johnson, Gloria
Kelly, Francesca
Mackie, Donald
Millar, Nigel
Morris, Kevin
Nightingale, Susan
Oliver, Mary
Patel, Arvind Chhotu
Pike, Pieter
Rasiah, Rebecca
Sage, David
Simmons, Gregory
Simpson, Andrew
Stolarek, Iwona
Watson, Tom
Welch, Lorraine
Wilsher, Margaret
Young, Wilson Wai Sang

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, Tat Yin David
Lam, Mei Yee
Lee, J P Ping-yan
Lee, Shuk Han
Lee, Ha Yun
Leung, Ting-hung
Leung JP, Pak Yin
Lo, Su Vui
Lo, Chi-yuen Albert
Lui, Joseph
Ma, Hok Cheung
Mak, Sin-ping
Pang, Fei Chau
So, Pik-han Kathleen
Tinsley, Helen
Tung, Sau-ying
Yeoh, E K

Overseas
Davidson, Lindsay Alexander G.
Ferguson, John
Jacobalis, Samsi
Jones, Frederick Gordon
Parker, Ronald
Parrish, Mark McKenzie
Paul, Gershun Chandy
Rees, Neville Clark
Sills, Thomas d
Stokoe, Philip
Tse, Vicki

Bruessel, Thomas
Drane, Alan
Griffin, Robert
Guduguntla, Murali
Hallam, Lavinia Ann
Kecskes, Zsuzsoka
Loa, Peter
Looi, Jeffrey Chee Leong
Lum, Gary David
McDonald, Timothy
Mohamed, Abdel-Latif

NSW
Abell, Fiona
Adusumilli, Sunil
Al Khawaja, Darweesh
Bellamy, Lynette
Bofkin, Kelly Ann
Brown, Katherine
Bruce, Lenert
Brydon, Michael Paul
Cheng, Nga Chong Lisa
Chihumbiri, Charles
Chung, Stephen
Cox, Wendy
De Silva, Kashmira
Evans, James
Fiore-Chapman, Jeniffer
Gatt, Stephen Paul
Goh, Shyan Lii
Harrison, John Anthony
Ho, Vincent
Ingham, Jane
Kennedy, Nicolette
Kossoff, Lana
Kremer OAM, Edward Phillip
Kwong, Wyman
Lee, Cheok Soon
Lee, Saretta
Li, Stephen Chiu Ho
Lim, Chi Eung Danforn
Madapusi, Vinodh
Malik, Mushtaq Ahmad
Mathers, Margaret
Mathew, Vivin
McClintock, Colin
McLean, Anthony Stuart

Associate Fellows

ACT
Abhayaratna, Walter
Adair, Steven
Bowdren, Francis
Mulligan, Michelle
New, Brigadier Charles
Oakeshott AM, Robert John
Pai, Nagesh
Perumpanani, Abbey
Ramanathan, Jayanthi (Jay)
Reppas, Napoleon
Sinclair, Barbara
Sinclair, Murray
Singam, Romesh
Speechley, Ronald Alwyn
Spencer, Clayton
Stanley, Timothy
Stone, Bevan Hopetoun
Taitz, Jonathan
Varadhan, Hemalatha
Wood, Rebecca
Yap, Tom
Yuile, Phillip

NT
Powell, Nadia

QLD
Abdi, Ehtesham Askari
Allison, Roger William Gordon
Aung, Thi
Baqir, Yaser Al-Lawati
Beacom, Graham
Brophy, Conor
Brown, Nigel
Buckland, Stephen
Chand, Dip
Chapman, Kenneth
Dascalu, Jack
Dhupelia, Dilip
Dick, Stephen
Gabbett, Michael
Gianduzzo, Troy
Govindaiah, Venkatesh
Gray, Curtis
Grew, Jennifer
Harvey, Keren
Humphrey, Andrew Reid
Johnston, Andrew
Joshi, Viney
Khanna, Neeraj
Kilian, Johannis
Kumar, Jashnil
Lennox, Denis
Lewin, Morris Walter
Likely, Michael John
Liu, Chang-Han
Lloyd-Morgan, Timothy
Maguire, Marc
Mallett, Andrew
Mansoor, Manadath
McConaghy, John
Menon, Mahesh
Morgan, Clare
Mottarelli, Ian Wayne
Moyle, Robert
Newland, Jill
Nydam, Cornelius (Kees)
Parthasarathy, Bhargavaraman
Purushothaman, Subramanian
Quigley, David Thomas
Rattenbury, Sandra
Reade, Michael
Reddan, Jill Georgina
Rothwell, Sean
Rutz, Dominik
Samy, Chinna
Seddon, Mary
Seet, Geoffrey Peng Soon
Sheehan, Nathanael
Stevens, Samuel
Ueno-Dewhirst, Yusuke
Urwin, Alston Melvyn
Upanal, Nazeer Ahamad
Walker, Stephen
Wang, John
Whiley, Michael
Wilson, John Gilmore
Withers, Stephen
Wong, Bernadette
Wu, Min-Hua
Yee, Kah

SA
Chitrarasu, Asha
Fergusson, Alistair
Fielke, Rick
Flood, Louise
Furst, Paul
Giannakoureas, Angelos
Giri, Geetha
Govindan, Thiru
Kochiyil, Venugopal
Krishnan, Preethi
Lethlean, Margaret
Nath, Lakshmi
Nath, Shriram
Nguyen, Hoa
Nottage, Casey
Olver, Ian
Parthasarthy, Raghunandan
Penhall, Robert
Roertgen, Daniel
Roy, Amitesh
Russo, Remo
Sanap, Vrushali
Sanap, Milind
Shroff, Behzad Daran
Singla, Amita
Spernat, Daniel
Sundararajan, Krishnaswamy
Thomas, Rebecca
Van Wijk, Roelof
Visvanathan, Thavarajah
Wilson, Douglas

TAS
Harkness, Nicholas
Hickman, John Arthur
Huckerby, Emma
Jose, Matthew
Kalpurath, Krishna
Lambeth, Leonard
MacDonald, Alasdair
Mulligan, Beth
Skinner, Marcus
Van der Veen, Christina
White, Craig
Wilde, Christopher
Wilson, Deborah
Woo, Lennie
Xabregas, Antonio
Zalstein, Sandy
VIC
Agrawal, Yogendra
Allen, David
Atkinson, Victoria
Barton, David
Bell, Richard
Bohra, Suresh
Brichko, Lisa
Brooks, Anne Marie Vickery
Bryan, Sheila
Castle, Robert
Chao, Michael Wan-tien
Chen, Leonard Yi-Ming
Conyers, Robert Anthony James
Danvers, Linda
Davies, Glenn
Drummond, Roslyn
Fawcett, Rodney Ian
Francis, Paul Howard
Gleason, Andrew
Hannam, Jared
Harley, Nerina
Hayhow, Bradleigh
Howell, Jocelyn
Inglis, Susan
Jensen, Frederick Owen
Joshi, Sachin
Judson, Rodney Thomas
Karabatsos, Georgia
Kennelly, Eric
King, Joel
King, Scott
Kotler, Eli
Lai, Michelle
Lakshmana, Raju
Leow, Fiona
Ling, Yee-May
Lo, Emily
Longmore, Peter Graham
Lynch, Rod
Mosenki, Seikisi
Mudalil, Selva Nathan
Newton, John
Ng, Karen
Oakley Browne, Mark
Pedagogos, Eugenie
Plakiotis, Christos
Prince, Henry
Robertson, Megan
Rosenfeld, Jeffrey Victor
Rotella, Joe-Anthony
Rozen, Leon
Sarat, Sudeep
Sarode, Vineet
Shearer, Bill Arthur Joseph
Singh, Pawan
Siotla, Rajiv
Subramanian, Rajiv
Sullivan, Danny
Tang, Kenneth
Teo, Jon Paul
Toogood, Geoffrey
Trivedi, Amarendra
Taanglis, Maria
Vaughan, Stephen Lawrence
Wan, Aston
Waters, Mary Josephine
Waxman, Bruce
Williams, Richard
Williams, Daryl
Wong, Michael Tak Hing
Woodhouse, Paul Damian
Workman, Barbara
Yuen, Nicola

WA
Andrews, Reginald
Arcus, Meredith
Barratt, Peter Stewart
Baruah, Partha
Crampin, Emma
Donnelly, Jacqueline
Edmonds, Sally
Graydon, Robert Harold
Jackson, Anthony
Keller, Anthony John
King, Benedict Pui-Yan
Kling, Neill
Langford, Stephen Alan
Mohamad, Wael
Nair, Sathiaseelan
Nowrojee, Sharon
Reddy, Anju
Rhodes, Helen Christine
Rogerson, Tania
Rudolph, Peter
Sheridan, Carmel
Sonawane, Roshni
Stokes AM RFD, Bryant Allan Rigbye
Warne, Roger
Williamson, Geoffrey Donald

New Zealand
Alexander, Dallas
Anand, Muthur
Bailey, Matthew
Bolotovski, Alexander
Creighton, Jane
Earnshaw, Steven
Ewens, Andrew
Imran, Suhail
Kam, Susan
Kehoe, Matthew
More, Kiran
Shirley, Alan John
Shuaib, Mohammad
Stapleton, Andrew
Watson, Peter
Wong, Deanne
Zaidi, Moazzam

Overseas
Al Amri, Badria
Giele, Henk Peter
Kukreja, Anil
Thomas, Adrian Powell

Candidates

ACT
Benson, Jo-Anne
Sharkey, Sarah Edith
Talaulikar, Girish

NSW
Adusumilli, Sunil
Ah Kit, Samuel
Ali, Osama
Baruah, Partha
Baskaranathan, Suhanthini
Bibikov, Sergey
Costantino, Kathryn
De Silva, Kashmira
Dennington, Peta Michelle
Diez Alvarez, Sergio
Doherty, Belinda
Elias, Daryl-Anne
Ferreux, Maryann
Ghan, Christian
Ghannam, Jamal
Giddings, Patrick
Greenberg, Randall
Luong, Kevin-Gia-Dat
McNamara, Antony
Savage, Paul
Sharma, Anita
Simoes Metelo de Almeida Lourenco, Marco
Souvannavong, Deky
Thomas, Peter
Watters, Gregory
White, Andrew

NT
Goodwin, Samuel
Harwood, Louise

QLD
Beck, Christopher
Bryant, Carl
Carrahar, Eleri
Chanchlani, Sonia
Choudhary, Anand
Cooke, Georgia
Cooper, David
Day, Gavin
de Silva, Astor
Doshi, Deepak
Fellows, Nigel
Fisher, Andrew
Hadikusumo, Stephanie
Holmes-Brown, Stewart
Jensen, Felicity
Keogh, Sean
Kotkar, Swarada
Mackinnon, Angus
Matic, Vladislav
McGrath, Robert
McKinlay, Lynne
Mein, Jacqueline
Motamarri, Balaji
Nunnink, Leo
Paramanathan, Premala
Paul, Ranjit
Seddon, Mary
Thompson, Peter
Uppal, Saniyya
Vonau, Marianne
Westacott, Lorraine
Winter, Amber
Zappala, Christopher

SA
Tan, Christopher

TAS
Fletcher, Scott
Glading, Jodi
Harris, Helen
Hickling, Deborah
Song, Wan Jun
Tan, Kuan

VIC
Abhary, Sotoodeh
Banerjea, Kaushik
Braitberg, George
Chan, Thomas
Chandrasiri, Singithi
Danvers, Linda
De Muelenaere, Catharina
Gazdar, Aradhana
Howlett, Glenn
Imran, Abdul
Iyengar, Vasudha
Kirk, Michael
Konpa, Adam
Lee, Harvey
Leong, Trishie
McConnon, Katherine

ORDING-JESPersen, Sean
Ponniraivan, Anand
Rahimi, Amir
Sie, Boon Shih
Tan, Chun Yee
Thancanamootoo, Kaviraj
Theda, Christiane
van Zyl, Nicolaas
Wainer, Zoe
Wong, Anthony
Wong, Wei
Worsley, Katherine

WA
Billinghurst, Kelvin
Cheng, Victor
Chua, Xin Nee
Gaskell, David
Hawkings, Philippa
Heble, Samir
Johns, Allison
Kandadai, Dhanvee
Krishnasivam, Deepan
Kuzich, Emily
Magana, Natalia
Murphy, Karen
Nair, Ajitha
Tay, Susanty

New Zealand
Bagrie, Emma
Hughes, David
Mackersey, Susan
McCann, Lloyd
Muir, Paul
Nair, Anil Kumar
Roberts, Michael
Robson, John
Russell, Greig
Thornton, Vanessa
Wallace, Jonathan

Hong Kong
Ko, Pat Sing Tony
Lai, Bo San Paul
Li, Theresa
AFRACMA Trainees

NSW
Alshahri, Saeed
Brownlow, Amanda
Chiu, Mary Jung-Ting
Fung, Paul
Hardacre, Geoffrey
Malik, Aditya Prakash
Markuli, Lakshmeesh
Un, Fey-Ching
Vignakaran, Navarathnasothie
Wiley, Janice
Williams, Jodie-Kate

QLD
Alempijevic, Nenad
Aram, Narelle
Bhullar, Sunit inder pal Singh
Currie, John
Eskandari-Marandi, Babak
Khadri, Syed
Oltvolgyi, Csongor George
Parashar, Nakul Raj
Wren, Kellie Ann

SA
Brien, Sean Matthew
Ma, Scott
Meyer, Hendrika
Ramkumar, Tharapriya
Turnbull, Thomas
Wong, Vun Vun

TAS
Jonsson, Ulla Margret

VIC
Barnett, Craig Ross
Brahmibhatt, Anjalee
Chowdary, Zarrar Ashraf
Cronin, Andrew John
Harrison, Benjamin
Huang, Andrew
McKenzie, Ben Andrew
Mills, Christopher

Moodley, Indren
Morley, Peter Thomas
Nathoo, Shainal
Rane, Vinay
Rimer, Romi
Steed, David
Tran, David
Waterdrinker, Astrid
Wehbe, Julie
Yeo, Vivien

WA
Marillier, Eleanor Ann
Pratsis, Koula Kyriaki
Ramesh, Parthasarathy

New Zealand
Broadbent, Jacqueline Clare
Cole, Cameron
Conaghan, Carin Jeanette

Affiliates

ACT
Gatenby AM, Paul

NSW
Chew, Gerald
Searle, Judy

QLD
Nel, Pieter
Sinnya, Sudipta

TAS
Hickling, Deborah

VIC
Chopra, Prem

New Zealand
Earnshaw, Steven
Pidgeon, Grant
Ranta, Annemarei
Warring, Penelope
Australian Capital Territory
Chair
Dr Christina Wilkinson
Honorary Secretary
Dr Rod Lambert
Coordinator of Training
Dr Leonard Brennan
CEP Coordinator
vacant
Fellow
Dr Nicola Ward

New South Wales
Chair
Dr Tony Sara
Honorary Secretary
Dr Nick O’Connor
Treasurer
Dr Tony Sara
Coordinator of Training
Dr Claire Blizard and Dr Tony Sara
CEP Coordinator
Dr Eva Pilowsky

Queensland & NT
Chair
Dr Luis Prado
Honorary Secretary
Dr Liz Rushbrook
Treasurer
Dr Greg Coffey
Jurisdictional Training Coordinator
Dr Leah Barrett-Beck
CEP Coordinator
Dr Nicola Murdock
Fellow assisting the JTC
Dr Donna O’Sullivan
Fellow
Dr Stephen Ayre
Associate Fellow Representative
Dr Michael Gabbit
Coopted Candidate
Dr Michael Clements
Candidate Representative
Dr Dale Seierup

South Australia
Chair
vacant
Treasurer
vacant
Coordinator of Training
Dr Susan Merrett
CEP Coordinator
vacant
Fellow
Dr Sally Tideman
Candidate Representative
vacant

Tasmania
Chair
vacant
Honorary Secretary
Dr Peter Renshaw
Treasurer
vacant
Coordinator of Training
Dr Helen McArdie
CEP Coordinator
Dr Helen McArdie
Candidate Representative
Dr Helen Harris

Victoria
Chair
Prof Erwin Loh
Coordinator of Training
Prof Erwin Loh (Acting)
New Zealand
Chair
Dr Grant Howard
Honorary Secretary
Dr Dilky Rasiah
Treasurer
Dr Peter Gootjes
Coordinator of Training
vacant
CEP Coordinator
Dr Stewart Jessamine
Candidate Representative
Dr Debbie Holdsworth

Candidate Representative
Dr Greig Russell
Fellow
Dr Dell Hood
Fellow
Dr Wilson Young
Fellow
Dr Don Mackie
Fellow
Dr Allan Davis
Fellow
Dr Iwona Stolerek
Fellow
Dr David Sage

Hong Kong
President
Prof Hong Fung
Vice-President
Dr Leung Ting-hung
Honorary Secretary
Dr Mandy Ho
Treasurer
Dr Nancy Tung
Chief Censor
Prof Hong Fung
CEP Coordinator
Dr Helen Tinsley
Clinicians are the stewards of our health system. Whether you’re working in a group practice or hospital, in insurance or another health care setting, developing your leadership and management skills are essential to your patient outcomes, your organisation and your career.

The RACMA Management for Clinicians (M4C) program provides doctors with an excellent platform from which to build skills for leadership and management. This introductory program is aimed at the practitioner entering into or those who have recently been appointed to a leadership and management role.

Delivery of this 2 day program is conducted by experienced Fellows of The Royal Australasian College of Medical Administrators.

These Fellows are working in leadership and management roles, serving on Boards and committees and responding to the challenges of working in a complex and adaptive health system.

---

The 4 study themes below will be covered within the 2 day Management for Clinicians program

1. Clinical to Clinician Manager
2. Understanding Health Care Systems
3. Clinical Governance
4. Communication and Building Effective Teams

Register Now
For further information regarding the Management for Clinicians program(s) or to register your interest please contact Nicky Jacob, Program Coordinator p 03 9824 4699 or e njacob@racma.edu.au or alternatively visit our website racma.edu.au