RACMA
The Royal Australasian College of Medical Administrators

The Quarterly

The Royal Australasian College of Medical Administrators

Volume 41 Number 4
December 2008

Margaret Tobin Challenge Award

Revising RACMA's Constitution

List of Fellows, Candidates and Members

2008 New Fellows

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The Royal Australasian College of Medical Administrators

The College was founded in 1967 as the Australian College of Medical Administrators and attained its Royal Prefix in 1978. In August, 1998 when links with New Zealand were formally established, the College changed its name to The Royal Australasian College of Medical Administrators. The College when first established had the aim of promoting and advancing the study of health services administration by medical practitioners.

Profound changes in health administration have occurred since that time, but the need for competent well-trained health sector managers has not diminished.

The College works to achieve its aims through a rigorous university-based training course, supervised posts in medical administration and postgraduate education programmes for Fellows, Members and Candidates.

The College headquarters are situated at 10/1 Milton Parade, Malvern, Victoria 3144 and there are active Committees in each State and Territory of Australia and New Zealand.

2007/2008 Office Bearers
President, Professor Gavin Frost
Vice President, Dr David Rankin
Immediate Past President, Dr Philip Montgomery
Honorary Secretary, Dr Roger Boyd
Honorary Treasurer, Dr John Menzies
Censor-in-Chief, Dr Lee Gruner
National Director, Continuing Education/Recertification, Dr Kim Hill
Chief Executive, Dr Karen Owen

Editorial

Dr Andy Robertson

As with the normal procedure in recent years, I present this as *The Quarterly* Annual Report. As I reflect over the last financial year, I am pleased to see how *The Quarterly* has continued to evolve. We have again seen the production of four issues of *The Quarterly,* in September, December, March and June, and the settling in of an Editorial Advisory Committee, who have been instrumental in encouraging authors to submit their papers to the Journal.

We are planning for at least another 4 issues in 2009, and, with changes to the Fellowship assessment process, we anticipate more articles from the candidates, particularly in the form of "Letters to the Editor". Having recently been involved in the review of these Letters, I was impressed with the standard of the submissions, particularly the topics chosen, their thoughtful analysis and the conclusions, sometimes controversial, drawn. I look forward to some lively correspondence on issues as diverse as the role of the coroner and the need for accreditation. I am hoping this process will encourage candidates, as well as Fellows and Members, to submit longer original articles and reviews as well.

Our range of topics has remained diverse, with articles on everything from credentialling, healthy leadership and the National Health Service to governance in hospitals (or the lack there of), a challenge for all of us. All the articles are designed to inform, educate and widen the strategic viewpoint of our readers. We welcome discussion on the more controversial issues, including the role of nurse practitioners and physician assistants, medical workforce, negligence, reproductive technology, elective surgery and emergency department demand, and patient safety.

Our regular sections continue to develop, with continuing regular contributions from Dr Lee Gruner (Focus on Quality), Dr Kim Hill (Continuing Education Program), and Dr Erwin Loh (Candidate Perspective). These regular submissions are most welcome and we encourage all readers to write short articles on their areas of expertise.

I remain keen to see *The Quarterly* evolve and am always happy to hear from Candidates, Members and Fellows who would like to contribute. *The Quarterly* needs to remain relevant to all groups and any papers, reviews, letters or other contributions that progress that ideal are most welcome.

Finally, thanks to Dr Karen Owen, our Chief Executive, who, along with the staff of the Secretariat, ensure that the production of *The Quarterly* is smooth, seamless and timely.

I look forward to continuing to work with all our readers to further develop and grow *The Quarterly.*

Dr Andy Robertson
Editor

From the President

Dr David Rankin

At its November meeting the AMC granted RACMA four years accreditation. This is a great achievement for the College and recognises the extra-ordinary work that Dr Karen Owen, as Chief Executive, and the other members of the College Secretariat have put into this project over the past few years.

I would like to also acknowledge the work of Gavin Frost and Kim Hill in particular. Gavin has led the College through a period of significant change and built a lot of the infrastructure that was clearly recognised by the AMC. Kim, who recently retired as National Director CEP/R, contributed many hours with the CEP committee and developed a range of documents, structures and policies. Without this very significant contribution we would have been unable to achieve the AMC recognition.

The College recognised the contribution Susannah Ahern made to researching and then writing the draft of the submission in her receiving The Young Fellow Achievement Award at the national conference.

We cannot however sit back and wait for out first review in 2011. There are a large number of recommendations that will take further effort and time to put into place. One of these challenges will be to create a well founded, robust curriculum on which to base our training programme.

In order for the College to operate effectively, we need to revise our Constitution. The debate at the 2008 AGM gave the Council a clear direction for a way forward. We have now identified four options that would ensure jurisdictions have a voice on the Board. You should have all received a copy of the short discussion document and I would strongly encourage you to consider each option. Council believes each of the options is realistic although some reflect a representative board while others reflect a more contemporary governance model.

There are a number of ways to respond to the options – by returning the response form accompanying the options paper, by email or by writing to myself or the secretariat. Responses close on December 12th and will be considered by Council at our executive meeting on December 19th. The lawyers will then revise the constitution document accordingly and have a new constitution ready for discussion and then voting in late February.

I am keen to see the College develop a clear vision for the future – one that ensures the College forms an invaluable part of the professional lives of all medical administrators. This will require the continued engagement of all members as we shape the future of our College.

One of the challenges the AMC has given to the College is to increase our recognition amongst State and Federal agencies. Here in New Zealand the newly established Medical Training Board has reflected that medical administration – with its understanding of strategy, economics, planning and workforce development is an area of medicine that is desperately needed in the current climate of change and reconfiguration.

Gaining recognition of the value of the role of competent medical administrators is a challenge that faces us all. The College Executive will lobby funding and training agencies for the establishment of funded training positions in each state. However it is as we each exercise our professional skills that we demonstrate the unique contribution that medical administration makes to the efficient, safe delivery of health services.

Some years ago I was reprimanded by a rural GP for wishing him a Merry Christmas. He was about to face the busiest time of year with an influx of drunk, sun burnt and intolerant revellers to his sleepy beach town. This was always made worse when he spend months trying unsuccessfully to recruit a locum to assist him survive the festive season.

No matter where you end up this year end, I trust that it will be memorable and that you will have the opportunity to recharge your batteries.

Dr David Rankin
President

College Matters

Dr Karen Owen

October this year was the time to celebrate our College achievements and what more apt way than to acknowledge the success of our candidates. I hope that you enjoy some of the photographs from the annual conference in Adelaide that are included in this edition.

Congratulations to all who have now made that passage to Fellowship and we look forward to continuing participation through the CEP and most importantly as College ambassadors and emerging College leaders.

This was my first time to see one president hand over to another. I was fascinated to see what might become a new tradition at the Langford. Professor Gavin Frost publically 'relinquished the chain of office' and ceremoniously placed it on the shoulders of Dr David Rankin. The College formally acknowledged its new leader just as earlier, on 28 October, the 42nd Council had been sworn in at the AGM.

There has been much discussion of late about College leadership and debate will continue about what constitutes good corporate governance long after the issue of revising the constitution has been laid to rest.

Our College leaders have significant strategic issues to address over the next few years. 147 Fellows are now over 65 with a further 107 approaching this traditional threshold. For the College governing body discussion about our aging workforce and succession planning is not just needed to keep the College sustainable but to also address health services leadership by doctors who are trained and competent medical managers.

It takes some 12 years or more to produce a medical administrator. At this rate and with our small intake of candidates (average age 44) and increasing resignations/retirements some estimates place College recruitment needs at up to 20 per year. Perhaps we might, instead, see more medical administrators remain in the workforce into their 70s? I understand there is emerging overseas data beginning to show this trend for some workforce groups.

We have much to do, not the least of which is preparing our College response to the AMC report. Four years accreditation is a welcome achievement even if it comes with 48 recommendations. I look forward to College discussions about the curriculum. This is a fantastic opportunity for members to be engaged in discussing, what is after all, the core business of the College. It is the right time to evaluate our training design and delivery and to integrate the ideas and perspectives of members across the jurisdictions. The curriculum development process will enhance conversation and communication within. I hope that it will be cathartic and bring people together.

As I finish I am reminded that the presentations from the annual conference are now available to view at www.achs.org.au/nationalforum08/#3446 I also want to welcome Ms Rebecca Mason and Ms Marie Paraskakis to the Secretariat. I am already most grateful for the support and progress they are making in the short time they have been with the College.

Dr Karen Owen
Chief Executive

Looking Back on 2007-2008

Dr Roger Boyd

Council's and the Secretariat's very active 2007/2008 year included three main areas of attention, on top of the routine running of the College.

The first, which followed discussion at the time of last year's AGM, was the move to much more functional and modern rented premises at Malvern and the sale of the College's property in Carlton. As will be reported by the Honorary Treasurer, this resulted in a good financial outcome for the College as well as greatly improved conditions for our staff and for the numerous meetings held there.

The second area of focus this year was preparation for and the conduct of the Australian Medical Council's accreditation review of our College. This called for a major contribution from many Fellows, Members and Candidates, as well as our staff, but I would particularly thank Dr Susannah Ahern and Dr Karen Owen, assisted by Dr Bill Appleton, for their sterling efforts in the lead-up to the AMC visits. In parallel with the review of many areas of the College's operations in preparing for accreditation, there was considerable activity around the development of our fellowship and continuing education programs, which will be reported on by the Censor-in-Chief and the National Director Continuing Education/Recertification.

Although the formal outcome of the accreditation review is awaited, and will be communicated when available, the draft report shows there is recognition of much good work that is done by the College, including developments that have been achieved over recent years, but there are also numerous suggestions regarding opportunities for improvement that will keep us busy in coming years!

The third major activity over the past year has been review of the College's constitution, leading to recommendations that will be put to the membership at this year's Annual General Meeting. This work has been lead by our President, Professor Gavin Frost, with considerable support from RACMA Fellow Dr Heather Wellington and her colleagues at DLA Phillips Fox and our Chief Executive, Dr Karen Owen. Considerable detail on the proposed changes to the constitution has been made available previously to Fellows, Members and Candidates.

As in past years, the College has continued to contribute to deliberations on a range of health policy issues, both at national and state/territory levels, through representation on a range of boards, committees and working parties as well as through representatives' attendance at meetings and written submissions. To all those involved in supporting the College in this way, thank you. I should add that advocacy and a clearer public voice on relevant policy matters is a priority for the College in the year ahead and we have very recently welcomed a new staff member, Ms Marie Paraskakis, as Policy and Programs Manager, to assist in this regard.

As implied already, our Chief Executive, Dr Karen Owen, has provided energy and vision to help drive these developments over the past year, supported by Kathy Griffiths in Business Support, who has recently left and been replaced by Rebecca Mason as Education Program Administrator, and Jan Stephenson assisting with Accounts.

In addition, the secretariat is supported by several other Fellows who serve in various roles. I thank Dr Andrew Robertson, Honorary Editor, and the members of the Editorial Advisory Committee, for the production of College journal, The Quarterly; and Dr. Bill Appleton for his assistance as Honorary Returning Officer.

Through this period of significant activity for the College, Council and the Executive of Council have met almost monthly, generally alternating between the two groups, and toward the end of the financial year a new Finance Committee was established as a sub-committee of Council. Details of attendance at meetings are summarised in the Councillor's Report that accompanies the Financial Report. During the past year we have welcomed Rod Lambert and Erwin Loh as new members of Council and thanked retiring Councillors – Peter Bradford, Harvey Lander, Elizabeth O'Leary and Vino Sathianathan – for their contributions.

I would like to express my personal appreciation to Karen Owen and the secretariat staff for their support over the past year and wish the College and all involved, further success in the year ahead.

Dr Roger Boyd
Honorary Secretary

Honorary Treasurer's Annual Report 2007/08

Dr John Menzies

This year, as Hon Treasurer, I would like to reflect on the major changes that are currently affecting the College and their impact on our financial situation.

For the first forty years of the College's existence, it was a reasonably easy task to set a budget each year knowing the expected income and expenditure, and being able to make a small operating profit each year to shore up the capital reserves of the College. College membership was based upon a solid core of fellows and members with small but steady annual increases in College membership. The College was also able to invest wisely many years ago when it acquired the old College headquarters building in Drummond St Carlton. The College's building, staff and education requirements were relatively small and stable in nature and it was relatively easy to accommodate the periodic additional extra expenditures that were required.

Over the last few years, however, there have been some major changes that have impacted upon the College. The first and most important change related to the necessity to upgrade the fellowship training program and support for the ongoing education for fellows and members. The second and related issue, was the need to satisfy the accreditation standards of the Australian Medical Council (AMC). As a result, the College commenced implementing more rigorous and complex training, assessment and validation activities similar to those required of tertiary training institutions. The third change, which is peripherally related, has been the need for the College to engage additional staff expertise to undertake educational and support activities. Many of these activities had previously been provided pro bono by College Fellows. Sadly, modern day work pressures and time commitments mean that there is increasingly less time for voluntary work by Fellows.

The fourth change related to the way new candidates and the membership receive education and support. There is increasing reliance on the use of information technology to support members and College activities. Finally the College needed a better work environment for its staff. The old College building was adequate for the functions of a College in the first few decades, but it was grossly inadequate as a professional, modern day environment.

Due to the five major changes just described, there has been a progressive shift in the way the College has had to manage its finances. The costs associated with delivering professional education and training services has increased and to be sustainable the College must move to cover its costs and return small surpluses to invest for future initiatives. Over the last few years, the College has commenced to position itself to move forward for the next forty years. Over the next year, these developments will continue as the College implements the recommendations for improvement that are required as part of the AMC accreditation process. The budget and the proposed financial planning activities for 2008/9 will ensure the College is in a good position to move forward and meet the evolving needs of its membership.

Before commenting upon the budget for 2008/09, I wish to report on the audited accounts for 2007/08. I am pleased to report that the College's auditor- Morton Watson and Young - has provided an unqualified audit report for the year. The profit and loss statement shows a net profit for the year of $1,029,672. This is primarily due to the sale of the old College premises. However, if the proceeds of the sale are removed, the College actually made an operating loss for the year of $79,255. This underlying loss was largely attributed to two factors. The first, as predicted last year, was the need to meet the additional costs of our AMC accreditation preparation.

sound position to grow

This necessitated the draw down on special purpose funds that had been set aside from the once off special AMC levy on all members. (It is projected that some $150,000 will have been spent on the accreditation process). A second contributing factor to the loss was the extra-ordinary expense associated with the sale and relocation to the new College office and the associated rental costs. The specific details of the College's 2007/08 annual income and expenditure are shown in the accompanying financial statements.

With the sale of the College property for $1.185M, it will be noted that at June 30, 2008, the Balance Sheet shows that the total equity of the College increased to $1.842M. The net proceeds of the sale have initially been invested in short term interest bearing accounts.

During the year, the College Council established a new Finance Committee. This Committee will take on a more active role in reviewing the budget, audit and financial planning activities of the College. During the first half of 2008/9, one of the first tasks for the Finance Committee will be to plan a new financial and investment strategy for the College. As the College now has a reasonable capital reserve for the first time, it can consider alternate ways for investing its reserves and if appropriate, utilising the reserves for future developments. The new investment strategy and other possible revenue opportunities should allow the College to manage more reasonable annual fee increases, whilst supporting more educational and member services. As the new investment and financial planning strategies are yet to be developed, the budget for 2008/9 has been based upon the traditional budget setting approach.

In preparing the budget for 2008/9, the College has made allowance for:

i) increased expenditure on office rental and staff costs including an enhancement to the position of Policy and Programs Manager,

ii) capital expenditure on new IT equipment; and

iii) some allowance for recommendations expected from the AMC accreditation report.

The College Council considered that the best way to meet the increased expenditure was to use a combination of annual fee and subscription increases and a small call on reserves. With this combination, it is expected that the College will budget for income of $846,752 and expenditure of $845,566 thus resulting in a small surplus of $1,186. It should be noted, however, that if the cost of implementation of the recommendations of the AMC Accreditation Report are higher than expected, there may be a need to further draw upon capital reserves.

Overall, I can report that with the changes that have occurred over the last year, and the planned financial opportunities over the forthcoming years, the College is in a sound position to grow and evolve its training programs and support services for its membership.

I commend the annual financial report to fellows and members for endorsement.

Dr John Menzies
Hon Treasurer
October 3, 2008

Note A copy of the Annual Audited Accounts can be found on the College website

How Do We Engage Doctors in Quality and Safety?

Dr Erwin Loh
2008 Margaret Tobin Challenge Award Winner

It is my privilege and pleasure to represent the wonderful garden state of Victoria in this year's Margaret Tobin Challenge 2008. My presentation is provocatively titled "How do we engage doctors in Quality and Safety?" I say this is provocative because this leads us to ask the next obvious question: "Why do we need to engage doctors in Quality and Safety?" Why should doctors be engaged in Quality and Safety initiatives in health systems, when a lot of them appear to have very little understanding of the issues? Well, I will now proceed to tell you why we need to engage doctors, and how we can do so, using available evidence in the literature. Quality and safety is for everybody in health care, and that includes doctors.

My presentation will be based on a television series familiar to a lot of us – House MD. Gregory House MD, as you may already know, is a medical specialist, peculiarly in both Nephrology and Infectious Diseases, and significantly, is the Head of the mysteriously and ambiguously named Diagnostics Department at the Princeton Plainsboro Teaching Hospital. If you have time to watch television, and I doubt that any of you have since you are all busy with medical administration, you will know that Dr House has had multiple run-ins with the hospital administration, specifically with Dr Cuddy, the medical administrator, who is also, incidentally the Dean of Medicine and an Endocrinologist, multi-talented like most medical administrators are.

My presentation will be divided into 5 sections. I will start with providing the context of the presentation. I will then discuss why we should engage doctors and then move on to how we do this. I will summarise my presentation and then take questions.

1. Background

The background to my presentation, and in fact, the background to this whole conference, is the fact that patient safety and quality in health care matters. The Australian Quality in Healthcare Study, the seminal piece of work in the Medical Journal of Australia published over 10 years ago, showed that adverse events frequently happen in hospitals, and most of these are preventable.

When the Australian Council of Healthcare Standards (ACHS) surveyed over 600 hospitals 5 years ago, they found that over 50% of these hospitals had inadequate quality control systems for patient safety. Bear in mind that this is a few years after the initial publication of the MJA article. It was clear a lot still needed to be done.

Most of us will recognise the photographs of the three Australian hospitals in the above slide. The first photo is that of the King Edward Memorial Hospital, where an inquiry into the stillbirth rate took place in 1999. The middle photo is that of the Campbelltown/ Camden Hospitals, where in 2002 the NSW medical board investigated 16 doctors because of alleged clinical governance failures. And last but not least, there is no one left in Australia, least of all in healthcare, who has not heard of the events that occurred at the Bundaberg Base Hospital in 2005, now part of the Australian medical folklore.

I think we can all agree, after my introduction, that patient safety and quality in Australia is an important and crucial aspect of health service delivery. I daresay that none of us would be here at this conference otherwise.

2. Why Doctors?

So, why doctors? Why should we bother trying to involve doctors, like Dr Gregory House, who walks around our hospitals as though they own it, and who seem to have a poor understanding of organisational culture, who childishly want things done their way or it's the proverbial highway? Why not just leave them behind to their archaic hierarchical ways and instead work with other health professionals who are more progressive and proactive?

Here you see two doctors who are engaged with you in the delivery of patient safety and quality initiatives. Dr House is friendly, charming, helpful, understanding, and cannot wait to jump in and assist you in collecting audit data, review health records and speak to patients and their family using non-jargonistic plain English on your behalf. Dr Wilson, the head of Oncology, is so relaxed with you his feet are on top of your table, and he is overly joyful that trended data is on track, that the hospital key performance indicators are benchmarking well with State and National standards, and

that the hospital has just received an Outstanding Achievement rating from ACHS for their risk management mandatory criteria.

When you have engaged doctors like these two, especially when they are unit heads and key opinion leaders in your hospital, you basically have your change champions, who will help you to effect change in your organisation.

Here you see, contrastingly, two doctors who are both disengaged from the clinical governance agenda of the hospital. They are suspicious of you, suspicious of management, suspicious of the Department of Health, and in fact, suspicious of each other. A disengaged doctor can often-times be difficult, uncooperative, and to some people, may come across as unhelpful and even scary. They may appear to block change, and to be doing so unreasonably with no obvious rationale or logic. Disengaged doctors may come across as being selfish as they appear to lack a holistic view of things with their focus narrowed to their own unit or specialty.

What happens when it is the Clinical Department Head who is disengaged? What if they are like Gregory House MD, someone who has become a Unit Head, not because they have good management or people skills, which House obviously lacks, but because they are the very best at their clinical work, an expert esteemed by their peers, nominated to that position based on their exceptional clinical skills even though they may have no management skills whatsoever.

So why does it always seem to be that doctors are the most difficult group of health professionals to engage, when we are supposed to be the most intelligent and skilled?

What makes a doctor different? I would suggest that there are 3 main reasons.

1. Historically, doctors have evolved out of an elite and egalitarian professional class. They were held in high esteemed, and were totally independent and answerable to no one but themselves and their patients. In relation to public hospitals, as recently as fifty years ago, doctors were all honorary visiting medical officers, donating their services pro bono to hospitals and were not employees of them. Although things are very different now, especially in the public system, the medical culture is still trying to catch up with this change.
2. Educationally, doctors are trained, not to be employees of an organisation, but to be independent and autonomous. Our training puts into us a deep sense of personal responsibility for what happens to our patient, which leads doctors into a culture that does not lend itself to systemic, blame-free thinking. Younger student doctors model off older doctors and learn how to behave – they learn how to work overly long hours, interact with their non-medical colleagues and other patterns of behaviour that may or may not be maladaptive.
3. Legally, doctors have a unique duty of care relationship with their patients that doctors take very seriously, and the law is set up in a way that is contradictory to contemporary quality systems thinking – in the eyes of the law, there is no such thing as a blame-free culture – someone has to be blamed so that the plaintiff gets paid damages, and that someone in a lot of cases ends up being the doctor, who courts perceive is where the buck stops (and who also in many instances has the most amount of "bucks" to pay the plaintiff, in this case, through the medical insurer).

All these factors lead to doctors being fiercely autonomous, with a deep sense of responsibility to their patients and not to their organisations. As such, doctors have their own clinical priorities and not the priorities or vision of the organisations that they are in.

So, am I excusing doctors who behave badly, who are actually unreasonable, or who are in fact difficult? No, I am not. My intention is to try to provide some of you with an understanding as to where doctors come from, so you know why some of them act they way they do. When a child behaves badly, sometimes we need to look at how the child was brought up.

3. How to Engage Doctors

So how do we engage doctors? How do we engage the doctors who are the key opinion leaders, such as the Unit Heads, so that they can be change champions for us?

My review of a selection of research literature reveals that there are ways we can, as medical administrators, quality professionals and risk managers , engage doctors. I have, for your benefit, just like a brewer who distils fine premium beer for his patrons, distilled all the myriad of principles and recommendations out into 8 simple strategies.

I will go through these strategies quickly now.

a. Understand Culture

The first strategy has been partially fulfilled by this presentation so far

How Do We Engage Doctors in Quality and Safety? continued

already. To be able to engage doctors, we need to understand that the medical culture is distinctly different to other health professional culture, based on the factors I've already discussed.

It is important to note that the culture is changing. Younger doctors, who have grown up training in public hospitals, where they have always been public employees working in a multidisciplinary team environment, are more used to working within a quality system. The danger is that these younger doctors may be adversely influenced by the older generation in the tried-and-true apprentice medical education model we have. The emphasis is now on ensuring there is clinician-leadership, where frontline senior clinicians lead the way in patient safety initiatives.

b. Establish Common Purpose

The second strategy is to discover a common purpose with your doctors. It is important to make the doctor understand that you and your hospital are on his or her side, and together, ultimately, we are all about improving patient outcome. This may take some convincing, as doctors have become cynical and suspicious of clinical risk initiatives, believing them to be expensive projects that wastes money used by the department of health as public relations exercises and to give a whole bunch of people jobs. Doctors need to know that we are all on the same team with the same goal. They play full forward – we play centre line or full back. But we play on the same team.

c. Reframe Values and Beliefs

The third strategy is to reframe the values and beliefs of doctors, so that they have an understanding that the world, really, doesn't revolve around them, but that they work within a very complex health system, and things go wrong, not just because individuals fail, but because sometimes the system fails the individuals instead.

Doctors require further education in relation to this issue. The great sense of responsibility that doctors feel for their patients need to be extended to patient safety initiatives as well, so that doctors have a holistic view of health that goes beyond the traditional doctor-patient relationship. Again, the medical culture is changing, and more and more doctors, who once were blind, now can see.

d. Engage at the Coal Face

The fourth strategy is to engage the doctors at the coal face. I used to hate the word "coal face" as it implies that all of us work as hard as coal miners deep within the bowels of the earth, but I suppose, that is not that different from working in public hospitals. Practice improvement should be centralised for better coordination, but the impact of the improvements need to be felt at the work unit level. For example, regular, minuted multidisciplinary team meetings act both as peer review opportunities for doctors as well as an important avenue to review quality and safety issues, unit performance indicators and come up with innovative ideas and projects for improving care.

The front line is where the action is, so let us equip those at the front line with the right tools, so that clinicians themselves can take up a leadership role.

e. Segment Engagement Plan

The fifth strategy is to ensure we have an engagement plan that is segmented and targeted. In other words, just like using monoclonal antibodies to target melanoma cells, we want to be strategic and target the key opinion leaders of our organisations and those most likely to be champions of our cause. We want to put our efforts into the people who are going to be most useful to us, but on the other hand, we cannot neglect the laggards. We just need to remember that we cannot waste energy on the 20% when we can work with the 80% who are amenable to change.

f. Use Engaging Methods

The sixth strategy is to use methods that are engaging to doctors. First of all, hospitals should make use of people like us – medical administrators. Although a lot of doctors think of us as bureaucrats, we are still doctors after all, so to other doctors, we must be better than the non-medical 'paper pushers' out there. We can talk the jargon, we understand and are trained in clinical governance methodology, and we are also able to navigate the medical culture because we came out of it. Medical administrators can act as translators, as well as coaches, to train up clinician managers to take up a leadership role.

The second thing we need to do is to use data sensibly. Doctors are trained from medical school to practice evidence-based medicine. Therefore, doctors are unconvinced unless we have evidence to show that a quality initiative actually does work, the more robust the data the better. It is very interesting to observe when the evidence-based, clinical guidelines movement first started twenty or so years ago, the medical fraternity was very much against it as they felt that

being told how to practice medicine would cause them to lose their autonomy, but doctors today are some of the greatest proponents of evidence. This suggests that when doctors take up something, they really do go all the way and become passionate about it, which, in a way, bears well for patient safety and quality, if we can get the doctors on board.

Thirdly, we need to make the right thing easy for doctors to try, so they can try before they buy, and also, to do, because doctors are busy people and don't have a lot of time to waste.

g. Adopt Collaborative Style

The seventh strategy is that we need to adopt a collaborative style. This means we involve doctors from the very beginning – doctors hate to be left out in the loop. We need to choose our messages carefully so we use the right jargon. We also need to choose our messengers carefully – pick your change champions correctly by using engaged doctors who are key opinion leaders, and half your battle is won. Lastly, make doctor involvement visible to encourage the other doctors.

h. Show Courage

Last but not least, just like Dr Lisa Cuddy, our beautiful but tough medical administrator at the hospital where House works, we need to show courage. When faced with a doctor like House, who is stubborn, recalcitrant, and potentially abusive, we need to stand firm, and to deal with conflict through the right channels. This is a whole other presentation in of itself, so I will stop here.

4. Summary

In summary, we can further group the 8 strategies into 4 main points.

1. We need to establish a leadership culture where clinicians take the lead.
2. We need to adopt a collaborative approach so that clinicians know we are on the same team.
3. We need to have education that trains people to not only be good clinicians but understand clinical governance and management.
4. We need to show courage.

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Annual Training Program Report

Dr Lee Gruner

The process of continuous improvement in educational activities continued throughout 2008. The following areas provided the focus for the work of the Censor In Chief, Censors and the secretariat.

- Application process – Recognition of prior learning (RPL) / advanced standing
- Management Practice Folio
- Case study
- Oral examinations
- Curriculum
- Costs of training program
- Priorities for 2009

Application process

New improved application forms were developed for downloading from the website. These have more information relating to the candidate's supervisor and job description. Candidates need to provide three referee names.

- A template for referee reports will be developed and this will also be available on the website. From 2009, candidates will be requested to provide the completed referee templates with their application to speed up processing.
- There are now separate applications with separate fees to apply for advanced standing and/or RPL. A Chair of Board of Study written recommendation is also required before this will be considered.
- Clearer documentation is now provided on the candidate assessment form recording how much advanced standing is approved and when candidate will be eligible to sit the oral. These assessment forms are place on the candidate's file and provided to the Chair of the BOS and the candidate's preceptor once allocated.

Management Practice Folio

This new set of written tasks aimed at honing writing skills commenced for all new candidates from 2008

- The MPF consists of a set of writing tasks as a formative assessment and some of these tasks are work already prepared in the work environment
- All candidates are assessed individually to determine how many MPF points they need to do depending on RPL. A candidate who has not been given RPL is expected to complete 100 points over 3 years.
- The MPF has one compulsory task. This is a Letter to Editor of the Quarterly based on an article in the Quarterly in the previous 12 months. Almost all eligible candidates have submitted this task and feedback has been provided by the Censors appointed to do the assessment.

Case Study

The case study task has now been more clearly defined as reflections on learnings during candidacy linked to RACMA competencies and the assessment criteria have also been clarified. There is a structured process for submission marking and review to ensure that all candidates are ready to present the case study at the 4 day workshop in April. The process consists of:

- Submission between June 1 and December 1 in the year prior to the oral. No extensions are allowed
- Submission must be by the preceptor who completes the cover sheet indicating that they have read the case study
- The case study will be formally assessed by mid to late January
- Only one minor re-write will be allowed to be submitted by the end of February
- In order for the candidate to attend the four day workshop and be eligible to sit the orals, the candidate must have passed 3 weeks prior to 4 day workshop

Oral Exams 2008

- 12 candidates presented for the oral examination and 10 passed. There were 3 candidates who passed after supplementary exams that tested gaps in knowledge by questions related to borderline case studies
- Data from the examinations was collected and collated to assist in assessment of Censor performance and degree of difficulty of individual questions and this will be used in preparation of examination questions and Censor education in 2009
- Consideration will be given to addition of short cases from 2010. This will be discussed at the Censors meeting in February 2009 and information disseminated after this
- Formal feedback is being sought from candidates who sat the oral using the on line survey monkey tool

Costs of Training Program

The increasing complexity of the training program, candidate assessment and workshop speakers led to a rigorous assessment of all costs. These costs determine fees that need to be charged based on resources expended by RACMA

- Costs have now been allocated for each part of the training program (other than the academic component)
- Costs will be reviewed annually to ensure fees continue to cover college costs

Curriculum

Following AMC accreditation in June, the report has identified a major set of recommendations in relation to the lack of a clear curriculum

- This curriculum will be developed in 2009 using an expert working party and a curriculum expert to document the final curriculum
- Nominations will be sought for this working party late in 2008

Priorities for 2009

- The major priority is the documentation of the curriculum as AMC will expect considerable progress by the end of 2009
- There will be more emphasis on preceptor role with the appointment of a preceptor coordinator to assist CiC. Dr Draginja Kasap has been appointed to this role to ensure all preceptors are formally educated in the requirements of candidates, linkages with supervisors and preceptor responsibilities.
- Improvement in administrative processes to ensure all RACMA requirements have been met prior to the 4 day workshop

Thanks to the hard working team of Censors and Board of Studies chairs who contributed to progress in 2009. A special vote of thanks to Dr Mark Platell who has now completed his term as Censor for Case Studies.

Dr Lee Gruner
Censor in Chief RACMA

Annual Continuing Education Program Report

Dr Kim Hill

It is with pleasure that I provide this Report on developments in the College's Continuing Education Program, as I draw to the end of my second term as National Director, Continuing Education/Recertification.

The past twelve months has seen considerable advancement of new CEP initiatives, and the culmination of some of the longer-term goals. As with all the College's endeavours, these have been the combined achievement of a team of dedicated individuals, who bring energy, expertise and enthusiasm to the task at hand, and for the benefit of the College in general.

One of the most significant achievements has been the establishment of the educational platform of the College's Continuing Education Program, through the development of the Continuing Education Program Curriculum and associated mapping of CEP activities to the RACMA curriculum areas and competency domains. The result is a series of guides that can be used prospectively (or retrospectively if needed) to explore priorities for professional development, and as part of a CEP learning contract.

RACMA Council approved the CEP Curriculum on 16 February 2008. It is now formally part of the College's CEP educational platform, and is available on the CEP pages of the College's website, for ready access. I would like to take this opportunity to especially acknowledge the work of Dr Gabrielle duPreez-Wilkinson in the development of this College CEP curriculum and competency domain matrix. My thanks also go to the CEP Coordinators for ensuring that there has been discussion within the local State/Territory/NZ Committees in its development.

The creation of the electronic CEP environment where Fellows and Members can record and report their participation in CEP has been a welcome addition to the College's CEP infrastructure in 2008. The two electronic environment CEP tools were demonstrated in their early stages at the 2007 RACMA National Conference, where feedback was invited from conference participants on both online tools. Now, one year later, I am pleased to say that the in-house RACMA eCEP tool is now in place, and Fellows and Members are now being actively encouraged to use eCEP to document their CEP learning plans and activities as of 2008. For Queensland Fellows, the electronic environment has been created through partnership with ACRRM, and the associated RRMEO tool is also in place. The further advantage of the electronic environment is its application to facilitating CEP Coordinators, the National Director Continuing Education/Recertification and the National Secretariat in relation to approval and certification of participation, which is then of benefit to all concerned. I would like to thank Dr Bernard Street, Dr Karen Owen and Dr Gabrielle duPreez-Wilkinson in particular, for the support they have given in moving our electronic CEP environment agenda forward during recent years.

This past year has also been marked by substantial review of governance around CEP, including delineation of roles of RACMA CEP office bearers, and the CEP committee structure and reporting lines. Policies on mandatory participation in CEP, the annual audit program and the mentoring program have been developed and approved, and extensive work has been done in defining and documenting RACMA CEP Business Rules, to provide Fellows and Members with clear and concise information about aspects of CEP (most recently in relation to Fellows and members who undertake CEP conjointly with another medical College). In 2008, the CEP Committee also reviewed the structure and content of the CEP pages on the College's website, to ensure that it was a suitable and accessible source of up-to-date information about CEP.

These initiatives were instrumental to successful preparation for AMC Review, and members of the CEP Committee met with the AMC Review Team at the College in Melbourne and via teleconference on Wednesday 18 June 2008. The outcome of this discussion, as evidenced by the preliminary report of the AMC Team, was positive and constructive.

In 2007-2008, Council formally restated its expectation that Fellows and Members participate in the College's CEP as part of being in good professional standing. The revised policy on Implementation of Mandatory

Participation in the Continuing Education Program was informed by the results of the 2007 CEP Survey, where Fellows and Members were asked their views on different aspects of the Continuing Education Program, via a survey conducted through the RACMA website.

In the outcomes of this CEP Survey, awareness of the requirements for participation in CEP by Fellows and Members was rated as high, with 85% of respondents confirming that they were aware they had given a commitment to participate in CEP, and 63% indicating that they had completed the College's CEP requirements. In relation to reporting and certification, 53% of those who responded said they did not report their CEP for RACMA to RACMA. Of those who did report, 52% of respondents thought the existing reporting arrangements were adequate, while 46% believed reporting arrangements need improvement. Feedback was also received about the barriers that affected participation, including access to relevant CEP activities and uncertainty about how to participate in the RACMA program.

The CEP Committee responded to this feedback by the development of material and tools directed to the educational components of CEP, and explored ways to clarify and streamline the processes of contract development, review and certification. A communication strategy was developed and is now being implemented around CEP, and has included letters and email to Fellows and Members, communication with local RACMA committees and articles in *The Quarterly* on CEP.

Despite these initiatives, there has been little change in participation in recent months, as measured by the rate of formal certification of participation. The rate of certification of participation for Fellows has fallen as of end May 2008, while the rate has actually increased for Members. It is expected that these rates will increase soon, once the transition to the new electronic CEP tools is in place, and the final report on 2008 participation rates will be completed in October 2008, for presentation to Council at the National Conference. Participation rates will continue to be monitored as the College moves towards its target of achieving 100% engagement in its Continuing Education Program by Fellows and Members.

I would like to take this opportunity to thank the members of the RACMA CEP Committee for their substantial contributions during the past year. The College is very much dependent on the voluntary time of its State/Branch/New Zealand CEP Coordinators, and I would like to acknowledge Dr Jennifer Baker and Dr Rod Lambert (ACT), Dr Fung Hong (HK), Dr Eva Pilowsky (NSW), Dr Bob Boyd and Dr Pim Allen (New Zealand), Dr Gabrielle duPreez-Wilkinson (Qld/NT), Dr Bruce Swanson (SA), Dr Helen McArdle (Tas), Dr Bernard Street (Vic) and Dr Robyn Lawrence (WA), all of whom have been part of the deliberations and achievements of the CEP Committee in 2006-2007. I would also like to thank the College Secretariat, Dr Karen Owen, Mr Dino DeFazio and Ms Kathy Griffiths, who provided their support and assistance in moving CEP initiatives forward during the past year.

Dr Kim Hill
National Director Continuing Education/Recertification

CEP Handover

Dr Bernie Street

Welcome from the new National Director of CEP/recertification

As I take up the mantle, I would like to acknowledge the extraordinary contribution of our previous National Director of CEP/R Dr Kim Hill. Dr Hill's achievements include the establishment of the CEP Curriculum and competency domains, the development of a series of guides to assist members establish their CEP goals, commitment to learning groups and ongoing professional activities and commitment to a three-year planned CEP cycle. Dr Hill presided over the revision of the CEP manual which are available on the College website. She enthusiastically embraced electronic CEP and backed the development of two electronic

Annual Continuing Education Program Report continued

platforms -RRMEO in Queensland and the eCEP program on the College website. She provided strong leadership to the CEP committee who assisted her endeavours. The quality of the CEP program was a major factor in the College obtaining four-year accreditation from the AMC. I salute Dr Hill and will endeavour to provide the same level of leadership. Kim is certainly a hard act to follow.

I would also like to acknowledge the role of the CEP committee and in particular Dr Gabrielle Du Preez-Wilkinson. Dr Du Preez-Wikinson has established a model of CEP in Queensland which sets the standard for the rest of the Australia. Dr Du Preez-Wilkinson generously provides access to the monthly teleconferences she conducts in Brisbane. Members wishing to access these teleconferences can get details directly from Gabrielle.

My major project over the latter half of 2008 was the CEP certification project. Over 160 Fellows and Members completed the online survey. 115 triennial certificates were issued, bringing our CEP certification rate well over 60%. But remember that CEP is compulsory and we certainly have not achieved 100% certification. During 2009 we will continue to encourage all members to document their CEP activities online.

The CEP certification project provided information about learning groups. Most of these are located in major centres. The CEP coordinators are following up and will contact members who have expressed an interest in joining a learning group within the next few months. Feel free to discuss this with them.

Regarding electronic CEP. RRMEO is available in Queensland. Access information can be obtained from Dr Gabrielle Du Preez- Wilkinson. The RACMA eCEP program is available on the College Website and the secretariat can assist with passwords. Both electronic platforms are functioning well and I invite all Fellows and Members to participate and give feedback.

Finally I would like to acknowledge the RACMA Secretariat, particularly our Chief Executive Dr Karen Owen. Karen's skills, encouragement and enthusiasm makes many of these projects possible.

Wishing you a very merry Christmas and a safe New Year. I look forward to working with you all in 2009. And please use the opportunity presented by the Christmas break to access one or other of the electronic CEP programs.

Best wishes,

Dr Bernard Street
National Director of Continuing Education/ Recertification
2008

Please visit the college website at

www.racma.edu.au

or call the National Secretariat on

03 9824 4699

to get login and password

RACMA Constitutional Change: Next Steps

Background

The Council of the Royal Australasian College of Medical Administrators (RACMA) has been working to reform the College's governance structures to position the College for a sustainable future. Many of the governance changes proposed as an outcome of this work can only be implemented by revising the College's constitution. A revised constitution was drafted accordingly.

Copies of the current constitution and the revised constitution and a summary of the proposed constitutional changes can be accessed on the RACMA website.

RACMA is established by the *Corporations Act 2001* (Cth) (the Act) as a company limited by guarantee. The Act requires any changes to a company's constitution to be endorsed by a special resolution of members - that is, a resolution of which notice has been given in accordance with the Act and which is passed by at least 75% of the votes cast by members entitled to vote on the resolution.

A resolution to adopt the revised constitution was presented to Fellows at the 2008 Annual General Meeting. Fifty two Fellows supported the resolution and 28 Fellows opposed it. A 75% majority of the votes cast (i.e. 60 Fellows) was not reached and the resolution, therefore, was defeated.

The present situation is that the current constitution continues and none of the governance structures and processes which were recommended as an outcome of the governance review and which are reflected in the revised constitution, have been adopted.

Purpose of this paper

This paper explains the main issue of concern which appears to have caused some Fellows to vote against adoption of the revised constitution and presents some options for progressing governance reform for RACMA.

Council recognises the importance of understanding Fellows' views before submitting a further resolution to vote of Fellows. This paper will assist the Council to seek further feedback from the Fellowship about the future governance of RACMA.

The current and proposed structure of the RACMA board

Although the revised constitution incorporates many changes to the structures and processes of governance of the College, the main issue of concern appears to be the proposed structure of the College Council (i.e. the RACMA board).

The current Council comprises up to 22 directors, including at least 1 and up to 3 directors elected by the Fellows of each of the States, Territories and New Zealand. At present RACMA's Council is large in comparison to the boards of most commercial and not-for-profit organisations and it incorporates the increasingly unusual concept of 'representation' of constituent groups, on the basis of where they live.

The revised constitution, if it had been adopted, would have established a significantly smaller board of between 8 and 10 directors elected on a skills-basis by Fellows across Australia and New Zealand, with the following additional conditions:

- the Fellows elected to the board would have included a Fellow from New Zealand (who would have been elected by all Fellows, however, not just the Fellows from New Zealand);
- the board would have included a Candidate elected by Candidates and an Associate Fellow elected by Associate Fellows (the proposed class of Associate Fellows broadly encompasses the current MRACMAs);
- no more than 2 Fellows who reside in a single state or territory could have served as directors at any one time; and
- the board would have had the authority to appoint up to 2 additional directors with special expertise who are not medical practitioners, subject to confirmation by members at the next annual general meeting. This reflects the recommendation of the Australian Competition and Consumer Commission and Australian Health Workforce Officials' Committee 2005 Report to Health Ministers *Review of Australian Specialist Medical Colleges* that all colleges should consider how consumers could play a role in their decision making with a view to expanding consumer/community input. This recommendation was reinforced by the Australian Medical Council in its 2008 accreditation review of the College.

With respect to the current State, Territory and New Zealand Committees, it should be noted that:

- they are not referred to in the current constitution;
- their authority is uncertain; and
- formal links between them and the RACMA Council vary.

RACMA Constitutional Change: Next Steps continued

Custom and practice is to refer jurisdictional issues raised with the College by external bodies to jurisdictional committees. There currently is no formal requirement for State, Territory or New Zealand committees to report to RACMA Council – minutes of some committees regularly are submitted to RACMA Council 4-6 months after the meeting while other committees do not submit their minutes at all.

To ensure future jurisdictional input into RACMA's governance systems, the proposed constitution formalised the role of jurisdictional committees and provided for a mandatory meeting at least annually between the board and representatives of each jurisdictional committee.

Fellows' responses to the resolution to change the constitution

There was strong support at the Annual General Meeting, and in teleconferences between Fellows and the President prior to the Annual General Meeting, for most of the changes proposed in the revised constitution.

Stakeholder groups including Council members, FRACMAs, MRACMAs and Candidates generally offered strong support for most of the changes proposed in the revised constitution.

Those Fellows who did not support the resolution to adopt the revised constitution appear mainly to have been concerned that the proposed changes would remove the concept of 'representation' from the RACMA governance structure.

The concern was expressed in two ways:

- the revised constitution does not provide for Fellows from every jurisdiction to have 'a seat at the board table'; and/or
- 1 or 2 jurisdictions could 'dominate' the RACMA board – for example, up to 2 Fellows, 1 Associate Fellow, 1 Candidate and 2 external non-medical members could reside in a single jurisdiction.

The rationale for the proposed changes to the composition of the RACMA board

Introduction

The revised constitution was drafted to reflect contemporary governance theory and practice. The premise is that RACMA, as the college of specialist medical managers, should both promote and exercise good governance.

The proposals in the revised constitution which provide for a skills-based board rather than a larger nominee-based Council are based on contemporary expert opinion as well as on an understanding of the legal duties of directors. The rationale for the proposed changes is described below and in Appendix 1 and 2 of this paper.

Board size

Numerous credible bodies and individuals advocate for small boards on the basis that large boards can become dysfunctional and ineffective. Relevant contemporary references are presented in **Appendix 1.**

Nominee directors

RACMA is a company formed under the Corporations Act 2001 and as such its directors are obliged to meet the requirements established by that Act.

Section 181 of the Act provides that:

"A director or other officer of a corporation must exercise their powers and discharge their duties:

(a) in good faith in the best interests of the corporation; and

(b) for a proper purpose."

The term "in the best interests of the corporation" conveys a basic principal of the law and good governance that a director must act in the interests of the company as a whole and not in the interests of a particular group of members, even if he or she has been nominated or elected to the board by those members and may feel a sense of obligation to act in a way which reflects their views.

The establishment of a board of governance based on jurisdictional nomination creates potential conflicts of interest and raises the likelihood that directors will not meet their legal obligations and/or that governance processes will become dysfunctional. Contemporary governance theory and practice do not support the concept of nominee directorships. Rather, boards are advised to seek input from stakeholders through means other than by providing a 'seat on the board', recognising that those who occupy such nominee positions often face conflicting loyalties to the board and their nominating group which can be extremely difficult to recognise and manage.

The objective of writing the constitution in its revised form was to establish a truly national board structured to act in the best interests of 'the College' rather than a board structured to 'represent' jurisdictional or local interests.

Relevant contemporary references are presented in **Appendix 2.**

Options for moving forward

Introduction

The specialty of medical administration needs to develop and strengthen to ensure its continuing relevance in a changing health care environment. Projections suggest that the number of active RACMA Fellows will fall significantly in the coming decade. RACMA already is a small organisation with limited resources and there is a danger that its membership will fall below that required for sustainability. There is a critical need for strategic leadership if RACMA is to thrive in a challenging environment. This requires a contemporary constitution and a governance structure that supports a national approach.

"The Council does not support a 'do nothing further' option"

The Council does not support a 'do nothing further' option, and believes that the vast majority of RACMA Fellows also recognise the need for change.

It is important that this process of governance and constitutional change:

- proceeds to an outcome; and
- reflects a national consensus amongst Fellows.

The following options are presented with the hope that Fellows will engage in debate and express their views about the best way forward, enabling the Council to agree on a process for constitutional change which will optimise the interests of the College as a whole.

Option 1

Resubmit the revised constitution (without further change) to Fellows at another general meeting (either a postal vote, or a vote at general meeting)

Only 80 of the almost 400 Fellows eligible to vote exercised their voting rights at the recent annual general meeting. Twenty eight Fellows voted against adopting the revised constitution. The Council is not yet sure whether the outcome of the recent ballot reflects the views of the entire Fellowship about this critical issue.

Depending on the preferences expressed by Fellows during this further consultative process, the Council may resubmit the revised constitution to Fellows for a further ballot.

Option 2

Maintain the proposed revised board structure but mandate six monthly formal meetings between the board and the jurisdictional committees

This option would require the RACMA board to meet with the jurisdictional committees 6 monthly to ensure jurisdictional input into governance, while maintaining a board of smaller size and composition in accordance with contemporary theories and practices of good governance.

Option 3

Increase the size of the board from that which was proposed in the revised constitution, ensuring that each jurisdiction has a resident Fellow on the board

Under this option, the board size would increase from that which was proposed in the revised constitution to up to 13 members (1 nominee from each of 9 jurisdictions, plus 1 Candidate, 1 Associate Fellow and up to 2 external directors). This option would address concerns about lack of jurisdictional 'representation' on the board, but the board would be larger than optimal and the board composition would reflect a nominee-based rather than a skills-based orientation.

Option 4

Refine the proposed revised board structure further by allowing each jurisdiction to nominate a Fellow as a director, if there is no Fellow who resides in that jurisdiction serving as an elected director and the jurisdiction believes a nomination is appropriate

The proposed board structure in the revised constitution provides for the board to include 6 elected Fellows who reside in at least 4 and up to 6 jurisdictions.

Under a further-revised option, the board would be a skills-based board with the Fellows who are directors elected by the Fellowship as a whole, but an additional flexible number of directorships would be created (up to 5) to allow jurisdictions in which no resident Fellow has been elected as a director to nominate a director who could serve (subject to the other limitations in the constitution including restrictions on length of term and period of service) until a director from that jurisdiction was elected to the board by the Fellowship as a whole.

The size of the board would increase from the proposed maximum of 10 to a maximum of 15 members. The board would assume a partially nominee-based orientation if jurisdictions elected to exercise their right to nominate a Fellow as a director.

Analysis of options

	Option 1 (proposed in the revised constitution)	Option 2	Option 3	Option 4
No of directors	Minimum 8, maximum 10	Minimum 8, maximum 10	Minimum 11, maximum 13	Minimum 8, maximum 15
Special conditions on board composition	No more than 2 elected Fellows from a single jurisdiction Must include a New Zealand Fellow (all Fellows participate in election of that director, not just those residing in New Zealand) Associate Fellows and Candidates elect 1 director respectively Up to 2 external directors appointed by the board and endorsed by members	No more than 2 elected Fellows from a single jurisdiction Must include a New Zealand Fellow (all Fellows participate in election of that director, not just those residing in New Zealand) Associate Fellows and Candidates elect 1 director respectively Up to 2 external directors appointed by the board and endorsed by members	Each jurisdiction (x9) elects 1 Fellow Associate Fellows and Candidates elect 1 director respectively Up to 2 external directors appointed by the board and endorsed by members	No more than 2 elected Fellows from a single jurisdiction Must include a New Zealand Fellow (all Fellows participate in election of that director, not just those residing in New Zealand) Associate Fellows and Candidates elect 1 director respectively Up to 2 external directors appointed by the board and endorsed by members A jurisdiction in which no elected director who is a Fellow resides may nominate a Fellow as an additional director
National approach	National basis for election Fellows elected by Fellows, Candidate elected by Candidates, Associate Fellow elected by Associate Fellows nationally Board appoints up to 2 additional directors, endorsed by membership	National basis for election Fellows elected by Fellows, Candidate elected by Candidates, Associate Fellow elected by Associate Fellows nationally Board appoints up to 2 additional directors, endorsed by membership	Not a national basis Jurisdictionally-based election, other than Associate Fellow and Candidate (who would be elected by those categories of members nationally) Board appoints up to 2 additional directors, endorsed by membership	National basis for election in the first instance, but may be modified by additional appointments Fellows elected by Fellows, Candidate elected by Candidates, Associate Fellow elected by Associate Fellows nationally Board appoints up to 2 additional directors, endorsed by membership Jurisdictions may nominate a Fellow as an additional director, if no resident Fellow elected as a director
Jurisdictional engagement	Directors have an obligation to demonstrate jurisdictional consultation Jurisdictional committees meet at least annually with board Special requirements for submission of minutes	Directors have an obligation to demonstrate jurisdictional consultation Jurisdictional committees meet at least 6 monthly with board Special requirements for submission of minutes	Directors have an obligation to demonstrate jurisdictional consultation Special requirements for submission of minutes	Directors have an obligation to demonstrate jurisdictional consultation Jurisdictional committees meet at least annually with board Special requirements for submission of minutes
Comments	Addresses concerns about 'representative' directors Addresses concerns about excessive board size Has not addressed concerns of Fellows about the board's links with the jurisdictions	Addresses concerns about 'representative' directors Addresses concerns about excessive board size Does it adequately address concerns of Fellows about the board's links with the jurisdictions?	Does not address concerns about 'representative' directors A larger than optimal board Addresses concerns of Fellows about lack of 'representation' of small jurisdictions	Partially addresses concerns about 'representative' directors and impact on governance May result in an excessively large board, depending on election results and whether jurisdictions exercise their rights to nominate a director May address concerns of Fellows about lack of 'representation' of small jurisdictions

Appendix

Appendix 1 – References regarding the optimal size of boards

1. In November 2002, Prime Minister the Hon. John Howard commissioned former Rio Tinto and Westpac chairman, John Uhrig AO, to review the corporate governance of statutory authorities. The report of that review: Review of the Corporate Governance of Statutory Authorities and Office Holders (the Uhrig Review) was released in August 2004. The Uhrig Review suggested that:

   "Based on current thinking on best practice in the private sector a board of between six and nine members (including a managing director if there is one) represents a reasonable size. Boards with members within this range seem to be more easily able to create an environment for the active participation in meetings by all directors. Boards with less than six members may have difficulty in meeting their statutory responsibilities due to workload pressures and the potential lack of breadth of views."

2. The Australian Institute of Company Directors suggests that:

   "Size of the board is usually related to the size of the company. A public company would have between 8-12 directors, depending on its size. Too many directors can be detrimental to boards because discussions become quite lengthy and it is difficult to get agreement. Large boards can also factionalise."[1]

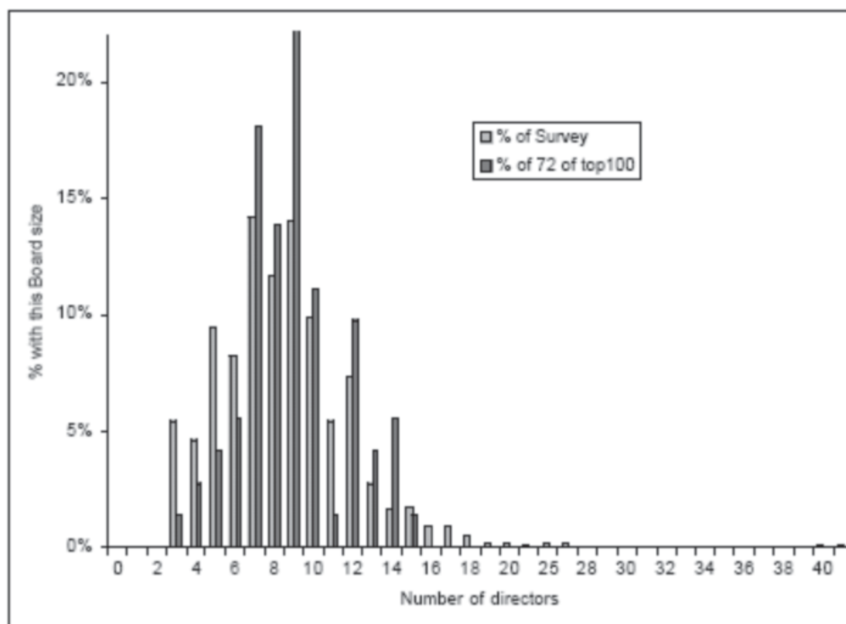
3. BoardWorks International observes:

   "Over recent years we ve noticed a marked reduction in the number of directors on not-for-proût boards. It was not uncommon to find a dozen or more board members sitting around the boardroom table. Board numbers have now come down to 7 or 8, occasionally fewer. A smaller board can be more focused, is easier to manage and makes greater demands for relevant contribution."[2]

4. The board manual *Reinventing your board* is widely acclaimed in the not-for-profit sector. Their advice is:

   "There is no right number for board size, but try to keep the board small! The bigger the board, the less likely it is to be businesslike and disciplined. Have a good reason if you want to make it bigger than seven. If you want to be representative, remember that you cannot be big enough to duplicate the diversity of ownership unless, of course, the ownership is very small. Strategies of obtaining outside input to an effective board can ensure that large numbers of people have a voice more surely than expanding the board to an inefficient size."[3]

5. A number of major reviews have identified the size of university governing bodies as important factors in effective governance. The 1988 White Paper *Higher Education: A Policy Statement,* the 1995 Hoare Report and the 1998 West Review all noted the excessively large size of university governing bodies and recommended that they should have between 10 and 15 members. The 2003 *Our Universities – Backing Australia's Future* policy recommended a maximum of 18 members on a University Council. The *Review of Australian Higher Education Discussion Paper* released in 2008 by the current Australian government noted that the previous Commonwealth Government introduced National Governance Protocols in 2004 and that all universities have made changes to the size and composition of their boards as required by the governance protocols.



RACMA Constitutional Change: Next Steps continued

6. The Melbourne University Centre for Corporate Law and Securities Regulation undertook a national survey of non-for-profit companies, the results of which were published as a major report in 2004 - *Reforming not-for-profit regulation.* More than half the companies had boards of 8 or more directors, with the average being 8 and the mean being 8.5. Only 4% of not for-profit companies had 15 or more directors. The results were compared with those of a survey of the top 100 listed companies. The comparison showed that, in terms of Board size, the average number of directors on the Boards of the respondent NFP companies was 9 which was similar to the 'Top 100' average of 9. There were, however, some significant differences at either end of the spectrum. Only 1 of the 'Top 100' boards had the legal minimum of 3 directors, compared with 6% of the NFP Boards. At the other end of the spectrum, the largest 'Top 100' Board had 15 directors, but 4% of the NFP group had more than 15 directors, including 1 respondent with 40 and 1 with 45.
7. The comparison was thought to be of interest because arguably both groups should have a high degree of public accountability and a high standard of corporate governance.
8. The review recommended that:

   "As a 'best practice' guideline, Boards need to periodically review their size to make sure they are small enough to work effectively as a group, but large enough to contain an appropriate mix of skills and perspectives. While there is no ideal size for Boards, it is unlikely that very large Boards work effectively or efficiently."

Appendix 2 – References regarding 'nominee' directors

1. Chief Justice Street of the New South Wales Supreme Court described the tensions faced by nominee directors in his oft-quoted judgement in *Bennetts v Board of Fire Commissioners* (1967):

   …each of the persons on such a board owes his membership to a particular group, but a member will be derelict in his duty if he uses his membership as a means to promote the particular interests of the group which chose him … the member must not allow himself to be compromised by looking to the interests of the group which appointed him."

2. Anne-Maree Moodie, Managing Director of the Boardroom Consulting Group, explains the dilemma of nominee directors as follows:

   Our study, 'The Ties That Blind?', investigates how nominee directors cope with their dual roles as board members and as representatives of investors in the company. Nominee directors by definition operate within a framework of potential conflicts of interest. Unfortunately, the Corporations Act does not define a 'conflict of interest', because each breach is circumstantial and is therefore attended to by common law. (The exception is s 187 that applies to directors of wholly-owned subsidiaries). In order to separate their duties as directors from any influence or pressure exerted by the investors they represent, survey respondents say that they 'play a role', 'erect Chinese walls', or 'put on a different hat'. But once again, this language is ambiguous because it does not explain how nominee directors behave and how they make decisions in order to separate their duties and deal with potential conflicts. As I wrote in my corporate governance opinion column for CFO magazine, academic research indicates that by occupying multiple roles with potentially incompatible expectations to the nominator (be it a supplier, customer or investor), board members experience a type of 'inter-role conflict'. North American academics Karen Golden-Biddle and Hayagreeva Rao studied this problem in a non-profit medical research organisation whose directors are elected by members and volunteers. The study concluded that the board members put the governance of the entity under duress because they were unable to separate their duties from their obligations to the interests of the organisation's membership.[4]

3. A paper by Cameron and Ralph[5] in June 2006 the Australian Institute of Company Directors publication *Company Director* lists the potential advantages and disadvantages of 'representative' boards as follows:

Disadvantages	Advantages
There may be a lack of critical skills and experience, including in many cases, experience as directors. Removing the ability to consider composition of the board from an organisational perspective will inevitably produce gaps, and perhaps the most dangerous one of these is lack of an effective, independent chairman.	Where directors are personally connected to the industry, cause, or activity they typically are enthusiastic and committed contributors.
There is a tension between the directors' obligations to the Company and their commitments to at least some of the goals of their constituency. This often exhibits itself in conflicts between the need for a board to operate in confidence and demands from constituencies for reporting back. Conflict of interest management is critical here, as inevitably all directors appointed by a constituency have some degree of conflict. The distinction between delegates, those appointed to ascertain and act on the instructions of the constituency, and representatives, those appointed to an office to make up their own mind on issues in the interest of the organisation, is not well understood.	On boards where the representatives come from a range of constituencies, a healthy diversity of views and experience is certainly possible.
Often as a direct result of these boards being quite large, there may be poor group dynamics – factionalism, caucusing, or defending prior positions (as opposed to productive discussion). Even messier are governing bodies which have split into two (or more) due to the large number of constituencies, resulting in the confusion of roles and responsibilities.	Having directors who are respected within their constituencies can provide credibility and ownership amongst stakeholders and such directors should be more likely to be able to predict whether management strategies and proposals will be acceptable to stakeholders.
There is a common confusion around the respective accountabilities of board and management, as current customers/ users often lack the ability to see the appropriate boundaries to their role. Simple enthusiasm for a cause can make representative Directors more likely to assume 'hands – on' roles and inevitably slide into 'micro-management'.	
Constituencies can fail to monitor the performance of their appointee, once the appointment has been made, resulting in reduced individual accountability.	

The authors conclude that while all of the disadvantages do not mean that such boards are "fatally flawed and only one step away from certain disaster, it is unfortunately, more frequently that the negative aspects of these boards crowd out the positives".

Dr Heather Wellington (FRACMA)

[1] AICD. *Improving Board Effectiveness.* Available at http://www.companydirectors.com.au/Policy/FAQs/Performance+And+Appraisal/

[2] BoardWorks International – Boardroom Excellence. Good governance issue 57.

[3] Carver, J et. al. *Reinventing your board.*

[4] Moodie AM. *Applied Corporate Governance. The meaning of independence.*

[5] Available at http://cameronralph.com.au/Downloaded%20documents/The%20Challenge%20of%20the%20Representative%20Board.pdf

Membership & Candidate Update

Admission of New RACMA Fellows, October 2008

New Fellows

Congratulations to all the new College Fellows who received their testamurs at the 2008 Langford Oration:

Dr Kathleen Atkinson
Queensland

Dr Peter Bristow
Queensland

Dr Amanda Dines
Queensland

Dr Jillann Farmer
Queensland

Dr Lizbeth Jordan
Queensland

Dr Jose Arnel Polong
Queensland

Dr Christian Rowan
Queensland

Dr John Wakefield
Queensland

In absentia

Dr Inglis Chern
Queensland

Dr Stewart Jessamine
New Zealand

Dr Cate Kelly
Victoria

Dr Frank Le Bacq
Queensland

Dr Kathleen Atkinson

Dr Peter Bristow

Dr Amanda Dines

Dr Lizbeth Jordan

Dr Arnel Polong

Dr John Wakefield

Members and Candidates

A warm welcome is extended to all new Members and Candidates who have recently joined the College:

Members

Dr Leigh Trevillian
Northern Territory

Candidates

Dr Patrick O'Neill
Queensland

Dr Lorraine Welch
New Zealand

Dr Heather McPherson
New Zealand

Dr Paul Mark
Western Australia

Dr Timothy Williams
Western Australia

Dr Alan O'Connor
Queensland

Dr Amanda James
Victoria

Retirements

The following Member has retired:

Dr Anil Kukreja
Malaysia

Dr Jillann Farmer with President Dr David Rankin

Dr Christian Rowan with President Dr David Rankin

Dr James Oldham formally admitted to Membership at the 2008 Langford Oration

Dr Raju Lakshmana formally admitted to Membership at the 2008 Langford Oration

The Virtues of Fighting:
the Commonwealth *Privacy Act* and Regulation of Privacy

By David Ruschena[1]

On 30 May 2008, the Australian Law Reform Commissioner handed down a review of the operation of the *Privacy Act* 1988 (Cth) (the Act).[2] The review included specific findings in relation to health privacy. This article considers the recommendations made by the Commissioner and the regulation of privacy generally.

National Consistency

The ALRC report identified a number of important problems with the Act. Foremost amongst these is the overlapping and inconsistent legislation that governs health information in Australia. The Act applies to private sector health services throughout Australia, but other legislation applies in the private sector in New South Wales, Victoria and the Australian Capital Territory. In the public sector, the Act governs the federal public sector, but State- or Territory-specific legislation applies in New South Wales, Victoria, Tasmania, the Australian Capital Territory and the Northern Territory. Administrative protection of privacy in the public sector occurs in Queensland and in South Australia. Inconsistency and overlap between regimes is said to lead to confusion and uncertainty, increased compliance costs and (for sophisticated organisations acting in bad faith) forum shopping.

To rectify the problem, the ALRC has recommended that the Privacy Act be amended so that it overrides and excludes state and territory laws governing personal information, including health information, so far as they apply to the private sector.[3] The State and Territory governments would be free to impose their own rules on their own public sectors, but a single regime would otherwise apply. Complaints handling and dispute resolution would be handled by the Federal Privacy Commissioner, who would nonetheless have the power to delegate powers to handle complaints to a state or territory body, such as the Victorian Office of the Health Services Commissioner.[4]

Separate Health Privacy Principles

The ALRC also considered whether it was necessary to include a separate set of principles governing health information. The Act includes health information with information about a person's racial or ethnic origin; political or religious beliefs; criminal record; sexual preferences; and other genetic information, as one of the types of information that may be 'sensitive information'. Sensitive information about a person may (generally) only be collected with the person's consent, must not be used without consent for a secondary purpose unless the purpose is directly related and is within the reasonable expectations of the person, must not be used for direct marketing, and cannot be shared by 'related bodies corporate' in the same way as other personal information.[5]

Nevertheless, the ALRC noted that stakeholders have expressed the view that the health sector is different from other sectors, that health information is more intimate or has the potential to be more stigmatising than other information, and that people need greater access to health information than they need to other forms of information about themselves. The ALRC recommended that specific principles governing health information should be promulgated in new regulations under the Act, to be called the *Privacy (Health Information) Regulations.*[6]

Statutory Cause of Action

The recommendation that received greatest news coverage was the ALRC recommendation that a statutory cause of action be introduced in respect of serious invasion of privacy. The ALRC made this recommendation because it acknowledged that the common law was developing in a way that suggested that a right of action for breach of privacy was likely.

"The ALRC report identified a number of important problems with the Act"

regulation of privacy

In such circumstances, the Commission appears to have considered that it would be best for the cause of action to be shaped in a way that is proportionate, consistent, and properly reflective of the wishes of the community.[7] Claims for serious breach of privacy could only succeed if there were a reasonable expectation of privacy and the conduct complained of was both highly offensive to a reasonable person of ordinary sensibilities and performed intentionally or with recklessness about the consequences of the conduct. This construction was intended to set a high threshold for claims; the ALRC stated that a serious invasion of privacy may occur where:

- there has been an interference with a person's home or family life;
- a person has been subjected to unauthorised surveillance;
- a person's correspondence or private written, oral or electronic communication has been interfered with, misused or disclosed; or
- sensitive facts relating to a person's private life have been disclosed.

Analysis: the problem of regulation without contest

Many of the recommendations contained in the ALRC report are sensible and appropriate. However, many of them are made on the basis of speculation about how the Act is being applied in practice. In the 200 pages of the report that relate to health privacy, precisely three examples are used, two of which are based on anecdotal evidence. In fact, there is a startling lack of information about how both the subjects of personal information and the holders of that information approach the Act.

I suggest that the lack of understanding about compliance with the Act and the lack of debate about the meaning of privacy are part of the same phenomenon, which is a general reluctance to engage in hard debate about the issues. A conservative interpretation of the Act has become the orthodoxy, and organisations are either reordering their businesses, or ceasing their conduct, in order to comply with this orthodoxy. The absence of debate about interpretation and the absence of information about compliance leads to the third and most important absence, which is the absence of a contest about the place of privacy.

Until these issues are the subject of a series of meaningful fights based upon real circumstances, a conservative approach to privacy will remain and the problems of the Act will remain unsolved. The health community would benefit from a series of contests – fights – about where the lines of privacy should be drawn. Concepts such as how to determine individuals' "reasonable expectations" about the uses to which their information would be put need to be articulated in a way that allows them to be understood and applied easily. This requires a body of decisions, rather than single decisions. From these contests, wider debate can start about the place of privacy in our community.

Anecdotal evidence suggests that many projects that could significantly assist medical treatment, from medical research to the implementation of electronic records, are being held back because of conservative interpretations of the Act. In addition, without a high level of public trust and confidence in their benefits and safeguards, such projects will not realise their full potential. At this point, without robust debate or efforts to normalise health privacy legislation within research or medical treatment, the public is left to its own devices. Ignorance about the application of the Act and lack of participation about debates regarding the relative worth of privacy mean that health privacy is liable to crisis-based regulation.[8] For both sides of the privacy debate, therefore, fighting is the only way to take discussion about the Act away from abstraction and put it into people's lives where – to a greater or lesser extent – it belongs.

[1] Consultant, Health Legal. This paper is based on a presentation given at the Health Privacy Futures: Realising the Opportunity conference held 10 and 11 November 2008, in Brisbane by the Informatics Society of Australia Law. The views expressed in this article are those of the author alone and do not necessarily reflect those of Health Legal.

[2] Australian Law Reform Commission – Inquiry into the Privacy Act, ALRC 108 (Final Report): available at http://www.privacy.gov.au/act/alrc/index.html#final

[3] ALRC report at Ch 3.

[4] See ALRC report at [60.50] – [60.54].

[5] Privacy Act, Sch 3, NPP 2

[6] ALRC report at [60.96] – [60.103]

[7] See the discussion at [74.112] – [74.127].

[8] See Ruschena D (2008) A Primer in the Politics of Privacy and Research: see http://ses.library.usyd.edu.au/bitstream/2123/2685/1/LegalFramework_Ch17.pdf

MRACMAs Comment on Proposed Changes to the College Constitution

In September 2008 an online Member (MRACMA) survey was conducted to ascertain MRACMA views about proposals to revise the College constitution. By 17 October 2008, 40 (of 203) Members (MRACMA) had completed the online survey indicating significant interest and support for the proposed revisions most likely to impact on the MRACMA group.

Professional profile of participating MRACMAs:

As part of the survey MRACMAs were invited to report on their professional profiles. This was sought in preparation for development of the transition arrangements which will apply for MRACMAs changing got one of the new membership classes when the constitution is amended. Based on the survey sample only, the MRACMA group is described by the following attributes:

Medical College Fellowship

Most (82 percent) were Fellows of other Colleges particularly from the RACP, RANZCP, RACPA, and the RACS.

Management Qualifications

28 percent held masters degrees in business administration or a related health management discipline; 17 percent had postgraduate diplomas in health service management or the like; 22 percent had no management qualifications; 35 percent did not respond to the request for information about their management qualifications.

Qualification	Number	Percentage
Masters of Business Administration	7	18
Other Masters Degree – health mgt related	4	10
Grad Dip. Health Service Management	2	5
Other Grad Dip. Management	5	12
None	9	22

Years of Management Experience

Most (80 percent) had more than five years in management and 60 percent had more than 10 years management experience.

Years management experience	Number respondents	Percentage
0-5	6	15
6-10	7	18
11-15	10	25
16-20	3	7
21+	8	20

Professional title

22 percent of the respondents were directors of medical services; 42 percent were consultants, 14 percent were medical advisors and 14 percent were academics.

Professional title	Number respondents	Percentage
Chief Executive Officer	2	5
Chief Medical Officer	0	0
Director Med Ed & Training	3	8
Director of Medical Services	8	22
Deputy Director	2	5
Medical Advisor (govt)	5	14
Academic	5	14
Consultant	5	14
Registrar	1	2
Other	4	11

Place of employment

A large proportion (45 percent) of respondents were employed in hospitals/health services; 27 percent were employed in other public or private organizations that provide a range of health related products and services. The remaining 12 percent were employed by government departments and universities.

Place	Number respondents	Percentage
Government Department	2	5
Hospital/Health Service	18	45
University	3	7
Other	11	27

Geographical distribution

Most respondents resided in Queensland (33 percent), Victoria (20 percent) and New South Wales (18 percent).

	ACT	NSW	NT	NZ	QLD	SA	TAS	VIC	WA
No.	2	7	2	3	13	2	1	8	2
%	5	17.5	5	7.5	32.5	5	2.5	20	5

Length of membership

Most (77 percent) of those surveyed have been the College during the last 10 years.

	1-5	6-10	11-15	16-20	20+
No.	18	13	8	0	1
%	45	32	20	0	3

Participation in College activities

Most survey respondents primarily engaged with the College by reading the Quarterly (97 percent) regular email bulletins (88 percent) the website (78 percent and by participating in RACMA CEP Programs (30 percent).

2. Views on the revised Constitution

MRACMAs were invited to express their views about the proposed revisions to the constitution. The following summarises some of these responses.

Transition to Associate membership

78 percent of respondents expressed support for a transition to an Associate Fellowship provided that the qualifying requirements were not overly onerous and that they did not incur a significant increase in membership costs.

The 22 percent of respondents who did not support the changes felt that the term "Associate" implied a demotion in their membership status. This view was also expressed in teleconferences with the RACMA President (Note: the terminology "Associate" has been changed to "Associate Fellow")

Representation on RACMA Board

Despite the divergence of views regarding the changes to the post-nominals, all respondents agreed that Associate Fellows should be represented on the College's Board.

Further, as shown below, 47 percent of the respondents indicated that they would be interested in being a member of the new RACMA Board if nominated.

Interest in being Associate Fellow nominee	Percentage
Yes	47
No	53

MRACMAs Comment on Proposed Changes to the College Constitution continued

Additional comments

In response to a request for additional comments reflecting their overall views on the revised Constitution 11 members responded stating:

"Most suggested changes are good."

"The changes will help move the College forward."

"Change of name from council to board is welcome."

"It's a necessary evolution."

"Most changes represent changing governance to a more corporate model, as is occurring at the other Colleges."

"I believe the move towards a smaller Board is a good decision and ideally will result in greater awareness by Board members of their corporate as well as professional responsibilities and lead to more effective Board functions."

"I think its important that the Board continue to have representatives from the diverse geographic areas but it should not be dominated by New South Wales and Victoria at the expense of other jurisdiction. We should remain inclusive of our colleagues from New Zealand and Asia. There should be no more than two representatives from each jurisdiction.

"Happy with the changes, but would prefer the existing nomenclature of membership."

"Don't make it too hard for existing members to transition. It's better to have fee paying."

"There must be an adjustment in fees with the opportunity to have a full refund if members chose not to be an associate or affiliate."

"Members who demonstrate an interest in the ideals of the College, than have them leave in frustration and save money. "Grandfathering comes to mind."

What next?

MRACMA views have been taken into account in drafting revisions to the constitution and there will be further consultation on transition provisions and fellowship pathways over the next six months.

The College thanks all those MRACMAs who participated in this survey and joined the consultation process about revising the College's constitution.

Marie Paraskakis
Policy & Programs Manager, RACMA

Young Fellow Achievement Awards

Dr Michael William Hills MBChB; FRCS; MPH; FRACMA

Date of Fellowship: October 2004

Almost immediately after gaining Fellowship in late 2004, Dr Hills nominated for and was elected to the NSW State Committee as a Recent Fellow. He has remained an active member of the State Committee since then.

In addition, Michael has been the Coordinator of the NSW RACMA Scientific Program since early 2006. He has brought a high level of intellectual rigor and enthusiasm to the role, revitalising the program and making a very significant contribution to the activities of RACMA in NSW.

Michael demonstrates the value that Medical Administration can bring to a modern response to disaster and terrorist threat.

He is currently the Associate Director Coordination for South Eastern Sydney and Illawarra Area Health Service. This position is responsible for health service coordination for disasters and major events from central Sydney to the South Coast of NSW.

Appointed in 1997 to the NSW Department of Health Counter-Disaster Unit, Michael was responsible for health service Olympic disaster planning. This also involved the development of the first Australian health service capability to manage chemical, biological and radiological (CBR) disasters forging new relationships with emergency services, defence and non-health agencies.

Michael has also worked for the World Health Organisation on the development of the new edition of the WHO guidance on CBR management (2002), CBR training for the Ministry of Health Education in the Islamic Republic of Iran (2003), for the WHO Headquarters in Geneva on capacity evaluation tools for Member States (2003), and strengthening national health preparedness (2005). At a regional level Michael has worked for the WHO South East Asia Regional Office (WHO-SEARO) and its partner, the Asian Disaster Preparedness Centre (ADPC), on emergency response to infectious diseases and International Health Regulations (2007).

Dr Susannah Ahern MB BS, FRACMA

Date of Fellowship: 25/8/2005

Dr Ahern made an outstanding contribution to RACMA in assisting with preparation of the College accreditation submission to AMC. Susannah wrote the first draft and early communication sheets which provided a strong foundation for the final submission. Dr Ahern has been an active contributor to Victorian State Committee activities.

Throughout the accreditation preparations, Dr Ahern demonstrated strong leadership in her commitment to the goals of the College. She certainly helped both the Federal Council and the Victorian State Committee in their preparations for accreditation.

College Medallion Awarded to Dr Peter Bradford

Dr Peter Bradford (MBBS FRACMA) has been awarded the 2008 College Medallion for outstanding contribution to the College.

Dr Peter Bradford is a long serving fellow of RACMA and a leader among Victorian fellows. He is currently Executive Director of Medical Services, Melbourne Health. For four years the Victorian Committee of RACMA was well led by Dr Peter Bradford who simultaneously served many years as a College Councilor and member of the Executive of Council. He was Honorary Treasurer until 2007.

Dr Bradford is a very well respected, hard working medical administrator. He is principled, fair and professional and continues to be an advocate for medical administration in all its aspects and for quality and safety in our healthcare system. He has an engaging and collaborative style and has provided a high level of support and mentorship to young fellows and members of the College.

We salute Dr Peter Bradford.

2008 Annual Reports
of State/Territory and New Zealand Committees

Victoria

Chairman's Report
Dr Bernard Street

Office Bearers

Chair
Dr. Bernard Street

Honorary Secretary
Dr. Humsha Naidoo

Honorary Treasurer
Dr. Susan Sdrinis

Chair, Board of Studies
Dr. Wayne Ramsey/Cate Kelly/
Alison Dwyer

CEP Coordinators
Dr Bernard Street /Peter Trye/ Vicki Tse

Member Representative
Dr. Menindert VanderVeer

Country Representative
Dr. Peter O'Brien

Candidate Representatives
Drs Erwin Loh/ Malcolm Mohr

Highlights for 2007-08

AMC Accreditation

Victorian Fellows, Members and Candidates were actively involved in this year's AMC accreditation. Particular acknowledgement to Dr Susannah Ahern for her part in preparing the early drafts of the accreditation submission.

The Candidate Training Program continued through 2006-07 under the stewardship of Dr Wayne Ramsey, Chair of the Board of Studies assisted by Dr Cate Kelly. The Candidate Training Program is a major strategic priority towards the future success of RACMA. Dr Erwin Loh was successful in his oral examinations.

RACMA DHS Fellowship Positions

After considerable work by the Victorian State committee, particularly Susan Sdrinis, and Wayne Ramsey these DHS funded positions are now in place. These positions provide a significant boost to RACMA training in Victoria.

Educational and CEP events

The National Conference on the Gold Coast was a successful and stimulating event.

The RACMA Website continues to develop. In the CEP Area under Links and Resources there is a large repository of relevant material.

Dr Wayne Ramsey and Dr Cate Kelly ran a series of educational events for candidates

Dr du Preez-Wilkinson in Queensland runs a very active CEP and Candidate Training Program in Qld. The presentationa are available on disc.

The Victorian Management for Clinicians Workshop was held in July 2008, convened by Dr Lee Gruner. Topics included Successful Leadership, Clinical Governance, Building Effective Teams and Managing Change. There were 24 participants and the feedback was very positive.

CEP Program

I have been actively involved as acting Victorian CEP coordinator working with Dr Kim Hill, National Director Continuing Education/Recertification and the National CEP Committee in the development of the electronic CEP program.

CEP was a priority in the lead-up to accreditation. Both the Victorian Committee of RACMA and the Federal Council continue to strive towards developing effective educational programs.

We participated in the VMPF Careers Advice Day held in June 2008. There continues to be strong interest in the work of the College and the RACMA Fellowship qualification.

Relationships with DHS

RACMA continued to work closely with DHS Victoria in programs relating to the recruitment, retention and support of DMSs in Hospitals throughout regional Victoria.

DHS is currently focusing on Clinician Leadership.

Acknowledgements

I would like to thank all the members of the State Committee for their enthusiasm and hard work, especially our Secretary Dr Humsha Naidoo, Treasurer Susan Sdrinis and Board of Studies Chair Wayne Ramsey. I would also like to thank our RACMA Chief Executive Dr Karen Owen, Business Support People, Kathy Griffiths and Maria Taylor, webmaster and IT guru Dino De Fazio and all at the Secretariat for their support over the past 12 months.

Dr. Bernard Street
Chair

Australian Capital Territory

Office Bearers

Chair
Dr. Rod Lambert

Honorary Secretary
Dr. John Donovan

Chair, Board of Studies
Dr. Jennifer Baker/
Dr Grahame Dickson

During the past 12 months the ACT group has met regularly to conduct its CEP and other activities.

Several members have retired from their full time administrative posts during this year including Peter Wilkins, Tony Austin and Jennifer Baker but often, have continued to participate in the branch activities.

I would particularly like to thank Dr's Jennifer Baker and Grahame Dickson for organising our meeting venue at the TGA building in Symonston, Dr John Donovan for continuing his tireless work as the branch secretary and all of the members who have spoken or contributed to our scientific discussions throughout this year.

Dr Rod Lambert
Chair

New South Wales

Current Office Bearers

Chairman
Dr Beth Kotze

Honorary Secretary
Dr Draginja Kasap

Honorary Treasurer
Dr Tony Sara

Chair, Board of Studies
Dr Tamsin Waterhouse
to January 2008

Dr Steevie Chan from January 2008

Coordinator, Continuing Education
Dr Eva Pilowsky

Convenor, Scientific Program
Dr Michael Hills

The New South Wales State Committee continues to strive in promoting the College in a range of forums including its representation on the New South Wales Medical Board, in support of a number of projects conducted by fellow Colleges, and the NSW Institute for Medical Education and Training.

There were three NSW Candidates all of whom successfully completed the oral examinations in August 2007, namely Dr Darrell Duncan, Dr Jo Karnaghan, and Dr Harvey Lander. In addition, Dr Helen Parsons and Dr Stephen Golding, having passed the oral examination previously, completed all candidacy requirements in the last year and have been admitted to Fellowship of the College. Congratulations to the successful Candidates.

Congratulations are also due to Dr Marc Lakos, the NSW entrant in the 2007 Margaret Tobin Challenge Award who went on to win the national competition. Well done! The Committee extends its thanks to Dr Tamsin Waterhouse who completed her term as Chair of the NSW Board of Studies during the year and has been replaced by Dr Steevie Chan.

The Committee welcomed four new Candidates – Dr Clayton Spencer, Dr Susan Lumsdaine, Dr Yogendra Narayan and Dr Steve Davis – plus two Candidates who are new to NSW – Dr Meredith Arcus (moved from Northern Territory) and Dr Gerald Chew (moved from New Zealand).

Dr Michael Hills convened a number of successful presentations during the year including " Linking Health Education to Health Workforce Outputs - The Global Challenge" presented by Prof Peter Brooks, "Genetics in Healthcare, and the Survival of the Fittest" presented by Dr Graeme Suthers in conjunction with the Royal College of Pathologists of Australasia, Health Policy Reform: System change rather than just more money presented by: John Menadue - Centre for Policy Development, and National registration, recent legislative changes & governance issues arising from recent high profile cases presented by Mr Andrew Dix.

The Annual General Meeting for 2007 was held on Thursday 1 November 2007, at which all office bearers reported to NSW Fellows, Members and Candidates on activities over the preceding year and the Returning Officer reported on the changes to the Committee membership.

2008 Annual Reports of State/Territory and New Zealand Committees continued

The meeting was followed by a brief presentation from Professor Debora Picone AM, Director-General NSW Health during which she expressed her views on the future of NSW Health and invited comments from the floor. The Committee extends it's thanks to all presenters and particularly Professor Picone for making herself available and inviting participation of the College.

During the year the NSW State Committee convened a "Management for Clinicians" seminar which was held over two days on 6th and 7th November 2007. In spite of a range of other workshops available to clinicians, the seminar was well attended and continues to be a feature of the NSW State Committee's activities.

The State Committee has been greatly assisted in its work by the Secretarial support contracted from the Royal College of Pathologists of Australasia and wishes to thank the Chief Executive Officer, Dr Debra Graves, and Ms Danielle Yannieh for their assistance. Finally, the Chairman and Secretary wish to thank all members of the State Committee as well as Fellows, Members and Candidates for their support throughout the year.

Dr Draginja Kasap
Honorary Secretary

New Zealand

Current Office Bearers

Chairman
Dr Bernie Brenner

Honorary Secretary
Dr Wilson Young

Honorary Treasurer
Dr Kevin Morris

Chair, Board of Studies
Dr David Rankin

Coordinator, Continuing Education
Dr Bob Boyd

New Zealand continues to develop the role and recognition of medical administration in the local health system.

Earlier in the year the Minister of Health established the Medical Training Board to advise on workforce development and training needs in New Zealand. This Board has now presented their first set of discussion papers and recommendations. A key recommendation is that the number of medical graduates in New Zealand needs to be urgently increased. The Medical Training Board sought advice from RACMA and has signaled strong support of the development of a medical workforce with an understanding of business principles and management.

RACMA is finalising a proposal to the Clinical Training Agency for funded registrar training positions. Initial indications have been positive and we hope to have several funded training positions available shortly.

Candidate numbers continue to rise with a number of senior clinicians in management roles now formally committing to training and moving to recognition of their roles through vocational registration in medical administration.

During the year, the New Zealand branch hosted two workshops for medical managers. A successful session on media management was hosted in Christchurch. Participants received instruction in managing the media and then participated in both radio and TV recorded sessions. The presenters demonstrated an extra-ordinary ability to seek out and drill down on topical issues for each participant.

In November, a further two day workshop is planned for medical managers.

Both Auckland and Wellington continue to operate monthly CPD sessions focusing on topical medical management issues. These sessions have attracted a ranged of prominent speakers who have shown considerable interest in reflective discussions with senior medical administrators.

The New Zealand committee is grateful to the College Council for its continued support of the development of medical administration in New Zealand.

Dr. Bernie Brenner
Chair

Western Australia

Current Office bearers

Chair
Dr Mark Salmon

Honorary Secretary
Dr Philip Montgomery

Honorary Treasurer
Dr Terry Bayliss

Chair, Board of Studies
Dr Mark Platell

Coordinator CEP
Dr Robyn Lawrence

As usual we continue with our massive health reform agenda, now with an added twist with the change of State Government and reassessment of priorities. Most notable is the policy shift to retain Royal Perth Hospital as a major trauma centre and to continue with the new Fiona Stanley hospital and other projects. Much planning is taking place and this makes for an interesting time in WA health for fellows and members, many of whom are playing a significant role in shaping the future.

Our educational activities continued during the year and included opportunistic joint ventures with ACHSE and a regular journal club each month before our branch meeting. We hope next year to be a bit more proactive in organising our own events as these were a bit light on this year given all that has been going on.

South Australia

Current Office bearers

Chair/ Honorary Secretary
Dr Sally Tideman

Honorary Treasurer
Dr Bruce Swanson

Chair, Board of Studies
Dr Susan Svilans

Coordinator CEP
Dr Richenda Webb

Candidate Representatives
Dr Jayanthi Jayakaran/
Dr Anthony Wong

National Conference Liaison
Dr Michael jelly

A small core group of active Fellows/Candidates continue to maintain a profile for the College in South Australia.

State Issues

The SA Healthcare Plan (2007-2016) released in June 2007 and the SA Country Health Plan released in June 2008 are having a major impact in South Australia with all operational and strategic energies focused on health system redesign to promote health, support disease prevention, manage demand and ensure sustainability across the primary to quaternary levels of healthcare.

The Plans may have scope for new regional Medical Administrative positions (Riverland DMS recently advertised) linkages and networked services and the SA State Committee recognizes the critical need for RACMA Fellows to lead the medical / clinical input into the development of the services, the medical workforce and the new Healthcare Governance into the future.

SA has had a highly successful Enterprise Agreement negotiated August 2008, with SA now highly competitive nationally in salary and conditions.

Committee Activities

Dr Jayanthi Jayakaran was accepted as a new Candidate 2007 and is currently appointed to the Assistant Director of Medical Services role, Modbury Hospital, Central Northern Adelaide Health Services. Dr Sue Svilans has been instrumental in ensuring the ongoing training position at Modbury and supporting Dr Jayakaran in the position.

Currently there are no SA Health Department RACMA training positions and this is a matter of ongoing concern to the Committee.

The 2007 Committee actively supported Dr Sally Tideman in preparation for the oral Fellowship Examination August 2007 and congratulates Dr Tideman on her success and on her appointment as the Director of Medical Services, The Queen Elizabeth Hospital.

A Special meeting/AGM was held 14th May 2008 to elect a Chair due to the retirement of Dr Bruce Swanson, to plan the Committee input to the AMC Accreditation Review and to confirm the future activities of the SA State Committee. The Committee was elected as above with Drs Svilans/Tideman supported for the RACMA Council.

The new Committee was elected with the future focus agreed:

- support current candidates;
- continue to identify, advocate for and support training positions and provide an environment that encourages Medical Administration as a career option;

- continue to reinforce to the Health Regions (Central Northern Adelaide Health Service/Southern Adelaide Health Service/Child, Youth and Women's Health Service) and State Health Department, through action and advocacy, the critical role of Medical Administration /Directors of Medical Services in leading change and championing Healthcare Governance;
- Strengthen links with the National RACMA Secretariat and contribute as a State to matters of national Medical Administrative/Health Service importance;
- Contribute to the AMC Accreditation review;
- Develop further collaboration and formal arrangements with the other States/Territories in regard to Candidate education and training, preparation for examination, the continuing education program and other matters of national importance; and
- Contribute to the RACMA National Conference/s where possible in 2008 and into the future.

The State Committee wishes to thank Dr Bruce Swanson for his Chairmanship and the National Secretariat for the ongoing support of South Australia through what continues to be very challenging times and environments for Fellows and Candidates in South Australia.

Dr. Sally Tideman
Chair

Tasmania

No report

Queensland

Current Office bearers

Chair
Dr Richard Ashby

Honorary Secretary
Dr Judy Graves

Honorary Treasurer
Dr Don Martin

Chair, Board of Studies
Dr Gabrielle du Preeze Wilkinson

Coordinator CEP
Dr Gabrielle du Preeze Wilkinson

2007/08 was a busy year for the Queensland Faculty. Ten CEP Sessions were conducted during the year and all were well attended, including at teleconferenced sites within Queensland and other states as far away as Tasmania. In addition, training sessions were held regularly for Fellowship Examination candidates with nine candidates successfully passing the Fellowship Examination.

During the year, Queensland Health committed funds for an additional six registrar posts in recognition of the increasing demand for medical managers in Queensland.

During the year, 50% of fellows and approximately 75% of trainees joined the Australian College of Rural and Remote Medicines RRMEO Program to record CEP and to undertake other online medical education and development activities.

I would like to acknowledge the efforts of the Queensland State Faculty Board in supporting the training and CEP programmes and for representing RACMA at key state forums and committees. In particular, I would like to thank Dr Gabriel Du Preez-Wilkinson for her tireless efforts in supporting trainees across the state.

Dr Richard Ashby
Chair

Northern Territory

No report

Update on Administrative Medicine Training in Hong Kong

1 The purpose of this paper is to provide a brief progress report on the education and training activities in Administrative Medicine involving the Hong Kong College of Community Medicine (HKCCM) and RACMA.

2 There are now 26 HKCCM fellows who are also RACMA fellows and there are a total of 15 trainees in Administrative Medicine. In the past years the HKCCM has organized systematically education and training events with expert input from RACMA, including the training workshop in 2005, 2006 and 2007 conducted by Dr Lee Gruner, the Annual Scientific Meeting in 2006 with the keynote speech delivered by Dr Philip Montgomery. Both Dr Philip Montgomery and Prof Gavin Frost, had also attended the College's Joint Conferment Ceremony with RACMA in 2006 and 2007 respectively, and presented fellowship certificates to RACMA fellows in Hong Kong. Useful exchanges were made on the training programs in Administrative Medicine while they were in Hong Kong.

3 We are also pleased to have Prof Gavin Frost and the RACMA Chief Executive Dr Karen Owen attending the HKCCM's Annual Scientific Meeting and Fellowship Conferment Ceremony on 27 September this year. We have taken the opportunity to have a preliminary meeting with Prof Frost and Dr Owen on 26 September to discuss the joint RACMA-HKCCM Conference to be held in Hong Kong in 2010. .

4 We have also arranged a hospital visit for Dr Owen on 29 September. The visit was led by one of the RACMA fellows in Hong Kong who is also the Hospital Chief Executive of the hospital. Dr Owen was also introduced to the General Secretary and Senior Conference Manager of the Hong Kong Academy of Medicine and an initial discussion was made on the logistics of the joint RACMA-HKCCM Conference in 2010.

5 The College is keen to arrange further workshops for Administrative Medicine trainees in 2009 and is looking forward to having experts from the RACMA to conduct the workshop.

6 We appreciated very much that RACMA representatives were present at the HKCCM's annual events in the past years and I believe that this will definitely foster exchange of knowledge and facilitate communication between RACMA and HKCCM. In fact, HKCCM also makes an effort to send representatives to attend the RACMA Annual Conference since 2001.

7 In Hong Kong, we are revising the syllabus of the Part I Examination and we have now established a rotation program for the Higher Specialist trainees in the Hospital Authority, with half of the training period working in the head office and half working in the hospitals to maximize their exposure to different management settings. Meanwhile we plan to accept part time training in Administrative Medicine provided such training is equivalent to a six-year full-time training recognized by the College. We are also ready to qualify certain organizations as Affiliate Training Institutions to provide a board spectrum of training ground for the Administrative Medicine trainees. Proposals to review the Administrative Training program are in the pipeline such as reviewing the competencies for Higher Specialist Training, the log book and credit system etc.

Update on Administrative Medicine Training in Hong Kong continued

8 To promote and broaden training and research opportunities for individuals with an interest in Community Medicine, the College has set up a Training and Research Scholarship to advance the cause of Community Medicine through research and training. Two scholarships each of HK$50000 were offered since 2007 and this year an Administrative Medicine trainee was offered the Scholarship for his research project on "The Perspectives and Needs of a Community Health Call Centre: A Cross-Sectional Study of Chronic Ill Patients".

9 The College is also very interested in RACMA's Clinical Attachment Program which enables mature and experienced clinicians to become RACMA fellows. In Hong Kong we definitely have a need for such a program to facilitate development of senior clinicians to become good managers. Hence we would very much like to work with you on the required training programs, case studies and the oral examinations. In fact the subject was initially discussed with RACMA's Chief Censor Dr Lee Gruner when she was in Hong Kong and we would like to pursue this further.

10 In Hong Kong, College fellows are also required to fulfill the Continuous Medical Education(CME)/ Continuous Professional Development (CPD) requirements as required by the Hong Kong Academy of Medicine. In past years our fellows attained a very high compliance rate of about 99%. Dr Fung Hong, your CEP Co-ordinator in Hong Kong, will continue to ensure that RACMA fellows in Hong Kong will comply with our local requirements making reference to your Continuous Education Programs.

Dr Kathleen So (FRACMA)
President
Hong Kong College
of Community Medicine
October 2008

List of Fellows August 2008

Australian Capital Territory

Austin AM, Tony K
Baker, Jennifer L
Burnand, Josephine T
Cheah, David F
De Souza AM, David
Donovan ED, John W
Dumbrell, David M
Edmondson, Kenneth W
Elvin, Norman A
Lambert, Rodney P
Langsford OBE, William A
O'Leary, Elizabeth M
Orchard, Barbara W
Palmer AM, David H
Proudfoot, Alexander
Refshauge AC CBE, William D
Rushbrook CSC, Elizabeth C
Wells AM, Ronald H
White, Gordon E
Wilkins MBE, Peter S

New South Wales

Alexander, Jennifer A
Appleton, Joanne
Arya, Dinesh K
Bashir AC CVO, Marie
Bearham(Jnr), George P
Benjamin, Susanne J
Bennett, Andrew G
Bennie, Alexander S
Best AO, John B
Blizard, Claire M
Blok, Charles R
Bolton, Patrick G
Boyd, Roger G
Boyd Turner, Mary J
Boyd-Irvine, Susan
Brennan, Leonard B
Bull, Robert R
Burrows, Donald L
Cable RFD, Ronald H
Campbell, John D
Carless, Alan J
Chan, Steevie Siu Wei
Child AM, Donald S
Cleary OAM, Maurice P
Collie, Jean P
Collins, John M
Conley, Jeanette C
Currow, Elwin G
Curteis, Owen G
Curtis, Paul W
De Carvalho, Vasco E
Desgrand, Vincent G
Dewdney, John C
Donnelly, Roy D
Doolan, David
Douglas, Paul
Duggan AM, John M
Duncan, Darrell J
Ellis, Vivienne M
Finlayson, Peter J
Forster, Susan L
Gardiner, Brett P
Gillies, Peter S
Gobius, Risto J
Godding, Robyn M
Golding, Stephen J
Graves, Debra J
Greenwell, John B
Grimes, Donald
Grunseit, Barbara A
Guanlao, Luisito P
Haski, Robert R
Hely, Joanna K
Hill, Kim N
Hills, Michael W
Ho, Leong K
Hockin OAM, Ralph L
Holland, Howard J
Hooper, Roger C
Horvath AO, Diana G
Hoyle, Philip M
Jones, Roslyn E
Jump, Marie-Antoinette
Karnaghan, Jo-anne E
Kasap, Draginja
Killen, Alice R
Kotze, Beth L
Lander, Harvey
Latta, Alison L
Laughlin, Allan
Lee, Lynette A
Mackertich, Martin P
Mallarky, Stephen G
McEwin AM, Roderick G
Miskell, Sharon
Mok, Anne
Morey AM, Patricia S
Murugesan, Ganapathi A
Niall, Paul D
O'Brien, Lisa
O'Connor, Nicholas J
Pantle, Annette C
Parrish, Mark M
Parsons, Helen
Peters OAM, Harry
Pilowsky, Eva J
Pisk, Dennis W
Porter, Robert K
Price, Edward D
Reeve AC CBE, Thomas S
Repin AM, George D
Rewell, Ian L
Ross, Bronwen A
Ruscoe, Warwick J
Saave OBE, Jan J
Sanderson, Russell B
Sanger, Margaret M
Sara, Antony
Scarf, Christopher G
Sesnan, Kevin
Shea, Peter B
Shepherd, Webster G
Smith, Denis A
Spencer, Ronald B
Stewart, Gregory
Swierkowski, Piotr
Tindal, Mabel L
Tridgell, Paul K
Vago, Leslie
Vanderfield AO OBE, Ian R
Ward, Nicola M
Wasti, Syed F
Waterhouse, Tamsin R
Webb, Freda H
Westphalen, John B
Wills, James T
Woolard, Thomas J

List of Fellows
August 2008 continued

Wooster, Arthur G
Yoong, Helen P
Yu AM, John S

Northern Territory

Joyce, Brian B
Katekar, Leonie V
Sathianathan, Vinothini I
Wilson AM, Pauline I

New Zealand

Allen, Pim (Patricia) M
Bolevich, Zoran
Boyd, George R
Brenner, Bernard
Chamberlain, Nicholas J
Feek, Colin
Gollop, Bruce R
Gootjes, Peter R
Holmes, John David
Hood, Dell A
Hope, Virginia T
Jessamine, Stewart S
Kelly, Francesca
Morris, Kevin Alec
Nel, Andre
Patel, Arvind C
Pike, Pieter W
Rankin, David B
Richards, Ruth
Robinson, Peter H
White, Janis M
Young, Wilson Wai Sang

Overseas

Cheng, Man-Yung
Cheng, Beatrice
Cheung, Wai-lun
Ching, Wai Kuen
Chiu, Lily
Choi, Teresa Man-Yan
Chow, York Yat-ngok
Choy, Khai Meng
Davidson, Lindsay A
Fong, Ben Yuk Fai
Fung, Hong
Hedley, Anthony J
Ho, William Shiu Wei
Jacobalis, Samsi
Jones, Fredrick G
Lai, King-kwon
Lai, Lawrence Fook-ming
Lam JP, Ping-yan
Lam Tat Yin, David
Lee, Shiu Hung
Leung, Ting-hung
Leung JP, Pak-yin
Lo, Su Vui
Lo, Chi-yuen Albert
Ma, Hok Cheung
Mak, Sin-ping
Marikar, Mahd A
Parker, Ronald
Paul, Gershu Chandy
Rajput, Abdul M
Rees, Neville C
Shaw, Rosalie J
Sills, Thomas D
Sin, Jaime Tan
So, Pik-han Kathleen
Spence, Derek W
Stokoe, Philip
Tinsley, Helen
Tung, Sau-ying
Walsh, Michael K
Yeoh, E K

Queensland

Alcock, Annabelle
Alcorn, David
Ashby, Richard H
Ayre, Stephen J
Baker, Christine A
Bell, Brian L
Brennan, Colin K
Brierley, Stephen A
Bromwich, Christine E
Campbell AM, C Bryan
Catchpole, Michael J
Chick, Pamela H
Coid, Donald R
Cooper, Barbara M
Copeland, Geoffrey
Costello, Gerard J
Daly, Michael P
Devanesen, Dayalan M
Doherty AO, Ralph L
Donald AO, Kenneth J
Du Preez-Wilkinson, Gabrielle E
Edwards AC, Llewellyn R
Emmerson, William B
Evans, David K
Falconer, Anthony D
Farmer, Jillann
Fitzgerald, Gerard J
Fitzhardinge, Ruth
Fothergill, John L
Gilhotra, Jagmohan S
Ginsberg, Samuel A
Golledge AM, John G
Good, Michael
Graves, Judith Ann
Griffin, James V
Henderson, Alan
Herriott, Bruce A
Hodge, Jonathon V
Holloway, Alison M
Houston, James H
Hudson, Julie D
Jaumees, Kay
Jellett, Leon B
Jensen, Graeme R
Johnson, Andrew J
Keating, Darren W
Kennedy, Christopher J
Kitchener, Scott J
Kuehnast, Barbara
Le Ray, Lance E
Margetts, Craig C
Martin, Donald J
Mattiussi, Mark P
McFarlane, Jean F
McGregor-Lowndes, Victor A
Menzies, John W
Miller, Peter M
Montague, Andrew J
Mowatt OBE, Keith S
O'Donnell, John J
O'Dwyer Susan M
O'Sullivan, Donna M

Pakchung, David N
Palmer, George R
Pearn AM, John H
Pegg AM, Stuart P
Porter, Robert
Powell OAM, Owen W
Reilly, Robert Q
Russell, Douglas A
Scanlan, Brian J
Seidl, Isaac A
Shapiro, Ralph A
Shaw, Alexis E
Shearer, Alexander B
Smart, Timothy F
Sparrow, John L
Stable, Robert L
Stuart, Duncan J
Taylor, James R
Thomas, David A
Ulrich, Peter E
Wakefield, John G
Waller AM RFD, John P
Waters, Mark F
Weinstein, Stephen
Wilkinson, David P
Wuth, Gregory K
Young, Jeannette R

South Australia

Allan, Barbara M
Barrington, Dianne L
Beal, Robert W
Buttfield, Ian H
Czechowicz, Andrew S
Dowie, Donald A
Farmer, Christopher J
Frewin AO, Derek
Fuller, Clarence O
Germann, P A Scott
Hackett, William E
Hoff RFD, Lothar C
Jelly RFD, Michael T
Kearney AM, Brendon J
Lian-Lloyd, Nes Bie Sian
McCoy AM, William T
Morton, Peter G
Mylius, Raymond E
Rozenbilds, Elizabeth S
Scragg OBE, Roy F
Svilans, Susan E
Swanson, Bruce A
Tideman, Sally
Van Deth, Arthur G
Wagner, Christopher A
Webb, Richenda M

Tasmania

MacCarrick, Geraldine R
McArdle, Helen M
McCann, Paul E
Renshaw, Peter J
Ross, Alasdair D
Sparrow AM, John M

Victoria

Ahern, Susannah F
Appleton, William T
Barker, Coralee A
Bartlett, Jennifer R
Batten, Tracey L
Bearham (Snr), George
Bennett, Noel M
Bessell, Christine K
Blake, Douglas H
Bradford, Peter S
Brand AM, Ian A
Breheny, James E
Brennan, Peter J
Campbell, David H
Champness, Leonard T
Christie, John C
Cole, Brian E
Collopy AM, Brian
Davis, Alan S
Devanesen, Sherene
Duncan, David R
Dwyer, Alison J
Egan, John B
Flower, Clifford J
Flynn, Eleanor M
Funder, John W
Gallichio, John L
Graham, Ian S
Gray AO AM, Nigel J
Griffin, James J
Grogan, Robert S
Gruner, Lee
Gurner, Colin M
Hall, Robert G
Hamley, Lee
Hanning, Brian W
Hillis, David J
Jones, Michael R
King, Jennifer M
Krupinski, Jerzy
Leslie, Peter L
Lubliner, Mark
Maclean, Alison M
Majoor, Jennifer W
Malon, Robert G
Mason, Elizabeth R
Mathews, Colin L
McCleave, Peter J
McDonald, Wayne L
McNab, Kirsty
Mead PSM, Catherine L
Naidoo, Humsha
O'Brien, Peter H
Oliver, Brian H
O'Rourke, Francis J
Osborne, Clifford B
Perrignon, Andrew C
Peyton, Thomas M
Pisasale, Nella M
Power, John M
Ramsey AM CSC, Wayne P
Ratnayeke, Valentine J
Sachdev, Simrat P
Sandford, Alan S
Schofield OBE, Graeme C
Scown, Paul W
Sdrinis, Susan
Shepherd AM, Stuart J
Stoelwinder, Johannes U
Street, Bernard J
Sumithran, T Lakshmi
Sunderland, Ian S
Trevaks AM, Gad
Trye, Peter J
Tse, Vicki

List of Fellows August 2008 continued

Wake, Arlene H
Walsh, Laurence N
Warburton, David J
Warton, Robert B
Watson, Sara E
Wellington, Heather L
Wellington, Clive V
Westwood, Geoffrey
Wooldridge, Michael
Yeatman, John S

Western Australia

Bayliss, Colin T
Beresford, Bill W
Carruthers, Kenneth J
Dunjey, Malcolm V
Ellis AM, Archie S
Flett, Penelope R
Forgione, Nicholas S
Frost, Gavin W
Fry, David F
Galton-Fenzi, Brian L
Gill, Jagjeet S
Kelly, Shane P
King AM, Alan J
Lawrence, Robyn A
Lee, Kwang Beng (Norman)
Lipton, George L
Loh, Poh-Kooi
Mahmood, Farhat
Masters, Geoffrey H
McNulty AO, James C
Montgomery, Philip D
Mulligan, Jonathon B
Murphy, Kevin J
Nickel, Norma R
Oldham, David R
Platell, Mark S
Quadros, Caetano F
Roberts, William D
Robertson CSC, Andrew G
Russell-Weisz, David
Salmon, Mark A
Smith, Darcy P

List of Members August 2008

Australian Capital Territory

Buckingham, John M
Dickson, Grahame J
Gatenby, Paul A
Griffin, Robert C
Hallam, Lavinia A
Killer AO, Graeme T
Looi, Jeffrey Chee Leong
Lum AM, Gary D
Mays, Lawrence J

New South Wales

Arthurson, Robert M
Baker, Andrew
Baylis, Martin S
Brown, Katherine M
Brydon, Michael P
Bull, Colin
Challis, Daniel E
Cheng, Nga Chong Lisa
Chung, Stephen
Dayan, Linda S
Dennington, Peta M
Gatt, Stephen P
Goh, Shyan Lii
Hanson, Ralph M
Harrison, John A
Ho, Maria T
Kossoff, Lana
Kremer OAM, Edward P
Lee, Cheok Soon
Li, Stephen Chiu Ho
Liddell, Stephanie J
Liew, Siew Foong
Mackie, James D
Malik, Mushtaq A
McLean, Anthony S
Milross, Christopher
Molloy RFD ED, William B
Naing, Thaw
Oakeshott AM, Robert J
Olver, Ian
Petersen, Rodney W
Rajkumar, Sadanand
Reppas, Napoleon P
Rumma, Pauline Yuk-Chan
Smith, Michael C
Speechley, Ronald A
Stone, Bevan H
Thye, Hsu-Ming
Vinen, John D
Way, Raymond T
Wells, John V
White AM, Leslie

New Zealand

Bolotovski, Alexander
Brown, Ian McLaughlan
Keam, Susan Joy
Mackie, Donald S
Rosman, Johan
Shirley, Alan J

Overseas

Giele, Henk P
Kishore, Kamal
Kukreja, Anil Kumar
McEachen, Stuart C
Menon, Suresh K
Oldham, James
Thomas, Adrian P
Tiernan, Paul J
Waring, Paul M
Yon, Rohaizat B

Queensland

Abdi, Ehtesham A
Allison, Roger W
Baqir, Yasir Al-Lawati
Brophy, Conor
Buckland, Stephen M
Chapman, Kenneth
Chinnasamy, Dhamodharan
Choo, Kelvin Li-Ming
Colby, Anthony Craig
Costello, Stephen M
Dascalu, Jack
Davies, Keith L
Gabbett, Michael T
Groessler, Adrian J
Joshi, Viney
Killer, Douglas V
Kisely, Stephen R
Lewin, Morris W
Likely, Michael J
Mahlo, Karen Lee
Mahoney AO, Mary D
Mansoor, Manadath
McCrossin, Robert B
McGaughran, Julie
Menon, Mahesh
Mottarelly, Ian W
Moyle, Robert J
Nydam, Kees
Oliver, Nicholas W
Quigley, David T
Reddan, Jill G
Seet, Geoffrey P
Stone, Michael J
Ueno-Dewhirst, Yusuke
Unwin, Alston M
Vecchio, Phillip C
Whiley, Michael
Wilson, John G
Withers, Stephen J
Xabregas, Antonio A

South Australia

Atkinson, Robert N
Baggoley, Christopher J
Byrne AM RFD ED, Peter Dudley
Foreman, Mark John
Hale, Claire Marie
Langlois, Suzanne L
Lethlean, Margaret G
McGee, Roderick I
Penhall, Robert K
Roberts OAM, Robert M
Shroff, Behzad D
Singla, Amita Arun
Szekely, Suzanne M

List of Members August 2008 continued

Tasmania

Flett, Peter J
Hickman, John A
Ho, Vincent
Lamplugh, Ross
Muller, Hans K

Victoria

Allen, David G
Arumugam, Arumugam A
Barton, David A
Bell, Richard
Bohra, Suresh
Brooks, Anne M
Bryan, Sheila
Burrows AO, Graham D
Callaly, Thomas
Castle, Robert N
Chan, Thomas
Chao, Michael Wan-tien
Chau, Roger
Chopra, Prem K
Clarke, Caroline F
Conyers, Robert A
Cordner, Stephen M
Damodaran, Saji S
Dewan, Patrick A
Dohrmann, Peter J
Drummond, Roslyn M
Fawcett, Rodney Ian
Fielding, John M
Fitzgerald, Mark C
Francis, Paul H
Fraser, Simon H
Goh, Eugene
Haughton, Marianne W
Ibrahim, Joseph E
Janson, Adam R
Jefford, Michael H
Jensen, Frederick O
Judson, Rodney T
Kambourakis, Anthony G
Kilpatrick, Christine J
Lakra, Vinay
Lakshmana, Raju
Longmore, Peter G
Lowthian, Peter J
Lynch, Rodney M
McGrath, Katherine
Mudaliar, Selva N
Newton, John
Oakley Browne, Mark A
Perera, Mahendra H
Phelps, Grant
Prince, Henry M
Rambaldo, Salvatore
Rodrigo, Rohith V
Rosenfeld, Jeffrey V
Rozen, Leon
Schifter, Denis A
Shearer, Bill A
Singh, Ashok K
Smith, Jacqueline B
Snell, Anthony P
Spencer, John Colin
Steele, Brendan J
Stocky, Andrew J
Tan, Gim Aik
Van Der Veer, Meindert
Vaughan, Stephen L
Wassertheil, Jeff
Waters, Mary J
Waxman, Bruce P
Weeks, Anthony M
White, Craig A
Williams, Richard A
Williams, Daryl L
Wolff, Alan M
Wong, Michael Tak Hing
Woodhouse, Paul D
Zalcberg, John R

Western Australia

Andrews, Reginald
Barratt, Peter S
Blackham, Ruth
Davidson, Rowan M
Graydon, Robert H
Joseph, David J
Keller, Anthony J
King, Benedict Pui-Yan
Langford, Stephen A
Lenzo, Nat Patrick
Mark, Paul David
McGrath, Gregory B
McLaughlin, Virgina Anne
Nagree, Yusuf
O'Connor, Alan
Rhodes, Helen C
Robins, Anthony M
Stokes AM RFD, Bryant A
Vaughan, Richard J

List of Candidates August 2008

ACT

Curtis, Nicole M
Pelkowitz, Allan R
Seah, Michael Tek Unn
Smart, Tracy

New South Wales

Arcus, Meredith E
Ash, Nicole
Beswick, Theresa A
Chew, Gerald
Davis, Stephen C
Farrow, Glendon B
Fletcher, Nicholas J
Greenberg, Randall
Harris, Anita M
King, Michael R
Lakos, Marc P
Lumsdaine, Susan
Mackinnon, Angus M
McGirr, Joseph G
Moore, Carmel
Narayan, Yogendra
Olsen, John R
Ramesh, Nadarajah
Robbins, Aphra G
Sharkey, Sarah E
Spencer, Clayton
Yeats, Heidi
Zwatrzka, Nelly

Northern Territory

Madas, Eshwar

New Zealand

Hulme, Richard I
Humphrey, Andrew
Johnson, Gloria A
Kerruish, Timothy B
Rasiah, Rebecca D
Sage, David J
Wong, Deanne L

Overseas

Adesanya, Adesina
Murray, Adin Campbell
Rogers, Grant

Queensland,

Atkinson, Kathleen
Beck, Christopher J
Bristow, Peter
Chern, Inglis W
Cleary, Michael I
Clift, Andrew
Coffey, Gregory
Crawford, Rosalind
Delaney, Darren J
Dines, Amanda J
Duke, Benjamin J
Dulhunty, Joel
Finniear, Karynne J
Golding, Michael
Gopalan, Vinod A
Jordan, Lizbeth
Le Bacq, Frank
Lee-Archer, Matthew
Mistry, Yogesh
Moss, Gerald A
Naidoo, Mellissa
Parmar, Nilesh
Polong, Jose Arnel
Prado, Luis M
Rowan, Christian A
Schedlich, Russell
Thomas, Dale L
Trujillo, Monica
Venkatesh Murthy, Shashidhar
Vonau, Marianne
Ward, David I

South Australia

Brayley, John Q
Jayakaran, Jayanthi
Wong, Anthony Kai

Victoria

Cendana-Paiva, Maria E
Cudmore, Gerard P
Damodaran, Saji S
Davies, Glenn A
Dhulia, Anjali
D'Souza, Russell
Garwood, Mark Innes
Howlett, Glenn R
Ip, Albert Chee-Tsun
Kaya, Yelda
Keetse, Nakedi
Kelly, Catherine B
Lim, Kang-Yao (Paul)
Loh, Erwin Chun Kong
Mohr, Malcolm L
Saxena, Atima
Sharma, Vishnu
Taylor, Michael D

Western Australia

Bentley, Peter J
Biyani, Mukti
Bydder, Sean A
Jeremijenko, Andrew M
Williamson, Geoffrey D
Wong, Kingsley Shung Lai

RACMA Governance 2008

The 42nd RACMA Council was sworn in at the 2008 AGM in Adelaide

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MB BS, DGM, FRACMA

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Immediate Past President
Prof. Gavin W Frost
MB BS, MPH (Syd) FRACMA, FAFPHM FHKCCM (Hon)

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Dr Mark Platell
MB BS, FRACMA, FAFPHM

Dr Robyn Lawrence
MB BS, FRACMA

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Dr Sally Tideman
MB BS, FRACMA

Dr Rod Lambert
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Dr Helen McArdle
MB BS, MPH, FAFOM, FRACMA

Dr Richard Ashby
MB BS (Qld), BHA (NSW), FRACGP, FRACMA, FACEM, FIFEM

Candidate Nominee
Dr Erwin Loh
MB BS, LLB(Hons), MBA, MHSM, FACLM, FCLM

2008 State Office Bearers

New Zealand Office Bearers
Chair – Dr Bernie Brenner
Honorary Secretary – Dr Wilson Young
Treasurer – Dr Kevin Morris
Chair, Board of Studies – Dr David Rankin
CEP Coordinator – Dr Bob Boyd

ACT Office Bearers at present are:
Chairman and National Councillor – Dr Rod Lambert
Honorary Secretary – Dr John Donovan
Chair, Board of Studies – Dr Jennifer Baker
CEP Coordinator – Dr Jennifer Baker and Dr Rod Lambert

NSW Office Bearers
Chair – Dr Beth Kotse
Honorary Secretary – Dr Draginja Kasap
Treasurer – Dr Tony Sara
Chair, Board of Studies – Dr Steevie Chan
CEP Coordinator – Dr Eva Pilowsky
Scientific Program Coordinator – Dr Michael Hills

South Australian Office Bearers
Chair – Dr Sally Tideman
Secretary (temporary) Dr Bruce Swanson
Chair of Board of Studies – Dr Sue Svilans
Treasurer – Dr Bruce Swanson
CEP Coordinator – Dr Richenda Webb

Western Australia Office Bearers
Chair – Dr Mark Salmon
Honorary Secretary – Dr Philip Montgomery
Treasurer – Dr Terry Bayliss
Chair, Board of Studies – Dr Mark Platell
CEP Coordinator – Dr Robyn Lawrence

Victoria Office Bearers
Chair – Dr Bernie Street
Honorary Secretary – Dr Humsha Naidoo
Treasurer – Dr Susan Sdrinis
Chair, Board of Studies – Dr Wayne Ramsey & Dr Cate Kelly
CEP Coordinator – Dr Bernie Street

Tasmania Office Bearers
Chair – Dr Jack Sparrow
Honorary Secretary – Dr Peter Renshaw
Treasurer – Dr Paul McCann
Chair, Board of Studies – Dr Paul McCann
CEP Coordinator – Dr Helen McArdle

Queensland Office Bearers
Chair – Dr Richard Ashby
Honorary Secretary – Dr Judy Graves
Treasurer – Dr Don Martin
Chair, Board of Studies – Dr Gabrielle du Preez Wilkinson
CEP Coordinator – Dr Gabrielle du Preez Wilkinson

Hong Kong Office Bearers
President – Dr Kathleen So
Vice President – Dr Mak Sin Ping
Honorary Secretary – Dr Thomas Chung
Treasurer – Dr Lo Su Vui
Chief Censor – Dr Leung Ting Hung

The Quarterly publication schedule

The timelines for submission of material to *The Quarterly* are as follows for the next 12 months:

Issue	Submit by	Publication
1	20 February 2009	March 2009
2	22 May 2009	June 2009
3	28 August 2009	September 2009
4	25 November 2009	December 2009

If your paper comes in late it may not be published until the next edition. It can take 2-3 weeks after these dates for papers to be edited and a final proof signed off before the journal goes to print.

We also now have a very small team of reviewers for feature papers submitted to *The Quarterly*. If you are interested to be part of the team of reviewers please let Dr Andy Robertson or Dr Karen Owen know this. Having feedback from a couple a reviewers offers writers the chance to further edit and develop their papers. We hope that this will add depth and quality to your College journal.

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