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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 35 Drummond Street, Carlton, Victoria 3053 and there are active Committees in each State and Territory of Australia and New Zealand.

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One of my recurrent themes in these Editorials has been disaster preparedness, a theme that was tested again in June 2006 with Australia’s response to the Yogyakarta earthquake, which left nearly 6000 dead and over 30000 injured. As proposed previously, in March 2005, medical administrators may have an important role as team leaders of such teams, where well-developed health management skills can be put to good use in interesting and challenging circumstances. I know in WA Health that we are looking for at least 2 additional team leaders to train up to manage such teams. I am grateful to Wayne and Karen stepping in whilst I was in Java to get the June 2006 issue out.

I have recently been fortunate to attend Health Protection 2006, the annual conference of the United Kingdom’s Health Protection Agency, in Coventry. While much of the focus was on a range of public health issues, from healthcare acquired infections to measles to the Buncefield fire, there were several presentations on risk communication and getting difficult messages across to the public. We often concentrate on the facts and the target of the message to the detriment of getting an effective message across to the public. The communicator and their relationship with the audience and the relevance of the message to the public, need to be carefully considered. Use the wrong messenger and, at best, the message will be ignored. I am sure we can all cite good examples of where that has happened. When we are trying to get critical public health messages across, this may be very counter-productive. Effective risk communication is an important skill for health managers to develop.

We have another excellent issue of The Quarterly and I appreciate the regular offerings from a number of contributors. All contributions are most welcome and I would encourage all Fellows, Members and particularly Candidates to contribute.

This is the end of yet another busy year during which there have been significant changes in our College. I wish you all well and a safe holiday period. We will be in touch again in 2007.

Dr Andy Robertson
Editor
I would like to offer my seasons greetings to the loyal readers of this illustrious publication and wish you all the best for 2007. The festive season really gets underway now with office parties, drinks and generally it happens to you that there is a feeling of "….well another year is over", so I will save myself for the "big one" next year.

I am moving around with my work and my locum EDMS at Mount Isa Health Service finishes in December. I am very lucky to be taking up a locum EDMS position on the Queensland coast in the delightful but hot, steamy and wet Cairns which will prove a bit different to a semi-arid Mount Isa with all its rugged scenic splendour.

I have really enjoyed learning about the Queensland Health system and appreciating the difficulties in maintaining a well functioning and sustainable medical workforce in such an isolated place as Mount Isa (Pop 23,000) 1,800 kms from Brisbane.

The RACMA communication survey results have been collated by Colin Dunn with some help from "Monkey". I understand there was a moderate response but enough to get some definite ideas about the type of material people want to read and also a map for change in how the material is presented. There is a way forward on how we tackle the issue of peer review for publishable articles from Fellows and Members/Candidates of the College. The next step is to determine the "how" for that way forward and to get College support for that change. The Chief Executive no doubt will take this on and I will be very interested to be involved.

I attended the 2006 Biennial Health Conference, Exploring and Debating Acute Care Provision, in November in Sydney. It was a good value conference and very well put together by DOHA with an excellent selection of high profile speakers from the private health insurance industry, the private sector and the acute public sector as well as some State and DOHA bureaucrats for good measure. It was disappointing not to see many other medical managers there but perhaps they are saving themselves for the Casemix conference which is also sponsored by DOHA and alternates with this one. Dr Russell Stitz, President and Chair of Council and Executive, RACS was adamant that the chronic under-resourcing in Australian public hospitals had resulted in many instances of compromised care for patients and he emphasised the need for clinicians to be involved in finding solutions for more effective and efficient care. He also stressed that health administration should be lean and orientated towards health outcomes rather than being totally focussed on the bottom line. This may be a challenge that RACMA can take up by giving a presentation at the next Biennial Conference. It would be good for one of our senior Fellows or the Chief Executive to temper this approach and to explain the role of a medical administrator in tackling those particular issues.

In this edition of The Quarterly we have even more informative articles for you. Kathleen Atkinson has provided an overview of the challenges she encountered when establishing a palliative care service in a rural and remote region of Australia. The article written by Amanda Ling and Brian Davies shows how Best Quartile Benchmarking (BQB) can drive change in the tertiary hospital sector in WA by involving clinical divisions in the analysis of the raw data.

Fortunately, we do have regular contributors to The Quarterly. Lee Gruner discusses risk management and the concept of shared responsibility, Miriam Martin has written about the Theory of Constraint and dealing with that overloaded feeling when trying to recruit a suitable locum. I always enjoy reading Meredith Arcus's Candidates Corner as it is reflecting on life in Alice Springs in the Northern Territory; another very isolated spot on the map. I would like to thank the Chief Executive, Karen Owen for the extra work she puts into The Quarterly making it more interesting, full of good book reviews, journal updates and other regular features.

Dr Wayne McDonald
Deputy Editor
Dear Dr Robertson

I read with interest, but concern, the article entitled *The role of podiatric surgery in Western Australia* by Dr Biyani in the July Edition of *The Quarterly*.

The role of medical management is highlighted by Dr Biyani as challenging in reviewing and restructuring existing health services to improve access whilst operating within tight budgetary constraints. Perhaps more challenging is the ability to advocate for adequate resources particularly for priority areas and ensure that standards are maintained, monitored and any variability that is beyond normal practice is identified and corrected.

I believe the enquiries generated within the United Kingdom, King Edward Memorial Hospital and Bundaberg Hospital have demonstrated that advocacy for standards is critical. Without this budget compliance, not access, does not have a meaning.

The other key for medical management is to be able to recognise appropriate standards and the requirements to achieve them. I totally agree that the delivery of services needs to be reviewed with more effective models always being actively desired. Health care is a 'team game'. Within the clinical team tasks can and should be effectively delegated. The development of the Physician Assistant model in the United States is a prime example where clinicians can focus on the diagnostic and therapeutic aspects of care whilst the essential administrative activities are undertaken by another member of the team, under the leadership of the clinician. This is an approach consistent with the view articulated by the Committee of Presidents of Medical Colleges, as well as individual Colleges, and described in the *Medical Journal of Australia* (Collins, Hillis, Stitz). This was also the view explained clearly to the Productivity Commission in undertaking the report ‘Australia’s Health Workforce’. It was these responses, amongst others, that caused the Productivity Commission to remove comments about Podiatric Surgery from its draft report.

The role of paediatric surgery requires careful analysis. Unfortunately Dr Biyani in the article does not appear to differentiate these issues clearly. Podiatry in Australia is based on Chiropody which has a very important role in the care of feet. Traditionally this has been focussed on the forefoot and particularly nail care. They play a very important role in the team approach to foot care particularly with the diabetic and vascular compromised populations. Podiatry in the United Kingdom has a similar profile and role. Podiatry in the United States of America is different with the paediatric surgeon also having a degree in Podiatric Medicine which may be considered comparable to a medical degree, before they undertake a surgical training program. The American training is most substantial.

So the first question that the medical manager needs to raise is “*Does a medical degree matter?*”. Having been educated in the era when basic sciences, pathology, pharmacology, infectious diseases were stressed in medical courses, I need to declare both personal interest and I assume a conflict of interest. However, a medical degree does matter. Secondly, “*Does a Surgical Fellowship matter?*” Every professional group states they are well trained. However the rigour applied to the training program in Australia and New Zealand for orthopaedic surgery and also plastic and reconstructive surgery is high. Fellows of the Royal Australasian College of Surgeons (FRACS) would have performed close to 2000 operations before they become independent specialists. All specialist surgical training posts are accredited and supervised. This is not the case for the Australasian College of Podiatric Surgeons and its academically focused program. Again I need to declare a conflict of interest as I am the Chief Executive Officer of the Royal Australasian College of Surgeons (RACS).

However the answer is that a surgical Fellowship accredited by the Australian Medical Council does matter. The foot is not a simple anatomical structure and the ankle joint substantially complex with all the challenge of weight bearing. The third question is one that was answered for me in a morbidity and mortality meeting twenty years ago “is there such a thing as minor surgery?” The answer is never if you are the patient. Unfortunately, however, there are occasionally minor surgeons. So the question should and does come back to the issue of quality and standards. In the case of podiatrists they should be called paediatric proceduralists.
Is the College structure (recognised by the Australian Medical Council) the only way to obtain surgical training? Absolutely not, and no College acts in a monopolistic manner with regards to standards or training. The common theme is always the availability of proper training roles that are clinically relevant and adequately supervised. The College (RACS) is working closely with other providers of surgical training to improve the quality and breadth of the training experience. However, I do need to highlight that a medical degree and a formal Surgical Fellowship have their own validity and importance.

The medical manager plays a substantially different role today compared to a decade ago. Clinical governance is real. Politicians, policy makers and funders have ensured that medical practitioners are able to provide high quality services to the Australian public. Medical managers must identify the treatment standards for the patients that are cared for by their Organisation. Is it at the level required with peer review, audit and rapid identification of clinical risk issues? These are important issues. As the health sector works through issues of task delegation, systems redesign, change management, healthy doses of turf protection and conservatism it is too simplistic to talk only of budgets and access. Do standards count? Absolutely!

Yours sincerely

Dr David Hillis
Chief Executive Officer
Royal Australasian College of Surgeons
MBBS (Hons), MHA, FRACGP, FRACMA, FCHSE, FAIM, FAICD

Dear Candidates, Members and Fellows,

I am honoured and delighted to take this, my first opportunity to talk with you.

My first wish is to thank Phil Montgomery and the Council for the honour they have done me by electing me to this position. The College is in fine shape, and the past presidents and staff can take credit for that.

But now we have several important jobs to do.

Members, in particular, tell us they want more opportunities to interact with the College, for formal and informal continuing professional development; we need to find those ways. Candidates need to have greater input into College affairs—we have recently welcomed our first candidate to national Council, and look forward to even more knowledge tapped to benefit the College as a whole.

Our Censor-in-chief is working hard with our Education Co-ordinator and secretariat staff to continuously develop our training program and I know what a challenge this task is. The Hon. Treasurer is engaged in the balancing task with which most of us are only too familiar—the eternal income/expenditure battle. We continue to try to develop alternate income streams to keep our subs at a manageable level, and continue to offer more and better educational and support services to the membership.

We have a new Strategic Plan 2006–2009 that is challenging but achievable. I hope that you have all had a chance to read this document which is on our web site. It describes an exciting future for our college and I hope that you will all support us to achieve this. It is your college after all.

Thank you for the helpful suggestions you have made in our recent on-line survey. As I believe our main task is to develop and maintain a community of medical managers committed to teaching and learning, we need to ensure that measures of our commitment (such as preceptorship, mentoring, CPD etc) are evident to all. Our new Chief Executive and I will work with Council to meet your aspirations of the College.

Being in good standing with this (or any other) learned college is a matter of great pride to me and to you. We need to continue the task begun by those who preceded us and progress these important matters for the future of a better health system in Australia, New Zealand and wherever else you may be reading this.

Please join us in this exciting endeavour.

Dr Gavin Frost
President
A SUMMARY
INTRODUCTION TO
EQuIP 4TH EDITION

After a lengthy and highly consultative development phase, August 2006 saw the release of EQuIP 4th edition; the accreditation standards from the Australian Council on Healthcare Standards (ACHS).

Since the current 3rd edition standards of the Evaluation and Quality Improvement Program (EQuIP), were finalised in April 2002, there have been significant changes impacting on the national patient safety agenda. In total 35 criteria from the 43 in the 3rd edition have been retained as criteria in EQuIP 4. In addition key issues identified by the previous Australian Council on Safety and Quality in Health Care have been given greater emphasis to address these changes.

EQuIP 4 is an evolution from the 3rd edition as it retains all the key content, however some 3rd edition criteria have been reconfigured. For example some multiple criteria have been condensed into one, some single criterion have been separated into more than one and other criteria have been included in EQuIP 4 as elements.

There are 14 mandatory criteria for EQuIP 4, which were determined through a lengthy consultation, involving an electronic survey to which almost 900 responses were received.

CONSULTATION AND REVIEW

Commencing in November 2004, the review of EQuIP 3rd edition and development of EQuIP 4 began with an examination of the relevant literature and a comparison of the EQuIP standards and criteria with those of the UK, Canada, the USA, New Zealand, Ireland, France and Japan. The ACHS established over ten different working groups as well as reference panels, expert advisory groups and focus groups throughout Australia for specific topics in addition to other consultative forums and pilot studies. The final version of EQuIP 4 was subsequently adopted by the ACHS Board in May 2006.

One of the outstanding features of this review process, apart from it being the most extensive ever undertaken by the ACHS, has been the high level of input received from across the industry. The comments and advice provided have had a significant effect on the final version and the way in which the program is to be published and operated.

Through EQuIP 4 the focus of the program has been strengthened in relation to clinical care and consumer participation. As part of the effort to increase the clinical focus of EQuIP the arrangement of the EQuIP 3rd edition standards in six topic areas, known as functions, has been restructured into three topic areas: clinical, support and corporate, for EQuIP 4.

EVOLVING STANDARDS

The Australian Commission on Safety and Quality in Health Care is undertaking a review of accreditation, which was recommended by the Patterson Review of the future governance arrangements into safety and quality. This report was handed down last year. The review is strongly supported by the ACHS as it offers a major opportunity to develop stronger symmetries between the various and increasing number of sets of standards that impact on the health system. It is expected to not only impact on all sets of standards but influence what we do and how we do it in the future. Updates of EQuIP 4 will be made as necessary, to reflect the outcomes of this national review of accreditation.

TIMING FOR IMPLEMENTATION

Organisations scheduled to undergo a self-assessment or an onsite survey from 1 January 2007 to 30 June 2007 will have the option to utilise either EQuIP 3rd edition or EQuIP 4. From 1 July 2007, all ACHS member health care organisations need to self-assess and be surveyed against EQuIP 4.

This introductory period is aimed at addressing concerns that the four-year cycle of EQuIP membership requires the same organisations to be the first assessed by the new standards each time they are updated.
THE DIFFERENCES BETWEEN EQuIP 3RD EDITION AND EQuIP 4?

While there is a new function structure, which makes the standards appear quite different at first glance, the focus of the update has really been to strengthen the existing standards rather than creating a new framework.

The vast majority of issues addressed in EQuIP 4 were also included in EQuIP 3rd edition. Most ‘new’ criteria were in the 3rd edition as elements.

In addition to the 35 criteria from EQuIP 3rd edition retained as ‘criteria’ in EQuIP 4, key patient safety issues which were included as elements and guidelines in the 3rd edition now appear as ‘criteria’. The purpose is to strengthen the focus on these issues. For example: medication management, correct site surgery, falls management, and management of blood and blood components, which were addressed under the Continuum of Care function in the 3rd edition, are now specified as criteria in EQuIP 4. Credentialling, which was previously addressed in the elements of the Human Resources criteria, is now a specific criterion.

RIGHT PROCEDURE - RIGHT PATIENT - RIGHT TIME

‘Appropriateness’, one of the nine dimensions of quality, was introduced into this edition after a gap was identified and it is intended to ensure organisations have systems in place to determine and evaluate the ‘appropriateness’ of care provided. In other words do organisations have a process for assessing if an intervention is necessary – is it the right procedure on the right patient at the right time and in the right setting?

As a ‘developmental’ criterion for a four-year period, organisations will work towards achieving the standard, however rating of this criterion will not be considered when determining an organisation’s accreditation status. The purpose of this approach is to create awareness, encourage improvement and research and commence collaborative national action.

ACHIEVABLE STANDARDS?

The standards need to provide a realistic framework for improving the safety and quality of care. Consultation with industry helps ensure they are achievable. It is also important to note that the vast majority of safety and quality issues highlighted in EQuIP 4 were already included in the 3rd edition.

ACHS accreditation standards have been reviewed 13 times before the introduction of EQuIP in 1996 and, including this latest review, four times since.

As always, the ACHS will be providing supporting information as well as the assistance of our Customer Services Managers who work to help prepare organisations for accreditation assessments. In addition the final standards are available around ten months prior to when it will be essential for organisations to be surveyed against them.

The ACHS is confident that EQuIP 4 is a clear step forward in improving the safety and quality of health care in Australia. The standards address the safety and quality issues identified as national priorities.

For the first time the standards (Part 2 of the EQuIP 4 Guide) are accessible via the ACHS website, www.achs.org.au - under What’s New?

Mr. Brian Johnston
ACHS Chief Executive

For your EQuIP 4 questions, please email: equip4@achs.org.au

Alternatively you may contact the Australian Council on Healthcare Standards on: +61 2 9281 9955.
The provision of end of life care to rural and remote Australians presents many challenges for clients, carers and health professionals. Whilst there is a paucity of Australian literature examining rural and remote palliative care, there are indicators that geographic isolation, accessibility and affordability of health services influence when and how rural individuals cope with poor health, chronic disease, malignancy and terminal illness.

The following literature review and discussion illustrate the experience of providing end-of-life care in far North Queensland. Service delivery issues are examined, as are the challenges of managing pain and symptom control for individuals living far from major population centres.

The importance of providing culturally sensitive services to Indigenous clients with limited English is discussed in detail. Communication, the importance of addressing grief, loss, funerals and bereavement are vital in reducing pathological grieving in Indigenous communities. Indigenous liaison officers can provide support to clients and contextual cultural links to communities.

Managing client and family expectations around end-stage renal disease is an area that needs further examination as the overall population of clients on dialysis in Northern Australia increases.

This report proposes a direction for health policy makers and planners with the further development and funding of integrated, community-based palliative care services. Local health care professionals can be encouraged to develop their skills in this area and supported with education, advice backup and support wherever necessary.

Some of the directions presented include strengthening the links between acute, mainstream health services and the community sector and affirming community palliative services with a funding level commensurate to their activity.

**INTRODUCTION AND BACKGROUND**

The treatment of life limiting illness and provision of end of life care to rural and remote Australians presents many challenges for clients, carers and health professionals.

Isolated, marginalized, itinerant and Indigenous Australians have reduced access to health services including specialist palliative care and oncology.

Geographic isolation, reduced life expectancy, cultural traditions and expectations- including place of terminal illness and circumstances surrounding death, determine quality of life, grief and bereavement.
Rural Health and Palliative Care

The body of Australian ‘rural health’ literature does not specifically examine rural and remote palliative care. There are indicators, however, that issues such as geographic isolation, accessibility and affordability of health services influence when and how rural individuals cope with poor health, chronic disease, malignancy and terminal illness. The Australian Institute of Health and Welfare, 19984 and 20035 and Humphreys, 19996 state that “the identified rural health disadvantage is not solely a result of poorer Indigenous health but, instead, reflects the unique issues that relate to living conditions, social isolation and distance from health services”.

Recent articles on health service provision, mortality and morbidity data give some indicators of health status. The all cause mortality rate decline experienced in New South Wales between 1970 and 1994 was significantly reduced in small rural communities7. Explanatory factors included poorer socioeconomic status in rural areas and lack of access to health services. General Practitioners provide most end-of-life care in remote areas8, with only 12% of medical specialists working rurally, many of whom are visiting, not resident. Most rural specialists work as general physicians or surgeons, occasionally with a sub-specialty interest.1

Indigenous Palliative Care

There is a growing body of literature examining rural and remote Indigenous palliative care issues in Australia. The ‘living model’ of Indigneous palliative care service delivery9. places the patient and extended family at the centre of care. Issues of cultural safety, community participation, personal advocacy, empowerment and choice support patient and family care.

Communication issues outlined by McGrath et al-ensuring the “right story” is told to the “right person”10 highlight the struggle associated with effective communication when working in a cross cultural setting at the interface of Indigenous and Western health care.

Whilst only 2% of Australia’s population is Indigenous, in the Northern Territory and Far North Queensland percentages are significantly higher. (NT 24.9%, Cairns Health Service District 9.5%, Cape York 51.1%, Torres Strait 74%11). There are differences in the cultural practices between many Torres Strait Islander people and the many different groups of Aboriginal people12. Language issues are also significant. 16% Torres Strait Islanders speak an Australian Indigenous language and there are over 40 language groups in the Northern Territory alone13/14.

Maddocks and Rayner15 examined issues in palliative care in Indigenous communities in South Australia in 2003. Reaching similar conclusions to McGrath et al, they found that Indigenous people use health care services reluctantly, preventative services, rarely (leading to late presentations of common malignancies16 particularly carcinoma of the cervix17. The stated reasons being lack of access to acceptable services for reasons of geography and cultural appropriateness.

Premature mortality in Indigenous Australians, particularly in young adults at 5-8 times and an overall reduced life expectancy of 19 years compared to non-Indigenous leads to an almost continuous, community-wide grieving. High suicide rates and high prevalence of mental illness (Queensland Health, 200118 and National Rural Health Alliance, 2003 1 place this population at extremely high risk of abnormal or pathological grieving with cumulative grief experiences.

Both McGrath P, and McGrath C, identify the importance of place of death (preferably their ‘own country’), post-death practices involving community elders, and funerals as a critical part of the mourning and healing process. In an effort to address the cultural and psychosocial issues which place Indigenous communities at such high risk of abnormal grieving, the National Palliative Care Program and Mangabareena Aboriginal Corp have produced a resource kit to facilitate culturally appropriate palliative care provision to Indigenous Australians19.
include hospitals at Mareeba, Atherton, Chillagoe, Croydon, Georgetown, Herberton, Babinda and Innisfail. These facilities are staffed by skilled remote area nurses, indigenous health workers, generalist medical practitioners with some limited resident and regular visiting surgeons and general physicians from Cairns.

Indigenous community controlled health services are located in Cairns, Mareeba, Ravenshoe and Innisfail with regular attendance by local Indigenous people at Queensland Health facilities – acute, primary, community and mental health.

Limited specialist medical oncology, haematology, palliative care, interventional radiology, respiratory medicine, cardiology, neurology and gastroenterology services are available at Cairns Base Hospital. The renal dialysis unit is the second busiest in the state. There is no resident public sector urology, radiation oncology, neurosurgery or interventional cardiology.

**SERVICE DELIVERY ISSUES**

The Cairns, Cape York and Torres Strait Island Health Service Districts provides services to a population of approximately 200,000 people situated across a geographic area the size of Victoria. The population density maps indicate the degree of remoteness of most of the health service district.

The non-Indigenous population of the region reflects that of Australia overall with almost 13% aged over 65 years. The Cairns HSD also cares for the seasonal influx of international tourists and ‘grey nomads’, some of whom require medical services whilst visiting the area.

Small rural hospitals (1-3 doctors maximum) are located at Thursday Is., Bamaga, Cooktown, Mossman and Weipa. Remote Primary Health care centres (1 remote area nurse with visiting medical clinics from Royal Flying Doctor Services (RFDS), at Aurukun, Coen, and on most of the inhabited Torres Strait Islands. Tablelands Health services

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**Far North Population Data: Australian Bureau of Statistics Census 2001**

Far North (SD 350) 269223.9 sq. Kms

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<th>FEMALES</th>
<th>PERSONS</th>
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<td>Indigenous persons aged 18 years and over</td>
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<td>Overseas visitors</td>
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The **palliative care** unit is located at Gordonvale Hospital, 25km south of Cairns. Palliative care services are also provided at Cairns Base Hospital and Cairns Private Hospital. The medical oncology unit at Cairns Base has expanded from 170 to 600 patients since the arrival of a single resident medical oncologist in 2004.

Health services have varying degrees of accessibility by road, air and sea. Wet season flooding, landslides and cyclones prevent access to many parts of the Cape between November and April. Aeromedical evacuation is available in emergencies using the Careflight helicopter and Royal Flying Doctor Service. Some islands in the Torres Strait are accessible only by light aircraft and boat.

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**CAIRNS HEALTH SERVICE DISTRICT**

**DISCUSSION**

Providing adequate services to the bush means overcoming **geographic isolation** and **lack of access to generalist and specialist facilities.** Screening services are often absent or underutilized leading to late diagnosis of preventable malignancy. Across northern Australia these issues are often compounded by language and cultural barriers 5 6 7 8

One of the major issues explored by McGrath in 2004 and 2005 focuses on **relocation and dislocation** of Indigenous people when they are forced to leave their communities for treatment. Clients and families are confronted by a bewildering array of technology, difficulties in understanding explanations about complex medical treatments and procedures, problems in achieving ‘informed consent’ for treatment and inadvertent cultural insensitivity by health professionals.

Barriers to education lead to **communication difficulties** exacerbated by **language and cultural issues.** (McGrath P et al, 2005) discusses this in detail in the Living Model of Indigenous Palliative Care. Indigenous (and non-Indigenous) individuals with end-stage **renal disease** are living longer with dialysis. Pre-dialysis counseling is often undertaken without an interpreter and many patients really do not understand the palliative nature of dialysis. This, in turn, creates compliance issues and huge problems around the end stage. Ashby et al 23. have explored these issues in a predominantly non-Indigenous Victorian dialysis unit.

Cairns Base Hospital has the second busiest unit in Queensland, receiving referrals from the Torres Strait, Cape York Peninsula and coastal communities. Queensland Health’s Information centre (Qhealth, 2005 19) showed renal dialysis admissions topping the list of inpatient DRG’s 2003/4(see Table).

Two-thirds of Cairns’ dialysis patients are Indigenous. Demographic issues, language, racial and cultural differences between the Cape York Aboriginal people, the Torres Strait Islander and individuals from PNG provide service delivery challenges for the social work department with only a very limited number of Indigenous Liaison Officers. It is particularly important to ensure cultural sensitivity around gender issues (eg. Female genital malignancies would require a female ILO). Health worker burnout is a constant threat.
DISTRICT PUBLIC HOSPITAL EPISODES OF CARE FOR TOP 10 DRGS (V4.2) 2003/2004 :TOTAL INPATIENTS (PUBLIC AND PRIVATE) 19

<table>
<thead>
<tr>
<th>DRG NO</th>
<th>DRG NAME</th>
<th>No. OF EPISODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>L61Z</td>
<td>Admit for Renal Dialysis</td>
<td>9,454</td>
</tr>
<tr>
<td>R63Z</td>
<td>Chemotherapy</td>
<td>1,472</td>
</tr>
<tr>
<td>O65B</td>
<td>Other Antenatal Admission W Moderate or No Complicating Diagnosis</td>
<td>1,113</td>
</tr>
<tr>
<td>O60D</td>
<td>Vaginal Delivery W/O Complicating Diagnosis</td>
<td>1,086</td>
</tr>
<tr>
<td>O64Z</td>
<td>False Labour</td>
<td>689</td>
</tr>
<tr>
<td>G44C</td>
<td>Other Colonoscopy, Sameday</td>
<td>663</td>
</tr>
<tr>
<td>O65A</td>
<td>Other Antenatal Admission W Severe Complicating Diagnosis</td>
<td>489</td>
</tr>
<tr>
<td>G45B</td>
<td>Other Gastroscopy for Non-Major Digestive Disease, Sameday</td>
<td>477</td>
</tr>
<tr>
<td>J64B</td>
<td>Cellulitis (Age&gt;59 W/O Catastrophic or Severe CC) or Age&lt;60</td>
<td>457</td>
</tr>
<tr>
<td>C08Z</td>
<td>Major Lens Procedures</td>
<td>418</td>
</tr>
</tbody>
</table>

(Queensland Health: Health Information Centre Review Date: November 2005)

LOGISTICS OF SERVICE PROVISION, PATIENT TRANSPORT AND COST

Specialised interventional procedures (radiology, radiation oncology and interventional urology) often require a trip to Brisbane or Townsville. Resource allocation becomes a real issue with even urgent radiation oncology up to a 6-8 week wait. Providing symptomatic relief for frail, elderly or palliative clients may mean choosing between suboptimal symptom control or painful, time consuming travel for clients and their families. Emergency transport services are also a limited resource. Access is determined by centralized clinical coordinators who have an acute care focus. Circumstances do arise where palliative clients get ‘offloaded’ in transit for ‘more acute’ emergencies.

It is impossible to meet patient expectations under these circumstances.

The costs of returning to a remote island community is often prohibitive for families. ILO’s and social workers spend hours organizing ‘Angel flights’ to move people around at times of crisis. Transportation of deceased persons is also costly and almost never seen as a priority by medical evacuation services.

GRIEF, LOSS AND BEREAVEMENT

Palliative care team policy aims to identify those at high risk of pathological or abnormal grieving. Indicators for this would include repeated losses within a short time period, very sudden, violent or unexpected death (such as a suicide), previous psychiatric history or multiple psychosocial stressors within the family or community.

It is recognized that Indigenous communities carry a large burden of unresolved grief due to multiple losses. The high mortality rate in young people (Indigenous people living on average 20 years less than non-Indigenous Australians), high suicide rate and high prevalence of mental illness place this population at extremely high risk of abnormal or pathological grieving with cumulative grief experiences. 3, 10 The importance of place of death (preferably their ‘own country’), post-death practices involving community elders, and funerals are identified as a critical part of the mourning and healing process.

Death, dying and funerals take on special cultural significance for Indigenous peoples. It is often inappropriate to use the name of the deceased person and funerals become community-wide outpourings of grief. There are particular issues associated with attribution of cause and blame which may limit the willingness of health workers to be involved with dying indigenous clients.

The distances in remote north Queensland preclude anything other than telephone bereavement follow-up. This is less than ideal when people are in transit, itinerant, have limited access to transport and only mobile telephone communication. Mobile networks rarely operate outside large population centres and the cost of CDMA and satellite telecommunication is beyond the budget of many palliative care clients.
RURAL AND REMOTE PALLIATIVE CARE – CHALLENGES AND SOLUTIONS

Many of the patients treated in rural and remote settings with advanced malignancy are unable to access treatment modalities regarded as standard within metropolitan settings. Late presentations for potentially preventable cancers are more prevalent, particularly in indigenous, indigent or very remote clients.

Palliative treatment in the form of chemotherapy or radiation oncology is only available in larger centres (Cairns, Townsville, Brisbane) necessitating long distance travel or even relocation by whole families during the course of a protracted illness. Health policy and planning needs to take into account the difficulties in providing services closer to home versus the impact of travel and relocation.

Ageing infrastructure and reduced numbers of all health care providers make the challenges of delivering palliative care services to rural and remote dwellers, quite formidable.

Generalists providing these services located close to, or flying distance from, scattered populations are responsible for the vast majority of end of life care in the bush. Larger centralized health services need to support these providers with timely back up and advice. Relocation of dying patients to palliative treatment centres removes them from their community at the very time that they would most benefit from having supports close to home. Every effort needs to be made to provide services locally if possible.

Examples of service delivery integration are already occurring in North Queensland with RFDS doctors seeking attachments to the palliative care unit in Cairns. Education and inservice delivery at the nursing, medical and health worker level is now a regular event at the Wuchoppern Community Controlled Indigenous health service.

2006 should see the further development of a regional service to the Cape York Peninsula and Torres Strait. Finally, data collection and evaluation of service delivery models will be integral from the outset.

CONCLUSION

High quality end of life care can be achieved in rural and remote settings. Required, is a commitment from health policy makers and planners, mainstream health services and the local and volunteer sectors in each small community.

Palliative services need to be recognized as of equal priority to acute services and adequately funded.

General physicians and general practitioners need to be encouraged to develop their skills in this area and supported with education and advice whenever necessary.

Indigenous health services should be recognized as vital cultural bridges and affirmed in assisting with aspects of end of life decision making for their clients and families.

Managing client and family expectations around end-stage renal disease is an area that needs further examination as the overall population of clients on dialysis in Northern Australia increases.

This report proposes a direction for health policy makers and planners with the further development and funding of integrated, community-based palliative care services. Local health care professionals can be encouraged to develop their skills in this area and supported with education, advice and backup wherever necessary.

Some of the directions presented include strengthening the links between acute, mainstream health services and the community sector and affirming community palliative services with a funding level commensurate to their activity.

Associate Professor Kathleen Atkinson is A/Medical Superintendent Innisfail Health Services District.

Dr Atkinson has applied to become a candidate of The Royal Australasian College of Medical Administrators


9. McGrath CL: Issues influencing the provision of Palliative Care services to remote Aboriginal Communities in the Northern Territory Aust J. Rural Health (2000) 8, 47-51


12. Queensland Health: Aboriginal & Torres Strait Islander Issues in Cairns Base Hospital Resident Medical Officers Information Manual Section 3 – General Information. 3-1-3-5. Queensland Health Publications. Reviewed 2000


ACHIEVING PERFORMANCE TARGETS

THE BQB APPROACH

Dr Amanda Ling and Brian Davies

BACKGROUND
North Metropolitan Area Health Service (NMAHS) is one of the two major metropolitan health networks in Perth, and includes Sir Charles Gairdner Hospital, Osborne Park Hospital, Swan Kalamunda Health Service and Graylands Hospital. Sir Charles Gairdner Hospital, one of the major teaching tertiary hospitals in Perth, and the two major hospitals from the South Metropolitan Area Health Service, Royal Perth Hospital and Fremantle Hospital, participated in a project to improve hospital performance.

In the autumn of 2005, comparisons of hospital performance against Health Roundtable data showed a significant gap, and as a result NMAHS initiated the Best Quartile Benchmarking (BQB) project, an initiative for improving, the length of stay of acute inpatient episodes, the percentage of elective surgical procedures treated as same-day episodes, and the percentage of multi-day elective surgery inpatients admitted on their day of surgery. The BQB set performance targets at best quartile benchmarks when compared to peer group hospitals nationally, with targets at clinical department level, and composite targets set at clinical division, hospital and health service levels.

The NMAHS Executive monitored progress through a monthly balanced report card process, monthly generation of league tables, and also offered a reward for consistent achievement of targets over a minimum of a three consecutive month period aggregated to the clinical division level. The raw data was made available to the clinical divisions allowing detailed analysis and verification of the results.

The results in the July to December 2005 Health Roundtable report showed significant improvement, and the January to June 2006 showed further gains. Revised BQB targets for 2006 – 2007 will further refine the targets and add the increasing challenge of achieving best quartiles. The initial project did not include the secondary hospitals, however, peer group benchmarks will be available from 2006-2007.

METHODOLOGY
Best Quartile Benchmarks were constructed from nationwide data obtained through membership with a peer organisation, the Health Roundtable (HRT), and were based on the Diagnosis-Related Groups (DRG) classification system, version 4.2. This facilitated the tailoring of performance targets to match the casemix of each department, division, and when necessary, individual clinicians.

The DRG classification system groups inpatient episodes into over 600 groups, is used nationally for coding, and in some States, the funding of hospital based episodes of care, and forms the basis of much of the Health Roundtable data. However, the use of DRGs assumes hospitals in the reference group and the evaluation group have reasonably similar clinical case profiles. While DRG classification schemes and cost weights facilitate comparisons among similar hospitals, they do not provide a robust comparison of hospitals with major clinical differences, such as the comparison of a dedicated maternity hospital to a general hospitals, or tertiary hospitals to secondary hospitals.

Hospitals in the HRT peer group were ranked for each inpatient DRG, and the best quartile performance was identified and defined as the benchmark for each DRG. This was in contrast to earlier benchmarks, which measured quartiles across all episodes of care. Departmental, divisional and hospital targets were then derived according to the contribution of each inpatient DRG to their respective workloads.

The construction of the Sameday Episode Rates and the Day of Surgery Admission Rates were developed using a similar methodology. Hospitals in the HRT peer group were ranked for each of these rates, and the best quartile performance was identified and defined as the benchmark. Departmental, divisional and hospital targets were then derived.

The development of the BQBs required the replication of the HRT methodologies to facilitate the comparison of BQB results, with results in other standard HRT reports. One example of these adaptations was the exclusion of sameday dialysis episodes from most of the comparisons. A further adjustment was due to the difference between the standard measure of length of stay, which are date-based, and the HRT measure of length of stay, which is time-based. The existence of multiple variations of similar performance indicators was a source of confusion at all levels.

The Reference Data Set was Version 3 of the HRT 2003/2004, as this data set had been analysed extensively by members in WA and elsewhere. This version of the AR-DRGs was in current use by the Department of Health, Royal Street, and had been used for HRT analyses and reports up to 2003/04. Derived data items in this database were based on AR-DRG v4.2 (Victorian adaptation), and National Cost Weights were available for this version.

Implementation of the benchmarked data occurred through the monthly balanced report card and league table process, with detailed review of the results by Area and hospital executives, divisional directors and divisional business managers. Monthly
meetings occurred with each of the divisions to discuss these performance measures and ongoing operational plans. Areas of concern were reviewed ad hoc for further analysis and the development of specific action plans. The league tables were disseminated at the Hospital Executive meeting for discussion and review.

The divisional business managers had access to the raw patient level data allowing detailed analysis and verification of this data, and details of the methodology for the generation of the benchmarks was available on the shared drive. This access to the data provided a transparent report generation process that alleviated the concerns of the divisions regarding accuracy of the reports. The division business managers compiled the monthly reports.

RESULTS

Results for the July to December 2005 half year were encouraging when compared to the previous financial year. The HRT reports showed that for the 37,951 inpatient episodes with an average case weight of 1.23, benchmarked in the six month period, the Relative Stay Index decreased from 112% to 94%, the Sameday rate reduced from 49% to 48% and the Day of Surgery Admission Rate went from 82% to 84%.

The average length of stay for multi-day acute episodes, based on standard NHDD definition, reduced by 16%, from 6.5 days in 2004-2005 to 5.4 days in 2005-2006.

Table 1. Results for the BQB Project based on Health Roundtable Data October 20051 and March 20062

<table>
<thead>
<tr>
<th></th>
<th>Full Year 2004-2005</th>
<th>Half Year July-Dec 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WA</td>
<td>SCGH</td>
</tr>
<tr>
<td>Total Separations</td>
<td>192,199</td>
<td>71,132</td>
</tr>
<tr>
<td>Relative Stay Index</td>
<td>105%</td>
<td>112%</td>
</tr>
<tr>
<td>Same Day Admission Rate</td>
<td>47%</td>
<td>49%</td>
</tr>
<tr>
<td>Day of Surgery Admission Rate</td>
<td>78%</td>
<td>82%</td>
</tr>
</tbody>
</table>

DISCUSSION

The development of the Best Quartile Benchmarking project provided a framework for measuring and managing the performance of acute inpatient hospital care. Access to reliable benchmarking data from peer group hospitals and access to the detailed inpatient data was critical to the adoption and integration of the project into the management culture. Compilation of the balanced report cards by the division business managers alleviated concerns regarding the transparency and accuracy of the data and provided the necessary skill set to perform detailed analysis of key areas of concern.

The use of best quartile benchmarks, derived at the DRG level for peer group hospitals, resulted in work practice changes at the patient and ward level, and extended the focus into community based care. A detailed understanding of the DRGs that fell outside the target range supported clinical departments to develop specific plans to address these lengths of stay variances. The ability to closely monitor the performance targets on a regular basis ensured that steady progress was achieved.

FURTHER DEVELOPMENT:

Best Quartile Benchmarking targets for 2005-2006 were determined using HRT peer group data for 2003-2004, and revised targets for 2006-2007 have been based on similar data for July-December 2005. Average Length of Stay Targets for some clinical specialties require investigation and refinement. Examples of skewed targets include Medical Oncology, which are too high, and Emergency Medicine, which are too low. As the overall performance of the peer group improves each year, the 2006-2007 targets are more challenging than the current set. The revised average length of stay target is approximately half a day shorter.

The initial project only included the tertiary hospitals, and for 2006-2007 targets have also been developed for the non-teaching hospitals in NMAHS, and for the two teaching hospitals in SMAHS.

Amanda Ling
MBBS, FRACGP, MBA
A/Area Executive Director
Sir Charles Gairdner Group

Amanda has worked in public and private hospital management, mainly in the areas of clinical and medical management. She also has a special interest in performance management and evaluation, and has spent time working in Casemix analysis and development.

Brian Davies B.Sc.
Manager, Management Information Services
North Metropolitan Area Health Service
WA Department of Health

A mathematical statistician by training, Brian has mainly worked in the public sector health services and hospital management areas, with some excursions into mining, groundwater, and international fisheries management.

1 Health Roundtable, Clinical Service Group Data for Total All Cases, version 1, October 2005
2 Health Roundtable, Clinical Service Group Data for Total All Cases, version 1, March 2006
FOCUS ON QUALITY

RISK MANAGEMENT – BUILDING SHARED RESPONSIBILITY

Dr Lee Gruner
Director, Quality Directions Australia

For some time I have been concerned by the momentum engendered by the risk management movement. It has seemed to me that we have placed ourselves on an every speeding roller coaster and put ourselves in its power with our brains totally disengaged.

We have adopted the jargon:
➣ Risk ratings
➣ Root cause analysis
➣ Airline industry
➣ Blame free culture

These terms that were barely in existence in Australia 5 years ago are now blithely bandied about and regarded as gospel.

However, after 5 years we need to ask ourselves:
➢ Are we better off?
➢ Are our patients better off?
➢ Are our health services better off?
➢ Have we demonstrated better outcomes?

The answers to these questions are far from clear.

It is true that there have been positives:
➢ We have increased the reporting of incidents although how useful this has been is debateable
➢ We are more aware of risk and so have put in place some better systems
➢ We have learnt a new tool - the redoubtable Root Cause Analysis (RCA)

On the other hand the questions that I have asked myself and others are:
➢ Are we using our knowledge base effectively?
➢ Are we using our new tool appropriately?
➢ Is the reporting of increased numbers of incidents beneficial?
➢ Has awareness made an impact on outcomes?

It is clear to me that we need to get back to first principles and ask ourselves, why we are focusing on risk management and what we are trying to achieve.

Firstly let us consider the airline industry comparisons that we hear about ad infinitum. How far can we stretch this analogy? How close is health care to flying a plane? In an aeroplane we have two pilots and hundreds of people in a confined space that they can’t escape from easily all dependent on these two pilots and very complex equipment that tells them what is happening every step of the way. In health care, we are far more dependent on individuals who need to demonstrate clinical acumen and need to work together as a multidisciplinary team with complementary skills. We are far less dependent on equipment in most situations and if something goes wrong we do not have hundreds of people at our mercy.

Certainly the airline industry is a useful learning mechanism about the importance of systems thinking, but is that all there is?

What about RCA? What is RCA but a structured problem solving tool adapted for a specific purpose. However, over time its use has become inappropriate in many situations and considerable time is given to the use of the tools with the learnings often not clear. Because it is used for a specific purpose i.e. examining bad apples, the systems results are extrapolated from one event and often using a team that does not understand the specific circumstances. This is in contradistinction to the structured problem solving approach that aims to look at present processes with a team that understands the process and thus
move the quality curve to the right. This is based on in depth knowledge of the present system and thus is not merely an extrapolation. RCA recommendations are often non specific and/ or not adopted and/ or fallacious if the process has been inappropriate. In addition RCA is just a tool. You can’t build a robust structure with just one tool. Ask any builder!

I was asked in questions time, how it possible is it that RCA has nevertheless become so popular that everyone is demanding training. My answer to this is twofold. Firstly it has been taken up by governments as the investigation panacea and this is very powerful. Secondly it demonstrates marketing theory very clearly. New products are taken up by people as follows:

➢ innovators,
➢ early adopters,
➢ early majority,
➢ late majority
➢ laggards

We are now in the stage of the late majority, where people who have not had training feel left out of the process and feel an enormous urge to get on the roller coaster to be like everyone else. By this time of course the innovators have been into something new for a long time and the early adopters are busily adopting this!

So what about incident reporting. This has spawned a whole new industry! There has been new software and new technology, hosts of people employed and even organisations formed to meet the demand. I am still to see what this huge investment in time and energy has delivered. I am not even sure that what it is supposed to deliver is totally clear.

The issue is that we do need to think much more carefully about how we spend our ever limited resources and what outcomes we expect to achieve. Where is the real cost benefit? We need to start looking beneath the jargon and question more openly. I have heard from learned colleges that doctors have not been engaged in the risk management movement and I have observed this myself. How is it that key professionals have not been engaged and what is being done about this?

Are we really looking for a blame free culture? I have found that many health care professionals and particularly doctors find this terminology inappropriate. They ask what should happen if someone does do the wrong thing? Should there never be any blame? In fact we have seen plenty of blame apportioned in some of the prominent adverse events, despite the jargon. The question is then where can we look to enhance our learning about the sort of culture we need to engage all health professionals and increase quality and safety in health care?

I believe that there is a lot to learn from modern culture and the epitome of this is the reality TV show. One of the most popular in this genre is Supernanny, an English nanny who tries to sort out dysfunctional families. This provides us with one of the most important principles that one can apply to risk management in health care-

THE SUPERNANNY PRINCIPLE OF CONSEQUENCES.

This principle demonstrates what happens where there is no culture of shared responsibility:

➢ The parents have abrogated their responsibility to discipline their children to ensure they become good citizens
➢ The children have not learnt to be responsible for the consequences of their actions

What Supernanny does is introduce consequences. If the children’s behaviour is “unasseptable” they need to spend time on the naughty step/ corner/ spot to reflect on what they have done. The Supernanny Principle Of Consequences relies on:

• Engaging children by getting down to their level and speaking their language
• Explaining the impact of their behaviour on others
• Clearly relating the consequences of their behaviour to outcomes
• Educating parents on how to carry out these steps consistently, so that children make the right behavioural choices
• Parents putting the time energy and effort into this

In this way:

• Responsibility is instilled in children by the use of consequences
• Responsibility is instilled in parents by the use of education on how to introduce consequences

How can we relate this to risk management in health care?
In health care, we need to develop a culture of shared responsibility if we are really to make inroads in improvement of quality and safety:

- Leadership needs to be educated to ensure that it will listen to staff, assess the evidence and take action where evidence demonstrates clear risk to the organisation
- Staff need to understand the consequences to themselves, patients and the organisation if they do not speak up about areas of significant risk or if they make the wrong choices

Based on the Supernanny principle of consequences:

- Staff need to be engaged using the right techniques and language
- They need to understand how their behaviour can impact on patients and staff
- There need to be appropriate consequences clearly related to outcomes
- Management needs to be educated in consistently carrying out these steps so that staff make the right behavioural choices
- Management putting time, energy and resources into this

It is not only modern culture that has lessons to teach us. Sixty years ago, that great quality pioneer, William Edwards Deming was teaching the Japanese to become self sufficient by espousing his 14 principles. Principle number 8 still has a lot to teach us: DRIVE OUT FEAR

This has always been my favourite Deming principle. Organisations that successfully do this develop a culture where all staff contribute over and above the call of duty.

What are we fearful off?

- Retribution
- Not being listened to
- No action being taken
- Questioning the status quo

Driving out fear acknowledges that not everything relates to systems. People are an important part of the equation and they may make the wrong choices for many reasons so things go wrong:

- Accepting the status quo
- Not asking if they don’t know
- Trying to do it all themselves
- Impatience or lack of time
- Lacking competence

This is why we need not to talk about a blame free culture, but a culture of shared responsibility that involves staff and management:

- A culture of responsibility means that if people make the wrong choice and thus do the wrong thing, they know that there will be consequences
- A culture of responsibility means that leadership must establish consequences for behaviour and support staff to develop appropriate behaviours
- A culture of responsibility means that management must visibly lead the effort
- A culture of responsibility means that all staff should question and evaluate accepted norms

We need to accept that in health care as in life, there will always be consequences. Consequences must be appropriate to the actions taken and are not necessarily punitive, but may involve education, changes in procedure, and more resources for example. However if we change the terminology we are likely to develop enhanced risk management systems and engage staff more effectively.

This paper was supposed to be controversial and engender some discussion. I was approached by many people at the conference who had been thinking the same and congratulated me for speaking out. I am encouraged that they will return to their organisations and institute changes in what they are doing.

In promoting quality and safety we should always be thinking whether we are doing the right thing and then if we are doing it the right way. Once what we are doing and the way we are doing it becomes the only way, we have a major problem.

We need to stop simply doing and start serious reflection and evaluation in relation to our risk management experiences and procedures:

- Are we doing the right thing?
- Are we doing it in the right way?
- Are we continually thinking about the underlying principles?
- Are we continuing to enhance and apply our learning from the world around us?
- What outcomes do we still need to achieve?
- What progress have we really made towards a culture of shared responsibility?

THIS PAPER WAS PRESENTED TO THE AAQHC CONFERENCE IN AUGUST 2006
INTRODUCTION
To assist with the preparation for Australian Medical Council (AMC) college accreditation in 2008, prior AMC accreditation reports of other specialty colleges were reviewed to identify any common areas of concern.

The review covered the accreditation of the Colleges of General Practitioners, Physicians, Psychiatrists, Obstetricians and Gynaecologists, and Anaesthetists. These reviews were undertaken between 2002 and 2005. The first accreditation report related to the College of Anaesthetists, and no formal recommendations were made in the main body of the report. However, for each subsequent college review, there have been such recommendations, and the number of these for each college has varied from 34 to 72.

To the maximum extent possible, individual recommendations were assigned to the standard or standards to which they were most closely related. In some cases, this was not easy as some recommendations were only loosely linked to particular AMC standards.

In this context, the philosophy of the AMC accreditation would appear to be based strongly around an interactive process of broad review. For example, for each of the defined standards, there was not necessarily evidence that compliance against some defined objective standard had been rigorously or comprehensively evaluated. Rather, the standards appeared to define parameters outlining particular areas of interest in the review. They seem to define a curriculum for the assessment, rather than represent specific criteria for evaluation.

WHAT WERE THE RESULTS?
A total of just under 200 recommendations were reviewed, and these covered 22 of the 26 discrete areas in which AMC has defined standards. 90% of these recommendations relate to the training program. Of the last 10%, about half relate to continuing professional development and under-performing fellows, and the other half relate to the College ensuring there is appropriate liaison with relevant related agencies and the community in establishing the education goals for training.

A breakdown of the recommendations relating to the training program is set out in Table 1. Two of the three standards relating to training positions were far and away the most prominent area in which past recommendations have been made. Given this prominence, it will be important for the College to look closely at this aspect of its training programs in the preparation for accreditation.

Table 1: Recommendations Relating to Training

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Number of Recommendations</th>
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<tr>
<td>Training Position Accreditation</td>
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<tr>
<td>Supervision of Training</td>
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<tr>
<td>Assessment and Examination</td>
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<td>Curriculum</td>
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<tr>
<td>Trainee Selection</td>
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<tr>
<td>Overseas Trained Candidates</td>
<td>10</td>
</tr>
<tr>
<td>Measuring Training Outcomes</td>
<td>5</td>
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</tbody>
</table>
FURTHER ANALYSIS OF THE HOSPITAL/TRAINING POSITION RECOMMENDATIONS

There are three AMC standards for this area, and these are set out in table 2.

TABLE 2: ACCREDITATION OF HOSPITALS/TRAINING POSITIONS

- The training organisation specifies the clinical experience, infrastructure and educational support required of the accredited hospital and/or training position, and implements clear processes to determine whether these requirements are met.
- The training organisations accreditation requirements cover: clinical experience, structured educational programs, infrastructure supports such as library, journals and other learning facilities, continuing medical education sessions accessible to the trainee, dedicated to time for teaching and training and opportunities for informal teaching and training in the work environment.
- The accreditation standards of the training organisation are publicly available.

There were no recommendations regarding the public availability of training position accreditation, and there was considerable overlap with regard to the two other standards. In other words, many recommendations embraced aspects of both of these. On further review, it was possible to identify five main themes underlying the recommendations, and these are discussed below:

- The Nature of the Training Program. 13 recommendations concerned how the training program was constructed. The majority related to structural aspects of the particular training programs, and are probably not of great relevance in our context. There were two recommendations of possible interest. Consideration of encouraging more training posts in the private sector, and a suggestion that ongoing dialogue with health service providers in relation to workplace training may enable better understanding of workplace priorities, while still ensuring the educational needs of the college are appropriately met.
- Availability of Training Positions. A few recommendations appear to have arisen from concerns of trainees that they faced various barriers in terms of accessing training positions relevant for their needs. The workforce studies already undertaken in medical administration have considered various aspects of the supply and demand for training positions.
- Work issues. Nine recommendations concerned work issues, such as long hours of work, arduous on-call responsibilities, or geographical relocation. It was believed these issues interfered with study commitments, and created difficulties in terms of work and family balance, particularly for women. A recurrent theme was difficulties in accessing part-time training positions, or these not being available at all. It would be important for the College to understand whether our candidates believe there are significant concerns in this area.
- Training Requirements and the Standards and Assessment of Training. There were 18 recommendations related to this area, which is probably the most substantive area of concern. However, it is a complex issue as our accreditation of designated work experience is managed differently from other colleges, and at least some of the recommendations may not really be relevant. However, the college needs to be mindful of the high focus of past recommendations relating to this area in the lead up to accreditation, and for us to be quite articulate in specifying what our particular requirements for administrative training are, and how these are defined and assessed.
- Education Support. This was concerned with the availability and access to formal education support, such as library facilities and other educational resource material. Again, our context may well be different. However, some further review of whether there is sufficient educational resource material available to our candidates and whether these resources are universally accessible may well be worthwhile.
A BRIEF OVERVIEW OF ALL RECOMMENDATIONS

Table 3 outlines each of the broad areas covered by the AMC accreditation, with the total number of recommendations from the four survey reviews, and a brief commentary on each area, except for training position accreditation, which has already been discussed in more depth.

**TABLE 3: SYNOPSIS OF ALL AMC RECOMMENDATIONS**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Number of Recommendations</th>
<th>Brief Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standards Relating to College Overall</td>
<td>12</td>
<td>There is a significant expectation that Colleges will consult widely with all relevant stakeholders, including other service providers and the community at large, in terms of setting and defining goals and objectives of their education programs.</td>
</tr>
<tr>
<td>Content of Education &amp; Training</td>
<td>22</td>
<td>The recommendations seek more formality and rigour in defining both the curriculum, and ensuring it is consistent with goals and objectives of training.</td>
</tr>
<tr>
<td>Assessment &amp; Examination</td>
<td>37</td>
<td>There are a large number of recommendations regarding assessment, embracing the accuracy and competency of assessment, providing feedback to trainees in regard to assessment outcomes, and working towards better understanding issues contributing to difficulties faced by trainees.</td>
</tr>
<tr>
<td>Hospital/Training Position Accreditation</td>
<td>74</td>
<td>These recommendations are discussed in the section above.</td>
</tr>
<tr>
<td>Supervisors, Assessors, Trainers &amp; Mentors</td>
<td>40</td>
<td>Recommendations embrace a strong push for more formal training and evaluation of supervisors and others responsible for training, with clear cut and effective two-way feedback on performance.</td>
</tr>
<tr>
<td>Trainee Selection and Recognition of Overseas Trained Specialists</td>
<td>25</td>
<td>There are recommendations in these areas for all four Colleges.</td>
</tr>
<tr>
<td>Outputs &amp; Outcomes of Training</td>
<td>10</td>
<td>There are few recommendations in this area, and these recommendations do not appear particularly onerous.</td>
</tr>
<tr>
<td>Continuing Professional Development</td>
<td>13</td>
<td>There is nothing unexpected or surprising in any of these recommendations, which emphasise continuing development of these programs towards universal involvement, and greater monitoring to ensure activities actually meet relevant needs.</td>
</tr>
</tbody>
</table>

For RACMA there is nothing overwhelming or daunting in any of the recommendations. Most appear to have arisen from concerns, or comments, expressed by members of the relevant college community during the accreditation visits, and they generally encourage the college to continue with its endeavours into this particular area. The greatest focus appears to have been on various aspects of the training positions. While many of the concerns that were raised may not actually be of particular relevance to our training program, the RACMA is encouraged to give this area some priority in the lead up to accreditation.

**Dr Bill Appleton**

*Accreditation Co-ordinator*
THE THEORY OF CONSTRAINTS

GET MORE LOAVES AND SLICE BREAD FASTER,
Sick of access block and waiting lists? Read on…..

DR MIRIAM MARTIN
MBChB, DCH, DipObst, DipCEM, TOC Practitioner
miriam@ausstat.com.au

Miriam is a long term locum and now works in recruitment and has an interest in systems and processes.

“The more complicated the problem, the simpler the solution must be”

Dr Eli Goldratt

The Theory of Constraints (TOC) is a management tool devised in the 1980s. Eli Goldratt, a physicist by trade, got involved somewhere, somehow, in production and management. The TOC approach is a management approach to identify the rate limiting step. Solving the issues around the rate limiting step is the key to improving the overall system. The great thing about this approach has been good buy in from staff, quick implementation of good changes and a consultative approach that achieves more results than screens of paper.

Current thinking is that to improve an overall system all you need to do is make local efficiency gains. However, this does not deal with issues of “links within the chain”. A huge effort could be made over the whole system but only a resultant small overall improvement. This is because the rate limiting step only has small modifications and improvements.

Manufacturing and business systems that have applied the Goldratt TOC approach have experienced 10-20% improvements in overall throughput and productivity. This has resulted in massive improvements in profit and customer satisfaction.

The TOC approach penetrated the Health Sector in the NHS in the late 1990s. You can read about what happened to Oxford-Radcliffe Hospital on http://www.goldratt.co.uk/succ/oxfordstory.pdf . This was a typical small NHS hospital with typical issues around access block and trolley waits in the Emergency Department. The hospital has approximately 30,000 patients per year through the Emergency Department and trolley waits exceeding 12 hours on a regular basis (does this sound familiar?). The problems experienced were related to delays in moving patients from one kind of care to the next. As the Emergency Department is the only area in the hospital with “spare capacity” the patients end up there blocking the system even if the block actually relates to discharging patients out into the community.

The TOC approach at the Oxford-Radcliffe Hospital was to identify the main cause of access block in the Emergency Department and then work on those constraints one at a time. The resultant improvement in throughput was a startling 30-50% and the results were sustainable over a long period. They then went on and worked on constraints right through the hospital to the discharge process and into the community. One hospital even eliminated its two year neurosurgery waiting list in 12 months using TOC. This approach has been repeated in many hospitals in the NHS with equivalent or even better results.

The TOC Approach:
1. IDENTIFY the system constraint
2. EXPLOIT (maximise the use of) the constraint
3. SUBORDINATE everything to the constraint
4. ELEVATE (remove load from the constraint)
5. GO BACK (don’t let inertia become the system’s constraint)

The TOC approach is not just about improving throughput. It is also a management tool that helps
you to identify all the problems within a system, develop a really good picture around the current reality and devise a solution that is robust and sustainable. Identifying the “core conflict” within a system is extremely important. Believe it or not, usually there are a whole lot of symptoms within a system resulting from the core conflict. As doctors we all know this intuitively, remember they always told you that for any set of symptoms there is usually only one pathology? Just think about thyroid disease—a raft of symptoms that appear totally unrelated but with one core problem (figure 1). A hospital may have a core conflict around treating acute patients versus chronic patients. (figure 2). In my discussions with many medical managers in Australia it is becoming apparent that core conflicts can include things like “Political interference”, “under-funding” or “poor leadership”.

To verbalise this conflict you say: In order to “have an effective hospital” we must “run a good health service in the short term” and in order to “run a good health service in the short term” we must “spend resources on short term solutions”. Then for the other side of the conflict: In order to “have an effective hospital” we must “run a sustainable service in the long term” and in order to “run a sustainable service in the long term” we must “spend money and resources on long term solutions”. As a result “spend resources on short term solutions” and “spend money and resources on long term solutions” are in conflict.

To develop a meaningful and sustainable solution you must break the core conflict. As part of the process you investigate any negative effects that you might have and then devise a strategic plan for implementing the solutions. So the age old problem of: “what to change”, “what to change to”, and “how to change” are addressed with this approach.

As managers, we are involved in selling ideas to our staff, clients and boards all the time. The TOC approach is excellent at developing an “unrefusuable offer”. The unrefusuable offer is a sales proposition that is so good that the buyer cannot refuse. This is because you have listened well and devised a solution that fits exactly what they are wantign.

We all have people coming to us with “half baked ideas”. This is the enthusiastic person who is convinced that their solution will solve all the hospitals problems (if only…). The TOC thinking processes tools are useful in being able to quickly evaluate these kinds of ideas in a non-confrontational way that communicates to the person that you have been listening.

Communication of change is also very important. The TOC approach has a large emphasis on the presentation of improvements within the system; this vastly improves buy-in and thus the success of the project.
To learn about TOC you can read any of Eli Goldratt’s books. These are very readable and written like novels in a narrative style. Purchase these via www.amazon.com as they are not readily available in Australia or New Zealand. Start with “The Goal” and then go on to “Its Not Luck” or “Critical Chain”. In 2006 a book was published specifically about Healthcare and TOC called “We All Fall Down”. You can also now do a Masters in Health Care Management at the University of Nottingham (UK) in TOC. Alternatively you can attend an introduction or course on TOC by contacting me on miriam@ausstat.com.au. For more information just drop me a line.

Dr Miriam Martin
TOC Practitioner

References and more reading:

Oxford-Radcliffe Story
http://www.goldratt.co.uk/succ/oxfordstory.pdf


MSc –Theory of Constraints (Health Care Management)

Wright, J, King, R; 2006. We All Fall Down, Goldratt’s Theory of Constraints for Healthcare Systems. 2006. www.amazon.com

A guide to implementing the Theory of Constraints (TOC). Kelvyn Youngman, http://www.dbmfg.co.nz/ This website has a large section on Healthcare and TOC.

http://www.goldratt.com/for-cause/applyingtocinhcpt1fco.htm AGI Goldratt Institute Website, but previously published in Spring 2002 (Volume 10, Number 3) of Quality Management in Health Care, Aspen Publishers, Inc. This includes links to other good TOC Healthcare information.

THE QUARTERLY IS GOING ELECTRONIC

The Quarterly is now available in an electronic form that enables you to just select those articles that interest you most. Follow the link under Member Services on the RACMA website at www.racma.edu.au

In the future as we move to a data base web site you will be able to complete searches for articles on topics of interest.
Superb, amazing, absolutely spectacular. My expedition to St Petersburg was a great success and I would recommend the destination to any of you who enjoy the arts. Since I was a teenager I had wanted to visit the city and a “Medico legal conference” finally gave me the opportunity.

Three hundred years ago Peter the Great decided to build a European styled city named after St Peter. It was Catherine the Great who brought Russia to the world stage of art and created the Hermitage which houses one of the world’s largest art collections. I counted 14 Gauguin’s including the first he painted in Tahiti. There were over 5 rooms of Picassos and the list goes on and on. The Winter Palace, Catherine’s residence is next to the Hermitage. We also visited the Summer Palace outside the city.

More sobering is the recent history of this great city. Only 60 years ago during WWII the Nazis lay siege to Leningrad for 900 days. They never entered the city but a third of the 3 million inhabitants died. Stalin was not kind to those who remained. Many of the palaces and buildings have been restored to their former glory. The stunning Amber room at the Summer Palace is an example of this. The magnificence of the city and the desperation of the recent past create the mystery that is the Russian people.

A highlight for me was attending the Mariinskiy Theatre (can we put in IMG290 photo here somehow) built in 1860 to see the Kirov ballet. Both Pavlova and Nureyev began their careers in this theatre. (Did you know Pavlova died when she developed pneumonia while touring in Australia?) I also attended the opera Eugene Onegin based on a novel by Pushkin. A performance of Shostakovich symphony 8 and 12 completed my cultural feast. He wrote the 7th Symphony during the 900 day siege and the 8th soon after. These performances were held during the White Nights Festival of the northern summer.

Finally, I attended a performance of Giselle in the Hermitage theatre. This was Catherine’s private theatre and it is quite understated and beautiful. I could just imagine Catherine sitting in her throne in the centre of the theatre enjoying performances of the artists she had brought from across Europe.

My suitcase was lost for 3 days, so I learnt the true value of a clean pair of socks. I stayed in a great hotel and ate at wonderful restaurants. Nothing was going to stop me from enjoying this amazing city. I recommend it to you all.

The cultural life in Alice Springs continued while I was away. I missed the beanie festival and camel cup! Next weekend is the famous Henley on Todd regatta during the Desert Festival. Of course I will be marching in the Town Band in the parade. A highlight of the Festival is the Desert Mob Exhibition were recent works from Aboriginal art centres in Central Australia which are shown at the Araluen Gallery.

In my first “Candidates Corner” I stated that a month was a long time in medical administration.
Well, it’s happened again and I am now the Director of Medical and Clinical Services at Alice Springs Hospital. The Northern Territory is land of opportunity and challenges!

Another rare species in the NT are Preceptors for RACMA candidates. When I was involved in GP politics the rural GPs would constantly say that the training was city based and irrelevant to them. In the centre of Australia I am developing a better understanding of their concerns. We need “Medical Administrators without borders”! I am sure a preceptor will appear in the desert. I am off to a patient flow workshop in Melbourne today. See you next edition and take self care.

Dr Meredith Arcus
Snr District Medical Officer
Central Australia Remote Health
meredith.arcus@nt.gov.au

**BOOK REVIEW:**
**DISPUTES AND DILEMMAS IN HEALTH LAW**

By: Dr Mukti Biyani,
Medical Administration
Registrar, DOH, W.A.


Hot on the heels of its predecessor “Controversies in Health Law”, “Disputes and Dilemmas in Health Law” (by the same editors) delves much deeper into the ever changing landscape of Health Law and draws upon the opinions and expert knowledge of more than 36 well known and dedicated lawyers, health professionals and policy makers. Undeniably designed to be more of a comprehensive guide than a pocket sized reference, Freckelton and Peterson have done a remarkable job in beefing up the current edition with over 30 stimulating chapters compared to just 18 chapters for its predecessor.

With Health Law gaining more prominence than ever before in health care delivery as a result of advancement in technology, scientific knowledge base, increase in community expectations, changing legislations and human rights, this well-referenced book does well by providing well-supported and logical discussions on the matter. Although eminently readable, the target audience remains people experienced in Health Law. Therefore, it is hardly surprising that with my limited exposure to Health Law in medical school and early years of residency (not uncommon for most medical students), the material was a bit inundating. However, it has served to be a useful resource and provided a good overview of different kinds of controversial and challenging issues that health professions are likely to face during their working life today and into the future.

The Chapters are broken up into parts covering Litigation and Liability; Reproductive Technologies; The Sequelae of the End of Life; Public Health; Ethical Frameworks and Dilemmas; Regulations; Human Rights and Therapeutic Jurisprudence; Research and Vulnerability and Information; Privacy and Confidentiality. While the book primarily deals with dilemmas and disputes in Health Law in the Australian context, it also has enough common law material from international jurisdictions to keep non-Australian readers interested.

Over all, this book is a handy reference for Health professionals, lawyers and policy makers keen on gaining an understanding of the core controversial concepts in Health Law. Given that generally every chapter can be read in isolation, it gives the reader the flexibility to focus on his / her interests without needing to read the whole book.
CHANGES IN THE NATIONAL SECRETARIAT

2006 has seen big changes in the profile of staff in the National Secretariat. I would like to introduce two new members of staff to you.

NEW ASSISTANT DIRECTOR – CURRICULUM AND MARKETING

Colin Dunn has recently been appointed to this new position in the College. He came to RACMA from RMIT University in Melbourne where he was Senior Lecturer in Small Business and Entrepreneurship and Program Coordinator of the University’s Bachelor of Business (Entrepreneurship) program. He co-wrote the curriculum for this innovative undergraduate degree program, the first in the world to have a focus on building a business whilst studying business at the University level.

Colin has over 30 years experience in curriculum development and teaching and in managing national and international projects mainly focusing on innovation, entrepreneurship and enterprise. From 2005 to June 2006, Colin was President of the International Council for Small Business (ICSB). This international academic organization has over 2200 members and in June this year celebrated it’s 51st anniversary in Melbourne at the annual ICSB conference. Colin convened and managed the conference which had over 450 attendees most of whom submitted academic papers through a peer review process.

Prior to becoming President of the ICSB, as ICSB President Elect, he led the team that built the new Council website. Colin was president of the Australasian affiliate of the ICSB, the Small Enterprise of Australia and New Zealand (SEAANZ), from 2002 to 2005 and co- managed the SEAANZ Secretariat from 1998 to 2006 largely being responsible for its financial affairs. SEAANZ has over 300 members in Australia and New Zealand.

Colin’s focus will be to support the CEP program and the development of new training activities, including:

- more opportunities for relevant and innovative professional development;
- an improved website; and
- greater level of support for it’s annual conference,

Colin’s appointment is welcome. Colin can be contacted at the National Secretariat at any time.

NEW BUSINESS SUPPORT OFFICER

Ms Kathy Griffiths has recently been appointed to the College in this role.

The role is to take daily responsibility to liaise with candidates, fellows and members, organize workshops, meetings and respond to the numerous enquiries that come to the Secretariat on a daily basis.

Kathy will be the first person to answer the telephone when you ring the National Secretariat. She has taken over from Ben Trewarn in this. She has already begun to organize the office and establish connections and new administrative systems. Please contact Kathy as a starting point if there is anything you need.

Kathy received an introduction to RACMA when she attended to help with the Hobart examinations earlier this year. Candidates may recall her being there and helping the new Chief Executive with the organization and co-ordination of arrangements for examinations, Council meetings and the Langford Oration.

Kathy comes to RACMA with considerable experience as an administrative officer in the tertiary education sector. She has also been involved with the International Council for Small Business where she helped to organize the 2006 World Conference. This included organizing the design and publication of posters, brochures and other promotional materials, networking with management staff at the conference and establishing a data base of more than 500 interested people and organizations across the world. This experience and other responsibilities with the Small Enterprise Association of Australia and New Zealand, make her an ideal appointment to support RACMA activities.

We welcome Kathy to The Royal Australasian College of Medical Administrators.
BEN TREWARN

Ben Trewarn has been with this College for nearly eighteen months in a number of administrative support roles. Ben has a strong interest in matters IT and has been studying a business course through a Melbourne TAFE program with a view to moving into an information technology/web development role.

Ben’s role has returned to part-time work and is currently updating the files for the web site and assisting the College’s web developer to convert the web site to a content management system back end.

The new Secretariat team has had much to learn and your forbearance is appreciated. The transition has been challenging in the absence of ‘old hands’ in the office and I can assure you all that we are continuing every effort to meet each person’s needs.

Dr Karen Owen  
Chief Executive

Do you have something to say?

Contributions, letters and articles for The Quarterly are welcomed and should be addressed to:

The Editor, C/- National Secretariat  
35 Drummond Street, Carlton, Victoria 3053.

CONFERENCES 2007

6 – 9 February  
“Medicine meets Virtual Reality 15”  
The Hyatt Regency Long Beach Hotel, Long Beach, California, USA,  
www.inderscience.com/mapper.php?id=17

22 -23 March  
Clinical Decisions, Ethical Challenges,  
Cairns, Queensland,  
www.changechampions.com.au

17 – 18 August  
The Eighth International Mental Health Conference Mental Health Prevention – From Policy into Practice, Holiday Inn Gold Coast,  
www.qcimh.com.au

28 – 30 August  
Third International Conference on Information Technology in Health Care: Socio-technical Approaches,  
www.hic.org.au

29 – 31 August  
Annual conference of The Royal Australasian College of Medical Administrators, Holiday Inn Surfers Paradise, Queensland  
Telephone: 07 3858 5500;  
Email: racma07@eventplanners.com.au;  
www.racma.org.au

AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES 2007  
50TH Annual Congress on Healthcare Leadership – “Innovation”, March 19 -22, 2007, New Orleans, Louisiana, USA. Go to the Congress area of  
www.ache.org

The American College of Healthcare Executives is an international professional society of healthcare executives who lead hospitals, healthcare systems and other healthcare organizations. This conference may have interest for some.

BAMM SUMMER SCHOOL AND AGM 2007  
June 27th - 29th 2007  
“Beyond the Box” - Creativity and Innovation in Delivering Healthcare,  
The BAMM Summer School is being planned and may be have interest.
EXECUTIVE OF COUNCIL

The Executive of Council consists of 7 Fellows of the College. They are - the President, Vice-President, Honorary Secretary, Honorary Treasurer, National Director of Continuing Education/Recertification, Censor-in-Chief and the Immediate Past-President. Current Executive Members are:

A/Prof G. W. Frost - President
MB BS, MPH (Syd) FRACMA, FAPPHM FHKCCM (Hon)
Dr Gavin Frost has recently been appointed as Domain Head Population and Public Health at the Sydney School of Medicine Notre Dame University. A Censor of the College, Dr Frost was appointed to the position of Censor-in-Chief of RACMA in 1999 and was reappointed to this position for a further three year term in August, 2002. Dr Frost became Vice President in 2004. Dr Frost has an active interest in health care systems, their measurement and improvement.

Dr D. Rankin - Vice President
MBCHB MPH MHA DO FRACMA
Dr David Rankin is the Senior Advisor on health issues to the New Zealand Ministry of Social Development. Prior to this appointment he was General Manager at the Accident Compensation Corporation, with oversight for the health services portfolio. David has served for eight years as a censor for the college and has championed the establishment of the New Zealand branch of RACMA. He is Chairperson of the New Zealand Health Information Standards Organisation and has a special interest in provider behaviour change.

Dr R. Boyd - Honorary Secretary
MB BS (Syd), MBA (Geneva),MHP (NSW), FRACMA, AFCHSE
Dr Roger Boyd joined the Council in 2001 and was appointed Honorary Secretary in 2002. Dr Boyd is the principal of Boyd Health Management, providing consulting services in health management, policy and planning. He is currently Chair of the National Prescribing Service and is the immediate past Chairman of the New South Wales State Committee.

Dr P. Bradford - Honorary Treasurer
MB BS (NSW), MPH (NSW), FCHSE, FRACMA
Dr Peter Bradford joined the Council in 1996 and was appointed Honorary Treasurer in 2001. Dr Bradford is a member of the Victorian State Committee. He is Executive Director Medical Services at Peninsula Health.

Dr K. N. Hill - National Director Continuing Education/Recertification
MB BS (Syd), MHP (NSW), FRACMA
D. Kim Hill joined the Council in 1991 and was Honorary Secretary from 1994 to 2002. In 2002 Dr Hill was appointed National Director Continuing Education/Recertification. Dr Hill is Director of Clinical Governance at the Hunter New England Area Health Service NSW.

Dr L. Gruner - Censor-in-Chief
MB BS, B Sc, BHA, MBA, FRACMA, GAICD
Dr Lee Gruner is the Director of Quality Directions Australia Pty Ltd. Dr Gruner joined Council in 2003. In 2005 she was appointed as Censor in Chief.

Dr P. Montgomery - Immediate Past President
MB BS, FRACMA
Dr Philip Montgomery joined the Council in 1996. In 1997 he was appointed National Director Continuing Education/Recertification and carried out this role until his appointment in 2002 as Vice President. Dr Montgomery was President between 2004 - 2006. Dr Montgomery has served as Honorary Treasurer of the Western Australian State Committee and as CEP Coordinator and continues to serve as a member of the Western Australian State Committee. Dr Montgomery is the Executive Director of Royal Perth Hospital.

OTHER COUNCIL MEMBERS

The Council Members comprises Fellows of the College who are elected on a bi-annual basis. Current Council Members are detailed below.

Dr R. Ashby
MB BS (Qld), BHA (NSW), FRACGP, FRACMA, FACEM, FIFEM
Dr Ashby was appointed to Council in 2005, having been a Fellow since 1986. He is currently the Executive Director of Medical Services at the Princess Alexandra Hospital in Brisbane and is a member of the Qld State Committee.
Dr J. W. Menzies
MB BS (Hons), MHP, FRACMA, AFCHSE, CHA
Dr John Menzies is the senior consultant medical adviser in JTA International Health Consulting. Dr Menzies was appointed to Council as one of the Queensland State representatives in 1999 and was Honorary Treasurer in 2000/01. He is the Chair of the Queensland State Committee.

Dr H. M. J. McArdle
B Med Sci, MB BS, MPH, FAFOM, FRACMA
Dr Helen McArdle is the Director of Medical Services and Occupational Physician at the Royal Hobart Hospital.

Dr B. Kotze
MB BS FRANZCP, FRACMA
Dr Beth Kotze is the Area Director of Mental Health Services for the South Eastern Sydney and Illawarra Area Health Service in NSW. She is the recipient of the Bernard Nicholson Prize in 2000 and the New Fellows Achievement Award in 2005. She is a Censor of the College. She is currently Chair of the NSW State Committee RACMA. Beth was first appointed to Council in 2006.

Dr R. Lawrence
MB BS, FRACMA
Dr Robyn Lawrence was appointed to Council in 2006. Dr Lawrence is also a Censor of the College and a member of the WA State Committee as the CEP Coordinator. Dr Lawrence is currently the A/Executive Director of the Child and Adolescent Health Service.

Dr A. Nel
MB BCh, MBA, FRACMA
Dr Andre Nel is Chief Medical Officer of Nelson-Marlborough District Health Board. Dr Nel was appointed to Council in 2004 as one of the New Zealand representatives.

Dr M. S. Platell
MB BS, FRACMA, FAFPHM
Dr Mark Platell is the Acting Area Chief Executive North Metropolitan Health Service, Perth, Western Australia, including Sir Charles Gardiner Hospital. Dr Platell is a Censor of the College and since 1998 has also served as the Censor for Case Studies. Dr Platell joined Council 1999.

Associate Professor W. P. Ramsey AM CSC
MB BS, BMed Sc, MHA, FRACMA
Dr Wayne Ramsey became the ACT representative on Council in 2002. Dr Ramsey is currently Chair of the ACT committee.

Dr V. Sathianathan
MB BS, FRACMA
Dr Vino Sathianathan is the Deputy Medical Superintendent at Royal Darwin Hospital and became the Northern Territory representative on Council in 2002. Dr Sathianathan also serves as Chair of the Northern Territory Committee and is the CEP Coordinator.

Dr B. Street
MB BS, DGM, FRACMA
Dr Bernie Street is Clinical Director of Geriatric Medicine at the Bendigo Health Care Group. He is currently Honorary Secretary of the Victorian State Committee. Dr Street joined Council in 2004.

Dr S. Svilans
PhD, MB BS(FUSA), MHA(UNSW), AFACHSE, FRACMA, CHE, ASIM
Dr Svilans is A/Medical Director, Central Northern Adelaide Health Services, Royal Adelaide Hospital. She is Chair of the Board of Studies, for the South Australian Committee and joined the Council first in 2005.

Dr B. Swanson
MB BS, BSc (Maths), BSc (Hons), MHA, FRACMA
Dr Bruce Swanson is Medical Adviser, Research Policy and Ethics in the South Australian Department of Human Services. He is also a member of the South Australian State Committee and is the local CEP co-ordinator and joined Council in 2002.

CANDIDATE REPRESENTATIVE

Dr H. Lander
Bachelor of Medicine (Newcastle)
Dr Lander is currently a Director of Medical Services with Eastern Health in Melbourne. He was appointed as the inaugural Candidate representative on Council in 2006. He is also an active member of the Victorian State Committee.
LIST OF FELLOWS – 2006

AUSTRALIAN CAPITAL TERRITORY
Austin (AM), Tony K
Baker, Jennifer L
Cheah, David F
De Souza (AM), David
Donovan (ED), John W
Dumbrell, David M
Elvin, Norman A
Evans (OBE), Cyril P
Hallett, Philip
Lambert, Rodney P
Langsford (OBE), William A
Mason, E Robyn
O’Leary, Elizabeth M
Orchard, Barbara W
Proudfoot, Alexander
Ramsey (AM, CSC), Wayne P
Refshauge (AC), Sir William D
Wilkins (MBE), Peter S

NEW SOUTH WALES
Alexander, Jennifer A
Appleton, Joanne
Baker, Andrew
Bashir (AC), Marie
Baker, Andrew
Appleton, Joanne
Alexander, Jennifer A
NEW SOUTH WALES
Wilkins (MBE), Peter S

QUEENSLAND
Alcock, Annabelle
Ashby, Richard H
Baker, Christine A
Bell, Brian L
Brennan, Colin K
Blenner, Stephen A
Brown, Sarah A
Campbell (AM), Bryan C
Cattell, Robert K
P earce, Richard V
Payne, Andrew L
Powell, Owen W
Reilly, Robert Q
Russell, Douglas A
Scanlan, Brian J
Shapiro, Ralph A
Shaw, Alexis E
Shearer, Alexander B
Sparrow, John L
Stable, Robert L
Stuart, Duncan J
Taylor, James R
Thomas, David A
Ulrich, Peter E
Wallar (RFD, AM), John P
Waters, Mark F
Weinstein, Stephen R
Wilkinson, David P
Wuth, Gregory K
Young, Jeannette R

SOUTH AUSTRALIA
Allan, Barbara M
Barrington, Dianne L
Barron, Vincent J
Beal, Robert W
Butfield, Ian H
Cockington, Richard A
Czechowicz, Andrew S
Dowie, Donald A
Farmer, Christopher J
Frewin (AO), Derek B
Fuller, Clarence O
Gerrard, Peter S
Hackett, Earle W
Hart, Gavin
Hoff (RFD), Lothar C
Jelly (RFD), Michael T
Kearney (AM), Brendon J
Lan-Lloyd, Nes B
McCoy, William T
Mylius, Raymond E
Reynolds, David J
Rozembils, Elizabeth S
Scrapp (OBE), Roy F
Svilas, Susan E
Swanson, Bruce A
Van Deth, John M
Wagner, Christopher A
Webb, Richardia M

TASMANIA
Ayre, Stephen J
MacCarrick, Geraldine R
McArdle, Helen M
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Sparrow (AM), John M
VICTORIA
Ahern, Susannah F
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Barker, Coralee A
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Batten, Tracey L
Bearham, George P (Snr)
Bennett, Noel Mck
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Brook, Christopher W
Campbell, David H
Carnie, John A
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Champness Leonard T
Christie, John C
Cole, Brian E
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Fearon (AM), David N
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Gray (AO), Nigel J
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Hamley, Lee
Hanning, Brian W
Hillis, David J
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Jones, Michael R
Krupinski, Jerzy
Leslie, Peter L
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Major, Jennifer W
Malon, Robert G
McCleave, Peter J
McCloskey, Bertram P
McNab, Kirsty
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Morris (AO), Jack P
Naidoo, Humsha K
Oliver, Brian H
Osborne, Clifford B
O’Rourke, Francis J
Perrignon, Andrew C
Peyton, Thomas M
Pisasale, Nella M
Power, John M
Race, David
Ratnayeke, Valentine J
Sachdev, Simrat P
Sandford, Alan S
Schofield (OBE), Graeme C
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Shepherd (AM) Stuart J
Stoezwind, Johannes U
Stoller, Alan
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Sumithran, Lakshmi
Summers, Robert O
Sunderland, Ian S
Trevaks (AM), Gad
Trye, Peter J
Turner, Mary J
Wake, Arlene H
Walsh, Laurence N
Warburton, David J
Warton, Robert B
Watson, Andrew L
Watson, Sara E
Wellington, Clive V
Wellington, Heather L
Wooldridge, Michael
Yeatman, John S

WESTERN AUSTRALIA
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Beresford, William
Curruthers, Kenneth J
Coid, Donald R
De Campo, John F
Dunjoy, Malcolm V
Dunkin, Helen C
Ellis, Archie S
Flett, Penelope R
Frogione, Salvatore N
Fry, David F
Gill, Jaijeet S
Kelly, Shane P
King (AM), Alan J
Lawrence, Robyn A
Lee, (Norman) Kwang B
Lipton, George L
Loh, PK
Masters, Geoffrey H
Mahmood, Farhat
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McNulty, James C
Montgomery, Philip D
Mulligan, Jonathan B
Murphy, Kevin J
Nickel, Norma R
Oldham, David R
Plattel, Mark S
Quadros, Caetano F
Roberts, William D
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Russell-Weisz, David J
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Smith, Darcy P
Stewart, Lindsay A

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Allen, Patricia I
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Bolevich, Zoran
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Gollop, Bruce R
Gootjes, Peter R
Holmes, John D
Hood, Dell A
Hope Virginia T
Kelly, Francesca
Levy, Lester
Leung, Ting-hung
Morris, Kevin A
Nel, Andre
Patel, Arvind C
Pike, Pieter W
Rankin, David B
Richards, Ruth
Robinson, Peter H
White, Janis M
Young, Wilson W

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Cheng, Beatrice – Hong Kong
Cheng, Man-Yung – Hong Kong
Choi, Teresa Man-Yan – Hong Kong
Chow, York Yat-ngok – Hong Kong
Chiu, Lily – Hong Kong
Choy, Khai Meng – Hong Kong
Christie, John C – Papua New Guinea
Davidson, Lindsay A – United Kingdom
Duncan, David R – Saudi Arabia
Fong, Ben Y – Hong Kong
Fung, Hong – Hong Kong
Hedley, Anthony J – Hong Kong
Ho, William S – Hong Kong
Jacobalis, Samsi – Indonesia
Jones, Fredrick G – United States of America
Kukreja, Anil K – Malaysia
Lai, King-kwong – Hong Kong
Lai, Lawrence Fook-ming – Hong Kong
Lam, David – Hong Kong
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Lee, Shiu H – Hong Kong
Leung, Pak-yin – Hong Kong
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Ma, Hok Cheung – Hong Kong
Mak, Sin-ping – Hong Kong
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Rajput Abdul M – Pakistan
Rees, Neville C – United Arab Emirates
Sannasey, Gummad- i – Malaysia
Sathiaasan, Nagamoney K – Malaysia
Shaw, Rosalie J – Singapore
Sills, Thomas D – United States of America
Singh, Kartar – Malaysia
Smart, Timothy F – Fiji
So, Kathleen – Hong Kong
Spence, Derek W – England
Stoke, Philip – Indonesia
Tinsley, Helen – Hong Kong
Tung, Sau Ying – Hong Kong
Yeoh, EK – Hong Kong
Wong, Vivian Chi-woon – Hong Kong
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Alcorn, David
Atkinson, Kathleen
QUEENSLAND
Arcus, Meredith

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