THE QUARTERLY

THE ROYAL AUSTRALASIAN COLLEGE OF MEDICAL ADMINISTRATORS

VOLUME 38 NUMBER 4 DECEMBER 2005

***The Quarterly* is the Journal of The Royal Australasian College of Medical Administrators**

It is published quarterly and distributed throughout Australia and New Zealand to approximately 900 College Fellows, Members and Candidates.

Publisher

The Royal Australasian College of Medical Administrators
A.C.N. 004 688 215
35 Drummond Street, Carlton, Victoria 3053
Telephone: (03) 9663 5347
Facsimile: (03) 9663 4117
Email: info@racma.edu.au

Honorary Editor

Dr Andrew Robertson
C/- The Royal Australasian College of Medical Administrators

Honorary Deputy Editor:

Dr Wayne McDonald
C/- The Royal Australasian College of Medical Administrators

Reader Classification: Fellows, Members and Candidates of The Royal Australasian College of Medical Administrators. These include medically qualified senior executives of health care organisations.

Please contact the publisher for advertising bookings and deadlines.

The Quarterly is prepared by staff of the RACMA Secretariat.

Design and Production:

Art Throb / Thinking Printing
169 Mt. Dandenong Road, Croydon Vic 3136
Telephone: (03) 9723 7755
Email: malcoe@bigpond.net.au

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, 1988 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.

2005/2006 Office Bearers

President, Dr Philip Montgomery
Vice President, Dr Gavin Frost
Immediate Past President, Dr Sherene Devanesen
Honorary Secretary, Dr Roger Boyd
Honorary Treasurer, Dr Peter Bradford
Censor-in-Chief, Dr. Lee Gruner
National Director, Continuing Education/Recertification,
Dr Kim Hill
Registrar, Mr. Bob Bishop

ISSN 1325-7579

ROYM 13986

Website: http://www.racma.edu.au

Email: info@racma.edu.au

CONTENTS

ACHSE

Australian College of Health Service Executives
and The Royal Australasian College of Medical Administrators

2006 Joint National Congress 2-4 August
The Hotel Grand Chancellor – Hobart, Tasmania

For more information please check our website www.achse.org.au

Inquiries, Sponsorship and Exhibition Opportunities contact:

Australian College of Health Service Executives

Telephone **61 2 9878 5088** Facsimile **61 2 9878 2272** **www.achse.org.au** email **achse@achse.org.au**

EDITORIAL

It is difficult to believe that summer is now officially with us and 2005 seems to have largely evaporated as a year. I write at the end of Exercise Eleusis, an avian influenza exercise, which has challenged Agriculture and Health Departments around the country. Generally, the exercise was handled well but the usual difficulties arose with coordination and communication, particularly between advisory committees. The continued clarification of roles and streamlining of processes will assist in future responses.

One of the major issues for many jurisdictions over the last three months has been the preparation for a pandemic influenza outbreak. This has been exacerbated by continuing media concern about the H5N1 avian influenza outbreaks in Asia and has been taken up at the highest level by Health Ministers, with over an hour devoted to it at the last Australian Health Ministers Conference. This has been a useful exercise for all, for, although many suspect that the current avian influenza outbreak will not lead to the pandemic, an influenza pandemic is a tangible risk over the next few years. Whether this equates to the 1918 'Spanish Influenza' pandemic or the milder pandemics of 1957 and 1968 remains to be seen. While many State and Territory programs are progressing well, preparations at a hospital level are probably less well developed and need continued input and focus.

In a recent article by Dr Eric Toner in the Clinical Biosecurity Network Bulletin (01 December 2005), Dr Toner notes the release of a new version of CDC's FluSurge program, which projects the impact of a flu epidemic on hospitals. The FluSurge program calculates the impact on hospital capacity over the course of an epidemic, including the number of hospital beds, ICU beds and ventilators, and now can be used to model a severe pandemic.

When the program was used to look at a 1918 type epidemic, 7 times the numbers of ventilators available in the US were required, which is obviously not going to happen. Dr Toner argues that, rather than spending resources on critical care surge capacity, more effort should be spent on 'how to provide hydration, antibiotics, oxygen, analgesia and other supportive care on a very large scale'. This is a challenging concept but does pick up the tenet of 'doing as much as we can for the majority of the patients'. It also highlights a need to considered tiered levels of response, depending on the severity of the epidemic and our capacity to deal with the more severe cases. As we continue our preparations in hospitals and health units, some of our current preconceptions may need to be reviewed.

We have another excellent issue of *The Quarterly*, with many interesting articles. I am grateful for the wide range of excellent articles coming in and encourage Fellows, Members and trainees to continue to submit. Finally, before passing over to Wayne, I wish all Fellows, Members and trainees a Happy and Safe Christmas and 2006.

Dr Andy Robertson
Editor

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.

Of the total number of medical practitioners working in rural NSW in 1994, 33.3% were specialists and 9.2% were specialists in training. This compares with 23.6% of the population of NSW which is rural. (K McEwin)

In 1996 there were 65-66 vacant specialist "establishment" positions in the Rural Health Services and based on recommended specialist population ratios rural NSW is seriously undersupplied with specialists.

Kirsty McEwin collated the survey result in March 1997. The results of the 336 specialists who returned survey questionnaires, 35.5% of the respondents grew up in rural areas; 92% of the specialists were male; 8% were female; 90% were VMOs 13% were staff specialists. The mean age was 48 years.

The major concerns of rural specialists are professional isolation and a desire for locum assistance. A rural specialists locum scheme combined with a program to enhance the access of rural specialists to CME offer a long term investment for rural specialist services. (K McEwin)

A recent medical workforce issues survey I conducted at a larger rural hospital in NSW demonstrated the usual common themes. The numbers were not large but it did highlight some recurring issues.

The physicians stated that there was the increased clinical workload which at times can be heavy because of the lack of a critical mass of both specialists and the support in the form of middle medical management. This occurs in a variety of specialities because of roster gaps ensuing onerous hours, an inability to fill positions or not enough registrars to go around from the metropolitan teaching hospitals.

There is this pervasive lack of the full compliment of medical and nursing staff in many specialities in rural areas. This is a negative factor when an organisation is trying to retain and recruit qualified staff. This occurs in intensive care, obstetrics, renal, medical administration and medical subspecialties.

There is a mistrust of the area health service administration and this includes facility managers because of past perceived failures, and an apparent lack of demonstrable strategies to address all of the gaps. According to Hoyle, someone has to be blamed.

There are positives associated with working in a rural/regional hospital for some specialists. These include the Doctors felt they were actively involved in the community eg Dialysis and Diabetes Fund Raising groups. More appreciative patients. The specialists enjoyed a less stressful lifestyle choice when they resided in a regional/rural centre. You can always drive to work from the farm as some certainly do. There were definite opportunities to teach with the development of Rural Clinical Schools and the UDRH hub and spoke models throughout the State.

The broad scope of practice was seen as a positive. The very challenge of providing a quality service in a rural environment was particularly rewarding for some individuals.

It seems that the misdistribution of the medical workforce will skew any survey results. In other words it is not representative of our Australian demographic.The sample had two females and in general the rural medical specialist workforce is male.

While there is feminisation of the medical workforce I don't see how the inequalities will be addressed. There are numerous strategies and workforce planning groups attacking this problem but what is being done to address the gender imbalance.

If there was an award or EBA system so male rural specialists got paid at a differential rate compared with female medical practitioners this would recognise the contribution that males make. The male medical students will be the rural specialists of the future. Should there be a spousal allowance for a married rural specialist of $50,000 per year that would partly compensate for the family upheaval/partner's job dislocation that occurs when a male specialist decides to go bush?

References:

1. The Medical Specialist Workforce in Rural New South Wales
2. Kirsty McEwin March 1997. A Rural Doctors Resource Network Discussion paper.

Dr Wayne McDonald

Deputy Editor

PRESIDENT'S REPORT

As we rapidly proceed to the end of another calendar year, it is usually worthwhile reflecting on the year just gone. Sadly, uncertain times continue with further natural disasters including the Pakistan earthquake, the continued threat of terrorism attacks as witnessed in Bali again and London and issues of pan influenza and avian flu as new challenges. We have also followed progress of the Bundaberg enquiries which emphasises the need for continued development in areas key to the College namely education, learning, and clinical safety and quality.

At the beginning of the year, challenges identified included the continued preparation for the AMC Accreditation in 2008, the finalising of our reciprocity with the Hong Kong College of Community Medicine, growth and sustainability of the New Zealand branch, continued involvement with CPMC and improvements in secretariat services. I am pleased to report that significant progress has occurred in all areas and that we will formally review our progress through a Strategic Planning Workshop in February 2006. Our website has been continuously upgraded and our Mentors Program recently reviewed.

At a national level, one of the more significant documents commented upon is the Productivity Commission position paper on Australia's Health workforce. I will arrange for a copy of our submission to be accessible on our website but to my mind, the most significant issue was the proposal to establish a National Accreditation Council which would lead to a significant change to the present Australian Medical Council and Specialist Colleges roles. At the last CPMC meeting in Sydney, we had the opportunity of discussing a number of issues including the Productivity Commissions Report with the Minister for Health and Ageing, the Hon Tony Abbot MP. I am pleased to report that the Minister was very supportive of the position of the AMC and Specialist Colleges with regards to their continued role in accreditation. He was also very supportive of the importance of the role that medical colleges have to play in HealthCare in the 21st century.

The year in review has continued to see the hard work of your national councillors and secretariat. I thank them all for their tireless work this year on behalf of all Fellows, Members and Candidates.

As this will be the last edition of *The Quarterly* for 2005, I take this opportunity to wish everyone a safe and most enjoyable festive season.

Philip Montgomery
President

ISQua®

Linking you with the world of quality and safety in health care

LEADERSHIP IN A CRISIS

ISQua AUSTRALIAN SEMINAR PROGRAM 2006

• **Melbourne:** February 20 • **Adelaide:** February 22 • **Sydney:** February 24

ISQua, in conjunction with the Department of Human Services Victoria, Department of Health SA and the Clinical Excellence Commission NSW, is presenting this seminar program for executives and senior managers from across the health system, both public and private.

The aim is to highlight the range of management and leadership issues which confront senior managers in major crisis situations, and the different approaches required in the various circumstances.

The program will feature international and local speakers with 'hands on' experience in situations such as mass casualty disasters, SARS, and their impact.

- **Mr Mark Ackermann, Chief Corporate Services Officer, St Vincent Medical Centers of New York.**

  Mr Ackermann was chief spokesperson for St Vincent's Manhattan, the closest trauma centre to the World Trade Center on 9/11.

- **Ms Bonnie Adamson, CEO North York General Hospital, Toronto.**

  During the SARS outbreak, this Hospital managed 47 cases of SARS, 35 of whom were staff.

Go to www.isqua.org for more information about local speakers and topics.

VENUES

Melbourne: Eden on the Park, 6 Queens Rd Melbourne.
Adelaide: To be confirmed.
Sydney: John Lowenthal Auditorium, Westmead Hospital.

Registration Fee: A$110 (includes GST);
A reduced fee of A$93.50 (includes GST) will be provided for ISQua members.

Registrations can be submitted on-line at www.isqua.org from Monday 12 December 2005.

This seminar program has the endorsement of AHA, RACMA, RCNA, ACHSE and AAQHC.

State Government Victoria Department of Human Services

CLINICAL EXCELLENCE COMMISSION

The International Society for Quality in Health Care
Clarendon Terrace, 212 Clarendon Street, E. Melbourne, Victoria 3002, Australia.
Telephone: +61 3 9417 6971 ▪ Facsimile: +61 3 9417 6851
Email: isqua@isqua.org ▪ Website: www.isqua.org

FOCUS ON MEDICAL ADMINISTRATION

Dr Lee Gruner

After strong representation from RACMA, funding was recently obtained from the Australian Government Department of Health and Ageing (DoHA) to conduct a study into factors affecting recruitment and retention of medical administrators.

In common with other specialist groups, there is a shortage of medical administrators in most states. Positions, particularly in rural areas, have been difficult to fill and with the emphasis on clinical governance, the importance of medical administration expertise has been acknowledged and supported.

A tender was let and this was won by a joint proposal put forward by Lee Gruner of Quality Directions Australia and Roger Boyd of Boyd Health Management. Over the past 2 months, we have been assembling the data needed to inform future directions and have begun to notice some interesting trends.

A literature review was conducted utilising a researcher from Monash University in Melbourne, who has conducted previous research on workforce. Not surprisingly, there is little literature, either here or overseas on this topic. Most literature applies to other specialties. However, there were some interesting insights into career choices of junior doctors and medical administration roles. These included:

- Early exposure to management both theory and practice
- Good mentoring from people with management responsibilities
- Doctors responding to doctors and the difficulties of the different value systems of doctors and non medical managers
- Supporting clinicians through responsible autonomy
- Building medical manager roles around the trends in health service delivery and needs of the population
- Influence of extrinsic factors and needs of women doctors on career choices
- Providing management training for junior medical staff so they see a pathway to either part time or full time professional management

College records have been analysed to determine trends in numbers enrolling for and completing medical management training, RACMA candidate, member and fellow numbers plus age profile, distribution among the states and active versus inactive/retired status where able to be determined.

Two surveys were set up on the RACMA web site. The surveys utilised a web based tool known as SurveyMonkey. I first came across this tool last year in a survey conducted by ACHS and found this very user friendly. We explored the use of the tool and found it was very inexpensive to purchase, was very easy to use, gave access to a large number of question types, collated the data as it was collected and provided the ability for narrative. It also had the ability to pop up on a web site or use an email link.

We prepared two surveys, one for hospital CEOs/General Managers and the other for RACMA fellows, members and candidates. We decided to have each linked to the RACMA site. It was fairly easy to contact those affiliated with the College as we had most of their email addresses. We experienced some difficulty in deciding how best to contact CEOs. We needed to contact both public and private hospital CEOs. We knew that in private, only certain hospitals had medical director input and that a mail out to all CEOs would only garner a small number of relevant hospitals. In the public sector - who was a CEO? There are so many different structures in different states that we needed a way to ensure that we got to all of these. Eventually, we purchased a mailing list of all hospitals from AMPCo, writing to the CEO of all hospitals on the list and asking that a copy of the letter also be sent up line, if there was an area type CEO who would not otherwise have received a letter. We knew that a letter was less user friendly than an email as it needed typing in of a link, but it seems no one had a complete and up to date email address list that you could feel reasonably confident would reach the CEO's office.

RACMA emails were sent out earlier than CEO letters and the surveys were supposed to close off on November 11. We decided to give an extra week to allow CEOs sufficient time to apply. We also decided to offer a fun motivator in the form of bottles of champagne if people completed the survey in the

first 10 days and provided their email address. Most replies included the email address although one person commented that having this sort of motivator detracted from the seriousness of the survey.

The final method of collecting data is by face to face interview of a variety of stakeholders in each state and territory. Selection of people to interview was through chairs of state committees. We are in the process of interviewing active fellows, retired fellows, clinician managers, non medical managers, government representatives, RACMA candidates and junior medical staff. The interviews focus on experiences with or as a medical administrator, roles of medical administrators, future roles and the value of the professionally qualified medical manager. With Fellows, the interviews explore what motivated them to take on medical administration as a career and what are the most satisfying and least satisfying parts of the job. In addition we are exploring the diversity of roles that Fellows might take on in their careers and ways to promoting the speciality to medical graduates.

The FRACMA survey site has now closed and we received 100 completed surveys, 60% of whom were Fellows. Of these 75% were capital city and 25% rural or regional. The distribution from states was as expected in relation to population. All age ranges were covered with the largest number in the 50-59 age group. There were large numbers of useful comments in the narrative questions. The next step is to collate the narrative comments and analyse the data more fully.

The interview data has been useful in developing a number of broad themes in relation to FRACMA roles - past, present and future and things that are most satisfying in the medical administration role. The non-FRACMA interviews have been very helpful in identifying the value that a professionally qualified medical manager brings both to the executive and the organisation as a whole.

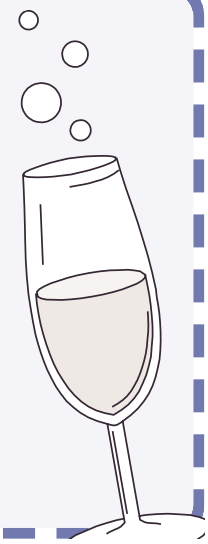
What has been particularly interesting is the difference between the states in areas such as medical administration roles, FRACMA credibility, remuneration systems and candidate training.

What happens next?

Early in December Roger and I will be able to analyse the data and agree on the common themes contributing to recruitment and retention of medical administrators and other issues that have emerged that will be of value in future college planning. We will consider any recommendations to be made and prepare a report that will be available initially to both RACMA Council and DoHA. It is intended that the report will be completed by the end of December and be available to Council to inform its strategic planning session in February. The full report will be available on the RACMA website, once ratified, and the executive summary will be emailed to all of those who were interviewed and/or completed the on line survey.

Both of us feel privileged to be part of this important study. We are very grateful to all of those Fellows, Candidates and Members who have made time to complete the surveys and spend time with us honestly discussing their careers and perceptions.

CHAMPAGNE WINNERS



As part of the DoHA/RACMA Medical Management Recruitment and Retention Project, a survey of the RACMA Membership and Public/ Private Hospital CEOs was conducted. Respondents were eligible to win a bottle of champagne and the lucky winners are:

Dr Geoff Williamson, Dr Robert Grogan, Dr Nelly Zwatrzka, Ms Karen Ramzan, Ms Karon Devenish and Mr Ken Barnett.

Congratulations to the winners and thank you to all respondents.

THE PATHOLOGY WORKFORCE CRISIS

MYTHS, MYSTERY, AND IMPLICATIONS FOR MEDICAL MANAGERS

THE MYTHS

On 20th September 2005 the Australian Financial Review published an opinion piece by Allan Fels and Fred Brenchley titled *An Unhealthy Monopoly*. In this article they claimed that efforts to increase pathology trainee numbers were "risible", and implied that the College of Pathologists was a closed shop, limiting the number of people approved to undertake pathology training.

Nothing could be further from the truth. As I responded in the AFR letters page at the time, the College does not control training places or select trainees as the article suggested. It accredits facilities as a whole (rather than individual training posts), and it oversees the training and examination of trainees who are selected by employers.

In a separate incident, I met with a very senior official in medical workforce planning recently and tried to impress upon him the need to have pathology included as a priority area for consideration in that jurisdiction. He looked at me somewhat sympathetically and said "Yes, I can understand your concern. It's so hard to know how we can attract people to train in these unpopular specialties".

Another myth. Every year we turn away excellent candidates who are keen to train in pathology, because there are simply not enough training posts. To become a pathology trainee one needs 3 things: a medical degree, a job and an interest in pathology. The first and third do not generally present a problem, but time and again pathologist hopefuls cannot secure a position in which they can train. Some keep trying, many move off to work in other fields.

The College has been meeting with Ministers and health department officials for some time, urging them to fund more training positions, but here again the myths are flourishing and little headway has been made.

There's the one about pathologists doing all their training in the public sector only to move straight into the private sector – and so, it's claimed, there's no incentive to fund training positions. Sounds justifiable, but it isn't borne out by the statistics – in NSW, for example, only 3 out of 29 Fellows who have finished training in the last three years have moved into the private sector. What's more, surveys in some states have indicated that many of those who've moved into the private sector shortly after becoming Fellows have done so because there were no jobs on offer in the public sector! It is also not uncommon for pathologists to move from the private sector to the public during their careers, because the range of research and teaching opportunities is perceived as better in the latter.

Then we have the "pathology is all automated now, so there's no longer any need for pathologists" school of rhetoric. Ever tried to get a machine to peer down a microscope and differentiate between a dysplastic naevus and a melanoma-in-situ? And although a number of tests are automated, specialist skills are still needed to interpret them and provide advice to treating clinicians. Pathologists are far from obsolete, regardless of automation.

And we mustn't forget the "workforce substitution" paradigm, increasingly seen as a universal panacea to manpower shortages. The trouble is, pathologists have been at the forefront of workforce substitution for many years, which means that many of the tasks that are appropriate for delegation to other groups have already been delegated. There is a limit, however, to what can be taken over by less highly trained workforces (many of whom are facing their own manpower shortages) without risking a compromise in quality standards.

Enough myths – so what are the real reasons behind the lack of interest in the pathology workforce crisis?

THE MYSTERY

Pathology is a mystery. Its role is not well understood by those outside the medical fraternity (and even, I suspect, some within it). For the majority of patients, the pathologist is at most a faceless name on the bottom of a test report. Pathology doesn't appear on the front page of the tabloids, nor raise the ire of talkback radio hosts. In the abundant parliamentary speeches and debates on health care issues, pathology rarely, if ever, rates a mention.

A mystery, yes, but one that doesn't inspire widespread curiosity, other than through the proliferation of forensic pathologists in television shows (who can solve any crime within an hour – including ad breaks – and actually outnumber the bona fide forensic pathologists working in Australia). As for day to day pathology - it just isn't perceived to be sexy.

Pathologists simply continue their work behind the

scenes. And therein lies the other reason why there is so little attention to this workforce crisis – they continue. Pathologists are still providing a first class service, many working longer and longer hours, others working well past an age when they had planned to retire, because there is no one to take over or share the load. How long these stop-gap measures can safely continue is a mystery in itself.

There is no mystery, however, in the AMWAC recommendations – 100 additional pathology training positions are needed per year for the five years from 2004-2008. These recommendations were endorsed by Health Ministers, but so far we have only managed to achieve funding for 28 posts – and some of these are about to have their funding withdrawn.

THE IMPLICATIONS

As a medical administrator I well understand the need to fight the fire burning on the front door step before going looking for blazes elsewhere. The political imperative to address Emergency Department delays and surgical waiting lists is very real, and can be all consuming.

Shortages of pathologists have implications for both of these issues. Turnaround times are already increasing for anatomical pathology, and delays in the diagnosis of tissue biopsies can lead to increased lengths of stay, and consequently access block and cancellation of surgical cases. A lack of haematologists has implications for the availability of blood transfusions for both trauma and surgery patients. Delayed validation of troponin results by a chemical pathologist could mean patients with non-cardiac chest pain occupy an ED bed for hours before being cleared to leave so the bed is freed for someone else.

The adverse impact on patient care is also clear. Patients do not want to wait weeks before receiving confirmation that a biopsy result indicates cancer, or that a prenatal test shows a serious congenital disease.

And as the shortage worsens, so will the risks. Who wants to be the Director of Medical Services in the first hospital where a child with meningococcal disease has their treatment delayed because there was no microbiologist available to make the diagnosis? (That would certainly put pathology on the front page, but we'd rather it doesn't come to that).

DEMYSTIFYING PATHOLOGY

The College is actively attempting to address the pathology workforce crisis on a number of fronts.

Firstly, we continue to meet with Ministers, government department officials and other stakeholders to debunk the myths and impress upon them the need for funded training positions in pathology.

We are raising the profile of pathology in the community. The College publishes a quarterly magazine – "PathWay" – which contains articles of interest to both doctors and the lay public. We are also arranging a "Blood, Bugs and Bodies – The Mystery of Pathology" exhibition at the Powerhouse Museum in March 2006. This will be combined with a video clip on the many roles pathology plays, copies of which will be sent to schools.

We also try to educate the media about pathology – arranging visits to laboratories so they can look behind the scenes and providing media releases as issues arise. The College holds an annual media lunch with prominent pathologists, and in recent years has arranged media events to highlight the involvement of pathologists in scenarios such as the Asian Tsunami and Bali bombings.

Efforts are being made to reintroduce more pathology into university medical curricula, so that there is a greater awareness of how important pathology is in all areas of medicine. This will help to raise the profile of pathology even amongst those who ultimately choose to pursue other medical careers, as they can be drivers for change from within the medical fraternity.

And finally, we have started encouraging pathologists to talk to the managers and executives in their hospitals and health services, and tell them how dire the situation really is. It may sound obvious, but it's clear the message is not getting through at a local level and that's where the groundswell for change is needed.

Since arriving at the College almost a year ago I've found that by and large pathologists don't like to make a fuss. They are not the squeaky wheels that run back and forth outside the Director of Medical Services' office until they achieve their aims.

So if a pathologist comes knocking at your door, it means things are pretty desperate. And who knows, an extra pathologist or pathology trainee installed behind the scenes may be just what you need to clear those ED beds and trim those surgical waiting lists.

Dr Tamsin Waterhouse

Deputy Chief Executive Officer
Royal College of Pathologists of Australasia.

STATE/TERRITORY NEW ZEALAND UPDATE

NEW SOUTH WALES

Since the last report the NSW State Committee has held two Scientific Programs and conducted its Annual General Meeting on the 12th October, 2005. The Annual General Meeting was attended in greater numbers than in the past, which was encouraging. As part of the AGM the results of the recent ballot for election of a Candidate to the Committee were announced, in which Dr Joanne Appleton received the most votes and was declared elected. There was one position vacant for a Member representative, which was subsequently filled by Dr Martin Baylis from Tamworth, co-opted by the Committee. The 2006 Committee comprises:

Councillors	Dr Roger Boyd Dr Gavin Frost Dr Robert Porter
Fellows	Dr Tony Sara Dr Vasco de Carvalho Dr Draginja Kasap Dr Beth Kotze
Members	Dr Tessa Ho Dr Martin Baylis
Recent Graduates	Dr Jo Burnand Dr Michael Hills
Candidates	Dr Joanne Appleton Dr Vicki Tse
CEP Coordinator	Dr Eva Pilowsky
Chair Board of Studies	Dr Tamsin Waterhouse

In addition, at its next meeting the Committee co-opted Dr Denis Smith, who is the RACMA Nominee on the NSW Medical Board, to continue to sit on the Committee. A warm welcome is extended to all new members of the Committee.

The AGM was followed by an informative presentation by Dr Diana Horvath reflecting on the impact and potential of the recent restructure of NSW Health, including opportunities for medical administrators.

The last scientific program was held on 1st December, 2005, with Dr Mark Brown, Chair of the newly formed NSW Institute of Medical Education and Training, as our speaker. Again the meeting was well attended with considerable interest expressed from the floor.

The proposed dates for the Scientific Program during 2006 are listed for diary purposes:

16th February 2006

27th April 2006

22nd June 2006 (Margaret Tobin Challenge Award NSW State heat)

24th August 2006

October 2006 (date TBA) Annual General Meeting

7th December 2006

The speaker on 16th February will be Prof Merrilyn Walton, Associate Professor of Ethical Practice in the Faculty of Medicine at the University of Sydney, with the topic of "Getting the Workforce Right". All Fellows, Members, and Candidates are encouraged to attend.

On 8th and 9th November, 2005, the NSW State Committee convened its second "Management for Clinicians" workshop this year. Although the numbers weren't as high as previously, overall the workshops have been both an educational and financial success.

Over the past few months a working party of the NSW State Committee has been involved in discussions with NSW Health and the NSW Clinical Excellence Commission, hoping to develop an extended role for RACMA in conducting a leadership development program for our clinical colleagues based on the British Association of Medical Managers' "Fit to Lead" program. The Committee is keen to pursue this opportunity and more information will be forthcoming next year.

The Institute for Medical Education and Training has also been approached with an invitation to conduct a review of the State-based education and training needs of RACMA Candidates.

Draginja Kasap
Honorary Secretary

QUEENSLAND

RACMA State Committee in Queensland have been very active of late. The Annual General Meeting was held on Thursday 10th November and elections were as follows:

Chairman Dr John Menzies

Secretary Dr Judy Graves

Treasurer Dr Duncan Stuart

Chair, Board of Studies and Coordinator of Continuing Education
Dr Gabrielle duPreez Wilkinson

Elected Fellow and Assistant to Chair
Dr David Evans

Elected Fellow and Assistant to Board of Studies
Dr Michael Daly

Elected Fellow Representative
Dr Craig Margetts

Elected Fellow Representative for North Queensland
Dr Andrew Johnson

Members Representative
Dr Adrian Groessler

Candidates Representative
Dr David Alcorn and
Dr Andrew Montague

Dr Michael Catchpole has stood down as Federal Councillor due to change of employment and at the AGM, Dr Richard Ashby was elected as the new Federal Councillor.

On Thursday 10th November, a half day workshop was held for RACMA Fellows. This was funded by Support Scheme for Rural Specialists. The topic was 'Seizing the Agenda – Reshaping the Queensland DMS/Clinical Governance Role'. It was facilitated by Dr Lee Gruner (FRACMA). Given the changing nature of health in Queensland at present, the workshop was designed to more clearly define the role for the modern medical manager and to shape the future for RACMA Fellows in Queensland. The clinical governance agenda was seen as a major role for Directors of Medical Services, and strategies for advancing this agenda and improving the influence of Directors of Medical Services in the provision of health services were developed.

One of the outcomes of the workshop was that there was strong agreement that the Royal Australasian College of Medical Administrators should be considered a College like every other College, and it was recommended that positive steps should be taken in this regard. These matters will be taken forward to Council. We were fortunate that two Council members were at the workshop, Dr Lee Gruner and Dr Roger Boyd.

The Registrar Training Program continues to progress well. There are now 6 training positions available in Queensland and there will be 6-8 people sitting the exam next year.

Dr Judy Graves
Honorary Secretary

VICTORIA

The 2005 Annual General Meeting of the Victorian State Committee was held on 1 December, 2005 followed by the State Committee's annual dinner held at Abla's restaurant, Carlton.

Dr. Lee Gruner summed up the highlights in her Chairperson's Report.

- The major event for the year was the 2005 RACMA National Conference held at the Melbourne Hilton from 24 – 26 August. The Conference attracted 175 delegates – a record number for a RACMA standalone conference. Feedback indicated a very positive response to both the scientific and social programs.
- **Victorian Candidates performed strongly in the RACMA Oral Examination**

  Congratulations are conveyed to Dr. Susannah Ahern and Dr. Alison Dwyer who were successful at the 2005 Fellowship Examination. The Bernard Nicholson Prize was awarded to Dr. Alison Dwyer and the Challenge Award was won by Dr. Malcolm Mohr. Congratulations are extended to them both.

  Thanks particularly to Dr. Kim Hill, Chair of the Board of Studies and those involved in the Candidates program. Results over the past two years have been outstanding.
- **The annual Clinicians Managers Workshop** was held in late July. There were seventeen registrants and feedback indicated a most successful workshop.

- **SSRS Activities** convened by Dr. Gruner have included a number of teleconference and workshops covering topics such as "Dealing with the Difficult Doctor".
- Dr. Gruner will be stepping down from the State Committee to devote attention to her role as Censor-in-Chief. She thanked members of the Victorian state Committee for their support.

Victorian State Committee for 2005-2006

Chairperson	Dr. Bernard Street
Honorary Secretary	Dr. Humsha Naidoo
Honorary Treasurer	Dr. Susan Sdrinis
CEP Coordinator	Dr. Alison Maclean
Chair, Board of Studies	Dr. Alison Dwyer
Scientific Program Coordinator	Dr. Alan Sandford
Rural representative	Dr. Peter O'Brien
Member representative	Dr. Meindert van der Veer
Candidate representative	Dr. Harvey Lander
Candidate representative	Dr. Malcolm Mohr

A Changing of the Guard

The 2005 Annual General Meeting marked a significant change to the composition of the Victorian State Committee.

Dr. Lee Gruner is stepping down as Chair and is leaving the Victorian State Committee to focus on duties as RACMA Censor-in-Chief.

Dr. Kim Hill is stepping down as the Chair of the Victorian Board of Studies to pursue her role as RACMA's National Director of Continuing Education/Recertification.

Dr. Ian Carson and Dr. Sherene Devanesen are also leaving the Victorian State Committee after many years of outstanding contribution including terms as State Chair.

I would like to take this opportunity to acknowledge the contribution of Drs Gruner, Hill, Carson and Devansen towards the success of RACMA and particularly the Victorian State Committee.

Thanks to the Outgoing Committee – I would like to thank members of the Victorian State Committee and Board of Studies for their enthusiastic work over the past twelve months. I welcome the incoming committee and new office bearers and look forward to continuing our activities and successes in 2006. I also thank the RACMA Secretariat particularly Bob Bishop and Gary White for their assistance over the year. And finally to all Fellows, Members and Candidates best wishes for the Festive Season.

Dr. Bernard Street

Outgoing Honorary Secretary/Chair Elect

NEW ZEALAND

We were pleased to hold the inaugural meeting of the New Zealand Committee on Tuesday 25 October 2005 in Auckland. The meeting was attended by:

Andre Nel - Chair
Wilson Young - Secretary
Allan Pelkowitz - Treasurer
Bernie Brenner - CPD Co-ordinator
David Rankin - Board of Studies Chair
Peter Gillies - Candidate Representative

A number of matters relating to initial establishment was confirmed such as a constitution, office and contact details and financial structure.

The committee is planning to conduct a training day on a suitable topic early next year. It is hoped that this will be the first of regular training days offered by the College in New Zealand.

The educational programs held in Auckland and Wellington are established and enjoy satisfactory attendance by College Fellows and Members as well as others.

In response to an invitation, the College will, in future, have a presence on the New Zealand Council of Medical Colleges.

Andre Nel
Chair

TRANSFUSION MEDICINE INITIATIVES IN NEW SOUTH WALES

In Australia, as in other developed countries in the world, the "tainted blood" scandals of the '80s and early '90s led to a raft of measures – donor screening, donor deferral policies, and nucleic acid testing (NAT) for various viral and bacterial markers - being put in place to minimise the risk of transfusion-transmitted infection. While these measures have enhanced the quality and safety of blood they have, at the same time, led to a reduction in the number of donors able to donate blood. As a consequence, blood is considered to be more precious than ever before and attention has turned to the need to conserve blood and blood products so they are neither wasted (through not being used) nor used inappropriately, with appropriateness in this context meaning using them only when it is necessary and when the benefit to the patient outweighs any risk involved.

In recognition of this, a number of initiatives aimed at improving transfusion medicine practices have been carried out in NSW. The first such initiative was undertaken in 1998 when, concerned by reports in the literature that between 16 and 67%[1] of all red cell transfusions were inappropriate, the NSW Council on Quality in Healthcare commissioned the Australian Centre for Effective Healthcare to determine the appropriateness of red blood cell transfusions in NSW hospitals. The study included a systematic review of the literature on triggers for red blood cell transfusion. This revealed that the application of restrictive triggers[a] for red blood cell transfusion was associated with a reduction in the use of red blood cells, reduced patient hospital stays and, in some circumstances, reduced patient mortality. In the light of this evidence, the investigators concluded that 35% of the red blood cell transfusions performed in the NSW hospitals participating in the study might not have been justified. The final report, known as the "Rubin Report", recommended that:

1. NSW Health, The Australian Red Cross Blood Service NSW and relevant Colleges develop red blood cell transfusion policies with criteria for use and that the policies should include guideline triggers for red blood cell transfusion and recommended formats for hospital blood request forms.
2. The guidelines should be prescribed for use in all hospitals where blood transfusions are conducted and their implementation should be monitored as part of the hospital's ongoing safety and quality monitoring processes.
3. NSW Health and the Australian Red Cross Blood Service-NSW should devise an education strategy to inform clinicians and managers working with blood transfusion services of the results of the systematic review and newly developed transfusion policies and practices.

The Rubin Report resulted in the National Health and Medical Research Council (NHMRC) and the Australian Society of Blood Transfusion (ASBT) developing clinical practice guidelines on the use of blood components[2]. These guidelines, which included recommendations for formats for hospital blood request forms, were published in October 2001 for national adoption in line with the proposed move to a national blood system.

New South Wales' health quality body, the Institute of Clinical Excellence (ICE) - now the Clinical Excellence Commission (CEC) - oversaw the implementation of the NHMRC/ASBT guidelines. Recognising that the issue of guidelines alone would not necessarily change clinical practice, ICE granted a 12-month contract to the consortium of the Blood Transfusion Improvement Collaborative (BTIC) based at the Northern Centre for Healthcare Improvement to implement the guidelines using the Breakthrough Collaborative Improvement Methodology[3]. Seventeen participating hospital teams representing 11 Area Health Services took part in the BTIC initiative. At the conclusion of the initiative in 2003, BTIC reported a reduction in inappropriate red cell transfusions in heamodynamically stable patients in the participating hospitals, with the greatest improvements occurring in hospitals where (1) there was a clear transfusion policy disseminated by an Area Health Service Transfusion Medicine Committee and the guidelines had been well disseminated and endorsed; (2) red cell transfusion requests had been vetted for compliance with the NHMRC/ASBT guidelines; and (3) clinicians involved in red cell transfusion had received education in appropriate transfusion practice. BTIC made the following recommendations for leading

and sustaining further improvements in blood transfusion practices[4]:

- strengthening local commitment to ensure appropriate transfusion practice in the hospitals;
- establishment of measurement systems to provide data on the management and use of blood;
- the requirement for hospitals to be accountable for their use of blood and blood components;
- the development of standardised transfusion ordering practices;
- improved transfusion practice education of medical staff;
- increased patient/consumer education and involvement
- the application of the current NHMRC/ASBT guidelines to patients with chronic anaemia; and
- the need for improvement in the appropriate use of all fresh blood products.

In response to these recommendations, NSW Health issued guidelines[5] and a policy directive[6] relating to the management and appropriate use of fresh blood and blood components. Amongst other matters, these guidelines outlined the requirement for each health care facility engaged in transfusion therapy to have a Committee – either an existing one or one specifically established for the purpose – to oversee transfusion-related issues.[b]

In addition, NSW Health established the Fresh Product Advisory Committee (FPAC). Under the Chairmanship of Professor James Isbister this Committee has built on the experiences gained from the BTIC project and developed a comprehensive proposal for the way forward for transfusion medicine in NSW[7]. The proposal addresses issues of appropriateness, reporting of adverse transfusion events, data collection on usage and appropriateness of use of fresh blood components, clinical governance and a model for costing transfusion medicine. Since there is currently no agreed basis for costing[c] , it is difficult to develop convincing cost-effective proposals to improve transfusion medicine. For example, it is recognised that the use of non-leucodepleted products may be associated with post-transfusion complications and hence longer hospital stays. Leucodepleted products, on the other hand, are more expensive but have been demonstrated to be associated with better clinical outcomes and an overall reduction in the cost of patient treatment. Yet, without the means to cost this accurately, it is difficult to gain acceptance for the practice.

The FPAC has asked for the CEC to undertake the project with the assistance of the Department of Health.

In tandem with the CEC initiative, the NSW Health Department has devolved the blood budgets to the Area Health Services. (Details of this are given in the Departmental Policy Directive Number PD2005_332[8]). Blood and blood products, which previously might have been perceived as being "free"[d], are now costed and it is hoped that this, in conjunction with the vetting of transfusion-related practices by hospital Transfusion Committees, will ensure the most appropriate use of blood and blood products as well as a reduction in possible wastage resulting from over ordering and products passing their expiry dates.

As with all initiatives of the kind being undertaken by the CEC, its success will depend on a number of factors including awareness of the initiative and the wholehearted backing by the health sector to ensure that recommended practices and procedures are adopted and sustained in NSW hospitals. If this is achieved, the standard of transfusion practices in NSW will be world-class.

References

1. Red Blood Cell Transfusion Practices in New South Wales (2000) http://www.health.nsw.gov.au/health-public-affairs/publications/rbc/RBCfinal.PDF

   See also Rubin GL, Frommer MS et al (2001) Appropriateness of red blood cell transfusions in major urban hospitals and effectiveness of an intervention. Med J Aust 175: 354-358.

2. NHMRC/ASBT Clinical Practice Guidelines on the Use of Blood Components (2001)

   NHMRC/ASBT Clinical Practice Guidelines on the Appropriate Use of Red Blood Cells. (2001)

   NHMRC/ASBT Clinical Practice Guidelines on the Appropriate Use of Fresh Frozen Plasma and Cryoprecipitate (2001)

   NHMRC/ASBT Clinical Practice Guidelines on the Appropriate Use of Platelets (2001).

   http://www.nhmrc.gov.au/publications/synopses/cp77syn.htm

3. NSW Department of Health (2001). Implementation Plan for Clinical Practice Guidelines in the appropriate use of red blood cells. NSW Health Department, North Sydney.

4. BTIC Final Report(2003; Revised version, 2005). BTIC Blood Transfusion Improvement: Reducing Inappropriate Red Cell Transfusion. www.nchi.org.au (under special projects) or

   http://www.health.nsw.gov.au/public-health/clinical_policy/blood/pubs-links/BTIC.pdf

5. NSW Health Guidelines for the Management of Fresh Blood Components (2003)

   http://www.health.nsw.gov.au/pubs/g/guide_fresh_blood.html

6. NSW Health Policy Directive PD2005_261: Management of Fresh Blood Components.

   http://www.health.nsw.gov.au/policies/PD/2005/PD2005_261.html

7. NSW Health Department Fresh Products Advisory Committee Report: Transfusion Medicine in NSW: the way forward (2004).

8. NSW Health Policy Directive PD2005_332: National Blood Authority – Accountability for Blood and Blood Products in NSW. http://www.health.nsw.gov.au/policies/PD/2005/PD2005_332.html

a The term 'restrictive trigger' refers to a threshold haemoglobin level below which red blood cell transfusion is indicated.

b The specific roles of the Committees are stated to include:

- Monitoring the safety, adequacy and reliability of the supply of blood, blood components and alternatives to transfusion;
- Monitoring the usage of blood components in the health care facility;
- Review incidents of severe adverse effects or errors associated with transfusion;
- Develop systems and procedures for the implementation of the policy within the health care facility;
- Promote the effective implementation of the policy through the education and training of clinicians and blood bank staff involved in the transfusion process; and
- Monitor the implementation of the policy in the health care facility and take appropriate action to overcome factors hindering its effective implementation.

c European studies have indicated that the actual cost of transfusion medicine varies between 3 and 7 times the cost of the actual blood and blood products. In NSW, the annual cost of blood and blood products alone is currently in the region of $200 million.

d In Australia blood is donated voluntarily and the donors are not paid and in this sense blood is "free". However, considerable costs are incurred in collecting the blood and processing it.

Jill Carstairs

Senior Analyst, Clinical Policy
NSW Health Department

LOCUM TRENDS

Can you wait for global warming to bring the coast closer?

Dr Miriam Martin
MBChB, DCH, DipObst, DipCEM
miriam@kiwisstat.com
A long term locum and now works in recruitment

Casualisation of the workforce is a global phenomenon. The trend over the last 10-15 years for junior and middle tier doctors to work as locums in New Zealand and Australia is not abating but is this trend here to stay? Overseas, the medical workforce in places such as USA, UK, and Canada confirms they are a lot further down the path of a locum workforce.

The reasons that many people locum appear to relate superficially to the increased financial return for working in a casual position. This may be the case in metropolitan areas, where peripheral hospitals have gaps in their rosters. Locums come from teaching hospitals to fill the gaps. However, most doctors have an altruistic streak and genuinely do want to help people so they need more than just extra money to push them fulltime into the locum lifestyle.

There is no doubt about it; the money is great working as a locum. However, most full time locums use this as a way of reducing their hours rather than increasing their income. There are phenomenal numbers of doctors working 40-80 hours per month leaving time for family and a life. And don't underestimate the attraction of this lifestyle. There is now a trickle of doctors who are going for early semi-retirement and this includes specialists as well as CMO/MOSS level doctors.

Doctors are driven out of their regular jobs due to the long hours. Most doctors work at least a 50-hour week and many are working 60-65 hours with large proportions out of normal working hours such as nights and weekends. Many cite the continual week in, week out monotony of arduous shifts as the trigger for looking for alternatives. Full time JMO work is not conducive to parenthood and the feminisation and aging of the junior medical workforce is putting more people into this situation. Many hospitals do not offer part time work or regular working hours that assist parents. The benefit of locum work is that you can pick and choose your hours –if nights work best for you then the world's your oyster! You can also pick evening and weekend work and work as little and as much as you like.

Many doctors talk about the relief from "hospital politics" as one of the reasons they enjoy locum work. We all know about the problems with hospital culture and the bullies and manipulators that exist in the medical workforce. The great thing about locum work is that if you find a workplace you enjoy you can keep going back but alternatively, it is easy to walk away. Many people find moving jobs after a period of 3-6 months in each location not only relieves the monotony of the location. And, if you don't know what's going on, its difficult to let it upset you!

Lack of suitable training is an important factor in the locum scene. Most doctors will stay in training positions if they find an area they enjoy working in and access to training positions really pays a part in this. Don't forget, doctors look in from the outside so if your trainees are not being treated well don't expect to find doctors flocking to sign up. Flexibility in training schemes to fit in with modern lifestyles is an issue that still needs to be addressed in most specialties.

In Australia, since the 1995 moratorium on provider numbers, many doctors who have partners with jobs that keep them in metropolitan areas find that the only work they can do is work in a public hospital. One wonders how successful the moratorium is when many doctors are under utilised working in the cities, working odd shifts as locums and barely stepping into rural areas.

In New Zealand, poor pay in general practice and the uncertainty of a government that keeps moving the goal posts has resulted in many doctors working "in limbo" as a locum while they wait for the government to "make up its mind". There are also many doctors who actually enjoy hospital work over general practice but do not want to specialise and have only the option of working in a rural hospital in New Zealand or commuting to Australia for a similar job. Many metropolitan hospitals in New Zealand do not have locum work at CMO or MOSS level although this is in good supply in rural areas.

So how can you ensure your workplace retains your regular staff and if you live in a rural area, maintains the good locums and keeps them coming back? Attending to the simple things is probably the best thing you can do. As they say in business circles –85% of the improvement can be affected by 10% of the change. Providing part time work, flexible rosters and access to leave at short notice will help the parents amongst the workforce. Attending to the hospital politics and improving culture will create a work environment that is constructive. Training, teaching and access to good supervision that is encouraging and positive are the biggest step to a happy hospital. Protecting your medical staff from attack from nurses, administrators and doctors in other departments and encouraging them to work well together are very important.

Rural hospitals in New Zealand and Australia are now looking down the barrel of a future dominated by locums. How can you ensure that, although the horse has already bolted, he stays in the paddock? In my humble opinion, the forces that attract and maintain good locums are the same forces that retain your regular staff. Most important is geographical location and unfortunately you can't do much about that. However, if you have a lake, coast, ski-field or vineyard nearby, make the most of it in your advertising material.

The actual hospital building plays a large part in attracting locums and keeping them coming back. No one wants to work in a grotty, cramped department with no air-conditioning in the summer and many hospitals have found that, with a revamp, their recruitment and retention woes have disappeared. Small things like decent desk space, enough computer terminals for the doctors working there and smooth running systems for pathology and X-ray all help to reduce the feeling that you are "working in treacle". Even small things like having the eye-fridge in the eye-room and luer-caps on the cannular trolley can make a difference –take a look around your own hospitals, ask your doctors and you could make a huge difference here.

If the hospital working environment needs to be good then the same has to be said for the accommodation. I can't emphasise this more strongly. You are working with professional people and referring to your locums as "overpaid yuppie bastards that should be grateful that the accommodation is free" just shows you don't "get it". In my experience, a rural hospital with an accommodation problem pays $10-$20 extra per hour for locums. It's not rocket science, poor accommodation is costing you $700-$1400 per week for one shift per day –well more than renting a good furnished apartment. Many locums are "accommodation sensitive" and choose their work depending on the accommodation offered. The more experienced and senior go for the best places

and we all know that better doctors are cheaper to run. Small things make a huge difference, for example, DVD, Video players and dishwashers are all worth the investment.

I'm only going to say this once: **your night doctor needs quiet accommodation**. You really don't want your night doctor next to a main road, over the dental department's compressor, next to the helipad, across the road from jet boat races, or in a room next to a lecture theatre or building site. A homicidal night doctor is not pretty! **This is simple stuff guys – get it right!**

Air-conditioned accommodation in hot climates comes a close second to quiet. It never ceases to amaze me how many hospitals still are not providing air-conditioned accommodation in rural Australia!

Many New Zealand and Australian hospitals are still in the era of the "nurses hostel". This type of accommodation is just not acceptable this century. American hospitals are now providing compound-like accommodation for all their casual and seconded staff. This consists of 2-3 bedroom furnished apartments and houses with a shared facility with essentials like a gym, swimming pool and internet facilities.

Locum work provides an important service for doctors searching for their niche. It's a great way to get experience in lots of specialties and to visit lots of geographical locations –many locums end up staying. Many doctors also find locum work useful to help them to take time off to study, to fill the gap between an overseas trip and starting in a training scheme or at the end of training while waiting for that perfect job. In many cases, doctors end up working where they have previously worked as a locum.

Locums are a valuable part of the medical workforce. There are many places in Australia and New Zealand that "are great to visit but you wouldn't like to live there forever" but are fantastic to work as a locum for 6-12 months. Examples of this would be small indigenous communities or very isolated locations. Locums also fill the gap when the regular doctor needs time off for a holiday or has a long illness. They also dovetail between someone leaving and a new employee beginning.

So if the locum trend is here to stay what are we to do? Putting our heads in the sand is not the way forward. Let's at least make locum work attractive and make our positions competitive. It's not all about the money, providing a good working environment and fantastic accommodation go a long way to attracting mature, experienced doctors who will do your community good. And if that doesn't work, bowl the hospital, dig a lake or wait for global warming to bring the coast nearer. If you can't wait for the coast, ask your council to plant you a vineyard.

A NEW STRUCTURE FOR MEDICAL ADMINISTRATION AT TAMWORTH HOSPITAL

Alastair Quarterman, Business Manager Medical Administration Tamworth Hospital

Almost every Hospital in Australia struggles with the notion of managing the medical workforce. The medical workforce is often comprised of a large (and usually not large enough) group of men and women who are attempting to ensure the best outcomes for their patients, competing for limited resources, making an adequate income and avoiding the plague of bureaucracy. Further, in many cases as the medical workforce are often a large body of visiting consultants, many administrative decisions are made in isolation of the medical workforce which can lead to disharmony in the Hospital. So how can this be overcome?

Whilst certainly not professing to be perfect, Tamworth Hospital has attempted to overcome some of the problems with the appointment of a (Business) Manager Medical Administration. Whilst the appointment has a business flavour – I am the resident bean counter, the role covers a wide gambit of responsibilities – including the personnel management of the medical workforce, working with the medical staff to manage the hospital's medical services and training activities and interacting with the Hospital and Area Executive to ensure strategic goals are achieved. The role also meshes with the Director of Medical Services, but allows him to be more of a conduit to the medical workforce, without having to be (always) the bad guy in Medical Administration.

By way of background, Tamworth Hospital is a Rural Referral Hospital of Hunter New England Health and is a 270 bed hospital and the main referral centre, for acute care within the New England/North West region of NSW. Medical Services at Tamworth Hospital are provided by a mix of visiting and staff medical officers. The key challenge in my role has been working with the medical staff to ensure that we have the right doctor at the right place at the right time – a lofty ideal which all managers and medical administrators aspire to, but incredibly difficult to achieve.

The biggest impediment to this goal has been workforce. When I started in this role, there was no clearly defined workforce – this isn't a criticism, but rather a reflection of the fact that everyone was so busy doing their jobs, there hadn't been time to plan. As a result we knew we needed more doctors, but didn't know exactly what types and how many. To overcome this I spent a long time in consultation with the senior medical staff and the Hospital and Area Executives to devise a workforce structure and a personnel plan that reflect the current needs of the community and provided for some succession planning. Once we clearly knew what we required, it made it easier for us to actively recruit and target our marketing. In the two years that I have been here Tamworth have been able to attract fifteen new medical specialists and have four resign and/or retire. Included in these figures are two home grown specialists in Emergency Medicine and Paediatrics.

In addition to these successes, there have been a few dismal failures, including the specialist who arrived (unbeknownst to us) having already signed an employment contract with another Hospital, an ED doctor who completed a weeks worth of shifts before deciding to return to India and some interviews with medical officers who appeared to have less knowledge about medical procedures than me!

The resident workforce is also a very important component of the service delivery of the Hospital. The key challenge in their domain is how to manage the competing service delivery requirements, with the educational and training needs of the residents and the individual desires of the junior medical officers. To achieve this Medical Administration have developed a team approach to management with myself, the Director of Clinical Training, the Medical Education Coordinator and Medical Officer Coordinator working together to ensure that rostering, term allocations and education and training needs are being coordinated in such a manner as to provide the best environment for professional development and ensuring the Hospital is meeting community expectations.

The key to the success of Tamworth has not been because of any individual brilliance on my behalf, or other members of the Medical Administration Team – but rather that we and the medical community work together to achieve results. To assist in this we have regular meetings with the different specialty

groups to ensure that we are all meeting each others expectations, there is a monthly lunchtime liaison meeting for all senior medical staff to attend with the Hospital Executive and a monthly resident meeting with the JMO Management Team. All these meetings provide an environment where there can be frank and robust discussion on operational issues surrounding the medical workforce and how we can work together to address issues and overcome deficiencies. In addition to these meetings, the Hospital retains a Medical Staff Council and a Clinical Council, which look specifically at strategic clinical issues and is able to provide advice and guidance to the Area Executive as well as the Hospital.

As a result of these interactions there is an acknowledgement within the Hospital management that the success of our hospital is underpinned by all of our clinical staff and a result, rather than being in conflict with one another, we attempt to work together to achieve results. We don't always agree on the results, but then if we did, work wouldn't be a challenge!

Alastair Quarterman has a background in logistics and operational management in the Australian defence force as well as an MBA. He commenced work in Tamworth at the University Department of Rural Health as the Business Manager. Since then he has been in health service management for the last three years. He is now studying Law part-time and he works in the medical administration unit at Tamworth Base Hospital. His real passion is Rugby.

MOVING ON?

Please let us know, so that we can ensure you continue to receive all College information, updates and *The Quarterly*. It is as easy as filling out the form and posting it to us at:

The Royal Australian College of Medical Administrators
35 Drummond Street
Carlton, Victoria 3053, Australia
Telephone: (03) 9663 5347 or Facsimile: (03 9663 4117
Email: info@racma.edu.au

Name _____ Credentials _____

New Title _____ New Organisation _____

New Address _____

City _____ State _____ Postcode _____

Telephone _____ Fax _____

New Home Address _____

City _____ State _____ Postcode _____

Telephone _____ Fax _____

COLLEGE ACCREDITATION NEWS UPDATE

The Australian Medical Council (AMC) is the peak advisory body to the Federal Government in regard to the recognition of medical specialties in Australia. The number of recognised specialties is increasing. Organisations may seek specialist recognition for the purposes of the Health Insurance Act (that is, to gain higher Medicare rebates). Alternatively, recognition may be sought to acknowledge specialist medical skills and knowledge, and for recognition of a particular professional organisation's education and training programs as the standard for a specific area of medical practice. The Royal Australasian College of Medical Administrators will undergo an accreditation survey by AMC in 2008. If you would like further information, or to become more involved with accreditation, please contact Bill Appleton, who is the Accreditation Co-ordinator, on 03 95928520 or baplin@bigpond.net.au.

College Accreditation as a Medical Specialty: What's it all about?

In some of the early discussions with various College groups and individuals, there seemed to be some background uneasiness about Medical Administration being acknowledged as an area of specialist medical practice.

The best response to these concerns is to look at the key issues the AMC has identified in the recognition of a specialist area of medical practice.

AMC has defined the main aims of the process of specialist recognition as being the recognition of:

- Areas that have developed in response to a need for specialist medical expertise, and which will contribute to improved standards of health care.
- Areas of practice that are based on sound clinical and scientific principles.
- Specialised areas that are underpinned by a group of practitioners with the mission and the capacity to define, promote and maintain standards of medical practice that lead to high quality health care, and which uses available health care resources wisely.
- Specialised areas whose practitioners are appropriately trained in the knowledge, skills and attitudes required for safe and competent practice, and are participating in accredited continuing professional development programs to maintain their standard of practice.

The College should be able to fit comfortably, and align with, all of these aims. The real question is not do we fit in, but rather, do we measure up.

Work in Progress

Over the past few months I have discussed accreditation by teleconference with various State and Territory committees, including New South Wales, Victoria, Western Australia and the Northern Territory. These discussions are intended to provide an introduction to the broader issues that underlie the accreditation process.

The next developmental step in our preparation is to map out a response template. The template is an itemised list of the issues expected to be covered during the accreditation process. An appropriate coordinator will be nominated for each topic, and the role of the coordinator will be to ensure we prepare a response, which appropriately addresses all aspects of the AMC standards. The template will be finalised by the end of 2005, and this will enable a first draft response to be assembled during early 2006.

MEMBERSHIP AND CANDIDATE UPDATE

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

MEMBERS

Dr. Stephen Chung
Staff Specialist
Department of Rehabilitation Medicine
Gosford Hospital
GOSFORD NSW

Dr. Caroline Clarke
Executive Director Medical Services
Royal Children's Hospital
MELBOURNE VIC

Dr. Simon Fisher
Chief Executive Officer
Medical Developments International Limited
BRIGHTON VIC

Dr. Mark Foreman
Shanghai East International Medical Centre
SHANGHAI PR CHINA

Dr. Rodney Petersen
Clinical Services Director and
Head of Department, O&G
Sunshine Hospital
ST. ALBANS VIC

Dr. Roderick McGee
General Medical Practitioner
Adelaide Road Clinic and
Quality Improvement Medical Officer
Gawler Health Service
GAWLER SA

CANDIDATES

Dr. Darrell Duncan
Senior Medical Officer
School of Infantry
SINGLETON NSW

Dr. Paul Tiernan
Executive Officer
Calvary Health Care
SYDNEY NSW

Dr. Anthony Wong
Medical Director (Part-Time)
Gawler Health Service and Wakefield Health
GAWLER EAST SA

Dr. Heidi Yeats
Deputy Director Health, Health Plans and Operations
Headquarter Air Command
RAAF
GLENBROOK NSW

All new Members are asked to contact the Continuing Education Coordinator in their State/Territory/New Zealand for assistance with joining a continuing education group.

New Members and Candidates are encouraged to forward their profiles, together with a passport size photograph to the National Secretariat for publication.

CONFERENCES 2006

20 – 22 February

15TH MEDICO LEGAL CONGRESS

Crowne Plaza
SYDNEY NSW
Telephone: (02) 9923 5090
Facsimile: (02) 9959 4684
Email: info@iir.com.au
Website: www.iir.com.au/law

1 – 3 March

8TH HEALTH CONGRESS

BUILDING A QUALITY AUSTRALIAN HEALTHCARE INFRASTRUCTURE

Four Point by Sheraton
Darling Harbour
SYDNEY NSW
Telephone: (02) 9080 4307
Email: registration@informa.com.au
Website: www.informa.com.au/health2006

2 – 4 August

ACHSE/RACMA CONGRESS

THE POWER AND THE PASSION

The Hotel Grand Chancellor
HOBART TAS

22 – 25 October

THE INTERNATIONAL SOCIETY FOR QUALITY IN HEALTH CARE 23 INTERNATIONAL CONFERENCE

IMPROVING HEALTHCARE THE CHALLENGE OF CONTINUOUS CHANGE

QE11 Centre
Westminster
LONDON UK
Telephone: (03) 9417 6971
Facsimile: (03) 9417 6851
Email: isqua@isqua.org
Website: http://www.isqua.org

OBITUARY

DR. GEORGE MACKAY SMITH

Foundation Fellow, George Mackay Smith, "Mac Smith", died in Hobart on 3 October, 2005.

Mac was farewelled at a Celebration Service held on 10 October, which was attended by Mac's family members, former Tasmanian Health Ministers, numerous medical and nursing colleagues and Mac's many friends from his distinguished 40 years health administration career in Tasmania and from his equally active community, sporting and family life.

Past College President, Jack Sparrow, whose medical administration career was fostered and mentored by Mac Smith, delivered the eulogy. Jack outlined Mac's career prior to moving to Tasmania as follows:

Born in Dungog, New South Wales in 1923, educated in Queensland, started medical studies at the University of Queensland in 1941 at the age of 18.

Stopped after one year and served in the RAAF between 1942 and 1946.

Resumed medical studies in 1946 and graduated in 1950. Intern at the Royal Brisbane Hospital in 1951, Resident Medical Officer at Nambour 1952 and 1953. Superintendent at Marrickville 1953 -1956.

In 1957, Mac moved to Tasmania, for a brief flirtation with a career in Anaesthetics as a Registrar in 1957 and 1958.

In 1959, he commenced his legendary Tasmanian and national career in Medical Administration, initially as Deputy Medical Superintendent at the Royal Hobart Hospital, where he stayed until 1962.

During 1963 and 1964 he was Medical Superintendent at Burnie, and in December 1964 he returned to the Royal Hobart Hospital as General Superintendent and Chief Executive Officer.

Mac Smith personally knew by name every staff member at the Royal, during an era when a career in medical administration was often marked by a long term of office at a major hospital or a Health Department.

There is a legion of stories about Mac's seven years as the head of the Royal Hobart Hospital, some of which Jack Sparrow fondly recalled at the Celebration.

A prominent theme was of Mac's honesty, warmth, humility and integrity.

When he was drafted by the Government in 1972 to leave the Royal to become Deputy Director General of Health Services, Mac's response to a media invitation to outline the highlights of his career at the Royal was to state "It's difficult to recall any development for which I can take credit – the changes have been in spite of, not because of, any effort on my part."

The then Board Chairman, Sir Basil Osborne, threw aside that modest statement by outlining Mac's key role in the commencement of the Tasmanian Medical School, the massive building redevelopment of the Royal Hobart Hospital complex, the acquisition of land around the hospital for future development, along with the establishment of many important new clinical services.

Mac Smith was Deputy Director General with the Tasmanian Department of Health between 1972 and 1977. In 1977 he took over from an ailing Iain McIntyre as Director General of Health Services for Tasmania, a position he held until his retirement in 1988 on turning 65 years of age.

Health services in Tasmania saw massive change and development over that 16 year period, including building works such as the planning and construction of the new Launceston General Hospital, the establishment of new nursing homes and a progressive change in the role of the network of rural hospitals around Tasmania, as the provision of aged care and community based health services took on an increasing importance.

Mac worked with no less than eight Health Ministers over his career, with the inevitable skirmishes when political imperatives clashed with common sense and sound health outcomes. Jack recalled one such difference of opinion, when a disagreement between the political and bureaucratic heavyweights of the day resulted in every Departmental Head being required to submit a confidential list of people to be made redundant to achieve cost savings. The Health Department list, compiled by Mac Smith, listed the number one candidate for involuntary redundancy as George Mackay Smith.

In 1985, his service was acknowledged by the award of a Companion of the Imperial Service Order in the Queens Birthday Honours List.

The citation was simple, but it spoke for Mac's legion of friends and colleagues, with its words "For outstanding public service in Tasmania in the field of health."

Typically, Mac gave the credit for the award to those with whom he worked and to the support of his wife Anne and his family.

There is much more which could and probably should be said about the life and career of George Mackay Smith. However, I am sure that I have said enough to bring back fond memories, particularly on the part of our more senior Fellows and Members, of a remarkable and widely liked and respected friend and former colleague.

The Editors of *The Quarterly* thank Dr. Jack Sparrow for providing this account of the Celebration Service for Dr. George Mackay Smith.

THE AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS

The 4th Australasian Conference on Safety and Quality in Healthcare will be held from 21 – 23 August, 2006 at the Melbourne Exhibition and Convention Centre.

The ACHS has called for abstracts for the Conference which the ACHS is co-hosting in partnership with the Australasian Association for Quality in Health Care.

Contributions are invited for abstracts addressing one or more of the conference themes (clinical quality, support quality and corporate quality) from general practice, primary and aged care, community and mental health, consumers, clinicians and health managers from all sectors of the public and private health system.

ADVANCE NOTICE

WORKSHOP: LEADERSHIP IN A CRISIS

For senior managers across the health system, this workshop will increase your awareness of the range of management and leadership issues that arise in major crisis situations and the different approaches required for various scenarios.

The program will feature international and local speakers with 'hands on' experience with SARS and mass casualty disasters and their impact. These include:

- Ms Bonnie Adamson, CEO North York General Hospital, Toronto. During the SARS outbreak, this Hospital managed 47 cases of SARS, 35 of whom were staff.
- Mr Mark Ackermann, Chief Corporate Services Officer, St Vincent Medical Centers of New York. Mr Ackermann was chief spokesperson for St Vincent's Manhattan, the closest trauma centre to the World Trade Center on 9/11

The one day workshop will be held in Melbourne, Perth and Sydney in mid February 2006.

Details of dates, program, venues and cost will be available in the December Quarterly.

Organised by ISQua, The International Society for Quality in Health Care (see www.isqua.org) in conjunction with DHS Victoria, Health Department of WA and the Clinical Excellence Commission (CEC) of NSW.

Supported by AHA and RACMA.

College Member Benefits

New Member Service - MEMBER ADVANTAGE ELECTRICAL

The RACMA and Member Advantage are delighted to announce the launch of another brand new member service. **Member Advantage Electrical** offers significant savings on a range of electrical items from digital cameras, TV's, home theatre systems, fridges, iPods and much more.

You find it, we'll beat it!

You can access many top brands like Sony, Hitachi, Panasonic, LG, and Kelvinator, just to name a few. What's more, all purchases come with a full manufacturers' warranty (extensions available) and will be delivered to your door FREE* at prices below recommended retail.

Access Member Advantage Electrical by logging onto www.member-advantage.com/racma
Here you can view the product lists and easily place orders in a secure and user-friendly environment.
Remember that some products may still be available even if they aren't listed.
For complete information of products available call Member Advantage Electrical on 1300 652 992 and never pay retail prices again!

Member Advantage Electrical is offered in partnership with theMembers Pty Ltd.
* May not include some remote areas.

Does your other Card compare to the Medical Colleges Australasia Gold Credit Card?

Member Advantage and your College are pleased to offer you a Gold Credit Card, which offers excellent benefits that out-weighs other comparable Credit Cards within the marketplace.

Rewarding benefits include:

- **No annual Card fee** for the life of the card. (*Save $70 p.a.*)
- **Free supplementary cards** for your partner or any family member. (*Save $20 p.a.*)
- Up to 55 days interest free on purchases.^
- Option to join one of two Membership Rewards™ program options where you can earn 1 point for every dollar spent on the card.

American Express is now accepted in more places than ever before including supermarkets, restaurants, petrol stations and most major retail outlets.

For more information or to apply online, visit www.member-advantage.com/racma
Alternatively, you can call RACMA Member Advantage on 1300 853 336.

American Express Australia limited (ABN 92 108 952 085) ®Registered trademarks of American Express Company.
Subject to terms and conditions. Fees and charges apply. Only available to Australian residents.
^ Depending on when you make your purchases, when your statement is issued and whether or not you are carrying a balance on your account from the previous statement period. There are no interest free days on cash advances and balance transfers.

Don't forget

Save time and money on your next car purchase by using the ***Member Advantage Car Buying Service***. You can access new cars at fleet prices and second hand vehicles at wholesale prices.

By all means do your homework…. then come to us and enjoy a significant purchase price discount.
For more information visit www.member-advantage.com/racma or call 1300 887 588.

THE QUARTERLY

is going electronic!

If you would prefer to receive your copy of *The Quarterly* by email, please advise the Secretariat on

info@racma.edu.au

NOTES