ROYAL AUSTRALASIAN COLLEGE of Medical Administrators

Q2. 2018

THE QUARTERLY

Joint **RACMA & HKCCM Conference**

Hong Kong

5-8 SEP 2018

Change
Disruption.
Innovation.
Transformation.

Contents

RACMA ROYAL AUSTRALASIAN COLLEGE of Medical Administrators

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 1000 College Fellows,Associate Fellows, Affiliates, Trainees and Candidates, as well as selected libraries and other medical colleges.

Publisher
The Royal Australasian College of Medical Administrators
A.C.N. 004 688 215
Suite 1/20 Cato Street Hawthorn East Vic 3123
Telephone 03 9824 4699 Facsimile 03 9824 6806
Email: info@racma.edu.au
Website: http:/www.racma.edu.au

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

The Quarterly is prepared by staff of the RACMA Secretariat.
ISSN 1325-7579
ROYM 13986

Design and Production
PI Creative – Printing Intelligence
51 Park Street South Melbourne T: 03 820 5311 E: info@printell.com.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 1979.

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, Associate Fellows, Candidates and Trainees.

From the President

Welcome to this edition of the Quarterly.

Firstly I would like to congratulate A/Professor Alan Sandford and Dr Iwona Stolarek on being the President and Vice President Elect for the College. They will take these roles on after our Annual General Meeting of 27 October, 2018. At this AGM we will see a significant change to the membership of the RACMA Board, with many Board members finishing their time on the Board. You will find profiles on Sergio Diaz-Alverez and Jeffrey Braithwaite, who are both finishing their terms as Board members and I will talk more about the outgoing Board in the next edition of the Quarterly. The elections for new Directors in the Candidate and Associate Fellow are still ongoing.

The College is entering one of its busiest periods for years. September sees our Annual Scientific Meeting being held in Hong Kong in conjunction with the Hong Kong College of Community Medicine (HKCCM). I would like to recognise the work of A/Professor Alistair Mah and the Steering Committee and Dr Mellissa Naidoo and the Program Committee on their work on the conference. I look forward to see many of you in Hong Kong at what will be a great conference.

October sees the AMC undertake their accreditation visits across Australia and New Zealand and spend a week with the RACMA Committees and staff. As you all know this is an important process for the College, to view our submission on the RACMA website click here - I encourage you to read it. I would like to recognise the work of the Dean, Dr Lynette Lee in preparing this submission.

As the end of my term as President draws close, I look forward to reflecting on the work of this board in the next edition of the Quarterly.

See you all in Hong Kong.

Prof Michael Cleary PSM
President

Censor-in-Chief Update

2018 has seen the Board of Censors (BoC) and other key College groups tirelessly continuing the work commenced last year on the further development and refinement of the RACMA Programmatic Learning and Workplace based Assessment processes. This is a collaborative process that aims to deliver a 'fit for purpose' model that meets AMC Standards and is in accord with contemporary education platforms which the College demonstrates.

Other key activities of the BoC for the year include:

- a comprehensive review of the examination/assessment processes;
- fostering of an appropriate appraisal environment for assessments using contemporary and equitable methodologies;
- a review of the Declarations of Interest guidelines for Censors and Candidates;
- implementation of rigorous peer review processes: and
- reviewed and updated regulations and guidelines.

Liaison with the Candidate Advisory Committee and the sharing of feedback which resulted in review of processes was also noteworthy and facilitated by the Chair of the Education and Training Committee.

We have inducted and welcomed in a number of new Censors throughout the year. These new Censors are a diverse group of highly skilled professionals who are committed to contributing to College activities and standards.

The Board of Censors continues to be an extraordinarily valuable and generous gathering of professionals committed to supporting, maintain and developing College assessment and learning processes aimed at enhancing standards and clinical system integrity.

As Censor-in-Chief, I have the pleasure of working with a committed group of Fellows of the College. We have record numbers of Candidates undergoing Fellowship and I would encourage anyone who may be interested in becoming a Censor, to contact me via the College. The role is interesting and rewarding and for younger Fellows, you will be provided with appropriate induction, training and guidance. As a group of peers the interaction and peer support within the group is both powerful and enriching for those that participate.

A/Prof Alan Sandford AM
RACMA Censor-in-Chief

Dean of Education Update

By the time you are reading this update, many of you will have been involved in completing the mid-year In-Training Performance Report, either as Candidates or as Supervisors of Training. The 'new-look' report has more opportunity for Candidates to log the many activities in which they have been involved in their self-directed learning, in preparation for their 'sign-off' meetings with their supervisors; and more flexibility for supervisors to comment on specific areas for future development in medical administration practice as they complete the learning objectives rubric in the second part of the report.

Pilot rubrics for observed management tasks and for guided reflection sessions have been provided for those Candidates who wish to use them.

These ITP reports will be collated by College Office staff for review by the Training Progress Committee, which is made up of Jurisdictional Co-ordinators of Training. Your satisfactory progress in supervised medical management practice is recorded in terms of time (three months or six months full-time equivalent) in your training records.

We will be seeking feedback later in the year on your opinions on the usefulness of the guides for observation and feedback, which have been developed; and your thoughts on improvements that could be made.

As many of you are aware, our Curriculum (with its learning objectives, training syllabuses and modes of assessment) is now ten years old. The Board has had two special planning topics in the past two years – our position on Clinical Governance and our position on Digital Health in Health Systems – which have implications for adoption and adaptation for the Curriculum for trainees in their learning as they progress to Fellowship and for Fellows as they maintain their personal and professional continuing education.

The second development that has kept us busy in this quarter has been the preparatory meetings of the Curriculum Steering Committee for a renewal of the Medical Management and Leadership Curriculum over the next two years. Working groups on all aspects of the Curriculum will be meeting in the second half of 2018 to identify our priorities and plan our consultations. Expect to be surveyed on these issues as well!

Dr Lynette Lee
Dean of Education

The 2018 Annual Scientific Meeting boasts a jam-packed program including hospital tours, workshops, two days of plenary sessions and plenty of time to connect with peers. Hosted by the Royal Australasian College of Medical Administrators (RACMA) and Hong Kong College of Community Medicine (HKCCM), this year's conference will also incorporate the World Federation of Medical Managers Forum.

Join hundreds of delegates from Asia, New Zealand, Australia and beyond to learn more about the medical leader's role in leading positive disruption, transformational change and innovation.

Be an integral part of forming ideas on future processes and methods for competency and training of medical managers for disruptive change in healthcare. A number of international leading medical professionals will also examine approaches to occupational health, workforce culture and policy for staff wellbeing. You can also take advantage of a number of workshops to discuss and challenge industry ideas and practices surrounding these topics.

KEY SPEAKERS INCLUDE:

Dr Steve Boorman (UK), who trained as a specialist GP before moving to a 30 year career in occupational medicine. Dr Boorman spent more than 20 years working with Royal Mail developing innovative approaches to occupational health improvement and was commissioned by the UK Health Secretary to highlight the links between good staff health, improved patient outcomes, better efficiency and higher performance against Regulatory targets in the NHS. Dr Boorman received the CBE for services to occupational health in 2013 and is an Honorary Professorial Fellow of the Royal Society for Public Health. Dr Boorman chairs the UK Council for Health and Work, which has more than 750,000 members.

Professor Graham Dickson, who trained as a specialist GP Professor Emeritus at Royal Roads University Canada and founding director of the University's Centre for Health Leadership and Research. His specialty is leadership development and succession planning within the health sector. Graham was the principal investigator in the cross-Canada research project on the LEADS in a Caring Environment framework. This framework has been endorsed by the Health Care Leaders' Association of British Columbia, the Canadian College of Health Leaders and the Canadian Health Leadership Network, including the Canadian Medical Association. Graham is academic advisor on the Board of Directors of the Canadian Health Leadership Network and a member of the Physician Assistants Certification Council of Canada.

Dr Bertalan Mesko (Hungary), PhD, who analyses how science fiction technologies can become reality in medicine and healthcare. He is globally renowned for his voice on healthcare technology.

Dr Grace Frelita (Indonesia), who introduced the Joint Commission International (JCI) Accreditation to Indonesia in 2007.

Prof Mike Daube (Australia), who is a leading figure in national and international action on tobacco, alcohol, and other public health issues for 45 years.

RACMA
ROYAL AUSTRALASIAN COLLEGE
of Medical Administrators

Report from the Education and Training Committee – 2018 Overview

(Incorporating the work of the Dean, the Research Training Domain, the Training Progression Committee, the Rural Advisory Group, the Continuing Professional Development Committee)

Professionalism, Respect, Integrity, Excellence

As a sub-committee of the Board, the aim of the Education and Training Committee (ETC) is to provide advice to the Board on the strategic directions and development of the educational activities of the College including the Fellowship Training Program and the Continuing Education Program. The ETC oversees the development of policies related to assessment, training compliance, accreditation and any matters emerging from its sub-committees. The ETC will make recommendations to the Board for final approval.

The College activities around the AMC accreditation, transition to a programmatic and work-based assessment of learning shaped the discussions and determinations made by the ETC, developing a range of actions and objectives, in particular with the aim of improving the delivery of the Fellowship Training Program, its cost effectiveness and learning outcomes in the implementation of the programmatic and workplace based assessment. The ETC has also engaged in the discussions to strengthen RACMA governance of the Fellowship Training Program and the College management structure.

1. The ETC has appointed a Community representative to enhance Consumer Engagement in the RACMA governance in line with the AMC requirement. The Board is considering future appointments of community representatives on all appropriate committees.
2. The ETC continuously reviews Policies and Regulations from its sub-committees in relation to governance and assessment in the Fellowship Training Program (FTP), as well any establishments of specific-purpose panels, working groups and committees proposed by the Dean of Education to meet the objectives set out as a result of the College's adoption of Programmatic and Work-based Assessment. These have included:
    - Programmatic and Work-based Assessment Working Group (set up for a short-term advisory committee to develop an implementation plan for the Programmatic and Work-based Assessment).
    - Curriculum Steering Committee (reconvened to review the RACMA Curriculum, address deficiencies in the delivery of the Fellowship Training Program and develop clear learning objectives in Medical Management Practice and Personal and Professional Leadership Domains)

Function for the CSC would be to consider the development of a 'structure' for training in the context of WBA for part and full time candidates, ensuring maximum consistency for mandatory training requirements and knowledge development, and making the FTP as a 'fit for purpose' program that satisfies the requirements of an efficient medical administrator.

Other activities instigated by the Dean, with the ETC Chair, include:

- Review of the RPL process and business rules around exemptions and credit for academic and training elements/study components
- Instigation of meetings with the JCTs to address Candidacy issues and roles of the JCTs
- Establishing ongoing Supervisor Training Programs, including a workshop on 5 Sept in HK
- Appointment of a Lead Fellow for the Personal and Professional Leadership Development Domain (PPLD) in the FTP to improve its syllabus development and assessment.
- Development of e-Modules in the FTP as part of the integrated learning Model on a range of curriculum topics and FTP domains.

3. The ETC has reviewed it membership and Terms of Reference at the start of 2018 and will further review these in line with the proposed developments in the governance and management structures around FTP. These are in discussions with the Dean of Education and will be presented to the ETC with appropriate recommendations for review and endorsement to the Board.
4. The Research Training Domain (RTD) Committee has undertaken a review of the Research Training Program and its assessment via conducting strategic evaluation and surveying candidates in the FTP undertaking RTD, recently graduated Fellows who can provide input on their experience and views of the program, and the RTD Assessors engaged in the assessment of research related work, including Oral Presentations as summative assessment. Recommendations on the findings from the review will be forwarded to the ETC once they are formally finalised. It should be noted as well that the RTD committee has appointed a Candidate Representative on its membership. In particular, the review of the RTD focuses on the following objectives:
    - Reflections on the significance of the RTD current requirements
    - Improving delivery of the RTD objectives and learning outcomes
    - Enhancing the robustness of the program and its 'fit for purpose'
    - The quality and scope of research projects undertaken by Candidates in a 3 year training program
    - Developing the monthly teleconferences with the candidates into a more robust and educationally based mini-training research programs that build on the objectives and learnings of the RTD and have these to underpin theoretical studies as well.

The College should note that the review is a timely one for the AMC re-accreditation and will develop strategies in the RTD to be incorporated in the Programmatic and Workplace Assessment.

5. The ETC notes the work of the Training Progress Committee (TPC) whose role is to review performance of Candidates and develop recommendations for remediation of those identified at risk by the Committee. The Committee comprises Chair, the Dean of Education and the Jurisdictional Coordinators of Training. The ETC have endorsed the TPC's revised Terms of Reference so as to tailor to the Programmatic Assessment objective of the transition from a progression model of learning in preparation for an exit examination, to an integration model wherein Candidates satisfactorily complete each of the four learning and assessment domains of the FTP.

   The work undertaken by the TPC brings to the College's attention some serious issues associated with a small number of Candidates who have not engaged in the FTP for a long time and that developing required business rules on how to formally address these issues will be considered in the near future. The ETC also would like to acknowledge the work by the College Office and the JCTs in the actioning of a large number of follow-ups from the meeting and brining Candidates' issues to conclusion. In the past, the College had no data on poorly performing Candidates and we have now developed an on-going and comprehensive data base/ dashboard on all Candidates' progress in the FTP, which is impressive and provides a great overview of Candidate's performance. The Committee also noted an increasing level of engagement from the JCTs, including NZ, over the years and their commitment to remediation of Candidates. The TPC also have highlighted the need to focus on Candidates who have failed exams in the past and who require specific support for them to proceed to the exams again.

6. Engagement with Candidates: The ETC Chair and the new Chief Executive met with some Candidates last October at the RACMA Annual Conference to discuss a range of concerns raised around FTP, Jurisdictional issues, supervision, preceptorship, quality of service and support from the College and quality of communication. Together with the CE and the Dean, the ETC Chair have been developing remediation strategies and a plan of support to improve their candidate experience.

7. Subsequently, the Chief Executive implemented a newsletter to Candidates with a range of communications for the Candidates, including:

   a. The establishment of an EAP counselling service available to Candidate through the College via an independent external provider.

   b. The inclusion of the Chair of the Candidates Advisory Committee (CAC) on its membership.

   c. Changes to trial examination schedules

   d. A review of fee schedules for part time candidates

8. The ETC endorses the applications to Fellowship Training Program as part of its governance role and approves the entry to CPD education programs of doctors who seek membership with the College in categories of AFRACMA. The ETC also endorsed the accreditation of the Queensland Rural and Regional Medical Leadership and Management late last year for implementation from Jan 2018.

9. The ETC recommended to the Board consideration of an action plan for the Reconciliation in the context of Indigenous Australians which incorporates existing RACMA activities and the RACMA training program. This consider improvements in the support the recruitment and training for Indigenous Candidates towards RACMA specialist qualification.

10. The ETC noted the work undertaken by the Rural Advisory Group (RAG) who makes the recommendations to the ETC on matters related around improvement of training and support for Candidates in rural and remote regions while undertaking FTP. The committee agreed that it's vital to ensure that contextualising an indigenous aspect from NZ perspective in the work and development of RAG (and include Maori context in the RAG's Terms of Reference), noting that there is a significant deficiency amongst Australian doctors on indigenous matters for Australasia. It was highlighted by the Committee that Board will be having significant discussions on RACMA's policy and strategy on Indigenous health and Indigenous service matters. The

Report from the Education and Training Committee – 2018 Overview

discussions will include both Aboriginal and Torres Strait Islander and Maori and Pacific Islander issues.

11. Under the leadership of the Dean and CE, the ETC Chair, as the Board sponsor, has been engaged in the work for the submission of the AMC re-accreditation report, with the following updates:
    - The AMC has set up a Panel of 7, to be chaired by Professor Ian Civil
    - The RACMA submission was completed and provided to the AMC by the due date of 12 June.
    - The Panel will meet with the RACMA project team on 15 August - the team consists of ETC Chair - A/P Pooshan Navathe, the Dean - Dr Lynette Lee, and Ms Melanie Saba - RACMA CE.
    - The AMC Panel will visit the RACMA Trial Oral Examination in Sept 2018
    - The AMC panel will visit a range of training posts during the week beginning 8 October, and these will include meetings with the Jurisdictional committees
    - The AMC panel will visit the College in the week beginning 15th October. They will be expecting to meet with members of committees such as the Board, the ETC and BOC, the Training Progress Committee, the CPD Committee, and the Candidate Advisory Committee.
12. The ETC works closely with the CPD Committee and its Chair, reviews the recommendations from its meetings and engages in the discussions on the new CPD standards and peer review requirements. The Chair of the CPD committee reported that:
    - CPD Committee membership is excellent and reflects the work on the evaluation of the CPD compliance of the members
    - A report would be provided to the Board on non-compliant members, audited by AHPRA
    - The CPD compliance audit was enabled more efficiently with the migration of the CPD into the new myRACMA system, and new FAQ forms, instructions for members on CPD submission, new templates are being developed for members to outline their CPD activities and guidelines for what can be included.
    - The ETC may consider for future reference the College's role and status on its obligation to report non-compliant RACMA members to the regulatory authorities.
13. The Chair ETC works very closely with the Board of Censors and the Censor in Chief to develop a Professional Development training program for Censors to enhance examination techniques and provide peer review feedback. Further sessions were provided to censors in May 2018 aimed at a better understanding of the reasons for inter-rater differences. The footage from the recordings made at the National Trial exams last year was used for upskilling in the examination processes. Moderation processes have been improved by simulating moderation at the trial exams and holding a feedback session at the end to review the processes.
14. The ETC Chair and the Censor in Chief attended the Ottawa – ICME conference and underwent the Fundamentals of Medical Education (FAME) course (with partial support from RACMA). It was pleasing to note that RACMA has adopted contemporary methods and processes in line with the world assessment standards in medical education. Further areas for review and reflection have been identified for adaptation in the RACMA Assessment Framework.

RACMA members are well aware that Committees and Chairs are only as effective as the people who actively participate in the work of the group. Much of this work is done after hours and on weekends. I posit that the knowledge and experience of this group of professionals is second to none, and I would like to extend my sincere appreciation for the dedication and commitment of all members on the ETC and all the sub-committees and thank them for their participation. Lastly, but importantly, I thank the CE and the members of the National Office who have shown initiative and diligence, and without whose assistance (dare I say it, nagging) these outcomes would never have eventuated.

A/Prof Pooshan Navathe
Chair, ETC and RACMA Board Member

Continuing Professional Development Update

MyRACMA

The new MyRACMA platform is now up and running and has received positive feedback regarding the functionality and access it provides. Since the launch in June:

- more than 70% of members have logged into the site;
- more than 25,000 CPD records have been imported into the system; and
- There has been 100% access, with no time offline for the application.

We have made it easier for you to enter your activities and points on the new platform, which is also accessible on your phone and tablet. Log in via the RACMA website and take advantage of the user friendly dashboard, which highlights the number of points achieved against each CPD category together with a clear overview of your progress

All previous CPD information has been migrated to MyRACMA and is available for you to access as well as supporting templates and reference guides to help you complete your CPD activities. You will also be able to print certificates and activity statements once sign off has occurred.

We thank everyone who provided feedback which helped guide the development of the new platform. If you have any queries or need help accessing MyRACMA email cpd@racma.edu.au

Continuing Professional Development Update

CPD Points Reminder

Now is a good time to take stock of the training and professional development you have undertaken and record your points. Avoid the last minute rush and stress of back tracking through the whole year to find the details of each activity completed. Give yourself time to organise any further professional development needed. Log into MyRACMA to track your progress and find out about upcoming CPD activities.

New Handbook

After extensive consultation and feedback, we have updated the CPD manual to provide our members with a simplified handbook which clarifies CPD requirements for 2017-2018. This handbook seeks to meet the flexibility requirements for our members; it supports the elements of self-reflection, professional development, peer review, audit and continuous medical education. For an electronic copy of the new handbook go to

http://www.racma.edu.au/index.php?option=com_content&view=article&id=401&Itemid=116

CPD contacts

For any queries regarding CPD, don't forget to contact your jurisdiction's co-ordinator or the Chair for further information or help.

Chair of CPD Committee
Dr Elizabeth Mullins
Email: cpd@racma.edu.au

Australian Capital Territory
Dr Kate Tindall
Email: cpd@racma.edu.au

New South Wales
Dr Yogendra Narayan
Email: cpd@racma.edu.au

Queensland and Northern Territory
Dr Dale Seierup
Email: cpd@racma.edu.au

South Australia
Dr Nes Lian-Lloyd
Email: cpd@racma.edu.au

Tasmania
Dr June Song
Email: cpd@racma.edu.au

Victoria
Dr Ian Graham
Email: cpd@racma.edu.au

Western Australia
Dr Allan Pelkowitz
Email: cpd@racma.edu.au

New Zealand
Dr Virginia Hope
Email: cpd@racma.edu.au

Hong Kong
Dr Helen Tinsley
Email: cpd@racma.edu.au

Fellow Q&A Profiles

Professor Jeffrey Braithwaite

BA [UNE], DipLR, MIR [Syd], MBA [Macq], PhD [UNSW], FIML, FACHSM, FAHMS, FFPHRCP [UK], FAcSS [UK], Hon FRACMA

- International Society for Quality in Healthcare President-Elect, Founding Director, Australian Institute of Health Innovation

Director, Centre for Healthcare Resilience and Implementation Science, leading health services and systems researcher.

- retiring Honorary Fellow Board Member (External)

What attracted you to take up the role of a Board member of RACMA?

In late 2011 I was approached by Roger Boyd, then Chair of the RACMA Board, with a message from the Board that they would like to appoint an independent member. Roger asked: would I consider an invitation to join the Board? Much more than merely being willing to accept an invitation, I was both delighted and humbled to have been asked. I took up the appointment on 27 February 2012.

I have been involved with RACMA candidates, participants and fellows for 25 years, going back to the time when at UNSW I taught subjects in the Master of Health Administration program (as it was then) and through this mechanism, I met every year a range of RACMA Candidates and other RACMA colleagues doing an MHA. I was also a frequent attender and contributor to RACMA educational events. So, my reply to Roger was that I already felt part of the RACMA enterprise way before I ever had any formal involvement.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?

In my view (although admittedly I am fully committed to the RACMA cause and therefore biased) having medically-qualified people in leadership and management positions is crucial. Medical Administrators/Fellows/Members bring something to the table that is both tangible and intangible. It is of key importance to healthcare all the way from policy through leadership and management of organisations and services through to the clinical frontlines of care.

I gave a presentation to the 2015 International Medical Leaders Forum in Hong Kong, discussing one of my edited books in health reform across the world. At that talk I made the point that medical leaders are the glue that make things work clinically and they are, in reality, the initiators, interpreters and translators all the way from policy and politics in the upper echelons of systems through to the way things function at the coalface. As I think about that three years on, the point I was making is more relevant now than ever before. RACMA is where the discipline of medicine meets the benefits of good management. Try running an effective health system without RACMA's contribution, is what I say to people at every opportunity.

Is there a particular achievement of RACMA during your tenure on the Board that you are most proud of?

It's not so much about my achievements, but RACMA's successes, to be frank. There's a lot of these, but for me the 50-year celebrations were amongst the most uplifting of things to occur for ages. These events brought many achievements together, and allowed us to sit back as a community (and even though I'm an independent member, I consider myself fortunate to be a member of this community) and celebrate individuals, their careers and success stories going back into the mists of time when RACMA was first formed. It really was a pleasure to be part of those and revel in the many achievements that RACMA-associated people have contributed.

You were made an honorary Fellow of RACMA in 2016- what does that recognition mean to you?

This came completely out of the blue. The Board had managed to have discussions without me being in the loop and I was suddenly asked to gown up and receive this award after I'd given a talk at the annual conference that year. I know because of my longstanding involvement with RACMA that an Honorary Fellowship is awarded only every now and again. I'm fortunate to be a Fellow or member of quite a number of colleges and societies and, as I said at the time, because of my long-term support of RACMA this was the most thrilling of things for which I have received an award. I remain forever grateful for being conferred, and have the Honorary FRACMA placed on my CV and letterhead with pride!

What is next in the career of Professor Braithwaite? You recently published a new book Healthcare Systems: Future Predictions for Global Care- what can you tell RACMA members about this publication

My teams' and fellow investigators' research in the Australian Institute of Health Innovation at Macquarie University is going from strength to strength. I am series editor on three books on health reform across the world. This latest 2018 book, Health Care Systems: Future Predictions for Global Care asked authors in 152 countries what they think the future of healthcare is and how they are coping with the transformation of their system in this turbulent, fragmented and challenging era.

In addition, I'm doing work on patient safety, implementation science, human factors, health systems reform, accreditation, and research to try and improve health outcomes. I am also leading with my colleagues a large NHMRC grant to help create a more sustainable health system, another looking at how to get evidence into routine practice in oncology and another on documenting how much of care is in line with evidence or consensus-based guidelines in residential aged care facilities.

I'm also supervising higher research degrees and running projects which underpin new models of how to change healthcare for the better. For example, with colleagues I am leading a series of projects looking at why change is so difficult and how conceiving of healthcare as a complex adaptive system presents new challenges but also offers opportunities to think in more sophisticated ways about shaping the system and transforming it over time. Using this complexity lens, we are looking at, for example, how to bring genomics into routine practice and how to be better at doing quality improvement.

Interested readers can go to http://aihi.mq.edu.au/people/professor-jeffrey-braithwaite and scroll down to Publications to find collections of articles and summaries of books. Needless to say, all of this is at least partly designed with RACMA interests in mind. I will continue to do research which I hope is relevant to the interests of all those associated with RACMA into the future as I leave the Board. In fact my final point is I may be leaving the Board but I'm certainly not leaving RACMA. It was H. Jackson Brown, Jr. who said: "Acquaintances we meet, enjoy, and can easily leave behind; but friendship grows deep roots." Thanks to my fellow Board members, 2012-2018, and all those in the RACMA family, for the opportunities and friendship.

Fellow Q&A Profiles

Dr Sergio Alvarez

MBBCh, FCP, FRACP, FACP, MAICD, PDip Diabetes, PDip Critical Care, PCert Clinical Ultrasound, MClin Med (Management and Leadership), FRACMA

- Retiring Candidate Board Member

What attracted you to take up the role of a board member of RACMA?

I have been involved in Board duties in other professional societies but this position was particularly attractive because I felt I could form the interface between trainees and the Fellowship by leveraging my understanding of College matters as discussed at a Board level. I felt 2017 was a rather complex year for trainees coming out of the poor results in the exit exams. Thus it was important the curriculum and other developments being discussed at a board level were being influenced by a candidate with an understanding of the programmatic needs of the pathways to fellowship.

I was also interested in gaining a deeper understanding of the breadth of issues a College Board has to grapple with, especially leading up to an AMC accreditation.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?

RACMA trainees and Fellows contribute on a daily basis to the fabric of the health care system in Australia. The interface between executive and administration and the clinicians is a difficult one and is fraught with the nuances of clinical practice. Experienced clinicians with training in both the science and art of medicine, but also systems awareness are critical to the long term success and sustainability of the system. There continue to be clinical governance challenges and RACMA Fellows need to be leaders in this area and provide the context for clinical care.

Most importantly, I feel much of clinical medicine is carried out by individuals on individual patients and RACMA Fellows need to be at the forefront of providing clinicians with the leadership and the tools to carry out effective, efficient and safe care of the highest quality.

Is there a particular achievement of RACMA during your tenure on the Board that you are most proud of?

I think it is difficult to pinpoint a specific example. I think my focus was to try to re-instil a sense of trust between trainees and the College and to try to provide closer linkages between jurisdictions, the college and the Candidates Advisory Committee. I feel I have hopefully laid the foundation for this journey.

I am also passionate about education and I hope some of the work we have done at a Board and College level, to provide educational opportunities for trainees and Fellows, will continue to mature into a national standard in leadership education for clinicians.

What is next in the career of Dr Diez Alvarez? Will you continue to be active in RACMA?

I want to continue to provide support for other trainees and my linkage is currently through supportive education for those undertaking the exam in 2018 and beyond.

I also hope to form a group of young Fellows willing to take the College forward and advocate the introduction of leadership and managerial training to a broader range of clinicians in the future.

Dr Sidney Chandrasiri

MBBS

Dr Sidney Chandrasiri is Acting Executive Director Academic & Medical Services and Director, Medical Workforce & Clinical Training at Epworth HealthCare

What lead you to undertake the Fellowship training program of RACMA?

At the risk of being labelled a cliché, medical management had actually always been my true calling – I just never knew it. At least not until the end of my internship, when a senior specialist said to me "how is it that you seem more interested in running this hospital than being an intern in it?" That moment was somewhat pivotal for me. It acted as something of a trigger, because I began really reflecting on what seemed to be an inherent inclination for this field. Although I had always found the one on one patient interactions very rewarding, I realised what I genuinely wanted was to be able to influence healthcare on much larger and grander scales, and lead change for better patient care that has the potential to impact whole populations of patient cohorts at a time. The Superintendent of the hospital, who was a great mentor to me at the time, directed me to RACMA specialty training and it was from there that a clear path was illuminated, and what led to the start of this incredible journey through RACMA Fellowship training and of medical leadership.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?

Although I'm still at an early stage in my career, I have had the great privilege of working with many senior medical administrators thus far, including both those who are RACMA Fellows and those who are not. As a result, I have first-hand experience to appreciate that holding College Fellowship is an absolute imperative in being an effective medical leader. However, I don't believe that's enough. I think one needs to venture beyond that. What is truly important to the Australasian (or any other) health care system in its medical leaders, are those administrators with a true and genuine commitment to improving the status quo and those with an unwavering dedication to patient safety above all else. Qualifications or certifications can certainly equip us with the foundational skills for navigating the complexities of the healthcare system. But ultimately it is the inherent conscientiousness and authentic intentions for healthcare improvement that drives medical leaders to make the right decisions, in ensuring a higher standard of clinical governance for our patients and communities.

What are the challenges you can see that RACMA will face in the future?

Adapting to meet the evolving training needs of a specialist medical admin workforce, in order for them to be equipped to work across an expansive and ever growing breadth and depth of medical leadership roles and healthcare contexts, will be a key challenge for RACMA going forward. The increasing advancement of private healthcare into domains that traditionally may have been the purview of public hospitals (such as medical education and research) and increasing state based regulations aiming to align the private-public health governance chasms, are both emerging disruptors that shouldn't be underestimated. Medical management workforce maldistributions particularly in regional/rural contexts, impending shortages of registrar training positions amid funding constraints and challenges in meeting targets for gender and racial diversification of our medical admin specialist workforce, are further potential concerns. I believe that under the stewardship of our new CEO, RACMA is well placed in developing a proactive and strategic approach to these challenges and I look forward to the future growth and positive influence of the College across many of these areas.

What is next in the career of Dr Singithi (Sidney) Chandrasiri? Now that you are a Fellow of RACMA how would you like to continue to be involved in the work of the College?

Having started as a FRACMA in the private healthcare context, I am looking to consolidate my career in the public health sector and build a well-rounded portfolio of skills and experience across clinical, corporate and board governance roles. I hope to also continue my passion for furthering academic writing and publishing in the field of medical administration and endeavour to progress innovative initiatives for women in healthcare leadership. I feel very fortunate I have been offered opportunities to contribute to the work of the College already as a first year FRACMA, through my current role as a Supervisor of a RACMA registrar, a Mentor for an exam candidate, member of the Victorian RACMA State Committee, and being part of the exciting new work being undertaken by the National RACMA Curriculum Steering Committee. I think there is great potential for RACMA as a Specialty College to shape the future direction of medical leadership across Australasia, and welcome opportunities for involvement in other key areas of work and in helping to lead the College through the exciting times ahead.

I also hope to form a group of young Fellows willing to take the College forward and advocate the introduction of leadership and managerial training to a broader range of clinicians in the future.

Fellow Q&A Profiles

Professor George Braitberg AM

MBBS, FACEM, FACMT, FRACMA, MBioethics, MHlthServMt, Dip Epi Biostats

– RACMA Fellow, Executive Director Strategy, Quality and Improvement Royal Melbourne Hospital, Director Barwon Health, Professor of Emergency Medicine, Department of Medicine Royal Melbourne Hospital and University of Melbourne and Director of Emergency Medicine, Royal Melbourne Hospital.

What lead you to undertake the Fellowship training program of RACMA?

I have been a Director of Emergency Departments for 30 years and while the clinical aspects of patient care are still important to me over the last few years I became increasingly interested in how doctors work together, how they make decisions and how they understand the complexities of the healthcare system in which we work. I completed a Master of Bioethics in 2014 which furthered my interest in the behavioural and governance issues in healthcare delivery. This led me to the RACMA Fellowship training program. I have always believed that in order to understand an issue it was important to acquire the knowledge and tools necessary to deal with it, whether it is emergency medicine, toxicology, or health system literacy. Until now medical schools and professional colleges have not taught clinicians about the environment in which they work. We are taught how to deal with the patient in front of us but not about the consequences of our decisions beyond that. As my interest in healthcare delivery grew I realised that I needed to undertake Fellowship training to gain expertise in medical management. At the time of starting training I organised a secondment to Safer Care Victoria as a Senior Medical Advisor which provided me with an insight into policy development and large scale project management. My career has now moved into healthcare quality, innovation and improvement with my appointment as Executive Director of Strategy Quality and Improvement at Melbourne Health; an appointment that would not have been possible without RACMA training. I am fortunate that I can still continue with my research interest in emergency medicine and have now been given the opportunity of designing a unit on Innovation and Implementation in Healthcare through my appointment to the Health Sciences Unit at Monash University. I continue to do a shift the Emergency Department to maintain my clinical skills which also provides me with the opportunity to engage with patients and staff in a clinical setting.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA to the Australasian health care system?

I believe the major impact that RACMA Fellows have on the Australasian health care system is that they provide the leadership, advice and expertise that promotes an understanding amongst "disease specialist" doctors that decisions taken in a health service must be inclusive of the needs of all providers and lead to improved patient care. The RACMA Fellow must be able to translate the prioritisation process taken in organisational decision making to clinicians while representing doctors at the table where those decisions are made. The RACMA Fellow provides a "whole of system understanding" to clinicians and influences and supports them in understanding system priorities. The Medical Administrator safeguards the system by inserting clinical governance principles into organisational discussions and provides the rationale for the use and acquisition of technology, the reduction of variation in practice, the use of data for measuring clinical outcomes and ensuring patients receive care from doctors that are credentialed and appropriate to deliver that care. RACMA Fellows are best placed to ask "why" and challenge the status quo of care delivery in a diverse range of clinical settings.

What are the challenges you can see that RACMA will face in the future?

I believe the single biggest challenge facing the RACMA Fellow remains the culture of "single disease specialist" care. Changing the conversation from "my patient" to our patient is increasingly difficult as "super specialisation" of the medical profession continues. Excellent patient care is not about improving the care of one patient at a time; it is about creating a system where the most patients benefit. In some ways the challenge is Rumsfeldian; influencing a doctor who doesn't know what they don't know, the so called "unknown unknown." Another major challenge is safeguarding the care of vulnerable populations in a competitive case-mix activity based funding model. The introduction of electronic medical records and artificial intelligence will challenge and change our care delivery models and the Medical Administrator will take an increasing role in the translation of safe clinical practice into the digital world. Digitisation is one of the biggest change management projects that any health care provider will undertake. In terms of the challenges facing the College it must become more relevant to younger clinicians who want to undertake a clinical leadership role without necessarily wanting to be full time medical administrators. What can RACMA offer these emerging leaders that will prepare them in a way that is compatible during the most "practice busy" times of their careers? I became a Director of Emergency Medicine at the age of 31 and had to develop my management skills through trial and error and mentorship. While leadership programs exist RACMA must be seen as the "go to" place for courses and support, as it must be seen by government seeking input into policies and issues of clinical governance and system safety.

What is next in the career of Professor Braitberg? Now that you are a Fellow of RACMA how would you like to continue to be involved in the work of the College?

Having been a State Censor and Senior Examiner of the Court of Examiners of the Australasian College for Emergency Medicine (ACEM) I am keen to be involved in the move towards worked based assessment (WBA) in the RACMA training program. ACEM went down this pathway 6 years ago and I believe I can bring the benefit of this experience (the good, the bad and the ugly) to RACMA. I have always loved interacting with trainees as a teacher, mentor and collaborator and would hope to continue with this opportunity through the College. As a lifelong learner I am keen to contribute to the College as I develop further in my current role. My next career goal is to balance my interests so that they add to each other; administration, clinical and academic and personal. I am extremely fortunate to be in the position I am in and have a great deal to be thankful for, first and foremost my wife, children and grandchildren.

Dr Monica Trujillo

MBBS (COL) MPH FACHI
- RACMA Fellow

Dr Trujillo undertook her medical training in Colombia before migrating to Australia and becoming a Fellow of RACMA in 2009. She is currently the Chief Clinical Information Officer & Executive General Manager Clinician and Consumer Engagement and Clinical Governance at the Australian Digital Health Agency.

What lead you to undertake the Fellowship training program of RACMA?

Medical Administration is a fascinating specialty. The ability to make a difference to a community's health and well-being as a whole was really appealing to me. When I learnt there was specialty training in this area I seized the opportunity.

How would you describe the importance of qualified Medical Administrators/Fellows/Members of RACMA?

As medical practitioners we are uniquely equipped with understanding, designing and developing health systems that are fit for purpose. In addition to this, once we add the special skills gained by RACMA training we are uniquely positioned to be leaders in all areas of the health sector.

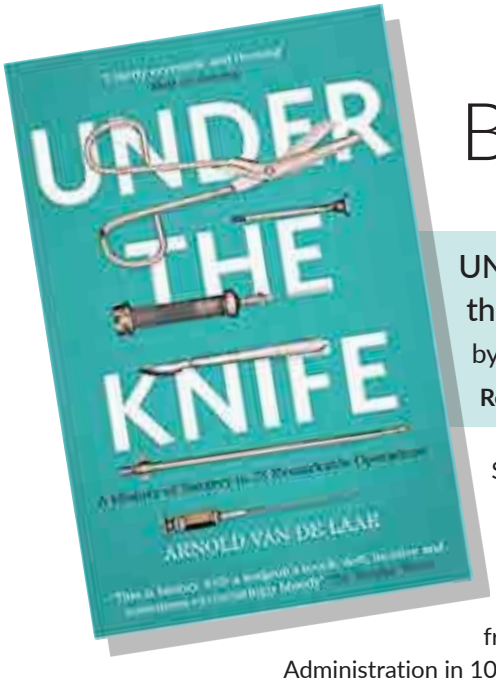
What are the challenges you can see that RACMA will face in the future?

There are many challenges for current RACMA members and for future ones but the most immediate and pressing is digital health. Digital technologies already are present in every aspect of our daily lives. This is no different in healthcare where consumers expect and deserve better. We are seeing a range of digital health products and services emerge and we need to be prepared to embrace, respond and lead them.

The introduction of new technologies will change how we design, deliver and implement new health initiatives. RACMA fellows should be prepared to understand all aspects of technology and be leaders in all aspects of change.

What is next in the career of Dr Trujillo?

Since focusing on digital health, I have witnessed firsthand what a difference technology and data can make to the individual patient encounter, as well as the community at large. It is a real privilege to be at the forefront of this change and to be able to make a difference, this is a space worth working in!



Book Reviews

UNDER THE KNIFE:
the history of surgery in 28 remarkable operations

by Arnold van de Laar; John Murray; London; 2018

Review by: Robert Grogan, FRACMA

Should readers of The Quarterly pen their memoirs they may well be titled anything from 'Medical Administration in 100 Triumphs' to 'Medical Administration in 100 Disasters'.

Arnold van de Laar has chosen to write a history of surgery by describing 28 operations. The author works at the Slotervaat Hospital in Amsterdam. The book is based on articles that originally appeared in the Dutch surgical journal, Nederlands Tijdschrift voor Heelkunde.

The operations vary from circumcision to appendicectomy, and the recipients of the procedures Involving both well known, and not so well known patients, range through history from Abraham to President Kennedy and the Shah of Persia.

Each chapter begins with a description of an operation, based on historical sources, media reports, and biographies. These operations are often performed by European surgeons not well known in the English speaking world, surgeons such as Ambrose Pare, Theodor Billroth, Friederich Trendelenberg, Sven Ivar Seldinger, Rudolf Nissen, Maximilian Nitze, George Kelling, and Kurt Semm.

Then usually follows an explanation of the symptomatology of the condition and a discussion of the disease process, sidetracks into other historical figures who may have suffered the same symptoms, and an outline of how the procedure is now performed, with boxes explaining the intricacies of modern surgery.

He has a great interest in the origin of surgical terms, and the book is littered with interesting etymology. It was embarrassing for me, as a once upon a time O&G Registrar, to realise that the 'lithotomy (from the Greek, 'lithos' (stone) and 'tomos' (cut) position' was so named because it was originally developed for the cutting of bladder stones.

There is also a chapter on the process of making a diagnosis, comparing the thought processes used by surgeons (induction as used by Hercule Poirot), with that used by physicians (deduction as demonstrated by Sherlock Holmes).

This is one of the most entertaining and informative books I have read in recent years.

AN IDEAL HOSPITAL: is leading a workforce engagement strategy the key to tackling bullying, harassment and discrimination in surgical practice?

Article by Sidney Chandrasiri MBBS

The following is a summarised version of the complete article by the same author originally published in the *'Leadership in Health Services'* Journal by Emerald Publishing, August 2017.

It is a frequent citation that "employee engagement is a prerequisite for high performance… (and is) essential to the success of any organisation" (Lowe, et al., 2012). This statement holds true with reference to many outcomes in the current climate of Australia's healthcare industry.

What relevance does it really hold though, when it comes to the complex, multi-layered health workforce dynamics at the frontline? Are clinical outcomes and the very quality of the education and training of successive generations of medical and surgical professionals indeed contingent on how engaged staff are with their hospitals and with each other?

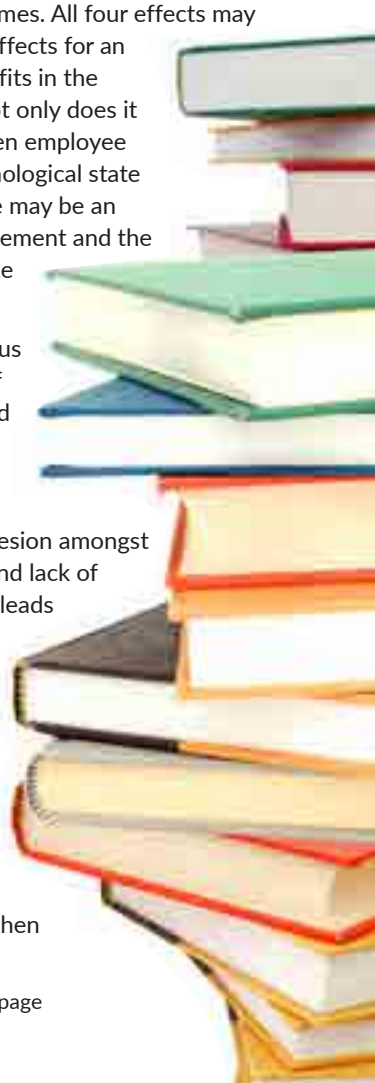
If indeed they are, then the recent work by the Royal Australasian College of Surgeons (RACS) which uncovered staggering levels of bullying, harassment and discrimination in Australian and New Zealand hospital training environments, has cast a harsh light on the obvious systemic and staff engagement failures that are apparently very much still prevalent in our hospitals today. In fact, the reality of poor engagement seems not only apparent within and between staff and health industry management, but also with key policies and strategic goals that underpin probity principles and anti-discriminatory ethos of the health institutions themselves!

This apparently glaring lack of workforce engagement amongst healthcare regulatory bodies, individual hospitals and the clinical workforce has been evident in the key themes that emerged from the RACS review. It seems that abuse of power is tolerated, gender inequity is prolific, complaints handling processes are opaque and corrupt, unhealthy working hours are expected as the norm, and all these are being endured secondary to a fear of reprisal if one were to speak out.

These should alert us in our roles as medical leaders, to the importance of poor staff engagement and the far-reaching, multi-directional impact that medical workforce disengagement actually has on the various different aspects of healthcare delivery.

At a local level, given that this workforce issue is central to vocational surgical training, it has a direct impact on both the various large metropolitan private and public hospital settings in Australia. A significant if not all of the case mix is surgical in nature in the private sector, and senior surgeons providing training and supervision to junior surgical trainees is an everyday occurrence in the public sector. Therefore, any incidences of bullying, harassment or discrimination occurring in either of these contexts are very likely to significantly impact a majority of health organisations and health professionals in Australia, in a range of diverse ways and on a much larger scale.

It is logical to reason that impacts on the psychological health and well-being of the junior surgical staff who are victimised will lead to reduced productivity from both an individual and organisational perspective. From a human resources perspective, effects of this are often reflected in increased rates of absenteeism and high workforce turnover. From a clinical perspective, increases in adverse patient outcomes and longer lengths of stay are likely outcomes. All four effects may cause associated economic flow-on effects for an organisation. Loss of revenue and profits in the medium to long term is inevitable. Not only does it then seem that an association between employee engagement and an individual's psychological state exists, it becomes apparent that there may be an association between employee engagement and the financial and professional performance for the organisation as well.



In the context of this scenario, a vicious cycle of deterioration in the quality of care is likely to be set-up. Substandard clinical practice resulting from poor staff morale, low job satisfaction and weak organisational commitment leads to low levels of hierarchical cohesion amongst the surgical teams. Poor interaction and lack of cohesion amongst the surgeons then leads to a disconnect within and between the multi-disciplinary teams. This inevitably results in dangerous troughs developing in the level of patient care provided by the entire clinical workforce. A definitive erosion of the patient safety and quality improvement culture that fortifies the Australian and New Zealand healthcare industry today is then triggered.

Continued next page

Book Reviews

The unintended consequences of these impacts will be far more complex and far-reaching. Ramifications will permeate across the Australian health workforce sector, amplifying the already existing clinical workforce retention and recruitment difficulties and specialist workforce mal-distribution patterns nation-wide. Extrapolating to the health policy /health economic arena, our currently growing costs of health care expenditure will increase, medical education and vocational training structures will be disrupted and the way for possibly calamitous consequences will be paved in a range of tangential and unforeseen areas.

However, in appreciating the importance of workforce engagement, we must also be mindful of "the 'dark side'. Dangerous precedents of work intensification and expecting employees to go excessively beyond their work roles could be set up as the norm (Purcell, 2012). This will only lead to "employees experiencing burnout, health problems and further disengagement (Welbourne, 2011). Strategizing established and novel ways to mitigate and prevent these impacts will obviously then need to be considered from a strong workforce engagement platform.

Current literature suggests two main approaches to creating an engaged workforce. Providing employees with 'job resources' such as role autonomy, task ownership and accountability, task significance, performance appraisal from both supervisors and peers, and procedural and distributive justice has been cited as one approach. Providing 'personal resources' such as self-esteem, self-efficacy and personal optimism is another. Each organisation's capacity for providing each of these obviously varies to differing degrees but will need to be factored in accordingly during the initial phases of strategy formation.

In building workforce engagement at the organisational level, it is necessary to develop cultures of two-way trust. Employees need to feel they can trust their leaders, managers and the system. Leaders and executive of health organisations need to trust that their organisational vision and values are well represented by those at the frontline. It must also be acknowledged that engagement is fostered when there are relatively flat hierarchies, widespread use of rituals and rites to celebrate contributions and success (of employees), and where there is consistent celebration of accomplishments and innovation (of clinical teams)" (West, 2012).

Armed with these generic strategies cited in current literature to foster engagement both on an individual and an organisational level, we are now equipped to focus on strategizing priority actions to confront the impacts of this specific workforce issue. Action areas to be targeted most notably will include an overarching change in surgical workforce culture and leadership, and establishing independent oversight and review of surgical education practices for trainees and supervisors. Engagement mechanisms geared towards shifting the gender imbalance in surgical training and building confidence in the complaints handling processes within organisations and between external bodies are further key action areas that should be considered.

It should be anticipated that engaging surgical consultants particularly in the context of a private hospital may uncover an extra layer of complexity. This is largely due to the symbiotic customer-client relationship that exists in the Australian private health sector, where employees are privately contracted visiting medical officers, whose business is essential for the future sustainability of the private health institution. Consequently, a higher degree of personal and clinical role autonomy coupled with a lesser capacity for enforcement often exists in the private healthcare 'business' model compared to that of its public counterpart. It follows then that any clinician engagement strategies in this context will need to come from a platform of mutual benefit and shared goals. There will be a need to re-frame the organisations' or managements' motivations and strategic vision in a clear patient and staff quality and safety agenda that is agreeable to the vested interests of its doctors. The archetypal 'carrot and stick' methodology of enforcing top-down change will need to be revised and rebranded, if not completely abandoned.

Kumar et al., (2013) suggests four key areas in engaging clinicians to transform operational change. Firstly, present compelling explanations (to clinicians) that are grounded in clinical evidence for how and what the proposed changes will accomplish. Then identify clinician leaders to 'role model' expected behaviours followed by publicly recognising their successes. Thirdly, invest in capability-building programs to help surgeons better understand how their decisions can translate to inefficiency in care delivery. Lastly, ensure that structures are established to support the alterations in behaviour they are being asked to make. These 'structures' would include appropriate monetary and/or relevant resource compensation, aligned incentives (to encourage behaviour modification, lead change, as well as to engage other frontline clinicians more broadly) and governance arrangements such as performance management frameworks.

Above all, workforce engagement strategies must be undertaken simultaneously with an assessment of individual organisations' baseline performance in each action area that is targeted for improvement, with rigorous and ongoing benchmarking with both internal and external peer hospitals. These are to be informed and guided by recommended standards as set forth by key industry bodies and validated international practices.

In addition, there needs to be a review of existing policies and protocols pertaining to each target area. Promotion and negotiation of clear consistent standards and expectations of professional behaviour from all staff in the workplace (not just surgeons) will be required. Diverse representation of the workforce on all committees and working groups tasked with these undertakings to foster broader buy-in and engagement levels must be ensured.

Given that "professional bureaucracies (and thereby all Australian public and private hospitals) are characterised by dispersed or distributive leadership… (and current evidence based thinking validates) this importance of a collective leadership model" (Ham, 2008) strategies must be brought forth and actioned by

leadership teams rather than individuals in management or the executive team. There must be collaboration and engagement with external industry groups. It must be realised that a change in workplace culture and a shift in the status-quo led by better leadership of staff engagement strategies takes time, is cumulative in effect and therefore must be robustly sustained in the long term.

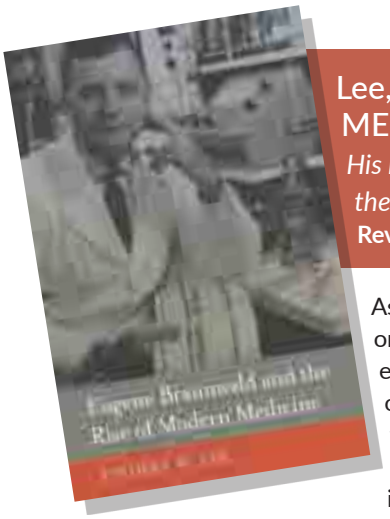
Emphasis particularly needs be given to recommendations for fostering diversity and improving gender equity in surgery. Providing flexible training options, family-friendly practices in terms of working hours and arrangements will aid this. Having targets for numbers of women on key Boards and leadership roles are definitive measures that are easy to enact. Integrating a specific gender equality strategy to existing organisational goals is also important. This approach will link and support the broader business objectives of the organisation, and foster engagement and productivity through facilitating a consistent approach to build long-term support. Universally, all and any planned strategies should be actioned and reinforced on a strong platform of collegial-style clinician engagement processes and empowerment initiatives.

Transparent, independent complaints management processes must be developed and entrenched both internally and external to the organisation, within a clear framework of accountability. This will build confidence in the integrity of existing process. An overarching cultural and organisational change to this issue will require an end to bystander silence about discrimination. Lobbying for the development of whistle-blower protections grounded in legislation for the private healthcare sector, and the introduction of a nationally-recognised standardised framework outlining fair and just punitive measures for inappropriate behaviours must similarly be established.

No doubt a high degree of engagement within the health industry and between peak surgical vocational training bodies, accreditation and licensing authorities and government health departments will be essential in bringing any of these strategies to fruition.

The issue of bullying, harassment and discrimination in contemporary surgical practice, and the true extent to which strengthening workforce engagement permeates every aspect of health service management and leadership, affects us at a national and global level. Whether in relation to this specific workforce issue or any other that challenges optimal standards in healthcare delivery, we must realise that a flawed status quo will not serve the future. It is only with this ideal that we as health professionals and health leaders can nurture and sustain a formidable healthcare workforce that will be capable of achieving true excellence in healthcare delivery for generations to come.

References
Extensive and available on request.



Lee, Thomas H: EUGENE BRAUNWALD AND THE RISE OF MODERN MEDICINE; Harvard University Press; 2013

His insight that doctors could intervene to reduce injury to the heart opened the door to the entire field of modern heart-attack treatment [Boston Globe]

Review by: Robert Grogran, FRACMA

As stated on the RACMA website one of our challenges it is to ensure that the best principles of administration are joined to those of medicine, for the public good. It is, therefore, instructive to learn about those practitioners who have made significant contributions to knowledge in clinical areas.

This book outlines the life and work of Eugene Braunwald, an American cardiologist.

In 2000 The European Society of Cardiology asked the living winners of the Nobel Prize for Medicine or Physiology to nominate the person who had been most influential in the field of cardiology in recent years. They were unanimous in nominating Eugene Braunwald for his work in basic science, translational research, clinical trials, and medical education.

Eugene Braunwald (1929 -) was born in Vienna and migrated with his family to America in 1939. He obtained his medical degree at New York University. Braunwald served as chief of cardiology and clinical director at the National Heart, Lung and Blood Institute of the National Institutes of Health (1958-1968), was the founding Chair of the Department of Medicine at the University of California, San Diego (1968-1972), and at the Harvard Medical School he was Chair of the Department of Medicine (1972-1996). Braunwald was then appointed as the Distinguished Hersey Professor of Medicine. He now describes himself as being in the 'still' part of his life, ie 'still working'.

In 1967 Braunwald was shown dogs with experimentally-induced hypertension. Implanted stimulators of the animals' carotid sinus nerves restored their blood pressures to normal. His team began implanting stimulators of the carotid sinus nerves in patients to relieve angina pectoris. This treatment was short-lived because of the near simultaneous introduction of coronary bypass surgery.

A year later, one of Braunwald's patients with an implanted carotid nerve stimulator was admitted with an Acute Myocardial Infarct (AMI). Fearing that stimulating the carotid sinus nerves would exacerbate the evolving MI, Braunwald asked the patient to turn off the device. The patient ignored him and continued to press the stimulator to relieve his pain. Eventually, after several 'on-off' episodes, Braunwald, in exasperation, removed the stimulator's battery pack. Later, when he was reviewing the patient's electrocardiogram, the oxygen deficiency of his patient's heart improved whenever he stimulated his carotid sinus nerves, and worsened when Braunwald turned off the stimulator. Braunwald later stated that episode gave him the idea that an AMI could be modified whilst it was progressing.

In 1971 their continued research yielded the discovery that the size of a myocardial infarction could be influenced by controlling the amount of oxygen required by the heart and the amount of oxygen that could be delivered to the ischaemic myocardium.

Until that time, physicians had believed that once a patient exhibited symptoms of crushing chest pain, little could be done to affect the outcome. Patients were sedated, put on strict bed-rest and, if necessary, defibrillated. If they survived, they were sent home on various medications. During the next year, a quarter of the survivors died, usually of heart failure.

In 1981, Braunwald's team showed that when streptokinase was administered to open blocked arteries, myocardial tissue threatened during an AMI could be salvaged by restoring the supply of oxygen-laden blood.

In 1984 Braunwald established the Thrombolysis in Myocardial Infarction (TIMI) Study Group. Their first study found that intravenous tissue plasminogen activator (tPA) was superior to streptokinase in opening occluded arteries. Subsequent studies (the TIMI Study Group now works with more than 1,400 hospitals in 46 countries, and has conducted more than 55 trials, most which have involved more than 10,000 patients) have developed the concepts of thrombosis superimposed on atherosclerosis as the pathological bases for acute myocardial infarction, and have led to treatments that reduce damage to the heart from myocardial infarction.

His textbook, Braunwald's Heart Disease, is now in its 11th edition (2018), and for over 30 years from 1967 he was an editor of Harrison's Principles of Internal Medicine. Braunwald also has over 1,100 articles published in peer-reviewed journals in the areas of congestive cardiac failure, coronary artery disease, and valvular heart disease.

In summary, much of the improved survival rate from myocardial infarction since the 1950s can be traced to Eugene Braunwald's ground breaking work.

References

Braunwald E,; Karliner JS; Ashburn WL; Kazamias TM; Ross J; Maroko PR; Sobel BE; Braunwald NS; *Research on the diagnosis and treatment of myocardial infarction*; California Medicine 114 (5); 44-63 (May, 1971);

Braunwald E, McCabe C. *The TIMI Trials, 1984–2009: 25 Years of Clinical Trial Research*. Boston, MA: TIMI Study Group; 2009;

DuBois, Lisa : *Eugene Braunwald: Maestro Of American Cardiology* (http://www.mc.vanderbilt.edu/lens/article/?id=181&pg=999);

Musgrave, Elaine; *On the Frontiers of Cardiology: An Interview with Eugene Braunwald*; Clin Transl Sci. 2010 Dec; 3(6): 275–278 (Published online Dec 2010);

Zipes, DP; Libby, P; Bonow, R; Mann, D; Tomaselli, GF: (2018); *Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine*;

wikipedia.org/wiki/Eugene_Braunwald.

I am grateful to A/Prof Chiew Wong (University of Melbourne) for alerting me to the work of Dr Braunwald.

THE AUSTRALIAN MEDICINE CAREERS GUIDE

By: Manda Raz (Editor), Erwin Loh (Editor)

Review by Dr Gemma Bilkey

The Australian Medicines Careers Guide (the guide) edited by Manda Raz and Erwin Loh, aims to assist medical students and junior doctors throughout their career as they progress to the end goal of becoming a specialist.

The guide opens with an initial chapter on how to get into medical school, offering insights into the application and interview process.

The guide continues with a chapter on 'inside medical school' followed by 'the transition from medical school to medical employment.' For the reader who is fortunate to receive this book as a new medical student, there are valuable and practical insights on dealing with perfectionism, competition, failure and mental health.

The chapters on medical school will appeal to the highly ambitious medical student, detailing how to set oneself apart from the rest from involvement in research during medical school years, encouraging applications for scholarships, and further educational opportunities. There is a comprehensive guide of how and when to be involved in these extra activities outside of the stipulated university teaching terms. Lesser so will these chapters appeal to the average medical student, who may choose backpacking through Asia, or catching up on fictional novels over focusing on networking and getting ahead during those seemingly endless summer days.

To any pre-vocational trainees who are contemplating which training program to join but have not already published papers in their ideal specialty, I would recommend skipping the first three chapters to avoid experiencing significant C.V. anxiety. The guide has the propensity to catalyse the average pre-vocational trainee into a cold sweat on learning all the things that you missed achieving during medical school while you were too busy acting in a play, learning about the importance of insect repellent on camping trips, or just too busy socialising.

"Most newly ordained doctors start planning their career during internship. This strategy is overdue. You should've started much earlier, in med school."

Following from medical school, the guide outlines the pragmatics of training for many of the major specialties, as well as some of the more niche specialities, such as aerospace medicine and transplant surgery. It provides factual outlines of the structure for each training program, as well as selection criteria on what programs look for in prospective candidates.

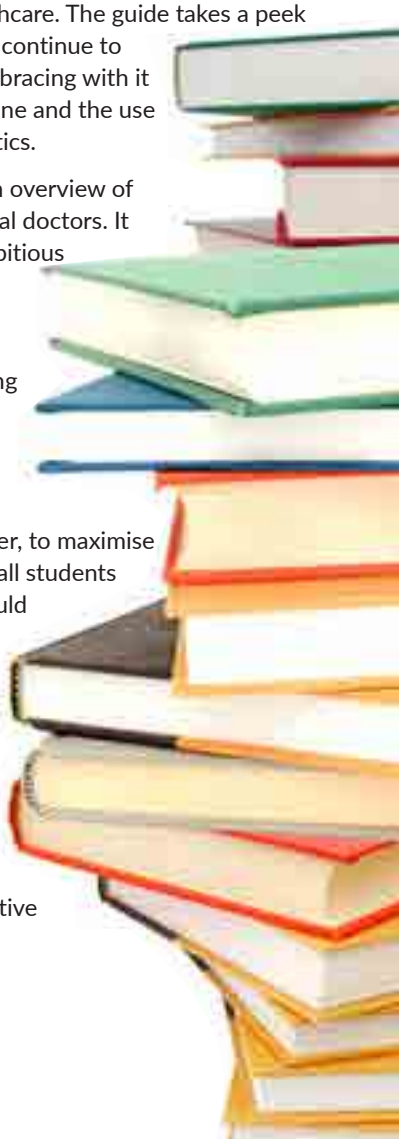
The niche specialty chapter includes an additional section on employment opportunities. To truly assist junior doctors and medical students who may be uncertain about which specialty may be right for them, future iterations would benefit from more general advice within the described major specialties around the best and worst parts of each specialty, as well as the daily business of each specialty. Consideration of the predicted medical workforce areas of shortage and oversupply would also be beneficial to aid decision-making for prospective trainees.

After details of training programs, the book touches on making the transition to becoming a specialist, and details strategies for applying for senior positions. There is also an excellent chapter on medicine and the law, outlining many of the medicolegal areas shrouded in uncertainty for many doctors such as advanced care directives, confidentiality, and the certification of death. This chapter alone makes the guide worthwhile reading for RACMA fellows, trainees as well as any doctor.

To close the guide is a thought-provoking chapter on the past, present and future of medicine, exploring the continual need for change in the delivery of healthcare. The guide takes a peek at the future of medicine that will continue to evolve at an exponential pace, embracing with it advances such as precision medicine and the use of artificial intelligence in diagnostics.

In summary, the guide provides an overview of the myriad options open to medical doctors. It is most applicable to the new, ambitious medical student looking to set themselves apart from the crowd. It provides a one stop shop for understanding the practical training requirements for each training program, which could also assist pre-vocational trainees in decision-making for which specialty is right for them. However, to maximise its readership and applicability to all students and pre-vocational trainees, it would benefit from more description of the advantages and disadvantages involved in the day to day work of each specialty discussed.

The author of this review would like to acknowledge Neve Keen, who provided valuable insights from the perspective of a prospective medical student.



Budhaditya Gupta[1], Kannan Sethuraman[2] and Vikas Wadhwa[3]: The transferability of task-shifting practices from developing nations to the developed world

[1] Faculty of Business and Economics, The University of Melbourne,
[2] Melbourne Business School, The University of Melbourne,
[3] Eastern Health, Melbourne, Victoria, Australia

Abstract

Task-shifting, the transfer of clinical activities to less-specialised health workers, has been extensively adopted in secondary and tertiary care delivery in developing nations. In contrast, the extent to which task-shifting practices have been implemented in developed countries has remained limited. We suggest that in response to increasing demand from an ageing population, rising healthcare costs, excess wait times and poor access to care in remote areas, policy-makers and healthcare practitioners in developed nations should reassess the barriers inhibiting the adoption of task-shifting and explore the potential of leveraging task-shifting to a greater extent.

Developed countries around the world are burdened with an increasing demand for health services, rising health care costs that are closely tied to rapid advancements in diagnostic and therapeutic technologies, and an increasingly ageing population with multiple comorbidities and chronic diseases.

Much has been discussed in recent years about healthcare challenges in developed countries relating to cost[1], excess wait times[2], and access to effective care in remote areas[3]. Health services in these nations are expected to come under even greater pressure to enhance their performance in these dimensions due to growing fiscal constraints, an increasing demand from patients for more effective (but expensive) new technologies, and stringent scrutiny by insurers on the appropriateness of care provided.

Interestingly, a few Indian hospitals, such as the Aravind Eye Care System and Narayana Health, have pioneered innovative health delivery models that enable them to provide high-quality care at a fraction of the cost incurred by their Western counterparts[4]. These new models of care, while often viewed as isolated islands of excellence, have highlighted the effectiveness of task-shifting practices. Task shifting, a term coined by the World Health Organization (WHO)[5] to represent a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers, has emerged as an effective strategy to mitigate the acute shortage of skilled health workers in low-resource settings such as India. Today, there is a growing body of evidence on the effectiveness of shifting clinical tasks involving complex secondary and tertiary care procedures from experienced physicians to (i) junior physicians[6], (ii) non-physician staff such as nurses and paramedics[7] and (iii) field workers[8]. For example, task shifting has enabled Narayana Health to perform more than 5000 adult cardiac surgeries annually at a price of approximately US$2000-3000 per case. In comparison, large hospitals in the United States typically handle 600 to 1800 cardiac surgeries annually at prices exceeding US$100,000 per surgery[6].

Although observed more commonly in resource-poor nations, the practice of task shifting is not exclusively restricted to them. Developed nations such as the United States, Germany, Australia and New Zealand have experimented with the use of nurse practitioners and physician assistants to alleviate the shortage and maldistribution of primary care physicians[9]. Despite this discussion, many would argue that opportunities to implement task-shifting practices through greater involvement of non-physician staff, such as nurses, physician assistants, radiographers, physiotherapists, and pharmacists, in care delivery have largely remained untapped to date. Further, the adoption of task shifting in developed countries has been largely confined to situations of low risk, such as health education and screening, and scenarios where physician assistants or nurses are required to perform shifted tasks under the close supervision of physicians. Consequently, there has been little, if any, advantage resulting from the implementation of task shifting practices in developed nations.

In contrast, in the aforementioned exemplar hospitals in India, task shifting has been used extensively to achieve a better match between the skill levels of their health professionals and the basic requirements of tasks. Through the creation of fresh categories of low-cost health care workers and the provision of appropriate training to these workers to undertake several tasks supporting the more critical areas of care typically performed by specialist surgeons and physicians, these hospitals have enhanced productivity manyfold[4]. This raises an interesting question: Can developed nations emulate the innovative use of task-shifting practices found at these pioneering hospitals?

To answer this question, we need to understand the factors that inhibit the adoption of task shifting in secondary and tertiary care contexts in developed nations. First, critics of task shifting fear that the new cadres of health professionals to whom tasks are to be delegated lack the nuanced skills, deep knowledge,

rapid decision-making ability, and specialized multi-year training required to perform complex procedures and warn that quality and health outcomes may thus be compromised[8]. Second, regulatory standards, governance models, legislation, enterprise agreements and industry practices, designed with the intent to improve care quality, are often varied and pose restrictions on the extent to which task shifting can be adopted. Third, even where task shifting is not prohibited by law, high-risk exposure to malpractice litigation may discourage its adoption. Fourth, concerns about the blurring of the boundaries of their profession may impede doctors from being receptive to the implementation of task-shifting practices. Fifth, greater health literacy and patient expectations regarding access to expert resources may also curtail the adoption of task shifting in developed countries. Finally, the implementation of task shifting in specialised care often requires significant funding and necessitates major changes to established operating policies and procedures, staffing models, IT systems, and training programs.

Because of these barriers, healthcare systems have been reticent to support the widespread adoption of many relatively easy-to-implement task-shifting practices, including the use of health assistants in nursing to help with patient feeding and general care, medical scribes to assist doctors with clinical documentation, and pharmacists to support doctors with medication charting. However, emerging evidence from across the world suggests the need to consider task shifting as a possible approach to respond to ever-growing fiscal and resource constraints in developed countries. For example, the Institute of Medicine[10] highlights that in certain situations, appropriately educated and trained nurses can deliver care comparable in quality to that provided by physicians. Such evidence reaffirms the necessity of expanding the scope of nursing practice to increase the affordability of healthcare while not compromising either its quality or its safety.

Ultimately, any attempt to adopt task shifting in the delivery of complex health care in developed countries will require a thorough understanding of the discussed barriers and a strong commitment to overhauling the historical, regulatory, cultural and cognitive pillars underpinning current care delivery models. Despite these challenges, the adoption of task shifting has the potential to create new opportunities through the resultant upskilling of the health workforce and thereby achieve holistic improvements in the efficiency and quality of health services. To this end, it seems that the time is ripe to re-evaluate past obstacles and limitations and explore task shifting as a viable option to improve healthcare delivery in developed countries.

References

1. Schoen C, Osborn R, Squires D, et al. Access, affordability, and insurance complexity are often worse in the United States compared to ten other countries. Health Affairs, 2013, 32(12), 2205-2215.
2. Sutherland J M, Crump R T, Chan A, et al. Health of patients on the waiting list: Opportunity to improve health in Canada? Health Policy, 2016, Vol. 120(7) pp. 749-757.
3. Russell D J, Humphreys J S, Ward B, et al. Helping policy-makers address rural health access problems. Australian Journal of Rural Health, 2013, 21(2), 61-71.
4. Govindarajan V, Ramamurti, R. Delivering World-Class Health Care, Affordably: Innovative Hospitals in India are pointing the way, Harvard Business Review, 2013, November issue.
5. World Health Organization. Task Shifting to Tackle Health Worker Shortages, 200, WHO/HSS/2007.03. Available at http://www.who.int/healthsystems/task_shifting_booklet.pdf (January 16 date last accessed).
6. Gupta B, Huckman, R S, Khanna, T. Task shifting in surgery: Lessons from an Indian Heart Hospital. Healthcare, Elsevier, 2015, Vol. 3, No. 4, pp. 245-250.
7. Chu K., Rosseel P, Gielis P, et al. Surgical task shifting in sub-Saharan Africa. PLOS Med, 2009, 6(5), e1000078. doi:10.1371/journal.pmed.1000078
8. Chilopora G, Pereira C, Kamwendo, F, et al. Postoperative outcome of caesarean sections and other major emergency obstetric surgery by clinical officers and medical officers in Malawi. Human resources for health, 2007, 5.17, doi: 10.1186/1478-4491-5-17.
9. Maier, C B, Aiken, L H. Task shifting from physicians to nurses in primary care in 39 countries: a cross-country comparative study. The European Journal of Public Health, 2016, 26(6): 927-934.
10. Institute of Medicine report brief: The Future of Nursing Focus on Scope of Practice. October 2010.1-4.

Obituary
Dr 'Rocky' McEwin

Dr "Rocky" McEwin who has died of pneumonia aged 95 showed a deep, personal commitment to providing the best health care and became chairman of the NSW Health Commission.

Dr Roderick Gardner McEwin was born in Balaklava, South Australia, the second of four children of Keith McEwin, a country GP, and Rita (nee Gardner). At the age of eight, Roderick, known as Rocky, was sent to board at St Peters College, Adelaide. He studied medicine at Adelaide University where he met his wife Betty (nee Marshall), smitten when he saw her on the basketball court. Betty was a zoologist researching cestodes collected from Antarctic seals during Sir Douglas Mawson's Antarctic Research Expedition. They married in 1945 and had four children.

Rocky interrupted his medical course to enlist in World War II as a gunner, 1940-41, before being instructed to finish his medical course. Having graduated in medicine, he rejoined the AIF for a further two years.

He worked in the Commonwealth Repatriation Department (now Veteran's Affairs) for 27 years and rose to the department's most senior medical post, Chief Director Medical Services. He gave repatriation hospitals a new life and regained their prestige by attracting high quality staff.

His research on the rare disease, porphyria, gained him an international reputation.

In 1973, he was offered the position of chairman of the newly formed Health Commission of New South Wales. He served in this post for more than nine years, responsible for 77,000 staff, 300 hospitals and an annual budget of up to $2 billion.

The Health Commission was a new concept in the delivery of health services. Previously the public health, hospital and ambulance services of the state had been administered by four independent organisations. He advised the governments of Victoria and South Australia on the formation of their health commissions.

He oversaw the decentralisation of health services to 13 health regions within NSW which enabled improved and more responsive local community health services and programs.

He introduced major health promotion programs with the emphasis on smoking, alcohol and drugs. The health commission became widely recognised for its effectiveness in this field and many of its successful programs were copied by other health authorities in Australia and overseas. He and his team got Westmead hospital up and running in record time. He led by example and his courage was evident when he crawled through confined spaces of twisted metal looking for survivors of the Granville train disaster of 1977.

He travelled to all 300 hospitals in NSW and met with staff and hospital boards. Recalling one particular trip, he said "briefing a minister while he is piloting a chartered Beechcraft Baron light aircraft in a storm somewhere over the Great Dividing Range isn't the most restful way to spend a Saturday afternoon, and then to find that the minister has landed on the wrong runway, a disused one at that, with cows grazing on it ... it's not the ideal way to start a ministerial visit to a country centre".

Following his retirement from the health commission in 1982, Rocky engaged in private practice as a specialist physician and specialist rehabilitationist until 2004. He had over 150 publications in medical and scientific literature and had been a member or chairman of some 70 councils (including chairman of the Federal Council of the Royal Flying Doctor Service), committees and boards. He retired from medicine at the age of 83.

His career in clinical medicine and medical administration has been recognised by the awards of fellowships to 10 professional health colleges, including the Royal Australasian Colleges of Surgeons and Physicians. In 1990, he was appointed a Member of the Order of Australia for his significant and valuable service to medical administration.

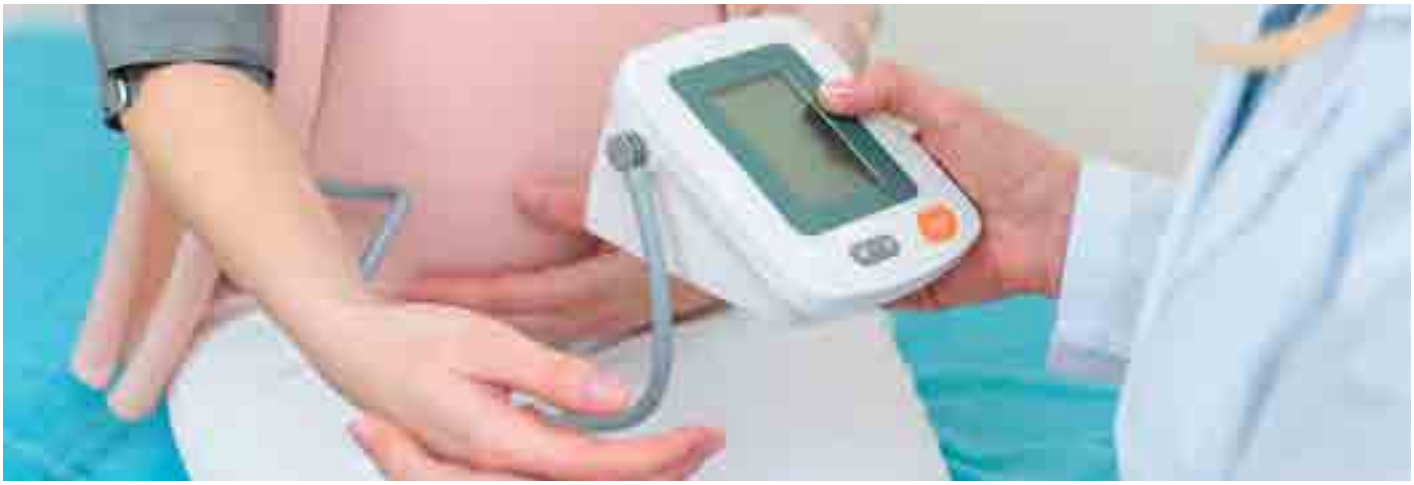
Outside the health services, Rocky's chief interest was farming. He was one of the first in Australia to breed the European cattle breeds Chianina and Maine-Anjou. Sometimes when he bought rams he would keep them tied to the family's suburban clothesline until he could get them to the farm. That kept Betty agile when she was hanging out the washing.

Rocky McEwin is survived by Betty, their four children, eight grandchildren and six great grandchildren.

A McEwin

Women's opinions on obstetric quality of care indicators: a pilot survey

By Associate Professor Amar Trivedi MB BS (Hons I), MRNZCOG, FRANZCOG, DDU, AFRACMA



Abstract:

Background: Traditionally, quality of obstetric care has been assessed by rates of medical interventions or complications during childbirth, with very little input from women. Over the years, obstetric and midwifery practices and women's level of expectations have changed, but the KPIs have not.

Aim: The aim of this study was to get the women's viewpoints regarding the factors, which in their opinions, were a better yardstick of measuring their quality of care.

Materials and Methods: A cross-sectional survey involving primigravid women was conducted at Peninsula Health. A questionnaire was designed to measure four major domains of interest; preference on choice of health-professionals, preference of self-decision on timing and frequency of medical check-ups, preference of self-decision on choice of type of medical procedures, and perceptions regarding the questions being indicators for quality of obstetric care. Statistical analyses were performed in STATA 12.1.

Results: Majority of women liked to see a single health-professional throughout the course of pregnancy and childbirth, preferred making decisions on different aspects of pregnancy care unless there was medical contraindication and believed that the quality of care indicators, as in the questionnaire, were not very good reflectors of their quality of care. 85% of women believed that post-partum hemorrhage and perineal tear rates, were not as important measures of quality of care as holding a healthy baby at the end.

Conclusions: Within its limitation of a small sample, this study demonstrated that women's views are not truly reflected in current KPIs. Further research with larger samples is needed.

Introduction:

Performance of clinical units or hospitals as a whole is assessed by a series of key performance indicators (KPI), which are usually health professional and epidemiologist driven without input from women [(1)]. This study endeavors to understand what women regard as the important indicators of their quality of care. Their views could be incorporated in designing new KPIs, which truly meet the perceptions of women. Over the past decade, there has been a lot of focus on incorporating consumers' views in different areas of health care, except this area. In fact, the extent of involvement of consumers in different processes in itself forms KPI in some health institutions.

Secondly, the practice and philosophy of midwifery and obstetrics has changed considerably over the couple of decade but unfortunately KPIs around pregnancy care have failed to reflect these changes [(2)]. As care and expectations have changed over time, this perception has continued to be a priority for researchers during this time. Patient surveys, which have their own pit-falls, have been used in many parts of the world to get an idea of patients' satisfaction ratings but there are not many studies that have used patient surveys to design new KPIs (1). This small study is a step in this direction. Women's perception of their quality of care mainly comprises of three factors: continuity, choice and control [(3)]. Many women approach their childbirth experience with fixed ideologies and expectations. The relationship between these expectations and the actual birth experience can affect their judgment of quality of care. With widespread acceptance of obstetric technologies and surgical approaches as a norm in childbirth, women's perception of care has also altered.

Materials and Methods:

A cross-sectional survey was conducted to understand the women's preferences and perception of key performance indicators of pregnancy care at Peninsula Health. Peninsula Health is the only public hospital in Melbourne peninsula area with a catchment population of nearly 400000.

The questionnaire was designed to measure the level of patient preferences, choices and perception about some of the important performance measures. It was designed using a mixture of closed and open-ended questions. Questions were developed based on the available literature and statutory instruments available to obstetricians and midwives. These included tools like The Labor Agentry Scale [4], McGill Pain Questionnaire [5] and Mackey Childbirth Satisfaction Rating Scale [6]. A 17 item questionnaire was designed to measure four major domains of interest; preference on choice of health-professionals, preference of self-decision on timing and frequency of medical check-ups and procedures, preference of self-decision on choice of type of medical procedures, and perceptions regarding the questions being indicators for quality of obstetric care.

Each item in the questionnaire had to be responded in five-point likert-type scale ranging 1 to 5, 1 being the least preferred and 5 being the most preferred option. Participation in the study was voluntary. The survey was offered to primigravid women. Multigravid women were excluded from this study, as authors believed that their judgments might be colored with their prior experiences, prejudices and biases.

Women were approached in the Antenatal clinic around 36 weeks gestation. Verbal and written information about current study was provided. Written consent forms for participating in the study were collected. Privacy and confidentiality of information provided was assured. The survey was in accordance with the Peninsula Health Ethics Committee guidelines.

Each response on each item was categorized in binary scale by considering a response of 4 or 5 as high preference, and proportion of respondents for high preferences with 95% CI was calculated. Chi-square test was used to measure the significance of difference in responses by ethnicity.

A p value of <0.05 was considered statistically significant. Cronbach's alpha was calculated to estimate the internal consistency of the questionnaire items for each specific domain of interest and a grand proportion was calculated by pooling the responses in all items in specific domain of interest regarding its potential for future application of same questionnaire to measure the changes. Statistical analyses were performed in STATA 12.1 (College station, Texas).

Results:

A total of 197 patients were approached for participation in the study. 156 patients consented and completed the questionnaire. The mean age of respondents was 27.5 [Standard deviation (SD), 5.9] years. The mean gestation period was 35.2 (SD, 2.6) weeks. Majority (92.9 %) of respondents were Australian born.

Preference on choice of health professionals: Overall, 52% (95% CI, 47%, 56%) participants strongly preferred their involvement in choice of health-care professionals during the prenatal, labour and postnatal care. About 71% (95% CI, 63%, 78%) of participants highly preferred to see the same health professional throughout, however only less than 45% had high preference to see specific type of health professionals, such as a midwife or a doctor (Table 1).

More than 50% participants believed that the attitude and behaviour of health professionals were important aspects of quality of care.

Preference of self-decision on timing and frequency of medical check-ups and interventions: Overall, only 39% (95% CI, 0.35%, 0.45%) participants had strong preference of self-decision on timing and frequency of medical check-ups. 57% of women preferred to decide timing of administration of intrapartum analgesia. About 42% of participants preferred that timing of events leading to delivery of baby should be determined on their convenience. Only about 31% preferred that they should determine the frequency of vaginal examination during labor (Table 1).

Preference of self-decision on choice of type of medical interventions: Overall, 54% (95% CI, 51% to 57%) of participants strongly preferred to have their own decision on choice of medical procedures during antenatal and intrapartum care. More than 50% of participants highly preferred their decision on mode of delivery (Vaginal vs. Caesarean), and choice of analgesia. More than 80% strongly preferred immediate contact with baby and self-decision on bottle/breast feeding. In contrast, only about 20% strongly believed that choice of caesarean section without a medical indication should be their own and prefer to opt out of active pushing in second stage of labour even against health professional's decision (Table 2).

Women's views regarding obstetric complications as KPIs: Overall, about 56% (95% CI, 53%, 60%) of the participants strongly believed that the indicators set in the questionnaire were important quality of care indicators. More than 50% believed that participation in decision-making in different aspects of childbirth process, and not bleeding excessively were important aspects of good quality of care. Interestingly, about 85% believed that holding a healthy baby at the end, was much more important than the overall process. Only about one-third of participants thought that having adequate pain relief and not sustaining perineal tear during childbirth were important indicators of quality of care (Table 2).

Australia born vs. Born elsewhere: We compared the difference in proportion by ethnicity for preferences in each domain as well as for each item, but no difference in preferences (p>0.05) was detected.

Discussion:

This study was designed to evaluate women's preferences in obstetric care, with the ultimate goal of using these preferences to develop new KPIs. The study revealed that a majority of the participants (>50%) considered the questions included in the survey to be good indicators of their quality of care. Furthermore an overwhelming majority (85%) of the participants did not feel that current KPIs such as post-partum hemorrhage and perineal tear rates were important measures of quality of care. Our study highlights the gap between current KPIs and women's preferences and suggests that incorporating the latter in new KPIs is the way forward for healthcare organizations.

Preference on health professional:

This survey included questions on women's preference on choice of health professionals during pregnancy. A Cochrane review of 11 trials compared different care models with a view to establish an optimum pattern of care for childbearing women [7]. However, there seemed to be lack of consistency in conceptualization and measurement of women's experiences and satisfaction of care [8]. Bearing this in mind, we included specific questions in this survey pertaining to the women's preference on choice of health professionals. Our findings revealed that 71% of the respondents preferred to see the same health professional during antepartum, intrapartum and postpartum periods (Table 2).

Currently, the choice of seeing a midwife or a doctor for pregnancy care in public healthcare system is often not the woman's. While some women are faced with a dilemma as to which health professional, midwife or doctor, might be best for them [6], others have a pre-existing plan and decision regarding their choice of health professional. However, results from this study indicate that contrary to popular notion, the choice between seeing a doctor or a midwife was almost evenly spread. Behaviour and attitude of health professionals towards the women are other factors that significantly influence women's satisfaction [2]. More than 50% women in our study believed that attitude and behavior of health professionals and participation of women in decision making in different aspects of childbirth processes were valid indicators of their quality of care (Table2).

Preference of self-decision on timing and frequency of medical check-ups and interventions:

Frequent vaginal examinations during labour by different professionals causes unnecessary pain and discomfort, which could impact on the overall satisfaction of the labour process irrespective of the outcome. American College of Obstetricians and Gynaecologists and American society for Anaesthesiologists asserted that maternal request was a sufficient medical indication for neuraxial analgesia, irrespective of the stage of labour [9]. Above observations prompted us to include questions pertaining to women's preference on timing and frequency of medical interventions like frequency of intrapartum vaginal examinations, timing of amniotomy and epidural analgesia. In our survey, 42% of participants preferred that timing of events (induction/ augmentation of labour) leading to baby's birth should be determined at their convenience (Table 1). It is a common observation of the obstetric workforce in this region

that increasing number of patients request induction of labour for "social" (non-medical) reasons. Majority of these requests / demands are declined by the Obstetricians/ midwives in the public sector because of the stigma attached to "social induction of labor" and also because the rate of induction of labor (IOL) for "social reasons" is a key performance indicator. Victorian Obstetric units are expected to keep their IOL rate for social reasons close to zero. Although in practice, IOL for social reasons is the second most common indication of IOL in Victorian public hospitals [10]. The finding of our survey reflected the common observation in this region. Nearly 1/5th of the women surveyed preferred a caesarean section without any medical reason [11]. There has been growing debate in this area of obstetrics and a sizeable number of obstetricians believe that women's views regarding the mode of delivery even without a medical reason should be respected. Nearly 1/3 of women preferred that the frequency of vaginal examination during labor should be determined by themselves (Table 1). Nearly a decade ago, it was a common practice that women in labor used to have a vaginal examination almost every three hours, but over the last decade, midwifery philosophy has shifted in favour of increasing the interval of vaginal examinations and delaying amniotomy until the cervix was at least 6-7 cm dilated.

Preference of self-decision on choice of type of medical procedures:

Literature search revealed that a lack of appropriate knowledge and awareness of possible medical interventions like episiotomy, instrumental delivery and caesarean section can have a detrimental effect on a woman's psychological state and emotional wellbeing [12]. Various studies where women have received adequate analgesia, have reported better levels of childbirth satisfaction as compared to those who have experienced more pain (9,13). Based on above reports and further literature review, the current questionnaire incorporated specific questions pertaining to choice of certain medical procedures like type of analgesia, invasive procedures like amniotomy, choice of instrumental delivery, choice of elective episiotomy or sustaining tear naturally and caesarean section on demand [11]. Majority of women felt that the mode of delivery should be their decision. 1/5th wanted a caesarean section without any medical reason. (Table 1, 2)

Preference on Breast-feeding: There is a long-standing debate whether breast-feeding an infant is a choice or a compulsion. Bearing this in mind, we included specific questions gauging women's decision to breast-feed or formula feed their infant. 85% of the surveyed women felt the decision to breast or bottle-feed should be theirs (Table2).

Perceptions regarding obstetric complications as KPIs:

These days, most women prefer to be involved in the decision making process. Our survey revealed that 54% participants preferred making decisions themselves on different aspects of antenatal, intra-partum and postnatal care including medical interventions during intrapartum period, followed by choice of healthcare worker as compared to determining the timing and frequency of checkups and medical procedures. More than half of the patients believed that the quality of care indicators, as in the questionnaire, were highly important. Post-partum hemorrhage and perineal tear rates, very important current KPIs, were not as important measures of quality of care as holding a healthy baby at the end (85%). Only 1/3rd of women surveyed felt that rate of perineal tear was a good indicator of the quality of care. Similarly, only 1/3rd of women also felt that the timing of administration of analgesia at their request during intrapartum period was a good KPI (Table 2).

Within its limitation of small sample size, this study demonstrated that women's views on KPIs are not truly reflected in the current KPIs. Only a small percentage of women thought that some of the current KPIs, such as post-partum haemorrhage and perineal tear rates were important measures of quality of care. Further research is warranted and should include a larger sample and incorporate other potential KPIs of childbirth process. Therefore, although such surveys have a pivotal role in assessing maternal care, we argue that they should be used as a guide in shaping new KPIs and institutional strategic clinical goals.

Acknowledgement:

We thank Dr. Shikha Snigdha, research scientist, University of California, USA, for painstakingly reviewing the manuscript.

References:

1. Draper M, Cohen P, Buchan H. *Seeking consumers' views: what use are results of hospital patient satisfaction surveys?* International journal for quality in health care 2001, Vol13 (6), 463-468.
2. Goodman P, Mackey MC, Tavakoli AS. *Factors related to childbirth satisfaction.* Journal of advanced nursing (2004)46(2): 212.
3. Sandall, J. *Choice, continuity and control: changing midwifery, towards a sociological perspective.* Midwifery 1995; 11(4): 201-9.
4. Hodnett ED, Simmons-Tropea DA. *The Labour Agentry Scale: psychometric properties of an instrument measuring control during childbirth.* Research in nursing & health 1987, 10(5): 301–310
5. Niven C, Gijsbers K. *A study of labour pain using the McGill Pain Questionnaire* Social Science & Medicine Special Issue: Chronic Pain
Volume 19, Issue 12, 1984, Pages 1347–1351
6. Mas-Pons R, Barona-Vilar C, Carreguí-Vilar S, et al. *Women's satisfaction with the experience of childbirth, validation of the Mackey Childbirth Satisfaction Rating Scale* Gac Sanit. 2012 May-Jun; 26(3): 236-42.
7. Sandall J, Hora S, Simon G, et al. *Midwife-led continuity models versus other models of care for childbearing women* Cochrane Database of Systematic Reviews 2013, Issue 8. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub3.
8. Hatem M, Sandall J, Devane D, Soltani H, Gates S. *Midwife-led versus other models of care for childbearing women.* Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub2.
9. Massimo M, Cinnella G, Perchiazzi G, et al. *Patient-requested Neuraxial Analgesia for Labor Impact on Rates of Cesarean and Instrumental Vaginal Delivery.* Anesthesiology 2007 May; 106(5):1035-45
10. Consultative Council on Obstetric and Paediatric Mortality and Morbidity. *Births in Victoria 2007 and 2008*, Quality, Safety and Patient Experience Branch, Department of Health, October 2010, Melbourne
11. Singh R, Trivedi, A N. *Is the caesarean section rate a performance indicator of an obstetric unit?* J Maternal Fetal Neonatal Med 2011;24: 204-7.
12. Murphy DJ, Pope C, Frost J, et al. *Women's views on the impact of operative delivery in the second stage of labour—qualitative study.* BMJ. 2003;327:1132–1135. doi: 10.1136/bmj.327.7424.1132.
13. Dickinson JE, Paech MJ, McDonald SJ, et al. *Maternal satisfaction with childbirth and intrapartum analgesia in nulliparous labour.* Aust N Z J Obstet Gynaecol. 2003 Dec; 43(6):463-8

Table 1: Proportion of responses with high preferences regarding health professionals and timing and frequency of medical interventions

SN	Question	Proportion with high preference (95% CI)	Grand proportion with high preference (95% CI)	Cronbach's alpha
1	Self-preference regarding health professionals			
	I prefer to see the same health professional during antenatal visits, labour and after birth	0.71 (0.63, 0.78)	0.52 (0.47, 0.56)	0.96
	I prefer to see a doctor during the antenatal visits, labour and after birth	0.39 (0.32, 0.48)		
	I prefer to see a midwife during the antenatal visits, labour and after birth	0.45 (0.38, 0.53)		
	Behaviour and attitude of health care professional/s towards you	0.63 (0.55, 0.71)		
2	Preference of self-decision on timing and frequency of medical interventions			
	I prefer that the health professional should determine the timing of delivery according to my convenience	0.41 (0.36, 0.48)	0.39 (0.35, 0.43)	0.97
	I prefer that the timing of administration of analgesia be at my discretion	0.57 (0.49, 0.65)		
	I prefer that the bag of water be broken during labour at my request	0.29 (0.22, 0.36)		
	I prefer that the frequency of vaginal examination is determined by myself	0.31 (0.23, 0.38)		

Table 2: Proportion of responses with high preferences regarding choice of type of medical interventions and importance of obstetric complications as KPIs

SN	Question	Proportion with high preference (95% CI)	Grand proportion with high preference (95% CI)	Cronbach's alpha
1	Preference of self-decision on choice of type of medical interventions			
	I prefer that the mode of delivery should be according to my choice	0.5 (0.42, 0.58)	0.54 (0.51, 0.57)	0.97
	I believe that I have a right to ask for a caesarean section even without a medical reason	0.23 (0.16, 0.30)		
	I would like the health professional to make the decisions for me, so long they are discussed with me	0.47 (0.39, 0.55)		
	I prefer that the choice of analgesia in labour be mine	0.66 (0.59, 0.74)		
	I prefer that it be my decision to opt for either a vacuum delivery or a forceps delivery when either is needed, provided there are no contraindications for either	0.49 (0.41, 0.57)		
	I do not mind sustaining a perineal tear of any degree, so long as my baby comes out healthy	0.63 (0.56, 0.71)		
	I prefer it be my decision to opt out of active pushing in the second stage of labour, as opposed to health professional's decision	0.16 (0.10, 0.21)		
	I believe that an immediate contact with my baby after birth will help/helped during bonding with my baby	0.93 (0.89, 0.97)		
	I prefer that breast or bottle feeding decision should be entirely mine without any pressure from health professionals	0.82 (0.76, 0.88)		
2	Patient's views re the importance of obstetric complications as KPIs			
	I participate in decision making regarding various interventions of child birth process	0.65 (0.57, 0.72)	0.56 (0.53, 0.60)	0.96
	I decide when I should be given pain relief in labour	0.42 (0.34, 0.51)		
	I didn't mind bleeding excessively in labour, so long the baby was healthy	0.53 (0.45, 0.61)		
	I didn't mind sustaining a perineal tear during child birth, so long the baby was healthy	0.33 (0.26, 0.41)		
	Holding a healthy baby at the end is all that matters, the process does not	0.85 (0.79, 0.91)		

Fellowship Training Program

Applications for Fellowship Training Program at RACMA are now open, closing 31 October, 2018.

Doctors who identify as a Medical Leader and wish to have system wide impact on the health systems of Australasia should apply to the College and training towards RACMA Fellowship and secure professional qualification in the speciality of medical administration (with RACMA). The academic year commences February 2019.

Also, those doctors with significant experience in medical management and who have worked in senior medical management executive roles across health care settings are encouraged to apply for Recognition of Prior Learning and Experience (RPLE) as part of their application to Candidacy with RACMA. Applications close for this process on August 31, 2018.

For more information click here or email Tim Maddocks at tmaddocks@racma.edu.au

RACMA
ROYAL AUSTRALASIAN COLLEGE of Medical Administrators

Suite 1/20 Cato Street
Hawthorn East Victoria 3123 Australia
T +61 3 9824 4699
F +61 3 9824 6806
info@racma.edu.au
racma.edu.au
abn 39 004 688 215