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Question from Members

Please note: Duplicate questions have been removed. One question has been removed as containing inappropriate content. Three others have been edited to remove some inappropriate content.

Dear members as there is a 150 word limit I have exceeded this in some cases to give you a more detailed answer that you deserve. Some questions are so similar I have combined them and directed you accordingly. I imagine my work will be edited so I will be publishing this in full elsewhere to do justice to your time and mine.

Dr Price has agreed to her responses being cut to 150 words to the nearest sentence.

No	Theme	Question
1	GPs in Training	How do you plan to support the current GP registrars due to sit exams in October? The lack of information is causing increased stress in an already stressful environment. **Better transparency, better collegiality and much better communication. Improving networks and communication are key features of my campaign. Plus support issues for the great uncertainty of 2020 needs review within the RACGP. Up until training is returned to the RACGP most of the interactions between the RACGP and GPs in training have been transactional. I don't believe this is a good way to start a life long association with the College. As regards October there needs to be some thought given to practice based assessments and no disadvantage clauses for those who underperform due to Covid and all the disruption of a pandemic. Deferred payments and benevolent funds may be able to help out some trainees who are finding payments difficult. The RTO MCCC in Melbourne paid for their registrars practice exam which was a helpful innovation.**
2	GPs in Training	A lot of registrars have felt let down by the RACGP on various topics for a long time. What will you try to achieve for GP Registrars if you become elected RACGP President? Answer to Q 2 3 and 4 **We need to bring the College to life for you as a medical Collegiate home. As per previous up until now it has largely been a transactional relationship. It now needs to be a true fellowship. So community networks, informal role models and much more interaction within the RACGP to provide a diverse range of opportunities. I think mapping out career paths too is an important part of this transition. There is so much going on for GPs as they enter the profession so lots of time and support is needed to smooth the path.** **Disparity in entitlements with hospital registrars** **Honouring entitlements from a previous employer would mean no practices could afford to employ registrars. One solution may be to advocate at Government level for an independent organisation to manage a Registrar Entitlement Fund through which GP registrars can access study leave, sick leave, maternity leave etc. This idea is completely novel, and would require the cooperation of governments, GPRA, GPSA and RTOs. It also requires funding, always the greatest challenge. As such, I**

		would like to begin this conversation understanding the establishment of such a fund will take time if it gathers momentum. **Registrar Earning Capacity Option 1** **GP training begins a transition from being an employee of an organisation as occurs in hospital to an independent contractor or business owner once fellowed in most cases. Part of our training needs to include teaching registrars the business of general practice and how to manage financial success once working independently. Our current business model relies on billings for our remuneration. The most vulnerable time financially for registrars is the first 12 months of training when they see fewer patients, and the emphasis (rightly so) is on learning the specialty over seeing large numbers of patients. To protect registrars' earnings and to make entering general practice more attractive to doctors in training, a reviewed minimum terms and conditions needs to be addressed. Rather than frighten practices away from training by demanding higher remuneration for registrars, a protected rate per hour commensurate with a hospital registrar rate could be considered for the first 12 months. This is similar to New Zealand. Allowing registrars to transition more gradually in to the model of payment. If a registrar's percentage of billings falls under that threshold, practices can be compensated for making up the shortfall via a centrally administered fund.** **Registrar Earning Capacity Option 2** **To protect registrars' earnings and to make entering general practice more attractive to doctors in training, a reviewed minimum terms and conditions needs to be addressed. To enable practices to offer registrars a greater percentage of their billings, one solution may be to advocate for greater practice remuneration for teaching registrars in their first 12 months.**
3	GPs in Training	What are the main issues affecting GPs in training and what will you do to improve them as RACGP president? **As above.**
4	GPs in Training	How do you see yourselves closing the gap between GP supervisors and registrars when it comes to remuneration in a way that both parties are happy? **As above** Are you satisfied that the fellowship exams in their current format are helping the purpose of producing an independent GP who may practice anywhere in Australia? Do you see that RTOs (in the current set up) are delivering similar training programs across Australia?
5	GPs in Training	Employment conditions for GPiT are atrocious and enrolment numbers have been dropping over recent years. The pandemic has exacerbated and highlighted these challenges with many registrars either losing their jobs or having their hours cut. What is your plan to address the gross inequities in entitlements and pay compared to our hospital counterparts, with a view to attracting more doctors to the specialty and whilst supporting practices to take on registrars? **Agree it's been such a difficult time and you have entered GP land at a historically bad time. As someone said it's like entering a burning building. It's so hard for**

		you and I am eternally sorry for the year of 2020. These issues all need to be addressed vigorously and the whole sector needs massive refunding for which I am going to fight. I also believe practices need to have management consultancy available to improve business operations and funding and to assist some practices to decrease reliance on bulk billing. Generally though the Government has been defunding Medicare. That's the issue. **Looking after the experience of our next generation of GPs is a priority even as we all deal with the financial constraints ourselves**
6	GPs in Training	What do you intend to do about the financial impositions being placed on general practitioners in training by the RACGP's refusal to reduce the cost of exams and its charges for practice exams in a year when registrar incomes have been, in many cases significantly reduced? **It's been such a tough year for many people. This has to be worked through carefully. As I understand it the RACGP has also suffered financially this year with loss of major educational deposits made for conferences that will never happen and operational income that due to Covid has not arrived.** **The sudden drop in income for all GPs has been distressing and concerning and intense lobbying about mandatory bulk-billing telehealth continues and refunding of primary care continues.** **Unfortunately too, because of the cost of running the program and the very high costs of creating and running an exam, candidates do need to pay a contribution to become a fellow. The Government also contributes a significant amount to GP training (for example, pay for registrars to attend out-of-practice learning and for teaching with their supervisors amongst other things).**
7	GPs in Training	What are your thoughts on paid maternity/paternity leave for GPs in Training? How would you support practices with this? **It is scandalous that Australia is 50 years behind Scandinavian countries for paid parental leave. Norway passed the Kindergarten Act in 1973. We are lagging behind industrial reform and to some extent anything else is a stopgap to a full system reform that is way overdue.** **Industrial reform for full parental leave entitlements is one of my soap boxes. Failing that these entitlements are enshrined at a national level the proposals for registrar leave entitlements need to be provided as you enter practice. Working out the best way of doing that is still ongoing but I would favour a flexible model and the funds should be held by an independent statuary body. You don't want to trade your professional independence away nor your flexibility so the terms and conditions need really careful oversight. Support the proposal but will need review for unintended consequences.**
8	GPs in Training	How do you plan to fix the widening pay and condition disparity between GP registrars and hospital registrars? **A number one priority for the whole GP sector. It wasn't like that in the early 2000's when bulkbilling was less and Registrars generally got an improved income on leaving hospital employment.** **See earlier extensive answer**

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9	IMGs	IMGs are poorly represented at all levels of RACGP, AHPRA and medical boards...etc, what is your plan to improve their representation? **We judge a person not by their demographic but their interest & ability. We rely on encouragement to all, not discrimination** **For example, Victoria has recognised since 1996 the need for a council that represents all its members & has many IMGs. We no longer use that term- once a Fellow, you are a fellow & our equal** **Committees are the backbone of every organisation & to be effective must be welcoming , polite & well run by their chair. They must be good at what they do or others will not want to join.** **We start with the New Fellows Committee which introduces new GPs into the College & encourages all to participate in the activities of the College around education, training, standards, advocacy & research. Many examiners.** **I would also champion the re- introduction of a leadership training course but more broadly focussed.** What is your plan to end discrimination in payments to trainee GPs (item 53 v 23)? **This will need a skilled conversation to the legislators about why we are enshrining discriminatory practices. I would invite you to join with me in this important conversation. If you are a GP in training there should be no difference.**
10	IMGs	Considering a big proportion of GP workforce are IMGs, what measures is the RACGP going to take to address the unfair moratorium restrictions on RACGP fellows (i.e. Medicare restrictions 19AB and 19 AA) even if they are trained in Australian hospitals and completed the fellowship via an RACGP training provider? **The moratorium is a failed government ploy to provide an indentured, low cost medical workforce in the bush.** **The doctors deserve better, the bush deserves a properly resourced, fully trained rural workforce that is appropriately remunerated.** **A strong RACGP will stand with its sister College to demand quality services for rural areas & justice for our fellows. You are a fellow and colleague of our College.** **This is a terrible imposition and the moratorium needs review. The family separations and upheavals are challenging and the other part of this is the increased support. The lost in the labyrinth report for doctors was in 2012 detailing a raft of measures and these should be audited to see if they have been properly implemented.**

No	Theme	Question
11	IMGs	The current training programs discriminate between local graduate and overseas graduate IMGs. Local graduates are issued with provider numbers which allow them to practice anywhere in Australia. IMG provider numbers allow them to practice in MMM2-7 only. Also IMGs have to spend 10 years in the Bush before they are allowed to practice in Metropolitan areas. What steps are you going to take to stop this institutional discrimination? **The rural situation is a travesty** **The discrimination between locals & IMGs is artificial. If they are fellows,**

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		they are fellows. **Under the current system, if they are not fellows, they are usually registrars or grandfathered.** **We will not apologise for wanting the best of ourselves & our College or the best for Australia** **The plight of doctors is not the only health issue in the bush.** **We doctors & other health care workers are happy to work with governments to provide effective solutions.** **Misunderstanding between the bush & others has hurt our College & we will not forget those sad lessons. We will not repeat the past.** **Health reform for the bush involves so many people. For doctors it starts with the selection of medical students by universities, training in rural areas and a great need for skills diffusion along that pipeline and career path.**
12	IMGs	What is your view on the 10 year moratorium for overseas trained GPs? If you are elected president, what advocacy will you participate in for overseas trained doctors who are subject to the 10 year moratorium? **I will name it and shame it as a discriminatory practice and one that potentially disadvantages the doctors and the rural communities. Unhappy coerced GPs is not a good solution. It is a temporary solution that has politically changed into a voting strategy. We need better solutions overall to solve this very wicked and challenging problem. I am hoping to elevate your voice and bring pressure to bear on those who legislated this. Your college needs to work with you together on this. Also see answer to Q11.**
13	Membership Engagement	How do you feel your past experience with involvement/activity in the College will shape your presidency and how will you ensure our Board does not make mistakes which might alienate its members? **I have demonstrated my ability to manage advocacy and engagement for the members with GPDU a six year, 24/7, 365 day effort. I have not showed up for an election to do this work.** **I will be able to influence here to generate a more open and inclusive vision and action for member engagement. On GPsDownUnder we have modelled this as much as possible. It is possible and the time is right to do so. The so called secret squirrel stuff must be relegated. I propose to hold regular (thinking weekly) members zoom meeting through the College possibly on a Friday night to be available for the members. As particular issues arise inviting the expert into that space will be helpful. Also inviting various other board members for you to meet and greet and understand their role is vital. We do need to understand better how RACGP works and operates.**
14	Membership Engagement	How will the College ensure that its history is well documented via its own Archives to better inform its future leaders?

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		History is so important lest we are doomed to repeat it. The RACGP hasa rich and beautiful history. Sometimes a gnarly and challenging history. Sometimes a forgotten history. This is a rich field for research and review. I have already worked with the ARCHIVES committee to develop a template to request the living history of the women of the RACGP. This request arose as the archive committee Assoc Prof Christopher Hogan; Professor Max Kamien Assoc Professor John Kramer and Dr Gillian Riley found that there was not a proportional review of the history of some of the outstanding female GPs (for instance) who were pioneers at the RACGP. People like Dr Jill Murtagh who was an early rural GP-anaesthetist and married to Dr John Murtagh.
15	Membership Engagement	Why should I vote at all? The college feels so far removed from my day to day reality as a coal face GP. If not for some I would not know much about anyone even on my state RACGP board or national board or their values. It seems I pay a fee to RACGP so some GPs can make a career out of clinical governance and unfortunately based on my education and training (overseas) I won't even stand a chance to be noticed when they do their succession planning (as RACGP last campaign showcased). **Hi there, that is so sad to hear. I would like to invite you to consider joining into this very important discussion about overseas trained doctors with me. I want to hear it and act on it. As noted on GPDU this cohort is 50% of the workforce and so must be represented. The purpose of the RACGP is member led so if this is not happening then we need to make changes and not carry on with business as usual. The RACGP must make members lives easier. The RACGP must become a HOME for GPs for their education, professional development and professional collegial community. We have governance to distribute power and to carefully be custodians of the RACGP finances so that no single person has control which is essential to the continued service of members. However I agree that should not be the focus of RACGP engagement.**
16	Membership Engagement	Why is the annual subscription so high? **The college was building up some cash reserves to assist with taking back education and training as well as manage the potential loss of members with the CPD legislation. The annual subscription rates need to be reviewed and considerations given for different levels of membership that suit your circumstances. This cash buffer I imagine will have largely disappeared during this horrendous year of 2020. As a not for profit company and a registered charity any surplus must be for the benefit of the members. Directors of the College (the National board) have a prime responsibility to ensure that the College remains afloat and financially viable. Answering to members regarding those financial challenges is absolutely vital.** Are you aware of the struggle of the current COVID circumstances?

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		Oh yes. It's been so challenging hasn't it. I have participated in the Victorian RACGP faculty webinars where the members can ask direct questions of the chief medical officers and senior department of health public servants. There have been twelve of these so far. The burden of delayed diagnoses, poor supply of PPE, poor communication, chronic disease and mental health are evident in our patients. AHPRA has waived the necessity for CME this year!! Are there specific reasons? **This is a sensible decision when especially in Victoria at the moment we are locked indoors if not working and experiencing high levels of stress ourselves with the many difficulties of this year.**
17	Membership Engagement	Do you think there should be a GP (Doctor) advocacy group just as we have patient advocacy group to assist members when they run into problems with AHPRA or any other body for just cause? If so how would you go about it? **In a word yes although I think a series of scaffolded responses are needed depending on circumstances. Support can be simply peer mentoring or very specific task focussed requirements. This is essential at a time of great stress regardless of the circumstances. People can often feel isolated ashamed and alone and we know from the UK experience of suicides for Drs under GMC investigation this is a dangerous and troubling issue. We should also engage with our Medical Defence organisations to ensure that support can be partnered with legal backup if needed.** If not why do you think it is unnecessary? **It is absolutely necessary. I am 100% onto this!**
18	Membership Engagement	Is there any plan to support SOLO GPs networking? **Yes. Community hubs and networks. I am planning to establish the equivalent of the RACGP divisions of General practice. More local contextual groups for education and learning. If not in person then by virtual means. Having a local peer group for education and professional support is vital. As colleagues we have a fellowship and so we must live by this maxim. The RACGP needs to be able to come to you wherever you are in a large engagement piece for improved communication** I believe we are a dying breed with little support on the professional and financial aspects. All funds for any projects go to big clinics? Little attention from all organizations including PHN!!!" **I hear you here and I agree we need to better support you. PHNs are government agencies and in my opinion do not support. As a professional college focussed on member benefits this is our vision and should be our strategy**.

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19	Membership Engagement	How do you think the RACGP should support the mental health of its members, especially in regard to the recent extreme stresses of bushfires and COVID? **Great question. Well-being is defined as 'a multidimensional construct that comprises the core dimensions of (i) positive affect, (ii) personal relationships and social engagement and (iii) a life view that is meaningful and optimistic' (From Murray 2016) This is a complex question that ranges from the thriving individual through various levels of distress to burnout and beyond to depression and mental illness.** **At the wellness level keeping well means having a great peer community for the levels of support we are familiar with in practice. Comparing notes checking management, witnessing listening, and empathising with the challenges of our job. This socialisation is so important to enable sustainability. Refocussing on our core purpose with patient safety and patient outcomes knowing we are practicing to our full scope of practice helps us develop meaning. By performing advocacy for appropriate professional remuneration for members GPs must feel rewarded and valued by the community.**

No	Theme	Question
20	Membership Engagement	What plan do you have to defend GP rights when it comes to Bullying tactics by DOH compliance department such as the "nudge letter campaigns "? **This is a blunt instrument that supposedly is there to "help us" review our practices and consider our profile in comparison to others. It works basically to frighten us out of good patient care. The realities of variations in practice have made this a useless exercise for me who has a very particular practice profile. We need to point to the world's best practice of General Practice in our quality of CPD and our quality and standards and ignore the Government in its attempts to defund Medicare. We need to get our own data for meaningful quality and improvement activities for which most of us would be interested in as we are lifelong learners dedicated to patient care. We need to also campaign to the patients about the coercive attempts to deprive them of Medicare rebated services simply because the Government cannot face the electorate on health care funding.**
21	Membership Engagement	So there is a great debate about the RACGP's role and its obligations to its members. The College is a professional body for education, standards of education and quality assurance in General practice or it is also a lobby group for representation of General Practice in Australia. We are keen to find out if you will settle this issue once and for all. In your view what is the best way forward and what change you will bring which will satisfy many members who feel disenfranchised?

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		As I have said before trying to rank hierarchically the activities of the College is a false approach. All of these are important and the RACGP is a large enough and robust organisation to manage all of them. We must protect our education and standards. We must look after the Registrars, (now called GPs in Training) the supervisors and medical educators and ancillary staff. **The Advocacy is ongoing, nuanced and sits across the multidimensional roles of a thriving college. The funding of General Practice supports all the activities from education and training to advocacy issues and at the moment the sector is at breaking point with the successive defunding of Medicare as a universal insurance. This has flow on effects into education, training, exam costs, and overall viability of practices and the College. Trying to find the mutual exclusiveness of these issues misrepresents complexity.**
22	Membership Engagement	How do you plan to change the perception of general practice - in the community, in other medical professions (including specialists, hospitals and junior doctors considering GP as a career) and with government? **I aim to provide recognisable brands of quality associated with the RACGP. We have a beautiful crest with the motto from the RACGP web site *"The motto, Cum Scientia Caritas, adopted with the generous concurrence of the College of General Practitioners (it is their own motto), may be translated: "with skill, tender loving care".*** **This brand needs to be recognisable by patients as a standard of quality care. As well as the RACGP GP specialist these are images that can be proxies for quality care and standards for which the College is famous and works hard. This can be promoted by members as a value proposition for their practices and of course means that GPs are upholding the highest principles of professional medical practice including the gold standard CPD that the RACGP provides and which is recognised as such by the Australian Medical Council.**
23	Membership Engagement	Engagement of members within the College is increasingly important. What is your strategy to change the narrative from the commonly used 'The College', to 'My College'? **We need to bring in the critics and the curmudgeons and hear from them. It seems people feel they are not being heard which is a pity. I also believe the RACGP needs to be more widely distributed to where busy General practitioners work. This is the idea behind the Community hubs and networks. If the RTO organisations can deliver pre vocational training in their areas why not post vocational. To eventually have standard academic practices setting educational and collegial events as we used to have with the divisions. Every RTO has subdivisions and so the network is already there. With some skilled logistics these can become unique hubs that become a focus point for GPs everywhere for College activities and communication. My college is my professional home.**
24	Membership engagement	GPs who specialise in aged care have a unique set of issues and challenges facing them on a daily basis. What do you see as the main areas that need attention with regard to helping and supporting these GPs, and do you have

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		a plan for this? If so, what are the main elements of this plan? **I can remember talking to Frank Jones when he was President about this. Aged Care is in dire need of medical reform and the ethics of what has happened to this sector has warranted an aged care inquiry. GPs have been whistle blowing for a long time. There are many excellent GPs who have dedicated their practices to the aged care sector which provide efficiencies and systemise the work flow. It is a challenge to provide the more traditional one patient in seven different aged care sties and Medicare has made this challenging and virtually a charitable event which is a disgrace to our older citizens. A vital area in need of advocacy and innovation for systems thinking. It is essential that we provide excellent models of quality care as this is a prime area where we can produce data for avoidable hospital admissions.**
25	Advocacy	Financial viability is a major stress for practice owners. Can you please discuss your plans to ensure GP clinics remain financially viable. I believe this is the most important issue at the moment. Do you agree? **You are 100% correct. I cannot imagine any of the candidates disagreeing with you although the GP sector needs so much reinvigoration it is the funding is essentially the issue. We need to improve the remuneration through applying significant electoral pressure to a Government facing an election in 2022. We need to mobilise the electorate as we are actually in the fray for their ability to access health care. Universal health care will be a distant memory with this progressive and steady defunding.** **We have areas and clusters of inequality though and so flexible models are required to support high quality practice. Yes we need to use data and we need to retain governance of it. I am concerned at the trend to use data in a top down approach that misses the local contextual issues of practice.**
26	Advocacy	I would be interested in the candidate's opinions about reform to the payment arrangements within Australian general practice. Is a payment system based on fee for service non-negotiable? **Every system proposed must have physician autonomy. Fee for service must remain but equally may not be suitable for every context. NACCHO for instance does not use this model and community co-operatives are another area ripe for funding reform and innovation** Or does the candidate have a willingness see the RACGP exploring new payment models as have been introduced in a variety of international models of the patient centred medical home? **The evidence for any single payer system is that all have advantages and disadvantages and the consensus is that a blended system of payments is perhaps more realistic. Having this as a flexible mix would be ideal to manage clusters of inequality versus cluster of affluence. To think one payment model could serve every context in Australian General Practice is not helpful to manage a thriving sector.**

		As stated at the beginning physician autonomy is essential and fee for service the basis of that but other models are necessary to cope with practice differences and patient variations. Safety nets need to be used more widely if the Government are serious about universal health care.
27	Advocacy	Is the Medicare system fixable for GPs? If so, how would you go about making changes and what main areas of Medicare for GPs would you target? If not then how would you propose to radicalise the broken Medicare system? **Yes it is fixable. Funding primary care is an investment in avoidable hospital admissions. Denmark demonstrated so ably that closing tertiary hospitals was possible by reinvesting in primary care. There has to be political will and political courage though, as hospitals are sexy beasts in elections. Ironically federally the health system relies on General Practice. We must demand the end to disrespect in our sector. We must fight for resources for our patients and we must involve them in that fight for their social contract of health. We see most of the population and this is an ethical imperative given the evidence not to let General Practice fall into any more fiscal disrepair.**
28	Advocacy	How do you defend GPs against financial loss caused by pharmacies, Medicare? **There is no reason for a patient to attend a Pharmacist when Drs have a properly functioning telehealth system of care. The argument for convenience is nonsense if your own Dr with your own history can be reached easily. We enlist the help of the Pharmaceutical Society of Australia which represent every pharmacist as a professional organisation. We know that non-prescribing pharmacists have evidence of benefit in practice. We know that changing some of the legislation about pharmacies existing within practices is a great 'convenience" for patients. We know that Amazon is going to threaten the pharmacy market and the productivity commission have recommended a decrease in numbers of pharmacy graduates. We need good pharmacists we don't need pharmacists being Doctors. We need to embrace the modernisation here and make it work for us in new models of collaborative care.** How you can protect our profession against other professions trying to take financial advantage? Pharmacies administer flu vaccine and in some states children's vaccinations. How you can protect prescribing in a GP's job and not allow others to take it? **The level of record keeping by Pharmacies has not been adequate. If we managed pharmacies inside our practice this becomes a different proposition. If we are truly talking convenience and not the Pharmacy Guild then we can manage cooperative models of care. But fragmentation worsens patient care and the Government must be held to account for every failure and loss of dollar benefit to the Australian tax payer that a fragmented health system provides.**
29	Advocacy	The government won't change any strategy until BB rates drop. How would you go about organising the College to advise its members to drop their BB rates, essentially as a tactical show of power?

		By providing business management and management consultancy services within the RACGP to assist practices manage a transition away from Bulk billing. There is a national faculty of specific interests in business and this is an ideal role for it. Benchmarking and using demonstrated models that provide ethical business models that aid practice solvency, efficiency and flourishing are what's needed. If most health expenditure is wasted in/on hospitals, what role do you see the College having in talking to State governments to get this money diverted to GPs, who as we know, from copious amounts of data, do a more efficient job? **3 billion dollars of savings for avoidable hospital admissions.** **Denmark see earlier comments** **Money talks.** **The government will need to get wise and responsible in the time ahead and post Covid recovery. We have an election in 2022.** **So the moral argument may not work, the fiscal argument may take too long but the imperative of votes in an electoral cycle gives us some leverage .**
No	Theme	Question
30	Advocacy	Some candidates advocated to increase GPs' remuneration from Medicare. This is unlikely to be fruitful, given the economic reality of Covid-19. Some of the candidates however are also practice owners who charge GPs a service fee of 30-40% before tax which leaves many GPs struggling. Would you advocate limiting the service fee to 20% as a way of helping GPs to have a decent income? **This is challenging. I am a contractor but used to be a practice owner. If the service fee was 80% we would send General Practice to the wall. What we need to do is have a win-win situation where if the owner thrives then so do you. And that means a reinvestment in primary care. There is money available the government just needs the political courage. This can be ably managed by use of the word votes and enlisting our patients in this fight for their health care resources. Contractors must be thriving if practice owners want to thrive and vice versa. You have your own business within someone elses so I would like to change the perception of that too.**
31	Advocacy	GPs across Australia have embraced Telehealth and the flexibility that it gives us in providing patient centred care. I have found that Telehealth is a wonderful tool to provide care for my patients with disability as one example. What will you do as RACGP president to advocate for the continuation of Telehealth item numbers for general practice post COVID-19? **Everything I possibly can. Building on the advocacy already started by the late great Dr Harry Nespolon. Firstly it needs to be disengaged from compulsory bulk billing which to my mind is unconstitutional and GPs equally have a responsibility to be careful with the stewardship of Government funding. We must always put patient care first. This is the hallmark of professional practice.**

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32	Advocacy	The COVID19 Pandemic has really highlighted the problems GPs have working within a state based healthcare system, and yet being federally funded. We are following the guidance of our state based chief health officers, but we are often forgotten in state based planning. I would love to know the candidates' thoughts on this, and their suggestions for a solution. **The rural generalists are doing interesting work here with the Murrumbidgee model of funding. Looking at Monash Medical centres proposals for hospitals developing outreach into community chronic disease management there is a role here for General Practice to step in. We already do this work and we should be able to generate a statement of works for state hospital funding. We can keep patients out of state hospitals and so it is worth their while to fund us to do so. There are some legislative issues here that need urgent attention. Covid has shown us just how dysfunctional the federated states are when it comes to GP care in the community.**
33	Advocacy	Is the RACGP's 'Vision for general practice and a sustainable healthcare system' (https://www.racgp.org.au/advocacy/advocacy-resources/the-vision-for-general-practice) still relevant, appropriate and useful? Do you believe that it should be the basis for the RACGP's discussions and negotiations with government and other third party funders of health care? If you think that it needs to be changed or updated, in what ways should it be changed or updated? **Yes it is still relevant and useful as it describes the principle of longitudinal continuous care and the policy required to support and strengthen it.** **It describes a variety of models for health care funding although I think there should be some flexibility within these as what might suit Double Bay likely won't suit Alice Springs.** **There was also no mention of the use of technological consultations which have occurred via Covid. This was unforeseen of course. I would like to see considerations given to textual and email correspondence. Also technology was mentioned but not data governance. This might not have been in the terms of reference but our risk matrix for achiev ing the vision was not mentioned and therefore I am uncertain of the RACGP strategy to mitigate the various threats that may prevent implementation.**
34	Advocacy	Why are we called "" just GPs"" but AHPRA register us as Specialists? Why are we not called Family Medicine Specialists? **Good question. I believe our speciality should be ring fenced and recognised like rural generalism. It will help to describe bids for funding and describe a commitment to quality and standards. It is something that can be understandable as a brand to patients that we can claim. The actual name itself is not as important as the concept of the ring fencing and making the claim. Ahpra recognises us but not the Medicare Health insurance act and that should change.** I believe websites of medical centres should change the title of fellows to Specialist Family Medicine Physician or Specialist Generalist Physician and non Fellows should be classified as Family Medicine Physician Registrar or

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		Generalist Registrars while those not training should be called Career Medical Officers our integrity is down. What are your thoughts? **I think this has merit and needs further discussion with the members. On Dr Sam Heards blog site he lists under his politics tabs around eight different categories all of whom can be a GP but only one of which has a fellowship. That doesn't happen for cardiologists. If patients are going to have a hope of understanding this then we need to declare it better and name it better.**
35	Advocacy	Regional and country practices are being subjected to new restrictions in recruiting and training new doctors and facing immediate workforce shortages. How do the candidates address the shortages and improve the distributions of GPs? **90% of graduates are going into speciality training in hospital disciplines and we are getting a 10% pipeline. This is in direct response I believe to the disrespect and defunding of General Practice which must be addressed. If we don't have a pipeline then rural will suffer first. Getting every medical student and resident Dr to spend time rurally will help end some of the disrespect and disregard within tertiary training centres. The RDAA have a range of strategies that address community needs for incoming rural GPs and their families. Training in a rural district is important to demystify it and create the community contacts and rural medical students often returning home to practice are part of a range of scaffolded responses. But it starts with fixing up the pipeline when new graduates are choosing their speciality path.**
36	Advocacy	The RACGP lacks a national online members-only forum in which members can discuss issues among themselves. The Faculty Facebook groups go only a little way towards this. The GPs Down Under closed Facebook group with 7 837 members is the *de facto* national discussion forum for members of the RACGP. Are you satisfied with this situation? If not, how do you propose that the RACGP should enable members nationally to discuss issues among themselves? **As a cofounder of GPDU and a nearly completed PhD on Peer connection I know a little bit about this. To ensure that not only are the loudest voices but also the quietest voices are heard is an eternal problem. What is disastrous is when a group is silenced through systemic disadvantage and decisions are made based on a vocal few which may be out of context and which continue the leverage of privilege. This is a challenging question but one I have answered by forming and maintaining GPDU. It is not easy.**

No	Theme	Question
37	Advocacy	If elected as president of RACGP what measures you will take to make the Govt understand the importance of GPs in primary healthcare as GP

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		specialists and improve the Medicare rebate and improve the quality of service as GPs we are offering to community? Improved access for allied health services for chronic medical conditions instead of 5 visits per year and to make it as 10 visits per year. **I think we already offer good services to the community. The excellence of Australia's General Practice is well acknowledged in disease management. Of course there are always areas of improvement. Indigenous health and chronic disease management. Aged care and mental health of particular concern also. These are areas which have suffered chronic underfunding. I think with the aged care royal inquiry underway and chronic disease being an area where GPs can save hospital admissions we have a case to make for more funding. The pernickety bit will be what will be the terms and conditions associated with it.** **By entering into dialogue with patient grousp this can help with leverage at the electoral offices.**
38	Advocacy	There has been a lot of talk by one candidate in particular - about GPs needing a lobby group akin to the pharmacy guild. What are your feelings on this and the ethics of general practice using tactics like "pay for play"? (Donations to all political parties) **I am not in favour of political donations to one nation for instance. Maybe someone else will have another objection to supporting the coal lobbyists or those who continue with refugee detention or else the labour party and their policies on taxation schemes and social welfare. It becomes very difficult from a moral and ethical view point doesn't it?** **Furthermore the costs of sustaining this are enormous. The pharmacy guild took 30 years to get where they are and they only advocate for pharmacy owners. They represent commercial interests and I wonder if this is where GPs want to go? This will be a cost borne by the members to essentially influence through money the political decisions made. In many places that might be considered a bribe?** **So can the membership afford it? Unlikely.**
39	Advocacy	Considering the success of other groups who use professional lobbyists (e.g. Pharmacy Guild, NRA, etc) in achieving their advocacy goals, would you consider the same approach to be suitable for the RACGP? Why or why not? **I would hope never to be compared to the National Rifle Association and the politics of lobbying in the USA is not the same thankfully here in Australia. So far in USA it appears to have fractured and harmed their society in significant ways in a pernicious way it has cast a shadow on the democratic process.** **See my previous answer too as to why in Australia and for the RACGP this is not an ethically, or financially or strategically sound strategy unless we agree to do away with the role of the President.**
40	Advocacy	The evidence that a strong primary health care sector leads to better outcomes and reduced overall costs is well known, but general practice continues to be the poor cousin of the Australian health system, both metaphorically and literally. How will you convince government of our

		critical role and secure a meaningful increase in funding of Australian general practice? **Through a combination of skilful horse-trading; united front with other medical GP groups and aligning patients front and centre. We have access to every single electorate in the country and we should be making sure that patients argue for access to sufficient health care insurance for their needs.** **The other very large lever is to reduce the rate of bulkbilling for those who can and this will have a number attached on it in Canberra. The RACGP can and should assist practices who can detach themselves form the Medicare merry-go-round.**
41	Advocacy	We believe the Australian Primary Care Physician is facing the greatest challenge ever now. There are many examples from other countries when they did not rise to the challenge general practice became a dying profession or a mere referral and prescription platform. We are being constantly challenged by Pharmacists, Nurse Practitioners and even certain other specialists. (Pharmacy led prescriptions is an example) Young GPs are being exploited by big corporates who puts profit before care. They are being forced to work for lower percentage seeing higher number of patients per day. This leads to significant reduction in quality of care and less confidence in people of their GP. Most of us still believe small family practices are the essence of primary care. But they are struggling to survive when facing giant corporates. When compared to other Specialist colleges, the majority of membership feels RACGP has less control over their training programme AGPT, which may need a touch of redesigning. Could each candidate please explain to members their plans and vision to these challenges. **Two powerful levers money and votes.** **The Government will not be able to afford a fragmented health system. One only has to look at the USA to see the GDP spend and worsening morbidity and mortality data compared to other western nations. The risk of commercialisation of health care is a great one and economically does not make sense. Snake oil sales people can only take you so far before we would see a rise in avoidable hospital admissions.** **this is estimated to be at last 3 billion. Post Covid we are going to be financially constrained for quite a while**. **Electors** **We need to engage patients in arguing for their taxpayer funded medicare insurance and access to community care.**
42	Advocacy	Why have AHPRA fees risen when for the most part the income of GPs has fallen and the cost of running a GP business has increased? **This needs greater transparency and accountability from AHPRA's board of directors. I think we notice it as our income has fallen relatively to just about**

		everything else so natural price rises seem even more significant. We have to pass these costs onto patients eventually.
43	Advocacy	Primary Health Networks offer tens of thousands of dollars to General Practices to obtain patient clinical data. It is called QIPIP. Our PHN installs software onto our computers to extract data. We have no oversight or control. PHN contractors are supposed to de-identify the data. Has your practice signed up for this Project? Does this Data extraction worry you? What position should the RACGP have regarding this multimillion-dollar National Government Project? **It is a crock and a trap for the unwary. AGPA group and the e-committee at the RACGP have been advocating very hard on this. It is a critical issue over the control of our data.** **We must retain control. We are liable for privacy breaches but are relying on patchy data security from the PHN and really it's a level of expertise in cybersecurity that is above most in General Practice. We will be moving towards a National Data Custodian.** **Our practice had no idea initially but when I alerted them have responded appropriately to the data issues to protect our data from being siphoned off.** **The National data custodian for primary care data needs to NOT BE THE PHN.**

No	Theme	Question
44	Advocacy	Characterising patients as "consumers" has eroded the doctor-patient alliance, causing loss of respect for doctors, unrealistic expectations of care, less patient responsibility for their health, more defensive practice, rising complaints and an attitude by complaints authorities that doctors are guilty until proven innocent. Will you promote abandoning the consumer model restoring the concept of joint responsibility through the principle of the doctor-patient alliance? **YES!!!! Absolutely. The biggest risk to our profession is the erosion of the therapeutic relationship or a shift to a transactional model of health care. The linguistics are deliberately manipulated and we must make sure we resist this push vigorously!!**
45	Advocacy	How do you propose to lobby government and make changes to the current situation of GPs being forced to bulk bill certain Telehealth MBS items? The government does not force specialists to do this, so why target the frontline primary care physician? Imagine spending an hour of your time drawing up a Mental Health Care Plan for a patient you are concerned about, putting safety precautions in place to protect that patient and get paid all of $138 for your efforts.

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		This is one of the first cabs off the rank. Although the review will happen at the end of September so within the President elect time so a funny time but in general this has to be removed. My question to Greg Hunt has not been answered over the point of law regarding the potential unconstitutional nature of conscripting Drs to charge a set fee. Within the Australian Constitution it is not allowed to set Drs fees. It's a good question and it needs to be fixed. The National council of primary care doctors (formerly the UGPA) is a good vehicle for this as well as individual Presidential leverage. This is a must achieve outcome.
46	Climate Change	Do you feel the RACGP should play a more active role in Environmental health issues for the well-being and health of our patients? If so, how? **YES** **By promoting the national faculty of specific interests in climate change to develop curriculum for the RACGP education outputs.** **A summary form the Lancet below makes this such a complicated question. Health and the impacts of climate must be integrated into every part of our responses. 2020 has been a year of reckoning and we must hold our Governments to account.** **How to do it means firstly understanding WHAT which the countdown indicators show. Integrating into curriculum for the GPs of Australia is important which is a key stakeholder part of rACGP functions. Advocating to Government stakeholders means applying pressure consistent with the policy statements of health care adaptation indexes as described below and marshalling the considerable forces of public opinion acroos all sectors of the community. That we must attend to the health care of mother earth is obvious.**
47	Climate Change	Climate change has been recognised as the greatest health challenge for the 21st century. How will you ensure that the GP workforce is prepared to face this challenge? **See answer 47.** **The co-burden of disease from Tim Senior and the Lancet.** **Understanding too that solving some of the climate issues such as car pollution and improving public transport also helps with metabolic syndromes. Less processed food has less environmental impact as well as less health impact. Less fossil fuels means cleaner air and less respiratory exacerbations. There are many co-benefits for health of acting on climate change.** **I think too there is some existential anxiety which is an issue that needs addressing more broadly in a culture that has become itself a little more fragmented and contributing to mental health burdens.**
48	Climate Change	COVID-19 has demonstrated the enormous disruption and health impacts caused by a global emergency. The climate emergency effects are arguably more profound. The catastrophic bush fires of 2019-2020 saw lives lost, communities destroyed and GPs put on the front line of action. How will you

		as RACGP president lead primary care to mitigate against, but also prepare for the impacts of climate change on the health of the Australian people? **Apart from my above answers on Q 46 and Q47** **This needs the damn state disaster management responses to recognise General Practice in their responses. It is a catastrophically negiligent act to exclude highly trained health professionals who are in the community from delivering to the state health service just because they are funded federally. This has been brought up a few times in the twin disasters of 2020 but I will be pushing for this through the National Council of Primary Care Doctors and through the National Cabinet levels.** **I call it the federated states of dysfunction. Increasingly this creates an argument too for a revenue stream to flow to General Practice from the states as we of course contribute significantly to the avoidance of hospital admissions and low acuity ED visits. That needs to be accounted for and the legislation reviewed which prevents payment from the hospitals/states.**
49	Climate Change	How can RACGP better prepare for and mitigate climate change, the public health threat of our time? What are our international responsibilities as communities face increasing frequency and severity of extreme weather events?" **See above Q 46-48.** **International responsibilities are well outlined in the upcoming implementations of Paris agreement 2020.** **From the lancet** 2019 The 2019 report of The Lancet Countdown on health and climate change: ensuring that the health of a child born today is not defined by a changing climate. *The Lancet*, *394*(10211), 1836–1878. ***Despite this slow progress, as the material effects of climate change reveal themselves, so too does the world's response. 51 of the 101 countries tracked have developed national health adaptation plans, 70 countries provide climate information services to the health sector, 109 countries have medium to high implementation of a national health emergency framework, and 69% of cities have mapped out risk and vulnerability assessments. Health adaptation funding continues to climb, with health related funding now responsible for 11·8% of the global adaptation spend.***
50	Climate Change	Climate change has been recognised as the greatest health challenge for the 21st century. How will you ensure that the general practice workforce is prepared to face this challenge? **See Questions above 46-49 A multi-layered response from education and policy to disaster management for individual practices.**

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51	Climate Change	Congratulations to each of the candidates and I wish you all the very best in the upcoming presidential elections. There is a growing body of scientific evidence demonstrating pollution, such as air pollution, impacts human health. This includes the health of our patients. What role does the RACGP play and what can you do to help address this global issue? **Thank you for your wishes that is nice to hear and the job ahead is a big one.** **In regards to your Qn Please see above answers Q 46-49** **Carbon emissions play a large role in the overall impacts of chronic respiratory disease. Well demonstrated by the recent bushfires and the air quality index of various large global cities this is an ongoing advocacy issue at a policy level, at an education level and a disaster response level.**
52	Issue Specific	Obesity societies globally recognize obesity as a chronic Progressive disease. Why has the RACGP been the only learned medical college in Australia to reverse the unanimous vote of the college presidents? I know the reason. A total lack knowledge of this disease process within college academic circles. Weight stigma is pervasive and without addressing it we cannot progress prevention and management of this global pandemic. How will you address this? **Damn that. I will encourage Dr Liz Sturgiss to promote her excellent research and her NHMRC funded brain power onto this! Obesity is a chronic disease and interleaved with some of the answers on climate health poverty and #SDOH not to mention town planning and general infrastructure. Have organised numerous educational events with Obesity specialist Professor Sharon Marks in Melbourne so to reject this seems a bit odd. Thank you for alerting me and please keep up the pressure. Be sure to contact me after the election result is announced.** **By the way I loved that you answered your own question. LOL!**
53	Issue Specific	How do you see the RACGP and ACRRM working better together into the future that respects rural and city based GP practice really are different? **I can see a mutual national rural generalist CPOD provider stream occurring through the RTO's . I think this should be expanded into a post vocational education role too.** **I have already spoken with the new Chair of the National Rural Faculty Dr Michael Clements about bringing our Colleges closer together sharing resources and aligning interests for our future Dr training and for the benefit of rural communities. ACRRM and RDAA will be sitting on the National Council of Primary Care Doctors. You will note at the GPDU18 Conference we symbolically buried the hatchet in a sand bucket. A bit of fun but symbolic of my attitude and determination to bring the colleges together whilst respecting fundamental identity and purpose**.

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No	Theme	Question
54	Issue Specific	What is the first issue you will work on once you are elected? **Building the team around me because the President is not an elected monarch but one of a team. The President is to be the interlocutor between the board and the members and the board and advocacy roles with stakeholders .** **Without unity of vision mission goals and strategy the delivery of a member led people powered President will be difficult.** **I have demonstrated my ability to communicate and disentangle the toxicity of stuck conversations and this is the number one priority because all other actions will be derived from that. Not adverse to disagreements or influence or good dialogue on gnarly issues but maintaining dignity and respect is key in all conversations.** **The other important role is to examine the books in detail to more fully understand the current financial status of the RACGP. As a National Director being responsible for the solvency of the College is a prime responsibility.**
55	Issue Specific	The barriers to implementing fax-free General Practice appears to be politically driven. There is a lot of commercial interests that act as a barrier (companies already invested money in various platforms). They lobby for an ongoing profit stream. Already implemented, government funded platforms such as CDA/My Health Record platform can be a "not-for-profit" alternative. This supports the HL7 standards and CDA used for interactions between providers. Could each candidate provide a specific, measurable, achievable, relevant, and time-bound policy in collaboration with non-GP specialists to implement a Fax-free workplace by the end of your term? Let's start with provider-provider communications. **This sounds like a Question from the E-committee.. Is that you Dr Frank?** **I would seek their expertise and accordingly push for a technical solution that encompasses the requirements.** **Interoperability occurs in a technical sense and is one layer of this problem.** **Interoperability occurs in human factors and complexity theory as you indicated. Professor Trish Greenhalgh Oxford Primary Care Professor has published on the implementation of technical solutions in health care and suggests that "muddling through" is a way forward. This of course is not a satisfactory answer for those who like methodical logical and linear steps but perhaps it is a real answer from implementation science.** **S smart goal reduce and remove fax led communication in GP land**

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56	Issue Specific	General practice research, led by GPs, can help to generate the evidence that can be used to guide the development of our profession and the models of care in which we work. I would like to ask the candidates their (a) vision for building the academic general practice workforce, **Fundamentally important. I would engage my academic colleagues in this and I have already touched on this idea with Professor Grant Russell and Professor Paul Glazsiou. There are models overseas that work. My idea of community networks and hubs based on education and collegiality are ideal places to link to an academic teaching practice that becomes like an ACADEMY for that region of the hub. Ideally to have a DEAN of that area to help non-academic clinicians enable their quality improvement activities which are a form of research and would require the benchmarking of standards. It's a big bold step but one I think is necessary for the self determination of our profession. Also remembering and reminding Government that GP research is not just a technical data frenzy and that there are qualitative inputs too without which we risk tyranny of our profession.** (b) how to engage and enable clinical GPs to generate research questions and participate in research and **By having visible researcher-clinicians. By utilising the GP academic academies above as demonstration practices and integrating with an expanded role for the RTO networks. By making sure that every day hardcore clinicians understand that their work is supported by academic work and that the two large disciplines are complimentary and dependent upon each other. Using the communities and collegiality to integrate and interest GPs in small and large research projects based on a spoke and wheel effect of the GP academies this will help integrate GP research into GP life.** **The continued support of BMeddSci and Honours projects plus GP Academic registrars is essential. Apparently Monash had a role for mature GPs to return for a year of academic research and it would be good to understand how this might work again as bringing in experienced clinicians into research in a more formal pathway is important too.** (3) how we can facilitate a network of practice based research networks across the country. **See above. I have a plan and it is based on my academic work. Utilising community hubs for education and developing the equivalent of the divisions of General practice for the RACGP. I nearly said I had a cunning plan but thought better of it. Its late and I am up to Q 56 part (C.)called #3**
57	Issue Specific	In what ways do you believe social media realistically and potentially hurts and harms our profession and how can the RACGP do it better?

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		Social media is an informal dialogue that makes visible what is normally invisible within our daily lives. That means all the micro-aggressions all the structural and intersectional power issues that exist within culture occur just as they do in the corridors of any family, practice, conference, or parliamentary sitting. **There are also issues of anonymity and of the miss-use and return to textual coding as a means of communication after a century of the telephone. I always advise people to read 19C letters to see the flowery prose needed for text based communication. Not that we have a lot of time. I also advise them to consider the penny universities-coffee houses of the scientific enlightenment and think how that might be a parallel to the social media communities of today.**
58	Issue Specific	I want representation for AMDS GPs. I feel like we have been sidelined as if we are not college trainees/not working towards the fellowship. **This is a problem that needs addressing. GPDU allows you onto our collegiate platform and is an indication of my commitment to education and support. We must recognise the diversity of our sector and of the importance the AMDS services provide in AH and overnight care to support regular care General Practice.** If the criticism is for the doctors who come from different specialities and work in AMDS then maybe this should be brought up at higher level to restrict those doctors from working in an after-hours setup. **I think this needs some jurisdictional oversight but certainly those who identify as General Practitioners are welcome within any College I might lead. Professional isolation is a risk to all of us and I hope you can be a part of this solution and help me to help you and your colleagues in this important collaborative and collegiate reframing**.
59	Issue Specific	Will you support the new President if you are not successful? Loyalty? **I have always supported General practice leadership in ACRRM, RACGP, AMA and other organisations. Entering into respectful dialogue is one of my trademarks even if I disagree on a topic so I see no reason to change my personality just yet.** **If we do not support our leadership then we are lost. A past president has informed me of the harsh loneliness of leadership and the endless criticism. I hope to reframe that into a dialogue where we all emerge a bit better off in a dialogic of benefit.**
60	Issue Specific	If you are NOT successful in your presidential campaign, how will you continue to demonstrate your commitment to the values and aims you have highlighted in your campaign? **As I have always done on line, in person, in educational formats, in practice and on various committees that support General Practice. I don't expect my**

		values will change whether I win or lose the election. Having seen a fair bit of the dastardly things of life retaining values and integrity is one of the few things you can hang onto that are truly yours.