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There are no problems, only solutions!

I am a full time General Practitioner with 30 years' **clinical** experience of rural and regional practice. I am a **practice owner**, am intimately involved in **GP education** and have broad based **corporate skills**. If elected, I will lead with **reasoned passion and firmness**, be reflective of member opinion, and will work collaboratively with stakeholders. The College will work in a constant **pro-active advocacy** mode.

It is a complex and crowded health environment with increasing risks of care fragmentation: GPs are the expert generalists: general practice must be front and central in any health-discourse. Promoting and refining brand GP and brand RACGP is critical.

The **expert-generalist concept** needs to be a key message to government and our communities however, to maintain control of our professional parameters we must practice quality medicine, with our College at the helm.

Member input and faculty opinion is central and vital: it is essential the College provides the appropriate mechanism for this to take place.

Front line GPs are so busy seeing patients that it is sometimes difficult to keep the perspective in the delivery of health care. GPs do need a presence at multiple stakeholder gatherings: if we are absent, decisions around general practice are made with adverse consequences. Firm leadership is required, guided by a strong **evidence base**.

The **RACCGP foundation pillars** of standards, quality, e-health, education [and the exam], and research must remain vibrant and focussed to enable the RACGP Council to provide the required leadership. Council has to be cohesive and strategic to empower administration to enact.

General Practice has to continually evolve as an academic discipline: the FRACGP reflects the expert generalist.

I believe I have a solid grounding in General Practice, both at a clinical level and at an administrative level, and can bring this global perspective to help improve both the quality of patient care within general practice, and advocate for the profession within the community at large.

I have been a front-line general practitioner for 30 years in my home town of Mandurah WA: prior to that I was senior medical officer with the RFDS.

I am an owner practice principal at the Murray Medical group in Mandurah: we have grown from a small 4 man practice to now a large progressive, multi-disciplinary, non-corporate

private practice of 21 GPs: we have a multitude of allied health professionals working from the same site. I understand the **business of General Practice**, and how this can impact on the services we are able to provide.

Future funding models for General Practice will be critical for both quality patient outcomes, and the long term sustainability of practices. This dialogue will need to involve all GP service provider models and will be central for the College in discussion with government. Family doctors manage the majority of health problems whilst absorbing only 5-10% of the health budget. This simple statistic should also be a key message to government.

I was a **procedural GP** obstetrician for 25 years: I still have VMO rights at our local hospital, and continue to care for medical in patients and my palliative care patients. Community hospitals need GP input: indeed all hospitals need to acknowledge the patients' GP at the head of the bed alongside specialist colleagues' names, enhancing continuity from hospital to community.

Careful reflection of the case-mix within a community will determine individual generalist skills: my home town demography has changed dramatically: my skill base has had to change and adapt: this ability to be flexible and versatile must be embedded in our training programmes.

We must constantly lobby government and our communities about what GPs actually do and achieve: we need **simple consistent messages**. General practitioners are expert in:

1. **Diagnosis** [physical, psychological and social determinants of disease]: we also understand the concept of clinical uncertainty and have developed innovative and cost effective skills to deal with this issue.

2. **Therapeutics** [pharmacotherapy and associated referrals]

3. **Continuity** [personal, increasingly team based and organizational dependent]: the patent-centred Medical Home model. Prevention is embedded in each and every consult.

Standards and quality are central to our ethos and must be maintained as core College responsibilities. There are many challenges: specific standards need to be evidence based and user friendly. Quality of patient care needs to be driven both by individual practitioners and the College: the College's role is to enable and enhance.

Clinical variability is an issue. Re-validation is smouldering: the College must ensure its QI-CPD programme is well researched, well -resourced and continues to be evidence based.

After hours/**urgent access** is a particular bone of contention: continuous after-hours access was part and parcel of a GPs life for many decades. Due to constant underfunding eventually impacting on the work-life balance, many urban and major regional GPs and

some rural GPs have walked away from the responsibility. If General Practice was appropriately funded to provide urgent access care, quality continuity of care would be enhanced, along with cost savings to government with reduced ED presentations [20% less].

The mal-distribution of the **GP workforce** remains critical. The College must be intimately involved in a robust workforce planning discussion and have an increased presence within medical schools, and at both resident and intern levels to enhance the image of general practice, underlying the positive career potential within the trajectory of a GPs life. Selection of GP trainees should be core business.

Rural GPs have specific well documented needs, which are site-specific. The FARGP impetus must be sustained and supported as the ultimate ambition for rural colleagues.

Information technology must be at the heart of any discussion around quality 21st century general practice. High quality patient records are fundamental to good patient care, and e-health records, telehealth, and telemedicine is pivotal College business: we must lead this debate.

The College needs a measured and increased **social media** presence.

The updated RACGP Vocational Training standards (outcomes based) and bi-college accreditation of regional training providers has re enforced the control and centrality of the College in attaining the **FRACGP**. The College must maintain ownership of the **curriculum**, the **standards of training**, and the **assessment** process: this is immutable. The recently announced closure of GPET provides an opportunity for the College to explore alternative training models, maintaining high quality training.

Alternative pathways to Fellowship will be a way forward for a select few, but the assessment method must be sound, reproducible and evidence based.

The attainment of **Fellowship** is the ultimate goal for all our registrars, a specific IMG cohort and all doctors entering via the SPP, to practice un-supervised anywhere in Australia. The **college culture** needs to be aspirational, inspirational and welcoming for new Fellows.

The College must maintain and enhance its special relationship with both the **supervisor and registrar organisations.**

IMG GPs represent a significant number within our workforce, especially in rural areas: there are specific issues which are well documented: College support and policy must reflect actual need, listening to our IMG colleagues: there is expertise within each Faculty from previously settled IMGs: we need to heed their advice and opinion.

The RACGP is an academic College and **research** needs to be embedded into our culture. The majority of GP research is carried out by a minority of general practitioners: general practice only receives 2-3% of total health research funding and yet we are seeing 85% of

the population annually. Our practice systems have a wealth of information: the College's role is to enable favourable research pathways. Academia needs to reflect front line GP needs.

Nothing happens without appropriate **funding**: systems without a designated appropriately-funded primary health sector have poor health outcomes: solution-based, dynamic, fully costed proposals from the RACGP are imperative. Recent co-payment proposals widen the gap to accessible healthcare, to already disadvantaged groups.

The College must reflect **member and Faculty opinion**, be agile, nimble and proactive.

Our College needs to be the 'go-to' place for all things general practice.

The College should have a **presence in each consult** a GP makes: bringing guidance and guidelines on all clinical aspects of patient care.

The College should have a **presence in the practice**, providing the relevant tools to enhance practice systems: patients need to know who we are: at the moment we are invisible.

The College needs to continue to identify and target **key stakeholders** at both local and national level to debate primary care: simple solutions for complex issues should be presented, using case based studies to change and educate our communities and politicians.

We need to drive the primary health debate: **General Practice front and central**.

If elected, my goals will include **enhancing brand general practice, enhancing the professional status of the RACGP and strengthening the College presence at the practitioner and practice level.**

It is an enormous privilege to be a GP: everything the RACGP does should support this premise.