Collated Q&A For RACGP Presidential Candidacy

Thanks for making it to this document here. Below is a collated list of questions posed to me through different avenues, include the GP Doctors Down Under Facebook group Q&A session where members posted questions for candidates to respond to. The GPDU RACGP Presidential Candidate Q&A session was fantastic, and great to see so much interest in the upcoming election. There were so many questions and not enough time to answer them all on the night I wanted to provide a response to all who had questions.

This collated list brings the best of the bunch, thematically organised and responded to with my vision, priorities, and perspectives. Please note that my full list of priorities and a breakdown of some of the immediate action items are available on my website.

Categories of Questions include:

1. RACGP Membership and Organisation
2. Models of Care / Healthcare Funding / Policy and Advocacy
3. GP Workforce and Training
4. Diversity, Equity and Inclusion
5. GP Recognition and Respect
6. Climate Change
7. Candidate Information

1. RACGP Membership and Organisation

Question: *I'm interested in hearing about your approach to improving internal issues, namely around GP training within the college. Things that are completely within our control. For example, lack of transparency around exam processes and costs (e.g. dates recently brought forward for written exam causing concern with eligibility and semester timing), process of de-accrediting practices who aren't meeting the mark for training and exam.*

> **Response:** I agree that there are issues which the RACGP can improve upon when it comes to creating and maintaining the best training standard and experience. Since GP training transitioned back under the College, there have been some challenges, which need to be acknowledged as every additional stressor compounds an already stressful exam process for registrars. This is particularly important for issues within the control of the College, which can be really frustrating for trainees.
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> I am committed to ensuring that we further refine and improve these processes within the College with some of my immediate priorities on this front being:
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> - Provide additional cost transparency for College membership;
> - End-to-end GP trainee experience mapping with solutions implemented at key pain points.
> - More stringent standards for GP Training Practices and clearer processes for de-accreditation.
> - A commitment to improve funding for improved GP training for registrars and supervisors.
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> It is imperative that the GP trainee experience is high quality, consistent, and that trainees are best prepared for independent practice when they complete training. Some of these ideas can apply across the College more broadly than then education and training funding and will help College perform better and provide better experience and value for money for all doctors.

Question: *Who will commit to pursuing a joint subsidised conjoint membership for GPs who wish to be associated with both the RACGP and ACRRM, and what do you think this should look like?*

Response: I can understand the motivation behind such a membership category. My approach would be to formally get the opinions of the members. Most certainly there are benefits to conjoint membership, but there are also associated challenges, some foreseeable, some potentially unforeseen. But definitely a unified approach in much of what we do will get the most effect.

Question: *GP principal tries to keep clinic afloat but facing huge hurdles. 1. Hospital credentialling requirements, 2. GP supervisor credentialing requirements from RACGP.*

Response: Look I get it. The challenges and costs of keeping a practice open are getting more and more with burgeoning year on year increases for Ahpra fees, increasing staffing costs and increasing accreditation, credentialing, and supervision costs. Even the RACGP membership fee and indemnity costs are rising. Add in a cost-of-living crisis, the imperative is stronger than ever for the RACGP to provide better value for money for members and to provide greater transparency and accountability of its costs. This is what I intend to do.

Among my key priorities relating to funding reform and transforming the RACGP to become a more active listener, with clearer advocacy outcomes and improved responsiveness to member concerns being critical to ensuring that RACGP members feel that their member fees are well utilised.

Question: *What can we do to improve on the turnaround time in getting responses to questions from RACGP admin? Takes weeks sometimes to get a reply to an email and phone call queries often directed to the wrong department and bounced around before getting a non-response.*

Response: There are no doubt administrative and member experience improvements can be made. Oftentimes, the front door for members is administration; and to ensure that new members feel welcomed and existing members feel respected, it is important that this front door is clearly open and responsive to all member concerns. Furthermore, with my intention to improve active listening of member concerns and my goal of mobilising all members towards shared advocacy goals, it is crucial to improve this.

To achieve this, we need 1. Clearer Communication Systems and 2. KPI's around effective communication and response times. And I believe I have the right skillset to do this. I've been a member of the RACGP for 25 years with great working relationships with the 'behind the scenes' team at the RACGP. And over the last decade, chairing or sitting on several committees, I'm familiar with the internal structures of the College, understanding areas for potential improvement. I've also led this type of optimisation in my other organisations, setting clear KPIs and outlining appropriate accountabilities. All of these will help me address your concern whilst also helping us achieve better advocacy outcomes.

2. Models of Care / Healthcare Funding / Policy and Advocacy

Question: *I'm keen to know the candidate's opinion of single-issue services, such as dedicated Telehealth cannabis or weight loss clinics and if you think that is in line with community expectations for GPs. Do you think colleague members should be supported or discouraged from participating in these models?*

Response: We've seen it with everything from menopause to impotence to hair loss treatments which can and should be provided in our own GP practices, but patients are taken for a ride with an expensive alternative

service. And I also see a lot of members, who have started to work in these more specialised niche areas, oftentimes single-issue services with a digital component of care associated with it. And whilst I can understand the reasons behind this trend, with inadequate Medicare rebates, I ultimately believe that these types of services fragment care for patients.

The Medical Board has raised concerns for these models of care. I'm concerned about the impact of these models of care too.

These services are not providing comprehensive general practice and shift us away from the core tenets of primary care and General Practice. I want to ensure that we bring this care back into mainstream general Practice, in a way that improves access to care within existing practices, and also by removing the barriers that these single-issue services are often exploiting currently. These single issues are a part of General Practice but this is danger in them being carved out and commoditised solely for financial gain.

Question: *What are your views on the boundary creep occurring with AHPRA trying to micromanage CPD more and more? This is traditional college jurisdiction being eroded. What will you do about it?*

Response: We all know the CPD Home changes were nonsense. The previous system was working very well whilst simultaneously providing a better experience and outcome, compared to the dumbing down of CPD to 50 hours. We've got a real problem here that regulators are trying to take over the role of the College. We need to move quickly in this area of quality and safety before the Medical Board or the AMC take over the important work of the College.

Unfortunately, these changes are likely here to stay, however I'm pledging to make this as seamless and easy as possible so we can just get on with our lives and the true job of General Practice.

Question: *How are you going to counter the UCC-FREE fragmentation juggernaut?*

Response: These practices are by no means free. They are using large amounts of health dollars that would be better and more efficiently spent by supporting more GP service with greater capacity. They are confusing to patients who are uncertain about where to present, they are shifting care much of which could be provided in regular practices, and we have no insight into the health outcomes. I think the way we deal with this juggernaut is by highlighting the safety issues and the costs – these are already emerging. It's crazy that I can see a patient I know for an urgent issue, and they have a large out-of-pocket cost, but if my patient presents to a facility that has no knowledge of their history there are no costs for them – that is the wrong way to design the incentives. We need to provide an alternative model where general practices have the choice to provide urgent care within our practices at a fraction of the price within our existing infrastructure.

We keep hearing that 'patient love these centres' but really, it's politicians who love them because they love opening them. We need to hide their scissors and red ribbons and instead get some proper evaluation done before any expansion of this program.

Question: *Part of leadership is vision and clear communication. How will you suggest individual doctors advocate for our profession? What are the key messages about what is general practice that we want others to understand? What are we asking of the government?*

Response: I agree that vision and clear communication is the cornerstone to strong leadership. That is why, as part of my work with the RACGP Funding and Health System Reform expert committee, I've led the development of RACGP's Vision for General Practice, worked with PwC in developing economic evidence about the benefits or RACGP's Vision and worked with the College to develop an advocacy strategy that includes a clear plan involving individual GPs in regional advocacy networks to be the well-informed local voice of the College to patients and politicians. We need a concerted strategic approach – pairing on the ground, grassroots GP and patient voices, with cohesive and strong federal advocacy. That is the foundation needed for success in our advocacy goals.

The key messages that we need policy makers, politicians, and the public to understand is twofold. Firstly, we need to put out a clear positive narrative – GPs are an amazing group of specialists, who provided over 150 million appointments last year to nearly 90% of our population.

Secondly, we need to outline the fact that we are the solution to the health care crisis – not the cause of it. Investment in General Practice and primary care is the most cost-effective investment for the community and health system. Spending on fragmented care, such as UCCs or the proliferation of single-issue clinics or mediocre and exploitative services causes damage to patients and increases costs.

If patients want ongoing access to high quality General Practice care we are all going to have to mobilise together, talk to our MPs and demonstrate to policy makers the value of General Practice.

Question: *What is the solution to geographical narcissism and the gross inequity we currently see between health resources between metropolitan and rural/remote areas? What will you do to address this issue?*

Response: We know that we have workforce challenges around the country but they are most urgent and serious in rural areas and we also know that more health resources get allocated to urban centres and if we talk about the inverse care law the majority of the services are spent where people don't have the highest need. And so we need major injection of funding into rural and remote areas beyond fee for service. This involves capacity and practice payments to support practices which are providing more than a source of primary care, they're an important employer and a crucial community asset in these rural centres.

Question: *Changes to legislations - forced to change rather than choose to change: 1) Mymedicare enrolment for GPs and patients, 2) Mymedicare enrolment for nursing home patients - most clinic doctors choose not to do nursing home rounds now than ever before, 3) Mymedicare changes to care plans/TCA. Where is our say? How do we keep up?*

Response: I believe this is where the college has really struggled for the last couple of years in that our involvement in health policy has been largely providing feedback after decisions have been made, rather than during the design process of solutions. Unfortunately, we have treated as a concerned stakeholder, rather than an integral part of the design and solution to the problem.
This is why I believe I am the right person to step up into this role. I have the clinical, economic and policy skills to describe the design and funding of effective programmes, and the crucial, longstanding working relationships with key decision makers to implement change. I feel comfortable that I will be able to influence these policies earlier in the design phase so that General Practice is a partner in design for these policies.

For instance, the latest General Practice in Aged Care Incentive program is overly complex and the design is not consistent how care is provided.

It is crucial that the college is more active in presenting solutions to funders at an early stage, rather than waiting passively and responding to what is produced.

Question: Patient voice. How do the candidates plan to use it if they were to become President?

Response: We know that patients are often our strongest allies. So many patients across Australia have a General Practitioner that they love and go back to as the centre of their care. So many doctor-patient relationships have been created to the benefit of the community.

This is a unique relationship that needs to be conveyed to the rest of the country. I feel we've been victims of policy makers trying to squeeze money in the wrong places, and simultaneously being wedged between the worst of inadequate NHS style public funding, and having the rapid growth of costly US-style sub-specialty services.

As mentioned in a previous response, part of my work with the RACGP Funding and Health System Reform expert committee, has been to develop RACGP Vision, the costing for that vision and to develop an advocacy strategy that includes a clear plan involving individual GPs in regional advocacy networks as well as patients. A concerted strategic approach – pairing on the ground, grassroots doctor and patient voices with cohesive and strong federal advocacy is foundational to success for our advocacy goals.

The key messages that we, patients, and GPs, need policy makers, politicians, and the general public to understand is twofold. Firstly, we need to put out a clear positive narrative – GPs are an amazing group of specialists, who provided more than 150 million appointments last year to nearly 90% of our population.

Secondly, we need to outline the fact that we are the solution to the health care crisis – not the cause of it. Investment in General Practice and primary care is the most cost-effective investment for the community and health system. Spending on fragmented care, such as UCCs or the proliferation of single-issue clinics or mediocre and exploitative telehealth services causes damage to patients and increases costs.

If patients want ongoing access to high quality General Practice care we are all going to have to mobilise together, talk to our MPs and demonstrate to policy makers the value of General Practice.

Question: We have seen a shift from universal bulk billing to universal private billing in many practices, which has been an effective strategy as it has made primary care funding a significant policy issue that the government have had to address. However, as a result, GP care has becoming increasingly inaccessible to our more vulnerable populations and the financial barriers to accessing primary care will certainly have downstream effects on a population level in all areas of health. I have seen and heard many GPs express that they prefer private billing over mixed or bulk billing and are unlikely to return to bulk billing in the future, no matter what funding increases occur. What is your opinion on this situation? Do you believe that the RACGP has any responsibility for population health and equitable access to primary healthcare? How do you think we can balance this against the sustainability of the GP profession given the dwindling numbers of medical students expressing interest?

Response: This is a really important but difficult issue. Equity of access to high quality primary care (continuous, comprehensive, accessible and affordable) such as general practice is the foundation of successful health

system. For too long general practice has been taken advantage of and our altruism has meant that we have been underfunded for decades. Many of us we have been able to shift to private billing but that's not an option everywhere and patient access to fully subsidised services is decreasing because of increasing costs.to keep our doors open. Now this is something that the government needs to take responsibility for because we can't continue to subsidise the rest of the health system.

We do have limited health funding and it looks like the government is getting comfortable that out-of-pocket costs are going to remain for a large portion of our population. We need to call that out. The challenge will be working out and agreeing who are the most vulnerable people in the community, who should have access to fully subsidised care, and putting funding to support the doctors who care for those patients so that they have viable practices.

We need to make better use of our existing GP workforce through allowing us to work in funded multidisciplinary care teams, and that includes freeing up MBS item numbers so that we can delegate our care to other people within our practice team.

And there are several barriers that could be removed that would make general practice more attractive career for early graduates. This includes fixing the many of the pain points along the GP training journey, from pay disparity, loss of entitlements including parental and study leave, administrative hassles during the training program including problems with placements, inadequate time and support for exam preparation, even the delays in accessing the Fellowship on completion. All of these are important barriers that make the journey to being a GP less attractive and by dealing with them all we can make this journey much better.

Question: PHNs v divisions of GPs. Practical support appears to be inversely proportional to geographical distance to regional PHN hubs. If not sitting in the board or working committee, not a lot of communication / connections. Most funding benefits bigger regional centres compared to the small towns that just edge along the catchment border.

Response: Yeah, this is a real challenge for PHN's because increasingly they're given limited funding for direct support which means that most administration is focused centrally with less resourcing available on the ground, and notably less in regional areas. I've been actively involved with my PHN, and I feel we've made great strides in trying to prioritise services for underserved populations like people living with homelessness, the LGBTIQ+ community and Aboriginal and Torres Strait Islander people . However I know the experience with PHNs across the country is variable.

Question: Mandatory reporting and the fear of losing their livelihood as a result is a significant disincentive to GPs (or other health professionals) seeking assistance for their mental health. There are way too many medical suicides, many preventable. Western Australia I understand has addressed this issue in part by clarifying exemptions and making it clear that doctors can seek help without fear of being reported. What can we do to expand the scope of these types of guidelines to other states and fortify protections to ensure that doctors don't get penalised when they become patients and have to choose between seeking help of being able to support their families and communities?

Response: This is something that I've worked with the College in trying to resolve and advocated for an expansion of the WA model nationally. I think it's vitally important that all doctors feel that they can talk to their own GP if they have health problems and that all doctors, those who need care, and those provide care recognise that their own health is the priority.

In my role with Avant, we frequently support doctors who do have questions about mandatory reporting, So I would hope that any doctor who felt unsure, they would speak with their medical indemnity provider and get step by step advice about dealing with these situations. But it is simultaneously important for the College to step up its efforts to protect all of our doctors when they are in distress. I wouldn't want anyone to choose between their own health and their career.

Question: RACGP has a weak voice / influence in health department / heath minister.

Response: Well, that weakness is going to change. For over a decade I've created strong connections with staff within the Department of Health and Aged Care, and among politicians on both sides of the aisle. I feel I am a trusted and common-sense advisor, who can articulate the challenges and solutions to issues within General Practice in a way that they understand. I intended to utilise my expertise in clinical practice, health policy research and health economics to convey the value of our solutions more effectively in both clinical and economic terms. I feel this is a unique differentiator of mine among the current presidential candidates, along with my experience, which places me in a strong position to develop policy and lead discussions as we come to the next Federal election.

3. GP Workforce and Training

Question: *How will you advocate for our members who are IMGs? Since their training is not subsided by the government anymore and they must pay 30k for their training while paying minimum 50% service fee to their employer clinics, why are they still subject to 10 years moratorium?*

Response: For too long IMGs have been treated poorly as 'workforce solutions', and have been deprived of the adequate financial, clinical, or pastoral support that they have needed to enable them to thrive as GPs. As the backbone of many of our communities, particularly in regional or remote areas, they have not been provided the support they truly need.

We need a range of financial and workplace supports including getting the Fellowship Support Program funded again. We we need to make training costs more transparent and accountable. We need to make sure that supervision is high quality. The RACGP also needs to be much stronger in providing non-clinical support to IMGs.

A large component is related to helping IMGs thrive in the Australian Healthcare System, with everything from education about Medicare and MBS billing to cultural sensitivity and different communication styles. During my time at Avant, as Chief Medical Officer, I have worked to develop such material to better support IMGs of all backgrounds coming to work in our health system.

Furthermore, I am pleased to see the National IMG Committee being stood up and led by Associate Professor Shenouda, something that has been long overdue, as the issues facing such a large proportion of our GP membership have been sadly overlooked. I look forward to working with that Committee; but that is just one Committee. Representation and support for IMGs must be across the entire College so that these key issues are better understood and advocated for by the College.

Question: *What programs can we implement to give students and junior doctors exposure to primary care so they have an understanding at least and perhaps can get a taste of true undifferentiated medicine at its finest?*

Response: As mentioned in my campaign documents, we've really got to have a strategic whole of system / whole of medical pipeline approach to this problem, with buy-in from stakeholders across the spectrum. Individual bit-part solutions are only temporising, and don't consider the intricate workforce dynamics and numbers at each stage of the doctor pipeline.

But specifically, regarding initiative targeted towards medical students and junior doctors, my key initial priorities will be:

- Integrating Primary Care rotations as foundational aspects to PGY1 or 2. An opportunity exists within the new developed PGY2 Accreditation Framework and Standards, to translate this into reality.
- Extending funded clinical placements (announced in last budget for nursing and teaching students) for medical students within general practice settings.
- Improving Practice Incentive Payments so support students, trainees, and supervisors.
- Supporting University initiatives to provide better education on the health system, emphasising the macro-health system role that General Practice play and preference support for universities that produce greater proportion GP graduates.
- Support outstanding initiatives such as the RFDS Scholarships that expose students to generalism.

Question: *The RACGP is now the largest training organisation responsible for the training and ongoing education of GPs in Australia. How will you approach and prioritise this as President?*

Response: There is a lot in this great question. We need high quality training and that starts with a clear curriculum that creates the GPs that we need in the future. This is in both clinical and non-clinical skills.

RACGP needs to support a consistent training experience. I've been speaking with registrars, and I've heard that although many training experiences are positive this is not universal, with variable quantity and quality of support and training reported.

Registrars need to be provided with uniform and positive training environment. Encouraging feedback on terms and better assessment or accreditation of practices could help to identify low performance, and to help identify great training practices, and encourage turnover of those practices unable to provide the necessary support. Then we also need to increase support for supervisors to enable them to spend time with trainees. Then the College needs to make sure its processes are fit for purpose - exam failures must never happen again, and multiple administrative barriers need to be removed.

While most registrars have a reasonable experience, I've heard that bad experiences are not uncommon- whether they bad training practice experiences or major difficulties with college processes. Those bad experiences leave a long-term bad taste in people's mouths and are definitely a barrier to long term college membership. So, a priority for me is identifying these difficulties and creating clear solutions so that more GP registrars have a positive experience.

My vision is ultimately for all GPs to have an excellent training experience and to graduate competent and independent.

Question: Work for whole life - 40 years - end up with no long service leave? Compared to other specialties, at least they have some accrued!!

Response: As GPs, we have highly transferable skills which are very attractive for many businesses so I'm not too worried about our ability to get employment. I never expected to get long service leave but have accrued superannuation and have been privileged enough to earn a good income in general practice, but I want to make sure that continues for future generations.

There's major disparity between what GPs earn and what other medical specialists earn and I'm going to fight for reducing that disparity as that is one of the major disincentives for going into General Practice. I like the freedom and autonomy of being an independent contractor, and previously of being a practice owner. I recognise for some; a salary does sound more attractive with the certainty of long service and holiday leave and parental leave, so we need to have different models. We really need flexibility and choice in how we practice and how we are paid.

4. Diversity, Equity and Inclusion

Question: How will you advocate for our members who identify as Aboriginal and or Torres Strait Islander? Are you familiar with the Australian Indigenous Doctors Association (AIDA) and mark PRIDOC in your calendar for Dec 2-6 if elected.

Response: Advocacy and support for members who identify as Aboriginal and or Torres Strait Islander, has been a theme throughout my leadership roles, and I am committed to ensuring that this is done well by RACGP if I am elected.

I have championed an Aboriginal Advisory Committee at our local PHN (including meetings with the Board of Directors). I have launched two Reconciliation Action Plans for the Central and Eastern Sydney PHN and Avant Mutual, and currently Chair the RAP committees. I have also supported Indigenous medical students through AIDA's bursaries. This is such an important priority, and I'm excited to explore the additional possibilities if I'm elected as President.

And yes, I know AIDA well, having worked with the fantastic people there previously; and I very much have those dates in my calendar and look forward to PRIDOC on Kaurna Country this year.

Question: What are your views on health of LGBTIQA+ people? What are your views on the health of transgender, gender diverse and nonbinary people and gender affirming care?

Response: The LGBTQIA+ community have been discriminated against and been subject to worse health outcomes for generations. I believe it is crucial that we provide equitable access to all those who need it. In my work with Avant, I advocated strongly for the importance of continuing access to care for transgender and gender diverse people. If doctors don't feel comfortable, there is training that they can do to upskill, or they can refer to colleagues with more expertise. There is no excuse for discrimination or failing to support anyone needing healthcare, especially in our digital world, there should be no excuse for not being able to provide education which might upskill you in providing care and respect for all of our population.

5. GP Recognition and Respect

Question: *What is your plan to approaching the current issue of the poor public image of General Practice (especially with the lack of respect leading to nurses and pharmacists being promoted as replacements for GPs)?*

Response: There is no doubt that public respect for general practice and medicine more broadly, has been eroded, and accelerated by those who see general practice as single issue service (eg for a referral, prescription of medical certificate. GP Morale has improved marginally since the depths of the GP crisis, as many of us felt able to move to mixed billing. However morale levels are still very low. Many of us are working less hours, nearly 1/3 of us are planning to retire in the next 5 years according to the last Health of the Nation survey, we are more frequently working in other roles to supplement our GP income and trainees are increasingly seeking alternative careers. This has compounded a long-term workforce shortage and seen the emergence of opportunistic health providers expanding their 'scope' into General Practice.

These are all critical issues that need to be addressed. Many of these issues ultimately relate to us mobilising and changing the narrative around General Practice. As mentioned in an above question response, the key messages that we need policy makers, politicians, and the public to understand to reverse this reputational damage are twofold. Firstly, we need to put out a clear positive narrative – GPs are an amazing group of specialists, who provided 166 million appointments last year to nearly 90% of our population.

Secondly, we need to outline the fact that we are the solution to the health care crisis – not the cause of it. Investment in General Practice and primary care is the most cost-effective investment for the community and health system. We need to be supported as the general practice team, while highlighting that spending on fragmented care, or single-issue clinics cause damage to patients and increases costs.

Question: *Changing the name of GPs: 1. Is it something you believe in? 2. If so, is it worth attempting? Given that there are obviously unseen and seen hurdles that prevented any traction from previous Presidents.*

Response: I can understand the sentiment regarding a name change and recognise that this might be a small part of the solution to the public perception of General Practice and decreasing morale amongst GPs.

Personally, I am proud to be called a General Practitioners, and I was in the UK. I know in the US, they use the terms Family Physicians or Primary Care Physicians, and previously the College journals utilised Family Physician as a name. What is most important, is that we are all specialists in continuity of care and generalism.

I'm less concerned about the title and believe there is still significantly more opportunity with greater returns if we were to channel the College's efforts towards conveying the value of General Practice to policymakers and emphasising positive messages regarding generalism. We can look to making General Practitioner a protected title, but we need to make sure that is the title we want first.

6. Climate Change

Question: *What is your understanding of climate change and its impact on health? Have you read the National Health and Climate strategy? Have you read the RACGP's climate change and human health position statement?*

Response: Addressing climate change is essential and urgent. GPs and the College should be taking the lead in climate initiatives as we are the greenest part of the health system. In fact, there is a unique opportunity for the RACGP to lead the healthcare system in this transition, and from a human health perspective, preventative healthcare is really core business for General Practice.

I've read the national strategy the national strategy and while applauding its focus on prevention and health promotion as a priority, it unfortunately says very little about how we must shift care away from hospitals back into the community (led by general practice) if we are to meet our carbon reduction targets.

Whilst the College has started some initiatives into supporting planetary health and environmental sustainability, I believe this is more space to grow our advocacy and system-wide leadership initiatives. I'm excited by the prospect on further tackling this challenge, especially with experience at Avant Mutual, where I've led our recently established sustainability function, in the hopes of identifying strategies to help doctors and practices, as well as the broader business, to reduce carbon emission. I have also led Green Practice initiatives through my PHN – Central and Eastern Sydney PHN.

I speak frequently with Dr Kim Loo, in her role with Doctors For the Environment in NSW, and I'm eager to chat to any GP who is passionate about this topic for further ideas and initiatives.

7. Candidate Information

Question: *What drew you personally into general practice instead of other option?*

Response: This is an easy one. My father was a GP in country Victoria before moving to Queensland. He had his practice at home for several years after he had a cancer scare. So, I spent most of my teenage years witnessing the effectiveness of comprehensive long-long term care, of high-quality General Practice, and the impact he had made upon our community.
My father was an inspiration, but witnessing the value of continuity of care and generalism on a daily basis was what truly inspired me. I never thought of myself doing anything differently although I did also like economics at school, so that's where that interest germinated. And that's why even while I've learnt other skills in health economics, leadership, or research, I've always kept working as a GP.

My information on my background and motivations are on my website: https://drmichaelwright.com.au/.

Question: *For the candidates without senior board experience, I'd like to hear about what skills you have outside of clinical general practice and medical education that give you the capabilities for the role of president in this area. And for those with Board experience, I'd love to hear about it.*

Response: I've been a Board Director for nearly 15 years and have been a Board Chair of three organisations including my local PHN in NSW, my previous division in Qld, and a national philanthropic research foundation. I also currently report to the RACGP Board in my current role as Chair of the College's Funding and Health System Reform expert committees. I am a Graduate of the AIDC about to apply for my fellowship with them. I take governance seriously and I recognise that a well-functioning Board is essential to supporting the work I would do as President. I have strong existing working relationship with most of the current Board.