Human judgement needs reliable systems behind it

What Australia and New Zealand's Medical Leaders told us at RACMA 2026 about workforce sustainability, safe communication, culture, AI governance and care beyond the hospital walls, and what health services can do next.

Royal Australasian College of Medical Administrators Annual Conference · Melbourne Cricket Ground · Synthesis of Day 1, Day 2 and poster sessions

EXECUTIVE SUMMARY

Across two days of keynotes, case studies and posters, one message kept surfacing: Clinicians are being asked to exercise excellent judgement inside systems that routinely hand them incomplete information, constant interruptions and unclear expectations. The fixes that worked were rarely expensive technology. They were structure, transparency, feedback and governance, applied with discipline.

We have grouped what we heard into five themes, each grounded in real outcomes shared on stage and in the poster hall. To close, we look at where Med App fits: the practical ways our platform helps Medical Administrators turn these lessons into everyday practice.

1. **Workforce sustainability starts with listening**
   Retention, transparent allocation, onboarding and wellbeing
2. **Handover and communication are safety work**
   After hours handover, peer norms and paging noise
3. **Culture beats curriculum**
   Fear driven decisions, low value care and learning from success
4. **AI: the technology is ready, governance is not**
   Shadow AI, evaluation and value
5. **Care and education without walls**
   Virtual care, home care and a distributed workforce

THE NUMBERS THAT FRAMED THE CONFERENCE

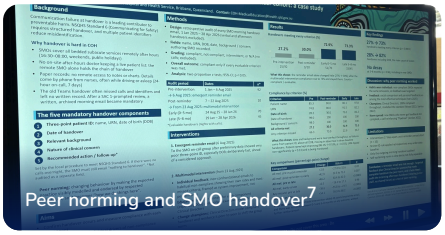
49% → 72%
Doctor retention at a territory tertiary hospital in one year, now tracking at 88% for 2027, with zero forecast RMO vacancies[1]

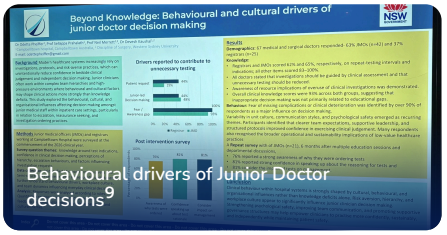
27% → 73%
After hours handovers meeting every safety criterion once peer norming replaced a reminder email, with no decay at 8 months[7]

87% vs 24%
Leaders who call workforce a critical strategic risk, versus those who feel ready to use AI and digital tools to address it (n=531)[3]

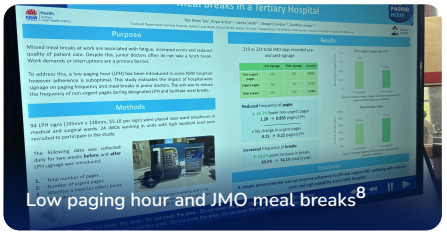
93% / 90%+
Junior Doctor clinical knowledge score, yet over 90% say fear of missing deterioration drives their decisions[9]

FROM THE POSTER HALL


Peer norming and SMO handover[7]



Behavioural drivers of Junior Doctor decisions[9]


Low paging hour and JMO meal breaks[8]

THEME ONE

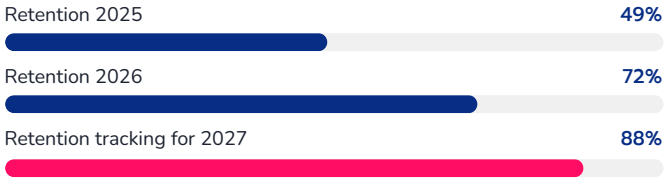
1 Workforce sustainability starts with listening

The workforce shortage is real and expected to worsen. A national survey of 531 Healthcare Executives, Board Members and Clinicians found 87% of Leaders rate workforce a critical strategic risk, only 21% say they have enough clinical capacity for the next two to three years, two in three expect their position to deteriorate, and three in four say shortages put sustainable care at risk.[3] Yet the most compelling turnarounds at RACMA were not built on recruitment campaigns. They were built on listening to Doctors and redesigning the system around what they said.

Case study: from 49% to 72% retention in a single year

A territory tertiary hospital, the largest employer and training site for Doctors in its jurisdiction, was losing roughly half its Doctors every year and carrying a 20% vacancy rate, largely backfilled by Locums.[1] Doctors said they could not get the terms they needed to progress, faced heavy workloads and overtime, and struggled to access leave. The response was systematic:

- Characterised the workforce: 50% of prevocational Doctors wanted general practice or rural generalist careers, against 19% nationally
- Restructured allocations to match both Trainee preference and service need, with transparent waitlists and local Doctors prioritised
- Protected a daily low paging teaching hour, approved 100% of first round leave applications and expanded part time options
- Ran anonymous JMO forums and closed the loop: "this is what you told us, this is what we did"



Applications rose 20%, then a further 34%. No RMO vacancies are forecast for 2026 or 2027, with an estimated $4 million saved in locum salaries in 2026 alone.[1]

> "The key is to listen to your Doctors. They know the problems, they usually know the answers as well."
>
> Medical Workforce Lead, territory tertiary hospital



Poster: hospital Volunteers pairing with International Medical Graduates for weekly informal catch ups[4]

Onboarding is a retention tool

A regional NSW hospital paired International Medical Graduates with trained hospital Volunteers. Culture shock, loneliness and social norm confusion improved for 6 of 7 Participants, every IMG said it helped them understand daily life and build English confidence, and all reported a better work experience. The program is now standard onboarding for every new Doctor.[4]

> "More than just helping me understand how things work, my Aussie Auntie made me feel valued and at home."
>
> International Medical Graduate, Pilot Participant

Grow your own, then anchor them

In a remote NT region heavily reliant on agency Locums and fly in Specialists, a single employer model now lets Rural Generalist Trainees rotate across hospital, primary care and community without changing contracts. Trainee numbers reached 23, with 11 more starting. A visiting Rural General Surgeon prevented 54 aeromedical retrievals in two weeks, at roughly $17,000 per retrieval, a 3 to 1 cost benefit.[2]

Five moves for Leaders, from the national workforce survey[3]

Govern **Plan** **Redesign** **Unlock** **Enable**

Govern workforce like any major organisational risk with a named Executive Owner, plan workforce before approving service expansion, redesign work so Clinicians practise at the top of scope, unlock barriers for qualified Doctors, and independently measure whether digital tools actually create capacity.

Coaching for new Consultants and competitive, engaged senior appointments were also raised as levers for wellbeing, safety and long term commitment.[5,23]

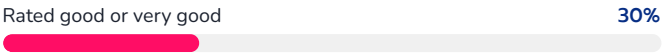
THEME TWO

2 Handover and communication are safety work

Handover is a transfer of responsibility and accountability, not just information.[6,24,25] An after hours evaluation in a Sydney district found the structure was in place but the content was not: handover happened at set times 92% of the time, yet only 59% reliably conveyed critical information and only 30% were rated good or very good. 75% of JMOs believe incomplete handovers cause errors.[6]

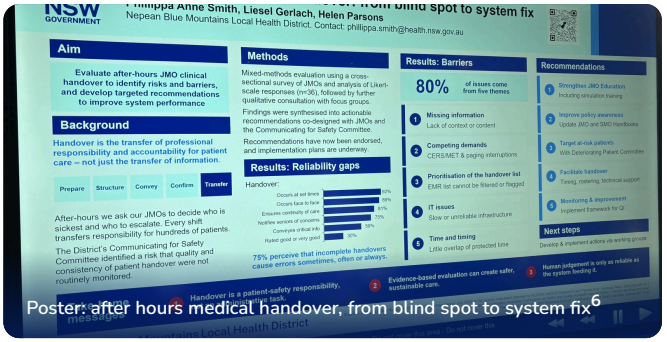






80% of issues came from five themes: missing context, MET calls and paging interruptions, EMR lists that cannot be filtered or flagged, unreliable IT, and too little protected overlap time.[6]

> "Human judgement is only as reliable as the system feeding it."
>
> After Hours Handover Project Team, NSW Local Health District



Poster: after hours medical handover, from blind spot to system fix[6]

Peer norms beat reminder emails

A Queensland community health service audited 16 months of remote after hours SMO handover. A reminder email moved full compliance from 27% to 30%. Targeted personal feedback plus Clinical Directors modelling the standard moved it to 73%, and date of birth capture from 28% to 82%, with no decay at 5 to 8 months, even in new SMOs who never received feedback.[7]

Protect time from paging noise

94 signs at $5.18 each cut non urgent pages during a low paging hour by 33.7%, with no change in urgent pages, and lifted JMO meal breaks from 63.5% to 74.1%.[8]

THEME THREE

3 Culture beats curriculum

When 67 Junior Doctors and Registrars were surveyed, clinical knowledge averaged 93%, and every Respondent agreed tests should be guided by clinical assessment. But fear of missing deterioration influenced decisions for 100% of Registrars and 93% of JMOs. The gap was behavioural, shaped by hierarchy, unit culture and psychological safety.[9] Six months of education and team discussion later, 81% felt confident speaking up about why a test was ordered.

The same pattern showed up in pathology stewardship: more than 40% of panels were repeated within 24 hours, around three quarters of repeats after a normal result were normal again, and only about 15% changed management. Soft digital prompts, justification messages and removal of default test bundles cut ordering 6.3% hospital wide and 12% in surgical specialties, with 92% of Consultants recommending the program continue.[10]

30% → 95%

Medical mandatory training compliance after redesign around what Doctors needed, with 77% satisfaction[11]

6.3%

Fewer pathology tests hospital wide after digital prompts and education[10]

Leaders were also challenged to study success, not only failure. Success cause analysis applies root cause tools to what went well, and in one case revealed that biennial simulation drills were the hidden factor in a flawless emergency response.[12] A Former International Rugby Team Manager put it simply:[13]

> "Performance is only the outcome." The environment Leaders build is the real work.
>
> Keynote, Former Manager of an international rugby team

THEME FOUR

4 AI: the technology is ready, governance is not

Healthcare AI was framed as a four year arc: 2023 was wonder, 2024 the pilot graveyard, 2025 validation and 2026 governance.[14] Organisations are no longer stuck on whether AI works but on how to evaluate, procure, implement and monitor it. In a survey across 35 countries, 86% of Clinicians use AI daily or several times a week, most with no employer guidance. Shadow AI was described as both a cry for help and a proven MVP: find those people and make them champions.

> "The technology is robust. Governance is the handbrake."
>
> Keynote on healthcare AI governance

The proposed operating model: Board and CEO set the tone with a named Accountable Executive, an AI committee owns policy, risk appetite and an audit of what is already in use, workforce training goes beyond a 50% reach, a control register supports monitoring, and incidents feed back into policy.[14]

Govern to maturity, not to the worst case

A statewide patient reported measures program showed both failure modes. Over governance (two years of security and procurement review) killed a project before it started. Under governance let an automated text reach the wrong patient, exactly as designed. The lesson: every stage of maturity needs a matching level of governance.[17]

Evaluate like a clinical intervention

One framework scores AI knowledge retrieval tools on 12 dimensions across three tiers using a 300 question stress test corpus. Quality and performance can trade off. The safety tier, including citation faithfulness and risk of harm, cannot regress between versions.[16]

> "Value does not come from technology. It comes from the leader who deploys it, the culture that surrounds it, and the clarity of purpose that drives it."
>
> Keynote on AI value and health leadership

Leaders were also urged to decide their decisions: which need a human in the loop, which can run by exception, and which can run alone.[15]

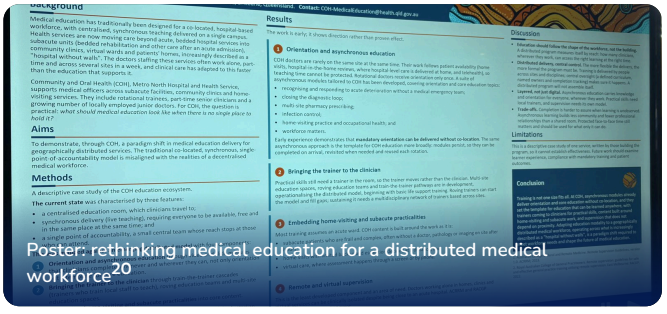
THEME FIVE

5 Care and education without walls

Care is moving into community clinics, virtual wards and homes. One national provider aims to deliver more than half of its care touch points outside traditional settings within five years.[18] GP partnered iron infusions cut the cost of delivery by 25% and, at one point, delivered half of all iron infusions commissioned by the hospital, with same or next day access and extended hours.[21] A virtual emergency service now provides 24/7 medical cover to 63 police watchhouses across Queensland.[22]

But evidence must lead enthusiasm. A National Telehealth Leader noted that the largest independent study of virtual wards found no consistent system benefit, while proven telehealth uses such as telestroke and teledermatology should be protected.[19] As a Digital Health Professor put it, "the barriers are not the technology"; awareness and value are.[18]

> "To improve system performance, we must combine human judgement with evidence to build safe, sustainable pathways, resisting the temptation to layer digital technology onto already strained systems."
>
> National Telehealth Leader, New Zealand, on virtual hospitals



Poster: rethinking medical education for a distributed medical workforce[20]

Education must follow the workforce, not the building

Doctors in subacute, community and home services often work alone, part time and across several sites. One Queensland service now delivers orientation and core education asynchronously, brings Trainers to Clinicians for practical skills, builds content around home visiting realities and is developing remote supervision drawing on ACRRM and RACGP guidance.[20,26]

> "Distributed delivery, central control. A distributed program will not assemble itself."
>
> Medical Education Team, Queensland community health service

FROM INSIGHT TO ACTION

How Med App helps health services act on these themes

Med App is a mobile first, offline ready Clinician communication and workforce platform supporting 60+ hospitals across Australia, New Zealand and the UK.[27] It does not replace the EMR, rostering engine or LMS; it closes the gaps between them that conference Presenters kept describing.

THEME	WHAT WE HEARD	MED APP CAPABILITY	EVIDENCE
1 Workforce sustainability	Retention rose when allocations became transparent and preference based, Doctors were heard, and new starters (including IMGs) were welcomed early.	In app preference collection and AI assisted allocation; pre employment access and digital orientation; IMG, intern and rotational staff programs; anonymous pulse surveys and wellbeing tools with EAP access.	**Up to 5 weeks saved on allocation; 34% improvement in Junior Clinician return rates**
2 Handover and communication	Missing context, interruptions and broadcast noise undermine handover; peer norms and visible feedback make standards stick.	Cohort, role and location targeted messaging with read and sign receipts; ROVER rotation handover documents; hospital phone directory; QI and change campaigns to embed standards and share audit feedback.	**80% read rate vs ~5.3% for email**
3 Culture and judgement	Fear, not knowledge, drives low value testing; mandatory training works when it is short, relevant and accessible.	Point of care protocols, consult guides and escalation pathways within two clicks, offline; test ordering and prescribing change campaigns; QR code attendance, RSVPs and feedback for education sessions.	**Up to 6× faster protocol access; ~$3m saved on test ordering, prescribing and procedural errors**
4 AI and governance	Shadow AI is already here; Leaders need policy, an audit trail and controlled adoption.	NSQHS aligned policy, procedure and guideline authoring with optional AI assisted authoring under organisational control; signed acknowledgement trails; one click accreditation reporting; ISO 27001; Microsoft AD integration.	**88% completion of mandatory orientation and policy acknowledgement**
5 Care and education without walls	Distributed Doctors need asynchronous learning, central oversight and supervision that does not depend on proximity.	Network wide broadcast across sites; asynchronous orientation; AMC accredited mobile EPA and multi source feedback; competency sign off; CPD capture and pass through; usage analytics across 60+ hospitals.	**15 to 23 minutes saved per assessment; ~0.3 FTE saved on accreditation prep**

See it running in your health service

A 30 minute live tour maps Med App to your workforce, handover and education priorities.

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6. Nepean Blue Mountains LHD. After hours medical handover: from blind spot to system fix. RACMA 2026 presentation and poster; survey report July 2026 (n=36).
7. Community and Oral Health, Metro North HHS. Peer norming to effect behavioural change in a Senior Medical Officer cohort: a case study. RACMA 2026 poster.
8. Concord Repatriation General Hospital, Sydney LHD and MDOK. Improving adherence to low paging hour and facilitated JMO meal breaks in a tertiary hospital. RACMA 2026 poster.
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10. Pathwise: reducing low value repeat pathology testing in surgical specialties, South Western Sydney. RACMA 2026.
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12. Keynote: Success cause analysis and the move towards Safety 4.0. RACMA 2026.
13. Keynote: The team around the team. RACMA 2026.
14. Keynote: Healthcare AI governance, from wonder to operating model. RACMA 2026.
15. Keynote: AI, value and the leader's role in health. RACMA 2026.
16. An automated framework for evaluating the clinical accuracy of AI powered knowledge retrieval tools. RACMA 2026.
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Synthesised from RACMA 2026 session transcripts and poster photographs captured by MedApps. Quotes attributed by role. Figures are as presented and have not been independently audited.