Scrutiny of the Australian Health System
Current Health Reforms in New Zealand
Bradley Report on the Higher Education Sector
Beyond the Intervention
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On Saturday, 7 February 2009, dawn broke to a near perfect late summer’s morning at our home in Anglesea.

By 10 am, a gentle sea breeze had kept the temperature to around 20º, and one of our house guests suggested that the forecast maximum of 43º would not be reached.

But we had seen it before and locals all hurried home to fill buckets, pack cars, block downpipes and fill gutters with water.

By 11 am, the wind had turned to the north and started to blow, and within two hours the forecast maximum had been exceeded.

The wind peaked at 94 k/h that day and the temperature at 45.3º, but by 8 pm the cool south-west change had come through, this time with no lightning strikes, and we knew that, this time, the danger for us had passed.

But across Victoria others had not been so lucky. From Bendigo, through Kinglake, St Andrews and Marysville, and down to Gippsland, the firestorm had scorched over 500,000 hectares of countryside taking with it over 2,000 homes, countless farm and native animals and over 200 human souls in the worst natural disaster in Australia’s history.

I asked Australia’s Chief Medical Officer, Professor John Horvath, whether he needed physicians to assist the injured, but I was reassured that the Department of Human Services, Victoria had prepared well and that hospital emergency departments and burns units, whilst stretched, had the crisis in hand.

Eight years of drought had left Victoria tinder dry. No rain fell for a further three weeks during which time the fires continued to burn in inaccessible hill country—the first real rain since early December finally extinguishing the remaining embers only last week.

We have been numbed by the horror and devastation of Black Saturday, but subsequently uplifted by the courage and determination of the fire fighters who saved thousands of homes from advancing flames over the four-week period until the rains finally arrived. We have been overwhelmed by the spirit and generosity of a community that has given clothing, furniture, food and toys, as well as nearly $300 million in cash, to the bushfire appeal to help those affected to rebuild their houses and their lives.

The people of Victoria have suffered a most harrowing experience but, as a community, feel closer and stronger and in a better position to overcome adversity in the future. Most of us have family, friends or colleagues who lost property or lost lives.

Professor Rob Pierce, an inspirational leader in the respiratory medicine community, was in my graduate year in Melbourne in 1970. Rob sadly lost his life in the St Andrews firestorm.

Professor Geoffrey Metz AM, PRACP RACP President

Professor Rob Pierce (15.1.1947 - 7.2.2009)

Professor Robert John Pierce died tragically on 7 February 2009, defending his home against the Black Saturday bushfires.

Rob was born to Frank and Catherine (Nell) Pierce in Melbourne on 15 January 1947 and was brought up in Yarraville, Victoria, where he attended the local Christian Brothers College. From there he went on to study Medicine at Melbourne University, graduating in 1970 and completing his house officer years at St Vincent’s Hospital. Inspired to enter the field of respiratory medicine by the late Dr Doug Gauld at the Repatriation General Hospital, Heidelberg, he was one of the first in Australia to become proficient in fibreoptic bronchoscopy.

Rob was one of a cohort of young respiratory physicians who headed to the Royal Brompton Hospital during the 70s to complete their training. His MD thesis entitled ‘Estimating lung volumes from chest radiographs and radioisotope scan images’ was carried out under the supervision of Professor David Denison and published in 1980. Rob returned to Heidelberg and developed his clinical and research skills working with both the late Dr Alistair Campbell and Dr Colin Barter. An excellent clinician and teacher, his inquiring and incisive mind and capacity for hard work led to research publications in the fields of pulmonary physiology, asthma, chronic obstructive pulmonary disease, lung cancer and, more recently, sleep and upper airway mechanics.

Rob became well known and highly respected in his chosen fields, forging strong collaborations and enduring friendships with colleagues in many different parts of the world. In 2000 he founded the Institute for Breathing and Sleep, and was also integral to the development of the newly formed Australian Sleep Trials Network. This year he was successful in receiving major funding through the Victorian Neurotrauma Initiative to further the understanding of sleep disorders in patients with quadriplegia.

Rob always maintained his clinical skills and was loved by his patients, many of whom became his friends. His abiding interest in respiratory and sleep health in Indigenous Australians was deepened during a recent sabbatical in northern Australia. In remote Aboriginal communities he saw many unmet needs in the understanding and treatment of common respiratory and sleep health problems and was actively pursuing an advocacy role, as well as developing educational materials to address some of these issues. He was also working towards establishing a sustainable respiratory health service in this region.

Rob loved living, walking and camping in the bush. He enjoyed music and art as well as sailing in his yacht, *Terra Nova*.

For someone so prominent in the respiratory and sleep medicine fields, Rob was an extremely humble person, whose door was unfailingly open to patients, students, colleagues and friends. His sphere of influence was wide and stories abound attesting to his laid-back but hands-on attitude to work and to life. Always down to earth, he had a laconic sense of humour and a lifelong desire to minimise administrative red tape and get the task done. He inspired and was a role model for generations of research students, scientists and registrars—all of whom would be proud to have considered him their friend.

Rob leaves his wife Jan, their children Chris, Lucy, Nick and Tristan and their families. Taken from us all so suddenly—he will be sadly missed.

Christine McDonald and Peter Holmes
Dr Yvonne Luxford reviews the main features of the substantial Interim Report of the National Health and Hospitals Reform Commission.

It is simply impossible to miss the flurry of commissions, taskforces and inquiries that are scrutinising the Australian health system. The Maternity Services Review has recently handed down its report, the National Preventative Health Taskforce is due to deliver its National Preventative Health Strategy by June 2009, there are two current inquiries into Men’s Health, and one into Women’s Health about to begin.

Perhaps the inquiry with the most extensive scope is that of the National Health and Hospitals Reform Commission (NHHRC), which is due to submit its final report in June 2009 encompassing ‘sustainable improvements in the Australian health system’ and addressing eight specific areas of identified need for reform.

Developing a long-term health reform plan for Australia is no small task, as reflected in the size of the Interim Report of the National Health and Hospitals Reform Commission, A Healthier Future for All Australians. Paediatrician Dr Christine Bennett heads the Commission, which has absorbed input from 535 written submissions, 80 formal consultations and 19 commissioned discussion papers to produce a report which attempts to span as many aspects of the Australian health system as possible.

One aspect of the RACP’s submission which has been acknowledged is a commitment to the expansion of Specialist Outreach Services. Such services can make significant differences to the health of Australians in rural and remote locations, as well as to Indigenous communities and others with reduced access to health care. Currently the College is exploring ways that it can better contribute to Specialist Outreach Services, and is working in conjunction with rural specialists, peak Indigenous health organisations and the Department of Health and Ageing to achieve this. I would welcome any suggestions that you have in this regard.

Another item is the creation of an independent National Health Promotion and Prevention Agency, supported in our submissions both to the NHHRC and the National Preventative Health Taskforce. This agency will lead action on the proposed Healthy Australia Goals—a set of national targets around health promotion and prevention. For such an agency to operate effectively it will need to have commitment from state and territory government agencies across different sectors to ensure whole-of-government action. This builds upon an acknowledgement that prevention goes far beyond health departments, and requires support and leadership from multiple agencies. It would also be valuable if such an agency drew together the multiple existing and planned prevention programs into a coordinated national prevention strategy.

One area with direct impact upon the College is the recommendation for the creation of a National Clinical Education and Training Agency. The interim report does not clarify how the development of this agency would improve postgraduate specialist training, although the proposition that it would play a major role in national workforce planning is attractive. Given the lack of specificity on the proposed agency, this provides a great opportunity for the College to proactively develop some frameworks around the potential role for this body. Please forward me any ideas that you have on this issue.

Apart from the establishment of a universal dental scheme, ‘Denticare Australia’, the topic within the report generating the most vigorous debate is centred on health system governance arrangements. Three options are proposed:

**Option A** The Commonwealth is responsible for all primary health care policy and funding, and pays the states and territories benefits for delivery of all hospital treatment—inpatient, outpatient and emergency.

**Option B** The Commonwealth has sole responsibility for public funding, policy and regulation of health care. Health care is then delivered through regional health authorities with three-year funding

Regarding Indigenous health, although a number of the generic recommendations will greatly benefit the health of Aboriginal and Torres Strait Islander peoples, the report neglects to recommend the development of a comprehensive, long-term plan of action to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030, as called for in the Statement of Intent. Without such a broad framework, developed in partnership with Indigenous people, success in reducing the life expectancy gap will be limited.

It is not surprising that a report which encompasses such a broad remit does not provide great detail within its recommendations. One area with direct impact upon the College is the recommendation for the creation of a National Clinical Education and Training Agency. The interim report does not clarify how the development of this agency would improve postgraduate specialist training, although the proposition that it would play a major role in national workforce planning is attractive. Given the lack of specificity on the proposed agency, this provides a great opportunity for the College to proactively develop some frameworks around the potential role for this body. Please forward me any ideas that you have on this issue.
agreements. It is possible that the states and territories could be classified as regional health authorities, or the areas may be smaller.

**Option C** A system of social insurance is established with the Commonwealth having sole responsibility for health care. All Australians would be required to choose a health plan between competing, predominantly private health plans funded through taxation.

Analysis of these options has largely divided experts between options B and C, as the first option is too close to the current system to warrant consideration as a real reform. Option B has the attraction that it could facilitate a system with greater responsiveness to local regional needs. The key to this would be creating regions small enough to be responsive, whilst avoiding a proliferation of small health authorities. Most commentators agree that regions the size of states are unlikely to meet local needs.

Option C offers the most significant change from our current conglomeration of health systems. A concern with this option is the extent to which people are equipped with the necessary health literacy to navigate a wide range of competing health plans.

As with other sections of the report, it is difficult to nominate a preferred governance option without more clarity on the detail of the proposals. However, the fact that this Commission has opened up the health care system to close scrutiny, and the potential for real and dynamic reform across a broad spectrum, is welcome and valuable.

### CURRENT HEALTH REFORMS IN NEW ZEALAND

In the wider context of health reform, two major reviews are underway in New Zealand. The first, the Health Practitioners’ Competence Assurance Act (HPCA Act), seminal legislation governing all New Zealand registered health practitioners, is undergoing an operational review. This is relatively new legislation, and so the review is focused on implementation and process, rather than debating the pros and cons of the underlying policy.

A range of issues relating to specific sections of the Act have been put forward for comment:

1. How can the public be better informed regarding the HPCA Act?
2. How can processes be improved around the scope of practice?
3. What are the issues relating to the accreditation of educational institutions?
4. Can the requirements relating to quality assurance programs be relaxed?

One of the issues arising from the review is the need for all stakeholders to discuss and develop methods for collecting and analysing accurate workforce information.

The Health and Disability Commissioner Act (the Act) and the Code of Health and Disability Services Consumers’ Rights (the Code) are also under review. The Commissioner is obligated to review the Act and the Code every three years, and he has put forward some innovative concepts relating to his future role. For example, he has asked for feedback on the following:

1. Should the Act and/or the Code be amended so that the Health and Disability Commissioner may include investigations relating to health information privacy issues?
2. Should ethics committees be under the oversight of the Health and Disability Commissioner?
3. Should the Code be amended?
4. Are the functions of the Health and Disability Commissioner appropriate?

The Commissioner has also suggested that the Act and the Code be amended to include a right to access publicly funded services. Although this concept would be difficult to operationalise, it does demonstrate the Commissioner’s responsiveness in addressing issues of health reform.

Many physicians may feel that the outcomes of these reviews will have minimal impact on their day-to-day activities; however, these Acts, along with the Injury Prevention, Rehabilitation, and Compensation Act 2001, influence greatly the environment in which health practitioners operate in New Zealand. For example, if funding issues were included in the Code, then physicians would need to re-evaluate how they prioritise patients within the health system. The HPCA determines the regulatory environment, and while this is an operational review, it is timely to remind physicians that they may wish to refer to this Act from time to time.

Both reviews have significant potential to influence health outcomes, including patient safety, in New Zealand, and therefore the College awaits the outcomes of these reviews with interest.

**Ruth Anderson**
New Zealand Manager
November 2008 brought one of the hottest build-ups for many years in the Top End and saw the Northern Territory branch of the RACP and the Faculty of Public Health Medicine convene their Annual Scientific Meeting at Royal Darwin Hospital. The theme of the conference was 'Beyond the Intervention'. The broad church of the College in the Northern Territory was well represented across paediatric, public health and adult medicine disciplines and participants travelled from Alice Springs Hospital and the Katherine region to attend.

We heard fascinating presentations covering a wide range of topics, including assessment of renal function and measurements of body composition in Indigenous Australians, achieving food security in outback stores, and the eradication of the dengue mosquito from Groote Island. There were sobering and sometimes inspiring tales from the coal face presented by representatives of the child abuse task force, the Australian Defence Force in its role supporting the Northern Territory Emergency Intervention, the media and a senior teacher working in the troubled remote town of Wadeye.

The trainee presentations were excellent, with a notable audit done by one of our interns. The audit looked at the understanding Indigenous and non-Indigenous patients have of the reason for their admission following the first consultant post-take ward round, with some unsettling findings. Other trainee presentations covered the topics of severe vivax malaria infection, osteomyelitis in children, changes to the pneumonia severity score, neuromelioidosis and post-streptococcal glomerulonephritis.

A highlight of the conference was our guest speaker, the Honourable Malarndirri McCarthy, Minister for NT Children and Families, Child Protection, Policy, Senior Territorians, Young Territorians, Statehood, and Multicultural Affairs. Minister McCarthy spoke inspiringly about her experience in government, her work in her remote electorate, and about communicating with, educating and encouraging all people to become engaged and informed and participate in the mature debate that needs to be had in the Northern Territory around many issues, including Indigenous health inequity. She also spoke about the need for us as health professionals to be ‘very honest’ with our political leaders about what needs to be done to ‘close the gap’.

Finally, the wealth of discussion and information presented at the meeting was harnessed in an advocacy forum run by senior paediatrician Dr Paul Bauert and the communiqué, reproduced overleaf, was drafted.

We present this with one voice.

Dr Emma Spencer FRACP
Physician, Royal Darwin Hospital
Chair NT Branch of the RACP
Health System Reform

Dr Jaquie Hughes, Nephrologist and PhD student at Menzies School of Health Research

Trainees enjoying a break

Dr Paul Bauert, Paediatrician, Royal Darwin Hospital

Dr Steve Brady, Director of Medicine, Alice Springs Hospital, presenting on specialist outreach services

Audience participants at the Annual Scientific Meeting 2008
STATEMENT OF POSITION OF THE ANNUAL SCIENTIFIC MEETING OF PHYSICIANS, PAEDIATRICIANS AND PUBLIC HEALTH PHYSICIANS

At the Annual Scientific Meeting of Physicians, Paediatricians and Public Health Physicians, entitled ‘Beyond the Intervention’ the following position was endorsed.

We welcome the recent attempts by the Department of Health and Ageing, the Department of Health and Families and the Aboriginal Medical Services Alliance of the Northern Territory, to engage and consult with Indigenous people and local health professionals. We have felt that such consultation has been lacking to date in the Australian Government Intervention.

We call upon the Northern Territory Government to follow the Victorian Government’s example and become a signatory to the Letter of Intent of the Close the Gap Campaign to commit to the following:

- To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030.
- To ensuring primary health care services and health infrastructure for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gap in health standards by 2018.

We support all the National Indigenous Health Equality Targets identified in the Close the Gap Campaign.

We reaffirm that:

- Good education for all children is a fundamental right and essential if sustainable advances in health outcomes are to be achieved in Indigenous Australians.
- Adequate housing does not exist in many remote NT towns and sustainable improvements in health will be markedly hindered until this situation is reversed.
- 1500 additional Aboriginal Health Workers throughout Australia, most of whom should be community based, will be required to achieve sustainable improvements in primary health care.
- Services for Indigenous adolescents must be improved as a matter of urgency.
- A highly skilled local medical workforce of sufficient numbers is essential to achieve sustainable health outcomes.
- This workforce is essential for provision of efficient specialist outreach services and for supporting the targeted Centres for Excellence.
- The establishment of Centres for Excellence in Indigenous Health Care and Training, incorporating Indigenous Health Professional Development Units, must occur as a matter of urgency.
In recent years there has been a considerable increase in the use of prescription opioids in Australia and New Zealand, especially since the introduction of sustained-release preparations of morphine (MS Contin, Kapanol) in the early 1990s, and of oxycodone (Oxycontin) in 1999. In Australia, total morphine base supply has risen 4-fold and total oxycodone base supply 10-fold since the introduction of these preparations.

This may reflect increasing prevalence of chronic non-malignant pain (CNMP) and/or a greater willingness by the medical profession to prescribe opioids, given the greater safety and effectiveness of sustained-release oral opioids, in part reversing a trend over many decades of 'under-treatment' of chronic pain.

In the USA the number of deaths due to overdose of prescription opioids has been rising.

From the point of view of pain management, the replacement of short-acting oral and injectable opioids by longer-acting orally well-absorbed opioids is a welcome development because of their potential to maintain therapeutic plasma levels through the inter-dosing period. However, the diversion and injection of prescription oral opioids has been increasingly reported, and in some parts of Australia and New Zealand these are the main opioids used illicitly. This may reflect shortage of heroin and/or unmet demand for opioid substitution treatment. While good data are lacking for Australia and New Zealand, in the USA the number of deaths due to overdose of prescription opioids has been rising.

The RACP Prescription Opioid Policy is an initiative of the Australasian Chapter of Addiction Medicine (AChAM). In 2006, in response to community and professional concerns about increasing harms associated with the use of prescription opioids, the AChAM invited representatives from the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists (FPMANZCA), the Royal Australian College of General Practitioners (RACGP), the Joint Faculty of Intensive Care Medicine (JFICM), Community Pharmacy, the NSW Health Department Pharmaceuticals Branch, the National Prescribing Service (NPS), the NSW Therapeutic Assessment Group (NSW TAG) and consumer groups to work together to develop a policy on the use of opioids in chronic non-malignant pain.

The AChAM recommends that the four Colleges involved in the development of this policy work in partnership with clinicians in primary health care and other settings to improve practice in prescribing opioids. The policy document calls for the establishment of a National Expert Advisory Group to oversee the implementation of a number of recommendations, some of which call for profound changes to the health care system as follows:

1. **Develop a set of guidelines appropriate to and useful for general practice** to incorporate a nationally standardised decision-making process for the assessment and management of patients with CNMP, integrate non-pharmacological elements of treatment with a pharmacological approach in a biopsychosocial framework, and allow better coordination between the management of pain and of addiction in a primary care setting.

2. **Introduce a system to monitor the prescription of drugs of dependence** which is web-based, confidential and real-time. This will enable prescribing doctors and dispensing pharmacists to provide more effective, safer and cost-effective health care, and government to monitor the overall use of these medications and evaluate the effectiveness of policy and other interventions.

3. **Standardise the regulation and control of opioid analgesics across jurisdictional boundaries** in collaboration with relevant government bodies and agencies.

4. **Minimise the unmet demand for opioid substitution therapy (OST)** by supporting an adequately sized, appropriately resourced variety of OST options for the treatment of heroin and other opioid dependence. This will reduce the diversion of pharmaceutical opioids on to the black market.

5. **Implement training and research measures**, ensuring there are stringent supports for medical practitioners for continuing medical education (CME) to enable them to engage in best practice management of CNMP and opioid prescribing. The policy document also identifies a number of deficiencies in service provision, regulation, attitudes and practice, pointing to the need for adequately funded research and resources to ensure these deficiencies are dealt with.

The process for development and implementation of this policy has brought together the efforts of Divisions, Faculties, Chapters and College staff in a way that may serve as an example in the future for a coordinated approach to College activities. Implementation of the policy has the potential to improve use of prescription opioids and management of chronic non-malignant pain in Australia and New Zealand, an area of health care that has been neglected for too long.

If you would like further information on this policy, please contact Mary Osborn at: mary.osborn@racp.edu.au.

Written by members of the Opioid Policy Core writing group:

- Dr Richard Hallinan FRACP
- Dr Alex Wodak FRACP
- A/Professor Milton Cohen FRACP
- Dr Malcolm Dobbin FRACP
- Ms Mary Osborn
NATIONAL REGISTRATION AND ACCREDITATION SCHEME - SPECIALIST REGISTRATION

In March 2008 the Council of Australian Governments (COAG) agreed on a National Registration and Accreditation Scheme (NRAS) for a group of 10 Australian health professions. The proposed scheme is covered by an Intergovernmental Agreement (IGA).

The establishment of the legislative framework for the system will be led by Queensland. As a consequence of the Federal Constitution it is necessary for this to be state legislation. Queensland will pass the template legislation and the other states will adopt the laws by means of reference to the Queensland legislation. Implementation of the scheme requires that national legislation be introduced into the Queensland Parliament in two stages. The first Bill, Bill A, was passed by the Queensland Parliament in late 2008 and provides the legislative basis for the structural elements of the scheme. The second Bill, Bill B, will be introduced into the Queensland Parliament in the second half of 2009. This Bill will cover the arrangements for:

- Registration
- Accreditation
- Complaints and discipline
- Privacy and information sharing
- Other matters.

As the consultation process evolved during late 2008, it became clear that there was a need for additional consultation on the matter of the arrangements for specialist registration. Consequently, a consultation paper was released in late January 2009, and the College provided a submission in response to the paper. The main areas of the College submission are outlined below.

Qualification standards and registration

The College supported the proposal to use the current Australian Medical Council (AMC) standard for accreditation of specialist training as the ‘qualifications standard’ and to apply this standard to all existing medical specialist training. That is to say, the AMC standard will be the generic standard for all specialties, with the AMC using it to accredit existing and new training programs.

It is the College’s view that the independence of the accrediting body (the AMC for medical practitioners) and the board (the AMB for medical practitioners) must be assured and recognised within the Bill, and that existing accredited and recognised medical specialities must be recommended and approved as specialties and endorsements on the register.

The College supported the proposal that the national board take advice from the Australian Medical Council on the list of specialties and associated specialist qualifications, against which the board could endorse individual registrants as specialists.

Scope of practice

An additional requirement was proposed in relation to the scope of practice of professions. It was proposed that ‘any new specialities or specialty areas of practice will require Ministerial Council approval. Where a board is proposing to recommend to the Ministerial Council a change to scope of practice or a new endorsement for a regulated profession, the board should be required to consult with all other boards. Where other boards hold contrary views, these must be drawn to the attention of the Ministerial Council.’

The College strongly supported the additional requirement for consultation and the provision to the Ministerial Council of contrary views where changes to a profession’s scope of practice or endorsements were proposed. The College believes that this proposal not only ensures that all views are available to the Ministerial Council but it has the potential to lead to a more cooperative approach to the development of innovative approaches to addressing health workforce issues.

Continuing professional development

The College supported the recognition of current continuing professional development (CPD) requirements. It also supported the development of a standard for CPD and that the boards will be required to ensure that the CPD arrangements for different sub-groups within the profession meet that standard.

This is especially important for the non-procedural sub-groups where competency would otherwise be difficult to measure. The College would support the AMB requiring maintenance of CPD for ongoing registration.

Specialist titles

The College supported the proposal regarding the protection of specialist titles but stressed that it strongly believes that the endorsement ‘medical specialist’ must be qualified with the area of specialty in which the registrant is qualified (and registered) to practise (e.g. paediatric nephrology). The College believes that this must be done in the public interest, and that this information must be publicly available on the register to allow the public to confirm the qualifications of medical practitioners from whom they are receiving or intend to receive treatment.

The College recognises the need for the consultation papers to be sufficiently flexible in the terms used in order to cover the diverse range of health professions encompassed by the National Registration and Accreditation Scheme proposals. It also recognises the consequent lack of clarity and specificity within the papers. However, measures which would lead to a reduction in the quality of existing medical profession standards and processes, in an endeavour to reduce the demands placed on other health professions which do not presently have a significant number of practitioners or high-quality accreditation systems, were not, and are not, supported. The College believes that the AMC should form the standard for the other health professions to follow.

The College supports the principles that the system must balance the rights and interests of consumers with those of health practitioners and that the system must be sufficiently robust to protect public safety.

The draft Bill B is planned for release in April. There will be a six-week consultation period during which public meetings will be held and submissions made.

Greg Armstrong
Senior Policy Officer
Queensland State Office
**EDUCATION NEWS**

**Full accreditation for all training and CPD programs**

The Australian Medical Council (AMC) has advised that the College has been awarded the full duration of accreditation, i.e. six years, for all of its Continuing Professional Development programs and training programs for the Adult Medicine and Paediatrics & Child Health Divisions, the Australasian Faculties of Public Health Medicine, Rehabilitation Medicine, and Occupational and Environmental Medicine, and the Australasian Chapters of Addiction Medicine, Palliative Medicine, and Sexual Health Medicine, through until the end of December 2010.

This is an outstanding outcome for the RACP. The AMC noted significant changes in the education programs of the College in the last four years, commending multiple areas of our educational endeavours.

The AMC first visited the College in 2004, making a number of recommendations which they required the College to meet before they revisited in 2008. They have commented favourably on the enormous progress that the College has made. The AMC states there is some way still to go and they will require us to report annually on progress against areas they consider require improvement.

I would like to thank all of the Education Committees of the College for their excellent work both in the running of the programs and in their presentation and preparation for the AMC visit and, perhaps most importantly, the Fellows who give of their time, energy and expertise to support the education initiatives of the College. I am most grateful to those Fellows whose commitment ensures that we provide high-quality education to our trainees.

**New developments coming in Advanced Training programs**

On Tuesday, 24 February 2009, the Chairs of the College’s Education Committees met to consider issues around Advanced Training.

The day was facilitated by Professor Brian Jolly, Head of Medical Education, Monash University.

The aim of the meeting was to explore ways to systematically develop common frameworks around the curriculum, assessment, teaching, and learning and e-learning environments, to span the breadth of Advanced Training.

Topics explored included:
- Curriculum design
- Curriculum framework
- Assessment
- Online portal for learning
- Curriculum strategies
- Next steps.

One of the key outcomes of the day was recognition that there are many common elements and that it is extremely important to move towards a common framework for the curricula.

We discussed how the PREP Basic Training program will lead into Advanced Training in 2011. It would be beneficial to have symmetry between our Basic and Advanced Training programs.

We also discussed the notion of a common assessment toolbox for Advanced Training, supported by the Education Deanery. Each Advanced Training group would draw up assessments appropriate to them from this tool box.

It will take 2009 and 2010 to develop a new PREP Advanced Training program. This process has begun.

Professor Kevin Forsyth  
Dean

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**NOTICE TO RACP MEMBERS**

**REPORT BACK FROM YOUR BOARD**

The Board is pleased to announce that after each Board meeting the President will prepare a written report, which will be available to members on the RACP website. The report on the February Board meeting is available at: www.racp.edu.au/members/myRACP/comm/board_rep0209.cfm

Reports will appear as soon as possible after each Board meeting.

Board meetings for the rest of the year are:
16 & 17 May 2009  
16 & 17 July 2009  
1 & 2 October 2009  
10 & 11 December 2009.

Any questions? Contact David Puls on 02 9256 9611.
EXTENDED SETTINGS FOR SPECIALIST TRAINING PROGRAM: 2009 AND 2010

The Expanded Settings for Specialist Training Program (ESTP) is an initiative of the Australian Government, implemented through the Department of Health and Ageing (DoHA). The program is designed to develop and implement specialist training in a range of new settings to better reflect the changing nature of health care in Australia. The RACP participates in this federal funding initiative alongside the other 12 Medical Specialist Colleges in Australia.

The Federal Government has provided funding over four years for sites to develop alternative pathways for the education of physicians. These extended settings include private clinics, Aboriginal Medical Services, private hospitals, community settings, non-clinical settings, regional, rural and remote settings, and ambulatory care settings.

Placements under this program provide specialist trainees with the opportunity to gain access to a range of clinical experiences and treatment options that may not be available in metropolitan teaching hospitals.

The Federal Government has approved funding for 115 new sites for RACP trainees nationwide in 2009. They vary from 3-month rotations to 12-month placements. To find out more details, you can view the current list of sites on the College website at the Trainees’ Cafe. Please get in touch with the contact person at each site to determine whether that position has been filled or not. If it has been filled in 2009, you may like to enquire about the position in 2010. The RACP strongly supports trainees undertaking part of their training program within these settings.

If you are an Overseas Trained Physician (OTP), you must be registered with the RACP in pursuit of Fellowship. You also need to contact the Department of Health and Ageing to confirm your suitability for this program.

2010 and onwards

Until DoHA has their annual budget meeting in May 2009, they are unable to confirm what the ESTP funding will be in 2010. Likewise, they are unable to confirm what the application process for funding in 2010 will be. From discussions held with DoHA, it is highly likely that those sites which were funded in 2009 will be offered repeat funding in 2010. The application process will be much less onerous that it was for funding in 2009. There may be a slight increase in the numbers of positions funded in 2010. Any site that would like to apply for funding in 2010 is strongly encouraged to ensure their site accreditation is current before applying for funding. Accreditation criteria can be found on the College website at: http://racp.edu.au/page/physician-education/training-site-accreditation/.

The College expects to have clear information by June 2009 regarding the number of positions available and the processes required to obtain funding in 2010. Any further enquiries can be directed to: estp@racp.edu.au.

Further information on the ESTP program can be found at the Federal Government’s website: www.health.gov.au/better-specialist-training.

Kelly Weir
Projects Officer
Education Deanery

2009–2010 RACP TRAINING POSITIONS SUPPLEMENT

Information about placing your hospital training positions in the Training Positions Supplement

As in the past, the June 2009 issue of the College’s newsletter, RACP News, will include a special feature on training positions available in hospitals from July 2009 to June 2010. (Please note that this is not necessarily a comprehensive listing of all positions available.)

This is a great opportunity to promote your hospital’s training vacancies at a minimal cost. Positions will also be listed on the College website, free of charge.

Please note the following details for submitting your positions:

Submission email address: TrainingPositions@racp.edu.au
Deadline: Tuesday, 28 April 2009
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Please note: As the June issue will be published mid to late June, ensure you have some leeway with your position closing dates.
THE BRADLEY REPORT: A COMMENT

The aim of this review of the higher education sector in Australia was to establish whether the sector was organised and resourced in a way that would position Australia to compete effectively globally.

The review concludes with recommendations for major reforms to the financing and regulatory frameworks for this sector. It does not touch on the role of postgraduate medical colleges and their position as a major contributor to higher education and training in Australia.

There is concern that Australia is ‘falling behind’ and will be disadvantaged in the global economy. Only 29% of 25–34-year-olds have a degree level qualification, while other OECD countries have set targets of up to 50%. The review acknowledges that there are still many groups under-represented in the higher education sector in Australia, including those from regional areas and Indigenous people.

Although the review argues strongly for increasing university participation, a major concern is Australia’s capacity to deliver on this.

Given the tight timeline for the review, it was always going to face the challenge of not going far enough, or failing to be comprehensive. However, it is disappointing that implications for the specialty training sector do not feature. Some criticisms of the review have been that it targets research-intensive universities and fails to recognise their value in the sector. The Group of Eight universities, with their push for research concentration, are suggesting the review will lead to mediocrity rather than excellence in higher education.

Although the review argues strongly for increasing university participation, a major concern is Australia’s capacity to deliver on this. With a limited pool of academics and stretched teaching infrastructure, there would have to be significant investment in the sector to increase student numbers. This undoubtedly has particular challenges for medical education, given the stress already being felt from student number increases.

One concern raised in the review was the need to increase the number of high-quality academics—to enable successful research and innovation and to provide good-quality teaching and learning. As well, there is the imminent retirement of a large cohort of academics to be factored in. Universities need to enrol more higher-degree research students. It is also noted that the cost of providing good-quality research training is not sufficiently covered by current funding.

Despite extensive feedback to the review team from specialty colleges, including the RACP, vocational specialist medical training appears to have been overlooked. Recommendations around funding models, different approaches to research funding and so on are focused on the university sector.

Alison Jones
Manager, Educational Development, Research and Evaluation
Education Deanery

NOTICE FOR RACP FELLOWS AND STAFF
New Closing Time
Macquarie Street reception will now close at 5 pm instead of 5.30 pm.

This change has been decided following a period of monitoring incoming calls to the switch between 5 pm and 5.30 pm. The number of calls was minimal and did not warrant staying open until 5.30 pm.

The front doors of 145 Macquarie Street will be closed at 5 pm unless an evening meeting is scheduled in the building, in which case, the doors will be open, or there will be a person allocated to let attendees in.

From 5 pm onwards, please exit via the back door in the basement.

Please note reception hours are now: 8.30 am - 5 pm.
ADVANCED TRAINEE SELECTION AND MATCHING: UPDATE 2008 AND PLANNING 2009

Developments 2006–08

Achieving optimal outcomes for Advanced Trainee Selection and Matching (ATSM) relies on effective partnerships between the RACP, Specialty Societies, government and state/regional/hospital groups, with each taking responsibility for specific aspects of the process.

Over the past three years, the RACP has concentrated on developing and providing the administrative infrastructure to support ATSM, including software to support electronic documentation, application, preferring and matching, in addition to venues and logistic support for interviews. Because of the philosophical differences regarding selection and the desire to preserve the decision-making autonomy of individual groups, the processes by which trainees are shortlisted, interviewed and ranked have remained the responsibility of individual institutions and Specialty Societies, with variable degrees of involvement by government departments.

Over an eight-week period, 625 trainees registered on the RACP website and 258 positions were offered in 17 matches.

The following groups participated in the selection process, using various parts of the RACP ATSM system.

Cardiology – NSW and VIC
Endocrinology – NSW, ACT and VIC
Gastroenterology – NSW, ACT, VIC and TAS
Medical Oncology – VIC
Nephrology – NSW and VIC
Nuclear Medicine – NSW
Respiratory Medicine – NSW and VIC
Rheumatology – NSW, ACT and VIC

Following this process, comments were sought from participating trainees and heads of department and a number of issues were identified.

Inadequate communication

Some trainees felt that there was inadequate communication from the College and insufficient information about the selection processes available on the website. In addition, some information either changed during the course of selection or was incorrect. Some of these problems related to late notification of information to the RACP and some to the structures in place for dealing with enquiries. It is planned to address these issues this year by defining dates as early as possible, increasing email updates and providing clear paths of communication for trainees with escalation options.

Rushed process

A number of trainees felt that the selection process was rushed, with some specialty applications closing soon after the clinical examination results were released. A variety of factors influenced the timing of the processes, including the need to match the oversubscribed specialties first, and individual clinician availability (one reason for this was conferences occurring around the same time).

At present, the plan for 2009 is to reduce the number of match dates by aligning the timing of selection within states and specialties as much as possible (hopefully in the first week of September, although interviews may be held across a longer period to enable trainees to attend interviews in various states if desired).

Website instability

At various times, the RACP website or email crashed causing a few problems. This has been addressed by changes in the situation of information on the RACP servers, as well as by further resources being allocated to support any unforeseen issues.

Difficulty completing the electronic CV

Some trainees found the need to fill in an electronic CV in addition to their ‘normal’ CV onerous and wished to upload their existing document. The reason for an electronic CV is to standardise the format of applications and to ensure that comparisons can be made easily between trainees. In addition, some trainees’ CVs are very long and interviewers wished to limit the amount of paper printed out. The standardised CV will remain for 2009, but problems identified in the entry of information (such as the ability to reorder information and lists without re-entering all data) will be rectified.

 Difficulty for New Zealand trainees

New Zealand trainees had difficulty accessing the website and were treated by the system as ‘overseas’ trainees. This will be rectified and a process is already in place for 2009 to ensure that they will have the same access as Australian trainees.

Changes required to referees’ reports

The numerical rating scale for individual aspects of performance was not sufficiently discriminatory between trainees. Referees will be asked to give an overall rating and to provide text comments on individual aspects of performance.
Duplication of information with NSW Health

NSW trainees were required to apply to both the RACP and the NSW Health websites. This caused extra work, but also resulted in some trainees applying to one but not the other, which then led to additional problems with interviews and administrative processes. The College is negotiating with NSW Health regarding this matter, but as NSW Health cannot release trainee details the likely solution will be for the relevant information on the RACP website to be ‘mirrored’ to the NSW Health server. Unfortunately, it appears that dual applications in NSW will remain in 2009, but the difficulty that some trainees faced in 2008 finding the positions on the NSW Health website will be addressed.

Confusion over interviews

Issues surrounding the interview times/organisation were noted. Some trainees had grievances relating to whether they were offered interviews, or the timing of notification of interviews, especially in regard to the release of examination results, etc. In most cases, these were beyond the control of the RACP; being the responsibility of the local organisers. However, in 2009, a suggested timeline will be circulated to all coordinators in an effort to avoid this reoccurring.

International medical graduates and visa holders

In NSW, in particular, it was noted that it was not clear that international medical graduates (IMGs) and other visa holders were not eligible to take positions that could be filled by a local (Australian) candidate. This is a legislative requirement and not within the control of the RACP. In 2009, IMGs and other visa holders will be advised to check their eligibility carefully with the appropriate bodies prior to application.

Plans for 2009

Currently, the software that supports the ATSM process is being redeveloped to address many of the issues identified during the 2008 process.

Communication with trainees will be improved and trainees should be able to email match coordinators directly with questions rather than these being routed via the College administrative staff.

Coordinators will have the ability to control nearly all of their own online content, ensuring accurate, up-to-date information for trainees, as opposed to updates/information having to travel through several different people before the website could be updated.

Matches will be held in late August/early September to allow trainees more time to think about their options.

Hopefully, increasing ease with the electronic matching process will allow more widespread use and consolidation of matches, which will in turn allow trainees to preference positions across states and specialties, which is where the major benefits of a broad electronic match lie.

Geoff Hebbard FRACP
Emma Cunningham
Senior Project Officer

DO YOU HAVE PATIENTS WITH KLINEFELTER SYNDROME?

Klinefelter Syndrome (KS) is the most common chromosome disorder in males (47XXY), affecting approximately 1 in 650 males. That represents almost 15,000 males in Australia—yet up to 70% of cases remain undiagnosed, even though they may benefit from treatment. Despite decades of work on the medical aspects of KS, almost nothing is known about how diagnosis with KS impacts psychosocially on an individual, and how this is influenced by age at diagnosis.

Andrology Australia, the national men’s health organisation, together with the

Murdoch Childrens Research Institute, Prince Henry’s Institute and Monash University, is undertaking a unique questionnaire study to determine how treatments and interventions accessed at different ages affect biomedical and quality of life outcomes in adulthood.

Individuals with KS aged 18 years and older, but diagnosed at all different ages (including prenatally), are invited to take part in the study.

Doctors with KS patients are asked to provide study information to their patients by mail or at a consultation. Study posters are also available for clinic waiting rooms. For colour copies of these materials or further information, please contact the project coordinator:

Amy Herlihy
Public Health Genetics, MCRI
10th Floor, Royal Childrens Hospital
Flemington Road
Parkville VIC 3052
Phone: (03) 8341 6370
Fax: (03) 8341 6212
Email: klinefeltersyndrome@gmail.com
I am extremely honoured to have been selected for the Eric Susman award of the Royal Australasian College of Physicians. The award reflects my contribution to clinical research in neurological diseases, and particularly to disorders of the motor neurone.

My interest in neurological research began during the decade of the brain in the 1990s, with clinical and research training at the Institute of Neurological Sciences, Prince of Wales Hospital, under the guidance of Professor David Burke. The Institute was originally established by Professor James Lance as the first academic department of neurology in Australia and developed an international reputation as a centre for neurological research.

When I commenced my studies with David Burke, we were involved in clinical trials involving riluzole, the first neuroprotective medication to show survival benefit for MND patients. In addition to our clinical studies, we were keen to develop non-invasive methods to investigate the function of ion channels in the axonal membrane. This field of nerve excitability research grew from a need to develop methods suitable for studying patient symptomatology, disease mechanisms and disease pathophysiology. In an attempt to broaden the application of excitability methods, during my tenure as a CJ Martin and RG Menzies Fellow based at the Institute of Neurology, Queen Square, United Kingdom, I was involved in the development and validation of testing protocols, which have now been introduced into clinical use.

In the past 40 years there have been few significant changes to the neurophysiological investigation of patients with suspected neurological disorders. Nerve conduction studies, in combination with electromyography, have remained the method of choice for clinicians. While routine nerve conduction studies can document the presence of a neuropathy, they do not always provide insight into disease mechanisms. This is particularly relevant now that ‘ion channel disorders’ are being increasingly recognised, often due to underlying hereditary processes, sometimes due to immune attack.

With the establishment of a research unit at the Prince of Wales Medical Research Institute in Sydney, our research group has been utilising these novel techniques to investigate nerve function in patients with neuropathic disorders (particularly motor neurone disease and neuropathy). Working with fine clinicians and scientists including Cindy Lin, Arun Krishnan and Steve Vucic, our research has delineated disease mechanisms that involve neuronal ion channels and has identified targets for potential therapies in patients with neurological disease.

Recent translational studies in motor neurone disease have identified abnormalities in patients before deficits become apparent. As a result ... we hope that treatments for this uniformly fatal neurodegenerative disorder may have a greater chance of rescuing diseased motor neurones ‘before the horse has bolted’. Based on our findings, neuroprotective treatment trials have recently commenced, supported by the National Health and Medical Research Council.
To further facilitate clinical trials in MND, we have developed local consortiums, and with colleagues from across Australia we have been involved in the development of the Australian Motor Neurone Disease Registry. This local registry forms part of a growing worldwide trend to obtain epidemiological and natural history information for MND, and provides a hub for collaborative approaches.

To further support and improve the care of patients, I have been involved in the establishment of a multidisciplinary MND clinical service based at Prince of Wales Hospital, and also the Hereditary Nerve and Muscle clinical service, to care for patients from Sydney Children's Hospital with neuromuscular disease, as they move from adolescence to adulthood. As chair of the scientific committee of the Australian Brain Foundation, I am privileged to be part of the process in allocating funds to research and medical education for the treatment and prevention of neurological disorders.

In addition to my clinical responsibilities and research, I have enjoyed participating in the training of future neurologists, recently completing tenure as Chair of the Specialist Advisory Committee in Neurology for the Royal Australasian College of Physicians and as the Honorary Secretary of the Australian & New Zealand Association of Neurologists (ANZAN). The award of the Eric Susman prize reflects the strong support and training that I have received from my teachers and mentors through the College and ANZAN.

Dr Matthew Kiernan FRACP
Winner of the Eric Susman Prize 2008

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**CALL FOR NOMINATIONS - ERIC SUSMAN PRIZE 2009**

The Eric Susman Prize was established by a bequest of Eric Leo Susman (a Foundation Fellow of the College) and has been awarded annually since 1962 to a Fellow of the College for the most outstanding contribution to the knowledge of any branch of internal medicine (Adult Medicine or Paediatrics).

For more information or to obtain a nomination form, please contact the Research and Education Foundation via email <foundation@racp.edu.au> or visit the College website <www.racp.edu.au/page/about-the-racp/research-and-education-foundation/applying-for-an-award>.

**Closing date for nominations is 29 June 2009.** Nominations received beyond this date will not be considered.
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Dr Jacky Hewitt. Inaugural Winner,
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FAREWELL TO JO JONES
NZ CEO 1993–2008

On 21 November 2008 a farewell tribute and lunch was held at the James Cook Hotel, Wellington, for Jo Jones, which was attended by a group of current and former officer bearers who had worked closely with Jo during her long years of dedicated service to the College.

Jo demonstrated a personal ‘hands on’ approach in relating to Fellows and trainees and consequently became well known to and respected by the NZ Fellowship.

From the beginning, Jo assumed responsibility for minuting many major committee meetings (NZ Committee, Training Committees, and Board of Censors) and clearly had an aptitude for detail and processes. She also had an excellent rapport with external bodies, particularly the Medical Council of NZ. She developed a remarkable knowledge of overseas trained physicians and the processes around interviews, assessments and recommendations.

In addition, Jo coordinated the national clinical examinations, which are a major logistical exercise, and involved herself in running examinations, and so got to know many trainees.

Jo developed a great knowledge of the complexities and scope of the College across both countries and her opinion was much respected as the College evolved over the years, in particular with regard to the Governance Review.

She developed good relations with her peers from other college branches in NZ and significantly contributed to the Council of Medical Colleges.

Jo worked industriously and, at times, long hours, but always displayed warmth and humour even when very busy.

Jo’s husband, Graham, also joined the RACP (NZ) office and had responsibilities for finance and information, and his support was acknowledged at her farewell.

Jo supported and advised my predecessors, Martin Searle and Brian Darlow, in cementing the special place of New Zealand in the constitution and retaining oversight of NZ finances and training.

Jo Jones made a remarkable commitment to the RACP, with a very significant contribution over 15 years. This was sincerely acknowledged in the various speeches at her farewell function by both Fellows and staff.

GM Robinson FRACP, FACHAM
President RACP (NZ)

Letters to the Editor

Recently, a 96-year-old lady was sleeping after having spent most of the previous night in the casualty department. I was asked to see her to ensure that her previous ‘not for resuscitation’ request was properly up to date and current.

My refusal to do so annoyed the nurse and I was given instruction as to the hospital policy and my legal responsibilities.

I am surely not alone in being dismayed as to how the ‘Law’ has been allowed to demean and dehumanise a profession once considered noble.

George R Crowe
Physician

John Kolbe and the College are to be congratulated on ‘getting serious about advocacy’ (RACP News, February 2009). The College will advocate for ‘excellence in health and medical care’, he says, which is not quite the same as advocating for good health itself, however. It suggests that the advocacy may be more in the interests of the profession and not quite so much for the population. Or at least it may confine advocacy to the safe end of the spectrum of political activism: advocating for good services for the obese, for example, but not tackling the powerful vested interests that contribute to its cause. This is understandable in a conservative professional organisation where getting offside with government, even temporarily, is seen as ‘bad form’ and being unreasonable.

Elsewhere in the February issue (Letters, p. 33), Professor John Boulton refers to the segregation of Australian Aboriginal people with leprosy and the failure of those doctors who knew this was not good policy to advocate against it. We do not know what caused this failure, or what private representations may have been made, but it is not hard to imagine how difficult it might have been in the 1930s to have advocated for lepers. It would probably have seemed quite unreasonable.

One needs to remember George Bernard Shaw’s dictum that all progress depends on the unreasonable man, the man who is not prepared to adapt to the existing order. Advocacy that achieves major benefits in the population will commonly be divisive and even unpopular within the profession. It may only succeed if the College leadership is prepared to lead
College opinion towards any particular goal it identifies, and then become politically active in a way unfamiliar to the College of the past.

That would be serious advocacy indeed.

Alister Scott FRACP, FRCP

The NT branch of the RACP met recently and discussed the College's review of administrative support to regional, rural and remote RACP branches.

We read with interest a brief reference in an appendix to a concept of a 'Top End' or 'Tropical Australia' focused region running north of the Tropic of Capricorn, with the administrative hub in Darwin. We note that Alice Springs is 30 kilometres south of the Tropic of Capricorn and much of its large catchment area south of this again.

Whilst we welcome the notion of a united Northern and Central Australia across state and territory borders, this is a vast geographical region covering many differing people, language and cultural groups. Some of our northern shorelines are within paddling distance of our closest international neighbours. It is truly an expansive multicultural region from both an Indigenous and a non-Indigenous perspective. In its entirety, it is united mostly by common problems of inadequate local resources, service provision, utilities and basic infrastructure.

We would not seek to dominate resource allocation to an area stretching across from Western Australia through the Northern Territory, the tip of Cape York and the Torres Strait to North Queensland and down to our borders with South Australia and New South Wales.

We would absolutely support the concept of a united Northern and Central Australian network seeking to improve communication and training infrastructures across these borders. We would absolutely seek cooperation and collaboration in addressing issues that affect the provision of health services to all remote-living Australians across these borders, and we would absolutely advocate to address workforce inequity that compromises the provision of these services and the development of training structures across these borders.

We understand clearly, however, that within the states and territories the historic and logistic relationships between remote hospitals and their southern tertiary and quaternary referral centre partners must be maintained and enriched. This is necessary to access services which in all reality will never be available in remote centres and to support continuing professional development activities in a reciprocal manner.

As Fellows in the Northern Territory we see ourselves as 'One College'. Adult, paediatric and public health physicians meet regularly and conduct an annual scientific meeting, alternating between Darwin and Alice Springs. The artificial lines which divide these disciplines in other areas of Australia do not exist here. This is of great benefit to our practice, maximising the limited resources we have access to.

In order to maintain and develop this unique structure, we need to grow local capacity to nurture the activities of our branch. The College is a broad church, its strength coming from the concept that it is the Fellows who are the College not the sandstone of Macquarie Street.

Administrative support and capacity building must occur where the Fellows practise, not just where the bricks and mortar reside. This will be challenging, but the challenges faced in providing this assistance at the coal face are the same challenges we face on a daily basis conducting our clinical work.

To address these challenges we need to build local capacity around education, policy and advocacy. We acknowledge that, as Fellows, we must set up these educational structures, we must develop policy and we must develop skills in advocacy. To do this, however, we need professional assistance to facilitate what are complex and time-consuming activities. For these activities to be seen as a priority this assistance must be largely locally based.

We believe a combination of structures supporting local activities, including both College central structures—especially around event management—and locally based administrative support around education advocacy and policy would be acceptable. We would seek to attract someone with a communications, IT and media skills set.

It is widely acknowledged that the new College training structure, while generally a positive and progressive step forward, requires huge physician resource allocation for which material local Department of Health support is often absent. We seek a dialogue with the broader College as to how much of this structure it is reasonable to expect the College to support at the local branch level and how much it is reasonable to expect state and territory health departments to provide by adequately resourcing their physician workforce.

Dr Emma Spencer FRACP
Chair NT Committee

Who’s That Fellow?

As you may have noticed in the February issue, we have introduced a new feature, ‘After Hours’, to replace ‘Who’s That Fellow?’, which has been running for a long time.

We hope this is not too disappointing for those readers who enjoyed wracking their brains to work out who the Fellow featured was.

FEBRUARY COMPETITION WINNER

Congratulations to A/Prof Graham Young of NSW (first correct entry received), who identified Dr Ian Lyall Thompson.
MY LOVE AFFAIR WITH ULYSSES

On 16 June 2004, in North Great Georges Street, Dublin, I, along with about 10,000 other James Joyce tragics, had a breakfast of Denny’s sausages, black pudding and a pint of Guinness. That was the start of Bloomsday 2004, the 100th anniversary of the day in 1904 when Leopold Bloom and Stephen Dedalus walked the streets of Dublin and finally met. An odd way to spend one’s time, but for many of those there, a demonstration of complete dedication to the novel of the 20th century, Ulysses. It is a book in which not much happens but everything happens—a book about love, about life and death, about families, and above all a book about Dublin.

Bloom, despite all his manifest weaknesses, is one of the most sympathetically drawn characters in English literature.

Sure, Roddy Doyle once famously said that Ulysses was in great need of an editor, but let’s put that down to Irish spite and the anxiety of influence! It’s a simple tale. Stephen Dedalus gets up in the morning, discusses life with Buck Mulligan with whom he shares lodgings in a Martello Tower, teaches a history lesson, gets paid three pounds twelve, walks on the beach, thinks a lot, drinks a lot, meets up with some medical students, drinks more, visits a brothel, nearly gets bashed, is saved by a Good Samaritan and ends up at 7 Eccles Street, the home of the Good Samaritan—who is none other than Leopold Bloom who earlier in the novel also gets up, has a breakfast of pork kidneys, defecates, walks around Dublin, inadvertently tips the winner of the Irish Gold Cup, eats a lunch of a gorgonzola sandwich and a glass of burgundy, thinks a lot about the adulterous act to be committed that afternoon by his wife, Molly, with Blazes Boylan, masturbates on the aforementioned beach, nearly meets Stephen several times, finally does and saves him from the aforesaid bashing.

I started reading Ulysses in 1996 when I was 40—an ‘annotated student’s version’, of great benefit for deciphering the clues and riddles on every page—and finished in time for the Bloomsday breakfast in Dublin in 2004. In some ways, one of the most readable, funny and moving books one would ever hope to encounter. Bloom, despite all his manifest weaknesses, is one of the most sympathetically drawn characters in English literature. In other ways, a complete struggle—the Oxen of the Sun episode, set in the Holles Street Maternity Hospital, describes the birth of the English novel in 60 paragraphs. The first 10 are intercourse and conception expressed through parodies of Latin and Anglo-Saxon; the next 40, gestation through caricaturing a chronology of prose writers from Bunyan to Defoe to Newman to Dickens; the last 10, birth and infancy through Dublin slang. Certainly not to be read without an annotated student’s version!

It is told that when Joyce pompously declared that he was leaving Ireland forever with his only weapons being ‘silence, exile and cunning’ his friends got together to raise enough funds for the fare out.
When ‘Stately, plump Buck Mulligan came from the stairhead, bearing a bowl of lather on which a mirror and razor lay crossed’, I was intrigued; when Stephen contemplated the ‘ineluctable modality of the visible’ as he walked along Sandymount beach, I was immersed; and when Leopold Bloom ‘ate with relish the inner organs of beasts and fowls’ I was completely enraptured by the prose of this most fascinating and complex man. The dedication of Joyceans was not shared by many of his countrymen, then or now. It is told that when Joyce pompously declared that he was leaving Ireland forever with his only weapons being ‘silence, exile and cunning’ his friends got together to raise enough funds for the fare out.

So, as I awaited Bloomsday 2005 after the immersion of 2004, I was astounded to learn that the regular Bloomsday celebrations were not to be held that year—a tragedy. I had been to several of the previous Bloomsday events, including a memorable evening at the Jewish Museum, Darlinghurst, where the theme was Bloom’s Jewishness. A wonderful Rabbi from Trieste, where Joyce had lived for several years, spoke about Italo Svevo, Joyce’s likely model for Bloom. Those Bloomsdays had largely been organised by Clara Mason. My first recollection of Clara was her filling in for Bob Carr at the Jewish Museum to read from one of the most hilarious episodes in the book, Cyclops, where Bloom encounters a bellicose Irish patriot who waves a burning cigar in his face. I suppose Clara had read that passage dozens of time, but that night she could not get through it as she dissolved into fits of laughter. Most of the audience was in fits too—for a passage written nearly 100 years before!

A close friend of mine and fellow Joycean tragic decided that the non-celebration of Bloomsday in 2005 had to be rectified and thus began my involvement in organising one of the several Bloomsday celebrations in Sydney. Clara has taken up the cudgels again, too. We like to think that our Bloomsdays are the intellectual ones and not just recitations of boring slabs of text. But if truth be told, I think most attendees mainly enjoy the music that follows the serious stuff—‘Tim Finnegan’s Wake’, ‘Danny Boy’, ‘The Croppy Boy’, and many more.

In 2006, it was a walk from Darling Street Wharf to the Bald Rock Hotel, Balmain, along the White Bay cliff, with linked readings about the wharves of Dublin, the night sky, etc. We stopped along the way in the garden of Sir Henry Parkes’ house and heard a reading about the British Empire from his great-grandson, Roger. We were, of course, delighted to share a Guinness and many Irish songs when we finally arrived at the Bald Rock. Last year our theme was the vagus nerve. At Royal Prince Alfred Hospital we heard very serious dissertations about the role of the vagus nerve in psychiatry, surgery, forensic pathology and sex therapy. Why the vagus? Because it’s the wanderer, as were Stephen and Bloom on that one day in Dublin; and because, in Joyce’s own words, Ulysses is ‘the epic of the human body’.

This year we will focus on the character of Stephen, from his early years as described in A Portrait of the Artist as a Young Man through to his final encounter with Bloom at 7 Eccles Street. Whilst urinating together in Bloom’s backyard they observe ‘the heaventree of stars hung with humid nightblue fruit’, the weary travellers now finally in communion as surrogate father and son. Then Stephen declines Bloom’s kind offer of a bed for the night and departs. The End, apart from one of the most famous passages in literature, Molly’s soliloquy. But that is another story.

So for all those in Sydney on 16 June this year, look out for Bloomsday 2009. And for those contemplating reading Ulysses, remember Molly’s last words: ‘yes I said yes I will Yes’.

Dr Greg Stewart FAFPHM, FRACMA
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Come and meet us at Physicians Week 2009

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FRACP Clinical Exam Candidates
Preparation Course for FRACP Clinical Examination (Adult Medicine)

Melbourne
Saturday 2nd May 2009

Sydney
Saturday 9th May 2009

DeltaMed will again be running a one-day examination preparation course for candidates sitting the FRACP clinical examination in Adult Medicine in 2009. The course will be held in Melbourne and Sydney.

The course will assist in defining and developing the skills and knowledge necessary to pass the examination. It will consist of lectures and video as well as small group teaching with experienced tutors.

For further details contact:
DeltaMed, 53 / 85 Grattan Street, Carlton, VIC, 3053
Phone: (03) 9347 2718 Fax: (03) 9347 2918
www.deltamed.com.au Email: info@deltamed.com.au

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Before prescribing, please review full Product Information. Full Product Information is available from Janssen-Cilag upon request. CONCERTA® (methylphenidate hydrochloride) Extended-Release Tablets.

**Indications:**
Treatment of ADHD (DSM-IV criteria).

**Contraindications:**
hypersensitivity to methylphenidate or any inactive ingredients in this product, anxiety, tension, agitation; Tourette’s syndrome (or family history); glaucoma; hyperthyroidism; arrhythmias; severe angina; MAOIs (including within 14 days of cessation)*, phaeochromocytoma, drug dependence*, uncontrolled hypertension*, ischaemic heart disease*, myoccardial infarctions*, severe depression*, anorexia nervosa*, psychotic-symptoms and suicidal tendency*.

**Precautions:**
Drug dependence* , severe depression, psychosis; history of seizures, abnormal EEG; GI narrowing; visual disturbance*, sudden death and pre-existing structural cardiac abnormalities or other serious heart problems; hypertension and other cardiovascular conditions; aggression; dysphagia. Monitor haematology; hepatic or renal impairment*, growth/weight gain; pregnancy; lactation; children < 6 years.

**Adverse Reactions:**
nasopharyngitis, insomnia, headache, dizziness; cough, pharyngolaryngeal pain; abdominal pain; vomiting; pyrexia; tic; anxiety; affect lability; nausea; diarrhoea; stomach discomfort; irritability; aggression; hypersensitivity reactions; weight decreased; other see full PI.

**Drug Interactions:**
MAOIs (see Contraindications); vasoressor agents; coumarin anticoagulants; anticonvulsant agents eg phenobarbitone, phenytoin, primidone; TCAs, SSRIs, clonidine, other alpha-2 agonists.

**Dosage:**
Treatment should be started on the lowest possible dose. If treatment is restarted following discontinuation of greater than 3 months then dosing will need to be re-titrated. Administer once daily in the morning with or without food. Swallow whole with liquid. Do not crush, divide or chew. Maximum dosage of 54 mg/day for children and 72 mg/day for adults*.

**Presentation:**
Extended-release tablets 18 mg, 27 mg, 36 mg, and 54 mg. Prepared January 2009. Please note changes (presented as * italicised text *) in product information.

**References:**

**PBS Information:**
Authority Required. For the treatment of attention deficit hyperactivity disorder (ADHD) in a child or adolescent aged between 6–18 years inclusive, who has demonstrated a response to immediate release methylphenidate hydrochloride with no emergence of serious adverse events, and who requires continuous coverage over 12 hours.
Australasian Chapter of Sexual Health Medicine

Upcoming Chapter events in 2009
Please put these important dates in your diary now!

Sexual Health Update 2009
Saturday 2 May
9am to 4pm

Jasper Hotel
489 Elizabeth Street
(near Victoria Market) Melbourne

Topics will include:
- Syphilis is back
- HIV post-exposure prophylaxis
- What's new in urethritis and forgotten in vaginitis
- And talks on aspects of herpes, warts, PID, sex workers and gay men.

For further details please contact:
Tel: 02 9256 9643 Fax: 02 9256 9693
Email: sexualhealthmed@racp.edu.au

For more information on either event please contact:
The Australasian Chapter of Sexual Health Medicine
145 Macquarie Street
SYDNEY NSW 2000 AUSTRALIA
Tel: (61 2) 9256 9643 Fax: (61 2) 9256 9693
Email: sexualhealthmed@racp.edu.au
History of Medicine Library Tour & Lecture

When: Sunday 17 May 2009
Time: 1.00pm – 3.00pm
(Please arrive at the College reception foyer 15 minutes prior)
Location: The Royal Australasian College of Physicians
145 Macquarie Street, Sydney
RSVP: Liz Rouse on (+ 61 2) 9256 5413
liz.rouse@racp.edu.au by 4 May 2009

The College Library invites Fellows, Trainees and their guests to a tour of the College building (built 1848) and a display of rare books in the Library.

At 2pm there will be a History of Medicine lecture given by Professor John Rasko FRCPA FRACP of Royal Prince Alfred Hospital, titled “Did the Ancient Greeks foreshadow regenerative medicine?” Refreshments and discussion will follow.

Queenstown Course in Internal Medicine
An update Course for Physicians
Millbrook Resort    Queenstown    New Zealand
27 – 30 August 2009

This course is designed to cater for the practicing specialist in Internal Medicine. The meeting is held biennially at the spectacular Millbrook resort, on the outskirts of Queenstown. Abundant leisure activities exist including skiing, bungy, rafting, wine tours, cycling. The Resort hosts one of the finest golf courses in New Zealand. Queenstown is serviced by an international airport.

Places for the 2009 course are limited to 60 participants and early registration is encouraged. Registration, along with information about this popular course and the proposed programme is available online at our website. http://dnmeds.otago.ac.nz/departments/mss/medicine/teaching/postgrad/queenstown.html

Programme
- Rheumatology - Professor John Highton
- Respiratory Medicine - Professor Robin Taylor
- Haematology - Dr Ruth Spearin
- Oncology - Dr Blair McLaren
- Gastroenterology - Dr Michael Schultz

All enquiries to:
Linda Cunningham
Postgraduate Education Coordinator
Dunedin School of Medicine
University of Otago
Email: linda.cunningham@otago.ac.nz
Tel: +64 3 474 7077 ext 8520

Gastroenterologist

Digestive Health Clinics, in conjunction with Brisbane Gastroscopy and Colonoscopy is an association of Gastroenterologists delivering both consultative and adult open access services with multiple site practices located in Brisbane city, Indooroopilly, Gaythorne and Ipswich. Our services are expanding and we are seeking a suitably qualified Gastroenterologist to join us.

If you are looking for an opportunity to work in a dynamic environment with growth potential and a guaranteed income in your first year of service and satisfy the following criteria, we would like to hear from you.

You must be:
- Queensland Registered Gastroenterologist or eligible of being registered in the State of Queensland
- Credentialed and have proven experience in Upper and Lower G.I. endoscopy
- Prepared to promote the business and work in alignment with the strategic objectives of the business
- Prepared to embrace the corporate values of delivering excellent patient care
- Able to demonstrate excellent interpersonal, communication and presentation skills
- Able to network effectively and project a positive corporate image

Digestive Health Clinics and Brisbane Gastroscopy and Colonoscopy work within Montserrat Day Hospitals.

For expressions of interest please contact:
Ms Leith MacMillan
Business Development Manager
Montserrat Day Hospitals
Level 1/35 Astor Terrace
BRISBANE QLD 4000
07 38336737 or 0417 737122
lmac@montserrat.com.au
or Leith@dayhospitalconsulting.com.au
Physicians Week 2009 will feature:

- Professor Tony McMichael (ACT)
  Joint College Plenary
  Climate Change: Eroding the Foundation of Population Health.

- Associate Professor John Henley (Auckland, New Zealand)
  The Specialty of General Medicine - Past, Present and Future.

- Dr Mariane Gausche-Hill (California, USA)
  Paediatrics & Child Health Keynote Plenary
  Paediatric emergency services and current controversies in paediatric emergency medicine.

- Professor Frank Oberklaid (Victoria)
  Howard Williams Oration (Paediatrics & Child Health)
  Topic to be advised

- Associate Professor Melissa Wake (Victoria)
  Paediatric Research Society of Australia and New Zealand (Paediatrics & Child Health)
  Topic to be advised

- Professor Kyle Steenland (Georgia, USA)
  Australasian Faculty of Occupational & Environmental Medicine Keynote Plenary
  PFOA: A five year research plan to study effects of community and worker exposure in a contaminated community in the US, and some preliminary results.

- Dr David Pencheon (UK)
  Australasian Faculty of Public Health Medicine Keynote Plenary
  The health sector’s role in promoting sustainable development and mitigating climate change.

- The Education Deanery will deliver as part of Medical Education program a series of workshops on (amongst other things) effective learning; providing effective educational supervision; facilitating reflective practice using work based assessments; effectiveness of CPD through reflective practice and assessment of OTP's.

- A series of policy and advocacy sessions will stimulate and challenge your thoughts around the various priorities for the College in 2009. All sessions will encourage your involvement in the consideration of current projects and consideration of new strategies.

- The Australasian Faculty of Rehabilitation Medicine is offering a one day program consisting of workshops and symposiums promoting the advancement of knowledge in the field of rehabilitation medicine.

- And much, much more!

For regular updates on the programs and for more detailed information, please visit the Physicians Week 2009 website.

We look forward to welcoming you to Sydney in May 2009!
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For more information, visit our website at www.healthmatchbc.org

MEET HEALTH MATCH BC’S RECRUITMENT CONSULTANTS AT:

Physicians Week 2009 RACP
Sydney Convention & Exhibition Centre, Booth 13
May 18-20, 2009

OR JOIN US FOR AN INFORMATION SESSION AT:

The Sebel Playford Adelaide
120 North Terrace, Adelaide
Tuesday, May 12 at 7:00 pm

Holiday Inn on Flinders Melbourne
575 Flinders Lane, Melbourne
Thursday, May 14 at 7:00 pm

Crown Plaza Darling Harbour
150 Day Street, Sydney
Thursday, May 21 at 7:00 pm

Specialists must have a fellowship from one of the specialist training authorities.
Family Physicians/General Practitioners must have a minimum of two years of approved and accredited postgraduate training.

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