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HEALTH IN THE PACIFIC
5 Challenges for the Pacific Region
8 RACP Fellows support health and education in Timor
10 Renal medicine in Samoa
11 Pacific Island wanderings

EDUCATION
14 Consensus Statement: Medical Professionalism
15 2012 meetings of the Tripartite Alliance – RACP, RACS & RCPSC
16 Supervisors’ professional development at Congress and beyond
16 Practical Skills for Supervisors workshop
17 New – Progression through Training Policy
18 NSW Clinical Practice Improvement pilot program
19 College making sound progress against AMC accreditation standards
19 Want to know about Supporting Physicians’ Professionalism & Performance (SPPP)?

THE VINE
26 Volunteering in the Solomon Islands – a highlight of my career
27 Tips for success in the RACP Clinical Examination

CULTURAL COMPETENCE
28 Working with Aboriginal and Torres Strait Islander peoples and communities
29 Indigenous health at the RACP Future Directions in Health Congress 2012
30 Online resource for physicians working in Aboriginal child health
30 Partnership with RACS and College of Dermatologists
30 Share your story

RACP FOUNDATION
36 Cottrell Fellowship and Cottrell Memorial Lecture
36 Research endeavours of Cottrell Fellowship recipients
37 The RACP Foundation at the RACP Future Directions in Health Congress 2012

GENERAL
4 Letter from the President
13 Professor Cyril Dixon
20 Risk management and the College
21 Dr Sergio Diez Alvarez, AMA Supervisor of the Year
22 The challenge of change
23 Susan Moloney, Board Director
24 Beyond the scientific program at Congress 2012
25 RACP Future Directions in Health Congress 2012
31 Physician readiness to adopt e-Health – Are we any closer?
32 Electronic Medication Profile
34 Dr Robin Chase, AFOM President, honoured by Royal College of Physicians of Ireland
35 Expansion to the Specialist Training Program 2012–2013
38 Obituaries
39 AFOM to host 7th World NeuroRehabilitation Congress
40 Book Reviews
41 Letters to the Editor
42 After Hours
44 Classifieds
47 Member Advantage

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The major areas of activity of the College can be described as education, policy and advocacy, research, finance and fellowship relations. Within the current governance structure, each of these areas of activity is represented by a Board committee, with one exception. Somewhat astonishingly this exception is a committee devoted specifically to Fellows and trainees, namely a Fellowship Relations committee.

At its last meeting the Board established a working party to determine whether such a committee is required in light of the role and scope of activity it could deliver in support of the Fellowship. The establishment of such a committee would align with one of the Board’s strategic objectives: to enhance and strengthen engagement of Fellows and trainees. It would also be in line with the development of the value proposition for Fellows and trainees and the future provision of expanded membership services, thus building on the existing membership advantage offerings.

Determining just what Fellows and trainees of a diverse organisation such as the RACP actually want from the College is quite a challenge. To assist with this, the College is conducting a segmentation study. (If you have been sent a questionnaire on this, I strongly recommend you ‘have your say’). This survey will not only help to define the services that Fellows want, but will assist in directing such services to the most appropriate groups. This is an important area of activity that requires oversight by a Board committee, particularly in acting on the results of the survey and evaluating the effectiveness of any initiatives introduced as a result.

There are other important areas of activity in the College in which Fellows have limited direct or strategic involvement; one of these is communication. When the issue of communication is raised with Fellows, there is a diversity of opinion; for every Fellow who wants RACP News in hard copy, there is someone else who equally and vehemently wants to receive it in some form of electronic communication. Communication with Fellows and trainees is such an important, albeit challenging, activity that it is essential that oversight of this is incorporated into the governance structure of the College.

Some current important committees do not have clear or particularly effective reporting lines in the College; an example is the committees responsible for organising the Annual Scientific Congress. Other committees which currently ‘officially’ report to the Board require more effective, supportive and appropriate mechanisms to engage with the governance structure of the College. These committees may be better served by coming under the ‘umbrella’ of a Fellowship Relations committee.

By the time you read this newsletter the results of the College elections and therefore those responsible for ‘steering’ the College and its activities for the next two years will be known. I would like to thank all who participated in the process and congratulate those about to assume leadership positions in the College.

Finally, I hope to catch up with many of you at the Annual Scientific Congress in Brisbane from 6 to 9 May 2012.

John Kolbe
President

RACP SEGMENTATION STUDY AT CONGRESS 2012: BUILDING THE COLLEGE OF THE FUTURE

As mentioned above in the Letter from the President, the College is about to commence the final stage of the RACP Segmentation Study, designed to better understand what products and services could be delivered to meet the needs of current and future RACP Fellows.

Looking to the future – and the ways in which we might grow and further support our Fellows – is a key priority for the College. Around 450 Fellows were sent an advance invitation to undertake the final stage survey as part of the Segmentation Study in February and March this year, with more than 30% completing the survey to date. This survey was used as the pilot to test the effectiveness and usefulness of the survey, and to ensure we were asking the right questions of our Fellows. We are pleased to report that all participants in the pilot stage provided us with valuable and useful data that will allow the College to understand your needs and perceptions even better.

All Fellows and Advanced Trainees will be receiving their invitation to participate in the final stage during April this year.

The College encourages delegates to visit the College exhibition booth at the RACP Future Directions in Health Congress 2012, being held in Brisbane, 6–9 May, to view the latest real-time indicators from the Segmentation Study and to find out what products and services could be delivered to meet the needs of the Fellowship.

College representatives will also be available to discuss all the latest developments at the College, and to listen to your thoughts and views about how we can work with you to build the College of the future.

Trina Backstrom
Communications Manager
CHALLENGES FOR THE PACIFIC REGION

Dr Teuila Percival, Director of Pacific Health at the University of Auckland, looks at the broad challenges facing the Pacific region into the future, and their impact on health policy and health service delivery in the countries of the region.

Geographic, demographic, economic and social challenges

Geographical isolation, widely scattered populations and limited natural resources are dominant features of the Pacific region. Together with these inherent challenges, the Pacific is experiencing the effects of the recent global financial and economic crises, high fuel and food prices, and the recent climatic disasters and conflict situations. In addition, most countries in the region are lower middle income economies.

Population growth is another major challenge in most Pacific Island countries, with regional growth predicted to increase from the current 9.9 million to 50 million by 2035. However, in contrast, some of the smaller countries (Cook Islands, Nauru, Niue and Tokelau) have shown recent population decline due to emigration, bringing additional social and infrastructure challenges.

Along with population increases, there is rapid urbanisation throughout the Pacific resulting from outer island and rural migration to main population centres. Rapid urbanisation has introduced a host of health and social concerns including child malnutrition, infectious diseases and youth crime.

Inadequate urban services, overcrowding, unemployment and pollution are all testament to the challenge Island governments face in keeping pace with urban migration and the shift from a largely subsistence way of life to cash economies.

Small size, limited domestic markets and dependence on international trade and aid ensure the region is particularly vulnerable to the external economic environment. Some of the smaller, less well-resourced islands are heavily dependent on remittances from overseas family or the exporting of maritime and seasonal agricultural workers. Tonga, for example, averages 35% of GDP from overseas remittances.

Many Pacific Island countries are relatively new and in a transitional phase of political independence. More recently independent are Vanuatu (1980), Tuvalu and Kiribati (1970s), with more established countries like Samoa celebrating 50 years of independence this year.

Economic and demographic transition has not been smooth in the Pacific and has seen the emergence of inequalities in health and social outcomes within countries. The gap between the rich and the poor is growing. Poverty is an ongoing concern in a number of countries, particularly in the urban and peri-urban areas.

National Poverty Needs lines derived from household income and expenditure surveys (HIES) suggest that one in four households and almost one in three of the population in the region are below their respective poverty lines.

At village and household level some of the economic, environmental and social problems in the Pacific are mitigated by the preservation of traditional social structures. These are structures where the importance of family, collectivism, service, and reciprocity are universal values. Following the 2009 tsunami in Samoa, for example, displaced and traumatised families were immediately supported by extended family, and Faifeau (Church Ministers) provided first-line grief counselling. Nevertheless, changing traditional structures, supports and controls are an emerging feature of urban migrant areas, and countries are seeing hitherto uncommon graffiti, youth street gangs and crime.

Health challenges

Basic indicators relating to human health and wellbeing vary dramatically across the region. Infant mortality varies from a high of 53 per 1000 in Papua New Guinea to less than 20 per 1000 in Samoa.

Best available estimates of Life Expectancy are 55–60 years in Melanesian and Micronesian countries and above 70 in the low-mortality countries. Accurate mortality data is a particular problem in the Pacific with Life Expectancy estimates varying by as much as 10 years depending on the source.

In regard to nutrition, the Pacific faces a double burden of nutritional problems, with protein, calorie and micronutrient malnutrition coexisting with rising rates of obesity. With child malnutrition and stunting, most data is limited to demographic health surveys and Multiple Indicator cluster surveys. Latest information here suggests that underweight five-year-old prevalence varies from 1.6% in Tuvalu to 16% in Vanuatu, and our own work with the Pacific Child Health Indicators Project in Samoa and Tonga has shown rising rates of hospitalisation for serious malnutrition in under two year olds.

Immunisation in the Pacific is a public health and health system success, with the majority of countries meeting targets of 90% full immunisation. This is testimony to the huge investment in infrastructure, systems, resources and technical assistance from UNICEF, WHO, Secretariat of the
Growing and sustaining a health workforce to meet the needs of Pacific Island countries and territories is a priority and certainly an area where Australian and New Zealand medical colleagues and colleges could provide very direct and practical support.

Pacific Community (SPC) and AusAid. Exceptions are the bigger countries of Papua New Guinea and Solomon Islands where health service delivery is particularly challenging, and of late, Samoa, where a recent drop in immunisation rates occurred with the change from team outreach and mass community vaccination to individual patient-initiated, clinic-based delivery.

While some countries in the Pacific have made good progress on the Millennium Development Goals (MDGs) (a framework for regional and country development), the same cannot be said of the entire region, and the Pacific would appear to be seriously off track to achieve the MDGs by 2015.7 Melanesian countries still have a long way to go, while for the Polynesian, and to a lesser extent the Micronesian countries, the challenge is to maintain the excellent progress already made.

Of the health-related Millennium Development Goals, reducing maternal mortality (MDG 5) is the one with the least progress in the Pacific. International estimates of Maternal Mortality Ratio (MMR) are largely lacking and reliable maternity mortality data is difficult to obtain, with varying sources and estimation methods. A recent New Zealand Parliamentarians Report into Maternal Mortality in the Pacific8 estimated that five women a day die in the region due to childbirth and pregnancy. The need to address ongoing preventable maternal deaths in the Pacific is compelling. The quality of data that underpins not just the MDGs but health outcomes, mortality and health services in general is limited in a region where a lack of accurate vital statistics and death registrations is the norm rather than the exception. Nonetheless, using what data is available from hospital sources and demographic health surveys, the picture of disparate mortality, educational access and poverty across the region is of concern.

Impact of these factors on health service delivery

Geography, limited resources, developing economies, and demographic and social change provide real challenges to health service delivery and policy makers. Geographical isolation, too, poses a number of difficulties. Populations are often scattered across far-flung islands, increasing absolute costs. Low population densities additionally impede the development of economies of scale.

Providing services is further hampered by shortages of trained health personnel.

Growing and sustaining a health workforce to meet the needs of Pacific Island countries and territories is a priority and certainly an area where Australian and New Zealand medical colleagues and colleges could provide very direct and practical support.

What is being done and what should be done?

In 2008, WHO and SPC's combined 2-1-22 NCD Prevention and Control Programme commenced as a response to the mounting NCD crisis. So far, 18 countries have costed National NCD Action Plans and there have been 74 small country grants for NCD activities.13 However, whereas there is much activity and enthusiasm in Pacific NCD solutions, there is very little evaluation or research into the effectiveness of interventions. In addition, much of this activity is focused on educational strategies for which there is also limited evidence.14

Major health issues facing our Pacific Island neighbours

- Pacific Island countries face the double burden of high rates of communicable and non-communicable diseases (NCDs).
- Infectious diseases, such as pneumonia, gastroenteritis, meningitis and sepsis, which for children are a leading cause of hospitalisation and death.6
- Tuberculosis is a major health concern in the whole region but particularly Micronesia, Kiribati and Papua New Guinea. Latest WHO estimates of sputum smear positive pulmonary TB show the highest rates of 180/100,000 in Kiribati and a regional low of 9/100,000 in Samoa.9
- Multi-drug resistant TB is as high as 11% of new cases in Micronesia and is a focus area of the SPC Surveillance and Technical Assistance Tuberculosis Programme.10
- HIV is uncommon in Polynesian countries but is reaching epidemic proportions in Papua New Guinea, with overall adult population prevalence at 1% and over 30,000 adults and children currently living with HIV/AIDS.11
- Non-communicable diseases are now the leading cause of death in the Pacific. Most Pacific countries have carried out but not necessarily published WHO’s STEPS surveys on non-communicable diseases and risk factors.
- Obesity rates in the region are some of the highest in the world, with adult obesity prevalence as high as 74% in both American Samoa and Tokelau.
- Over half of adults smoke tobacco on a daily basis in Tokelau, Kiribati, Nauru and Wallis & Fortuna.
- Hypertension prevalence exceeds 25% in American Samoa, Cook Islands, Nauru and Wallis & Fortuna.
- Diabetes in the region is of major concern with prevalence averaging around 20% of 25–64 year adults and rates exceeding 40% in American Samoa and Tokelau.12
Strategies and solutions must be multi-layered and receive continuing technical and financial support from international organisations and developed countries. A lack of donor coordination has in the past hampered efforts in the region. This has been addressed through a number of important regional strategies such as the Cairns Compact. There is a move, too, for countries to lead their own development agenda with donor support, with mixed results.

Within the health sector, rather than multiple and sometimes overlapping vertical programs, there is now a shift to fund and develop health governance and infrastructure, allowing sustained local capacity development and ownership over health change.

Attention to an enabling policy framework that works across sectors is also needed in developing countries. The limited resources and human capacity, along with changing social structures and rising inequity, require this.

**Of the important and modifiable determinants of health in the region, education and literacy are a leading priority.**

Information and evidence to support health services, government decision making and policy is another priority.

Of the important and modifiable determinants of health in the region, education and literacy are a leading priority. This was recognised by the recent South Pacific Forum in 2011. Primary school retention in the region is variable but is now attracting additional funding to support educational access and development.

Economic development, employment and income will always be of considerable importance to improving health in the region and remain significant barriers to progress in most countries. Pacific Island country political commitment and leadership is surely one of the most important determinants of health.

There are some outstanding examples of political leadership and vision in the region. Look north to tiny Tuvalu with around 11,000 people scattered over nine remote islands accessible by irregular boat travel. This country has developed a maternal health policy and program which suits their context and saves lives. Every island has a trained midwife and registered nurse. The Government pays for all high-risk pregnancies and primigravida at 36 weeks to travel to Funafuti, the only island with a hospital equipped for obstetric emergencies. The women receive a small daily allowance, enabling them to wait safely on Funafuti until they deliver.

Tuvalu is not a rich country but its government has committed what resources they have to innovative policy and service delivery for its women and babies, addressing their unique geographical and health service challenges.

There are other compelling examples of Pacific Islands developing their own solutions. Reliance on external aid continues but the positive news is that Pacific self-directed health and social development is increasing.

**Dr Teuila Percival QSO FRACP**
Consultant Paediatrician, KidzFirst Childrens Hospital, Auckland
Director of Pacific Health, School of Population Health, University of Auckland

References


As East Timor celebrates 10 years of formal independence this year, it is a poignant time to celebrate the inspirational assistance our Fellows and staff provide in health and education to our Timorese neighbours.

As one of the poorest countries in the Asia-Pacific region, East Timorese people have a life expectancy of 60 years, and 44% are malnourished. Diseases long eradicated in the Western world still affect the wider population and 46% of children aged 0–5 years are underweight for their age.1 Whilst East Timor receives some funding from the Australian Government to try to address these issues, more assistance is needed and thankfully there are Fellows of our College who contribute their time and efforts to assist the Timorese community, utilising their medical skills and charitable nature.

Dr Noel Bayley is one such physician. Based in Warrnambool, Victoria, Dr Bayley has spent the last 10 years visiting East Timor and has been involved in various projects aimed at enhancing the quality of life and health prospects of local communities. Whilst working on a clean water project in the hills of East Timor, Dr Bayley became aware of a large number of people with untreated cardiac disease, mostly due to rheumatic fever originating from early childhood skin infections. As a Cardiologist, Dr Bayley decided to work with Dr Dan Murphy, an American doctor, at the Bairo Pite Clinic in Dili. Together, they concentrated their efforts on diagnosing and arranging surgery for young adults with conditions readily treatable in Australia, but usually fatal due to the lack of resources in East Timor.2 Initially, in some cases, Dr Bayley was funding the cost of flying patients to Melbourne himself; however, in 2010 the Australian public took up the plight of two young Timorese women for whom funding was required and the outpouring of support and public funds was heart-warming. Shortly after, Dr Bayley and his associates created the East Timor Hearts Fund, a medical aid organisation that provides life-saving heart surgery for young East Timorese. With the support of Professor Richard Harper and his team at Southern Health’s Monash Heart, as well as the Royal Melbourne Hospital, the past 12 months has seen the funds bring eight patients to Australia for surgery or procedures such as balloon mitral valvuloplasty. All are now doing well, with another two patients on the way this year.

Paediatric Cardiologist Dr Lance Fong is also familiar with the significant burden of disease amongst the Timorese population. Dr Fong first visited East Timor in 2000, responding to the plight of children in East Timor after independence. On witnessing the high level of congenital or acquired heart disease among these children, Dr Fong approached the Australian organisation ROMAC (Rotary Overseas Medical Aid for Children) to request their support in treating East Timorese children with heart disease in Australia. Subsequently, in 2003, Dr Fong contacted another two patients on the way this year.

RACCP FELLOWS SUPPORT HEALTH AND EDUCATION IN TIMOR

Dr Noel Bayley examines Maria Viegas, aged 17, a young local patient with heart problems (wide open aortic insufficiency and a weakened left ventricle) at Bairo Pite Clinic in Dili, East Timor. Photo Basil Ronaldsen, courtesy of RA Magazine.

cardiac surgeon Mr Andrew Cochrane to outline his work in East Timor. This led to the establishment of paediatric cardiac services as part of ATLASS (Australia Timor Leste Program of Assistance for Specialist Services), a government-funded program run through the Royal Australasian College of Surgeons, which sends teams of medical professionals to Dili and five regional hospitals every year to provide much needed specialist surgical services.3 Whilst Dr Fong is still involved in both ROMAC and ATLASS, he laments that the last three to five years have been tough due to budgetary constraints on Australian Public Hospitals. No longer are our hospitals as willing or able to accept international charity patients. His wish is for the Government to recognise this and support an Open Heart Cardiac Surgical Team for East Timor, similar to those currently operational in the Pacific Islands.

Our Asia-Pacific neighbour also has an appalling maternal and infant mortality rate throughout the country. With maternal mortality 110 times higher than in Australia and infant mortality 9 times higher⁴, East Timor is struggling to cope. Whilst Australian Government funded family planning services have had some impact, reducing the fertility rate from 7.8 to 5.7 children per woman between 2003 and 2009⁵, East Timor is still the fastest growing population in the world, with an average growth of 3.2% between 2005 and 2010.

Addressing this issue is locally run organisation Frontline, which instigated a program which brings a nominated
Children at Asulau Village School, East Timor, are taught by community volunteers as the school receives no support from the government. Photo UNMIT/Martine Perret.

Dr Aida at the mobile health clinic. Dr Aida requested 50 midwife kits in 2010, another 35 were delivered by Vega in 2011 and more are needed for 2012. Photo UNMIT/Martine Perret.

Community member from a rural village to the capital, Dili, to receive three months of intensive training in midwifery. In July 2011, Victorian Medical Education Officer Alexis Marsh travelled with the Frontline team and two United Nations representatives on one of their tri-monthly visits to Asulau, East Timor. When the team arrived to set up their mobile health clinic, there were over 40 women either pregnant, with newborns, or both who were ready for a check-up. These were performed by East Timorese born Dr Aida Goncalves, who undertook medical training in the USA and has returned to assist her community. Infants presented with various medical conditions ranging from fungal infections to heart defects, and those with serious conditions were taken back to Dr Dan’s free clinic in Dili that day for further medical treatment. Alexis was there as a representative of humanitarian tall ship Vega and delivered one of 35 donated midwife kits to the Asulau midwife, Marcelina.

With half of the Timorese population unable to read or write, Vega is also involved in distributing educational supplies to rural schools in East Timor and isolated communities throughout the Maluku Islands of Indonesia. In the 10 weeks Alexis spent aboard the tall ship as a volunteer crew member, she visited many primary and secondary schools distributing donated items. The Alfred Hospital in Melbourne donated over 1000 retractable disposable syringes that Alexis personally delivered to Dr Dan’s clinic in Dili, which were gratefully received.

This article spotlights only a few of our many altruistic Fellows involved in charity work around the world, and it’s important also to recognise and celebrate the amazing work that is done by all of our Fellows, both locally and overseas. The RACP would particularly like to thank Dr Noel Bayley, Dr Lance Fong, Professor Richard Harper and Mr Andrew Cochrane for their dedication to this important work over a long period of time.

For more information on the East Timor Hearts Fund please go to www.easttimorheartsfund.org.au/. Information on ATLASS can be found at www.surgeons.org/government/community-and-international-programs/timor-leste/. For a list of medical supplies needed by Sail Vega for their 2012 mission leaving in July, please contact Alexis at Alexis.Marsh@racp.edu.au or visit www.sailvega.com to see if you or your hospital can assist.

References
5. ibid.
6. ibid.
RENAL MEDICINE IN SAMOA

Samoa is an independent state in the South Pacific. With a colourful political history, Samoa’s population is of mixed ancestry with primarily Samoan Polynesian mix (92.6%), mixed Polynesian and European (7%), and Europeans (0.4%). German and Japanese ancestry is strong from occupation during the two World Wars.

Medicine delivery in Samoa is chiefly through the central government funded (public) Tupua Tamasese Meaole national hospital in the capital Apia. Other small clinics are dotted around the two main islands of Upolu and Savai’i, routinely staffed by registered nurses. The community is well supported by private medical care, with both private general and specialist practitioners and a private hospital (opened in December 1998) with 16 in-patient beds and two well-equipped operating theatres.

Renal disease is prevalent, and is one of the top 10 causes of NCD (non-communicable disease) admissions to the national hospital.

In 2000, with assistance from the overseas aid budget of the NZ Government Ministry of Foreign Affairs (now NZAid), I undertook a sabbatical in Samoa to assess the prevalence of renal disease in the Samoan community. At that time there were approximately 15 patients on peritoneal dialysis in Samoa and another 10 in Auckland on haemodialysis. The cost to the Samoan Government for care in New Zealand was estimated at WST1 million (NZ$0.67 million) per annum. Two main issues were identified: the immediate problem of how to manage those patients already on dialysis; and how to deal with the future growth. The worldwide growth in end-stage kidney failure was beginning to affect the small Samoan state.

I recommended establishing renal health screening in high-risk groups, including an early detection system of proteinuria in patients with diabetes mellitus; early use of ACE inhibitors (ACEi) in such cases; and improved monitoring of glucose control with more widespread acceptance and use of glucose meters. Possible support with funding and training through aid organisations was also suggested. Although some of these actions were in practice, they were neither coordinated through the National Hospital Suka (Diabetes) Clinic uniformly or consistently, nor disseminated across the country.

The four most common reasons for attending my regular three-monthly visiting clinics are: diabetes mellitus and diabetic nephropathy (46%); query about kidney health (22%); nephrolithiasis (7%); hypertension (8%).

I estimated 15,500 diabetics were living in Samoa in 2000 and that, conservatively, nearly 3000 had diabetic nephropathy. An estimate of one new end-stage renal failure patient per week was also calculated. The cost of an appropriate service to all-comers would consume a substantial portion of the Samoan Government health budget and was clearly non-sustainable. Such expenditure would also be at the expense of early detection and prevention programs.

Some time later the Samoan Government secured a favourable agreement with the Singapore National Kidney Foundation (NKF) through which a spectacular 60 patient capacity haemodialysis facility was built and officially opened on 14 March 2005 in Apia. As part of the Samoa NKF strategy of a pre-dialysis management system, a clinic was established encouraging local practitioners to refer to the clinic when the serum creatinine was above 400μmol/L. The same clinic has the responsibility to manage the early management of diabetic nephropathy and delay progression of renal failure with standard interventions.

The WHO STEPS survey instigated in Samoa in 2002 was charged to investigate the prevalence of the key NCDs and their risk factors: 2817 people (approximately 1.5% population sample size) were surveyed (with representative groups from villages in rural and urban Samoa). Diabetes mellitus had now risen to epidemic proportions: with 23.1% prevalence in the sample population (male 22.9%, and female 23.3%). This was a doubling of the prevalence indicated in a 1995 survey. These increments were paralleled by an increase in obesity. Three major NCDs and modern-world health risks were shown to be escalating in prevalence in Samoa: obesity, diabetes and hypertension, all fuel to the renal failure fire.

The four most common reasons for attending my regular three-monthly visiting clinics are: diabetes mellitus and diabetic nephropathy (46%); query about kidney health (22%); nephrolithiasis (7%); hypertension (8%). The frequency of glomerulonephritis in Samoa is not documented as there is no general screening process, and no on-island renal biopsy facility. Occasionally Samoans will travel to New Zealand for renal biopsy and definitive management, but most are managed in Samoa with empirical treatment: 45% of consultations are new patients; the remainder are patients returning for further management and monitoring. Many patients are shared with their regular practitioners, but some still use the visiting specialist as their main medical caregiver.

Over the past decade significant improvements in the delivery of care for renal NCD has been observed. In 2000 the number of patients in the public diabetic clinic or in the community on ACEi was less than 70%. Now over 90% of diabetics I see are prescribed an ACEi or ARB (angiotensin receptor blocker) where indicated. Glucose monitoring at home was rare, and monitors were often no longer used once the life of the first battery expired. Approximately 15% of patients in my clinics who are not on insulin are now monitoring their glucose throughout the day several days per week. All medications are imported. They are expensive, and many cheaper generic options from low-cost (non R&D) production firms (mostly in India) are the major source for medications. Restupply of medications can be erratic, and this only worsens compliance. Families are extended around the globe, especially in Australia, New Zealand and the West Coast of the United States, and frequently family members will use their own resources to source medications from these overseas nations to ensure regular use.

The National Kidney Foundation – operating for seven years – has screened for renal disease over the past five years. Community-based screening in villages and churches and, more recently, government and corporate screening (at their employees’ place of work) has identified a
substantial renal-potential disease profile within the community. Screening involves blood pressure, finger-prick glucose, serum creatinine, urine dipstick (for blood, protein and glucose), BMI and percentage body fat. Of 1252 people (corporate and government employee subjects) screened in the 12 months to June 2011, 22% had both haematuria and proteinuria, and a further 32% had isolated haematuria. On retesting and further analysis (43% of them responded to an invitation for retest), 41 responders were found to have persisting renal pathology – CKD3-5 (eGFR < 60ml/min/1.73m² body surface area), or urine abnormality. If we assume that the corporate population screened is representative of the general population, and extrapolate this prevalence across both responders and non-responders, then the prevalence of renal abnormality in the general population of Samoa is approximately 9.4%.

These screening programs are the main source of patients (currently 106) seen in the NKF pre-dialysis CKD clinic.

A closer look at the end-stage renal failure (ESRF) statistics, presenting for renal replacement therapy (haemodialysis is the only modality offered in Samoa at present), reveals an incidence of one patient per week, consistent with my predicted estimates 12 years ago, and an incidence of new ESRF of 278 per million population (pmp) in Samoa, compared with 107 pmp (Australia) and 131 pmp (NZ).

Inroads to early detection of renal disease and health have been made; however, there is still much work to do. A shortage of both people and expertise has limited more in-depth work and broader community involvement in the screening program.

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1. Based on prevalence of diabetes in the Samoan population statistics within the NZ community (1999) and Samoan Government estimates of that time. Detailed statistics and calculations available on request.

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From the traditional rural Solomon Islands to the more modern sophistication of Rarotonga and from the peaceful isolation of Niue to the vibrancy of cosmopolitan South Auckland, represents a broad spectrum of Pacific lifestyle experienced as a physician working in the Pacific region over the past 35 years.

Having trained in the concrete jungles of London, Birmingham and Manchester, I first visited New Zealand in 1976 with my wife Jo, a physiotherapist. Impressed by the lifestyle, we bonded ourselves enthusiastically to the Auckland Health Board and commenced a long allegiance with South Auckland, and Middlemore Hospital in particular. At Middlemore, staff and patients alike represented, both then and now, a rainbow mix of colours and cultures with a large component originating from the various Pacific Islands.

On obtaining my Australasian medical fellowship in 1982, I deviated from the conventional career route, experiencing an instructive year in women’s health and neonatal paediatrics in Middlemore’s O&G Unit before signing up for a five-year stint at Helena Goldie Hospital in Munda, at the confluence of the Roviana and Vonavona lagoons in the rural Western Solomon’s.

In the absence of other expatriates this was, by necessity, a deep-immersion cultural experience! Dr John Kere, the Solomon Islands’ first Fijian-trained medical practitioner, provided a rapid induction course in the management of the principal maladies, whilst the local people taught us their Roviana language and customs including basic plantation and more advanced spear fishing skills. Paediatric and infectious diseases, particularly malaria, made up a greater part of the medical workload, but interestingly, there was little evidence of the lifestyle non-communicable diseases (NCDs) that comprise so much of the workload for physicians in modern-day Auckland, Rarotonga and Niue – despite the dietary habit of eating (in the evening) until fully sated. This traditional Melanesian and Polynesian custom was better suited to a fish, tuber and fruit-based diet than the more sedentary lifestyle and the high fat/energy/salt foods that have tended to replace it.

In a cross-sectional survey of 1500 adults living in the two villages of Munda...
and Paradise, which we conducted in 1985, the mean body mass index (BMI) was 25kg/m² for men and 28kg/m² for women, and the prevalence of abnormal glucose tolerance was below 1%! By contrast, the mean BMI calculated for 600 NCD clinic attendees in a recent survey at Rarotonga was 37kg/m², a situation mirrored in Manukau, where Pacific people have in excess of a 25% lifetime risk of developing diabetes.

Village life in the Western Solomon’s was often centred around the church and the soccer pitch. Education was locally available up to the mid-teens, though further study required moving to Honiara. There was no crime (and therefore no police), and no locks. However, there was a pervasive, supportive altruism, compassion and sharing – and it was only family ties that eventually pulled us back to Auckland.

Returning to Middlemore in 1989, there were ongoing opportunities to maintain Pacific Island links, but with the Polynesian Cook Islands and Niue rather than Melanesia. One quarter of the half million people served by the Counties Manukau District Health Board (CMDHB) today are of Pacific Island origin. Of these, the 20,000 Cook Islanders and 8000 Niueans outnumber those still resident in the Cook Islands and Niue (15,000 and 1500 respectively). A strong link has therefore been forged in Adult General Medicine between Middlemore and these two countries, all of whose citizens are automatically New Zealand residents, and between whose populations, at home and in Manukau, there is considerable overlap, both in the people involved and with the medical problems encountered. The emphasis of these links has been to support ongoing treatment and management of Adult General Medicine patients in the Cook Islands and Niue, but to facilitate transfer to Middlemore when additional tertiary level intervention such as specialised imaging or subspecialty input for renal biopsies/dialysis, coronary angiography/revascularisation is required.

All three populations – in Manukau, Niue and the Cook Islands – face similar health challenges, largely driven by changed lifestyle practices, leading to the diabetes and hypertension that result in renal failure and cardiovascular disease, heart failure and stroke. Fifty of the five hundred dialysis patients at Middlemore are of Cook Island origin. Smoking-related emphysema and the infectious toll of post-streptococcal rheumatic heart disease pose additional challenges.

Following in the footsteps of Dr Tim Cundy who initiated a link between Auckland and Rarotonga some 20 years ago, I have provided collegial support by telephone and email to the local medical staff over the past 15 years and, by putting aside some annual leave for regular NZAID supported visits, have participated in shared clinical reviews and triage sessions. Such visits include not only the main centres of Rarotonga and Alofi, but also the outer islands, from Mangaia to Manihiki and from Pukapuka to Palmerston. Other Middlemore physicians have established similar links with Fiji and Samoa.

As Cook Islanders do comprise 10% of Middlemore’s 500 renal dialysis patients, the setting up of a local dialysis unit at Rarotonga has been periodically discussed with the Middlemore nephrologists, but the skill infrastructure required mandates retaining the service in Auckland, at least for haemodialysis. The peritoneal modality can be supported locally but the freight charges can be prohibitive.

Another more unique problem encountered is Ciguatera poisoning from the Rarotongan lagoon fish. Although the majority of such cases comprise mild self-limiting sensory inversion, recurrent episodes can, and do, result in more severe neurological deficits. While Ciguatera poisoning has been a long-established hazard (there is an early description of the clinical manifestations in the logbooks of Captain Cook), there is increasing focus on reducing contamination of the lagoon areas.

Still, to visit is also to share and learn, and one pearl that is a common denominator for traditional Melanesians at Munda, as well as more modern Polynesians in Rarotonga/Niue, is the health benefit of the kindness, compassion and happiness within families and communities, which enhances the quality of life led in the ‘Pacific way’. In the Pacific, families care for their own at all ages, above all else. There are lessons for all of us to take from the unique values of Pacific life, and it has been a privilege to be able to share in some of these.

Dr Bob Eason FRACP
General Physician
Middlemore Hospital, South Auckland
bobeason@ihug.co.nz

Reference
In 1935. An early interest in public health saw him acquire the DPH diploma in 1938, which set him on the public health pathway which he was destined to follow. In 1939 he was awarded an MD by the University of London.

Professor Dixon’s connections with New Zealand began in 1942 when he responded to an advertisement for the position of Medical Officer of Health in Northland. Here he spent three years practising what he describes as ‘shoe leather medicine’. He travelled extensively around the region, creating Northland’s first chest medicine service. Tuberculosis was endemic within the predominantly Maori population and he set up TB wards in all of the smaller regional centres within Northland.

In 1947 he returned to England and as he had no immediate prospects he volunteered to join a British army deployment to North Africa. Fortuitously, in the greater scheme of things, he arrived in the middle of a smallpox epidemic. It was here that his interest in smallpox burgeoned, and this experience led to his first significant publication on smallpox, ‘Smallpox in Tripolitania: an epidemiological and clinical study of 500 cases, including trials in penicillin treatment’ (Cambridge 1948). On his return to England, after a year in North Africa, he was appointed Reader in Epidemiology at Leeds University Medical School. Here he continued to research the disease and published ‘The diagnosis of smallpox’ in 1951. During his time in Leeds, which he left in 1959, he became a much sought after authority on smallpox and was appointed as a consultant on smallpox to the UK Ministry of Health. Much of the work on his definitive book was done during this time.

In 1959, Professor Dixon’s connection with New Zealand was re-established when he was appointed to the chair of Preventive and Social Medicine at the University of Otago where he remained until his retirement in 1976 at the age of 63. He found a department that was small and somewhat rundown, and he brought a very different perspective to the University. He was a man with a focus on health systems, in terms of organisation, planning and evaluation. Many believe that the whole development of health workforce planning and its impact on academia in terms of training places in medicine and dentistry go back to Professor Dixon’s early days in this role.

Under him, the department grew to 10–14 teaching staff, and a range of programs were developed.

Cyril and his wife, Jean, retired to the ‘Winterless North’ of Whangarei where he had worked briefly in the 1940s. Those of us who live here thoroughly approve of Jean’s decision that she and Cyril should retire to ‘somewhere warm’. Not content to sit back and contemplate a career of great eminence, Cyril gave 13 further years to the local family planning service. Jean and Cyril have four sons and a daughter. Considering Cyril’s early dalliance with engineering and the subsequent career choice of engineering by three of his sons, we can only wonder what engineering marvels he would have been responsible for had he not been deflected from that trajectory by his father.

We are honoured to have such a man living in our community, and, with the Fellowship, wish to congratulate him for achieving his one hundredth birthday and for a lifetime’s contribution to ensuring the wellbeing of the countless who might otherwise have succumbed to smallpox. To celebrate this milestone birthday, Cyril was awarded, on behalf of the Australasian Faculty of Public Health Medicine, a Faculty tie and letters signed by Faculty President, Associate Professor Leena Gupta, and the New Zealand College President, Dr Johan Morreau.

Dr Roger Tuck FRACP
Paediatrician
Whangarei, Northland, New Zealand

If you know of other Fellows who have reached or almost reached this auspicious birthday, please contact Kathryn Lamberton at racpnews@racp.edu.au.
CONSENSUS STATEMENT: MEDICAL PROFESSIONALISM

MEDICAL PROFESSIONALISM IN A CHANGING CONTEXT: BEYOND SPECIALTIES; BEYOND BORDERS

A profession is defined as:

An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics, and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly of the use of its knowledge base, and the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.

Based on a definition of a profession proposed by Geoffrey Davies the medical profession also has a duty, individually and collectively, to put the interests of patients ahead of those of the individual practitioner, of the profession and of other bodies. Ancillary to that duty is a wider duty to existing and future patients generally. These are duties of public service.

Traditionally, characteristics of medical professionalism involve a duty to patients that embodies professional competence and performance and includes:

- Honesty and integrity
- Confidentiality
- Altruism
- Respect and compassion.

The context in which the practice of medicine occurs has changed significantly in the 21st century. Changes in recent times include increasing societal expectations of the profession; advances in information technology; changing models of care and increasing demands on health care systems in the context of finite resources.

Contemporary medical professionalism must also include:

- Demonstration of continuing professional development and lifelong learning
- Maintenance of patient confidentiality and professional boundaries
- Clinical leadership, including health advocacy
- Intra and inter-professional communication team skills
- Responsibility for one’s health and fitness to practise
- A collective duty to meet societal needs.

Intrinsic and extrinsic factors impact on professional performance. The use of professional development tools, including frameworks that describe professional behavior, assist doctors to enhance their performance.

The attributes of professionalism and their application to medical practice require continual review as evidence of the commitment of the profession to the health and well being of society.

In the 21st century the characteristics of medical professionalism continue to be applicable to all doctors and are grounded in a duty to individuals and society.

References
2012 MEETINGS OF THE TRIPARTITE ALLIANCE – RACP, RACS & RCPSC

In 2009, as part of the Statement of Strategic Intent (SOSI), the College made the decision to work more closely with the Royal Australasian College of Surgeons (RACS) and the Royal College of Physicians & Surgeons of Canada (RCPSC), concentrating mainly on medical education issues where collaborative work could benefit all three Colleges. This Tripartite Alliance has progressed and strengthened over the past three years.

In February this year the Tripartite Alliance hosted a program of three meetings in Melbourne to expand on the work begun at their Sydney meeting in 2011.

On Monday, 27 February, representatives of the three Colleges met at the RACS offices in Melbourne to develop a Learning Management Strategy (LMS) which may be used by the Colleges for both ‘training’ and lifelong education. As defined by the group, ‘a Learning Management Strategy guides Fellows and trainees, educators and regulators by providing a comprehensive framework containing standards, tools, assessments and approaches to encourage management of individual ongoing professional development for all stages of one’s career within individual scopes of practice’. While this definition requires some refinement, it contains most of the key elements of an LMS.

By the end of the day, with the assistance of the facilitator, the group had agreed five principles which will form the basis for a well-defined Learning Management Strategy. These principles are:

1. Recognises stages and transitions in the medical career
2. Aligned to competency and performance
3. Aligned with the scope of practice
4. Capable of assessment
5. Based in contemporary learning principles and modalities.

The overarching philosophy of the LMS is of improved performance leading to better outcomes for patients and the community. Although yet to be determined, some ways that the LMS may be used by the RACP include:

- as a guide to the development of a College Learning Management Plan
- to guide individual Fellows in their learning
- as one of the benefits Fellows obtain from their membership of the College
- to guide RACP educators/supervisors
- to guide the choice of (external) partners
- to convince regulators that the

Colleges are satisfying community expectations and discharging our responsibilities with respect to a degree of self-regulation and autonomy, in light of the privileges conferred.

The Tuesday meeting continued the successful format of the inaugural Medical Education Seminar workshops in Sydney last year. Thirty-six Fellows, trainees and staff again participated in these workshops on Professionalism, Workplace Based Assessment, and Judgment & Clinical Decision Making. Collaborative work had continued in their respective areas through teleconferences and emails over the past year and each reported on the outcomes achieved for the three Colleges.

The Professionalism Group finalised the Consensus Statement on Medical Professionalism in the 21st Century. This statement was presented at the Conjoint Medical Education Seminar on the last day and the three Colleges discussed the alignment of current College initiatives with this document. The Consensus Statement is reproduced on the page opposite and can also be viewed on the College website. The statement and an accompanying editorial will also be published in the RACS and RCPSC journals and on their websites.

The Workplace Based Assessment Group completed and presented its review of this broad topic at the Seminar, and now plan to focus on workplace based assessment to assess ‘professionalism’ competencies. The Judgment & Clinical Decision Making Group produced a schematic on clinical decision making to guide trainees and educators, which is being developed further before release.

The Conjoint Medical Education Seminar was a new initiative and perhaps the most tangible outcome from the Tripartite Alliance. This one-day conference, held at the Hilton on the Park Melbourne, was open to the medical community and attended by over 200 participants. The theme was ‘The Medical Professional in the 21st Century: Competent, Fit and Safe’, and the topics of the sessions aligned with the conference theme: ‘Challenge of Professionalism’, ‘The Competent Professional’, ‘The Fit Professional’ and ‘The Safe Professional’.

Keynote speakers included Sir Liam Donaldson, Chairman of the National Patient Safety Agency in London; Professor Linda Snell, Professor of Medicine at McGill University in Canada; Dr Kieran Le
Speakers at the Conjoint Medical Education Seminar
Professor Linda Snell, Professor of Medicine, Centre for Medical Education, McGill University Canada; Dr Kieran Le Plastrier, Psychiatry Registrar, Director, G7 Medical Consulting, Australia; Professor Clifford Hughes AO, CEO, Clinical Excellence Commission, NSW

The College is undertaking two projects to enhance supervisors’ professional development, in collaboration with supervisors, through committees and working groups. These projects are:

• The Supervisors Professional Development Program – a multi-module education program based on ‘Teaching on the Run’ – which will be conducted throughout Australia and New Zealand (in development from 2011; launching in early 2013)

• Supervision Policy – a project that will underpin future education programs through accreditation and recognition of prior learning and redefine the current models of supervision and support for supervisors, including recruitment, retention, rewards and recognition (in development now; launching in late 2013).

These projects will be underpinned by rigorous research and evaluation processes as well as the input of Fellows. Please visit the Supervisor Support site on the College website to keep in touch with news about these projects.

Plastrier, Psychiatry Registrar and Director of G7 Medical Consulting; and Professor Clifford Hughes AO, Chief Executive Officer of the NSW Clinical Excellence Commission. The ‘wrap-up’ plenary was given by Professor Ron Paterson. All sessions were recorded and will be available in podcast/virtual conference format for Fellows of the three Colleges.

Attendees at the conference commented on the high level of experience of the speakers and ‘discussants’ and the particular relevance of the theme for the medical community in the 21st century.

The advisory group managing the Tripartite Alliance met with participants to evaluate the progress of the collaborative process over the previous 12 months, as well as the outcomes from the Melbourne program. The group agreed that the Tripartite Alliance had produced positive results for each of the Colleges through meaningful discussions in areas of mutual interest, the development of useful tools and the building of strong relationships between Fellows and staff across the Colleges.

A further meeting of the Tripartite Alliance will take place in October 2012 during the Institute for Clinical Research Education (ICRE) meeting and a further seminar on a different aspect of ‘The Medical Professional in the 21st Century’ is planned for March 2013, when the meeting will be hosted again in Sydney.

Professor John Kolbe
President
NEW – PROGRESSION THROUGH TRAINING POLICY

The Progression through Training Policy is an important step in the development of a suite of education policies that reflect the College’s commitment to high-quality training and education. In order to produce exemplary medical specialists who display the highest standards of knowledge, skills and professionalism, the College must ensure that trainees meet each required standard before they progress to the next stage of training.

The new Progression through Training Policy defines the requirements for trainees and Fellows enrolled in all College training programs to progress in training. The policy details the requirements for prospective approval of training periods, certification of training, completion of training requirements, summative examination assessments, and satisfactory completion of an entire training program.

The policy was developed using the new education policy development model, which included extensive consultation and peer review. The peer review process ensured the representation of views from the full diversity of Fellows and trainees within the College, and allowed for a robust policy to be developed for the benefit of all. The process of peer review comprised:

- consideration of all research findings and feedback gained from the consultation process
- review of the policy assumptions, clarity and logic of writing, structure and appropriateness of policy terms and items
- creation of the final version of the policy, including frameworks for implementation and communication.

The full policy document, an ‘at a glance’ guide, and frequently asked questions are available on the College’s website at: www.racp.edu.au/page/education-policies.

Highlights of the policy include:

- Short-term training periods (less than one continuous month) undertaken – at full-time are not recommended and may not be approved
  - at part-time are not eligible for approval.

- Trainees are responsible for ensuring that all training requirements are satisfactorily completed within a given training period or prior to completion of the entire program.

- Training will be certified if the trainee has satisfactorily completed all training requirements for that period, the supervisor has confirmed that the trainee’s performance has been adequate for the level of training, and the trainee’s financial obligations to the College have been met.

- All training periods not satisfactorily completed by the relevant deadline or during an agreed extension period will not be eligible for certification.

- There are time limits and/or limits to the number of attempts taken to complete summative examination assessments across the Divisions, Faculties and Chapters. The full policy document and frequently asked questions provide further information.

- Trainees who have not passed both Divisional Examinations are required to continue to work in an accredited Basic Training site and complete training requirements, under supervision, unless they have applied for and been granted an interruption in their training.

- Conditional Advanced Training will be discontinued. Basic Trainees who have completed Basic Training time and not passed both Divisional Examinations are not eligible to apply for entry into an Advanced Training program.

- Trainees whose training has been involuntarily discontinued because of failure to progress are not eligible to re-enrol in any College training program.

The College will support trainees during the implementation of this new policy and there will be consideration of exceptional circumstances in accordance with the policy.

The College expects that this clear articulation of requirements around progress in training will provide a useful framework for all parties involved in physician training. The policy also delivers an additional mechanism to facilitate the early identification of trainees who may be experiencing difficulty, in order to outline the avenues of support for trainees in their progress through training.

A range of communications around this policy and how it will be implemented are currently occurring across the College.

Dr Jonathan Christiansen
Chair, Peer Review Working Group for the Progression through Training Policy

Holly Moraes and Rebecca Udemans
Education Policy and AMC Accreditation

The College Education Committee is pleased to announce approval of the Progression through Training Policy, which will come into effect on 1 January 2013.

The College Education Committee is pleased to announce approval of the Progression through Training Policy, which will come into effect on 1 January 2013.
February marked an exciting start for 2012 for 24 Advanced Trainees as they attended the beginning of the NSW Clinical Practice Improvement (CPI) Pilot Program sponsored by the NSW State Office. The CPI Training Program is an established training program of the Clinical Excellence Commission (CEC) and is led by the Directorate of Clinical Leadership Development and Training, led by Ms Bernie Harrison, with Ms Cathy Vinters acting as CPI program manager. The program opened with a two-day workshop on 24 and 25 February delivered by representatives from the CEC. This interactive workshop not only gave the trainees a more in-depth understanding of CPI, but also offered them an opportunity to learn about the formulation and execution of a successful clinical practice improvement project.

During this workshop the trainees addressed several topics that will assist them as they construct their research projects, including quality improvement (QI) methodology, QI tools and techniques for approaching a clinical challenge, measurement for improvement, teamwork and leadership, change at the level of microsystems, and sustaining change. Over the course of the workshop trainees brainstormed as teams and developed their pre-chosen project ideas in an environment that allowed them to effectively apply the methodologies just learned. Initial feedback from this workshop has been positive, with approximately 90% of respondents reporting that, as a result of the workshop, their confidence in completing a project has increased, with 100% of respondents reporting that the CPI workshop proved useful in building confidence in improving healthcare processes.

As 2012 progresses, trainees will be able to use a specific CPI website developed by the CEC to gain a deeper appreciation of the importance of CPI in a physician’s clinical environment, while also providing a place to network with the other participating trainees as they all strive to complete their CPI research projects prior to the end of the year. Many resources will be available to participants via this website to assist with research, data collection and data analysis, such as quality measurement data collection tools, an example of a project Gantt chart and a worksheet to keep each trainee on track with their outcomes and expectations. Additionally, the website will host many CPI interactive modules which will increase each participant’s understanding of CPI.

A goal of submitting a project of publishable quality by 15 January 2013 has been set for each trainee. To that end, it is the hope of the College and the CEC that these projects will be finalised by 31 December 2012. Throughout the year, trainees may draw on several sources of support, apart from the online module, including NSW State Office staff, CEC staff, their own supervisors and other trainees participating in the program. Trainees will also receive continuing support throughout the year by having direct access to several key physicians well versed in CPI, as well as structured mid-year and end-year reviews to ensure that each person’s project is progressing.

The NSW State Office is very excited about this pilot program and wishes to thank Professor Richard Doherty, Dr Marie-Louise Stokes and Associate Professor Martin Veysey from the College for their assistance in the planning process, as well as Ms Bernie Harrison, Ms Cathy Vinters, Dr Kim Oates, Dr Peter Kennedy and Dr Jonny Taitz from the CEC for planning assistance, delivery of the two-day workshop and ongoing trainee project support. This pilot program will be reviewed as 2012 progresses and a decision regarding the continuation of the program in the future will be made later in the year.

Thank you to all the Advanced Trainees who are participating in this program. Both the College and the CEC have every confidence that your projects will be successful and a benefit to clinical practice improvement in NSW. I can be contacted with any queries regarding this program at tamsen.maher@racp.edu.au.

Tamsen Maher
NSW State Manager
COLLEGE MAKING SOUND PROGRESS AGAINST AMC ACCREDITATION STANDARDS

What is AMC Accreditation?
The Australian Medical Council (AMC) has assessed and accredited specialist medical education and training and professional development programs since its introduction as a voluntary quality improvement process in 2002. From 1 July 2010, the process has been mandatory with the AMC now acting as an external accreditation entity for the purposes of the Health Practitioner Regulation National Law Act 2009.

AMC processes involve both accreditation (validating that standards are met) and peer review. The standards relate to the context of education and training, the outcomes of the training program, curriculum content, teaching and learning methods, assessment of learning, monitoring and evaluation, issues relating to trainees, delivery of educational resources and continuing professional development.

The approach is consultative and the training organisation under review is provided with advice and feedback on its training program, curriculum content, based on the curriculum, the pleasing evidence of trainee and supervisor support, and the finalisation of governance work by the College. There are no areas of concern. The AMC commends the RACP’s strong, clear report.

The AMC has confirmed that six recommendations have been satisfied and no longer require reporting. These include those relating to development of the College’s Recognition of Prior Learning Policy, blueprinting process for the Divisional Examinations, and Accreditation of Training Settings Policy. This is an excellent achievement, although work will continue in some of these areas.

It is extremely encouraging to note there are no new areas of concern for the AMC. This is a considerable improvement since the first accreditation review of the RACP in 2002 and reflects the breadth and speed of the educational reform which has occurred within the College. The sustained effort of College leaders, the Fellowship, supervisors, trainees and staff in effecting this change is to be congratulated.

A further 32 recommendations continue to require ongoing reporting. Aspects of RACP education programs that have been highlighted for progress reporting in 2012 include the External Review of Formative and Summative Assessments, support for supervision in rural and remote areas, consequences of non-completion of formative assessments, selection into training policy, implementation of supervisor training courses, and utilisation of the guidelines for retraining and remediation of Fellows who are underperforming.

What is happening in 2012?
The College is required to submit a progress report for 2012 in September this year. Planning and monitoring strategies are in place to facilitate continued progress in the RACP’s approach to education and training and to ensure that AMC recommendations and standards are addressed in 2012.

All College submissions to the AMC are available on the College website. For further information please contact AMC Accreditation staff via amc@racp.edu.au.

Julie Gustavs
Manager, Educational Development, Research and Evaluation

Rebecca Udemans and Holly Moraes
Executive Officers, Education Policy and AMC Accreditation

RACP FUTURE DIRECTIONS IN HEALTH CONGRESS 2012
06 – 09 May 2012 Brisbane Queensland Brisbane Convention & Exhibition Centre

WANT TO KNOW ABOUT SUPPORTING PHYSICIANS’ PROFESSIONALISM & PERFORMANCE (SPPP)?

The official launch of the SPPP Guide and the SPPP session will be held at Congress on Monday, 7 May, 3.45 – 4.00pm and 4:00 – 5:30pm respectively (Mezzanine 1 at the Brisbane Convention & Exhibition Centre).

President John Kolbe will launch the SPPP Guide and the SPPP session will be facilitated by Dr Grant Phelps and Dr Sarah Dalton, Co-Chairs of the SPPP Executive. The session will explore the practical applications of the SPPP Guide and its usefulness as a self-reflection tool. Also, the results and feedback from the SPPP pilot study (conducted throughout February and March 2012) will be presented by the pilot study project leads. The session will provide an opportunity for Fellows and trainees to develop a greater understanding of the SPPP Guide, the benefits of utilising the SPPP framework and the ongoing evolution of the SPPP project.


To access the electronic version of the SPPP Guide via the RACP website: www.racp.edu.au/page/sppp. For additional information or to provide feedback regarding the SPPP Guide, please contact Fiona Hilton, SPPP Project Manager, via phone +61 3 9827 7708 or email sppp@racp.edu.au.
RISK MANAGEMENT AND THE COLLEGE

Before we start talking about risk management, let’s take a moment to consider what we mean by ‘risk’. In the context of the RACP, a risk is anything about which there is uncertainty, and which affects the College’s chances of achieving our stated objectives.

Simply put, risk management is a process intended to allow the College to identify potential barriers to the achievement of our objectives, and to decide:

- how likely they are to arise
- what their effects may be
- whether we can accept those consequences, and
- what we can do to limit either the likelihood or the effect if we cannot.

The process involves communication with the persons involved in College processes (Fellows, College bodies, staff, various levels of government), to identify contributing or mitigating factors, and obtaining ‘buy in’ to improve the chances of successful treatment of the risk.

The Board has recognised that effective management of risk is central to the achievement of the College’s strategic goals. To achieve this, the College must have a current, correct and comprehensive understanding of the potential barriers to success, and a means of differentiating a roadblock from a speed hump or a bump in the road. By understanding what risks we face, and treating those which we feel have undesirable effects, the College will be better informed, more decisive, and function with increased confidence to achieve our goals, and can also provide greater certainty and security for Fellows, employees, regulators, and all stakeholders.

Risk management does not differ greatly from differential diagnosis in clinical medicine, as can be seen from the table below.

Managing risk is a part of daily life, one of which we are not even conscious. Think about crossing the road: where and when you cross, and whether to cross at all, are risk management decisions, weighing the convenience of a shorter walk against the likelihood and consequences of being struck by a vehicle. In the same way, every person involved in the running of the College makes countless daily decisions which affect the achievement of the College’s objectives.

Most of us would think of the College as conservative and risk averse, yet our decisions can affect the livelihood of individuals (assessments) and the ability of hospitals to attract staff and provide care to patients (training site accreditation). These are hardly ‘low risk’! We have always had processes in place to reduce the likelihood of an incorrect decision or limit the effects of an error, but we are working to improve these through a more systematic approach. To this end, the Board has approved the creation of a College Risk Management Committee, supported by a Risk Officer. A Risk Management Policy and framework, and by-laws for the Committee have been approved. Stay tuned for more thrilling announcements!

Iain Muir
Risk and Compliance Manager

<table>
<thead>
<tr>
<th>Differential Diagnosis</th>
<th>Risk Management</th>
<th>Example</th>
</tr>
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<tbody>
<tr>
<td>Document the symptoms</td>
<td>Identify the risk</td>
<td>Two days before the clinical examination, the airline pilots’ union calls a three-day work stoppage.</td>
</tr>
<tr>
<td>Identify potential environmental and other factors contributing to the condition</td>
<td>Define the context and boundaries within which the College operates, and what levels of risk we will accept</td>
<td>The clinical examinations are a key activity of Education Services of the College, and require months of planning and arrangement to run smoothly and simultaneously in multiple locations. The Australian Medical Council may question our professionalism and suitability to act as trainers of specialist medical practitioners if the examinations did not run smoothly.</td>
</tr>
<tr>
<td>Review key information about the condition</td>
<td>Analyse the situation, identify the likely consequences, and estimate the likelihood of the risk eventuating</td>
<td>Cancellation or postponement of the examinations would have financial, reputational and logistical repercussions, which would be unacceptable.</td>
</tr>
</tbody>
</table>
| Review alternative treatments | Review options for managing the risk | We could:
  - announce that there may be a delay (using which channels?)
  - arrange alternative transport for examiners. |
| Communicate with the patient, their family (the community) and other stakeholders as necessary to gather information and ensure the effectiveness of treatment | Communicate with Fellows, College staff, health authorities and other stakeholders as necessary to gather information and ensure the design of effective responses to the risk | The Chair of the Assessment Committee contacts:
  - the College to check on the travel policy and preferred travel suppliers
  - a sample of examiners to assess their response to a change in travel plans. |
| Decide on a treatment | Decide on a treatment | Alternative means of transport are identified, bookings are made, and details communicated to examiners. |
| Monitor the patient’s response and revise treatment if necessary | Monitor the College’s risks and revise treatment if necessary | The College Assessments staff provides scheduled updates to the Committee and College management on the numbers of examiners contacted and confirmed to be aware of the new travel arrangements. |
DR SERGIO DIEZ ALVAREZ, AMA SUPervisor OF THE YEAR

General medicine physician and Fellow of the Royal Australasian College of Physicians Dr Sergio Diez Alvarez has been recognised for his outstanding contribution to trainees in the hospital setting.

Dr Sergio Diez Alvarez, a Spanish born, South African trained physician who completed the overseas trained pathway through the RACP, was presented with the Australian Medical Association (AMA) Supervisor of the Year award at a national awards ceremony in March.

Dr Diez Alvarez was nominated for his contribution to other staff at the Coffs Harbour Health Campus, where he operates as Director Medical Assessment Unit & CAPACS. Dr Diez Alvarez was recognised for fostering a collegiate environment and for going out of his way to ensure training opportunities are available for staff. As a Director of Physician Education and a member of the RACP New South Wales State Committee, Dr Diez Alvarez has a strong involvement with trainee education in both the hospital and College setting.

According to Dr Diez Alvarez, good supervision and mentorship lead to trainees reaching their full potential. ‘The role of the supervisor is to help trainees, to share in their clinical success and to guide them through times of difficulty,’ Dr Diez Alvarez said. ‘All trainees have the potential to be great clinicians; we just help them to achieve their goals through gentle guidance.’ Associate Professor of Clinical Medicine at the University of New England and Senior Lecturer at UNSW, Dr Diez Alvarez said he was humbled by the nomination. ‘I am pleased that the AMA has supported this peer nominated award, as it highlights the need for excellence in supervision.

‘The motivation for the pursuit of excellence comes not from awards, but from the experience of being a supervisor and a mentor to our colleagues. A passion to help others underpins everything we do in medicine, and this extends to excellence in mentoring our junior staff to themselves become the best they can be.’

Dr Diez Alvarez credits his experience as an overseas trained physician to fostering a deeper understanding of the challenges trainees face in the complex field of medicine. ‘Emigration to another country is always going to be a life-changing decision. The trepidation felt is compounded by having to adjust to a health system that may be different to the one you trained in.

‘Some people have the added complication of having left their family behind and may have come to Australia with minimal local support structure in place and with a background that may be very different culturally.’

Dr Diez Alvarez credits his transition into Australian life with the three years spent in Armidale, allowing him to integrate into the community. ‘I was under peer review supervision myself in Armidale for one year under the OTP pathway and learnt the value of supportive supervision from colleagues. I now use all these learnt tools to encourage trainees who may be new to Australia, as is often the case in regional and rural centres. We become their family and support structure and they are very thankful for this. It is very rewarding.’

RACP President Professor John Kolbe said the contributions of supervisors like Dr Diez Alvarez are an immeasurable investment in the healthcare system. ‘The RACP congratulates Dr Diez Alvarez on receiving this award,’ Professor Kolbe said.

‘To be recognised as being the very best at what you do is a significant achievement. We are fortunate at the College to have a number of supervisors who generously dedicate their time and expertise to mentoring our trainees. Dr Diez Alvarez exemplifies this commitment to producing outstanding physicians for tomorrow.’

For Dr Diez Alvarez, this award confirms the importance of the supervisor role, which he will continue to undertake alongside his clinical and teaching commitments. ‘I enjoy interacting with colleagues with different responsibilities in the hospital system,’ Dr Diez Alvarez said.

‘The medical students are so keen to learn and it is a joy to share my clinical experience with them. We are very lucky to have great BPTs rotating to Coffs Harbour and I try to spend as much time tutoring them as I can.

We share interesting cases and discuss management difficulties that we can all learn from.

‘My advice to all trainees is to continue your passion for medicine and for lifelong learning and ensure that uncompromising patient care is the number one priority. See every patient as an opportunity to grow, both as a person and as a clinician. Support each other; we will all need a helping hand at some point.’

Kate White
Communications Officer
THE CHALLENGE OF CHANGE

After Montgomery (Monty) Spencer gained training and experience in paediatrics at Great Ormond Street and at Boston Children’s Hospital, including considerable expertise in infant feeding, he set up his paediatric practice in Wellington. But he found that Truby King was already established as the self-appointed doyen of child health and infant feeding, and had in place the Plunket Society and an army of Karitane Nurses to impose his strict infant feeding protocols. Monty was concerned that Truby King based his strict feeding formulae on ‘theories abandoned in every western country but New Zealand fifteen or twenty years ago’, based on the presumed harmfulness of dietary protein in infants. Yet Monty knew that he was wrong. He documented a high rate of children with failure to thrive and signs of malnutrition, and noticed that virtually all cases were Plunket babies. He established that the Plunket formulae contained insufficient protein. The only redeeming feature was that the feeding regimens were so strict that compliance was low, and many mothers cheated (or abandoned them altogether); and the lower the compliance, the healthier the baby. With some hesitation, he took on the might of the Plunket Society, and the authority of Truby King, and asked the Plunket Society to modify their recommendations on infant feeding: increase the protein, encourage demand feeding so the infants got enough, and where the child seemed to need extra calories, allow earlier introduction of solids.

This produced an outpouring of emotion and vitriol. The Plunket Society saw Montgomery’s request as an attack on their Society. They dug their heels in. In due course they referred it safely to their in-house committee. Matters worsened when Montgomery questioned the appropriateness of the composition of their advisory committee, as it had no paediatrician on it. In December 1937 Montgomery felt obliged to write that ‘those in charge of teaching [Plunket] nurses are setting themselves up as authorities greater than [those] who have devoted their lives to the study of infant feeding’. He was concerned about their rigidity, the lack of scientific evidence for the strict regimens, and the inappropriateness of their behaviour in resisting change. For its part, the Plunket Society was more concerned about the reputation of their Plunket Nurses than whether his complaint had any merit.

With time, support for Montgomery was added from other quarters, including other paediatricians and the New Zealand Medical Journal: ‘will not the Plunket Society reconsider their standard teaching and be prepared to modify it in the light of recent investigation and experience?’

How might we learn from Montgomery’s experience, and what are the equivalent issues into the 21st century? We live in a time of increasing specialisation in child health and an increasing expectation of the highest quality care and best clinical outcomes. Moreover, there is general acceptance that we should provide treatment as close to home as possible without compromising access to specialist services or clinical outcomes, and recognise the need to facilitate a reconfiguration of child health services in New Zealand to accommodate this. Part of this process has required a paradigm shift where clinicians who previously saw themselves as working for an individual hospital or department are now encouraged to work for a service or a region. This process has been facilitated by the government recently encouraging clinicians to be more actively involved in leading the reconfiguration of services and developing clinical networks. Yet surprisingly, it has not been hospital policies, government or funding arrangements that have been the greatest impediments to these changes, but rather clinicians themselves. And interestingly, the strongest impediments to change have usually come from clinicians not central to the specialty in question, whereas there tends to be a high degree...
of consensus amongst the actual providers of care in that specialty. This is reminiscent of adult physicians obstructing the establishment of purely paediatric services 50 years ago.

In New Zealand, the most common arguments against accepting outreach specialist services in child health have related to clinicians’ concerns that being a recipient of them may weaken their own unit (in reality the reverse happens), that their current results have been considered acceptable locally (at least until now) so there is no need for change, a fear of being ‘taken over’ by outsiders, concern about loss of skills locally (this can be a major issue, especially for acute conditions) and loss of control of the service. These are all legitimate anxieties, and each has to be addressed carefully. At least now, District Health Boards (DHBs) are developing better mechanisms to expand clinical networks across DHB boundaries.

In paediatric surgery there are additional challenges for those provincial hospitals without resident specialist paediatric surgeons. Nowadays, general surgeons have no, or very limited, training in children’s surgery, yet there remains a strong desire to provide equitable access to quality services close to home. Adult general surgeons have a perception of medico-legal vulnerability, and rigorous credentialling processes may restrict their scope of practice. Public expectations are higher and there is greater community awareness of the relative quality of services. There is a trend to downgrade smaller hospitals, in part because of increasing specialisation. This problem is not peculiar to New Zealand but puts an obligation on paediatric surgeons to provide for all the children in their region, not just those in their tertiary hospital, even if this means frequent travel to the smaller centres to do clinics and operate. The specialty is lucky in that many paediatric surgical procedures lend themselves well to outreach surgery, limited mainly by anaesthetic capability. We now have good data on the effect of this type of service on clinical outcome, leading to significant improvements for the children in more remote areas. For many conditions (e.g. pyloric stenosis), the determinants of outcome are well established and can be used to configure services across a region. A comprehensive outreach service has been shown to markedly reduce the unnecessary surgery rate, reduce the re-operation rate, and improve clinical outcomes, resulting in the development of benchmarks for outcome for common conditions such as inguinal hernia in children. It has also encouraged the development of referral and treatment guidelines which could easily be implemented in other areas of New Zealand. And what has occurred in specialties such as paediatric oncology, paediatric surgery and paediatric neurology is equally applicable to most other tertiary services.

As we work towards improving the quality of child health services to all parts of New Zealand we can be inspired by the vision, perseverance and determination of Montgomery Spencer as he improved the plight of New Zealand’s starving children in the 1930s.

Spencer W Beasley MB ChB (Otago), MS (Melb) FRACS

SUSAN MOLONEY, BOARD DIRECTOR

Why did you agree or nominate to join the College Board?

I nominated for the position of President Elect of the Paediatrics & Child Health Division, which automatically made me eligible to be a Board Director. My reasons for nominating were that I had previously been on the Divisional Council and enjoyed that position, and I felt that I would be able to lead the Division in the direction it required over the next two to four years. I was previously on the Council of the College in 2005, and it is encouraging to see that the mechanisms of College oversight have changed significantly over that time. As Board members, we are reminded that this is a large not for profit organisation, and good governance is as important a role of the Board as carefully setting the strategic course for the future.

What do you wish to contribute during your time on the Board?

I feel I can contribute to the Board through my understanding of regional and non-tertiary issues and as a generalist. As a Board Member, I was asked to chair the College Education Committee, at a time when the Educational Governance review was underway, and this has allowed me to have a broader understanding of the many and varied training programs the College is responsible for.

What are your interests away from work and the Board?

Outside College and work activities, I enjoy travelling to see various siblings and friends in far-flung parts of the world, as well as reading and cooking.
BEYOND THE SCIENTIFIC PROGRAM
AT CONGRESS 2012

In addition to the robust scientific program, the RACP Future Directions in Health Congress 2012 will feature informative workshops, to be hosted by the RACP Communications Unit and the RACP Policy & Advocacy Unit.

Media and Health Workshop: ‘The rules of engagement’
Sunday, 6 May 2012

An understanding of how the media works, how to engage with media and how to effectively manage reactive media is a priority for the RACP. This workshop will look at all aspects of the RACP media management framework, including the College’s processes for working with our Fellows to engage with the media to raise awareness of issues or provide comment on health policy. Led by Sasha Grebe, RACP Director of Professional Affairs, and Trina Backstrom, RACP Communications Manager, the session will take an in-depth look at the RACP Media and External Communications Policy and process, which provides clarity on the role of Fellows and the College in effective media engagement.

Health Publishing Workshop: ‘Publish or perish?’ Current and future trends in health and medical publishing
Sunday, 6 May 2012

The role played by health and medical journals in contributing to the development of scientific thought and discourse is unquestionable. This session will be an informative and lively discussion from scholarly publishing experts on current issues and future trends in the competitive and influential world of journal publishing, and what this means for those seeking to publish original research articles or other works of scientific merit. Speakers include Chris Graf, Editorial Director Health Sciences, Wiley-Blackwell, publishers of the RACP Internal Medicine Journal and Journal of Paediatrics & Child Health.

Indigenous and Māori Health: What the College and Fellows can do
Sunday, 6 May 2012

This session will look at the role of the College in helping to improve the health of Aboriginal, Torres Strait Islander and Māori peoples, including the vehicles available to the College to progress its work and the important role of established College committees, and will workshop current initiatives underway across the College to improve Indigenous health.

Making eHealth work for you
Sunday, 6 May 2012

E-health and telehealth have become increasingly important to the role of the specialist physician in the delivery of care. Discussion will focus on the Personally Controlled Electronic Health Record (PCEHR), while representatives from the Australian College of Rural and Remote Medicine (ACRRM) will present on telehealth developments, including guidelines and standards.

Improving access to specialist services in rural Australia: A new model of care
Tuesday, 8 May 2012

This session highlights the drivers for change in the health workforce including government reforms, workforce planning and the shifting demands on the health services, particularly in rural and remote areas. The session also outlines the College’s work in meeting these changes, including developing a new model of physician service delivery for rural areas, and the potential for new dual-training pathways to improve the number of treatments and reduce costs related to transfers.

Medico-legal – Legal issues that may arise from the doctor–patient encounter
Tuesday, 8 May 2012

This session will look at problem areas in doctor–patient relationships, identified from a 10-year review of 1800 complaints against doctors, the legal issues that arise out of the doctor–patient relationship, and how to deal with the relationship when things go wrong.

National Health Platforms: An update from the Australian Department of Health and Ageing
Wednesday, 9 May 2012

Mr David Butt, Deputy Secretary of the Australian Department of Health and Ageing (DoHA), and Mr Mark Booth, Acting First Assistant Secretary of the Primary and Ambulatory Division of DoHA, will discuss Medicare Locals and their implications for primary health outcomes. The session will include an insight into the Lead Clinicians Groups, including the Local Lead Clinicians Groups, by Dr Alasdair MacDonald FRACP who was recently appointed to the National Lead Clinicians Group.

Health of Doctors
Wednesday, 9 May 2012

The Australasian Faculty of Occupational and Environmental Medicine has led the development of a College green paper on the health of doctors and invites attendees to a presentation of the key issues by Dr Kristin Good, followed by a panel discussion to identify priority topics related to the health of doctors, chaired by Dr David Beaumont FAFOEM.

EDUCATION SERVICES WORKSHOPS AT CONGRESS

Sunday, 6 May

• Skills for supervisors
  Professor Fiona Lake and Associate Professor Andrew Cole

Monday, 7 May

• Supporting physicians’ professionalism and performance (SPPP)
  Dr Grant Phelps, Dr Sarah Dalton, Dr Julie Balint, Dr Sheila Cook,
  Dr Nicki Murdock and Professor Ron Paterson

Tuesday, 8 May

• Continuing professional development (CPD) in practice
  Dr Marion Leighton and Dr Hamish McCay

• The sense and nonsense of work-based assessment
  Professor Lambert Schuwirth and Dr Marie-Louise Stokes

• What does it take to make education change happen in your health service?
  Dr Emma McCahon

• Wiley-Blackwell Publishing Award for Excellence in Medical Education
  Chair – Associate Professor Sue Moloney

Wednesday, 9 May

• Supervising diverse student and trainee groups at multiple levels in high-volume work environments
  Dr Victoria Brazil, Dr Alison Mudde and Dr Spencer Toombes

• Hands-on hands-off – a model of effective supervision
  Professor Rick Iedema and Associate Professor Wendy Hu
CONGRESS THEME

The theme of this year’s four-day Congress is ‘Disease and Injury Prevention’.

Sessions will be hosted by the College’s Divisions, Faculties, Chapters and Specialty Society partners. In addition to these groups, the Congress program will be supported by other units at the College.

WHAT IS THE CONGRESS PROGRAM OFFERING?

:: 2 Joint Keynote Sessions  
:: 4 Named Orations / Lectures  
:: Pre-Congress Sessions  
:: Sunrise Interactive Sessions  
:: Concurrent Sessions  
:: Debates  
:: Award / Prize Presentations  
:: Free Paper and Poster Presentations  
:: 3-day Exhibition  
:: Social Program

WHO ARE THE KEYNOTE SPEAKERS?

The Congress is honoured to have a number of medical / health experts and educators from Australia and overseas present at the Congress including:

Professor John Rasko (Australia)  
Opening Plenary: ‘Our Challenge to Repair & Restore Tissues: No Fate But What We Make’

Sir Michael Marmot (United Kingdom)  
Priscilla Kincaid-Smith Oration: ‘Social Determinants of Health’ and  
Fergusson-Glass Oration: ‘Employment, Work, and Health Equity’

Professor Ian Frazer (Australia)  
Cottrell Memorial Lecture: ‘Cancer Immunotherapy in the 21st Century’

Professor Louise Newman (Australia)  
Paediatric Plenary: ‘Mental Health - Roles of Paediatrics and Psychology/Attachment and Beyond’

Dr Ken Nunn (Australia)  
PRSANZ Plenary: ‘Predicting Response/Reaction to Psychotropic Medication’

Professor Dame Carol Black (United Kingdom)  
Closing Plenary: ‘The Role of Physicians in Maintaining a Healthy Working Age Population and Sustainable Economy’

Professor Graham Vimpani (Australia)  
Howard Williams Oration: ‘Child Health: Contexts, Consequences and Challenges’
Almost 1000 beautiful islands make up the Solomon Islands, which is less than three hours by air from Brisbane. A population of half a million is scattered amongst this tropical archipelago, often remembered for its strategic location in World War II and intense fighting around Guadalcanal. These days Solomon Islands is a developing country, with warm, friendly people and a culture distinctive for its hospitality and strong sense of community.

I worked as a volunteer at the National Referral Hospital in the Solomons for four months at the end of 2011. The hospital is known as Lukim Yu (‘Goodbye’) Number Nine, Number Nine being a reference to old district names (‘Number Ten’, incidentally, was the cemetery). For many years the Centre for International Child Health at the Royal Children’s Hospital Melbourne has had a strong collaboration with Number Nine. Situated in the nation’s capital, Honiara, the hospital is a final stop for patients who may take up to five days to travel there from peripheral islands. Together with the support of the AusAID program, Australian Volunteers for International Development (AVID) offer an extra hand to the paediatric department at Number Nine, at the same time providing training registrars with an insight into medicine in a resource-poor environment.

Children in the Solomon Islands suffer from diseases we rarely see in Australia. Tuberculosis, malnutrition and infectious diseases like malaria, rheumatic fever and bacterial meningitis are common. Due to distance and lack of basic public health measures children often present late to health services.

The 20-bed nursery is repeatedly filled with up to 30 babies, accommodating premature and low birth weight neonates, and babies with respiratory distress and sepsis, without the modern technology that adorns NICUs. Rather than an incubator, an east-facing room is used, with the morning sun creating a cozy and humid room for the babies. There is no ICU or ventilator, and amenities like power and water can run out at any time. In a typical week there would be several very low birth weight babies, premature twins, a neonate with genetic problems or cardiac disease and a baby with sepsis in the acute area of the nursery alone.

On one of my first night shifts at Number Nine, the mother of Baby Roy, a struggling 900g newborn with respiratory distress, asked me: ‘Isn’t there anything else you can do?’ As my mind drifted towards an answer involving lack of CPAP machines, ventilators, incubators and surfactants, a senior nurse confidently replied, ‘We are doing everything we can’.

It became an uncomfortable answer I too often had to give, but one I would never have had to use in Australia. There were many situations where the medical staff at Number Nine knew that more could be done, but did not have the means to do so: a child requiring blood or a medication which had run out; a blood test needing to be done but no reagent for the machines; a premature newborn needing respiratory support or an operation for congenital heart disease.

From the first night with Baby Roy and countless times afterwards, the resilience, patience and compassion of the staff at Number Nine were the pillars for providing the best clinical care possible, even when faced with complex medical problems and few resources, and the poor health status of the children. Solomon Islands under-five mortality was 27 per 1000 (Australia 5/1000) in 2011 (UNICEF).

Just three hours separates our world of hospitals, with their monitors, imaging, abundant medications and many modes of investigation, from theirs. Without the luxury of all these facilities, the diversity of medical complaints in the Solomon’s requires a much greater focus on clinical signs, symptoms and judgement.

A sense of frustration with the Solomon Islands health system is inevitable. Staff morale is affected by recurrent systemic failures and lack of quality executive leadership in the health system. As one of the hospital staff said to me, ‘It just makes me feel like I want to go back to my own island’.

The doctors and patients at Number Nine are often visited by Australian and international medical teams. As well as providing treatment for patients, these visits offer an opportunity for building the capacity of the local staff. As the Solomon Islands’ most developed and wealthiest neighbour, Australia offers a standard of

Assessing a newborn with sepsis. Photo: Michael Bainbridge/Australian Volunteers International.
With Sister Evelyn, checking on a baby in the postnatal ward. Photo: Michael Bainbridge/Australian Volunteers International.

Dr Ray Boyapati

medical care worth striving for. Increased funding through AusAID and other governments amounted to over $261.7 million in 2011–12 and much of that funding will go directly to healthcare.

The experience of working in the Solomon Islands has been one of the highlights of my medical career to date. In addition to exposure to diverse medical problems, this placement provided many broader lessons on the importance of public health, effective management of resources and medical education, as well as the need for careful consideration as to how aid can be effectively delivered. Despite challenging circumstances in the Solomon’s, the experience and knowledge of the medical and nursing staff result in good outcomes for patients, including Baby Roy, who three months later is now thriving.

Dr Shidan Tosif
Paediatric Registrar
Centre for International Child Health
Royal Children’s Hospital Melbourne

Ray Boyapati, a Gastroenterology Registrar at Southern Health, shares some tips on the daunting upcoming RACP clinical exams. He is well placed to offer the advice having received two medals: one from the Austin Hospital in Melbourne and one from RACP Victoria for the highest achieving candidate in Clinical Medicine for the FRACP exams in 2011. Dr Boyapati’s advice for Registrars preparing to sit the RACP clinical exam is threefold.

TIPS FOR SUCCESS IN THE RACP CLINICAL EXAMINATION

First, after the exhausting written exam process, it is important to take some time off to relax and celebrate your success.

Second, following this initial break, throw yourself into the deep end by starting long cases and short cases early. Too many trainees want to delay doing these until they feel they have ‘perfected’ their technique but this often leads to delays in receiving valuable feedback from colleagues and supervisors. Moreover, it is hard to obtain good technique simply by reading books – making mistakes and getting feedback is all part of the process of improving. William Osler’s advice rings true: ‘He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all.’

Remember that your colleagues and your supervisors expect you to be substandard when you first start off – it is better to perform like this at the start when you can do something about it as opposed to near the actual exam when you can’t!

During this time, of course, it is important to develop the techniques necessary to do well by knowing how to do each type of short case in a fluent and efficient fashion, as well as having a set routine for long cases.

The third, and most important factor, however, is practice. Practise, practise, practise. Create a schedule of long and short cases that you plan to do over the next few months and stick to it. Around two long cases and a few shorts a week is about right. The ‘minimum’ number of long cases you need to do to give yourself the best chance of success is a difficult question: essentially I don’t feel that there is one number that suits everyone. I did about 25–30 long cases and felt by the end of those I was well prepared.

Take advantage of the knowledge and experience around you – your Advanced Trainees, Senior Registrars and Consultants – they have all gone through the same process and most are empathetic to your requests for advice.

Most importantly, enjoy the process! It is easy to say once it is all over but the process definitely makes you a more compassionate, well-rounded, confident doctor with perspective on the major issues affecting your patients.

Dr Ray Boyapati

Ray Boyapati, a Gastroenterology Registrar at Southern Health, shares some tips on the daunting upcoming RACP clinical exams. He is well placed to offer the advice having received two medals: one from the Austin Hospital in Melbourne and one from RACP Victoria for the highest achieving candidate in Clinical Medicine for the FRACP exams in 2011. Dr Boyapati’s advice for Registrars preparing to sit the RACP clinical exam is threefold.
Continuing our series on cultural competence, this issue focuses on strategies for working with Aboriginal and Torres Strait Islander peoples in a culturally sensitive way, at both an individual and system level, to improve health outcomes for Indigenous Australians.

It is no secret that Aboriginal and Torres Strait Islander Australians continue to experience poorer health outcomes than non-Indigenous Australians. There is a multitude of reasons for this including the history of colonisation, dispossession and marginalisation; the ongoing impact of the social determinants of health; and the difficulties many Aboriginal and Torres Strait Islander peoples experience accessing adequate and culturally appropriate health services.

The College is in a good position to advocate for improvements to the availability and delivery of culturally appropriate health services, and can support and encourage physicians and trainees to develop skills in cultural competence. As part of the RACP News series on cultural competence, this article begins to explore opportunities to design culturally appropriate health systems and deliver culturally competent healthcare to Aboriginal and Torres Strait Islander peoples.

The focus will be on how physicians and trainees can help to integrate cultural competence into health systems to reduce barriers to access and to improve the experience and health outcomes of Aboriginal and/or Torres Strait Islander patients and their families.

Aboriginal and Torres Strait Islander culture

There is substantial cultural diversity within Aboriginal and Torres Strait Islander communities. Aboriginal and Torres Strait Islander peoples comprise a number of diverse nations, each with their own language and traditions, and with varied spiritual and cultural beliefs and practices. As a result, developing cultural competence cannot solely be an academic pursuit but should also involve life-long learning that stems from building strong and respectful relationships with Aboriginal and Torres Strait Islander peoples and their communities.

Despite the cultural variation, there are a number of commonalities across Aboriginal and Torres Strait Islander populations. Firstly, notions of and respect for family and community are of central importance. Family relationships connect people to other people and to country, resulting in a complex kinship system that governs relationships and interactions within society. As a result, an Aboriginal or Torres Strait Islander patient may involve members of their extended family, or an elder of their community, in their healthcare planning and decision making.

Another similarity between Aboriginal and Torres Strait Islander peoples is a holistic understanding of health and wellbeing that encompasses the physical, spiritual, emotional and social health of the individual, and the whole community, across the lifespan. As such, the shared history of colonisation and dispossession for Aboriginal and Torres Strait Islander peoples, and the ongoing experience of institutionalised disadvantage at all levels, has, to a large extent, resulted in the poorer health outcomes experienced by Aboriginal and Torres Strait Islander peoples and, particularly, in high rates of trauma, grief and emotional distress.

Culturally competent practices

Cultural competence is a core competency for physicians and trainees. Both the College’s Professional Qualities Curriculum (PQC) and the Supporting Physicians’ Professionalism and Performance (SPPP) Guide include the domain of cultural competency in its broad sense, and as it specifically applies to Aboriginal and Torres Strait Islander peoples. In both these documents, cultural competence is more than just knowledge and awareness of culture, but involves actively applying this knowledge to the delivery of care, to the critical review of one’s own cultural values, and to possible cultural bias within health services.

Health practitioners often understand the importance of cultural competence, but are uncertain of the steps they must take to demonstrate cultural competence. This is because cultural competence involves much more than a ‘tick-box’ approach. Cultural competence means tailoring the patient’s management, treatment and care to their cultural context, including their background and beliefs, and to their cultural and linguistic needs. This involves taking the time to build trust and rapport with the patient, and listening carefully to the patient’s verbal and non-verbal communication.

Communication styles for Aboriginal and Torres Strait Islander peoples can be vastly different and miscommunication is rife, which directly contributes to the barriers experienced by Aboriginal and Torres Strait Islander peoples in accessing healthcare. Communication is often more gradual and indirect, incorporating stories and narratives.

Physicians and trainees should seek to employ the following strategies to aid effective communication and to support patient and family understanding:

- Always use plain English and employ visual tools, including diagrams and models, where possible.
- Be aware of and attuned to body language and its meaning.
- Observe and question carefully and respectfully.
- Involve the patient’s extended family and/or other designated person in the consultation and decision-making process as requested or required by the patient.
- Engage Aboriginal and Torres Strait Islander health workers, liaison officers and interpreters where available or as required by the patient.

The use of the above strategies will vary depending on the patient and their needs. None of the above strategies should be utilised without first taking the time to get to know and understand the patient and their background to ensure tailored, effective communication and thus improved health outcomes.

Cultural competence at the system level

At a system or organisational level, attitudes, structures, policies, procedures and services should embed cultural competence, to deliver consistent and comprehensive access to culturally appropriate, high-quality healthcare. The history and process of colonisation and ethnocentrism has resulted in institutions and systems that can and do discriminate against Aboriginal and Torres Strait Islander peoples.

Health services must therefore actively work to reduce and remove any ingrained
cultural bias to develop and deliver culturally appropriate care. As a first step, health services should have policies and procedures that recognise Aboriginal and Torres Strait Islander health beliefs, stipulate a non-discriminatory environment and seek partnerships with Aboriginal and Torres Strait Islander health services and communities. Health services should value culturally diverse and culturally aligned healthcare teams by appropriately resourcing and supporting Aboriginal and Torres Strait Islander health practitioners, health workers, liaison officers and interpreters. Health services should aim for an environment with infrastructure that is welcoming and respectful to Aboriginal and Torres Strait Islander peoples and their culture. This may be demonstrated through the display of Indigenous artwork, the raising of the Aboriginal flag and ensuring that waiting and consulting rooms are of sufficient size to accommodate extended families.

Physicians and trainees can play an important role in assisting health services and organisations to be culturally competent. The following strategies are recommended but are not exhaustive. As per the PQC, physicians and trainees should continually identify and act to address cultural bias in oneself, in colleagues and within healthcare organisations.

- Seek out information about the Aboriginal and Torres Strait Islander organisations operating in your locality and the relationship your health service has with them.
- Take advantage of local and/or state initiatives to learn more about Aboriginal and Torres Strait Islander culture. Many health services offer cultural competence training.
- Advocate within the health service or organisation for resources, systems, processes and policies that improve cultural competence, provide opportunities for Aboriginal and Torres Strait Islander peoples, and demonstrate a commitment towards reconciliation.

The College encourages all Fellows and trainees to undertake cultural competence training. There are a number of cultural competence training providers who offer online and face-to-face training options. Reconciliation Australia maintains a cultural awareness training register for all states and territories, which is located at www.reconciliation.org.au/home/resources/cultural-awareness/cultural-awareness-training-register.

Tamara Mackean
Chair
Aboriginal and Torres Strait Islander Health Advisory Committee
Sarah Barter
Policy Officer

Further reading
- Australian Health Ministers’ Advisory Council’s Standing Committee on Aboriginal and Torres Strait Islander Health Working Party. Cultural respect framework for Aboriginal and Torres Strait Islander health 2004–2009.
ONLINE RESOURCE FOR PHYSICIANS WORKING IN ABORIGINAL CHILD HEALTH

Our learning modules focusing on Australian Aboriginal child health will be launched at Congress on 6 May 2012.

The Australian Aboriginal Child Health Modules project is funded by the Rural Health Continuing Education (RHCE) program and supported by the Poche Institute, Sydney Medical School, and Nindilingarri Cultural Health Services, Fitzroy Crossing, Western Australia. RHCE is a joint initiative of the Australian Government’s Department of Health and Ageing (DoHA) and the Committee of Presidents of Medical Colleges (CPMC).

Phase 1 of the project aims to develop two modules to introduce:

i. cultural awareness relating to Aboriginal families and communities, with examples from the Fitzroy Valley, Kimberley WA;

ii. the social determinants of Aboriginal child health – past, present and future.

Online forums will be run over a three-week period, facilitated by medical experts and an Aboriginal Health Worker. Phase 1 will go live 6 May 2012.

Phase 2 of the project aims to update the modules from Phase 1 and develop two additional modules for the course to introduce:

iii. the spectrum of common illnesses in Aboriginal children in remote and urban settings (including ear, skin, and eye infections, anaemia, bronchiectasis, rheumatic heart disease and post-infectious glomerulonephritis);

iv. developmental problems, including Foetal Alcohol Spectrum Disorders, and the effects of early life trauma (adverse social, nutritional and emotional experiences) on development.

Online forums will be run over a six and a half week period, facilitated by medical experts and an Aboriginal Health Worker and/or Nindilingarri Cultural Health Services Officer and a medical expert. Phase 2 will go live 6 August 2012.

The online modules will include video and audio footage. They are designed to be case-based and interactive including a question–answer format, with links to relevant clinical images and guidelines.

The project lead, Dr Megan Phelps, is working with the project team comprising Dr James Fitzpatrick, Associate Professor Elizabeth Elliott, Anne Morris and Dr Hasantha Gunasekera, to gather content. The project team is supported by the eLearning Design & Development Unit at the College in developing the resource online.

For more information contact Jamie Owen from the eLearning Design & Development Unit at the College by email at Jamie.Owen@racp.edu.au or by phone on 02 8247 6225.

This Project has been funded by the Department of Health and Ageing under the Rural Health Continuing Education Sub-program (RHCE) Stream One which is managed by the Committee of Presidents of Medical Colleges. The RACP is solely responsible for the content and views expressed in any material associated with this project.

SHARE YOUR STORY

As part of the Royal Australasian College of Surgeons’ Australian Indigenous Health Online Portal project, the RACP has been asked to provide case study material to showcase a specialist’s work on Indigenous health and cultural competency and safety training.

The format in which to tell your story is entirely up to you. Images, text, audio and/or video can be used. The College can assist you to capture your experiences.

If you are interested, please contact Jamie Owen by email at Jamie.Owen@racp.edu.au or by phone on 02 8247 6225.
PHYSICIAN READINESS TO ADOPT E-HEALTH – ARE WE ANY CLOSER?

As information technology is destined to play a huge role in the delivery of 21st-century healthcare, there is a pressing need for physicians to prepare for these changes. This is becoming imperative, with the launch of the PCEHR in July this year.

The importance of eHealth as an enabler of healthcare reform and as a clinical tool has been highlighted to Fellows for some time.1 With the Personally Controlled Electronic Health Record (PCEHR) due to go live in July 2012, there is an urgent need to assess the readiness of the specialist community to adopt eHealth and reap the benefits from these important health reforms.

Key to the success or failure of the national health information program will be the engagement of clinicians, particularly in its implementation, as highlighted by the UK experience. Further, underestimating the change management effort in encouraging clinicians to adopt new technologies is a potential barrier to successful implementation and the broader reform agenda.

So, have physicians become any closer to adopting eHealth in the last few years?

The McKinsey study – are specialists any closer?

Whether specialists have made any significant advances since the 2009 study by Osborn et al.,2 which concluded that physicians had failed to incorporate computerisation into their work practices, particularly in the private sector, is becoming clearer. Early in 2011, McKinsey1 undertook a readiness assessment for the Department of Health and Ageing of the specialist community’s willingness to adopt eHealth. The focus was primarily on the private sector and included most specialist groups, not just physicians. The findings provide important guidance on appropriate change and adoption strategies for physicians.

The McKinsey study looked not only at whether specialists were ready to adopt and use eHealth technologies and solutions, but whether they were on track to benefit from future developments. Although not directly comparable to the Osborn study, the McKinsey study broadly suggests that utilisation by specialists of computers for education has increased, although in other areas there has been little change. The McKinsey study was based on a smaller sample but, nonetheless, provides some very useful insights into areas not explored by Osborn et al.2

The study identified that specialists have strong foundations for eHealth adoption and use, but are far from realising its full potential (Figure 1). Specialists generally appeared to take a practice-oriented view, rather than seeing the broader benefits of eHealth. The study concluded that current use is typically self-contained within a practice or hospital rather than integrated across networks. Specialists seem ready to adopt eHealth technologies that improve their practice’s operational efficiency, but only to the extent that delivery of care within their practice is not disrupted. While they have the skills and tools needed to support self-contained eHealth use, most lack the basic connectivity, IT support and conviction required to drive more widespread adoption of eHealth.2

The study highlighted that individual attitudes vary between specialists based on their own perceptions of eHealth as well as their work setting, the nature of their work and the structure of their practice. Among all specialty groups there is also a high degree of variation.

To understand these variations, McKinsey analysed the eHealth readiness of Australia’s specialists along three dimensions: their infrastructural readiness; aptitudinal readiness; and attitudinal readiness. They found consistently strong infrastructural and aptitudinal readiness for basic, self-contained computer applications, but differences emerged when systems that facilitated information sharing through more connected applications were considered. These were amplified by differences in attitudinal readiness.

Infrastructural readiness

Medical specialists generally have the necessary basic infrastructural readiness. However, system reliability, connectivity and interoperability concerns are major barriers to the use of connected, information-sharing eHealth applications, especially among early adopters.

Most medical specialists have access to computers, the internet and broadband in their main practice setting, although the figure is lower for specialists in more remote areas.

Specialists identified that they need access to reliable, easy-to-use systems that enable information sharing across practices. For 34% of specialists, improving reliability and useability will help reduce a major barrier to adoption.

Aptitudinal readiness

The study suggests that specialists are as technology literate as their colleagues, with widespread computer use. Usage rates decline with age but not steeply, with 76% of specialists aged 55–64 using computers in their workplace, and
93% of specialists aged 65+ spending some personal time online each week. Those specialists who have transitioned to computerised systems acknowledged that they suffered a loss in productivity in part due to the early learning process. Some specialists were concerned that their patients would lose confidence in them if they were perceived to be struggling with the use of computers, and hence avoided using them.

While training and support for system implementation was seen as important, specialists also need real time IT support when things go wrong – they expect systems to work, and are not always willing or able to spend time resolving IT problems. This is less of an issue in larger practices and hospitals where they have access to dedicated IT personnel, but specialists in smaller practices often struggle to find competent, affordable support when they need it, or do not appreciate the need to set up access to such support until they encounter a problem.

**Attitudinal readiness**

Understanding how specialists perceive eHealth is critical to the change effort. Specialists have varied attitudes towards eHealth, with some being strongly convinced of its benefits, and others remaining negative. Through their attitudes-based analysis, McKinsey identified five distinct attitudinal ‘clusters’ across the practice groupings of specialists:

- **E-health entrepreneurs** (24%); network adopters (17%); capable but unconvincing (13%); apprehensive followers (30%); and uninterested (16%).

This cluster contains a fairly even mix of specialists across all specialties, as it is not closely tied to any specialty-specific characteristics. Collectively, they could have some positive influence on most other medical specialists.

- **Network adopters** (17%) commonly work in an environment, such as public hospitals, where computer use is expected. While enthusiastic about the benefits, they are difficult to influence directly because they have restricted influence over their operating environment and so are less likely to control investment decisions. Accordingly, use of eHealth applications by others in their network is a much stronger driver for adoption than financial incentives or patient demand. They also tend to be adept at working with technology and interested in the use of computers to improve their workflow.

- **Capable but unconvinced** specialists are generally comfortable using technology, have financial resources and IT support, and are less influenced by potential barriers such as IT compatibility, cost or privacy concerns. They currently use a range of eHealth applications, but only those with clear perceived benefits. Relative to the first two clusters, they are much less interested in adopting new eHealth solutions. Their interest is in solutions that improve efficiency without detriment to clinical care, or that improve clinical care without sacrificing practice efficiency.

- **Apprehensive followers** see some benefits in eHealth applications, but these are heavily outweighed by perceived barriers and risks. This cluster contains a fairly even mix across all specialties, as it is not closely tied with any specialty-specific characteristics or drivers.

- **Uninterested** specialists have the lowest IT usage rates and negative perceptions of all eHealth benefits. The cluster is skewed towards older practitioners who, with retirement looming, have less incentive to adopt new technology.

Although specialist segments often have one or two dominant clusters, most segments are represented across four or five and there are strong eHealth supporters in each specialist segment.

Each cluster exhibits differences in perceived benefits and barriers as well as the likely enablers that will drive their use and adoption of eHealth and solutions. The most significant influence in defining the boundaries between clusters has proven to be the barriers perceived by medical specialists.

Among specialists, physicians were more open to adopting eHealth technologies than many other specialty groups, although not to the same extent as emergency physicians and diagnostics (Figure 2).

**Conclusions**

The outcome of the McKinsey study shows some support to the view expressed by Hannan in 2009 when he suggested that specialist physicians in Australia are yet to understand the fundamental importance information technology will play in the delivery of 21st-century healthcare.

McKinsey concluded that medical specialists are ready to adopt eHealth technologies; however, they are not yet ready to use eHealth in a way that connects and coordinates care more widely. Many specialists still lack access to the basic eHealth infrastructure that will allow them and their patients to benefit from the PCEHR.
E-health use by specialists is largely driven by two demand-related factors: a strong perception of benefits; and pressure from others in a specialist’s working environment. Connecting eHealth use with tangible, relevant benefits and building an influential network of eHealth advocates will best promote future use and help overcome the perceived barriers.

Based on the current evaluation of the readiness of the specialist community, when the PCEHR goes live in July 2012 the initial impact on most physicians will vary depending on setting. For most it will be minimal. All physicians will, however, be able to view the records of patients who are registered and give their consent, allowing them to see the value to clinical care.

Looking to the future, physicians have a window of opportunity to invest in the foundations that will put them in a position to benefit from the PCEHR once it is in place and the initial problems ironed out.

Given the right incentives, leadership and direction, physicians are likely to continue to make further progress but, ultimately, the decision to invest the time, and for those in the private sector, significant funds, in order to adopt eHealth remains a personal decision.

To read the complete report, or for more information, please visit:

Dr R Hanson FRACP
Deputy Chair, eHealth EAG

References
Each year the Faculty of Occupational Medicine in Ireland invites an eminent scholar to deliver the James Smiley lecture. On 2 December 2011, Dr Robin Chase, President of the Australasian Faculty of Occupational & Environmental Medicine (AFOEM), delivered the 24th Annual James Smiley Lecture at the Royal College of Physicians of Ireland in Dublin. In addition to this honour, Dr Chase was conferred as an Honorary Fellow of the Irish Faculty of Occupational Medicine and received the James Smiley medal. The audience included Irish Fellows, the son and daughter-in-law of Dr Smiley, and the Australian Ambassador to Ireland, His Excellency Mr Bruce Davis.

The Smiley Memorial Lecture was established in 1988 to commemorate the significant and prolific work of distinguished Irish Occupational Medical Specialist Dr Jim Smiley. Dr Smiley was a founding Fellow of the Irish Faculty of Occupational Medicine in 1976. The honours bestowed on him were numerous and varied; he was the only Irishman to be president of the Society of Occupational Medicine (UK) and was a member of the exclusive Collegium Ramazzini.

In his lecture, ‘Occupational and Environmental Medicine – the Australasian perspective’, Dr Chase spoke of the strong historical and ongoing links between Australia and Ireland, as well as our shared history in Occupational Medicine. He also spoke of AFOEM’s position in the RACP and how the concept of ‘One College’ has resulted in stronger ties between the Divisions, Faculties and Chapters. Dr Chase talked about AFOEM’s recent triumphs, most notably the Faculty’s achievements with The Health Benefits of Work Consensus Statement, from its ‘extraordinarily successful launch’ to the more recent stakeholder meeting, emphasising the ‘tangible outcomes’ resulting from the meeting, especially in light of the broad church of Australian and New Zealand signatories. He also talked about the common challenges that all of us face: workforce, relevance, and the changes in education. Indeed Dr Olivia Carlton, President of the Faculty of Occupational Medicine, Royal College of Physicians, observed that she was struck by how identical are the problems we all face. Dr Chase called for closer ties between practitioners of Occupational and Environmental Medicine, and initiated dialogue between the Irish, UK, Canadian and US Faculties and Colleges.

Dr Chase is to be congratulated on his induction as an Honorary Fellow of the Irish Faculty. He has contributed extraordinary time and effort as AFOEM President, most notably in fostering and strengthening relationships within the College, across Australasia and internationally.


Deborah Lockart
Senior Executive Officer

Lauren Quinn
Administrative Officer

Continued from page 33

The ability of consumers to add over-the-counter and complementary medicines should be of particular benefit to health professionals, given the scale of their use and increasing evidence of their side-effects and drug interactions. Too many clinicians currently make prescribing decisions without being aware of the patient’s use of these medicines.

There will be many teething problems with the PCEHR and EMPs in particular. One problem is the ability of patients to censor their PCEHR information and this will need to be managed on a case by case basis but is of particular importance when prescribing a medication. Also, eHealth ‘readiness’ varies considerably among physicians. This problem is not confined to the private sector since many public hospitals are still electronically poorly resourced.

The success of the PCEHR will depend on a large extent on its uptake not only by general practitioners, but by specialists and other healthcare professionals. Many RACP Fellows are actively involved on NEHTA working groups. More generally, this is an opportune time to advocate to government and hospital administrators for support in adopting the PCEHR. At the end of the day, patients will benefit when physicians are fully integrated into eHealth. This is not least because, when it comes to patients with complex and multiple chronic medical conditions, physicians have a far greater influence upon what is prescribed in the community than is appreciated.

Dr Shane Carney FRACP
Chair, Therapeutics Expert Advisory Group
Member of NEHTA Medications Management Reference Group

References
1. For the year ending 30 June 2011, the Federal Government’s expenditure on pharmaceutical benefits was $8872.7 million, about a 5% increase over the previous year. Figures available at www.health.gov.au/internet/main/publishing.nsf/Content/pbs-stats-pbexp-jun11 (viewed 16 January 2012).
2. More recent figures are not available, but the Australian Institute of Health and Welfare estimated that $1.7 billion was spent in 2003–04 on over-the-counter medications, and in 2004, $800 million was spent on complementary medications. See Australian Institute of Health and Welfare (2006). Australia’s Health 2006. AIHW, p. 354.
3. This is not expected to be a big problem but mental illness and communicable diseases are the obvious areas where this might occur.
4. See The eHealth readiness of Australia’s medical specialists (Department of Health and Ageing, May 2011), which discusses aspects of eHealth readiness, including five ‘attitudinal’ clusters.
The Specialist Training Program (STP) is now in its third year of administration by the Royal Australasian College of Physicians (RACP). Each year since 2011, the Department of Health and Ageing (DoHA) has increased funding, which means an increase in STP funded posts in training centres outside the traditional public teaching hospitals.

In 2011, the RACP administered 188 STP posts across Australia for RACP specialty training, increasing to 232 posts, commencing from the 2012 training year. Of these 44 newly funded positions, 39 were taken from new applications, which were selected from the 225 applications received, and the remaining 5 were selected from the reserve list of the previous application round due to surplus funds available. The 232 posts within the RACP form part of the total 600 posts funded across the different medical specialties. This figure is set to increase to 750 posts in 2013 and to 900 posts in 2014.

**STP posts – by specialty**

Figure 1 shows STP posts by RACP specialty, highlighting the new posts funded from 2012. As demonstrated in Figure 1, the specialties for which the number of posts has increased the most are General Medicine and General Paediatrics, reflecting the generalist focus of the 2012 STP funding round. Priority areas for 2012 were private settings, regional/rural/remote settings, Indigenous health, chronic disease and Generalist Medicine.

The specialties of Medical Oncology, Public Health Medicine, Rehabilitation Medicine, and Palliative Medicine had medium increases in STP placements in 2012. Other specialties that received additional STP post funding included Endocrinology, Geriatric Medicine, Immunology/Allergy, Nephrology, Rheumatology, and Respiratory/Sleep Medicine.

**STP posts – by state**

All states and territories in Australia received additional STP post funding in 2012 with the exception of the ACT, as demonstrated in Figure 2.

New South Wales gained the most newly funded STP posts (17), with other states/territories gaining 1–7 new posts.

**Newly funded posts for 2013**

Applications for the 2013 training year were submitted during March–April 2012, and will be assessed by the RACP for educational merit, by state/jurisdictional representatives for the health workforce need, and by DoHA.

**Bree Waters**

Project Officer

Specialist Training Program (STP) Unit
For 22 years, the Cottrell Fellowship and the Cottrell Memorial Lecture have been supporting research and training in the areas of epidemiology and social or community medicine. The Cottrell Fellowship is also used to support research and training in areas of special relevance to the Asia Pacific. Both the Fellowship and the Memorial Lecture were established by a generous bequest from Dr Jack Dinham Cottrell.

Jack (John) Dinham Cottrell was born in England in 1903 and during his childhood his family migrated to Australia. Dr Cottrell completed his medical degree at Sydney University in 1928, and his medical training and career took him to numerous countries, including posts in many prestigious organisations.

Dr Cottrell was best known for his work in post-war Europe with the World Health Organization (WHO). During his tenure with WHO from 1947 to 1964, he filled a number of esteemed positions, including director of health services, regional office for the Eastern Mediterranean; secondment to United Nations as chief, Health Section Arab Refuge UNRWA; adviser on health programs to UNICEF Far East Mission; and deputy director of WHO Regional Office for Europe. His book, The teaching of public health in Europe, was published in 1969. Dr Cottrell retired to Australia in 1971, where he enjoyed living in his childhood home of Wentworth Falls, NSW, before his death in 1989.

Jack Dinham Cottrell was known for his compassion and dedication to the field of Public Health. The RACP Foundation is proud to preserve his legacy and honour his bequest by continuing to fund research in this field through the Cottrell Fellowship.

Miranda Handke
Executive Officer
All Fellows and trainees are invited to attend our anniversary breakfast and participate in the collaborative program developed with the College Trainees’ Committee, Adult Medicine Division, Paediatrics & Child Health Division and the Australasian Faculty of Occupational & Environment Medicine (AFOEM).

RACP FOUNDATION
21ST ANNIVERSARY BREAKFAST

Date: Wednesday, 9 May 2012
Time: 7.30 - 9.00 am
Venue: Brisbane Convention & Exhibition Centre
Ticket Price: Complimentary - limited places available

Please join the RACP Foundation on Wednesday, 9 May 2012 for a complimentary breakfast to celebrate the past 21 years of the RACP Research and Education Foundation and the emergence of the RACP Foundation. The RACP Foundation extends this invitation to all Fellows and trainees to graciously acknowledge their generous support through the Opt Out contributions.

The morning will include an introduction from the College President, an address from the 2011 Susman Prize recipient, Professor John Rasko, and a gourmet breakfast buffet. The event is free of charge, but attendees are required to register.

Spots are limited, so register today on the Congress website: www.racpcongress2012.com.au/registration/ and help celebrate 21 years of supporting research excellence.

IS THE PHYSICIAN SCIENTIST AT RISK OF BECOMING A DINOSAUR?

Presented by the RACP Foundation at the invitation of AFOEM
Wednesday, 9 May, 2.00 - 3.30 pm

President of the College, Professor John Kolbe, will introduce this session, outlining the difficulties faced by young Physician Scientists and asking what role the College should take in promoting and supporting research.

This will be followed by a ‘Hypotheticals’, led by Professor Richard Larkins and posing questions such as ‘Is it all too difficult’ to an expert panel (to be announced).

Fellows and trainees from all Divisions, Faculties and Chapters are invited to attend, so please register at www.racpcongress2012.com.au/registration/ and join this fascinating conversation.

APPLICATION TO PUBLICATION: THE ABC OF RESEARCH

Presented by The RACP Foundation & the College Trainees’ Committee
Sunday, 8 May 2012, 10.00 am - 12.30 pm

The Clinician-Researcher
Professor Philip Bardin will talk about clinician-researcher phenotypes, the benefits both personally and professionally of doing research and the appropriate times to undertake research.

Understanding the research process
Dr Harriet Hiscock will discuss the practical elements of undertaking research including how to choose a supervisor, obtain research support and apply for funding.

‘At the coal face’: experience of a young Clinician-Researcher
Dr Garun Hamilton will give a personal perspective on getting started as a researcher and where this has led.

Q&A with the panel will follow the presentations.

RACP TRAINEE RESEARCH AWARDS

Paediatric Award: Monday, 7 May 2012, 4.00 - 5.30 pm
Adult Medicine Award: Tuesday, 8 May 2012, 9.00 am - 12.30 pm

Representatives chosen from each State, Territory or Region present research to which they have made a significant contribution to the concept and execution. The two trainees (one from each topic area: Adult Medicine or Paediatric Medicine) whose presentations are judged the most meritorious for both content and presentation will each be awarded a cash prize of $1500. The work may have been published or presented at a Specialty Society, Faculty or Chapter Meeting.

The RACP Trainee Research Awards are open to all trainees of the College, its Divisions, Faculties and Chapters.

All Fellows and trainees are encouraged to attend these sessions to support our young researchers.
VALE PROFESSOR ALLAN CARMICHAEL
OAM MBBS (MONASH) MD (MELB) MD (HON TASMANIA) FRACP (17.5.1945 – 28.1.2012)

Allan Carmichael, retired Dean of the Faculty of Health Science and Head of the School of Medicine at the University of Tasmania until March 2011, died on 28 January, less than three months after being diagnosed with mesothelioma. Allan grew up on a farm in northern Victoria and attributed his final illness to exposure to fibro-cement whilst helping renovate the family home and building a dairy.

Given his rural background it is not surprising that Allan began his tertiary education studying Agricultural Science at Melbourne University, but fascinated by genetics, transferred to Medicine at Monash. His 40-year career was almost evenly divided between the Royal Children’s Hospital in Melbourne and the University of Tasmania as Professor of Paediatrics and Child Health from 1992. He was appointed Dean of the Faculty of Health Science and Head of the School of Medicine in 1997. One of his most notable achievements during this time was overseeing the establishment of the University Department of Rural Health in Launceston and the Rural Clinical School in Burnie.

Allan was a great friend and colleague of the eminent Melbourne paediatrician, Howard Williams, and they, along with their nursing and sociological colleagues, conducted the renowned follow-up study of 272 families in the inner-suburban, multiethnic, low-socioeconomic suburb of Brunswick, confirming the reality of the ‘new morbidity’ in Australia, noting that the major health problems in children were not physical, but behavioural, stemming from family dysfunction, conflict and isolation; adverse life events and the consequences of maternal depression. The important role of maternal and child health nurses in addressing these family issues no doubt underpinned his commitment to the major expansion of the School of Nursing in Tasmania, described by many as a powerhouse for nursing in Australia.

Allan’s influence extended far beyond the University and Tasmania. He was a strong and wise supporter of the establishment of the Faculty of Community Child Health within the Australian College of Paediatrics in the early 90s. He was a State Advisor in Child Health Services to the Department of Health and Human Services from 1992, in which role he served as a member of the National Council of Community Child Health until last year, playing an influential advocacy role in the development of the first National Child Health Policy in 1994. Previously he had played a significant role in child protection reform in Victoria. He was Chair of the Medical Deans of Australia and New Zealand from 2007 to 2009 and had an influential role in national health policy development and enhancement.

Allan was a driving force in the implementation of the Partners in Health program that aimed to improve links between the Health Sciences Faculty and the Tasmanian Department of Health and Human Services and an influential board member of the Tasmanian Early Years Foundation. He also had an influential role internationally, taking a leadership role on a number of international bodies with a focus on child health.

As a clinician, Allan had an outstanding reputation for his professional skills, humanity and compassion. Younger clinicians have commented on his willingness to be ‘on-call’ over Christmas and Easter. He was an outstanding, knowledgeable and thoughtful administrator who respected the opinions of others. As a person he was wise, self-effacing, approachable and utterly trustworthy. He never sought the limelight or his own self-advancement. His support as a mentor for younger colleagues is well recognised. Underpinning all facets of his life was a quiet spirituality and faith that sustained him through his final illness. In a letter to some of his friends at the end of last year as he told us of his illness, he continued to manifest ‘grace under pressure’.

His trustworthiness and wisdom were especially valued by his friends and colleagues in medicine and beyond. Speaking at his funeral, his friend, Bishop John Harrower, with whom he used to breakfast every two or so weeks, commented on Allan’s capacity to place events in their setting and provide a perspective that others had missed. He spoke of how important it was to have someone who was utterly trustworthy and outside one’s own professional or organisational group with whom to share difficult issues and from whom to get an independent perspective. He counted himself blessed by Allan’s fulfilling of this role, noting that the Old Testament Book of Proverbs reflected that ‘reliable friends are hard to find’ and ‘faithful friends are a rare treasure’ and how grateful he was that friends shape and sharpen one another, as ‘iron sharpens iron’.

Allan was planning more bushwalking with friends and family and time at last to tinker with his vintage motor bikes, and being able to spend more time with his wife, Beryl, and twin grand-daughters, who evidently have already acquired the Carmichael professorial walk, reinforcing his lifelong belief in the importance of genetics. Sadly the plans will not come to fruition. His children, Heather and Glenn, expressed a sense of privilege in having had him as their father and noted the important role Beryl played in sustaining the family in the context of Allan’s many external commitments.

Allan’s legacy will live on in the lives of those he has touched and in a strong Faculty of Health Sciences and markedly improved health service provision in Tasmania. Allan’s achievements and personal characteristics led to his being awarded a Medal of the Order of Australia in 2007 and an Honorary Doctorate in Medicine by the University of Tasmania in 2011.

Professor Graham Vimpani AM
Clinical Chair
Kaleidoscope Greater Newcastle
graham.vimpani@hnehealth.nsw.gov.au
DR MIKE WILLIAMS 1962–2012

We were all saddened to hear of the death of one of the Territory’s leading paediatricians, Dr Mike Williams, on New Year’s Day.

Mike graduated from Monash University with distinctions and credits in Medicine in 1986. He won the Queen Victoria Medical Centre Award in Paediatrics. Once he had the appropriate training, Mike planned to use his skills to assist those most in need. He hoped to have the opportunity to work in a regional centre with Aboriginal Australians. It was our good fortune that the regional centre Mike chose was in the NT.

In 1991, Mike attended the Annual Scientific Meeting of the Royal Australasian College of Physicians in Darwin. He met Dr Alan Walker who encouraged him to return. In 1993, Mike took up a position as an advanced paediatric registrar at Royal Darwin Hospital. He completed his training in 1994. Soon after, he began work as a consultant paediatrician at both the Royal Darwin Hospital and in the rooms of the Northern Consultant Paediatricians at the Darwin Private Hospital.

Mike worked tirelessly in both hospitals for the next 18 years. His rooms were a welcoming place where children could play and worried parents could feel supported. Mike remained a ‘generalist’ who liked a challenge. He was comfortable looking after children with the most complex problems. Countless families benefited from Mike’s high-quality care and generous nature. His neonatal and intensive care skills were legendary.

Always looking to make a difference, Mike identified deficiencies in our service and did everything he could to put them right. Thanks to him, we saw dramatic improvements in neonatal intensive care and emergency transport, the development of a paediatric endoscopy service, a greater commitment to the long-term care of children with complex chronic diseases, and a more accessible (and broader scope) of community paediatrics.

Every month, Mike travelled to Katherine to see children at the Katherine District Hospital, Kintore Clinic, Wurli Wurlinjang, and in the communities of Barunga, Beswick, Binjari, Kalkariningi, Lajamanu and Pine Creek. He supported the development of the Aboriginal community-controlled Katherine West and Sunrise Health Services.

Even in his last months, he continued to advocate for better health services (and bus services) to the region.

Mike was an enthusiastic teacher of junior paediatric staff and medical students. He was awarded an adjunct appointment with the NT Clinical School of Flinders University soon after it opened. He lectured on general paediatrics, gastroenterology, and the use of information technology in medicine. Mike also supported a range of research studies conducted with the Menzies School of Health Research, especially those involving children from the Katherine region.

In addition to his clinical commitments, Mike served as President of the NT Branch of the Royal Australasian College of Physicians, and as a member of the Asthma Foundation, NT Management Committee, and the Darwin Private Hospital Medical Advisory Committee.

Mike was diagnosed with a brain tumour in 2009. Showing immense courage in difficult circumstances, he continued working (between operations and chemotherapy) until 2011. His good humour continued until his death. Many of his family and friends are still chuckling at his jokes.

The Department of Health is deeply grateful to Mike for his dedication and commitment to the care of NT children. Our thoughts are with Mike’s wife, Jill, and his children Gabby, Lachie, Flipper and Digby.

Associate Professor Peter Morris FRACP

AFRM TO HOST 7TH WORLD NEURO-REHABILITATION CONGRESS

Leading international experts will convene in Melbourne next month for the 7th World Congress for NeuroRehabilitation, hosted by the Australasian Faculty of Rehabilitation Medicine (AFRM). Over 1500 delegates from around the world are expected to attend the four-day program from 16 to 19 May 2012.

Keynote speakers include Randolph J Nudo, Director of the Landon Center on Aging and Professor in the Department of Molecular and Integrative Physiology at the Kansas University Medical Center (US); Professor Bruce Dobkin, Professor of Neurology who directs the Neurologic Rehabilitation Program at the University of California (US); Dr Robert Teasell, Chair-Chief of the Department of Physical Medicine and Rehabilitation, University of Western Ontario (Canada); and Professor Jorg Kesselrigh, Head of the Department of Neurology at the Rehabilitation Centre in Valens (Switzerland).

The invited presentations will focus on the theme of innovation and new directions in neuro-rehabilitation medicine, providing a focal point for discussion on the latest developments in all major subgroups within the field, including traumatic brain injury, multiple sclerosis (MS), stroke, Parkinson’s disease, post-polio syndrome and neuro-oncology.

From an Australian and New Zealand policy perspective, discussions around disability care and community health will be particularly significant, given recent Productivity Commission reports into disability care and aged care, and the impending Federal Budget announcements.

The Congress will be held in conjunction with the 35th Annual Brain Impairment Congress of the Australian Society for the Study of Brain Impairment and the 20th Annual Scientific Meeting of AFRM.

Registrations are still open. For further information please visit: www.dcconferences.net.au/wcnr2012/

Kate White
RACP Senior Communications Officer
AN ‘EXQUISITELY READABLE BOOK’

RPA & Beyond – An Unauthorised Memoir,

T he Royal Prince Alfred Hospital (RPAH) Sydney has been the subject of several traditional histories in the past. The most recent, published in 2007, is a pictorial history celebrating the institution’s 125th anniversary, for which Dr Hassall was invited to contribute the introduction. The introduction, however, was rejected by the ‘executive ranks’ as unacceptable, as not ‘sufficiently positive in tone’. This disregarded piece of commentary was the stimulus for Dr Hassall to set out his own ‘unauthorised memoir’ of this famous institution where he had practised his ‘privileged and sheltered medical career’ for a period of 50 years.

The result is a small and exquisitely readable book. For those who think they will be delivered a chronological history of this great hospital, they will be very disappointed; and for those who might revel in scandal, Dr Hassall has carefully avoided ‘naming names, hailing heroes or vilifying villains’. Rather, the reader is provided with an eloquently written contemporaneous insight into half a century of what has been an extraordinary period of medical practice.

The book is divided into two parts. In Part I, the cast-off introduction, which was so offensive to the traditional history, is now published and sets the scene for what we can expect in subsequent chapters. These chapters cover the changing face of medical practice as witnessed by the author. Brief insights follow into the changes brought about by healthcare reforms, specialisation and medicine’s relations with the law, ethics and politics, to name a few. As I read Part I, I felt that I was absorbed in a superbly taken oral history, in this case Dr Hassall is both inquisitor and responder, and I gained a background insight into what might have really happened during this extraordinary epoch. For those who wish to explore any of these issues, a comprehensive list of endnotes follows Part I.

Part II consists of a series of essays that Dr Hassall was invited to deliver over the period spanning 1967–2007. These essays take us beyond RPAH to those bigger issues of the future of medicine (1969–1972 perceptive), the changing nature of practice with the growth of specialisation (1967) and technology (1986), and the introduction of Medibank (1975). Once again excellent references are provided with the essays to allow examination of primary source material.

Who then should read the book? I would suggest that for the young doctor these very readable tales would provide an excellent insight into the evolutionary changes on which their contemporary practice is based; for the older physician, a chance to reminisce with these eloquently written reviews; for future doctors and historians of health sciences this will surely provide an invaluable resource of what actually happened as related by a player in this history, and will fill in the spaces between the lines of a traditional history of medicine of the 20th century.

Catherine Storey 0AM, FRACP

REFLECTIONS OF A LATE 19TH CENTURY COUNTRY DOCTOR


Dr Felix Bartlett lived from 1855 to 1944. This unique book is a first-hand account of a rural New South Wales medical practice written by one who was there over a century ago. The editors of this very interesting book have edited Dr Bartlett’s memoirs, which were written towards the end of his life after he returned to England, but the text remains in the first person.

Dr Bartlett trained at St George’s Hospital London and the story of how he came to Australia as a patient’s personal doctor is itself fascinating. While the book follows his entire life, the largest portion describes his almost 20 years of practice from the early 1880s as solo doctor in Cowra in central western NSW. At the age of 26 he provided medical care 24 hours a day, seven days a week to the town, and the surrounding area. The scope of his clinical work and the difficulties in providing care to extremely sick patients who were sometimes in almost physically inaccessible circumstances would be incomprehensible to a medical graduate of the present day. He gives fascinating descriptions of complex and interesting cases, many of which would still be considered complex problems for a tertiary referral hospital. It is interesting to read that most of these patients not only survived but returned to good health.

In addition to individual cases, he singlehandedly managed epidemics of diphtheria, typhoid, pneumonia and influenza. His first-hand exposure to these episodes was a stimulus for him to obtain a Diploma in Public Health while back in London for a well-earned rest.

A few years after returning to Cowra with ‘a complete little bacteriological outfit’ and a fresh supply of the new diphtheria antitoxin, he developed a severe infection derived from ‘the sharp point of a decayed bone’ during an operation to remove a four-month-old dead foetus. With great regrets he sold the practice and returned to England where he later recommenced work in Devon.

Besides medical matters, he provides a personal insight to the problems of being a sole country doctor at that time. However, he enjoyed the complete confidence of the local population. He describes numerous interesting incidents and depicts the way of life at that time in a way that can only be done by one who was there. Dr Bartlett’s memoirs should be read by anyone with an interest in our medical history or the challenges encountered by our pioneers.

Michael Kennedy FRACP
HAVE YOUR SAY

Learning from history
In his letter (RACP News, December 2011) Dr Crowe said it was understandable that President Kolbe should advocate unity within the College. How to find unity among physicians, paediatricians, the Faculties and the Chapters will be a difficult problem. The remnant of the College as it used to be is the Division of Adult Medicine, but it is too disunited. Most of its Fellows transferred their allegiance to the special societies long ago, paying their College fees to maintain registration via the (in effect) compulsory supervised CPD programs. Adding the paediatricians, Faculties and Chapters made the College a boarding house for unrelated groups with nowhere better to go. The word ‘physician’ has more than one meaning.

Dr Crowe also said that there will be a continuing role for medical generalists, adding that the role will need better definition. Autopsies show that old people often suffer multiple pathology. Even when there is one major cause of death, a number of different conditions may have needed to be treated – allocation of priorities being one of the tasks of the generalist. The growth in knowledge and technology makes it difficult to train and maintain standards in both general medicine and a specialty, and those who make the effort may come to be regarded as second-rate specialists. The holistic medicine to which Dr Crowe refers needs specialists who cannot say, ‘That is not my sphere’, even if they sometimes request a second opinion. Though positions may become available in the emerging field of acute general medicine and lip service given to the importance of a holistic approach, it seems that in teaching hospitals, at least, there is a shrinking place for general physicians, and they will come under increasing pressure in the major regional centres.

Derek Meyers FRACP

College policy and advocacy
Fellows who pressed on to the end of President-Elect Bolitho’s article (RACP News, February 2012) may have concluded that planning the D Day invasion was simpler than developing College policy. The reality is even worse. In addition to the RACP, there are 14 other medical colleges in Australia, each entitled to its own ideas about where medicine should go. These bodies are linked through the Committee of Presidents of Medical Colleges. On top of that, there are seven partner organisations and individuals, including the Committee on Safety and Quality in Health Care, the Australian Medical Council, the Chief Medical Officer, and the National Health and Medical Research Council, all with their own ideas and priorities. Then there are Commonwealth and state governments and health departments, with their budgets and local problems.

Years ago, our College decided to act on the slogan ‘get big or get out’. Now, with its Divisions, Faculties and Chapters, it has found that the attempt to be all things to as many types of doctor as possible, has created a need to go back to being ‘One College’. This task will give committee members and their supporting administrative and secretarial staff play therapy for years to come.

There is only one body in a position to speak on behalf of all doctors in Australia, and that is the Australian Medical Association (AMA). The RACP should face the fact that, in the field of policy and advocacy, it is not, and never will be, an alternative to the AMA. Our leaders should be reminded that they owe their mostly comfortable incomes and congenial working conditions to the vigour and determination of the BMA in Australia (the forerunner of the AMA) in the late 1940s, when the attempt by the Chifley government to force nationalisation onto the medical profession was prevented in a successful action in the High Court.

All Fellows and the community would benefit if the College submitted its policy documents to the AMA for commentary, before moving on to advocacy. As EF Schumacher said, ‘Small is beautiful’. It’s often efficient and economical as well.

Derek Meyers FRACP

Response from the College
The RACP is indeed a diverse organisation. The ‘One College’ philosophy emphasised those qualities that bind us together as a College while at the same time celebrated the diversity that exists within the College. All areas of the College are expected to function within College-wide policies, providing a degree of consistency in how things are done across the College, together with attendant efficiencies. This also provides a degree of transparency and equity of access to the resources of the College. However, this is not an attempt to have complete uniformity across the College. One size does not necessarily fit all in the College and this does need to be acknowledged and respected.

To a large extent we have gone beyond the original intent of the One College philosophy; we now have a College Education Policy that determines education policy across the College, we have a single framework for ‘advanced’ training, and there has been great progress in harmonising policy and procedures in the College etc. The term ‘One College’ may now be more a source of confusion for some and a focus for reaction by others. We should now move on.

The College view is that the communities of Australia and New Zealand are best served by a spectrum of physicians ranging from the sub-specialist through to the generalist. Although the precise distribution may vary according to the type of practice, the health system and geography, it is generally agreed that the spectrum has swung too far towards specialisation. This is not just an issue confronting physicians; it is an issue for a number of other branches of medicine. It is even becoming an issue within individual medical specialties. There is a Working Group within the College currently examining the role and other aspects of the practice of general physicians. General and dual-trained physicians certainly do have a major role in the provision of health services as demonstrated by events in New Zealand in the last 10 years or more and now in a number of regions of Australia as well. Being a general physician most certainly does not equate to being ‘second-rate’ (quite the opposite), nor does it indicate a reluctance to refer appropriately.

In any comparison of the RACP with the AMA, it needs to be borne in mind that the RACP has always had a commitment not to engage directly in matters of an industrial nature or directly related to remuneration. AACP undertakes that role on behalf of the physicians. The RACP has the unique advantage in that it acts in the best interests of the communities it serves and is not directly influenced by industrial or remuneration considerations and influences. As such, its opinion is respected as being expert, considered and unencumbered by self-interest.

John Kolbe
President
HOW I LEARNED TO ROW

With age, one reverts to form – my main focus at school was sport and the lunch needed to fuel it. I now find that the ‘next row’ is a principal preoccupation.

Some years ago our 13-year-old daughter coxed for the eight in the local girls high school rowing team. A year or two later she was stroking the eight. Despite a lifetime in sport I had never seen such a committed, skilled and consistently healthy, happy and focused group of young people. As inevitably happens when one’s daughter or son is involved in a sport, many of the parents, including myself, contributed to running the rowing club in our small provincial town in New Zealand. Over the years we have had the pleasure of watching a significant number of our young school-age rowers progress to become part of the New Zealand age group, university and more recently New Zealand elite Olympic squad.

Being part of this strongly committed volunteer organisation eventually led to discussions around setting up a Masters program. All the coaches were supportive and a small group of our wives began learning how to do this.

Then the challenge was presented: ‘What about you?’

Despite having always thrived on competition and being involved in a range of sports, I was concerned that tight hamstrings, back injuries sustained playing rugby and cricket and a general lack of flexibility (age and physique) would make rowing impossible. I’ve always been a bit reluctant to set myself up to fail, so I needed to be sure that I had a good chance of being successful. I had always struggled to sit and paddle comfortably in a sea kayak and was concerned that rowing would be too difficult.

Some time after this, while out on a run I passed a gymnasium that sold top-level rowing machines (never buy a cheap one, only a very good one will give you the impetus to make full use of it). I decided to buy one, and my daughter taught me how to use it properly. (Good instruction can also be found on the internet and visualisation of rowing techniques is available on relevant YouTube sites.) I then began to develop some confidence that, with time, I would be able to row.

A number of other things contributed to this growing confidence. A small group of similarly aged friends had taken up rowing at the same time, and some had rowed at secondary school (it’s always important to have a good role model). Then there were the coaching and rowing camps – two or three consecutive days of rowing for several hours a day. This was a significant factor in ‘getting past go’ and was needed to build up the ‘memory’ required for a consistently repetitive activity.

So, we became the club’s nucleus of Masters rowers. Coaching was largely ad hoc. Initially we rowed (single oar) and sculled (two oars) an eight or quad (it’s safer in larger boats), then over the next six to twelve months progressed to a double scull prior to, with confidence, moving to a single scull, which I can now drop into the water from our front lawn (one of the benefits of living in provincial New Zealand).

This has now become a three to five day a week activity (either on the rowing machine or on the water) and when not so I miss it – especially the time on the water and the friends I row with. At the beginning, after a 15 km row my calves would cramp and my back would hurt, but over time as the body has strengthened, discomfort has reduced and flexibility improved. I feel better and fitter. My blood pressure has returned to 30–40-year-old levels, my weight has improved – and the body looks slightly better in the mirror!

Some of the benefits may be endorphin related: there is no question that after a...
The power of a team Our first 'Bronze'

solid two-hour row one has a strong sense of wellbeing, having had complete body exercise involving legs, trunk, shoulders and arms, as well as aerobic physiology (when racing this becomes anaerobic and lactic acid build-up is painful).

Another benefit comes from what our psychiatrist colleagues are now calling ‘mindfulness’ (also worth a Google). Focused repetitive action in a natural environment enables all of those issues and problems that our busy lives generate to ‘circulate in a subconscious, uncontrolled cerebral ether’, and then, when the activity is over and one is feeling relaxed, those issues ‘find a spot’, are in perspective and sensible decisions can often be made.

There is nothing more pleasurable than getting a boat ‘humming’. With the rhythm of the stroke and all those in the boat synchronised, the boat literally lifts to become higher in the water (water resistance reduces and air bubbles are generated – audible and felt – under the boat). The satisfaction of every stroke making a difference, the power and the teamwork really creates a buzz. In a single, you just ‘get lost’, enjoying the peace and beauty of the lake with its varying light, watching your ‘puddles’, and staying close to the doubles or quads who are keeping an eye out for you.

For those with a competitive streak, it takes around five years of active rowing to start to become competitive with those who have rowed since they were boys. We have just started to compete at National Masters regattas – it is an exciting, adrenalin-charged experience to line up alongside old Olympians and National title holders. Usually the start is the last time we see them (apart from at the barbecues and coffee/drinks afterwards), but we have improved so that in both mixed and men’s quads we are now winning bronze medals. Our quad sculling ‘girls’ won a gold last year and that was very exciting – we men were going ‘nuts’ on the banks of Lake Karapiro, New Zealand’s rowing capital.

All of this comes complete with significant pre-race tension and lack of sleep, as well as pain during the race. I never imagined two or three years ago that we would be able to achieve ratings of 30–35 a minute (the elites get up over the 40s). And there’s no question that the boat lifts, picks up speed and satisfying bubbles are heard when we manage this.

On top of all this is the ‘adventure’ option. Three years ago we took two Masters crews to France for a 200 km, 40 km a day time trial, rowing the Canal du Midi from Toulouse to Béziers. In temperatures around 40°C, this was a fantastic experience. Embedded in French culture (and red wine), using schoolboy French, we were well received and made many new international friends who all have beautiful spots at home to row in.

Our spot, Lake Rotorua, is one of these – stunning in the early mornings when the lake is flat, covered in winter mists, or lit by a sunrise. There are times when it feels like we live in paradise.

Our latest plan is for a substantial South Island camping holiday, rowing some of the spectacular, often mountain shielded, waterways.

At the end of it all, some 50-year-old (plus) men and women are a lot fitter, have had a great time and have made some lasting friendships (you spend a lot of time with each other, including your spouse).

I would recommend rowing to anyone who loves the outdoors and has the opportunity to be taught how to row well. It requires a reasonable amount of time – one needs at least 12 months of perseverance and some frustration before ‘getting past go’. You will not be disappointed once you have achieved this.

I couldn’t live anywhere I couldn’t row.

Johan Morreau FRACP
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