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Cover photo by John Garrett, Paediatric Registrar, Whangarei, New Zealand.
Sun setting on Australia, as seen from Pioneer Hut at 2360 metres on the Fox Glacier névé, Westland, New Zealand.
professionals in all fields have always known the importance of new knowledge, improved skills and development of personal qualities. But there is now a clear acknowledgement of the need for professionals to continuously acquire new knowledge, not only for ongoing development of one’s expertise but also to fulfil the increasing expectations of consumers who expect a higher level of duty of care and service than in the past.

Attaining a professional qualification is not the end of the road, but merely the first step towards lifelong learning.

We believe that almost all Fellows undertake some form of Continuous Professional Development (CPD), though many do not report to a CPD program.

The mandating of CPD has been discussed internationally for a very long time and many developed countries took this step a number of years ago. The New Zealand Medical Council introduced mandatory CPD for all its medical practitioners in 2001. In Australia, eight of fourteen medical colleges have mandatory CPD requirements.

Research suggests that CPD activities that include individualised educational activities geared towards identified needs are shown to improve learning and hence competence.

In recognition of the worldwide trend, and indeed the trend already occurring in most Colleges across Australia and New Zealand, the Council of Australian Governments has developed legislation which is currently in draft form but which is likely to be passed later this year, making medical registration in Australia conditional on the practitioner being involved in an approved CPD program.

Our CPD Expert Advisory Group put a well-argued proposal to the College Board in May of this year arguing that the RACP should have mandatory CPD. The Board has agreed to this.

There were two major reasons why the Board has done so.

First is the recognition that mandatory CPD is beneficial for both standards of practice and expectations in the community.

Second, it is virtually certain that involvement in CPD will be a requirement for medical registration from 2010 or 2011, and supporting the concept now will give Fellows adequate time to learn how to become involved in CPD if they are not so already. In forthcoming editions of RACP News, the Dean will explain how the College is making it increasingly easy to comply with CPD.

There are undoubtedly barriers to the introduction of a CPD program. Some argue that professionals should be accountable for their own effective performance, that CPD involvement does not guarantee change in attitude or improved patterns of practice, that performance of the incompetent physician will not necessarily be brought up to standard by involvement in a CPD program. Moreover, CPD involves finding time in already very busy schedules.

Participation and recording of CPD in an online program, such as the RACP program, becomes increasingly time efficient when one becomes familiar with the practical issues of recording. It has also been demonstrated that recording CPD gives users time to reflect on and to recognise what has been achieved and what still needs to be achieved, and then to prioritise learning.

The vast majority of physicians will not find mandatory CPD particularly onerous as they already participate in regular CPD activities.

Whilst Fellows in New Zealand have had mandatory CPD as a requirement of continued registration with the New Zealand Council for some time, it is felt that the College should be consistent and that CPD should become a College-wide requirement.

The new RACP program is believed to be fair and to take into account private practice and rural practice barriers. Hence the program has introduced limits to some categories to ensure that those with little or no hospital work or teaching commitments are not penalised.

MyCPD offers a suite of activities to suit all types of practice. These include teaching, supervising, mentoring, research, publication and presentation, attendance at seminars, conferences and workshops, participation in self-assessment programs, structured learning projects, practice review and appraisal and attendance at grand rounds, journal clubs, teaching ward rounds, journal reading and so on.

The Board acknowledges that most Fellows are maintaining a very high level of competence through practice and lifelong learning and that a very high percentage of Fellows is already meeting or exceeding the voluntary CPD requirement set by the College.

No longer can keeping up to date be optional; it is increasingly essential to all professionals and the success of organisations that CPD be an integral part of one’s work activity.

No longer can keeping up to date be optional; it is increasingly essential to all professionals and the success of organisations that CPD be an integral part of one’s work activity.

With apologies to William Shakespeare

RACP President

Professor Geoffrey Metz AM, PRACP
HEALTHCARE PROGRAMS RELEVANT TO THE PRACTISING PHYSICIAN

Professor Chris Baggoley, Chief Executive of the Australian Commission on Safety and Quality in Health Care, talks about just some of the work being done by the Commission to improve healthcare standards.

In the RACP News of April 2009 Dr Yvonne Luxford observed that ‘it is simply impossible to miss the flurry of commissions, taskforces and inquiries that are scrutinising the Australian health system’. In preparing this article for RACP News, I am mindful that this flurry of activity is often peripheral to the daily life of the practising physician, so I will focus on two of the Commission’s programs that should resonate with this clinical work. The first program is clinical handover; the second is recognising and responding to clinical deterioration.

Clinical handover

Clinical handover is a key initiative of the Commission, which has adopted the AMA 2006 definition:

the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.1

At least 7 million handovers occur annually in Australian hospitals, many of which, such as telephone referrals, go unnoticed as handover. Poor handover can lead to delays in diagnosis, treatment and care; repeated tests, or missed or delayed communication of test results; and incorrect treatment or medication errors.

Given the lack of ready-made guidance on good clinical handover, the Commission has funded 14 pilot projects to develop practical and transferable tools and solutions for improving handover. The pilot program included workplace research and the implementation of standardised handover processes at more than 30 hospitals in six jurisdictions. Aspects of 10 of these projects were published in the MJA Supplement to Volume 190, No. 11 of 1 June 2009. Highlighted in the paper by Christine Jorm and her colleagues were the common themes expressed in the articles.2

The need for ‘flexible standardisation’ is the first of those themes. While not all who have been consulted on our clinical handover guide have understood or embraced the concept, project teams have found that both flexibility and standardisation are required in developing successful handover programs. Thus a minimum data set may need to be implemented, but it will need to be customised to ensure that it meets the requirements of the local clinical context.

The importance of clinician involvement in any quality improvement process is well understood. In clinical handover it provides more than ownership; it allows the opportunity for creativity in tailoring the handover process to be relevant to the clinical circumstances.

Methods for ensuring that handover results in a shared understanding of information are assisted by a standardised approach, which can help clarify the purpose and content of handovers and reduce confusion. The use of mnemonics to underscore the basic elements and key data elements, and of the whiteboard and technological solutions, can assist in this process.

The fourth theme that emerged from the research is one understood by all physicians. The complexity of healthcare means that maintaining continuity of patient care is a challenging process. Here, training in communication has been shown to help.

Finalised tools, solutions and reports are already freely available from the Commission’s website, including the following:

• protocols for medical shift-to-shift handover, such as staff engagement strategies, content requirements and discipline-specific training materials
• materials on using the iSoBAR (Identification, Situation and status, Observations, Background and history, Action agreed plan and accountability, Responsibility and risk management)³ data set for handover, which is highly transferable and adaptable to local context
• a tool kit developed to enable clinicians to observe their own handover practices using video to reflect and redesign those practices
• six hours of clinical handover online education.

A guide based on workplace research from
the Royal Hobart Hospital – University of Tasmania pilot project and the Western Australia Country Health Service – Royal Perth Hospital pilot project is available to assist clinical leaders and managers to develop solutions for improving clinical handover practice. Furthering the use of mnemonics, which does irritate some but is applauded by most, it is called the ‘OSSIE Guide’, a mnemonic developed by the Tasmanians. OSSIE stands for Organisation leadership, Simple solution development, Stakeholder engagement, Implementation, Evaluation and maintenance.

The Commission has organised three workshops in Adelaide, Broome and Perth on how to use practical tools to make clinical handover safe. The workshops have been attended by more than 500 clinicians, with doctors being present in strong numbers. A fourth workshop is being planned for Melbourne in November. The Commission looks forward to presenting a workshop on its clinical handover work at the World Congress of Internal Medicine in Melbourne, in March 2009, during Physicians Week.

If you wish to learn more about the Commission’s clinical handover program, visit the Clinical Handover Program webpage on the Commission’s website at: www.safetyandquality.gov.au.

**Recognising and responding to clinical deterioration**

As you are all too well aware, the characteristics of patients in Australia and internationally are changing. Acute care hospitals now have an increasing proportion of patients with complex problems who are more likely to be or to become seriously ill during their hospital stay. Warning signs often precede serious adverse events such as unexpected death, cardiac arrest and unplanned admissions to intensive care units. However, there is consistent evidence that these warning signs are not always identified and, if they are, they may not be acted upon.

Survival rates from cardiac arrest are lower on weekends and at night, and mortality rates of patients admitted to intensive care from general wards are higher than those admitted from emergency departments or operating theatres, suggesting that these patients are not receiving optimal care prior to their admission.3,4

The factors contributing to failure to recognise and respond appropriately to deterioration are complex and overlapping. They include knowledge and skills of staff, the way in which care is delivered, organisational systems, attitudes and communication of information. All of these factors need to be addressed for patients who are deteriorating to consistently receive safe and high-quality care.

Much of the development of recognition and response systems to support the care of such patients has come from bottom-up processes, and a range of systems have evolved to meet the specific needs of individual hospitals. The use of systems to respond to the needs of these patients is increasing, and in 2005 approximately 60 per cent of hospitals in Australia and New Zealand with an intensive care unit reported having a medical emergency team. However, the use of a medical emergency team is only one aspect of the recognition, response and organisational supports that are required to provide effective care to these patients, and the limited anecdotal information that is available about the wider use of these systems suggests that their implementation and effective use is variable.

The only national initiative in Australia to promote the use of rapid response systems was part of the Safer Systems – Saving Lives program which did not continue past the end of its funding in 2007, and the sustainability of the initiative was limited. Several jurisdictions are now developing and implementing their own programs in this area.

In 2008, the Australian Commission on Safety and Quality in Health Care commenced a new program of work with the goal of improving recognition of and response to clinical deterioration in hospitals and other acute care facilities. An Advisory Committee was convened to inform the program, with a significant proportion of Committee members being clinicians who had longstanding interest, expertise and, often, research in this area. Dr Rick McLean, who is well known to RACP Fellows and is now a general physician in north-eastern Victoria, has added considerable expertise to the group.

The main initiatives in this program are the development of:

- a consensus statement setting out the essential elements for recognising and responding to patients who deteriorate
- guidelines to applying the essential elements in specific settings, namely paediatrics and smaller facilities with no intensive care or limited medical cover
- a guide to implementation of programs to improve the recognition of and response to clinical deterioration
- an evidence-based adult general observation chart that supports recognition of deterioration and prompts action.

The consensus statement will provide the platform for the development by the Commission of the additional guidelines
and other supporting materials. The draft statement is now available for consultation and can be found on the Recognition and Responding to Clinical Deterioration webpage on the Commission's website (www.safetyandquality.gov.au). Responses are welcome until 25 September 2009.

The draft statement is applicable to all types of acute care settings and all types of patients. The statement focuses on the broad elements of care required to recognise and respond to patients who deteriorate, and does not specify how they should be achieved. The broad nature of the statement supports the flexibility required for different contexts, as well as the standardisation that is an important aspect of the delivery of safe and high-quality care. Quite spontaneously, the concept of ‘flexible standardisation’, as articulated in the Clinical Handover (OSSIE) Guide, is emerging as a key component of other programs of the Commission.

There are eight elements included in the draft statement. Four of these relate to clinical processes that need to be delivered based on the circumstances of the facility in which care is provided. They are:

- measurement and recording of observation
- escalation protocols
- rapid response systems
- communication processes.

The other four elements relate to the structural and organisational prerequisites that are essential to the effective operation of systems for recognising and responding to clinical deterioration. These elements are:

- organisational supports
- education
- evaluation and monitoring
- use of new technology.

Your feedback on this program, on clinical handover or on any aspect of the Commission’s work is most welcome. Our work must be of direct clinical relevance to physicians if it is to make a difference for your patients.

**Professor Chris Baggoley**
Chief Executive
Australian Commission on Safety and Quality in Health Care

**Select References**


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**E-HEALTH AND PATIENT SAFETY**

Here, the National E-Health Transition Authority outlines the important contribution a national e-health system can make to the quality and safety of healthcare for all Australians.

Australia faces a growing demand for healthcare reform driven by an ageing population, an increase in the prevalence of chronic diseases, better informed health consumers, and a demand for improvements in the quality and safety of healthcare.

To ensure a sustainable future, Australia’s governments have promoted healthcare reform. Integral to this is e-health.

The National E-Health Transition Authority (NEHTA) was established by the Australian Commonwealth, State and Territory governments on 5 July 2005 to develop better ways of electronically collecting and securely exchanging health information.

In early 2008, Australian Health Ministers, through the Australian Health Ministers’ Advisory Council (AHMAC), commissioned Deloitte to develop a strategic framework and plan to guide national coordination and collaboration in e-health. The National E-Health Strategy provides a guide to the further development of e-health in Australia.

The benefits of a national e-health system extend to all sections of the healthcare landscape with the safer, more accurate, timely and reliable transfer of clinical information from known sources, which healthcare providers can access and use for patient care with certainty. Understanding how e-health can address patient safety is key to NEHTA’s work.

Gathering patient information from multiple sources in many formats is arduous and inefficient. Mismatching of patients’ records and results is a documented problem for the health system. A clear link
has been established between avoidable delays in patient care, deaths and poor medical records management. For instance:

**Preventable errors**
- Up to 18 per cent of medical errors are attributed to inadequate availability of patient information.
- Medication prescribing errors are estimated to cost $380 million per year in the public hospital system.

**Reduced productivity**
- 25 per cent of a clinician’s time is spent collecting information rather than administering care.

**Costly misuse of resources**
- Up to 35 per cent of referrals to hospitals could be avoided by improved communication of health information.

Helping to inform and guide NEHTA’s work are more than 20 well-respected and experienced clinicians. National Clinical Lead Dr Mukesh Haikerwal has responsibility for coordinating this accomplished and multidisciplinary group of clinicians.

A commissioner with the National Health and Hospital Reform Commission and an executive councillor with the World Medical Association, Dr Haikerwal has been a Melbourne general practitioner for more than 20 years and is also a former Australian Medical Association President.

‘My role with NEHTA is to make sure that the “health” is put into e-health ensuring that e-health developments are clinically relevant and meaningful and that they are safe and do work. We have to show that the benefits from the use of this new technology support and enhance clinical method—not replace it,’ says Dr Haikerwal.

E-health systems are already in use across Australia. To maximise the benefits for the future, Australia needs a truly national system operating to the highest standards of safety and security. A focus of NEHTA’s work is to develop the specifications that will underpin a national e-health system.

Healthcare patients need to see information relating to their healthcare managed in such a way that there is no risk to their care, confidentiality or safety due to mismanagement of health records or poor systems. NEHTA’s work is helping to achieve this.

The information that will be exchanged electronically across the healthcare sector includes discharge summaries and referrals, pathology and radiology requests and reports, prescriptions and patient medication histories. There are benefits, too, from the use of clinical decision-support information and patient self-care options.

Defining a set of secure messaging protocols for e-health will ensure that data exchanged between healthcare providers remains just that—secure, but also accurate.

A requirement for a safe and secure e-health system is the ability to uniquely identify everyone involved in a single healthcare transaction. This includes the person receiving healthcare, the person administering healthcare, and the place where healthcare occurs. NEHTA has contracted Medicare Australia to scope, design, build and test Unique Healthcare Identifiers to provide this function.

To ensure that only the right authorised person can access the information, the National Authentication Service for Health (NASH) will provide the first nationwide authentication service for healthcare organisations in Australia.

Having an e-health system that uses a ‘common language’ which can be interpreted accurately is critical for patient safety. The common language is SNOMED CT (Systematised Nomenclature of Medicine Clinical Terms). NEHTA is customising SNOMED for the Australian healthcare environment by developing supplementary terminologies for clinical concepts and conditions unique to Australia, recognising nomenclature systems currently in use.

To achieve a national interoperable e-health system, vendors and healthcare providers require certification to be a part of the system. This brings with it assurance for system designers and those who purchase and use it that the system is fit for task, will communicate with other systems, and that the data stored and exchanged maintains safety, quality, accuracy and confidentiality.

Compliance ensures e-health specifications have been met and leads to the correct use of relevant international standards. Compliance also relates to the adherence of an individual or organisation to regulatory requirements and standards. Conformance relates to how products and services accurately implement the national e-health specifications. Accreditation is associated with the recognition that an organisation or person is competent to carry out a set of tasks or functions.

NEHTA is also developing e-procurement solutions. The National Product Catalogue (NPC) uniquely identifies healthcare products, including medicines and medical devices and equipment, and records important supply chain and clinical information about those products such as the components of products and pack sizes. As a standardised catalogue, the NPC reduces the chance of introducing erroneous data into procurement transactions and the errors these cause. This is particularly important in the healthcare supply chain where getting the right products at the right place and time can be critical to ensuring quality patient care.

NEHTA’s work on e-health security, safety and quality is informed by strict consideration of privacy issues and legislation. NEHTA is committed to developing the national foundations for the electronic exchange of information for healthcare purposes in a way that ensures individual privacy is protected. Six privacy tenets have been developed that guide NEHTA’s work. Together, the tenets map a total commitment to privacy, underlining the need for an individual’s participation in his or her data collection and management and a transparency of purpose for data collection.

Through understanding the factors affecting patient safety and being able to demonstrate the benefits of e-health and the value that the electronic exchange of information can provide to improving patient safety, NEHTA’s work is positioned to help overcome the challenges facing our healthcare system.

For further information on NEHTA’s work go to: www.nehta.gov.au.
THE CENTRAL NORTHWEST CONSORTIUM
PREP PROGRAM: LAUNCHING THE MINI-CEX

The Central NorthWest Consortium is working hard to implement the new PREP program. In this and the following article, Stephen Warrillow and Sarah Kliene bring us up to date with their progress, insisting that it’s easier than they had imagined.

The College’s new physician education program brings a host of welcome changes to invigorate specialist training in internal medicine. Along with a reaffirmation of trainees taking responsibility for their own education and development, there is a new emphasis on formative evaluation. This latter aspect of the program is generally welcomed by trainees, many of whom are familiar with this approach from earlier learning experiences. For supervisors and educators, it also has many potential benefits, but may also require additional support and resources for them to effectively deliver the program. Within our physician training consortia, we recognised the challenges of implementation and sought to develop strategies to address them.

We realised that we should move on from discussing the mini-CEX as a concept, and get on with actually completing some.

The Central NorthWest Consortium comprises Austin Health, Northern Health, Bendigo Health and Wimmera Healthcare Group. After several discussions about the PREP program at our regular videoconferenced consortium management meetings, there emerged a consensus from the Directors of Physician Training that we should focus on introducing the mini-CEX as a matter of priority. This was partly because it was viewed as a potentially useful tool for evaluating and assisting trainees earlier in their progress through the program, but also because our trainees were increasingly asking about its introduction. Several options for rolling out the mini-CEX were canvassed and the scoping process continued for some time. Ultimately, however, we realised that we should move on from discussing the mini-CEX as a concept, and get on with actually completing some.

To make progress, the key elements were finding a willing trainee to be the ‘test case’, involving a few supervisors to do the evaluation and providing the logistical support required via our consortium manager. One brave soul from the trainee ranks agreed to be the first and was even sporting enough to allow a curious audience of other trainees to watch. The senior medical registrar at the site found an appropriate patient for the clinical evaluation and the consortium manager coordinated date, time, venue and paperwork.

When the fateful day arrived, it was all so straightforward as to be almost an anticlimax. The trainees provided positive feedback on the experience and the whole process worked well. However, while we had achieved ‘proof of concept’, could we move the mini-CEX to the next phase?

To do so, it was clear that we needed streamlined processes. With the help of a small group of supervisors we decided to be a little more ambitious and aimed to run the mini-CEX for all trainees wishing to undertake one. After some fine-tuning, we settled on a format. Supervisors notified the
The manager of their availability. The manager matched these slots with eligible trainees.

The senior registrar found a suitable case, and the trainees were advised to bring the downloaded PDF form. So as to ensure all followed through, the manager arranged to text message both the supervisors and the trainees the day before and again an hour prior to the designated time as a reminder of the time and venue. Did this approach work? After over 40 mini-CEX encounters, we can say that it does. None of the evaluations took longer than 20–30 minutes and satisfaction has been consistently high from both trainees and supervisors.

Mini-CEX feedback and discussion—Dr Sara Baqar and Dr Ian Wilson, Northern Health.

We have learned several things during this process. Firstly, while the rollout with a small dedicated group of supervisors has gone well, there needs to be a high level of involvement from all physicians involved in trainee supervision. To this end, we have conducted short focused education sessions for all physicians during grand-round meetings at the Austin and Northern sites. These have been well received and we anticipate significant expansion of the ranks of those undertaking mini-CEX with their trainees. Soon we will undertake a similar approach at our rural sites.

Secondly, while our approach has been very successful, it is labour intensive for the manager and a better system is needed. Our solution has been to develop a web-based booking and notification system which will be trialled in the next few months. This new system will be available via a secure login on our consortium website and will allow supervisors and trainees to nominate availability for all sorts of educational activities, including mini-CEX. The system will track all trainees needing mini-CEX and allow them to book evaluations. An automated SMS text reminder will be sent to the trainee and supervisor to ensure that both attend. We anticipate that this will maintain the highly successful elements of our program so far, but with much less of an administrative burden on our consortium manager.

While the processes outlined have been very successful so far, an unanticipated but very beneficial outcome from the experience has been the discovery by the trainees and supervisors involved that the mini-CEX is far less onerous than had been imagined. There was clearly a bit of initial anxiety and uncertainty on the part of trainees (several came along suited up as for the FRACP clinical exam and were extremely nervous!). Likewise, the supervisors undertaking the evaluation had some reservations about the amount of work involved.

We have all learned along the way and now appreciate that the mini-CEX is intended to simulate the real-life work of a physician in training. They have been conducted on wards, in the emergency department and in outpatients. They are quick and can be completed in a short time (including the documentation). Trainees now feel more relaxed about the process and supervisors know that the format is flexible enough to be worked in to a busy schedule. This increased confidence means that, while we will continue to develop our processes to support the conduct of the mini-CEX in our training sites, many will be arranged directly between trainees and their supervisors without the use of the formalised consortium booking process.

We see these two systems as working well in parallel, providing trainees and supervisors with an optimal balance of flexibility and support as desired. It is increasingly clear from our experience that this innovative and flexible approach will allow the most effective introduction of the PREP program as we move our program rollout on to other areas such as the SIAT, multi-source feedback and the Professional Qualities Curriculum.

The final key ingredient for success, however, has been a preparedness by trainees and supervisors alike to take the plunge and start!

Acknowledgement
The Central NorthWest Consortium mini-CEX rollout has been extremely well supported by several key individuals, especially Dr Henry Ma (Austin Health DPT), Professor Judy Savige (Northern Health DPT), Dr Pat Charles (Austin Health Educational Supervisor), Dr Mark Ng (Elizabeth Austin Registrar) and Dr Sara Baqar (Northern Health Senior Medical Registrar).

Stephen Warrillow FRACP
Consortium Director of Physician Training

Sarah Kliene
Consortium Manager
The College’s new Professional Qualities Curriculum (PQC) outlines many of the important areas of knowledge, ethics, communication, behaviours and attitudes that complement the clinical skills and knowledge of an effective physician/paediatrician. It consolidates a long-standing tradition of high standards in professional life established and exemplified by College Fellows for a very long time. While trainees acquire or develop many of these qualities through working closely with their supervisors, some aspects of the curriculum are amenable to a more structured approach. In considering how best to undertake this important part of trainee development, our consortium has developed a professional development program to provide several parts of the PQC. There has been increasing interest in assisting trainees from various programs with professional development for several years now, and most state postgraduate medical councils have undertaken significant work in this area. We decided to modify a model trialled by the Postgraduate Medical Council of Victoria (PMCV) and conduct a one-and-a-half day residential program for our consortium’s physician trainees.

The Central NorthWest Consortium comprises Austin Health, Northern Health, Bendigo Health and Wimmera Healthcare Group. Our program has evolved somewhat over the last three years or so that we have run it and now provides trainees with several elements of the PQC in a structured, but less formal setting, which has become highly valued by all participants.

Our approach involves heading to a rural retreat centre about an hour out of Melbourne. Trainees who have just started their first rotation as a medical registrar (or are about to do so) are invited to attend, and assistance with roster arrangements is provided. We have focussed the PD weekend on this group of trainees as they are starting to climb the ladder of seniority in the medical hierarchy and are very receptive to the issues covered. Between 8 and 12 participants attend each time, leaving for the venue on a Friday evening after work. On arrival, they are provided with an outline of the program, meet the conveners and mingle with one another. Once all have arrived, the program begins.

One of the key themes that we promote in the program is that of peer support and mentorship. The first presentation is actually provided by advanced trainees who have recently moved on from their own experience as a general medical registrar. Issues that often come up are those associated with the transition from residency to registrar roles, and the opportunity to share various pearls of wisdom is very popular with the new registrars and instils a real sense of continuity and collegiality. The program then moves on to cover concepts of self-understanding and working with others. This is facilitated in part through the Myers-Briggs Type Indicator test and provides a range of interesting insights as well as material for dinner conversation.

Once the formal aspect of the evening is concluded, we move to dinner. An invited physician, who is often a fairly new Fellow, gives an informal after-dinner talk about their own journey through physician training and an insight into the world of consultant practice. Most often, this informal presentation gives way to lengthy and far-reaching discussions about the nature of medical practice, work–life balance and the like.

Participating trainees have universally provided very positive feedback about the experience … Many can specifically identify skills and strategies they have learned which they can usefully implement in their clinical work.
After breakfast the next morning, the program resumes early. A whole host of issues are discussed using an interactive format. Topics include: leadership, conflict resolution, teaching, educational styles, organisation, teamwork, dealing with ethical issues, decision-making, giving (and receiving) feedback and communication. A variety of styles are utilised, such as group teamwork activities, group discussions, focused teaching sessions, role-playing and communication games. This ensures that the content remains stimulating and that the intensity of the issues discussed does not cause too much overload.

After a very full day, conveners and participants alike have usually had enough by around 4 pm. Participating trainees have universally provided very positive feedback about the experience and indicate that the program is both informative and enjoyable. Many can specifically identify skills and strategies they have learned which they can usefully implement in their clinical work. We have found that the best way of attracting participants for the next program is via the positive word-of-mouth appraisals from our trainees.

Taking most of a free weekend from the busy work and study schedule of a medical registrar is not done lightly, but the positive results that we have seen make the venture well justified.

Acknowledgement
The Central NorthWest Professional Development Program and PQC has benefited greatly from the expertise of Dr Jag Singh from the Confederation of Postgraduate Medical Education Councils as program convener.

Stephen Warrillow FRACP
Consortium Director of Physician Training

Sarah Kliene
Consortium Manager

The new National Registration legislation is likely to include a mandatory Continuing Professional Development (CPD) requirement. With support from the Board, the CPD Expert Advisory Group is considering policy which will make CPD mandatory for College Fellows before National Registration comes into force in July next year.

The MyCPD program is an online system developed not only to make it easier to record credit points, but to incorporate sound educational principles into the College’s CPD program.

We have designed this innovative user-friendly tool with you, our Fellows, in mind. It combines the features of a diary and a learning log into an integrated learning navigator, enabling you to review, reflect, evaluate and plan individual ongoing CPD activities as you go.

The program is based around a calendar year and Fellows may log in their CPD activities retrospectively and prospectively throughout the year. Annual points are submitted online and an official statement of participation is available to be printed immediately from the program upon satisfactory submission of an annual return.

Since its inception in May 2008, 3500 Fellows have used MyCPD to record their CPD activities.

The CPD team is continuously improving and upgrading the program as the College receives valuable feedback from its members.

Just a reminder that Maintaining Professional Standards (MOPS) will cease to be available to Fellows from January 2010.

For more information on MyCPD please visit www.racp.edu.au/mycpd or contact the CPD secretariat on 02 8247 6239.

Christine Jusuf
CPD Education Officer
Deanery

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**Did you miss Physicians Week 2009?**

**Or did you miss a session you really wanted to attend because of conflicting session times?**

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Don’t worry—many of the sessions from Physicians Week 2009 were recorded and are now available to purchase.
The rollout of the newly restructured Basic Training Program, the Physician Readiness for Expert Practice (PREP) Program, is well underway in both the Adult Medicine and the Paediatric Divisions in New Zealand. Such a substantial change in training was always going to be a major challenge to implement, but good progress has been made. The commitment, flexibility and goodwill of all those involved in Basic Training has been crucial to the initial success of PREP.

**Educational supervisors vital to success**

As we move to a more structured and educationally robust training program, the role of the local educational supervisor is critical. The Directors of Adult Physician and Paediatric Training have been exemplary in their willingness to take on the additional workload that PREP has brought, often without an immediate increase in financial or other resources. They have been patient with the NZ Education Committees as we have grappled with the optimal approach to implementing the components of PREP, and many have contributed to the transition planning throughout the past two years. They deserve as much support as the College can provide.

**Training in transition**

The long-term vision for the PREP Program includes a comprehensive set of teaching and learning tools, curricula and workplace-based formative assessment. However, we will only reach this goal in stages, and in New Zealand we have cautiously ensured that the transition is manageable for both trainees and educational supervisors. In effect, there are two simultaneous transition pathways. The first is the progressive enrolment of new Basic Trainees in the PREP program. Currently, more than two-thirds of trainees are still completing training under the ‘old’ system. The second transition is the staged introduction of the components of PREP, focusing initially on the Mini Clinical Evaluation Exercise (mini-CEX) and yearly supervisor’s reports. Training requirements for PREP in 2009 have been kept to an achievable minimum, limiting the burden on existing educational supervisors while additional resourcing is being established.

**Guiding the supervisors**

Supervisors have been keen to ensure they have the necessary skills to implement PREP for their trainees, and a range of ongoing initiatives are fulfilling this need. Face-to-face workshops for supervisors have been highly successful, led primarily by Drs Ralph Pinnock and Jonathan Christiansen, Chairs of the NZ Education Committees for Paediatrics and Adult Medicine respectively. The Deanery has provided both resources and personal support, and workshops have now been held in most major training centres. More are planned as the year progresses. Importantly, workshops have been open to all supervisors (whether Directors of Training or day-to-day run supervisors) and also to trainees of all levels. This format has provided an excellent forum for often vigorous discussion of issues in both training and the implementation of PREP, and has assisted in communication between the College and the workplace. Videoconferencing has been an excellent adjunct to the workshops, especially in Paediatrics, allowing many smaller training sites to participate and interact directly with colleagues in larger centres. Online resources have been a minimal part of supervisor training until now, but will greatly assist in the future. There is a wealth of information on the Basic Training Portal, and the mini-CEX tutorial is a valuable e-learning resource.

**Trainees take the lead**

The grassroots implementation of PREP has not just been driven by the Chairs of the Education Committees or Directors of Training; the trainees have taken the lead also. Individual trainees have assumed responsibility for ensuring that supervisors are up to date with changes and are undertaking the mini-CEX. The Trainees Committee has been active in promoting PREP, and senior trainees have run workshops—Dr John Garrett, Paediatric Advanced Trainee, led one that was video-linked to a national audience. The future success of PREP rests primarily with the willingness of trainees to take control of their own learning.

**Mini-CEX in the workplace**

The mini-CEX is a key focus for the introduction of PREP, and it has been widely accepted. Supervisors and trainees often have had prior experience with this tool at undergraduate level, and can see the immediate applicability of this formative feedback to regular clinical work. Responses from the workshops, and particularly to the input of Dr Paul Reeve, Waikato Director of Physician Training and Chair of the Written Examination Committee, have allowed us to bring together a more general resource to assist those involved with PREP in integrating the tool into the routine workflow of a clinical team. This document is now available as a download from the Portal, and will hopefully be of value to our Australian colleagues. A yearly progress report is required for PREP trainees in 2009, representing a fundamental change for Basic trainees. A move to the use of the online Portal should streamline the reporting systems, and we have been pleased to work closely with the


We are conscious of the volunteer nature of our teaching workforce, and the need to support our supervisors and nurture their passion for educating the next generation of Fellows.

Looking ahead

We have reached a critical juncture in the implementation of PREP in New Zealand. The first stages of the rollout have been achieved, but as the number of PREP trainees increases, and more elements of the program are introduced, adequate resourcing will be essential. Achieving this is the challenge for 2009–2010, and will require a multifaceted approach. Discussions are underway with the central funding body (the Clinical Training Agency), and communication is ongoing with employers (the District Health Boards). Site accreditation is a crucial mechanism through which the College can support local Directors of Training in gaining greater time and remuneration for the increased workload of PREP. We are conscious of the volunteer nature of our teaching workforce, and the need to support our supervisors, maintain their goodwill and nurture their passion for educating the next generation of Fellows.

Jonathan Christiansen FRACP
Chair, NZ Adult Medicine Division Education Committee

By 2011 there will be new training programs in Advanced Training. Called PREP Advanced Training (PREP:AT), these programs will be integrated with, and bear some similarity to, the new PREP Basic Training (PREP:BT) Program.

Meanwhile, 2009 has been an exciting one for curriculum development at the College as it has seen the launch of the PREP:AT11 project, which will see the implementation of Advanced Training curricula from 2011. The development of relevant curriculum documents and assessments will mean that the Advanced Training Program will be completely aligned with the Basic Training Program.

An Advanced Training Summit was held on 24 February to consider the nature and shape of Advanced Training from 2011. Professor Brian Jolly, an international medical education expert, facilitated the summit, which was attended by 61 people representing the 25 specialties across the Divisions, Faculties and Chapters. A clear outcome of the day was the desire for all specialty groups to progress in a synchronised way, utilising the Deanery to support the harmonisation of curriculum development, assessments and an electronic learning environment for all advanced trainees.

A plan for PREP:AT11 was also developed. This is divided into four distinct phases.

In 1993, Brian co-led a team in a successful tender to the Commonwealth Government of Australia for a research project to evaluate and redesign the training scheme for general practitioners in Australia.

Brian completed a Masters Degree in Medical Education in 1981, and a PhD for work on clinical education at Maastricht University in the Netherlands in 1994.

In January 2002, he became Professor of Medical Education and Director at the Centre for Medical and Health Sciences Education at Monash University. He was on the Federal Ministerial Steering Committee for the recently completed Australian Medical Education Study, and last year co-hosted the Ottawa Conference on Medical Education—Ozzawa 2008.

Brian is a member of the Postgraduate Medical Council of Victoria and of various committees associated with the Australian Curriculum Framework for Junior Doctors. He has engaged in consultancy work for the AMC (undergraduate and specialty accreditation committees), the RACS, the RCSEng, RACP, ANZCA, PMCSA, PMIT, and many universities in Australia, the United Kingdom and the Middle East.

WHAT’S COMING IN ADVANCED TRAINING?
INTRODUCING PREP:AT11

DR BRIAN JOLLY

As a graduate in Psychology, Dr Brian Jolly began working in medical education in 1972. In 1983, he helped develop the Cambridge Conference: a series of conferences that has had a major international impact on medical education. In 1989, Brian obtained a United Kingdom learning improvement grant (£752,000) for staff development and student-centred education, which at that time was the largest grant ever awarded for medical education. This was later eclipsed by a successful bid from a consortium of four schools in North Thames, in which he was a Chief Investigator, for development of community-based medical education (£852,000).
Phase 1: March–July 2009

This phase involved the development of processes for curriculum development, ratification and implementation. It also involved defining the current situation and establishing the necessary resources.

In March, the College Education Committee ratified the new Curriculum Development and Ratification Process, developed by the Education Deanery.

The Curriculum Development and Ratification Process recommends an external review of each curriculum prior to ratification. The review panel may include Advanced Trainees and Adult Medicine, Paediatric and Specialty Society representatives. The first aim of the review panel is to gain broader input to curriculum content. The second aim is to engage people who have not been involved in the initial writing of the curriculum to ensure that there is a balance in the overall emphasis of the document, that there are no significant gaps and that the content sits at about the level of emphasis, complexity, depth and breadth that those from the discipline, but not involved in its preparation, will be more likely to find acceptable.

The curriculum will be reviewed from an educational perspective by Deanery staff, whose expertise includes adult education, curriculum development, assessment and e-Learning. A senior administrator has been appointed by the Deanery, and the Faculties have also appointed Senior Executive Officers and Project Officers to assist in curriculum development and implementation.

Phase 2: July 2009 – July 2010

Phase 2 will see the Deanery further engaging trainees and the Specialty Societies through the development of an online portal for curriculum development, which will include an Assessment Toolkit, online forums and individual webpages for each specialty.

The Assessment Toolkit is being developed as a resource for the specialties and their curriculum writing groups. The College recommends the use of specific tools covering workplace-based assessments, assessments aligned with the Professional Qualities Curriculum and research projects. The toolkit will outline the principles for assessment, questions to be addressed, and guidance and details on appropriate methods. The current thinking is to aim for formative assessments, introduced gradually, to enable trainees and supervisors in Advanced Training to become familiar with these new assessments. Being formative, their role is to guide the trainee in their learning.

When SACs, STCs and JSACs are ready, formative assessments will be piloted and refined.

An Advanced Training e-portal, similar to the Basic Training Portal, will be finalised during this phase and available to support trainees and supervisors.

Phase 3: July 2010 – December 2010

During Phase 3, all curriculum documents will be refined, finalised and made available to trainees and supervisors. Depending on the preference of the specialty group, curriculum documents will be made available online to supervisors some time before they go to trainees. A variety of forums will be used to draw attention to the new curriculum documents.

The assessments will also be refined during this phase and made ready for implementation in 2011.

Phase 4: 2011–2014

During Phase 4, the curriculum framework, documents, resources and assessments will be formally implemented and systematically evaluated. The review will involve online surveys, interviews and focus groups.

Since the initiation of PREP:AT11, three curricula have been ratified under the new process. At the College Education Committee Meeting in March, the Dermatology Curriculum for New Zealand was ratified, and the Haematology and Neonatal/Perinatal Curricula were ratified in June.

The College would like to thank everyone who has worked tirelessly on these curriculum documents. The curricula are well written and ready for implementation. Congratulations to the Dermatology, Haematology and Neonatal/Perinatal groups.

Professor Kevin Forsyth
Dean
Judith McGhie
Curriculum Development Officer
Education Deanery
Tagrid Yassine
Curriculum Development Officer
Education Deanery

AUSTRALASIAN FACULTY OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE: UPDATE ON NEW CURRICULUM

The Australasian Faculty of Occupational and Environmental Medicine has been working closely with Deanery staff on its new curriculum for some time and is on track for implementation in 2011. The Faculty has just completed its final phase of consultation with 63 internal and external stakeholders. The new curriculum is expected to go to the College Education Committee for formal ratification in September. In line with the new curriculum, the Faculty has developed an implementation strategy that includes the development of a communication plan, policies, online resources and assessment tools.
RAISING OUR PROFILE THROUGH ADVOCACY

In the February issue of RACP News, John Kolbe and I discussed a new approach to the College’s policy agenda, with a specific focus on advocacy. Over the past few months, a dedicated band of Fellows and staff has been actively engaged in advocacy activities which, whilst directed at improving the health of the community, have the added advantage of improving knowledge and understanding of the College amongst governments, other health organisations and the community. In case you have missed all of the positive media attention lately, the following provides a taste of some of the ongoing success stories.

Alcohol

Probably the area where the College’s sustained program of advocacy throughout 2009 has had the greatest impact has been alcohol and its associated harms. The Alcohol Advisory Group (AAG), formed in mid-2008, was well prepared to comment when the NHMRC Australian Guidelines to Reduce Health Risks from Drinking Alcohol were released.1 Spokesperson Dr Steven Skow was extensively quoted in the print media following the release of the Guidelines, in addition to completing several live interviews.

In the lead-up to consideration of the ‘alcopops’ tax by the Australian Senate in March, the AAG took a different approach from the usual media opportunities, instead publishing an article in the Medical Journal of Australia (MJA) arguing for a comprehensive review of alcohol taxation.2 The article itself generated significant media attention, plus the College position was cited on numerous occasions in the Senate inquiries into the alcopops tax, the Henry tax review, the Preventative Health Taskforce and the Senate inquiry into Men’s Health. Such submissions have firmly established recognition of the College’s expertise in these fields.

Whilst the real measure of success will be a reduction in harms caused by alcohol, positive results of this effort can also be witnessed in other ways. In June, the College was invited to participate in a coalition of health organisations to meet with Ministers, Shadow Ministers and Senators during a parliamentary sitting. Not only was the meeting valuable in advocating directly to appropriate politicians, it also provided an opportunity to forge partnerships and thus strengthen our efforts.

But don’t think that all this advocacy is limited to Australia. In New Zealand, the Sale of Liquor Act is under review, led by Sir Geoffrey Palmer from the Law Commission. Following his comments on the relative lack of medical input into this review as compared to Scotland and the RCP, the College in New Zealand instigated a letter from the Council of Medical Colleges (CMC) (NZ). Signed by Presidents and Chairs of all Colleges, the letter illustrated the array of medical problems related to alcohol intoxication, abuse and dependency which are encountered by all medical practitioners. In addition to offering assistance to the Commission, the CMC acknowledged the need to better describe the epidemiology of alcohol-related medical problems, and their costs, in New Zealand. The Commission was also supplied the College’s comprehensive Alcohol Policy: Using evidence for better outcomes.3

And if you are in New Zealand, don’t miss the roadshow lecture ‘Ten Things the Liquor Industry Won’t Tell You’, led by Professor Sellman of the National Addiction Centre, and ably supported by a number of RACP Fellows speaking on various medical and epidemiological issues, including the ‘cardioprotective’ effect of low-dose alcohol. The lecture purports a ‘5 + Solution’ related to price, purchase age, alcohol accessibility, advertising, and drink-driving. A series of articles aligned to this campaign are being produced for the NZ Medical Journal.

Mandatory reporting of sexual activity in the Northern Territory

Several months ago, the Northern Territory Government approved legislation requiring mandatory reporting of underage sexual activity to either the police or the health department, even if it is consensual and between peer-aged partners. Concerned at the potential negative impact such reporting could have on the health of young people through unwanted pregnancies and undiagnosed or untreated STIs, the College joined a coalition of health organisations calling for revision of the law.

In May, the College wrote to the various relevant Ministers and Shadow Ministers, and distributed a media release detailing concerns that mandatory reporting is likely to reduce young people’s trust of health professionals, and could ultimately be detrimental to their wellbeing.4 Alice Springs paediatrician Dr Rob Roseby took on the role of College spokesperson on the issue, was interviewed by a wide range of media outlets, and the College argument was broadly quoted.

Within days of the College’s letters and media onslaught, the NT Minister for Health announced that the Government would change the legislation. Since this time, a College representative has participated in various meetings to negotiate the nature of the changes. It is hoped that a mechanism will be developed and appropriate legislation drafted to enable passage of a revised bill through the August parliamentary sitting.

Non-prescription opioids

Since completion of the Prescription Opioid Policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use, the College has been engaged in ongoing advocacy regarding the policy’s recommendations.5 In keeping with the
Policy and Advocacy Department’s agenda of briefing politicians and bureaucrats, very positive meetings have been held with the Federal Minister for Health and with the Department of Health and Ageing—the latter attended by more than 50 government staff, including five unit directors.

Information regarding the policy has now been presented at eight conferences and published in four journals with another four nearing completion.

This effort in advocacy has been rewarded by the inclusion of the College in a planned National Pain Summit, discussion of the policy on the agenda of the NHMRC and regular positive media commentary, notably gaining a mention on the front page of the *Sydney Morning Herald* in June.

**What’s next?**

Following several successful sessions at the 2009 Congress in Sydney about the relationship between climate change and health, the College is initiating an action group to develop appropriate strategies relevant to the health system, the College—both Secretariat and the Fellowship, and broader integration of health-related climate change issues into government and other policy.

A call has been issued through ebulletins for membership of a working group which, it is envisaged, will operate in a similar fashion to the Alcohol Advisory Group, predominantly exchanging information electronically, with the occasional teleconference to consolidate viewpoints.

The success of advocacy in this area, and in any of the agreed priority policy topics, is reliant on the dedicated enthusiasm and input of all participants. Contributions to the advocacy effort are greatly appreciated and valued. **If you are interested in joining the working parties on either alcohol or climate change, or would like to suggest another area for development, please don’t hesitate to contact me at Yvonne.Luxford@racp.edu.au**

Dr Yvonne Luxford
Manager, Policy and Advocacy

Dr Geoffrey Robinson FRACP
New Zealand President and Chair of the New Zealand Joint Executive


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**ART BY DOCTORS FOR DOCTORS**

**CALLING FOR EXPRESSIONS OF INTEREST**

Doctors’ jobs are stressful, requiring serious decisions to be made all the time—sometimes life and death decisions. However, many doctors are more than the protocol-driven, evidence-based decision-makers they appear to be.

Many have found healthy ways to release their stress and tension through music or sport, for example, and it also appears that quite a few are regularly finding fun and solace in unleashing the creative potential of the right side of their brain, as opposed to the logical, sequential, rational, analytical and objective left side which most doctors have in overdrive from 8 am to 6 pm.

As a doctor who dabbles with a bit of paint here and there (for fun and therapy), I am interested in seeing if there is any interest from like-minded doctors in putting together an exhibition of ‘Art by Doctors for Doctors’.

Expressions of interest welcome. Please send to:

Dr Jeremy Rosenbaum FRACP
Department of Gastroenterology
The Royal Children’s Hospital
50 Flemington Road
Parkville VIC 3052
There is good evidence that online learning programs generate significant and durable learning in competency in systems-based practice. Online module-based teaching is an effective method for delivering and assessing material proposed in this project across a wide range of medical specialties, institutions and levels of training. The modules being prepared have the potential to be readily implemented across the Basic Training Portal and useful for continuing professional education (CPD).

It is envisaged that 20 modules will be available by November 2009; they will be maintained by the National Prescribing Service (NPS) and evaluated by the Therapeutics Expert Advisory Group (TRACP).

In 2006, the TRACP of the College met with the Education Deanery to map out a framework for a series of educational modules to enhance the Basic and Professional Qualities Curriculums. The mapping exercise included working across all aspects of the Professional Qualities Curriculum and the Basic Training Portal to identify areas where Quality Use of Medicines (QUM) could be applied through the use of a learning module.

The Quality Use of Medicines is a national framework contained in the National Medicines Policy and has been used as the principle base for the development of all the modules. The scoping exercise highlighted the importance of having a link to these modules in almost every area of Basic Training.

Topic areas considered for module development include:

1. Optimising pharmacotherapy/practice
   - History taking—medication history
   - Therapeutic objectives
   - Ongoing review
   - Adverse events
2. Interaction with pharmaceutical industry
3. Optimising therapeutic relationship
   - Communication
   - Cultural differences
   - Patient education to communicate risks and benefits
4. Teamwork/communication across the broad therapeutic community and leadership, including pharmaceutical network
5. Safety, error and recognition of uncertainty
6. Appreciation of the macro-therapeutic environment—resources; regulatory environment
7. Broader therapeutic context, including complementary medicines and reasons people take these medications; the modules take a non-judgemental stance
8. Information about complementary medicines
9. Sources of drug information.

The NPS first offered modules on QUM aspects of training to 10 medical schools in 2002. These comprised the curriculum in Clinical Pharmacology. These modules used case-based scenarios and allowed medical students to self-assess and receive feedback from experts engaged by NPS.

With these resources having already been developed and evaluated, it seemed logical for the College to work closely with the NPS to develop modules that suited the educational needs of College Trainees and Fellows.

For further information, please contact Mary Osborn at mary.osborn@racp.edu.au

Mary Osborn
Senior Policy Officer
Policy, Advocacy & Communications

CTC – QU’EST-CE QUE C’EST?

The College Trainee Committee (CTC) is comprised of RACP trainee members from New Zealand and all states and territories of Australia. We represent trainees at many levels of RACP governance and report directly to the RACP Board. The CTC is a powerful avenue for the expression of trainees’ voices within the RACP.

The significant investment by the RACP in redeveloping the training curriculum in recent years has resulted in cultural change within the College, making us, the future fellows of the College, more accountable for our training experience and more aware of the structure and process of the College.

This evolution is embedded within broader cultural change in our society, whereby the ‘democratisation of knowledge’ facilitated by digital media requires us not only to become experts in medical knowledge and its application, but also experts in those professional qualities outlined in the new curriculum: advocacy, leadership, communication (and more!).

At the core of our CTC agenda is the development of effective communication: between trainees, between trainees and their representative committees, and between trainees and the RACP. Thanks to the efforts of the CTC, events such as the College Mentor Awards and Meet the Dean evenings have gone some way to improving communication in our College. We (try to) regularly publish our CTC newsletter, ‘The Vine’, updating trainees about current CTC activity, we are working closely with IT to give Trainees Café a facelift and we now have a spot in RACP News too (so thanks for reading it).

2010—Year of the Trainee

After ploughing through hefty agendas for the last few years, the CTC was keen to develop a positive strategy to raise the profile of trainees within our College, and to improve engagement in both directions. The idea of a Year of the Trainee (YOTT) has been met with enthusiasm at many levels, including receiving the imprimatur of the RACP Board.

The main focus of the Year of the Trainee will be Trainees’ Day at the World Congress of Internal Medicine in Melbourne (20–25 March 2010). Trainees’ Day will include a range of sessions designed to be relevant to both basic and advanced trainees. Utilising a variety of formats, these will cover topics such as leadership for trainees, teaching skills for advanced trainees, issues facing trainees who wish to conduct research, and exotic medicine and aid work during training. Trainees’ Day will also be an opportunity to meet hundreds of your colleagues from the Asia-Pacific region—culminating in a fantastic party at the end of the day.

Book your leave for late March 2010 now!

Until then, the CTC welcomes your ideas regarding the Year of the Trainee, and on all matters you consider important to your training. YOTT needs to work at a grassroots level, so get involved and tell your supervisors.

Dr Robin Guttinger
CTC Communications Director

Dr Zoe Raos
Chair of CTC

While the focus of this article has been to introduce the CTC in RACP News, and announce the Year of the Trainee, please be aware that the CTC also considers trainee issues such as the recent fee hike, matching and selection of training posts, rural training, exam matters, and more. There is constant turnover of members as we finish training, so we always need keen trainees to get involved with New Zealand and State Trainee Committees as well as the CTC itself.

Please email traineescommittee@racp.edu.au for more information.

ADVANCED TRaineE SELECTION AND MATCHING 2009 HiTS THE ROAD

The RACP ATSM MyTraining site has been open since mid-June for trainees to enter CV details and request referees’ reports, and for trainees to register for State Specialty Groups’ (SSGs) positions since 16 July. A match was conducted on 29 June for continuing Gastroenterology trainee positions in New South Wales and Victoria to test the software and algorithm (details of the algorithm used are available at www.nrrmp.org/fellow/algorithm) with great success.

The next round of matching will take place in late August and will involve both new entrants to training programs and continuing trainees in some specialties. Although one of the aims of the process has been to consolidate matches to a single date (to allow maximum flexibility in preferencing), this has not been possible this year because of timing issues for some SSGs (conferences, etc.). As a result of this, the ‘Supermatch’ for most SSGs will be held on 28 August 2009, with two other matches in the week before that.

The State Specialty Groups which are confirmed as participating as of the time of writing are shown on the next page.

Each SSG has appointed a coordinator who is responsible for ensuring that the information on the site is correct and for overall coordination of the selection process for that SSG. The contact details of the coordinators are available on the College website and are sent in emails to participants when they are registered as an applicant or to the head of department for that SSG.
The ATSM website has been substantially upgraded to allow SSG coordinators more control over their information and the ability to update this in real time without needing to go through the College administration, and we hope that this will lead to a more responsive process with a greater feeling of ‘ownership’ by the SSGs. Trainees considering applying for the SSGs listed above are strongly encouraged to log on to the website via MyTraining, fill in their online CV and request referees’ reports. Trainees can then ‘register’ for the SSGs that they are interested in, which will allow heads of department to view their CVs and referees’ reports. Once trainees are registered, they will be able to view position descriptions and begin to preference positions. For some SSGs, trainees will be asked to nominate up to five hospitals at which they would like to be interviewed, and this list will be taken into consideration when deciding which candidates will be interviewed. It is important to note that registration on the RACP website is not a formal application for a position and, in some instances (e.g. all NSW positions), candidates need to put in parallel applications (in the case of NSW, via the NSW Health website). Trainees should check with the relevant SSG coordinator if they need more information in this regard.

For further information please contact: atselection@racp.edu.au

Geoff Hebbard FRACP
Manager, Victorian State Office

Trainees should check with the relevant SSG coordinator if they need more information in this regard.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>States and Territories</th>
<th>Trainees</th>
<th>Date of match</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>NSW, ACT, Vic, Tas, Qld, WA</td>
<td>New</td>
<td>28 August</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>NSW, ACT, Vic, SA</td>
<td>New, Continuing</td>
<td>28 August</td>
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<tr>
<td>Respiratory/Sleep</td>
<td>NSW, Vic</td>
<td>New, Continuing</td>
<td>28 August</td>
</tr>
<tr>
<td>Cardiology</td>
<td>NSW, Vic</td>
<td>New</td>
<td>25 August</td>
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<tr>
<td>Nephrology</td>
<td>Vic</td>
<td>New, Continuing</td>
<td>28 August</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Vic</td>
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<td>20 August</td>
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<td>Infectious Diseases</td>
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<tr>
<td>Medical Oncology</td>
<td>Vic</td>
<td>New, Continuing</td>
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MEDICAL ONCOLOGY GROUP OF AUSTRALIA LAUNCHES FREE ONLINE CANCER EDUCATION PROGRAM

Funding from Cancer Australia has enabled the Medical Oncology Group of Australia (MOGA) to undertake the development of a unique education program in oncology for medical practitioners. The online education program, called the Education Program in Cancer Care (EPICC), is set for release in August 2009. EPICC includes key areas of cancer care information, education activities and resources for non-cancer specialist medical practitioners, including general practitioners, general physicians, gynaecologists, surgeons, etc. Freely accessible online at www.epicc.org.au, EPICC is designed to be available for medical practitioners in rural and remote areas of Australia who may have limited access to specialist cancer services.

EPICC includes the following cancer care topics:
- General principles of cancer, surveillance, prevention and screening
- Cancer diagnosis
- Cancer treatment
- Multidisciplinary care
- Side effects of cancer treatment and symptom management
- Oncological emergencies
- Psychosocial care
- Follow up.

The topics were developed by multidisciplinary working groups, led by the Medical Oncology Group of Australia. Thank you to those MOGA members, cancer nurses and other medical practitioners who contributed to the development of this program.

EPICC will launch at the MOGA Annual Scientific Meeting, 13–14 August, in Canberra, ACT. The launch of EPICC will contribute to the many thirtieth anniversary year activities of MOGA, including a Gala Black-tie Anniversary Dinner at Parliament House, a commemorative video of the past 30 Chairmen of MOGA and the first ever photographic competition for MOGA members, called Visions of Oncology.

Additionally, for the first time in Australia, MOGA will be hosting the Best of ASCO®—highlights from the research presented at the American Society of Clinical Oncology Meeting—on 15–16 August, directly after the MOGA Annual Scientific Meeting.

To learn more about cancer care, visit www.epicc.org.au. For information on the MOGA Annual Scientific Meeting and Best of ASCO®, visit www.moga.org.au.
NEW RACP WEBSITE TO BE LAUNCHED AUGUST 2009

The redevelopment of the Royal Australasian College of Physicians’ website is well underway and the end is now in sight. Input has been sought from a range of people within the Australian and New Zealand offices of the RACP regarding the strengths and weaknesses of the College’s current web presence and the future direction of the online space. This consultation process has involved teleconferences, videoconferences, email advice from many parts of the College and workshops, and further videoconferences and teleconferences regarding specific components of the College’s web presence, including online education tools such as Curricula, Learning Needs Analysis and the suite of formative assessments tools.

The ultimate goal was to achieve a quality, university-grade web presence that defined the College in the new technological age, whilst supporting our Fellows and trainees and enabling them professional grade mechanisms to access the many new educational and technical resources currently emerging across the College.

Two significant changes that will impact on the way you use the website are:

1. **Single sign-on across all web applications.** To achieve this, we have had to move away from user selected login names to using your College MIN or the primary email address that we use to communicate with you. This guarantees unique logins and, in turn, will ensure that the access granted to you is appropriate for your needs and your interaction with your colleagues and College services.

2. **No separate Members’ area.** The existing website is divided into two broad public and private areas. This has served us well but is not appropriate for our future needs. The new site has a single comprehensive architecture, incorporating both public and privileged sections. The latter is only available to Members, based on their role and relationship with certain areas of the College. You will be prompted to log in when you first access one of these sections.

These changes set the basis for a more secure, personalised and relevant web presence that will provide you with access to the information and services most pertinent to you.

A huge amount of work has gone in to overcoming the many technical and content development challenges, with the help of many individuals to whom we are very grateful. We are delighted to announce that the new website will be launched at the end of August 2009.

Although the transition from the existing web presence to a new look, new feel website, with new base functionality, will not be without its challenges, with the support of Staff, Fellows and Trainees alike we will endeavour to make this transition as smooth as possible.

**Warren McDonald**  
Chief Information Officer

**Emma Cunningham**  
Manager, Victorian State Office

HISTORY DAY

The History of Medicine Library held a History Day in the historic College building at 145 Macquarie Street on 17 May to coincide with Physicians Week in Sydney.

Sixty Fellows, trainees and their partners toured the building (built in 1848), and enjoyed an exhibition of rare books in the Council Room before listening to a history of medicine lecture given by Professor John Rasko.

The Library holds the most comprehensive collection of Australian and New Zealand medical history material as well as a large international section. It is also fortunate to own a significant number of rare medical texts from the 16th, 17th, 18th and 19th centuries. The oldest of these are fascinating artefacts in themselves: the paper is often in remarkably good condition, having been manufactured from rags, while finely detailed lithographic illustrations and pull-out sections of anatomical drawings are included.

Some of the treasures are: William Harvey’s *De Motu Cordis et Sanguinis* (1671); a first edition of *Journal of a Voyage to New South Wales* (1790) by John Hunter, principal surgeon to the First Fleet; the first and second editions (1790 and 1800) of Edward Jenner’s account of his discovery of smallpox vaccination (with hand-coloured illustrations); and a first edition of Charles Darwin’s *On the Origin of Species* (1859).

We are also fortunate to hold Sir Thomas Anderson Stuart’s bound original medical notes and collected papers. The most valuable items in the Library were donated by Sir Edward Ford, former Fellow of the College and one of Australia’s greatest book collectors.

Donations by other Fellows have greatly added to the breadth and value of the collection.

The visitors, including the visiting Presidents of the Colleges of Canada and Glasgow, particularly enjoyed inspecting (with cotton gloves) the display’s open volumes, some from the 19th century being produced in huge illustrated format for the education of medical students.

Professor Rasko’s lively lecture, titled ‘Did the Ancient Greeks Foreshadow Regenerative Medicine?’, enlightened both medical and non-medical audience members on the unique self-repair qualities of the human liver, while examining the myth of Prometheus to see how much the ancient Greeks understood these attributes.

**Liz Rouse**  
Librarian
The Research and Education Foundation is delighted to announce that the Jacquot Research Entry Scholarship has recently been extended to a three-year period. This is a welcome extension to the prestigious Jacquot Award Program. The fellowships and scholarships are jointly administered by the Royal Australasian College of Physicians and the Australian and New Zealand Society of Nephrology.

The Don Jacquot Fellowship was established in 1985. Don, a successful businessman and founder of the Trash and Treasure company in Australia, suffered from renal failure. Following his premature death, his wife, Lorraine Jacquot, donated money to assist young nephrologists in their research training, with the hope that this would lead to better outcomes for people with renal disease. Over the subsequent 10 years this funding supported a number of now prominent Australian nephrologists to travel overseas for advanced research training.

In 1992 Lorraine suddenly and tragically died. In her will she stipulated a substantial increase in the value of the bequest. As a result of this now major bequest, renamed the Don and Lorraine Jacquot Fellowship, the research careers of young nephrologists are being supported in multiple ways. These include PhD scholarships, fellowships for overseas research training, research establishment awards for nephrologists at an early stage in their career following completion of a higher research degree, now offered over three years, and a substantial award for establishment and running of clinical trials in nephrology. This represents a substantial proportion of the total research funding for nephrology research in Australia, and most of the senior nephrology researchers in this country have directly benefited.

The Australian and New Zealand Society of Nephrology and the Royal Australasian College of Physicians, on behalf of their members, are enormously grateful to the Jacquot family for this bequest and to the Rowling family for their guidance and support in administering the awards.

JACQUOT AWARDS 2010
Closing date for applications: 31 August 2009
Don & Lorraine Jacquot Fellowships Value: $90,000–$100,000
Purpose: To provide opportunities for nephrologists who have completed a postgraduate research degree and are still at an early stage in their research career, to help develop independent research programs to advance knowledge in the treatment of renal disease. The fellowship is primarily intended as stipend support, or part stipend support.

Jacquot Research Establishment Award Value: $90,000 p.a.
Purpose: To assist establishment of a career in nephrology research for a nephrologist at any early stage in their career who has a postgraduate research degree in an area of relevance to nephrology. The Award is normally intended to provide laboratory costs or stipend for a Research Assistant, but may also be used for part-stipend of the applicant. The Award is normally for one year with the option of renewal.

Jacquot Research Entry Scholarships Value: $30,000
Tenable: One to three years
Purpose: To provide stipend for younger Fellows or Advanced Trainees in Nephrology to undertake a higher research degree. Projects may be in basic, clinical, epidemiological or public health aspects of nephrology.

For full details of the above awards and for application details see our website: www.racp.edu.au/page/about-the-racp/research-and-education-foundation/applying-for-an-award
Email: foundation@racp.edu.au
THE ROAD TO RESEARCH

PROFESSOR RANDALL FAULL’S JACQUOT AWARD STORY

I was fortunate enough to be one of the early recipients of a Jacquot overseas fellowship, to support my postdoctoral research position at the Scripps Clinic in La Jolla, California from 1991 to 1993. Not only was this a delightful place to live and a great life experience, but the chance to have immersion exposure to world-class research in this dynamic institution was career defining. I was also able while there to meet Lorraine Jacquot, when she visited San Diego and kindly took my wife and myself to dinner. Tragically she died only a few months later, but I had been fortunate enough to hear first hand her vision of support for nephrologists and care of patients with kidney diseases.

Since returning to Australia I have benefited from this award through development of my own research program and interests, as well as continuing work as a clinical nephrologist at first St George Hospital in Sydney, and now the Royal Adelaide Hospital in Adelaide. My achievements in the subsequent years have included serving as President of the Australian and New Zealand Society of Nephrology, and my current (part-time) role as Dean and Director of the Medical Program at the University of Adelaide.

As with all other beneficiaries of this generous support, I remain extremely grateful to the Jacquot family for enabling me to undertake this time overseas.

Professor Randall Faull FRACP
Senior Consultant Nephrologist, Royal Adelaide Hospital
Dean and Director of the Medical Program, University of Adelaide
President, Australian and New Zealand Society of Nephrology

JACQUOT AWARDS CENTRAL TO ESTABLISHING INDEPENDENT RESEARCH GROUP

I am a Consultant Nephrologist at Flinders Medical Centre and Professor of Nephrology at Flinders University and continue to pursue activities in clinical medicine, teaching and research. For the preceding five years I was the University Lecturer in Nephrology and General Medicine at Oxford University. Having moved to Adelaide in May 2007, I have been attempting to establish an independent Research Group at Flinders focusing on the regulation of gene expression by oxygen and its implications for renal diseases. The Jacquot Award has been central to this process by enabling me to recruit an excellent scientist, Dr Calida Neal, who is currently pursuing the regulation of microRNAs by hypoxia and in renal cancer. Furthermore, I have been able to continue productive scientific collaborations with colleagues in Oxford and elsewhere.

My research interests have focused on the sensing of oxygen by cells, a topic with broad relevance to the understanding of cellular physiology, ischaemic disease and cancer. With colleagues in Oxford, I characterised and named a family of oxygen dependent prolyl hydroxylase enzymes (PHD 1, 2 and 3) which sense oxygen and control the transcriptional regulation of genes by oxygen. The greatest high in my research career was personally undertaking the first experiments which defined these oxygen sensors. Subsequent work has defined the particular roles of these oxygen dependent hydroxylases, contributed to the demonstration of the role of asparaginyl hydroxylation, provided an understanding of the transcriptional responses to hypoxia and to hydroxylase inhibition, and studied the responses of microRNAs to hypoxia.

Having spent much of my research career in a very well-funded and supported laboratory in Oxford with excellent research colleagues and supervisors, there is now a major challenge in achieving scientific independence and the establishment of appropriate laboratory facilities and a research group at Flinders. The Jacquot Award has enabled me to take the first step in this. The other major challenge lies in linking this very basic scientific research to my clinical activities in the care of patients with renal and other conditions and in translating this research to clinical practice.

Professor Jonathan Gleadle FRACP
Jacquot Research Establishment Award Winner 2008 and 2009
The RACP, through the Research and Education Foundation, is a partner organisation of the Australian Youth Ambassadors for Development (AYAD) Program, coordinating the placement of trainees in hospitals in developing countries.

The AYAD Program is an Australian Government, AusAID initiative aimed at strengthening mutual understanding between Australia and the countries of the Asia-Pacific region, while making a positive contribution to development.

The Program achieves these aims by placing skilled young Australians, aged 18–30, on short-term assignments in countries throughout the region. Assignments typically last from six months to one year. AYAD volunteers work with local counterparts in Host Organisations to achieve sustainable development outcomes through capacity building, skills transfer and institutional strengthening. Travel, insurance and a small living allowance is provided by the AYAD Program, which also has an in-country manager to support the Ambassadors.

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The RACP has previously partnered with the Fiji School of Medicine (FSM), supporting honorary lecturers/senior registrars. The FSM is the major tertiary institution in the South Pacific for the training of health professionals and the study of the health sciences. It is the only institution other than the University of PNG which has an MBBS and MMed postgraduate program. Most medical practitioners based in Fiji and surrounding Pacific Island nations undertake training through the FSM.

For more information about Dr Angus Ritchie's experience as an AYAD Ambassador at FSM, see his article in RACP News, December/January 2008/09, page 29, at: www.racp.edu.au/members/racpnews/PDF_issues/RACPNews_Dec08.pdf

The Research and Education Foundation is looking to continue their relationship with the FSM and possibly expand their partnership with the AYAD Program into other countries in the Asia-Pacific region. We are therefore seeking expressions of interest from trainees who may be considering becoming an AYAD Ambassador in 2010 or 2011.

Interested trainees should contact Claire Hanley at the Research and Education Foundation on 02 9256 9620 or claire.hanley@racp.edu.au

For more information on the AYAD Program please go to: www.ayad.com.au/aspx/home.aspx
Please help support our young physician researchers achieve their goals …

“Clinicin-researchers play the role of converting discoveries made at the laboratory workbench to improved patient care at the bedside, and similarly, bring questions arising from the bedside back to the laboratory workbench. The Vincent Fairfax Research Entry Scholarship has kick-started my role as a clinician researcher, and the beginning of my quest to find the truth.”

Dr Hang Quach
Vincent Fairfax Family Foundation Research Entry Scholarship 2008

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Research and Education Foundation
145 Macquarie Street
Sydney  NSW 2000
Fax: (02) 9256 9697

or send your details by email to
foundation@racp.edu.au

For more information, visit our website at: www.racp.edu.au

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OR ☐ I prefer to remain anonymous

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Quarterly payments only available when paying by credit card.
Profiles of Generous Supporters of the College

KEN ROBERTS AM FRACP (HON)

In this new feature we will include profiles of people who give generously of their time to support the work of the RACP and the Research and Education Foundation, for which we are all most grateful. The first profile is of Ken Roberts, Chairman of the Foundation and tireless volunteer fundraiser.

Ken Roberts has been involved in the Research and Education Foundation (REF) since its inception in 1990. In that time he has seen major changes in the area of medical research.

‘As the science underlying medical practice becomes more and more complex, it is increasingly essential to have physicians equipped with research skills that can bridge the gap between basic research and clinical practice,’ he explains. ‘Every year we face an increase in the costs of conducting meaningful research, and every year we have to turn away talented and eager young researchers.’

Working in an honorary capacity since the creation of the REF, on the board since 1996 and as Chairman since 2002, Ken has been instrumental in establishing philanthropic partnerships between physicians and corporate and institutional donors to provide funds to support Australian medical research. He has been personally responsible for raising several millions of dollars to support the work of the REF.

Ken is well qualified to carry out this work, bringing a wealth of experience and contacts from an impressive corporate career. Ken became Chairman and Managing Director of Wellcome Australasia in 1978 and in 1994 was appointed Director of Marketing Development for the Wellcome worldwide group, based in London, while continuing as Chairman of Welcome Australasia. Following the merger of Glaxo and Wellcome, Ken was appointed Managing Director of the Australian Technology Group, a government funded venture capital company with the mission to commercialise Australian early-stage research in the areas of bioscience and information technology.

Ken’s contribution to medical research, business and the pharmaceutical industry has been recognised by numerous awards and honours over the years, including becoming a Member in the General Division of the Order of Australia in 1995 for ‘…the promotion of medical research and its application to the community’. In 2001, the RACP awarded Honorary Fellowship to Ken in recognition of his dedication to the support of medical research. Most recently, he was honoured as the 2007 Research Australia’s Lifetime Achievement award winner.

Ken says: ‘It has been a privilege to have been involved in the Research and Education Foundation for close to two decades and see a generation of the brightest and the best young physicians launch their careers as clinical researchers.’

‘Medical research and education are recognised as one of the primary objectives of the 1938 RACP Charter and the REF’s work as the RACP’s philanthropic arm is fundamental to achieving this objective.

‘The Foundation is dedicated to raising funds to support medical research and alleviate suffering and disease. We achieve this through enabling young, talented physicians to have the opportunity to become world-class researchers. ‘It has always been a challenge to keep up with the demand for grants for important new research. I hope that the Fellows will respond favourably to the current proposal to channel a small proportion of the College annual subscription directly to the REF. It is a once in a lifetime opportunity to secure the financial base of the Foundation into perpetuity.’

‘I hope that the Fellows will respond favourably to the current proposal to channel a small proportion of the College annual subscription directly to the REF.’
TWO RACP FELLOWS RECEIVE PRESTIGIOUS NICS FELLOWSHIPS

In June this year, the National Health and Medical Research Council (NHMRC) awarded six NICS Fellowships, including two to Fellows of the RACP. ‘The NHMRC offers these unique Fellowships through our National Institute of Clinical Studies (NICS), to help build Australia’s own cohort of leaders in evidence implementation,’ said NHMRC’s CEO Professor Warwick Anderson.

Dr Alissa Walsh, a consultant gastroenterologist at St Vincent’s Hospital and St George Clinical School in Sydney, received an NICS Fellowship from the NHMRC and its funding partner, the Gastroenterological Society of Australia (GESA). Her Fellowship will be used for a two-year implementation project to address an evidence–practice gap in the management of inflammatory bowel disease (IBD), primarily a disease of young adults, which can cause debilitating inflammation of the bowel.

As Dr Walsh explained, ‘Medications effectively manage symptoms but they can also suppress general immunity. This encourages opportunistic infections which are hard to detect and potentially fatal. While immunisation provides protection against these infections, people with IBD are not routinely screened or offered immunisation. This is the gap I’m going to address through my NICS-GESA Fellowship.’

Professor Anderson commented that Dr Walsh’s project ‘will help identify and protect people at risk and provide improved guidance on preventive measures to all clinicians working in this area.’

Reducing the risk of cardiovascular disease in people with chronic kidney disease is the goal of RACP Fellow Dr Nigel Toussaint who also received an NICS Fellowship from the NHMRC. A nephrologist from Melbourne’s Monash Medical Centre, Dr Toussaint will use the Fellowship to undertake a two-year implementation project to improve detection and management of bone and mineral disorders in people with chronic kidney disease (CKD).

‘Cardiovascular disease is the leading cause of mortality in people with chronic kidney disease,’ said Dr Toussaint. ‘We know vascular calcification ... is a major risk factor for cardiovascular disease, and that bone and mineral disorders, often found in people with CKD, can lead to this build up of calcium. While guidelines exist to manage optimal levels of these disorders and prevent calcium deposits, targets are not routinely achieved.’

Dr Toussaint will work with healthcare staff and people with CKD in kidney clinics and dialysis units, to identify barriers to optimal control of mineral metabolism disorders. He will also promote improved detection and management of these disorders through an awareness-raising education program.

The two-year, part-time Fellowships are open to early-to-mid-career health professionals across the healthcare spectrum, including doctors, nurses, allied health professionals, paramedics, healthcare managers and policy-makers.

The Fellowships provide an annual stipend as well as professional development opportunities, training programs in evidence implementation, mentorship, and opportunities to network with and learn from world-class experts who come to Australia as part of NICS’s Visiting Experts program.

Dr Walsh’s project mentor is Professor Michael Grimm, from the St George Clinical School, University of NSW, Sydney, and Dr Tou ssaint’s is Professor Peter Kerr of the Monash Medical Centre, Melbourne. Both mentors are Fellows of the College.

Applications for NICS Fellowships 2010 will be open later in 2009. For more information, go to www.nhmrc.gov.au/nics; or email NICSFellowships@nhmrc.gov.au.
From harmony, from heav'nly harmony,
This universal frame began.

John Dryden, set by Handel in his Ode for St Cecilia’s Day

There's something about great music that can really take over your soul. At least that's how I've felt for most of my life, and I know the same applies to many others in our profession. Without music as a source of relaxation, stimulation and diversion, I would have found it much harder to maintain the momentum that a busy professional and academic life demands. And there's some reason to think that medicine and music are linked at a deeper level, judging by the frequency of involvement of doctors in musical activities, and the impact of music on the psychological and emotional wellbeing of doctors and patients alike. Indeed, for the ancient Greeks, Apollo was the god of both medicine and music, and music has long been considered to offer a special means of access to a higher state of consciousness—what Beethoven called 'the mediator between intellectual and sensuous life'.

If one was looking for an ideal medium for personal and social enjoyment, one could hardly devise a better vehicle than music. A wide repertoire of recorded pieces can be accessed at almost any time, be it at home in front of a good sound system or when driving the car. With modern electronic media, whole masterworks can be carried in the pocket and enjoyed on long plane trips—Bach and Brahms to beat the boredom! After appropriate exposure and conditioning, music is capable of inducing a physiological response as intense as that provided by the most powerful of addictive drugs—and indeed both sensations appear to be mediated by the same deep brain processes, involving dopamine release in the limbic reward centres. It provides an excellent basis for a social gathering, either at a concert hall or in a private home, and the shared enjoyment of a loved piece can be a strongly bonding experience for a group, or indeed just a couple (the 'food of love' cited by Shakespeare). And of course for performers, there is the opportunity to come together to create music as part of an ensemble.

My dual passion for medicine and music has led to my involvement in a number of activities that unite the two interests. As a flautist, I was delighted to be a member for many years of the Australian Doctors' Orchestra in rehearsal, Canberra, 2005.
Oliver Sacks visits a Medicine and Music class, with myself and John Carmody.

Orchestra, formed in 1993 by Hobart plastic surgeon Miki Pohl. This group consists entirely of doctors and medical students who relish the opportunity to assemble once a year to prepare a concert of classical favourites to benefit a nominated charity. There's no shortage of talented performers among the ranks of the profession, and we all enjoy sharing our ‘after hours’ interest in music with like-minded colleagues while catching up also on a bit of interdisciplinary medical gossip. Similar groups have now been formed in several states; indeed, I was pleased to play with the NSW Doctors Orchestra (Musicus Medicus) when it performed in 2006 at the Sydney Conservatorium of Music as part of the 150th anniversary celebrations of my own medical school, the Faculty of Medicine at the University of Sydney.

Being on the staff at Sydney has also given me the opportunity in recent years to contribute to an innovative Masters program in Medical Humanities. Initiated by Jill Gordon (who had previously been closely involved in the creation of the graduate-intake medical course at Sydney), this program consists of multiple units of study which bring the warm light of the humanities to shine on medical practice and so illuminate our daily work from a variety of cultural perspectives. While literature and history were early components of this course, in 2004 I was invited to start a Medicine and Music unit, which, together with Sydney music critic and physiologist John Carmody, I have been running ever since. Our discussions range over a wide spectrum of medical associations with music: from the science and aesthetics of music perception, through issues in music and health (including occupational health of musicians, illness and musical creativity, and music therapy), to broader considerations of music and healing in a social context. Some of these topics are explored in a recent book Musicophilia by the famed neurologist–author Oliver Sacks: indeed, we were delighted when the great man himself dropped in on one of our evening classes during a visit to Sydney (see photo).

A further program I have been involved with at Sydney University has been the creation of a special pathway for entry into Medicine for high-performing high school students with a strong musical background. As with similar articulated pathways for students from science and other faculties, this small cohort is given the opportunity to complete a first degree (in this case in music) before proceeding to enter the medical course. This initiative was enthusiastically supported by the deans of both Medicine and the Conservatorium of Music, and was developed in conjunction with another prominent musician-medico at Sydney Medical School, the Pro-Dean Ben Freedman, himself a cardiologist, violinist and, like me, some time member of the Australian Doctors’ Orchestra. We await with interest the outcome of this experiment in wedding tertiary studies in the two disciplines.

Something of a turning point in my understanding the importance of music in my own life came in 2007 when I was invited onto Margaret Throsby’s ‘Morning Interview’ program on ABC Classic FM. Quite apart from the joy of speaking publicly with such an iconic broadcaster, I was thrilled to be able to talk about and play some favourite recordings for a large listening audience, and gained enormous satisfaction out of receiving feedback from dozens of listeners who had enjoyed my presentation. Since then, I have harboured the dream of becoming involved in regular classical music broadcasting, possibly through community radio—though the time required for this means it will probably have to wait till my retirement.

In this 200th anniversary year of Charles Darwin’s birth, we would all do well to heed the reflection which this esteemed man recorded late in his life: If I had my life to live over again, I would have made it a rule to read some poetry and listen to some music at least every week.

Every day would be even better.

Michael Field MD FRACP

Some relevant additional reading


QUEEN’S BIRTHDAY HONOURS AWARDED TO AUSTRALIAN AND NEW ZEALAND FELLOWS

Congratulations to all recipients of these awards from Fellows and staff of the RACP.

Officer in the General Division (AO)

Professor Robert Michael Graham AO FRACP (NSW)
For service to medicine, particularly through stewardship of the Victor Chang Cardiac Research Institute and research in the field of molecular cardiology.

Professor John Hemsley Pearn AO AM FRACP RFD (QLD)
For service to medicine, particularly in the areas of paediatrics and medical ethics, to medical history, and to the community through injury prevention and first-aid programs.

Member in the General Division (AM)

Dr Margaret Jessie Baikie AM FRACP (TAS)
For service to the community of Hobart through refugee resettlement programs, and to medicine.

Dr Helen Margaret Creasey AM FRACP (NSW)
For service to medicine as a geriatrician and neurologist and through advisory roles with professional and community organisations.

Dr Paul Hutchins, AM FRACP (NSW)
For service to medicine as a paediatrician, particularly through the interdisciplinary management of care for children with complex developmental problems and their families.

Professor Richard Frederick Keff ord AM FRACP (NSW)
For service to medicine in the area of oncology research, to professional organisations, and as an educator.

Professor Balakrishnan (Kichu) R Nair AM FRACP (NSW)
For service to medicine and to medical education through the development of undergraduate and professional development programs and as a geriatrician.

Associate Professor Lynne Pressley AM FRACP (NSW)
For service to medicine, particularly cardiology, as a clinician, teacher and mentor, and to the community through the Heart Foundation.

Professor Napier Maurice Thomson AM FRACP (NSW)
For service to medicine through research in the field of chronic renal disease, to medical education and through a range of professional associations.

Associate Professor John Bernard Ziegler AM FRACP (NSW)
For service to paediatric medicine in the areas of infectious disease, HIV/AIDS, and immunology and allergy as a practitioner, researcher and educator.

Officer of the Order (ONZM)

Associate Professor John Henley ONZM FRACP (Auckland)
For services to medicine. Associate Professor John Henley was the Senior Physician at Auckland Hospital before retiring at the end of 2008. He is described as being a role model, mentor and friend to many Auckland physicians.

Member of the Order (MNZM)

Dr Richard John Isaacs MNZM FRACP (Palmerston North)
For services to oncology. Dr Isaacs is a Medical Oncologist who has worked as a consultant at Palmerston North Hospital since 1996.

Medal in the General Division (OAM)

Associate Professor John William Agar OAM FRACP (VIC)
For service to renal medicine, and to the community of Geelong.

Dr William John Duirs McKellar OAM FRACP (VIC)
For service to medicine as a paediatrician, and to the community of Barwon.

Associate Professor David Alexander Richards OAM FRACP (NSW)
For service to medicine in the field of cardiology, and to the community through the Sydney City to Surf fun run.

Dr Laila Leah Rotstein OAM FRACP (VIC)
For service to medicine as a clinician, educator and mentor.

Dr Peter Schiff OAM FRACP (VIC)
For service to health in the field of hematology, and to the Jewish community.
Need for a ‘Family Officer’ within the RACP

Can the College improve its management of, and involvement with, trainees experiencing significant maternity, family or personal issues?

In late 2007 I was completing my second year of advanced training in Cardiology when I discovered, to my somewhat unexpected delight, that I was pregnant. Over the next few months, amongst the excitement and planning by my husband and me, loomed the question of continuing and completing my training in Cardiology.

I remember telling my two hospital supervisors in January 2008 of my news—and their pleasure in hearing it. That was tremendously reassuring as I faced questions about working with radiation, about continuing the fairly intense working schedule and about planning for work with a very small child. We were all aware of the need for both planning and flexibility in the coming months.

It is often discussed amongst female trainees that if your baby is born in your final year of training after mid-October (when the final paperwork is due), then the leave taken to care for your newborn child may not be a problem for training. I wished more than once that I’d better timed my pregnancy.

But with a baby due in June it seemed that this would affect my training. I meticulously planned working to 39 weeks, taking 8 weeks maternity leave, 5 weeks annual leave and a week of conference leave to take our son to meet his European family—a total of 14 weeks leave. I listed our unborn baby with many local childcare organisations with the aim of returning to work full-time for the last 4 months, and with a goal to complete training in 2008. I made contact with the SAC in Cardiology to discuss the ways this plan may affect my ability to complete training in that year.

The rules in this situation are not clear. What is clear is that there is some discretion on behalf of the SACs, and this flexibility has a significant number of benefits; however, prior to the events that unfolded, it meant I had very little certainty of what lay ahead. The College prefers only 8 weeks of leave in any given 12-month training period, and taking more than 12 weeks required ‘Interruption of Training’ to be formalised. There was discussion that I may need to complete a further 6 weeks of training in 2009, or even another full year of core training in Cardiology. I could get nothing in writing, and nothing was certain.

With immense pride I completed work at 39 weeks, heavily pregnant and unable to stand for long periods! Fortunately, my colleagues, husband and friends were amazing. I sat at home for the first two weeks trying to relax and bring on labour; my tight schedule of 14 weeks leave meant the longer he took to be born the less time we’d have together before my return to work! Then at 41 weeks I haemorrhaged and was rushed to hospital and there was no foetal heartbeat. My son was dead after placental abruption.

Having seen many people, patients, families and friends in a wide spectrum of grief and distress, I suspect that the loss of a child at the end of pregnancy is one of the worst things to happen. It’s senseless, incredibly painful, and it takes a remarkable period of time to recover. Devastation underestimates it. There are no words.

But I remember worrying about my Cardiology training in the weeks after Igby died. I attempted to return to work two weeks after giving birth, and would sit shaking in an office for an hour or two in an attempt to finish my training. I emailed the College to rescind my ‘Interruption to Training’ and received no response. I emailed the SAC contact and, again, no response. My son was dead, and I may have been a bit crazy with grief.

Six weeks after Igby’s death I had spent portions of the previous four weeks at the hospital pretending to ‘work’ (mostly hiding in a darkened Echo reporting room) when I had a conversation with the Human Resources Manager at my hospital. He told me that because Igby was dead I was not entitled to maternity leave. This caused pain, distress and worry and was ultimately found to be incorrect, but I realised that the support I had at work wasn’t perhaps all I had hoped for, and decided to take my leave properly. A three-week trip to Europe (including the ESC Congress) was very well timed for both my husband and me.

However, I stuck to the plan, returning to work 12 weeks after giving birth. As my concentration and physical recovery improved, work was often both a relief and a distraction from a grief that was still often overwhelming. And about four or five months after Igby died I started to feel better and to think more clearly.

My supervisor and I completed the ‘final assessment’ paperwork at the beginning of October and the SAC in Cardiology discussed my case in November. My ‘numbers’ and ‘performance’ were all within acceptable limits, and using the above-mentioned discretion, I was given my fellowship by the RACP in December 2008. I am acutely aware that I am not the only trainee to have had a stillbirth or neonatal loss during training, and that there are many other complex and challenging family and personal situations amongst the broad population of trainees through the RACP (having a live baby is apparently a great challenge!). However, it would have been helpful for me both before Igby’s birth, and afterwards, to have had a central contact person at the College who could have provided coordinated information and support. I felt both my ante- and post-natal situations would have benefited from such a person—someone who knew my details and could have provided information to me and to the College, and liaised with the relevant parts of the College apparatus.

Training in Cardiology over the past three years has been a great privilege and pleasure, and many times I have been very grateful to have a career to distract me and allow me to enjoy life again. There is undoubtedly a complex interrelationship for all trainees between their family and their work. With an increasing proportion of female trainees, these sorts of situations relating to maternity leave, family leave and questions regarding completion of training will become more common. There is
a role for a central contact person—a ‘Family Officer’ perhaps? It would be a genuine move by the College to provide their trainees with support in practice as well as in word.

Dr Arnegetta Hunter BA(Hons) MBBS FRACP

Postscript: I have gone on to undertake further fellowship training to ensure in my own mind that my training is complete, and had a small celebration of my own after six weeks of fellowship—I’d ‘Done My Time!’ We are also expecting baby #2 in September, and this time planning lots of rest beforehand.

Response from the College

The College deeply regrets the loss of Dr Hunter’s child and has contacted her personally to express this and to discuss her comments further.

Dr Hunter’s recommendations regarding a specific case officer are being examined by the College. If you would like to provide feedback on this, or have any queries, please do not hesitate to contact us via basic_training@racp.edu.au or advancedtraining@racp.edu.au

Another ‘sound’ lawyer has completed his commissioned enquiry into health services (Special Commission of Enquiry: Acute Care Services in NSW Private Hospitals. Sydney: NSW Government, 27 November 2008). I await the time for an eminent physician to be commissioned to enquire into a dysfunctional legal system but doubt (the sufficiency of) my longevity.

The Garling Report advocates ‘bottom-up reform driven by physicians’. Were the will to exist, this at least is achievable. The CEO of a hospital should be elected by the accredited clinicians of the hospital for a term of two years with the right to serve for a further two years only. The successful candidate would be guided and assisted by the hospital administration in a manner similar to how the public service serves the Prime Minister.

Cracking the code of behaviour

Our College used to have an Ethics Committee; now it has an Ethics Expert Advisory Group. (To become expert ethicists, do Fellows need a PhD in that field, or would a master’s degree suffice?) The Group is reviewing the College’s Code for Professional Behaviour; behaviour, also referred to as conduct, is different from ethics, though both may be referred to in a hearing before a court or tribunal.

The Australian Medical Association (AMA) has a Code of Ethics, a short document, last revised in 2006. The Australian Medical Council (AMC), whose members include nominees of all state and territory medical boards, the AMA and the Committee of Presidents of Medical Colleges, will soon publish a Code of Conduct, the final draft of which was available for comment for three months last year. It is intended to be used nationwide by medical boards, in conjunction with their own regulations. Outstanding among the comments received on the draft was strong objection to its authoritarian tone, and to use of the words ‘must’ and ‘should’ (see AMC website: www.amc.org.au). This will be corrected in the final version.

Our College’s Code for Professional Behaviour is a document of 24 pages in pdf format, which few Fellows are likely to have read. In its present form, it would attract the same criticism as the AMC draft. The Expert Group would need compelling reasons not to adopt the AMC Code, but could if necessary add a supplement to cover specific facets of the work of physicians. By doing so, it would save much time and effort, and avoid undue complexity.

Good medical practice in Australia should be guided by one code of ethics, and one generally applicable code of behaviour. The AMA and AMC Codes should meet the need admirably.

Derek Meyers FRACP
Brisbane

Professor David Tiller in his Arthur E Mills oration, published in edited form in the June RACP News, states that the length of professional training is a problem and ‘There is no good educational reason why internship cannot be spent in specialist areas’. I disagree with this statement.

This is a road that the United States medical training went down many years ago. During my fellowship at the Children’s Hospital in Los Angeles in the late 1980s, I was considerably surprised by the difference in the standard of Australian Fellows and that of American trainees who had come straight from medical school into their subspecialty training. In my estimation, the breadth of the latter’s general medical knowledge and their ability to consider alternate diagnoses was unmistakably impaired. Without a broader knowledge base, the old saying applies: ‘If the only tool you have is a hammer, then every problem looks like a nail’.

During my physician training, some of the best physicians I worked with were older physicians who had come to the College following years as general practitioners. The breadth of their knowledge and their ability to sort the chaff from the wheat was significantly enhanced by this general training. I have no problem with Professor Tiller’s desire to reduce the length of training; however, I feel that to do this by sacrificing some of the initial diverse exposure is unwise. It may be better to look at streamlining the basic and advanced training elements of the trainees’ education as an alternative approach to reducing the overall length of training.

Stephen Allwright FRACP
Sydney

I add a personal salute to Associate Professor John Henley for his Priscilla Kincaid-Smith Oration at this year’s Physicians Week. In the edited version (RACP News, June 2009), Professor Henley appropriately calls for workforce planning to address the imbalance between the supply of generalists and subspecialists in meeting community needs. Professor...

Letters to the Editor

GR Crowe FRACP
Adelaide
Henley calls for systems to cope with acute and chronic care in both metropolitan and rural settings. He draws attention to the proliferation of Medical Assessment Units throughout Australasia as providing a big impetus to generalism. An admired definition of a general physician working in hospitals is recorded: ‘A physician whose primary professional focus is the general medical care of hospitalised patients’ and one who ‘may engage in clinical care, teaching, research or leadership in the field of General Hospital Medicine’. Professor Henley laments low numbers of generalists in the workforce and derives a note of hope from the fact that in New Zealand around 130 of 170 postgraduate trainees are dual trainees in General Medicine and a specialty. In Australia, at the present time, there are only 120 advanced trainees in General Medicine, with very few in dual training. Professor Henley points out that cardiologists and gastroenterologists each outnumber general physicians in Australia.

Readers are likely unaware that present numbers of Australians in advanced training in geriatric medicine are now a close second to those entering cardiology training, with over 120 advanced trainees now developing their skills in the medicine of later life.

Physician trainees in geriatric medicine are overwhelmingly training in teaching hospitals where they spend substantial amounts of time in acute patient care, most being rostered in after-hours acute medical care. In both of my teaching hospitals in South Australia, we triage acute general admissions, and geriatric medical teams care for similar acute case loads as other general medical teams. Older patients are preferentially allocated to geriatric medicine if they have neurodegenerative disease, notably delirium and dementing illnesses, psycho-geriatric states or non-fracture falls. Most need interdisciplinary assessment before deciding on possible return to pre-admission care settings. The reassuring growth in trainees committing to careers in the generality of geriatric medicine (on both sides of the Tasman) has been, in great part, due to modelling by both generalists and geriatricians dealing with acute illness.

My ultimate career choice in geriatric medicine was certainly due to the example of now retired generalists committed to evidence-based medicine but whom, I now realise, fell short in their ability to optimally manage the complex healthcare needs of many of their older patients.

I direct Professor Henley and fellow generalists to this changing trainee profile to promote opportunities for a more collegiate approach to training, teaching, research and workforce planning.

It is readily apparent to those who walk the wards of our general hospitals that the challenge to our acute care services lies in the efficient and effective care of the older patient. A sizeable number of such patients present with syndromes of altered cognition, immobility and falls. And many are brought to Emergency Departments by a breakdown in their community care arrangements. Optimal acute bed usage will increasingly demand that the diagnostic and therapeutic skills of the generalist and geriatrician be coupled with the objective delineation of older patients’ mobility and personal and household-care skills.

Timing of discharge is often less about physiologic and test parameters and more about their functional capacity and the quantity and quality of support available beyond the hospital. Interdisciplinary decision-making in team-based care is crucial to quality care of the older inpatient.

Physicians caring for older patients need skills in identifying rehabilitation potential to avoid expeditiously and prematurely directing older patients to residential care facilities. A small gain in performance in an older person can make the difference in their regaining their precarious pre-admission living arrangements. Premature occupancy of residential care beds today will reduce the pool of places available for future elderly inpatients. Residential care places are supplied on a fixed ratio per 1000 persons over 70 years. Geriatricians are acutely aware of the need for early and continuing dialogue with family and key carers to forestall premature care decisions.

Professor Henley, in delineating the skills demanded of the generalist, repeats those expected of the internist–geriatrician, namely competency in using technology in a cost-effective and rational way. As geriatricians teach, the hardest thing to do in medicine can be to do nothing. Technology for the geriatrician includes the rational use of medication and the realisation that nearly a third of elderly inpatients have their admission caused or contributed to by the adverse effects of drug therapy.

General physicians and geriatricians, by sharing each other’s insights and educational forums, can do much for the cause that Professor Henley seeks in his oration.

I commend my non-geriatrician colleagues to view the Australian and New Zealand Society of Geriatric Medicine’s website at <www.anzsgm.org>, where Position Statements provide best practice information on many aspects of medical services and care for the elderly. In addition, scope for Professor Henley’s desire to reduce service loads, ease rosters and secure potential job sharing among increasingly female aspirants in both areas of practice may emerge from a reading of the role of the modern geriatrician, also contained on this website.

Dr Philip Henschke FRACP, FRCP(C)
Adelaide
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Congress Program
The Congress theme is World Medicine for the Next Decade: 2010 to 2020. The program will showcase excellence in Australasian Medicine and Medical Science and will offer a superb opportunity for physicians and medical specialists to attend expert updates on specialty areas outside their own specialty.

Themes running throughout the Congress will be:
- Science, Research and Innovation
- Policy, People and Politics
- Clinical Medicine
- Young People and Health
- Medical Education

Keynote Speakers
Professor Barry Marshall AC, together with Professor Robin Warren, was awarded the Nobel Prize for Physiology or Medicine in 2005. The award recognised their 1982 discovery that a bacterium, *helicobacter pylori*, causes one of the most common and important diseases of mankind, peptic ulcer disease. In 2007 Professor Marshall was awarded the honours of Western Australian of the Year and the Companion of the Order of Australia.

Professor Graham Brown is the Foundation Director of the Nossal Institute for Global Health, University of Melbourne. He has held advisory roles in health programs of organisations such as the World Bank and the World Health Organisation. His area of interest is Tropical Diseases, particularly malaria.

Host City – Melbourne, Australia
In the past two years Melbourne was ranked 1st & 2nd consecutively as the World’s Most Liveable City by The Economist Intelligence Unit. It is a vibrant and cosmopolitan city that is host to a multitude of international events, including the Australian Open Tennis Grand Slam and the Australian Formula One Grand Prix. March is the best time of year to visit Australia and New Zealand.

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Please visit the conference website to register
www.sexualhealthconference.com.au

Just a few of the key speakers are listed below,
please visit the website for the most up-to-date program

**International Invited Speakers**
Dr Sjoerd van der Burg, Department of Clinical Oncology,
Leiden University Medical Center, Leiden, The Netherlands
Dr Simon Barton, Clinical Director and Consultant Physician,
Chelsea & Westminster Hospital, London, United Kingdom
Dr Claudia Estcourt, Reader in Sexual Health & HIV at Barts and the
London School of Medicine and Dentistry, United Kingdom
Dr Graham Neilsen, Technical Advisor on Sexual and Reproductive Health,
Asia Pacific Regional Office of Family Health International, Thailand

**Gollow Lecture**
Prof Ian Frazer, Director of the Diamantina Institute
for Cancer Immunology and Metabolic Medicine, Australia

The conference is introducing a number of new topic areas into the program this year; they
include symposia on sex worker issues, sexual dysfunction and sexual assault

For further information about the conference please visit the conference website at
www.sexualhealthconference.com.au or
contact the secretariat at
info@sexualhealthconference.com.au or
on +02 8204 0770
New Zealand Health Careers

Specialist Physician
General Medicine / OP and RS
Permanent / Full time
Position No. 50906-21657

Applications are invited for a full-time Specialist Physician working 0.5 FTE in Older Persons and Rehabilitation services and 0.5 FTE within General Medicine. This position becomes available in August 2009. The successful appointee will have a broad range of acute general medical and experience in adult rehabilitation. The incumbent will provide expert consultation, education and training and will participate in the acute General Medicine roster. A commitment to customer focus, service development and teamwork are essential.

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- FRACP postgraduate qualification.

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New Zealand Health Careers

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Permanent / Full time
Position No. 50906-21658

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- Have a commitment to customer focus, service development and teamwork.

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You would also take up a part-time teaching appointment at Monash University’s East Gippsland Regional Clinical School, one of the School of Rural Health’s four regional clinical schools. These schools teach over 25% of Monash’s students in clinical years three, four and five of the MBBS course.

Your primary medical qualification should be registrable with the Medical Practitioners Board of Victoria. Your specialist qualification should be Fellowship of the Royal Australasian College of Physicians or other postgraduate clinical training, qualification and experience in Internal Medicine that the College assesses as suitable for the position. Remuneration arrangements are flexible and can be structured to meet your preferences. Benefits include * salary packaging* and conference and study leave.

Information about the Services, region and University may be found on www.brhs.com.au www.cghs.com.au and www.med.monash.edu.au Applications and requests for additional information may be sent in confidence to Leslie McBride at:

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