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Autumn starling migration over Rome.
Photograph by Dr Valerie Sung FRACP.
ne of the challenges for our College is the vexed issue of internal communication between Fellows. The Board is concerned that its decision making may be perceived as taking place distant from Fellows and thus has expressed a wish that Board decisions be made more widely available to Fellows.

At each Board meeting, a director is responsible for identifying the key issues for dissemination beyond the Boardroom and these form the basis of a brief but comprehensive communiqué. For this communiqué to be meaningful it needs to be released in a timely manner. Our current aim is for this to be produced within 10 days of the Board meeting. This communiqué was initially sent to the committees which report directly to the Board. However, at its last meeting the Board decided that in order to better inform Fellows of the decisions of the Board it will be distributed electronically to all Fellows.

Another activity which takes place at each Board meeting is that a director is assigned to undertake an appraisal of the functioning of the Board and the performance of the Chair. This is part of the process of the Board critically reviewing its performance and includes inter alia the appropriateness of items on the agenda, the quality of the agenda papers, the quality of the Board’s decision making, the calibre of discussion and the contributions of individual directors. I would encourage all committee members to instigate a similar process of review of performance for their committees. This is part of the more general process to ensure that Fellows’ time on committees is maximally efficient and effective.

Charles De Gaulle was noted to have said: ‘How can anyone govern a nation that has 246 different kinds of cheese?’ Whilst not wishing to debate which group is represented by the delicate and refined Brie de Meaux, or by the pungent and complex Roquefort, we do have quite a large number of groups ‘within the College tent’, especially if we consider the Specialty Societies and like organisations. We must all work towards an outcome whereby all groups see themselves as, and function as, part of the One College.

The Congress Business Committee has been charged with developing a proposal regarding the means by which the College should celebrate its 75th Anniversary in 2013. Somewhat along similar lines, the Research and Education Foundation is being asked to consider how the 20th Anniversary of the Foundation in 2011 should be marked.

Finally, I remind all Fellows that the rollout of PREP AT will begin in 2011. While the changes will not be as profound as those of PREP, I encourage all Fellows to become familiar with the program and its requirements through review of the relevant literature and attendance at RACP workshops.

John Kolbe
President
WHAT WE KNOW ABOUT ALCOHOL DEPENDENCE, HARM AND TREATMENT: THE AUSTRALIAN STORY

In Australia alcohol kills more people than any illicit drug (at least 5000 deaths per year) and kills at a younger age than tobacco. Internationally, alcohol is conservatively estimated to be associated with 4.4% of the worldwide burden of disease. Alcohol misuse is estimated to cost Australia $15 billion every year for the costs to drinkers themselves, and more than $20 billion for the impacts of alcohol on others. These estimates are likely to be conservative—in our drug and alcohol clinics we see many individuals who, decades later, are struggling with the after-effects of growing up with a violent, abusive or neglectful parent. While alcohol dependent individuals experience the most severe harm, most of the harms from alcohol nationally are linked to (non-dependent) problem drinkers, because they are so numerous—up to 35% of the community have put themselves at risk from short-term harm from alcohol at least once in the last 12 months.

Just under one in 20 Australians suffer from alcohol dependence—typically experiencing loss of control, craving, tolerance and often withdrawal symptoms. Many with milder dependence are employed and not immediately visible (and include judges, doctors and truck drivers) but alcohol impacts on their function. At the more severe end of the spectrum alcohol dependence is a debilitating, chronic relapsing condition that we have all seen too often. As with other conditions listed in the International Classification of Diseases, alcohol dependence has well-established polygenic and behavioural risk factors, evidence-based prevention and early intervention approaches, and pharmacological treatments with demonstrated effectiveness. Even more than with ischaemic heart disease, enabling behaviour change is a critical element of management. When treatment fails, palliation is important.

Australian researchers have had a significant role in developing the evidence base in all of these fields. For example, Whitfield and Martin’s twin studies demonstrated that half or more of our drinking pattern is genetically influenced; Saunders and others’ work in early intervention has had international impact; a recent international collaboration, including Haber, demonstrated that baclofen can safely reduce craving for alcohol even in advanced cirrhosis; and Harper’s pioneering work on the high prevalence of subclinical Wernicke’s Encephalopathy led to thiamine supplementation in flour. These are just a few of many internationally recognised Australian contributors to research on alcohol disorders. There are many other internationally recognised figures, including those providing world leadership in clinical management, epidemiology, policy and prevention.

Governments in their chronic disease policies tend to neglect alcohol dependence, and are often more ready to fund treatment services for illicit drugs than for alcohol.

We have seen a rapid professionalisation of the alcohol treatment field over the past 30 years, in parallel with a growing understanding of the cellular and molecular basis of alcohol dependence and the nature of effective prevention. The availability in Australia of relapse prevention pharmacotherapies (acamprosate, naltrexone and supervised disulfiram) has assisted in encouraging medical professional (and client) engagement with treatment. In Australia, the College of Physicians has had a key role in driving forward professionalism with the formation of the Chapter of Addiction Medicine in 2002. As well as supervising advanced trainees, Addiction Medicine Fellows (as well as members of the Section of Addiction Psychiatry) are heading hospital-based clinical units around the country. Rotation of generalist, internal medicine and psychiatry junior medical staff through such units has contributed to an increased understanding of both the patients and the available treatment options. Shared care arrangements with GPs and 24-hour specialist advisory services have also increased generalist clinicians’ confidence. The recent national clinical alcohol management guidelines provide further support.

In Newcastle, NSW, the simple measure of making inner-city pubs close earlier (at 3 am!) was able to reduce alcohol-related assaults by one-third.

So we can see that the alcohol problem is very big, a firm evidence base is available on what needs doing, and there is a body of professional expertise. So why then does prevention and treatment of alcohol problems in Australia so often fall outside the evidence base and into the realm of politics and opinion? The dollar value of the alcohol industry and their resulting influence is one important factor. The fact that everyone is familiar with alcohol is another. But the end result is not always the most productive. We know that simple education has very limited impacts on prevention, and that supply control works best (limiting density of licensed premises, controlling price and restricting opening hours), yet supply control is resisted. The Henry review supported a volumetric tax: that 10g of ethanol as wine should be taxed the same as 10g ethanol as beer or spirits. But this has not happened.

Associate Professor Kate Conigrave

In this article, Associate Professor Kate Conigrave discusses the prevalence and impact of alcohol dependence in Australia, highlighting the role of Australian researchers in advancing evidence-based prevention and treatment. She emphasizes the importance of professionalization in managing alcohol dependence and the need for a stronger evidence base in policy-making. The article also touches on the unique strategies employed in Newcastle, NSW, to reduce alcohol-related assaults, which serves as a model for potential interventions.
Newcastle, NSW, the simple measure of making inner-city pubs close earlier (at 3 am!) was able to reduce alcohol-related assaults by one-third. Yet, when similar measures were proposed by the Mayor of Sydney, we saw objections from the alcohol industry, and mystery websites with offshore origins popping up to decry Sydney’s ‘nanna state’. Bans on alcohol advertising to the young are circumvented by sports heroes wearing apparel emblazoned with beer company logos, and giveaways and promotions clearly target the young (e.g. pink lip gloss with sparkling alcohol). The internet is a godsend for the alcohol industry, with internet advertising that goes viral (did you see the ‘Big Beer Ad’ to the tune of Carmina Burana?) and now Facebook. My 17-year-old daughter showed me the latest Facebook page that all her friends were signing up to. It promotes a pre-mix cask, and is industry owned. Unfortunately, health professionals and governments are up against the mighty dollar of the alcohol industry. With over 60% of alcohol consumed on days when people are exceeding the (2001) guidelines for responsible drinking, the alcohol industry needs problem drinking.

Never is the funding shortfall more evident than in Indigenous-specific alcohol and drug interventions in Australia, where 24% of projects rely on short-term funding. Furthermore, staff in many regional and remote communities are typically overburdened, and services rely heavily on commitment or on volunteer labour. This is despite the stated massive public concern about alcohol in Indigenous communities.

Australian governments need to logically and systematically look at the range and type of services needed for evidence-based prevention and treatment of alcohol problems. As health professionals, we still need to work to keep alcohol on the agenda when planning prevention, treatment and chronic disease management services and also when assessing individual patients.

Associate Professor Kate Conigrave FACHAM FAFPHM
Royal Prince Alfred Hospital and the University of Sydney

While there is heavy drinking, Australia will still need quality treatment services. Currently the demand for treatment outstrips the supply. Service shortages are country-wide, but worse for regional and remote Australia. There are also shortages of trained professionals. For example, the Northern Territory has the highest alcohol consumption in Australia, but currently does not have a practising Fellow of the Chapter of Addiction Medicine. Even in big cities, the traditional reliance by governments on volunteer services and non-government agencies has persisted. While there are some superb non-government organisations, others struggle for the funding to employ sufficient skilled and qualified clinicians. And governments in their chronic disease policies tend to neglect alcohol dependence, and are often more ready to fund treatment services for illicit drugs than for alcohol.

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There was yet another event that summer that shaped the future. While preparing my last email bulletin as president to College fellows and members, I was struck by a couple of articles that drew attention to the negative impact of UK drug policy on health, and was moved to mention in my bulletin that perhaps it was time to debate again the issue of decriminalising heroin and treating addiction as a health rather than a criminal justice issue. I had tried for a decade to get alcohol issues on our newspaper front pages, but this single innocent remark on drugs produced the busiest day the media team at the RCP had ever experienced. ‘Top doc drug shock’ went on until I escaped to Adelaide! Since then I have been an (entirely amateur) expert on drug as well as alcohol policy, but it has made me appreciate the power of illicit drugs to attract media interest and I now refer to ‘alcohol and other drugs’ whenever I can.

I was particularly interested to discover that in Australia training in addiction medicine falls within the ambit of the RACP and the specialty is practised by physicians rather than psychiatrists, unlike in the UK and New Zealand. While I am in no way seeking a UK physiciansly ‘take-over’ of addiction, it may be that some specialties such as gastroenterology and emergency medicine could usefully look at some form of dual training in addiction. In terms of alcohol policy in Australia, I was greatly impressed by some of the innovative developments that had tackled availability (for example, Tennant Creek’s ‘Thirsty Thursday’ initiative)—price, strength and availability. These were often driven by leaders in the Indigenous population but sometimes foundered on the difficulty of sustainability after initial successes. Drink-driving measures are a notable success that the UK would do well to follow. To demonstrate that I am not ‘anti-alcohol’, my wife and I made a trip to the wineries of McLaren Vale and was amused at the tongue-in-cheek old advertisements on show at Hardys Tintara winery.

I was delighted when the RACP generously took up the suggestion of Dr Geoffrey Robinson of Wellington that I might finish my professorship in Adelaide with a trip to New Zealand to discuss alcohol policy there. This was particularly timely because government there was considering its response to an excellent report from the Law Commission under the leadership of former prime minister Sir Geoffrey Palmer. The Commission made over a hundred recommendations, and in particular picked up the vital importance of tackling price, availability and marketing to reduce harm—as have so many evidence-based reviews in the past. It fell to the Ministry of Justice to respond, and I had a chance to meet the Minister, Simon Power, to discuss this. He came over as both highly able and well informed, but his commitment to reducing alcohol-related harm was inevitably tempered by the political considerations of trying to get really effective policies through Parliament against the inevitable opposition. The Law Commission report has been seen as a ‘once in a generation’ opportunity to healthcare professionals to bring about meaningful policy change, but it is more likely to turn out to be a small step on a long journey. The New Zealand Government’s failure to seize the opportunity is reminiscent of the UK Government’s failure to heed the advice of Parliament’s Health Select Committee—who observed ‘We are concerned that Government policies are much closer to, and too influenced by, that of the drinks industry and the supermarkets than those of expert health professionals such as the Royal College of Physicians or the CMO’.

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In lecturing in four cities in New Zealand I had a wonderful opportunity to meet a wide range of people interested in alcohol and health. My host in Auckland was Mark Lane. I was particularly interested to hear the perspectives of the hepatologist Rachel Harry who had recently moved from Manchester in the UK. While the culture of heavy drinking and the associated immediate harm was very similar to that of the UK, the pattern of chronic harm seemed very different. Whereas our wards in the UK are home to many patients, often under 40 years of age and dying, with alcoholic hepatitis and advanced liver failure, this does not seem to be the case in New Zealand. When invited to talk to Mark Sainsbury on his evening Close Up program, I had the usual problem of moving the discussion away from legalising heroin to the more harmful (in societal terms) drug, alcohol, but got some points over. In Dunedin, Jennie Connor, a public health physician, hosted my lecture and I was delighted to experience the rich history of the medical school there. In Christchurch, I was so immersed in delivering my lecture that I failed to notice an aftershock of 5.2 on the Richter scale! I met Doug Selman there, an addiction psychiatrist who is an example to us all of commitment to advocacy for our patients on alcohol and drug policy. He has been recently wonderfully outspoken on New Zealand’s failure to lower the drink-driving limit from 80 mg% and the resultant complicity in ‘legal drunk driving’.

There was much to reflect on when I returned to the UK, as our new coalition government was establishing its policies. On the positive side, there is a strong commitment to supporting public health measures, but paradoxically some of the changes in how healthcare will be commissioned and provided may make it tougher for public health to influence local policies. Also there is a greater emphasis again on ‘personal choice’ in areas of ‘lifestyle’—which has always struck me as a curious concept in the context of a drug of addiction that is freely available and heavily marketed around the clock. There is a renewed emphasis on voluntary partnerships with the drinks industry on issues like public information and education, which is at risk of overlooking the fundamental conflict between effective public health measures to reduce alcohol consumption at a population level and the need for industry to maximise the needs of shareholders.

As health is a devolved responsibility in the UK, we now have the fascinating possibility of very different policies in England, Scotland, Wales and Northern Ireland—familiar in Australia where state and federal policies can diverge. I was conscious while in New Zealand that government was watching events unfold in Scotland with particular interest. There the Scottish National Party (SNP) is the largest in their parliament, although they do not have a majority. Aware of the particular burden of harm, health, criminal and social, north of the border, they have been seeking to tackle the availability of cheap alcoholic beverages through establishing a minimum price per unit of alcohol. To date the SNP have had little support from other parties and a minimum unit price is unlikely to survive the third reading of the bill, but it has been very influential in moving forward the debate in the UK. Scotland was the first part of the UK to ban smoking in public places and alcohol policy may be another area where they lead the other home nations in taking action. In the meantime, Westminster government is likely to continue to raise duty and taxes on alcohol above inflation—at least a recognition that cheap drink is central to our current alcohol problems in the UK—but the supermarkets are likely to absorb this …

Westminster government is likely to continue to raise duty and taxes on alcohol above inflation—at least a recognition that cheap drink is central to our current alcohol problems in the UK—but the supermarkets are likely to absorb this … remain the most popular ‘hook’ to attract customers into the major stores. It is proving hard to get our politicians to acknowledge that the moderate drinker is subsidising the heavy drinker in what they pay for their weekly grocery basket. And rises in duty and tax will hit pubs more than supermarkets and do nothing to halt the move towards home drinking while pubs are being forced to close.

I shall watch alcohol and drug policy in Australia and New Zealand with even greater interest in the future and am grateful to the RACP for making this visit possible. Surely this is an area where Colleges can be more effective by working closely together to make gains in the health of our populations.

Sir Ian Gilmore FRCP FRACP (Hon)
Consultant Physician,
Gastroenterologist and Professor,
Department of Medicine,
Royal Liverpool University Hospital
T his year was an historic opportunity for New Zealanders to contribute to the Liquor Laws which are under a major review by the National Government.

The Minister of Justice tabled a new 225-page Bill in Parliament on 9 November 2010, being referred to as the Alcohol Reform Bill.

One of its objectives is to ‘reduce excessive drinking by young people and adults’.

Alcohol intoxication is the problem

A great deal of concern has been expressed about drunkenness. Two surveys have suggested that about 700,000 of the New Zealand population (4.2 million) frequently drink heavily— which involves drinking six or more standard drinks on one occasion.\(^1\)

Clearly, alcohol is our most commonly used recreational drug, and accordingly was described in a recent *Lancet* article as the most harmful.\(^2\) As we know, the harms from drunkenness are numerous and include accidents, injuries, violence, assaults and crime. In New Zealand alcohol is found to be consumed by 30% of offenders, and in 49.5% of homicide cases (by either suspect or victim). It is frequently involved in boating tragedies, drownings and domestic fires. A study suggested that 147,500 New Zealanders had taken at least one day off work in the previous six months because of alcohol.\(^3\)

Alcohol poisoning may cause death. There has been much publicity from the Chief Coroner on this ultimate fatal outcome, usually involving young people drinking high-dose spirits. This is primarily due to alcohol depressing the respiratory centre. Inhalation of vomitus may also be a contributing factor.

However, acute poisoning contributes only a small burden to all the deaths from alcohol, which generally arise from accidents, trauma and organ effects of chronic excess (including disposition to various cancers).

Besides accidents and injuries (falls, fractures, head injuries), one-off heavy drinking can sometimes produce other clinical effects, including atrial fibrillation, gout flares, worsening of depression +/- suicidality, gastritis, hypoglycaemia (in children and diabetics on treatment), pneumonia, and of course hangovers.

The burden of drunkenness per se exceeds the more acknowledged issues of alcoholism (dependence) and its numerous medical and psychiatric complications. In fact alcoholics are somewhat protected from ‘drunkenness’ because of the marked tolerance these individuals acquire to the brain effects of higher alcohol doses. Alcoholics need much higher levels of alcohol than non-tolerant drinkers to produce the effects shown in Figure 1, which I have included to demonstrate just what a dangerous intoxication this is, despite its acceptance by the community. Given the adverse effects, it remains difficult to understand why people seek blood alcohols beyond 50mg/100ml.

It is clear that alcohol is a highly intoxicating, excessively commercialised drug that is ubiquitous and relatively inexpensive.

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**Figure 1: The effects of alcohol in non-tolerant persons**

- Relaxation
- Talkativeness, sociability, feeling happier
- Reduced - concentration - reaction time - decision-making - vision
- Dysarthria
- Disinhibited behaviour
- Poor social judgement/risk-taking
- Ataxia and incoordination
- Nausea and vomiting
- Vertigo
- Double vision
- Slow thinking
- Memory blackouts
- Aggression and violence (in some)
- Personality change
- Mood change, especially low mood
- Confusion
- Sleep
- Obstructive sleep apnoea
- Stupor
- Coma
- Respiratory depression
- Death (from alcohol poisoning)

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\(^1\) *Lancet*
\(^2\) Recent *Lancet* article
\(^3\) A study suggested that 147,500 New Zealanders had taken at least one day off work in the previous six months because of alcohol.
Medical endeavours in the Liquor Law review process

The Law Commission produced a preliminary report, and received submissions which numbered almost 3000. During this process, Sir Geoffrey Palmer, Chair of the Law Commission, questioned some of us about the relative lack of medical input into this matter, which he felt was in contrast to medical bodies in Scotland and England. Nevertheless, medical responses did occur, including submissions to the Law Commission from RACP(NZ) and other Medical Colleges here. The New Zealand Council of Medical Colleges (CMC), at the instigation of the RACP(NZ), wrote to the Law Commission confirming the Colleges’ concerns over the pervasive medical harms consequent to excessive use of alcohol.

Professor Doug Sellman, psychiatrist and Director of the National Addiction Centre, University of Otago Christchurch, and also a Fellow of this College (FACHAM), showed inspired leadership and formed a high-profile lobby group called ‘Alcohol Action New Zealand’. Professor Jennie Connor (FAPPHM) has ably supported him as medical spokeswoman for this group.

Professor Sellman toured New Zealand, speaking in most cities and towns on ‘Ten things the liquor industry won’t tell you about alcohol’. He facilitated a statement to the Law Commission from 450 leaders of doctors and nurses throughout New Zealand. There have also been numerous articles and responses led by Professors Sellman and Connor in newspapers and on radio and television.

As described in the accompanying article, the RACP(NZ) sponsored Professor Sir Ian Gilmore’s visit to New Zealand centres in September 2010, which covered the UK perspective, and brought media exposure and a meeting with the Minister of Justice.

Outcomes to date

The Law Commission produced a final substantive report in April 2010, Alcohol in Our Lives: Curbing the Harm. This has been used as the basis for the Alcohol Reform Bill, which includes a significant number of the Law Commission’s recommendations such as improving treatment opportunities. However, many of us are disappointed that the Bill does not include the really important and substantive steps (increased price, and reduced access and advertising) which are evidence based and could have more significantly influenced New Zealand’s binge-drinking culture. In our view, there has been insufficient acknowledgement of alcohol as a legalised, highly intoxicating drug which is widely available, commercialised and cheap. We have battled unsuccessfully to date to persuade government to put an end to:

- ultra-cheap alcohol—beginning with a minimum price for a standard drink
- highly normalised and accessible alcohol—by restoring supermarkets to being alcohol-free
- all alcohol advertising and sponsorship (except objective printed product information)
- legal drunk driving—by reducing the adult blood alcohol level to at least 0.05 (as happened in Australia many years ago).

Still, there is hope, as submissions to the Alcohol Reform Bill Select Committee will soon start. Colleagues wishing to make a submission can go to www.alcoholaction.co.nz to get information on how to do so.

No Liquor Law legislative changes will come into effect until after the Rugby World Cup has been secured by the All Blacks in October 2011 (sigh).

Dr G M Robinson FRACP FACHAM

References


QUEENSLAND’S FIRST INDIGENOUS DOCTOR CLOSING THE HEALTH GAP

Associate Professor Noel Hayman

The College is delighted to announce that Associate Professor and RACP Fellow Noel Hayman, Queensland’s first Indigenous doctor, has been named Queensland Australian of the Year.

This award recognises his efforts to improve the life expectancy of Indigenous Australians through his work at the Inala Community Health Centre, which he founded. Over the last decade he has helped increase the number of patients from 12 to 2500, with Indigenous patients travelling from all over Brisbane to the centre.

RACP President John Kolbe has heralded the outstanding work of Associate Professor Hayman in combating the issues of chronic disease in the Indigenous community.

‘Noel’s work is nothing short of outstanding, with a significant improvement in the control of diabetes and a major boost in immunisation rates,’ Professor Kolbe said. ‘Many Indigenous people avoid visiting major hospitals and Noel has created a place where Indigenous people feel comfortable and understood. This encourages them to seek treatment and to follow through on their treatment plans.

‘Most significantly, he actively recruits and trains much-needed Indigenous doctors, a long-term strategy to help combat the very real problems faced.’

Associate Professor Hayman will be put forward as the State’s nominee for the Australian of the Year award.
LECTURE TOUR OF NEW ZEALAND 
BY LEADING UK ALCOHOL REFORM ADVOCATE SIR IAN GILMORE

Professor Sir Ian Gilmore, a leading alcohol policy expert, was in New Zealand in September as a guest of the Royal Australasian College of Physicians for a series of lectures across the country. Sir Ian is an Honorary Fellow of the Royal Australasian College of Physicians and the immediate past-President of the Royal College of Physicians, London. He is a consultant physician, a gastroenterologist and a Professor in the Department of Medicine at the Royal Liverpool University Hospital. Sir Ian has an extensive background in alcohol reform having chaired the Royal College of Physicians' Alcohol Working Party Report, being a member of the Secretary of State’s Advisory Committee on Alcohol and Drugs and continuing to chair the United Kingdom Alcohol Committee and Alcohol Health Alliance.

While in New Zealand, Sir Ian had the opportunity to be interviewed by Mark Sainsbury on Close Up, a leading daily news and current affairs TV program. He also met with the Minister of Justice, Simon Power, and with members of the College to share his views on alcohol reform.

Sir Ian presented on the impact of alcohol consumption in the United Kingdom, Europe and internationally. As a cause of preventable premature death, alcohol is in the top three contributing factors internationally, smoking and blood pressure being the other two. Concerning statistics on youth binge drinking were raised by Sir Ian showing that many 15–16 year olds in Britain are having five or more drinks three or more times within a month. This means that they are binge drinking almost once a week. Binge drinking is extremely detrimental to an individual’s health as it increases the risk of all cause mortality by 300%. Youth binge drinking in New Zealand is a huge problem, with a high proportion of New Zealand youth consuming large amounts of alcohol within a sitting. The highest sources of all cause mortality due to binge drinking are myocardial infarction and death from external sources. It is also important to be aware that there is much more harm caused by passive drinking – collateral damage to innocent bystanders or third parties – than by passive smoking. Although there are so many detrimental effects in relation to the consumption of alcohol, Sir Ian does not advocate prohibition and he did show some evidence of the health benefits of moderate alcohol consumption.

In the lecture series Sir Ian explained the correlation between advertising, including sponsorship by the alcohol industry of sports and music events, and alcohol consumption. It has been proven that as the affordability of alcohol increases so does the amount of consumption. It has also been shown that price rises affect high-consumption drinkers, as those who consume large amounts of alcohol utilise sales and cheap alcohol in a way that moderate drinkers do not.

Areas for reform recommended by Sir Ian include:

- increasing alcohol duty (there needs to be a substantial rise in price, otherwise the extra duty is absorbed by other products)
- linking taxation to alcohol strength
- having tax incentives for low-alcohol alternatives
- setting a minimum unit price
- developing policies targeting price-based promotions, and possibly an all out ban on such promotions.

Many of these recommendations are in line with the College’s position on alcohol reform which can be found in the document ‘Alcohol Policy: Evidence for Better Outcomes’.

Gemma Bayley
Policy and Administration Officer
An Advanced Training Summit was held on Tuesday, 5 October 2010, in Sydney. The purpose of the Summit was to bring together representatives from the RACP Advanced Training Education Committees to discuss the development and implementation of the Physician Readiness for Expert Practice (PREP) Advanced Training programs from 2011, and to consult on the College Education Deanery’s associated plans and proposals.

Participants included representatives from each of the Advanced Training Education Committees across the Divisions, Faculties and Chapters. Representatives from the College Trainees Committee, College Board, a number of Expert Advisory Groups, some paediatric subspecialty groups, and College staff were also invited.

Professor John Kolbe welcomed participants to the meeting, and started the program for the day, which commenced with a few short presentations from Education Deanery staff.

Fellows, trainees and RACP staff engaged in a number of workshop-style group activities throughout the day to discuss proposals for educational directions and the next steps for implementing PREP Advanced Training programs.

Members of the College Trainees’ Committee had an opportunity to present their views on the program development for PREP Advanced Training, and had some valuable insights into how to achieve successful implementation of new elements in the programs.

The Advanced Training Summit was an important event for engaging and consulting with Fellows and trainees on a number of College plans and proposals. Major outcomes from the day included:

- **A common framework.** The PREP framework has been established as the common foundation for training program development across the College. Commonalities in program requirements across specialties were identified and strengthened.
- **PREP tools and resources.** The College development plans for tools and resources within the PREP framework were agreed. Feedback from representatives called for the development of further teaching resources for supervisors and trainees to be incorporated into future College plans, particularly in relation to teaching the Professional Qualities domains.
- **Planning implementation.** Communication and supervision were the two areas flagged as being essential for the successful implementation of the PREP Advanced Training programs. As elements of the programs are introduced over a number of years, a strong focus will be placed on providing clear and consistent communication, and on providing support and training for supervisors.

Following the Summit, the Advanced Training Education Committees will be continuing the development of training programs under the PREP framework. This includes establishing the minimum program requirements for PREP Advanced Training in each specialty for 2011 and beyond.

Elements of the PREP Advanced Training programs will be gradually implemented over a number of years, starting with first year Advanced Trainees from 2011.

Resources and training will be provided for supervisors and trainees to support them in using the formative assessment and teaching and learning tools within the PREP framework, and feedback will be sought from supervisors and trainees on their experiences in implementing the PREP Advanced Training programs.

Susi McCarthy
Curriculum Development Officer
Education Deanery
Over the past few years, the RACP has been developing Advanced Training programs using the Physician Readiness for Expert Practice (PREP) framework. The PREP framework introduces a common structure to all RACP training programs and aligns the PREP Basic and Advanced Training programs. A number of components constitute the framework, including curricula, formative assessments, teaching and learning tools, and an eLearning environment.

Elements of PREP Advanced Training programs that will be available from early 2011 include:

- Specialty Specific and Professional Qualities Curricula
- Advanced Training Portal—phase 1 release (updates and enhancements to follow across 2011)
- Learning Needs Analysis online tool
- Case-based Discussion formative assessment and online tool
- Mini-CEX formative assessment and online tool.

Specific program requirements for 2011 set by the relevant Education Committee will be made available towards the end of 2010.

Elements of PREP Advanced Training programs will be gradually implemented over a number of years. On an annual basis, as the rollout progresses, Advanced Training Education Committees will establish minimum requirements for each transitional year of training until full implementation is achieved.

Communication and training resources will be developed and disseminated to support the gradual implementation of these programs, and to ensure that trainees and supervisors are supported and equipped with the information needed to complete the requirements of PREP training.

Trainees and supervisors will be given the opportunity to provide feedback to the College throughout the transitional period.

The phased implementation approach will commence in early 2011. Additional PREP tools and resources (e.g. the Professional Qualities Reflection online tool) will be developed throughout 2011 for implementation in 2012. The Advanced Training Education Committees may ask their trainees and supervisors to familiarise themselves with additional PREP tools and resources throughout 2011.

Communication and training materials will be developed concurrently. The Advanced Training Education Committees will also establish and communicate 2012 program requirements throughout 2011.

Changing patterns of healthcare
Changes to working hours and shorter patient stays have served to challenge traditional teaching environments and processes. Greater educational structure assists learning in complex clinical environments.

Accreditation and certification
In 2004 the Australian Medical Council recommended a series of changes to the RACP training programs in order for the College to retain its accredited status as a training institution.

Expectations from regulatory bodies, governments and the public relating to physician competence were a further driver for change.

International best practice
The RACP is committed to providing a world-class training program that integrates an evidence-based approach to postgraduate medical education.

Professionalism and patient focus
The PREP program places emphasis on the provision of exemplary patient care within the context of an increasingly complex multidisciplinary team-based working environment.

For more information on what to expect in 2011, visit the College website <www.racp.edu.au/page/atp> or contact the College Education Officer for your specialty.
The RACP’s Specialist Training Program (STP) aims to support medical specialist training in an expanded range of settings beyond traditional public teaching hospitals. The program is being funded by the Department of Health and Ageing (DoHA). An evaluation of the STP posts was commissioned in 2010 to gain a better understanding of the experience and perspectives of trainees, supervisors and Directors of Physician Education (DPE) on various aspects of the clinical learning environment in expanded healthcare settings.

The additional purpose of the 2010 STP evaluation was to provide a baseline for subsequent evaluations and to form part of a comprehensive evaluation of specialist training posts being undertaken by the College over the next three years. A comprehensive report was developed by the Research and Evaluation Unit, the STP Unit within the Education Deaneary and an independent consultant, Argyle Research, during July–October 2010. This article highlights key findings of the evaluation.

The online survey instrument was adapted from similar training program evaluations conducted by the Research and Evaluation Unit. The trainee section within the survey included items based on rating scales as well as open-ended questions to assess trainees’ perceptions of the learning environment. Supervisors and DPEs were asked to reflect on the value of the STP as a qualitatively different form of medical specialist training and also to identify challenges within the program and possible areas for improvement. A total of 220 trainees, supervisors and DPEs were sent the survey in August 2010.

A response rate of 65% (N = 143) was recorded, which included 56 trainees, 72 supervisors and 15 DPEs. Of the trainee respondents, the majority (88%) identified themselves as Advanced Trainees. The main area of training of the trainee respondents was Adult Internal Medicine (72%) with smaller numbers in Paediatrics & Child Health and in the Faculty and Chapter training programs. Most of the trainee respondents were located in public hospitals (55.4%) and in metropolitan areas (48.2%) followed by regional (14.3%) and rural areas (8.9%).

Key findings

Trainees’ perspectives of the STP

- The settings and resources available at the STP sites were mostly rated as useful to very useful, with more than 80% of the respondents finding outpatient seminars, workshops and ward rounds of particular value.
- The majority (more than 80%) found that the training post made the best contribution to the development of clinical skills, patient care skills and communication skills. Respondents also indicated receiving substantial feedback in performance improvement in these skills.
- The contribution of the training post to the development of procedural skills, research skills and health advocacy was perceived unfavourably by more than a quarter of the respondents. In addition to these skills, cultural competency, administrative skills and teaching skills were the areas in which large numbers of the respondents reported receiving insufficient feedback.
- With regards to supervision, more than two-thirds of the respondents reported spending between one to two hours per week with their supervisors. Respondents, however, expressed the need for more regular interactions with their supervisors.
- In general, supervisors were perceived to be most helpful in role modelling exemplary clinical practice and procedures and in facilitating development of knowledge and skills, whereas their role in conducting formative assessments and in helping trainees identify and correct areas of weaknesses was rated as low.
- Access to supervisors and mentors throughout training was identified as an important issue for trainees in expanded healthcare settings.
- Protected learning time was found to be an area of concern as most of the trainees reported receiving less than two hours per week for participation in activities such as grand rounds, case presentations and peer consultations, and in self study.
- Trainees also expressed the need for access to additional online learning resources such as online journals and online case discussions and modules.

The analysis of respondents’ open-ended comments revealed mixed feedback, with some experiencing the STP post as positive and others finding the experience to be less useful than a major teaching hospital.

Trainee comment: [STP has] very different training environment in remote Indigenous communities, [provides] unique look at issues in the communities, ambulatory care and chronic diseases the focus.

Trainee comment: Yes, [STP is] markedly different. One-on-one consultant teaching and supervision every day and extensive exposure to high-tech medical and surgical procedures not seen in metropolitan teaching hospitals.

Supervisors’ and DPEs’ perspectives of the STP

Supervisors and DPEs were asked to describe how the program differed from the training in a major teaching hospital, what the gaps were in the training and how the College could better support trainees and supervisors.

- The majority of supervisor and DPE respondents considered that the trainees’ experience in the STP posts differed from the experience in a major teaching hospital in terms of exposure to diverse and challenging cases, especially in rural and regional areas. In addition, the experience of working with Aboriginal health communities was identified as a unique aspect of the STP.

Comment from supervisor and Director of Physician Education: [In STP] patients have multiple comorbidities, providing a very broad experience of General Medicine. Supervision and advice is from experienced generalists who have skills in many specialty areas. You don’t get these sorts of senior people in many major meto hospitals these days. Also unique insight into social problems and living conditions in remote Aboriginal communities and the challenges for patients trying to manage health problems.
Respondents, however, highlighted a range of gaps in the training program, mainly related to funding, management of the STP, training content and structure, and rural and remote issues. In relation to the College’s role in improving the training program, respondents expressed the need for more information from the College on the program, including support processes for supervisors such as workshops and online resources. Comments were also expressed about the need to reduce and simplify the administrative and reporting procedures.

The College is currently in the process of finalising its Business Plans for 2011. STP enhancement support activities planned for 2011 and identified as a priority include, but are not limited to, the following key domains:

- Building capacity for effective supervision of specialist training and providing local support for trainees and supervisors at funded STP posts
- Evaluation for quality improvement of posts
- Upskilling and support of international medical graduates
- Increasing the education e-learning network through the development of video lectures, online training modules and other e-learning materials.

For example, local workshops will be held by Medical Education Officers on:

- PREP Supervision
- Mini-CEX
- Learning Needs Analysis
- Advanced Trainee Supervision
- Computer training
- Significant Incident Analysis Tool (SIAT).

In addition to supervisor workshops, resources such as access to journals and online resources and protected learning and development time were identified as important. The Education Deanery within the College has developed, and will continue to develop, a suite of activities and online resources designed to equip and better support our trainees and Fellows. For example, the Basic Training Portal (BTP) will be visually and structurally redesigned so that its functionality is consistently reliable in providing easy access to relevant information, online learning tools and downloadable resources for each component of the Basic Training phase of the PREP program.

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In summary, the results from this evaluation strengthen the College’s understanding of the experiences and needs of trainees and supervisors in expanded healthcare settings and the areas we need to focus on to further support and improve the quality of training. The evaluation also provides the College with a baseline of quality data for comparison with subsequent evaluations of the STP, which will facilitate further planning, development and ongoing improvement of the training program.


Christine Frew
STP Manager, Education Deanery

Priya Khanna
Research & Evaluation Unit
Education Deanery

RECOGNISING THE ACHIEVEMENTS OF THE MEDICAL EDUCATION OFFICERS

Medical Education Officers (MEOs) were appointed at the end of 2009 to support Fellows, supervisors and trainees in implementing the PREP program at state level.

During the last 12 months, the MEOs have been conducting workshops and consultations throughout Australia. Statistics on the use of the Basic Training Portal and an online survey of key stakeholders have shown that in all states the MEOs are enabling educational advances and facilitating engagement with the PREP program.

Their achievements were recognised in October 2010, when the Board approved the extension of their contracts and the appointment of two additional MEOs, one each for Queensland and New South Wales. The New Zealand Joint Executive has also approved the appointment of an MEO for New Zealand, to be based in Auckland.

The MEO role will be expanded for 2011 to support the rollout of PREP Advanced Training and to promote MyCPD, to coincide with the introduction of mandatory CPD. This will be in addition to their current work of supporting the implementation of PREP Basic Training.

The MEOs came to Sydney in October for a week of upskilling. This included:

- attendance at the Advanced Training Summit
- training in the new elements of PREP Advanced Training, including Case-based Discussion
- educational principles underlying the PREP program
- new developments within the Basic Training and Advanced Training Portal

Supervisors identified a number of concerns, largely around funding, management and administration of the program. The College is currently finalising its agreement with the Department of Health and Ageing to take over the management and administration of the STP physician posts, which will enable it to work closely with Fellows to streamline administration and management processes for 2011–2013.

In summary, the results from this evaluation strengthen the College’s understanding of the experiences and needs of trainees and supervisors in expanded healthcare settings and the areas we need to focus on to further support and improve the quality of training. The evaluation also provides the College with a baseline of quality data for comparison with subsequent evaluations of the STP, which will facilitate further planning, development and ongoing improvement of the training program.


Christine Frew
STP Manager, Education Deanery

Priya Khanna
Research & Evaluation Unit
Education Deanery

Rachael Accardi
Physician Educators
Education Deanery
The MyCPD program runs on calendar years, 1 January to 31 December, and credits must be submitted annually before the due date of 31 March of the following year. Once the deadline has passed, the MyCPD program for the preceding year will close, and your Annual Return will automatically be submitted to the College.

The College routinely sends email reminders to Fellows as the deadline for submission approaches. These are sent to those who have not yet submitted an Annual Return that meets the minimum requirement of 100 credits. The reminders are sent monthly from November through to February, with a final two being sent in March.

All participants are required to keep adequate documentation to support credits claimed until the end of the following year.

Five per cent of all submissions are randomly selected for review in April each year. Those Fellows who are selected for audit are notified in writing.

As of 1 January 2011, if you are participating in a non-RACP CPD program and wish to retain RACP Fellowship you will need to notify the College and provide evidence of participation annually.

Your MyCPD Key Dates for 2011

1 Jan 2011
RACP CPD Mandatory Participation Policy comes into effect

1 Jan 2011
Plan your CPD activities for the year—enter your Professional Development Plan(s)

1 Jan 2011
Start undertaking your CPD activities

15 Jan 2011
Enter all your recurring CPD activities for the year in MyCPD

31 Mar 2011
Closing date for 2010 MyCPD Annual Return

15 Apr 2011*
Five per cent Random Review Selection of Participants

15 Jun 2011*
Random Review documentation due

30 Jun 2011
Review your Professional Development Plan(s).

1 Jul 2011
Continue undertaking CPD activities

1 Nov 2011 onwards
Finalise your 2011 MyCPD portfolio and submit Annual Return to the College

31 Dec 2011
2011 MyCPD calendar year ends (submissions due 31 March 2012)

* Relevant only if you are one of those lucky ones!

If you require further information, please email MyCPD@racp.edu.au.

Sally Tyrie-Greenwell
Education Officer, CPD Unit
Education Deanery

WHAT ARE YOUR MYCPD CREDITS REALLY WORTH?

College committee members contribute immensely to College operations, particularly in the area of standards, policy and procedures development. There is, however, some confusion regarding which activities undertaken as a committee member constitute CPD. MyCPD credits are not gained for simply being listed as a committee member, or for attending committee meetings. It is important to note that MyCPD credits ‘for attendance’ at committee meetings can only be accrued for ‘actual time’ allocated during these meetings to activities relating to improving the quality of care. MyCPD credits can also be claimed for activities undertaken as a committee member on behalf of the committee that contribute to enhancing clinical and healthcare standards.

The table to the right provides examples of some of the activities committee members may claim in one year in MyCPD.

### Category 1: Educational Development, Teaching & Research

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Recognised Credits</th>
<th>Reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion and development of standards, policy and procedures – 1 credit/hour</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Presenting to committee members (including presenting on behalf of committee members at external events) – 3 credits/presentation (credits can only be claimed for the first presentation of a paper)</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Site accreditation (i.e. hospital visit) – 1 credit/hour</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Curriculum development – 1 credit/hour</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Writing questions for, for example, examinations, self-assessment programs – 1 credit/hour</td>
<td>30</td>
<td>3</td>
</tr>
<tr>
<td>Assessment of OTP applications, including interviews – 1 credit/hour</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Reviewing CPD random review documentation – 1 credit/hour</td>
<td>3</td>
<td>3</td>
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### Category 6: Other Learning Activities

<table>
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<tr>
<th>Activity Description</th>
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<tr>
<td>Preparation for presentation – 1 credit/hour</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Other (preparation for committee meeting) – 1 credit/hour</td>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>

* Categories 1 and 6 are capped at a maximum of 50 credits per year; however, bonus credits can be gained for every reflective comment and these remain uncapped.

If you require further information on the above, please email MyCPD@racp.edu.au.

If you would like further information about becoming a College committee member, please contact the College to place an expression of interest.

Sally Tyrie-Greenwell
Education Officer, CPD Unit
Education Deanery
This year approximately 850 Adult Medicine and Paediatric & Child Health trainees undertook the RACP Clinical Examination. Organising this examination is an enormous task and many Fellows contribute their time generously to the process. The largest burden borne by any individual during the Clinical Examination is that taken on by the Organising Registrar at the hospitals involved. Many of us have done this over the years and know just how much effort goes into providing a high-quality experience for anxious candidates on the day.

The Clinical Examination Committee would like to take this opportunity to express our gratitude to the Organising Registrars at each of the hosting sites for their invaluable contribution to this essential process. We also acknowledge the role played by trainees, residents, medical students, and administrative and nursing staff who contributed to the smooth running of the examinations.

### Adult Medicine

<table>
<thead>
<tr>
<th>Organising Registrars</th>
<th>Hospital</th>
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<tbody>
<tr>
<td>Dr Bradley J Gardiner</td>
<td>Austin Health</td>
</tr>
<tr>
<td>Dr Vaibhav Tyagi</td>
<td>Ballarat Base Hospital</td>
</tr>
<tr>
<td>Dr Patrick Cooney FRACP</td>
<td>Bendigo Hospital</td>
</tr>
<tr>
<td>Dr Samantha Day FRACP</td>
<td>Blacktown Hospital</td>
</tr>
<tr>
<td>Dr Soliman Bahmani Kashkooli</td>
<td>Box Hill Hospital</td>
</tr>
<tr>
<td>Dr Suzanne Wiss</td>
<td>Calvary Mater Newcastle Hospital</td>
</tr>
<tr>
<td>Dr Manuprabha Ratnayake</td>
<td>Cairns Base Hospital</td>
</tr>
<tr>
<td>Dr Shalini Nilagi</td>
<td>Cairns Base Hospital</td>
</tr>
<tr>
<td>Dr Odette McNell</td>
<td>Campbells Town Hospital</td>
</tr>
<tr>
<td>Dr Jane Zhang</td>
<td>Campbells Town Hospital</td>
</tr>
<tr>
<td>Dr Wai-Kuen Chow FRACP</td>
<td>Concord Repatriation General Hospital</td>
</tr>
<tr>
<td>Dr Chin Goh</td>
<td>Concord Repatriation General Hospital</td>
</tr>
<tr>
<td>Dr Manjula Vidyaratne</td>
<td>Frankston Hospital</td>
</tr>
<tr>
<td>Dr Muhammad Anshad Peerbuks</td>
<td>Frankston Hospital</td>
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<tr>
<td>Dr Luke Gaffney</td>
<td>Fremantle Hospital</td>
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<tr>
<td>Dr Annie Chiu</td>
<td>Geelong Hospital</td>
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<tr>
<td>Dr Amy Crowe</td>
<td>Geelong Hospital</td>
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<tr>
<td>Dr Ali Aminazad</td>
<td>Geelong Hospital</td>
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<tr>
<td>Dr Ashok Ganganavardas Basavaraj</td>
<td>Gold Coast Hospital</td>
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<tr>
<td>Dr Brad Wilsmore</td>
<td>Gosford Hospital</td>
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<tr>
<td>Lauren Bradbury</td>
<td>Hornsby Hospital</td>
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<tr>
<td>Dr Vimalan Ambikaspaker</td>
<td>John Hunter Hospital</td>
</tr>
<tr>
<td>Dr Krishan Gupta</td>
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<td>Dr Madan Ravikumar FRACP</td>
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<td>Dr Elisabeth Jarvis FRACP</td>
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<td>Dr Lauren Sanders</td>
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<td>Dr Premjeet Singh Ram</td>
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<td>Dr Donald Lee FRACP</td>
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<td>Dr Chenlei Kelly Li</td>
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<td>Dr Krys Milburn</td>
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<td>Dr James Brown</td>
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<td>Dr Amy Wagstaff</td>
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<td>Dr Shenaz Seedat</td>
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### Organising Registrars for Paediatric & Child Health

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<td>Dr Vincent Goh</td>
<td>Queen Elizabeth Hospital</td>
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<td>Dr Dep Huynh</td>
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<td>Dr Christopher Tan FRACP</td>
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<td>Dr Tanya Faulkner</td>
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<td>Dr Subash Heraganahally FRACP</td>
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<td>Dr Shiveta Sahay</td>
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<td>Dr Tilinka Thynne</td>
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<td>Dr Jacklyn Chay</td>
<td>Royal Brisbane and Women's Hospital</td>
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<td>Dr Justin Jackson</td>
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<td>Dr (James) Andrew Black</td>
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<td>Dr Abhey Singh</td>
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<td>Dr Mark Lee FRACP</td>
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<td>Dr Francesco Piccolo</td>
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<td>Dr Roy Chetan</td>
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<td>Dr Peter Wu FRACP</td>
<td>Westmead Hospital</td>
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The role of the Director of Physician/Paediatrician Education (DPE) is vital to implementing the PREP Basic Training program as they are advocates for appropriate education infrastructure and training environments. They provide leadership and support within the workplace while overseeing the educational supervision of all trainees in their hospital and supporting the Educational Supervisors, Professional Development Advisors and Ward/Service Consultants.

On 15 October, the College’s Physician Educator Subcommittee hosted its first DPE workshop. DPEs from all over Australia and New Zealand came to Sydney for the full day event. Associate Professor Mitra Guha and Dr Jeffrey Post facilitated the workshop, which included discussion on the role and responsibilities of the DPE and dealing with the trainee in difficulty. Elizabeth Kennedy, the Medical Education Officer (MEO) for South Australia, and Carmen Axisa, the MEO for New South Wales, updated DPEs on PREP Basic Training and the role of the MEO. It was also an opportunity for them to upskill DPEs on the mini-CEX, Learning Needs Analysis and Professional Qualities Reflection tools.

This was a very useful day for all DPEs to brainstorm and share their experiences, particularly around how they can manage their facility and use the College’s supervision model. The workshop also highlighted how important the DPE role is to the implementation of PREP. The College received some very useful feedback from the DPEs who attended and will be taking this into consideration when planning the next workshop, which the Physician Educator Subcommittee aims to host in early 2011.

For regular updates on upcoming workshops, please visit: www.racp.edu.au/page/educational-and-professional-development/supervisor-support.

Rachael Accardi
Physician Educators
Education Deaney

MEDICAL BENEVOLENT ASSOCIATION OF NSW

For Doctors by Doctors

The Medical Benevolent Association of NSW (MBA) provides a free and confidential support service to medical practitioners and medical students in need, and their families, in NSW and the ACT. This support may be in the form of financial assistance and/or counselling.

Requests for assistance are made to the MBA social worker. Doctors and family members may approach the MBA themselves or they can be referred by a third party (e.g. colleague, family member, friend, Doctors’ Health Advisory Service), although the referral must be accepted by the doctor or other relevant person before the MBA is able to assist them. The social worker meets with the doctor or family to discuss their situation and make an assessment of the assistance required. The requests are then discussed with and, where appropriate, approved by the MBA Council.

The MBA is committed to ensuring that every medical practitioner in NSW and the ACT is aware that help is available when needed.

Further information can be obtained from the MBA website: www.mbarsnw.org.au. Or contact MBA Social Worker, Mrs Meredith McVey, on the website or telephone 02 9987 0504.

The MBA is entirely funded by donations from the medical profession in NSW and the ACT. If you would like to make a donation to the Association, please telephone 02 4739 2409 or send your donation to the Medical Benevolent Association of NSW, PO Box 221, Blaxland NSW 2774.
FAREWELL KEVIN

Professor Kevin Forsyth has left the College after over four years as Dean and Director of Education. Those who worked with Kevin during his time at the College felt inspired and privileged to be part of his team.

Kevin was instrumental in the formation of the Education Deanery and oversaw a period of enormous change in the training programs and across the College as a whole. Under his guidance, the Deanery expanded in size, from around 25 staff in 2006 to 57 in 2010. Kevin consistently supported his staff, enabling them to develop their potential and had a clear vision for building capacity within the Deanery to enable the staff to support and promote a sound evidence-based approach to specialty education. He ensured the RACP became a leader in the field of specialty training and that other colleges looked to the RACP for innovation and expertise.

Kevin’s passion for education was demonstrated in the development and introduction of the PREP Program, reflecting his philosophy that the trainee is at the centre of the program. This was particularly evident as Kevin met with trainees and supervisors at the Dean’s Welcome Meetings across Australia and New Zealand. The successful appointment of the Medical Education Officers in 2009 was an example of the support for trainees and Fellows Kevin saw as crucial to the success of the training programs. Kevin spearheaded the development of video and other resources to support the training tools, even starring in some. The need to demonstrate to the Australian Medical Council accreditation team in 2008 that the RACP was progressing to a more educationally sound approach was achieved thanks to Kevin’s leadership around best educational practice.

Kevin was involved in writing the Professional Qualities Curriculum, leading innovation with the design of the e-learning environment and overseeing the introduction of the Expert Advisory Groups and the College Education Committee, which he also chaired. Kevin valued wide consultation and initiated a number of events to consult with Fellows and trainees, notably the Supervision Summit (December 2009) and the more recent Advanced Training Summit (October 2010). He worked tirelessly to engage with Fellows, trainees, Specialty Societies and other stakeholders such as health departments and jurisdictions. A forum was held in 2009 with Peter Garling SC, to discuss the education and training for junior doctors, in particular how to provide vocational trainees with a supportive, clinically and educationally rich training environment.

Kevin also represented the RACP on the Enhanced Medical Education Advisory Committee (EMEAC), the Medical Training Review Panel (MTRP), the Education Subcommittee of the Committee of Presidents of Medical Colleges (CPMC) and the MedED09 implementation group, operated by the Medical Deans. He coordinated a proposal to Health Workforce Australia on behalf of the CPMC regarding an integrated model of supervisor training across all Colleges. Most recently, he established a Specialist Advisory Committee (SAC) in Academic Medicine.

Kevin’s contributions to the College and the Deanery are far-reaching. As an agent of change he leaves the College well positioned for the coming years. He will be greatly missed.
Fifteen years ago, the landmark ‘Quality in Australian Health Care Study’ (QAHCS) uncovered disturbing data about the extent of adverse events in Australian hospitals. A review of 14,000 admissions to 28 hospitals in 2 states found over 16% were associated with an adverse event caused by healthcare management. Over half these events were considered preventable; 5% of the events resulted in death.

In 2001, a New Zealand study based on the QAHCS found that adverse events occurring within or outside public hospitals were associated with 12.9% of admissions, and approximately 35% of adverse events were classified as highly preventable. Although less than 15% of adverse events resulted in permanent disability or death, an average of over nine days per event was added to hospital stay. Systems errors featured prominently in the analysis of areas for the prevention of recurrence.

Such findings are consistent with the international experience, and reflect the huge need and potential for quality improvement in healthcare, even in the most developed health systems.

Much has been done to improve quality and safety in healthcare provision since such studies illuminated these concerning outcomes: for example, the recent proposal to make the Australian Commission on Safety and Quality in Health Care a permanent body, and the development of national quality and safety standards and indicators. In New Zealand, as well as developing a process whereby ‘medical accidents’ were compensable, they also developed the Accident Compensation Corporation’s Treatment Injury & Patient Safety Unit (1993) and the Health and Disability Commissioner Act (1996), which established a legal framework for resolving complaints. These developments have made major contributions to the understanding of iatrogenic injury by examining and publishing comprehensive data. Earlier this year the New Zealand Government established an independent organisation, the Health Quality and Safety Commission, to focus on quality and champion improvements in patient care.

But how much has actually changed in this time? How much further is there to go? What can you do? And crucially, what is your College doing to make a difference, and to support you in this?

The RACP has also made changes and initiated programs as it continues to strive to support its members to improve quality, safety and performance in their setting and in their practice. This has been facilitated by new College-wide developments such as the development of MyCPD and the Supporting Physician Professionalism and Performance (SPPP) project, which aims to provide a framework for RACP Fellows to use in order to guide and support their performance and professional development.

The Quality Expert Advisory Group (EAG), the College’s peak quality and safety policy committee, led the College in pushing for change in the wider health system to facilitate quality improvement in healthcare. Along with developing the College’s relationship with key bodies such as the Australian Commission on Safety and Quality in Health Care, the EAG seeks to engage College members more directly through the development of policy and guidance and the provision of resources. To the end of supporting you to drive quality improvement in your own setting, and in your own practice, we have initiated an ongoing policy position statement development program for our members.

The first two of these statements are:

- **Credentiaalling and Scope of Practice**
  The RACP believes it is in the interests of all Fellows, wherever they deliver clinical services, to undergo a rigorous, appropriate and peer-based process of credentiaalling and defining their scope of practice, as set out in national standards.

  Credentials define the qualifications, experience and professional standing that a doctor brings to a clinical setting and are consistent across clinical settings. Scope of practice defines what you actually do and must be specified for each specific clinical setting.

  All Fellows appointed to healthcare organisations should be provided with an opportunity to undergo a formal recredentialling process at least every five years.

- **Clinical Indicators**
  There is increasing interest in measuring aspects of clinical performance as a means of supporting clinical practice improvement and reducing risk of adverse patient health outcomes. Clinical indicators are one of a number of measurement tools available to support quality and safety in clinical practice. The RACP supports the appropriate use of clinical indicators to support clinical practice improvement.

  The Clinical Indicators statement provides guidance on what clinical indicators are, the different types, and how to select appropriate ones for your desired purpose, and includes some useful resources for indicator development.

These policies are of relevance to Fellows in Australia and New Zealand, particularly as we move forward with the SPPP project. Both policies, as well as submissions, workshop presentations and other resources, are available in the Quality section of the College website, or feel free to contact us directly at: quality@racp.edu.au.

We encourage you to partake in robust debate around the quality and safety issues raised and polices developed, which will be featured in regular RACP News articles. We look forward to hearing from you on ways we may contribute to improving patient outcomes through new quality initiatives.

Karen Steadman
Senior Policy Officer
Policy and Advocacy

**Quality Expert Advisory Group**

**References**


The challenges now facing the Fellowship are vastly different from those we encountered together in the past.

In recent years the College has focused its resources and attention on a broad range of regulatory requirements, including accreditation, registration and certification, self-regulation, legal requirements, a host of legislative obligations and, in particular, the AMC accreditation compliance and reporting obligations.

The accreditation process is clearly a priority for the entire College. In 2008, the AMC extended our accreditation until 2010. These ongoing assessments involve significant compliance reviews and substantial expenditure. The AMC may, at its discretion, grant accreditation, with or without specific conditions attached to it, or may even refuse it. Clearly, the provision of education and training within the Australian health system cannot take place without the College having AMC accreditation. The loss of accreditation would have serious ramifications for the College and the current post-nominal arrangements.

Many of the key changes we have introduced, including formal budgeting, business planning and reporting, are a direct result of the 2004 and 2008 accreditation reports.

To develop the College of the future we must adapt not only to our changing environment but to the changing needs, demands and characteristics of our members.

As a result of the measures put in place to manage the accreditation and regulatory processes and other developments within the College, we now have a solid foundation on which to build the College of the future.

We recognise that membership organisations around the world need to adapt to the challenges of the 21st century, including new technologies, the rapid pace of change, the trend towards diminishing client loyalty, declining deference to and respect for authority, increasing media scrutiny and greater mobility.

Traditional avenues for social and professional networking are being replaced by new opportunities for engagement and communication. Membership organisations need to adapt to these changes and deliver the benefits and services that are relevant to their members.

To develop the College of the future we must adapt not only to our changing environment but to the changing needs, demands and characteristics of our members. To do this, we need to identify the behaviours and attitudes of our Fellows as they relate to the College and to examine closely what motivates them to engage with the College.

The College is therefore commissioning extensive market research, including a market segmentation study, in order to better understand what services the College should provide Fellows, and from the findings of the survey will be developed a Value Proposition for Fellows. The evidence collected through this process will enable the College to adopt a more proactive approach in the way it provides service and support to Fellows so that Fellows will see the College as a truly valued partner and the professional body of choice.

Our first task is to understand how the College is perceived by its Fellows as members of an organisation. Fellows as members selectively engage with the College as their organisation beyond the testamur and post-nominal processes. It is critical that we provide value for our Fellows as members and, in providing value, it is hoped that in turn Fellows will value their College because they have had a positive experience as members.

To begin the research process, the College has engaged an external service provider to develop and undertake a qualitative survey prior to Christmas to identify and understand the different segments of the membership. A basis for segmentation is usually a factor that varies among groups but is consistent within groups.

Using the insights gained from the qualitative survey we will then conduct a quantitative survey of members to refine and quantify the segments identified in the qualitative stage. It is expected that the quantitative survey will occur some time in the New Year once the results of the initial qualitative survey and consultations have been analysed and the quantitative survey developed and prepared.

This survey will cover the different geographic areas of Australia and New Zealand, the various entities and bodies of the College and the different sub-specialties of the Fellowship. We will also factor in trainees as Fellows of the future to identify emerging trends for future needs.

From the quantitative stage, meaningful clusters of discrete groups of Fellows who identify with various products and services that the College may offer that reflect similar usage, and attitudinal or behavioural characteristics, can be profiled for each RACP segment. Clustering can be conducted using an initial factor analysis of higher level needs and then linked to the database characteristics through a discriminant function to establish the key profiling predictors.

This detailed analysis will provide us with a clear understanding of how different groups of Fellows behave and we can align our organisation with their needs and what they are looking for from their College.

We can then start to tailor our approach and align our capabilities with the needs of our members. We can also make an informed assessment of the behaviours, products and other services that need to be in place for our members to be well serviced and supported. A well-researched and relevant positioning segmentation framework will provide a strategic basis for further development of services, products and messaging into the future.

While we continue to deliver exceptional training and continuing education programs, as a source of engagement and participation this only involves a small percentage of our member base and is not sufficient for a Value Proposition for Fellows. To address the needs of the broader group of nearly 13,000 Fellows, we need to continue to develop as a professional authoritative and advisory body, servicing their needs as members of their organisation. This means putting in place the structures, processes, products and services required to meet our responsibilities and to develop your College of the future.

Sasha Grebe
Director, Professional Affairs & Advocacy
COME JOIN THE AUSTRALIAN PAEDIATRIC RESEARCH NETWORK!

What is the APRN?
The APRN is a network of over 370 Australian paediatricians keen to contribute to child health research relevant to public and private practice.

The APRN aims to:
- Support paediatricians to develop new research questions, take part in research projects, learn new skills (both clinical and research) and foster collaborations with colleagues around the country, and
- Advance knowledge about relatively common paediatric problems identified by practising paediatricians in their day-to-day work.

Why establish the APRN?
In Australia, many children receive paediatric healthcare in private, community or hospital outpatient settings. These children experience many common issues that can present challenging problems of diagnosis, management and service access. While most children’s research is based in tertiary hospitals or in community settings like schools, the APRN provides a unique approach to solving issues in the ‘real world’ paediatric setting.

Why join the APRN?
If you join the APRN, you will have the opportunity to:
- Stimulate research into issues that are clinically important to you
- Participate in research without having to do all the work
- Contribute to research that may inform policy
- Be the first to hear about APRN research
- Enhance professional development around research design and processes
- Gain points for myCPD, and
- Network with other Australian paediatricians including attending our annual drinks night at the RACP conference.

Who can join?
APRN membership is free and open to all Australian paediatricians whether you are a trainee or a Fellow of the College.

Since its inception, the APRN has:
- Recruited over 370 paediatricians, with proportional membership in each state/territory.
- Launched with a Journal of Paediatrics & Child Health annotation (Hiscock et al. JPCH. Published 27/6/2010)
- Nominated regional representatives in every state and territory. Our regional representatives pilot questionnaires for our projects and act as a source of local knowledge.
- Developed its website <www.aprn.org.au> to be capable of providing APRN information, managing membership, reporting outcomes and delivering the Multi-topic Survey (see below).
- Submitted two manuscripts arising from CAPS summarising (1) the overall and (2) the developmental–behavioural caseloads for Australian paediatricians.
- Conducted our inaugural Multi-topic Survey (2010), an annual web-delivered survey of up to six member-proposed topics.
- Endorsed three stand-alone projects, now progressing to further development: (a) parent information needs after the diagnosis of autism; (b) effect of stimulant medication on puberty in girls; and (c) a pilot for an ADHD cohort study.

What’s next for the APRN?
Over the coming 12 months we will launch our online ‘How to Conduct Research’ module designed to help paediatricians with the initial stages of setting up a research project. We plan to explore intervention trials for common child health problems, conduct our 2011 Multi-topic Survey, and pilot novel IT approaches to inform clinical care and systematic data collection on patients seen in outpatient and private rooms.

*The APRN provides a valuable opportunity for general paediatricians to become involved in research that is relevant to everyday clinical practice. The Network has begun by identifying the issues that paediatricians deal with regularly and where the gaps lie in relation to current best practice. Establishing a ‘How to Conduct Research’ section on the website will be a huge help to those with minimal research training. This will particularly benefit Advanced Trainees and their supervisors when it comes to planning and designing their college project.’ - Donald Payne, WA Regional Representative*

For more information or to become a member please visit us at: www.aprn.org.au.
MULTI-DISCIPLINARY APPROACH TO REALISING THE HEALTH BENEFITS OF WORK

We’re here to talk about good work and consensus,’ said Dr Robin Chase, President of the Australasian Faculty of Occupational and Environmental Medicine (AFOEM), to the business people, occupational physicians, rehabilitation professionals, senior bureaucrats and insurers assembled at the Royal Australasian College of Physicians in Melbourne on Friday, 29 October.

These 70 or so diverse stakeholders had gathered to hear Professor Dame Carol Black share insights gained during the five years she has spent as the United Kingdom’s National Director of Health and Work.

‘Our systems are different from yours, but our challenges are just the same,’ Dame Carol said. ‘The burden of chronic disease is growing, as is the level of obesity. In both countries, we have people with mild, treatable conditions leaving the workplace and moving onto benefits. In the workplace, it can be difficult for senior and line managers to understand that interpersonal problems add to health problems; how can we encourage such an understanding? Engaging GPs and trade unions is another challenge we both face.’

In the week prior to the Melbourne meeting, Dame Carol assisted in the Faculty’s endeavour to rise to these challenges, meeting with the Department of Health and Ageing, Comcare, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), the Australian Medical Association, the Royal Australian College of General Practitioners, Medibank Private and the Australian Council of Trade Unions (ACTU). One of the aims of these meetings was to shore up support for the Faculty’s Consensus Statement, regarding the health benefits of good work.

‘Work is a determinant of our self-worth, dignity and place in society,’ Dame Carol said. ‘It is also a determinant of health. However, nothing in my training told me that work and health were connected. My teachers did a very good job educating me about the dangers of smoking, but when a patient told me that they were not at work, I never asked, “Why are you not at work? Would you like to be at work? How can I help you to get to work?”’

Many of the stakeholders with whom Dame Carol met have expressed provisional support for the Consensus Statement, with detailed comment to follow. According to Dr Chase, the meeting with the ACTU was particularly notable for its goodwill.

‘We are in the process of learning about how work determines health, just as medical organisations are,’ Dr Dunkin said. ‘The silo-isation within bodies of knowledge affects business too. We need to adopt a multidisciplinary approach.’

Dame Carol suggested that, in the future, this may take the form of a council bringing together all the bodies and professions with an interest in occupational health. For now, the Faculty’s Consensus Statement is available on its website <http://afom.racp.edu.au>, and is open for comment.

Gabrielle Lis
AFOEM Policy Officer

Business is also awakening to the value of a consensual, collaborative approach. Dr Ruth Dunkin, Director of Policy at the Business Council of Australia, addressed the Melbourne meeting after Dame Carol.

‘We are in the process of learning about how work determines health, just as medical organisations are,’ Dr Dunkin said. ‘The silo-isation within bodies of knowledge affects business too. We need to adopt a multidisciplinary approach.’

Dame Carol suggested that, in the future, this may take the form of a council bringing together all the bodies and professions with an interest in occupational health. For now, the Faculty’s Consensus Statement is available on its website <http://afom.racp.edu.au>, and is open for comment.

Gabrielle Lis
AFOEM Policy Officer
The Year in Pictures
We need trainee and consultant volunteers at the RACP Congress 2011 to participate as career advisers for their specialty of training or practice!

The RACP Congress 2011 will be held in Darwin from 22 to 25 May 2011.

If you are attending the Congress and are prepared to devote half an hour of your time during Congress lunch breaks to discuss career options and attractions with undergraduate students and/or current or future trainees of the College, please contact us to express your interest.

Lunch breaks will be from 12.30–2.00 pm on each day of the Congress.

A roster will be prepared based on your availability and this will be advertised in due course.

Please send your full name, specialty, and date and time of your availability to traineescommittee@racp.edu.au as soon as possible, and not later than 1 April 2011.

Thank you for your interest and support of this initiative of the College Trainees’ Committee.

NZ Trainees’ Day 2010: A great success

Wellington School of Medicine played host to the 2010 NZ Trainees’ Day on 15 October, an event which was enjoyed by around 80 attendees. The Trainees’ Day is an initiative of the NZ Trainees’ Committee with the goal of bringing together adult and paediatric trainees from across the country for professional development, engagement with the College and building of networks.

Next year’s event will be around the same time, in Christchurch, when we hope and expect to build on this year’s successes.

Wellington 2010 featured sessions on diverse topics, from dealing with difficult colleagues to international health, and we had the privilege of hearing from some very talented speakers. Career development options were discussed, including academic streams, and there was a wealth of practical tips for trainees wondering about PhDs, overseas fellowships, humanitarian work, coping with stress, and those just starting to plan for their advanced training.

Many of the speakers made themselves available for informal discussion during the day’s refreshment breaks and the post-conference drinks—which was a real highlight of the event for trainees and we are grateful for the time and effort contributed.

We would like to thank our speakers, especially Professor John Kolbe who opened the day and Dr Jackie Blue MP who was our keynote speaker. Dr Geoff Robinson offered some entertaining closing remarks over drinks.

The day was rounded off with a delicious meal on Wellington’s waterfront, which provided a chance for trainees to catch up with old acquaintances, make new friends, share experiences, swap advice and let their hair down—which, as we learned during the day, is a great way to build resilience to stress.

Dr Justin Beardsley
Co-chair of the Trainees Committee
2010 Year of the Trainee: ‘That’s all folks!’

Year of the Trainee (YOTT) opened with Kevin Rudd, Nicola Roxon and the College Trainees’ Committee announcing an exciting new chapter in the life of our College. The RACP would proudly be a College for trainees, a College that recognises trainees as the Fellows of the future, a College that values the contribution of trainees and respects trainees as young adult learners. The College would foster a more enduring and cooperative partnership with its trainees through robust trainee engagement in learning, mentoring and governance.

As YOTT draws to a close, it is time to reflect on what has been achieved and what remains to be developed in the future. As a key priority for YOTT, the College Trainees’ Committee sought to promote trainee awareness of, and participation in, College life. The following are some of the YOTT initiatives:

- **Trainees’ Day at World Congress.** Local and international leaders discussed issues of clinical leadership, getting started in research and learning how to be a better teacher.
- **Trainees’ Ball and welcome to new Fellows.** Trainees and Fellows gathered to celebrate YOTT over drinks and canapés at the Hilton on the Park.
- **The President’s Award for Trainee of the Year.**

A College first was to recognise the important role trainees can play as leaders and mentors, and to recognise the enormous contribution trainees can make to the College:

- **Trainee Welcome Pack.** A YOTT-branded mix of stationery, pens, torches, mints and stubby holders!
- **Advanced Training Summit.** Bringing together trainees, supervisors and staff to lay out the foundations for the next phase of PREP.
- **eVine.** A more direct and informal voice of the College Trainees’ Committee.

These built on already established and successful initiatives of the CTC such as the Mentoring Awards, Trainees’ Café and the Dean’s Welcome Meetings (DWM). The DWMs have been designed to bring the College closer to where trainees and supervisors live and work, to allow face-to-face discussion with key decision makers in the College and to promote the spirit of collegiality.

The CTC has also improved its own internal governance by reaching out to regional trainees’ committees to draw its membership and by strengthening lines of communication. The Trainees’ Café website is in the process of an overhaul to ensure it’s more user friendly, relevant and interactive, and to provide a forum for the social networking of all College trainees. A project manager has been appointed for this, and a group of trainees are advising on the structure and content of the Café.

Now at the end of YOTT the CTC has firmly established trainee engagement at every level of the governance structure, including the Board, education and assessment committees. The CTC has also established a vision for the future. The CTC seeks to promote flexibility in the way trainees work, learn and study while at the same time reducing uncertainty and the way trainees work, learn and study while at the same time reducing uncertainty.

The CTC will develop the following issues as part of a post-YOTT agenda:

**Training in non-traditional settings**

Traditional systems of accreditation of training time and location need to take into account the new educational framework and PREP tools, which don’t require context-specific learning and allow near total freedom for trainees to construct a program of clinical rotations and settings that suits them. Therefore, training could even be extended into non-traditional settings where there is no local physician supervisor, but rather...
remote educational and professional support. The College could support trainees to work and train in development settings to raise our global health consciousness and establish the RACP as a responsible global citizen.

Flexible work and study
A recent survey of trainees found that fully 58% of respondents were interested in flexible training, citing family commitments (83%), work-life balance (63%), exam preparation (42%), research (38%) and enabling earlier return to work from maternity leave (37%) as their reasons. The College could be a leader in promoting flexibility in working hours and establishing family-friendly training policies without compromising the educational integrity of programs.

Pathways into rural and remote practice
Pathways could be created for trainees to encourage quality training in rural and remote locations, to address the maldistribution of the specialist workforce. Enhancing the quality and status of training in rural and remote locations would create the right incentives to draw trainees into this kind of practice, rather than the current ‘one-size-fits-all’ strategy of mandatory rural rotations.

Progress through training
Trainees should be able to move through training without undue delay, subject to satisfactory performance. Therefore, basic training positions need to better reflect the number of advanced training positions available, and the clinical needs of the community. The CTC fully supports the rollout of the Advanced Trainee Selection and Matching system to create a bi-national marketplace for advanced training positions. If used in the right way, the scheme promotes both fairness and flexibility for trainees seeking an advanced training position in a competitive market.

‘One College’:
breadth and depth
The College could better deliver on the promise of ‘One College’ by better integrating the Faculties and Chapters so that it would be easier for trainees who have an interest in other areas of our College to gain ‘breadth’ as well as ‘depth’ experience by doing some training in an alternative discipline. The College could also be more active in providing ‘depth’ by scaling up educational content to trainees in the form of lectures, workshops and tutorials in a systematic way, embracing latest telecommunications. The Physician Education Program (PEP) series could be expanded and rolled out across specialties to include advanced trainees.

After a successful Year of the Trainee, I will step down as the Chair of the CTC to make way for a new cohort of exceptional trainee leaders. I will use the time to undertake a global health project and to improve my German. I hope to see you on the Trainees’ Café social network… keep in touch <thereslloyd@gmail.com>.

Dr Lloyd Nash
Chair, College Trainees’ Committee
As the Year of the Trainee comes to a close, Tasmanian trainees took centre stage at the Tasmanian Annual Scientific Meeting (ASM) held on 2 October at the Hobart Function and Conference Centre. It was great to see over 50 attendees at the ASM regardless of the event running on the day of the second AFL grand final—displaying true commitment and support!

Two of the four sessions were dedicated to trainee presentations and a total of 11 trainees showcased their research at the event. The calibre of the research presentations demonstrated the exceptional quality of training that Tasmania offers. A big congratulations to Dr Andrew Black (Advanced Trainee) and Dr Swarna Shashi Bhaskara (Basic Trainee) for their outstanding presentations and winning first prize in their respective categories.

Energetic discussions on the topics of National Registration and the Health Workforce highlighted the many challenges the Fellowship faces over the next five years. Medical practices, hospitals and health professionals will need to become tech-savvy to keep up with the evolution of medicine.

The final session for the day emphasised the difficult palliative care scenarios that many physicians and paediatricians face on a regular basis. The speakers and the subsequent discussion amongst the attendees highlighted the impact of palliative care decision making on the patient, family and healthcare team involved.

Many thanks to Dr Louise Nott and Dr Rosemary Harrup for ensuring a successful event.

The Tasmanian voice is becoming stronger and there are many opportunities for continued growth in 2011. Keep your eye out for future events in the Apple Isle!

Fiona Hilton
Policy and Senior Administration Officer
Victorian State Office
The Chapter of Sexual Health Medicine held its annual conference—the 2010 Australasian Sexual Health Conference—back to back with the Australasian HIV/AIDS Conference and a high resolution Anoscopy Workshop for Management of Anal Intraepithelial Neoplasia.

Over 600 delegates including special interest GPs, specialist nurses and health promoters, in addition to sexual health specialists and trainees from Australasia and overseas, attended. Visiting speakers included Professor Graham Hart, London (social scientist with interest in social and behavioural interventions of STIs), Dr Jorgen Jensen, Denmark (consultant physician with interest in Mycoplasma genitalium), Dr Douglas Kirby, USA (social scientist with interest in characterisation of education programs which lead to reduced risk behaviour) and Dr Joel Palefsky, USA (consultant infectious diseases physician with interest in anal intraepithelial neoplasia).

In keeping with the Harbour City, the theme of this year’s conference was ‘Harbouring Desires’.

The Chapter was honoured by having the Governor-General of Australia Ms Quentin Bryce AC open the conference. Her Excellency is passionate about women’s reproductive health and gave an inspiring opening address that spoke of the commitment of Australian physicians in being at the forefront of sexual health education. Her Excellency called for further action in addressing the rates of STIs in Australia, urging healthcare professionals to provide people with a reason to change, not just establish the need for change.

Dr Kerry Chant, a public health physician, Chief Health Officer for NSW and Deputy Director-General, Population Health, NSW Health, followed the Governor General’s address, with Professor Michael Kidd (Chair of the Federal Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections) delivering the Gollow Lecture on ‘Challenges for Sexual Health Medicine’.

Topics covered in the conference program were the nature of human desire, STI prevention strategies—particularly amongst adolescents—and genital mycoplasmas. There were also symposia on chlamydia, refugee health, sexual assault, sex workers and sexual dysfunction.

Media interest was high with a number of television and radio stations across the country covering the event.

Once again, there was a large exhibition associated with the conference and sponsorship received continues to increase each year. This highlights the good relationships between the Chapter and its supporters who see this event as the major regional sexual health event.

An innovation this year was the ‘Beer and Bull’ session held during the Welcome Cocktail Party, where delegates were encouraged to ask questions from a panel of experts made up of international speakers.

The Gala Dinner ‘Carnivàle Desires’ was held at the iconic Luna Park with delegates ferried by cruise boat across the harbour from the Convention Centre to the Park for a fun-filled evening.

The 2011 Australasian Sexual Health Conference will be held at the National Convention Centre in Canberra, 28–30 September.

For more information please go to www.sexualhealthconference.com.au where you can find abstracts of the 2010 conference as well as from previous conferences.

Dr Anne Robertson
Chapter President

Ms Suzanne Marks
Chapter Executive Officer
GOVERNOR GENERAL’S ADDRESS AT
SEXUAL HEALTH CONFERENCE

ADDRESS BY HER EXCELLENCY
MS QUENTIN BRYCE AC
GOVERNOR-GENERAL OF
THE COMMONWEALTH
OF AUSTRALIA
ON THE OCCASION OF
WELCOME ADDRESS FOR
THE 2010 AUSTRALASIAN
SEXUAL HEALTH
CONFERENCE
HOSTED BY THE
AUSTRALASIAN CHAPTER
OF SEXUAL HEALTH
MEDICINE OF THE
ROYAL AUSTRALASIAN
COLLEGE OF PHYSICIANS
SYDNEY CONVENTION &
EXHIBITION CENTRE,
DARLING HARBOUR
18 OCTOBER 2010

Ladies and gentlemen

I am pleased to join you here this morning
for the opening session of this year’s
conference, and I extend a very warm
welcome to your overseas participants.

I am impressed by the range of sexual
health professionals gathered here for this
important exchange: specialists, general
practitioners, nurses and counsellors;
public and Indigenous health workers;
experts in sexual health promotion.

What strikes me about this representation
is the depth and reach of the skills and
experience you bring to the table, and
that it clearly reflects the complexity of
the issues and the many-layered approach
required of the solutions.

One of the privileges of my role is seeing,
first hand, the extraordinary talent and
commitment in this country—Australians
working locally and internationally—all
of you here; at the forefront of your
fields; the relationships you’ve built over
many years; your collaborations across
disciplines and sectors within Australia and
the Asia Pacific region; and the spirit of
generosity and cooperation you bring to
your daily work.

Looking at your conference program I
can see a particular focus on Sexually
Transmissible Infections in marginalised
populations, such as young people, men
who have sex with men, Aboriginal and
Torres Strait Islanders, and sex workers.

While the rates of STIs in Australia are low
compared with those seen by our regional
neighbours, there remains a genuine need
here to discourage the discrimination
that leads to the flawed decision making
and marginalisation often associated with
poor sexual health, and to ensure that
the specialist and primary care sectors are
working together on prevention initiatives
and treatment management.

As I was catching up on these issues, I
was reminded of the body of work—and
achievements—Australia has to draw on
from our response to HIV/AIDS in the mid
1990s.

I listened to a radio interview recently
with Bill Bowtell, Director of the HIV/
AIDS project at the Lowy Institute and
one of the architects of that successful
and well-regarded response. He pointed
out that the very first thing we did was to
decide that there would be an Australian
response, we decided to act, rather than
sit on the sidelines and wait. We set about
devise a national strategy to tackle the
problem early and decisively.

It certainly wasn’t easy—it was hard,
grinding work—but this head-on
approach mobilised us at all levels.

We worked out very quickly that the
strategy must encompass all aspects of
care, treatment, prevention, scientific
and social research, that even small changes
in human behaviour would be critical to
good outcomes, and that an immense
power to lead those changes resided
within the community itself, in ordinary
members making the facts real and
compelling in people’s lives.

Melinda Gates is so right when she says
it’s not enough to establish a need for
change; we must give people a reason to
change.

I recall, too, the efforts of an organisation
I’ve had a great deal to do with over
many years, the Family Planning
Association in Queensland— their
profound understanding of sexual and
reproductive health issues; the sex
education they provide in schools; their
sexual assault services; their immersion in
the community; their training of clinicians,
allied health workers and educators; the
work they do with youth and migrant
women; their projects for the prevention
of blood-borne viruses in correctional
facilities.

Again, multi-faceted, innovative, targeted
approaches.

Hans Rosling, the Swedish doctor,
researcher and statistician extraordinaire,
says we have to use our hearts, our wallets,
and our brains to tackle these challenges.

There is so much data available to us if
we ask the right questions, analyse the
answers with the sophisticated knowledge
and insights we already have, and use
them to inform and guide the solutions.

There’s a demand for creativity too—
layered, expansive thinking.

The former politician and activist, Mechai
Viravaidya—he’s known as Mr Condom—is
proudly outspoken about his involvement
in making Thailand a better place.

Everyone had to be involved in AIDS
education.

Every media person had to be trained for
HIV, and they got half a minute extra for
advertising as an incentive to earn more
money.

And in the universities and schools, kids
began teaching kids. The best teachers
were the girls, so the girls who went
around teaching about safe sex and HIV
were known as the Mother Thereseas.

Police officers gave out free condoms as
part of their ‘cops and rubbers’ program.

Condoms were branded ‘weapons of mass
protection’ and were crafted into trendy
hair bands.

Honestly, his list goes on and on.

And though he has his audiences
in stitches, they all know that these
sometimes outrageous campaigns are
designed to address desperate problems
threatening his people’s very survival.

Ladies and gentlemen, I admire and
respect your work enormously, it makes
a vital and lasting difference. And I wish
you well in your discussions over the
coming days.

It’s my pleasure now to declare open
the 2010 Australasian Sexual Health
Conference.
Dear Fellows and Trainees

The Annual RACP Excellence in Mentoring Awards were established by the College Trainees’ Committee to promote and publicise the important role of mentors for trainees, for both their personal and professional development, and to formally recognise the significant contribution mentors make to our College.

All Fellows and registered trainees in Australia and New Zealand are invited to nominate a mentor and detail the contribution the mentor has made to the trainee’s personal or professional development. Any Fellow of the College can be nominated for an award. A maximum of one award will be made in each of the following categories:

- Academic and Research
- Clinical and Professional Practice
- Physician Educator
- Rural

Each award consists of full Congress registration, attendance at the Congress Dinner, economy return airfares, accommodation on the night of the dinner and a formal presentation of a plaque at the dinner.

We would like to encourage Fellows and trainees to nominate those who have made an outstanding contribution to mentoring or who have provided a high level of support and guidance throughout training.

Previous winners and nominees have been delighted to be recognised by colleagues as deserving of recognition. This is a positive way we can acknowledge those who tirelessly advocate for and support trainees in research, education and professional practice.

Judging

A Board sub-committee will judge nominations. If not specified, nominations will be assigned to one of the four categories listed above.

Eligibility

Current Fellows of the College recognised as mentors may be nominated, except those who have previously received a Mentoring Award within the last three years.

The nominator should address all of the following criteria and provide any other supporting evidence that they feel would be relevant to the nomination.

Criteria

1. Provision of mentoring over a sustained period of time and/or to a significant number of people
2. Provision of a training environment conducive to good practice, including intellectual and tangible support for development of research projects, as well as attention to the concerns of trainees
3. Establishment of explicit training expectations and provision of constructive feedback, to guide trainees’ learning and professional development
4. Demonstrated commitment to mentoring by sharing his/her knowledge, giving ownership, and actively helping trainees to prepare for and meet their career objectives
5. Demonstrated effort, where appropriate, to credit trainees’ work and promote visibility of their achievements in the work environment (e.g. both formally and informally through workshops, meetings, presentations and publications)

Procedure for nomination

- Complete the nomination form attached and ensure that:
  - nominations are not more than two A4 pages in 11 pt Arial font
  - optional: additional cover letter or testimonial(s) are attached
  - the nominator is a current Fellow of the RACP or its faculties and chapters or a current trainee with the College
  - the supporting nominator is a current Advanced Trainee or a former Advanced Trainee within five years of Fellowship who is or was supervised by the nominee.

- Address the criteria stated above.
- Confirm that the nominee is aware of the nomination and the expectation that they will be invited to attend the College Congress Dinner if a winner of an award.

Process for assessment of 2011 Awards

Call for nominations – December 2010
Closing date for applications – 7 February 2011
Nominees notified – 15 February 2011
Winners notified – week beginning 11 April 2011
Presentations will be made at the Congress Dinner – 24 May 2011

Lloyd Nash
Chair
College Trainees’ Committee

John Kolbe
President
# Nomination Form

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<th>Contact Details:</th>
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Nominee’s name as they wish it to be spelt on the certificate, and their title:

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<th>Print Nominator Name:</th>
<th>Qualifications:</th>
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Date:

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<th>Type of Nomination (Please tick one of the following):</th>
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<td>☐ Clinical and Professional Practice</td>
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<td>☐ Physician Educators</td>
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<td>☐ Rural</td>
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Please complete the following form:

1. Provide a brief description of the nature of the mentor’s work in relation to the category you are nominating them for.

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________
2. Describe the nature and duration of your relationship to the nominee.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. Give examples of the mentoring activities of the nominee.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. Describe the impact of the nominee’s mentoring on your or others’ professional development.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. Why is the nominee worthy of recognition as an outstanding mentor?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

☐ (Please tick) I confirm that the nominee is aware that he/she has been nominated for an RACP Excellence in Mentoring Award.

Please complete, scan and email your completed nomination form, together with testimonial and details of additional supporters of the nomination (both optional) to: radmila.jancic@racp.edu.au
PRESIDENT’S AWARD FOR TRAINEE OF THE YEAR

Dear Fellows and Trainees

I am very pleased to advise that the Board, in association with the College Trainees’ Committee, has established the President’s Award for Trainee of the Year.

The inaugural presentation was held at the Trainees’ Ball at WCIM in Melbourne on 21 March 2010. For the 2011 Award, please find below some guidelines for consideration when preparing your submission.

Eligibility: Anyone registered as a College trainee in 2010 from any Division, Faculty or Chapter is eligible for the award.

Profile: We are looking for a trainee who has made an outstanding contribution to College activities during 2010 (and earlier). This may include trainee leadership, mentoring and support of other trainees, contributions to education and training, involvement in policy development and advocacy, or other forms of activity.

Nominator: Any trainee or Fellow of the RACP can nominate a trainee for this award. As a nominator, it is important that the review criteria be addressed fully in the submission.

The prize is domestic or trans-Tasman travel to and from the RACP 2011 Congress in Darwin, Northern Territory, registration for Trainees’ Day at the Congress, two tickets to the Trainees’ Dinner and presentation of a plaque at the dinner.

The award will be judged by a committee made up of members of the Board. The decision will be based solely on the information supplied in the nomination. We therefore encourage you to nominate a trainee who goes the extra mile for the College. Nominations should be received no later than 25 March 2011.

This award will become an annual fixture on the RACP calendar to recognise and reward those trainees who provide exceptional contributions to our College and its activities.

Yours sincerely

John Kolbe
President

NOMINATION FORM: PRESIDENT’S AWARD FOR TRAINEE OF THE YEAR

Please complete the form below, specifically addressing all criteria, and scan and email the form to Radmila Jancic. If more space required, address the criteria below on a separate sheet.

Nominee:
Name / Position:
Location / Place of work
Nominee contact details (including email and phone):
Nominee’s name as they wish it to be spelt on the certificate:

1. Describe the nature and duration of your relationship to the nominee.

2. Provide a brief description of the nature of the trainee's contribution/s to the College, which might include leadership, mentoring and support of other trainees, contributions to education and training and/or involvement in policy development and advocacy.

3. Describe the impact of these contributions on others and/or how these efforts have contributed in a meaningful way to College activities.

☐ (Please tick) I confirm that the nominee is aware that he/she has been nominated for the RACP President’s Award for Trainee of the Year.

☐ Signature of Nominator and date

Return your nomination via email before 25 March 2011 to: Radmila.Jancic@racp.edu.au
and fish oil. I commenced warfarin. The assistance offered by the pathology service to patients on warfarin is truly excellent. Within hours of each periodic blood test, I am telephoned with the recommended continuing warfarin dose and the date of the next appointment. It is all simple and clear.

I was referred to an electrophysiologist who carefully explained the options and recommended a catheter ablation of part of the posterior wall of my left atrium. Sometimes, it seems, specialists wonder how much to say about investigations and treatments to their medically trained patients. In such oral communication, the treating practitioner walks the line between telling their patient what they already know and leaving gaps in explanations because he or she overestimates their knowledge or recall. Fortunately, the doctors who cared for me gave careful, detailed explanations. I love hearing such explanations of technical matters. As a medical educator, my crafting of explanations draws me to the highest reach of my art.

Both nurse and doctor appeared to think my comments [on my fellow patient’s loud snoring] were an invasion of privacy and they gave little heed. Sleep apnoea is no private matter if someone else is sharing the room!

Just prior to this procedure, I had a thallium scan. It was a new machine and I was told by the attendant that a loud American voice emanating from the machine would tell me when to hold my breath. Indeed it did during the preliminaries but not for the very moment that the thallium was injected. I could feel the substance go in but there was no loud American voice. Instead, the doctor in charge, in her not-very-loud South Asian voice, gave the order herself. Clearly, she had never been in the machine because its din drowns out all but loud commands. Yet I was assured that she obtained good pictures, despite my continuing to breathe. Message: once you induct someone to an activity, don’t suddenly change the rules!

The catheter ablation was done under general anaesthesia. That night in hospital I was prescribed analgesia so the main disturbance was my fellow patient’s loud snoring of sinusoidal intensity, with short bouts of apnoea. This was ethically difficult because, although I was in the very best position to describe what was occurring, both nurse and doctor appeared to think my comments were an invasion of privacy and they gave little heed. Sleep apnoea is no private matter if someone else is sharing the room!

The first night at home following the catheter ablation brought me severe, continuing chest pain—so bad that it necessitated my sitting through the night, hampering anything more than shallow breathing. I was within an inch of phoning the specialist. The pain gradually diminished through the next day.

I had temporarily stopped warfarin for five days before the ablation. On the morning of the third day after the procedure, I realised that I could not see my right hand in certain positions on the computer keyboard. A quick and worried trip to the local optometrist confirmed a visual field loss in a narrow wedge of the right lower visual fields of both eyes. The electrophysiologist had never seen this as a complication of ablation and doubted any relationship. A carotid ultrasound was essentially normal. Fortunately, the loss resolved in a few days and perimetry a month later was normal.

The combination of warfarin and clopidogrel has not usually been a problem. It is more of a nuisance if nicks during shaving bleed for longer and are a little slower to heal. The main problem occurred when, during orienteering, I tripped and crashed downward on to some rocks. My face bled, then my arms and legs turned vividly purple for a week.

The catheter ablation converted atrial fibrillation to atrial flutter. The electrophysiologist was encouraged by this ‘halfway house’ stage of improvement but my symptoms on exertion—breathlessness combined with a weak, hollow feeling—persisted. Continuation of atenolol and introduction of amiodarone did not resolve the flutter and, sadly, because of the latter drug I had to abandon my beloved morning grapefruit half.

Direct current reversion brought sinus rhythm which has persisted since. It is a truly liberating feeling to be once again

**M y adventure with personal healthcare started as I ran about a kilometre (mainly downhill) for a morning ferry at Mosman in Sydney. I was laden with a briefcase and a suitcase on wheels. As I sat on the boat, I remained breathless and sweaty for much longer than I would have expected and my pulse was irregular. Climbing stairs and ramps during the next five to six hours found me breathless, after which time my heart rate became regular. I had no chest pain.**

Back in Melbourne, my general practitioner referred me to a local heart service with a good reputation, associated with a private hospital. An exercise electrocardiogram at maximal exertion reproduced the atrial fibrillation and, when a coronary angiogram showed narrowing of the left anterior descending artery and its main branch, I was booked for stents to those vessels the following day. I was awake but sedated for this procedure and, apart from a large femoral haematoma, it went well. I started clopidogrel and aspirin.

My father survived a myocardial infarct aged 43. He lived to 91, but all his siblings died of coronary or carotid arterial disease. I had been for several years on atorvastatin for mildly elevated lipids but had no other cardiac risk factors.

Of course, the stents were for the ventricle, not the atria. Gradually, episodes of atrial fibrillation became more frequent and, as I climbed hills while orienteering, I became breathless and experienced a ‘weak and hollow feeling’, perhaps due to cardiac inefficiency and lowered blood pressure. A Holter monitor showed runs of atrial fibrillation and flutter.

Six months passed and the atrial fibrillation became continuous despite atenolol...
I was reminded of the lesson in 'The House of God'—be wary of the younger patients who do not complain, they die.

My experience of this series of episodes of care has been overwhelmingly positive. Not only are doctors knowledgeable and deft, but they take trouble to explain things and offer options, and seem genuinely interested in how their interventions have affected my life.

Dr David Goddard FAFoem

David Goddard is a senior lecturer in the Department of Epidemiology & Preventive Medicine at Monash University, Victoria and, since January 2008, has been part-time Education Project Officer for the Australasian Faculty of Occupational & Environmental Medicine.

I had enjoyed the Queenstown Conference, in particular the talk by the musculoskeletal sage, Barry Tait, and the sessions on geriatric rehabilitation. Three days of skiing in varied conditions—sun, fog and blizzard—and the beautiful scenery of Middle Earth made for a great trip.

Loretta and I boarded the plane for the flight from Christchurch to Sydney. In Sydney I felt washed out, and an irritative cough had started but there was no sore throat or aches and pains. I boarded the flight to Adelaide, downing Panadol throat or aches and pains. I boarded the plane for the flight to Adelaide, downing Panadol

Sleep would not come, the cough was persistent and I could not breathe lying flat. At midnight I decided to go to A&E. The triage sister was on the ball—'I have flu symptoms and I am a staff physician here' and a pulse oximetry of 68% got me a trolley, oxygen and a push through to a cubicle. There I waited and waited.

The old man in the next cubicle with the known abdominal aneurysm and abdominal pain was being assessed in series by the A&E resident, the surgical resident and the surgical registrar. The fact that he had fallen asleep between each assessment seemed to have been missed. I was reminded of the lesson in 'The House of God'—be wary of the younger patients who do not complain, they die. Loretta advised the nurse that my sats were dropping. A blood gas on air of 48% O2 and bilateral basal and mid-zone opacity on x-ray got me seen by the ICU registrar. I was put on a non-rebreathing mask but after 30 minutes my anxiety settled and I began day dreaming.

I was in ICU for five days, 48 hours on CPAP by mask and 48 hours on nasal CPAP. They were surprised that I responded so quickly is that it's great getting better. I looked forward to doing some exercise when I reached the medical ward. I spent a week on the medical ward and then a week at home before easing into work with a lot of assistance from my colleagues.

I was thankful for the Fellows in Adelaide who stepped in to help at Griffith Rehabilitation Hospital and Hampstead Rehabilitation Centre and for their personal support of Loretta and me.

Dr Adrian Winsor FAFRM
Rehabilitation Physician

My world view constricted. There were moments of panic, moments of fear and moments of love (visits from my girls). As I was improving they asked if I wanted a room overlooking the park—no, I was happy as long as I could see my monitor. I learnt that there were five others in ICU with H1N1. One died whilst I was there, of similar age, and like me with no risk factors. All I can say is that I was lucky, and thankful for the care I received.

One thing about getting very sick very quickly is that it’s great getting better. I was thankful for the care I received. My experience of this series of episodes of care was overwhelmingly positive. I have confidence in doctors. Not only are they knowledgeable and deft, but they take trouble to explain things and offer options, and seem genuinely interested in how their interventions have affected my life.
INDEMNITY FOR FELLOWS AND OTHER VOLUNTEERS

The College is committed to protecting its Fellows and other volunteers who commit so much time and energy to the College and its work. It wants to retain its existing volunteer workforce, and attract new volunteers.

The College wants its Fellows and other volunteers to be frank and fearless in assisting the College, and it wishes to limit their exposure to liability.

At the October Board meeting, a deed of indemnity was approved, and professional indemnity insurance is also held by the College.

The deed indemnifies Fellows and other volunteers against specific liabilities that may be incurred by them when they are acting on behalf of the College, or when they represent the College on an external specialist committee. There are limits on the indemnity, which are set out in the deed.

The deed indemnifies volunteers who serve on the various College bodies, and also any Fellows (or non-members of the College approved by the CEO) who represent the College on an external specialist committee. The definition of ‘Volunteer’ is broad and includes:

- a President, President Elect, Chairman, Committee Member, Council Member, or other holder of any office of the College or a College body; or
- Fellows and other members of the College, or non-members of the College who are approved by the CEO from time to time, who have become at the request of the College (or College body) a member of a specialist committee or other medical research, advisory, training, education, investigation or clinical body of any kind that is formed outside the College.

Non Fellows who wish to have the protection of the indemnity should seek the approval of the CEO by emailing her office at: ceo@racp.edu.au. A register will be kept of all non Fellows who are approved.

Volunteers do not have to sign the deed to be covered. A copy of the deed is on the ‘members only’ website at www.racp.edu.au/page/membership, together with an explanatory letter from the College legal advisers, Mallesons Stephen Jaques.

John Kolbe
President

FINDING PAPPWORTH

Maurice Henry Pappworth (1910–1994) was, by any standard, a controversial figure. A life-long outsider, he chose an unconventional career path as a private medical tutor rather than accept anything less than his first job choice—a consultant post in a London teaching hospital. This story is not in itself remarkable; many are disappointed in their careers and are forced to reconsider their options. What Pappworth did, however, was to excel in his role as tutor, helping 1600 junior doctors to pass the gruelling MRCP in post-war London. Many of these candidates were from Australasia and some have already written about their experiences.1

Pappworth’s legacy, however, does not rest solely with this facilitation of young Australians and New Zealanders to achieve their professional goals. His other major contribution, and one which has not been fully documented or appreciated, is his contribution to the development of medical research ethics. Pappworth was a whistle-blower and his 1967 book, Human Guinea Pigs2, is now regarded as a major milestone on the journey towards the modern system of research ethics committee review.

In my role as Director of the Glasgow Clinical Research Facility I have been involved for a number of years in teaching healthcare professionals about the conduct of clinical research. While working on a recent book on the history of clinical trials3, I encountered Pappworth for the first time and have been interested in his story ever since. I feel strongly that his contributions need to be re-evaluated and to this end I am now working on his biography.

I never met my subject and must rely on those who did, which is why I am now writing this letter. There are many Australasian physicians who attended Pappworth’s classes in his Harley Street consulting rooms, and I would very much like to hear their memories of the man and his methods. If you were one of Pappworth’s students and would be willing to share your memories with me, please consider contacting me by email at agaw42@gmail.com or by post at the address below.

Any historical research will only ever be as good as its sources. First-hand accounts of those who were actually there will always trump any others, and it is by speaking to those who worked closely with him that I hope to find Pappworth and offer him the re-assessment I feel he deserves.

Allan Gaw, MD, PhD, FRCPath, FFPM
Director, Glasgow Clinical Research Facility
Tennent Building
38 Church Street
Western Infirmary
Glasgow G11 6NT, UK

References

THE RESEARCH AND EDUCATION FOUNDATION: BACKWARDS AND FORWARDS

Both of us believe that there is an impending crisis in the academic medical workforce and the awards by the REF are targeted towards helping young physicians fill this vital area for medical education and research.

The Research and Education Foundation (REF) of the College was established in 1991 by the then President John Chalmers AC. Professor Chalmers and the Council of the College recognised that, while one of the original objects when the College was established in 1938, was to advance research, its activities in this area had hitherto been limited. There were few funds to support scholarships or fellowships and its major focus related to education, assessment and advocacy.

Under the strong drive of Professor Chalmers, an appeal was instituted and, with the enthusiastic support of Fellows, the pharmaceutical industry and benevolent foundations a number of fellowships and scholarships were established. Over the years the number of these awards has grown, so that, in 2010, 48 awards were made totalling $1.6 million. Emphasis is placed on supporting high-calibre physician trainees and Fellows in two broad categories—’research entry’ with the provision of PhD scholarships tenable in Australia and overseas and ‘fellowships/research establishment’ for early career researchers who have recently completed research doctorates or returned from overseas, to facilitate the development of a research career. Regrettably, each year, there are many more well-qualified applicants than there is available funding to support them.

The program has been extremely successful with many awardees pursuing successful careers in medical research institutes or university departments or as hospital specialists and continuing to conduct international quality research, often of a translational nature. The awardees are chronicled each year in the Annual Report of the REF. The seminal role of College support at these critical times in career development has often been referred to by the recipients of awards, at the time of the award and/or in subsequent years.

Ken Roberts was appointed to the role of Chair of the REF in 1996. At that time he was the Chair and Managing Director of Wellcome Australia and had extensive experience in the pharmaceutical industry and in corporate governance. Ken’s service to the REF has been extraordinary and has been recognised by the award of honorary fellowship of the College, as well as by Membership of the Order of Australia. He continues on the Board as Emeritus Chair of the REF.

The authors, as the current Chair of the REF and Chair of its Research Advisory Committee (RAC), which recommends the awards, are highly conscious of the capacity of the REF to play a critical role in the careers of young physicians. Moreover, both of us believe that there is an impending crisis in the academic medical workforce and the awards by the REF are targeted towards helping young physicians fill this vital area for medical education and research. Although many scientists are undertaking PhDs in medical science, we believe that physician scientists will become even more important to medical research in the future with genomic advances raising innumerable questions of clinical relevance, which can be answered most effectively by translational research guided by physician scientists.

The REF is an intrinsic part of the College, identified by the Board at its ‘strategy day’ earlier this year as having a pivotal role in helping the College achieve its objectives. As an initiative to encourage Fellows to donate funds to sustain its current program and in the hope of expanding it in future, it was suggested that Fellows donate a small sum ($50 in 2010) to the REF at the time of paying their annual subscription. Sixty per cent of Fellows chose to make this donation, raising some $270,000 for the REF. This attests to the commitment of the Fellowship to the objects of the REF and their recognition that the role of the College extends beyond education to supporting the career development of trainees and Fellows who are committed to advancing knowledge in medicine and its branches. This sum will provide support for additional awards in 2011 relating to ‘research entry’ and a senior ‘research fellowship’. These awards will give priority to clinical/public health/translational research.

It is the wish of the RAC and the REF that there is a stronger pool of applicants (both Australian and New Zealand) from the Faculties of the College and strategies to achieve this are being debated by the REF and its RAC. Fellows can be assured that the money they donate is much appreciated, will be used wisely and will play a crucial role in the development of our next generation of medical researchers and educators.

Richard Larkins AO, FRACP and Michael Horowitz FRACP

RACP News December 2010
PLEASE HELP SUPPORT OUR YOUNG PHYSICIAN RESEARCHERS ACHIEVE THEIR GOALS …

“It is a privilege to receive the support from the RACP Research and Education Foundation and the ResMed Foundation to enable me to continue my research. I am honoured to be able to contribute to the medical faculty further knowledge and insight into upper airway function as well as having the opportunity to learn from other leaders and researchers in the field. I look forward to continuing on this journey with my supportive supervisors, and to share our knowledge and skills with the medical profession in the future.”

Dr Benjamin Kwan, ResMed Foundation Research Entry Scholarship winner

Join the Research and Education Foundation: simply tick your level of support, complete your payment details and mail or fax to:

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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Quarterly payments only available when paying by credit card.
WHAT ARE OUR YOUNG RESEARCH AWARD RECIPIENTS DOING NOW?

After leaving warm and sunny Queensland in March 2009, I was greeted on my first night in Calgary, Canada, with a 25 cm spring snowfall, leaving me somewhat perplexed as to how to firstly dig out my hire car, and then start working through the rather extensive list of items one needs to sort out when moving to a new country! However, these hurdles crossed, I soon adjusted to both a new climate and a new work environment.

The research I have been performing is based at the Stephenson CMR Centre at the Foothills Hospital in Calgary. The centre is affiliated with the University of Calgary and the Libin Cardiovascular Institute of Alberta, and is one of the five largest centres for cardiac MRI in North America, performing close to 2000 scans per year. Under the supervision of Professor Matthias Fredrich, my research aims to investigate whether a new heart imaging technique is able to detect changes in the oxygen content of blood in the heart muscle. The new technique is called blood-oxygen-level-dependent (BOLD) CMR. We want to use this technique to take pictures of the oxygen content in the heart and so be able to assess how severe any disease in the heart arteries may be.

Despite significant advances in our understanding and treatment of heart disease, it remains the most important cause of early death and disability in well-off nations. The most common form of heart disease is coronary artery disease, which occurs when the main blood vessels that supply blood to the heart are blocked by cholesterol build-up. Narrowing of these heart vessels can lead to reduced blood flow and often results in decreased oxygen supply to the heart. If left untreated, this can lead to heart attack and even death.

Heart imaging techniques used to assess disease in the heart often require the use of contrast and/or radiation. Also, not all current methods measure oxygen in the heart muscle directly, but use indirect or substitute measures. By directly measuring the oxygen levels in the heart muscle, this MRI technique may improve our ability to diagnose heart disease and may mean that some people can avoid unnecessary procedures.

In our study, we are assessing heart muscle oxygen levels by looking at people who have had an abnormal heart stress test and who have been booked to have a coronary angiogram. Our patients have two heart scans: one before or soon after the angiogram, and another one month later. By comparing the results from the scan with some special blood pressure measurements made within the heart arteries at the time of the angiogram (fractional flow reserve), we hope to show that the new MRI scan can accurately tell us how narrowed the arteries are.

Over the last six months, we have made significant progress with this study. Initially, we performed some preliminary studies on normal volunteers to optimise our MRI sequences. After finalising protocols, we completed the project proposal and obtained ethics approval, secured competitive funding and then began the process of implementation. Our study requires close collaboration between the interventional cardiology research group and the MRI researchers. As such, there has been a lot of educational and liaison activity for a wide variety of staff members, including physicists, cardiologists, nurses, and MRI and catheterisation technicians. The medical and research staff at the Foothills Hospital have been very supportive and we have made great progress and are now well under way, with our first 30 patients finishing the protocol recently. We will recruit about 75 patients in total and we aim to finish this exciting project by the end of 2010.

Dr James Hare
RACP Bushell Travelling Fellowship in Medicine 2009 recipient

LETTER TO THE EDITOR

What’s in an acronym?

The October RACP News (a most informative issue, by the way) had an article entitled ‘Bridging understanding between Consultants and DITS’. Having never before seen the abbreviation ‘DITS’, I was reassured to learn it wasn’t in fact some sort of dermatological condition, but was rather less pleased to see it being foisted upon we trainees who are not yet Fellows. An equivalent term for Consultants could be ‘Doctors in Charge’, or DICS. See how insulting that sounds?

Dr Curtis Walker
Hamilton, New Zealand
FAREWELL DAVID LYALL MORTON FRACP

David Lyall Morton, a highly respected Regional Consultant Physician and colleague, died recently at the age of 80.

David was born in Creswick, Victoria, and spent his formative years in Ballarat. He completed Matriculation at Ballarat Grammar School in 1947. In his final year he was Head Prefect, Dux of the School, Captain of Boats, and a member of both of the 1st teams in cricket and football. Cricket remained one of his lasting recreational interests.

David began studying medicine in 1948 at the Mildura campus of Melbourne University, where he was joined by a group of ex-servicemen. He once described the feeling at that time of being ‘a boy amongst men’, surrounded by men who had fought in World War II. The final five years of medicine were completed in Melbourne, where he was in residence at Trinity College. David was awarded Trinity Council scholarships in 1949 and again in 1951.

During his time at university David excelled in sport, as well as his studies, playing cricket for the university and for Trinity College. The Trinity archives mention that the 30s and early 40s were unsuccessful for Trinity on the cricket field, but this changed dramatically in 1949 when Trinity, led by DL Morton, Court and Lucas, won the A’Beckett Cup for the College. It was during this time that David met Natalie Miles, his future wife. They were married in February 1953, and recently celebrated 55 years together.

Graduation was followed by a two-year residency at Prince Henry’s Hospital where he balanced formidable work demands with alternate weekend district cricket—without attending practice.

In 1956, David made a decision which determined the direction of his career when he returned to Ballarat to join Dr E Sheil and Dr P Griffiths in general practice. During his first year there he undertook a role as medical officer to the rowing community, who were in Ballarat for the 1956 Olympic Games. At that time he also became medical officer to the Blood Bank. During the next decade David was active in general practice, which at that time included some individual surgery, assisting Dr Griffiths in major surgery and also managing a significant obstetric practice.

It was during those years that he decided to change direction and become a Consultant Physician. It is extremely difficult for doctors in 2010 to imagine how David managed to study for the exams and attend outpatient clinics at Royal Melbourne Hospital for additional clinical experience, while still involved in a busy general practice. Having achieved his qualification, he then mixed consultant work with general practice for a short time before commencing his career as a Consultant Physician in General Medicine.

David was appointed as a Consultant Physician to Ballarat Base Hospital in 1967, and continued in this role until 1994. The first seven years were in an honorary capacity. During those 27 years, David cared compassionately for all admitted under his care. He taught, and mentored, a generation of medical students, residents, registrars and young consultants, all of whom owe him a debt of gratitude.

Professionally, David fulfilled many roles. He was a lecturer at the St John of God Hospital School of Nursing from 1958 until it relocated to Aquinas University in 1990. He served on the State Committee of the Royal Australasian College of Physicians for six years, and was Chairman of the Professional Staff Group at Ballarat Base Hospital in 1979–80. For some years he was Chairman of the Advisory Committee at St John of God Hospital, the hospital to which he committed himself tirelessly throughout his career. One of David’s lasting legacies is the St John of God Coronary Care Unit. He was the catalyst behind the establishment of this facility and then, through his role as director, he committed himself to the education of a generation of coronary care staff. This legacy was acknowledged by the St John of God organisation when he was awarded the John Jens Medal and the Centenary of St Johns Education Award.

In 2007 both David and Natalie were recipients of Rural Doctors Awards, acknowledging more than 35 years of service to a regional community. In that year David was also honoured by Ballarat Health Services, being asked to introduce the guest speaker, Professor Geoffrey Blainey, at the celebration dinner to recognise 150 years of hospital activity in the Ballarat community.

David was Honorary Medical Officer to the Ballarat Old Colonists Association for 38 years, and was made a Life Governor of the Association in 1998.

Throughout his career David maintained his passion for cricket. Having played with Melbourne University while a student, he then played 1st Grade District Cricket with Richmond while working at Prince Henry's Hospital. He also played locally for Ballarat—Redan, only retiring in his late 40s, and earned a reputation as a talented bowler and batsman. He represented the Association in matches against visiting teams including the West Indies and South Australia. Other interests included pigeon racing and gardening (both of which occurred simultaneously while still on call!) and fishing, both open water and fly.

In his professional life David was patient, compassionate, understanding, widely read and yet conservative in his approach to changing trends. He developed his own outlook on many of the controversial or debatable areas of medicine, and he remained true to this philosophy even during his final illness.

David was extremely modest about his achievements and his medical ability. He was meticulous in his approach to medical problems—he covered all bases, approached a game of cricket! Only a man like David could have managed a significant obstetric practice while still on call!)

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David was extremely modest about his achievements and his medical ability. He was meticulous in his approach to medical problems—he covered all bases, in much the same way, I suspect, as he approached a game of cricket! Only a total commitment was good enough. He demonstrated a holistic approach to his practice of medicine, reflecting the diverse experiences throughout his career. The Ballarat community is full of gratitude for David's life and service. It was undeniably an extraordinary journey well travelled.

David is survived by his sister Pam Hill, his wife Natalie, their children Denis, Jenny, John and Lynne and their families.

Associate Professor
John Richmond FRACP
MAKING WAVES


Few Australian doctors have been as influential and in as many fields as David Penington. His autobiography ends with his concluding that he has had ‘a fortunate life’. Penington pursued a series of successful careers over almost a half century. His vision, prodigious talents and relentless energy enabled him to reform tired institutions and systems and contribute immensely to Australian public life. We are the richer for that.

In 1967 Penington left a busy Harley Street private practice in London to return to Melbourne where he had grown up. Within two years, he had become Professor of Medicine at St Vincent’s Hospital. He was barely 40. The lack of a PhD had threatened to derail his aspirations to be appointed a professor, so for a few months Penington worked away on his thesis for several hours every morning before going to work. The thesis was completed and the expected appointment proceeded. Penington soon began vigorously transforming his newly inherited professorial department, implanting a strong commitment to expanding research and improving teaching. Funds were acquired to build a new research building. But Penington had decreasing time available for research on his beloved megakaryocytes. Soon he began transforming the medical culture of his hospital from its stuffy, anachronistic world of ‘honorary’ consultants to more recognisably contemporary arrangements. With a life-long strong sense of social justice, he built a community health centre in Richmond, a densely populated low-income area. Somewhere he also found the time to become involved in discussions about Medibank, Australia’s first attempt at establishing universal healthcare.

Within a few years of becoming a Professor of Medicine at the University of Melbourne, Penington was invited by the Vice Chancellor to rebuild the Social Work Department. Only eight years after being appointed a Professor of Medicine, he was appointed Dean of Medicine. Once again, he embarked on ambitious reforms against entrenched opposition. Eight years later he was appointed Vice Chancellor of the University of Melbourne. But this time Penington was on the receiving end of the reforming zeal of the then Federal Minister of Employment, Education and Training, John Dawkins, who was keen to amalgamate universities with colleges of advanced education and vocational education. Penington found himself leading the national resistance to this approach. Fortunately for Penington, after some time Dawkins moved on to another portfolio and subsequent Education Ministers lacked Dawkins’ enthusiasm for this reform.

In the early days of HIV in Australia, Penington was Chairman of the National Blood Transfusion Committee and inevitably rapidly drawn into the growing concerns about the safety of transfused blood. He then became Chair of the National AIDS Task Force where he made another of his major national contributions. His long training in the rapid and dispassionate scrutiny of scientific data helped him and the AIDS Task Force to quickly separate fact from fiction in an emotional, uncertain and turbulent environment. Penington describes acrimonious confrontations with gay activists over early attempts to stop gay men from donating blood for transfusion. At the time, some leaders of the gay community regarded such restrictions as blatant homophobia, an understandable reaction as these events took place soon after the gay liberation movement had just begun to emancipate homosexual men and women from centuries of oppression. With the benefit of hindsight, it is easy now to see that the right decision was to give any benefit of doubt to the protection of the entire community.

In 1995, while finishing up as Vice Chancellor, Penington was invited by Jeff Kennett, then Premier of Victoria, to chair a small committee enquiring into illicit drug policy. With his reverence for evidence over strongly help opinion, it did not take Penington long to analyse the situation and establish that drug prohibition was unsustainable. He quickly recognised the reality of drugs as an economic market where demand and supply inevitably meet. At the same time he recognised the difficulties of change in a world where politics is the art of the possible.

From 1993 to 2001 Penington played a central role in the development of a new Museum of Victoria as Chairman of the Council. In 1995 he began extensive involvement in a company manufacturing high technology medical equipment (Cochlear Ltd) and continued this commitment for the next seven years.

I had the good fortune to encounter David Penington at many periods during my career: first as a medical student, then as his Registrar, later appearing before the National AIDS Task Force and more recently after he became involved in drug policy. Though some are less than generous about his personal qualities, I have seen Penington act discreetly on many occasions and with breathtaking kindness to junior staff and public patients. A stellar career such as David Penington has enjoyed would have been impossible without relentless energy, formidable mental capacity and exceptional personal qualities. Penington has had a fortunate life. But he has also contributed prodigiously to Australia over an extraordinary range of areas. No doubt the world would have understood megakaryocytes much better if he had not strayed beyond their research. But the world is a better place for the fact that he did try to right so many wrongs.

Doctors interested in the interaction between clinical medicine and government policy, medical and university education, and public health will find David Penington’s autobiography an absorbing read.

Dr Alex Wodak AM, FRACP
Director, Alcohol and Drug Service St Vincent’s Hospital
GLASS ALCHEMY AND ART: A HOT PASSION

It is a frosty spring morning, early at Hobart's Salamanca Market. The clang of marquee poles and stall tables being erected mixes with the aroma of coffee and a sausage stall firing up. My table of glass art is ready for a thousand hands to experience the sensation of glass. Pendants, beads, platters, bowls. As the sun rises over the sandstone buildings my sales soar—the light reflected catching the attention of those out for that something special, handmade and bought from the artist.

Glass is magical stuff. We look through it daily, love to drink the fluids it contains and watch how water dances down it as we want for sunnier days. Wearing glass is precious—unlike plastic or resin, it has weight. Being made from sand, potash, lime and heat it has an organic presence. It comes in as many colours as you can imagine, and can be colourless, transparent or so dark that no light penetrates.

The most fantastic thing about glass is that you can melt it. Its form from solid to liquid is a function of the heat applied. From around 550 to 980 degrees Celsius it changes from a solid that can be cut to a glowing liquid pourable like honey. A propane and oxygen torch easily achieves this temperature range. Our barbecue no longer functions as the gas bottle is connected to one side of the inlet to my torch. The two ex-medical oxygen concentrators chug along beside it to deliver a lovely intense 1000-degree flame.

In the heat, the glass can be wrapped around a steel rod (a mandrel) to form a bead. A layer of ‘bead release’, a clay-like substance, is put on the mandrel each time to stop the glass from sticking to the steel. The mandrel must be constantly rolled to keep its own design. Gravity has not usually been my friend! There is an enchantment about working with a substance that you can’t touch and can only partially control. The glass, once on the mandrel, can then be pushed, shaped, poked and decorated with dots, stripes, colours, flowers or faces. A bead can be round, rondelle, oblong, cone or heart shaped, or like a huge lentil. It can be a perfection of precision in design, or organic and flowing. Glass can also be sculptured ‘off mandrel’ so there is no hole or ‘bead’ created—marbles, frogs, clowns, dragons, kitschy cats and gorgeous human forms.

There is nothing new about beads. They are part of the history of every culture, in all areas of the world. They are probably as old as our genetic material. At first made from shells, bones, rocks and wood, traded over continents, until the explosion of precious metals, stones and then glass from around 3500 BC. The kitschy cats have only taken off since modern times, with the explosion of the American crafter.

I purchase rods of glass from the US, Italy and New Zealand where there are hundreds of colour options available. Italian glass makers from Murano provide a range of hues based on hundreds of years of tradition—dark red, topaz, light aqua, olive and ivory to name a few. The newer, younger teenagers on the scene from the US and New Zealand have a more modern approach—dirty martini, Hades, phoenix, leaky pen and evil queen.

All colours are not, however, what they seem. Reactive glasses are those that contain silver, gold, copper and other elements that react with the heat and oxygen (or lack of it) within the flame and change colour accordingly. Manipulation of this alchemy can turn a clear glass rod into swirls of peacock greens, blues and purples on aqua and cooling the same glass and reheating quickly (a process called striking) can produce the colours of the rainbow lotus—reds merging with oranges and deep terracotta. Cooling and reheating the glass again in a flame with no extra oxygen (called reduction) makes the glass ‘pull’ oxygen from the air and causes a metallic sheen or oil slick effect over the surface. Overheated and it all turns a disappointing brown mess. The ‘three strikes and get out’ policy definitely applies. The mastery of colour, temperature and design is the true art of glass.

Glass itself has a scientific side. Not all glasses are equal. Each type of glass has its own COE, or Co-efficient of Expansion. This is the rate at which the glass expands with heat and subsequently cools. For example, Effetre (pronounced with an Italian slant) is COE 104. Bullseye (American, of course) is COE 96. They cannot be joined, mixed or worked together without disastrous results. With cooling at different rates, the two glasses create stresses where they mix and will shatter under any future pressure—in the heat of the dishwasher, the dash of your car or simply as you hang it round your neck.

Due to the COE, glass also has to be annealed. An individual piece of glass must be ‘soaked’ at a particular temperature
Creativity in the moment excludes thoughts of disease, distressed families, protocols, 157 emails and meeting deadlines.

(around 515 degrees Celsius) for enough time for all molecules of the glass to be at that temperature (half an hour for a bead, many hours for a platter) and then the piece must be cooled slowly to prevent stress forming in the glass. This process gives the piece strength and the potential to last for future generations. It also increases the price tag!

Like glass, glass artists are not created equal. Those who work slowly, cut cold glass and fuse it together in a slow kiln over many hours are 'cold workers'. They wait for hours to open the kiln and reveal the finished piece. Think dermatologists and rheumatologists. 'Lampworkers’ work in the moment on a flame, melting and combining molten glass and only stopping when the piece is finished and can be put into a kiln for the annealing process. Think resuscitation bays and high-risk surgery. True aficionados will say that you can only master one or the other. An amateur like myself likes to dabble in both—and perhaps never master either!

Being at a market provides an outdoor environment of constant flow and personal interaction away from the machine of the health system. Intrigue and questioning often prompt thoughts of my next design challenge and the finances supply funding for further glass purchasing. Most importantly for me, working with hot glass provides a space where no other thoughts can enter. Creativity in the moment excludes thoughts of disease, distressed families, protocols, 157 emails and meeting deadlines. A round bead suddenly drooping to the floor or the sting of my finger at 800 degrees sharpens the mind, leaving my subconscious to sort out the other stuff. If I am in the zone, then I can’t be anywhere else.

Dr Robyn Thomas FRACGP FAChPM

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PRELIMINARY ANNOUNCEMENT

2011 AUSTRALASIAN SEXUAL HEALTH CONFERENCE
28 – 30 SEPTEMBER 2011
National Convention Centre, Canberra, ACT Australia

Please mark the dates in your diary and share this information with colleagues

For further information please contact:
Australasian Sexual Health Conference Secretariat
Locked Mail Bag 5057, Darlinghurst NSW 1300 Australia
Phone: +61 2 8204 0770
Fax: +61 2 9212 4670
Email: info@sexualhealthconference.com.au
Web: www.sexualhealthconference.com.au

Key Note Speakers:
Dr. Charlotte Gaydos
Professor, Division of Infectious Diseases, Department of Medicine, Johns Hopkins University, Baltimore, MD, USA

Dr Jeanne Marrazzo
Professor, Division of Allergy & Infectious Diseases, Medical Director, Seattle STD/HIV Prevention, Training Center, University of Washington, USA
General Medicine Physician

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