Role of the College in Medical Research
The Health Reform We Don’t Need
New Education Initiative: Medical Education Officers
How Balanced Are You?
2010 Feature: Book Reviews
Acute Medical Units -
Mapping the Future of Acute Patient Care

SATELLITE MEETING

When: Sunday, 21 March 2010
Time: 9am to 4pm
Where: Melbourne Convention & Exhibition Centre, South Wharf, Melbourne
Costs*: A$180 per person - Satellite Meeting Registration Only
A$60 per person - Special rate for WCIM 2010 Delegate Registrants

* Includes morning tea, lunch and afternoon tea

Who should attend?
This seminar will be of value to physicians involved in acute hospital admission rosters, ED physicians, nurses, geriatricians, administrators, Department of Human Services employees and other hospital staff.

Many Australian and international hospitals have introduced Acute Medical Units to overcome barriers in medical patient flow between the Emergency Department and the inpatient wards. What are these units actually doing? How effective are the units? Do they improve safety and how should they interact with other services, both in the hospital and in the community? What can we do to improve their proficiency and care? What resources are required to enable them to fulfil their role? How should they be designed and what should be their model of care to suit different types of hospitals? Are there opportunities to streamline the systems used to allow better data collection for evaluation and comparison between units?

This seminar will address these and other questions from the perspective of clinicians and other staff as well as hospital administrators.

The following 4 key areas will be explored:
• Update on Acute Medical Units in Australian Hospitals
• AMU Incoming: Access
• Acuity and Boundary Issues
• AMU Outgoing: Discharge Planning and Interaction with Community Resources

Written abstracts for poster display will also be accepted.

For further information please contact:
Congress Managers: arinex pty limited
GPO Box 128 Sydney NSW 2000
Tel: +61 2 9265 0700 Fax: +61 2 9267 5443
Email: wcim2010@arinex.com.au

Register online at www.wcim2010.com.au - Registration is essential

Held in conjunction with the
World Congress of Internal Medicine
WCIM 2010
In conjunction with
PHYSICIANS WEEK
20 - 25 MARCH 2010
MELBOURNE, AUSTRALIA

AMU Satellite Meeting is supported by the Victorian Government Department of Health
Beautiful Melbourne—location of WCIM 2010 and Physicians Week. Photograph Tourism Victoria.

Send us your photos

Please send us your interesting digital photographs to be considered for publication in RACP News.

File formats of 300dpi, at A4 size, can be emailed as jpegs to racpnews@racp.edu.au

Articles and Information

Wanted: Medical practitioners who want to know more about cancer management
New Year Honours 2010
2011 Specialist Training Program funding applications closing soon
WCIM 2010 in conjunction with Physicians Week
The health reform we don’t need
Training to practise Occupational and Environmental Medicine
Sexual Health Medicine and Addiction Medicine recognised as specialties
Journeys into Medicine: New publication from AIDA
College stance on physician behaviour
Year of the Trainee: The Vine
Windows into Safety and Quality in Health Care 2009
Queensland Council of Medical Specialist Colleges
2010–2011 RACP Training Positions Supplement
College Roll on the internet viewed more than 45,000 times in 2009
Riding for Paceline
Farewell Peter Nigel Black FRACP
Book Reviews
Letters to the Editor
After Hours: Achieving work–life balance
Member Advantage
Classifieds
A FIRST FOR AUSTRALASIA: WCIM 2010

Letter from the President

It is now less than two months until the World Congress of Internal Medicine 2010, and I really hope that a very large number of you are planning to come to Melbourne in late March to attend this meeting. There are several excellent reasons to come along.

This is the first time the World Congress has been held in Australasia and so we have planned a very special program. In line with the broad theme, ‘World Medicine for the Next Decade: 2010–2020’, leading experts from home and around the world will speak on a range of issues of great relevance to us all.

The International Society of Internal Medicine (ISIM), together with the American College of Physicians (ACP), sponsor several internationally renowned physicians to speak each time this Congress is held, and they are sending outstanding speakers on this occasion.

This Congress is one of the first meetings to be held in the spectacular new Melbourne Convention and Exhibition Centre (MCEC), which was opened only a few months ago. The MCEC has state-of-the-art facilities which enable all parts of the College, including Paediatrics, the Faculties and the Chapters, to come together to hold their normal annual Congress within the same venue, together with the members of the Adult Medicine Division who, with the International Society of Internal Medicine of Australia & New Zealand (IMSANZ) and the ISIM, are staging the World Congress.

Thus, you will be able to choose whether to attend a session directly in your area of clinical or research interest, or to attend one of the many outstanding talks or seminars in an area not directly in your clinical sphere, but nevertheless of great interest.

The Congress opens with addresses from the Governor of Victoria, Professor David de Kretser AC, a Fellow of our College and leader in biotechnology development and innovation, and Professor Barry Marshall, who as an RACP trainee undertook research that confirmed that a bacterium is the cause of the vast majority of duodenal and gastric ulcers, work that led to his receiving the Nobel Prize for Medicine.

Later on the first day you can listen to Professor Dame Carol Black speak on maximising the health and wellbeing of the working age population or choose from any of the seven concurrent sessions across the spectrum of clinical medicine, medical research and medical education.

The plenary session on the second morning highlights global health initiatives and then continues with eight concurrent sessions from a wide range of medical specialties, including Public Health Medicine, The History of Medicine, Adolescent Health and sessions sponsored by our subspecialty societies.

The champagne continues to flow on the third day and the only difficulty will be the dilemma of choosing which of the excellent talks you will have to miss. The closing plenary session on that day, entitled ‘Climate Change and Health’, will feature Senator Bob Brown plus experts from home and Europe discussing how climate change is affecting patterns of health and disease around the world.

And if that is not enough, you can also attend the College ceremony and hear former Chief Justice of Australia, Sir Anthony Mason, deliver the Arthur E Mills Oration, dine out at some of Melbourne’s famous restaurants, attend the theatre or take part in day trips out of Melbourne to the wineries of the Yarra Valley, the penguin parade at Phillip Island or along the Great Ocean Road to view the shipwreck coast and the Twelve Apostles.

In fact, one of the world’s leading travel guides, Frommer’s, has just selected Melbourne in its top destinations for 2010. Frommer’s top destinations represent emerging spots and under-appreciated cities. Melbourne was recognised for its ‘vibrant cultural scene, a sports crazy population, and culinary indulgences aplenty’.

You will have noticed that Physicians Week is being held in March and not at the usual time of May. After winning the bid to hold the World Congress in association with our annual College Congress, we chose March as it is the best time to visit Melbourne and Victoria with its warm, autumn days and there is lots to do in and around Melbourne that week, culminating in the Grand Prix, which commences just after the closing ceremony of the Congress.

Together with Nip Thomson, Past President of the College and current President of the ISIM, I look forward to welcoming you to this year’s Congress.

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Professor Geoffrey Metz AM
President
Royal Australasian College of Physicians

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ROLE OF THE COLLEGE IN FOSTERING THE CLINICIAN-RESEARCHER

Emeritus Professor Richard Larkins believes that ‘the College must play a leadership role in ensuring that young physician-researchers have the opportunity to develop their research to the point where they can attract external research funding from bodies such as the NHMRC’.

One of the objectives of the Royal Australasian College of Physicians when it was established in 1938 was to advance knowledge of medicine through research. This has been restated clearly in the new Constitution of the College adopted in 2007 where the first part of Object 1.1.6 is ‘increase the evidence and knowledge on which the practice of physicians is based through research’.

We are all very aware of the extensive role played by the College in education and in the assurance of standards and quality through its training and examination programs and through its continuing professional development program. It has not always been obvious that the College and its Fellows are as committed to advancing knowledge through research.

The rigorous requirements of ethics committees and the logistical difficulty of recruiting the number of subjects and control subjects required for statistical significance make research very demanding. Although the National Health and Medical Research Council has strategies in place to encourage clinical research, it is still difficult to design and perform clinical research which satisfies rigorous scientific criteria.

The changes in the funding of teaching hospitals have also made the life of the clinician-researcher more difficult. Many teaching hospitals now run more like businesses and the financial bottom line is an important criterion of success. It is difficult therefore to conduct high-quality clinical research in a hospital environment without specific arrangements.

As I wrote in the Australian and New Zealand Journal of Medicine in 20002, it is sobering to think that one of the great clinical research contributions made in

Research involving human subjects conducted and overseen by clinicians is the only method of determining the cause of disease, new approaches to treatment and which innovative treatment works in a clinical setting. This research is becoming more and more difficult. The rigorous requirements of ethics committees and the logistical difficulty of recruiting the number of subjects and control subjects required for statistical significance make this research very demanding. Although the National Health and Medical Research Council has strategies in place to encourage clinical research, it is still difficult to design and perform clinical research which satisfies rigorous scientific criteria.

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It is sobering to think that one of the great clinical research contributions made in Australia, culminating in the award of the Nobel Prize for Medicine or Physiology in 2005, probably could not occur in the current hospital environment.
First it is essential that we have sufficient combination of skills and roles. There are believe, as I do, in the importance of this and funding in our health care system as considerable support from the College described above, this form of practice the physician-researcher is a species of impression from this that I think that I do not want anyone to get the antibiotic-based combination.

Helicobacter pylori as the cause of peptic self-experimentation. Yet this discovery of might well not have approved Marshall's such investigations. An Ethics Committee medical registrar could now expect in the current environment to have the time, funding or moral support to carry out such investigations. An Ethics Committee might well not have approved Marshall's self-experimentation. Yet this discovery of Helicobacter pylori as the cause of peptic ulcer has transformed the treatment of this disease from major surgery to a simple course of an appropriate antibiotic-based combination.

I do not want anyone to get the impression from this that I think that the physician-researcher is a species of the past, an object of historical curiosity. I think that, despite the obstacles described above, this form of practice will survive and flourish. But it will require considerable support from the College and insight from those in charge of policy and funding in our health care system as well as a lot of advocacy by those who believe, as I do, in the importance of this combination of skills and roles. There are a number of requirements.

First it is essential that we have sufficient committed young doctors and students who wish to take on roles of this type. Why should a young physician be interested in such a role? Frankly, because it is about as interesting a career as anyone could have. The combination of caring for patients on the one hand, with all that this entails, and the challenge of applying scientific method to answering the innumerable questions posed by the shortcomings of clinical care provides a wonderful balance of intellectual and emotional rewards. Throw in some teaching and you have the type of career that would fit the indentikit profile of an individual who is intelligent, curious and determined to make a positive impact on the world.

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Well, why should a young physician be interested in such a role? Frankly, because it is about as interesting a career as anyone could have. The combination of caring for patients on the one hand, with all that this entails, and the challenge of applying scientific method to answering the innumerable questions posed by the shortcomings of clinical care provides a wonderful balance of intellectual and emotional rewards. Throw in some teaching and you have the type of career that would fit the indentikit profile of an individual who is intelligent, curious and determined to make a positive impact on the world.

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There are countless examples of research by Australian physicians leading to discoveries which have a profound effect on clinical care and public health policy. Despite the difficulties, I remain very optimistic that the physician-researcher will continue to play a vital role in the 21st century. I think the reform of medical education where boring didactic teaching, which tended to suppress curiosity, has been largely replaced by student-centred active learning and enquiry has encouraged a life of continued learning and for some a desire to contribute to the body of clinical knowledge. The NHMRC has been proactive in nurturing the clinician-scientists and the introduction into clinical practice of evidence-based medicine has increased the need to further develop clinician-scientists to increase the evidence base. Moreover, I have enormous respect for the medical students and young graduates of today. I think that they demonstrate the commitment and ability to make a difference in our challenging world.

I also believe that the College must play a leadership role in ensuring that young physician-researchers have the opportunity to develop their research to the point where they can attract external research funding from bodies such as the NHMRC. The education of our young doctors and the advancement of knowledge are dependent on nurturing these early career researchers.

The Research and Education Foundation has done an excellent job in raising funds to allow the Research Advisory Committee to support a number of such early career researchers each year, but much more is needed. I am pleased to be rejoining the Research and Education Foundation to help to achieve the extra funding required to allow this to happen.

I believe it is every physician’s responsibility to help to honour the Charter of the College even if he or she is not personally involved in research. For this reason, I was delighted when the Board of the College decided that the default situation is for each Fellow to make a small contribution to the Research and Education Foundation each year unless an active decision to opt out of the contribution is taken.
throughout history, paradigm shifts in medicine have resulted in significant improvements to treatment, patient wellbeing and health outcomes. In the latter half of the nineteenth century, the discovery of bacteria propelled one such shift. Now, the best available evidence states that another paradigm shift is required, in relation to how we think about health and work.

Compelled by a growing body of international research, the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) has produced a Position Statement; ‘Realising the Health Benefits of Work’. This Position Statement summarises the evidence regarding the impact of work on common health conditions such as musculoskeletal problems, anxiety and depression, and makes recommendations for government, employers, treating practitioners, medical leaders and peak medical bodies based on three key principles:

- Work, in general, is good for health and wellbeing.
- Long-term work absence, work disability and unemployment have, in general, a negative impact on health and wellbeing.
- Return to work and maximum functional level should be seen as a desired outcome from any health care intervention.

AFOEM is calling for Australasian health care leaders and peak medical bodies to produce and commit to a consensus statement that acknowledges the positive relationship between health and wellbeing and the negative role that sickness certification plays in work absence and needless work disability.

AFOEM is currently seeking feedback on the draft Position Statement, ‘Realising the Health Benefits of Work’. If you would like to provide feedback on this important document, please visit the RACP Policy and Advocacy website, www.racp.edu.au/page/policy-and-advocacy, under Occupational and Environmental Medicine.

The Faculty is pleased to announce that Dame Carol Black will be giving the Ferguson-Glass Oration at WCIM. Dame Carol was responsible for the review, ‘Working for a Healthier Tomorrow’, which looked into the health of working age people in the UK. This is an exciting opportunity for the Faculty and the College to hear about progress on the implementation of the Black review and the lessons for Australasia.

A planned launch of the Position Statement in Wellington and Sydney is scheduled for May 2010.

Dr Mary Wyatt FAFOEM
Chair, Policy and Advocacy Committee

ADVOCACY AGENDA ON THE RIGHT TRACK

The first broad survey of Fellows and trainees regarding policy and advocacy has been a resounding success. At the time of writing, the survey has just closed, but the following initial analysis provides a quick summation of the results.

The survey was divided into two main areas—a request for opinions about areas of focus for the College’s policy and advocacy agenda, and the identification of expertise amongst College membership along with availability to contribute to the agenda.

In late 2008, three areas of priority focus were identified to guide the policy and advocacy efforts of the College. These were:

- Indigenous Health
- Prevention and Management of Chronic Disease
- Workforce.

Through the survey mechanism, Fellows and trainees proposed a total of 1,230 and 367 suggestions respectively. The good news is that the majority of the suggestions support the identified areas of focus, so we know that we are heading in a direction that the membership favours. This was further bolstered by the fact that the remaining suggestions were extremely varied, with no other area of focus emerging as strongly.

For both Fellows and trainees, workforce issues were the dominant priority, with significant concerns across both groups regarding internal workforce issues, although with different emphases. It is not surprising that many of the trainees drew attention to issues specifically affecting their current situation, such as the availability of part-time training positions, parental leave and the adequacy of supervision. In contrast, Fellows’ responses covered issues such as inter-professional relationships, quality and safety, and differing aspects of remuneration.

There were two areas where Fellows and trainees were aligned in their identification of advocacy topics related to workforce. These were the issues of safe working hours and support for the provision of health care in rural and remote areas. These matters, and the other issues raised, will be referred to the appropriate Expert Advisory Groups for action.

Other significant areas where people suggested action included refugee and migrant health, equity of access to health care, child protection, climate

Through the survey, 327 Fellows and 54 trainees offered to contribute to the development of Position Statements... [and] 404 Fellows and trainees offered to be involved with committees.
change and the health of disadvantaged populations. There were also calls for greater involvement by the College in international health, including disaster relief, and in different aspects of disability support. Many respondents identified the health of certain age groups as topics for action, specifically child health, adolescent health and care of the elderly.

The second half of the survey asked respondents to identify their areas of expertise and their availability to contribute to the College's policy and advocacy activities. It is a rare physician who has time on their hands, so the commitments made in this section of the survey are greatly appreciated. This information will be used to create a database, and Fellows and trainees will be approached for input in the fields they have identified as appropriate.

With the move to concise and targeted Position Statements, the College is developing a suite of policy documents, which can be viewed on the Policy and Advocacy section of the new website. Briefer statements mean a faster turn-around and greater output, so it is important to expand the breadth of input to ensure that the workload is not overly concentrated on a few contributors. Through the survey, 327 Fellows and 54 trainees offered to contribute to the development of Position Statements.

Reporting to the College Policy and Advocacy Committee are eight Expert Advisory Groups covering Aboriginal and Torres Strait Islander Health, Workforce, eHealth, Rural Taskforce, Medico-Legal, Ethics, Therapeutics and Quality. There is also a working party on Alcohol and another on Climate Change. Through the survey, 404 Fellows and trainees offered to be involved with these committees, either as full or corresponding members, or as providers of occasional expert advice.

Over the past 12 months, the College has increased its media presence and we are always seeking Fellows who have the appropriate expertise to interact with the media on behalf of the RACP. As a result of the survey, 190 Fellows and trainees have offered to take on this important role.

The survey also asked about the desire for media training. Of survey respondents, 40% identified that they would be interested in participating either in full media training or a refresher course. Media training courses have been offered at the College Congress in the past, but have not been well attended. Given that a strong interest exists, we will explore mechanisms to offer training at venues other than at Congress, possibly on a regional basis.

Overall, the survey results point to a very busy year ahead for policy and advocacy, with the benefit of increased engagement by both Fellows and trainees. All respondents will be contacted when we have processed all of the data. In the meantime, please look for opportunities to contribute to College submissions and for committee membership in the weekly ebulletins. Open submissions can also be located by following the link under Promoting Positive Health Outcomes on the homepage of the website.

Thank you to everybody who found the time to complete the survey; your contributions are valued and appreciated. If you missed the survey and would still like to contribute, please email me at: 
Yvonne.Luxford@racp.edu.au.

Dr Yvonne Luxford
Manager, Policy and Advocacy

Available online at www.epicc.org.au
EPICC provides cancer education, including:

- General principles of cancer care
- Side effects of cancer treatment and symptom management
- Oncologic emergencies
- Psychosocial care
- Follow up

EPICC is an educational program developed by a multidisciplinary group of medical practitioners led by the Medical Oncology Group of Australia.

For more information and to register your interest in the program, contact MOGA Secretariat, moga@moga.org.au or 02 8247 6210. Please call if there are any questions.
DEALING WITH THE MEDIA

Dealing with the media can be a double-edged sword. When we seek to communicate new policies to a wider audience, highlight our specific expertise, or advocate on behalf of physicians and paediatricians in Australia and New Zealand, media play an important part. However, in some instances, the media come to us—particularly when an issue or crisis has arisen. In those instances, while we would prefer not to participate in a ‘media storm’, rules for effective media engagement apply. Highlighted in this article are the typical communication objectives, what the media seek from us and how we go about providing them with information.

In order to take a considered approach to media activity and to address the diverse interests of the RACP, a comprehensive media strategy has been prepared. Below are the main media and communication objectives:

- To communicate clearly on matters where the RACP has expertise
- To be recognised as a key source of comment on certain issues
- To be regularly sought for such comment
- To develop a high profile and recognition factor in the media
- To encourage public debate on issues of importance to the community
- To be seen in a leadership position in the health community.

In order to achieve the above objectives, and to reach target audiences, the media strategy includes the following tactics:

1. Identify media spokespeople, their areas of expertise and specific topics on which they can speak.
2. Identify the media who report on those areas.
3. Introduce media training/coaching of spokespeople and other representatives of the RACP.
4. Identify key media for strategic relationship building.
5. Implement process for issue identification and publicity.

Identify media spokespeople

The first step of any media strategy is to implement a process of identification of the most appropriate people who can comment on behalf of the RACP. In many cases, the President prefers to speak on behalf of the RACP; however, there are instances where an expert in a specific field is the most relevant person. Clearly define the areas on which those people can be interviewed and identify sub-topics or related topics.

Having identified those who can usefully speak on nominated topics, the next step is to ensure that every spokesperson is fully prepared prior to engaging with the media.

**Media training and coaching**

Every leader or organisation spokesperson, no matter how experienced with the media, benefits from media skills training and refresher courses. To achieve the best result for the RACP, nominated spokespeople participate in a media training program specifically developed and tailored to their topic/area of specialisation and audience.

After an initial assessment of the current level of skills of individuals and their objectives, the program can be tailored accordingly.

Media coaching focuses on delivery, message and relationship management skills of the individual and usually includes exercises to address the specific interview situations each spokesperson could face.

Part of the training also provides a greater insight into how the media work so that expectations can be managed and opportunities maximised.

The three rules of engagement with the media are:

- **Rule No. 1** If you don’t want to see it in print … don’t say it!
- **Rule No. 2** Requesting media to embargo a release or making ‘off the record’ comments presents a risk to the RACP. Not all journalists accept/adhere to these requests.
- **Rule No. 3** Don’t agree to do a radio interview until you are prepared. Think/prepare/review your approach and then call the journalist back within an agreed time frame once you have had a chance to prepare.

**Relationship building with the media**

Media respond very well when they believe that:

- they have a credible information source who is accessible
- some effort has been made to identify issues that they are interested in
- the information has been well targeted.

Journalists become cynical when they recognise a ‘shotgun’ approach to media releases (not targeted, hoping that by sending a release to all media, you are bound to hit at least one target), or when the information is too lengthy or not focused, or when there are too many messages trying to be communicated.

In an interview situation, they want spokespeople who are:

- prepared to provide background information
- able to make statements on behalf of the RACP
- able to point them in a direction that will help them further develop the story.

By taking the time to get to know the most important journalists in selected topic areas, the RACP can also benefit from the media’s knowledge of the RACP and its Divisions, Faculties and Specialist Chapters.

The key is to ensure that you are not overly ambitious and don’t attempt to build relationships with every journalist and media on your list. Be targeted. Little wins along the way will be far more productive and successful.

**Process for issues identification and publicity**

A regular meeting should be held with the spokespeople in order to discuss the media strategy in relation to each topic. Specific aspects of these topics should also be discussed and a ‘position’ established by the College and communicated to all media spokespersons. A process of monitoring current issues and identifying who is seen to be commenting on specific topics...
can also be included in these regular meetings. Either the College can provide the information or one of the media monitoring services can be engaged.

If possible, this media strategy should be reviewed whenever major issues or opportunities arise and thereafter a report should be submitted and reviewed every two months in order to track media coverage of the RACP and ensure that the media strategy on specific topics is still relevant.

Protocol for managing media calls

The following media protocol serves to provide the nominated media spokespeople with an efficient process with which to manage media contact.

To ensure positive acceptance and management of the media activities recommended for the RACP, the media strategy and protocol should be communicated to all relevant people within the RACP. It is through this communication, together with a clear understanding of each person’s role, that a planned and structured approach can be taken to what are generally unplanned and unstructured events.

All media spokespeople and their administrative staff should participate in an initial briefing during which an outline would be provided of the objectives and procedure which must be followed to achieve those objectives. To be successful in this task, the RACP must ensure that the recommended procedure is adhered to.

Media call procedure

Below is the seven-step recommended procedure for handling media calls and interviews.

1. Get full details of the caller
   When media call, admin staff should get clear details of name, publication or media, and correct telephone number.

2. Ask questions
   Obtaining answers to the following questions will assist the media spokesperson to prepare for the interview:
   - What is the nature of the call (i.e. the topic)?
   - Who do you specifically wish to speak to?
   - What angle are you taking?
   - Who else are you speaking with?
   - What is the deadline?
   - What is your immediate availability so that we can call you back?

3. Contact the appropriate spokesperson
   The nominated media spokespeople have been chosen because of their expertise in identified priority areas for the RACP. They are trained/experienced in dealing with the media and will be prepared to take calls on their nominated topics.

4. When the spokesperson is unavailable
   If the nominated spokesperson is not available or cannot take the call, the message must be passed on in a timely fashion to another spokesperson or to RACP Media Liaison to advise of their unavailability in order to maintain good communication with the journalist.

   Note: In the above instance, if the call goes through to an alternative spokesperson, that person must advise RACP Media Liaison of the nature of the interview so that they can track media coverage.

5. Monitor media interviews
   Where possible, the RACP should view/listen to interviews and, where appropriate, request transcripts or a video.

6. Log/file media clippings
   Media clippings should be reviewed the next day, logged and prepared for tabling at council meetings. Some academics like to be notified immediately via email of any articles on the RACP that appear.

7. Prepare a media coverage report
   A report on media coverage should be prepared for distribution via email to RACP spokespeople and other interested parties within the RACP to ensure everyone is kept up to date.

Deanna Lane
RACP Media Liaison

NEW YEAR HONOURS 2010

Congratulations to the New Zealand Fellows who were mentioned in the New Year Honours List 2010.

Professor Vernon Harvey ONZM, FRACP, FACHPM
For services to medicine, in particular oncology research

Dr (Gordon) Murray Kirk ONZM, FRACP
For services to medicine

Professor Sitaleki ‘Ata’ata Finau MNZM, FAFPHM
For services to Pacific Islands community health

2011 SPECIALIST TRAINING PROGRAM FUNDING APPLICATIONS CLOSING SOON

The application rounds for the Specialist Training Program (previously Expanded Specialist Training Program or the Outer Metropolitan Specialist Trainee Program) are closing soon. The level of funding for each training post is $100,000. Applications need to be made to the College by mid-February for submission to the Commonwealth by 1 March 2010.

Details and forms are available from www.health.gov.au/internet/main/publishing. nsi/Content/work-spec or by emailing the College at accreditation@racp.edu.au.
We strongly urge you to complete the 2010 Workforce Survey sent to you with your 2010 subscription notice (see below for more details). Your participation is important to us—we cannot even think about sensible workforce planning if we don’t have baseline data.

The College collects workforce information to substantiate its strategic approaches to workforce policy. RACP is responsible for training physicians but has no control over available training places. As such, the College needs to monitor workforce trends in order to confidently advise government policy-makers on how to respond to population health needs. In addition, with a new national registration system and increasing numbers of medical graduates, it is all the more necessary for the College to know the demographics and career intentions of the physician workforce so we can plan the utilisation of College resources for training new Fellows and delivering CPD programs for the Fellowship.

The 2008 Survey had a 45% response rate (down from an average of over 70%) and thus we are unable to confidently generalise the results to inform our approach to strategic policy. Despite the small response rate, Fellows may be interested in some of the basic findings, including that gaps persist between generalists and other subspecialists, males and females, and among the rural, remote and metropolitan workforce. Other findings are outlined below:

- A relatively large proportion of overseas respondents (42%) indicated having professorial appointments compared to the percentage of respondents in Australia and New Zealand where most do not have any university appointment (48%).
- The total working hours in an average week for the majority of the respondents (42% in Australia and 40% in New Zealand) was between 38 and 50 hours. Overall, 35% of respondents worked over 50 hours per week, with 40% of Australian and 49% of New Zealand adult internal medicine specialists committing to long hours.
- 20% of Australian and 22% of New Zealand respondents worked fewer than 38 hours per week. The measures have changed, but it is noted that in 2003, 12% worked fewer than 40 hours a week.
- Approximately 30% of the respondents participated in outreach work. A greater percentage of General Physicians and General Paediatricians participated in outreach work than those in other sub-specialty areas, although over half of all respondents in most sub-specialties indicated a willingness to be involved.
- Just under a fifth of Australian respondents intended to retire in the next five years. There was very little intention to change practice hours or mode amongst New Zealand respondents.
- In the available sample, women formed about 24% of the physician workforce (compared with 21% in 2003 and 19% in 2001).

A greater percentage of General Physicians and General Paediatricians participated in outreach work than those in other sub-specialty areas.

How to complete the survey

The 2010 Workforce Survey sent to you is pre-populated with information held in the College system. Participants simply need to indicate any changes to their circumstances or add some small additional information.

An electronic version is available on the website when paying subscriptions that way. It should take less than five minutes to complete. We seek your help in improving the 2008 response rate by returning the questionnaire by 26 February 2010.

Reminders will be sent by email—although a surprising number of College Fellows have not recorded an email address with RACP. Email makes voting in College elections, participating in committees and steering the direction of College policy easier. Email is also the simplest way to manage information from the College as you can control what is delivered. Increased email usage by the Fellowship decreases the College’s communication overheads and may translate to cost savings and restraint on inflation-driven increases in subscription rates. If you haven’t notified RACP of your email address, please advise the College by emailing: racp@racp.edu.au in Australia or racp@racp.org.nz in New Zealand.

The College’s new Workforce Expert Advisory Group will work with other colleges and the Government to continually improve health workforce information in 2010. Comments or queries can be directed to policy@racp.edu.au.

Professor Peter Brooks FRACP
Chair, Workforce Expert Advisory Group
ANY OF YOU WOULD HAVE CONTRIBUTED TO THE MABEL (Medicine in Australia: Balancing Employment and Life (MABEL): The Australian Longitudinal Survey of Doctors) survey in 2008. Results from that first wave of the survey have now been released and indicate that both Fellows and trainees work long hours and are not particularly satisfied with their work-life balance. These concrete results provide background to the request that greater advocacy be focused upon the issue of safe working hours, as evidenced in the recent Policy and Advocacy survey.

MABEL survey responses were received from 4,596 specialists, of which 26% practised in RACP specialty areas. Data indicates that physicians are an average of 50.5 years old, and that 28.8% are female. Physicians work an average of 46 hours weekly, exceeding all other specialties except surgery. Female physicians work fewer hours than males, averaging at 33.05 and 44.05 hours respectively.

Only 43.07% [of physicians considered] that their professional and personal commitments were well balanced …

Despite this level of dissatisfaction … approximately 87% of physicians were satisfied with their work.

Just under 10% of male physicians under the age of 55, and just under 7% of females, intend to leave direct patient care within the next five years. Around 4% of each gender plan to stop working altogether in the same time frame. Figures for all other specialty areas were higher, excepting female surgeons.

Data was also collected from 1,072 specialists in training and, again, the majority of respondents were trainee physicians, although the spread was more even across specialties than for Fellows. The mean age of specialists in training was 32 years.

Trainees across all specialties work a mean of 48.4 hours for males and 45.2 hours for females per week. Physician trainee hours are close to this mean, although females’ hours are closer to the mean male figure. Around 50% of physician trainees work more than 50 hours per week. Surgical trainees report the highest percentage, working long hours.

Of all specialists working more than 50 hours per week, male physicians make up the largest percentage.

Almost 50% of all specialists positively responded to the qualitative question regarding satisfaction with work-life balance. In this question physicians fell behind, with only 43.07% considering that their professional and personal commitments were well balanced. Whilst this low figure may seem to directly flow from excessive working hours, this could only be part of the issue as surgeons have similar working hours yet consider their lives more balanced. It is probably more useful to address the overall result which is that over 50% of specialists are unhappy with the balance in their lives.

Despite this level of dissatisfaction regarding balance, approximately 87% of physicians are satisfied with their work, on a par across all specialties. Females reported greater job satisfaction than males, with the greatest level amongst female surgeons at 95.56%.

Around 80% of physician trainees are involved in on-call work, and nearly 40% of male trainees were called out in the week preceding the survey, compared to around 20% of female trainees. Surgical trainees experienced the highest level of on-call work.

Over 80% of physicians in training considered that they had good support and supervision from qualified specialists.

Satisfaction with work-life balance was similar for trainees and Fellows, although almost 60% of female trainees were happy with their professional/personal balance. Around 80% of physician trainees of both genders were satisfied with their jobs.

As would be expected with trainees starting out in their profession, only 2.9% stated that they would leave medicine within the next five years; 10.3% indicated they were likely or very likely to leave direct patient care within five years, a similar figure to that demonstrated by Fellows.

All of the data thus far released can be viewed at https://mabel.org.au/. Further information regarding the survey is also available on this site.

Dr Yvonne Luxford
Manager, Policy and Advocacy
CLIMATE CHANGE: WHY SHOULD WE CARE AND WHAT CAN WE DO?

Dr Steven Skov, Chair of the RACP Climate Change Working Group, believes that Fellows of the College should care because they will need to deal with the ill health caused by climate change; at the same time, they have a responsibility to promote wellbeing and prevent disease. Dr Skov goes on to discuss why action is so critical and what preventive measures can be taken.

People are suffering and dying because of global warming. A World Health Organisation report estimated that 160,000 people died in 2000 due to the effects of climate change and that there were 5,500,000 Disability Adjusted Life Years (DALYs) lost.1 A more recent analysis suggests that as many as 315,000 lives per year were lost due to climate change between 2004 and 2008.2 About 10% of these were due to weather-related disasters and the remaining 90% to gradual degradation of the environment.

How exactly does climate change affect people’s health? There is some increase in vector-borne diseases such as dengue, tick-borne encephalitis, leishmaniasis and especially malaria as increasing temperatures allow the insects that carry them to expand their range. Increasing temperatures also lead to a higher incidence of common bacterial gastro-intestinal infections, which has the greatest impact on young children. Extreme weather events such as floods, storms and fires are becoming more common and more extreme and cause substantial death and injury, as well as stress and anxiety about such events being more frequent.

Disadvantaged people will be the ones most adversely affected by climate change. This will also be true for Australian Aboriginal people. The impact on remote Aboriginal communities in northern and central Australia will most probably be even greater. Temperature rises in central Australia will be greater than in coastal areas. The cost of food and energy in remote communities is already much higher than in urban centres and this differential is likely to increase. In addition, sea-level rise will damage coastal wetlands and so lead to reduced access to an important source of nutrition and a loss of culturally and spiritually valuable activities such as hunting and gathering and caring for Country.3

As we have a responsibility to promote wellbeing and prevent disease, we should be active in reducing the carbon emissions that are the cause of this ill health in the first place. As a College, we can do so directly in relation to the carbon footprint of the health industry and by advocating within the broader society about the urgent need for readily and widely available renewable energy sources and energy efficiency measures and technologies.

Beyond the direct benefits of reducing carbon emissions, many of the strategies to do so would have the additional benefit of improving health status in other ways. For example, reducing carbon emissions from coal and petroleum would also reduce ill health due to air pollution, increasing the use of public transport could reduce road traffic trauma, increasing active transport such as walking and cycling would lead to improvements in obesity, diabetes and cardiovascular disease, and reducing consumption of red meat and associated saturated fat could lead to reductions in cancers and ischaemic heart disease.

The health care sector itself is a major producer of greenhouse gases. For example, the National Health Service (NHS) in the UK has calculated its carbon footprint at more than 18 million tonnes of CO₂ per year, which comprises 25% of total public sector emissions and 3.2% of all emissions in the UK.4 It is highly likely that the Australian health care sector is responsible for a similar proportion of government CO₂ emissions. In the Northern Territory, the Department of Health and Families was responsible for 38% of all government agency emissions in 2007-08, while in Victoria in 2002-03.

However, much more important than these is the impact of food and water insecurity. Many parts of the world will have an overall reduction in rainfall and more frequent droughts, and will be more prone to flooding when rain does come. This will lead to a widespread reduction in the production of food. Sea-level rise will exacerbate this as the soil in many coastal areas will no longer support food crops. The effect will be that tens, if not hundreds, of millions of people will have to live with less water, less food and less money. Social and political instability will follow and many will become climate refugees forced to move in search of the basic necessities of life.

So far, the overwhelming majority of people suffering and dying from climate change have been in developing countries. But developed countries, and Australia in particular, are not being spared. In the 2003 summer heat waves in Europe, there were an estimated 70,000 additional deaths.3 In early 2009, heat waves in southern Australia were accompanied by hundreds of unexpected deaths, mainly of old people, with 374 in Victoria alone.4 And then of course there were the Victorian bush fires.

Of all the developed world, Australia is likely to be the country most affected by climate change.5 Australia will probably adapt well to changes in vector-borne diseases and increased heat waves, but agricultural production could decline substantially. If there is no change to the current trend in greenhouse gas emissions, it is estimated that agricultural production in the Murray Darling Basin will decline by 12% by 2030, 49% by 2050 and 92% by 2100.5 If it does, then the price of food will rise substantially and result in poorer nutrition for Australians at the lower end of the socio-economic scale. The negative effect on the livelihoods and wellbeing of many rural communities already under stress from the drought will only get worse.

Australia will also be under pressure from significant numbers of climate refugees from the Pacific island nations and south and south-east Asia. It is thought that even under a best case scenario, climate change will increase the number of displaced people in the Asia Pacific region by hundreds of thousands, many of whom are likely to look towards Australia and northern Australia in particular.

Throughout the world, marginalised populations and economically disadvantaged people will be the ones most adversely affected by climate change.
public hospitals, health care facilities and nursing homes accounted for 60% of all Victorian government energy use.11

With their direct knowledge of the health effects, their public health expertise, their ability to bring an understanding of evidence to policy development and their credibility in society, [health professionals] are well placed ... to advocate for change.

There is much that health care professionals can do to reduce carbon emissions by action at the level of their own work unit, or by macro level system approaches such as hospital energy co-generation systems. For example:

- The NHS in the UK has established a Sustainable Development Unit to drive its Carbon Reduction Strategy. Their aim is to reduce 2007 NHS carbon emissions by 10% by 2015 as part of the UK’s aim to reduce total emissions by 26% by 2020 and 80% by 2050.11

- The World Health Organisation has recently published a discussion paper detailing seven elements of a climate-friendly hospital: energy efficiency; green building design; alternative electricity generation, transportation for staff and patients, food which is locally grown and nutritious, waste reduction and recycling, and conservation of water, including safe alternatives to bottled water.13

- In the US, Practice Greenhealth has created an energy impact calculator for hospitals, which allows an understanding of some of the health co-benefits which can be gained through energy efficiency and on-site energy generation (available at www.practicegreenhealth.org/tools/etc).

- In New South Wales, the Sydney West Area Health Service has already embarked upon a comprehensive strategy of efficiency actions and infrastructure investments to reduce its water and energy use.14

- Doctors for the Environment Australia has developed a resource of practical tips to help doctors reduce the energy use of their practices (see www.dea.org).

But health care professionals can and should do more. With their direct knowledge of the health effects, their public health expertise, their ability to bring an understanding of evidence to policy development and their credibility in society, they are well placed and indeed have a responsibility to advocate for change in the rest of society: in the community and with government and industry.

Several of the world’s leading medical journals, most notably the Lancet, have devoted a great deal of space in recent years to the health impacts of climate change and the need for broad societal action, including in late 2009 a series on the health benefits of a range of strategies to reduce greenhouse gas emissions.15,16 In May this year, the presidents of the colleges of physicians and surgeons from 12 countries, including the College, exhorted doctors to demand that politicians heed the health effects of climate change and not waste the opportunity for action at the UN Copenhagen Conference on climate change.17

At the 2009 College Physicians Week there was a joint College Plenary and an Australasian Faculty of Public Health Medicine Plenary on the subject of climate change, as well as an interactive session. In those discussions it was agreed, with the support of the College President and CEO, that the likely impact of Climate Change was of such importance to the health and wellbeing of Australian society that the College should act to reduce its carbon footprint and also to advocate for action in both mitigating and adapting to climate change. A large number of Fellows and trainees volunteered on the day to help and many more have done so since. A Climate Change Working Group has been formed and it held a workshop in November. Three themes for action were developed:

- To reduce the carbon footprint of RACP itself, its Fellows in their practices and the health care sector more broadly
- To enhance the nexus between physical activity and the built environment and transport systems and between nutrition and the food industry, with an emphasis on health and climate co-benefits
- To foster debate on international development and population issues.

Each theme has a smaller working group with responsibility for developing and implementing a plan of action for the next 12 months. The College has established a climate change webpage which contains details of these plans along with other resources and links.

Climate change is happening now and it is not just bad for ‘the environment’. It is bad for us and bad for our patients. It is damaging the lives of real people today. It is a serious situation but there is much we can do. The evidence is there for the College to be advocating for change within the health care sector and within society as a whole to both adapt to and prevent climate change. It is what we need to do to keep the climate, and ourselves, safe.

Dr Steven Skov FRACP
Chair, RACP Climate Change Working Group

References


MEDICO-LEGAL EXPERT ADVISORY GROUP

The purpose of this article is to introduce the Medico-Legal Expert Advisory Group (EAG) to the College Fellowship. Initially under the auspices of the Education Deanery, after a good deal of discussion it was decided to relocate it within Policy and Advocacy. The Chair of the EAG sits on the College Policy and Advocacy Committee (CPAC).

The responsibilities of the EAG are set out in the By-laws which were approved by the RACP Board in May 2008. They are as follows:

a) To assist the College to develop appropriate policy on medico-legal matters including provision of expert medico-legal evidence and medico-legal claims

b) To inform and educate Fellows and trainees about their legal obligations in specialist practice, including new legal issues and developments, new cases and new legislation

c) To assist with the development of educational resources linked to the College curriculum

d) To provide relevant committees and the Board with advice on appropriate submissions to any legislative reviews, hearings or commissions on matters affecting specialist practice

e) To liaise with the legal profession on matters of common interest.

The learning objectives in the Curriculum provide a good starting point for an understanding of how the law impacts on physician practice. This publication is recommended to all Fellows and trainees.

In 2009 the EAG relocated to Policy and Advocacy and a call was made for members. The response was overwhelming and it is hoped that the EAG has a balanced and representative membership reflective of the make-up of the College professionally and geographically.

The EAG has discussed the areas on which it will concentrate to ensure that it fulfils the responsibilities set out in the By-laws. Work has commenced in the areas of autonomy and beneficence; medico-legal implications of multi-disciplinary team care of patients; and the legal status of guidelines. The latter will be the topic of a breakfast session at the WCIM to be held in Melbourne in March.

The most pressing activity for the EAG is to provide a paper to the College Board on the subject of the expert witness.

The EAG does not intend to intrude into areas that are the province of Medical Boards and the Medical Defence Organisations. However, there may inevitably be some overlap.

During its first year of operation, the EAG was involved in the preparation of an education module for overseas trained physicians as an introduction to the medico-legal system. The EAG was also made aware of a 2007 College publication entitled ‘Professional Qualities Curriculum’. One of the themes in that publication is ethics, with a sub-theme of ethics and health law. This linkage caused some confusion around the establishment of the Medico-Legal EAG because it was felt that the two areas could be covered by the Ethics EAG. This was resolved with the establishment of a separate Medico-Legal EAG, with the Chair of the Ethics EAG sitting on the Medico-Legal EAG and vice versa.

The college with the most comprehensive publications on medico-legal issues is the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
If you do not provide medico-legal reports and you do not appear as an expert witness, then this process will not concern you. One wonders, however, how you could avoid providing a medico-legal report at some stage in your career because most patients will require one for some authority or other at some time and this must be regarded as part of your professional responsibility to them.

The process of preparing a paper for presentation to the Board will commence as soon as possible. It will most likely involve the following steps:

1. Arguments for and against an expert witness register will be put on the medico-legal EAG webpage, and Fellows will be given the opportunity to respond on the webpage within a particular time frame.

2. At the end of this period the comments will be collated and incorporated into a paper to be presented to the College Board via the CPAC.

If the concept of an expert witness register is accepted, the mechanics of the register will be developed after that. It does not seem sensible to spend a lot of time on these issues if the concept is rejected.

Communicating with the Fellowship

A website will be developed, containing material that will enable us to fulfill our responsibilities under b) and c) above. Links will be provided to other sites. It is hoped that this will enable the Fellowship to contribute to decisions, commentary and articles on issues that fit into our area of responsibility. The sphere is vast as we are dealing with the legal systems of two countries, one of which has a Commonwealth system embracing six states and two territories.

Any comments or questions relating to the work of this EAG can be directed to Mary Osborn at: Mary.Osborn@racp.edu.au.

The support of the late Craig Patterson in initiating the process which resulted in the establishment of this EAG is acknowledged.

Christopher W. Clarke FRACP
Chair, Medico-Legal EAG

For a number of years the College has been considering how partnerships between universities and the College can be improved, particularly in relation to supporting and nurturing the development of future medical academics. Few trainees today are equipping themselves with the requisite skills and competencies for academic medicine.

This situation is not pertinent to Australia alone; the cause has been taken up at a global level by the Lancet and others in an attempt to clarify the issues and find ways to increase the number of medical academics being trained. A paucity of medical academics has negative consequences for our health system. First, there will be fewer people in the system able to provide leadership at a local level on academic aspects of medicine, in particular, research and education. Second, medical academics have an important role to play in providing policy advice to governments and other organisations—the voice of medical academics is listened to by those who make important policy decisions for the future benefit of our health system. It is therefore critically important that training organisations, such as the RACP, consider their role in the development of future medical academics. It is our duty to ensure that we are able to offer a training program that supports medical academia.

Against this background, the RACP Education Deanery employed a Project Officer, Associate Professor Tim Shaw, from the University of Sydney. The aim of the project was to explore ways the RACP could work in partnership with universities to train doctors in medical academia.

There were a number of outcomes from this project, but one of the most important was a recommendation that a Medical Academic Stream be developed within the College. The Medical Academic Stream would specialise in training trainees who wanted to become medical academics. In a sense, their training path would be like the joint training programs that now exist between two Colleges, for example, the Joint Specialist Advisory Committees in Haematology and Microbiology. However, the partnership in this model would not be with other colleges but would be with the university to which the trainee was attached.

The College has written to all University Medical Schools to inform them of this proposed initiative and to seek expressions of interest. We have received many. The University of Sydney has established a small working group with senior members of the College to explore further the possibilities for supporting medical academic training. The outcome from this short-term working group was a recommendation to the Board for the establishment of an Academic Specialist Advisory Committee (SAC) to support a Medical Academic Stream of training. The Board has endorsed this recommendation.

The intention then during 2010 is for the Deanery, along with the Divisions, Faculties and Chapters, to develop a program that would be appropriate for trainees wishing to train in medical academia. Such trainees would fall under the authority of an Academic SAC at the Advanced Training level. They would also have a relationship with the university to which they are attached. This Medical Academic Stream has yet to be fully clarified, but it is likely to have either a PhD in Research as a component of training, or an EdD/PhD in Medical Education. The other alternative would be a combination of Research and Medical Education of significant substance. The trainee would then graduate with a combined FRACP and appropriate doctorate.

This is an exciting initiative for the College. Supporting medical academic training, and partnerships with universities, can only be good for trainees, our training program, and the future health and university workforce.

Professor Kevin Forsyth
Dean
Associate Professor Michael Hooper
President, Adult Medicine Division
Co-Chair, Universities Working Party

Supporting medical academic training, and partnerships with universities, can only be good for trainees, our training program, and the future health and university workforce.
ACHIEVEMENTS OF 2009
DIRECTIONS FOR 2010

Educational developments in 2009

Fellows and trainees will be aware of lots of developments educationally in the College during 2009. There is a strong sense of productive and inspirational developments that are positively positioning our College for both AMC accreditation and provision of leadership in postgraduate medical education.

To summarise some of these:

- There has been considerable refinement of the Basic Training Portal (BTP). The enhancements have occurred in the e-learning environment which supports trainees and supervisors in undertaking the program requirements within PREP Basic Training. Each trainee has their own login for the BTP and nominated supervisors or ward consultants who work with trainees around their learning needs or Mini-CEX now have access to that part of the BTP as well.

- The curricula for Advanced Training continue to be worked on by the Curriculum Development Team within the Deanery and by the many Fellows within the different disciplines of the College. These Fellows are undertaking superb work in the development and shaping of the curricula for Advanced Training, with the Curriculum Team within the Deanery ensuring consistency of approach and standard across the 49 curricula.

- The Teaching & Learning frameworks for Advanced Training are also being refined. Clearly these will be very similar to the PREP Basic Training frameworks such as Learning Needs Analysis, Significant Incident Analysis and formative clinical assessment tools, although there will be more reliance on Case Based Discussion at the Advanced Training level rather than the Mini-CEX, as is currently the case for Basic Training.

- Work has begun on an Advanced Training Portal to support trainees who will be undertaking PREP Advanced Training, with an e-learning environment similar to that available to Basic Trainees with the Basic Training Portal.

- A number of education policies have been developed during 2009.

These policies relate to training requirements, the ability of Fellows with an FRACP to be recognised in a different specialty, implementation of training programs, CPD and the requirements for ongoing practice.

- There have been numerous workshops throughout Australia and New Zealand during 2009 to support trainees, supervisors and Fellows in becoming equipped with knowledge about the new PREP program and its requirements and tools.

The Education Committees have worked hard at supporting training for their respective trainees. It is worth noting that the College has more than 4,600 trainees and is therefore the largest medical education enterprise in Australia and New Zealand and possibly the Southern Hemisphere.

Looking forward in 2010

Following is a very brief snapshot of activities the Education Deanery will undertake in 2010:

- The AMC will be visiting the College mid-year as part of their accreditation plan.

- There will be emphasis during 2010 on ensuring uptake of the new PREP Program for basic trainees (PREP:BT). The appointment of Medical Education Officers (MEOs), based in State offices across Australia, is an important initiative. Their role is to support Fellows, supervisors and trainees in fostering a greater knowledge of the PREP program. We hope that as the MEOs interact at State level, both trainees and supervisors will be better prepared to undertake the PREP program requirements. This is a critical mission for the College and has strong endorsement from the College Board.

- Throughout 2010 numerous workshops will be undertaken on the new education developments. Fellows are strongly encouraged to attend these workshops. The year will begin with a series of Dean’s Welcome Meetings across Australia and New Zealand, but of course there will be numerous workshops offered locally by the Medical Education Officers.

- This year will also see major refinements in PREP Advanced Training (PREP:AT) which will begin to be implemented in 2011. The progress in Advanced Training relies on the development of the curricula in each specialty. The project plan for PREP AT11 requires us to further refine the Teaching & Learning frameworks and the formative assessments. These are already well developed. Some of the SACs and STCs wish to pilot aspects of the new PREP:AT programs during the latter part of 2010.

- CPD will continue to be developed as a resource for our Fellows. At the moment, we have the ‘reporting engine’ online (MYCPD). We are working on a resource portal that will house specific CPD content for the availability of our Fellows. We also wish to see an expansion of support for Fellows around the Professional Qualities Curriculum and for their ability to participate in activities, workshops and content around the Professional Qualities domain. These domains include medical ethics, quality and safety, cultural competency, communication, leadership and management.

- The College is also working on ensuring that it has a systematic approach to content delivery. There are at present a number of lecture series run in various ways mostly through videoconferencing. We are increasingly turning our attention to podcasts as an efficient way to deliver content either by audio only or audio and video, which can be downloaded by Fellows and trainees, as required. This aspect of supporting trainees and Fellows through podcasting will see considerable developments during 2010.

I am very grateful to our many Fellows who contribute their expertise and time to support these developments and, of course, the thousands of Fellows who support trainees on a regular basis in the workplace. Without your input and engagement none of them would be possible.

This will be an interesting year, with many developments in education. I hope to bring to our Fellows and trainees a sense that there is forward movement and educational leadership provided by the RACP.

Professor Kevin Forsyth
Dean
INTRODUCING OUR MEDICAL EDUCATION OFFICERS

Fellows and trainees will be well aware of many of the new developments in education. There is a much greater need for support in supervision in this new era. How do we equip you, as Fellows, to know and understand the new education tools? Well, workshops are an important way for this to happen, but workshops occur intermittently. Reading articles such as this also helps. But an important strategy the College has adopted for 2010 and beyond is the appointment of regional Medical Education Officers. These people have been appointed at a State level to support Fellows and trainees in the new education initiatives. They will be directed at a State level by the Chair of the College State Committee, and they will be supported administratively by State Office Managers and with content by the Education Deanery.

The MEOs are there to support you. If there are concerns you have about knowledge of the new education program, the new education tools or the electronic learning environments for supervisors and trainees, then your local MEO can help you out. Indeed, the MEOs will be on the road frequently, attending hospitals and meeting with trainees and Fellows on a regular basis to support you in your endeavours with the new education program.

I welcome all the MEOs to the College. This is an important initiative. They are a resource for you based locally. Please utilise their expertise to the full.

Professor Kevin Forsyth
Dean

Elizabeth Kennedy – SA
Mobile: 0488 466 422
Email: Elizabeth.Kennedy@racp.edu.au
Hi, I am the MEO for South Australia. I answer to Elizabeth or Liz, so please feel free to use either. I am originally from Bristol in the UK, which you will probably know from my rolling “R”. When you talk to me, I trained as a nurse in England and have worked in general and surgical arenas, with specialty experience in many areas such as PICU, Paediatric Casualty, Maternity, Infectious Diseases, and Cardiothoracic surgery, theatre and recovery in both the UK and Australia. I have also had additional and interesting experiences as an industrial nurse.

I arrived in Australia, at Sydney, in 1986, and moved to Adelaide five years ago. For the past 14 years I have been involved in the education of clinical and non-clinical health employees, student mentoring, incident management, including WorkCover and rehabilitation programs, risk assessment, falls prevention, occupational health and safety, and software development of the AIMS program, an incident management system, including ontology development. This previous role encompassed collaboration with the World Health Organisation (WHO) and interstate and international department of health representatives, training and support of South African clients and managing pilot programs for various university and private health service projects.

I have been involved in community projects such as the Safety House Program in Gerringong and Gerringa in NSW, which required liaising with the police department, local businesses, residents, child-care and school facilities, media and other community groups such as Neighbourhood Watch to re-establish, educate, inform and promote the program.

You will frequently hear me mention three statements, which are “There are no problems, only opportunities”, “My knowledge is a work in progress” and “Communication is the key”.

On a personal note, I have a very supportive partner and two adult sons, who of course are gorgeous! I enjoy a good social life with family and friends; I relish experiences from opera to science fiction across all genres; and I am partial to watching a good game of cricket. I enjoy a chat, so feel free to contact me.

Jeanette D’Castro – WA
Mobile: 0488 466 344
Email: Jeanette.DCastro@racp.edu.au
I’m the new Medical Education Officer for Western Australia. I started in mid-November 2009, so I’m relatively new to the College. This role will be a change from what I have previously done throughout my career, so I’m looking forward to the challenge. I am an accountant by profession with significant experience in health and aged care. I have a post-graduate degree in Health Services Management and have held management positions in both the private and public sector. I have worked in two of the major teaching hospitals in WA, so hopefully I can draw on the contacts I’ve made in the past to assist me with this new role. As you can imagine, I have seen many changes in this constantly changing environment. So to be part of the process when the College is implementing a new education paradigm is exciting.

In my spare time (when will that be with a new role!) I love travelling, cooking, dining out, pilates and ballroom dancing. I would like to do more exercise this year, so maybe I’ll give yoga a try.

Kate Breen – VIC and TAS
Mobile: 0488 466 955
Email: Kate.Breen@racp.edu.au
I am one of the new MEOs for Victoria and Tasmania. In Victoria, I will be specialising in Paediatrics. My background is in higher education, having spent five years with Monash University in Melbourne designing and
implementing online admission systems. More recently, I have been a Project Manager specialising in research contracts at Southern Cross University in Lismore, NSW. I have post-graduate qualifications in Policy and Management and have spent many (earlier) years working in law courts, government and law firms all over Australia and in the UK.

I am experienced in online implementation and am happy to assist trainees and supervisors in becoming familiar with the PREP program and its associated online tools. I am always open to new ideas and suggestions and I am happy to feed back suggestions to the College. I welcome your contact; I am here to assist you with the PREP program, so if you see me at any functions or you are in the Melbourne office come over and say hello.

Personally, I enjoy travel and spent two months in 2009 travelling through the US and Canada. I enjoy the cultural highlights of Melbourne, especially the free MSO concerts and the Australian Ballet. I have a very spoilt dog and a great partner.

Alexis Marsh – VIC and TAS
Mobile: 0488 466 999
Email: Alexis.Marsh@racp.edu.au

I am one of the Medical Education Officers for Victoria and Tasmania, specialising in the Adult Medicine Division. My background is in communications in the education, science and health sectors. Previous roles include working at the Royal Australian College of General Practitioners as the Communications and Accreditation Officer for NSW and Tasmania, and streamlining administration procedures and training my counterparts as the Regional Training Providers. I then spent a year travelling throughout the UK, USA and South America, stopping to work in London as the Internal Communication Specialist at the Institute of Physics for a six-month contract role. On returning to Melbourne, I took up a role at The Institute of Chartered Accountants as an Event Specialist, which included recruiting and managing Educational Supervisors to run the Chartered Accountants Program in both Victoria and Tasmania.

More recently, I spent another year abroad, working as a Research Assistant at Cork University Dental School and Hospital in Ireland where the majority of my time was spent supporting the Professor of Orthodontics and managing the postgraduates.

I have a double degree in Business and Commerce and Communications, majoring in Public Relations, and have always loved working for membership-based organisations as the passion of the members is what drives me.

Being from Wangaratta originally and then growing up in Bairnsdale, I have a special interest in regional issues and am passionate about ensuring that my skills are utilised throughout Victoria and Tasmania in their entirety. I am looking forward to meeting and working with you during 2010 and hope to be out at your hospitals shortly.

Hi, I’m 28, a Pisces and enjoy long walks on the beach, though more importantly I’m also the newly appointed MEO for Queensland!

I’m originally from Canberra, and after finishing school I packed up and relocated overseas for a few years. When I returned to Australia with a very odd accent, I moved up to Brisbane to study Animal Science at the University of Queensland. After graduation, I worked for the RSPCA and a specialist veterinary clinic before starting with SPOT (Safe Pets Out There), an education program focused on safety around dogs for children aged five to eight years. After leaving SPOT, I landed at the Royal Australian and New Zealand College of Radiologists’ Sydney office, sparking my love affair with health! I was the Executive Assistant for the Faculty of Radiation Oncology and the Education Officer for the Southern NSW Radiation Oncology Training Network. I believe the knowledge and skills I developed at RANZCR will be a great foundation for my role with RACP.

In March 2009, it was necessary that I move back to Brisbane—my spiritual home. Upon returning, I took up a contract position organising a Youth Mental Health Public Forum for the Queensland Schizophrenia Research Foundation. Quite a different scene from Radiation Oncology!

Having surfaced in yet another mysterious area of health, I can honestly say I am really looking forward to diving in and enjoying the upcoming challenges and rewards. Away from work, I love barbecues with friends, live music and living the Queensland lifestyle!

Andrew Ferguson – NSW
Mobile: 0427 046 099
Email: Andrew.Ferguson@racp.edu.au

I am the MEO for NSW and the ACT. My background is in educational psychology and practice, theatre and English, and I hold a Bachelor of Arts and a Bachelor of Education from the University of New South Wales. Having taught Drama and English for several years in Sydney and London, I moved to Duke Corporate Education where I helped develop and deliver engaging and immersive leadership learning experiences for managers and executives from Fortune 500 companies. During this time at Duke, based first in London and later in New York City, I delivered programs in over a dozen countries in North America, Europe, Asia and Africa.

On returning to Sydney, I worked for the University of Sydney as an International Projects Manager prior to joining the College. I’m looking forward to further developing the College’s training profile and assisting trainees and physicians in the roll-out of PREP.

Note: Funds have been provided for an MEO in the Northern Territory. An MEO had been appointed but she was unable to assume her position due to health issues. The position is being readvertised and we will feature the NT MEO in a subsequent edition of RACP News.
Accreditation of training settings is an AMC requirement and a significant ongoing College activity over many years by committees that oversee training in the Divisions, Chapters and Faculties, each according to its own guidelines and process. In 2009, the Expert Advisory Group in Accreditation recommended a new policy on accreditation of training settings, which was ratified by the College Education Committee. This new policy will be effective from January 2011. The policy is accompanied by the RACP Standards for Accreditation of Training Settings, which are 16 broad standards to be used as an overarching framework of criteria for accreditation of training sites by all specialties.

In preparation for implementation of the policy and standards, existing site accreditation criteria are undergoing review to align them with the policy and the RACP standards. This review of site accreditation criteria is very timely. New curricula for Basic Training are already in place, and new Advanced Training curricula (PREP AT11) will be rolled out in 2011. It is crucial that criteria for the accreditation of training sites address the capacity of the site to provide a profile of work, facilities, and teaching and learning activities that are consistent with the objectives set out in the curricula.

The review is especially vital for Basic Training. While the aim of Basic Training—to provide trainees with broad-based clinical exposure to general medicine and general paediatrics plus a variable range of specialties to be developed in subsequent specialty programs—remains unchanged, the environment for training has grown and evolved, making an update to criteria essential.

Accreditation is an important means to ensure that there is enough supervision for increasing numbers of trainees at the level of individual departments and smaller settings.

The current Basic Training criteria emphasise university affiliation of hospitals and assume most training takes place in these large metropolitan sites. However, tertiary and university hospitals are no longer expected to be the sole providers of training. Outpatient clinics able to provide ambulatory exposure to trainees may not be co-located with hospitals or may be found in smaller settings. Occasionally, larger hospitals have moved whole departments into smaller satellite facilities that may not be accredited for training, reducing the availability of specialty experience in large hospitals. Smaller public hospitals are increasingly becoming direct employers of basic trainees, whether as stand-alone training sites or as part of a training network. At the same time, the number of trainees has increased significantly, doubling since 2004.

Accreditation is an important means to ensure that there is enough supervision for increasing numbers of trainees at the level of individual departments and smaller settings. New criteria need to be flexible enough to apply to a variety of settings. The new policy has expanded the scope of accreditation beyond ‘site’ accreditation to accreditation of ‘training settings’, which can include networks and multiple facilities.

Perhaps the single most significant change is the Basic Training Physician Readiness for Expert Practice (PREP) program. Under PREP, trainees manage their own learning experience, with comprehensive guidance, support and feedback from their supervisors. The Basic Training Curriculum provides a road map for trainees to plan their learning journey and navigate using online tools, including Learning Needs Analysis (LNA). Teaching and learning is given further structure through the use of formative assessments such as Mini-CEX and SIAT. Under the time-based program, supervision at the department level of Basic Training hospitals was unstructured and informal, with the official ‘sign off’ for time done by a single College representative who may not have had significant contact with all trainees. The new criteria must not only ensure that there is sufficient supervision for increasing numbers of trainees, but also that it is formalised, allowing trainees to complete PREP requirements.

New criteria for Basic Training are in draft form and will be finalised early this year following extensive consultation with Directors of Physician Training/ Paediatric Physician Training and Directors of Physician Education. The draft criteria contain detailed and specific requirements, especially around supervision, educational activities and trainee support. This work is being overseen by the Accreditation Subcommittees of the Education Committees of the Divisions, in conjunction with the Expert Advisory Group on Accreditation.

New criteria for both Basic Training and the specialty groups in Advanced Training will be published on the College website six months prior to implementation. New application forms will also be published, using a template consistent across all specialties, facilitating a consistent approach to accreditation of training settings College-wide. Fellows interested in learning more about the policy and standards for accreditation of training settings can view the policy at: www.racp.edu.au/page/education-policies. More information on accreditation of sites for Basic Training is available by contacting Eleanor Cameron in the Site Accreditation Unit, Education Deanery at: Accreditation@racp.edu.au.

Eleanor Cameron
Executive Officer
Site Accreditation, Education Deanery
AMC ACCREDITATION OF THE RACP: AN UPDATE

The AMC required submission of an annual report from the College in September 2009. This report addressed the 49 recommendations made by the AMC in its 2008 accreditation report on the College’s education and training and continuing professional development programs. We expect a response from the AMC in due course.

The College is continuing to monitor progress made against the recommendations and a further submission by the College is due in July 2010. The key issues that the AMC will want to see advanced include:

- implementation of the PREP Basic Training program
- development of curricula for Advanced Training programs
- defining assessments for Advanced Training programs
- development of the teaching and learning framework
- implementation of criterion-referenced assessments
- creation of supervision frameworks and provision of support for supervisors.

The first point, implementation of PREP Basic Training, is perhaps the most problematic issue. The College has now appointed Medical Education Officers to support Fellows, supervisors and trainees at a local level. They will be assisting trainees to meet the PREP program requirements by equipping supervisors and Fellows with knowledge of the PREP components. They will also be working with trainees to assist them in the use of the College e-learning tools (the Basic Training Portal). Although New Zealand does not have Medical Education Officers, there will be, through New Zealand, a comprehensive suite of workshops on the PREP program as part of the Dean’s Welcome series, probably in April. These workshops will be run by the Dean, the NZ President, the President-elect and the NZ General Manager. The College Board and the AMC wish to see rapid uptake of PREP training by trainees.

The College’s accreditation submissions and the 2008 AMC accreditation report on the College are available on the website—follow the About RACP link from the homepage.

Professor Kevin Forsyth
Dean

CALL FOR EXPRESSIONS OF INTEREST: MEMBERSHIP OF ACCREDITATION SUBCOMMITTEES AND SITE VISITORS FOR ACCREDITATION OF HOSPITALS FOR BASIC TRAINING

The accreditation of hospitals for Basic Training is essential in ensuring high-quality training environments for basic physician and basic paediatric physician training. Members of the Accreditation Subcommittees of the Adult Medicine Division Education Committee (AMDEC) and the Paediatrics & Child Health Division Education Committee (PDEC) are responsible for accreditation of hospitals. Assisting them is a dedicated group of around 30 Fellows who provide their time and expertise as site visitors.

The subcommittees are currently seeking expressions of interest from Fellows who would be willing to join the subcommittees, or participate in site visits for the accreditation of hospitals for Basic Training. Having a large cohort of Fellows involved will ensure that the amount of time given by individuals is kept to a minimum. The PDEC is particularly in need of members and site visitors. Having a critical mass of Fellows involved in this work is currently vital as the criteria for accreditation are being reviewed and expanded in line with the new policy for accreditation of training settings that will come into effect in 2011.

Many site visitors are Directors of Physician or Paediatric Training who enjoy the opportunity to share and learn from each other in the course of visits. In many cases, site visitors get the chance to travel interstate or to regional hospitals where training environments can be different from their own. Retired or semi-retired Fellows enjoy site visits as a chance to reconnect with their peers.

Each subcommittee meets three or four times per year by teleconference and also face to face at the College in Sydney.

For further information please contact Eleanor Cameron, Executive Officer, Site Accreditation at 02 8247 6233 or at Accreditation@racp.edu.au.
MyCPD

‘MyCPD is easy to use and makes me more aware of my learning and professional development needs. It provides a simple way of recording CPD activities to fulfil credentialling and registration requirements.’

Catherine, middle-aged female, full-time hospital geriatrician and general physician, late adopter of technology (if this doesn’t sound familiar, see www.facebook.com/pages/Youll-Love-Coles-Testimonials)

MyCPD is the new continuing professional development (CPD) program for Fellows of the RACP (see the College website: www.racp.edu.au/mycpd). We learned to use MOPS (Maintenance of Professional Standards), but participation rates were low. MOPS was essentially a record of activities rather than a personal plan to identify, undertake and then reflect on professional education and development.

To summarise the comments of the President of the College, Professor Geoffrey Metz, in the August 2009 edition of RACP News:

Almost all Fellows undertake some form of continuing professional development (CPD), though many do not report to a CPD program. The New Zealand Medical Council introduced mandatory CPD for all its medical practitioners in 2001. In Australia, eight of fourteen medical colleges have mandatory CPD requirements.

In 2009, the Board of the College decided that CPD should also be mandatory for Fellows in recognition of mandatory CPD being beneficial for both standards of practice and expectations in the community, and also because it is virtually certain that involvement in CPD will be a requirement for medical registration from 2010 or 2011.

Of course I agreed with this in principle, but there were always more urgent things than recording CPD activities. However, one evening, a few months ago, when I had finally cleared the emails and was about to attend a Board meeting, I logged on to MyCPD. I had already filed the various helpful publications sent by the College somewhere safe and out of sight, but that was no obstacle because they are all there, easily accessible, on the website—MyCPD Brochure, MyCPD Guide and MyCPD Help.

There are three easy principles:
1. Plan your learning.
2. Record your learning.
3. Reflect on your learning.

Those of us who teach medical students, interns and trainees are now acquainted with the ideas of learning objectives and logbooks, and it is part of the way we interact with them to try to ensure that they are not just observing but really acquiring the skills they need. So the principles of adult learning, which are integral to the MyCPD program, are familiar to us, and in the short time I have used the program it has already helped me to focus not just on attending grand rounds, listening to a lecture or reading an article, but on how these activities contributes to ‘keeping up to date, practising evidence-based medicine and providing best practice care’—the essentials for a clinician.

Most of us will not participate in all the six areas which are listed, but these options give scope for all physicians to use the program. For example, as a hospital-based physician who teaches students and junior staff, attends hospital meetings and a couple of conferences, and has a large pile of only partly read medical journals, I had reached the minimum annual requirement of 100 points by about the middle of the year in the following:

1. Educational Development, Teaching and Research: for me, teaching, supervision, mentoring, examining
2. Group Learning Activities: for me, seminars, conferences, workshops
3. Practice Review and Appraisal: for me, clinical audits, incident reporting/monitoring
4. Other Learning Activities: for me, grand rounds, journal clubs, ward rounds, hospital and other medical meetings, preparation for teaching.

So getting the points up is not difficult. Nor is recording activities. Having become familiar with the program, which took about 10 minutes, it takes me, at most, about one minute to log on and record an activity, and I have now got into the habit of entering this in the evening when I sit down at my desk. Much better than trying to do the MOPS form at the end of the year by going back through the diary!

Documentation is not difficult—just keep a folder with rosters for journal clubs, grand rounds programs, timetables for student teaching, certificates of attendance, conference programs. (I was audited once in the MOPS program.) Or you can upload the documents—I have not tried this yet; in fact, there are quite a few features of the program which await further exploration.

More importantly, I find the learning outcomes in the reflection section—I am aware of / have confirmed / am planning to / am committed to a potential gap in my knowledge or skill / new evidence or new skill relevant to my practice—really do make me think about the purpose of participating in various medical education activities, rather than just accumulating enough points. I confess I have not gained any bonus points for reflective comments, but acknowledge the value of this. I have used the program at a fairly basic level, but it really has much more potential to be a formative part of any physician’s own ongoing professional development, as well as providing recognised documentation as required to continue to practice.
As you should be aware, the National Registration and Accreditation Scheme (NRAS) is likely to be implemented throughout Australia from 1 July 2010. One of the key requirements is that medical practitioners engaged in active practice need to participate in relevant continuing professional development (CPD) to maintain their annual registration.

The Royal Australasian College of Physicians (RACP) will be adopting mandatory CPD in line with the proposed National Registration legislation. The College will enforce this from 1 January 2011, with non-compliance resulting in removal of Fellowship, effective from 1 January 2013.

The College understands that many of our Fellows who are active in medicine are already attending to their own educational CPD needs. However, under mandatory CPD, it will be a requirement that all CPD activities are recorded and structured within an accredited CPD framework. The vast majority of physicians will not find mandatory CPD particularly onerous as they are already participating in regular CPD activities.

MyCPD is an accredited CPD program which is streamlined, user friendly and easily available online at www.racp.edu.au/mycpd. It recognises a suite of learning activities to suit all types of practice. These include teaching, supervising, mentoring, research, publication, presentation, attendance at seminars and participation in self-assessment programs.

We would encourage you, if you are not already participating in an accredited CPD program, to examine MyCPD and utilise this to record your own educational developments. As part of our ongoing commitment to you, the College offers support for Fellows using the MyCPD program. If we can assist in any way, please contact the CPD team on 02 8247 6239 or email mycpd@racp.edu.au.

We look forward to your participation.

CPD Unit
Education Deanery

CALL FOR APPLICATIONS FOR A 2010 CPD GRANT

A s one of the key initiatives set up by the Royal Australasian College of Physicians, the CPD Grant is designed to promote and support education initiatives for Fellows’ continuing professional development.

The grant serves as a seed fund to provide financial assistance for the development of educational activities involving a community of Fellows that will contribute to the future continuing professional development of Fellows of the RACP.

The nature and complexity of proposed activities will vary and therefore the grant itself may not cover all costs involved.

Availability of funds

An amount of up to $5,000 will generally be approved for any application. However, this may vary at the discretion of the CPD Committee, funds available and the number of applications. We are delighted to announce that the total amount of grant funding the College is making available for the 2010 year is $40,000 for Australia and $15,000 for New Zealand.

Eligibility

All Fellows of the College from the Divisions, Chapters and Faculties in Australia and New Zealand are eligible to apply for a grant.

Please note: The funding is intended to support organisation of CPD activities for a community of Fellows, e.g. regional scientific meetings, updates, etc., and is not available to individual Fellows’ CPD undertakings.

Selection criteria

Applications will be assessed according to the following principles, with precedence given to those that align closely to them:

1. Exhibit innovation in content, design and/or method of delivery
2. Support as many Fellows as possible
3. Focus on assisting those who are unable to access the more usual channels of CPD
4. Provide the College with an enduring continuing education resource
5. Provide value for attendees and contribute to their continuing professional development.

Further information

For more information or to obtain a copy of the 2010 CPD Grant Application Kit, please contact the CPD unit of the Education Deanery via email mycpd@racp.edu.au or phone 02 8247 6239.

Closing date for applications is 31 March 2010. Unfortunately, applications received after this date cannot be considered.
WCIM 2010
In conjunction with
PHYSICIANS WEEK
20 - 25 MARCH 2010
MELBOURNE, AUSTRALIA

REGISTER NOW!
WCIM – FIRST TIME HELD IN AUSTRALASIA

Congress Hosts
The Royal Australasian College of Physicians, the
International Society of Internal Medicine, and the
Internal Medicine Society of Australia and New Zealand are pleased to invite you to attend the
World Congress of Internal Medicine 2010 to be held in Melbourne, Australia on 20–25 March 2010. WCIM 2010 will be held in conjunction with the College’s annual multi-disciplinary meeting, Physicians Week 2010.

WCIM 2010 and Physicians Week 2010 will incorporate:
+ The World Congress program
+ Internal Medicine Society of Australia and New Zealand Annual Scientific Meeting
+ RACP Annual Scientific Meeting
  (New Zealand)
+ Paediatrics & Child Health Annual Meeting
+ 18th Annual Scientific Meeting of the
  Australasian Faculty of Rehabilitation Medicine (AFRM)
+ Australasian Faculty of Occupational &
  Environmental Medicine (AFOEM) Annual
  Scientific Meeting
+ Australasian Faculty of Public Health Medicine (AFPHM) Annual Scientific Meeting

These combined meetings will provide delegates with a rich diversity of presentations to choose from, while paying a single Congress fee covering all the programs. Delegates are also invited to attend the RACP’s Annual Ceremony on Sunday, 21 March.

Congress Program
The main Congress program will be held from Monday, 22 March to Thursday, 25 March. The broad theme of the Congress is World Medicine for the Next Decade: 2010–2020. Current and future global health issues will be explored through various keynote plenary and concurrent sessions.

Throughout the Congress, several sub-themes will showcase excellence in Australian medicine and medical sciences, including science, research and innovation, health policy, clinical medicine, young people and health, medical education and healthcare technology.

For more information visit: www.wcim2010.com.au/program.asp

The Paediatrics & Child Health Annual Meeting will be held from Monday, 22 March to Wednesday, 24 March, with a program theme of Adolescent Medicine: From One Generation to the Next. A wide range of interesting topics relevant to all paediatricians will be included in the program.


Keynote Speakers
WCIM
+ The Governor of Victoria, Professor David de Kretser AC FRACP
+ The Victorian Minister for Health, The Hon. Daniel Andrews MP
+ Nobel Laureate Professor Barry Marshall AC FRACP
+ Procolia Kincaid-Smith Orator, Professor Ian Reid
+ Cottrell Lecturer, Professor Rebecca Mason
+ Professor Peter Deutschmann
+ Professor Will Steffen
+ Senator Dr Bob Brown
+ Professor Ian Gilmore

RACP Orations and Lectures
+ Dame Carol Black, Ferguson-Glass Oration (AFOEM)
+ Professor Richard Smith, Redfern Oration (AFPHM), with a response provided by Professor Stephen Leeder
+ Professor Richard Jones FRACP FAFRM, Burniston Oration (AFRM)

Paediatrics and Child Health
+ Dr Russell Viner FRACP (Paediatrics & Child Health Plenary)
+ Professor Don Robertson FRACP (Howard Williams Oration)
+ Dr Keith Grimwood FRACP (PRSANZ Plenary)
Pre-Congress Program

2010 Year of the Trainee

Initiated by the College Trainees’ Committee, Year of the Trainee will feature a number of activities at the Congress in recognition of the important role that physician and paediatric trainees play in our College, the healthcare systems of Australia and New Zealand, and our communities. The activities will include:

- Trainees’ Day – Sunday, 21 March
- Trainees’ Ball – Sunday, 21 March
- Careers Corner – Monday, 22 March to Wednesday, 24 March

To register and for more information visit: www.wcim2010.com.au/program-yott.asp

Australasian Faculty of Occupational & Environmental Medicine (AFOEM) Events

- AFOEM Annual Training Meeting – Saturday, 20 March (for AFOEM trainees)
- AFOEM Faculty Training Day – Sunday, 21 March – which will include the Ramazzini Presentations and the AFOEM Annual Members Meeting and Supervisor Workshop

To register and for more information visit: www.afoem.racp.edu.au

Department of Health employees and other hospital staff. The following four key areas will be explored from the perspective of clinicians and other staff, as well as hospital administrators:

- Update on Acute Medical Units in Australian Hospitals
- AMU Incoming: Access
- Acuity and Boundary Issues
- AMU Outgoing: Discharge Planning and Interaction with Community Resources

The AMU Satellite Meeting is supported by the Victorian Government, Department of Health

To register and for more information visit: www.wcim2010.com.au/program-amu.asp

Congress Social Functions

- Welcome Ceremony and Welcome Reception – Monday, 22 March
- Congress Dinner – Wednesday, 24 March at the Etihad Stadium. Join your colleagues for a wonderful evening of great food, entertainment and dancing. Several awards will be presented at the Congress Dinner, including the RACP Mentoring Awards.
- Paediatrics & Child Health Division Annual Dinner – Tuesday, 23 March at Atlantic, Central Pier, Docklands. Be prepared to dance the night away at this fun-filled evening!
- Trainees’ Ball – Sunday, 21 March at the Hilton on the Park. The College Trainees’ Committee warmly invite trainees and Fellows to a great night of food and dancing.
- AFOEM Dinner – Sunday 21 March at The Terrace, Royal Botanic Gardens Melbourne, South Yarra

To register and for more information visit: www.wcim2010.com.au/social.asp

Melbourne Convention and Exhibition Centre

The new Melbourne Convention and Exhibition Centre (MCEC) has a distinctly ‘Melbourne’ look and feel about it, blending effortlessly into the existing landscape as though it has always been there. Located at the heart of Melbourne city, the Centre gently curves around the banks of the Yarra River to create a riverside gateway to the city’s new South Wharf precinct, making it just a short stroll from many of the city’s restaurants, hotels and shopping areas.

To register and for more information visit: www.wcim2010.com.au
PROGRESS ON DEVELOPMENT OF COLLEGE-WIDE EDUCATION POLICIES

The Education Deanery is working to develop College-wide policies for all areas of education. An education policy framework has been mapped to determine which policies and procedures need to be written and if these can be College-wide. Policies are written by the relevant Expert Advisory Group, together with the Education Policy Executive Officer.

In 2009, 10 policies were ratified by the College Education Committee:
- Academic Honesty and Plagiarism
- Specialist Recognition in a Subspecialty of Adult Medicine or Paediatrics & Child Health without Completion of the Relevant Advanced Training Program
- Post Fellowship Training Requirements (Divisions)
- Special Consideration for Assessments
- Mini-CEX
- Continuing Professional Development Mandatory Participation
- Accreditation of Training Settings
- International Medical Graduates: Requirements for Undertaking Physician Training in Australia
- Assessment of Overseas Trained Physicians (Australia)
- Assessment of Overseas Trained Physicians (New Zealand).

In 2010, we will focus on policies relating to training and assessment tools, such as:
- Recognition of Prior Learning
- Dual Training
- Trainees in Difficulty
- Assessment.

A new page on the RACP website has been created to house all education policies that have been ratified by the College Education Committee. To view the policies, please visit: www.racp.edu.au/page/education-policies.

If you have any questions relating to education policy, please email educationpolicy@racp.edu.au.

Briony Bounds
Education Policy Executive Officer
Education Deanery

APPLICATIONS FOR ADVANCED TRAINING - 15 FEBRUARY DEADLINE

A reminder for trainees and supervisors that the 2010 Annual Applications for approval of Advanced Training are due at the College by 15 February 2010 for approval of the entire year.

Trainees who have completed Basic Training, are attempting the 2010 Written Examination and would like to apply for approval of Conditional Advanced Training need to lodge their application with the College by no later than 31 March 2010, once they know their Written Examination result.

Trainees applying for approval of Advanced Training for the second half of 2010 only should lodge their application no later than 31 August 2010.

The application form can be downloaded from our website at: www.racp.edu.au/page/educational-and-professional-development/advanced-training/applications-and-forms/

Both the trainee and supervisors must sign the form, and the original must be sent to the College.

It is recommended that trainees nominate two supervisors for their Advanced Training; however, please note that some subspecialties require two supervisors. If a trainee is unable to find a second supervisor in their subspecialty, they may nominate a supervisor from another subspecialty with whom they have a working relationship, or a remote supervisor.

If you have any questions, contact the Education Officer listed on the first page of the application form or email AdvancedTraining@racp.edu.au

SUPERVISOR SUPPORT

In 2010, the College is providing a suite of workshops to train and support supervisors. Workshops will cover a range of topics including PREP, the new training curricula and assessment tools, and supervisor skills. Information and a workshop calendar can be found on the website: http://racp.edu.au/page/educational-and-professional-development/supervisor-support

We are also developing a Community of Practice to equip Fellows in Medical Education competencies. The online community will include discussion and readings on a different Medical Education subject each month. To register your interest, please email supervisor@racp.edu.au
THE HEALTH REFORM WE DON’T NEED

On 11 December 2009, 20,600,000 entries popped up on Google when I typed in ‘health reform’. Like obesity, there’s a lot of it about. Much of it is stimulated by the desire of those who pay for health care to control new technologies that are expensive and seductive but add precious little to life expectancy. More of it comes from the need to adjust a health system built on concepts of traditional warfare to one where we deal with the new age of chronic disease management which requires an unaccustomed degree of coordination and community-based care.

The Prime Minister, Mr Kevin Rudd, has concluded an extensive ‘direct consultation with the health sector and with communities around the nation’ about the health reforms proposed by the National Health and Hospitals Reform Commission (NHHRC) whose final report was received on 30 June 2009. He has gathered first-hand information. As President Obama has done in the US, Mr Rudd has taken a deep personal interest in health reform, and this is immensely encouraging.

The report of the NHHRC is a thoughtful, expansive document that embraces the complexity of the health care system in its 123 recommendations, ranging from concerns about public hospitals through to the more arcane need for improvement in health literacy in Australia.

A cautious response to proposals for health reform followed from the Commonwealth, states and territories at their recent Council of Australian Governments (COAG) meeting. Mr Rudd had threatened that unless things improved he would seek a mandate from the people on reform, but he was speaking in muted tones after COAG.

The unfortunate acronym of COAG suggests policy thrombosis. That is unfair because COAG has taken great strides in achieving efficient Australia-wide administration and regulation in trade, labour relations, education and transport. Changes have been made in the past two years in the way states receive money from the Commonwealth, with much less earmarked funding, and much more ‘do it your way and we will hold you to account’.

Mr Rudd has made it plain that there are constraints upon health reform, not least the economy. ‘Whatever options we adopt,’ Mr Rudd declared in stentorian voice, ‘we will be adopting them within the context of fundamental fiscal discipline’.

An additional constraint is the sheer political and bureaucratic complexity of the health system, a sprawling mediaeval nation-state full of caprice, intrigue and vested interest.

Against the backdrop of Mr Rudd’s travelling consultative caravan and the 123 recommendations of the NHHRC, one idea has received disproportionate attention. It is that we should change Medicare quite radically.

The proposal calls for the establishment of perhaps three private health insurance funds, each rather like Kaiser Permanente in California or the Veterans Administration arrangement here, that have complete responsibility for every aspect of care for their enrollees.

As a moderate-sized nation sprawling across one of the largest continents on earth, our attention is drawn to the health care systems created through decades of travail and angst in two of the geographically smallest and most demographically compressed nations— the Netherlands and Israel. Neither society bears serious similarity to Australia.

Both Israel and Netherlands collect health taxes, and then distribute a capitation payment to sickness funds on an individual and prospective basis. Israel adjusts its payment for age; Netherlands adjusts its payment for age, sex, region, employment status, and disability. Employers play a role as well.

Under Medicare Select, the euphemism given to this new arrangement, we are assured there will be no managed care; the ills of the current system will disappear. Doctors will willingly move to the bush. There will be no more miscarriages in hospital emergency departments. Money, presumably a great deal of it, including $11 billion a year for public hospitals, $10 billion for the PBS and $17 million a year for the MBS, will be rolled into one pool and allocated to whichever insurer you choose to arrange your care with, according to a formula that takes account of your age and health risk.

Questions? First, what is the problem Medicare Select is meant to solve? Waiting lists, no doctors in the bush, poor mental health services? If we were clear—and this is where the NHHRC Report is weakest—on the definition of the needs that would drive reform, then we might be better able to assess the proposed solutions, including Medicare Select.

The realities are that there is a major imbalance between hospital and primary care in Australia, there is a health bureaucracy that has grown beyond the wildest imagination, there are entrenched political resistances in the medical profession and elsewhere, panthechnicians carrying chronic disease shipments are thundering down the toll way, public hospitals have been stripped and general practice struggles. Will Medicare Select help solve these problems?

Second, is what is being proposed any better for Australians’ health, rather than better for the private sector providing health care, and if so, is that a reason to change from Medicare to Medicare Select?

Third, if you worry that the current administration of Medicare is inefficient, and you would have a hard time proving that, would splitting it into three improve efficiency?

Fourth, how would competing health funds—the three or so agencies that would make up Medicare Select—be managed and by whom and with what skills? The workforce challenge would be large.

Fifth, how would we assure equity in this setting? Reflect for a moment on the problems of getting privatised Telstra interested in the bush. Why should an agency (Green, Red or Blue Medicare Select) not seek to provide care only where the costs to them were low?

Time, I think, to turn our attention to the other 122 recommendations. In the words of AMA president Andrew Pesche, we should seek to fix what’s broken.

Professor Stephen Leeder AO, FRACP, FAFPHM

This is an edited version of an Opinion piece by Professor Stephen Leeder and Dr Angela Beaton that appeared in Australian Doctor on 9 October 2009.
On 4 December 2009, the College Education Committee ratified the training curriculum for the Australasian Faculty of Occupational & Environmental Medicine (AFOEM). Here, David Goddard looks at what happens next.

Why become an occupational physician you ask? An occupational physician applies high-level medical skills to the interface between a person’s work and his or her health. This may include assisting return to work after injury, assessing fitness for safety-critical work, promoting health, seeking evidence for the work-relatedness of a disease, or researching the effects of exposures or clusters of adverse health effects.

The intellectual challenge is to consider a patient’s mobility, dexterity, mental function, and the health of their skin and special senses against a background of work where exposures, workplace relations or management styles bring issues for health. Success depends on the physician’s ability to seize opportunities to persuade, to advocate, to create understanding of health-related matters among individual workers and those who lead teams in workplaces.

Occupational physicians work with land and air transport, mining and petroleum companies, armed services, police and fire, maritime services, or as consultants in suburban practices to serve workers and assist the work of other medical practitioners and other occupational health professionals. Some occupational physicians work with teams to assess the spread and health effects of an environmental incident, or to plan to reduce the risks of fires, explosions or sabotage.

There is fascination in getting to understand the demands and exposures in many different types of work. There is happiness in daily practice when return-to-work negotiations or preventive programs are effective. And it is commonly possible to control one’s hours of work in this specialty which tends to make it family-friendly. These are some of the key features that attract medical practitioners into the diverse and exciting specialty that is occupational and environmental medicine.

The newly ratified curriculum will apply from January 2011. Its content spirals through three stages—one basic and two advanced—to cover the nine competencies. The curriculum incorporates many parts of the RACP Adult Basic Training Curriculum and the whole of the Professional Qualities Curriculum. Each of the 172 learning objectives—in 62 themes—is carefully detailed in regard to knowledge, skills, ways to learn, links to other areas, and the scope of learning required. Things to be learnt by a university course or other training external to the Faculty ambit are listed. For each theme, the modes of assessment are tabulated—both summative and formative—using methods both traditional and more newly recommended by the RACP Education Deanery (RACP News, December 2009, p. 16). Entry and exit criteria are defined for each stage. Expectations of a trainee’s progress with learning and the role of the Educational Supervisor and Regional Director of Training are stated.

Vital to the successful implementation of a curriculum is a sense among Fellows and trainees that the curriculum speaks for us, that it reflects our current aspirations for good and effective practice within our specialty. Accordingly, with each iteration during its development, the views of AFOEM Fellows and trainees were widely canvassed. Also, beyond AFOEM, we sought and obtained advice from sister Faculties and a Chapter, from other individuals and organisations in occupational health and safety and, very significantly, from the RACP Education Deanery. The curriculum is a living document and, as workplaces and medical practice changes, so it will evolve.

Several things must be done before the curriculum can be implemented. First among these is to communicate to trainees, Educational Supervisors, Regional Directors of Training and Fellows at large what will change in training and why. A communication plan has been developed and three supervisor workshops have already been conducted in Sydney, Perth and Auckland. Another is planned for Melbourne just prior to WCIM. Communication is aimed to inform those already involved in training, but also to recruit Fellows anew to roles in educational supervision and assessment. AFOEM considers that attentive, timely and well-focused supervision is of central importance to sure-footed development of trainees.

Trainees’ learning will be planned and their progress audited in six-monthly periods. For planning of learning, trainees and their Educational Supervisors will use an adaptation of the online RACP Learning Needs Analysis Tool. Items for learning will be selected from the curriculum. At the end of six months, a trainee will audit his or her learning by starting with the learning plan created six months before and adding evidence of the learning that has occurred.

The new curriculum introduces formative assessment—the sort of non-graded assessment that occurs during an episode of learning to address a trainee’s question of ‘How am I going?’ Various types of formative assessment are proposed—online quizzes, Mini-CEX, multi-source feedback, case-based discussion and feedback on presentations at trainee meetings. Explanations and rating forms must be developed to be offered online, quizzes generated, and times and venues for Mini-CEX organised—probably at annual training meetings or through video-link because training in occupational and environmental medicine is typically not hospital-based.

Summative assessment will gradually evolve from the present essay-style of questions to include more varied types of probe such as extended-matching questions and online scenarios.

The gaining of Fellowship is one point in a process of learning that continues through a lifetime of practice. A powerful source of learning for Fellows is the educational supervision of trainees.
**SEXUAL HEALTH MEDICINE AND ADDICTION MEDICINE RECOGNISED AS SPECIALTIES**

because any small-group teaching/learning activity is a two-way process. The AFOEM CPD Subcommittee is actively reviewing points allocated for CPD activities. We seek to better structure the allocation of CPD points for Fellows’ educational activities. Any change would be accompanied by a curriculum for Fellows—particularly directed to assist their educational pursuits.

Introduction of the 2011 curriculum is a major change. Transitional arrangements for three years will apply to trainees already in the program in January 2011. To find out more about the AFOEM training curriculum and the entry requirements visit [http://afoem.racp.edu.au/](http://afoem.racp.edu.au/).

David Goddard
Education Project Officer, AFOEM

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**JOURNEYS INTO MEDICINE:**

NEW PUBLICATION FROM AIDA

In this new book published by the Australian Indigenous Doctors’ Association (AIDA), 15 Indigenous medical graduates and 5 medical students have shared their journeys into medicine—their challenges and their triumphs—and their experiences within the profession, to encourage Indigenous high school students and medical students contemplating their future. Amongst them are Associate Professor Noel Hayman FAFPHM, Dr Luke Burchill FRACP and Dr Alex Brown FCSANZ, FRACP (Hon).

Associate Professor Ngiare Brown—one of AIDA’s pioneering doctors and Foundation Chief Executive Officer—cites the critical role of mentors in ensuring Aboriginal and Torres Strait Islander people take up offers from medical schools, graduate as doctors and remain in the profession: ‘It is those who have successfully navigated their way through medical school and through the profession who have a pivotal role in supporting others on their journey.’

The Australian Indigenous Doctors’ Association is a not-for-profit, non-government organisation dedicated to the pursuit of leadership, partnership and scholarship in Aboriginal and Torres Strait Islander health, education and workforce, with a vision that is today much broader than its initial focus of supporting Indigenous doctors and students. AIDA’s vision is to create a healthier Aboriginal and Torres Strait Islander population where:

- Aboriginal and Torres Strait Islander people have equitable health and life outcomes.
- There is parity of Aboriginal and Torres Strait Islander health professionals across the entire health sector.
- AIDA is seen as a medical professional body with a central role in the health and wellbeing of the nation.
- The Australian health system is culturally safe, high quality, reflective of need, and respects and integrates Aboriginal and Torres Strait Islander cultural values.

Journeys into Medicine will also be of interest to those who work in partnership with Indigenous doctors within the health sector. It can be downloaded from AIDA’s website: [www.aida.org.au/pdf/Journeys.pdf](http://www.aida.org.au/pdf/Journeys.pdf)

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In a letter to the President of the College, dated 8 December, the Hon. Nicola Roxon, Minister for Health and Ageing, approved the disciplines of Sexual Health Medicine and Addiction Medicine ‘for the purpose of inclusion in the AMC List of Australian Recognised Medical Specialties’. This is wonderful news, and will mean a great deal to junior doctors hoping to train in both specialties, along with those who are already Fellows.

There is still the major issue of working with the Department of Health and Ageing to determine Medicare Benefits, and this process will not be finalised until the new financial year. Until then, Fellows in Australia who bill Medicare will continue to claim using the item numbers that they currently use. For those Fellows in New Zealand, recognition by the Australian Government as a specialty will have pay-offs and hopefully make it easier to maintain specialty status in New Zealand.

The AMC assessed the education and training programs in Addiction Medicine and Sexual Health Medicine in August 2008. The AMC then advised the Minister for Health and Ageing that the programs of the Australasian Chapter of Addiction Medicine and the Australasian Chapter of Sexual Health Medicine met the criteria for AMC accreditation, thereby completing Stage 2 of the recognition procedure.

The AMC assessment of specialist education and training programs is a collegiate process for quality assurance and continuous quality improvement of specialist medical education and training programs. Listing on the AMC List of Australian Recognised Medical Specialties allows training organisations to participate in the AMC accreditation process.

In the case of Sexual Health Medicine, it has taken nearly two decades to achieve specialty recognition. The process was begun with the formation of the National Venereology Council of Australia, then the Australasian College of Sexual Health Physicians, and finally the joining of this body with the Royal Australasian College of Physicians to become the current Chapter in 2004.

Congratulations to everyone in both chapters who worked so hard to achieve this outcome!

Clinical Associate Professor Darren Russell
President
Chapter of Sexual Health Medicine

Associate Professor Yvonne Bonomo
President
Chapter of Addiction Medicine

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COLLEGE STANCE ON PHYSICIAN BEHAVIOUR

Physicians generally pride themselves on their tolerance, their respect for others and on the collegial way in which they interact with each other and with others. Indeed, these attributes are fundamental tenets of our Professional Qualities Curriculum and reflect the expectations we have of our trainees and Fellows. Harassment and bullying in the workplace decreases the quality of care, increases psychological stress, ‘damages’ individuals and substantially compromises the learning environment. Appropriate physician behaviour is part of our medical professionalism and is recognised as integral to patient safety and the provision of quality health care. Unfortunately, some physicians may regard the evidence of endemic bullying and harassment in the workplace as not being applicable or relevant to them, or that it does not apply to other situations such as their College activities. Is there any conceivable reason as to why the high standards of physician behaviour expected in the clinical environment should not equally apply to interactions with other Fellows and College staff as a consequence of our engagement in RACP activities?

Sadly, the behaviour of a small minority of Fellows engaged in College activities sometimes falls below expected standards in their interactions with College staff or other Fellows. This results in distress to those subjected to the bad and inappropriate behaviour, often embarrassment to the Fellow responsible and a diminution of the image of physicians and the College. ‘Bad behaviour’ is, quite simply, unacceptable and cannot be tolerated under any circumstances. The fact that the harassment or bullying was not intentional is no defence; nor does it make the behaviour any less unacceptable. As a responsible employer with a ‘duty of care’, the College cannot tolerate harassment or bullying of staff either by other staff or by Fellows. Considering the role and standing that the College wishes to maintain in the community, I would argue that a much higher standard of behaviour is expected from the College and its Fellows than that deemed necessary by compliance with industrial legislation.

A high standard of physician behaviour is required of all physicians in all situations and under all circumstances. This stance is unequivocally supported by the Board. The Board of the RACP has endorsed the development of a Quality Clinical Framework for Physicians, and a Working Party of the Quality EAG has been established to develop this framework, which will provide clear guidance on the expected standards of behaviour of physicians in the workplace and elsewhere.

In this area of policy development, the RACS has shown considerable leadership and proactivity with the production of two excellent, related and publicly available documents: ‘Surgical Competence and Performance’ <www.surgeons.org/Content/ContentFolders/Policies/PUB_2008_Surgical_Competence_Performance_Guide.pdf> and ‘Bullying and Harassment’ <www.surgeons.org/Content/NavigationMenu/CollegeResources/Publications/BRC_2009-12-01_Bullying_Harassment.pdf>.

At its last meeting, as tangible evidence of its commitment in this area of medical professionalism, the Board endorsed the RACS document on ‘Bullying and Harassment’ as RACP policy while our own policy is being finalised. It was considered unacceptable that the College’s commitment not be reflected in written policy even in the interim. Fellows are strongly encouraged to familiarise themselves with these brief, practical and pragmatic documents from the RACS. To quote from the RACS document on bullying and harassment:

No more:
- Intimidation
- Vicious reports
- Malicious rumours
- Threats, yelling, screaming, offensive or inappropriate behaviour
- Undermining work performance

Those attending meetings at the College premises next year will note the prominent display of posters indicating that bullying and harassment will not be tolerated by the College.

On a related matter, all of us need to be aware of pressures on us and how these can affect our performance and our behaviour towards others. Most of us are extremely time-pressured and have too many demands on us; our employing health service wants cost cuts along with increased service delivery; our university wants increased research output and more teaching; our College (!) makes increasing demands on our time; our patients are more demanding and we are expected to cope with substantial changes in the delivery of health care. To again quote the RACS document:

Do you need help about ‘letting off steam’:
- Speak to colleagues
- Try stress management
- Take up walking, running, riding on a bike
- But the main thing is to talk about it!

On a less sombre and less directive note, may I wish all Fellows all the very best for 2010. This promises to be an exciting and productive year for the College. I urge all of you to become involved in the continued roll-out of PREP and in other College activities. Also, I hope to see many of you at WCIM 2010 in Melbourne in March.

John Kolbe FRACP
President-elect

‘Bad behaviour’ is, quite simply, unacceptable and cannot be tolerated under any circumstances.

John Kolbe FRACP
Welcome to Year of the Trainee! The energy is palpable! The CTC can barely control their excitement, and hope that all trainees from our fine College can join in the fun. Hyperboles aside, these events will only be awesome if you turn up, so please show your support and come along. Make sure you sign up for Trainees’ Day at Congress—especially you Victorians! Shortly we will be pleading with NZ and State committees to help organise and drum up numbers for YOTT activities, so get ready.

Zoë Raos, CTC Chair
Jemma Anderson, CTC Communications

RACP President’s Award for Trainee of the Year

OTT is really catching on at the RACP. At the last Board meeting, this award was developed to promote the important place that trainees have as the Fellows of the future and to recognise trainees who make an outstanding contribution to College activities (such as leadership, mentoring and support of other trainees, contributions to education and training, involvement in policy development and advocacy). The inaugural presentation will be at the Trainees’ Ball at WCIM on 21 March 2010.

Who is eligible?
Anyone registered as an RACP trainee in 2009 from any Division or Faculty.

Who are we looking for?
A trainee who has shown outstanding leadership in all aspects of College life.

Who can send in a nomination?
Any trainee or Fellow can email Radmila.jancic@racp.edu.au or visit traineescommittee@racp.edu.au to nominate. Deadline is 15 February.

What is the prize?
Travel to and from WCIM, registration for Trainees’ Day at WCIM, two tickets to the Trainees’ Ball and presentation of a plaque at the Trainees’ Ball.
Mandatory rural placement in paediatrics ... and beyond!

This remains an important issue for trainees, the Paediatrics & Child Health Division and the College Education Committee. There is also talk of rural placements for adult med trainees (see ‘The New Wave’ opposite). No firm decisions have been made, but there is encouraging mention of increased flexibility, increasing the number of accredited sites and a clear appeals policy for those trainees with outstanding circumstances who are unable to relocate. Our goal is to see trainees progress through their training with maximum flexibility while maintaining the highest standards for physician and paediatrician training into the future.

Rationalisation of trainees’ fees under two colleges

Advanced trainees in this situation (e.g. infectious diseases and haematology) pay two whopping great College fees—ouch! The Deanery is looking into this to make the situation more equitable for trainees and to streamline funding to bring costs down. We will keep you posted.

Dual training with academia

There are moves afoot to introduce an option for dual training with an academic stream by setting up partnerships with universities in Australia and New Zealand through a new committee—the Academic Specialist Advisory Committee (see page 16). The aim is to equip College trainees with qualifications and expertise in education and research. Trainees would become Fellows with two qualifications (e.g. FRACP + PhD, FRACP + Masters). This is an exciting opportunity for trainees to get involved with university and college research and academic life early in their career.

PREP yourself and PREP others for 2010

PREP yourself and PREP your boss

The PREP program, the cornerstone of Basic Training for the future physicians and paediatricians of Australia and New Zealand, is here to stay. The portal has been upgraded and, while not perfect, is much easier to use for both trainees and supervisors.

The Divisions and the Board have now set minimum requirements (this means mandatory!) for all basic trainees for 2010. The requirements are subtly different, depending on which Division you are training under, and in which country (go to: www.racp.edu.au/page/ aus-minimum-requirements). If these minimum requirements are not met, a basic trainee cannot progress to the next year of their training.

Be reassured that trainees and supervisors who PREPed in 2009 (snags aside) found that the Mini-CEXs were do-able and reflect the everyday teaching that occurs on ward rounds.

PREP your boss and PREP advanced trainees

Online training is available for the Mini-CEX tool. We suggest that all trainees have a look at this tool, and take their consultants through the process—help will be much appreciated by less tech-savvy colleagues. There are supervisor workshops available year round in both countries for Fellows. Advanced trainees are encouraged to attend these supervisor workshops—this sets up senior registrars to positively participate in the education of their junior peers. starts the ball rolling for supervision as a Fellow and looks great on your CV!

Sounds great ... but what to do if PREP is impossible to do at your hospital?

Unfortunately, a minority of hospitals exist where it may be impossible to meet these mandatory requirements due to limited supervisor resources or other difficulties beyond the control of trainees. The RACP is very sensitive to this, and will ensure that trainees who work in these hospitals are not disadvantaged. Attention needs to be drawn to these centres so more support can be put in place to support you and future trainees. Therefore, in 2010, if you struggle to complete your PREP requirements for reasons beyond your control, an appeals process will ensure that affected trainees can appeal their individual situation anonymously without disadvantaging their progress through training. The CTC is here to keep a watchful eye and provide support to trainees (traineescommittee@racp.edu.au).
Preparing for the written exam 2010?

Not long now people. Hopefully you’re on the home straight, revising old exam papers, attending study group wine and beer tastings, have exhausted the local stationer of memory cards and are wishing this big drain on your free time was over. Words from those who have been there—you never feel like you’ve done enough, you can never know everything. Try and remain positive and don’t give up. Keep up the momentum, eat well, exercise, get plenty of rest. And good luck!

CTC eVINE—coming soon to your inbox

Busy? Stressed? Wondering how to keep up with current training issues when you have to study for exams, fulfil PREP requirements, work full-time and still attempt to have a social life?

We can help! If you have ever wondered what the College Trainees Committee was up to or what the current College issues were, wonder no longer. You will soon be receiving a regular eVine email to update you on all things trainee related. It will be short and to the point with links to follow if you want more info or want to get involved. Look out for it in your inbox soon.

If you have any ideas or contributions for the next RACP News or eVine, please email us at traineescommittee@racp.edu.au—we would love to hear from you.

Zoë, Jemma and the CTC gang

RACP lectures online—Yes please!

Many areas in NZ and Australia hold fantastic lecture series, which in this brave new world of technology would ideally be available to trainees through podcasts and live webcasts. This would be particularly advantageous for trainees at distant sites. The Deanery does not want to replace current lecture series that are working well, but may be amenable to adding to the current pool of learning opportunities using the website: www.racp.edu.au.

Dean’s Welcoming Meeting 2010

These are coming shortly to a town near you. On the agenda:

- PREP Program for Basic Training
- Educational tools
- PREP for Advanced Training

There will be plenty of time to mingle, network, ask questions, have your say and have a glass of wine. We’ve been promised a higher standard of finger food than in 2009. Go to http://traineescafe.racp.edu.au and find out when Kevin Forsyth and the team will be in your area.

We’d like to know what you think. What do trainees want? Would it be useful to have an array of lecture series podcast, with a menu and calendar so you have the option of tuning in or downloading to watch at your leisure? Email us at: traineescommittee@racp.edu.au.
The Australian Commission on Safety and Quality in Health Care each year produces a publication intended to provide a focus for discussion and a flavour of the activity being undertaken by the Commission. Windows 2009 comprises 10 chapters with an emphasis this year on measurement and reporting, although a variety of diverse topics is covered.

The chapter on recognising and responding to clinical deterioration expands the material published in the August 2009 edition of RACP News. It provides analysis and examples of research being carried out for the Commission regarding human factor aspects of observation chart design by researchers at the University of Queensland.

The Commission’s work on antimicrobial stewardship, which will be the subject of specific recommendations to Australia’s Health Ministers and of a separate major publication in 2010, is featured in Chapter 4 of Windows. All physicians would be aware of the evidence that overall rates of antibiotic resistance correlate with the total quantity of antibiotics used, as determined by the number of individuals treated, prior exposure and the average duration of each treatment course. Studies have demonstrated that as many as 25–50% of antibiotic regimens prescribed in hospitals are considered inappropriate and data collected through Australia’s National Antimicrobial Usage Surveillance Program (NAUSP) demonstrate a higher overall rate of inpatient antimicrobials in our hospitals compared to hospitals in northern Europe.

The chapter lists four essential strategies for all hospitals, developed by the Commission through its Healthcare Associated Infection program, led by prominent infectious diseases specialists from all over Australia.

These strategies are:

- implementation of clinical guidelines that are consistent with the latest version of “Therapeutic Guidelines: Antibiotic”
- formulary restriction and approval systems, particularly for broad-spectrum and later generation antimicrobials
- clinical microbiology laboratory reporting of susceptibility testing results
- involvement of prescribers in review, audit and feedback processes.

Also highlighted in Windows 2009 is the impact of clinical quality registries (Chapter 10), which can have a key role in monitoring and improving the quality and safety of Australian health care, having the potential to provide a strong evidence base for determining the efficacy, safety and quality of health care providers, interventions, medications, devices and treatments. The Commission is piloting operating principles and technical standards for Australian Clinical Quality Registries and this chapter highlights the Australian Stroke Clinical Registry, the Australasian Rehabilitation Outcomes Centre and the Australian Cardiac Procedures Registry, among others.

The Windows 2009 Report is available on the Commission’s website—www.safetyandquality.gov.au—and hard copies can be provided by application to the Commission via mail@safetyandquality.gov.au.

All but the Retrospective chapter are referenced; the Report should provide the focus for discussion it promises. Any and all feedback is most welcome.

Professor Chris Baggoley
Chief Executive
Australian Commission on Safety and Quality in Health Care
As colleges struggle with the changing landscape of postgraduate medical education, human resources and health care delivery, it is becoming increasingly obvious that there are many current and evolving issues that are common to all colleges. Issues such as workforce, training, and clinical service delivery are not only of common concern to all colleges but naturally are of great concern to government and other key stakeholders, both at federal and state level. On a state level, communication between colleges and between colleges and government has waxed and waned over time. Ad hoc and informal groupings and coalitions have been formed and dissolved. Although most colleges communicated and worked with government and key stakeholders, this was done on an individual basis and usually in isolation from the other colleges.

In early 2009, the Queensland State Committee identified a need for a forum or body whereby Queensland specialist medical colleges could discuss issues, develop consensus and consolidate approaches to government and other key stakeholders. Additionally, the formation of a group comprising the state management staff of the colleges could work in the background to enhance communications and coordination.

In late November last year, an informal meeting of the chairs of medical colleges in Queensland was convened with the aim of discussing the formation of such a body. The meeting, sponsored by the Queensland State Committee, provided the opportunity for the chairs and management to discuss their concerns and outline their thoughts on its formation. The group unanimously agreed to the formation of a formal body and developed the basis for its terms of reference. The Queensland Council of Medical Specialist Colleges (QCOMSC) has now been established with the RACP State Chair as its inaugural Chair. As noted above, the RACP was the driving force behind the establishment of this new and important body and will host and chair the Council for its first term.

Council membership is open to any AMC Accredited Medical College. The Terms of Reference of the Council acknowledge its formation is based on mutual recognition of the need for such a body in Queensland and that its role is to canvas issues common to all colleges. These issues are:

- Standards of education for trainees and professional development of Fellows
- Present and future workforce issues
- Service delivery and standards of clinical care
- Local policy and advocacy as they relate to the above.

The Council seeks to provide clinical leadership in an apolitical, cooperative and collaborative manner with Queensland Health and other key stakeholders.

The current membership is as follows:

- Australasian College of Dermatologists
- Australasian College of Emergency Medicine
- Australian and New Zealand College of Anaesthetists
- Royal Australasian College of Medical Administrators
- Royal Australasian College of Physicians
- Royal Australasian College of Surgeons
- Royal Australian College of General Practitioners
- Royal Australian and New Zealand College of Obstetricians & Gynaecologists
- Royal Australian and New Zealand College of Psychiatrists
- Royal Australian and New Zealand College of Radiologists
- Royal College of Pathologists of Australasia.

The Council will provide a forum for discussion of issues relevant to all colleges. The considerations of the Council will primarily be at a strategic level and deal with issues related to the system as a whole. Accordingly, most of the considerations of the Council will relate to problems that are of mutual concern, are strategic in nature and require a broad and cooperative approach. The Council will be concerned with Queensland only matters and will provide a conduit for the Colleges to government. It should be seen as complementary to the Committee of Presidents of Medical Colleges. It will meet quarterly.

It is hoped that this new era of cooperation and communication between the colleges in Queensland will lead to improvements in medical education and training, workforce and health care delivery standards, and the development of a recognised and respected voice of the colleges.

Dr Douglas Shelton
Chair, Queensland State Committee

Greg Armstrong
State Manager, Queensland

The considerations of the Council will primarily be at a strategic level and deal with issues related to the system as a whole.
A deceased Fellow’s biography on the College website is a widely available and permanent record of the achievements of their professional life. The biography is available to anyone who enters the name of the Fellow into an internet search engine such as Google. Because an increasing number of people are using the internet as a source of reliable information, the College Roll website usage statistics have grown in the past year from more than 25,000 hits, or downloads, in 2008 to more than 45,000 in 2009.

The uploading onto the College website of the contents of the two print volumes of the Roll of the RACP, which cover Fellows whose deaths occurred between 1938 and 1990, is almost complete. The College Roll Officer has commenced the systematic loading of photographs to accompany the biographies where these are available. It is hoped that this project will be completed by the end of 2010.

If there is a recently deceased Fellow who was well known to you, the College Roll Honorary Editors, Drs Richard Mulhearn and Bruce Storey, encourage you to write their biography for the College Roll. The College Roll Officer will provide you with an information kit, Guidelines for Authors, and reference support. Biographies are generally about 500 words in length.

Contact: Dianne van Sommers, College Roll Officer
Phone: 02 9256 5433 (usual working day is Monday)
Email: Dianne.vanSommers@racp.edu.au

Dianne van Sommers
PLEASE HELP SUPPORT OUR YOUNG PHYSICIAN RESEARCHERS ACHIEVE THEIR GOALS …

“I was involved in translational research (bench to bedside) and clinical research into this chemotherapy resistant cancer. In the past six months I have witnessed and have been part of the single most significant change in metastatic melanoma treatment history. People once given a dismal prognosis now have hope. A further 12 months of research will enable me to see my many projects come to fruition. I intend to make this a lifelong project and am grateful for your support.”

Dr Georgina Long FRACP
Australia Post Medical Research Fellowship 2009 and 2010

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### RESEARCH AWARD RECIPIENTS FOR 2010

For 2010, the Research and Education Foundation has presented 48 awards totalling $1.63 million. This represents a massive contribution to Australian and global medical research, covering a wide range of research areas. None of this would be possible without the generous support of our donors within industry, other foundations and the countless RACP Fellows who contribute annually.

On behalf of the Research and Education Foundation, I would like to wish all of our supporters, donors and awardees a very happy 2010.

Ken Roberts AM, FRACP (Hon.)
Chair, Research and Education Foundation

<table>
<thead>
<tr>
<th>Award recipient</th>
<th>Project</th>
<th>Award</th>
<th>Institution</th>
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<tbody>
<tr>
<td>Dr Paul Andrew Brooks</td>
<td>Fetal cardiovascular programming in maternal and placental disease: exploring the Barker Hypothesis from the rodent to human.</td>
<td>Eric Burnard Fellowship, Robert and Elizabeth Albert Study Grant</td>
<td>University of Alberta and Division of Cardiology, The Stollery Children’s Hospital, Edmonton</td>
</tr>
<tr>
<td>Dr Simon Chatfield</td>
<td>&quot;The interaction of monocyte and macrophage subsets with Th17 cells and the role of this newly described inflammatory axis in rheumatoid and related arthritis and potential as a treatment-response biomarker&quot;</td>
<td>RACP Australian Rheumatology Association Fellowship</td>
<td>Walter and Eliza Hall Institute, Melbourne</td>
</tr>
<tr>
<td>Dr Joseph Chiha</td>
<td>Do retinal microvascular signs predict ischaemic heart disease subtype? The Australian Heart Eye Study</td>
<td>McCaughy Research Entry Scholarship</td>
<td>Westmead Hospital – University of Sydney</td>
</tr>
<tr>
<td>Dr Jacqueline Anne Curran</td>
<td>Efforts to improve provision of culturally appropriate care to Australian Indigenous youth with type 2 diabetes from lessons learnt in indigenous Canadian children</td>
<td>Ruth Gledhill Research Entry Scholarship</td>
<td>University of Manitoba</td>
</tr>
<tr>
<td>Dr Benjamin Kane Dundon</td>
<td>Evaluation of myocardial delayed contrast enhancement by 320-slice cardiac computed tomography for the prediction of myocardial viability prior to coronary revascularisation</td>
<td>Foundation for High Blood Pressure Research Fellowship</td>
<td>Monash Medical Centre, Melbourne</td>
</tr>
<tr>
<td>Dr Craig Alastair Gedye</td>
<td>Characterisation of ovarian cancer stem cells and their niche.</td>
<td>CSL Fellowship</td>
<td>Ontario Cancer Institute, Toronto, Canada</td>
</tr>
<tr>
<td>Dr Emily Jaye Gianatti</td>
<td>Testosterone treatment in men with type 2 diabetes mellitus and borderline low total testosterone levels</td>
<td>RACP Osteoporosis Australia Research Entry Scholarship</td>
<td>Austin Health, Victoria</td>
</tr>
<tr>
<td>Dr Susan May Gorton</td>
<td>Creating pathways between distance education rural and remote school students and the health professional careers</td>
<td>Murray Will Fellowship for Rural Physicians, Geoffrey T E Travelling Fellowship for Isolated Rural Physicians</td>
<td>James Cook University, Queensland</td>
</tr>
<tr>
<td>Dr Nathan Grills</td>
<td>Learning to link; determining the effectiveness of health networks in improving primary health care access</td>
<td>Rowden White Overseas Travelling Fellowship</td>
<td>Nossal Institute of Global Health, Melbourne University</td>
</tr>
<tr>
<td>Dr Kenneth Wai Kheong Ho</td>
<td>Role of deferasirox (DFS) in treating obesity and type 2 diabetes</td>
<td>JT Tweedle Fellowship for PT Research</td>
<td>Garvan Institute of Medical Research, NSW</td>
</tr>
<tr>
<td>Dr Andrew Jabbour</td>
<td>Contrast cardiovascular magnetic resonance in the assessment of diffuse cardiac fibrosis</td>
<td>Vincent Fairfax Family Foundation Fellowship</td>
<td>The Royal Brompton Hospital, London (in collaboration with the Imperial College, London)</td>
</tr>
<tr>
<td>Dr Margaret Joan Jardine</td>
<td>ACTIVE dialysis study</td>
<td>Server Staff Research Fellowship</td>
<td>The George Institute for International Health in Sydney</td>
</tr>
<tr>
<td>Dr Yasmin Jayasinghe</td>
<td>Risk factors for early onset cervical cancer and high grade dysplasia: are there high risk groups who require earlier pap screening or vaccination?</td>
<td>Novartis Scholarship for Sexual Health Research</td>
<td>Murdoch Children’s Research Institute, Royal Children's Hospital, Victoria</td>
</tr>
<tr>
<td>Dr Christine Jellis</td>
<td>Non-invasive cardiac imaging in the detection and assessment of subclinical cardiac dysfunction and myocardial fibrosis</td>
<td>Vincent Fairfax Family Foundation Research Entry Scholarship</td>
<td>The University of Queensland</td>
</tr>
</tbody>
</table>

I am delighted to announce the Research and Education Foundation award winners for 2010.

In December 2009, I was privileged to meet some of our 2010 award winners at our end-of-year cocktail function in Sydney. The RACP President, Geoffrey Metz, hosted a similar function in Melbourne. Our award winners truly are an inspirational group of young researchers who have taken the courageous decision to dedicate their lives to medical research.
<table>
<thead>
<tr>
<th>Award recipient</th>
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<tbody>
<tr>
<td>Dr Kirk Keh Huat Kee</td>
<td>Effects of continuous positive airways pressure on loop gain and respiratory work in congestive heart failure</td>
<td>ResMed Research Entry Scholarship</td>
<td>The Alfred Hospital, Melbourne</td>
</tr>
<tr>
<td>Dr Anur Krishnan</td>
<td>Glucose dysmetabolism and peripheral neuropathy: the development of a novel biomarker</td>
<td>RACP GlaxoSmithKline Australia Fellowship in Neurology</td>
<td>University of New South Wales</td>
</tr>
<tr>
<td>Dr Saurabh Kumar</td>
<td>Pathogenesis and treatment of atrial fibrillation in man</td>
<td>McCaughhey Research Entry Scholarship</td>
<td>The Westmead Hospital, Sydney</td>
</tr>
<tr>
<td>Dr Dennis Lau</td>
<td>A three-dimensional evaluation of the electrophysiological atrial fibrillation substrate</td>
<td>CRB Blackburn RACP Overseas Travelling Fellowship</td>
<td>Maastricht University, The Netherlands</td>
</tr>
<tr>
<td>Dr Egene Lim</td>
<td>The identification of novel targets and therapeutic agents in the treatment of triple negative breast cancer at the Dana Farber Cancer Institute, Boston, Massachusetts, USA</td>
<td>JI Billings RACP Overseas Fellowship</td>
<td>The Dana Farber Cancer Institute, Boston, Massachusetts</td>
</tr>
<tr>
<td>Dr Georgina Venelia Long</td>
<td>Clinical and biomarker correlates of melanoma chemosensitivity and epidemiological studies of outcomes in stage 4 melanoma (all incorporated into one project)</td>
<td>Australia Post Medical Research Fellowship</td>
<td>Sydney Melanoma Unit, Royal Prince Alfred and Westmead Hospitals</td>
</tr>
<tr>
<td>Dr Sukafa Matanaicake</td>
<td>A three-month placement to increase her knowledge in 'trans-thoracic echocardiography and trans-oesophageal echocardiography'</td>
<td>RE Ross Trust Scholarship</td>
<td>The Alfred Hospital in Melbourne</td>
</tr>
<tr>
<td>Dr Peter Wayne New</td>
<td>A randomised controlled trial of a multidisciplinary inreach team to address the unmet needs of hospitalised patients with acute spinal cord injury</td>
<td>AFRM Ipsen Open Research Fellowship</td>
<td>The Caulfield Hospital, Melbourne</td>
</tr>
<tr>
<td>Dr Louisa Ng</td>
<td>Effectiveness of a peer-support intervention (life moves) in motor neurone disease and multiple sclerosis</td>
<td>AFRM Bruce Ford Scholarship</td>
<td>The Royal Melbourne Hospital</td>
</tr>
<tr>
<td>Dr Sean O’Neil</td>
<td>S100 proteins A8, A9 and A12 in patients with systemic lupus erythematosus</td>
<td>RACP Australian Rheumatology Association Fellowship</td>
<td>Liverpool Hospital and the University of New South Wales</td>
</tr>
<tr>
<td>Dr Sanjay Patel</td>
<td>The use of induced pluripotent stem cells to augment in vivo angiogenesis</td>
<td>Bushell Travelling Fellowship</td>
<td>Stanford University Cardiovascular Research Centre, California</td>
</tr>
<tr>
<td>Dr Anton Yariv Peleg</td>
<td>Molecular mechanisms of bacterial-fungal interactions: the potential to identify novel therapeutic targets</td>
<td>AstraZeneca Fellowship</td>
<td>The Monash University, Melbourne</td>
</tr>
<tr>
<td>Dr Carmel jo Pezaro</td>
<td>Characterisation and immune targeting of stem cells in genitourinary cancers</td>
<td>Arnott Research Entry Scholarship</td>
<td>Ludwig Institute for Cancer Research, Austin Hospital, Heidelberg, Victoria</td>
</tr>
<tr>
<td>Dr Myra Sui Yen Poon</td>
<td>Environmental risk factors for type 1 diabetes complications</td>
<td>Juvenile Diabetes Research Foundation Fellowship</td>
<td>The Institute of Endocrinology and Diabetes, The Children’s Hospital at Westmead, Sydney</td>
</tr>
<tr>
<td>Dr Peter James Psaltis</td>
<td>A study of the myelopoietic potential of vascular adventitial progenitor cells (APCx) and their role in atherosclerosis</td>
<td>Marjorie Hooper Scholarship</td>
<td>The Mayo Medical School in Rochester, Minnesota</td>
</tr>
<tr>
<td>Dr Gahan Roberts</td>
<td>Preventing learning difficulties through early intervention for working memory deficits in early childhood</td>
<td>Cottrell Fellowship</td>
<td>The Centre for Community Child Health, Royal Children’s Hospital in Melbourne</td>
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<tr>
<td>Dr Ingrid Scheffer</td>
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<td>Eric Susman Prize 2009</td>
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<tr>
<td>Nurse Ruth Soso</td>
<td>A three-month placement to increase her knowledge in high dependency care of infants</td>
<td>RE Ross Trust (Paeds) Scholarship</td>
<td>The Royal Children’s Hospital, Melbourne</td>
</tr>
<tr>
<td>Dr Daniel Lindsay Worthley</td>
<td>The origin, contribution and molecular characteristics of myofibroblasts in gastric carcinogenesis</td>
<td>IMS Overseas Travelling Fellowship</td>
<td>Columbia University, New York</td>
</tr>
<tr>
<td><strong>Jacquot Awards</strong></td>
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<tr>
<td>Dr Suet-Wan Choy</td>
<td>Regulation of renin secretion by the AMP-activated protein kinase</td>
<td>Jacquot Research Entry Scholarship</td>
<td>Austin Hospital, Heidelberg, Victoria</td>
</tr>
<tr>
<td>Dr Louis Li Huang</td>
<td>Mechanisms of macrophage mediated diabetic renal injury</td>
<td>Jacquot Research Entry Scholarship</td>
<td>Prince Henry’s Institute, Monash Medical Centre, Victoria</td>
</tr>
<tr>
<td>Dr Darren Hiu Kwong Lee</td>
<td>The role of the lysosomal protein SCARB2 in kidney disease</td>
<td>Jacquot Research Entry Scholarship</td>
<td>Austin Hospital, Heidelberg, Victoria</td>
</tr>
<tr>
<td>Dr Marcus Boon Peng Tan</td>
<td>Mechanisms of atherosclerosis in apolipoprotein E deficient mice with subtotal nephrectomy</td>
<td>Jacquot Three Year Research Entry Scholarship Award</td>
<td>University of Melbourne</td>
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</table>
Riding for Paceline

I am an Occupational and Environmental Physician in Melbourne and was one of five riders (and a support driver) taking part in a now annual event called the Paceline Ride, established to increase awareness of Cardiac Arrhythmia and to raise money for both the Victor Chang Cardiac Research Institute in Sydney and The Baker IDI Heart and Diabetes Institute in Melbourne.

This year’s Paceline Ride saw the riders complete the gruelling 1,100 km ride from Melbourne to Sydney over eight days, from 14 to 21 November.

Paceline took the opportunity to maximise the media coverage of the event, both locally and nationally, and created a strong internet presence through its website (www.paceline.com.au) and social networking sites such as Facebook and Twitter. There were media activities in each of the stopover towns along the route, a departure and arrivals event at the Baker IDI and Victor Chang respectively and a pre-event cocktails-networking night in October.

The route was up the coast road, paralleling the Pacific Highway as much as possible. We stopped in Traralgon, Lakes Entrance, Cann River, Eden, Narooma, Ulladulla, Kiama and Sydney, talking to as many of the locals along the way as we could. Their interest and friendliness was astounding, as were the supportive ‘beeps’ from passing motorists along the way. We only had one logging truck driver who tried to wipe us off the road: sadly there is always one.

Highlights of the trip were obviously the camaraderie and lifelong friendships that come from undertaking an adventure like this, but the police escort from the Baker along Beach Road, the hills into and out of each of the towns we stayed in, the endless plates of pasta in the restaurants at night (washed down with a glass or two of red wine), the ride through the National Park and then the view from Stanwell Tops (pictured) and the welcoming party at the Victor Chang all remain fresh memories.

We are already planning next year’s ride from Adelaide to Melbourne along the coast, with 20 riders, so keep an eye out. One day we will take Paceline internationally and I personally am looking forward to the ride up the Champs Elysées!

Dr David Elder FRACP

<table>
<thead>
<tr>
<th>Jacquot Awards</th>
<th>Fellowship/Institute</th>
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<tbody>
<tr>
<td>Dr Suetonia Cressida Palmer (Kidney injury molecule-1)</td>
<td>Don and Lorraine Jacquot Fellowship, Brigham and Women’s Hospital and Harvard Medical School</td>
</tr>
<tr>
<td>Dr Germaine Wong (Colorectal cancer and chronic kidney disease)</td>
<td>Don and Lorraine Jacquot Fellowship, The University of Sydney</td>
</tr>
<tr>
<td>Dr Muh-Geot Wong (The role of cationic independent mannose-6-phosphate receptor (CI-M6PR) inhibitor in diabetic nephropathy)</td>
<td>Don and Lorraine Jacquot Fellowship, Kolling Institute of Medical Research, Royal North Shore Hospital, Sydney</td>
</tr>
<tr>
<td>Dr Robert Peter Carroll (Complications after renal transplantation and relation to immune phenotype)</td>
<td>Jacquot Research Establishment Award, The Queen Elizabeth and Royal Adelaide Hospitals and the Princess Alexandra Hospital, Brisbane</td>
</tr>
<tr>
<td>Dr Natasha Cook (Do changes in fatty acid metabolism within the kidney cause obesity-related hypertension?)</td>
<td>Jacquot Research Establishment Award, Austin Health, Heidelberg, Victoria</td>
</tr>
<tr>
<td>Dr Shaun Andrew Summers (The role of mast cells in progressive renal injury)</td>
<td>Jacquot Research Establishment Award, Department of Medicine and Nephrology, Monash Medical Centre, Monash University</td>
</tr>
<tr>
<td>Dr Angela Clarie Webster (Improving the evidence base for diagnostic decision making in chronic kidney disease)</td>
<td>Jacquot Research Establishment Award, School of Public Health, University of Sydney and Westmead Hospital, NSW</td>
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</table>
FAREWELL PETER NIGEL BLACK FRACP

Professor Peter Black was an outstanding teacher and researcher at The University of Auckland and General Physician at Auckland City Hospital. Having completed a ward round on Sunday, 10 January 2010, he died suddenly later at home. Peter was the greatly loved husband of Bernadette Salmon FRACP, paediatrician, and proud father of Claire.

Peter held a myriad of roles across the university and hospital, nationally and internationally. Although he had an international reputation in respiratory pharmacology research, Peter remained passionately committed to general medicine, quality use of medicines, and medical education.

After completing his MBChB in 1980 at the University of Auckland and FRACP in 1985, Peter spent the next three years at the Department of Clinical Pharmacology, The Hammersmith Hospital, London, under the mentorship of Professor Sir Colin Dollery, one of the founding fathers of the discipline of Clinical Pharmacology. On his return to New Zealand in 1990, Peter was appointed Tutor Specialist, then consultant General Physician at Auckland Hospital, and Senior Lecturer, The University of Auckland.

Clinically, Peter had few equals, proving an encyclopaedia of medical knowledge for his colleagues, and a dedicated doctor to a wide range of patients, including those with complex airways diseases. He loved nothing better than to debate diagnoses and patient management, and was increasingly interested in clinical reasoning. Areas for administrative improvement received his swift and full attention, with Peter often the first to offer practical solutions.

To his trainees and students, he was a true mentor, and ‘walked the walk’ of clinical excellence. He had incredibly high expectations of all of them, only exceeded by the standards he set for himself. For all his mentees, he was a staunch advocate, providing advice and support throughout their paths to senior positions.

In the important area of medicines’ safety, Peter developed an integrated theme of clinical pharmacology, prescribing and therapeutics within the MBChB program, complementing this with leadership of regional strategies to improve prescribing.

Peter’s research was remarkable in its breadth and depth, covering the complete spectrum from basic research, through to translational and clinical research in its many forms, including Cochrane systematic reviews and clinical trials. He had collaborations with many international groups, recently establishing the Australasian COPD Research Network with TSANZ colleagues. His current projects include the role of fibroblasts in COPD, and diet in airways diseases. The author of over 80 publications, one of his proudest moments came when he was promoted to Professor in 2008, delivering his inaugural lecture in October to a packed lecture theatre.

At the time of his death, Peter was a member of the SAC Clinical Pharmacology, and Director of Advanced Training, Auckland region—a unique role he developed to improve coordination of training pathways, especially for those dual training in general medicine and a subspecialty. He had served as Chair of the NZ SAC in General Medicine from 1996 to 2000, as a Director of Physician Training, a member of the RACP Therapeutics Advisory Committee, and as an FRACP Part 1 clinical examiner. He was an active member of TSANZ, IMSANZ, ASCEPT, ASCIA and other respiratory societies.

Peter’s sudden and untimely death has shocked everyone. He will be greatly missed by his many colleagues, patients, junior staff and students. While the magnitude of the loss of such a talented and productive clinical academic at the peak of his career is yet to be fully appreciated, he is recognised for his exceptional contributions to health care, research and medical education in the region.

Prepared by Dr Phillippa Poole, with the assistance of Dr John Kolbe, Dr James Paxton and Dr Zoë Raos, Chair of the College Trainees’ Committee
The mainstream of bioethics’ theoretical abstract universal philosophical principles. In this book, Paul Komesaroff contends that the everyday clinical ‘lifeworld’—the lived world experienced and shared by clinicians and patients—is neither trivial nor banal but the most important dimension of medical ethics. It is in face-to-face interactions and the ‘small behaviours’ of embodied patients and doctors that morality is expressed or lost and the drive to ethics is created or fed. Although this paramount socio-moral existence demands attention, it does not receive it in the orthodox bioethics discourses where it is neither fully realised nor systematically examined in ethical inquiry.

Enclosed within bioethics, clinicians and patients, isolated from each other, are reduced to secondary roles and walk-on parts: their concrete presence in the world displaced from the centre of the ethical universe and made subservient to abstract universal philosophical principles. The mainstream of bioethics’ theoretical tradition also sees morality through the lens of universal reason, stripping the intrinsic and inherent place of complexity, emotion and the corporeal body from moral and social life. This, Komesaroff argues, leads to the separation of ethics from practice. He writes: ‘[bioethics is] divorced from the real concerns of doctors and patients, with many of the most important issues being obscured or passed over’ (p. 22).

Case vignettes ... yield a sense of the emotional texture—the play of satisfactions, the risk of being misunderstood, the tensions and the intimacies—of apparently routine face-to-face relationships that make them such a profoundly moral thing.

The book consists of 13 chapters with a ‘manifesto’ and epilogue. The first half of Experiments in Love and Death follows on from Komesaroff’s earlier thoughts, particularly his concept of ‘microethics’. Real lives and real events are the raw material of ethical theorising and practice. Komesaroff believes: ‘Every clinical relationship consists of a continuous series of ethical events, each of infinitesimal dimension and often inconspicuous to the participants’ (p. 5). Set against the contingencies and complications that are a part of embodied life as it is lived in the clinic and laboratory, he details the possible ways in which microethical events impinge on the ethical enterprise and make interactive behaviour accountable. Topics include the ethics of research on non-human animals, the knowledge and fear of their own or a close relation’s imminent death. And the socially situated disaffections that churn within medicine, e.g. what patients take to be an intractable health care system/moral and social life. This brief overview cannot do justice to the book’s intricacy: its mooring in clinical practice, philosophy, sociology and cultural theory; its creativity, and...
its direct application for moral decision-making in medical settings. It is a work of considerable imagination, intellectual depth and complexity that painstakingly redefines several key problems and tasks of contemporary biomedical ethics: the tension between theory and practice; micro and macro linkages; the function of ethics; the intersection of technical expertise and action; and ethics and meaning.

Some readers will have questions about aspects of Komesaroff’s argument. Nevertheless, the book represents unequivocally an important contribution to bioethics/biomedical ethics, adding much that is new to the conversation about the moral processes of medical practice. I thoroughly enjoyed reading Experiments in Love and Death and I will certainly return to it again.

Rob Irvine PhD
Centre for Values, Ethics and the Law in Medicine
University of Sydney

A bold new voice

Little White Slips by Karen Hitchcock.
Sydney: Picador Australia. 2009. RRP $29.99

Little White Slips arrived in the letterbox just in time for my New Year holiday in Rotorua, New Zealand.

Love, loss, betrayal and redemption. Dermatitis, eating disorders, precocious sexual debut and leukaemia. Suicide, depression, schizophrenia and Lacanian psychoanalysis. Transitions, motherhood, absent fathers and the pain of adolescence. These are some of the themes that Karen Hitchcock ambitiously grapples with, with brutal but exquisite honesty, in her debut collection of short stories.

Characters are painted in complex relationships all along the functional–dysfunctional continuum. Hitchcock often uses metaphors to reflect on the protagonist—a darkly handsome study group partner, a plastic Freud doll, a maternity dress (the latter in ‘little white slips’)—offering a compass into the unexplored territory of the character’s inner world.

The first story, ‘Drinking when we are not thirsty’, deserves a special mention: first, for being a tragicomedy with a great narrative; and second, for bringing the unique nightmare of studying for the RACP exams screaming and gnashing into my otherwise peaceful Rotoiti lakeside holiday. I’d suggest that those who are currently studying for the March quiz save this story for later (lest the unanswered multiple-choice question that opens the book drive you to insanity).

For everyone else, these stories offer a sharply focused study of the lives of modern women, how we see ourselves, and what it is to be a female doctor. Hitchcock’s sense of humour makes light work of the heavy subject matter. All in all—a great summer read.

Zoë Raos
Chair, College Trainees’ Committee

Letters to the Editor

‘Your’CPD

The biggest step forward in postgraduate medical training in Queensland was the change in attitude to interns—junior hospital staff in their pre-registration year. Previously treated as labourers, they became trainees under instruction.

A few years after having retired from my teaching hospital, I was asked to return as acting director of intern training and chairman of the Clinical Training Committee. I did not teach—there were consultants and registrars to do that—but I saw to it that the paperwork was done thoroughly and by the book. The outcome was that all interns qualified for registration, and the hospital was given the maximum period of accreditation, three years, as suitable to train interns.

Fellows, I believe this would be the better approach to ‘Your’CPD. Continue your usual educational activities, which will be determined largely by your place and type of practice, workload and other calls on your time and make what use you can of the MyResources Gateway when it becomes available. Above all, ensure that the records of your studies are impeccable and sent to the College on time. It is not the reality but the appearance that is all important. Big Brother, and these days Big Sister too, must be appeased.

As the standard of practice of physicians was not measured prior to the introduction of the voluntary MOPS program, its impact, if it had any, will never be known. ‘Your’CPD will, however, give evidence that Fellows, individually and collectively, are committed to continuing medical education—as the great majority of you always have been. Whether patients will benefit from the additional time and effort involved in keeping records of your activities and points scores will remain in doubt; but the Deanery will have no doubt that formal, supervised and, in effect, compulsory CPD, like motherhood, is a good thing.

Derek Meyers FRACP
Retired Physician
ACHIEVING WORK–LIFE BALANCE

I believe we can achieve what seems quite impossible if we just have a go, push our boundaries and enjoy the journey, preferably with family and friends. Having a work–life balance is what we all would like, and I have been a strong advocate of finding a passion outside my busy work and home life.

I have always been keen to maintain a basic level of fitness. I was an average swimmer as a child but preferred diving, cycling was usually social and running was almost impossible. Being a mother of three, it was initially difficult to get this balance but things improved when I got my golden retriever. The beach was his backyard so we had to do our daily walks, progressing to a jog at chat speed with friends (I was told you lose more weight when you exercise and chat simultaneously).

Ten years ago, my friend, Mary, suggested a team short triathlon so I dusted off the rusty mountain bike and took part in my first triathlon in East Fremantle. Yes, I was slow, but excited to have completed the 300 m swim, 10 km cycle and 3 km run. I started taking part in more of these events, increasing the distance to a long course 700 m swim, 20 km ride and 5 km run. This progressed to other community events like the City to Surf 12 km run (overtaken by most people) and open water events in the spectacular Indian Ocean (I feel safer swimming in numbers). Wherever possible, I would encourage family and friends to join in. After a few years of short events I thought it would be fun to try out some of the more iconic events in WA.

I have taken part in the Rottnest swim, which is a 20 km swim from Cottesloe mainland to Rottnest Island, usually as a team of four, but also as a duo. This can be a very challenging event in rough seas—yes, there are a few sharks! In February 2010, four of us paediatricians—the Dreamtime Team (Fiona Stanley, Jane Valentine, Kay Johnson and myself) will brave the sea and fundraise for the Starlight Foundation.

The Blackwood marathon is another fabulous rural event, which consists of a 12 km run (mostly uphill), 7 km kayak, 1 km swim in the freezing Blackwood River, 18 km horse ride (which is spectacular) and 20 km cycle through one of the few hilly regions of south-west WA. This has become a sociable calendar event in which a number of paediatricians compete, some of them being John Wray, Liz Davies, Carol Bower, Rex Henderson and Jane Valentine. This event does attract some incredibly good athletes, hence we are in competition with the slower folk! The best part of the event is the dinner afterwards where all the great stories are told.

The Cocos Island swim is an annual sociable 10 km swim across the warm lagoon (this tiny horseshoe-shaped jewel of the Indian Ocean is located 2,750 km north-west of Perth). I managed to convince a number of paediatrician swimmers to join me, including Fiona Stanley, Carol Bower and Janine Spencer. It was the most spectacular swim, full of colourful fish and coral. Unfortunately, 1 km before the finish line I was pulled out of the water as a 4.5 m tiger shark was getting too curious! I don’t think I will take part in that event again, although Cocos Island is a top spot to visit.

With the Menzies to Kalgoorlie cycle ride, a 132 km road bike event attracting the more elite cyclists around Australia, we discovered there was a novice group that started the race, but was soon overtaken by the pros in their large pelotons. I was not used to sitting on a small bike seat for many hours but was very pleased to complete the event—with no flat tyres.

We hope to encourage other similar minded work colleagues to have a go, preferably with friends, as anything is possible and you are guaranteed plenty of fun.
The Avon Descent is considered the longest white water paddling event in the world, comprising a 134 km paddle down the Avon valley over two days. This race is an annual event on the first Saturday in August, and attracts a large overseas field. Four mothers, including paediatrician Liz Davies, decided to take on this challenge. We would meet on the Swan River at 6.30 am three times a week, watching the sun rise over Perth and enjoying the river wildlife in the flat, shimmering water and perhaps chatting more than paddling. The race itself was very challenging as the water was flowing fast and the rapids felt like waterfalls. I now know what it is like to be in a washing machine. Despite this exhilarating and frightening experience, our team came in second (being a male dominated event there were only two female teams) covered in bruises and a few good stories. We are hoping to take part again this year.

I was keen to challenge myself further and considered the Half Iron Man held in Bussleton. I had a rotator cuff operated on eight months before the race following a ski accident and was keen to get fit. The race distance was challenging, with a 1.9 km swim, 90 km cycle and 21 km run. The training program was lots of fun, but I had to be organised and was only able to make about 60 per cent of the recommended training.

I found the best time for training was in the morning before work but on some days I had to double up with an afternoon or evening session, time permitting. I would train in a swim squad twice a week, ocean swim once a week, run four to five times a week, usually on the beach (with my faithful dog who is now slower than me), and ride two to three times a week, including a three-hour ride over the weekend. Getting fluids, electrolytes and calories is crucial in a long race.

Annkathrin Franzmann, another fellow paediatrician, was also taking part in this challenging race. Annkathrin was introduced to triathlons about eight years ago, starting off with the swim in a team event and quickly getting hooked on a solo challenge. She joined a triathlon club and realised her strength was in the cycle part of the event, and now spends many early mornings riding around the Swan River. The race went extremely well and we both enjoyed the whole experience and were particularly thankful that we completed uninjured. It took us just over six hours and to our surprise we both qualified for the World Long Course Triathlon to be held in Perth in October 2009, in which Annkathrin would represent Germany and I would wear the green and gold.

Representing our respective nations was unexpected and a great honour. We both had to try and keep up some level of training. The early morning rides were fun but it was difficult getting out of bed on a cold, windy winter’s morning. Our focus was to be part of the event and attempt to complete. The build-up to the event was exciting, with a team breakfast, a pasta evening and a parade of the nations. I had the opportunity to get some race tips from Craig Alexander, the winner of the Hawaiian Iron Man 2009, and Annkathrin enjoyed meeting the elite German team.

The race was not in ideal conditions. It was a very hot, windy day, 35°C, but the atmosphere was fantastic, with plenty of crowd support. Perth came to a standstill as the ride was on the freeway and it was closed with little public notice. Again, we were excited to complete, towards the back end of the field, exhausted and uninjured.

We are not fanatical sportspersons but enjoy being part of these events and always feel a sense of achievement. We hope to encourage other similar minded work colleagues to have a go, preferably with friends, as anything is possible and you are guaranteed to have plenty of fun along the way.

Desiree Silva FRACP
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