FOCUS: WHAT MEMBERS WANT
RACP PRIORITIES FOR FEDERAL BUDGET 2013–2014 SUBMISSION
FINDINGS OF EXTERNAL REVIEW OF ASSESSMENT
LATEST ON AMC ACCREDITATION
FROM THE BOARD – THE HONORARY TREASURER
The Royal Australasian College of Physicians invites you to attend the RACP Future Directions in Health Congress 2013 in Perth.

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**Latest Updates / Highlights**

The Organising Committee is pleased to announce the following Keynote Speakers for the 2013 Congress:

**Dr. Mark Graber, MD, FACP**
Senior Fellow, RTI International
Professor Emeritus, SUNY Stony Brook School of Medicine, NY, USA
Founder and President, Society to Improve Diagnosis in Medicine

**Winthrop Professor Fiona Wood, AM**
Director, WA Burns Service of Western Australia
Consultant Plastic Surgeon, Princess Margaret Hospital and Royal Perth Hospital, Australia

The Congress program will include sessions of the following working topics*:

- Physicians as Advocates
- Physicians as Clinical Leaders
- Physicians as Educators
- Physicians of the Future
- Physicians as Medical Experts
- Physicians’ Performance and Professionalism
- Physicians in Research
- Physicians in the Workplace

**Plus...**

- Basic Trainee Workshop: How to Present Yourself Best in the Clinical Examination
- Advanced Trainee Workshop: Becoming a Physician
- Supervisors Workshop
- RACP Trainee Research Awards for Excellence
- Wiley-Blackwell Publishing Award for Excellence in Medical Education
- The Best of Grand Rounds – Wiley-Blackwell Publishing Award for Clinical Excellence
- HIV Master Class
- 75th College Anniversary Gala Dinner
- Trade Exhibition
- Poster Presentations
- And more...

Refer to the Congress website for latest Congress announcements and program updates.

*Detailed descriptions of working stream topics can be viewed on the Congress website.*

racpcongress2013.com.au
RACP News May 2013

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RACP members may belong to One College, but they also have individual views on what they expect from their College. To read more, go to the results of the RACP Member Research Study 2012 on pages 6–9.

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Diplomacy is the art of letting someone else have your way.
– Sir David Frost

He who has learned to disagree without being disagreeable has discovered the most valuable secret of a diplomat. – Robert Estabrook

The most important trip you may take in life is meeting people half way. – Henry Boyle

These writers each have highlighted, whether in jest or in earnest, a significant element of constructive relationships – that of negotiation. Diplomacy describes the art or practice of conducting negotiations, and commonly implies that the conduct of negotiation is sensitive and constructive.

Each individual has developed skills in the art of negotiation. Negotiating for our own needs or objectives is a basic instinct and underlies our survival and progression within society. Family life, schooling, university and careers depend on how skilfully we can negotiate with our family, friends, peers and especially our spouse to ensure we achieve as much of ‘our way’ as is possible whilst maintaining harmony and goodwill in the relevant relationship.

There are key elements to the negotiation process which can be refined over the years. While most negotiating skills are common sense, acquired as we grow into more complex environments and relationships, purposeful and careful preparation and discipline is necessary if we seek to secure the best deals possible under any circumstances. Reliance on emotion or manipulation has no place in successful negotiations. The more significant or complex the purpose or circumstance, the more important it is to control one’s ambition and ego and to focus on the principal object – the bigger picture – at all times.

As President of our College, my aim is to encourage and enable a focus on the bigger picture, the immediate and long-term relevance and value of the College to medicine, to healthcare, to our Fellows now and in the future, and to the broader community. Fostering an environment of constructive and careful negotiation within the Board, throughout the College structure, within the Fellowship and with external bodies is critical to that.

Careful evaluation of desirable, and possible, outcomes and equally careful preparation and consideration of information assists all parties to engage in successful negotiations. Preparation allows those involved to be aware of the aims and expectations of the other parties and to consider how best to meet them halfway, to disagree without engendering dissonance, and to focus on one’s own objectives whilst respecting and, as appropriate, accommodating those of the others.

The art and skill of negotiation

The literature on the art and skill of negotiating is interesting, providing a raft of ‘how to’ advice for the thoughtful. This includes advice on how to approach negotiations, how to conduct oneself, how to work through a negotiation process, and how to keep one’s eye on the bigger picture. There are basic principles which apply to all negotiations:

• All negotiators should have a strategy to ensure successful negotiations.

• All parties to a negotiation should have the desired outcome in their mind as they plot their own strategy, including elements which may be traded interchangeably as required.

• Once a negotiation process is complete, the involved parties usually need to continue to work effectively with each other. While heated discussion is a common occurrence during negotiations, at some point collaboration and compromise are needed to complete a deal.

Advice as to how to engage in successful negotiations towards a particular end includes:

• The first offer is usually the most
important and the benchmark against which all subsequent offers will be judged and compared. Always have something to give away without hurting your negotiating position.

- Watch for clues such as body position and movement, speech patterns and reactions to what you say.
- Be prepared to suspend or cancel negotiations if you feel things are getting nowhere or the other party seems stuck in their position.
- Being patient with the other proponents is essential – a challenge for those with a passion for instant gratification!
- Your goal should be to achieve the best outcome possible, without causing significant distress to the other parties in the negotiation.
- Throughout the negotiation, try to determine what you believe to be an acceptable outcome for the other party. This may be a combination of different things which can be included in the negotiations. Satisfying some of the other side’s priorities, so long as it does not weaken your overall position, may allow the construction of a satisfactory outcome proposal.
- Know your limits and how far you are willing to go on all aspects of the deal.
- To avoid misunderstanding, offers should be presented in writing and include all elements under discussion.

The art of compromise

The great men of a nation reach out to all mankind. They are unifying, not divisive; internationally conciliating and still great nationally. – Gustav Stresemann

There are good reasons why compromise is also described as ‘an art’. Each party needs to figure out what to give, where to hold firm, and how to achieve the goals envisioned. Compromise is the very essence of negotiation and involves getting the best possible solution for all parties.

Learning the wisdom as well as the art of compromise is also important as it is better to bend a little than to break. Importantly, conciliation is fundamental to the art of compromise.

Provided that the balance is good, whatever you lose in compromise, you gain in collaboration.

Managing competing interests within the College

Whilst demonizing one’s opponents may be useful in the short-term … effective leadership must routinely involve an ability to compromise in order to achieve lasting solutions to our problems. – Amy Gutmann

To bring this discussion back to the College, we can apply University of Pennsylvania President Amy Gutmann’s philosophy to guidelines for managing competing interests within our College. She and co-author Dennis Thompson recommend the following in their book, The Spirit of Compromise.

Broaden our world view. All of us – Fellows, trainees and staff – must look past our own, often limited outlook and recognise that there may be other perspectives. This is how compromise begins.

Appreciate diversity. The College builds an appreciation for diversity in many forms, and we need to listen to and heed what others are saying instead of talking past one another. Compromise grows out of respect for others’ positions.

References

As Australasia’s largest medical college, The Royal Australasian College of Physicians represents the educational and professional interests of more than 13,500 Fellows and over 5000 future Fellows. The College has been undergoing a transition in recent years towards a more contemporary and responsive organisation better able to adapt to change quickly and meet the needs of its stakeholders. In line with its Statement of Strategic Directions, the Board of the RACP has also reaffirmed the importance of demonstrating value for members. Recognising the need to better understand its members, the RACP is exploring ways that College operations can be improved and better services delivered to Fellows and trainee members.

To support this, and gain much needed insight into what RACP members want and need from the College, a detailed member research study was undertaken in 2012. Nearly 3000 members took the time to respond to the landmark study, which was the largest member research exercise ever undertaken by the College.* The research identified various groups of members who responded differently to College activities and offerings, and the findings will be used to focus efforts on aligning College services to the specific and differing needs of the various member groups.

To support the College in this undertaking, and to ensure the study was as independent and as meaningful as possible, the research was designed and conducted by external research group The Market Intelligence Co (TMIC). The College recognises that the survey was lengthy and thanks members who gave their valuable time. In designing the survey with the objective of gaining a better understanding of current and future needs of members, the College aimed to balance the time needed to complete the survey with the depth of information necessary for the results to be meaningful.

While the survey demonstrated that members have diverse preferences and perceptions, the findings indicate that the vast majority of members want the College to continue focusing on the core business area of education and representing College interests in the broader health and healthcare policy landscape. Vision for the future – and the ways in which the College might grow and further support its members – was a key consideration when designing the survey.

*All Fellows and Advanced Trainees were invited to participate in the study.

The Fellowship Committee will assume stewardship of the member research study results. Established by the RACP Board in 2012, the Committee will oversee the development of a suite of member services, and provide advice and recommendations on improving communication with Fellows and on specific Fellow initiatives such as the annual College Congress.

The Fellowship Committee consists of representatives from each of the Divisions and Faculties, the New Zealand Committee and the College Trainees’ Committee. In addition to having a prominent role in the work that will be undertaken as a result of the member research results, the Fellowship Committee will be working closely with all College bodies, including the Divisions and Faculties, to support the enhancement of services to Fellows and identify ways to increase the engagement of Fellows across the College.
Who are our members?

**College body/bodies* (multiple response question)**

<table>
<thead>
<tr>
<th>College Body/Bodies</th>
<th>Member Type</th>
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<tr>
<td>Adult Medicine Division</td>
<td>Fellow 12% (1444)</td>
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<tr>
<td>Paediatrics &amp; Child Health Division</td>
<td>Trainee in Advanced Training 87%</td>
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<tr>
<td>Australasian Faculty of Public Health Medicine</td>
<td>Retired (unprompted) 1%</td>
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<tr>
<td>Australasian Chapter of Community Child Health</td>
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<tr>
<td>Australasian Faculty of Occupational &amp; Environmental Medicine</td>
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<td>Australasian Faculty of Rehabilitation Medicine</td>
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<td>Other Overseas</td>
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* Other than The Australasian Faculty of Public Health Medicine, this graphic is generally reflective of overall membership of College bodies.

Where do our members reside?

**Main work/practice location (1)**

- QLD: 15%
- NSW: 25%
- ACT: 2%
- VIC: 23%
- TAS: 2%
- SA: 7%
- WA: 6%
- NT: 2%
- NZ: 11%
- Other Overseas: 5%
- Australia (84%)

This is generally reflective of the RACP membership location distribution.
What factors affect member participation and interaction levels?

A range of factors influence the participation in, and interaction with, the College.

A. Life and life stage factors
- Gaining qualifications/study
- Establishing a career
- Family commitments
- Being busy
- Being able to make time (very time poor)
- Other interests
- Retirement

B. Relevance of the College
- Changes in their life/career stage
- Heterogeneous membership – other affiliations may be better suited to fulfil their needs

C. A range of perceptions regarding College issues
- Ignoring particular groups within the College such as Paediatricians and Medical Researchers (vs Clinicians)
- Getting too big, losing focus, trying to be all things to all Fellows
- Decreasing quality standards in accreditation
- Increasing bureaucracy/slow to action
- Lack of value for money
- Increasing numbers of committees
- ‘Arrogance’ and ‘elitism’
- Lack of support for supervisors
- Communications with members (including website issues)
- Overly complicated processes/systems, e.g. CPD point recording system not regarded as user-friendly

Key areas to increase participation and interaction with the College

Those members who rated their participation in and interaction with the College within the last 12 months as low suggested the following as ways to increase their participation in and interaction with the College and College activities:

- More engagement with and support of Fellows and trainees: for example, more activities in non-Sydney locations; more/better interaction with subspecialty societies/groups
- Improvements to education and professional development: for instance, via more/better online training options/resources and improvements to the CPD platforms/processes
- Better advocacy: including advocating to governments regarding medical standards, work practices and health outcomes, and on social issues
- Relevancy: to the professional needs of Fellows and future Fellows and their specialty/subspecialty/group
- College improvements such as less bureaucracy, more transparency and more recognition of contributions/roles
- 17% of respondents said that there was nothing/very little the College could do to increase their level of participation and interaction.

MOST APPEALING RACP OFFERINGS

Twenty-four offers were presented to survey respondents in randomised order, in 20 sets, to determine which offerings were the most appealing to them as part of their RACP membership.

The four offerings listed below appealed to at least 96.2% of respondents:

- Programs to enable you to obtain CPD points through the College, e.g. online learning modules, access to electronic journals
- Representing the profession to government, registration authorities or other entities
- Updates on current knowledge in specialty areas other than your own (e.g. cardiac updates for non-cardiologists)
- Provision of training for supervisors of trainees.
Member groups

The following types of member groups were identified based on their different responses to RACP activities and offerings.

<table>
<thead>
<tr>
<th>Group and size</th>
<th>Descriptor</th>
<th>Interaction/participation with the College</th>
<th>Demographic group/characteristics/attributes</th>
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</thead>
<tbody>
<tr>
<td>Group 1: 12.3%</td>
<td>‘Driven, Single minded’</td>
<td>Not engaged or involved</td>
<td>Fellows, Adult Medicine Division, males aged 51–65 years. Very time poor, not engaged or involved with the College.</td>
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<tr>
<td>Group 2: 16.4%</td>
<td>‘Fulfilled, Advocate’</td>
<td>Not engaged</td>
<td>All demographic groups. Able to make time for the ‘important’ things and feel it is important to ‘give back’.</td>
</tr>
<tr>
<td>Group 3: 26.4%</td>
<td>‘Fulfilled, Involved, Concerned’</td>
<td>Currently engaged and contributes</td>
<td>Main work/practice location New Zealand. Like to connect with colleagues/peers, feel it is important to ‘give back’/advocate on issues of social responsibility, engaged with/contributes to the College.</td>
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<tr>
<td>Group 4: 10%</td>
<td>‘Go-getters’</td>
<td>Currently disengaged</td>
<td>Advanced Trainees, Paediatrics &amp; Child Health Division, aged &lt;40 years. Career builders, time poor, disengaged with the College, would like to know more to participate/be involved.</td>
</tr>
<tr>
<td>Group 5: 13.1%</td>
<td>‘Juggler’</td>
<td>Not currently engaged</td>
<td>Advanced Trainees, Paediatrics &amp; Child Health Division, females aged &lt;40 years. Career builders, time poor, disengaged with the College, would like to know more to participate/be involved.</td>
</tr>
<tr>
<td>Group 6: 10.8%</td>
<td>‘Satisfied’</td>
<td>Disengaged from the College</td>
<td>Fellows, Adult Medicine Division, males aged 51–65 years. Proud to be Fellows of the College, work in capital cities, disengaged from the College.</td>
</tr>
<tr>
<td>Group 7: 10.9%</td>
<td>‘Relaxed, Comfortable’</td>
<td>Not engaged</td>
<td>Fellows, males aged 65+ years. Proud to be Fellows of the College, work in regional areas, able to make time for the ‘important’ things, not engaged with the College.</td>
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Next steps

A range of initiatives to respond to this feedback are either already underway or in various phases of planning.

For example, the College has been working with Fellows and increasing its policy and advocacy efforts over the last 24 months on a wide range of matters. Most recently, the College made a comprehensive submission to the Federal Government Budget 2013–2014 process, demonstrating a concerted focus by the College to advocate for improvements to healthcare initiatives and expenditure. You can read more about the College’s Budget submission in this issue on pages 10–15.

Recognising the vital contribution made to the education of future physicians, the College marked 2012–2013 as Year of the Supervisor. See pages 30 and 31 to read more about the College’s work on training programs supporting RACP supervisors.

The RACP Honorary Treasurer, Clinical Associate Professor Michael Hooper, has provided information about the operational aspects of the College and how they are funded. This is the first in an ongoing series of RACP News articles that will discuss a range of matters identified in the member research as areas that may be affecting members’ perceptions of the College. Visit pages 34–35 to read this article.

The Fellowship Committee will continue to provide further information and updates on the insights gained from the RACP Member Research Study 2012, and the activities and initiatives that are underway, in future issues of RACP News.

Associate Professor Christopher Poulos
RACP Board Director
Chair, Fellowship Committee
“RAPID TESTING IS BEING USED INTERNATIONALLY TO ENSURE THAT PEOPLE NEWLY INFECTED WITH HIV CAN QUICKLY ACCESS TREATMENT.”

THE HON. TANIA PLIBERSEK MP, MINISTER FOR HEALTH

For more information relating to the Federal Budget and media engagement, please go to the Media Releases section on the homepage of the RACP website: www.racp.edu.au.

“THIS YEAR’S BUDGET ADVOCACY WORK BUILDS ON THE SUCCESSFUL OUTCOMES THE RACP EXPERIENCED WITH THE 2012–2013 FEDERAL BUDGET SUBMISSION, IN TERMS OF BOTH REFORM AND RECOGNITION AS A KEY HEALTH STAKEHOLDER AND CONTRIBUTOR TO THE HEALTH WORKFORCE.”

The announcement of the Australian Federal Budget is one of the most important dates on the calendar for the healthcare industry, and for The Royal Australasian College of Physicians (RACP). The Budget provides a clearer understanding of the funding priorities of the Federal Government and lays the foundation for healthcare investment. This upcoming Federal Budget, to be announced on 14 May 2013, comes at a crucial time, with pressure on the Federal Government to deliver a tight fiscal Budget, advance the National Disability Insurance Scheme (NDIS) and carefully navigate through issues of state and territory jurisdiction.

The RACP Federal Budget submission is a significant piece of work produced by the College, representing the policy priorities of the Fellows and trainees of all Divisions, Faculties and Chapters. The aim of the RACP Federal Budget submission is to help influence, and work with, the Federal Government, the Minister for Health and the Department of Health and Ageing to improve the healthcare system for all Australians, particularly the most vulnerable and disadvantaged groups, including those in the aged care setting, Indigenous Australians, and patients living in rural and remote communities who do not have equitable access to healthcare services.

Whole-of-College priorities in the RACP Federal Budget submission include health workforce capacity and the provision of general medicine in the rural and remote setting. Additional critical components of the RACP Federal Budget submission include Indigenous health, equitable access to pharmaceutical products, and delivering coordinated and integrated healthcare through National Health Reform structures such as Medicare Locals and Local Hospital Networks.

This year’s Budget advocacy work builds on the successful outcomes the RACP experienced with the 2012–2013 Federal Budget submission, in terms of both reform and recognition as a key health stakeholder and contributor to the health workforce. In May 2012, the Government announced an aged care package and dedicated funding to improve oral health throughout Australia. The RACP, along with other key stakeholders, advocated for funding for both aged care and oral health in the lead-up to the Budget announcement.

The Federal Budget at a glance

**Budget to be delivered:**
14 May 2013

**RACP priorities for the 2013–2014 Federal Budget:**
- Models of care in the community, including rehabilitation care and aged care
- Indigenous health, including access to services and continued funding for the National Partnership Agreement (NPA)
- Equitable access to pharmaceutical products
- Increasing support for the screening and treatment of sexually transmitted infections (STIs) and HIV

**Funding allocation in the 2012–2013 Federal Budget:**
- $1 billion over four years for the first stage of a National Disability Insurance Scheme
- $515.3 million to improve dental services and strengthen the future dental workforce
- A $3.7 billion package to ensure a better, fairer, more sustainable and nationally consistent aged care system
Adverse drug reporting ... the facts

ACTION NEEDED TO VASTLY IMPROVE LEVELS OF ADVERSE DRUG EVENT REPORTING

Adverse Drug Events (ADE) are a significant cost to the Australian community in terms of related visits to healthcare professionals and hospitals. It has been estimated that over 1.5 million Australians suffer an adverse event from medicines each year, resulting in at least 400,000 visits to general practitioners, 190,000 hospital admissions and, in severe cases, death.

Despite these costs, the reporting of adverse events by healthcare professionals is not mandated by the Therapeutic Goods Administration (TGA) and, as a result, only 9% of all problems reported to the TGA originate from healthcare professionals.

Medications are the most commonly used health intervention in Australia. According to the Australian Commission on Safety and Quality in Health Care (ACSQHC), the associated risk of error and harm is significant. ACSQHC estimates approximately 2–3% of all hospital admissions are medication-related and, of those, approximately 50% are preventable.

With so few healthcare professionals currently reporting adverse events there is a danger that potential safety issues with medications are going unreported, according to Professor Richard Day from the RACP Therapeutics Expert Advisory Group.

‘Reporting adverse events allows the early identification of risks and effective communication of safety related information that ensures patients can be appropriately managed to achieve the best clinical outcomes,’ Professor Day said. ‘The value of reporting all adverse events is to identify previously unknown risks that require changes in patient management or, if necessary, urgent action to be taken to withdraw a product.’

The RACP is calling for the Australian Government, through the TGA, to implement strategies to increase awareness of, and improve adverse event reporting by, healthcare professionals. Proposed strategies include mandated reporting, reimbursement for the time taken to complete administrative work associated with adverse event reporting, training for all healthcare practitioners in adverse event reporting, and the formation of a working group of multidisciplinary stakeholders to develop tools to support medication safety that capture timely adverse event reporting in all settings.
Only 9% of all problems reported to the TGA originate from healthcare professionals.

It has been estimated that over 1.5 million Australians suffer an adverse event from medicines each year.

These events result in at least 400,000 visits to general practitioners and 190,000 hospital admissions each year.

And in severe cases, death.

The cost to the community is significant with estimates for medicine-related hospital admissions in 2008 at $660 million.1

The College Calls for Equality in eHealth Incentives

The RACP is calling on the Federal Government to equal the incentives provided to general practitioners (GPs) to encourage uptake of emerging eHealth technologies. Currently, GPs have access to a Practice Incentive Payment (PIP) to encourage them to engage with emerging eHealth technologies, including personally controlled electronic health records (PCEHR).

‘Unfortunately, at this point in time, a similar incentive is not available to specialist physicians,’ RACP President, Associate Professor Leslie E Bolitho AM, said.

‘For eHealth to be successful, all medical practitioners in Australia, including both GPs and specialist physicians, will need to adopt eHealth technologies. The advantages of eHealth are well established. At the most basic level, eHealth can better streamline patient interactions with the healthcare system, and will also help better manage patient outcomes.’

Extending the PIP to specialist physicians will encourage the use of emerging eHealth technologies by physicians both in rural and metropolitan settings. This will enable physicians to update online patient records as required, leading to more complete online records and better coordination of care.

‘By extending Practice Incentive Payments to physicians, there is the opportunity to better promote communication between medical services and greatly improve the exchange of information, such as discharge summaries and referral letters, between health services to allow patients to receive improved continuity of care.

‘The RACP recommends that a Specialist Practice Incentive Payment be made available to enhance the eHealth readiness of specialist physicians and to encourage the uptake of technology. By doing so, this would formally acknowledge the critical role of the specialist in the care of patients living in isolated communities.’

 administered by the Australian Government Department of Human Services, on behalf of the Department of Health and Ageing, PIP is part of a blended payment approach for general practice. Currently, PIP is made up of 11 incentives, and practices can apply for as many of the incentives as they are eligible for. For further information, please visit www.medicareaustralia.gov.au/provider/incentives/pip.
CALL FOR CONTINUED NPA FUNDING, CRITICAL FOR INDIGENOUS HEALTH REFORM

Aboriginal and Torres Strait Islander peoples continue to experience poorer health outcomes than non-Indigenous Australians. Life expectancy remains 10 years less on average, and up to 80% of this difference is attributed to chronic disease. Timely access to high-quality and culturally appropriate specialist medical care is essential to prevent and manage chronic disease and to close the gap in life expectancy and infant mortality between Indigenous and non-Indigenous Australians.

The RACP is calling for the Australian Government to improve access to specialist services for Aboriginal and Torres Strait Islander peoples by extending funding for the National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes and supporting Aboriginal and Torres Strait Islander people to access specialist medical care through primary healthcare services, especially Aboriginal Community Controlled Health Services.

The main difficulty facing Aboriginal and Torres Strait Islander peoples is the lack of systematic access to timely healthcare that is appropriate to their needs and culture. The poor distribution and planning of the specialist physician workforce means a shortage of physicians in rural and remote locations, which typically have a high proportion of Indigenous people in the population. In these instances, Indigenous people may need to travel long distances to reach specialist medical care, expending time and money in the process.

In July 2009, the Council of Australian Governments (COAG) committed $1.6 billion over four years to close the health and life expectancy gap between Indigenous and non-Indigenous Australians through the NPA on Closing the Gap in Indigenous Health Outcomes. This NPA has provided the bulk of funding for Indigenous health services, including the Australian Government’s Indigenous Chronic Disease Package. Existing programs funded through the NPA as part of the Chronic Disease Package, including the Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease (MSOAP-ICD), must be continued in recognition of time being needed to establish services, engage communities and achieve long-term improvements in health outcomes.

With the NPA funding due to cease on 30 June 2013, it is crucial that Australian Governments continue to ensure that funding is available at a comparable or increased level to maintain essential programs and services. There is currently no undertaking from either Federal or State Governments that this funding will be extended.

Timely access to high-quality and culturally appropriate specialist medical care provided by specialist physicians is essential to prevent and manage chronic disease and improve the health and life expectancy outcomes of Aboriginal and Torres Strait Islander peoples.

“LIFE EXPECTANCY REMAINS 10 YEARS LESS ON AVERAGE, AND UP TO 80% OF THIS DIFFERENCE IS ATTRIBUTED TO CHRONIC DISEASE.”

“THE POOR DISTRIBUTION AND PLANNING OF THE SPECIALIST PHYSICIAN WORKFORCE MEANS A SHORTAGE OF PHYSICIANS IN RURAL AND REMOTE LOCATIONS, WHICH TYPICALLY HAVE A HIGH PROPORTION OF INDIGENOUS PEOPLE IN THE POPULATION.”

According to the RACP Aboriginal and Torres Strait Islander Health Advisory Committee, if funding for the NPA is not continued and the Australian Government does not support improved access for Aboriginal and Torres Strait Islander people to specialist medical care, it will mean a large reduction in funding for healthcare services for Aboriginal and Torres Strait Islander peoples. This will severely impact on the goal of closing the gap in life expectancy and infant mortality between Indigenous and non-Indigenous Australians.
RACP CALLS FOR NATIONAL HEALTHCARE STANDARDS FOR INCARCERATED ADOLESCENTS

As part of its 2013–2014 Federal Budget submission, the RACP is calling for a significant shift in engagement with adolescents in the justice setting, a marginalised group often beyond the reach of traditional health services.

Led by the Paediatrics & Child Health Division, the RACP is urging the Government to develop national standards for the provision of healthcare to adolescents and young adults in incarcerated settings in Australia. In doing so, the RACP is seeking to address challenges facing adolescents within the justice system who experience poorer health outcomes and disproportionately high levels of disadvantage over that of the general population.

Adolescents within the justice system suffer a broad range of psychosocial problems and decreased opportunities and, as a result, rank amongst the most disadvantaged group within the community, according to Princess Margaret Hospital, Perth-based paediatrician Dr Andrew Kennedy. Dr Kennedy chaired the Working Group responsible for developing the Health and Well-being of Incarcerated Adolescents Policy Statement, launched at the 2011 RACP Congress in Darwin.

‘The challenge is to provide accessible, innovative and effective treatment to adolescents particularly in the custodial setting,’ Dr Kennedy said.

‘There is a disproportionately high number of Australian Aboriginal and Torres Strait Islander youth in the custody setting compared to the non-Indigenous population. The time in custody provides an opportunity, which must be taken, to provide comprehensive healthcare to a population which has high levels of healthcare needs and frequently receives minimal healthcare when in the community.’

At present, there are no national standards or policies reflecting best practice for these groups in either Australia or New Zealand, rather each state, territory or district provides healthcare in their own way. The College is calling for a service for adolescents in custody that provides health screening within 24 hours of entry into detention, to establish current health status and identify and intervene where appropriate for health risk behaviours.

Despite the reasons for incarceration – social background and the potential ill effects of prison – it may also be an opportunity to start to correct social and health disadvantages, according to Dr Kennedy. ‘It is critical that we offer incarcerated adolescents care that is developmentally appropriate, culturally safe, community based and sensitive regardless of the custodial setting. Clinicians need to play a key role and collaborate with staff to educate, promote and develop effective mental health programs in youth detention, and work to reduce the stigma toward mental health evaluation and treatment.’

The College is calling for the services offered in the juvenile system to be continued once the adolescent returns to the community and, ideally, to include parents and carers through a whole-of-government approach.

“ADOLESCENTS WITHIN THE JUSTICE SYSTEM SUFFER A BROAD RANGE OF PSYCHOSOCIAL PROBLEMS AND DECREASED OPPORTUNITIES AND, AS A RESULT, RANK AMONGST THE MOST DISADVANTAGED GROUP WITHIN THE COMMUNITY…”

“IT IS CRITICAL THAT WE OFFER INCARCERATED ADOLESCENTS CARE THAT IS DEVELOPMENTALLY APPROPRIATE, CULTURALLY SAFE, COMMUNITY BASED AND SENSITIVE REGARDLESS OF THE CUSTODIAL SETTING.”

For further information relating to the RACP Federal Budget submission, please go to the Policy & Advocacy page on the RACP website www.racp.edu.au.
NEW SPECIALIST ADVANCED TRAINING PATHWAYS IN REGIONAL NSW

A terrific opportunity for trainees keen to gain a breadth of experience and skills.

Two new specialist Advanced Training positions will commence in Dubbo and Orange in regional NSW in 2014.

The dual-training positions will be in General and Acute Care Medicine and Respiratory Medicine, and General and Acute Care Medicine and Endocrinology. The positions will be supported by structured, accredited four-year training pathways.

Successful applicants will be based in Orange or Dubbo for general medicine training, with mapped out rotations for additional specialty training to facilities accredited in respiratory medicine and/or endocrinology.

It is envisioned that there will be consultant physician positions available in Dubbo and Orange at the conclusion of training.

Trainees who want the knowledge, skills and expertise to manage a wide range of challenging clinical scenarios, with the additional scope to practise in a specific specialty area, and who are passionate about rural medicine, can look for the advertised positions in the NSW Junior Medical Officer recruitment round in July.

The positions have been funded by the NSW Government specifically to increase the dual-trained and general physician workforce in NSW. For further information, contact Anne Mooney, Senior Policy Officer, on 61 2 9256 9655 or by email, anne.mooney@racp.edu.au.

WORKING AS A GENERALIST IN THE BUSH

Being a generalist physician has led to some rewarding and unique experiences for Katherine-based Dr Simon Quilty. With a background in engineering, Dr Quilty developed an interest in healthcare sustainability and, from there, a desire to become a ‘solid doctor’ with the capacity to act independently and in a rural or remote setting.

Dr Quilty recently commenced his final year of RACP Advanced Training in general medicine, and is now one of two physicians practising at the Katherine Hospital, 360 km south of Darwin, providing services to some 29,000 people living in Katherine and its surrounds. Over 80% of the patients are Indigenous, many of whom have limited understanding of Western culture and concepts of healthcare. Dr Quilty treats patients with a myriad of complex conditions including rheumatic valvular disease, diabetes, liver failure and sexually transmitted infections, such as chlamydia and gonorrhoea, often left untreated by patients.

It is his experience of disease management in the rural and remote setting that has propelled Dr Quilty to become an advocate of the generalist stream. ‘My decision to pursue general medicine was made after I completed Basic Training and, not finding an organ that particularly caught my eye, I felt that to add value in a setting like Katherine, the best option was to follow a pure generalist path,’ Dr Quilty said.

‘General medicine is an evolving necessity in medicine, with the increasing complexity of care that our profession is offering.’

“The positions have been funded by the NSW Government specifically to increase the dual-trained and general physician workforce in NSW. For further information, contact Anne Mooney, Senior Policy Officer, on 61 2 9256 9655 or by email, anne.mooney@racp.edu.au.
As medicine becomes more complex, the exciting potential is to extend the reach of high-quality medicine Australia-wide and, according to Dr Quilty, the College plays a vital role in providing this. ‘I see many opportunities for young generalists who are prepared to invent themselves to suit their unique locations, to improve the quality of medicine practised in the bush. Every hospital deserves a physician.’

Dr Simon Quilty
Senior Communications Officer

Are you a general medicine physician? RACP News welcomes stories and insights into the general medicine experience.

RACP TRAINING POSITIONS GUIDE 2013–2014 BOOKINGS NOW OPEN!
Promote your hospitals’ training vacancies at minimal cost while advertising to over 5000 Basic and Advanced Trainees.
Submit now your training positions available from May 2013 to June 2014 to be included in the annual RACP Training Positions Guide.
Find out more at www.racp.edu.au/page/positions-vacant-ads#guide
Contact Fay Varvaritis, Advertising at trainingpositions@racp.edu.au or on +61 2 9256 5482.
The Royal Australasian College of Physicians (RACP) policy and advocacy initiatives aim to represent and support both our Fellow and trainee members, and to improve the health of our communities.

Under these new arrangements, only those matters considered controversial by a College body, CPAC, or the Policy & Advocacy Unit will be referred to the CPAC Advisory Committee and or CPAC Council before they are progressed further.

The process for commencing policy and advocacy work by any College body will be facilitated by the ‘Go/No-Go’ rule that evaluates the relative priority and capacity of the College.

Except for decisions made by the CPAC Council during strategic meetings, the decision as to whether the College should proceed with any policy proposals will be made by the CPAC Advisory Committee on the recommendation of another College entity working with the Policy & Advocacy Unit.

All policy requests will be initially assessed by the Policy & Advocacy Unit and the Senior Executive Officer of the relevant College body, including Division, Faculty and Chapter Policy and Advocacy Committees, regional committees and New Zealand, for ‘Go/No Go’ and then to determine whether the work is controversial/non-controversial. Where unanimous agreement with all parties is not reached, the request must be reviewed by the next College entity to which the requesting College body reports.

These new arrangements will help streamline the College policy and advocacy process.

The RACP Board considers these changes to the CPAC structure and governance model as representing the College’s strong commitment to, and more dedicated focus on, policy and advocacy activities, initiatives and projects on behalf of our Fellows and trainee members.

The RACP Board has approved the changes to CPAC for an initial period of 12 months. A review of the new structure and governance model will be undertaken prior to the

Continued on page 19
IN BRIEF

The issue of medical or professional indemnity insurance is one that is undoubtedly of interest to RACP Fellows.

As a medical specialist, ensuring you review the types of insurance coverage available, and assessing the suitability of the various types of insurance available for your particular circumstances, is important.

Apart from undertaking your own research and conducting a review of your level of cover and insurance type from time to time, it may be appropriate to seek independent advice from an insurance broker or other qualified professional to make sure that your medical liability or professional indemnity insurance covers all your activities.

Questions that you might ask could include, but are not limited to: What risks are covered? What is the interpretation of each particular risk? What risks are not covered? What activities or circumstances would deem the insurance null and void?

Additional steps that you might like to take when assessing your insurance types and coverage could be talking to your relevant insurance provider and seeking assurances in writing if you have any concerns or doubts about what may or may not be covered by your medical liability or professional indemnity insurance coverage.

Insurance cover is complex and technical and working out the best cover depends on the circumstances of the professional who is covered, and the exact terms of the policy. It should always be remembered that each insurer will have different levels of coverage, inclusions and exclusions, and all of these factors need to be taken into account when considering which insurance policy is adequate to provide the appropriate level of cover and protection for your day-to-day medical practice, circumstances and location.

Continued from page 18

end of the 12-month period, with a further recommendation to be submitted to the Board at this time.

Further information about the changes, including the By-Laws for the new model and the guiding principles for the ‘Go/No Go’ and Controversial/Non-Controversial Models can be found at: www.racp.edu.au/page/policy-and-advocacy.
The Paediatrics & Child Health Division (PCHD) is honoured to be hosting the 27th Congress of the International Pediatric Association (IPA) – the International Congress of Pediatrics 2013 (ICP 2013). This lauded triennial event will be held for the first time in Australasia at the Melbourne Convention and Exhibition Centre, 24–29 August 2013.

Of special note, the Victorian Government and Melbourne Convention and Visitors Bureau are providing $300,000 to support ICP 2013 delegates from developing countries – 150 travelling scholarships will be awarded to delegates from low-income and lower-middle-income nations as rated by the World Bank.

‘Bridging the Gaps in Child and Adolescent Health’ is an appropriate theme for the Congress as we rapidly approach the checkpoint for the United Nations Millennium Development Goals target of reducing child deaths by two-thirds by 2015. The IPA is a signatory to this project, so ICP 2013 will provide a venue to review progress towards achievement of the goals and to learn from national successes.

The opening plenary of the Congress on Sunday, 25 August is ‘The State of the World’s Children: Where Are the Gaps?’ Speakers for this highlight event are Professor Sergio Cabral, President of the IPA (Brazil), Professor Robert Black, Johns Hopkins School of Public Health (USA), and Dr Mickey Chopra, UNICEF (USA).

The ICP 2013 program will focus on the gaps between research and healthcare practice, the gaps in services availability, and the transition gaps between child, adolescent/young adult and adult services. Disparities in the availability of vaccines, essential medicines and medical technology use will be specifically addressed.

Each day of the Congress has a specific theme supported by eight parallel sessions, Meet the Expert breakfast sessions, afternoon site visits and evening industry-sponsored symposia. Each morning will kick off with a plenary session, with two or more speakers, and keynote speaker presentations will be held each afternoon. Every day there will be eight workshops, symposia and paper presentations running in parallel, covering the widest possible range of paediatric, child health and paediatric surgery topics, from the acute management of burns, eating disorders and medical education to pre-conception origins of health and environmental impacts on child health. In other words – plenty of variety and choice!

Supporting and delivering this comprehensive program will be around 80 invited international speakers and session chairs, together with an even larger contingent of local paediatricians. Eminent speakers include adolescent health experts, Professors George Patton, Susan Sawyer (Australia) and Russell Viner (UK); Professor Zulfiqar Bhutta, from Pakistan, who will speak on diarrhoeal disease; and Professor Kim Mulholland (Australia) speaking on pneumonia vaccines. Current environmental threats will be discussed by Dr Ruth Etzel (USA), Professor Peter Sly (Australia) and Professor Mitsuaki Hosoya (Japan).

This year, the Annual Scientific Meeting of the PCHD will be integrated into the ICP 2013 event rather than being held at the RACP Congress in May. This means that the annual PCHD Howard Williams Oration will be held at ICP 2013 on Wednesday, 28 August. In addition, the PCHD Wiley Blackwell Publishing New Investigator, Best Poster Presentation
and Rue Wright Memorial Awards will attract, for this year only, an international field of contestants and will be presented at ICP 2013, together with the paediatric component of the esteemed College Research Trainee Award, which is open to candidates across Australia and New Zealand.

There will be plenty of opportunity to network and enjoy yourselves. The Opening Ceremony of ICP 2013, the evening of Saturday, 24 August, is always a highlight of the IPA Congress. This year, the Opening and Closing Ceremonies will have a distinctive Australian and New Zealand flavour with entertainers and performers from both sides of the Tasman. The IPA will hold an Alumni Dinner, and the Gala Congress Dinner will be held at a Docklands restaurant. Please book early!

ICP 2013 is a wonderful opportunity to showcase the best in paediatrics and child health from New Zealand and Australia and to learn and work together so that, collectively, we can make a difference for children around the world.

Check www.ipa-world.org/IPAcongress regularly for updates and register now for this exciting event.

ICP 2013 Congress President

Associate Professor Neil Wigg

ICP 2013 WORKSHOPS

On 24 August, the day of the Congress Opening Ceremony, a series of Pre-Congress Workshops will be held, requiring separate delegate registration. The workshop themes are:

- Advocacy and Tobacco Control
- Environmental Health
- Early Child Development
- Immunisation Champions Workshop
- Helping Babies Breathe: Master Training Course
- International Network of Paediatric Surveillance Units
- Dealing with Children in Disasters
- International Pediatric Academic Leaders Association (IPALA) Meeting.

This is a fantastic opportunity for PCHD Fellows and trainees to present their work to an international audience and to engage with a diverse global educational program.

IN BRIEF

Professor Stephen Davis FRCP Edin FRACP has been appointed the new President of the World Stroke Organization, the Geneva-based international NGO working to reduce the global burden of stroke. His predecessor Professor Bo Norrving congratulated him, saying, ‘The society will be in the best of hands with Steve Davis as my successor. He has all the qualifications needed and more.’ Professor Davis is Director of Neurosciences and Continuing Care, Director of Neurology and Director of the Melbourne Brain Centre at Royal Melbourne Hospital.

College Fellow Professor Robin Mortimer AO has been elected as the new President of the Australian Medical Council (AMC). An internationally recognised physician, Professor Mortimer is the Executive Director of the Office of Health and Medical Research, Queensland Health. He also holds the positions of Senior Specialist and Director of Endocrinology at Royal Brisbane and Women’s Hospital, and is Professor, Disciplines of Medicine, Obstetrics and Gynaecology at The University of Queensland. Professor Mortimer’s long service to medical education and research includes an important contribution to the AMC’s assessment and accreditation of medical education programs.

RACP Past President Professor Richard Smallwood AO recently stepped down as President of the AMC. Professor Mortimer paid tribute to Professor Smallwood’s contribution to the AMC, saying that under his leadership, ‘the AMC moved to its position as the accreditation authority for medicine under the National Law’, and to his ‘wise counsel to the Directors, committees and AMC staff’.

Recognised as a leader in paediatric education, Associate Professor Jillian Sewell AM FRACP has been elected as Deputy President of the AMC. She also chairs the AMC’s Specialist Education Accreditation Committee. Professor Sewell is the Deputy Director, Centre for Community Child Health at the Royal Children’s Hospital (RCH), a principal paediatric specialist at RCH and Associate Professor in the Department of Paediatrics at the University of Melbourne.
NZ NEW YEAR AND AUSTRALIA DAY HONOURS AWARDEES

The College offers warm congratulations to the following physicians mentioned in the 2013 Australian and New Zealand Honours Lists; in particular to Senior Australian of the Year for 2013, Professor Ian Maddocks AM.

NEW ZEALAND NEW YEAR HONOURS 2013

Member of the New Zealand Order of Merit
Dr William Childs FRACP – For services to health

Companion of the New Zealand Order of Merit
Professor Ivan Donaldson FRACP – For services to neurology

SENIOR AUSTRALIAN OF THE YEAR

Professor Ian Maddocks AM FRACP FAFPHM FAcHPM
Eminent palliative care specialist, recognised internationally for his work in tropical and preventative medicine as well as his exemplary care for the terminally ill

PHYSICIAN FINALISTS FOR AUSTRALIAN OF THE YEAR AWARDS

Senior Australian of the Year Finalists
Dr Sadhana Mahajani FAFPHM – 2013 NT Senior Australian of the Year
Professor T John Martin AO FRACP – 2013 Victorian Senior Australian of the Year

Dr Susan Sayers FRACP – 2013 NT Finalist

Australian of the Year Finalists
Professor Adèle Green AC FAFPHM – 2013 Queensland Australian of the Year
Professor Christine Bennett FRACP – 2013 NSW Finalist
Professor Alex Brown FRACP (Hon) – 2013 NT Finalist

Dr David Joske FRACP – 2013 WA Finalist

Young Australian of the Year Finalist
Dr Linny Phuong, Basic Trainee – 2013 Victorian Finalist

Australia’s Local Hero Finalist
Dr Steve Fiecknoe-Brown FRACP – 2013 NSW Finalist

AUSTRALIA DAY HONOURS 2013

Member (AM) in the General Division

Professor Stephen Davis FRACP
For significant service to medicine in the field of neurology

Associate Professor Jeno E Marosszeky FAFRM
For significant service to rehabilitation medicine and through contributions to people with arthritis

Professor Bruce W Robinson FRACP
For significant service to medicine in the area of research into asbestos-related cancers and to the community, particularly through support to fathers

Professor Peter Silburn FRACP
For significant service to medicine as a neurologist, particularly in the treatment of neurodegenerative diseases

Professor David Sillence FRACP FAFPHM FAFRM
For significant service to medicine in the field of clinical genetics

Professor Roger Smith FRACP
For significant service to medical research and development in the Hunter region and in the field of maternal health

Professor Richard Speare FAFPHM
For significant service to medical and biological research through leadership roles in the areas of public health

Associate Professor Jitendra K Vohra FRACP
For significant service to medicine in the field of cardiology

Professor Neville D Yeomans FRACP
For significant service to tertiary education, research and clinical practice in the field of medicine

Medal (OAM) in the General Division

Dr James E Breheny FRACP – For service to medical administration

Professor Bradley S Frankum FRACP – For service to medicine as an educator and administrator

Professor Robert Iansek FRACP – For service to medicine in the field of neurology

Public Service Medal
Queensland

Associate Professor Neil Wigg FRACP
For outstanding public service to paediatrics and child health in Australia

Western Australia

Dr Andrew Robertson CSC FAFPHM
For outstanding public service as Director, Disaster Management and Preparedness within WA Health
CONJOINT MEDICAL EDUCATION SEMINAR 2013

Friday 8 March 2013
Sofitel Sydney Wentworth, Australia

“Serving the Community: Training Generalists and Extending Specialists”

Further Information:
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CELEBRATING OUR 75TH ANNIVERSARY AND LOOKING TO THE FUTURE AT CONGRESS 2013

This year the College has reached a significant milestone in its history – its 75th anniversary. The RACP Future Directions in Health Congress 2013, to be held at the Perth Convention Exhibition Centre from 26 to 29 May, will start a year of activities to celebrate this milestone with members.

Congress is the key annual event in the College calendar and the largest annual multi-disciplinary internal medicine meeting in Australasia. Along with providing Fellows and trainees with a forum to learn about new developments for physicians, the RACP Future Directions in Health Congress 2013 is an opportunity for delegates to network with their peers and colleagues.

Our 75th Anniversary theme is to recognise and celebrate the significant history of the College, focusing primarily on the College as it is today and where it is heading into the future. The celebrations will commence with a 75th year Anniversary Gala Dinner at Congress.

Online registration is now open for Congress. To take advantage of the Early Bird discount, which includes attendance at the 75th Anniversary Gala Dinner, simply register and pay by 27 March 2013 at: www.racpcongress2013.com.au.

We encourage all our members to join us at this event, participate in the Congress program, and experience the amazing surroundings and lively atmosphere of our host city Perth and other wonderful parts of Western Australia.

For more information and recent updates, visit the RACP Future Directions in Health Congress 2013 website at www.racpcongress2013.com.au.

TOPICS AND STREAMS AT CONGRESS
An engaging and stimulating program has been developed for the Future Directions in Health Congress 2013, incorporating the following topics and streams.

- Physicians as Advocates
- Physicians as Clinical Leaders
- Physicians of the Future
- Physicians as Medical Experts
- Physicians’ Performance and Professionalism
- Physicians in Research
- Physicians in the Workplace
- Physicians as Educators

One of the highlights of this stream is that Professor Fiona Lake will be delivering teaching and learning in healthcare settings in an interactive workshop on supervision within the College program.

WELCOMING EVENTS AND CELEBRATIONS AT CONGRESS
Attendees at Congress will be able to participate in and enjoy a number of events and celebrations at the Perth Convention and Exhibition Centre, including:

- The College Ceremony at Riverside Theatre – 26 May 2013
- The College Ceremony Reception at the Foyer – 26 May 2013
- The Congress Welcome Reception at Congress Exhibition Hall – 27 May 2013
- The College 75th Anniversary Gala Dinner at the BelleVue Ballroom – 28 May 2013

TWO SPECIFICALLY DESIGNED SESSIONS FOR RACP TRAINEES
How toPresent Yourself Best in the Clinical Examination
For Basic Trainees

Becoming a Physician
An opportunity for Advanced Trainees to learn more about the PREP Advanced Training programs, including the associated tools and requirements.
Professor Mark Graber has a longstanding interest in patient safety, founding Patient Safety Awareness Week in the US in 2002, which is now recognised internationally. He is also regarded as an international authority on diagnostic error in medicine, and in 2011 founded the Society to Improve Diagnosis in Medicine.

Professor Graber has over 70 peer-reviewed publications on biomedical and health services research topics to his credit.

Winthrop Professor Fiona Wood is a Plastic and Reconstructive Surgeon specialising in the field of burn care, trauma and scar reconstruction.

W/Professor Wood was the recipient of the 2003 Australian Medical Association ‘Contribution to Medicine’ Award and an Order of Australia Medal for work with Bali bombing victims. She was named West Australian of the Year for 2004, and was nominated as a National Living Treasure and Australian Citizen of the Year in 2004. W/Professor Wood was again named West Australian of the Year for 2005, and received the honour of being named Australian of the Year in 2005.

Associate Professor Jos Verbeek is an occupational health physician who has conducted research in the area of evidence-based occupational health. He is an associate professor at both the Coronel Institute of Occupational Health in Amsterdam and the University of Kuopio in Finland.

In Finland, he set up the Occupational Safety and Health Review Group in the Cochrane Collaboration.

Associate Professor Verbeek is co-author of 18 Systematic Reviews and editor of a guidebook on Evidence-based Occupational Health published by the World Health Organization.

For detailed activities and listings, visit www.racpcongress.com.au.
Members of the Direct Observation of Procedural Skills working group engaged in the development of this new assessment tool

A new evidence-based assessment, the Direct Observation of Procedural Skills (DOPS) tool aims to guide trainee learning and achievement of competency. The trainee performs a procedure on a real patient in the workplace and is observed by an experienced and knowledgeable assessor who reviews the trainee’s performance against a structured checklist. The assessor provides feedback to the trainee, which allows the trainee, the assessor and the trainee’s supervisor to collaboratively identify learning needs and plan future learning opportunities.

Development of DOPS was guided by a working group of Fellows and trainees who were representative of 10 Division and Faculty training programs to which the assessment is relevant. Convening of a working group of Fellows and trainees is now standard practice for the development of any College educational resources, to ensure that any new assessments and teaching and learning resources are tailored to best meet the needs of trainees and Fellows and are easily implemented in the workplace.

Implementation of the Direct Observation of Procedural Skills assessment is supported by resources such as information sheets, workflows, specialty-specific assessment guides and example videos, planned in partnership with the working group, RACP Medical Education Officers and Education Services.

The specialty-specific assessment guides, which are to be used in conjunction with the RACP Direct Observation of Procedural Skills rating form, information sheet and workflow, list the observable behaviours relevant to that specialty for each DOPS rating form criterion. These behaviours are considered to be markers of satisfactory performance of the procedure. Each assessment guide has been developed by a group of Fellows and trainees from the relevant specialty, ensuring that the DOPS assessment tool is relevant to trainees and assessors working across the range of RACP specialties.

Direct Observation of Procedural Skills is a mandatory training requirement for trainees in Dermatology and Neonatal–Perinatal Medicine from 2013, with a phased implementation in a number of other training programs over the coming years.

An online manifestation of the tool, which was developed collaboratively by Education Services and Information Technology, is available through the Advanced Training Portal for all Divisional Advanced Trainees to use.

The Australasian Faculty of Occupational & Environmental Medicine already has a similar formative assessment tool – the Direct Observation of Field Skills (DOFS). This tool is being reviewed with a view to aligning it further with the Direct Observation of Procedural Skills tool.

In 2013, the Australasian Faculty of Public Health Medicine will pilot a tool based on the Direct Observation of Procedural Skills – the Direct Observation of Practical Professional Skills (DOPPS) – with a view to implementing it in 2014.

Further information on the Direct Observation of Procedural Skills assessment can be found in the Advanced Training Portal.

Katherine Deller
Education Program Development Officer

Genevieve Foster
Education Program Development Officer
In Australia, all providers of specialist medical education must be accredited by the Australian Medical Council (AMC). In New Zealand, the process of accreditation is managed by the Medical Council of New Zealand (MCNZ). The primary objective of these accreditation processes is to provide external assurance of the quality of medical education, based on explicit standards.

During the last review in 2010, the RACP was granted accreditation until December 2014 by both the AMC and the MCNZ. As a condition of accreditation, colleges are required by the AMC to submit Annual Reports describing significant changes to education programs and detailing progress on AMC recommendations.

Positive AMC feedback on 2012 Annual Report

The College submitted an Annual Report to the AMC in September 2012. The AMC’s Specialist Education Advisory Committee has now provided feedback to the College, concluding that:

The college has made significant progress with a structured approach to training and ongoing professional development. There is clear evidence that earlier planning processes are now delivering outcomes for both trainees and Fellows. This gives confidence to the community that the college responds to expectations and that the quality of their educational programmes is at an international standard. Credit should be given to the leadership of the college by the President and the CE and the staff should be commended for their professionalism in implementing the strategies and supporting the Fellows and trainees.

A number of recommendations are now satisfied and the AMC no longer requires reporting on recommendations pertaining to the College’s:

- development, delivery and implementation of all curricula
- links with rural hospitals to facilitate an adequate number of supervisors
- provisions for interrupted training and promotion of a family-friendly work environment
- development of positive relationships with health jurisdictions.

However, some of these areas remain developmental priorities for the College.

The sustained effort of College leaders, the Fellowship, supervisors, trainees and staff in this positive result deserves commendation.

Preparations have commenced on the 19 remaining recommendations as well as compilation of the 2013 Annual Report, referred to by the AMC as the 9th Year Report.

What is the 9th Year Report?

The purpose of the 9th Year Report is both to report on progress since the 2012 Annual Report and to assist the AMC/MCNZ in preparing for the 2014 reaccreditation review. Unlike previous annual reports which are due in September each year, the 9th Year Report is due to the AMC and MCNZ in July 2013. This is to ensure that the AMC/MCNZ can adequately prepare for the reaccreditation review, including selection of an appropriate reaccreditation panel.

What will reaccreditation involve?

The purpose of the 2014 reaccreditation review is to ensure that the College continues to meet the AMC Standards and MCNZ Criteria, and will continue to meet these during the years of reaccreditation following 2014. This process of review will involve:

1. Submission of the 2014 Comprehensive Report, including:
   a. progress on Standards/Criteria and recommendations since 2008
   b. areas for improvement, previously identified in the 2013 Annual Report
   c. the RACP’s five-year plan for education and professional development programs
   d. relevant statistics required by the AMC/MCNZ

2. Site visit, conducted over five days in October 2014

3. Evaluation surveys targeting trainees and Fellows.

Content will be written for the AMC Reaccreditation Report during September/October 2013.

The College Education Committees will have the opportunity to review draft content and provide feedback during the first quarter of 2014.

For further information, please contact amc@racp.edu.au.

Julie Gustavs
Manager, Education Development, Research & Evaluation
PRODUCTIVE EXTERNAL REVIEW OF ASSESSMENT PLANNING FORUM

The College was commended for the quality of its assessment program by the External Review team, who also made constructive suggestions for improvements which were discussed and prioritised at the recent Planning Forum.

RACP Director of Education Dr Marie-Louise Stokes led a session on reviewing and prioritising the 45 recommendations, spanning the 12 keys areas of the External Review Report. Working in groups and guided by focus questions, participants reviewed the recommendations and discussed the level of complexity for implementation as well as the level of priority to be assigned for each recommendation. This was followed by a consensus ranking activity, facilitated by Dr Julie Gustavs, for the 12 key areas. Recommendations within the following key areas were identified as the top four priorities of the College (3 and 4 were voted equally important):

1. Alignment of curriculum and assessments
2. Supervisors
3. Professional Qualities Curriculum

The consensus ranking enabled the College to clearly identify the recommendations which should be given our immediate attention. At the same time, it was reassuring that the College has already commenced development and ongoing improvement in most of these areas. It is also vital that steady progress be made on these existing programs, projects and activities and that steps be taken for those identified priorities which are still in the early stages of development.

For a complete copy of the report, visit the College website at: www.racp.edu.au/page/educational-research-and-evaluation.

Dr Julie Gustavs
Manager, Education Development, Research and Evaluation

See page 42 for Further Reading on this topic.
KEY FINDINGS OF THE EXTERNAL REVIEW OF FORMATIVE AND SUMMATIVE ASSESSMENT

1. The Review Team was impressed by the overall quality of the RACP assessment program, by the pertinence of the changes that have been and are being introduced, and by the enthusiasm with which Fellows are participating in the changes. The additional changes suggested by the Review Team are to make the assessment program more robust and better able to deal with anticipated future changes.

2. An assessment program should be evaluated against many factors, not solely on the reliability of the tests used. In particular, assessment should be viewed principally as a driver of teaching and learning towards competence. Success and usefulness of future modifications to the assessment program should be determined by using a multi-factorial index such as the Van der Vleuten utility index.

3. An overarching framework of standards should be developed to guide programs and assessments, and learning outcomes at all levels of training should be clearly expressed to facilitate the constructive alignment of learning activities and assessments with the standards.

4. The component parts of the written examinations should be administered and scored separately and offered sequentially earlier in training. Success on each should be a prerequisite to continuing training and sitting the next component, resulting in greater alignment between the training requirement of exam success and the progression of learning activities and skill development during Basic Training.

5. The clinical examination is the anchor of the current assessment for the completion of Basic Training. This should remain as is, given that many other changes to the assessment program are currently being introduced and consolidated as part of the PREP program.

6. The range of assessment tools in the PREP program should promote authentic assessment of daily workplace practice. Currently, however, they are mostly used too much like examinations – occurring periodically and outside of real daily clinical practice. Trainees and supervisors must be supported to ensure that the assessment tools are integrated into daily practice and supervision, and are used effectively to assess outcomes identified as being indicative of competence.

7. Formative assessment by a well-trained supervisor, based on identified desirable outcomes derived from standards is more onerous than many summative examinations, as trainees must demonstrate the acquisition of competence in order to progress. To capture this information, an electronic portfolio, linked to all standards and desired competencies, should be developed for use by trainees throughout their entire training. A well-constituted portfolio provides much better evidence of competence than any single summative examination; for this reason, it is not recommended that the RACP develop exit examinations for Advanced Training.

8. Trainees in difficulty must be identified early, rather than at the end of a long period of training, and certainly not at the end of their program. Emphasis should be placed on earlier periodic review using clear standards and appropriately defined expected competencies, which will reduce subjectivity and facilitate decisions when potential difficulties are detected. Local solutions should be the rule, while College support may still be needed at times.

9. Focused training and support should be provided to ensure that supervisors are knowledgeable about the purpose and use of new assessment tools.

10. The curriculum documents are of high quality and will contribute greatly to the success of the RACP training programs. It is important, however, to be sure they are aligned with clinical reality and that the expectations they generate are both achievable and aligned with competence. The Professional Qualities Curriculum should be reviewed to identify competencies that are required for all trainees and to ensure alignment with both learning opportunities and assessment.

11. Planning should be mindful of increases in medical graduate numbers. Issues around selection into training, workforce planning and sustainability must take account of trainees, training and supervision and marry with the future shape of the medical workforce.

ASSESSMENT SHOULD BE VIEWED PRINCIPALLY AS A DRIVER OF TEACHING AND LEARNING TOWARDS COMPETENCE

THE CURRICULUM DOCUMENTS ARE OF HIGH QUALITY AND WILL CONTRIBUTE GREATLY TO THE SUCCESS OF THE RACP TRAINING PROGRAMS
WHY BE A SUPERVISOR?

We discuss here the crucial role supervisors perform in educating and training the next generation of physicians, and the resultant benefits for both themselves and the wider community.

Supervisors play a key role in the development of trainees, both in the oversight of their day-to-day practice and in the support and orchestration of their learning experiences, aims and objectives. With increasing trainee numbers and the recent quality improvements to many training programs, it is more important than ever that new supervisors are recruited and existing supervisors are motivated to continue in their roles.

There are many intrinsic benefits of being a supervisor, which are well reported by Fellows. As part of the Year of the Supervisor, the College conducted a number of video interviews with leading College supervisors in Australia and New Zealand. One of the questions we asked them was: what do you get out of being a supervisor?

Responses were varied, but largely fell into three main themes: the satisfaction of giving back to the profession; contributing to the skill development and learning of others; and improving one’s professional practice by learning and ‘remaining current’ through engaging with trainees.

Giving back

I think it’s useful to share your personal experience, your personal journey, how you’ve gotten to where you are, things you might have done differently with trainees.

Dr Daryl Efron

Many Fellows look back on their own training experiences fondly. They appreciate the efforts of their own College supervisors who inspired them and generously shared their craft. They are keen to do the same for the next generation of doctors.

Contributing to the professional development of the next generation of doctors

If you can help a person be confident in the sort of person they want to be they will go on to achieve a lot and to be a physician who can support the community ... I think that’s the foundation.

Dr Donald Campbell

Helping someone to learn is a very satisfying life experience. On a personal level, it is an opportunity to contribute to someone’s growth and development. On a system-wide level, it ensures that quality standards are maintained in the profession.

Remaining in touch with latest trends in medical practice

... having trainees around is really, really valuable in terms of keeping me honest and keeping me up to date because I have no choice, they will call me out.

Dr Andy Lovett

There is no better way to learn than to teach. Trainees challenge you by asking questions and sharing their learning from the literature. This contributes to a supervisor’s own professional development and helps them to stay abreast of the latest trends in medical practice.

Supervision is fundamental to the success of the College’s training programs and to the future of the medical profession. The College is committed to providing ongoing educational, professional development and networking opportunities for supervisors to support them in their roles.

To learn about the role of supervisors, how to become a supervisor and the support the College provides to supervisors in their role, please contact the Supervisor Learning Support Unit by email at supervisor@racp.edu.au, or phone 61 2 8076 6300.

Julie Gustavs
Manager, Education Development, Research & Evaluation
There is a lot of evidence on the importance of feedback in medical education, which also acknowledges the complexities of feedback provision. Some of the challenges include: providing honest and accurate feedback; being mindful of the psychosocial needs and self-esteem of trainees; and protecting professional standards and the rights and safety of the patients involved. The subtlety required to maintain this balance may explain why supervisors say they regularly give feedback but trainees do not always recognise it as such.

Feedback should involve a conversation with the trainee, in which the supervisor seeks to understand not only the trainee’s perception of their own performance, but also the meaning of the task to the trainee and the motivation with which they have approached it.

Factors that may influence the impact of feedback

Although medical learners have been shown to value the provision of well-timed feedback from credible sources, circumstances have been identified in which feedback may be rendered meaningless to learners.

Watling et al. (2012)

Factors which can impact how influential feedback is include:

- **Timing.** When received at critical junctures in training, feedback can inspire new goals and aspirations.

- **Appropriateness to stage of training.** Giving positive praise to a senior trainee who is comfortable and proficient performing a simple procedure will generally be of little value to the trainee.

- **Reflection.** Over time, feedback which is initially discouraging can become motivating as the trainee reflects on the situation and reconsiders why the situation occurred.

- **Engagement.** When trainees perceive the person giving them feedback is not engaged in the creation and exchange of informed and accurate feedback, they may reject the feedback.

- **Incentives to performing a task.** There are aspects of medicine that trainees ‘want to do’ and others that they ‘have to do’. For example, breaking bad news is something that has to be done in the profession, and the trainee wants to do this well. In circumstances such as this, a mix of corrective and positive feedback can be useful.

- **External forces.** Aspects of the environment such as the professional culture or personal problems are likely to influence how trainees perceive and respond to feedback.

RACP Practical Skills for Supervisors workshop

If you are interested in finding out about how to give more effective feedback, the RACP will be running Practical Skills for Supervisors workshops on this topic around Australia and New Zealand in 2013. If you are interested in attending one of these workshops, or would like to be trained by the RACP to facilitate and deliver one of these workshops, please contact the Supervisor Learning Support team by email at supervisor@racp.edu.au or by phone, 61 2 8076 6300.

Erin Murphy
Acting Senior Executive Officer, Supervisor Learning Support

See page 43 for Further Reading on this topic.
STP MEDICAL ONCOLOGY POST HELPS CANCER CARE AT TOP END

A Specialist Training Program (STP) post established two years ago by the sole medical oncology consultant at Royal Darwin Hospital, Dr Narayan Karanth, is helping improve cancer care in the Northern Territory.

Dr Narayan Karanth was an independent medical oncology consultant at the Royal Darwin Hospital and Alan Walker Cancer Centre when, in 2010, he saw the potential for an advanced medical oncology traineeship in the Northern Territory.

‘I could see a variety of cancer cases at the Top End from the very beginning,’ he told RACP News. ‘Population dynamics, socioeconomic status and the geography make the Northern Territory very unique with respect to exposure to cancer patient therapy. Trainees get to know the management of Indigenous Australian cancer patients as well as the Culturally and Linguistically Diverse (CALD) population in addition to the Caucasian population.’

Dr Karanth successfully applied for STP funding for 2011–2013 (extended now to December 2015) and worked with Dr Nadarajah Kangaharan, Co-director of Medicine at Royal Darwin Hospital, and Dr Sudarshan Selva, Director of Medical Oncology from Royal Adelaide Hospital, to achieve College site accreditation. He also established a network with Dr Selva whereby medical oncology trainees from Royal Adelaide Hospital could complete a six-month rotation in the STP post.

This position offers broad medical oncology training in most cancers, with wide exposure to consultants (currently three on site and one visiting) and involvement in both outpatient and inpatient management. There is close interaction with other specialties such as radiation oncology, haematology and palliative care. The post also allows for participation in clinical trials and exposure to telehealth and outreach services.

‘There is wide heterogeneity in the type of patient population which can be accessed and assisted,’ Dr Karanth said.

‘Trainees get to know how to provide cancer therapy while simultaneously dealing with various social and geographic issues. There is one-to-one supervision with consultants as well as independent clinics, making the training suitable for both the novice and the final year trainee.’

Dr Michail Charakidis, the first advanced medical oncology trainee to hold the STP post, agrees that the interaction with patients from different cultural backgrounds is a valuable learning experience and a chance to develop strong communication skills.

‘Achieving a clear understanding [by the patient] of the disease, prognosis and treatment is essential to maintain trust and engagement with your proposed treatment and medical follow-up,’ he said.

The position also allowed Dr Charakidis to be exposed to a variety of tumour types, as there are no specialised cancer clinics in Darwin.

‘The oncology unit at the Alan Walker Cancer Centre is small, allowing easy and personal communication amongst team members and other specialties, facilitating potentially better outcomes for patients,’ Dr Charakidis said.
QUEENSLAND FLOOD CRISIS

The recent flood crisis that has impacted Queensland and New South Wales has devastated a number of communities and has had a significant effect on the College, our Fellows and trainees.

Along with our Queensland colleagues who are feeling the biggest impact of the current flood crisis, Fellows and trainees in New South Wales, Victoria, Tasmania and Western Australia have also been affected by significant bushfires, in what has been a difficult and challenging start to 2013.

For our colleagues in Queensland, this current flood crisis has come within two years of the last devastating natural disaster. The communities along the east coast of Australia have shown tremendous strength under difficult circumstances.

Following the Queensland and New South Wales floods of 2011, we applauded the professionalism and adaptability of our Fellows and trainees in dealing with the natural disaster and I am confident we will again do so in these circumstances.

It has been a difficult start to the year in Australia with floods and cyclones challenging us and the communities in which we operate. The loss of life and damage to infrastructure in Queensland is devastating, and the College offers our support to all those affected. The College recognises the enormity of the crisis facing many, the immediate dangers posed by the rising water levels and the lasting impact of such a natural disaster. We would also like to acknowledge the hard work and dedication of all our Fellows and trainees during a difficult and uncertain time.

We recognise the recovery process will be long and arduous, however the College will continue to explore how we can best support and assist our Fellows and trainees in Queensland and New South Wales.

Associate Professor Leslie E Bolitho AM
President RACP

On the other hand, there is only one Advanced Trainee position in medical oncology, and at times you may feel isolated. Participating in registrars’ tutorials can be challenging, although the telecommunication system available at Darwin’s cancer centre may assist future trainees to attend these.

Dr Karanth said feedback on the post had so far been encouraging.

‘We have had successful completion of core training of trainees (six months each) in the preceding 12 months. Thanks to the continued STP funding at our regional centre, we have been able to recruit trainees for 2013 through the South Australian trainee pool,’ he said.

‘Commencement of the Advanced Training has definitely impacted the overall quality of cancer care at the Top End.’

Dr Charakidis said he would highly recommend, and encourage, other medical oncology Advanced Trainees interested in rural and Indigenous health to apply for the STP position.

‘There is a lot to be gained in both the professional and personal field. It is a lot more challenging than some may think.’

Louise Young
Specialist Training Program

STP is an initiative funded by the Department of Health and Ageing (DoHA) to increase training opportunities for medical specialists in expanded healthcare settings, including rural and remote, private healthcare and community care. For more information, email stp@racp.edu.au or visit www.racp.edu.au/page/stp.

DR CHARAKIDIS SAID HE WOULD HIGHLY RECOMMEND, AND ENCOURAGE, OTHER MEDICAL ONCOLOGY ADVANCED TRAINEES INTERESTED IN RURAL AND INDIGENOUS HEALTH TO APPLY FOR THE STP POSITION.
FROM THE HONORARY TREASURER

Following on from the RACP 2012 Member Research Study, we are introducing a series of articles by RACP Board Directors to keep you informed about your College and the wide range of College activity. We begin with a communiqué from the Honorary Treasurer, Clinical Associate Professor Michael Hooper.

In each upcoming edition of RACP News there will be an Honorary Treasurer’s column in which I will address business issues of the College that are relevant to Fellows and trainees of the RACP.

Some of you may not be aware of the role or responsibilities of the Honorary Treasurer, or indeed who I am and how I hold this role.

Role of the Honorary Treasurer and Finance Committee

The Honorary Treasurer of the College is elected by the Board of Directors and is responsible for oversight of all financial, commercial and investment activities of the College. To many Fellows, this may seem to be an odd role for a Fellow for, as physicians, we are often not involved in these activities. The Honorary Treasurer is supported by a strong Finance Committee of which she/he is the Chair. The Committee is made up of Fellows and, most importantly, community members who bring vast experience and knowledge to the governance, operation, reporting and performance of financial, commercial and investment activities. Some Committee members are Board members and others are not.

I would like to acknowledge the enormous pro bono commitment Members of the Finance Committee make to Fellows and the College.

My background as a Physician

I am an Endocrinologist, currently in private practice, and a Clinical Associate Professor at Sydney University. I have been a Member of the RACP for almost 40 years and during that time have held the position of President of the Adult Medicine Division and the Honorary Treasurer role for four years, with two further years to serve of this second term of office. I also have been actively involved with the Specialist Societies, being the founding Honorary Secretary and a past President of the Australian and New Zealand Bone & Mineral Society.

Where does the money come from and where does it go?

Like the other Directors and many of the Fellows, I am acutely aware of the tremendous volunteer work of many of our Fellows as Clinical Examiners or Training Supervisors, or in serving on the vast array of committees of the College including State, Training, Policy & Advocacy, and Governance committees. At the present time, the RACP has more than 250 committees, which support training and the activities of Fellows. While the volunteer work of the Fellows is on a pro bono basis, the committees create a significant cost of some $8 million each year for the College. These costs relate to travel and accommodation for face-to-face meetings, video and teleconferencing, and administrative and professional support to each committee. A challenge for 2013 is for the College to achieve savings in this area under the guidance of a Working Party.

I WOULD LIKE TO REITERATE MY THANKS TO THOSE FELLOWS AND TRAINEES WHOSE PRO BONO WORK FOR THE COLLEGE REPRESENTS AN ENORMOUS ONGOING COMMITMENT … AND A SUBSTANTIAL FINANCIAL CONTRIBUTION TO OUR ORGANISATION.
I am often asked by Fellows, ‘What do I get for my money?’ and ‘What is my annual subscription used for?’

The College primarily derives its income from Fellow subscriptions and training and examination fees. Whilst, historically, annual subscriptions received from Fellows subsidised training, the College now directs all Fellow fees towards Fellow support and services, and training and exam fees reflect the costs involved.

**What do Fellows want?**

In the recent RACP 2012 Member Research Study, Fellows told the College that they wanted more CPD resources and additional policy and advocacy activity and membership-type services. The additional resources required have resulted in an increase in Fellow subscriptions of 7% for 2013. The Board is very conscious of this increase and the need for efficiencies and productivity across the College to mitigate costs. One of the key components in this efficiency and productivity program is the introduction of a New Administration System for the College, which will generate many benefits for members from 2014, including the ability to manage your own personal data and to choose how and what the College communicates to you.

**A time of greater regulation and costs in meeting regulatory requirements**

The College must meet the accreditation standards set by the Australian Medical Council (AMC), a role delegated to the AMC by the Medical Board of Australia and the Medical Council of New Zealand, to continue to offer its various Fellowships. The regulation that now governs the College’s education programs and associated costs will continue to increase, as will regulatory requirements from other government bodies such as those that oversee the not-for-profit sector.

**A caring College that recognises Fellows differing circumstances**

The College recognises Fellows who have reached the age of 70 as Life Fellows and Fellows who have retired from clinical practice. Neither of these categories of Fellows pays subscription fees, but they continue to receive the full privileges and rights of RACP membership. The Board also recognises the disparity in incomes that Fellows receive, and Fellows can claim a reduction of their annual fees, depending on their expected income for the subscription year or on representation by a Medical Benevolent Society.

I hope that this information has given you some additional insight into the business aspects of the College, of which many of you may have been unaware. I would like to reiterate my thanks to those Fellows and trainees whose pro bono work for the College represents an enormous ongoing commitment to the communities of Australia and New Zealand in training the next generation of specialists and a substantial financial contribution to our organisation.

I look forward to answering your questions and discussing a wide array of related topics in the coming months. If you do have any questions or would like to comment on any business matters, please contact me, Honorary.Treasurer@racp.edu.au.

Clinical Associate Professor
Michael J Hooper
Honorary Treasurer

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**DIRECTOR PROFILE – DR CHARLES GUEST**

Charles Guest is President of the Australasian Faculty of Public Health Medicine. He has worked in government and academic public health medicine in Australia and elsewhere, since graduation from Melbourne, Deakin and Harvard Universities, and from the Epidemic Intelligence Service, United States Centers for Disease Control and Prevention.

A former Councillor of the Public Health Association of Australia and of the Australasian Epidemiological Association, he served as Australian Capital Territory Chief Health Officer until 2011. Dr Guest is currently Senior Specialist, Population Health Division, ACT Government Health Directorate, and Adjunct Professor in the College of Medicine, Biology and Environment, Australian National University.

My experience preparing for the RACP Clinical Examination

I was lucky enough to pass the RACP Paediatrics & Child Health Clinical Examination in 2012. I was then unlucky to be the person the Clinical Examination Committee asked to write an article about my approach to the exams, and was still so dazed by my pass that I said yes!

What worked for me is by no means the only answer. Everyone is different. We have all come to this point, having studied for years through medical school. Some have learnt to take the high workload road, some the last-minute cram, but there seems to be something about these exams that makes us forget what we have spent years learning how to do. I found that it is best to stick with what you know.

In 2012, the pass rate for the RACP Paediatrics & Child Health Clinical Examination remained high, and this is certainly something to be celebrated. For those trainees about to face these exams, this should be encouraging: it means that the vast majority of you will pass – whichever workload road you take!

The sheer difference between exam study techniques is best highlighted by two colleagues’ polar opposite approaches. One of my colleagues hired a cleaner and a gardener for the year prior to the exam to ‘take the stress off’ (note that post-exam they remain employed), whereas I sought refuge in cocktails on a tropical island, returning calmer (and more tanned)! Both of us passed, and subsequently we realised that, at the end of the day, what is important is being, or at least feeling, prepared on the day of the exam. It is hard not to get caught up in the growing peer pressure in those weeks leading up to the exams and lose confidence in your own preparation style.

It is also very hard not to fall into the trap of studying exclusively for the written exam, putting your life on hold and then having an intense few weeks trying to transform yourself from a bookworm vitamin D deprived Basic Trainee to a seemingly calm and confident Advanced Trainee. I concentrated on attending outpatient clinics, mainly general paediatrics – nothing fancy – and doing the mini-CExs, and I found that I could present, as well as discuss and examine children, in front of seniors without nerves overtaking me. Being able to express sensibly what you know or think is the biggest hurdle to overcome for the clinical exams. Watching how consultants and Fellows approach their clinic patients is a brilliant resource, which also gets you thinking about what the family of a child with a chronic illness might need.

For those trainees taking their exams in New Zealand, there is a shorter period of time between the exams here in New Zealand than abroad. The shorter period of time between the exams here in New Zealand does make you start to think about the clinical exam earlier, but it doesn’t seem to harm the pass rate.

The key thing to remember is that this is a General Paediatric exam. The New Zealand Chief Examiner in Paediatrics (a renal...
physician) has a stark look of panic on her face when asked to perform a neurological exam (or anything outside the abdomen) and the Starship DPE turns a shade of grey when asked to differentiate cardiac murmurs! The examiners aren’t expecting a specialist level of knowledge; they want a sensible and calm approach. Because of my clinic exposure, I approached the exam like I was talking to families in an everyday outpatient setting.

All of the above is based on being a Basic Trainee in New Zealand with a very supportive training environment. For the information of my fellow Australian trainees, this means that medical education leave is allocated and paid for, as is conference leave. This reduces the financial stressor of paying for textbooks, preparatory courses and even for attending the exam itself: everything except your clothes and shoes on the day can be claimed in New Zealand. You might think that this might reduce the financial incentive you have to pass first time, but in reality the less stress and more support around you the better.

The preparation courses in New Zealand deserve special mention as a major contributory factor in candidates’ success: from the weekly Thursday sessions that nudge us gently along to the two-week lecture series that tends to scare us all into frenzied action.

President’s Award for Trainee of the Year

The President’s Award for Trainee of the Year, established in association with the College Trainees’ Committee in 2010, is now an annual fixture on the RACP calendar. We are currently seeking nominations for the 2013 Award. Guidelines for submissions are given below.

We are looking for a trainee who has made an outstanding contribution to College activities during 2012 (and earlier). This may include trainee leadership, mentoring and support of other trainees, contributions to education and training, involvement in policy development and advocacy, or other forms of activity.

Anyone registered as a College trainee in 2012 from any Division, Faculty or Chapter is eligible for the award. Any trainee or Fellow of the RACP can nominate a trainee for this award.

RACP Excellence in Mentoring Awards 2013

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

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

1. Academic and Research
2. Clinical and Professional Practice
3. Physician Educator
4. Rural
5. Trainee Mentor

We are also lucky in New Zealand to have a small community of experienced examiners, consultants and Fellows who are accessible and willing to put in one-on-one time with us in the months and weeks leading up to the clinical exam. They are your best asset.

Finally, think about the Clinical Examination throughout the years of Basic Training and practise ‘discussing’ patients so that you learn to express yourself coherently. Trust that you know your work and find ways to reduce the stress – whether it be through cooking, eating, exercise or cocktails (all in moderation, of course) – and, importantly, take time out along the way to be fresh and relaxed on the day.

Dr Katie Moynihan
Paediatrics & Child Health

The award comprises full RACP 2013 Congress registration, attendance at the Congress Dinner, return economy airfares, accommodation on the night of the dinner and formal presentation of a plaque at the dinner.

Nominations should be received no later than 22 March 2013.

For further information, including eligibility requirements, and to download a nomination form, please visit the RACP website at: www.racp.edu.au/index.cfm?objectid=EA81AD85-FEB4-42DD-2A41B719ECA53632.
My interest in research began during my undergraduate medical degree at Sydney University, when I spent one year doing full-time research under the Bachelor of Science (Medicine) program, after the third year of medicine. I was introduced to experimental physiology when working in cardiovascular physiology under the supervision of Professor Michael Taylor. My project was to investigate blood pressure control and, specifically, to measure the dynamic properties of arterial baro-receptors.

After graduation and residency at Royal Prince Alfred Hospital (RPAH), I was Professorial Fellow under Professor John Read at the Page Chest Pavilion, where I trained in Thoracic Medicine. Apart from a very busy schedule managing both severe asthma cases and young adults with cystic fibrosis, I undertook a clinical research project using radioactive xenon to examine airflow distribution in asthma patients, working with Professor James McCrea, the founder of Nuclear Medicine at RPAH, and Dr Peter Valk. This was the beginning of my career as an experimental researcher working with both normal subjects and patients.

Following completion of MRACP training, I returned to the Physiology Department at Sydney University to embark on a PhD on control of breathing under the supervision of Professor David Read. A major theme of the research was attempting to understand sudden infant death syndrome (SIDS), which was the beginning of my interest in how sleep alters breathing. At the time, all the studies were with anaesthetised animals, but we realised that we had to use unanaesthetised animals and normal subjects to measure breathing in normal sleep. Two other medical graduates, Michael Hensley and David Henderson-Smart, also began PhD programs with David Read and we formed a very active and productive team.

It was during this time (1974) that we became aware of obstructive sleep apnea. Michael began a program aimed at measuring hypoxic responses in human subjects, as well as conducting the first sleep studies on patients with sleep apnea, and David began ground-breaking studies of breathing in newborn lambs. This was a solid foundation for several years of postdoctoral work at the University of Toronto, Canada, funded by an Asthma Foundation of NSW scholarship. David Read had met a young Canadian clinical scientist, Eliot Phillipson, who had begun pioneering work on breathing control in trained sleeping dogs and arranged for me to join Eliot to study breathing in sleep. This was a highly productive period, in which a basic understanding of how breathing changes in sleep began to be realised. Working with unanaesthetised animals provided me with a foundation on how to design experimental studies for both normal human subjects and patients, which then led to the experimental work that would produce nasal continuous positive pressure therapy for sleep apnea.

In 1979, I took up a position as Senior Lecturer in Medicine in the Department of Medicine, Sydney University, and Honorary Physician at Royal Prince Alfred Hospital, where my role was to develop a respiratory failure service. Under the leadership of Ann Woolcock, there was a strong academic presence in the clinical environment, enabling a very constructive combination of clinical practice and basic and clinical research, as well as teaching medical students. This was the beginning of the first clinical sleep laboratory in Australia, the recognition of sleep apnea as a major chronic illness, its treatment with nasal continuous positive pressure therapy, the development of non-invasive ventilation to manage respiratory failure, and the beginnings of a new medical specialty of Sleep Medicine.
My current work is in pregnancy and fetal development and unravelling our recently discovered link between sleep breathing disorders and pregnancy-induced hypertension, as well as indentifying the early stages of sleep breathing problems in children. I am greatly honoured to receive the RACP Neil Hamilton Fairley Medal which recognises a great Australian medical researcher whose work, driven by an urgent, unmet need to solve a very serious medical problem, is an exemplar of clinical research – in Sir Neil’s case, it was the massive toll taken during war through diseases such as malaria. The Hamilton Fairley story is one that should be told as part of medical student training to inspire future generations of clinical researchers. It is a privilege to be associated with his name.

Professor Colin Sullivan
Director David Read Research Laboratory
University of Sydney

Professor Colin Sullivan will be presented with this medal at the RACP Future Directions in Health Congress 2013 which is to be held in Perth.

ANNOUNCING 2013 SUMMER FUNDING ROUND!

The RACP Foundation administers a number of Education Grants and Fellowships; however, despite feedback from within the College and from Fellows indicating that there is a need for financial support for educational initiatives, application rates have been significantly low. To date, these educational awards have been administered similarly to the research awards, on a competitive basis, with closing dates. The feedback received noted that the period between planning, granting and supply of funding is too long (around 12 months), with funding being required on a ‘need now’ basis.

To be able to better support Fellows and trainees, the educational award strategy has been reviewed and a new process set in place. Study grants will be offered throughout the year, on a quarterly basis, until the total funding approved for the year has been awarded. The RACP Foundation is therefore pleased to announce that the 2013 Summer Funding Round for the RACP Study Grants is now open (see below).

RACP FOUNDATION STUDY GRANTS

Gaston Bauer Work Shadow Grant
To provide funding for rural Fellows and trainees to undertake a short course Work Shadow Program with specialists at a hospital or institution. Value: up to $3000 per grant

Queensland State Committee Educational Development Grant
To assist Fellows and trainees implement or undertake educational projects or activities including the following:
• Gaining new technical expertise
• Training at an appropriate institution
• Provision of education services (e.g. webinar, lectures).

Requests for funding to allow attendance or participation at a conference will not be considered. Value: up to $10,000 per grant

RACP AFOEM Education Development Grant
To support and encourage advancement of knowledge in matters connected with the field of occupational and environmental medicine. The funds may be used for:
• gaining new technical expertise in a field relevant to occupational or environmental medicine
• training at an appropriate institution in one or more of the AFOEM competencies
• to participate in and present a paper at a conference or scientific meeting.

Other proposals, such as webinar support, leading to the advancement of knowledge for more than one individual, will be considered. Value: up to $10,000 per grant

Applications close Thursday, 28 February 2013. Applicants will be advised end April/early May of the results.

Details of the eligibility criteria, how to apply, and Terms and Conditions can be found on the RACP Foundation website at: www.racp.edu.au/index.cfm?objectid=0D7519E7-02D1-DC51-C4BA11F5ACBD75D. Please direct all enquiries to: foundation@racp.edu.au.
Many ways, Margot McIver’s life reflected the story of the 20th century, one of advancement of medicine and advancement of women through education.

Margot Anne McIver was born on September 27, 1934 at Nanango, Queensland, daughter of Ian McIver, a motor mechanic, and his wife, Lillian (nee Bock), a teacher. She went to Brisbane Girls Grammar on a scholarship and in 1951 won a place in medicine at the University of Queensland, one of 10 women in a class of more than 100.

On the first day, the dean was welcoming all the gentlemen when he realised there were women sitting at the back. He insisted that they all move to the front row and from then on that row was dedicated to them to make sure they paid attention.

McIver graduated in 1957 and worked first in Queensland as a paediatric and medical registrar. She soon realised that her paediatric work would be greatly enhanced if she became a member of the Royal Australasian College of Physicians. In those days it was almost impossible to enter the College from Queensland, so in 1962, she moved to Sydney. Over the next five years, she worked at the Royal Hospital for Women, Prince Henry and Prince of Wales. The move to Sydney paid off in 1964 when she became a member of the College, the first female graduate from Queensland to do so, and a Fellow in 1978. She helped to establish the renal unit at Prince Henry Hospital, which performed the third kidney transplant in Australia.

She also found time to meet Dr Jack Hobbs. They went on coffee dates at 10 pm, after she had finished her patients’ dialysis. He proposed with, “Come with me and I’ll show you the world.” So she did and he did. They married in 1967 and moved to Boston.

She worked at the Hospital for Sick Children, then as a clinical and research fellow at the Massachusetts General Hospital. She was also a teaching fellow at Harvard Medical School.

Then Margot and Jack were offered permanent tenured positions but Margot was kind enough to postpone this to allow Jack to do a PhD at ANU. The deal was that, after that, they would return to Boston.

When she got to Canberra, Margot realised that there was no renal medical services, renal unit or dialysis program in the ACT, so, in 1969, she established one with the support of Professor Malcolm Whyte.

Two years later, Jack’s PhD was complete. It was time to return to Boston but they decided to work at the Royal Melbourne Hospital for a year. This turned into 24 years.

They made a home in the hills east of Melbourne that was part hobby farm and part experimental research facility, with a laboratory and electron microscope. There was also a couple of large pigs. The male would often break out and destroy the garden but he also helped to prove that aspirin does not have long-term effects on kidneys, as was thought at the time. The farm was an integral part of the development of Jack and Margot’s biotechnology company, Silenus, which produced diagnostic anti-serum, the basis for most tests conducted in pathology departments. Silenus established markets in Europe, Japan, Australia and the US.

By 1996, Margot and Jack were looking for a fresh adventure. For Margot, Dubbo presented an opportunity to work with a community spread over an area larger than most European countries. Together with Gail O’Brian, McIver developed renal services at Dubbo Base Hospital. In addition, her international experience in academic and clinical medicine helped in the establishment of the University of Sydney School of Rural Medicine in Dubbo.

In 2009, McIver was made a life member of the Australian and New Zealand Society of Nephrology in recognition of her work. Along with her work, McIver loved to cook and garden and was an avid reader.

Margot McIver is survived by John, sons Ralph and Matthew, daughters-in-law Sophie and Rebecca, stepmother Sumner and grandchildren India, Hugo, Henry and William.

Matt Hobbs

This obituary first appeared in The Sydney Morning Herald on 23 November 2012.
Australia has lost one of its foremost endocrinologists with the death of Jim Stockigt from pancreatic cancer at the age of 73. He achieved an international reputation in two fields of endocrine research: first in the investigation of causes of hypertension, and then in the understanding of thyroid disease. He championed the role of the clinical-laboratory interface for optimal treatment of hormonal diseases. In addition to his distinguished medical career, he was a noted bassoonist.

Born in Hamburg, he came to Australia in 1946. During his medical studies at the University of Melbourne, he maintained his passion for music, performing in a number of orchestras including the Melbourne Symphony Orchestra. After internship at the Royal Melbourne Hospital, he commenced specialty training in endocrinology at the Alfred Hospital under Pincus Taft, one of Australia’s premier clinical endocrinologists. He then became a teaching fellow at Prince Henry’s Hospital in the new Monash University Department of Medicine.

After postgraduate study (MRCP and MD), he was awarded a Squibb Fellowship in 1968 to work in the Department of Physiology, University of California San Francisco, where he set up the world’s first highly sensitive assay for renin. This was a key training period for him. After a year at St Mary’s Hospital in London, he returned to the Alfred, first as Deputy Director and later Director of the Ewen Downie Metabolic Unit. He modernised the Alfred Hospital laboratory, setting up radioimmunoassay platforms. While continuing work on endocrine hypertension, thyroid disease became his major interest. His internationally recognised work included studies on thyroid hormone changes in critical illness and the mechanisms of unusual genetic serum protein binding abnormalities of thyroid hormones. He also undertook a prolonged critical assessment of thyroid hormone assays, achieving an international reputation in free hormone assay methodology. His work in this area was recognised by the award of a Fellowship of the Royal College of Pathologists of Australasia. He was appointed a full Professor of Medicine in 1992.

In 1995 he relinquished the Director’s position but remained as senior endocrinologist at the Alfred for a further ten years. He also commenced a private practice at Epworth Hospital in 1995 and continued to practise as a clinical endocrinologist until shortly before his death. He was Secretary, and then President of the Endocrine Society of Australia (1990–1992), and a Vice-President of the Asia and Oceania Thyroid Association.

With the assistance of a German colleague, Gerhard Scholz, he established a medical student program with Leipzig University enabling 30 students, all initially educated in the GDR, to come to Melbourne for an elective period in the Department during the 1990s, a very positive experience for all concerned.

Jim was a fine clinician with high standards and an expectation that others would meet those standards. He was passionate about teaching at the undergraduate and postgraduate levels. His clear exposition of complex clinical problems, founded on careful medical history and examination, a profound understanding of physiology and disease, and precise use, documentation and interpretation of laboratory tests was inspirational to his colleagues and represented a standard of clinical excellence that the many endocrinologists who trained under him have sought to follow.

His musical career began by learning the clarinet at school then the bassoon. From 1982 he became one of the first in Australia to grapple, self-taught, with playing the 18th-century bassoon, and performed with this instrument in Australia, New Zealand and Germany. From 1995 he became a collector and curator of the baroque and classical aria repertoire with obbligato bassoon. His work enabled many of the arias to be accessible online for the first time.

Jim is survived by his wife Janice (Jan), daughters Julia and Clara, former partner Andrea and son Michael, and five grandchildren.

Duncan Topliss and Shane Hamblin
Both were trained by Jim Stockigt and worked with him for many years.
OBITUARY

PNG PIONEER PHYSICIAN
DR ADOLF SAWERI

Born 28 July 1941 in Sarmi, West Papua; died at Port Moresby, 11 November 2012.

Dr Saweri was known to virtually all Australian physicians who worked in, or visited, Papua New Guinea (PNG) from the 1960s. His early schooling in what was then Dutch New Guinea was conducted largely in Dutch. In 1960, he was one of seven students chosen for medical training in Port Moresby at the newly established Papuan Medical College. The lives of these students were completely changed by the invasion of their homeland by Indonesia and the demand that they return home. They had been vigorous opponents of Indonesian threats to their country, and faced brutal sanctions there. Advocacy by their lecturer in Medicine, Anthony Radford, with his politician uncle, Sir Wilfrid Kent-Hughes, achieved permission for them to stay in Papua.

Adolf graduated Dip. Med. in 1965 with the prize in medicine, and went on to pioneer postgraduate training in his adopted country. He was the first PNG graduate to be appointed as an RMO at an Australian teaching hospital (Royal Prince Alfred), the first to complete the Diploma of Tropical Medicine, the first to be appointed to the medical academic staff of the University of Papua New Guinea (UPNG). He was a member of the Council of the Institute of Medical Research in Goroka and its chairman from 1976. In 2008, he was awarded an MBE and granted an honorary MD by his university.

As a schoolboy, Adolf had a Dutch pen-friend, Wilhelmina van Hulzen, but they lost contact until 17 years later when Wila arrived in PNG to work in the field of nutrition; they met again, and marriage ensued. There are three children, Wisa, Nellie and Dr Moyai Saweri.

In the 1970s, a postgraduate award, Master of Medicine, was instituted to provide PNG with its own corps of specialists. Surprisingly, Adolf never undertook this degree, perhaps because he was already recognised as a genuine physician. Over nearly 40 years of service to PNG medicine and to the UPNG as physician and teacher he provided a remarkable continuity and consistency of leadership through many staff changes. He received and mentored scores of Australian physicians who came to provide consultations and teaching in Port Moresby, and to medical scientists who undertook research there or through the Institute of Medical Research. In spite of his recognised expertise and seniority, he was humble and generous, always a willing workhorse.

It was important to have Adolf in a medical meeting. He contributed from left field comments that were provocative, humorous, witty, wise, and occasionally outrageous. His broad awareness of issues in medicine and local and international affairs was reflected in his contributions. He was a living library of knowledge and history relevant to PNG medicine; his passing leaves a huge gap.

Emeritus Professor Ian Maddocks AM

SUGGESTED READING FOR ARTICLE ON PAGE 28


A HIGHLY RECOMMENDED READ


The title of this book led me to believe it was a self-help book for patients, but it is so much more than that. Not only does it give patients an understanding of how to get more from a consultation, but it also describes the complexity of trying to improve decision making by patients.

Peter Ubel has spent his professional life researching how people make decisions, what influences them and how we wittingly, or unwittingly, can influence those decisions. He uses that knowledge to craft a book that is of use both to patients and doctors, as well as other healthcare workers and students.

The book is essentially divided into four parts: ‘The Rise of the Empowered Patient’, ‘Empowerment Failure’, ‘From Empowerment to Partnership’, and ‘Learning to Share’. Each part of the book is enhanced by the use of stories to illustrate different pitfalls that the patient and the doctor fall into with alarming regularity.

The first part of the book discusses the history of the Patient Empowerment movement with descriptions of key cases, their complexities and the landmark decisions that resulted. Peter Ubel draws the conclusion that the involvement of lawyers and ethicists set the Empowerment Movement off on the track of Decision Making Trees and other ‘logical’ ways of describing treatments and how a patient would decide what happens next in their treatment. Ubel describes how this neglected the preference-sensitive decision-making process, the process that makes a patient choose an option that to the doctor seems incomprehensible.

The second part of the book laments that ‘information’ is not necessarily power; that information is not necessarily knowledge. Why does the same ‘information’ result in different choices? It asks: What do numbers mean to patients? Why does a risk of a side-effect seem worse if described as 100 in 1000 compared to 1 in 10? And what can we do to change this?

Part three looks at progress in ‘Decision Support Tools’ and the Decision Coaches available to lucky patients in a few hospitals. The tools range from leaflets and pamphlets to DIY clips on YouTube. But even then the effect depends on the preparation beforehand.

Part four is based around Peter and his wife Paula’s experience as they dealt with her diagnosis of breast cancer. Despite all of his experience in the field of decision making and ethics, they still found it difficult to get the information they needed, to feel empowered to make the ‘right’ decision, to realise that maybe there wasn’t a ‘right’ decision.

Finally, from the content of the book, Ubel pulls together eight ways for patients to get more out of the consultation and treatment decision process.

Written in a ‘popular’ style, Critical Decisions is an easy read. Some might be put off it for that very reason, but I found it valuable despite that. The history lesson was interesting – my only criticism being that it drew exclusively on the North American experience. I would have liked to read more of the progress made in other countries, for surely they too have contributed to the dialogue around this important topic?

For me, this book posed more questions than it answered, demonstrated more problems than it solved. However, I have no doubt that my increased knowledge of what influences decision making will improve my interactions, not only with patients but also with other professionals. I have already recommended it to others in my hospital.

Dr Nicola Murdock
Acting Director of Medical Services
Gladstone Hospital

Suggested Reading for article on page 31


In June 2012, the New Zealand Doctors Orchestra (NZDO) gave its first performance. This played to a full house, having sold out over 48 hours in advance, and to a standing ovation. My wife, son and I organised it. So where did all this come from?

Music has always been a part of my life. My mother was a piano teacher, so piano music always filled our house. I learnt piano from a young age and the flute after entering medical school. I’d rather thought that playing flute would open opportunities for more ensemble playing; however, I soon discovered that amateur orchestras only really need two to three flute players and there were many other flautists with similar ideas to mine. Rolling up to orchestra rehearsals to sit alongside the 20 or so other flute players wasn’t what I’d envisaged. My piano and flute experience taught me my first lesson: choose your instrument carefully.

Registrar years are tricky times to keep up a hobby. Irregular hours, competing demands and various exams have an annoying knack of getting in the way. It’s not surprising, then, that university and immediate postgraduate years are high-risk periods for doctors to give up musical performance interests. Partly in response to this, Christchurch has run an annual Artist Doctors’ Concert for over 20 years. Under the selection criterion of ‘superb mediocrity’, this aims to draw out the hidden or forgotten talents of doctors. Part of the concert has been a doctors’ orchestra, which I have helped organise for over 10 years. Most importantly, it has provided my second lesson: giving opportunities for doctors to dust off their musical instruments and play in an ensemble fills an important niche.

Once postgraduate exams were out of the way, and my PhD was completed, I had this very odd experience of having some time on my hands for hobbies. The temptation was to fill this spare time with more work, but fortunately I resisted this trap. Around the same time, one son started to learn trumpet and the other started to learn trombone. This led me to realise that a more versatile instrument might be quite fun.

My sons had started playing in orchestras and jazz bands and I must confess I was very jealous – why didn’t I play an instrument that could fit into either genre? Furthermore, sitting in on my sons’ orchestra rehearsals, I noticed that an orchestra that included a double bass sounded so much better – it gave that solid foundation and depth that many children’s orchestras lacked. So, how could I get to play in orchestras and jazz bands, yet not risk permanent strained relationships with my kids by taking up the same instrument? What about double bass?

Christchurch has a vibrant school of music and actively encourages what are euphemistically called ‘late starters’. The prospectus has a blurb about each instrument – under double bass it says, ‘always in demand, progress can be rapid’. The case was clinched. Three months after my first lesson, I had my first invitation to play in an orchestra. Given I could barely tune it, and knew about six notes in total, two of which were unreliable, this first gig wasn’t entirely positive. But progress was rapid and I slowly made my way up the various

WHEN MUSIC BECOMES AN ADDICTION
The New Zealand Doctors Orchestra in rehearsal

orchestras, briefly including the local youth orchestra (odd, I know, but double bass players really are in demand). Things haven’t really looked back since then; I now play in three to four different orchestras. So, lesson number three is: when space becomes available in your life for new activities, think carefully about what you fill it with and don’t just drift into doing more work!

Alongside my double bass lessons, I took a course in jazz and improvisation, which opened up this genre. For several years I played in a jazz group at a nearby pub, but the Christchurch earthquakes destroyed that pub and several others. Maybe lesson number four is: sometimes things stop you playing that are out of your control. Let’s hope this barrier is temporary.

My brief period with the youth orchestra introduced me to a conductor from the UK who conducted the European Doctors Orchestra. I had not heard of this before, let alone that it was a product of the successful Australian Doctors Orchestra (ADO). Even though I didn’t realise it, the seeds were sown for the NZDO.

Organising orchestras has now become a bit of a household activity. My wife (a GP) plays violin and is chairperson of a local amateur orchestra. We’re both involved in helping organise an annual orchestral summer camp. So, orchestra camps, my wife’s experience with amateur orchestras, lessons learnt along the way about organising a youth orchestra, and over 10 years experience in organising an annual doctor’s orchestra in Christchurch makes our house sometimes seem like ‘orchestra central’.

The 2011 Christchurch doctors’ orchestra sounded particularly good, so in a brief rush of blood to the head, I thought the time had come to explore an NZDO. By then, one of our sons was a medical student, and so the committee was formed! Taking very good advice from and drawing on the experience of the ADO, we soon had the names of over 250 medical musicians in New Zealand.

On 22 June 2012, 65 doctors and medical students (including nine College Fellows) gave a very successful concert in Nelson, playing Lilburn’s Aotearoa overture, a Schumann piano concerto, some Puccini arias and Tchaikovsky’s 5th Symphony. We’re planning another concert on 23 June 2013 and are still on the lookout for medical musicians (go to nzdo.org.nz).

Needless to say, I have found some parallels between learning music and health professional education. I have a new-found sympathy for a teacher’s instructions: ‘don’t do it like that, just do it like I do it’. I peer closely at my teacher’s technique and it seems like mine, yet doesn’t get the same sound. My students peer closely at how I hold my stethoscope and can’t quite hear the murmur that I hear. A student’s performance anxiety at an OSCE has a new reality for me when I’m at a gig.

I think my hobby now almost fulfils the definition of an addiction: I can’t say no to invitations to play, the amount I play is gradually increasing, I miss it desperately if I go away, and it’s interfering with my work. Fortunately the work impact is positive as it helps me keep a much better work–life balance. It’s also not interfering with my family as I suspect they’re at risk of a similar addiction. I find it intellectually stimulating because playing orchestral works helps you understand those works much more. It’s socially stimulating as you meet lots of interesting people. It’s frustrating as there are so many ways you can play a note the wrong way, but mostly it’s exhilarating when you play fantastic works with other people.

Professor Tim Wilkinson FRACP FRCP is Associate Dean (Medical Education) at the University of Otago, and a geriatrician at Princess Margaret Hospital, Christchurch.

Websites
New Zealand Doctors Orchestra: nzdo.org.nz
Waitaki Summer Music Camp: waitakimusic.org.nz
New Zealand Association of Artist Doctors: artistdoctors.org.nz
Welcome to Medicine in Addiction 2013
15-17 March 2013, Sydney
SMC Conference and Function Centre

MiA2013
Medicine in Addiction 2013

CPD entitlements:
Credit for participation in Medicine in Addiction Conference 2013 activities can be claimed in accordance with the RANZCP CPD Program Guide.
A certificate of attendance will be available to verify attendance at the conference.
This conference is a component of an Active Learning Module (ALM) to be approved by the RACGP QI&CPD program in the 2011-2013 triennium. Completion of all ALM components will entitle participants to 40 category 1 points.
The RACP’s MyCPD Framework indicates that this Conference will entitle participants to 1 credit per hour as per the Group Learning Activities listed in Category 2.
Please keep a verified log of activities attended in case of audit of claim.

This is the second co-convened conference of the Royal Australian and New Zealand College of Psychiatrists’ (RANZCP) Section of Addiction Psychiatry, the Royal Australian College of General Practitioners (RACGP) and the Royal Australasian College of Physicians’ (RACP) Chapter of Addiction Medicine. Building on the success of the first conference in Melbourne, MIA 2013 provides a great opportunity for delegates to hear from the country’s leading addiction clinicians and researchers, update their skills and knowledge, and network with colleagues and peers.
The event will address a wide range of topics, including sessions around the neurobiology of addiction, pain management, drugs in pregnancy, the pharmaceutical drug misuse strategy, psychostimulants and forensic issues. Concurrent half-day workshops will allow delegates to explore some of these topics in more detail.

We trust that you will make the most of the opportunity to network with hundreds of medical colleagues working in the addiction field, and look forward to seeing you in Sydney in March.

TO REGISTER:
Please register online at online.saneevent.com.au/mia2013
Website: www.ranzcp.org/MIA2013
Email: MIA2013@saneevent.com.au

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If you are interested in learning more about this opportunity, contact: Dr Timothy Shanahan – Ph (02) 6056 3366 or 0412 361 326 e-mail: mobiletsh.work@bigpond.com

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The Royal Australasian College of Physicians

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**Contact:** Jenni Harris tel: 03 9345 2555 email: ctc@wehi.edu.au

Register online at www.wehi.edu.au/phd_opportunities_forum

Travel assistance is available for rural and interstate attendees.

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