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Overlooking the water in Darwin. Congress delegates were fortunate enough to experience Darwin’s beautiful sunrises and sunsets. Photograph Les Bolitho, RACP President-Elect.

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I am very pleased to devote a significant part of this column to the recent Annual Scientific Congress (ASC) held in Darwin from 22 to 25 May 2011. The Conference Program Committee, in conjunction with Northern Territory Fellows and College staff, put together an excellent scientific program. Indeed, I received many comments to the effect that the program for some streams was so good that Fellows felt unable to attend other sessions. In addition, many Fellows commented that they had heard that the future of the Annual Scientific Congress after 2013 was being reviewed; however, based on the success of the 2011 event, the sentiments expressed suggest that the format should remain unchanged.

The theme of Congress was Indigenous Health and Chronic Disease, with the topic being magnificently introduced in the first plenary session by a sobering yet optimistic lecture by Professor Sir Mason Durie (see page 5 for an abridged version of Sir Mason’s address). His address highlighted two main points: the first being that the potential for substantial health gains for Indigenous peoples in Australia and New Zealand has never been greater. And secondly, that the realisation of that potential will be accelerated by a wide range of aligned interventions, Indigenous leadership, medical expertise, and advocacy by the Royal Australasian College of Physicians, all acting in concert.

 Appropriately in Darwin, the Board approved the RACP Reconciliation Action Plan, which was subsequently launched at Congress.

The ASC provided an opportunity to meet a wide variety of Fellows, and it became clear that there is a large number of Fellows who have specific interests and skills who are not on College committees but who wish to be engaged. As a College, we must encourage a much wider section of the College to be involved in its activities. All College committees should engage in succession planning, as we need to continually revitalise our committees by recruiting younger Fellows. I encourage all of those interested Fellows whom I met at Congress to respond to calls for Expressions of Interest and to put their names forward for committees or working parties.

As most Fellows are aware, the Paediatrics & Child Health Division and the three Faculties were formed following the merger of previously stand-alone colleges with the RACP. These groups brought with them funds from their original entities into our College. Although, strictly speaking, these funds became RACP funds at that time (there being only one legal entity), the original intent was that these funds be ‘used for the benefits of the members’. In the spirit of the original agreement, the Faculties of Rehabilitation Medicine and Occupational and Environmental Medicine have agreed to the transfer of their funds to the Research and Education Foundation (REF). Their funds will be invested, along with other REF funds, but ‘ring-fenced’ for use by the Faculties for the purpose of research grants and other awards for Faculty Fellows and trainees. Advertisements will appear for these awards and grants for the 2012 academic year.

The Board Working Party reviewing the governance of education reported to the Board that they are now at the stage of progressing the development of the preferred option. A further Working Party will soon begin its deliberations on the governance and functioning of the College Policy and Advocacy Committee and the other committees and Expert Advisory Groups in the Policy and Advocacy area.

At the recent Board meeting, the Board approved the eligibility of all Fellows for the award of the John Sands College Medal. Reviewing the original deed, it was clear the intent was that all Fellows of the College should be eligible for the award, not just those in the two Divisions.

All Fellows will soon receive an invitation to comment on the first draft of the SPPP (Supporting Physicians’ Professionalism and Performance) document, which was also launched in Darwin. I urge all of you to read this and feed back your comments. This is a very important document as it represents the operational rollout of the Professional Qualities Curriculum and is part of the College’s strategy to position itself favourably in relation to the ‘threat’ of impending revalidation.

Thank you to all Fellows and trainees who attended the 2011 Congress. We hope to see you again next year.

John Kolbe
President
Indigenous Health and Chronic Disease

A STRATEGIC FRAMEWORK FOR INDIGENOUS HEALTH

Professor Sir Mason Durie delivered the opening address at the RACP Congress in Darwin on 23 May 2011. This is an abridged version of his presentation, in which he calls for College and physician participation, individually and in partnership with Indigenous organisations and government, in helping to realise health gains among the Indigenous peoples of New Zealand and Australia.

There are two main points in this presentation. The first is that the potential for substantial health gains for Indigenous peoples in Australia and New Zealand has never been greater. And second, the realisation of that potential will be accelerated by a wide range of aligned interventions, Indigenous leadership, medical expertise, and advocacy by the Royal Australasian College of Physicians, all acting in concert.

The notion that the potential for health gains has ‘never been greater’ might appear to fly in the face of statistical evidence that Indigenous peoples are over-represented in almost all types of disease categories, including chronic disorders. But over the past quarter-century substantial foundations have been laid that not only recognise the particular situation of Indigenous peoples but also give strong pointers as to how gains might be achieved.

At the same time, and despite the optimistic prediction, the health status of Indigenous populations in Australia and New Zealand does give ample cause for concern. In a post-urbanisation environment another set of lifestyle diseases has emerged including cancers (breast, lung, stomach), mental disorders and youth suicide, alcohol and drug related disorders, obesity, ischaemic heart disease, stroke and diabetes. The incidence for all is two to three times higher than for the non-Indigenous population.

Diabetes Type II is of particular concern. It has become progressively more frequent among Maori and Aboriginal and Torres Strait Islander peoples since 1960, with a steadily falling age of onset and an increased prevalence of childhood Type II diabetes. Compared to the rest of the population, mortality rates from diabetes are high, with greater rates of hospitalisation. The diabetes phenomenon has coincided with a transition from tribal, rural environments to urban settings and urban lifestyles, and has been linked to a number of risk factors including obesity, unhealthy nutritional patterns, sedentary lifestyles, smoking and economic disadvantage—prevalence is greater in communities where there are high levels of deprivation. There is also some suggestion, yet to be fully understood, of a genetic predisposition.

From passive positions as patients and service users, the promotion of health for Indigenous peoples has seen the emergence of a range of innovative solutions, largely driven by Indigenous peoples themselves.

Signs of change

Despite the continuing high prevalence of chronic diseases among Indigenous peoples, there is considerable evidence that a transformational drive has been underway over the past quarter-century. From passive positions as patients and service users, the promotion of health for Indigenous peoples has seen the emergence of a range of innovative solutions, largely driven by Indigenous peoples themselves. Those initiatives have established strong platforms for addressing health challenges over the next 25 years.

In this respect Indigenous potential has never been greater. Not only are Indigenous populations youthful and growing, but there is a trend towards greater life expectancy with proportionately more elders. Cultural revitalisation, together with a determination to retain a secure cultural identity and resist assimilation, has led to a more determined generation of Indigenous peoples, many of whom are competent in two cultures and in two bodies of knowledge and are able to move easily from one culture to another. Moreover, a global solidarity between Indigenous peoples across the world has resulted in a high level of Indigenous pride and a readiness to participate fully in society without abandoning an Indigenous identity.

Transformational pathways

Based on Maori experience in health over the past two to three decades, it is possible to identify five pathways that have led to a transformation of the health system and of Indigenous participation in health: (1) the articulation of Maori health perspectives based on Indigenous world views and customary Maori approaches to health and wellbeing; (2) government health policies and programs for Maori—reduction of disparities, multiple delivery options, Maori health workforce development, socioeconomic gains; (3) the introduction of Maori cultural concepts and Maori knowledge into health services; (4) increasing numbers of Maori health providers able to contract with funders to provide services to Maori; and (5) workforce development.

The results of the five-part approach to improving Indigenous health can be measured from several perspectives. Life expectancy for Maori females, for example, increased from 70 years in 1985 to 73 years in 2002, while Maori male life expectancy rose from 65 years to 69 years. Moreover, by 2002 there was evidence that the disparity was reducing. Other indicators also point to health gains. Cessation rates for smoking have never been higher, childhood immunisation uptake has increased by 50%, and after an initial surge in prevalence there has been a recent decrease in youth suicides. Other gains include a reduction in child mortality rates, a strengthened primary healthcare infrastructure, better utilisation of hospital services and, importantly, a greater level of health awareness by Maori leaders, tribal organisations and Maori community groups.
The next developmental phase

Over the past 25 years strong foundations have been laid as platforms for realising even greater Indigenous health potential. But medical interventions by themselves will have little impact if they are not part of a wider suite of strategic interventions delivered along an ‘opportunity continuum’.

At least five levels of intervention can be distinguished along the continuum and each constitutes a specific strategy. ‘Long distance’ interventions, for example, refer to the macroeconomic policies of government, social policies, policies to reduce inequities, and government policies for Indigenous peoples. A measure of the latter is in support for the United Nations Declaration on the Rights of Indigenous Peoples. Both Australia and New Zealand were among a small number of states that refused to sign the Declaration in 2007, arguing that in several of the articles the Declaration was contrary to domestic law. However, since then, both countries have signed, accepting that the Declaration has important principles for relationships with Indigenous peoples, though it is not necessarily binding on governments.

Further along the continuum, a second strategy focuses on health promotion and health education, aimed at particular communities or ethnicities, with a focus on reducing the impacts of known risks to health such as smoking, lack of exercise, nutrition, alcohol and drug use—as well as increasing access to information, educational success and full employment. A third strategy is for the ongoing development of the health workforce so that Indigenous peoples are well represented within the health professions and all practitioners are culturally competent and able to work collaboratively across the wider health sector and with professionals from other sectors. Short distance impacts constitute the fourth and fifth strategies. The fourth strategy is aimed at family interventions, and the fifth is about creating services that are relevant, readily accessible, and committed to quality outcomes and gains in health for individual patients.

Principles for realising Indigenous health gains

Based on experience over the past 25 years, and in anticipation of the known challenges in the years ahead, it is possible to identify three principles that will accelerate progress and contribute towards the realisation of Indigenous health gains: integrated solutions, Indigenous pathways, empowering partnerships.

Integrated solutions

It is clear that Indigenous health gains cannot be considered in isolation of other strategies and programs. Increasingly, integrated solutions will be necessary to meet old and new risks to health and wellbeing. The principle of integrated solutions recognises that no single sector, discipline or service has all the answers. Indigenous health strategies must become part of a comprehensive set of actions that include economists, environmentalists, biologists, statisticians, technologists, advertising agencies, social entrepreneurs, politicians and community leaders—as well as health professionals. In addition to the integration of social and economic factors, a similar case can be made for the closer integration of physical and mental agendas. Distinctions between mental health and physical health are also becoming less and less tenable. Co-morbidities are more frequent than previously recognised.

Indigenous pathways

A second principle, Indigenous pathways, recognises the importance of tradition, culture, and the modern realities of Indigenous peoples to health. Distinctive pathways to health arise from population diversity. Culturally based systems of knowledge, for example, explain health and wellness from perspectives that are different from scientific knowledge. Those systems may be based on religious beliefs, ethnic customs, or Indigenous world views; faith, rather than empirical studies, underlies knowledge, and longstanding experience with the natural environment provides a framework for understanding the world.

Effective clinicians will be able to engage in a way that endorses the cultural identity of their patients and creates a space for patients to actively contribute to the encounter.

Indigenous peoples must be directly involved in solutions for Indigenous health. When Indigenous peoples themselves are actively involved in the search for solutions, meaningful answers will be more likely to be found and then absorbed.

Empowering partnerships

The third principle, empowering partnerships, recognises that realising gains in Indigenous health involves society generally, as well as Indigenous peoples. This principle has particular relevance to physicians and the Royal Australasian College of Physicians. Every clinical engagement has the potential to be a partnership between doctor and patient in which each contributes to the best possible outcome. Effective clinicians will be able to engage in a way that endorses the cultural identity of their patients and creates a space for patients to actively contribute to the encounter. Moreover, an empowering engagement will be one where self-management and self-respect are part of the treatment outcome.

Research partnerships between researchers and Indigenous communities will go some way towards identifying research questions that are relevant and of some priority and findings that are more likely to be embraced and translated into action. There is little room for research programs that are shaped only around researcher interest, without recognition of the hopes and aspirations of the communities being researched.

On behalf of physicians, the College also has the opportunity to contribute to Indigenous empowerment by developing partnerships for health with Indigenous organisations and with both state and federal governments in the formulation of Indigenous policies and programs. Further, recognising education as a critical agent of empowerment, the College will have an increasingly important role in building Indigenous medical capability through partnerships with tertiary education institutions and regulatory bodies such as those responsible for the registration of medical practitioners.

A framework for Indigenous health

On the basis of a set of values and a series of interventions arranged along an ‘opportunity continuum’ it is possible to construct a framework for accelerating the realisation of Indigenous health gains. The framework incorporates three principles, integrated solutions, Indigenous pathways, and empowering partnerships, which can be applied to five strategic directions: political and professional leadership, community action, workforce development, family empowerment, and accessible healthcare.

Sir Mason Durie is Professor of Maori Research and Development and Deputy Vice-Chancellor (Maori & Pasifika) at Massey University, New Zealand.
Aboriginal and Torres Strait Islander people are living through truly exciting times. Never before in the history of our nation has there been such a focus on bringing First Australians in from the cold of colonial marginalisation to be fully accepted members of the national family, and not since colonisation have First Australians had such opportunities to lead lives of their own choosing.

The heart of this generational change: first, as inaugural Co-Chair of the National Congress of Australia’s First Peoples and now as Chief Executive of the Lowitja Institute, Australia’s National Institute for Aboriginal and Torres Strait Islander Health Research. Together with other Indigenous organisations, we are working hard to ensure that Aboriginal and Torres Strait Islander people can lead full and productive lives free of the prejudice, poor education and ill health that has so blighted previous generations.

However, while there are now strong grounds for optimism that Australia is at long last moving in the right direction in terms of its dealings with this island continent’s original inhabitants, the legacy of more than 220 years of colonisation is hard to overcome. Our health, for instance, is not just a matter of popping down to the doctor for a quick fix. Research shows that health and wellbeing correlates strongly with a number of social and environmental factors, such as housing, racism, parental education levels and inter-generational poverty. To achieve and sustain long-term improvements in Indigenous health, we need to shift the underlying factors—the social determinants of health—in a positive direction.

Dr Kerry Arabena

The work in this area continues at the Lowitja Institute, particularly in Program 2 (Healthy Communities and Settings), where we are supporting research into the effects of social and physical environments on individual and community health. Two projects are already underway, one examining the potential of reducing racism through action at a local level and the other in creating healthy environments through the establishment of an Aboriginal Health Promotion Network. Many more projects are in the pipeline.

But now I would like to focus on another factor which I believe also has a profound influence on First Australians’ self-esteem and sense of wellbeing: the use of language. In particular, I want to shine a light on the recent introduction of military language in discourses around the need for interventions in the affairs of Aboriginal and Torres Strait Islander peoples.

I believe that language constructs our relationships, our identities and our future together as peoples and as a nation in an immensely powerful way. In the Redfern Oration I delivered at the recent Annual Congress of the Royal Australasian College of Physicians, I talked about the way in which the language being used reverts to identifying First Australians as problems rather than as equal and creative participants in our society. To achieve and sustain long-term improvements in Indigenous health, we need to shift the way we talk about these social determinants in a positive direction.

Here are literally billions of dollars being poured into cohesive, bipartisan, evidence-based, long-term policies designed to close the gap that exists between Indigenous and non-Indigenous Australians. Infant mortality is falling and life expectancy is increasing. Aboriginal and Torres Strait Islander students are finishing Year 12 and entering the tertiary education sector and trade apprenticeships in record numbers. Across the country there is a growing number of our people working as politicians, doctors, nurses, executives, researchers, lawyers, academics and other professionals.

A new generation of Indigenous leaders is coming through at the national level, ready to build on the hard-won gains fought for by our illustrious forebears. It has been my great privilege to have worked for two of the organisations at the heart of this generational change: first, as inaugural Co-Chair of the National Congress of Australia’s First Peoples and now as Chief Executive of the Lowitja Institute, Australia’s National Institute for Aboriginal and Torres Strait Islander Health Research. Together with other Indigenous organisations, we are working hard to ensure that Aboriginal and Torres Strait Islander people can lead full and productive lives free of the prejudice, poor education and ill health that has so blighted previous generations.

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The Lowitja Institute and its predecessor organisations, the Cooperative Research Centre (CRC) for Aboriginal and Tropical Health and the CRC for Aboriginal Health (CRCaH), have put substantial resources into quantifying the impact of these social determinants. Indeed, Social Determinants of Aboriginal Health was one of the five program areas within the CRCaH and it supported research in such areas as the transport needs of Aboriginal people (Aboriginal People Travelling Well), the impact of racism on health (Racism and Health: Setting the Research Agenda), the effects of incarceration on health (Evaluation of the Lotus Glen Correctional Centre), and the Australian leg of a major international study into the benefits of community-based primary healthcare (Revitalising Health for All—Teadsdale Cort). The program also contributed to the publication of the ground-breaking, widely read textbook, Social Determinants of Indigenous Health (Allen & Unwin 2007), which continues to have a significant influence on the development of Indigenous health policy (please go to www.lowitja.org.au for more information on all of these projects).

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measures such as removing human rights protection for Aboriginal people in the Northern Territory.

The problem, of course, is that this was no sudden calamity: there had been countless reports and failures to act by governments prior to 2007. But by using military language and military strategy to resolve chronic social and health problems stemming from poorly designed and poorly executed policies implemented over many decades, it allowed the military concept of ‘acceptable loss’ to take root.

Acceptable loss refers to the negative outcomes that are considered tolerable when striving for a positive outcome from a particular strategy or tactic. In the case of the NTER, the strategy was to protect Aboriginal women and their children. Even though the Little Children Are Sacred report never identified Aboriginal men as the only or even the major perpetrators of sexual abuse, the inflammatory message that many Aboriginal men are paedophiles and sexual predators shifted perceptions about the causes of Indigenous squalor and successfully reframed the history of Indigenous disadvantage. So, in order to improve the lives and health of Aboriginal women and children, Aboriginal men became the acceptable loss. NTER language included scant acknowledgement of the positive roles Aboriginal men play in their communities, as fathers and husbands in particular, or the dangers inherent in their stigmatisation.

Indigenous society loses because the roles and responsibilities of men as fathers are absent in the policy, program and resourcing chain. This absence shakes the very foundations of our families and communities. It falsifies gender roles and responsibilities in our communities, and accomplishes the colonial mission that began in 1788.

Contrast the damage done by the use of military language with the healing engendered by the positive use of language: for instance, the institution of a ‘Welcome to Country’ at the start of public addresses. Kevin Rudd’s moving Redfern Speech, in which he asked his fellow Australians to imagine what it would be like to be dispossessed and unacknowledged as proud peoples. For it is the act of imagining, the ability to put yourself in someone else’s shoes, that is the necessary ingredient in our quest for national catharsis. Military language, by contrast, serves only to divide us and entrench a power dynamic that inhibits equality.

However, compared with previous eras, Aboriginal and Torres Strait Islander people now have a much greater capacity to push back in creative ways against narrow, negative discourse. Rather than being mere bystanders to a debate occurring over our heads, we are making our voices heard and asserting our rights to have the same opportunities and the same health as other Australians without being made the same. In particular, we now have two powerful initiatives occurring at the national level that are among the new vehicles for the proliferation of our ideas and aspirations. I am talking here about the National Congress of Australia’s First Peoples and the Lowitja Institute, both of which have been born from among our modern intellectuals with ancestral connections to country.

The National Congress has been established after five years of consultation around the country to ensure that the way it operates is responsive to the needs of Indigenous Australians. Once again we have a national voice after several long years without one, and this time the voice is one that we designed ourselves. Gender equity, ethical standards and democratic processes are hardwired into Congress, as are cultural understandings that see membership built around the combined 200 nations of our people rather than the colonial divisions of State and Territory. Democratically elected delegates are about to meet for the first time to decide on Congress’s priorities, and the conversations flowing from this collaborative endeavour will undoubtedly deliver perspectives and outcomes not possible within the current dominant discourses on Indigenous affairs.

The Lowitja Institute came into being in February 2010 with the express purpose of providing a permanent source of support and funding for research into Aboriginal and Torres Strait Islander health, as well as boosting the participation of Indigenous Australians in the health and health research workforce. We have an Aboriginal and Torres Strait Islander majority on our Board and strong, well-credentialled Indigenous leadership. As with Congress, the Institute has been structured as a company to allow for entrepreneurial thinking and action, and until June 2014 it hosts the Commonwealth-funded CRC for Aboriginal and Torres Strait Islander Health. Together with our highly experienced staff and researchers, we intend to break the shackles of short-term funding cycles that have so bedevilled Indigenous health research and deliver our proud tradition of research excellence far into the future.

It is this combination of increased institutional strength, community capacity and individual self-belief that, for the first time, gives us as First Australians the critical mass to rechannel the national conversation down more positive pathways. We must never forget that we—all of us—have it within our power to change history, and that there is no more powerful tool to effect that change than language itself.

Kerry Arabena, with David Moodie

Dr Kerry Arabena is the Chief Executive of The Lowitja Institute—Australia’s National Institute for Aboriginal and Torres Strait Islander Health Research, and Inaugural Co-Chair of the National Congress of Australia’s First Peoples.

Reference
Professor Zulfiqar Bhutta delivered the Paediatric Plenary at Congress. In this abbreviated version of his address Professor Bhutta makes the point that ‘nutrition interventions are among the best investments in development that countries can undertake’.

Malnutrition is one of the biggest health challenges facing the developing world with enormous consequences for child health. Commonly, the three main indicators of malnutrition in children are intrauterine growth retardation, wasting (including severe acute malnutrition) and stunting (low height for age). Among children under five years old in the developing world, an estimated 195 million, a third of all children, are stunted, whereas 129 million are underweight. More than 90% of the developing world’s stunted children live in Africa and Asia and a mere 24 countries bear 80% of the developing world burden of undernutrition as measured by stunting. The major risk factor for undernutrition is poverty, affecting food security and dietary intake, but in many countries family behaviours and feeding practices during health and disease also play an equally important role in diet quality. Poor environments and poor sanitation/hygiene significantly increase the risk of diarrhoea and other illnesses that deplete children of vital nutrients and can lead to chronic undernutrition, increasing the risk of death.

Table 1 outlines the common micronutrient deficiencies in children and the extent of their contribution to the worldwide burden of disease in women and children. Micronutrient deficiencies have serious repercussions for the developing foetus and later child development. For example, iodine deficiency disorders may cause foetal brain damage or stillbirth, while folate deficiency may result in neural tube or other birth defects and preterm delivery. Similarly, both iron deficiency anaemia and vitamin A deficiency may have significant effects on the future infant’s morbidity and mortality risk, vision and cognitive development.

Micronutrient deficiencies are more likely in children who consume diets that are poor in nutritional quality, or who have higher nutrient requirements due to high growth rates and/or the presence of bacterial infections or parasites which are common findings in the developing world. In particular, a diet that is low in animal source foods typically results in low intakes of iron and zinc, calcium, retinol (pre-formed vitamin A), vitamin B2 (riboflavin), vitamin B6 and vitamin B12. Out of many interventions available, those that focus on exclusive breastfeeding and fortification or supplementation of food with vitamin A and zinc have the greatest potential to decrease the child mortality burden.

Often, poor quality diets also lack fresh fruits and vegetables, which means that intakes of vitamin C (ascorbic acid) and folate will also be inadequate. Improving status in one micronutrient, or even several micronutrients simultaneously in the case of multiple deficiencies, can potentially have great benefits for the health of children in developing countries.

Table 1: Common micronutrient deficiencies in childhood

<table>
<thead>
<tr>
<th>Micronutrient deficiency</th>
<th>Burden of disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin A deficiency</td>
<td>Nearly 800,000 deaths among women and children worldwide can be attributed to vitamin A deficiency (VAD). VAD is attributed to 20% of maternal deaths worldwide. South East Asia and Africa have the highest burden of VAD.</td>
</tr>
<tr>
<td>Iron deficiency and anaemia</td>
<td>Iron deficiency contributes to 18.4% of total maternal deaths and 23.5% of perinatal deaths. Iron deficiency is attributed to 115,000 maternal deaths and 591,000 perinatal deaths globally. The total global burden attributed to iron deficiency anaemia is 814,000 deaths.</td>
</tr>
<tr>
<td>Zinc deficiency</td>
<td>The estimated global prevalence of zinc deficiency is 31%. Zinc deficiency contributes to increased risk of childhood diseases, a main cause of death among children. It is estimated that 665,000 child deaths, or 5.5%, are related to zinc deficiency.</td>
</tr>
<tr>
<td>Folic acid deficiency</td>
<td>Access to adequate folic acid supplementation is estimated to reduce the incidence of neural tube defects—affecting up to 5 babies per 1000 live births worldwide; 95% of cases occur from a first pregnancy.</td>
</tr>
</tbody>
</table>
**Micronutrient interventions**

The sustainable solution to multiple micronutrient deficiencies must be the formulation and implementation of innovative, affordable ways to improve poor people’s diets. Public health interventions are available for tackling the problem of malnutrition, and these must become an area of priority in the developing world. Effective interventions include promotion of breastfeeding, creating awareness about safe and proper diet for children, and provision of micronutrient supplements.

**In addition to these nutrition interventions, other health promotion strategies must be implemented to address unsafe water, inadequate sanitation and poor hygiene.**

The *Lancet* undernutrition series published estimates on maternal and child undernutrition, giving the most up-to-date burden of disease as well as interventions that can be implemented to decrease that burden. To reduce stunting, severe acute malnutrition, micronutrient deficiencies and subsequently child deaths, effective interventions are available that would reduce disability-adjusted life years (DALYs) by about 25% in the short term if implemented on a sufficient scale. Out of many interventions available, those that focus on exclusive breastfeeding and fortification or supplementation of food with vitamin A and zinc have the greatest potential to decrease the child mortality burden. Improving vitamin A status reduces mortality among older infants and young children and reduces pregnancy-related mortality; it also reduces the prevalence of severe illness and clinic attendance among children. Improving zinc status reduces morbidity from diarrhoeal and respiratory infection. Treatment of established infection with vitamin A is effective in measles-associated complications, but is not as useful in the majority of diarrhoeal or respiratory syndromes. Zinc supplements, however, have been of significant benefit to the clinical outcome of diarrhoeal and respiratory infections.

Maternal and child undernutrition is a global problem, largely affecting developing countries and poor populations (see Table 2). Stunting reflects chronic nutritional deficiency and is a problem of greater magnitude in comparison with other forms of undernutrition.

There is a critical window of opportunity to prevent undernutrition—during pregnancy while the foetus is growing and during a child’s first 24 months of life. Evidence-based nutrition interventions can make a difference to short-term outcomes and also offer children the best opportunity for long-term growth and development. These interventions include strategies to improve maternal nutrition before and during pregnancy, early and exclusive breastfeeding, and good-quality complementary feeding for infants and young children, with appropriate micronutrient interventions. In addition to these nutrition interventions, other health promotion strategies must be implemented to address unsafe water, inadequate sanitation and poor hygiene.

Improving child and maternal nutrition is not only entirely feasible but also affordable and cost-effective. Nutrition interventions are among the best investments in development that countries can undertake. What is needed is the implementation of this knowledge through community participation at scale. Large-scale programs, including the promotion, protection and support of exclusive breastfeeding, provision of vitamins and minerals through fortified foods and supplements, and community-based treatment of severe acute malnutrition, have been successful in many countries. The recent global economic and food price crises have underscored the importance of preserving food and nutrition security among vulnerable populations. We now need the combined efforts of practitioners and policy makers to make hunger and undernutrition history.

Professor Zulfiquar A Bhutta is Founding Chair, Division of Women and Child Health, The Aga Khan University, Karachi, Pakistan

**Table 2: Global burden of childhood undernutrition**

<table>
<thead>
<tr>
<th>Factor</th>
<th>DALYs lost percentage</th>
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<tbody>
<tr>
<td></td>
<td>As direct effect</td>
</tr>
<tr>
<td>General malnutrition</td>
<td>1.0</td>
</tr>
<tr>
<td>Micronutrient deficiencies</td>
<td>9.0</td>
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<tr>
<td>Total</td>
<td>10.0</td>
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</table>

**References**


**SUPPORTING PHYSICIANS PROFESSIONALISM & PERFORMANCE DRAFT FRAMEWORK**

Now available for feedback by the Fellowship

Please email sppp@racp.edu.au to find out how you can be involved.
Professor David Simmons gave the Priscilla Kincaid-Smith Oration at the recent Congress in Darwin. He spoke on the importance of building and sustaining mutual respect and trust between non-Indigenous and Indigenous peoples in order to effect positive change in the health of Indigenous communities.

The purpose of my presentation at the Darwin Congress was to flag the importance of the relationships between Indigenous and non-Indigenous individuals, and across communities, and beyond all, the key role of building and sustaining mutual trust. I have used my own work in South Auckland and the Waikato in New Zealand and the Goulburn Valley in Victoria as ‘case studies’.

The key messages are:

- Indigenous people are willing to work with physicians who wish to support the health of individuals, their communities and future generations.
- Such working in partnership can be successful and lead to improved health and strengthening of the initial trust.
- Misunderstandings and other obstacles will occur.
- A framework for mutual respect can minimise the risk of misunderstandings.

Although this article focuses on relationships in academia, many of the principles relating to communication and respect assist relationships within clinical practice.

Case studies

The South Auckland Diabetes Project (SADP), New Zealand

The SADP ran between 1991 and 1998 as a research program linked with community action and service development. It included (1) a house-to-house census and survey of known diabetes among 100,000 residents in inner urban South Auckland; (2) the development of a framework for understanding barriers to diabetes care; (3) a training program for local long-term unemployed people (including Maori) as surveyors and community diabetes educators; (4) the development of Maori and Pacific peoples community-based diabetes prevention programs; (5) the development of diabetes support groups; and (6) the development of the Diabetes Care Support Service to assist primary care with their diabetes services. The work of the SADP led to a local diabetes plan, a range of service developments for those with diabetes, the development of a district-wide diabetes control program (‘Let’s Beat Diabetes’: www.letsbeatdiabetes.org.nz) and transition to the Diabetes Projects Trust (www.dpt.org.nz), which continues to deliver many of the service-related functions in the community, including for Maori. Approximately 60% of the long-term unemployed involved in the program went either into jobs or other training programs.

The Department of Rural Health (UDRH), Shepparton, Victoria

The mission of the UDRH was ‘To improve the health and wellbeing of rural and Indigenous communities by providing leadership and excellence in collaborative, multi-disciplinary and culturally sensitive research and education’. From 1999, the department established a range of educational activities and an active rural and Indigenous health research program. Aboriginal people were involved in the management committee, the departmental team, and several of the educational and research initiatives. A partnership program with local Aboriginal organisations was established, inviting all Aboriginal community-controlled organisations in the region into a partnership to oversee the cultural appropriateness of the department’s projects and to develop activities to improve the health and wellbeing of local Indigenous people. A range of joint initiatives and evaluations were conducted, which led to increased partnerships between the University of Melbourne and the Aboriginal community, including the Rumbalara Diabetes Clinic, student placements and the Academy for Sport, Health and Education.

The Waikato Diabetes Translational Research program, 2003–2007, New Zealand

Although this work had its ‘hub’ at Waikato Hospital, most took place across the Waikato District Health Board area and the Ngati Tuwharetoa rohe (tribal area). The purpose was to put in place ways to prevent diabetes and its complications. This involved (1) the creation of a research team (including a Maori health researcher) and partnerships (including a kaitiaki (guardianship) group and joint work with local iwi (tribes) and Maori health services); (2) a program to define barriers to care, including among Maori (which was successfully completed); (3) an Integrated Diabetes Care Initiative (which was piloted in South Waikato, including a diabetes clinic in Taumarunui); (4) a program to improve nutrition and physical activity among children (Project Energize, led by Dr David Graham); (5) the joining
of diabetes-related information across service providers (the Regional Diabetes Information Service); and (6) Te Wai o Rona: Diabetes Prevention Strategy, a community-based randomised controlled trial to test whether diabetes could be prevented among Maori through lifestyle support. This trial was slow to recruit, but achieved the 5000 participants needed to be adequately powered to show a difference in incident diabetes. Twenty Maori Community Health Workers were trained, the intervention was successfully developed and piloted, and the partnership between local Maori and researchers intended the trial to continue. After three years, the funding was completed and the host university decided not to apply to the Health Research Council for further funding.

Conceptual progression

Using the experiences from the three programs above, it is possible to identify a range of issues that helped and hindered the development of trust and joint working. The original framework was developed in South Auckland for the diabetes prevention work between the health services/ researchers and local Maori. This was then used and adapted for the establishment of the health and education program with local Indigenous people by the UDRH in Victoria. The same framework was then used for the establishment of the Waikato Diabetes Translational Research program. The latter was built for evaluated service development that would improve Maori health through the control of the diabetes epidemic. The work in South Auckland and Victoria has continued and grown and some aspects of the Waikato work have also continued, highlighting the importance of empowerment of local communities and, where possible, creating sustainable ways ahead.

Understanding priorities

In 1994, funding was obtained through a Health Research Council Rangahau Hauora award for the Manager of Kaumatua (tribal elders) Care in rural South Auckland to undertake work among rural Maori. One component of this work was to interview rural Kaumatua (43/44 (98%) interviewed), regarding their priorities using open questions. Table 1 ranks and provides the proportion reporting the answers to two of the open questions: (1) where health was placed in comparison with other issues, at that time, among this group; and (2) the importance of diabetes among health issues.

This information was key to being able to place the importance of health and diabetes in discussions with Maori in South Auckland, and in confirming the importance of the training program for local long-term unemployed people.

Table 1

<table>
<thead>
<tr>
<th>Rank</th>
<th>Most important issues facing Maori</th>
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The support, trust and cultural guidance of community leaders are essential. Such leaders need to be comfortable with the physician’s agenda in order to introduce ‘outsiders’ to their family, community and organisational networks. This approach also applies in the clinical setting: for example, in the Rumbalara Diabetes Clinic, an Aboriginal Health Worker provided guidance to the physician on recent life events for individual patients, to guide the tone and approach of the subsequent consultation. Letting leaders down can result in significant loss of face for them, and this can occur unintentionally. Although relating to a single leader is easier and allows trust to be deeper, the loss of such a leader may result in difficulties with the Indigenous community.

Indigenous governance over their lands, communities and activities is pivotal. Shared governance over any planned work is a prerequisite. This shared governance needs to be formalised and documented. A ceremony publicly declaring the joint working is helpful.

Being aware of the tensions within Indigenous communities, being impartial and seen to be impartial, and finding ways to support all factions is essential, but can be difficult. Hopefully the leaders will facilitate insight into the local situation, but they will also have their own perspectives and positions. Key issues remain such as urban versus rural perspectives, historical issues between tribes and families, the power of Indigenous versus non-Indigenous organisations,
the role of women within the tribe
and the gaining of power through
non-Indigenous organisations
-especially organisations linked to
government). The perennial tensions
between personal power and the
power of the tribe are well recognised:
when is a person acting in their own or
their family’s (or tribal) interest rather
than the interest of the wider
community?

• Beyond documentation of the
governance arrangements, there needs
to be documented clarity over purpose
and roles. Defining the mechanism for
managing any funds is also crucial.

• It takes time to evolve from the initial
trust, with its in-built wariness, to an
increasingly sound relationship that can
withstand mistakes and difficulties. The
latter increases the chances that health
and educational initiatives will survive,
grow and be owned by the community.

A synthesis of the steps for developing
a program is shown in Figure 1.

Derived from this is a framework for
research (see www.mja.com.au/public/
issues/176_10_200502/hen10605_fm.html).

Competing agendas

Sadly, even after building trust within a
successful partnership, others without a
focus on the health of local individuals
or communities can be disruptive. While
this is a global truism, for Indigenous
communities additional issues arise from
differences between Indigenous and
non-Indigenous priorities and values and
the power given to Indigenous individuals
within non-Indigenous organisations. Alas,
dealing with these appears to be a case-
by-case issue, for which a roadmap may
not be helpful. Some of these are listed in
Figure 1.

Conclusion

It is clearly worthwhile reaching out
to work together in partnership with a
shared vision—much can be achieved
and trust can be built. People do want
to work together, but there can be initial
and understandable wariness. Trust has
two phases: (1) the initial contact, and
(2) action, process and achievements to
sustain trust. Figure 1 shows a framework
for avoiding misunderstandings and
helping to build relationships and a level
of trust that can withstand the inevitable
mistakes that will occur. While initiatives
can be built on mutual respect, they need
joint governance and guidance from
within the community to be maintained.

He aha te mea nui o te ao? He tangata!
He tangata! He tangata!
(What is the most important thing? It is
people, it is people, it is people.)

David Simmons FRACP
Rural Health Academic Centre, University
of Melbourne
Institute of Metabolic Science
Cambridge University Hospitals
NHS Foundation Trust

Adapted from Voyle J, Simmons D (1999), Community development through partnership: promoting health in an urban Indigenous
The Annual Congress, which was held in Darwin this year, provided the College with a further opportunity to promote continued engagement with the Fellowship and, in particular, to survey the attendees on how the College can better serve the needs of the Fellowship.

The focus of the College stand in Darwin was on Fellowship relations, with the theme of ‘Building Our College of the Future: Together as One’.

The College stand included a number of ‘polling booths’ (provided by the Australian Electoral Commission) for Fellows to complete a short questionnaire or suggestion form. While there may have been ice creams given to participating Fellows, the fact that we were able to receive over 200 forms indicates a strong level of interest in providing feedback.

Through this process, the College is seeking to highlight a renewed focus on the Fellowship, starting with how the organisation can best serve your interests and meet your needs.

We will be expanding the Fellowship Relations area within the College to develop a greater capacity to focus on Fellows as key contributors and participants in the life and operations of the College and also as members and recipients of support and services. Through this process we are striving to achieve higher levels of Fellowship satisfaction which will in turn support greater engagement and deeper levels of commitment to the College and its activities.

A key development will be the establishment of a dedicated Fellowship Services unit to better service the needs of Fellows. Our aim is to ensure that Fellows receive more efficient and responsive communications and support. Further announcements will be made on developments during the year.

To commence the process of achieving enhanced Fellowship engagement, the College is currently undertaking an extensive survey across the entire Fellowship to identify Fellows’ needs and to learn how the College might best go about meeting these and delivering on the expectations of Fellows.

In recent years, it was critical that the College focus on ensuring that our education and training services were accredited by the Australian Medical Council (AMC). These services must meet the changing needs of trainees, supervisors and the respective healthcare systems of Australia and New Zealand. The College has now secured accreditation from the AMC until December 2014. This accreditation covers the programs for trainees as well as the Continuing Professional Development (CPD) program for Fellows. This is core to the College’s role but we now need to focus upon the services the College provides to the 13,500 Fellows of the College.

To ensure that you are getting what you need from your organisation—we do ask for your support.

Message from the President

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

We recognise that membership organisations around the world need to adapt to the challenges of the 21st century, including new technologies, the rapid pace of change, the increasing volume of information, growing regulation, increasing media scrutiny and greater mobility. Traditional avenues for social and professional networking are being replaced by new opportunities for engagement and communication. Together we must adapt to these changes and deliver the benefits and services that are relevant to you as Fellows of the College.

To develop the College of the Future, we must recognise our changing environment as well as the changing needs, demands and characteristics of our Fellows. To do this, we need to identify the behaviours and attitudes of our Fellows as they relate to the College and to examine closely what motivates you to engage with the College. The College is therefore commissioning extensive market research, including a full survey across the Fellowship, in order to better understand and develop the services the College could provide.

While we continue to deliver training and continuing education programs, as a source of engagement and participation, this only involves a small percentage of Fellows. To address the needs of the broader group of nearly 13,500 Fellows, we need to continue to develop as a professional, authoritative and advisory body, servicing your needs. This means putting in place the structures, processes, products and services required to meet our responsibilities and working together to develop our College of the Future.
We have already started the process. One-on-one interviews were conducted in late April and early May, involving a randomly selected sample of Fellows from urban and regional centres from a range of disciplines and across Divisions, Faculties and Chapters. These interview responses have helped form the questions that will feature in the survey.

During the College Congress, we encouraged you to visit the College stand to complete our 10-minute questionnaire that will also contribute towards identifying and developing the services that the College provides to Fellows.

We have also engaged a professional research firm with broad experience with professional organisations, including the health sector. After extensive internal consultation, all 13,500 Fellows will shortly receive a web-based survey for completion. This will be a secure personalised link to a survey that will take between 15 and 20 minutes to complete. All survey results will be anonymous and will be collated on an aggregated basis for analysis.

We will keep Fellows updated throughout the entire process, to ensure that Fellows are engaged, involved and have the opportunity to provide maximum input to the College. The results of this survey will be made available to the Fellowship and will be followed by further engagement with Fellows about what the College can better do for its Fellowship.

Sasha Grebe
Director Professional Affairs & Advocacy
Ruth Anderson
Director of Fellowship Relations & New Zealand Manager

The Australasian Faculty of Occupational and Environmental Medicine (AFOEM) is extremely proud to have hosted Dr Tom Calma, who delivered the Fergusson Glass Oration at Congress. Dr Calma is well known to many as a champion for Indigenous rights in Australia. He was the Australian Human Rights Commission’s Aboriginal and Torres Strait Islander Social Justice Commissioner from mid 2006 to February 2010. His passion and his determination are now being applied to tackling the challenge of tobacco smoking, having accepted the position as the first ever National Coordinator for Tackling Indigenous Smoking.

Dr Calma was interviewed by the media in Darwin. The Faculty will continue to engage with Dr Calma.

Founding Fellows of the Faculty who attended Congress and the 21st birthday celebration

Fellows and trainees celebrated AFPHM’s 21st birthday during the recent Congress in Darwin. The Faculty developed from groups of physicians practising public health or community medicine in Australia and New Zealand who wanted to take responsibility for recruiting medical workers to the public health workforce, providing adequate training and setting standards for professional practice, to assist public health physicians in developing a satisfying career path. The celebration was attended by several Founding Fellows, including Dr Sue Morey, the Foundation President.

Associate Professor Leena Gupta (current AFPHM President) and Dr Sue Morey (founding AFPHM President)
MEDAL RECIPIENTS AT CONGRESS CEREMONY

Congratulations to all those who received medals from the various Divisions and Faculties for their outstanding work, to the recipients of College medals for their contribution to the College, and to those who received awards for their services to medicine and medical education.

Adult Medicine and Paediatrics & Child Health Divisions

A gold medal is awarded in each of the Adult Medicine and Paediatrics & Child Health Divisions for the best overall performance in both Written and Clinical Examinations.

Bryan Hudson Medal 2010
Adult Medicine
Dr Wallace Brownlee (pictured above)

Examination Medal in
Paediatrics 2011
Dr Bryony Ryder (pictured above)

Australasian Faculty of Public Health Medicine

AFPHM President’s Award for Outstanding Contribution to Education
Professor Donna Mak

In recognition of her contribution over several years to all aspects of educational activities within the Faculty

Australasian Faculty of Rehabilitation Medicine

Adrian Paul Prize 2011
Dr Seema Radhakrishnan

The Adrian Paul Prize is awarded annually for the best scientific paper at the previous Faculty Annual Scientific Meeting, or best scientific publication in a refereed journal, by a trainee or first-year Fellow.

Basmajian Prize and Merit Certificate 2011
Dr Richard Bignell

The Faculty awards a Merit Certificate and the Basmajian Prize for the most outstanding candidate in the Fellowship Clinical Examination. This book prize, named in honour of the late Professor John Basmajian, an Honorary Fellow of the Faculty, has been donated annually since 1989.
Australasian Faculty
of Occupational and
Environmental Medicine

Dean Southgate Award 2010
Dr Arthur Stratigopolous (right) being congratulated by President John Kolbe

The Dean Southgate Award is presented annually to the graduating Fellow with the highest aggregate mark in the AFOEM Written and Practical Examinations.

AFOEM President’s Award 2011
Dr Rob Gillett
(Education, Training and Assessment)
Dr Mary Wyatt (Policy and Advocacy)

The purpose of the AFOEM President’s Award is to formally recognise the outstanding contributions made by Fellows and trainees to the Faculty. All Fellows and trainees in Australia and New Zealand are invited to nominate a Fellow or trainee and detail their contribution to Education, Training and Assessment or Policy and Advocacy.

College Medals

The College Medals are awarded for outstanding service by Fellows of the College, its Faculties or its Chapters who, in the opinion of the Board, have particularly contributed to the welfare of the College, but who have not attained the office of President of the College. Where a College Medal is awarded to a Fellow of the College, it is known as the John Sands Medal.

College Medal 2011
Dr Peter Colville (pictured on page 16)
John Sands Medal 2011
Dr Glensys Arthur (pictured on page 16)
Professor Elizabeth Elliott
(pictured on page 16)
Dr Bruce Hocking (Australasian Faculty of Occupational and Environmental Medicine)

Dr Bruce Hocking (right) being congratulated by Professor John Kolbe

Professor Craig Mellis (nominated jointly by Adult Medicine and Paediatrics & Child Health Divisions and the Thoracic Society of Australia and New Zealand, pictured on page 16)
Associate Professor Peter Procopis (to be presented at a later date)
Professor Ian Scott (nominated jointly by Adult Medicine Division and IMSANZ, pictured on page 16)
Dr Geoffrey Robinson

Dr Geoffrey Robinson (above) and Professor Darlow (below) being presented with their medals by Professor Kolbe

RACP Medal for Clinical Services in Rural and Remote Areas 2011
Dr Valda Ahern

RACP Medal for Clinical Services in Rural and Remote Areas 2011
Dr Valda Ahern

Dr Robert Brodribb
(pictured on page 16)
Dr Neil Gordon MacKenzie
(pictured on page 16)
Dr Christopher Moyes

Eric Susman Prize 2011
Dr Stephen Kent

The Eric Susman Prize is an annual award by the College Council for the best contribution by a Fellow to the knowledge of any branch of Internal Medicine. The contribution must have appeared as a published work in the two-year period preceding the award. Preference is given to a younger Fellow whose work has a direct bearing on clinical medicine.

Arthur E Mills Memorial Oration
(Medal) 2011
Professor Marcia Langton

Oration title: Aboriginal custom and tradition: their relevance in improving Indigenous health outcomes

The late Arthur Edward Mills of New South Wales was a Foundation Fellow of the College and an outstanding physician, medical administrator and teacher. The Arthur E Mills Oration was endowed in 1950 by his widow, and established within the College for the promotion and encouragement of medical education and general culture.

Professor Marcia Langton (centre) with Dr Bryony Ryder and Dr Wallace Brownlee
THE 2012 Specialist Training Program (STP) application round and funding for infrastructure and clinical supervision in STP private settings were two initiatives launched by the Department of Health and Ageing in May 2011.

Applications for 2012 were open from 9 May to 9 June 2011. An anticipated 82 new STP places will be made available in 2012, with an as yet unspecified number going towards physician posts. Priority will be given to applications from the private sector and regional, rural and remote areas, with chronic disease, Indigenous health and generalist specialist practice targeted from within these two sector areas.

The Department’s Private Infrastructure and Clinical Supervision Funding Round is open from 9 May to 23 December 2011. This allowance supports activities associated with clinical supervision and training infrastructure undertaken in the private sector. The funding was introduced to STP as part of the 2010 National Health and Hospitals Network initiative, ‘Expand and Enhance the Specialist Training Program’.

Last year, the Department received more than 340 applications for physician posts for the 2011–2013 round of STP funding. Of these, 188 were shortlisted—a significant increase from 115 places in 2010. One successful applicant was Associate Professor Nicola Spurrier, of the South Australian Department of Health, Public Health, who is a clinical supervisor for STP Public Health Medicine trainee Dr David Johnson.

‘A number of interested Public Health Medicine physicians met and mapped out a comprehensive three-year training program, which specifically covered the range of competencies required by the Australasian Faculty of Public Health Medicine,’ Associate Professor Spurrier said of the application process.

‘Using the expertise of this group was important, because it allowed for a much richer and more comprehensive range of possible training experiences and rotations.’

As a result of this wide consultation, the STP-funded Aboriginal public health medicine position can include rotations through the South Australian Department of Health’s Health Promotion Branch and Communicable Disease Control Branch; the Environmental Health, Epidemiology Branch; the South Australian TB Service; Drug and Alcohol Services South Australia; the Aboriginal Health Council of South Australia; and the Centre for Injury Studies at Flinders University.

The application was further strengthened by the 2010 application round’s focus on chronic disease and Indigenous health.

‘Public Health Medicine aims to prevent disease through health promotion, health protection, screening and early intervention activities undertaken at a population level,’ Associate Professor Spurrier said.

A primary motivator for the STP application by the Department of Health, Public Health was the under-funding of public health compared to other medical specialties across all Australian states and territories.

The STP funding has made a significant impact on the development of Public Health Medicine training in South Australia, contributing towards the establishment of three full-time three-year positions for advanced Public Health Medicine trainees.

‘I think having the STP position made it possible to now have a training program, rather than just a single position,’ Associate Professor Spurrier said.

Improving the health of Indigenous Australians was also a personal career goal for Associate Professor Spurrier.

‘Our successful STP position has allowed a Public Health Medicine trainee to undertake health promotion and protection activities which directly impact on health outcomes of Indigenous Australians,’ she said.

‘The STP trainee in Aboriginal Public Health Medicine has, and will undertake, some very significant pieces of work which would not have been possible without the STP.’

The Royal Australasian College of Physicians has received Australian Government funding to administer the Specialist Training Program for 2011–2013. Associate Professor Nicola Spurrier is currently a member of the College’s STP Advisory Group.

Louise Young
Project Officer
Specialist Training Program Unit

STP AT CONGRESS 2011

STP Program Manager Ms Christine Frew, with Dr Nicole Hancock FRACP, Royal Hobart Hospital, and Associate Professor Nicola Spurrier FRACP, FAFPHM, South Australian Department of Health, Public Health, presented a session titled ‘Supervision in Expanded Settings’ at the 2011 RACP Congress in Darwin.

Approximately 50 Fellows attended the session, which provided an overview of supervision in expanded settings, drawing from the Commonwealth’s STP program, literature and research undertaken by the College in 2010, and recent initiatives and future projects focusing on building capacity for effective supervision within the College.

Key take-home messages included:

• High-quality supervision is essential for high-quality training.

• Teaching environments do not influence how medical doctors perceive the quality of their supervision, rather key influencing factors include:
  – lack of time for teaching
  – effective supervision skills
  – communication skills
  – provision of feedback.
AWARD WINNERS PRESENTED AT CONGRESS 2011

Congratulations to all winners of these awards, which were judged at RACP Congress 2011. We also wish to thank all our award sponsors for their support, and special thanks to the judges involved in the review and judging processes.

**Adult Medicine Division**

**Wiley-Blackwell Award for Clinical Achievement (The Best of Grand Rounds)**
Dr Antony Attokaran
For his case: Idiopathic Cardiomyopathy … idiopathic only until diagnosed

**Internal Medicine Society of Australia and New Zealand (IMSANZ)**

**Young Investigator Award**
Dr Sara Barnes, receiving the IMSANZ Young Investigator Award from President of the Society Associate Professor Nick Buckmaster (top right)

**Paediatrics & Child Health Division**

**Howard Williams Medal**
Professor John Boulton (left), with Dr Gervase Chaney, President, Paediatrics & Child Health Division

**RACP Trainee Research Award** (Adult Medicine)
Dr Claire Gordon, receiving the Trainee Research Award (Adult Medicine) from AMD President Dr Catherine Yelland
For her research presentation: 2009 Pandemic influenza A (H1N1) infection and low immunoglobulin subclass G2 (IgG2)

**RACP Trainee Research Award**
Dr Peter Azzopardi
The health and wellbeing of Indigenous young people: identifying the evidence base

**Rue Wright Memorial Award**
Dr Sharon Goldfeld
Four year old outcomes of a universal infant–toddler shared reading intervention: the Let’s Read randomised trial

**PRSANZ Research Award**
Dr Nicholas Wood
Long-term immunity following acellular pertussis vaccination at birth

**Wiley-Blackwell Publishing New Investigator Award**
Dr Kelly Saltman
Presence and frequency of urinary incontinence associated with childhood overweight and obesity

**Best Poster Prize in Paediatrics & Child Health**
Dr Samantha Lade
Long-term effects of BMI in paediatric renal transplant recipients: report from the ANZDATA registry

**Australasian Faculty of Occupational and Environmental Medicine**

**Ramazzini Prize**
Dr Kristin Good
General practitioner attitudes to ‘Fit Note’ certification: an NZ perspective
INDIGENOUS SCHOLARSHIP RECEPIENTS

Congratulations to the four recipients of the College’s Indigenous Scholarships, which were presented to them at Congress.

Of Maori descent, Dr Liza Edmonds has conducted research on topics that are highly relevant to the RACP 2011 Congress theme, including research into extremely low birth weight infants. Dr Edmonds is based at Townsville Hospital within the Neonatal Intensive Care Unit.

Lismore medical student Miss Angela Wood is currently studying at the University of Western Sydney and has contributed to paediatric research on topics such as The burden of paediatric ‘infected scabies’ in North Western Queensland.

Dana Slape is studying medicine at the University of Western Sydney. Her Aboriginal heritage is from the Larrakia people. Miss Slape was the 2010 recipient of the Mary MacKillop Aboriginal and Torres Strait Islander scholarship, and she is the current student representative from UWS to the Australian Indigenous Doctors Association (AiDA). She is also the Indigenous Officer for the UWS Rural Health Union, and is active in advocating for equality in Aboriginal and Torres Strait Islander health and education.

Neva Atkinson is Echuca Regional Health Aboriginal Liaison Officer. She is currently studying for a Diploma in Community Services. Her studies include a drug and alcohol module and a mental health component. Miss Atkinson is passionate about preventive measures as a means of addressing the various challenges in Indigenous healthcare.

Dr Leo Buchanan with College Indigenous Scholarship Award recipients Angela Wood, Dr Liza Edmunds and Dana Slape.
SNAPSHOT OF CONGRESS

A captivated audience at Congress 2011

CEO Dr Jennifer Alexander welcoming guests to the Congress dinner

Under the Stars dinner—a highlight of the four-day Congress program

Guests enjoying the event

Associate Professor Noel Hayman, Clinical Director, Inala Indigenous Health Service, Brisbane, delivering the Cottrell Lecture on Indigenous chronic disease: challenges in access, diagnosis and management

Australasian Faculty of Public Health Medicine Dinner

Back row (left to right): Dr Anne Robertson (President, Australasian Chapter of Sexual Health Medicine), Associate Professor Leena Gupta (President, Australasian Faculty of Public Health Medicine), Professor Marcia Langton (presenter of the Arthur E Mills Oration at the College Ceremony), Dr Gervase Chaney (President, Paediatrics & Child Health Division), Sir Mason Durie (the plenary speaker for the Congress), Professor Donna Mak (AFPHM Council Member and winner of the 2011 AFPHM President’s Award)

Front row (left to right): Dr Catherine Yelland (President, Adult Medicine Division), Associate Professor Noel Hayman (Chair of the Aboriginal and Torres Strait Islander Health EAG), Lady Arohia Durie, Dr Michael Ross (Honorary Fellow, Australasian Chapter of Sexual Health Medicine)
RACP Excellence in Mentoring Awards

The Excellence in Mentoring Awards are in their fourth year and regularly attract nominations of a very high standard.

Congratulations to the winners of the Excellence in Mentoring Awards in 2011.

They are:

**Professor Peter Fuller**
Academic and Research Category

**Dr John W Masson**
Physician Educators

**Dr Peter Davoren**
Clinical and Professional Category

Excellence in Mentoring Awards this year:
- **Academic and Research**
  - Dr Clayton King
  - Associate Professor Amanda Oakley
  - Associate Professor Marius Rademaker
  - Dr Terence Yoong
- **Clinical and Professional Practice**
  - Associate Professor Darryl Burstow
  - Associate Professor Donald Cameron
  - Dr Louis Cheung
  - Dr David Cunnington
  - Associate Professor Jo Anne Douglass
  - Dr Clayton King
  - Dr David Krieser
  - Professor Peter Macdonald
  - Associate Professor Scott Nicholas Parkes
  - Dr Michael O’Callaghan
  - Dr Robert Slade
  - Dr Max Williams
- **Physician Educators**
  - Dr Peter Connaughton
  - Dr Elizabeth Ann Gillett
  - Dr Simon Harvey
  - Dr Con James
  - Dr David Krieser
  - Dr David Levitt
  - Dr Patrick Moore
  - Dr Margot Nash
  - Dr Ralph Pinnock
  - Dr Sabe Sabesan
  - Associate Professor Erica M Wood

Dr Peter Davoren being congratulated by Professor John Kolbe

The judges would like to commend Dr Harriet Hiscock as a strong runner-up in the Academic and Research Category.

The following were nominated for

**President’s Award for Trainee of the Year**

This is the second year this award has been presented. Dr Bradley Gardiner, Adult Medicine Advanced Trainee in infectious diseases, was chosen as the recipient of the 2011 award from the following shortlist of talented trainees:

- Dr Donald McLeod
- Dr Farzan Fahrtash
- Dr Harry Eeman
- Dr Jonathan Kaufman
- Dr Matthew Webber
- Dr Thomas Reid.
Trainees’ Day at Congress 2011

R
da and special was the degree of engagement and honesty that pervaded this year’s Trainees’ Day as trainees and Fellows from all over Australia and New Zealand spoke up and shared their experiences on some of the more challenging aspects of medicine.

The day commenced with a breakfast to honour Indigenous participants at Congress, particularly the recipients of the new RACP Congress Indigenous scholarships. Next was a lively and, at times, controversial debate about whether rural terms should be mandatory for training. This stimulated a frank discussion amongst trainees, Fellows and members of the RACP Board about the important practical considerations relating to improving supervision, educational opportunities and general support for trainees on placements given the enormous benefits of rural training, including developing a broader range of clinical and procedural competencies.

Cultural competency and ethical decision making were the flavour of the afternoon with dynamic and confronting workshops that were immensely practical in their applications from guest speakers, Dr Leo Buchanan, Associate Professor Noel Hayman and Professor Paul Komesaroff.

Dr Leo Buchanan led with the poignant Maori concept of turangawaewae, the place where you stand on your own two feet. This is invaluable for us all to reflect on before we begin to grapple with the often fraught issues of identity, belief and culture which he skilfully led us through, highlighting key concepts in Maori traditions around health, spirit and family.

Next to speak was Associate Professor Noel Hayman, recent nominee for Australian of the Year, for his tremendously successful initiatives in closing the gap in Aboriginal health issues at a local level. He illustrated how easily cultural assumptions and ignorance can lead to potentially disastrous outcomes, while revealing how, with simple curiosity, integrity and respect, there are huge gains to be made.

The medical ethics session with Professor Paul Komesaroff further upped the ante encouraging us to consider how we negotiate our way towards the, at times, immeasurable gulf between our concepts of health and disease and those of our patients. Using real-life case scenarios, we engaged in group reflection on our values and blind spots as well as our processes for ethical evaluation across a broad range of issues, including end of life, resource allocation, burden of disadvantage, medicine and social engineering.

Next was the annual graduation ceremony for new Fellows and a sunset celebration down by the glorious Darwin harbour. Rounding out the evening was the Trainees’ Cocktail Party at the Ducks Nuts Tsar Bar where the prize for Trainee of the Year was awarded to Brad Gardiner for his outstanding contributions as a mentor and clinical leader within his hospital network.

All in all, a fabulous day and our heartfelt thanks go out to the inspirational speakers, the motivated attendees and in particular the tireless CTC Communications Director, Jemma Anderson, who made it such a resounding success.

See you all next year for Trainees’ Day in Brisbane!

Anna Hume
Queensland member of the CTC
DAME CAROL BLACK LAUNCHES
CONSSENSUS STATEMENT ON HEALTH BENEFITS OF WORK

On 30 March 2011, representatives of the medical and allied health professions, government, unions, business and workers gathered in Wellington, New Zealand, to join the Australasian Faculty of Occupational and Environmental Medicine of the Royal Australasian College of Physicians in launching the Australian and New Zealand Consensus Statement on the Health Benefits of Work.

The Consensus Statement was launched by Faculty champion Professor Dame Carol Black, who is the first national Director for Health and Work in the United Kingdom. The launch represented the culmination of an extraordinary amount of hard work and goodwill on the part of the Faculty, international leaders such as Dame Carol, and the 80 plus organisations who have endorsed the Consensus Statement to date. This diverse and still growing signatory list reaches across parties, political systems and countries.

The message of the Consensus Statement is simple and evidence based: work is generally good for health and wellbeing, while long-term work absence and worklessness present significant health risks. No organisation involved in the extensive consultation process by which the Consensus Statement was developed disputed this basic premise; nevertheless, the road to consensus amongst diverse stakeholders demanded deft navigation from those who drove the process.

‘I think if we’d seen one more version of the Consensus Statement we might not have signed on,’ joked Helen Kelly, President of the New Zealand Council of Trade Unions, before expressing her organisation’s pride in being a signatory to the final version.

Ms Kelly’s enthusiasm for the Faculty’s initiative was echoed by representatives of other key stakeholder groups.

Paul Mackay of Business New Zealand described the Consensus Statement as ‘fundamentally a good thing’ and said that it was ‘unthinkable’ that Business New Zealand would not be involved. Paul O’Connor of Australia’s Comcare characterised that organisation’s decision to sign the Consensus Statement as the ‘smart thing to do.

‘Not only does it deliver on corporate social responsibility, it improves workforce participation, decreases work disability, decreases absenteeism and decreases early retirement. We think it is also important in terms of the social inclusion agenda, because it helps us support people coping with change and challenge and disability,’ Mr O’Connor said.

Dr Harry Pert of the Royal New Zealand College of General Practitioners spoke of how his involvement with the Consensus Statement had caused him to reflect critically upon his own practice.

‘I prescribe medication everyday,’ Dr Pert said. ‘I order investigations every day—laboratory investigations, radiology investigations. My ability to do that safely is based on many years of preparation—chemistry and pharmacology and a lot of decision support throughout my career. I haven’t had that training and support in my prescribing of work and absence from work; it is a big gap in our knowledge. I think we have to do some work, in order to fix that.’

Despite expressing strong support for the Consensus Statement, Dr Pert identified some areas that the RNZCGP believes require further consideration, particularly around the management of potential unintended consequences that may flow from the association of work with health.

Dr Don Simmers of the New Zealand Medical Association also sounded a note of caution, calling for the Faculty to acknowledge the benefits of unpaid employment such as parenting and caring, as well as the possibility of some kinds of work to do harm.

‘We don’t have the “dark satanic mills” of the industrial revolution anymore, but we do have situations where workers are not enjoying what they’re doing, do not feel encouraged, do not feel as though they have any freedom, are time poor and feel discouraged in what they do. Work is good for health; but it can’t be just any kind of work.’

The tragedies of the Pine River Mine disaster and the Christchurch earthquake mean that New Zealanders have recently had cause to reflect on the harm that may befall people in their workplaces.
Yet as Dame Carol noted, it is also the case that beneath the facts and figures around work absence and worklessness lies ‘a lot of human misery and plenty of disruption to families’, with health consequences that may include premature mortality.

According to Faculty President Dr Robin Chase, there is a link between occupational health and safety and the health benefits of work. ‘The concepts about which we talk today are not exclusive of workplace safety, but complementary. We are talking about integrated health and safety, whereby we have workplaces that are not only safe, but beneficial.’

At a time when both countries are debating welfare reform, it is hoped that the extensive media coverage of the launch in Australia and New Zealand will bring the Faculty’s positive, empowering message to a broad audience.

Despite his enormous contribution to the success of the launch, Dr David Beaumont, Chair of AFOEM’s Policy and Advocacy Committee, flagged that the Consensus Statement is intended as a stepping stone rather than a finish line.

“We hope the Consensus Statement will facilitate further discussion about how the health benefits of work are best achieved in Australia and New Zealand,’ Dr Beaumont said.

With position statements planned that tackle the issues of health and productivity and the question of ‘good’ work, the Faculty is well placed to lead these discussions.

Gabrielle Lis
Policy Consultant
Consensus Statement

AFOEM TAKES HEALTH BENEFITS OF WORK TO INTERNATIONAL STAGE

The Australasian Faculty of Occupational and Environmental Medicine’s position statement, Realising the Health Benefits of Work, was the first step in a deliberate, coordinated physician-led effort to positively influence public policy in the best interests of patients and the whole community throughout Australia and New Zealand.

There is yet much to be done if we are to reach the target of a paradigm shift in the approach to return to work after illness or injury by health professionals, workers and employers. However, our experience already warrants engagement with our international colleagues. To that end, Associate Professor James Ross, President-Elect of AFOEM, is to deliver a paper at the ‘Unemployment, Job Insecurity and Health’ conference in Helsinki in September (see www.ttl.fi/en/international/conferences/unemployment_conference/pages/default.aspx). This meeting will occur under the auspices of the International Commission on Occupational Health, the premier global Occupational Health professional body.

Associate Professor Ross’s presentation will describe our process so far, focusing on the need for consensus across the spectrum of stakeholders, and arguing that physicians can and should be viewed as credible leaders, exerting influence on public policy. This not only will help us advance towards realising the health benefits of work, but indeed further the RACP goal of raising our profile in national and international forums.

For more information about the Health Benefits of Work, please visit the Faculty’s website (www.racp.edu.au/page/afoem-health-benefits-of-work) or contact Deborah Lockart, Senior Executive Officer, on Deborah.Lockart@racp.edu.au.
The management of addiction is a challenging yet rewarding one for medical practitioners and one which delivers socioeconomic benefits for an individual and society at large. On 16 December 2009 the Commonwealth Minister for Health and Ageing, the Hon Nicola Roxon MP, recognized Addiction Medicine as a medical specialty for the purpose of inclusion in the Australian Medical Council (AMC) List of Australian Recognised Medical Specialties.

To facilitate the growth of the specialty and the continuing professional development of the Addiction Medicine Fellows, the Australian Chapter of Addiction Medicine (AChAM), with support and funding from NSW Health, has developed a suite of online education modules for healthcare professionals interested in improving their knowledge and skills in the assessment and management of patients with drug and alcohol problems.

The online modules provide flexibility of learning to participants. They can be accessed from any location as long as a computer and internet connection is available. The modules can be completed in multiple sittings.

The content for each module has been developed by a Module Working Group comprising experienced specialists in addiction medicine. Each working group developed a series of relevant clinical scenarios typical of problems in clinical practice and reviewed them to ensure consensus on proposed management.

The modules include case studies with associated questions that participants have to answer. Model answers developed by the working group are then made available to the participant. The cases are supported by relevant readings, reference materials and online discussion forums. Passing a set of multiple choice questions signifies the successful completion of the module. A certificate of completion is then issued.

The modules are recognised for continuing professional development by some healthcare professional organisations. The online modules are housed on the RACP learning management system.

There have been more than 300 enrolments in the online modules to date. The feedback from participants has been positive and the modules have generated online discussion which has enriched the content.

The modules are outlined above.

<table>
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<tr>
<th>Module</th>
<th>Description</th>
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<tbody>
<tr>
<td>Alcohol Use Disorder Module</td>
<td>Covers the epidemiology of alcohol use, the impact of alcohol use disorders, elements of pharmacology and genetics as they relate to alcohol use, as well as the health benefits of moderate alcohol use and treatment approaches for alcohol use disorders.</td>
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<tr>
<td>Prescription Drug Misuse Module</td>
<td>Deals with the management of misuse of prescription drugs. You will study the epidemiology of prescription drug misuse, opioid pharmacology and the role of prescription drugs in the management of insomnia, and formulate a management plan for commonly occurring problems of prescription drug misuse.</td>
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<tr>
<td>Advanced Prescribers’ Module</td>
<td>Addresses the problems associated with diversion and misuse of prescribed opioid medication. You will learn the pharmacology of both agonist and antagonist drugs, assess patients for suitability for takeaway doses of opioid substitution medications, and manage relapse. The modules assume a basic level of knowledge of drug and alcohol problems. The Advanced Prescribers’ Module requires the completion of the Opioid Treatment Accreditation Course (OTAC) as a prerequisite (<a href="http://www.pac.med.usyd.edu.au">www.pac.med.usyd.edu.au</a>).</td>
</tr>
<tr>
<td>Opportunistic Intervention Module</td>
<td>Designed to increase the knowledge and skills of medical practitioners with a basic understanding of addiction so that they may be able to provide opportunistic interventions for patients with alcohol or other drug problems.</td>
</tr>
<tr>
<td>Alcohol Anxiety &amp; Mood Disorder Module</td>
<td>Addresses the epidemiology of symptoms and disorders of anxiety and mood, self-harm and suicide in the context of alcohol use disorders. The module covers the association between alcohol use disorders and co-morbid anxiety and mood symptoms, as well as formulates a management plan for patients.</td>
</tr>
<tr>
<td>Young People &amp; Addiction Module</td>
<td>Focuses on the epidemiology of substance use among young people, conducting a risk assessment for mental health and suicide risk, sexual health risk factors, drug and alcohol risks, and understanding ethical and legal issues relevant to working with adolescents.</td>
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Fellows interested in undertaking the online modules can register interest by filling in the application form at: www.racp.edu.au/page/acham-online-education-modules.

**Participants’ feedback**

These online modules (opiate prescriber and advanced prescription as also the alcohol) – all an excellent means of learning and keeping up with ‘the rest of Oz’ especially as I am remote from my colleagues—this method of participation has permitted me a level of shared knowledge as well as something by which to measure my own work and progress as I train towards the FChAM.

This is an enjoyable & convenient way to improve / test your knowledge. I look forward to modules on related topics. I think the problem of benzodiazepine misuse/abuse is very difficult to manage & look forward to a module on that topic &/or polydrug abuse.
ENSURING ETHICAL RELATIONSHIPS BETWEEN PHYSICIANS AND INDUSTRY

The Board of the Australasian Sleep Association (ASA) has been advised of approaches to physician members by a company proposing the establishment of a cooperative for sleep physicians to be involved in the sale of continuous positive airway pressure (CPAP) equipment to their patients with a promise of a share in the profit from such sales. The membership in this cooperative would remain ‘classified’.

The ASA has adopted the Guidelines for Ethical Relationships between Physicians and Industry (2006) of the Royal Australasian College of Physicians. With respect to medical devices, the guidelines state:

- It is inappropriate to obtain a benefit from the sale of a medical device to one’s own patients.
- Relationships between clinical practitioners and producers and suppliers of devices should be transparent.
- Where a conflict of interest is likely to arise, a recommendation to use a particular device should be made by a clinician at arm’s length from the sale or distribution of the device.

In addition, the position paper of the ASA (The Best Practice Guidelines for the Provision of CPAP Therapy 2009) states:

There is compelling evidence to suggest that despite the best ethical standards held by clinicians, pecuniary interests do influence behaviour and it is likely that the only way in which this potential conflict of interest can be managed is by a clear separation of roles and responsibilities.

For these reasons it is not desirable for an individual clinician engaged in diagnosis of obstructive sleep apnea (OSA) to derive income from the business of CPAP provision. Nor is it desirable for an organisation engaged in CPAP provision to provide diagnostic services with a view to profit from subsequently selling CPAP to a patient. If compelling reasons exist to prevent this separation of roles, for example geographic isolation, sleep physicians or sleep clinics involved in diagnosis and selling or hiring CPAP equipment should declare this conflict of interest by informing patients of this in advance of any such sale or offer for sale or hire and disclosing any financial intent or benefit they may have.

Both the Medical Board of Australia (MBA) Code and the Medical Council of New Zealand Code (both called ‘Good Medical Practice’) are available online (for Australia see www.medicalboard.gov.au) and spell out how individual practitioners should recognise and manage such potential conflicts of interest including declining any financial interest that they may have in any product endorsed or sold from their practice (section 8.11–8.12 of the MBA code and points 93–96 of the MCNZ Practice Guide).

This issue is raised in other circumstances. There are a number of persons who advertise the sale of products by various means and who, in doing so, indicate that they hold an FRACP. These persons sometimes provide dubious ‘scientific’ support for their claims and do not disclose their financial or other relationships with the company selling the products. These persons are also acting counter to RACP and other guidelines.

In the case outlined above, there has been direct correspondence with the company involved outlining the ethical standards that have been endorsed by the ASA and the RACP. The response to date has indicated that the company does not see anything wrong with this type of business arrangement. However, there has been a large volume of support for the endorsed ethical guidelines from the membership of the ASA, most of whom are RACP Fellows. It is understood that no Fellows have taken up this offer.


Recent events have shown the importance of being vigilant and being cognisant of the ethical guidelines governing the often close relationship between clinical practice and industry.

Associate Professor Craig Hukins FRACP
President
Australasian Sleep Association
craig_hukins@health.qld.gov.au

CPD 2 U ROADSHOW

Continuing professional development (CPD) has gained much scrutiny in recent years, both at home and overseas. CPD participation has been a requirement for purposes of registration in New Zealand since 2003, with Australia implementing mandatory CPD in 2010.

To help facilitate a smooth transition for our Fellows, the CPD Unit developed a travelling roadshow which was taken to 11 locations including all capital cities and other major centres in Australia earlier this year.

The roadshow covered key areas, including:

- The College CPD Mandatory Participation Policy
- How Fellows can best meet the new Medical Board of Australia regulatory requirements for CPD
- ‘What is CPD’ and ‘What counts as content’
- How to develop a Professional Development Plan within the RACP MyCPD program
- How reflection can be undertaken, the purpose of reflection and the mandatory requirement to complete this

- The online MyCPD program, including how to add activities, print statements and log recurring activities.

Feedback from the 400 attendees confirmed that the roadshow was well received and additional workshops continue to be conducted by regional Medical Education Officers (MEOs) as needed.

Sally Tyrie-Greenwell
CPD Education Officer
Fellows Learning Support Education Services
AMC AND MCNZ ACCREDITATION

The landscape of accreditation is changing in Australia and New Zealand. One significant change is that the Medical Council of New Zealand (MCNZ) and the Australian Medical Council (AMC) have established an agreement of understanding with the aim of aligning accreditation processes between the two countries. This is good news for all medical colleges as the submission processes are time consuming and duplication of effort can be avoided through these institutions working more closely together.

Another change is the reporting on accreditation outcomes. This has shifted to a compliance framework of substantially met, met and not met, in addition to the previous reporting of commendations and recommendations. This shift in language indicates a shift in focus. Medical schools and medical colleges can expect more rigorous scrutiny of their processes and determinations rather than recommendations about whether standards have or have not been met.

The accreditation standards of both the AMC and the MCNZ are constantly evolving. The AMC reviewed its standards in December 2010, mostly in order to streamline educational decision-making processes. The AMC is also aware of the need to work on strategies which will improve the ongoing concern of the AMC as is the further development of the mandatory CPD policy and remediation and retraining programs until 2014.

In all there are 68 standards across nine areas:
- The Context of Education and Training
- The Outcomes of the Training Program
- The Education and Training Program – Curriculum Content
- The Education and Training Program – Teaching and Learning
- The Education and Training Program – Assessment of Learning
- The Education and Training Program – Monitoring and Evaluation
- Implementing the Curriculum – Trainees
- Implementing the Training Program – Delivery of Educational Resources
- Continuing Professional Development.

For these standards to be met the College must make the successful transition from an institution which is dedicated to setting educational standards and assessment to a professional training provider in the fullest sense of its meaning.

In recent years, particularly with the advent of PREP in 2008, the College has made significant inroads into making this transition from a standard setter and assessor to a training provider. The aim of PREP is clearly to assist trainees in their learning through provision of curricula which articulate what they need to learn and formative assessments which provide a learning framework by which trainees gain feedback from their supervisors, which is vital to their evolving practice as physicians of the future. In addition, PREP provides e-learning platforms which support trainees to learn with the use of technology. As technology has been an integral part of trainees’ lives at home, school and university, we need to ensure that our learning solutions stay abreast with their learning needs and approaches.

As technology has been an integral part of trainees’ lives at home, school and university, we need to ensure that our learning solutions stay abreast with their learning needs and approaches.

The AMC recently acknowledged the significant achievement of the RACP, particularly in respect to PREP, by granting the College accreditation of its educational programs until 2014.

One of the key messages of the AMC is that it is thoroughly convinced of the PREP philosophy but is looking to the College to improve implementation. From April to July the College is engaging in a comprehensive strategy of consultation about PREP in regional sites with Fellows and trainees. This will involve engaging in consultation strategies to review and refine the existing programs and related tools so that they can be better integrated into the daily workflow of busy trainees and Fellows. Consultation processes—including pilots of trainees and Fellows in the healthcare settings—will also ensure that the development of future tools is robust.

The work of the College in terms of accreditation extends beyond refinement of PREP. In total there are 12 new and 25 ongoing recommendations. Other priorities of the AMC which the College needs to work on addressing include improvements to governance and program management, particularly in terms of the review of the by-laws so as to streamline educational decision-making processes. The AMC is also aware of the planned external review of formative and summative assessments which will take place later this year. The AMC is keen to gain an update on this review. The need to refine accreditation processes is an ongoing concern of the AMC, as is the further development of the mandatory CPD policy and remediation and retraining of Fellows. The development of principles surrounding the selection of trainees into Advanced Training, refinements of policy arrangements concerning mandatory rural rotations and improved supervisor support are also key concerns.

In 2011, the College will continue to work on strategies which will improve the system-wide changes taking place and ensure that the approaches adopted meet the needs of trainees and Fellows.

Julie Gustavs
Manager, Education Development, Research and Evaluation
Education Services
EXTERNAL REVIEW OF FORMATIVE AND SUMMATIVE ASSESSMENTS

An External Review of Formative and Summative Assessments at the RACP will take place, 21–25 November 2011.

Undertaking external reviews of an organisation’s processes and approaches is an essential part of the quality and continuous improvement cycle of any contemporary workplace. It is valuable in that it provides a thorough examination of organisational and professional practice and is outward looking in its orientation.

Three External Reviewers have been invited by the College to participate in the review: Dr Simon Newell, Vice President, Training and Assessment; The Royal College of Paediatrics and Child Health, UK; Dr Tim Allen, Associate Director Assessment, The Royal College of Physicians & Surgeons of Canada; and Professor David Boud, University of Technology, Sydney.

This External Review of Formative and Summative Assessments provides an invaluable opportunity for College Fellows, trainees and staff, as well as external stakeholders, to engage in critical dialogue with learned colleagues about core elements of the RACP training program. It is a vital part of ensuring that our educational approaches are robust, defensible and draw on the expertise of those engaged with assessment practices within the College as well as experts in assessment both nationally and internationally.

The review is timed so that the Physician Readiness for Expert Practice (PREP) training program, being in its third year of implementation, has now been embedded into the College assessment framework. The PREP program has seen the development of a more structured and formalised approach to learning, including the development of curricula, formative assessments, and policy and training site accreditation frameworks, as well as a structured model for supervisor training. An ongoing systematic evaluation of the elements of the training program has commenced at the College, but to date the alignment of the PREP model with summative assessments has not been formally reviewed. This External Review provides us with an opportunity to undertake this work as well as to formally evaluate the formative assessments, both implemented and planned, which make up the PREP framework.

The terms of reference for the External Review of Formative and Summative Assessment are:

1. Advise the College on the extent to which the current RACP assessment framework aligns with current best practice in education and assessment
2. Provide advice on the sustainability of current assessment processes in the changing climate of medical education and service delivery and given a substantial increase anticipated in trainee numbers
3. Advise the College on the educational and other impacts that current assessment processes have in preparing trainees for a career in specialist medicine
4. Provide advice on the validity of current assessment processes and their alignment to training program curricula
5. Provide advice on the reliability of current assessment processes
6. Advise the College on international best practice in summative assessments at the specialist level and the implications of these practices for RACP assessment programs
7. Provide advice to the College on development of an ideal suite of summative assessment tools and the timing of their application within the various training programs of the College, with reference to efficiency and sustainability as well as to validity, reliability and quality of the assessment programs.

In order to provide a focal point with the College, but outside both Education Services and the Examination Committees, Richard Doherty, the newly appointed Dean of the College, has agreed to act as the coordinating member of College staff to oversee the conduct of the External Review of assessment. Preparations for the review and coordination of the visits themselves will involve considerable input from Julie Gustavs, Manager Education Development, Research and Evaluation, and her team, as well as numerous other members of Education Services and staff of the Faculties and Chapters involved in assessment processes and a larger number of Fellows who are currently closely involved with the preparation and administration of the examinations.

The College will be conducting a range of activities throughout the year leading up to the External Review. Activities include:

- developing a briefing paper on formative and summative assessments summarising the current status of formative and summative assessments across Divisions, Chapters and Faculties of the RACP
- conducting a submission process inviting Fellows (including supervisors) and trainees from across the College’s Divisions, Chapters and Chapters, as well as key external stakeholders, to comment on the RACP assessment practices in relation to the terms of reference of the review
- evaluating written and clinical examinations by surveying trainees
- preparing a report on trainee and supervisor feedback from the College surveys
- undertaking a literature review in assessment for learning
- undertaking a review of current assessment practices across all Colleges in Australia and New Zealand, Canada and the UK.

By conducting this review of our assessment framework, we hope to be able to identify areas for improvement and make changes to further improve the RACP assessment process for our future trainees.

The views of College members are integral to this process. Within the next few months, all College members will be emailed a notification of the online submission forum. We look forward to receiving your feedback.

For more information on the review, please email evaluation@racp.edu.au.

Julie Gustavs
Manager Education Development, Research and Evaluation
Education Services
The Royal Australasian College of Physicians seeks to strengthen alliances with peer organisations such as the Royal Australasian College of Surgeons (RACS) and the Royal College of Physicians and Surgeons of Canada (RCPSC).

The senior leadership of the three Colleges have agreed to formalise an alliance and work together on issues of mutual concern. To this end, a joint medical education seminar was held at the RACP in Sydney, March 14–16 this year.

The 34 seminar participants were organised into three working groups, each tackling one of the following topics of mutual interest: professionalism, competency-based medical education, and work-based assessment.

**Professionalism**

The issue of professionalism is relevant to all medical practitioners and its scope is ever changing with the increased globalisation and modernisation of the health environment. Around the world governments are regulating medical practice and medical practitioners to a much greater degree, with doctors now required to actively demonstrate their medical expertise and professional qualities. The introduction of mandatory continuing professional development by the Medical Board of Australia and the Medical Council of New Zealand’s proposed peer review requirement are just two examples of this.

A primary focus of the professionalism working group therefore had to be on confirming a shared definition of professionalism across countries and specialties.

The fundamentals of professionalism were agreed and supported:

- Honesty, integrity and altruism
- Duty of care to patients and ‘doing the right thing’
- A commitment to lifelong learning
- Communicating in an accessible and meaningful way to patients and colleagues.

There was healthy discussion around how doctors continue to remain professional in the modern environment. With the speed of change increasing, how do medical practitioners maintain their competence and expertise? The bond with the patient has changed, with a recognised move from a more paternalistic approach to patient-focused care. The public expectation has also shifted. The new field of ‘e-professionalism’ and what that means in day-to-day interactions was also discussed.

Following this intense consideration the working group drafted a consensus statement on professionalism.

The statement, which is soon to be published, has an agreed definition of professionalism. It outlines the longstanding characteristics and the changes in recent times, including societal expectations of the profession, advances in electronic communication and the changing models of care. The consensus statement outlines that medical professionalism must include ongoing continuing professional development, maintenance of patient confidentiality in an electronic world, and good intra- and inter-professional communication.

Moving forward, the working group is considering commissioning greater research on professionalism, particularly in the areas of:

- the status of the ‘triangle of trust’ between the profession, government and society
- trainees learning unprofessional behaviours from professionals rather than other trainees
- the documentation of CPD and its impact on performance
- ethics and professionalism regressing in stressful situations
- the development of assessment and remediation tools.

**Competency-based medical education**

This topic was considered important for the three Colleges to address because a competency-based approach has the potential to meet various objectives in medical education, including improved accountability for public resources, more efficient use of training time, possible shortening of training time, identification of trainees capable of accelerated progression, increased rigour and validity in specialist training and assessment, and the evaluation of educational outcomes.
The working group decided that its initial focus would be on clinical judgement and decision making, because these involve integration of a number of competencies and because basic processes and principles of decision making are common across disciplines.

Given the end goal of improving clinical reasoning and decision making, it would be appropriate to introduce the competency approach via the existing formative assessment tool of Case Based Discussion. The project overall would involve:

1. Undertaking a literature review on Case Based Discussion
2. Developing a framework of expected competencies
3. Developing standards based on the existing RACS model, plus examples of the skills and behaviours demonstrated by a high-performing trainee
4. Developing tools to conduct an assessment of professional development of assessors
5. Planning logistics for implementation of the assessment tool.

The work for the next 12 months is to conduct the literature review, develop an assessment tool for a pilot, explore areas for professional development and plan the pilot to start in 2012.

**Work-based assessment**

The key outcome of the work-based assessment (WBA) group was to seek to answer four questions from the perspective of the three Colleges: the why, the what, the how, and the where to from here?

The group identified five main aims of work-based assessment:

1. Identify needs
2. Increase the accuracy of performance evaluation
3. Improve performance
4. Assess competencies that are hard to address in an exam
5. Meet expectations of the public and regulatory authorities.

The group shared plans for work-based assessment. The RACP discussed the current and proposed PREP tools including the Professional Qualities Reflection, the Multi Source Feedback, the mini-CEX, and the Direct Observation of Procedural Skills. The Royal Australasian College of Surgeons (RACS) uses clinical audit and is developing a Multi Source Feedback tool for Fellows and the Royal College of Physicians and Surgeons of Canada (RCPSC) is developing simulation scenarios for web-based learning.

The WBA group discussed the requirements for successful implementation of work-based assessment tools. In part, this is determined by key attributes of the individual assessments: validity, reliability, cost-effectiveness, educational impact, user acceptability and a clear relationship to the competencies being assessed. The other critical component is the context in which the assessments take place, and the support required from busy practitioners who take on the roles of supervisors and assessors. Professional leadership is essential to achieving a change in practice and culture.

The outcome of the working group will be the development of a paper or series of papers on the practicalities of implementing work-based assessment.

Keith Johnstone, Dennis Sligar, Julie Gustavs and Marie-Louise Stokes
Education Services

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**DEAN’S WELCOME MEETINGS**

The Dean, Professor Richard Doherty, and Director of Education Dr Marie-Louise Stokes embraced the meetings as an opportunity to meet trainees and supervisors at the onset of the 2011 training program. This coincided with the commencement of the PREP Advanced Training program in 2011 and, as such, was a great opportunity for the College to provide first-hand advice on the latest requirements of the PREP program.

Results of a survey of the participants indicated that more than 85% of participants were satisfied overall with the meetings.

Below are some of the comments made by participants:

- Detailed discussion of PREP components – useful.
- Appreciate the time senior members of the College made to make themselves available (accountable) to Fellows, basic and advanced trainees together.
- Enjoyed Q&A.
- Enjoyed mini-CEX formative assessment tool.
- More time allocated to go through specific training requirements, i.e. more time on Basic Training session.
- There should be some workshops/hands-on experience for supervisors; would help with evaluating candidates during mini-CEX.
- The feedback obtained will be incorporated into an evaluation report. The report will include recommendations regarding the future format and timing of these sessions.

Radmila Jancic
Senior Executive Officer
Education Services
INNOVATIVE WAYS TO TRAIN SUPERVISORS IN PREP

The Physician Readiness for Expert Practice (PREP) program has been in existence for three years, with the uptake most prevalent in 2010. Trainees and supervisors are becoming more familiar with the tools, and College Medical Education Officers (MEOs) and hospital Directors of Physician/Paediatric Education (DPEs) need to come up with innovative ways to keep the workshops interesting and relevant.

Throughout 2010, workshop evaluations highlighted the need for more information on what to do if you have a trainee in difficulty and how to give effective feedback. Furthermore, with the introduction of PREP Advanced Training, supervisor workshops are now needed to cover new tools such as Case-based Discussion.

Advanced Training

Due to the nature and scope of PREP Advanced Training 2011, the Victoria State Office trialled a new initiative where specialties and faculties were invited to attend a workshop that would ensure all were able to get the specific training that was required while networking with Fellows from other specialties and Faculties.

The first workshop of this kind was held on Saturday, 26 March 2011, at RACP Victoria and the specialties which participated were Geriatrics, Rheumatology, Neonatology, Haematology and Nuclear Medicine. The Faculties participating were the Australasian Faculty of Rehabilitation Medicine (AFRM) and the Australasian Faculty of Occupational and Environmental Medicine (AFOEM).

Based on a round-robin style workshop, attendees mixed with different specialties and Faculties and heard different opinions as they worked their way through sessions on giving effective feedback, Case-based Discussion, Trainee in Difficulty, Learning Needs Analysis and portal navigation sessions. Each specialty and Faculty also had a specialty-specific workshop. In this way five specialties and two faculties were able to train together and yet only receive information relevant to them.

The workshop also worked well due to the facilitators who were more than willing to give up a Saturday morning to assist colleagues. Thank you to Dr Stephen de Graaff, Dr David Goddard, Dr Andrea Bendrups and Associate Professor Benny Katz for their expertise.

Feedback from participants in the workshop

To evaluate the effectiveness of the workshop, evaluation forms were filled in so that the College was able to assess the relevance of the workshop to ensure that it was worthwhile. Feedback from five different supervisors/Fellows who participated was as follows:

The training needs to be extended to all assessors … tools will be used by other staff.

Well organised, perhaps better advertised, open to all assessors of trainees.

Appreciate the opportunity to do role-playing.

What about supervisor effectiveness, how can this be addressed?

Clear structured presentation, useful and will change my approach to trainees.

It is clear from the comments that there are areas that the College needs to focus on. This will ensure that future training is time effective so that the minimum amount of effort will obtain the maximum results of continual high-quality medical education for trainees and supervisors. In addition to these benefits, this training will ensure that assessors are clear on their role and are better supported by the RACP.

Due to the feedback the Victoria Office received, other regional and metropolitan AT round-robin workshops are currently being organised for June and July. Please see the ‘Upcoming PREP Workshops’ page at: www.racp.edu.au/index.cfm?objectid=D7FAA8D1-9F7C-82F6-10145899F0F3FB04 or contact Alexis

AFRM session with Dr Stephen De Graaff (far left) and AFRM Fellows

Rheumatology specialty-specific session with Medical Education Officer Shaylin Rose (left), Dr Andrea Bendrups (far right) and Rheumatology Fellows
Marsh alexis.marsh@racp.edu.au to organise a workshop for you.

Basic Training

Basic Training Directors of Physician Education are also coming up with innovative ways to inform their trainees and consultants on the use of PREP. At a recent Grand Round at the Royal Melbourne Hospital, DPE Dr Sam Hume utilised an audience polling system to promote interaction throughout the presentation and organised a real-life mini-CEX demonstration with a genuine patient and trainee who was asked to counsel the patient about using Warfarin.

While most trainees would be extremely nervous to be examined in front of a lecture theatre of 60 of their fellow trainees and highly qualified consultants, Basic Trainee Dr James Whittle did a brilliant job of remaining focused and calm under pressure. In the immediate public feedback session James was highly commended on his counselling and communication skills.

So why are the workshops important?

The workshops are an opportunity for trainees and consultants to upskill on the new PREP tools and are a very valuable networking occasion to discuss experiences and learn that the PREP program facilitates formalisation of medical education between trainees and supervisors that in most cases already exists.

Need assistance?

For over the phone personal assistance or to organise a workshop at your hospital, please don’t hesitate to contact your local Medical Education Officer. They are located in every state and territory of Australia and in New Zealand. Contact Head Office on (02) 9256 5444 for more information.

WILEY-BLACKWELL AWARD FOR EXCELLENCE IN MEDICAL EDUCATION AWARDED TO PROFESSOR CHERYL JONES

Congratulations to Professor Cheryl Jones on receiving this Wiley-Blackwell Award for her research on ‘Identifying the needs of early career researchers at the Children’s Hospital at Westmead’. Others involved in the research were Dr Nigel Clarke, Dr Patrina Caldwell, Mrs Wendy Oldmeadow, The Discipline of Paediatrics and Child Health, University of Sydney Medical School, and the Children’s Hospital at Westmead, Kids Research Institute.

In her presentation, Professor Cheryl Jones said:

‘Clinicians who actively participate in research are widely considered an asset in our health and research communities for their contributions to translational research and improving healthcare. However, at the University of Sydney, Children’s Hospital at Westmead Clinical School, we have become aware that clinicians face significant challenges in establishing research careers once they complete doctoral research degrees. We therefore sought to identify the determinants of success, challenges and unmet career development needs for successful establishment of a research career by early career researchers (ECRs) in a teaching hospital.

‘We conducted semi-structured group and individual interviews. Forty-four researchers at four different career stages participated: late-stage PhD students, ECRs (1–10 years post-PhD), senior researchers and people who had left active research. We analysed interview transcripts for main themes. The early post-doctoral period was identified as a critical stage for establishing a long-term research career. During this time, ECRs must learn key skills and achieve milestones such as grant success, developing a research niche and building a research team, but training is often not easily sourced in a clinical setting. Clinician ECRs had a unique set of challenges to face. They often struggled to fund part-time research while working parallel clinical careers. There is a lack of clear ‘post-doc’ positions within clinical settings and pressure to follow accelerated paths to independent research, despite insufficient time or opportunity to develop competitive research track records and attract funding. These hurdles, coupled with financial disincentives and competing family and clinical work commitments, prevent many clinician ECRs from establishing parallel research careers.

‘Specific support must be provided at an institutional level to overcome these hurdles. Mentorship by senior clinician researchers should be formally arranged for clinician ECRs to promote learning skills in career planning and scientific writing and for personal development. Training in leadership skills, people management skills, time management, project management and administrative skills should be addressed in a flexible seminar program that can be offered on-site and with e-learning tools.’
The Thoracic Society of Australia and New Zealand (TSANZ) is delighted to be celebrating its 50th Anniversary and very much values the longstanding support and close ties with the Royal Australasian College of Physicians (RACP).

The RACP was founded in the late thirties and provided a focus for Internal Medicine. Subspecialties such as Thoracic Medicine began to evolve in the 1940s, after the end of World War II. Tuberculosis was initially the focus for the early RACP physicians who had an interest in chest diseases and led to a desire to build a distinct discipline of thoracic medicine, initially in the teaching hospitals of Sydney and Melbourne. The Wunderly scholarships of the RACP enabled young physicians to travel to the UK for further training and return to Australia to establish respiratory units. In 1952 a small number of thoracic physicians formed the Laennec Society from a then tuberculosis organisation. In 1960 the name Australian Thoracic Society was adopted at a meeting of interested physicians and surgeons (12 October) with the name being changed to the Thoracic Society of Australia (TSA) early in 1961. On 4 May 1961 the TSA met in Perth for the first time and since then the Society has grown and flourished.

The Thoracic Society of New Zealand (TSNZ) was formed in 1968. The two societies were joined together as the Thoracic Society of Australia and New Zealand on 10 May 1988 during the Golden Jubilee meeting of the RACP.

The TSANZ has an Annual Scientific Meeting in different venues in Australia and New Zealand and runs postgraduate courses — and very appropriately held its 50th Anniversary meeting in Perth in April this year.

There are now more than 1100 members of the TSANZ and it is a robust and dynamic Society that aims to foster the highest standards in respiratory practice for both its members and those in the community with lung disease. It very much values the contribution made by all of those involved in these endeavours and the Society actively embraces research scientists and other clinical professionals involved in lung health. The TSANZ supervises with the College the training of thoracic specialists, accredits physiology laboratories, and strongly supports and fosters medical research. It works closely with the Australian Lung Foundation and other national respiratory organisations.

As a sign of its growing maturity, the TSANZ in its 50th year has changed to a company limited by guarantee, purchased its own headquarters in Hunter Street, Sydney, and established a 50th Anniversary Medal to be awarded to a member who has made an outstanding contribution to respiratory education and training.

We look forward to the next 50 years with great expectation and anticipate a continuing close working and productive relationship with the RACP.

Dr Michael Burns (TSANZ historian) and Professor Philip Thompson (TSANZ Immediate Past President)
PUBLIC POLICY TRAINING – HOW TO SUCCESSFULLY INFLUENCE KEY STAKEHOLDERS

The College hosted the first of a series of public policy courses on Monday, 21 March, at the RACP Sydney Office. The course focused on the political agenda and government policy and was based on a similar course run by the Institute of Public Administration Australia NSW.

The session provided an overview of the elements that create successful public policy and provided useful information on how to formulate strategic policy that will impact government.

The College is now making the course available to all Fellows and trainees, with training sessions to be held on a demand basis. Sessions will run with a minimum of 8 attendees and a maximum of 20 in all states and territories.

Why undertake public policy training?

If you are seeking to influence policy involving government at the Commonwealth, state, territory, or local government level, then you are engaged in public policy. The College is keen to encourage and develop the capability of physicians as individuals and members of the College to engage in and influence the public policy process. To do so we need to ensure that, as advocates, physicians understand how policy is developed and implemented in government, including the political, parliamentary and legislative processes.

This will ensure that the Fellowship can engage in the political and policy process with the same level of skill that they use in their clinical practice.

The RACP Public Policy Training Course will enable Fellows and trainees to better influence policy development in Australia and New Zealand. This will ensure that the interests of Fellows and trainees are promoted in health policy, the health systems of both countries are improved and the health outcomes for patients are in turn improved.

The course will enable you to anticipate and highlight the need for public policy, plan the policy development process, and gather and analyse information for policy development. You will also learn how to identify stakeholders and distinguish appropriate modes of consultation, determine public policy direction, and gain agreement for policy release and dissemination of policy.

Course details

The RACP Public Policy Training Course has been developed by Timmins/Stewart Consulting. The sessions will be presented and moderated by Dr Randal G Stewart and Professor Jeanette Ward. See below for their brief biographies.

Dr Randal G Stewart

Randal is a policy scientist with an extensive background in public policy and public affairs. His key areas of expertise are in policy formulation, institutional design, policy and issues management, and selected policy areas such as industrial policy, economic policy and regional development. Randal has published 10 books on politics and policy and conducted hundreds of policy training courses at all levels of government.

Professor Jeanette Ward

Jeanette brings 30 years experience in academia, service-based research and evaluation, health administration and the non-government sector. She is an influential advocate for evidence-based healthcare, having contributed to policy and guidelines development and implementation, workforce planning, and performance indicator development and application at various jurisdictional levels in Australia.

Participation fee

Cost per participant is $620 (incl. GST) for Fellows of the College and for non-Fellows $720 (incl. GST).

Continuing Professional Development (CPD) points

Fellows may enter this into MyCPD under Category 2 Group Learning Activities – Workshops. Fellows are eligible for 1 credit per hour of attendance excluding meal breaks.

Register your interest

We look forward to holding a tailored training session for you and your colleagues.

If you are interested in this training program, please email policy@racp.edu.au to be advised of the next available session. Sessions will be available in each state and territory and will be scheduled based on the number of registrations.

Fiona Hilton
Regional Policy Officer – Victoria and Tasmania
Professional Affairs & Advocacy
Email: Fiona.Hilton@racp.edu.au
THE ROAD TO RESEARCH

HYPERTENSION AND CHRONIC DISEASE IN RURAL AND REMOTE INDIGENOUS AUSTRALIANS

In 2007 I was 13 weeks pregnant and vomiting daily as I caught a light plane from Thursday Island to a low-lying coral atoll in the Torres Strait. With me were six Islander staff who regularly visited the islands to conduct adult health checks.

When we arrived, the staff hung hessian cloth from the roof to create a maze of impromptu cubicles. Over three days we saw 105 adults in this hotbox. I was graciously offered the air-conditioned clinic room to see the patients after the staff had put them through their paces—consisting of among other things checks on sexual health, cardiovascular risk and emotional wellbeing.

I was extremely encouraged. Here were 105 Indigenous adults addressing their own health risks. Some waited up to three hours to see me after they had been seen by the team. And here also were Indigenous health staff willing to put up with 37°C heat to engage with their fellow Islanders.

Fast forward to 2010. Once again pregnant and with severe morning sickness, I was Co-chair of the Editorial Advisory Committee for the Queensland Chronic Disease Guidelines. The guidelines are developed in partnership between Queensland Health and the Royal Flying Doctor Service, with the purpose being to assist clinicians, particularly those working in rural and remote areas, to identify and manage chronic disease. Compiling useful guidelines which are likely to promote best clinical practice is no easy feat. There is a constant tension between best scientific evidence and resource limitations, perhaps even more so when compiling evidence for use in rural and remote areas.

While involved with the Chronic Disease Guidelines Editorial Advisory Committee, it became clear that more evidence was needed to inform chronic disease screening programs for young Indigenous adults. It was in the hope of being able to contribute to this process that I applied for, and was successful in gaining, a Foundation for High Blood Pressure Research Fellowship.

The main aim of the project is to assess the prevalence of chronic disease risk factors in 15–24-year-old Indigenous people. Other aims include assessing what the relationship is between the different chronic disease risk factors and whether significant differences exist between Torres Strait Islander young people and Aboriginal young people. It is ultimately hoped that this information will inform preventive activities.

Projected life expectancies for Indigenous Australians lie well below that of their non-Indigenous counterparts. Cardiovascular disease contributes substantially to this discrepancy, with Indigenous Australians experiencing higher rates of cardiovascular disease and at a younger age. Hypertension is demonstrated to be a modifiable risk factor for, among other things, coronary heart disease. There is evidence that an increased prevalence of chronic disease risk factors, including hypertension, exists during Indigenous adulthood. To a lesser extent, evidence is available related to various childhood chronic disease prevalence estimates. Certainly among adults, high rates of hypertension and other chronic disease risk factors play an important contribution to this devastating burden of disease.

What has yet to be delineated is the prevalence of hypertension and other related risk factors in young adulthood. Similarly, the association between hypertension and other chronic disease risk factors at this crucial time of development is yet to be explored.
This lack of data has significant implications. For example, although there is a strong policy emphasis on screening for chronic disease risk factors, recommendations regarding the age of onset of screening for hypertension and other chronic disease risk factors are largely ad hoc. Similarly, a substantial emphasis on health promotion and preventive health programs exists at both state and national level. Greater understanding of crucial times in the lives of Indigenous young people would assist the targeting of both primary and secondary preventive activity.

Since 2009, a Queensland Health program has been conducting comprehensive Young Person Checks across the Cape York Peninsula and Torres Strait. Although the focus of the checks has been sexual health, a wealth of data related to chronic disease risk factors in the 15–24 year age group has emerged. To date the checks have delivered 2260 episodes of care across 11 different communities. Approximately 2000 of these episodes of care have been delivered to Indigenous people. The data generated from these checks has the potential to influence our understanding of the development of hypertension and chronic disease across the Indigenous lifespan. Subsequent implications for screening protocols and other preventive activity would follow.

The project involves close collaboration with Queensland Health staff responsible for the Young Person Checks, with supervision provided by Dr Patricia Fagan, the Sexual Health Public Health Medical Officer. I am based at Cairns Public Health Unit, which has facilitated a smooth transition from my previous role there as a public health registrar to research fellow. On a personal note, as the mother of a baby and pre-school-aged child, the Fellowship offers me a rare opportunity, namely, the flexibility of the research schedule allows me to pursue my passion for research and Indigenous health while still spending time with my children. I eagerly anticipate being able to disseminate results from this study in 2012.

Danielle Esler
Recipient of the Foundation for High Blood Pressure Research Fellowship for 2011

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**THE RACP RESEARCH AND EDUCATION FOUNDATION AT A GLANCE**

In 2011 the RACP Research and Education Foundation awarded 41 Scholarships and Fellowships totalling over $1.3 million. The REF is pleased to offer 55 awards for 2012, valued at over $1.8 million.

The talented and inspiring researchers who are recipients of RACP Foundation awards undertake research projects in Australia and overseas in an array of disciplines relevant to physicians. In 2011 RACP awardees attended conferences and commenced research programs at prestigious institutions in the United States, Canada, the Netherlands, Switzerland, Vietnam and the United Kingdom. Many others are carrying out vital research in universities and organisations across Australia and New Zealand. Some of this year’s unique projects include investigating human brown fat cells in Queensland; studying cardiovascular risk factors in rheumatoid arthritis in Victoria; and establishing a clinical research program in New South Wales to improve the symptoms and co-morbidities of advanced kidney disease.

Funding for these awards is comprised of generous donations from corporate and institutional donors, families, individuals and Fellows. Encouraged by the impact the awards had on their research careers, often past recipients will initiate or contribute to the establishment of a new award. These acts of generosity and goodwill towards young Fellows and trainee aspiring to establish a career in medical research ensure the vitality of the RACP Research and Education Foundation, and solidify the role of the College in supporting career development and ongoing investment in the future of medical research.

The RACP Research and Education Foundation is committed to supporting physicians at an early stage in their research careers, giving them an opportunity to build their portfolio of published research findings and consequently making them more competitive in securing substantial funding and research positions in the future.

Please contact the RACP Foundation to discuss how you can contribute or assist with our current funding initiatives. You can phone us on 02 9256 9620 or email foundation@racp.edu.au.

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**PHYSICIANS’ POETRY**

**STATISTIC**

Now I am the one in four awake to the other three
nearby but nowhere near
now I am the one.

Scan me, see me
not tested and sorry sore
is survival what it used to be?

Fear has made me patient, raw
as an open box maybe
fuller than before
now I am the one.

Jeannine Liddle FAPPHM

Please send your poetry to Kathryn Lamberton, racpnews@racp.edu.au
LETTERS TO THE EDITOR

Innovative P&CH strategies in the Kimberley

The April 2011 edition of RACP News had a welcome focus on the College involvement in regional and remote specialist services. This prompted me to offer a couple of comments from the truly remote perspective of Kimberley Paediatrics and Child Health (P&CH).

Although looking forward to hearing ripping yarns from Roger Tuck of the old days in Derby, I suggest that as he ‘desperately needs to look at different ways of doing business’ he should visit the Kimberley again and see if he can adapt to his large regional service some of the innovative strategies we are putting in place in the P&CH team in providing a comprehensive consulting service to the over 5000 Aboriginal children who live scattered across remote communities in the Kimberley. These children represent nearly 20% of the Aboriginal childhood population of WA. The strategies include:

• the implementation of the utilitarian construct of resource distribution according to need, based on childhood population adjusted for poverty through an index derived from ABS data on household income

• an explicit shift in resources to improve overall efficacy from an analysis of the greatest differential in skill between paediatricians and the highly skilled procedural hospital generalists, i.e. not doing what a DO can do

• the proposed recruitment of Paediatric Nurse Practitioners to take a key role in the management of low-acuity, long-term-care patients, such as children undergoing nutritional rehabilitation for malnutrition

• the development of the hospital in the home model.

May I also paraphrase Dr Tuck’s comment that ‘clinicians who want to make a difference cannot ignore the social …’ to ‘the clinician can only understand the antecedents of the child’s morbidity through knowledge of the historical and sociopolitical context of the family’s situation’. I question the validity of social determinants as being sufficient explanatory factors for the extent of Indigenous child morbidity, but in going beyond them we venture into disciplines such as anthropology in which we are strangers and unfamiliar with the language—hence the exclusion through benign blindness.

One dimension missing from the articles on remote practice, which were all couched in terms of the exotic (‘a little bit of paradise …’), was the emotional toll on paediatric staff from the vicarious trauma suffered from dealing with the horrors and tragedies of severe child sexual abuse, child and youth suicide, and death from alcohol and ganga-fuelled violence, homicide and road accidents affecting the children and grandchildren of Aboriginal friends and colleagues. For those who doubt that in remote Aboriginal communities there is a low-grade war on women and children mediated through these end points, and best understood through the lens of ‘structural violence’, then read ‘Living hard, dying young in the Kimberley’ by Nicolas Rothwell in The Weekend Australian, ‘Inquirer’, 30 April – 1 May 2011, page 5.

Dr Tuck’s advocacy for a ‘dignified retreat’ from acute on-call is now a major challenge to those of us in our late 60s who wish to continue to make an intellectual contribution. When I worked in Norway 30 years ago there was a retirement age of my senior colleagues of 70, and this was achieved through a shift from acute clinical practice to activities in which experience and scholarship were valued.

A final point of information: under ‘ATSI health—a policy focus’ (p. 10 of the April 2011 issue), Grebe writes that 70% of ATSI people live in rural and remote areas. In fact, of the 540,000 Indigenous population, 320,000 live in mainstream society, 145,000 live in disadvantaged circumstances in rural and urban areas, and 70,000 live in remote locations (Lane J 2009. Indigenous participation in university education. www.cis.org.au/issue_analysis/IA110/IA110. pdf, accessed 27.05.10).

John Boulton FRACP
Senior Regional Paediatrician
Kimberley Health

Registration woes

Like others, I have been surprised by the lack of discussion and consultation about tagging CPD points to registration renewal. I am sure there will be circumstances where physicians through no fault of their own will have to take a break from medicine because of ill health, the need to look after a family member for an extended time or simply to do voluntary overseas work where CPD points will be few and far between. I imagine it will be far more difficult to get re-registered (as this will be beyond the jurisdiction of the College) than re-accredited by the College after fulfilling necessary requirements. I am sure my GP colleagues have similar concerns.

Dr Nick Abbott FRACP
Port Fairy, Victoria

Response from the College

Neither the Medical Board of Australia nor the RACP want mandatory CPD to be seen as a punitive measure and will work to assist any practitioner in meeting expected CPD standards. The Medical Board of Australia and the RACP have aligned policies around exemption and the granting of pro rata credits due to ill health and prolonged absence from practice. The RACP Mandatory CPD Policy can be found on the website at: www.racp.edu.au/page/education-policies. Please contact our CPD Unit on 02 8247 6201 to discuss any individual cases.

MyCPD – is it structured to encourage learning?

MyCPD is designed to assist participants to keep professionally up to date. The program is designed to encourage participants to plan, record and reflect on professional development needs, as part of their pursuit of lifelong learning. We are writing to urge the College to look again at the structure of MyCPD and how points are awarded for various categories relating to continuing education.

Specifically, we believe that awarding only 5 points in the educational development, teaching and research category for any publication significantly undervalues this activity. In our opinion, such an allocation does not truly reflect the educational value of a critical review of the literature, planning a study, completing the study, analysing the results, and writing and publishing a manuscript, especially when compared with other activities which attract similar points (e.g. 5 hours of sitting in a conference). Publishing is not just the province of academic medicine. There are many good examples of physicians who work outside the teaching hospital environment who conduct good clinical research and publish their results. Their efforts are clearly not being adequately rewarded by the College’s MyCPD program and as such it does not encourage Fellows to put in the considerable effort to publish a paper. In fact, the disparity between the MyCPD point allocation and the educational value of publishing research really makes one question whether the program accurately reflects its stated objective to encourage learning.
We encourage the College to look at this issue in a constructive manner so that such a valuable educational activity does not remain relatively undervalued and possibly ignored by the majority of the College.

Professor Malcolm Smith FRACP
Associate Professor Michael Shanahan FAFOEM, FRACP
Rheumatology Unit, Southern Adelaide Health Service and Flinders University

Response from the College

It is important to note that the many hours of research and preparation undertaken in writing a publication should be recorded in Category 6 – Other Learning Activities – attracting 1 credit per hour, while the actual publication receives 5 credits for the first time of its publication. We recognise that it is the background for these works that holds the greatest opportunities for individual learning, but that the actual presentation and publication of works should attract recognition of completion as well. This occurs in Category 1 – Educational Development, Teaching and Research – at 5 credits (once only) for the publication and 3 credits for the presentation of material (once only).

Any Fellow who is unsure of where to claim credits or wishes to discuss MyCPD is encouraged to call the CPD Unit at the College on 02 8247 6201.

Dr Brian McGuirk, who died on 3 March 2011, was born in Newcastle in 1939 and went to Sydney to complete high school and to study medicine at the University of Sydney. After graduating, Brian spent time in the UK, as a House Officer, before returning to Sydney to take up general practice. He was awarded a special service medal for being the first medical officer to attend and treat patients injured in the Granville rail disaster in 1977.

Brian developed an interest in occupational health and joined the first group of candidates for the Diploma in Public Health (Occupational Health) at the University of Sydney in 1984. He became a founding Fellow of the College of Occupational Medicine (later to become the Australasian Faculty of Occupational and Environmental Medicine). Under the tutelage of Professor David Fergusson, Brian exhibited a talent for developing policy and regulations. After several roles in the NSW public service, and as an international adviser to developing countries in Africa, Brian was appointed as Commissioner for Occupational Safety in Western Australia. In that role, he wrote the OH&S regulations for that state.

Returning to the east coast, Brian became Chief Medical Officer for the Newcastle division of MMI (later to become Allianz). His role was to assess and approve (or not) plans of management for injured workers on compensation. In that position, he came to learn of the research studies into spinal pain being conducted at the University of Newcastle. When the university was awarded a grant to conduct the National Musculoskeletal Medicine Initiative, he offered to join the Directorate of the Initiative. Foregoing a handsome salary in the private sector, he became Deputy Director of the Initiative with the rank of Senior Lecturer in the university.

Brian assumed a pivotal role in developing the evidence-based guidelines for the treatment of low back pain, and testing their efficacy. He was the senior author of the first study ever to have tested, and shown, the efficacy of evidence-based medicine for low back pain. As the initiative drew to a close, Brian took on part-time work as a VMO in Staff Health at the Royal Newcastle Hospital, in which he applied evidence-based medicine to the management of injured workers. When his successes were recognised, this role was progressively extended across the Greater Newcastle Sector, and he became a Staff Specialist in Staff Health. In a landmark study he showed that evidence-based medicine virtually eliminated workers compensation claims for back injuries. This work was awarded the prize for best presentation by the Spine Society of Australia in 2007.

Brian worked half-time in Staff Health. The other half he spent in Orthopaedic Outpatients, where he helped GPs provide evidence-based care for their patients with back pain, and thereby avoid surgery. This work was recognised when Brian became a finalist for the NSW Health Baxter Awards in 2006.

Brian recorded his work in two textbooks: one on back pain and one on neck pain. In writing these books, Brian insisted that they be friendly to GPs. The books must not just state what should be done, but describe how actually to do it. He also wrote the chapters on acute low back pain and chronic low back pain in the recently published fourth edition of Bonica’s Textbook of Pain Management.

In November 2009, Brian retired from the Hunter New England Area Health Service, having reached the age of 70. His achievements in promoting, testing and using evidence-based care are unparalleled. Whereas academics preach the word, they do not treat patients. Brian did both. Neither his personal clinical talents nor the outcomes he achieved for his patients are likely to be replaced.

Nikolaï Bogduk FAFRM
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Phone: 02 4922 3505

References
**Obituary**

**DR ROSS ANDREWS MBBS (MON), DRANZCOG (ADV), FAFOEM (RACP), GRAD DIP OCC ENV HEALTH**

Dr Ross Andrews, Occupational Health and Safety Specialist in Wodonga, tragically died after a tractor accident on 1 March 2011.

Ross was born in Melbourne on 6 May 1958, and grew up in the suburb of Pascoe Vale. He attended Pascoe Vale State Primary School and Strathmore High School before graduating from Monash University Medical School in 1983.

Ross’s journey to the country began with a chance meeting in Melbourne in 1980, when he was a fourth-year medical student at Monash University. He was earning some money driving delegates to and from a RANZCOG conference in East Melbourne to the city, and met Dr Pieter Mourik, an obstetrician and gynaecologist in Wodonga. Pieter invited Ross to stay with his family in Wodonga for his fifth-year Rural Community Studies, to experience country living and a country practice.

Ross remembered this invitation and a year later, when he contacted Pieter, he was asked to come three days early.

“What for?” asked Ross.

“We are going 4-wheel driving to the mountains, camp out and go trout fishing.”

After a successful camping trip it was not only the fish that was hooked!

After graduation, Ross spent three years in the Northern Territory, including in Darwin, Katherine and Barunga. During this time he alternated mainly between anaesthetics and intensive care, accident and emergency, and obstetrics.

In 1987, Ross embarked on gynaecology and obstetric studies as a registrar in Hobart and then did neonatal paediatrics in Sydney for six months at the end of 1988. His first son, Marcus, was born in Sydney. Ross achieved his Diploma of Obstetrics, and returned to Wodonga in 1989 as a General Practitioner Obstetrician. Ross was a very experienced and popular GP Obstetrician and in 2001 received his Advanced DRANZCOG. His second son, Campbell, was born in Wodonga.

During his practice, however, Ross developed an interest in occupational medicine and in 1999 attained a Graduate Diploma of Occupational & Environmental Health from Monash University. Looking for a new direction in his career, Ross later decided to continue his studies in Occupational Medicine with Dr Andrew Watson as his supervisor.

From May 2006 to the time of his untimely death he established the first specialist occupational medicine clinic between Melbourne and Sydney and in 2010 became a Fellow of the Australasian Faculty of Occupational and Environmental Medicine.

His wife, Maree Andrews, was Practice Manager of his general practice and was instrumental in the smooth transition to the new business, Regional Occupational Medicine Albury Wodonga (ROMAW).

At all times of the day, Maree worked by Ross’s side assisting him with various tests and procedures required by the contracting business, fitting in with their varying shifts.

Ross then employed Dr Kevin Marks and Dr Andrew Watson to join him in his new business. ROMAW had contracts with large businesses like Riverlea, Worksafe, Wilson Transformer Company, Mars, Murray Goulburn and Australia Post and provided exceptional service to the community of Albury Wodonga and the surrounding region.

Ross had interests in bushwalking, trout fishing and snow skiing, all activities within the Victorian north-east and alpine regions. With Maree, he bought his first farm and started growing cattle, an interest which led him to a lifestyle he loved.

Ross was a person who was compelled to make the most of every minute, every day. When he wasn’t working professionally, he worked on his farm or leisure pursuits. He had a saying: ‘You only have one wildcard in life; you must live it to the full’. He certainly did that!

His untimely and tragic death has led to the closure of his practice, which employed nine staff, leaving a huge gap in the service to businesses and the community.

He will be sadly missed, but never forgotten.

Associate Professor Pieter Mourik
Mrs Elizabeth Mourik

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**RACP AWARDED QUALIFIED PRIVILEGE FOR MYCPD AND PQR**


The objective of the Act is to encourage efficient quality assurance activities in connection with the provision of certain health services.

For the purpose of achieving the objectives, the provisions:

1) prohibit:
   a) The disclosure of information that becomes known solely as a result of these activities; or
   b) The production to a court of a document that was brought into existence solely for the purposes of these activities; and

2) protect certain persons engaging in these activities in good faith from civil liability in respect of these activities.

A t a time of overemphasis on the use of pharmacotherapy to prevent and treat atherosclerosis and coronary heart disease (CHD), a book that underscores and elevates the importance of diet and lifestyle changes is most welcome and refreshing. The latter half of the previous century was a most exciting and fertile period of rigorous experimental and clinical research that established the paradigm that several components of the diet can influence the development of atherosclerosis and CHD. This extensive body of work richly deserves to be documented and articulated for all practitioners and researchers. Who better to do this than Emeritus Professor A. Stuart Truswell, a pioneer researcher, educator and academic in the field?

In this brief but succinct volume, Truswell catalogues the history of the research carried out in the 20th century that established the intimate relationship between several dietary factors and CHD. He systematically presents in a most lucid, scholarly and insightful style the research works relating principally to dietary fats, alcohol, coffee, antioxidants, proteins, sugars and salt. The text relies on three principal notions: first, that dietary factors (e.g. saturated fats) cause CHD via effects on plasma cholesterol; second, that dietary factors (e.g. n-6 polyunsaturates, soluble fibre) cause CHD via plasma cholesterol plus other mechanisms; third, that dietary factors (e.g. n-3 polyunsaturates, alcohol, salt) cause CHD by mechanisms independent of plasma cholesterol.

Beyond cataloguing the key research studies, Truswell elegantly distributes the text to include the seminal experimental and epidemiological studies in this important field of coronary prevention. He also refers to the development of nutritional guidelines and places their overall conclusions within the context of secular trends in the incidence of CHD within and across several countries. Insightful analyses are also presented of several ‘diet-heart’ debates, such as the role of dietary fats, sugar and salt, which were of great historical importance in the evolution of this field of knowledge.

This book certainly achieves its aims in providing a detailed chronology of nutritional research into CHD and atherosclerosis. Significantly, it does a great job of separating the wheat from the chaff, dispelling several myths and misconceptions that have crept into the popular literature.

The style of the book is such that it would appeal to a general readership, but perhaps more pertinently to both undergraduate and postgraduate students in the fields of nutrition and dietetics, clinical biochemistry, cardiovascular medicine and history of medicine. It also embodies a wealth of compact information and bibliography that is a treasure trove for PhD candidates researching the relationships between dietary factors and cardiovascular disease.

Does the book have any deficiencies? There are certainly none in academic content or in literary style. However, I considered that the presentation could have been more attractive in respect of more liberal use of diagrams and inclusion of illustrations that could emphasise the historical contexts. Nevertheless, I thoroughly enjoyed reading the contents of this excellent book and unreservedly recommend it to a wide readership. It is a very important addition to the literature and hence a must for the bookshelves of all university and postgraduate medicine libraries.

Gerald F Watts Dsc PhD MD FRACP FRCP
Winthrop Professor of Medicine
Lipid Disorders Clinic
Department of Internal Medicine
Royal Perth Hospital
School of Medicine and Pharmacology
University of Western Australia

Kickstart: Recharge Your Life with a Pacemaker or Defibrillator
By Dr John England
$24.95.

This is a collection of personal narratives drawn from Dr England’s patients who are recipients of pacemakers and from the doctor’s own experience. As a cardiologist, and having had his own pacemaker for 35 years, Dr England has a unique insight into the issues facing pacemaker patients, from medical transparency and responsibility to the emotional support and encouragement which is so important in these cases. The book is informative, inspirational, and at times humorous.

It is intended for new and old recipients, and will be of interest to some of our readers as well.
DOCTORING ON POLAR EXPEDITION SHIPS

The medical equipment on board an expedition-style cruise ship is rather basic and the next hospital is usually very far away.¹

I was schooled on stories about Scott, Shackleton and Mawson, heroes of Antarctic exploration. These stories sparked a desire to travel to the Antarctic. My chance came towards the end of my second residency year when I met some Australian expeditioners whose voyage was delayed for want of a doctor. My offer was accepted but was dashed by the objections of my hospital’s all-powerful medical superintendent.

Thirty-seven years later one of my sons was part of an Antarctic research team. His photos rekindled my polar ambitions, so I applied to a Dutch expedition company which was in need of doctors and, although over 70 years of age, I was deemed to be ‘sportive’ and signed up. I finished up making four voyages of a coffin. The voyages in the Arctic were on small Russian ships. The ships carried 50–60 passengers, 20 crew and 10 staff. Accommodation for passengers was adequate, for expedition staff, basic and crowded, and for crew, about twice the size of a coffin. The voyages in the Arctic and three in the Antarctic, 90 days in all.

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The ships’ surgeries averaged 3–4 square metres. There was little space for drugs and equipment, much of which was stored in large plastic containers piled one upon another. Some containers had to be stored in the hold with less accessibility than that accorded to alcohol and other saleable merchandise. Space is money and an extra cabin for paying passengers will always take precedence over an infrequently used medical facility.

Our ships complied with the directives of the ‘Medical supplies on board Dutch sea-going vessels’. These regulations are sensible. But the company confused the quantity of drugs needed for an adventure ship with that required for an ocean liner. On my last voyage I had access to 148 different drugs, many from the same pharmaceutical family. They also came in three different modalities: suppositories for the French passengers, injections for the Spanish and South Americans, and tablets and capsules for the rest.

There was enough metformin, haloperidol and permethrin to treat 300 psychotic diabetics with head lice for an entire 12-day trip, but there were no antidepressants, sunscreen, dry eye tears or, in the Arctic, Gypsona Plaster of Paris bandages.

I explained, repeatedly, to head office that the key to adequate remote area medicine is simplicity and accessibility. For example, one can save space by using eye ointment for otitis externa, but not ear ointment for eyes. But to no avail.

Common problems were seasickness, insomnia and constipation, forgetting to bring blood pressure or lipid medication and, despite my homilies on prevention, sunburn. The only vaguely evidence-based information on motion sickness comes from NASA which gives promethazine to its astronauts.² This is also effective for insomnia.

The English, Dutch, German and American passengers use the antihistamine, cinnarazine, as their drug of choice. Australian passengers use 11 different medications ranging from the cheap (ginger) to the expensive and ineffective (ondansetron).³ Clearly, there is no medical or pharmaceutical consensus on the treatment of motion sickness by Australian doctors and pharmacists.

Serious problems were fractures, including a complete mid-tibia and fibula fracture in a crewman who fell with his leg caught in the engine-room ladder. Nursing him on board for 15 days was a challenge. Another lady caught her arm between a zodiac and the landing platform, sustaining an injury identical to that in Rembrandt’s Anatomy Lesson. Other problems were acute urinary retention due to scopolamine-based drugs, a dislocated shoulder, knee effusions— and a young lady who had a miscarriage.

Vodka is plentiful and cheap and is, not infrequently, an underlying cause of injury and occasional fights.

Unexpected problems were an abjectly depressed crewman, a request for the ‘morning after pill’ and being asked to participate in group therapy sessions that actually alleviated an interpersonal and interracial dispute between the four cooks.

The passengers are usually an informed and interesting lot and range in age from 30 to 84. Several passengers reported having had coronary bypass surgery or knee and hip prostheses, and two had a pacemaker. None required my medical attention.

A major pitfall was the ‘corridor consultation’. There were usually several doctor and nurse passengers aboard who self-diagnosed and requested specific medication. One example was an orthopaedic surgeon who requested antibiotic eye drops. The next day he was no better and complained of photophobia and blurred vision. A proper consultation showed his problem to be a side effect of the scopolamine patches that he was using to prevent seasickness.

The crew was used to being treated symptomatically. They would request something for sore eyes, abdominal pain or headache. They were surprised when I

¹. The medical equipment on board an expedition-style cruise ship is rather basic and the next hospital is usually very far away.

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suggested a proper consultation. In a high proportion of cases their symptoms had a remedial or underlying cause. For example, the bosun kept asking for ibuprofen and paracetamol for his headaches. He had chronic sinusitis due to nasal polyps.

The dental health of the crew was horrible and consultations for toothache and dental abscesses were common. So was fungal skin disease and hypertension. Mitral heart murmurs were also common, probably due to previous rheumatic heart disease.

It was difficult to know if initiating treatment for a chronic disorder, such as hypertension, would result in short- and/or long-term compliance. But I think the ship’s doctor has a responsibility to diagnose and propose a health plan for crew with detected pathology.

The ship’s doctor also needs to be a strong advocate on behalf of crew members. The sailor with the fractured tibia and fibula needed to be repatriated to Russia lying down, i.e. in business class. This request was initially parried with: ‘But he’s only a crewman!’

Doctors, especially elderly ones, are used to being treated with a modicum of respect. The captain, passengers and crew followed that norm, but not always other key people such as the officers, tour leader, guides and hotel manager. The doctor is there because polar shipping regulations state that a commercial adventure boat cannot travel without one.

As in the armed forces, the officers have you summoned and expect to be treated within minutes for even the most minor symptoms or conditions. The hotel manager is always helpful in an emergency, but has little interest in or understanding of your everyday working needs. They expect you to do their bidding in regard to invaliding crew and catering staff off the ship. This may not always be in their best long-term interests, and their problems are best approached with due clinical acumen.

On board an adventure ship medical status is not important. I mention it because potential ships’ doctors need to be aware of where they stand in the scheme of things and, in the interests of shipboard harmony, bite their tongue.

Another of the doctor’s duties is to manage the ship end of the gangplank. This includes checking that all passengers have dipped their Wellingtons in antiseptic, are wearing a life vest and are not carrying dangerous objects, such as hiking poles with pointed, unprotected ends. The English, German, Dutch, Americans and Australians are culturally attuned to queuing, but many other nationalities are not. So the doctor has to tactfully ensure that there are not more than three people on the gangplank at any one time and that the less agile are not harassed by those adept at catching public transport in some of the major cities of Europe.

The polar regions are true wildernesses. There is no noise apart from wildlife and the sounds of nature. The Arctic is a white place of stark beauty. The Arctic is much less dramatic, but in the summer passengers, and the doctor, can go on long hikes in the tundra with its large patches of wildflowers and berries. The wildlife is far less prevalent than in the Antarctic but polar bear, musk ox, walrus, arctic fox, hare and beluga, blue and fin whales are all pretty impressive. So are the geological formations, blue glaciers, massive icebergs and the Northern Lights. Both places are addictive and expedition leaders and guides are clearly addicted. So are photographers and some of the passengers who talk about ‘The adventure of a lifetime’.

I have travelled with two octogenarians who between them had done more than 44 voyages. One, whose name should have been Jonah, was on the Explorer in November 2007 when it hit a small submerged iceberg and sank. Two years later he was on the Ocean Nova, when it ran aground on the west side of the Antarctic Peninsula not far from the Antarctic Circle. He remains addicted and undeterred.

Doctoring on a small polar expedition ship is mostly like being a passenger with an added interest and easy access to other passengers, staff and crew. In rough weather it can have its moments and you do need to feel that you can cope and make do with what you have got. If you are interested you can approach the main polar tour companies such as Aurora, GAP, Oceanwide or Quark.

Dr Max Kamien AM FRACGP FRACP

References
1. Rolf Stange (2008), Spitsbergen – Svalbard: a complete guide around the Arctic Archipelago, p. 22.
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Gallow Lecturer
Mr James Ward
Program Head of the Aboriginal and Torres Strait Islander Health Research Program, Kirby Institute, University of New South Wales, Australia.

Key Deadlines
Abstract Deadline: Friday 27 May 2011
Scholarship Deadline: Friday 17 June 2011
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Accommodation Deadline: Friday 19 August 2011
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The Australia & Asia Pacific Clinical Oncology Research Development Workshop (ACORD) is a week-long, residential program providing clinicians in all cancer subspecialties with training in best practice clinical trial design. Led by a world-renowned faculty, ACORD aims to develop and support oncology research across the Asia Pacific region.

Participants are selected through a competitive application process, and the submission of a clinical trial protocol to be developed at the Workshop. A range of fellowships are available for participants.

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Northern Territory Department of Health

Advanced Trainee Positions in Nephrology 2012

The NT offers 3 Advanced Trainee positions in Nephrology for 2012. These positions offer accredited training in all aspects of Nephrology including General Nephrology, Chronic Kidney Disease Management, all forms of Renal Replacement Therapy and the care of Transplant patients from one month post-transplantation. In addition there is an increasing Interventional Nephrology component consisting of Renal Biopsies, Tunnelled Central Lines and Vascular Access Management. This service will extend to placement of Tenckhoff Catheters within the next 12 months.

The 3 positions will be spread across the Top End and Central Australian campuses. The NT is the renal failure capital of the world. The positions also provide a unique opportunity to practice Nephrology in a remote setting and to work towards improving the many issues associated with Indigenous health.

Applications should be directed to:
Dr Greg Perry, Director NT Renal Services (email greg.perry@nt.gov.au) and Dr Cherian Sajiv, Director of Renal Medicine, Alice Springs Hospital (email Cherian.sajiv@nt.gov.au).

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EDUCARE has been providing specialist services to families within the Hunter region for the last 12 years. It is a private clinic with a strong referral base from a wide range of medical and institutional sources and has become a leading interdisciplinary and highly respected paediatric, adolescent and family centre.

EDUCARE recently transferred its practice into state of the art facilities within the new Sky Central Building complex. It has over 500m² of floor space and 20 clinical consulting rooms. Importantly, the practice is located in the hub of the Charlestown Square precinct and is also central to the medical and professional services within the Hunter Region.

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For further information, Telephone: Dr Youlden 0414-788 898
Email: office@educare.net.au

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