HIGHLIGHTS FROM RACP CONGRESS AND CEREMONY 2013

LAUNCH OF THE HEALTH OF DOCTORS POSITION STATEMENT

THE LATEST ON EDUCATION POLICY DEVELOPMENT

EXPLORING THE FUTURE DIRECTIONS IN PROFESSIONAL DEVELOPMENT

A MAJOR VICTORY FOR PATIENTS, PHYSICIANS AND THE CASE AGAINST TOBACCO
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18-21 May 2014 Auckland, New Zealand
4 President’s Communiqué

BOARD DIRECTORS’ COMMUNIQUÉS
9 Board Communiqué – May 2013
10 Board of Directors
11 From the Honorary Treasurer
12 Open letter from Associate Professor Susan Moloney, President, The Royal Australasian College of Physicians Paediatrics & Child Health Division
13 Finance Committee Communiqué

RACP CONGRESS 2013
14 Congratulations to all involved in our College Congress 2013
16 SPPP: Fellows and Trainees share their research and stories
17 Doctors, like anyone else, need to look after their own health
19 What’s race got to do with it? Healthcare and Aboriginality in the 21st Century
22 RACP Congress 2013 – Award and prize winners

EDUCATION
23 The latest on Education Policy development
25 Advanced Trainee Selection and Matching

TELEHEALTH
27 Physicians Telehealth Support Project National Road Show

PROFESSIONAL DEVELOPMENT
32 A lifetime of learning

POLICY & ADVOCACY
36 Evidence, focus and diplomatic finesse

RACP FOUNDATION
38 Announcing the RACP NHMRC Awards for Excellence
39 Leaders in research

THE VINE
40 From the perspective of an International Medical Graduate
41 A comment on the IMG’s journey

GENERAL
8 Conjoint Medical Education Seminar
12 RACP Fellow and Member access to the College’s academic journals
18 In brief
20 2013-2014 RACP Training Positions Guide
28 RACP History of Medicine Course 2013
29 NDIS no longer – now DisabilityCare
30 RACP response to the 2013-2014 Federal Budget
34 Good governance workshops
35 Doctors’ Health SA – A leader in health services for doctors
39 Postgraduate scholarships opportunity
42 International Congress of Pediatrics 2013
43 After Hours
44 Classifieds
47 Member Advantage

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Back row (L-R) Associate Professor Peter Gow, Professor Stephen Clarke, Professor Colin Sullivan and Dr Brent O’Carrigan
Front row (L-R) Dr Anne Robertson and Dr Catherine Yelland
Front cover images: RACP award recipients, presented at the 2013 Future Directions in Health Congress.

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FROM THE PRESIDENT ...
NEW HORIZONS FOR OUR COLLEGE

Looking back, looking forward in our 75th Anniversary year.

Why does history keep repeating itself? Because we weren’t listening the first time. — Anon

Never look down to test the ground before taking your next step, only he who keeps his eye fixed on the far horizon will find the right road. — Dag Hammarskjold

Beginning with the 2013 RACP Future Directions in Health Congress, held last month in Perth, the next 12 months will provide all College Fellows and Trainee Members with the opportunity to celebrate the progress made by our College over the past 75 years.

Our College has been established and maintained by the many Fellows and Trainee Members who have been actively involved in the activities of the College since the early days of formation. Each and every generation of Fellows has had the opportunity as well as the responsibility to fashion the College in a responsible and enduring way to meet contemporary and future healthcare needs of all Australians.

This is a year to applaud all Fellows and Trainee Members who are currently involved in the leadership and activities of the College; to recognise and salute those who have been involved over the life of the College; and to acknowledge that our College is the sum of all the excellent contributions by many to the many aspects of College life.

This is also a year to pause and reflect on the College purpose and mission, and to plan for the future in order to meet the many challenges and opportunities that will be encountered on our continuing journey to achieve the mission, vision and values that we have committed to as a College.

The College Strategic Directions document for 2012–2015 was prepared by the Board of the College and reflects the values and key objectives developed after widespread discussion and reflection throughout the College. There are six goals in the document and these are, and will be, regularly reviewed and revised as required to ensure the relevance of, and to measure, College activities.

Motto: Hominum Servire Saluti – to serve the health of our people
Vision: Striving for excellence in health and medical care through lifelong learning, quality performance and advocacy
Values: Professionalism, Excellence, Advocacy, Collaboration

Strategic Directions 2012–2015 aims to ensure the College:
- remains the preferred educator and assessor of physician performance
- has a major role in shaping the medical workforce agenda
- is a respected supporter of research
- provides value for Members
- is able to shape the health policy agenda
- is a robust and effective College.

Your Board members aim to ensure the College remains highly visible and central to your needs for ongoing education and Fellowship in the broadest sense.
Your College now and in the future

In keeping with the College vision, striving for excellence, our organisation is transforming, and will continue to do so as we respond to ongoing administrative and bureaucratic change, and to regulatory and community demands for heightened professionalism in the services we provide and the standards we keep.

This is a continuing journey in our quest to ‘serve the health of our people and communities’ and to:

• promote the College as a contemporary and responsive organisation meeting the needs of Fellows, Trainee Members and external stakeholders, and
• maintain and exceed our position as a leader in physician training and excellence.

Some of the many challenges facing the College include:

• the increasing demand for health services, with limitations on healthcare expenditure,
• providing excellence in education and supervision for our future physicians – at a time when medical graduate numbers are increasing – to ensure optimal healthcare for patients with assurance of quality and safety, and
• the increasing health literacy of the community and our patients, through access to the internet, and when presenting for consultations.

The College governance is in the process of considering significant changes to better comply with modern standards and to ensure greater transparency and accountability.

Lessons from the past for the future

1. College requirements for administration and education facilities

The College is now considering the requirements for office and education facilities for the next 5–10 years to meet the predicted needs of an increasing cohort of Fellows and Trainee Members.

Ronald Winton’s 1988 history of the College, Why the Pomegranate?, discusses the history of our College building in Macquarie Street, Sydney and recounts some of the vigorous debates over the years as to whether the College should ‘sell that prime site in Macquarie Street to build outside the bustle of the city on less expensive land’ or ‘occasionally a wistful thought arose of a nine-storey (or was it twelve-storey) new building once contemplated with planned office space, good meeting facilities and modern conveniences’!

The land in Macquarie Street was originally purchased by Charles Kemp in 1847. William Kemp built ‘Harley’ on 143, and John and Sarah Fairfax built on 145. The building was subsequently let for many years, eventually selling in 1921, and was then again let to the Warrigal Club – for ‘gentlemen pastoralists’. The Club moved out in 1931, and the building was let as professional rooms, with tenants in flats on the upper floors – to which three floors had been added between 1910 and 1936. The building was purchased for the future College in 1937 with the aid of a gift from the New South Wales Government. Tenants remained for many years on the upper floors with only the ground and first floors and part of the basement initially renovated for College purposes.

During the war the College marked time in its plans for further expansion and use of its premises. The RACS in Melbourne and the RACP in Sydney provided their premises to the Armed Forces for use in the war effort. The upper floors of Macquarie Street were let to residential tenants and rental was ‘frozen’ by wartime regulation.

Miss Dorothy Roseby, the College Secretary from 1938 to 1974, recounts there were many disadvantages with the tenants who were ‘a motley group of subtenants living in substandard premises, sharing antiquated bathrooms and using makeshift kitchens … All tenants, their friends and their tradesmen, used the main front door of the College during the day and at night time. The security risk was high …’ In 1956, after 17 years of occupation, the building was looking dishevelled, so another refurbishing began. In the following year the tenants vacated the third floor, and the Chartered Institute of Secretaries took over, expanding to the fourth floor in 1964 and remaining as tenants till 1971. The last tenants left in 1974.

In 1958 Dr Geoffrey Maitland had approached the College with an offer for the College to purchase 147 Macquarie Street, which could be used for a major College expansion. There was significant discussion, and after many pros and cons were considered the property was purchased in June 1959.

A Jubilee appeal was launched, with funds to be used for the ‘physical expansion of the College’, and applied to progressive renovations. However, ongoing maintenance costs were high and in late 1970 the College Council announced that it had approved proposals for a new building. The fiscal climate, however, did not support these plans. By 1973 there was a stalemate because of a Union ban on demolition, and by 1975 The National Trust had labelled the College as a ‘classified’ building which should remain permanently as part of the national heritage. Eventually renovation work began in June 1975, which involved a major upheaval, including demolition of Stawell Hall at the rear of the building.
Looking forward to the future

Maintenance and upgrade work during the past four years has completed restoration of the Fellows Room on the ground floor, refurbished meeting rooms, upgraded the fourth floor area and balcony for in-house functions and catering, and upgraded and expanded administration and education facilities in 52 and 70 Phillip Street to accommodate Education, IT, and facilities for the Divisions, Faculties and Chapters.

Ronald Winton forecast that another generation of physicians would revisit the question of the buildings in Macquarie Street and, indeed, there have been many discussions recently as to what would be the best use of College funds and resources to adequately service the needs of a modern, dynamic, robust and interactive College. I expect that these discussions will continue as we contemplate other alternatives – should the College aim to expand in its current location, or possibly relocate to a green site in Sydney, or elsewhere – in order to best meet the challenges and opportunities ahead?

2. Education, assessment and examinations

Over the past nine years there have been significant changes in education and assessment.

Under the guidance of the Dean(s) and the Director of Education, there are now written curricula covering PREP – Physician Readiness for Expert Practice – previously known as Basic Training, and now each of the 65 Advanced Training specialties have documented curricula. This has been an amazing collaborative – and at times exhausting – effort by many Fellows within our College, with each program organised and supervised by the Specialty Training Committees (STCs) and the previous Specialty Advisory Committees (SACs) which are jointly under the auspices of the College and the Specialty Societies.

We are now entering the revision phase, with all curricula needing to be reviewed and updated, or modified if indicated by experiences reported during the initial implementation phase.

The Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) have been actively involved, and through the accreditation process, have now provided full accreditation to the College as the preferred training provider of Physician Education for the next three years.

Future directions

The next phase in this process will be the reorganisation of the examination and assessment process. There have been requests to hold more than one examination each year. To enable this, there will need to be an enlarged bank of questions, which requires multiple group sessions, in which our College examiners are involved in writing, proofing and validating each question. Once there are sufficient validated questions, there could be more than one examination yearly. This would spread the load and, as the main clinical exams are held during the winter season, an increase in examination sessions should facilitate arrangements with tertiary teaching centres.

The ultimate aim would be to administer the examinations at multiple sites simultaneously, and on several occasions during the year. This will become essential with the rising number of candidates now reaching over 1000 Trainee Members sitting each examination day. Electronic marking will be another part of the overall changes to be introduced.

In December 2012, your College Board approved a five-year strategy to improve the way the examination is developed and delivered to better meet the expectations of trainees, examinations and jurisdictions, and also to manage risk.

Key elements of the strategy include:

- Outsourcing of the Written Examination logistics to a professional examinations delivery company
- Building a comprehensive question bank by increasing the number of approved examination questions per year
- Preparing to deliver two paper-based examinations per year
- Researching options to deliver a computer-based examination
- Allowing eligible BPT2 trainees to undertake the Written Examination
- Eventually moving to an on-demand computer-based examination.

Work commenced in 2013 on four of the key elements outlined in the strategy and I look forward to being able to advise you of progress in this key area of College activity.

How has the system changed?

When the College was formed in 1938 it was modelled on the London College and adopted the two-tier system of Fellowship and Membership. Membership was obtained by examination and Fellowship by election.

Foundation Fellows were elected by the Council (which arose from the preceding Association of Physicians of Australasia). The Fellows were regarded as established specialists in internal medicine, who held appropriate appointments as a physician in a public hospital and who limited their practice to internal medicine or a related discipline such as psychiatry or dermatology. Also included were a small number of other specialties such as radiologists and pathologists.

By the time of the Annual Meeting of the College in 1940 there had been three examinations in Australia and two in New Zealand with 88 members enrolled in the College, and it was noted that ‘A high
standard of professional knowledge and skill has been exhibited by the candidates in the examinations'. In due course, Fellows elected from the body of members were added to the Foundation Fellows.

This system of Membership by examination and election to Fellowship continued until 1978, when the Membership category was finally phased out and changes were made to the process of becoming a Fellow.

Why aim for Fellowship?

In 1963, Dr K B (later Sir Kenneth) Noad mused on the question of what was in the minds of the toiling majority who made Membership and Fellowship. 'Do those who wish to practice as a physician take the examination “because it’s there?” – in other words as a test of their knowledge of higher medicine?’ – or was it to join the circle of physicians who constituted the College and to be able to attend the scientific and clinical meetings which are the most important activity of the College.' These possible reasons were later to include other motives, which included Membership being recognised to signify a consultant who could be appointed to the medical staff of teaching hospitals, and to achieve a higher salary.

The College had taken time to ‘convince’ the everyday world of the full value of their Membership and Fellowship. By 1940 diplomas were recognised only in New Zealand, New South Wales, Tasmania and South Australia. Recognition in other States was not forthcoming until 1951 when it was announced that the additional medical qualifications were recognised as being registrable by the General Medical Council of Great Britain and in New Zealand and all states of Australia.

In 1964, an important change in the examination for Membership was made to encourage physicians who had already undertaken specialised training in paediatrics, dermatology or psychiatry to seek Membership. It was decided that on the written papers each question would consist of four alternative parts – and candidates could answer in accordance with the prior nomination made!

In 1968, the College Council decided to appoint two committees: (a) a Committee on Physician Training to consider (i) the training and recognition of a specialist physician and (ii) the role of Membership and Fellowship in relation to the foregoing; (b) a Committee on Hospital Accreditation to consider the question of hospital accreditation for the purposes of the training of physicians. Subsequently, in 1973, two phases of training were recognised: (i) basic training, in which a trainee would acquire a broad basis of knowledge and of skills in the principles and practice of internal medicine or paediatrics; (ii) advanced training, which might be undertaken in general medicine, in paediatrics or in one of the specialties of internal medicine.

After basic training for a minimum period of three years following the intern year, trainees were required to pass a written and a clinical examination (Part 1 FRACP). If successful in that examination, trainees would enter a period of advanced training, which would extend for a minimum of three years. Having completed that training, the trainee would be awarded Fellowship of the College (FRACP). If successful in that examination, trainees would enter a period of advanced training, which would extend for a minimum of three years. Having completed that training, the trainee would be awarded Fellowship of the College (FRACP) without further examination.

From 1988 the Part 1 examination could be taken, in addition to the end of basic training, during any year of advanced training. However, admission to the Fellowship of the College still required the completion of basic training and of advanced training and a pass in the FRACP examination, which continued to be a broadly based examination in internal medicine and paediatrics.

The hope was expressed by the Board of Censors that this change would ‘help reduce the stress associated with the FRACP examination’, since failure to pass at first attempt would no longer carry a penalty of additional years of training and it would help to reduce the adversary role which the College currently then held in the eyes of trainees.

Back to the future

There is a plethora of new current arrangements and designated training curricula, and the question for the future is: where will the new arrangements lead the College? One of the key Strategic Goals for the College is to be the preferred educator and assessor of physician performance, and our College has a vision to promote the highest quality medical care and patient safety through education, training and assessment, and to educate and train the next generation of physicians, whilst promoting the study of the science and art of medicine.

The new governance arrangements in Education will take time to transition and we look forward to your ongoing involvement and support.

3. College governance

Governance of the College has presented many challenges since the College’s formation as an Incorporated Body in April 1938. The concept of a Fellowship of like-minded professionals, governed by a Council or Board, who have been democratically elected by their peers, has led to numerous discussions and at times heated discourse. Leadership, equity, openness and transparency have been the virtues which the leaders of the College have been determined to display – however, at times accusations of introspection, factionalism, coverture and favouritism have been raised.

Transition to the College – 1938

In the lead-up to the formation of the College, the building at 145 Macquarie
Street, Sydney had been purchased, the King had granted the College the use of the title ‘Royal’ in 1938 and New Zealanders had agreed to unite in the College under the Dominion Committee. Incorporation was completed legally on 1 April 1938.

On 9 April 1938, the last day on which the Association of Physicians of Australasia met, the Council of the College held its first meeting in the building of the Royal Australasian College of Surgeons in Melbourne. Continuity was complete, although in practical terms there had been a great deal of overlap.

The inaugural ceremony of the College took place in the Great Hall of the University of Sydney on 14 December 1938 and was described as a ‘glittering gathering’. Notable presences included His Excellency, Lord Wakehurst, Governor of New South Wales; Dr Morley Fletcher, representing the Royal College of Physicians of London; and Dr Noble Wiley Jones, representing the American College of Physicians. Drs Fletcher and Jones were admitted as the first Honorary Fellows of the College.

The initial governing body of the College was constituted and an Executive Committee was formed, the President, Sir Charles Bickerton Blackburn (NSW), was elected, with two Vice Presidents, a Censor-in-Chief, an Honorary Secretary and an Honorary Treasurer, and a group of 10 councillors; together with a Dominion Committee (for New Zealand).

Miss Dorothy Roseby was appointed the College Secretary – a position she held for 36 years from 1938 to 1974!

Governess arrangements to lead into the future

In past years, a number of reports into College governance, structure and administration have led to iterative changes. Over coming months the Board will review governance structures to ensure that the College is best positioned for its continued development and growth with a Board and Committee structure that is efficient, effective and transparent. Changes are already underway in the governance of our education and policy and advocacy services.

In order to ensure a strong and robust College into the future and meet the challenges that we face, governance structures must be responsive and flexible.

Your role now and into the future

As Fellows and trainees, this year offers a rich tapestry of activity for each of you – opportunities to celebrate the achievements and contributions of your predecessors; to acknowledge and applaud those of your peers; and to participate in the thinking and discussion about the strength and capacity of our College that we will provide for our successors.

Associate Professor Leslie E Bolitho AM
President RACP

References
2. ibid.
4. op cit., p. 93.
Dear Fellow and Trainee Members

Welcome to the second Board Communiqué for 2013, which is made available to all Fellows, trainees and College staff after the latest Board Meeting as part of the communication initiatives to keep you informed and updated on current College activities. The Board Meeting took place in Perth over two days on 24 and 25 May 2013 in the lead-up to the College Ceremony and 2013 Congress.

Day 1 involved a facilitated session where Directors discussed in more detail the ‘in principle’ decisions taken in the March session relating to the review of the current Board and College structures. Consideration was given to the scope and extent of the review, how the review will be conducted, particular roles for Board Members and the desired outcomes, as part of the overall planning of the review. As was stated in the March 2013 Communiqué, the Board remains committed to ensuring that broad and continuous communication and consultation will be conducted with Members for their contribution and feedback once the review process commences. You can expect to receive a number of communications from the President, President-Elect, Presidents of the Divisions, Faculties and Chapters, the President of New Zealand, and other Directors over the coming months to keep you informed, and any questions or concerns you may have can be directed to any one or more of them to arrange responses for you.

Day 2 Saturday, 25 May 2013, was devoted to the formal Board Meeting with a full agenda of items for consideration and approval.

The following is a summary of the Board decisions and other actions taken at the meeting.

The Board:

• Approved a formal budget and the establishment of a project team to assist with the review of the Board and College structures considered on day 1.

• Approved amendments to the Standards Committee By-Law and considered a number of recommended changes to the College’s current Code of Conduct. Some of the recommendations were accepted but others needed more work so will be submitted to a subsequent Board Meeting for approval. The revised Standards Committee By-Law has been posted to the College’s website under the Governance section, and the revised Code will be posted once the Board has approved all proposed amendments to the current document.

• Approved a number of recommendations to improve the College’s processes arising from a recent appeal heard by the Appeals Committee. These recommendations will be the responsibility of the College’s Senior Leadership Group to implement.

• Approved the appointment of Dr Jonathan Beavers as the international medical graduate representative on the College Trainees’ Committee, following an extensive expressions of interest process.

• Approved an amendment to the College Finance Committee’s By-Law to allow for the appointment of an additional non-Director member of the Committee. Dr Charles Guest and Dr Jim Newcombe were also appointed to the Committee as new Director representatives.

• Approved a Policy (and procedure) for Acceptance of Membership of External Bodies to provide guidance as to which external bodies the College should be a member of to further its interests and activities, and which current memberships should be retained/ renewed.

• Reviewed the 2013 Work-plans for a number of bodies that report to the Board to ensure accountability and clarity of purpose for these bodies.

• Approved the appointment of a number of Fellows as members of the College Research Committee, following an expression of interest process, subject to each nominee formally accepting an offer to join the Committee. The final composition of the Committee will be advised to Fellows and trainees in due course.

The Board also noted the progress report of the Education Governance Implementation Working Group, which as the name implies, has been established by the Board to oversee the implementation of the Education Governance Review recommendations that have been approved by the Board.

The Board also received the standing reports from the President and the President of New Zealand as well as a comprehensive report from the College’s CEO outlining current operational issues as well as progress status of the new activities and projects for 2013.
This meeting also marked the last Board Meeting for the Community (Non-Fellow) Directors Geoffrey Laurence and Ron Paterson who have been Board Members since 2009 and 2010 respectively. Each has made a significant contribution to improving the College’s financial and non-financial controls, reporting and general governance procedures and processes in particular during their time on the Board. Both Directors were personally thanked by the President on behalf of the Board and the College for their commitment and contribution to the development of the College during their time on the Board.

Fortunately, their experience and expertise will not be entirely lost to the College, as Geoffrey Laurence has agreed to remain as a non-Director member of the Finance Committee and Ron Paterson will remain a member of the Revalidation Working Group.

The next Board Meeting will be held on 7, 8 and 9 August 2013 in Canberra, with a Board Executive Meeting to be held in the intervening period on 27 June 2013.

Annual General Meeting

The College’s 74th Annual General Meeting was held on Monday, 27 May 2013 where the College’s 2012 Annual Report containing the Reports of the President, Honorary Treasurer and CEO together with the annual financial statements and report were presented to Members.

Members confirmed the appointment of Grant Thornton Audit Pty Limited as the College’s external auditors.

The President also advised the Meeting of two questions received by Fellows and the responses provided. Details of the Meeting will be posted to the College’s website.

Associate Professor Leslie E Bolitho AM
President
June 2013

BOARD OF DIRECTORS
The College Finance Committee has been tasked by the Board with the oversight of financial projects and policies across the College that will benefit our Members and streamline processes. For further information relating to the outcomes of the March and February Finance Committee meetings, please go to page 13.

One of the key projects the Finance Committee has oversight of is the investment into a new IT and administration system for the College. The Finance Committee receives project updates regarding progress, risks, costs and timelines on a frequent and regular basis. In future Honorary Treasurer columns in RACP News, I will keep you updated on the progress of this significant and exciting investment.

Those members who have read the College Annual Report will recall that I mentioned the significant investment the College is currently undertaking in a new administration system – the OSCAR (Online System for College Administration & Reporting) project.

Some members may be asking why the College is investing in this system and what the outcome of the investment will be. As a longstanding member and more recently office bearer of the College, I can honestly say to you that this investment is badly needed due to the poor state our IT infrastructure and current operating systems, processes and practices were in.

Early in 2010 the Finance Committee commissioned a review of the College’s IT infrastructure by independent IT consultants who established that it was inadequate for the existing function of the College, placed it at risk, and was unable to support the technology development and improvements in College governance and operations many Fellows and Trainee Members were expecting and the regulators were demanding.

Some unacceptable aspects of the College’s IT infrastructure in 2010 were:

- A network that was geographically dispersed with servers located in general offices rather than in a secure and environmentally controlled computer room
- No monitoring facility to alert the College if the IT network crashed
- A College network run with two old and out-of-date operating systems
- Ageing and totally overloaded computer hardware requiring staff to continually remove data and emails as the system reached capacity
- Seven different internet contracts, with each state in Australia and the New Zealand office having their own internet provider
- A totally inadequate Wi-Fi system purchased from Dick Smith at minimal cost for the usage of Fellows and Trainee Members visiting College offices.

A strategic plan to provide a robust, stable and contemporary IT infrastructure that could support developing technologies and a new administration system to replace the highly complex and convoluted manual system operated by the College was approved by the Board in late 2010.

During 2011 and 2012 the College invested circa $2 million in creating a secure, robust, contemporary and professionally managed IT infrastructure. This has made a vast improvement to the performance of the College’s IT infrastructure: videoconferencing has improved, resulting in few drop-outs; Wi-Fi is available to all Fellows and Trainee Members in the College offices throughout Australia and New Zealand; and the Web and portals are accessible 24 hours a day.

The next stage has been the OSCAR project, which not only involves the replacement of multiple ageing software systems, but a complete revision of the way the College operates, involving technology, systems and people working ‘SIMPLER, FASTER & SMARTER’ (Simpler – processes will be streamlined and consistent; Faster – at the ‘click of a button’ access to information will be available; Smarter – online self-service will replace paper). This means that many of the College’s past ways of ‘doing things’ will be challenged and if appropriate changed.

Throughout 2012 and early 2013 College staff and a dedicated team of external contractors mapped the existing systems, processes and practices of the College, and from that
diagnostic mapping the College has been able to identify many processes that can be simplified through standardisation.

This exercise has taken significantly longer than expected because of the complexity and diversity of the systems, processes and practices that have been built up over many years in a siloed fashion with poor documentation. Examples include seven different processes by which a trainee could apply for training, many different ways committees made and recorded decisions, the use of different terminology for the same action, and often the processes and practices were ‘in the heads of staff’ rather than documented. We now have the majority of systems, processes and practices documented and this, in itself, significantly reduces the risk associated with them. Through automation and workflow, the OSCAR project will result in ‘Faster’ and ‘Smarter’ systems, processes and practices, allowing staff more time to undertake activities that add value to the support of Fellows and Trainee Members. College processes will be simplified and standardised to ensure members have a consistent experience when dealing with the College.

The OSCAR project has reached the stage where the knowledge and information regarding the current and future systems, processes and practices in the College will be transferred to the Karman Group, the software company that will configure the new proprietary software, Aptify, using Aptify’s existing functionality, to meet the requirements of the College. Based on current expectations and assumptions, the system will be implemented by late 2014. By utilising proprietary software and thus adopting a ‘proven solution’ developed and enhanced across a large user base, the College will reduce risk and receive software updates, making OSCAR adaptable for our future needs.

Clinical Associate Professor
Michael J Hooper
Honorary Treasurer

OPEN LETTER FROM ASSOCIATE PROFESSOR SUSAN MOLONEY, PRESIDENT, THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS PAEDIATRICS & CHILD HEALTH DIVISION

The Paediatrics & Child Health Division (PCHD, the Division) has a long and proud history of advocating for child health through the development of evidence-based policies, engaging in proactive and reactive media opportunities and seeking to work with government at all levels.

The health of incarcerated adolescents, particularly those housed in maximum-security adult detention centres, and the health and mental wellbeing of children and young people seeking asylum in Australia, are two of the most critical issues in which the College is seeking to bring about meaningful change.

Paediatricians and physicians across a broad range of specialties have contacted me, asking the Division, and the College, to do more. To achieve meaningful change, we need a consistent and sustained approach to advocacy. As such, and to complement the Health and Wellbeing of Incarcerated Adolescents Position Statement and the Towards Better Health for Refugee Children and Young People in Australia and New Zealand Policy, the College has developed two template letters, addressed to government ministers working within these important portfolios.

Through the development of these letters, the College is calling for a significant shift in the engagement with adolescents in the juvenile setting and is opposing the mandatory detention of children and unaccompanied children and adolescents in Australia and in offshore centres. In the midst of the current public policy discussions, it is imperative that we recognise these issues centre around two of the most vulnerable and at-risk groups within the community.

What can you do?

These letters are an important advocacy tool, and will enable us to voice our opinions, as individuals and as a collective. I urge all College Fellows and trainees to support this advocacy campaign, by downloading the template letters from the Division, Faculty and Chapter policy and advocacy page on the RACP website and emailing or posting the letters to the relevant minister. A list of ministers and government contacts can also be found on the RACP website. Send a copy of your letter to communications@racp.edu.au so we can track the letters that are sent on these issues. Thank you for your ongoing commitment to improving the health outcomes of incarcerated adolescents and children and young people seeking asylum in Australia.
FINANCE COMMITTEE COMMUNIQUÉ

The College Finance Committee met in March and February 2013, with key matters approved at both meetings.

MARCH 2013 MEETING

The Finance Committee met in March for the second of its eight scheduled meetings for 2013. At this meeting, the Finance Committee reviewed the College’s 2012 Financial Statements and Reports with the College’s auditors, Grant Thornton. It is intended that these Financial Statements and Reports will provide greater disclosure to members of how the College’s revenues are derived and the activities and operations that are funded by those revenues.

The Committee resolved to recommend to the Board that it adopt the College’s Financial Statements and Reports as a true and fair view of the College’s financial position as at 31 December 2012.

In addition to this, the following matters were approved:

- The booking of the Sky City Auckland Convention Centre as the venue for the Annual Congress in 2014.
- The fit-out of the College’s new regional offices in South Australia.
- The recruitment of a part-time staff member to provide secretarial support to the Honorary Treasurer and Assistant Honorary Treasurer.
- A new policy on Fee/Price Exemptions intended to establish the authority for the determination of Price Exemptions, the circumstances when a Price Exemption is allowable and to advise staff on when and who can action a Price Exemption.
- The establishment of a College Collections Working Group to manage the valuation, storage, access, display and security of the College’s collections of books, antiquities, paintings and artefacts. This group is also charged with developing a policy on how to manage these collections going forward.
- The meeting approved the additional funding of $7500 from the General Endowment Fund in support of the jointly funded RACP Osteoporosis Australia Research Entry Scholarship.
- The President’s travel to the ICRE, IMELF and Tripartite Alliance meetings being held in Calgary, Canada in September of this year.

FEBRUARY 2013 MEETING

The Finance Committee met in February for the first of its eight scheduled meetings for 2013.

The following matters were approved:

- An amendment to the College Office Bearers Travel and Expense Policy to define a ‘year’ to be aligned with the Office Bearer’s term of office, rather than the calendar year definition.
- A College Meetings Policy and Events Policy, which confirmed the ‘2+2’ meetings per year for each College Body (two face to face and two by teleconference or video link) unless the Board approves otherwise.
- A policy to determine the location of meetings of College Bodies, which is designed to limit the incurring of unnecessary travel and accommodation costs and time commitments by members of such Bodies. Essentially all meetings of Australian based Committees and other Bodies are to meet in Sydney and all New Zealand based College Bodies are to meet in Wellington, unless there are valid reasons to hold such meetings in other locations. The policy does not apply to the Australian based State and Regional Committees as they are expected to hold their meetings within their respective State or Territory.
- The Annual Work Plan for the Finance Committee which will now be submitted to the Board for approval.
- The scope of work for the recently formed Pricing Working Group established to review the pricing by the College for services provided. The Working Group will deliver its recommendations to the Finance Committee later in the year.
- The proposed terms to renew the lease of the College’s premises at 52 Phillip Street, Sydney, following expiry of the current lease in mid-2013.

The Committee also confirmed the College’s tradition of conferring a Life Fellowship upon attaining the age of 70 years.

The August edition of RACP News will feature updates from the June Finance Committee meeting.

Michael Hooper
Honorary Treasurer and Chair of the Finance Committee
The RACP Future Directions in Health Congress 2013 held in Perth 26–29 May has been deemed a resounding success. We were very pleased to welcome over 1000 delegates to the Perth Convention and Exhibition Centre. The facilities were excellent, the organisation professional and the program both inviting and challenging, with up to eight parallel streams exploring the role of professionalism in practice. There was truly something for everyone – although the program was demanding of close attention to optimise individual choices and maximise opportunities.

I would like to convey my sincere thanks and offer my congratulations to the Fellows who were the organisers and to the College staff, headed by Linda Smith, Director Fellowship Relations, who were well organised and competent in ensuring the program was delivered as envisaged. Professor John Wilson was Chair of the Congress Organising Committee and Dr Alasdair MacDonald chaired the Scientific Program Committee. They did an excellent job, with the assistance of an exceptional support committee.

We were honoured to have Professor Ron Paterson present the Arthur E Mills Oration. Professor Paterson is Professor of Health Law and Policy at the University of Auckland and a Community Member of the Board of the College. He was New Zealand’s Heath and Disability Commissioner for a decade, and will become a New Zealand Parliamentary Ombudsman in June. Professor Paterson’s address was on ‘The Good Doctor: competent, fit and safe’.

Both the Opening Ceremony and Plenary Session on Monday, 27 May were well attended, with a capacity audience. The Governor of Western Australia, His Excellency Malcolm McCusker AC CVO QC gave the Opening Address and officially opened the Congress. Associate Professor Dawn Bessarab from the Centre for International Health at Curtin University delivered the Redfern Oration, which was instigated by the Australasian Faculty of Public Health Medicine, on ‘What’s race got to do with it? Healthcare and Aboriginality in the 21st century’.

After the Opening Plenary there were excellent presentations on a wide range of topics spanning the spectrum of ‘Physicians as medical experts’, ‘Physicians of the future’ and ‘Physicians as educators’.

I had the pleasure of hosting the breakfast session for the International Presidents, or their delegates, on the morning of Tuesday, 28 May on ‘Current challenges in vocational training and revalidation’. I would like to thank all of the presenters at the session: Dr Phyllis Guze, American College of Physicians; Dr Li Chung KI, Hong Kong College of Physicians; Professor Lim Shih Hui, Academy of Medicine, Singapore; Associate Professor Alan Ng, College of Physicians, Singapore; Dr Udaya Ranawaka, Ceylon College of Physicians; and Professor Kriang Tungsanga, The Royal College of Physicians of Thailand. Professor Nick Talley and myself were present and participated in the discussion. Similar issues confront all College-based education and training programs, including increasing numbers of trainees, reduction in patient contact, and requirements for adequate experience.

CONGRATULATIONS TO ALL INVOLVED IN OUR COLLEGE CONGRESS 2013

The Congress 2013 program was diverse and challenging, providing attendees with a broad spectrum of thought-provoking topics to explore further and reflect on for individual practice.
and continuing professional development. Revalidation and recertification are under development in all countries and currently there is no agreement on process.

The opening plenary on Tuesday, 28 May was hosted by the Australasian Faculty of Occupational & Environmental Medicine. Associate Professor Jos Verbeek MD PhD from Finland presented on ‘What works in Occupational Medicine and what doesn’t’, examining evidence-based practice and Cochrane Collaboration results from an Occupational Medicine perspective – with some startling results. Jos Verbeek is Associate Professor at both the Coronel Institute of Occupational Health in Amsterdam and the University of Kuopio. This was followed by a full day’s program across the spectrum of internal medicine, which continued to challenge those in attendance – well done to all concerned!

Dr Mark Graber MD FACP, founder of Patient Safety Awareness Week in the US, now recognised internationally, gave the Priscilla Kincaid-Smith Oration on ‘Diagnosis and diagnostic error: the beauty and the beast’ on Wednesday, 29 May, which provided an interesting insight into clinical decision making and judgement and how to link investigations to improve diagnosis and clinical decision making.

Winthrop Professor Fiona Wood AM FRCS FRACS, highly honoured Director of the Royal Perth Hospital Burns Unit and the Western Australian Burns Service, presented
the Cottrell Memorial Lecture on ‘The quest for scarless healing’, which explored the development in modern burns wound management, including the development of spray-on synthetic skin to aid in burn healing and reduction in scarring. One of Winthrop Professor Wood’s main aims is to highlight prevention of burns and she urged the College to strongly advocate for restriction on access to alcohol and related substances and to promote responsibility for self-care to all individuals.

Congratulations to all the College Fellows and staff involved in the excellent collaborative effort in producing our College Congress 2013.

I am looking forward to welcoming many of you to the RACP Congress 2014 which will be held in Auckland, 18–21 May 2014, and suggest you mark these key dates in your diary. This will also be an opportunity to be involved in the finale of our celebrations of the College’s 75th year of striving for excellence.

Associate Professor Leslie E Bolitho AM
President RACP

SPPP: FELLOWS AND TRAINEES SHARE THEIR RESEARCH AND STORIES

Did you miss the Professionalism and Performance sessions at the RACP Congress this year? Would you like to know more about professionalism and performance?

The College is delighted to announce the launch of the Supporting Physicians’ Professionalism and Performance (SPPP) video at the RACP Future Directions in Health Congress 2013. The video, “SPPP – Making it Real for Fellows and Trainees”, provides stories and experiences from Fellows and trainees who have used the SPPP framework in their practice.

Why watch the video?

• The video provides “real” examples and experiences to show you how to use the SPPP framework and also undertake professional development in the non-clinical areas to improve their daily practice
• It also provides the learning outcomes of Fellows and trainees who have used the SPPP framework

Where can I access the video?

The video is available now via the SPPP webpage: www.racp.edu.au/page/sppp.

In conjunction with the launch of the video two sessions on professionalism and performance were held at Congress. A wide range of topics were discussed, including revalidation, the importance of physician leadership and management, end of life care and communication, and overseas trained physicians and professionalism. The scope of discussion certainly highlighted the spectrum of contemporary issues in professionalism.

The College is interested in your feedback regarding the usefulness of SPPP Guide and associated resources. Please contact SPPP Project Manager, Fiona Hilton on +61 3 9927 7708 or via email sppp@racp.edu.au with any feedback.
Doctors, like anyone else, need to look after their own health

The Health of Doctors session at the recent RACP Future Directions in Health Congress 2013 was one of the most popular, reflecting the strong interest in this issue from Fellows and trainees. The session was chaired by AFOEM President-Elect, Dr David Beaumont.

RACP trainee Dr Kristin Good (NZ), the clinical lead for Health of Doctors and member of the AFOEM Policy & Advocacy Committee, urged doctors to take better care of their own health, and give higher priority to personal and family healthcare, as she launched the RACP's Health of Doctors Position Statement.

Below is an abridged version of Dr Good’s presentation from the launch of the Health of Doctors Position Statement at Congress 2013.

The Health of Doctors Position Statement arose from a conversation at Congress two years ago in Darwin – it was acknowledged that we face specific health issues unique to our profession, and that although awareness of these issues was increasing, something had to be done.

RACP CEO Dr Jennifer Alexander also recognised the importance of this issue and supported the development of the Position Statement. Following two years of extensive consultation and feedback, today we are launching the Health of Doctors Position Statement.

In our profession we often don’t practise what we preach and as a result we may receive sub-standard care. The consequence is that, while we don’t have increased incidents of stress-related illness, when compared to the rest of the population, our outcomes from these diseases are much poorer.

Medical students and trainees, indigenous doctors, doctors working in isolation in remote and rural areas and women doctors are at higher risk – indeed, the risk of suicide for women doctors is six times higher than that of the general population.

Medical training can contribute to a doctor’s emotional ill health because of the emphasis placed on meeting academic demands at the expense of interpersonal or emotional skills. Maladaptive coping mechanisms and poor self-care can begin in the undergraduate years and continue through a doctor’s working life.

Doctors tend to be critical, hard-working, self-sacrificing and are always aiming for perfection – when you put all of these factors together, this can sometimes result in stress-related illness, burnout being just one example. Other adverse health outcomes include anxiety, depression, substance use problems or dysfunctional personal relationships.

The changes can be quite subtle and are not always easy to identify in yourself or others. An increased awareness of these issues is important so you can watch out for the signs in yourself and others.

When physicians and doctors get sick, we should not treat ourselves or write our own prescriptions, but rather consult a doctor in a timely fashion. It is important that doctors put aside the stigma attached to stress-related health issues and get the help they need, when they need it.

Would you recognise the signs of burnout in yourself or a colleague?
1. Emotional exhaustion
2. Cynicism
3. Perceived clinical ineffectiveness
4. Sense of depersonalisation in relationships with co-workers, patients or both

Consider how your health would be affected.

Doctors need to take personal responsibility for themselves and for their families and to make their health a higher priority in their life. However, this is also about collegiate responsibility and advising, mentoring and just being there when your colleague needs you.

Organisations also have a responsibility to drive a culture of mutual respect — this
will ensure individuals do not suffer stress and burnout as a result of counterproductive workplace behaviours.

The RACP recognises that increasingly efforts are being made to address counterproductive workplace behaviours and that managing one’s own health is an integral part of professionalism for all doctors.

By launching this Position Statement, the College is acknowledging that the health of doctors is a significant issue that is affecting not only doctors, but also their families, patients and the healthcare system.

The College is in a strong position to support and reinforce the health and wellbeing needs of the medical workforce in the early stages of medical careers, and it has put a number of initiatives in place to support the health of doctors.

In 2014 the RACP will launch a formal early intervention program to identify and support Trainee Members with health concerns. This is designed to help Trainee Members before they are subject to the formal Independent Review of Training consequent to unsatisfactory performance. A similar program is also being designed for Fellows in difficulty.

The College will also introduce self-care modules at the training level and incorporate these into Continuing Professional Development (CPD) programs for Fellows and similar modules for Trainee Members. In New Zealand, the RACP has published a resource entitled ‘How to Survive as a New Consultant’ that contains advice for newly qualified specialist physicians.

The objective of this Position Statement is to raise awareness, stimulate discussion and be a springboard for action. There are some simple steps you can take to improve your health and they are contained in the Position Statement. Get a GP, stop writing your own prescriptions, maintain a balanced life, and most of all have some fun now and then!

Dr Kristin Good

A copy of the Health of Doctors Position Statement can be found on the AFOEM webpage (Media and News Overview) of the RACP website. For general enquiries, please contact afoem@racp.edu.au.

To read more about Doctors’ Health, see page 31
WHAT’S RACE GOT TO DO WITH ‘IT’? HEALTHCARE AND ABORIGINALITY IN THE 21ST CENTURY

Highly regarded Aboriginal researcher, Associate Professor Dawn Bessarab, presented the Redfern Oration on 27 May at the RACP Future Directions in Health Congress 2013 in Perth, WA. This is an edited version of her presentation.

Introduction

Aboriginal health in Australia is at a crisis. Current health statistics on every indicator show that when compared to non-Aboriginal health, the disparities between Aboriginal and non-Aboriginal are far greater. Whilst it is well accepted that ‘barriers to healthcare access’ is a contributing factor to poor health in the Aboriginal population,1 the elements creating these barriers need to be named and understood in order to address and enable better access to healthcare services. What’s Race got to do with it? At the moment race has got quite a lot to do with healthcare; Aboriginal people continue to be treated differently in the healthcare system and challenged for their beliefs and ways of being in the world. This treatment will vary according to different individual understanding, beliefs and stereotypes health professionals hold, or have been told, about Aboriginal people.

I will draw on three diverse research projects exploring service delivery to Aboriginal people in urban and remote locations where findings reveal similar outcomes in relation to communication and healthcare access. Race was identified as an ongoing contributing factor which influenced how service providers responded to and worked with Aboriginal patients in the health system.

Aboriginal patients were constantly blamed for failing to understand their health condition, ask the right questions and communicate effectively; and having complex medical and cultural needs that interfered with effective service delivery and cut across tight timeframes within hospital and healthcare services. Within the context of race, this paper will investigate what is and is not working for Aboriginal people in health service provision, to provide a direction forward in facilitating change in the way healthcare is provided.

Methods

Two projects: One looking at positive experiences of Aboriginal people in the healthcare system2 (P1) and the second exploring the perspectives of palliative care health service providers3 (P2) applied qualitative methods which included participant action research, yarning,4 narrative/storying and one-on-one interviews. A third project involved a mixed method translational approach accessing linked data to investigate the incidence of co-morbidities in prevalent stroke cases from 2005-20095 (P3). These three projects were all involved in looking at healthcare from the perspective of Aboriginal patients, health service providers and the epidemiological story of cardiovascular disease and related co-morbidities in Aboriginal stroke patients of which the story is transferable across the chronic disease spectrum.

Discussion

The data emerging from these diverse projects, which have different scenarios, all say the same thing: It doesn’t matter what area of health we are talking about, the stories are the same despite the different people, different health conditions and locations in which these events take place. P3 talking about stroke cases demonstrates very clearly the complex nature of Aboriginal health which service providers need to be mindful of. Aboriginal people presenting with one condition may in fact have other associated co-morbidities that create complex health issues and needs. Not only do people have clinical complexities, but associated cultural and logistical complexities which should be considered and discussed at the time of consultation, treatment and before a patient leaves the hospital or surgery. These issues need to be discussed in tandem especially if there is more than one chronic condition, for example, diabetes and cardiovascular disease. Many Aboriginal people are not aware of the link and how one impacts the other. Another clear finding from P3 was the age differences between the Aboriginal and non-Aboriginal population. Aboriginal people tend to present at a much younger age than the non-Aboriginal population, see figure 1.

Although this graph represents myocardial infarction, P3 identified the same issue for all co-morbid chronic conditions, highlighting that if a younger Aboriginal person presents for treatment or consultation, alarm bells should be ringing. Instead of waiting for...
the patient to ask questions or provide information, as a physician or health professional, you need to be asking questions that you would normally think about or be asking an older non-Aboriginal person.

P1, which gathered stories about healthcare experiences, identified a number of assumptions inherent in the system. Health professionals assumed that English is a first language, that people understand the medical jargon, are confident to ask questions, know what the doctor is saying, understand their medical condition and their medication regime and, when transferred from rural areas to the city, know their way around and how to navigate a large hospital:

[Aunty] had to go to [Perth] to see the doctors ... to go on a dialysis machine ... she's one of the local elders from here and not very familiar with the city ... [town] is ... where she has been all her life, she was put in a taxi [by hospital staff] ... a lady at this age ... to put an aged care lady in the taxi? They got to make sure that they got the address and that they are fine and safe ... [the family were in a panic, looking for her] ... [the taxi] ... took her to the Belmont shopping centre. That's where the kids found her.6

Aboriginal people from regional and rural areas are not familiar with the city, and are easily scared and overwhelmed. They are also mindful of their Aboriginality and wonder if they will be treated differently because of the colour of their skin. Depending where they are from English may not be their first language, and if they do speak English it is probably Aboriginal English. Before sending patients to the city, ensure they know why and where they are going, have a contact person identified that they can call on arrival and ensure they know what will happen when they see the specialist. Another barrier is food; in hospital when people ask for kangaroo they are told it is not on the menu, despite it being touted as a healthy alternative and long recognised as an original food source for Aboriginal people. Yet for members of the Islamic faith some hospitals such as Southern Health in Victoria, is the first hospital to negotiate and include halal food on its menu. Veronica Jamison the director of Southern Health believes that “If the patients are not given the right food to eat, they are not going to get better”.

P2 exploring the experiences of health service providers (HSP) (n=15) in palliative care identified that many HSP felt ill-equipped in providing services to Aboriginal patients, were unsure of cultural issues and raising sensitive topics such as end of life care.

The following comment was made in the context of a discussion around the decision by some Aboriginal families to send their family member to hospital for end of life care.

‘The biggest myth about Aboriginal families, I don’t know, and maybe the word myth is too strong, but there’s a sense that you know, the Aboriginal community is tight knit, close [and] they’ll do anything. Well I’ve seen the opposite to be the case so many times that I no longer believe it to be the case.’ (Urban, non-Aboriginal)

This comment demonstrates the speaker’s stereotype of Aboriginal people and the lack of understanding around why a particular decision might have been made. Comments like these are not constructive and can impact on how a patient and their family are treated in a hospital and the quality of care that they receive.

Because of the complexities that exist for Aboriginal people, healthcare providers

Figure 1.

BECAUSE OF THE COMPLEXITIES THAT EXIST FOR ABORIGINAL PEOPLE, HEALTHCARE PROVIDERS NEED TO BE AWARE OF THE LOGISTICAL AND OTHER CHALLENGES THAT CAN EMERGE FOR FAMILIES WHEN CONSIDERING WHETHER TO LOOK AFTER A PATIENT AT HOME OR SEND THEM TO HOSPITAL.

ABORIGINAL PEOPLE PRESENTING WITH ONE CONDITION MAY IN FACT HAVE OTHER ASSOCIATED CO-MORBIDITIES THAT CREATE COMPLEX HEALTH ISSUES AND NEEDS.
need to be aware of the logistical and other challenges that can emerge for families when considering whether to look after a patient at home or send them to hospital. Many Aboriginal families and people are financially challenged and may be living in overcrowded housing or already caring for other family members who are also struggling. There could be addiction or domestic violence issues, no car, dealing with their own chronic condition such as diabetes or heart disease and the fear of having to administer medication or of making a mistake. Reasons for sending a family member to hospital may have nothing to do with not caring but more to do with being unable to care, however families might feel shame and will not discuss this with a health service provider who they perceive as judgemental.

Another familiar comment was ‘I don’t know how to talk to them’. What does this mean? Aboriginal people are human beings like anyone else, who when sick are seeking treatment and deserve to be treated and spoken to as would any other patient who is ill. It is comments like this that create barriers that prevent Aboriginal people receiving a service. Being treated as the ‘other’ can and does alienate Aboriginal people within the hospital and healthcare system. White health professionals also need to be cognisant of their ‘whiteness’ and how this can privilege and accord them power in the healthcare system. It is comments like this that create barriers that prevent Aboriginal people receiving a service. Being treated as the ‘other’ can and does alienate Aboriginal people within the hospital and healthcare system. White health professionals also need to be cognisant of their ‘whiteness’ and how this can privilege and accord them power in the healthcare system. It is comments like this that create barriers that prevent Aboriginal people receiving a service. Being treated as the ‘other’ can and does alienate Aboriginal people within the hospital and healthcare system. White health professionals also need to be cognisant of their ‘whiteness’ and how this can privilege and accord them power in the healthcare system.

To conclude, Aboriginal people in this country are just like any other population group in that we share a common humanity. Remember this the next time you have an Aboriginal person in front of you. However, unlike other population groups in this country, we have been subjected to a history of devastating colonisation, blatant racism and marginalisation, so for many Aboriginal people today oppression is still a raw and continuing experience.

Associate Professor Dawn Bessarab is an Associate Professor in the Centre for International Health at Curtin University and is a highly regarded Aboriginal researcher who advocates the importance of having an understanding of the cultural traditions of Aboriginal people.

The William Redfern Oration was instituted by the Australasian Faculty of Public Health Medicine in 1994 in acknowledgement of the debt owed to the late Dr William Redfern (1788 – 1833) for his pioneering work in public health medicine in Australia.

References
2. Creating cultural empathy and challenging attitudes through Indigenous narratives, 2010, Edith Cowan University, The Combined Universities Centre for Rural Health, Curtin University, The University of Notre Dame, The University of Western Australia and Health Consumers’ Council (WA). Funded by the Australian Learning and Teaching Council.
3. Improving Palliative Care Outcomes for Aboriginal Australians: Service Providers’ perspectives 2013, Shaouli Shahid, Dawn Bessarab, Katherine D van Schaik, Samar Aoun and Sandra C Thompson, Soon to be published.
5. Bettering Aboriginal Health in Western Australia, 2012, The Combined Universities Centre for Rural Health, Heart Foundation, The University of Western Australia, Curtin University, Contact. Judith.katzenellenbogen@uwa.edu.au
6. Christine Story 1, Creating cultural empathy and challenging attitudes through Indigenous narratives, 2010, Edith Cowan University, The Combined Universities Centre for Rural Health, Curtin University, The University of Notre Dame, The University of Western Australia and Health Consumers’ Council (WA). Funded by the Australian Learning and Teaching Council.

The Royal Australasian College of Physicians’ Foundation has been advised it is the beneficiary of a bequest of $1m. The will of the donor states the money must be used for research into Alzheimer’s disease. Every year the RACP Foundation makes a series of awards to young researchers, many of whom are establishing their research careers. Applications are judged on merit and only the best and brightest are funded. In this way, both the research and the researcher are supported.

The bequest is welcome news as the RACP Foundation focusses on building its financial resources with the aim of decreasing the number of worthy applications that are currently unsuccessful due to lack of funding. The recent 2013 Foundation Appeal solicited support from Fellows and Trainee Members and the general public.
RACP CONGRESS 2013 – AWARD AND PRIZE WINNERS

<table>
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<tr>
<th>Award</th>
<th>Name</th>
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<tbody>
<tr>
<td>Excellence in Mentoring Award (Academic and Research Category)</td>
<td>Dr Stella Milsom</td>
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<tr>
<td>Excellence in Mentoring Award (Clinical and Professional Practice Category)</td>
<td>Dr Habibur Bhurawala</td>
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<tr>
<td>Excellence in Mentoring Award (Rural Mentor Category)</td>
<td>Dr Rosemary Fahy</td>
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<td>President’s Award for Trainee of the Year</td>
<td>Dr Shopna Bag</td>
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<td>Best of Grand Rounds – Wiley-Blackwell Publishing Award for Clinical Excellence</td>
<td>Dr Francesco Piccolo</td>
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<tr>
<td>Wiley-Blackwell Publishing Award for Excellence in Medical Education</td>
<td>Dr Marie Bismark</td>
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<tr>
<td>Adult Medicine Division Poster Prize – Fellow</td>
<td>Dr Patrick Russell</td>
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<tr>
<td>Adult Medicine Division Poster Prize – Trainee</td>
<td>Dr Alice Tang</td>
</tr>
<tr>
<td>RACP Trainee Research Award for Excellence in the field of Adult Medicine</td>
<td>Dr Tiffany Shaw</td>
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<tr>
<td>AFPHM Gerry Murphy Prize</td>
<td>Dr Sarah Sheridan</td>
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<td>AFPHM John Snow Scholarship</td>
<td>Dr Katherine Hooper</td>
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<td>Ramazzini Award 2013</td>
<td>Dr Ben Johnston</td>
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RACP 2013 COLLEGE CEREMONY – MEDAL, PRIZE AND AWARD WINNERS

<table>
<thead>
<tr>
<th>RACP (or other institution title)</th>
<th>Name</th>
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<tbody>
<tr>
<td>Johns Sands Medallist 2013</td>
<td>Dr Anne Robertson</td>
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<td>Johns Sands Medallist 2013</td>
<td>Dr Robin Chase</td>
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<td>Johns Sands Medallist 2013</td>
<td>Dr Catherine Yelland</td>
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<td>Associate Professor Peter Gow</td>
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<td>Eric Susman Prize 2012</td>
<td>Professor Stephen Clarke</td>
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<td>RACP Neil Hamilton Fairley Medal 2012</td>
<td>Professor Colin Sullivan</td>
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<tr>
<td>Adrian Paul Prize 2012</td>
<td>Dr Saeed Al Shahri</td>
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<tr>
<td>Basmajian Prize and Merit Certificate 2012</td>
<td>Dr Jasmine Gilchrist</td>
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<tr>
<td>Deane Southgate Award 2012</td>
<td>Dr Uthum Dias</td>
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<tr>
<td>Bryan Hudson Medal 2012</td>
<td>Dr Brent O’Carrigan</td>
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<td>Sue Morey Medal 2012</td>
<td>Dr Paul Burgess</td>
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THE LATEST ON EDUCATION POLICY DEVELOPMENT

The development and release of four new education policies this year is a significant task, requiring the dedicated commitment of the involved Fellows, trainees and College staff.

Figure 1: Fellow-led and professionally supported education policy development

The College is a large and complex organisation with 64 training pathways covering more than 20 specialties. The development of educational policy is challenging in such an environment, as it requires the formulation of a One College approach which is flexible enough to cater to the needs of individual trainees and their supervisors in a variety of healthcare settings.

In May 2011, the College Education Committee approved a new model for education policy development. This model is designed to streamline the way in which Fellow-led and professionally supported decision making occurs at the College (see Figure 1). A key part of this process is the policy development working group workshop, during which Fellows, trainees and College staff work together to develop sound policy direction.

At the recent Recognition of Prior Learning (RPL) policy development working group workshop, Fellows and trainees were asked what they thought of the development process. Commenting on the strengths of the working group process, Associate Professor Mitra Guha, Chair of the RPL Working Group, commented: 

The strength of the workshop process is the ‘diversity of views, you get perspectives that a single individual may not have considered. You get the chance to talk through the issues and iron out problems and … a decision that was made earlier can be reconsidered in the light of further discussion’. 

She went on to say:

I think one of the key elements of the Working Group is you need two lots of
expertise. You need expertise from the people who are currently engaged with the various College committees, because they know what the current processes are and they’ve got experience with that. At the same time you also need people who are fresh to the process, who can bring a completely bias-free or new perspective on it. I think to have one or the other is a problem, but to meld the two together gives a very good combination of both logistic and experiential base with new ideas coming from people who are fresh to the process.

Similarly, Dr Clair Sullivan, a Director of Physician Education in Queensland, commented:

The structure of the working day has been really useful in allowing us to reach a consensus because it has provided practical activities. These practical activities give us a particular question or problem and then allow the group to brainstorm a solution. I have found this to be one way to really develop my own knowledge, to get feedback about difficult issues and to reach a consensus as a group.

This policy development process is assisting the College to develop four education policies in 2013: Supporting Trainees in Difficulty, Recognition of Prior Learning, Supervision and Selection, and Entry into Training. Progress on these policies has been significant.

Supporting Trainees in Difficulty

The College has made a commitment to support trainees who experience difficulty in training. As such, a development working group comprised of trainees and Fellows met in November 2012 and May 2013 to develop a comprehensive draft policy. This policy will:

- define what a trainee in difficulty is
- describe the principles to be employed when supporting a trainee in difficulty
- set standards to underpin the trainee support pathway, possible outcomes of the support pathway, and roles and responsibilities of the College, its committees, supervisors and trainees.

In addition, implementation support and communication plans have been developed to ensure that the policy is well accepted in training settings across Australia and New Zealand.

Consultation with the RACP membership on the draft policy document, implementation and communication plans will commence from June 2013.

Recognition of Prior Learning (RPL)

Monitoring and evaluation of the College’s RPL Policy (approved May 2010) indicated that a major revision would be required to meet the needs of all College stakeholders. A development working group was convened and met in February and April 2013. The revised policy will:

- define who may apply for RPL and what categories of learning may be eligible
- describe the principles of RPL, and possible outcomes of assessment, including exemption from one or more program requirements
- supersede the current RPL Policy, elements of the Post-Fellowship Training Requirements (Divisions) Policy, and other College practices which informally recognise prior learning.

Consultation with the RACP membership on the draft policy document, implementation and communication plans has commenced, and invitations for expressions of interest are being sought to form a Peer Review Working Group.

Supervision

In early 2012, based on feedback received during the PREP consultation, the College released the Supervision Support Strategy for 2012–2016. As part of this strategy, the College has undertaken to develop a policy on supervision. A development working group was formed and met for the first time in April 2013. This group has begun work to draft a policy which will:

- define supervision in the College context
- set out a framework to harmonise current supervisory functions, simplify terminology and clarify responsibilities
- describe expected principles and standards of supervision.

Development work on this policy and support structures will continue throughout 2013.

Selection and Entry into Training

The College has commenced scoping activities to develop a robust, fair and effective policy to select the candidates most capable of completing RACP training and progressing to competent independent practice. These activities include:

- a comprehensive literature review
- investigation of legislative and regulatory body requirements
- analysis of best practice of other specialist medical colleges.

As part of this scoping exercise, information will be gathered, via an online survey, on the criteria and processes currently used to select candidates for training positions. Fellows and trainees will be asked to complete this survey so that the College can gain valuable information about current practice.

For further information on all education policies currently in development, please access our new members-only webpage: Education Policy Development.

If you have any questions or feedback, or wish to be involved in education policy development at the College, please contact the Education Policy team at EducationPolicy@racp.edu.au.

Julie Gustavs
Manager, Education Development, Research and Evaluation

Jemma Peattie
Executive Officer, Education Services
ADVANCED TRAINEE SELECTION AND MATCHING

In 2013, the RACP will again facilitate the coordinated selection of Advanced Trainees for some specialties. Interested trainees should note the application closing dates below.

The Advanced Trainee Selection and Matching (ATSM) program is a coordinated process of Advanced Trainee selection developed by the RACP and administered over a number of years by the Victorian State office of the RACP. It consists of an online documentation and preferencing system that electronically matches trainees to available Advanced Training positions.

This year nine matches will be conducted and details of the specialties/states involved are listed in Table 1 below. For the first time, New Zealand will be involved, with a Gastroenterology match this year.

Trainees looking for information on specialties/states not currently involved in the ATSM process should contact the Specialty Society Group (SSG) of those specialties direct – see contact details under ‘Advanced Training Specialties’ on the RACP website: www.racp.edu.au/page/coordinated-selection-of-trainees.

Table 1: Matches involved in ATSM process and key dates*

<table>
<thead>
<tr>
<th>Specialty</th>
<th>State(s)</th>
<th>Applications open</th>
<th>Applications close</th>
<th>Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology VIC/TAS</td>
<td>NSW/ACT &amp; QLD</td>
<td>1 July 2013</td>
<td>8 July 2013</td>
<td>15 July 2013</td>
</tr>
<tr>
<td>VIC/NZ</td>
<td></td>
<td>1 July 2013</td>
<td>10 July 2013</td>
<td>19 July 2013</td>
</tr>
<tr>
<td>Nephrology VIC</td>
<td></td>
<td>5 July 2013</td>
<td>14 July 2013</td>
<td>17 July 2013</td>
</tr>
<tr>
<td>Respiratory &amp; Sleep Med</td>
<td>VIC/TAS</td>
<td>8 July 2013</td>
<td>19 July 2013</td>
<td>24 July 2013</td>
</tr>
<tr>
<td>Infectious Diseases VIC</td>
<td></td>
<td>15 July 2013</td>
<td>21 August 2013</td>
<td></td>
</tr>
<tr>
<td>VIC/NSW</td>
<td></td>
<td>15 July 2013</td>
<td>29 July 2013</td>
<td>14 August 2013</td>
</tr>
<tr>
<td>Cardiology VIC/TAS/NSW</td>
<td></td>
<td>25 July 2013</td>
<td>15 August 2013</td>
<td>9 September 2013</td>
</tr>
</tbody>
</table>

*Applications and matching dates are subject to change. Trainees are advised to check with their respective SSG for the most current information.
Endocrinology VIC/TAS First Year and Continuing Trainees*

<table>
<thead>
<tr>
<th>Applications open:</th>
<th>26 July 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications close:</td>
<td>9 August 2013</td>
</tr>
<tr>
<td>Match:</td>
<td>16 August 2013</td>
</tr>
</tbody>
</table>

Multi-Specialty Match (see list of Specialties in Table 2 below)*

<table>
<thead>
<tr>
<th>Applications open:</th>
<th>26 July 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications close:</td>
<td>9 August 2013</td>
</tr>
<tr>
<td>Match:</td>
<td>16 August 2013</td>
</tr>
</tbody>
</table>

* Correct at time of printing

The Multi-Specialty Match combines several specialties into one match. The opening and closing dates are the same for each specialty within the Multi-Speciality Match (see above).

Table 2: Specialties involved in the Multi-Specialty Match for positions commencing in 2014

<table>
<thead>
<tr>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nephrology (VIC) (first year and third year positions)</td>
</tr>
<tr>
<td>Medical Oncology (VIC/TAS) (first year and continuing positions)</td>
</tr>
<tr>
<td>Respiratory and Sleep Medicine (VIC/TAS) (first year positions)</td>
</tr>
<tr>
<td>Rheumatology (VIC) (first year and continuing positions)</td>
</tr>
<tr>
<td>Rheumatology (ACT/NSW) (first year and continuing positions)</td>
</tr>
<tr>
<td>Gastroenterology (NSW/ACT) (first year positions)</td>
</tr>
<tr>
<td>Gastroenterology (VIC/TAS) (first year positions)</td>
</tr>
<tr>
<td>Gastroenterology (SA) (first year positions)</td>
</tr>
<tr>
<td>Gastroenterology (WA) (first year positions)</td>
</tr>
<tr>
<td>Gastroenterology (QLD) (first year positions)</td>
</tr>
<tr>
<td>Infectious Diseases (VIC) (first year positions)</td>
</tr>
</tbody>
</table>

**Application**

Applications for available positions in the 2013 ATSM matches are via the RACP website. Applicants should follow the process for applying for positions in the ATSM trainee handbook. This is available on the RACP website (www.racp.edu.au/page/coordinated-selection-of-trainees) and provides step-by-step instructions to guide you through the registration and preferring process.

To be considered for a job in NSW (in the above identified NSW Specialties) all applicants MUST apply to BOTH the RACP website AND each training hospital via the NSW Health ‘HealthJobs’ website: www.health.nsw.gov.au/jobs/recruitment/jmo.asp.

It is important for trainees to begin the application process as early as possible to save a last-minute rush. Online applications can be made by entering your personal information, completing the online CV and lodging your preferences.

Interview schedules are organised independently by each specialty. For information on interviews please contact the relevant Specialty Society Group coordinator or check the RACP website. The SSG coordinator details can also be found on the website.

**Match results**

The results of the matches for each specialty will be released firstly to the State Specialty Group (SSG) coordinators, who will in turn inform the Head of Department for each position, before results are released to applicants.

**Further information**

The national telehealth road show proved a resounding success, creating a great deal of interest from Fellows and trainees.

The RACP’s Physicians Telehealth Support Project team completed the national Introduction to Telehealth road show last month after hosting eight events in six states and one in the Northern Territory.

More than 300 RACP members and their support staff attended events in Darwin, Geelong, Melbourne, Adelaide, Hobart, Sydney, Brisbane and Perth. The high number of attendees indicated a significant level of interest in the College’s telehealth support initiative as well as the need for more innovative modalities of specialist healthcare delivery for patients in rural or remote areas, residential aged care facilities and Aboriginal Medical Services.

The road show provided an exclusive opportunity for members to discuss the local telehealth perspective, exchange ideas, and identify the successes and challenges of providing healthcare at a distance. Each road show event also included a presentation on:

- RACP telehealth support services, including how to access the online continuing professional development Introduction to Telehealth module
- The Medicare Benefits Schedule (MBS) additional telehealth item numbers and incentives
- How to assess patient geographical eligibility for telehealth consultations.

A key highlight of the road show was a presentation at the Brisbane event by Queensland Health Minister, The Honourable Lawrence Springborg. Minister Springborg presented to more than 50 Queensland RACP members on the State Government’s commitment to provide equal access to specialist healthcare for the Queensland community.

Chair of the RACP Queensland State Committee, Associate Professor Michael Gabbett, said the Brisbane event was an excellent forum that facilitated peer-to-peer learning.

‘Question time clearly demonstrated that many Fellows are enthusiastic to take up telehealth and the road show piqued interest in embracing the technology,’ Associate Professor Gabbett said.

Another road show highlight was the Sydney event, which was attended by more than 60 people, with 29 participating via video link.

According to RACP NSW State Committee Chair, Professor Stephen Leeder, the event emphasised the need for physicians to consider the use of video conferencing to improve services to patients who have limited access to specialists.

‘We have seen the future, and it is us! Even though we will be connected by satellites and broadband in ways that are almost unimaginable, there is no need at all for us to fear these technologies as dehumanising the practice of internal medicine. It is quite the contrary,’ Professor Leeder said.
‘Telehealth opens the door on new forms of collegiality as we reach out via video link to support one another in expert diagnosis and treatment. It is totally centred on the patient. It is brilliant!’

Participant evaluations from the road show were encouraging, with around 77% of attendees more likely to use telehealth in the future as a direct result of the information provided at the event.

For members who were unable to attend the road show, a recording of the RACP Introduction to Telehealth presentation from the RACP Congress is available at: www.racptelehealth.com.au/resources/videos/.

Acknowledgements

The RACP gratefully acknowledges the following Fellows for their contribution to the telehealth road show:

Adelaide: Dr Robin Chase (SA State Chair), Dr David Allen (Presenter)
Brisbane: Associate Professor Michael Gabbett (Qld State Chair), Dr Michael Williams (Presenter) Darwin:
Dr Christine Connors (NT State Chair)
Geelong: Associate Professor Paul Talman (Presenter)
Hobart: Dr Jorge do Campo (Presenter)
Melbourne: Associate Professor Ian Fraser (Vic State Chair), Professor Paul Komesaroff (Presenter)
Perth: Professor Desiree Silva (WA State Chair), Dr Poh-Kooi Loh (Presenter), Dr James Williamson (Presenter)
Sydney: Professor Stephen Leeder (NSW State Chair), Dr David Allen (Presenter)

BOOK NOW - RACP History of Medicine Course 2013

Join some of Australia's most distinguished historians and medical experts as they take you on a journey through the evolution of medicine in a developing colonial society, covering patterns of disease in colonial Australia; the development of an Australian medical identity; health management in colonial Australia; and translational medicine: from Europe to Australia.

Held in Sydney at the RACP offices, and run over five consecutive Saturday mornings from 20 July – 17 August 2013, this unique medical history course has been designed for physicians, medical specialists, historians and other academics.

Special guest speakers include:

- **Professor Peter Stanley** from the University of NSW and the author of 25 books, is one of Australia’s most distinguished military historians.

- **Philip Sharp** graduated from the University of Sydney in 1973 gaining his FRACS and has since gained many professional achievements including Chair of the Section of Surgical History in the RACS.

Other guest speakers include Dr Michael Kennedy, Dr John Carmody, Professor Peter Curson, Professor John Pearn, Professor Robert Clancy, Professor Stephen Leeder and Hon A/Professor Paul Lancaster.

Book now! Visit The RACP Library page for course costs and to download the application form. For further details contact RACP Librarian David Russell at david.russell@racp.edu.au or on +61 2 9256 5413.
The Federal Parliament provided a commendable demonstration of bipartisan support on 14 March 2013 in passing into statute the NDIS legislation. Here we look briefly at how the scheme will work and some concerns of the AFRM.

At the time of the passing of the legislation, there was an announcement that the NDIS had been rebranded DisabilityCare. The new name is a mirror of Medicare.

Pilot projects will commence in July 2013 in the Hunter area (NSW), Barwon area (Victoria), South Australia (for children only) and Tasmania (for young people only). The first remote pilot project will begin in the Northern Territory in July 2014, covering the Barkly Region around Tennant Creek, for 100 disabled clients. This will reveal challenges in disability service delivery in remote regions. South Australia, NSW and Tasmania will have fully implemented DisabilityCare by July 2018.

Senior Faculty members have encouraged the College to advocate for medical input to NDIS planning, but the reality is that plans are already well underway without Faculty input.

At the end of April 2013 many draft NDIS Rules, covering children, adults, nominees and support for participants, were already on the internet. Draft Rules for Registered Providers can be found at: http://yoursay.ndis.gov.au/document/show/29.

So, how will the scheme work? Much of the detail is spelt out in the NDIS Rules, which cover participant eligibility, qualifying residence rules, definitions of how to determine who is an eligible child and what is a defined permanent disability, ‘early intervention requirements’, and how to determine reduction in functional capacity.

The centrepiece is an individual Care Plan. The Plan will include a statement of goals and aspirations to be developed by each participant, setting out their goals and objectives and personal circumstances. It will also include a statement of supports, setting out any supports provided or funded by the DisabilityCare scheme.

Rehabilitation physicians are not mentioned; perhaps they will be seen as providing cover for a ‘health condition’, which places their input outside the remit of DisabilityCare.

Rehabilitation physicians are concerned by the separation in the Rules of support provided in relation to a ‘person’s on-going functional impairment’ (which is covered by DisabilityCare) and rehabilitation and other services provided ‘where the predominant purpose is treatment directly related to the person’s health status’.

The latter are not covered by DisabilityCare. This scenario sets up a model for ambiguity, as the dividing line between support for a health condition and support related to functional impairment is blurred, to say the least. Public rehabilitation medical services are most unlikely to be covered by the new legislation, in the same way that additional public education services do not take into account disabled children.

AFRM President Chris Poulos and President-Elect Steve de Graaff met with the CEO of the NDIS Launch Transition Agency, David Bowen, in mid-April 2013. The meeting provided an opportunity to promote the important role of rehabilitation medicine in the success of DisabilityCare, as well as to express the AFRM’s concerns with the Draft Rules. Discussion also occurred around the potential ambiguity that could be created by the separation of support in the Draft Rules (as mentioned above).

There is also a lack of community-based rehabilitation available in Australia to support DisabilityCare. This point was made at a subsequent discussion with the Department of Health and Ageing.

The meeting with the NDIS Launch Transition Agency was essentially positive and led to a second meeting being held at the College on 16 May 2013. This meeting included rehabilitation physicians, paediatricians and other physicians who work with people with disabilities and explored ways that their skills could be used within the DisabilityCare model.

We look forward to working with the NDIS Launch Transition Agency in the future.

Associate Professor Chris Poulos, Dr Stephen de Graaff and Dr Gerry McLaren

NDIS NO LONGER – NOW DISABILITYCARE
The Royal Australasian College of Physicians (RACP) has cautiously welcomed additional spending on new health initiatives announced in the 2013–2014 Federal Budget by Treasurer Wayne Swan on Tuesday, 14 May 2013.

The Federal Budget addresses some critical issues related to health, including the Indigenous health gap and reducing the cost of cancer therapies.

The RACP particularly welcomes Australian Government funding of $777 million over three years to a renewed National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes and the provision of an additional $29.7 million to pay an additional $60 for each chemotherapy infusion for cancer sufferers, on an interim basis for six months.

‘Many of these new spending measures are consistent with health spending priorities advocated by the RACP,’ RACP President, Associate Professor Leslie Bolitho, said.

‘Targeted funding for Indigenous services is essential for improving health outcomes for Indigenous peoples. We will continue to advocate that State and Territory Governments renew their existing NPA funding commitment to ensure that adequate levels of funding are available to fund the programs and services necessary to address Indigenous health inequality. The Australian Government’s contribution should, hopefully, set a strong precedent for State and Territory Governments to shoulder their share of responsibility for Indigenous health.’

While the RACP cautiously welcomes measures surrounding health expenditure, a shortfall in funding provided to make a difference to healthcare prevention programs must also be recognised. An example of this is the proposed increase in the Medicare levy for the National Disability Insurance Scheme – DisabilityCare Australia (DCA). This increase will not adequately cover the projected costs of DCA. Furthermore, immediate community rehabilitation needs have failed to be addressed in the 2013–2014 Federal Budget.

In the lead-up to the Federal Budget announcement, the RACP called on State and Federal Governments to work together to extend funding for successful subacute projects currently provided under the National Partnership Agreement (NPA) on Hospital and Health Workforce Reform (HHWR) beyond June 2013. This NPA was agreed to by the Council of Australian Governments (COAG) in 2008.

Included in the NPA on HHWR was $500 million in Federal funding, to be used over four years, for subacute services, covering rehabilitation, palliative care, geriatric evaluation and management, and psychotherapeutic care. The NPA concludes on 30 June 2013, and there is still no commitment to ongoing funding for the services established.

‘The RACP welcomes the announcement of DisabilityCare Australia,’ Associate Professor Bolitho said. ‘However critical rehabilitation services will be lost Australia-wide if funding for these services is not extended beyond June this year.

‘The rehabilitation programs set up under the NPA have resulted in improved access to rehabilitation services by people who have suffered severe illness...’
or injury. Many programs have also demonstrated improved healthcare-system efficiencies. A vast majority of the projects established under the NPA will no longer be able to be continued without ongoing funding. This will mean reduced access to the multidisciplinary rehabilitation that patients need.

‘The RACP understands the need for a responsible Budget, however without funding for rehabilitation services, we will more than likely see longer stays in hospital, an increased cost per patient to the system and potentially a decrease in health outcomes.’

The RACP has also welcomed the $33.8 million investment boost to the General Practice Rural Incentive program in 2013–2014 to encourage more medical practitioners to move to regional and remote communities.

According to Associate Professor Bolitho, the additional spending will help lead to a fairer distribution of the health workforce across Australia. The RACP has been at the forefront of advocacy in this area, having recently implemented a trial of dual-trained specialist physicians in rural and regional NSW. There is a continuing need for more GPs as well as specialist physicians in the bush.

Kate White
Senior Communications Officer

BUDGET BREAKDOWN

The RACP welcomes the additional spending on new health initiatives announced in the 2013–2014 Federal Budget, and in particular:

- the $19.3 billion over seven years from 2012–13 to roll out DisabilityCare Australia
- an additional $2.2 billion for the Medicare Benefits Schedule over five years to meet the increased demand for medical services by the Australian population
- an additional $691 million over five years for new drugs in the PBS such as drugs for the treatment of chronic nerve pain, chronic hepatitis C and Parkinson’s disease
- the $226 million boost to cancer care for Australians, which includes additional spending for breast cancer screening, lung cancer treatment, prostate cancer research and chemotherapy treatments
- the $33.8 million boost to the General Practice Rural Incentive program in 2013–14 to encourage more medical practitioners to move to regional and remote communities
- the $26.4 million investment in new mental health initiatives for veterans.

CAPPING TAX DEDUCTIONS FOR SELF-EDUCATION EXPENSES

A key concern for the RACP in the 2013–2014 Federal Budget is the capping of tax deductions for self-education expenses at $2000.

Medical practitioners have significant responsibilities to engage in Continuing Professional Development (CPD) as a means of enhancing their knowledge and skills and keeping track of developments in their profession. This frequently requires attending a range of educational courses, conferences and workshops through their working lives.

According to Associate Professor Bolitho, patients are the ultimate beneficiaries of these self-education efforts through increased quality of care. ‘While the RACP understands the need for the Australian Government to look for Budgetary savings, the value of the cap being proposed has been set unrealistically low, at least in the case of medical practitioners.

‘The average cost of an educational course attended is typically well above $2000, particularly when airfares (economy within Australia and New Zealand), ground transport including airport parking, hotel accommodation (standard rooms) and conference registration are included.

‘Rural physicians are especially disadvantaged by this cap because they also have to incur higher travel expenses than physicians located in metropolitan areas in order to meet the requirements of their CPD. The RACP calls on the Australian Government to at least reconsider the value of its proposed cap on self-education expenses.’
The craft of the physician is an intellectually challenging pursuit. As a group, we are proud of our ability to work under ambiguous circumstances and to deal with diagnostic and therapeutic dilemmas. For many of us, the questions which arise are best addressed through formal research, with Fellows undertaking work ranging from qualitative studies in large population cohorts to molecular bioscience. For others, the questions are focused on the circumstances of specific patients and our expectation that we can find the right answers and make the most appropriate recommendations for each person. Regardless of the underlying motives, being a physician involves the willingness to learn from experience and through inquiry and to apply that learning to our practice, and we derive great satisfaction from encounters which challenge our knowledge and force us to learn.

Given the ethos of our craft, it might seem logical that physicians would embrace the concept of continuous professional development, but experience tells us that many Fellows are uncomfortable with the concept, especially when annual reporting and documented participation are required for renewal of registration. On the other hand, the presence of Fellows at formal and informal educational activities, their role in supervising trainees and their engagement with current literature suggests that there is a great deal of professional development under way.

Below, Craig Bingham, the College’s newly appointed Manager of Fellows’ Learning Support, outlines recent activity in the College to understand better the learning styles and needs of Fellows. Craig comes to the RACP with a background in medical publishing and the administration of medical postgraduate training. His understanding of learning management and online systems makes him a welcome new member of the professional staff at the RACP.

The College recognises that there is considerable scope to develop our CPD system and acknowledges the invaluable contribution of the CPD Expert Advisory Group to discussions of the future of MyCPD. We are keen to have further input from Fellows from all branches of the College and across all career stages. We look forward to your comments.

Professor Richard Doherty
Dean

The joy of learning and discovery is a big part of every successful medical career, but ‘CPD’ comes close to being a dirty word with many Fellows of the College. ‘MyCPD is a waste of time and effort – it just laboriously documents what we already do anyway. It’s time to get serious about CPD.’ So wrote one Fellow in the 2012 member survey, voicing a frustration with MyCPD that we know is shared by many. The College’s MyCPD program is one of the chief points of contact between Fellows and the College, and an area where the College hopes to enhance its service to members. How best to do this? Several key discussion papers will be released soon for consultation with Fellows.

We know from the membership survey and discussions with Fellows that the range of CPD needs and expectations is wide. Some Fellows are deeply engaged in teaching, research and policy work, and their professional development needs are satisfied almost as an incidental part of their daily activity. One Fellow regularly reports around 800 CPD points worth of activity each year; we know many others ‘stop counting’ once they get to 100 points but could easily report hundreds more. Yet other Fellows are in different circumstances: although they can meet their CPD requirements, they still feel that the learning opportunities they really need are out of reach. This can be a problem for physicians in private practice, particularly in remote locations, or for physicians moving into new or more senior roles, or for those in a field transformed by new research and technology (and isn’t that every field, every few years?).

There are professional development needs at every career stage. As one new Fellow wrote in the member survey: ‘What is really lacking is the support provided after qualification. How to start private practice? What admin skills do we need? How to run a business yet keep a kind heart, how to network with the hands that feed us, how to maintain relationship with our peers?’ And this from a Fellow at the other end of the spectrum: ‘RACP needs to pay attention to the needs of older physicians who have done their time in teaching hospitals and as supervisors. Medical registration depends on CPD, which can be difficult for some of these people. RACP should develop a system to assist these people get their CPD.’
In March the College hosted a joint meeting with the Royal Australasian College of Surgeons and the Royal College of Physicians and Surgeons of Canada. This ‘Tripartite Alliance’ of colleges has existed since 2010 for the purpose of developing a better understanding of common issues and, if possible, a shared approach to solving common problems. The most recent meeting focused on the growing community and regulatory pressure for doctors to demonstrate their professional performance through a regular process of recertification or revalidation. One conclusion was that ‘Providing support for lifelong learning that adapts across the continuum of the career stages experienced by a medical specialist and reflects their current scope of practice is now a critical role for the Colleges.’ Another workshop at the same meeting explored these issues in more detail, resulting in a discussion paper, *Lifelong learning for physicians and surgeons*, which proposes strategies for enhancing the learning of physicians and surgeons at every stage of their careers (view at: www.racp.edu.au/page/lifelonglearning).

The *Lifelong learning* paper adopts six principles that potentially reshape the College’s approach to CPD:

1. **A commitment to lifelong learning.** Every doctor has to make an individual commitment to lifelong learning, and it is the role of their colleges to support this commitment.

2. **Best practice in learning.** The colleges will pursue best practice in learning by using and contributing to the evidence-base of educational research. This is a commitment to adult learning principles, support for self-directed learning, a diversity of approaches to learning, and socially constructive learning.

3. **Learning aligned to competence and performance.** The colleges will focus on learning designed to fulfil the social responsibilities of medical practice. This means learning that supports continuous improvement of performance. The colleges must help to identify and clearly define competencies appropriate to all levels of practice. Part of this project is identifying a range of appropriate ways to learn and assess these competencies.

4. **Learning relevant to career stage and scope of practice.** The precise mix of competencies required for each practitioner varies with career stage, location and scope of practice. The colleges agreed in principle at the 2013 Tripartite Meeting that it would be useful to develop an assessment tool to assist practitioners to define their scope of practice across all professional domains, making it easier to develop a relevant and comprehensive learning plan.

5. **Meaningful assessment.** Self-assessment is a continuous feature of any self-directed educational program, but needs to be guided and developed by formative feedback. Doctors should be open to formative assessment at all stages of their careers. Summative assessments should be aligned to demonstrating competence and performance, valid, reliable, fair and flexible, feasible, and efficient.

6. **Learning enabled by information and communications technology (ICT).** Face-to-face learning is the most important mode of professional development, but ICT can improve access to learning, enhance face-to-face learning with supporting services, simplify the reporting of learning outcomes and increase the connectedness of learners. Online systems for learning need to be enabled for mobile learning, and should help learners communicate with each other and extend learning communities. College systems should be based on the learner’s ownership of the learning record, and interoperable with the learning systems of other partners in the professional development of doctors.

**WHAT IS ‘REVALIDATION’?**

In Canada, New Zealand, the United States and the United Kingdom, a combination of government regulation and professional self-regulation effectively requires doctors to revalidate their competence to practise at regular intervals. Revalidation (or recertification) is conducted by various methods.

In the **United Kingdom,** a revalidation scheme introduced in December 2012 involves formal evidence which is submitted annually for appraisal, supplemented with information from organisational clinical governance systems, with a recommendation by a Responsible Officer submitted every five years to the General Medical Council.

In the **United States,** medical licensure is managed by States which have varying requirements (often including examinations) for relicensing. Specialist boards in the US also require registered practitioners to sit recertification exams at regular intervals.

In **Canada,** revalidation is being progressively implemented by provincial medical regulatory authorities in accord with a position statement of the Federation of Medical Regulatory Authorities of Canada. The revalidation program uses standardised assessment tools to confirm competence within the scope of practice, and participation is a requirement for continuing registration.

In **New Zealand,** a formal recertification program is currently restricted to doctors with a general scope of practice (i.e. non-specialists), but all doctors are required to participate in continuing professional development (CPD).

In **Australia,** participation in CPD is a requirement for continuing registration, and the Medical Board of Australia has begun discussing the possibility of introducing a revalidation system.
Meanwhile, a working group of Fellows within the College has been evaluating the strengths and weaknesses of the current MyCPD program. The working group’s report agrees with the directions of the Tripartite Alliance papers, and suggests that a new and improved MyCPD system could be easier to use, better integrated with other software used by Fellows, better linked to learning resources, and more supportive of professional development across all the domains of professional practice.

All papers emphasise the importance of consulting with members before embarking on experiments with new technology. The internet is awash with promising technical possibilities for enhancing professional development, but none of these will be successful if they don’t excite and engage the Fellowship. Over the next few months, the College CPD Unit will be coordinating a dialogue with Fellows aimed at achieving a CPD system that supports, not just reports, professional development. We look forward to hearing what you have to say.

Craig Bingham
Manager, Fellows Learning Support
Office of the Dean

Please help the CPD Unit gather information about the CPD needs and preferences of Fellows:
Complete our short online survey at: www.surveymonkey.com/s/improveCPD.
Or email Craig Bingham, Manager, Fellows Learning Support at: craig.bingham@racp.edu.au. Or write to Craig Bingham, RACP, 145 Macquarie Street, Sydney, NSW 2000.

References
DOCTORS’ HEALTH SA – A LEADER IN HEALTH SERVICES FOR DOCTORS

The background to this important initiative to improve the health of the medical profession – the first article in a series on Doctors’ Health in RACP News.

Doctors, like anyone else, need to look after their own health. The Royal Australasian College of Physicians believes that doctors have a responsibility to themselves, their families, their patients and the health system to take care of their own health. As an important component of maintaining their own health, doctors must have their own general practitioner and undertake regular health checks. While doctors as a group enjoy comparatively good physical health, certain characteristics of the medical profession predispose doctors to certain health risks. Historically, the medical professional culture has encouraged doctors to sacrifice their own health through accepted practices such as working long hours and taking work home.

On 6 March 2013, the Medical Board of Australia (MBA) announced it would provide funding for external doctors’ health services across the country in 2013–2014. In South Australia, an initiative to improve the health of the medical profession had commenced as far back as 2006 and a South Australian program model was formulated in 2008.

Doctors’ Health SA

In 2010, a South Australian Doctors’ Health Working Group advocated strongly and obtained Medical Board funding to assist with creating a fully independent, profession-controlled organisation to assist the medical profession to find a doctor of choice. Doctors’ Health SA (DHSA) was constituted as a Company Limited by Guarantee and a Board of DHSA was appointed. In 2011, a Medical Director was appointed and premises secured at 327 South Terrace, Adelaide.

Clinical services commenced on 1 May 2012. The program offers a full range of General Practice services for medical practitioners and medical students and can recommend General Practitioners should doctors not already have a GP of their own, a comprehensive specialist referral network, and a confidential 24-hour health advice line. DHSA has also developed a training curriculum for doctors on the peculiar and specific challenges of looking after other doctors. It is offered through two one-day seminars per year and a series of evening seminars on topics relevant to the healthcare of the medical profession.

South Australian State Committee

In 2011, the Australasian Faculty of Occupational & Environmental Medicine (AFOEM) commenced work on a policy on Doctors’ Health at the suggestion of the RACP CEO, Dr Jennifer Alexander. As part of the ongoing policy commitment of the RACP to ensuring the health of doctors, the South Australian State Committee consulted with Dr Roger Sexton, the Medical Director of DHSA, and Dr Graham Wright, Occupational Physician, to encourage the SA RACP Fellowship to develop a professional relationship with their general practitioner. The Committee emailed all physicians and trainees in SA to inform them about the importance of developing and maintaining a relationship with their existing GP, to encourage them to obtain a GP should they not already have one, and to advise them about the services of DHSA. A separate email was sent to Fellows only inviting them to attend one of the training sessions and to consider being part of a referral network that would assess, treat and advise medical colleagues. This invitation was met with a very positive response, with interested Fellows from a range of specialties and subspecialties keen to be part of a specialist referral network. The interested RACP Fellows will shortly be provided training, covering doctors’ health and risk assessment of well and unwell doctors.

The SA Committee has been widely congratulated on this initiative and has been very pleased with the response. We applaud the RACP and the AFOEM on its draft position statement and the timely nature of its development. We hope and expect that similar initiatives will be taken up by all parts of the College, as ultimately it is our patients, their families, our members, and their families who will benefit.

Dr Robin Chase
Chair SA Committee

South Australian Fellows
Would you like to join the network of treating specialists?
Contact: Jo Sutton, SA State Manager
Email: jo.sutton@racp.edu.au
Phone: 08 8465 0972

Reference

For more on Doctors’ Health, see pages 12–13
CAST YOUR MIND BACK TO MAY 2011. AT THAT TIME, NICOLA ROXON WAS MINISTER FOR HEALTH AND HER PREOCCUPATION WAS THE PURSUIT OF PLAIN (OLIVE BROWN) PACKAGING FOR CIGARETTE PACKETS. WHILE THE RACP Supported this policy, this article shows how the RACP also quietly and effectively instigated action on a related issue. This success story for the RACP shows the importance of a clear, uncluttered and consensus position, the value of collaboration across the RACP and unheralded behind-the-scenes work to achieve a positive outcome for patients and the Australian public.

Way Back in 2011

In May 2011, the Australian Financial Review had reported that Australia’s Future Fund would retain its $150 million investment in 14 tobacco companies.

The Future Fund is an independent entity created in 2006 by then Treasurer, Peter Costello, to help future governments pay for Commonwealth public servant superannuation. These funds are managed by the Fund’s Board of Guardians and the Future Fund Management Agency. Investment priorities are determined independently by the Board of Guardians. David Murray was the first Board Chairman, while Peter Costello himself was appointed to the Board in 2009. In 2011, the Fund’s Chief Investment Officer, David Neal, reaffirmed that ‘politics’ did not frame the Future Fund’s investment decisions. In March 2011, the Public Health Association of Australia (PHAA) had already combined with the Australian Medical Association (AMA) and the Australian Council on Smoking and Health (ACOSH) to write to the Guardians of the Future Fund requesting that the Future Fund ‘withdraw funding from tobacco companies’. This effort failed.

It was time for the RACP as a credible champion for population health to step in.

Throughout 2011, the RACP ensured the progressive refinement of its position on Future Fund tobacco investments after initial development by the Australasian Faculty of Public Health Medicine. To support this work, the College Policy & Advocacy Unit (CPAC) stockpiled comparable policies and evidence from countries with sovereign wealth funds such as Norway. By liaising across the RACP and achieving consensus, this agreed position and back-up evidence guided all subsequent action by the RACP.

The RACP was well poised to act when, in November 2011, a private members’ bill was introduced to the Senate requiring responsible ministers to produce ethical investment guidelines for the Future Fund Board which would be compelled to have regard to these guidelines when making investment decisions. There were two aspects of concern: first, the potential to compromise the independence of the Future Fund Board of Custodians and, second, an expansion of the definition of ‘unethical’ investment. In response, the RACP remained focused, disciplined and distinctive in speaking only of the unacceptability of tobacco investments on clear grounds for population health.

A New Year (2012)

On 13 February 2012, the RACP President wrote directly to the then Chair of the Future Fund Board, Mr David Murray, to register the RACP’s concern over ongoing tobacco-related investments of the Future Fund. In response, Mr Murray advised that the Fund’s investment framework did not stipulate industries or sectors that the Board of the Future Fund should exclude. It was explained that ‘the Board takes the view that neither the legislation nor the Investment Mandate Directions require the Board to exclude investments in the tobacco industry and investments are assessed in the context of the risk and return requirements placed on the Board’.

Although disappointed with this response, the RACP network was nonetheless undeterred and alert to any environmental change. A new Chair for the Future Fund’s Board of Custodians was announced and, in April 2012, the RACP President wrote to this new Chair, Mr David Gonski, about tobacco investments. Mr Gonski replied:

The Board of Guardians has previously published a policy on environmental, social and governance risk management and committed to reviewing the policy and its implementation regularly. At its April meeting the Board of Guardians resolved to form a governance committee of the Board to provide focus to this work over time. I thank you for taking the time to write to us and assure you that the issues you raise will be put before the new committee as it considers this topic in the light of the Board’s investment strategy and mandate.

CPAC decided to await the outcome of the Governance Committee’s work, in recognition of good faith from Mr Gonski. The RACP agreed that any further advocacy work would target responsible ministers in finance as well as the Minister of Health and the Attorney General, and shadow ministers.
Media visibility brought forward

By May 2012, there was a good head of steam behind this singular compelling idea. The Policy & Advocacy Unit developed a list of elected parliamentarians for a focused letter campaign: Responsible Ministers, Supporting Ministers, and key MPs and Senators in Opposition with an interest. In July 2012, the RACP finalised a persuasive six-page submission to the Senate Inquiry into the private members’ bill with a list of recommendations, including reasons to withdraw from tobacco investments in the Government Investment Funds Amendment Bill. Our complete submission is well worth reading and is available on the College website. On 23 August 2012, the 51-page report of the Senate Finance and Public Administration Legislation Committee recommended that the Bill not be passed.

The RACP’s prescience in earlier approaching the Future Fund directly now proved crucial. In October 2012, it became public news that the Board of Custodians had created a Governance Committee chaired by Peter Costello to review its policy on environmental, social and governance risk management. In October 2012, the AMA Vice President proposed that this review be ‘brief’ and that it could have only one outcome: ‘to stop the tobacco investments immediately’.

The networks of Fellows, Members and Executive RACP staff were invoked effectively during these months to press one key message to any stakeholder persuaded to listen: how could the Future Fund continue to take the risk inherent in tobacco investments given the irrefutable withdrawal of public support for tobacco as a product with which it was morally unacceptable to make money?

Saving lives

On 28 February 2013, the Future Fund announced its investment policy would exclude primary tobacco product manufacturers:

The Board noted tobacco’s very particular characteristics including its damaging health effects, addictive properties and that there is no safe level of consumption. In doing so the Board also considered its investment policies and approach to environmental, social and governance issues.

What’s next?

Your RACP is delighted to have been instrumental in this major success for public health policy. This decision by the Future Fund is a credit to the behind-the-scenes work by the RACP and particularly the Australasian Faculty of Public Health Medicine.

Any Members ready to approach their own superannuation fund or investment portfolio manager are encouraged to do so. Superannuation funds including Health Super, UniSuper and First State Super have already abandoned tobacco investments.

No one wants to make money from tobacco. No one.

For information on the contents of this article, or to tell the RACP about your own advocacy on tobacco control, please contact Alex Lynch at: Alex.Lynch@racp.edu.au.

Professor Jeanette Ward FAFPHM FACHSM FAICD
Alex Lynch, Regional Policy Officer, NSW
ANNOUNCING THE RACP NHMRC AWARDS FOR EXCELLENCE

‘The Research Advisory Committee is delighted with this important initiative with the NHMRC – an association which it hopes will be strengthened further in the future. The award represents an additional incentive for clinicians of outstanding calibre to pursue a career with a substantial research component.’

Professor Michael Horowitz MBBS PhD FRACP
Professor (Personal Chair, University of Adelaide) in the Discipline of Medicine, University of Adelaide
Director, Endocrine and Metabolic Unit, Royal Adelaide Hospital

The National Health and Medical Research Council (NHMRC) and the Royal Australasian College of Physicians (RACP) are collaborating to support our top young clinical researchers with an Award for Excellence, as part of a shared commitment to nurture the next generation of medical researchers.

The RACP is also committed to developing vital research in health and social policy which will deliver improvements to the wellbeing of patients.

The NHMRC has worked to build a healthy Australia through fostering health and medical research since its inception in 1936. NHMRC-funded discoveries and advancements in health and medicine have helped to make our population healthier and reduce disease and suffering.

Scholarships valued at up to $10,000 per year for up to three years will be awarded as ‘top up’ scholarships to recipients of NHMRC scholarships who are members of the RACP. These scholarships will be awarded to Fellows and trainees at the discretion of the Research Advisory Committee following nomination of prospective recipients by the NHMRC.

The following scholarships will be awarded.

RACP NHMRC Awards for Excellence

RACP NHMRC CRB Blackburn Scholarship
Offered by the RACP in recognition of the contribution of Dr CRB Blackburn to the activities of the College

RACP NHMRC Kincaid-Smith Scholarship
Offered by the RACP in recognition of the contribution of Professor Priscilla Kincaid-Smith to the activities of the College

RACP NHMRC JJ Billings Scholarship
Offered by the RACP in recognition of the contribution of Dr JJ Billings to the activities of the College

RACP Fellows 21st Anniversary Recipients Scholarship
Funded in part by contributions received from past recipients of awards

RACP Jacquot NHMRC Awards for Excellence

In collaboration with the Australian and New Zealand Society of Nephrologists, the scheme has also been extended to include scholarships to be funded from the Jacquot bequest.

These scholarships will be awarded to Fellows and trainees in nephrology at the discretion of the Jacquot Selection Committee following nomination of prospective recipients by the NHMRC.

It is vital that Australia continues to invest in and support its young researchers, particularly to raise the profile of health medical research as a rewarding career path. Early investigator support is not well targeted, stipends are low, and any expansion of the PhD cohort requires career path options to be attractive.

This initiative of the RACP and NHMRC will hopefully be the first of a policy of collaboration and partnerships to assist and promote research.
LEADERS IN RESEARCH

Congratulations to the following Fellows who have been awarded grant funding under the NHMRC Centres of Research Excellence program!

**Professor Anne Chang**  
*Menzies School of Health Research*  
Centre of Research Excellence in Lung Health of Aboriginal and Torres Strait Islander Children

**Professor Geoffrey Lindeman**  
*Walter and Eliza Hall Institute of Medical Research*  
Centre of Research Excellence for Translational Breast Cancer Research: From Discovery to Better Health Outcomes

**Professor Michael Horowitz**  
*University of Adelaide*  
Centre of Research Excellence in Translating Nutritional Science to Good Health

**Professor David Whiteman**  
*Queensland Institute of Medical Research*  
Centre of Research Excellence for PROBE-NET: The Progression of Barrett's Esophagus to Cancer Network

**Professor David Cooper**  
*Monash University*  
Centre of Research Excellence for Patient Blood Management in Critical Illness and Trauma

**Professor Warwick Britton**  
*University of Sydney*  
Centre of Research Excellence for Tuberculosis Control: From Discovery to Public Health Practice and Policy

**Associate Professor Katrina Allen**  
*Murdoch Children’s Research Institute*  
Centre of Research Excellence in Paediatric Food Allergy and Food-Related Immune Disorders

The Centres of Research Excellence (CRE) scheme provides support for teams of researchers to pursue collaborative research and develop capacity in clinical population health and health services research. Of the 17 CREs funded in November 2012, 7 are led by RACP Fellows. This is an astounding figure and it is exciting to see so many College members leading the way in research.

POSTGRADUATE SCHOLARSHIPS OPPORTUNITY

The John Monash Scholarships (www.monashawards.org) are an outstanding opportunity for physicians or other medical professionals to undertake postgraduate study overseas. Eight to ten of the elite Scholarships, worth A$50,000 per year for up to three years, are awarded annually across Australia.

Over the last decade, 83 Scholarships have been awarded with around 25% in health, across clinical medicine, medical research, public health and global health. Examples include:

- Mark Dawson: PhD addressing leukaemia research at Cambridge
- Justin Moore: PhD in neurosurgery techniques at Oxford
- Sarah Meyer: PhD in public mental health, Johns Hopkins
- Rosie Dawkins: Masters in Public Health, Harvard

The Scholarships are open to all disciplines, and there is no age limit upon applicants. They can be taken up at any university outside Australia.

Selection is based upon academic excellence, leadership capabilities and expected contribution to Australia. Applications open in May and close at the end of August; two rounds of interviews culminate in announcement of the Scholars in November.

Contact information:
Website: www.monashawards.org  
Email: peter.binks@monashawards.org or carol.clark@monashawards.org  
Tel: +61 3 9620 2428 or +61 3 9621 1245

Dr Mark Dawson, RACP Fellow awarded a John Monash Scholarship to undertake a PhD at Cambridge
Sympathy for the IMG

Please allow me to introduce myself
I'm a man of drive and grit
I've been around for a long, long year ...*

And I'm the newly appointed International Medical Graduate to the College Trainees' Committee (CTC), a position recently introduced to try to better represent the growing segment of trainees who come to Australia having gained their primary medical degree overseas.

The process of moving your life halfway across the globe is daunting enough before one even navigates the challenges presented by the volumes of paperwork and, at times, tedious bureaucracy.

Once you've successfully secured a job offer and a sponsor, and committed to the decision to move your life thousands of miles (sorry, kilometres), there then comes an inordinate number of hoops to jump through by an ever increasing number of regulatory bodies. The Australian Medical Council, Australian Health Professional Regulatory Agency (AHPRA) and the Department of Immigration and Citizenship are all involved before you even set foot in the country. For some IMGs there will be additional College processes to complete: Recognition of Prior Learning or application for OTP assessment of comparability for those not yet fully trained and recognised as specialists.

Of course, each doctor heading to Australia comes with varying degrees of experience from countries with vastly differing systems of medical training, regulation and political conditions. The hurdles a doctor thus has to overcome during this process have to be comprehensive but can sometimes feel frustrating or irrelevant to the individual involved.

Everything seemed to be in place two weeks before I was due to leave behind life in the NHS in the UK and fly out to Australia. Our belongings (or rather, my children's toys and my wife's clothes, which I'm sure accounted for approximately 90% of our belongings) had been collected for shipping, flights were all sorted, accommodation arranged. The only thing we were waiting on was the rather important matter of my visa approval.

The Department of Immigration assured me they were just waiting to get approval from AHPRA and once they had received it my visa would be issued immediately. My application to AHPRA had been submitted about four months earlier and was still pending. Daily phone calls ensued until I was able to work out that the meeting where my application was being looked at was happening 10 days before our flight, but crucially that, yes, all the paperwork had been received and was in order. Surely, then, it would just be a formality?

Via email I was next informed:

'I'm writing to advise you that we are currently unable to process your application. You must be able to provide evidence of English language skills that meet the Board's English language skills standard. The requirement for exemption from sitting an English exam is that your secondary and tertiary education was undertaken in one of the approved countries. You have already provided evidence of your tertiary education in the United Kingdom (your medical degree), so to complete this requirement we ask that you submit some form of documentation confirming your secondary schooling. In this instance, a certified copy of your leaving certificate, or a letter from your school confirming your attendance, will satisfy the requirement.'

I grew up and went to school in England. Surely my moving to Australia wasn't going to be jeopardised by a requirement to prove that an Englishman spoke English?

After my ranting and raving, a hastily arranged phone call to one of my old teachers resulted in the final piece of required paperwork to confirm that my secondary education had indeed been completed in English. This was quickly dispatched and I thankfully got my visa approved with just a few days to spare.

When the role of IMG representative was
I’d also like to draw attention to the open vacancies that currently exist on the CTC. It seems illogical that there can be 80 expressions of interest for the IMG role and yet there are still no representatives on the CTC from the ACT or Tasmania. We really need trainees in these areas to step forward, represent your region’s trainees and improve your own personal and clinical leadership qualities in the process. We also have vacancies for representatives from amongst Aboriginal and Torres Islander trainees and the Faculty of Public Health.

So, make a difference. Contact us at traineescommittee@racp.edu.au with the issues that matter to you and get involved with your local trainee committee.

**Dr Jonathan Beavers**
IMG Representative, College Trainees’ Committee

* With thanks/apologies to Mick and Keith.

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**A comment on the IMG’s journey**

Jonathan Beavers’ comments emphasise two key points: the extraordinary challenges involved in international transfer of professional qualifications; and the opportunities which exist for Fellows and Trainee Members to participate in College affairs.

The process for recognition of international medical qualifications and registration as a medical practitioner for international medical graduates (IMGs) is undeniably challenging, but probably no more so than for comparable medical jurisdictions such as the UK, Canada or the United States. The situation in Australia changed significantly between early 2008 and mid 2010 with the introduction of the requirements of the National Registration and Accreditation Scheme.

Amongst many other changes, the scheme mandated a new program of requirements for anyone with international qualifications seeking registration as a medical practitioner: these included more rigorous verification of primary (i.e. medical school) qualifications, criminal record checks, the need to demonstrate recency of practice, and formal requirements for demonstration of English language proficiency regardless of whether an IMG was seeking general or specialist registration. Paradoxically, for those who had achieved full registration relatively recently in one of several jurisdictions, the road to general registration in Australia was made considerably easier with the so-called Competent Authority Pathway.

Australia is now almost unique in offering unilateral recognition in the form of initial limited registration to doctors who have been fully registered in the UK, Canada and the United States. This includes both domestic graduates as well as IMGs who have met requirements for registration in one or other of those jurisdictions. The pathway is also available to graduates of most Irish medical schools and to IMGs who have been granted general registration by the Medical Council of New Zealand. From his comments, I surmise that Jonathan has been registered through this pathway.

There are, of course, many internationally qualified medical practitioners from other countries not covered by this pathway. For these, achieving general registration in Australia requires that they have passed the formal written and clinical examinations offered by the Australian Medical Council. The Council has taken great pains to calibrate the examinations to the standard required of a graduating domestic Australian medical student, but recognises also that capacity for the clinical examination has been a major barrier to completion for many.

For internationally trained doctors seeking recognition as a specialist, the pathway has been refined and a round of consultations is currently underway to bed down changes to the process which have only become possible with the advent of a national medical registration program (rather than the individual State and Territory schemes in place prior to mid 2010). The Medical Board of Australia has assigned to each of the Specialist Medical Colleges the function of assessing internationally trained specialists in line with a series of common principles. It is important to recognise that the criteria governing specialist recognition (and particularly recognition as a consultant physician) are covered broadly by specific national legislation, something which is unlikely to lead to simple or easy processes.

There are, however, a large number of Fellows of the College who have undertaken this often arduous process and who have become key contributors to College committees and other aspects of College life. Their perspective and engagement is greatly appreciated.

**Professor Richard Doherty**
Dean, RACP
BRIDGING THE GAPS IN CHILD AND ADOLESCENT HEALTH

Hosted by the Paediatrics & Child Health Division (PCHD), the 27th International Congress of Pediatrics 2013 (ICP 2013) is a wonderful opportunity to meet the world’s most prominent paediatricians, public health practitioners and opinion leaders. For the first time, the ICP 2013 will be held in Australasia, at the Melbourne Convention and Exhibition Centre, 24–29 August 2013.

Each day of the Congress begins with clinically based, ‘meet the expert’ breakfast sessions followed by a plenary session. Parallel sessions follow, including research presentations and topics relating to child and adolescent health. Posters will be presented during lunch, after which a parallel seminar session will be followed by two keynote sessions. Industry-sponsored sessions will be held between 5 pm and 6.30 pm in the evenings.

We are fortunate to have secured the following eminent plenary and keynote speakers for ICP 2013:

- **Elizabeth Mason (USA):** *State of the World’s Children*  
  Director, Maternal, Newborn, Child and Adolescent Health, World Health Organization

- **Richard Horton (UK):** *Progress of the Millennium Goal*  
  Editor, Lancet; Hon. Professor, London School of Hygiene and Tropical Medicine; and President World Association of Medical Editors

- **George Patton (Australia):** *The State of the World’s Adolescents*  
  Professor of Adolescent Health Research, University of Melbourne

- **Russell Viner (UK):** *Social Determinants of Adolescent Health*  
  Professor of Adolescent Health, University College London

- **Zulfi Butta (Pakistan):** *Addressing the Global Challenges of Diarrhoea and Pneumonia*  
  Professor and Chair, Department of Paediatrics and Child Health, Aga Khan University, Pakistan; Member IPA Executive; Board Member, Global Partnership for Maternal, Newborn and Child Health; WHO Advisory Group for Vaccine Research

- **David Amor (Australia):** *Whole Genome Sequencing – the Future*  
  Clinical Geneticist and Honorary Paediatrician, Royal Children’s Hospital Melbourne

- **Mitsuaki Hosoya (Japan):** *Fukushima: Impacts on Child Health and Lessons for the Future*  
  Professor and Vice-Director, Fukushima University School of Medicine

- **Martin Pera (Australia):** *The Use of Stem Cells in Neurological Disorders*  
  Professor and Program Leader, Stem Cells Australia

- **Russell Wills (New Zealand):** *A Rights Approach to Child Health Advocacy and the Paediatrician*  
  Commissioner for Children, New Zealand

- **Gloria Krahn (USA):** *A Conceptual Framework for Disability*  
  Director, Division of Human Development and Disability, Centres for Disease Control and Prevention, Atlanta

- **James Gern (USA):** *Novel Rhinoviruses*  
  Professor, Department of Medicine, Division of Allergy and Immunology, University of South Florida, USA

- **Ed Mitchell (New Zealand):** *Preventing the Unpreventable: the Cot Death Story*  
  Professor of Child Health Research and Epidemiologist, University of Auckland; Howard Williams Medallist and Orator.

**HOW TO REGISTER FOR ICP 2013**

Register online now at the ICP 2013 website: www2.kenes.com/ipa/registration/Pages/Registration.aspx. Registration is very reasonable: until 14 August the cost is only $620 for the full five days! Do consider also sponsoring some of your junior staff’s attendance – just $340 for students, Fellows and nurses.

Professor Elizabeth Elliott  
Chair, ICP 2013 Scientific Program Committee
The Wellington City Chorus (with Dr Helen Moriarty at top right), competing at the Queenstown Regional Competitions in May 2013 prior to taking out the national championship and the honour of representing New Zealand in the 2014 International competition!

As an addiction medicine physician, most days I can be found at the University of Otago teaching medical students about addiction and important associated skills such as clinical reasoning and ethical and empathic communication; or I may be engrossed in writing up or conducting research into those fields; or else, as National Medical Officer of Health for Medicines Control at the Ministry of Health, I may be advising the Medicines Control team on cases of prescription medicine misuse or providing information and support to prescribers.

But some mornings you may find me down at the docks as the cruise ships come in.

I am a member of the Wellington City Chorus, one of three Sweet Adeline choruses in the wider Wellington region. The Sweet Adeline musical style is a cappella: four-part unaccompanied harmony. The emphasis is not only on musicality, pitch and fine tuning but also on showmanship and choreography. To my mind, all of this is a very good match with Medicine for a number of reasons: both a capella and Medicine hone listening skills to be highly attuned to others; both demand discipline, teamwork and collaboration; and both encourage self-reflection and self-directed learning.

Choral singing generates a lot of happiness in the singers as a group, as well as in the listeners. There is a great camaraderie in the all-female group of singers of all ages, each celebrating personal achievements as they struggle with the choreographed dance steps or with tricky musical intervals characteristic of a-capella harmony. Fundraising for coaching, costumes, music and travel also sees the chorus members engaged in a variety of fun activities ranging from triathlon marshalling to movie nights and paid singing engagements.

A medical colleague recently spotted me in a group of buskers at the Waitangi Park Sunday markets, but it’s the cruise ship engagements that are the major annual fundraising activity for the chorus. The Port of Wellington has a schedule of 91 cruise-ship visits for the 2012/13 cruising season. Small groups of chorus singers are shuttled through port security each morning to entertain the passengers for an hour as they disembark for sightseeing in the Capital. Cruise-ship passengers make a very appreciative audience: many sidle up alongside for a photograph and some sing along, dance or demonstrate how not to conduct. The hour at the docks in the morning is good training for the group in developing stamina as well as performance and vocal projection. Sweet Adelines sing without voice amplification and are energetic – we don’t stand still when singing – and the Wellington City Chorus sings a wide repertoire. While some songs are Sweet Adeline competition pieces with highly drilled choreography and spectacular showmanship, there is also a selection of classical and modern crowd-pleasers.

Sweet Adeline competitions are an important part of chorus membership expectations. At
AFTER HOURS

The Sunraysia/Mildura District in the N-W Victoria support a local population of 45,000-60,000 people. We have Mildura Base Hospital and Mildura Private Hospital as the key Inpatient facilities centres, and approximately 40-50 General Practitioner’s locally.

Radiology services which include x 3 CT Scanner and x 2 MRI Scanner, Nuclear Medicine. Local resident Surgical, Anaesthetic, Paediatric, O & G back-up.

Air retrieval to both Melbourne and Adelaide. Our General Medical/Oncologist and Haematological craft groups require a boost in Resident F.R.A.C.P. level personal.

Please direct enquiries to:-

Dr. Terry Cook
(W) 03 5023 5428 | (P) 03 5021 4802
(M) 0408 502 075 | Email: ti.cook@bigpond.com

During my time with the Sweet Adelines, I have competed at International competitions in Las Vegas, Hawaii, Denver, Colorado and Calgary (Canada). My medal haul (pictured) includes a ninth International chorus placing from the Calgary competition as well as regional championship medals.

Perth Harmony from WA will also be heading to Baltimore in 2014 to represent the Australian Sweet Adeline chapter, and despite the usual cross-Tasman comradeship we will expect to face stiff competition from our Australian counterparts!

Dr Helen Moriarty

CLASSIFIEDS

GENERAL PHYSICIAN/MEDICAL ONCOLOGIST/HAEMATOLOGIST

POSITION

The Sunraysia/Mildura District in the N-W Victoria support a local population of 45,000-60,000 people. We have Mildura Base Hospital and Mildura Private Hospital as the key Inpatient facilities centres and approximately 40-50 General Practitioner’s locally.

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Please direct enquiries to:-

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(M) 0408 502 075 | Email: ti.cook@bigpond.com

Private Practice Opportunity
Physicians* required
for Nowra Private Hospital,
NSW South Coast

There exists a significant opportunity for a Physician* to permanently relocate to the region & to establish a fully supported private practice in partnership with Nowra Private Hospital.

Benefits:
- A guaranteed minimum income of $300,000* pro-rata for the first 12 months whilst you build your private practice;
- Assistance with consulting rooms & practice management for a 12 month period;
- Relocation assistance to the value of $6,000;
- Accommodation assistance to the value of $6,000;
- Assistance with marketing your practice to GPs & other Specialists to establish your referral base;
- Teaching opportunities with the Rural Medical School, The University of Wollongong, Shoalhaven Campus.

To find out more, please contact:
Nowra Private Hospital: Kate Jerome, CEO on (02) 4421 5455; m: 0412 437 397 or email: Jeromek@ramsayhealth.com.au

*Must have FRACP & Specialist registration with AMHRA

www.ramsytdocs.com.au

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People caring for people
2014 Victorian Palliative Medicine Training Program (VPMTP)

Training Program 2014 Adult and Paediatric Palliative Medicine

Applications are invited from medical practitioners interested in training or gaining experience in palliative medicine.

Positions are suitable for doctors:

i. undertaking advanced training in palliative medicine with the Royal Australasian College of Physicians (RACP)
ii. undertaking training towards chapter fellowship with the Royal Australasian College of Physicians (FAChPM), or
iii. wishing to gain experience in palliative medicine as part of training in another specialty such as Medical Oncology, Radiation Oncology, Geriatrics, or General Practice.

iv. wishing to gain experience in Paediatric Palliative Medicine. There are 2 positions available and these are open to trainees in adult Palliative Medicine as well as trainees in Paediatric Palliative Medicine.

Some positions are also suitable for doctors wishing to undertake the 6 month Clinical Diploma of Palliative Medicine. Several Fellows positions will be available in 2014.

The VPMTP’s role is to coordinate and facilitate the process in both metropolitan and regional Victoria and across all facets of Palliative Medicine including: inpatient (hospice) units, community palliative care services and hospital palliative care consult services. It is expected that appointments will be for 6 or 12 months. There is a centralised education program as well as a mentoring program available to all trainees.

Participating institutions are:

- Austin Health
- Ballarat Health Services
- Barwon Health
- Bendigo Health
- Cabrini Health
- Calvary Health Care Bethlehem
- Eastern Health
- Northern Health
- Royal Children’s Hospital
- Royal Melbourne Hospital
- Werribee Mercy Hospital
- Peter MacCallum Cancer Centre
- Southern Health
- Peninsula Health
- St. Vincent’s Hospital
- Peninsula Health
- St. Vincent’s Hospital

Dr Juli Moran  juli.moran@austin.org.au
Dr Joe Ibrahim  josephi@bhs.org.au
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pallcare@southernhealth.org.au
Dr Brian McDonald  bmcdonald@phcn.vic.gov.au
mark.boughey@svhm.org.au

Details of the individual rotations and contact details for the directors are available from the web site below.

General enquiries should be made to: Medical Coordinator VPMTP
Tel: 9854 1644 Email: vpmtp@svhm.org.au

Formal applications via www.centreforpallcare.org **click on the VPMTP button**

Applications open June 1st 2013.
Applications close August 16th 2013

Interviews for new applicants will be conducted in the week commencing August 26th 2013.

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Topics covered include:
- Stroke
- Brain Tumours
- Disaster Management
- SCI
- Trauma Rehabilitation
- Prosthetics and Orthotics (P&O)
- Activity Based Rehabilitation
- Sprains, Strain & Pain

Keynote Speakers
Professor Leeanne Carey, Stroke Division, Florey Institute of Neuroscience and Mental Health, Melbourne
Dr Michael Dillon, National Centre for P&O, La Trobe University, Melbourne
Professor Sarah Dunlop, National Health & Medical Research Council, University of Western Australia, Perth
Dr James Gosney, WHO Liaison Subcommittee on Rehabilitation Disaster Relief of the ISPRM, Switzerland
Dr Harmen van der Linde, Department of Rehabilitation at Radboud University Medical Centre, the Netherlands
Professor Michael Nilsson, Hunter Medical Research Institute, Newcastle
A/ Professor Charlie Teo AM, Centre for Minimally Invasive Neurosurgery, Prince of Wales Hospital, Sydney

For further information:
DC Conferences – 02 9954 4400
Email: afrm2013@dcconferences.com.au
Twitter: @afrm2013

Geriatrician and Senior Lecturer/Associate Professor in Medicine

DEPARTMENT OF MEDICINE
(Health Care of the Elderly)
and CANTERBURY DISTRICT HEALTH BOARD (CDHB)

As you may be aware we are in a pretty unique position here in Canterbury but everything is now focused on the future. Not only could you be part of the evolution of a new city that will embrace community life and contemporary architecture, but you will play an intricate part in shaping and developing our future health system.

The Department of Medicine, University of Otago, Christchurch, in association with the Canterbury District Health Board seeks applicants interested in a Senior Lecturer/Associate Professor position specialising in clinical Older Person's Health. This position involves undertaking research activities, convening and teaching into the undergraduate medical student Medicine programme, and postgraduate programme, undertaking service activities for the University, as well as providing service commitments as a Clinical Geriatrician.

The University Department of Medicine has a major teaching role in the undergraduate medical course, and many active research groups. The appointee should have a capacity for top quality research, with the ability to attract funding, and enjoy and excel in teaching undergraduates and the oversight of undergraduate and postgraduate programmes.

Applicants must also meet vocational registration as a specialist geriatrician in order to be able to practise within the clinical Older Person’s Health Specialist Service of the Canterbury District Health Board. This expanding service, which will move into purpose built and expanded facilities over the next 2 to 3 years, is one of the largest in New Zealand and is internationally regarded for its wide range of services including inpatient geriatric assessment, treatment and rehabilitation wards, orthogeriatric rehabilitation, stroke rehabilitation, and psychiatric services for older people.

Applications quoting reference number 1300732 will close on Sunday, 30 June 2013.

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www.otago.ac.nz/jobs

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ALBURY WODONGA

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

MEDITATION

2014–15
HARKNESS FELLOWSHIPS in Health Care Policy and Practice

Call for Applications

The Commonwealth Fund invites applications from mid-career professionals (e.g. academic researchers, government policymakers, clinicians, managers, and journalists from Australia, Canada, Germany, the Netherlands, New Zealand, Norway, Sweden, and the U.K.) Harkness Fellows spend up to 12 months in the U.S. working with leading experts to conduct a research study that addresses a critical issue on the health policy agenda in both the U.S. and their home country. The Fellowship awards up to U.S. $119,000 which covers roundtrip travel to the U.S., a living allowance and project-related funds. For more details about the Fellowship program, application process, and suggested project themes, please visit the Fund’s website at www.commonwealthfund.org/fellowships.

Deadline for applications from Canada, Germany, the Netherlands, Norway, and Sweden: November 18, 2013.

The Commonwealth Fund aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society’s most vulnerable.

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RACP NEWS / JUNE 2013 47
Is your equipment finance as complex as a triple bypass?

It’s time for a second opinion

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