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That Luang Festival, Vientiane, Laos, during which monks from all over the country gather in their thousands and the faithful come to give offerings and receive benediction.

Photograph by Dr Amy Gray FRACP, who is currently working with the Lao paediatric training program.

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The first meeting of the new Board of the College was held in late July. Adjacent to the meeting of the Board were two other activities of considerable importance. The first was a Strategic Planning Day which had as its objective to chart the strategic direction of the College over the next two years and to determine how the College can best position itself to develop and meet the challenges it will face. The result was an updating and refinement of the Statement of Strategic Intent (SoSI) developed in 2009; it was gratifying to reflect on the developments and positive changes which have occurred over the past year.

The major goals for the RACP for 2011–2012 are to:

- align College governance with the strategic directions
- develop a robust model to assure physician competence
- improve engagement of Fellows
- influence health reform and engage with stakeholders
- ensure that the RACP has capable and committed staff.

The SoSI will form the basis of the College’s Annual Business Planning for 2011 and 2012. Further details of the SoSI, including the specific strategies to be implemented, can be found on the College website at <www.racp.edu.au/page/education-policies>. It is anticipated that this will form the basis of a similar process to support the Physician in Difficulty.

The College has entered into an agreement with the Department of Health and Ageing to administer the Specialist Training Program (STP) which is a merger of several former programs. With the anticipated future increase in the number of trainees, the provision of training in ‘non-traditional’ settings and circumstances will become increasingly important. By assuming administration of this program, the College is well positioned to ensure that RACP trainees have access to training under such a scheme. For more information on the Specialist Training Program, see pages 19 and 20.

One of the goals of the SoSI is to ‘improve engagement of Fellows’. A major part of the strategy to realise this goal will involve the development of a value proposition for Fellows based on a segmentation study to obtain more detailed information and understanding of Fellows’ expectations. However, it is hoped that even over the next few months you will become aware of a number of developments aimed at demonstrating the value of College Fellows.

The foregoing merely serves to underline how much is taking place in the College at the present time. I hope that, like me, you find this exciting and reassuring. I strongly encourage you to become involved at any level and in any role in the College. While I am aware that you have many other pressures on your valuable time, I am sure that you would find your commitment to the College rewarding—and greatly valued.
THE NEW WORLD OF NATIONAL REGISTRATION AND ACCREDITATION AND HEALTH WORKFORCE REFORM

The objectives of the National Law are to:

- provide for the protection of the public
- facilitate workforce mobility across Australia
- facilitate the provision of high-quality education and training of health practitioners
- facilitate the rigorous and responsive assessment of overseas trained health practitioners
- facilitate access to services provided by health practitioners in accordance with the public interest
- enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

The structure of the new scheme comprises:

1. The Ministerial Council, the oversighting authority which provides policy direction, approves registration standards and appoints the accreditation authorities, amongst other things.
2. The Australian Health Workforce Advisory Council, which will give independent advice to the Ministerial Council on any matter relating to NRAS. Health Workforce Australia (HWA) is the body that will be supporting this Council.
3. The National Boards, which have a range of functions, including the registration of practitioners, the development of registration standards for approval by the Ministerial Council, the approval of accreditation standards developed by the accreditation authorities, the approval of accredited programs of study, determining the suitability of overseas trained applicants for registration, dealing with matters concerning the performance or conduct of individual practitioners, advising the Ministerial Council on the recognition of specialties, and maintaining general and specialist registers.
4. The Australian Health Practitioners Regulation Agency (AHPRA), which is the body that will support the National Boards, together with their state and territory offshoots.
5. The Accreditation Authorities, appointed by the Ministerial Council on the advice of the National Boards, which will be responsible for developing accreditation standards for approval by the Boards. The Accreditation Authorities will accredit programs of study together with the education bodies which provide these programs. The National Boards have the final say on whether to approve individual accreditation decisions. The Australian Medical Council (AMC) continues as the Accreditation Authority for Medicine for at least the next three years.

It is evident from the provisions of the National Law and the NRAS structure that there is an increased measure of government control of health practitioner training and a consequent loss of professional autonomy. A nice example of this is the provision that allows the Ministerial Council to give a National Board a ‘direction’ on a proposed accreditation standard, or change to an existing standard, if the Council believes that there will result ‘a substantive and negative impact on the recruitment or supply of health practitioners’ (the Council does first have to consider whether their ‘direction’ will adversely affect the quality and safety of care). Thus the Ministerial Council could reject a standard developed by the AMC and approved by the Medical Board of Australia (MBA), on workforce grounds.

The focus on health workforce should come as no surprise, given the well-publicised difficulties that some jurisdictions have had in maintaining services, and Australia’s reliance on overseas practitioners. This, in the past, has led some jurisdictions to accept the recruitment of doctors, such as Dr Patel, who had not been through the AMC and College vetting and assessment processes. This should no longer be possible under the National Law, so in that sense, patient safety should be greatly improved.

The provision in the National Law that speaks of ‘a flexible, responsive and sustainable workforce’ and ‘innovation in the education of, and service delivery by, health practitioners’, together with the work program of HWA directed toward ‘health workforce innovation and reform’, tell us that government believes that the training of health professionals, and the way they deliver services, must change.

Competence, and hence performance, go beyond competencies. The tacit knowledge which directs higher order reflection and reasoning is a critical ingredient.
One example of change that is looming is the considerable interest in ‘competency-based training’, i.e. training directed toward acquiring a set of discrete, narrowly defined practical skills or elements of knowledge. These, when eventually acquired, will define the individual as proficient or competent. This approach to training, which has been applied to the Vocational Education and Training (VET) sector, is seen as allowing greater flexibility in the health workforce—‘competencies’ can be transferred from one craft group to another; new professional groups can emerge (e.g. nurse practitioners, physician assistants); and tasks can be substituted amongst different professional groups. Furthermore, training time could be reduced—the acquiring of competencies would obviate the need to serve out a designated training time. The problem of too few doctors might thus be ameliorated.

RACP Fellows are required to meet the standards for CPD set by the College, and they will be asked to declare that they have met those standards on renewal of their registration each year.

The AMC has recently released a discussion paper, ‘Competence-based Medical Education’. It argues that the complex role of the doctor requires the acquisition of both ‘codified’ and ‘tacit’ knowledge. There are explicit elements of knowledge and skills which can be codified and which allow various competencies to be precisely defined. But overall competence needs, in addition, tacit knowledge, which is the understanding that is the basis of judgement and the ability to deal with complexity and uncertainty, and which comes with experience. Tacit knowledge is not readily measurable or transferable and there is a time element in its acquisition. Competence, and hence performance, go beyond competencies. The tacit knowledge which directs higher order reflection and reasoning is a critical ingredient. A good physician is more than the sum of a set of discrete psychomotor skills and acquired facts. The AMC framework for competence-based education thus remains a broad one and not a list of narrowly defined, detailed individual elements of skill or knowledge.

It is not yet clear how government will want medical education to change, or how the tasks traditionally the responsibility of doctors might be transferred to other professional groups. While certain competencies might reasonably and usefully be shared between craft groups, if task substitution gathers momentum it will be important to ensure that the existing standards of medical care are not diminished.

In addition to its workforce reform role, HWA is charged with workforce planning, research and policy, developing a coordinated program for recruitment and retention of international medical graduates and, most importantly, with enhancing the capacity and quality of clinical training. Simulation is to be further developed as a training tool, there will be a major clinical supervisors support program, and substantial resources are being made available to create new settings for clinical training (e.g. in the private sector). The work of HWA will be of fundamental importance to the Medical Colleges. AMC hopes to work closely with HWA, but it is also imperative for the Colleges to understand and help inform the changes that are in prospect.

National registration has evident benefits. Doctors will be able to work in any state or territory without having to register multiple times; registration standards will be uniform across the country; and a repeat of the Patel affair becomes much less likely. There is now a national specialist register and a national list of specialties that the MBA has constructed, together with ‘fields of specialty practice’ and specialist titles. Our specialty is ‘Physician’; fields of specialty practice under ‘Physician’ comprise the craft groups we commonly think of as medical specialties, for example, cardiology, general medicine, neurology, etc., and the corresponding specialist titles are specialist cardiologist, specialist general physician, specialist neurologist and so forth.

There are a number of new registration standards being promulgated by the MBA which College Fellows should be familiar with. Of particular relevance is the Continuing Professional Development (CPD) Standard which applies to all registrants except those who are non-practising. RACP Fellows are required to meet the standards for CPD set by the College, and they will be asked to declare that they have met those standards on renewal of their registration each year.

It is crucial that the RACP and other Medical Colleges understand the nature and extent of any mooted changes, and work to ensure that such changes are informed by professional experience and expertise.

The MBA has subsidiary Boards in each state and territory which, it appears, will function much as the individual State and Territory Boards did before 1 July, using powers delegated to them by the MBA. Thus the regulatory structure which dealt with notifications concerning doctors’ performance or conduct before 1 July is, in effect, still there, to ensure ‘an effective and timely’ local response. The NRAS framework, with the new national bodies and their regional subsidiaries, is therefore likely to come at increased cost. Given that the ongoing activities under NRAS will be required by government to be self-funding, the increased cost of regulation will likely be reflected in higher registration fees.

The changes that will be happening to the health workforce are likely to be substantial. Practitioners’ education and training, the scope of their practice and the regulatory framework under which they practise are all in the mix for reform. It is crucial that the RACP and other Medical Colleges understand the nature and extent of any mooted changes, and work to ensure that such changes are informed by professional experience and expertise. That will do much to protect the high standard of medical care that all doctors aspire to.

Professor Richard Smallwood
AO FRCP FRACP
President, Australian Medical Council

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THE CARTWRIGHT LEGACY: SHIFTING THE FOCUS OF ATTENTION FROM THE DOCTOR TO THE PATIENT

In her 1988 Report of the Cervical Cancer Inquiry, Judge Silvia Cartwright noted that ‘old habits and attitudes’ had provided a sense of security for the medical professionals and administrators ‘buffeted by the cold winds’ of the Inquiry.1 Her far-reaching recommendations sought to change the regulatory landscape for patient care and research. They were a full-frontal challenge to the medical establishment, and to the model of professional autonomy and self-regulation that held sway in New Zealand. The judge said that ‘[t]he focus of attention must shift from the doctor to the patient’2, and made detailed recommendations to effect fundamental change.

All too often, the recommendations of major inquiries garner brief media attention, before gathering dust and being quietly shelved by officials.3 Inaction may be well advised; lawyers undertaking a one-off inquiry, unfamiliar with the subject matter of the inquiry, may make recommendations that are ill-conceived or impractical. And even recommendations that ‘hit the mark’ may still be ignored. Once the inquiry body is functus officio, and the media spotlight shifts to other issues, inertia, discrete lobbying from vested interest groups and a lack of political nerve will often lead to cosmetic change but no significant reform.

Yet from the vantage point of over two decades later, it is clear that the Cartwright Inquiry resulted in major and enduring changes to the legal and health systems in New Zealand. Why did this Inquiry lead to such a seismic shift in the relationship between doctors and patients, and the medical profession and the community? What is Cartwright’s legacy in the early 21st century?

**Changing times**

In the 1970s and 1980s, feminism, women’s health activism and a broad range of social movements were challenging traditional norms and changing the fabric of New Zealand society.4 This was fertile ground for the Cartwright Inquiry. As Joanna Manning notes, ‘public attitudes to the medical profession were undergoing a transformation’, and the Inquiry and Report ‘both reflected and accelerated these evolving attitudes’.5

The teaching and practice of medicine was slow to react to societal changes, and the New Zealand legal system in the late 1980s provided no incentive for reform. Patients’ rights (in particular the right to make an informed choice about medical treatment) were slow to develop in New Zealand, in part due to the constraints of accident compensation legislation.

Doctors (and other health professionals) were the beneficiaries of a system that looked to the state to compensate injured patients, and effectively barred claims for medical negligence.

The combined effect of social change and underdeveloped legal protections for patients in New Zealand meant that the time was ripe for reform.

**Shocking revelations**

But timing alone does not explain the impact of the Cartwright recommendations. The shocking revelations during the Inquiry had a profound impact on the New Zealand public, and made reform inevitable. As Silvia Cartwright has noted, “[t]his was a drama unfolding in the nation’s living rooms.”6 David Skegg recalls that ‘public attention was riveted by what seemed like the daily revelations from the hearings’.7

Helen Clark, who became Minister of Health six months after release of the Report, described the revelations as ‘truly shocking’.8 It was shocking (and, despite recent attempts to rewrite history, remains so) that so many women received inadequate treatment for cervical carcinoma in situ at New Zealand’s leading obstetrics and gynaecology hospital, and that some suffered needlessly and died; that patients and their families were kept in the dark; that medical colleagues failed to act; that the system for ethical approval and monitoring of research was woeful; and that abhorrent practices, including students practising the insertion of intra-uterine devices on anaesthetised women without their consent, and the taking of vaginal smears from babies without parental consent, were tolerated.

‘Adverse events’ are often accepted as a byproduct of a complex healthcare system, and the public becomes inured to news of avoidable harm to patients. Sometimes it takes a major scandal to ignite public outrage, compel government action and defuse professional resistance. Richard Smith wrote of the inquiry into deaths from paediatric cardiac surgery at Royal Bristol Infirmary that ‘All changed, changed utterly’ (quoting Yeats).9 The same was true of New Zealand post-Cartwright.

**Putting the patient first**

One other factor was critical. Judge Cartwright modelled, both in the Inquiry process and in her recommendations, an approach that put the patient first. In Chapter 7 of the Report, ‘Ethics and Patient Rights’, she quoted extensively from the testimony of the women, criticising the prevailing views of doctors and administrators at National Women’s Hospital, and contrasted the weaknesses of the ethical and legal framework for patient care and research in New Zealand with developments overseas.

The judge made a compelling case for patients to be treated with dignity, to receive all relevant information about their condition and treatment options, and to be fully protected as research participants. Her wide-ranging recommendations targeted both the individual patient–doctor relationship and the legal and health systems more generally.

Decades before the language of ‘patient-centred care’ and ‘consumer perspective’ became fashionable, Silvia Cartwright saw the need to make consumer voice central to the monitoring of healthcare delivery, via elected representatives to hospital boards, independent advocates and an independent Health Commissioner; to enshrine patients’ rights in legislation; to have much

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1. The Cancer Inquiry
2. The focus of attention must shift from the doctor to the patient
3. The combined effect of social change and underdeveloped legal protections for patients in New Zealand meant that the time was ripe for reform.
4. The teaching and practice of medicine was slow to react to societal changes, and the New Zealand legal system in the late 1980s provided no incentive for reform.
5. Doctors (and other health professionals) were the beneficiaries of a system that looked to the state to compensate injured patients, and effectively barred claims for medical negligence.
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9. The judge made a compelling case for patients to be treated with dignity, to receive all relevant information about their condition and treatment options, and to be fully protected as research participants.
greater lay involvement in a rigorous system of ethical review of proposed research; and to make the needs of patients pivotal to medical education and to the complaints and disciplinary process.

**Cartwright’s legacy**

The path to implementation of the Cartwright recommendations was not smooth. Despite the ‘public climate of expectation of change’ and vigilance by the women’s health movement, five years after the Report release there was still much ‘unfinished business’ (as described by Sandra Coney and colleagues in their 1993 book of that title). But significant reforms did follow and have proved enduring.

The system for ethical review of clinical research and innovative treatments is now subject to a rigorous approval process, with independent regional ethics committees (with a lay chairperson and 50% lay membership) operating in accordance with a national Operational Standard, and using guidelines developed by a statutory National Ethics Advisory Committee. Mechanisms for monitoring compliance with ethical approval remain problematic, but Jan Crosthwaite concludes that ‘New Zealand now has good regulatory protections in place, although we should not think we are immune to the possibility of rogue researchers’.

The Code of Health and Disability Services Consumers’ Rights, enacted in 1996, gives patients legally enforceable rights, far surpassing the puffery of non-binding charters adopted in many other countries. The rights closely mirror the template proposed by Judge Cartwright, including rights to be treated with respect, to effective communication and adequate information, to make an informed decision, to receive care of an appropriate standard, and to make a formal complaint to an independent advocate or Commissioner. The Code has become ubiquitous, visible on the walls of hospitals and health clinics and, more importantly, familiar to health professionals and the public (with surveys showing much greater awareness of patients’ rights).

Most importantly, there has been an attitudinal shift within the medical profession. Communication skills, professionalism and ethical reflection are now taught alongside clinical skills in the undergraduate medical curriculum. Informed consent, ridiculed by members of the profession in the immediate aftermath of the Inquiry, is now accepted as essential to securing the trust of patients and improving the outcomes of care. The focus has shifted to how to provide information in a way that meets the needs of patients, and has extended from the context of pre-surgery to the whole continuum of healthcare and disability service provision, including in the aftermath of an adverse event (‘open disclosure’). Ensuring that patients are treated with dignity and compassion within an increasingly complex health system remains a challenge, with debate about how best to achieve this, but no one contests the need to do so.

The complaints and disciplinary system in 2010 is transformed from the unwieldy and health professional-dominated system of the past. A nationwide network of independent advocates is contracted by a statutory Director of Advocacy, and is highly effective in resolving consumer complaints in local communities.

The Health and Disability Commissioner (HDC) complaints system enables independent resolution of complaints, with a minority leading to published investigation reports in which substandard hospitals and rest homes are identified. The reports are generally welcomed by professional groups and used for education, providing guidance on complex issues such as follow-up of patient test results and coordination of primary and secondary care. The Commissioner has become a highly visible ‘patient watchdog’, commenting on problems in the health system.

A combination of much greater appreciation of the role of systems in patient safety, together with the rehabilitative approach fostered by HDC and the Medical Council (using tools such as competence reviews, under the Health Practitioners Competence Assurance Act 2003) has resulted in far fewer cases leading to disciplinary hearings before the Health Practitioners Disciplinary Tribunal (a multidisciplinary body entirely separate from the individual registration authorities). Clinical negligence cases seldom result in discipline; charges of unethical behaviour, such as sexual or financial exploitation of patients, and improper prescribing, predominate.

Implementation of the national cervical cancer screening program recommended by Judge Cartwright was particularly vexed, with flaws exposed in the Gisborne Cervical Cancer Screening Inquiry in 2001, but the current scheme has been described by David Skegg as ‘a triumph of preventive medicine’. The program is estimated to be preventing at least 70% of the cases of cervical cancer that would otherwise be occurring in New Zealand, saving the lives of more than 100 women every year.

**A complex story**

The lessons to be learned from the Cartwright Inquiry remain contested territory. Yet even the revisionists, while seeking to downplay the significance of the Inquiry, hesitate to criticise the reforms described above. In retrospect, they can be seen to be timely and necessary.

It is, however, too simplistic to view the Inquiry as a triumph of external regulation over internal morality. As Charlotte Paul has described, the Cartwright story is more nuanced and complex, and over-reliance on the ‘blunt instruments’ of external controls can undermine trust and be counterproductive to a ‘functioning internal morality’.

The role of the doctors who attempted to raise concerns with National Women’s Hospital (notably Bill McIndoe, Jock McLean and Ron Jones), and of the professional leaders who sought to make the reforms workable for patients and doctors (including Robin Ewart as chair of the Medical Council in the 1990s), needs to be acknowledged. Sandra Coney applauds the ‘quiet but monumental shift in the attitudes’ of doctors, who ‘on the whole … grasped the nettle and changed their practice’.

Challenges remain. Despite all the rhetoric about putting patients first, the current emphasis is on clinical leadership. There is still a need to strengthen consumer voice at all levels in the health system. It is remarkable that the new (albeit interim) Health Quality and Safety Commission has no consumer member. There is also a sense of complacency about the current framework for ensuring health practitioner competence, and lay involvement in registration authorities has fallen well behind regulatory reforms in some other countries (notably the United Kingdom).

Finding effective ways to raise concerns within the health system is a particular concern. Too often, health professionals who attempt to do so lack institutional support and are met by denial and resistance. Even external inquiry bodies
learn to expect re-litigation of findings by interested parties, denigration by critics, and revisionism by subsequent commentators who did not hear all the evidence and sometimes seem wilfully blind to it.

Much has been achieved, and the focus has largely shifted from doctor to patient, but Silvia Cartwright’s words of warning bear repeating:¹

... [A]dministrators and health professionals need to listen to their patients, communicate with them, protect them, offer them the best health care within their resources, and bravely confront colleagues if standards slip. If this does not happen, then the kind of events disclosed during this Inquiry may well happen again.

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University of Auckland
RACP Board Member


References

NSW GOVERNMENT ENDS TRIAL STATUS OF THE SYDNEY MEDICALLY SUPERVISED INJECTING CENTRE (MSIC)

The NSW Premier, Ms Kristina Keneally, announced on 15 September 2010 that the NSW Government would soon legislate to end the trial status of the Sydney MSIC. She said that the centre ‘had made a positive difference to people’s lives’. While noting that ‘in an ideal world, the need for such a facility wouldn’t exist’, Keneally said, ‘the reality is different and the centre has provided help to people who are most at risk—particularly from overdose death, disease and street violence’ while also reducing ‘the incidence of public injecting’.

The Kings Cross Police Commander, Superintendent Tony Crandell, said that ‘while drug prohibition is not working, the centre has had a dramatic impact on drug deaths’.

More than nine years of service and ten independent and robust evaluations have established the substantial benefits and cost-effectiveness, as well as lack of significant negative consequences, of the Sydney MSIC. The number of ambulance call-outs for drug overdose death in the area had declined by 80%, a much larger reduction than seen elsewhere in Sydney. Of all drug overdose deaths in Australia, 10% occur within 10 sq km of Kings Cross. The facility handled about 3500 drug overdoses without recording a fatality and now oversees about 200 injections a day.

A recent survey found that 78% of local residents supported the centre. Ms Keneally said the centre had helped more than 12,000 drug users and distributed more than 300,000 clean needles and syringes. She said, ‘it has saved lives, it has reduced disease risk, it has reduced the incidence of public injecting, and quite frankly, it has brought people who live on the margins, who live on the edge, into contact with health services and drug treatment services’.

The decision by the NSW Government represents a triumph of evidence-based policy making and was strongly supported by the RACP. The Foundation Director, Dr Ingrid van Beek AM, and the current Director, Dr Marianne Jauncey, are both Fellows of the Chapter of Addiction Medicine.

The 1997 NSW Wood Royal Commission concluded ‘it is fanciful to think that drug addicts can be prevented from obtaining and using prohibited drugs’ and recommended a parliamentary inquiry into an official injecting centre. The inquiry found strong arguments for a medically supervised injecting centre but the majority voted against. A community group then established as an act of civil disobedience an illegal medically supervised injecting centre the ‘Tolerance Room’ in the basement of a Kings Cross church. This resulted in the question of establishing an injecting centre being considered by the NSW 1999 Drug Summit.

The MSIC attracts a particularly disadvantaged subset of injecting drug users. Many attend no other health facility. Homelessness, poverty, and limited education and employment are very common. Nearly 10% are from indigenous backgrounds. Less than 30% have completed their schooling.

There are now 90 such centres around the world.
Project background
The Royal Australasian College of Physicians is aiming to assist its members to deliver high quality services by developing a framework that can be used to guide and support their professionalism throughout their career. The framework will also support physicians in their endeavours to engage with their healthcare organisations and will assist in identifying underperformance and supporting return to high performance.

The framework aims to assist physicians:
• to understand their clinical practice
• to understand other practice elements (including teaching, research and management)
• in their efforts to demonstrate their professionalism to their patients, organisations and colleagues
• value add to their CPD processes
• engage at organisational and system levels
• as a prompt for enquiry and learning

What the framework is not
• A set of rules … ‘you must’
• A ‘how to’ do clinical practice
• A set of standards
• A rigid, externally imposed requirement

Next steps
• Planning is underway for broad stakeholder engagement
• Consultant engaged to develop a framework and assist with implementation plan
• Engagement with RACS, CPMC and other external agencies who have undertaken work in this area or who are interested in these initiatives

“Patients accessing healthcare have an expectation that their treating doctor’s performance is at or above a minimum standard”
Queensland Health Safe Doctors Fair System, February 2007

“SPPP IS ABOUT THE COLLEGE SUPPORTING ITS MEMBERS
There is a need to ensure performance support does not solely focus on competence to the detriment of assisting the majority of medical professionals to maintain and further develop their high standards of practice”
RACP Literature Review, Supporting Physicians’ Professionalism and Performance

www.racp.edu.au/page/sppp
The College promotes positive health outcomes through ‘establishing the highest standards of contemporary knowledge and skill in the practice of medicine’. The Supporting Physicians’ Professionalism and Performance (SPPP) project aims to provide a framework for Fellows to identify and exceed those standards through understanding their clinical practice, demonstrating professionalism to patients, colleagues and organisations, and will encourage engagement at organisational and system levels. The framework will support Fellows in their day-to-day work across the range of roles that they undertake, including clinical practice, management, research, teaching, policy and advocacy.

**Literature review**

In July 2010, the SPPP Executive Group appointed Dr Kelly Shaw (FAFPHM) to undertake a literature review to identify relevant published and grey literature, as well as relevant materials and clinical and non-clinical based performance frameworks that have been developed nationally and internationally, in the health sector and beyond. This literature review will assist with informing the development of the performance framework. A full copy of the literature review will be available on our website <www.racp.edu.au/page/sppp> within the next few weeks.

Some of the key findings of the review have been:

- Performance frameworks describe domains of professional practice and their interaction (e.g. CanMEDS).
- Performance frameworks may be embedded within performance support and development systems in order to increase their effectiveness.
- Most Australasian Medical Colleges with performance frameworks embed them within existing CPD processes.
- Effective performance processes incorporate the results of performance assessment into feedback that is positive, focuses on the strengths of the individual and assists the individual to identify future learning needs. It is a forward-looking process.
- Performance standards may assist in improving performance.
- Professionalism is a critical element of performance frameworks. Professionalism incorporates the skills, attitudes and behaviours Dr Ian Graham, consultant to the SPPP project

I always wondered about the Hippocratic Oath. People seemed to refer to it as some sort of guiding light for physician practice, but never was I asked to learn or recite it at medical school. I did know that, above all else, I was to do no harm, but was that really a good enough benchmark to guide my professional life?

Like many of us, I grew up as a student who more or less got good marks and eventually passed through medical school satisfactorily enough to call myself a doctor. Sometimes people would say, ‘Aren’t you doing well’, and I suppose by all objective assessments I was. The report card was full of ticks, examinations were passed, and ultimately I stood on my own two feet and became a paediatrician. I figured I must be capable of doing this because I had passed all the tests, but how was I going to be sure?

It is now some years down the track and I am still not sure that I am a ‘good doctor’. The objective assessments stopped a long time ago, and now the people who witness my work most frequently are my patients, my trainees and the multitude of professionals I work alongside every day. We work collegiately and strive to provide the best care for our patients, but although people often ask me how I am, I rarely have the chance to ask them how they think I am. Have I made the grade?

The Supporting Physicians Professionalism and Performance project (SPPP) gives me a chance to work this out. What are the elements of a good doctor, and how well do I meet those challenges? Like most of us, my practice revolves around diagnosing a problem and coming up with potential ‘cures’. SPPP will provide a framework I can use to review my practice and to assist in my professional development. It’s a bit like taking the car for a service. Whilst I cross my fingers that nothing is identified, at least I have confidence that issues will be addressed and I can happily continue my journey in the best possible condition. Which, according to Hippocrates, will allow me to ‘enjoy life and art, and be honoured with fame among all men for all time to come’. Count me in.

Dr Sarah Dalton
Paediatric Emergency Physician
Member of the SPPP Project Executive Group

Dr Ian Graham, consultant to the SPPP project

SPPP – WHAT’S IN IT FOR ME?
Professionalism and Performance

that are expected of medical professionals.

- Professionalism can be assessed using a variety of assessment approaches.
- Professionalism can be embedded within performance management systems and incorporated into practice standards, codes of practice and codes of professional conduct.

Introducing

Dr Ian Graham – Consultant

Following a selective tender process, Dr Ian Graham (FRACMA) has been appointed as the consultant to this project to undertake the stakeholder consultation. Dr Graham is the principal consultant to SED Health Consulting and has experience in a variety of settings, including healthcare planning, medical administration, clinical governance, risk management and quality improvement, health professional development, and clinical information systems. Dr Graham was the consultant appointed to the RACS project which developed the Surgical Competence and Performance Guide. SPPP is being developed independently of the Surgical Competence and Performance Guide but will be informed by it.

Next steps

The next phase of this project involves wide stakeholder consultation. Initially, all key groups within the College, as well as external stakeholders, will receive background information about the project. In addition, the consultant and members of the SPPP Executive and Steering Committee will optimise opportunities to meet face to face with Fellows to discuss the project further. Interested parties should contact bianca.heggelund@racp.edu.au, grant@ballaratgastro.com.au or sarah.dalton@mets.org.au. Otherwise please visit the project website: www.racp.edu.au/page/sppp.

IS IT OK TO DOB?

The new Australian mandatory reporting regime makes it necessary for all health professionals to make reports in relation to the conduct of other health professionals in particular circumstances. However, recent research confirms that doctors are clearly reluctant to do so.

The research report, Physicians’ Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues (JAMA 2010; 304:187–193), found a high level of commitment for the reporting of physicians who were significantly impaired or incompetent to practise. However, only 69% indicated that they would be prepared to take action to deal with impaired colleagues in medical practice; 64% reported being prepared to appropriately deal with incompetent colleagues.

Of significant interest was the fact that 17% of physicians indicated that they had personal knowledge of a doctor who was, or may have been, incompetent to practise in their hospital, group or practice. In those situations, only two-thirds had actually made a report to the relevant registration or disciplinary authority.

The research suggests that some of the reasons for not reporting were the belief that someone else was ‘taking care of the problem’ (19%), or that nothing would happen if a report was actually made (15%). Some had a fear of retribution (12%) and some believed that it was not their responsibility (10%).

The research was conducted in circumstances where mandatory reporting did not impose an obligation on the physicians to report impairment or incompetence.

That situation now changes in Australia where a report is required to be made by a health professional where there is a reasonable belief that ‘notifiable conduct has occurred’. Notifiable conduct is where a registered health practitioner:

- practises while intoxicated
- engages in sexual misconduct in connection with practice
- places the public at risk or harm in his or her practice in a way that constitutes a significant departure from accepted professional standards.

The new national legislation provides protection for notifiers from defamation and civil or criminal process where a mandatory report is made in good faith.

Michael Gorton AM
Principal
Russell Kennedy


Disclaimer: The information contained in this publication is intended as general commentary and should not be regarded as legal advice. Should you require specific advice on any of the topics or areas discussed, please contact the author directly.
ADVANCED TRAINEE SELECTION AND MATCHING IN 2010

Over the last five years the College has developed an online application and preferencing system that was this year used by 14 specialty groups to match trainees to positions via a fair and transparent process.

The website software was extensively rewritten following the 2008 match to give the State/Specialty Group coordinators more control over their own positions and to allow more sophisticated (multilevel) matching to take place. Further improvements were made after consultation and feedback from the process in 2009. As with all developing systems, some problems were experienced; however, the overall outcome has been positive, with the goal of a national entry-level trainee match clearly within our reach.

This year the Advanced Trainee Selection and Matching occurred over a longer period than last year, giving applicants more time to apply both before and after clinical examination results were released on 9 August. Overall, 511 trainees participated in at least 1 match (overall, 7 matches were held), with 85 (around 17%) spreading their preferences across 7 matches were held), with 85 (around 17%) spreading their preferences across states and/or specialties. Of 267 positions registered, all but 10 were matched.

Of the matches available for new trainees, the largest was the ‘Multi-Specialty match’ held on 6 September, involving 10 State/Specialty Groups. Specialties participating in the program overall included Gastroenterology (NSW/ACT/Vic/Tas/QLD/SA), Respiratory Medicine (NSW/ACT/Vic/Tas), Cardiology (NSW/ACT/Vic/Tas), Rheumatology (NSW/ACT/Vic), Nephrology (Vic), Medical Oncology (Vic), Infectious Diseases (Vic/Tas), and Endocrinology (Vic/Tas).

It became clear that combining continuing trainees and new entrants in a single match had risks for the continuing trainees, so we looked at methods to reduce those risks for the 2010 process. The main way of doing this was by conducting more separate matches for continuing trainees prior to the Multi-Specialty match which, this year, contained predominantly new trainees.

For those specialties including both new entrants and continuing trainees together, we encouraged a more structured approach to generating preference lists or allocating continuing trainees via a separate (non-matching) process. In addition, we have tried to communicate clearly to both continuing and new advanced trainees that preferring a limited number of positions may result in their being unmatched. If trainees do not prefer positions that they would have taken in preference to being unmatched, then they will not be matched to these positions and the positions will be allocated to other trainees.

The Multi-Specialty match was run on Monday, 6 September, and results were distributed to the coordinators over the remainder of the day. In most cases, trainees were informed of their matched position on the day of the match; however, there was still a small delay in some instances for NSW notifications/offers due to various NSW regulations and variance in processes that must be adhered to. This year, the waiting period for NSW applicants was significantly reduced through cooperation between the RACP and NSW Health to expedite the processes involved.

In 2011 we hope to include further State/Specialty Groups and will be discussing this with SACs/STCs at their November meetings. For information relating to the ATSM process or to request an invitation to attend the follow-up and/or pre-application workshops, please don’t hesitate to contact Emma Cunningham or Aaron Thompson at atselection@racp.edu.au.

Finally, we would like to thank all of the RACP staff involved in the process, from the IT staff who developed, debugged and maintained the program, to the Events and other RACP staff or allocating continuing trainees via a separate (non-matching) process. In addition, we have tried to communicate clearly to both continuing and new advanced trainees that preferring a limited number of positions may result in their being unmatched. If trainees do not prefer positions that they would have taken in preference to being unmatched, then they will not be matched to these positions and the positions will be allocated to other trainees.

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Geoff Hebbard
ATSM Coordinator
Emma Cunningham
Manager, Victorian State Office, RACP

SUPPORT FOR THOSE AFFECTED BY CHRISTCHURCH EARTHQUAKE

The RACP would like to extend deep regret and heartfelt support to our New Zealand constituents following the Christchurch earthquake that took place on Saturday, 4 September 2010. In particular, our thoughts are with our Fellows, trainees, College staff and their families directly affected by the natural disaster.

The extended state of emergency that was declared in Christchurch is evidence of the severity of the earthquake and the lasting impact endured by Christchurch residents and New Zealand as a whole. The city has shown exceptional character and overcome significant adversity in the wake of the immediate challenges faced. That Christchurch survived this natural disaster with no loss of life is testament to the preparedness of the city.

Search and rescue teams, all medical staff across a diverse range of disciplines and countless first aid volunteers have made an immeasurable contribution to the recovery process. Many of our Fellows persevered, providing specialist treatment and ongoing healthcare amidst the uncertainty, chaos and continuing aftershocks. The direct impact to health services was considerable as numerous clinics, hospitals and aged care homes were closed or cordoned off due to damage and associated safety concerns.

Christchurch will now be embedded in a rebuilding phase, as residents aim to get their disturbed lives back to normal following such substantial loss and devastation. The RACP recognises that this will be an ongoing recovery for the many people impacted and offers support to all.
ARE WE AT FULL CAPACITY? PART 1

In April this year, the Australian Department of Health and Ageing released the 13th report of the Medical Training Review Panel (MTRP). This report highlights an emerging challenge in postgraduate medical education: a predicted rise in the number of Australian medical graduates in the coming years. With this rise comes the issue of the College’s capacity to provide quality education and training within appropriate training settings and with adequate levels of supervision.

It can be seen from Figure 1 that the RACP trains the largest number of trainees of any postgraduate medical college in Australia (this is data for Australia only given that it is from the MTRP, which is an Australian Commonwealth committee). This single snapshot tells us that the bulk of the medical graduates coming through the system train within the RACP.

Fellows will be aware that the Australian university medical school graduate numbers are predicted to increase significantly over the next few years (Figure 2). It is thus highly likely that the number of RACP trainees will also grow considerably.

Figure 3 shows the number of trainees registered with the College for Adult Medicine Basic Training in Australia and New Zealand. There has been an increase in numbers since 2004 and, although it may appear that there has been a fall in numbers in 2009 and 2010 for both Adult Medicine and Paediatrics & Child Health Basic Trainees (see Figure 4), it is worth noting that not all trainees register from the start of their first year of Basic Training. As the College moves to prospective registration with PREP Training, it is likely that the actual numbers registering for Basic Training will increase by a moderate amount.

The new PREP program puts increasing pressure on supervisors of our trainees. Being aware of this, the College has established a Capacity to Train working group. This group is examining data trends for trainee numbers in an endeavour to get a sense of training implications, sustainability, clinical opportunity for training, ability of clinicians to provide supervision, etc.

* This number reflects only those trainees registered to the week commencing 20 July 2009. Numbers changed after the second intake of registrations at the end of August.
Figures 5 and 6 illustrate the rise in the number of trainees who are sitting the College Clinical Exam in both Australia and New Zealand. This gives a sense of the numbers of trainees entering Advanced Training. In Australia there is a steady increase in the number of candidates presenting for and passing the clinical exam. By contrast, in New Zealand in Paediatrics there has been a modest rise only in the number of trainees and in Adult Medicine a fall.

So where does this data lead us? We know there are more medical graduates coming through the system who will be entering postgraduate training in the near future. We also know that as a College, currently, we are the dominant vocational training provider. The trend data would suggest that we will continue to attract many trainees to our training programs. It is highly likely, therefore, that the number of trainees who wish to register for Basic Training over the next five years will increase substantially. Assuming that the majority pass through to Advanced Training, there will not only be pressure on our capacity to train Basic Trainees but also on our capacity to train in the specialties, so Advanced Training will be under increased pressure.

Critical to a good training program is access to clinical material of a varied sort, which ensures that the trainee covers the broad aspects of their discipline. Aligned to this is the requirement for supervisors to be able to spend time with, and shape and guide the experiences of, the trainee. Indeed, the requirements of the PREP program increase the pressure on supervisors to be supporting trainees with structured education activities.

Whether the College can continue to take in a large number of trainees for Basic Training and then take them through Advanced Training is an interesting question.

In subsequent editions of RACP News, there will be further discussion on our capacity to train. We will examine the evidence we have on where trainees are going and what their training choices are for Advanced Training, as well as a sense from the health system of the health needs of the community.

Professor Kevin Forsyth FRACP
Dean

Katherine Deller
Executive Officer – Advanced Training Programs
Education Deanery

References


WHATEVER IS HAPPENING WITH MEDICAL EDUCATION?

The College has produced excellent medical specialists for almost 80 years. Why then is the College doing so many new things with education? What is going on in medical education? Why is it that we’re hearing about a whole series of new terms, and expectations that we do all manner of things that we’ve never done previously?

Consider how specialist training was until our recent past. We had an apprenticeship model working well, where trainees, working under the guidance and direction of medical specialists, were exposed to a broad range of clinical conditions. Under specialist supervision, trainees learnt how to diagnose and manage complex medical cases. In addition, a difficult written and clinical exam ensured high standards and encouraged trainees to aspire for excellence. Given this model, why would the College change?

Fellows and trainees will be aware of new terms creeping in to our lexicon. Words like ‘competence’, ‘competency’, ‘assessment of competence’, ‘performance’, ‘certification’, ‘standards’ and ‘measurement’ are driving some of our direction with medical education. What do they all mean? Competency can be defined as the observable ability of a health professional, integrating multiple components such as knowledge, skills, values and attitudes. Competencies are both observable and measurable. Competence is described as the array of abilities across multiple domains or aspects of physician performance within a certain context. Performance is what a doctor actually does in practice.

Some of the changes driving medical education into a programmatic, formulaic approach to its offerings are occurring in the external environment. Take, for example, the changing patterns of healthcare. Patients are now in hospital for much shorter periods than they used to be and supervising consultants and trainees tend to work in blocks of time rather than continuously, so there is, to some extent, a breakdown of the close apprenticeship relationship between a trainee and a consultant. There has been an enormous growth in knowledge in medicine and it is impossible for doctors to keep up with all the information, even within the relatively limited scope of practice that they may choose to work in. Concomitant with this is the rise of information readily accessible to the public.

We then have, albeit infrequently, episodes where doctors such as Jayant Patel are viewed as practising beyond their competence level and the public calls for assessment frameworks and certification frameworks around doctors’ practice. Indeed, much of the safety and quality agenda is moving doctors to an accountability framework.

There is now a requirement in a number of countries for doctors to be recertified on a regular basis. In Australia and in New Zealand the medical boards require us to at least be active in CPD on an annual basis. Fellows and trainees will be aware of new terms creeping in to our lexicon. Words like ‘competence’, ‘competency’, ‘assessment of competence’, ‘performance’, ‘certification’, ‘standards’ and ‘measurement’ are driving some of our direction with medical education. What do they all mean? Competency can be defined as the observable ability of a health professional, integrating multiple components such as knowledge, skills, values and attitudes. Competencies are both observable and measurable. Competence is described as the array of abilities across multiple domains or aspects of physician performance within a certain context. Performance is what a doctor actually does in practice.

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There is now a requirement in a number of countries for doctors to be recertified on a regular basis. In Australia and in New Zealand the medical boards require us to at least be active in CPD on an annual basis. Fellows and trainees will be aware that there is a range of teaching and learning activities for trainees to undertake. There are, for example, curricula to guide learning; there are formative and summative assessments; there are teaching and learning processes. A principle we are operating to is that, wherever possible in training, we attempt to unpick tacit knowledge and make it discreet and codified. When consultants examine and consider patients with complex diseases and arrive at a conclusion for which they are unable to articulate the steps taken to reach that conclusion, the learning of a trainee is not necessarily assisted. When consultants make their thinking of such cases objective by working through their critical analysis and reasoning, then this process of turning tacit knowledge into codified knowledge by reflection assists doctors to interrogate their own reasoning and teaches trainees to learn these steps.

When consultants make their thinking of cases objective by working through their critical analysis and reasoning, then this process of turning tacit knowledge into codified knowledge by reflection assists doctors to interrogate their own reasoning and teaches trainees to learn these steps. So getting back to the competence, competency and performance issues, where is the RACP heading? The Australian Medical Council (AMC) recently put out for consultation a discussion paper on competency frameworks in medical education. This paper was a thoughtful discussion on the failure of competencies in the medical sphere to be able to be reduced to discreet measurable units. The AMC argued that there is both codified and tacit knowledge, that tacit knowledge is dependent on the quality of the learning experience and an opportunity for feedback and reflection, and that observed performance does reflect underlying competence, but is more than the sum of the set of competencies used.

The RACP has consistently maintained that moving towards a competency-based approach in training and assessment is of value but is insufficient overall. There are many tacit aspects of medicine gained only through considerable experience and exposure to the complexities of the human and human disease case. Even synthetic learning environments are unable to replicate the differences and nuances of clinical cases. Hence, the RACP considers that the training and assessment of trainees, and indeed Fellows, in a CPD context cannot simply be a summation of a set of measurable competencies.

In our new PREP education program, Fellows and trainees will be aware that there is a range of teaching and learning activities for trainees to undertake. There are, for example, curricula to guide learning; there are formative and summative assessments; there are teaching and learning processes. A principle we are operating to is that, wherever possible in training, we attempt to unpick tacit knowledge and make it discreet and codified. When consultants examine and consider patients with complex diseases and arrive at a conclusion for which they are unable to articulate the steps taken to reach that conclusion, the learning of a trainee is not necessarily assisted. When consultants make their thinking of such cases objective by working through their critical analysis and reasoning, then this process of turning tacit knowledge into codified knowledge by reflection assists doctors to interrogate their own reasoning and, more importantly, teaches trainees to learn these steps and so be able to follow the sequence. This mindfulness, this reflection and thinking about thinking, can clarify and sharpen reasoning and hence assist trainees in their learning. Given this, there should then be an emphasis on the reflective elements of learning in any education program. Such process of thinking assists in the transformation of tacit knowledge to codified knowledge, albeit with a recognition that not all elements of knowledge or practice can be codified. Clarifying the codified knowledge makes evidence of attainment easier.

There are expectations from regulatory authorities, from governments and indeed the public that we demonstrate, through the collection of education evidence, the competence of our trainees.
A key challenge in medical education is developing evidence of educational attainment by a trainee. Increasingly, regulatory authorities are suggesting that Colleges show evidence of performance by their trainees and, increasingly, of their Fellows. Assessment of competence is an issue that regulatory authorities are beginning to discuss with the College and which the College is increasingly moving towards in assessing trainees. It is entirely appropriate at the trainee level that the College certify to regulatory authorities the competence of its trainees; however, such competence is not necessarily measured by multiple competency assessments. Where competency assessments can be undertaken, well and good, but there needs to be recognition that tacit knowledge can be acquired only through significant periods of working with complex patients alongside senior clinicians—the apprenticeship model, although an apprenticeship model based on reflective thinking and learning.

So to go back to the beginning, externally we are in a very different context than the College was in its beginnings. There are expectations from regulatory authorities, from governments and indeed the public that we demonstrate, through the collection of education evidence, the competence of our trainees. The College endorses the Australian Medical Council’s view that medical education needs to focus on competency areas, but recognises that the practice of a physician is greater than the sum of the measurable competencies. Experience, exposure to good mentoring and supervision, and exposure to realistic clinical situations through a variety of presentations over a reasonable period of time with reflective thoughtfulness are all critical in shaping and forming a competent physician.

Kevin Forsyth FRACP
Dean

Medical Board of Australia mandatory CPD is here, and with the coming of mandatory CPD for RACP Fellows in January 2011, there is no better time than NOW to log on to MyCPD to begin entering your activities.

Under new government legislation implemented in Australia, with effect from 1 July 2010, medical practitioners are required to participate in CPD that is relevant to their scope of practice in order to maintain their medical registration. This is in line with increasing global awareness of the need to enhance clinical standards through CPD with a view to protecting public interest and providing high-quality patient care.

The College is supporting mandatory CPD as it recognises the importance of demonstrating to the community at large that our Fellows are committed to ongoing professional development and ultimately maintaining and improving clinical practice and patient care. New College policy, to be implemented in January 2011, states that participation in a recognised and relevant CPD program is required for retention of Fellowship.

The College has an online program called MyCPD to enable participants to record their ongoing CPD activities. MyCPD is a user-friendly online tool, designed to be easily accessible so that participants can log on from anywhere, and at their convenience. The program encourages users to track and record their own continuing professional development through reflection and self-assessment using a learner-centred approach.

Activities can be entered within the program both prospectively and retrospectively for the calendar year until the deadline for submission of 31 March the following year. Users can download an interim statement from within the MyCPD program; this statement is accepted by the Medical Board of Australia for registration purposes and credits are automatically updated as activities are entered.

MyCPD has incorporated quick and easy entries for CPD activities which are undertaken regularly, such as teaching or journal reading. By selecting the ‘add recurring activity’ feature, participants are able to enter the activity details only once, and select the dates of the recurrence to create multiple entries.

Evidence suggests that reflection is an essential component of an effective CPD program. MyCPD incorporates tools to help participants to record personal reflection on activities undertaken. Reflection enables participants to gain insight into the educational value of an activity and think critically about current practices to identify areas for future learning. Currently, one bonus credit is gained for every reflective comment entered.

Ready to give it a go? An online MyCPD Instructional Video and MyCPD Guide are now available on our website to help first-time users familiarise themselves with the MyCPD program.

Still need help? The CPD Unit is more than happy to answer any of your queries. Please contact us via our website, or by email or phone as listed below:

Website: www.racp.edu.au
Email: MyCPD@racp.edu.au
Phone: 02 8247 6239
02 8247 6215

Sally Tyrie-Greenwell
Education Officer,
Continuing Professional Development Education Deaney

MYCPD – HOW IT WORKS FOR YOU
What are your MyCPD credits really worth?

The role of a Supervisor is an important one in the ongoing educational support and development of trainees. The College recognises that Fellows in a supervisory role gain considerable educational benefit themselves and, as such, CPD credits can be claimed within the MyCPD program.

For example, as a Supervisor, your credits for the year could be as follows:

<table>
<thead>
<tr>
<th>Category 1: Educational Development, Teaching &amp; Research</th>
<th>Recognised Credits</th>
<th>Reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching (e.g. lecturing, reviewing projects) – 1 credit/hour</td>
<td>52</td>
<td>0</td>
</tr>
<tr>
<td>Teaching role on ward rounds – 1 credit/hour</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Teaching role on grand rounds – 1 credit/hour</td>
<td>24</td>
<td>5</td>
</tr>
<tr>
<td>Corridor consultation teaching time – 1 credit/hour</td>
<td>104</td>
<td>8</td>
</tr>
<tr>
<td>Dedicated teaching in clinic (3.5 hour session x 6) – 1 credit/hour</td>
<td>21</td>
<td>2</td>
</tr>
<tr>
<td>Educational supervisor of 5 trainees (e.g. meeting with trainees) – 1 credit/hour</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Ward/Service Consultant of 5 trainees (e.g. conducting formative assessments, supporting trainees to use the main clinical tools) – 1 credit/hour</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Professional Development Advisor of 5 trainees (e.g. meeting with trainees to provide feedback on reflections recorded in SIAT) – 1 credit/hour</td>
<td>75</td>
<td>5</td>
</tr>
<tr>
<td>Director of Physician Education of 3 Educational Supervisors (e.g. meeting with Educational Supervisors) – 1 credit/hour</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Presentation – 3 credits/presentation (credits can only be claimed for the first presentation of a paper)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Credits – Category 1</strong></td>
<td><strong>50</strong></td>
<td><strong>37</strong></td>
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<tr>
<th>Category 2: Group Learning Activities</th>
<th>Recognised Credits</th>
<th>Reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor Workshops (run by Medical Education Officers) – 1 credit/hour</td>
<td>2</td>
<td>1</td>
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<td>Supervisor Workshops (at Annual Scientific Meeting) – 1 credit/hour</td>
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<td>Leading Journal Club – 1 credit/hour</td>
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<td>Preparation for presentation – 1 credit/hour</td>
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*Note: Categories 1, 2 and 6 are capped at a maximum of 50 credits per year; however, 1 bonus credit can be gained for every reflective comment and these remain uncapped.

What CPD do you need for re-registration?

There has been a great deal of confusion over what CPD is required for re-registration and the answer is quite simple. As the Medical Board of Australia regulated mandatory participation in a CPD program as of 1 July 2010, you do not need to have completed the MyCPD program for 2009. Fellows who have undertaken MyCPD in 2010, your certificate of participation will more than meet the criteria. For registrations that fall due before July 2011 you will need to provide an interim statement of participation that is downloadable/printable from MyCPD. However, for all re-registrations that fall due after July 2011 you will need to provide evidence that you have completed at least 12 months CPD and are actively enrolled in an accredited Australian Medical Council (AMC) CPD Program. MyCPD at RACP is accredited by the AMC.

Reminder: Final Supervisor’s Reports Due Soon!

Advanced Trainees in Adult Medicine and Paediatrics & Child Health (Australia), please note the following deadlines for Final Supervisor’s Reports.

- **Deadline Applicable to:**
  - 15 October 2010: Final year trainees
  - Trainees in 12 month positions (Jan/Feb 2010 to Jan/Feb 2011)
  - 31 December 2010: Trainees in General Paediatrics (Australia)
  - 15 January 2011: Trainees undertaking two or more rotations in 2010, who are not in their final year of Advanced Training

The Final Supervisor’s Report can be downloaded from:

www.racp.edu.au/page/educational-and-professional-development/advanced-training/supervisor-s-reports

It is each trainee’s responsibility to ensure that the relevant report is submitted to the College by the due date.

Enquiries
Email: AdvancedTraining@racp.edu.au
Phone: 02 8247 6235
Medical specialist training in Australia needs to match the way healthcare is delivered. The necessity for a better trained and specialist workforce to meet the needs of an ageing population, changing patterns of disease and ill health, and community expectations for accessible, quality health services across Australia, including outer metropolitan areas of capital cities, regional centres, and rural and remote areas, was formally acknowledged in the 2006 COAG Better Specialist Training initiative.

In 2010, the Department of Health and Ageing (DoHA) announced the newly branded Specialist Training Program (STP). STP is an amalgamation of Commonwealth funded programs, including the ESTP, the Outer Metropolitan Specialist Trainee Program (OMSTP), the Overseas Trained Doctor—Upskilling program, the Pathology Workforce Support Program and the Advanced Specialist Training Posts in Rural Areas (ASTPRA) program.

STP is designed to provide opportunities for medical specialist trainees to rotate through an integrated program of learning in an expanded range of settings beyond traditional public teaching hospitals, in pursuit of becoming a specialist recognised by a College. The aims of the STP must be achieved without any associated loss to the capacity of the public healthcare system to deliver services. It does this by providing salary contribution funds for registrars in STP posts, which are paid to the employer of the registrar. In addition, contribution funding is provided for a range of support activities including developing:

- system-wide education and infrastructure support projects to enhance training opportunities, with a focus on regional and rural areas and private settings
- support projects aimed at Specialist International Medical Graduates (SIMGs) to assist these doctors to gain fellowship in a timely and efficient manner.

On 10 July 2009, a meeting between DoHA and the Royal Australasian College of Physicians was held to discuss the future of the expanded settings Specialist Training Programs in Australia. It was argued that medical specialist colleges like the RACP were in a unique position to effectively deliver the outcomes required by the Specialist Training Program, as they are the bodies responsible for accrediting the site as a suitable training setting and for determining the quality and standards of training for doctors seeking the qualifications required to practise in their specialty in Australia. At this meeting, DoHA proposed that the RACP take responsibility within the STP for:

- funding training posts
- developing networks of training
- developing support projects to enhance training networks in 2010 and beyond.

In order to allow time for the RACP to prepare to take over the administration and management of the STP program, DoHA put forward that 2010 would be a transition year when the current 117 STP positions would be managed by the RACP with funding allocated for the establishment of administrative infrastructure and support projects to enhance training networks in 2010 and beyond.

The agreement was ratified by the College on the grounds that it provided the following benefits:

- presented the RACP with a unique opportunity to shape the delivery of physician training outside traditional hospital settings
- provided funding to develop and support initiatives such as the Rural Child Health Training program, the Overseas Trained Physician Mentor Support Scheme, online physician training lectures and physician supervisor workshops
- strengthened the RACP’s position as the sole physician training provider
- provided funding for RACP infrastructure development.

The opportunity presented by the STP is significant for the College, Fellows and trainees. It is the largest project the RACP has administered and has the largest single funding allocation.
To DoHA, with due diligence and alignment in delivering clear outcomes in institutions to ensure that we are in agreement with third parties and resources. In taking on the STP, the College will do this by building and integrating streamlined processes and systems to enhance training networks across the College.

For the 2011 STP round of funding, 342 applications for funding of physician posts were received; of these applications, 188 are currently shortlisted for funding. In determining the STP funded posts, applications were assessed and ranked by DoHA, the State Health jurisdictions and the RACP according to defined criteria.

A program manager was recruited on 20 July to manage the STP unit and to establish an STP advisory group. This advisory group will contribute to the development and approval of systems for the STP support projects and criteria for the 2012 applications. It is planned that this group will comprise eight members, including the Dean, STP Program Manager, Business Manager, Accreditation Executive Officer, three Fellows and one trainee involved in STP programs. Invitations to express interest in membership of this group will be sent out shortly.

The STP offers the College a vehicle to expand training capacity and build efficiencies and systems within the College to meet its commitment to delivering excellence in physician training in expanded healthcare settings beyond the major teaching hospitals ...

In taking on the STP, the College will need to enter into formal contractual agreements with third parties and institutions to ensure that we are in alignment in delivering clear outcomes to DoHA, with due diligence and accountability within our own business practices. To this end, agreements are currently being drafted for each of the shortlisted STP 2011 sites, as well as for third parties that are engaged in the development of STP support projects and resources.

A comprehensive qualitative evaluation of 2010 STP posts is underway. The purpose of the evaluation is to explore ‘what makes a quality specialist learning experience and how these factors can be influenced’. A survey was sent to 256 recipients (95 Directors of Physician Education, 42 Supervisors and 119 trainees) on 31 August. Findings from this survey will be available in October.

On 11 August DoHA advised the College of the constraints on the caretaker role that they were currently facing, that is, they were unable to secure multi-year agreements at that stage. However, they anticipated that appropriate approvals would be in place early in September, with funding agreements established with the College by the end of October. The basis of those agreements will be the number of successful applicants in the 2011 STP application round. Furthermore, DoHA advised that it expected that funds associated with the salary contribution for registrars in STP shortlisted posts would flow prior to January, and continue across a three-year period. Funds would flow to the employer of the registrar at a rate of $100,000 (GST exclusive) per FTE, pro rata. Only the portion of time the registrar spends outside a traditional public teaching hospital is eligible for salary support under STP. Payment is made to the STP site, and it is up to the STP site to transfer the money to the public site if that is the location from which the trainee is paid.

The impact of this announcement means there is some uncertainty surrounding the time frame for the receipt of the STP funding agreement for 2011–2014. For hospitals and Fellows (i.e. third parties that are engaged in the development of STP resources) ongoing uncertainty about the time frame for funding agreements may impact on their ability to recruit eligible registrars for the start of the 2011 academic year.

Accreditation of shortlisted STP posts is another priority, yet complex, issue that STP and the Accreditation Unit are tackling. Discussions have commenced with relevant committees on the process to be implemented for shortlisted 2011 sites, with a recommendation to consider the merit of granting provisional accreditation for up to 12 months, based on a paper-based site survey due to the short time frame, i.e. ‘All shortlisted sites must be accredited by 30 December 2010’. The development of streamlined accreditation processes and a realistic time frame for the 2012 STP application round is currently in the early stages of development.

The STP offers the College a vehicle to expand training capacity and build efficiencies and systems within the College to meet its commitment to delivering excellence in physician training in expanded healthcare settings beyond the major teaching hospitals and to meet the challenges of the health system and community demand for access to quality and sophisticated services across Australia.

For information on the STP, please email stp@racp.edu.au or visit <www.racp.edu.au/page/stp>.

The December issue of RACP News will feature an article on the 2011 STP evaluation survey findings.

Christine Frew
Program Manager – Specialist Training Program
Education Deanery

Davy Loo
Business Manager
Education Deanery

GET RACP NEWS DELIVERED STRAIGHT TO YOUR IN BOX
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DO YOUR BIT FOR THE ENVIRONMENT

To receive an electronic copy of RACP News email racpnews@racp.edu.au with Electronic Copy Only in the subject field.
I advise everybody reading this article to think about being ‘repotted’. Some people need to be repotted every year to keep their energy levels high, but doctors often do jobs that are roughly the same for decades. This, I believe, is not good for them or their patients, and it’s certainly not good for leaders of organisations to go on for more than 10 years—because organisations need rejuvenation.

Having written that, I must confess to being Editor of the BMJ and Chief Executive of the BMJ Publishing Group for 13 years. Did I stay too long? I’m not sure, but I do know that being repotted is enlivening. It’s not so much that the many problems that kept you awake at night suddenly don’t matter; it’s more that you acquire a new perspective. The world looks different—and often more interesting.

I left the BMJ to become the Chief Executive of UnitedHealth Europe, the subsidiary of a large American company that worked with the National Health Service (NHS). A fair few people immediately wrote me off because I’d joined a for-profit company (and an American one to boot), which was interesting in itself. But more important for me was the move I made a couple of years later, when I became the Director of the UnitedHealth Chronic Disease Initiative, a philanthropic program to create centres in low- and middle-income countries to counter chronic disease (cardiovascular disease, diabetes, chronic obstructive pulmonary disease, and common cancers). If you’re interested you can read more about the program at: www.nhlbi.nih.gov/about/globalhealth/centers/index.htm.

But this repotting meant that I spent much more time in low- and middle-income countries. I’ve been travelling to such countries ever since I did the ‘hippy trail’ in 1973, but as you begin to think about their health problems and less about the endless reorganisations of the NHS you begin to see the world very differently.

Nigel Crisp, who once was Chief Executive of the NHS in England, had exactly this experience when he stepped down from his position and was asked by Tony Blair to tour the developing world and see how the NHS could help. One result was his excellent and radical book, Turning the World Upside Down: the Search for Global Health in the 21st Century. He concludes that probably the rich world can learn more from the poor world than vice versa, that health systems in developed countries are unsustainable, and that a combination of professional, academic and business interests always drives for more healthcare when that is not in the best interests of patients and their countries.

Inevitably Crisp paid more attention to public health than he would have had time to do in his chief executive position, and he observes that ‘Despite its successes … public health has become … the junior partner to clinical medicine and been less powerful and less well funded’. Public health separated from clinical medicine in the early 20th century, and although ‘public health over the years has revived and reinvented itself … it has never quite managed to link itself sufficiently to the scientific establishment and commercial interests to challenge the hegemony of clinical medicine’. But he ends on a cheerful note for public health by observing that ‘Now with the emergence of global health as a new discipline it is once again being viewed as of enormous importance’.

Africa has 25% of the global disease burden but only 3% of healthcare resources and 1% of health workers. North America, in contrast, has 3% of the disease burden but 25% of healthcare resources and 30% of health workers.

I’ve made similar observations as I’ve travelled a similar route to Crisp, and all of this was in my mind as I prepared my Redfern Oration for WCIM 2010. Unfortunately, I never got to Australia to deliver my oration as my mother-in-law had a severe stroke four days before I was supposed to leave. But one consequence is that a video is available of my talk in which, with a rather lugubrious tone but some useful slides, I describe my 10 lessons on rediscovering public health through global health. Because I can’t believe that anybody could bear to watch an hour of me, I’ve edited the video into the 10 lessons. You can find them at <www.3four50.com/v2/index.php?page=video2&cat=8&subcat=22&sp=1> and can watch, copy and use them should you so wish. In the rest of this article I summarise very briefly my 10 lessons.

Lesson 1: Modern clinical medicine is as out of control as the banks and is unaffordable globally.

I deliberately started provocatively and make my case both by describing what I see as futile procedures within medicine and by showing data projecting forward the rising costs of healthcare. Interestingly, the rising costs are driven not so much by the ageing of the population or by raising patient expectations but mostly by new technologies and medicine’s ability to do more to fend off death.

Lesson 2: Inequalities in our world are gross and need to be tackled.

Everybody knows this, but I wonder how many people feel it. Did you know that Africa has 25% of the global disease burden but only 3% of healthcare resources and 1% of health workers? North America, in contrast, has 3% of the disease burden but 25% of healthcare resources and 30% of health workers. Does that not make you feel uncomfortable if you are a health worker in a developed country?

Data from the WHO report on the social determinants of health show both that inequalities between the developed world and SubSaharan Africa are getting worse and that it is possible to make a rapid difference to inequalities—often through measures like providing potable water or increasing enrolment in primary education. Sadly, evidence from Britain also shows that it is also possible to spend a great deal of money (£21 billion) trying to reduce inequalities and fail completely.

Lesson 3: The Victorians eventually couldn’t live with the difference between rich and poor, and we got income tax with substantial transfers of wealth within countries. We now need such transfers between countries.

At the moment, most developed countries are failing to reach the United Nations target of spending 0.7% of their GDP in aid, but as the world becomes progressively smaller, more crowded and more threatened this may change and...
we may achieve a substantial transfer of funds from rich countries to poor countries.

Lesson 4: You can’t have healthy people without healthy places.

This is another lesson that everybody should know, but we continue to put most of our resources into treating individuals. However, we achieve little if we send people back to the same unhealthy places and, in particular, we may make things worse rather than better if we practise prevention with individuals who live in very unhealthy circumstances where, for example, exercise is impossible, fresh fruit and vegetables are unavailable or unaffordable, and the air is full of tobacco smoke. We make things worse because we achieve little and make the individuals feel like failures.

We should also remember that healthy places will begin to disappear as our planet becomes sicker. We need a healthy planet in order to have healthy places, and luckily what is good for individuals—avoiding motorised transport, exercising more, and eating more fruit and vegetables and fewer animal products—is also good for the planet.

Doctors have paid a lot of attention to fending off death, which, I fear, is why so many people experience bad deaths in hospitals. I argue that we should recognise that death is a friend, there are worse things than being dead ...

Lesson 5: We may not like to think in terms of money, but we have to pay close attention to costs—returning to the utilitarian roots of public health.

If you are rich you can be profligate, but with limited resources we need to pay close attention to value for money. Doctors treating individual patients feel very uncomfortable considering the financial consequences of their actions, but it’s easier and essential at a systems and public health level. I showed a graph at WCIM which illustrated that, with hospitals, there is no relation between cost and quality and data that a coronary artery bypass costs $27,000 per disability adjusted life year, whereas aspirin after a heart attack is cost saving. And reducing salt intake at a population level would cost 6 cents per person and reduce mortality by 2%.

Lesson 6: How we die may make a huge difference, and there are positive signs of the compression of morbidity. We must promote the idea that death is normal and a friend.

I’ve always been fascinated by the concept of ‘compression of morbidity’, which says that our lives have a finite limit and that the period of poor health at the end of life may be progressively compressed. Or might we live on to be 105 or 110, spending many years demented, depressed, Parkinsonian, arthritic, needing new joints, deaf aids and cataract operations? Clearly there are huge financial as well as human implications, but we don’t really yet know which is the more likely course as life expectancy steadily increases. However, a recent study suggested there was compression of morbidity—but among those with lots of education, hinting again at the possibility of widening inequalities.

Lesson 7: New challenges need new ways of thinking and behaving.

Figure 1 shows how even in rural Bangladesh chronic diseases now account for 80% of deaths. This is true the world over (apart from the poorest countries in SubSaharan Africa), and yet we still have health systems that are designed to deal with acute conditions. In the US, two-thirds of the spend of Medicare is on people with five or more chronic conditions. Table 1, taken from a Scottish report, summarises how health systems need to change, in particular, to being community and team based rather than hospital and doctor based.

Lesson 8: Ideology can get in the way of progress.

We often don’t recognise our ideological biases, but they go deep. I illustrate what I believe to be ideological biases by using the example of the polypill, a single pill with five components (three anti-hypertensives at half dose, a statin, and folic acid) which, if everybody took every day from their 55th birthday, might reduce heart attacks and strokes by 80%. Most public health practitioners hate the idea because it suggests to them that people might carry on living unhealthy lives and simply take a pill. But isn’t this an ideological bias?

Lesson 9: Developing countries don’t have to follow the disastrous path of developed countries but can leapfrog their failures.

The rapid and extensive spread of mobile phones in low-income countries is one of the best examples of ‘leapfrogging’. There is no need to lay miles of cables. Can we achieve the same with health or will low- and middle-income countries inevitably have to follow the epidemic of chronic disease experienced over the past century in developed countries? Perhaps low- and middle-income countries can shorten the epidemic by working hard on tobacco control, particularly among women, avoiding the Westernisation of diets and promoting exercise, perhaps through good transport policies and urban design.

Lesson 10: The rich can learn from developing countries.

Nigel Crisp concluded that the rich could learn more from the poor, and there are many examples of innovation in poorer countries spreading to developed countries. Some of these are technical innovations—like oral rehydration...
therapy, an artificial foot developed in India, or kangaroo care—but perhaps more are in the organisation of care and the approach to care, putting more emphasis on families, communities and social care.

Poorer countries have a better chance of building sustainable health systems because they don’t have the inertia and vested interest of the top heavy systems built in developed countries.

Dr Richard Smith
Director, UnitedHealth
Chronic Disease Initiative

Table 1: Current and future healthcare systems

<table>
<thead>
<tr>
<th>Current</th>
<th>Future</th>
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<tr>
<td>Geared to acute conditions</td>
<td>Geared to long-term conditions</td>
</tr>
<tr>
<td>Hospital centred</td>
<td>Embedded in communities</td>
</tr>
<tr>
<td>Doctor dependent</td>
<td>Team based</td>
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<tr>
<td>Epidodic care</td>
<td>Continuous care</td>
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<td>Disjoined care</td>
<td>Integrated care</td>
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<tr>
<td>Reactive care</td>
<td>Preventative care</td>
</tr>
<tr>
<td>Patient as recipient</td>
<td>Patient as partner</td>
</tr>
<tr>
<td>Self-care infrequent</td>
<td>Self-care encouraged and facilitated</td>
</tr>
<tr>
<td>Carers undervalued</td>
<td>Carers supported as partners</td>
</tr>
<tr>
<td>Low tech</td>
<td>High tech</td>
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Figure 1: Deaths from chronic disease are displacing deaths from infectious disease even in rural Bangladesh

A Coronial Inquest was recently undertaken in South Australia in relation to two infants with subgaleal haemorrhage who died shortly after birth.


A number of recommendations have been made by the Coroner that are relevant to paediatricians and the Royal Australasian College of Physicians. Among them are that the Royal Australasian College of Physicians draws to the attention of its members, and in particular neonatologists, the following matters:

a) That practitioners should recognise that subgaleal haemorrhages can behave in unpredictable ways and can have devastating consequences

b) That undue reliance should not be placed upon a clinical picture of haemodynamic stability alone as the clinical picture may be falsely reassuring

c) That regular monitoring of acidosis and haemoglobin levels, among other parameters (such as heart rate and blood pressure), is essential

d) That upon a diagnosis of a subgaleal haemorrhage in a neonate, practitioners should have regard to the potential need for cross matched blood transfusion and transfusion of fresh frozen plasma and that they should immediately take the necessary steps to ensure that cross matched blood and fresh frozen plasma is available to be administered at short notice

e) That if a decision is made to administer a blood transfusion or a transfusion of fresh frozen plasma that practitioners should ensure that it is administered without delay.


The RACP is currently considering a College Statement.

NEW MEMBER OF THE EDITORIAL BOARD

We are delighted to welcome
Associate Professor Leena Gupta, RACP Board Member and President of the Australasian Faculty of Public Health Medicine, as a new member of the Editorial Board.

Membership of the Editorial Board now comprises:
Dr Jennifer Alexander
Professor John Kolbe
Professor Kevin Forsyth
Dr Gervase Chaney
Dr Jemma Anderson
Associate Professor Leena Gupta
Mr Sasha Grebe

IMPORTANT NOTICE

SUBGALEAL HAEMORRHAGE MAY BE CAUSE OF DEATH IN NEWBORNS

A Coronial Inquest was recently undertaken in South Australia in relation to two infants with subgaleal haemorrhage who died shortly after birth.


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The RACP is currently considering a College Statement.
This reflection on the Australasian Faculty of Public Health Medicine (AFPHM) Statement of Strategic Intent is designed to keep you up to date with the AFPHM’s achievements over the past year and their plans for 2011.

In September 2009, the Australasian Faculty of Public Health Medicine convened a strategic planning workshop with the aim of developing a Statement of Strategic Intent which would describe the future direction of the Faculty over the following three years. The Faculty recognised that there was considerable change occurring in the Australian health system and that the Faculty needed to be clear about our role in relation to those changes, our place in the ‘One College’ structure, and how best to undertake our core functions of training, continuing professional development and advocacy.

The workshop presented an exciting opportunity for Fellows to make a significant contribution to setting the strategic direction of the Faculty. A mix of Faculty Councillors, Regional Committee Chairs, Lead Fellows and staff attended the workshop. There was lively debate about the challenges facing the Faculty now and those perceived for the future, and inspiring ideas about how to drive the Faculty’s success over the next three years.

A key task was to reflect on the Faculty’s existing strengths. A number of themes emerged:

- the commitment of Fellows to the Faculty and, more broadly, to public health
- recent efforts to strengthen the Faculty’s profile and advocacy on public health issues
- ongoing reforms to the Faculty’s education programs
- a mix of central and local/regional involvement
- strong links to the RACP and the Deanery.

In addition to building on these strengths, the group defined a number of characteristics that they believed were necessary for the Faculty in the future, including:

- to have a clear sense of the role of the public health physician and future workforce requirements
- to be more outward looking and have a higher profile within the College, across the medical profession and in the community
- to have a structured and funded education program
- to be involved in stronger advocacy on priority public health issues.

It is nearly 12 months since the workshop, and the Faculty is taking the opportunity to reflect on progress and achievement against the objectives set out in its Statement of Strategic Intent which are modelled on the College’s objectives.

Deliver high quality education, training and assessment

- The Faculty has been busy advocating for a national approach to training public health physicians. The paper ‘An enhanced national approach to training public health physicians in Australia’ was developed and presented to the Department of Health and Ageing in March 2010. Faculty President Associate Professor Leena Gupta met with the Chief Medical Officer and Principal Medical Advisor for Education, Training and Workforce, to promote this.
- The Faculty had 22 training positions shortlisted for Specialist Training Program (STP) funding in 2011. This builds on significant funding the Faculty has previously received through the Australian Government Public Health Education and Research Program. These STP positions are a significant development, offering an expansion of training opportunities for current trainees and those interested in joining the training program.
- Two thousand and ten is the first year of the transition to a new Faculty Education and Assessment Program. Features of this are:
  - a new competency framework which has been translated into the RACP Curriculum template
  - a new Assessment Scheme with an emphasis on ongoing workplace-based assessment linked to achievement of competencies.

Future developments scheduled for 2011 include the accreditation of training sites, a new format for learning contracts, development of online learning and assessment tools, and Supervisor Workshops.

Align the workforce to meet emerging needs

- A major priority was to strengthen the capacity of the Faculty to contribute to the development of Public Health Workforce policy. A Workforce Committee has been established and a forum will be convened later in 2010 to discuss how the Faculty can influence this agenda.
- The Faculty commissioned a study to better understand the role of physicians within the Australian public health workforce and to define their ‘unique’ contribution to inform both training and CPD activities. The study found that the number of public health physicians is declining and this decline threatens their ability to shape and direct public health policy and practice in Australia in the future. The Faculty will convene a workshop to discuss the implications of the findings and a report will be released later this year.

Increase the profile and position of the Faculty to shape the health agenda

- In conjunction with other College colleagues, the Faculty has been active in advocating on several issues of public health importance. At the national level, Climate Change, Alcohol policy and the National Preventative Health Agency are priority areas and ones in which the Faculty and College are working in both our own right and in partnership with other organisations.
- Action at the jurisdictional level is also important and the national Faculty and College have supported Fellows in the Northern Territory to successfully advocate concerning road safety and change to child protection legislation.

The Statement of Strategic Intent has given the Faculty Council a mandate from the Fellowship to implement key strategic
CAUTIONARY TALE: WORKING WHILE FATIGUED

Results from a recent survey by Salaried Doctors Queensland highlighted the issue of doctors working while fatigued. It indicated that 88% of doctors surveyed had experienced dangerous levels of fatigue while working, 80% felt they had made mistakes in prescribing medications while fatigued, and 59% felt they had made mistakes performing procedures while fatigued.

The AMA’s position statement on this issue identifies three central elements that are required to achieve the right outcome:

1. Establishing a safe system of work that is consistent with occupational health and safety legislation
2. Organisational commitment to developing and supervising the safe system of work
3. Medical officers’ commitment to ensuring the safe system of work is implemented at the workplace.

The effects of fatigue are difficult to predict in advance, as are the potential risks to patients from withdrawing healthcare service. Yet several studies indicate that the cognitive psychomotor impairment after sustained wakefulness is equivalent to the impairment of having a blood alcohol concentration over the legal limit.

What are the medico-legal ramifications?

All reasonable steps should be taken to reduce the likelihood of fatigue, which can diminish a doctor’s judgement and skill. Legal claims may follow adverse events caused by fatigue. While the primary focus is often on junior doctors in the public health system on call or working long shifts, doctors working excessively long hours in private practice are also exposed to fatigue-related risks and claims should complications occur.

Working time limits in EU countries have gradually reduced the maximum time doctors work per week to 48 hours, with 11 hours between work periods and at least one full day’s break in seven. Occupational health and safety legislation throughout Australia requires that employers minimise risk to both employees and the public by having safe work practices. Even where there are no specific limits stated for work periods, an employer that knowingly allows an employee to work excessive hours is likely to be in breach of legislation. An employee who works while fatigued, without taking steps to inform their manager of their condition or reduce the risk to others, may also be in breach. Breaches can result in penalties such as fines.

Doctors may be subject to complaints and disciplinary proceedings where harm occurs to a patient as a result of fatigue. This has in fact occurred—conditions were imposed on a junior doctor’s registration for deficient treatment of a paediatric patient who died. At the time of treatment the doctor was in the 20th hour of a 24-hour shift.

What to do if you are working while fatigued?

• See your own doctor if you feel that working conditions may be affecting your health.
• Contact your local Doctors Health Advisory Service.

In private practice

• Be aware of the possibility of fatigue when working long hours.
• In a group practice, ensure there is an understanding and discussion about the topic and arrangements to cover colleagues where necessary.
• Factor in at least one full day’s break in seven and regular longer breaks.

For employed physicians

• It is important to raise concerns with your immediate line supervisor.
• Clearly document when you have raised concerns about your working hours and the responses you receive.
• Raise the matter with your local medical association as they can assist with hospital management negotiations.

Harry McCoy
Avant Queensland State Manager
Reprinted with the kind permission of Avant.

References
2. ibid.
4. Doctors’ working hours: can the medical profession afford to let the courts decide what is reasonable? MJA 168:616–618, 1998.

See suggested reading opposite.
ARE YOU ON FACEBOOK?

Who is a friend?
To tell you the truth, the definition of a friend has become rather loose with the rising popularity of social networking websites. As simple as it sounds, a friend on Facebook may be someone you may hardly recognise if you tripped over them. People send friend requests, and if you accept all requests, you will eventually find yourself with a list of hundreds of friends. It is great for your self-esteem, especially if you are feeling unloved as a busy doctor with no time for friends or family!

Rules for friending and unfriending
1. If in doubt, ignore a friend request. They won’t hold that against you.
2. If in doubt, delete a friend. Most of the time they won’t even notice that they have been deleted from your list. If you have more than 150 friends, you should probably look through the list and delete all the names and faces that you can’t recognise.
3. Never hesitate to send a friend request even if it is to your boss.
4. Never hesitate to ignore a friend request even if it is from your boss.
5. Never send friend requests to patients or family members of patients, past or present.
6. Think twice before sending friend requests to work colleagues of the opposite sex in case they may see it as harassment.
7. Never accept friend requests from patients or family members of patients.

What is social networking?
In the old days, some of you had little address books next to your telephones. You used to ring up friends and families on the weekends and send birthday cards and Christmas letters once a year. Then came email, which made it even easier to keep in touch more frequently. You maintained a little email address book, and when you had something interesting, you sent an email to everyone in the address book. You sent photos and newsletters by email. Then came messengers like MSN and Yahoo, which made it possible to chat online in real time. You probably never found that as exciting as the school kids did.

Times have changed. Now most of your friends and family are on social networking sites like Facebook. You just add them to your friends list and you can keep up with what they are doing on a regular basis. Your friends might post a photo album of 50 or 60 photos, which may or may not be of any interest to you. Imagine if they sent all those to you by email! It is like each of your friends maintaining a private website which you are allowed to view and on which you can even make comments. Sound interesting?

Are you on Facebook?
Facebook is one of the most popular social networking websites boasting over 500 million users. If you are not already using it, chances are you will eventually join up, at least to keep in touch with your grandchildren! Here, Steven Bollipo tells you what you need to know.

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How I use social networking (Do not try this!)

When I was a DPT, most trainees and advanced trainees were my Facebook friends. I knew what they were up to at all times and was able to provide support. In return, they knew me well enough to trust me as their mentor. Having said that, this is not something that you can easily achieve, so please don’t try this unless you are really sure about what you are doing.

A few years ago when Facebook was new, I had very many friend requests from the medical students I was teaching. I would contact them and let them know when the tutorial was cancelled and they would contact me about their term assessments via Facebook. Now they have all become doctors in various parts of Australia, and I am following a cohort of medical students prospectively.

I also contact my GP through Facebook and my GP keeps an eye on how I am going by keeping an eye on my status updates. This again is not something that I would advise everyone to do, but if you can, the benefits are great.

I found my current job through a physician friend on Facebook and the director of the unit contacted me through the email I listed on my Facebook profile.

As you can see, the boundaries between work and personal life are blurred, but I would like to think that this is a sign of work and personal life in harmony. Are you convinced? My wife is not and is constantly threatening to delete my account if I don’t get off Facebook, like, NOW!!

Steven Bollipo FRACP
Chair eHealth Expert Advisory Group
Director of Gastroenterology & Endoscopy
John Hunter Hospital, Newcastle

Further reading

W

ith over 500 million users, Facebook has become the most popular and trusted social networking site in the world. Part of the appeal may relate to the ability to reach and reconnect with old friends, keep in touch with loved ones’ daily lives, especially when abroad, and communicate at a work level with colleagues and mentors. It has become ever more popular due to easy access via any 3G-enabled Smartphone, allowing the user to update their details and experiences with the push of a few buttons.

But just how safe is this social networking giant, and are there any negative impacts on its use?

Let’s face it, nothing in life is free, so when you are offered free access to the most popular site in the world, there must be a cost. This cost comes in the form of your privacy in one form or another. Although Facebook presents many privacy-setting choices, nothing on the internet is completely safe, and once you have posted data online, this is theoretically available to anyone with an internet connection, remaining stored in the depths of Facebook’s mainframe servers to be used by Facebook or their authorised agents for eternity—and this applies regardless of whether you delete it soon after posting. This is made clear in their privacy policy where they state that any data captured by them can be used for targeted advertising, to serve social advertisements to you and your listed friends, and that all information can be made available under certain legal circumstances.

In addition, the rules can change, often without due consultation with users. An example of this is the recent implementation of ‘Facebook Locator’, which enables people to know your exact location the moment you access your page using your 3G-enabled Smartphone.

Now, for the majority, the information shared on Facebook is harmless and of low sensitivity, but I would caution its use for any professional communication, especially if discussing confidential matters relating to patient care or personal issues. As a rule of thumb, you should not post anything on Facebook, or any similar social networking site, that you wouldn’t mind the entire world knowing about.

The negative issues of social networking are not just limited to the loss of privacy. Social networking also displaces social interaction, keeping people apart, which according to recent studies can start to affect social skills development. It also changes the way people interact and undermines skills such as reading body language and, in turn, responding empathetically to sensitive issues.

On balance, social networking sites like Facebook certainly have a role in keeping people connected, but like all advice we give to our patients, they must be used in moderation, because relying exclusively on electronic communication for social interaction is more likely to damage rather than enrich our lives.

Dr Spiro Raftopoulos FRACP
Gastroenterologist
YES TO FACEBOOK

Nadine Sharples is tired of being informed that Facebook is not an appropriate pastime for a grown-up paediatrician! Click to like/dislike.

My husband, who is the ultimate gadget man—strange for a geriatric trainee—really is very much opposed to my obsession with FB. It’s a strange obsession for someone who is a technophobe and a paediatric emergency trainee. However, I was asked by my FB buddy, Steven Bollipo, to write the affirmative perspective on FB for RACP trainees, although he didn’t instant message me to ask! It would have been a much more streamlined process had we had a chat via FB whilst I perused the pictures of his family and discovered his political views and choice in music and literature. But as I flit between FB and this article and updating my status, I wonder how FB will influence me as a practitioner.

When I was a junior doctor, it was almost impossible for me to imagine my consultants having lives outside the hospital walls. And I’m sure they had little idea of what I did in my spare time. When writing references that included such terms as ‘a good all-rounder’, would they have known that I was an avid reader of gruesome police procedurals, a renovator of Federation houses and a keen runner? If the FB phenomenon had been around (dare I say it?) in my day, would social networking have been the definitive ice-breaker? So much easier to have a chat about your boss’s weekend pics rather than that uncomfortable silence ... Now, as a senior registrar, when I look at my own relationship with junior staff (perhaps as I am on the cusp of Gen Y), the dynamic has changed significantly. I have been heavily involved in medical education and I have either been emailed or requested to be an FB friend by a number of junior staff on follow-up questions, career advice and even references. I can hear some gasping in horror, but in actuality it is much less confrontational and suits our busy lives with the constant juggle of work and play. FB provides the perfect opportunity to mix them both.

In the same vein, the hospital I worked in last year had its own FB page, advertising tutorials, exam practices and shift swaps, requests and job applications. This was such an advantage to the hospital and allowed trainees to access this information much like the Goodies—‘Any thing, any time, any place’—via the joy that is the iPhone.

Whatever your smartphone of choice, there is concern that it will distract you in the workplace. However, when your registrar posts a status update that they have passed their FRACP clinical exam, I would argue that seeing that on a message actually decreases the anxiety you have felt for them and saves you logging into the RACP homepage 17 times during the course of the afternoon instead of writing your discharge summaries. Similarly, medical friends will send a link via FB status post to a recent article or medical site of interest. This sharing of resources not only saves time but also helps ensure that there are no excuses from your study group at your next meeting!

Given the nomadic nature of the physician trainee, traipsing from hospital campus to hospital campus with each rotation, it is incredibly difficult to keep up the relationships with your intern/resident/registrar/nursing staff from your past rotation, with whom you have just spent every day (+/–nights if you are really lucky). I, for one, have worked in three Australian states and have many trainee friends overseas. To share the amazing news that my husband passed his FRACP exam (and subsequently his driver’s licence) was an obvious post to put on Facebook last year. The relief and outpouring of joy that comes back to you from those near and far is something that a million phone calls cannot encompass (not to mention the cost—22 cents per SMS to 200 friends—no thanks!). Besides, some of us are much more articulate with the written word—just think of how tongue-tied you become when trying to succinctly describe a complex cardiac murmur!

As another example, my Medical School class reunion was arranged mainly via Facebook, meaning we were able to coordinate our lives in a fairly relaxed environment. Does anyone else get that sinking feeling when you’re not on call and someone tries to ring at 9.30 at night for a catch up and all you want to do is go to bed?

Obviously, all this must be tempered with common sense, much as Dr Bollipo has done. I adhere to the golden rule of never accepting friend requests from patients, past or present, which is sometimes difficult as a paediatrics trainee. Similarly, inappropriate comment regarding patients or families is not good form. And I would never give medical advice online as it is not given in the privacy of a consultation and is not something you can ‘unsay’.

What I do find useful, though, is the understanding I get from my medical friends if I’ve had a rotten day or, conversely, the joy I receive from them if I’ve have an amazing success. But it certainly makes you realise that perhaps we are all connected by even less than six degrees of separation.

Interestingly, I have heard that the younger generation tends to be leaving FB as they don’t like hearing about what their mum gets up to while they are at school. And who can refuse a friend request from their mum?

As I head towards my consultancy, I realise that as time passes we must move with each technological advance but critically evaluate how it affects us and our patients. I find Facebook useful as it allows me time-efficient access to a variety of information and to my friends far and wide, as well as bragging rights to show off my beautiful little boy (and sometimes my husband, much to his disgust!).

Dr Nadine Sharples FRACP
NEW MEMBER OF THE RACP BOARD

On 30 July Ron Paterson was invited to join the College Board as a non-Fellow member and we are delighted to announce his acceptance.

Ron Paterson is Professor of Health Law and Policy at the University of Auckland. He was New Zealand Health and Disability Commissioner 2000–2010. Ron helped draft New Zealand’s Code of Patients’ Rights, and has written and lectured on a wide range of topics in health law, policy and ethics. His current research interests include the role of professionalism and regulation in ensuring the competence of health professionals. In 2004–05 Ron chaired two major health system reviews in Australia: the Review of the Assessment of Overseas-Trained Surgeons and the Review of National Arrangements for Safety and Quality of Health Care in Australia, which led to the creation of the Australian Commission on Safety and Quality in Health Care.

Ron is co-editor of the textbook Medical Law in New Zealand (2006). He is Chair of the New Zealand Banking Ombudsman Scheme.

2010 BRYAN HUDSON MEDAL WINNER

Congratulations to Dr Wallace Brownlee who has won this year’s Bryan Hudson Medal for the best performance in the combined FRACP Written and Clinical Examinations in Adult Medicine.

Wallace received the news of his win just as he was heading off for a holiday in Hawaii. A good note on which to start a holiday!

He is currently working as a Medical Oncology registrar at Auckland City Hospital, having done his basic training at North Shore, Waitakere and Auckland Hospitals. He hopes to start Advanced Training in Neurology next year.

New Zealand trainees have done well this year: the winner of the equivalent medal in Paediatric training is also from New Zealand—Dr Bryony Ryder, who works in the Neonatal Intensive Care Unit at Starship Hospital, Auckland. And last year’s Bryan Hudson Medal winner was from New Zealand—Andrew McNally, from Christchurch.

The Bryan Hudson Medal is named in honour of the late Dr Bryan Hudson AO FRACP, President of the College in 1982–1984 and an outstanding physician, teacher and administrator.

WINNER OF 2010 EXAMINATION MEDAL IN PAEDIATRICS

Congratulations to Dr Bryony Ryder, winner of this year’s Examination Medal in Paediatrics, for the best performance in the combined Paediatric FRACP Written and Clinical Examinations.

Bryony returned to New Zealand at the start of 2009 to further her paediatric training, after working in London for four years. She is currently working at Starship Hospital as a registrar in the Neonatal Intensive Care Unit. Starship has offered Bryony a fantastic learning environment with extensive support from senior colleagues, and she has been fortunate to gain subspeciality experience working as a registrar in Oncology, Neurology and Endocrinology within the past year. She plans to continue her training in the General Paediatrics Advanced Training program.
Why you need a hobby – self-care for doctors

RACP News, I had a sinking feeling that the void under hobbies could not be filled. I reassured myself that the rest of my resume was looking pretty good, but it did get me thinking about whether my lack of hobbies (except for an uncanny ability at ‘Singstar’ and a good working knowledge of the characters in Arrested Development) reflected that, like many other doctors, I wasn’t taking care of myself outside working hours.

Self-care for doctors is extremely important. Lots of trainee doctors in various training groups are stressed, depressed and in a mess. Some of this has to do with the jobs we do (seven night shifts in a row does not a happy doctor make) but there are some things we can control, which can go a long way to making life a more pleasurable experience:

• Get your own GP. I can’t stress this enough. The fact is that you don’t know everything and you can’t diagnose yourself (I am reminded of a fellow trainee who diagnosed indigestion when they actually had appendicitis).

• If you are feeling down, stressed or sick, ask for help. There is good confidential help available from your GP, state-based Doctors’ Health Advisory Service (see www.dhas.org.au), hospital-based counselling services or a trusted mentor.

• Look at the section on Trainees Cafe (via the RACP website) about Trainee Support.

• Make time for family and friends (real friends, not Facebook friends).

• Get a hobby. Singstar apparently doesn’t count.

• Take up some form of exercise.

Dr Jemma Anderson

It’s that time of year again, when job applications are submitted, resumes rewritten and dreams of Advanced Training jobs fulfilled (or crushed). It’s always a complicated time, especially when, on review of said resume, you notice a gaping black hole under one of the headings. For some it is under ‘Research’; for others it’s ‘Professional Development’ (I have been assured that ‘attended medical grand rounds’ counts as PD (sadly ‘attended Friday night registrar drinks’ does not). But for me the biggest, blackest hole of all is that mysterious resume filler ‘hobbies’.

I had a look at a few of my own past resumes for inspiration. In 1997, I listed the following hobbies: swimming, flute playing and French. Hmmm. Technically I can still swim, but listing it as a hobby would probably require that I had done more than some head-above-water breaststroke to the swim-up bar on my last holiday. French is a subject I last did in Year 10. I could probably get away with ordering a drink at aforementioned swim-up bar, but if I was asked by a potential interviewer, ‘Parlez-vous français’, I would immediately be found to be a fraud (see previous comment about crushing the dreams of Advanced Training jobs). And flute playing? Well, I’m pretty sure when I listed it in 1997 I was rubbish and I don’t think that it’s a skill that improves with time without practice (especially since my parents gave away my flute to save their ears at the earliest opportunity).

This led me to thinking about how I actually spent my time outside work.

After an hour of thinking (see the article regarding procrastination in last month’s

Dr Jemma Anderson
CANCER IN THE ELDERLY – AN AUSTRALIAN PERSPECTIVE

Geriatric Oncology, Cancer in the Elderly, Cancer in the Older Adult, Senior Adult Oncology— the issue goes by many names around the globe but the problem remains the same. As our population ages, the number of older adults with a diagnosis of cancer will increase. The provision of appropriate care to the older adult with cancer provides a number of challenges. Australian clinicians and researchers are starting to work together to improve care for our older patients.1

In 2006, the median age of patients diagnosed with cancer in Australia was 67.6 years, with 43.6% of patients aged over 70 at diagnosis.2 The number of new cases is rising out of proportion with population growth. Between 1996 and 2006, the number of patients over the age of 70 at diagnosis rose from 34,351 to 45,627, an increase of 32%. During this period, the Australian population rose by 13%.1

The definition of what constitutes an elderly patient depends on the clinical context. Haematologists who perform bone marrow transplantation consider patients over the age of 50 to be elderly. Medical oncologists, however, generally use the definition of patients over the age of 70. This differs again from the average patient seen by geriatricians who tend to be much more frail than those seen in the waiting room of an oncology clinic.

It could be argued that all medical oncologists are by definition ‘cancer in the elderly specialists’ given the median age of our patient population. However, it could also be stated that very few practitioners have the resources and training to deal with the complex needs of older patients. Dual training in geriatrics and oncology is now a recognised career path and clinicians with this expertise are driving research and education in the field. In Australia, there are currently three physicians who have either completed or are undertaking dual training.

Evidence suggests that intervention guided by geriatric assessment can enhance patient outcomes and even lead to improved survival in some clinical contexts.3

• Avoid undertreatment. Treatment decisions based on age alone can lead clinicians to either avoid potentially helpful therapy or to utilise non-standard treatments that result in inferior outcomes. In a recent randomised trial of adjuvant chemotherapy in older patients with breast cancer, use of a suboptimal chemotherapy regimen in an attempt to ameliorate toxicity actually led to significantly inferior survival in the experimental arm.4

• Fit elderly patients can tolerate treatment as well as younger patients and derive equal benefit. Although the ageing process does result in a reduction in functional reserve and therefore an increased likelihood of treatment related toxicity, this does not apply to all patients. Adequate assessment of organ function is a very important component of cancer care in this population. Adjustment of the dose of chemotherapy is sometimes required to compensate for reduced organ function.5

Improvements in supportive care over recent years have enabled more patients to derive benefit from chemotherapy and improve quality of life whilst on treatment. Routine use of colony stimulating factors in older patients receiving immunosuppressive combination chemotherapy results in major improvements in outcome and reduced incidence of infectious complications.

• A multidisciplinary approach is recommended. While many older patients with cancer can be successfully managed in the standard oncology clinic, there is a growing need for interdisciplinary cooperation and the formation of geriatric oncology services. Such clinics can streamline the assessment and management of elderly patients and enable oncologists to focus on management of the patient’s cancer. Geriatric oncology clinics have been set up in a number of centres around the world.

In a recent randomised trial of adjuvant chemotherapy in older patients with breast cancer, use of a suboptimal chemotherapy regimen in an attempt to ameliorate toxicity actually led to significantly inferior survival in the experimental arm.

As clinicians and researchers grapple with the specialised issues surrounding cancer in older patients, a number of basic principles apply, as follows:

• Know your patient. The population of older patients is quite heterogeneous. Care must be taken to individualise the treatment approach and not make treatment decisions on the basis of age alone. Adequate geriatric assessment is thus the cornerstone of the management of the older patient with malignancy. Geriatricians use multidisciplinary team assessment and, more importantly, intervention to enhance patient outcomes. Full comprehensive geriatric assessment for all patients is an unrealistic goal given the resources required and lack of time in a busy oncology clinic. An abbreviated assessment screening for geriatric issues that are not normally part of standard oncological assessment is, however, quite feasible.

The International Society of Geriatric Oncology (SIOG) and the National Comprehensive Cancer Network (NCCN) guidelines recommend that all patients over the age of 70 years undergo some form of geriatric assessment.6

RACP News October 2010 31
Australia’s first geriatric oncology clinic is now operating at the Royal Adelaide Hospital. It has been shown to be feasible and acceptable to patients. It is hoped that the ‘Adelaide model’ of care can be emulated around Australia as more clinicians realise the value of such specialised care.

Organisational issues
A number of professional bodies are now involved in the field of geriatric oncology in Australia. The Clinical Oncological Society of Australia (COSA) provides support for a special interest group that is leading debate and the education of clinicians around Australia. The Medical Oncology Group of Australia (MOGA) has focused on cancer in the elderly at its Annual Scientific Meetings and recently presented at the World Congress of Internal Medicine in Melbourne. It is hoped that clinical trials and research specific to the elderly will stem from interactions with COSA and the cooperative oncology groups.

It is also hoped that ongoing collaboration with groups such as the Australian New Zealand Society of Geriatric Medicine (ANZSGM) will lead to improved communication and increased sharing of knowledge. Primary care practitioners currently play a major role in the care of the elderly in the community and already have access to funding for provision of geriatric assessment (e.g., Medicare item number 700). Utilisation of these existing resources may provide novel solutions to the lack of resources to deal with this ever-increasing problem.

In my opinion, clinicians in Australia have the opportunity to draw on international experience and make significant advances in this growing area of healthcare. It is incumbent on us as healthcare professionals to work together to find a way of ensuring optimal care for all patients with cancer, regardless of age.

Dr Christopher Steer FRACP
Chair Geriatric Oncology Interest Group
Clinical Oncological Society of Australia

References

PHARMACEUTICAL BENEFITS ADVISORY COMMITTEE

Minister for Health and Ageing Nicola Roxon recently appointed Dr Matthew Doogue, clinical pharmacologist and endocrinologist, as a new member of the Pharmaceutical Benefits Advisory Committee, and reappointed Professor David Isaacs, Clinical Professor at the University of Sydney and paediatrician at the Department of Immunology and Infectious Diseases, based at The Children’s Hospital at Westmead, Sydney, for a further four-year period.

The RACP is well represented on this Committee. Of the 20 members of the current Committee, 10 are College Fellows. The other eight are: Dr Jim Buttery FRACP, Research Development Director, NHMRC Centre for Clinical Research Excellence in Child and Adolescent Immunisation and a consultant paediatrician and infectious diseases physician at the Royal Children’s Hospital, Victoria
Professor Terry Campbell AM FRACP, Professor of Medicine at the UNSW and Head of the Department of Medicine, St Vincent’s Hospital, Sydney
Professor Albert Frauman FRACP, Professor of Clinical Pharmacology and Therapeutics at the University of Melbourne and Director of the Department of Clinical Pharmacology and Therapeutics at Austin Health; also an endocrinologist

Adjunct Professor Michael Frommer FAFPHM FAFoem, Adjunct Professor at the School of Public Health, University of Sydney, and Director of the Sydney Health Projects Group
Professor David G Le Couteur FRACP, Professor of Geriatric Medicine at the University of Sydney, Director of the Centre for Education and Research on Ageing, Director of the Biogerontology Laboratory of the ANZAC Research Institute and Senior Staff Specialist Physician at the Concord RG Hospital, Sydney
Associate Professor Geoff McColl FRACP, rheumatologist, Clinical Dean at the Royal Melbourne Hospital/ Western Hospital Clinical School and Senior Lecturer, University of Melbourne Department of Medicine
Dr Andrew Roberts FRACP FRCPA, NHMRC Practitioner Fellow, Division of Cancer and Haematology at The Walter and Eliza Hall Institute of Medical Research; practising clinical haematologist and medical researcher
Professor Robyn Ward FRACP, Professor of Medicine at Prince of Wales Clinical School, UNSW, and Senior Staff Specialist in Medical Oncology and Family Cancer Services at St Vincent’s Hospital
MISPERCEPTIONS AND RISK: BRIDGING UNDERSTANDING BETWEEN CONSULTANTS AND DITS

For many consultant physicians in the public system, working with young doctors who are training is an everyday occurrence. The exchange can be incredibly rewarding or at times—when the unit is frantic and you are tired—incredibly frustrating. This article, prepared by Australia’s largest medical defence organisation, Avant, explores how misperceptions between doctors in training (DITs) and senior consultants and registrars (seniors) may occur. It also provides suggestions about how these might be improved.

Many of the frustrations Avant hears from doctors in training involve a sense that they are uncertain of what to do in unfamiliar situations. Many of the frustrations Avant hears from seniors is that DITs are ‘just not what they once were’. Nursing staff are in the middle and try to manage it all. And the patient, well, they are often caught in the middle too.

**Common situations where miscommunication issues can arise**

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<tr>
<th>Situation</th>
<th>Consultant’s perspective</th>
<th>DIT’s perspective</th>
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<tr>
<td>Activities and Tasks needed to be undertaken in the unit</td>
<td>Assume the previous fellow told the DIT what to do. Iritated that this new fellow does not know what to do. And why are they calling me? Was the registrar exam week really this week?</td>
<td>Previous fellow left for country rotation without any formal handover. No notes in existence of the job or what to do. Timetable supposed to be given by registrar who is away on exam leave.</td>
</tr>
<tr>
<td>Procedure needed to be done on a patient</td>
<td>What happened to see one, do one, teach one?</td>
<td>I have seen one but I have never done one of these procedures—they were all done in radiology where I last worked.</td>
</tr>
<tr>
<td>Cover for the evening needs to be provided for a unit where the DIT has never worked</td>
<td>Whatever happened to ‘general training’? They are all prima donnas nowadays.</td>
<td>I need to have my scope of practice better defined. I don’t feel comfortable here; I have never done this before or been in this ward before.</td>
</tr>
<tr>
<td>Forget about hospital policy: Go and get consent from that patient—they need a treatment now</td>
<td>I give up. What do the new DITs actually do because I seem to be doing all the work? And why I gave the registrar leave I will never know! I will not approve leave again!</td>
<td>I have been told that I do not have to do what I don’t feel comfortable doing. In the last hospital I worked in, junior doctors don’t get consent; it’s a consultant’s job.</td>
</tr>
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</table>

**Practical solutions to consider in these situations**

Having explored some of the common issues that can arise, we now identify a few practical ways to overcome these situations should they occur within your workplace.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Suggested action of the consultant</th>
<th>Suggested action of the DIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities and Tasks needed to be done in the unit</td>
<td>The consultant meets new DIT on their first day. Could be the Head of Unit or the consultant rostered on for the day, but they are charged with explaining: how the unit works, what the unit does and what the unit’s overall purpose is the various roles of an intern, postgrad year two, postgrad year three and registrar what is expected of the DIT the unit’s timetable and roster. Provide a list of key contacts and a unit induction handbook. An induction handbook will take time to develop but will be invaluable in better orienting anyone who comes to work in the unit.</td>
<td>Suggest a meeting during the first week and ask for answers to the following: the unit’s purpose clarification on the various roles of an intern, postgrad year two, postgrad year three and registrar what is expected of the DIT the unit’s timetable printed when, who and how to call for advice or assistance. Also ask for a list of key contacts.</td>
</tr>
<tr>
<td>Procedure needed to be done on a patient</td>
<td>As part of the first few weeks of the term, the consultant should confirm what skills the DIT has. Encourage and ensure the DIT is capable before suggesting they undertake anything unsupervised.</td>
<td>Keep a log book on what you have seen and what you have done. Be clear about any procedural experience so unit personnel are aware of your skill profile.</td>
</tr>
<tr>
<td>Cover for the evening needs to be given to another unit where the DIT has never worked</td>
<td>Be sympathetic to the concern, but if the DIT has the appropriate skill set, reassure the DIT that they have the skills to do the role. Advise the DIT to call the unit registrar with any concerns or call you if they get stuck. Contact the unit registrar the next day if your DIT had not been supported and ask the registrar to be more helpful in future.</td>
<td>Be positive. Don’t think you can’t cover a unit just because you have not done so before. Ask nursing staff if unsure, then the registrar, then the consultant. Have all the details about the patient about whom you are concerned including a recent set of observations.</td>
</tr>
</tbody>
</table>
PROCEDURAL FAIRNESS: PROTECTION FOR DECISION MAKERS

Every day the College makes decisions that affect its trainees, Fellows and overseas trained physicians. Their admission to training, whether or not they are awarded FRACP or other post-nominal, their ability to practise and their recognition by Medicare are all affected by decisions made by the College.

The College is committed to making decisions that could affect people unfavourably with consistent procedural fairness. The old-fashioned term for procedural fairness is ‘natural justice’. Although the term has a lovely romantic resonance, it wrongly implies a high-minded entitlement to ‘justice’ that is somehow ‘natural’—well above and beyond the dull reality of procedural fairness. To lawyers, a right to natural justice is just a right to procedural fairness.

Procedural fairness means that, as a decision maker, the College consistently follows a fair and proper process in reaching decisions that are likely to affect the rights, interests or legitimate expectations of a person. Following a fair process makes a fair decision more likely, and a successful challenge less likely. It is not about the outcome of the process, or about the merit of the decision made; it is all about the process that is followed.

Although a proper and defensible appeals process is the key to procedural fairness, it is essential that the initial (or ‘primary’) decision is properly made. Most primary decisions are not appealed, and every effort should be made to ensure that the initial decision is made fairly.

The College commitment to procedural fairness is reflected in the College Reconsideration, Review and Appeal Process, which is on the website at <www.racp.edu.au/page/education-policies>.

The process includes three key principles of procedural fairness:

- **The hearing rule**
  The College must give the person who is adversely affected by a decision the opportunity to be heard. It must inform them of the case against them, and give them a fair opportunity to answer it and the opportunity to present their case.

- **The bias rule**
  The decision maker must be unbiased, and not have an interest in the matter being decided, or reasonably be seen to have such an interest.

- **The ‘no evidence’ rule**
  The decision made must be based on evidence.

Before they reply, the person affected should have the relevant information before them. A summary of the issues is appropriate. Original documentation doesn’t have to be provided, and the identity of confidential sources doesn’t have to be disclosed.

The College Reconsideration, Review and Appeal Process also provides for an ultimate review by an Appeals Committee. No member of the Appeals Committee can have been a party to the previous decisions, and external members are included. This is good practice, to ensure that the most vexed cases are subject to independent review.

The Appeals Committee has broad powers to reconsider decisions.

In the past, the Courts have usually only intervened to require procedural fairness in decisions made by government bodies. Now, although the Courts remain reluctant to interfere in decisions made by private (non-government) organisations, they are increasingly reviewing any decisions that affect the rights or interests of individuals.

The College has designed its Reconsideration Review and Appeal Process to provide procedural fairness, and to protect its decision makers from challenges to their decisions.

Decision makers are protected by the integrity of College procedures, by their own thoroughness and professionalism, and by carefully following the procedures. To maintain the integrity of the College procedures, decision makers should resist any temptation to change or add to any part of the decision-making process.

The current professional indemnity insurances held by the College include indemnity for Fellows carrying out the authorised activities of the College.

If you have any queries about procedural fairness, please send them to me at generalcounsel@racp.edu.au.

Susan Myers
General Counsel
Royal Australasian College of Physicians
Changes to the RACP Internet/Web-Based Video Conferencing System Coming Soon!

Vidyo™ 2.0 Upgrade, 18 October 2010

We are pleased to announce a major upgrade to the RACP Vidyo™ video conferencing technology, which will now be accessed directly from the RACP website. This upgrade comes as part of a suite of enhancements to the way that RACP manages access to meetings and events using video conferencing which you can access via the button at www.racp.edu.au.

Why are we making the change?

This new service provides far better quality and a superior user experience. As many utilise this technology for critical meetings, we want to ensure you have access to the most advanced technology available. It also provides new functionality, including the ability to share your entire desktop and enhancements to the behind-the-scenes production management allowing greater quality control.

What do you need to do?

After the upgrade, everyone will need to download the new Vidyo™ 2.0 Desktop Client the first time they make a call. This will happen automatically when you try to participate in a video conference meeting or join a video room after 18 October. Simply follow the prompts on the pop-up window that appears on your screen and you’ll be connected in approximately two minutes.

If you wish to upgrade to the new Vidyo™ 2.0 Desktop Client ahead of time, you can do so by going to <www.racp.edu.au> and clicking on the button underneath the main menu bar on the left-hand side. Once you’re on the JOIN screen, click on the ‘Set up and test your system’ link and follow the prompts.

For assistance, contact RACP Web Support at web-support@racp.edu.au or on 02 9256 9690 between 8 am and 8 pm Monday to Friday.

Note: This will require administrator rights on your computer permissions to download and install .exe files if you are on a corporate network. Please make sure that you download the new software in plenty of time for your next important meeting to ensure that any issues can be addressed.

What does this mean for you?

Some of the great new enhancements include:

- Java is no longer required to install the Vidyo™ Desktop Client—it is a stand-alone install now.
- Vidyo™ 2.0 Desktop Client has voice echo cancellation enhancements.
- Selection/changing of audio and video devices is simpler and can be done whilst connected to your meeting.
- Users can share their whole desktop as well as individual windows.

Note: Future releases will allow for the sharing of video files. All future Vidyo™ product enhancements will be based on this new platform.

What else do you need to know?

If you are new to internet/web-based video conferencing (WVC), there are a few things you need to know. Using the system requires a PC or Mac computer manufactured within the last couple of years and the same skills used to browse the web or use email, so you just need to be comfortable using PC-based systems. You may need to seek assistance from a tech savvy family member or workplace IT support person.

The additional equipment required to participate in meetings is:

- A USB WebCam/Microphone. Visit the RACP website for current details of suitable equipment. If you will be attending meetings frequently, speak to your Committee Executive Officer to ask the College to supply you with a Webcam.
- Headphones, as used with iPods and other personal audio players.

RACP approved meetings and events via WVC are coordinated and supported by the RACP Events and Meetings Team. You can contact the team to organise a session for initial set-up and testing via racrevents@racp.edu.au or 02 8247 6240.

We recommend that you carry out a test before each meeting and certainly after you download the new Vidyo™ 2.0 Desktop Client. This will ensure that we can identify any issues and provide technical support and solutions, or suggest alternative attendance arrangements.

Further information about the upgrade will be available leading up to 18 October, so please ensure that you read your emails for important updates.

Please note: Older versions of Vidyo™ software can no longer be used after this date.

The Cartwright Papers

Essays on the Cervical Cancer Inquiry 1987-88

Edited by Joanna Manning. Published by Bridget Williams Books. RRP NZ$39.99

On pages 7–9 of this issue, Ron Paterson, Professor of Health Law and Policy at the University of Auckland, writes on the legacy of the Cervical Cancer Inquiry in New Zealand. If you would like to revisit this Inquiry, described as ‘a watershed in the history of medicine and health care in New Zealand’, The Cartwright Papers offers both a clear account of the ‘unfortunate experiment’ at National Women’s Hospital in Auckland and the Inquiry itself from some of the participants, and a strong rebuttal of recent challenges to the Inquiry’s findings.

Contributors include Clare Matheson, one of the patients; Sandra Coney who wrote the article leading to the Inquiry; Dr Ronald Jones, Honorary Professor of Obstetrics and Gynaecology at the University of Auckland and a visiting Obstetrician and Gynaecologist at National Women’s Hospital, one of three authors of the paper that exposed the experiment; Professor Charlotte Paul, a medical adviser to the Inquiry; Professor David Skegg, Vice-Chancellor, University of Otago, who as an epidemiologist has worked mainly on the causes and control of cancers such as breast and cervical cancer; as well as other specialists in health law, medicine and ethics.

The book is available from Bridget Williams Books at www.bwb.co.nz

RACP News October 2010 35
“I am thrilled to be able to continue this once-in-a-lifetime opportunity to work at a prestigious university and hospital known for advances in kidney injury and, most importantly, to have the opportunity to make possible new scientific discovery that will help people with kidney disease and their families. I am looking forward to developing this research further over the next 12 months, to forge new connections and collaborations, and to make a meaningful difference to the understanding of kidney disease.”

Dr Suetonia Palmer, Don & Lorraine Jacquot Fellowship 2010 recipient

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145 Macquarie Street
Sydney NSW 2000
Fax: (02) 9256 9697

or send your details by email to foundation@racp.edu.au

For more information, visit our website at: www.racp.edu.au

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<thead>
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<th>Levels of membership</th>
<th>$ Annually</th>
<th>$ Quarterly</th>
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<tr>
<td>Fellow-in-training</td>
<td>$120</td>
<td>$30</td>
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<tr>
<td>Member</td>
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<td>$75</td>
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<tr>
<td>Gold Member</td>
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<td>Benefactor</td>
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<tr>
<td>Life Member (one-off or cumulative donations)</td>
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<tr>
<td>Life Governor (one-off or cumulative donations)</td>
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Please list my name on the Honour Roll as:

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Quarterly payments only available when paying by credit card.
The jubilation of passing the FRACP exams and being accepted into the Victorian oncology training program was a distinctively vivid career milestone for me. Much of my focus up till then had been the pursuit of clinical knowledge and practice skills. At the same time, it dawned on me that the conveyor belt I had been on since graduation was coming to an uncertain end. I would soon have to make career defining decisions rather than merely going along with the flow.

My road to research began as an oncology registrar grappling with the excitement of a new beginning, mixed with trepidation concerning the enormous amount of knowledge I needed to grasp. Advances in cancer care have resulted in a rapid shift away from the empirical approach to a new paradigm of personalised medicine through the targeting of specific pathways and receptors, requiring today’s oncologist to have a good grasp of concepts such as proliferative and apoptotic pathways, mechanisms of cross-talk and resistance, tumour heterogeneity and appropriate patient selection. This new world of clinical trials with biological therapies exposed the deficiencies in the basic science and research skill sets of my clinical training to this point. I was overwhelmed and underprepared, but at the same time captivated by this new frontier unfolding before me.

In an attempt to learn from the research community, and armed with little other than enthusiasm, I was encouraged by Professor Jonathan Cebon, my supervisor during my first year of oncology training at Austin Health, to attend weekly laboratory presentations at the affiliated Ludwig Institute of Cancer Research. Whilst most did not make sense to me at that time, I persisted in the vain hope that some of the knowledge would diffuse into me and eventually become clear. Importantly, my mentors in oncology provided me with opportunities to explore my curiosity for research through participation in small projects that were achievable with the limited resources at hand.

Upon completion of my oncology training, I realised that I would need to further equip myself for a research-focused career. Two options that I considered were pursuing a laboratory-based PhD program, or obtaining broader training in analytical skills, biostatistics and epidemiology through a Masters of Public Health. Both required taking time away from my clinical career, and funding was competitive to obtain, and significantly less remuneration than for a service-oriented clinical position. I chose the first option because a good foundation in basic science was what I lacked most at this stage of my career and it was increasingly relevant to oncology. Crucial to proceeding with this decision was funding through scholarships from the National Breast Cancer Foundation and the Clinical Oncological Society of Australia.

In my four years in the laboratory under the tutelage of Professors Geoffrey Lindeman and Jane Visvader at the Walter & Eliza Hall Institute, I became an ‘expert’ in the focused area of dissociating human mammary tissue (my lab mates called me ‘the butcher’) and more broadly in mammary biology. I questioned the relevance of the repetitive nature of my laboratory experiments to my career as an oncologist. In hindsight, I did not acquire the encyclopaedic knowledge in cancer biology that I had naively hoped a PhD would bestowed on me. Rather, what I learned was dogged persistence and the processes of developing hypotheses, designing experiments and interpreting results. It was an apprenticeship that educated me to engage, communicate and collaborate with other biomedical research colleagues.

I still consider myself first and foremost a physician, whose primary focus is good patient care rather than laboratory research; my PhD supervisors would certainly attest to that.

In conclusion, I quote a Chinese proverb which states: ‘A journey of a thousand miles must start with a single step.’ Vital to starting my first steps in a relatively short journey in research have been two essential ingredients. The first was excellent mentorship … and the second was support from funding agencies.

Having equipped myself with some research skill sets, my hope was to contribute to the application of breakthrough therapies to patient care and to continue to play a role in the wider scientific community. This has led me to pursue a translational fellowship in the area of breast cancer at the Dana Farber Cancer Institute and Harvard Medical School as a fortunate recipient of the Fulbright Victoria Scholarship and a JJ Billings/RACP travel award. My current projects are focused on clinical trials with new biological agents and their correlative end-points, building upon the clinical and laboratory experiences obtained in Melbourne. The goals are to identify factors that predict for therapeutic efficacy, mechanisms of treatment resistance and strategies to overcome them. On a more personal note, this sojourn from Melbourne has also allowed me to take stock and chart a new direction for my personal growth and my career.

In an attempt to learn from the research community, and armed with little other than enthusiasm, I was encouraged by Professor Jonathan Cebon, my supervisor during my first year of oncology training at Austin Health, to attend weekly laboratory
IPA CONGRESS OF PEDIATRICS: BRIDGING THE GAPS BETWEEN CHILD & ADOLESCENT HEALTH

As you may be aware, the Paediatrics & Child Health Division of the College will host, on behalf of the IPA, its 27th IPA Congress of Pediatrics in Melbourne on 24–29 August 2013. Place the dates in your diary now and more about this event later ...

On 4–9 August 2010, the 26th IPA Congress of Pediatrics was held in Johannesburg, South Africa. Over 3500 delegates registered for the conference; of these, approximately 55 were from Australia and New Zealand. From the reports to date, the Congress was a huge success. The scientific program comprised a mix of clinical and public health sessions that were relevant to both developed and developing nations. An official handover occurred at the end of the Congress, from South Africa to Australia.

In line with current IPA process, Associate Professor Neil Wigg was appointed President of the 27th IPA Congress of Pediatrics by the IPA. In this capacity, he will also serve on the IPA Executive Committee in the lead-up to the Congress in 2013.

An Organising Committee has been established for the 2013 Congress comprising:

Dr Gervase Chaney  
Professor Elizabeth Elliott  
Dr Trevor Duke  
Dr Hasantha Gunasekera  
Dr Rebecca Mitchell  
Dr Jenny Proimos  
Associate Professor Jill Sewell  
Associate Professor Neil Wigg.

Following a call for expressions of interest made to the wider Fellowship in 2009, members of the Scientific Program Committee for the 2013 Congress were appointed as follows:

Professor Elizabeth Elliott – Chair (NSW)  
Dr Angela Alessandri (WA)  
Professor Paul Colditz (QLD)  
Associate Professor Andrew Day (NZ)  
Professor Keith Grimwood (QLD)  
Dr Harriet Hiscock (VIC)  
Dr Heidi Peters (VIC)  
Dr Jacqueline Small (NSW).

The Division felt that it was important to have a mix of paediatricians from different specialty/practice areas and at various stages of their career. The IPA will also be appointing members to the Scientific Program Committee to assist in planning across the entire program.

A number of the members of the Organising and Scientific Program Committees for the 2013 Congress attended the conference in Johannesburg. This allowed the opportunity for them to experience the IPA’s scientific program, gain further knowledge relating to the mechanics of an IPA Congress and to meet with representatives from the IPA’s Executive Committee. The RACP’s allocated booth in the exhibition area was inundated with paediatricians from all around the world expressing their interest in Melbourne and the Congress that the Division will be hosting.

The overarching theme for the 27th IPA Congress of Pediatrics is Bridging the Gaps between Child & Adolescent Health. It has been suggested that, within the Congress program, there would be themes related to the Millennium Development Goals (MDGs) and a plan for post-2015; the gaps between research and practice; transition care; beyond survival gaps in education and opportunity; therapeutic gaps (better medicines); workforce gaps in education and training; bridging gaps in professional partnerships; and humanitarian emergencies.

The Division aims to develop a program that is relevant to both international paediatricians and Australian and New Zealand Fellows/trainees, as well as members of the Chapter of Community Child Health. Discussions are also continuing with other allied health colleagues in relation to their involvement in the 2013 Congress.

The Division has determined that it will not meet as part of the RACP Congress in 2013 and that the 27th IPA Congress of Pediatrics will be the main congress for its members in that year.

The Division looks forward to seeing you in Melbourne in August 2013 and, in the meantime, it will keep you updated on Congress/program developments over the next three years.

Dr Gervase Chaney  
President  
Paediatrics & Child Health Division

Colin Borg  
Senior Executive Officer  
Paediatrics & Child Health Division
TRAINING – PATIENT SAFETY FOR THE NEXT 30 YEARS


Following the introduction in 2009 of the European Working Time Directive (EWTD) for the training of doctors in the NHS in the UK, Professor Sir John Temple conducted a review of its impact, the results of which are included in his report, Time for Training. This review has significant relevance, not only for medical training within the context of the NHS but also for Australia and New Zealand.

The process for the review is outlined in the graphic opposite. Sir John commented that ‘compelling judgement and information were used as a proxy for evidence’ as the EWTD was only introduced in 2009 and it was difficult to ascertain from quantitative data the impact of the EWTD on the ability to deliver high-quality training. The EWTD requires all training to be delivered within the 48-hour working week. Sir John noted that ‘the impact of the EWTD has to be considered within the context of a complex, ever-changing healthcare system and contemporary models of service and training delivery’.

The Review concluded that high-quality training can be delivered during the 48-hour working week. However, it noted that when trainees have a major role in out-of-hours services, are poorly supervised and have limited access to learning, then the quality of training does not meet the necessary standards. The major issues are:

- Gaps in rotas result in lost training opportunities and moves to full shiftwork often lead to an increase in gaps and a reduction in trainer–trainee interaction, as well as an increase in the number of handovers (always high risk for patient harm).
- The impact of the EWTD is greatest in specialties with high emergency and/or out-of-hours workloads, leading to an exacerbation in the loss of elective training opportunities.
- Traditional models of training and service delivery waste learning opportunities, with reduced hours resulting in a dilution in the quality and quantity of training.
- Despite the EWTD being in place and more consultants being employed, consultants continue to work according to traditional training models. That is, the traditional system persists, with trainees being responsible for delivering the majority of out-of-hours service and consultants not being used and/or facilitated to benefit training.

- The EWTD can be a catalyst to reconfiguring and redesigning service and training to achieve a ‘better, safer service to patients with enhancement of the quality of training’.
- Where the EWTD has been implemented effectively, positive impacts of reduced working hours are seen, with more appropriately experienced doctors involved in acute care and enhanced supervision of trainees out of hours leading to safer patient care.

The Review put forward five key recommendations within the context of trainees needing to learn in a service-based environment and each clinical encounter being an opportunity for learning. The Review states:

‘Training is patient safety for the next 30 years.’

A whole of system approach is required. Trainees need to be supported through close, appropriate supervision in order to increase learning opportunities and improve clinical decision making, diagnosis and treatment pathways, which will result in improved patient safety. The Review states: ‘to achieve this it is imperative that the NHS moves to a consultant delivered service’.

The key recommendations of the Review advocate that the NHS:

1. Implement a consultant delivered service, defined as a consultant 24-hour presence or ready availability for direct patient care responsibility. This would necessitate more flexible consultant working hours and reconfiguration or redesign of the way that services are currently delivered.

2. Move to more regional and national reconfiguration solutions, particularly for smaller specialties, so that service delivery explicitly supports training. This may result in some hospitals no longer supporting training. It may also require a reappraisal of current employment contracts for consultants.

3. Make every moment count, with training planned, focused and directed to the individual needs of the trainee. This requires a move from ‘experiential to competency-based learning relevant to the particular specialty’. Effective, safe and supervised handovers should be the norm to enable not only better patient care but better learning. Simulations and technology training must be enhanced to accelerate the acquisition of skills, along with better transfer of learning to the trainee. Working within multidisciplinary team environments is crucial to ensure training that enhances decision making and innovation through collaborative relationships.

4. Recognise, develop and reward trainees to enable consultant educators to be identified, trained, accredited and supported in their job plans. Additionally, consultants should be streamed to either training or non-training posts.

5. As training excellence requires regular planning and monitoring, ensure that funders provide incentives for training to be prioritised at a system level and monitored as to its impact on safety and quality of care.

RACP News October 2010 39
In conclusion, Professor Sir John Temple states in the Review that ‘what is very clear ... is that the status quo cannot continue if we are to train from now on the professionals of tomorrow for continued high quality healthcare delivery and patient safety’.

Dr Sharon L Kletchko MD
FRCP FRACP FACEM
Member of the RACP NZ Joint Executive and Policy and Advocacy Sub-Committee

DR BRUCE STOREY
16.11.1927 – 12.6.2010

Gilbert Norman Bruce Storey was born in Drummoyne on 16 November 1927. His grandparents had settled at Mort Bay in Balmain as shipbuilders in the 19th century, and his father, an accountant by training, worked in the family business, situated in Birchgrove.

Bruce grew up in Bondi and Balmain, attending Balmain Public School, before moving to Sydney Grammar School for his secondary education. He found a natural home at Grammar, forging many lifelong friendships and excelling at rugby, cricket, swimming, athletics and boxing. He remained committed to the school and later served for 16 years as a trustee.

In 1947, Bruce enrolled in first year medicine at the University of Sydney, residing in Wesley College, where he continued to pursue his rugby career, playing for the University 1st XV for four years before moving to the Randwick club for which he was vice-captain. Summer activities centred around the Palm Beach Surf Club, competing in carnivals as well as serving on the beach.

Graduating in 1954, he took positions at Marrickville District Hospital, Royal Alexandra Hospital for Children and Concord Repatriation General Hospital. While at the Children’s Hospital, Bruce met Doreen Procter whom he married in 1954. Felicity Ann was born in 1959 and in 1961, with wife and child, Bruce sailed for England to pursue his training. He had been influenced by a number of the paediatricians at the Children’s Hospital and realised that he needed to travel in order to achieve the necessary experience for specialist practice. Like many, he set forth with hope and aspiration but no firm job.

In England, Bruce worked at West London Hospital, Hammersmith, and at Guy’s Hospital. Life was not easy in England and so, once again fuelled with aspirations for a new experience, the family travelled to the United States, and Bruce took up a position of research fellow at Johns Hopkins Hospital, focusing on bilirubin metabolism, at that time a major problem in the newborn. Here, he gained valuable experience in neonatal medicine and was successful in the specialist examinations set by the Board of Paediatrics.

Returning to Sydney in 1967, Bruce wanted to practise as a Neonatologist in line with his training, but Neonatology was yet to be recognised as a sub-specialty and no positions were available. He worked in a number of positions before being appointed as a staff specialist at King George V Hospital in 1968. In 1969, he established the Neonatal Intensive Care Nursery where he spent the next 20 years.

During his tenure, he witnessed the rapid development of the fledgling specialty of Neonatology, which was driven by expanding technology and a huge reduction in mortality and morbidity. He was involved in the Australian Paediatric Association, serving as secretary for four years, and was the chairman of the Royal Prince Alfred Hospital Medical Board. He was the enthusiastic organiser of the early Saturday ‘Dawn Service’ meeting held at King George V and travelled within New South Wales as an invited lecturer, as well as to a number of overseas venues, including Buenos Aires, Atlanta, China and Indonesia. In 1990, Bruce moved to the Children’s Hospital where he worked as Director of Physician Training until his retirement in 1993.

Retirement gave Bruce the opportunity to pursue his interest in the History of Medicine. Over the ensuing years he served as honorary archivist for the Children’s Hospital, worked in the archives at Royal Prince Alfred and at the College, contributed to the undergraduate medical student program, and completed a masters degree followed by a PhD. Leisure activities included skiing which, although he took it up later in life, became one of his enduring passions. The annual family ski trip involved moving three generations to and from the higher and colder places in the Colorado Rockies and included many hours on the slopes with his daughter and grandchildren.

Bruce managed to secure a Gold Medal on the Nastar course at the age of 82!

Earlier this year, Bruce discovered that secondaries from oesophageal cancer would soon claim his life. Despite the grim prognosis, he continued to participate in his usual activities, displaying his ever-present enthusiasm. He even took his first-year medicine tutorial group only days before his death. Bruce died peacefully surrounded by his family on 12 June at Royal Prince Alfred Hospital. A celebration of his life was held at the Royal Sydney Golf Club on 17 June, attended by more than 400 people. He is survived by his daughter, Felicity, and grandchildren, Melanie and Timothy.

Bruce displayed an unerring zest for life, befitting of a much younger man. His enthusiasm, optimism, sense of humour and encouragement underpinned his unique contribution to neonatal medicine in Sydney.

Robert Halliday FRACP
Dr Allen Christophers was born in Melbourne in 1915. After graduating in medicine and later science, he looked to a career in research physiology at the University of Melbourne. This ended abruptly when, at one departmental meeting, he showed as foolish a line of argument presented by his professor. Cast from academia, he then turned to the Victorian State Health Department and occupational hygiene, and became Chief Industrial Hygiene Officer in 1956. He retired from that position in 1980 to follow intellectual pursuits and a life with his then new wife, Pam de Silva. In 2002, he was made an Honorary Fellow of the AFOEM.

As Chief Industrial Hygiene Officer, Allen advised government, workers and employers on the health effects of radiation and the toxicology of substances. He would explain toxicology from first principles, using original case reports together with his deep knowledge of physiology and physical chemistry.

I first met Allen in 1976. Others in occupational medicine had earlier cautioned me about ‘this formidable Dr Christophers’. In fact, I quickly realised that the people who were critical or fearful of him were simply offended by his insight, his original mind and his refusal to kowtow to anyone just because of his or her societal status. He was never humbled by a person with more expertise in a field and he could be stubborn; he would always take them on if he thought that their line of argument was weak. He held particular disdain for opportunists who distorted or mocked knowledge, particularly those who took the ‘post-modernist’ stance that objectivity and fact don’t exist and that science is a means of dominating people rather than expanding knowledge.

In late 1976, Allen recruited me to work with his team of scientific officers and technical staff. In my work with Allen, he was generous with sharing knowledge and acted wisely as a ‘sounding board’. Outside my parents and immediate family, Allen has had the greatest influence on my life. The most valuable thing he gave was to deepen my insight, to foster my critical abilities.

His influence still leaps from the pages of my student notes at Monash University—failure to account for multiple hypotheses in epidemiology … being cautious of the scary but vague statement, so much the grist of the bottom-feeders in exposure commentary: ‘Could low levels of exposure do harm?’ As well, he enthusiastically offered his ideas on individual topics such as heavy metals, phosphine, phenoxy herbicides, mites, melanoma, hyperventilation, circulatory physiology, mass psychogenic illness … and he introduced me to the cheeky philosophy of the late David Stove.

What built his influence among those close to him? Perhaps the obvious thing was his fearless pursuit of truth. To this, he lent sustained energy and intellect, and had the courage to defend his stances. People from outside the public service were invited to his Friday afternoon scientific meetings—postgraduate teaching in occupational health that preceded any university course in Victoria.

But it was more than that. Truth can be found in the phonebook. His passions and desires created a workplace where what we did had both meaning and pleasure (read ‘happiness’). He encouraged all his staff to build their talents and didn’t hold people distant by exerting control or by forcing a win/lose. His moral leadership put high human values into enduring and eloquent form, yet ever consistent with empirical knowledge. He seemed to live the true essence of socialism, through sharing knowledge and conveying to all our team the importance of what we did and how we could serve others.

A lasting image of Allen is of a small, lithe figure in a cardigan and slip-on shoes at the lunchtime game of solo whist. The effect of his dry wit was heightened by his sparing conversation. He’d commonly lead a low card, say a two of clubs. He’d admonish any dealer who made the bidding dull by excessive shuffling of the cards. And, if a naive bidder failed in a misere contract because he or she had a long suit without the ‘two’, Allen would offer firm but apt advice.

A long passage through life is not for wimps. Allen and his first wife, Marge, saw the untimely death of two of their children. And, too, Allen lost Pam, his second wife, to breast cancer. His closing words at her funeral in May 1997 were: ‘I started by adoring her with passion. As I grew older the passion slowly died, but the adoration remained unaltered.’

In the twilight years, he would travel by train or tram on Friday lunchtime to where I worked. He always had ideas about projects but I seldom had the time to be involved because of so many other demands—heavy workload and family. His last publication, a book, Paediatric Lead Poisoning in Queensland, was published in 2000 by the Department of Epidemiology & Preventive Medicine at Monash University.

From about 2005, our interactions were more to do with walking and eating (small amounts) than academic work. The walks were in Fawkner Park or the Botanic Gardens, but gradually, as his strength declined, these walks became of very modest scale. He still played chess, though.

In his last two years, deteriorating vision, severe deafness and failing short-term memory were together a formidable assault on his ability to communicate. When I visited him, I found myself shouting trivia about my own family in a one-way ‘conversation’.

Near the end, as I took his hand, he was aware of my presence but lacked the energy and presence of mind to interact. These quiet but poignant moments served simply to trigger recollections of the great influence he’d had on my life and the lives of others privileged to work with him.

Allen died on Monday, 30 August 2010, aged 94 years.

To Allen:

We thank you for the generous way you’ve helped us better understand our world. We’re glad that you could sway our insights by your guiding hand.

David Goddard
Education Project Officer, AFOEM
LETTERS TO THE EDITOR

The role of non-pecuniary interests in medical decision making

The August 2010 issue of RACP News contains on pages 28–29 a fragment of a discussion between Sanjeeda, Lee, Thuy and Kim, presumably Fellows of the College. The discussion makes a very valid point: that there are many things besides money which influence medical decision making.

Dr Lee discusses his or her problem with a current trial of patients with melanoma who are going to die and then states, ‘As their doctor, I think ‘Why don’t we just set up a narcotic infusion and facilitate their dying?’ This is said in a way that suggests, ‘Is that not what everyone does?’ Dr Lee does not state that these people are not being treated for pain relief that they require, which of course would be reprehensible, but rather that they should be killed because they are going to die anyhow.

It is extraordinary that, in a discussion about ethics, deliberately killing patients should be brought in and passed over as though it would be of no moment.

Frank Long FRACP
Canberra

Response to Dr Frank Long

Dr Long refers to a comment made by one of the contributors to a detailed discussion about the complexity of clinical decision making. It is clear from the context that Dr Lee’s remark was intended rhetorically. Nonetheless, his point is a serious and valid one which has nothing to do with euthanasia: that doctors make their decisions in relation to a variety of interests and values which on occasions may conflict with each other.

The conflict to which he was referring on this occasion was between the interest in alleviating pain and suffering and the interest in scientific truth.

Clinical decisions, including those often regarded as purely ‘medical’, very frequently incorporate judgements relating to values and—at least in this sense—personal interests. It is the responsibility of practitioners to identify the underlying assumptions, prejudices, and philosophical and religious commitments that drive their decisions and to declare them openly and transparently to their patients, just as much as they recognise that they have to do in relation to pecuniary interests.

This argument has the interesting consequence that the personal religious views of practitioners should be regarded as ‘interests’ and should be routinely declared to patients along with information about financial commitments. Where conflicts arise, these should be managed in the same way as pecuniary conflicts—on occasions requiring the clinician to divest himself or herself of the role that generated the conflict.

The discussion reported was part of the process for revising the RACP Ethical Guidelines for Relationships between Health Professionals and Industry. We would welcome any comments from readers about how they would like to see these guidelines revised, including about how non-pecuniary interests should best be managed.

Paul Komesaroff FRACP
Chair, RACP Ethics EAG

Ian Kerridge
Member of the RACP Ethics EAG

Mary Osborn
Senior Policy Officer

Sponsorship by the pharmaceutical industry

As a private solo rheumatologist, I welcome the recent AMA statement regarding educational events sponsored by the pharmaceutical industry. As I do not receive study leave, sick leave, annual leave or sabbatical leave and provide my own superannuation, as well as fund my rooms when I am away at conferences to maintain my now compulsory continuing education, I need financial assistance to attend conferences relevant to my specialty. As I choose to be in private practice, I have ‘made my bed’.

However, what I find particularly annoying regarding sponsorship is that ‘the rules’ are not made by people like me but rather by those who in no way understand or appreciate the circumstances of private practice. As I do not enforce or impose or propose ‘rules’ for those in the non-private sector, what right have they to impose rules on me. As far as I am aware, Australia still remains a free country, although the activities of some organisations involved with healthcare today are simply because there is a lack of funds. The problem is that money is spent badly, and simply providing more money to be spent badly is not the answer.

What do they say of people who constantly do the same thing, yet each time expect a different result?

Hospital Boards are not the solution. They have not worked previously and will not work if reinstituted. Why? Partly it is because it is impossible to have a Hospital Board that is ‘depoliticised’ and partly because those who aim to be appointed to a Hospital Board are necessarily talkers (or shouters) not ‘doers’. To have a Board that is free of ‘deeply vested interests’ is code for keeping doctors off the Board so that those who know most about how the hospital performs, and have the greatest interest in the hospital performing well, must be excluded. Democracy has great strengths, but if decisions are to be based on a majority vote, then either there is a tyranny of the majority or decisions become dependent on seeking the lowest common denominator of the group.

A sea change in attitudes is required. Firstly, rural country hospitals should not be represented nor directed by the large tertiary teaching hospitals

Gary Champion FRACP

Response to Professor Leeder

I read Professor Leeder’s article, ‘Health Reform and COAG’ (RACP News, June 2010) with a sigh. There is much with which no one could disagree, although I do not believe that the problems with healthcare today are simply because there is a lack of funds. The problem is that money is spent badly, and simply providing more money to be spent badly is not the answer.

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A sea change in attitudes is required. Firstly, rural country hospitals should not be represented nor directed by the large tertiary teaching hospitals
where the medical establishment is happily ensconced. The needs of the country hospital are not the same as those of a tertiary institution and are often in conflict. Professor Leeder writes of patients requiring hospital and community care and adds that, if primary care is inadequate, the patient will come to the hospital more often. Rural hospitals provide community care and once were well able to supervise the extramural care that tertiary institutions often do very badly—largely because there is no single person to supervise personal care. The local hospital is inevitably the hub from which rural services work. Rural hospitals can and should be used to provide local medical services cheaply, which those in elevated posts of teaching hospitals do not appreciate.

To be the Prime Minister of Australia is not, and nor should it be, a ‘job for life’. To be CEO of a hospital should not be a career choice but rather an elected post for two years with the chance of being re-elected for one other term only. The nature of the franchise and the electorate can be argued and need not be the same in all hospitals, but I would prefer to have a majority of clinicians on the roll.

Having solved that problem, will someone explain to me why all coroners (certainly in South Australia) must be lawyers? Is there evidence somewhere to demonstrate that an individual who has had minimal exposure to scientific thought can make better determinations about the scientific evidence than, say, a forensic pathologist?

G. R. Crowe FRACP
Adelaide

Queensland RACP Fellow and Haematology Specialist, Associate Professor Maher Gandhi, received the prestigious Australian Society for Medical Research (ASMR) Clinical Researcher Award in June. ASMR is the peak professional society representing Australian health and medical research. The Society has a long-established role in public, political and scientific advocacy. The award recognises Queensland’s outstanding health and medical researchers. Dr Gandhi received $2500, a medal and a certificate at a prize ceremony held at the climax of Queensland’s ASMR Medical Research week.

Dr Gandhi was honoured to receive the award: ‘I receive this award on behalf of my laboratory, in recognition of our work on EBV and lymphoma.’ He is researching new antiviral strategies that are applicable to a subset of lymphomas. ‘Epstein-Barr virus (EBV) is a herpes virus that infects B cells and is implicated in a number of lymphomas and other cancers, and we hope that our research can lead to a way to target this virus.’

Dr Gandhi is a Senior Staff Specialist in Haematology at the Princess Alexandra Hospital in Brisbane, and Head of the Clinical Immunohaematology Laboratory at the Queensland Institute of Medical Research. His research is supported by the NHMRC, Cancer Council of Queensland, Leukaemia Foundation and other funding bodies. In 2007 he received an RACP CSL Fellowship to conduct research into infectious diseases and cancer immunotherapy.
STAYING CLOSE TO NATURE’S HEART

Thousands of tired, nerve-shaken, over-civilized people are beginning to find out that going to the mountains is going home.

So wrote a man named John Muir in 1898. Muir was a Scottish-born naturalist who co-founded the Sierra Club, and was in large part responsible for the establishment and protection of the incomparable Yosemite Valley and its surrounds as a National Park. He understood then at the dawn of the 20th century, well before his time, the fundamental human need for ‘wildness’.

Hiking through mountains and wild places has proven a salve to the soul for a decade now and continues to provide me a balancing influence and key counterpoint to a life in medicine. In the year 2000, as a junior registrar sensing impending pre-FRACP exam burnout, I stepped off the beaten path for a year and decided to try something different.

A trip to the High Sierra of California on a holiday in 1999 had opened my eyes to the sublime grandeur of those mountains, and I vowed to return as soon as I could. Further research upon returning to Australia led to the discovery of a path called the Pacific Crest Trail. It turned out this one trail stretched in a single continuous ribbon for 4250 kilometres from Mexico to Canada along the spine of the mountains of the western United States. I bought a book a hiker had written about their experience on the trail, read it in one enthralled sitting and, in the words of Bill Bryson from A Walk in the Woods, thought to myself, ‘Sounds neat, let’s do it!’ How to let my Director of Clinical Training know about this plan?

Fortunately, and for which I am eternally grateful, she was supportive, and so off I went (it took a little more planning than that, but I digress).

My (now) wife had already spent countless nights on trails and under the stars when I met her for the first time. This was lucky for me, because I met her on the very first day of that five-month-long hike (147 days to be exact) for she happened to be embarking on the very same adventure. Through the inevitable blisters, ridiculous unnecessarily heavy backpack, camping disasters and fuel stove mishaps, she knew just what to do. Initially, all I had on the Pacific Crest Trail was a sense that this was somehow the right time and place and that I was simply heeding some fundamental call. The rest I’d make up as I went along. The deep end of the pool had always appealed.

In those first few weeks of hiking the PCT, as the Pacific Crest Trail would come to be known to us (and what is an article as the Pacific Crest Trail would come to be for my family, the holy grail of hiking trails. From the scorching valleys and stunning wildflowers of the Mojave Desert and Southern California to the spruce, hemlock, fir and cedar of the old growth forests of the Pacific Northwest of the United States that we now call home, the PCT offers a truly unique experience. The Sierra Nevada simply must be seen to be believed; there is a reason why our old friend Mr Muir called it the ‘Range of Light’. I grew to love the Cascades as well—a chain of stunning volcanoes that stretch from Northern California to the Canadian border. The hiking is pretty gentle, and the views will blow your polypro/wool blend moisture-wicking socks off.

We averaged about 33 kilometres per day (about seven hours of actually hiking) between 1 May and 24 September.
The other aspect of hiking is the chance to interact with other cultures. A hiking trip to the Himalayas of Nepal, India and Pakistan is the trip of a lifetime, but it is not only the rarified air and warmth of first light on those 8000-metre peaks that make it so. There, trails are really roads between villages that have been travelled for centuries, and connecting those pathways into a hike is the best possible way to view the ‘roof of the world’ while interacting with and supporting the local culture. We trekked the Annapurna Circuit in Nepal over five weeks in 2006, and loved the meaningful interaction with the locals as much as we did the views and the teahouses. In fact, at the end of our trip, we were invited into the Kathmandu home of our guide to meet his family (five people, one room, one small bed, no running water … but smiling faces and gratitude everywhere). In the global village, the culturally sensitive hiker is a global citizen.

The walking trails of Europe are also well worth exploring, though walking those trails is a different experience. The concept of the National Park as we think of it is really a New World phenomenon. The beautiful trails that wind through the Swiss Alps, the Dolomiti of Italy or the mountains around Chamonix in France always feel somehow closer to ‘civilisation’. Many of those areas were populated for many centuries before our modern concept of wilderness (the connection of indigenous cultures to the landscape notwithstanding) and thus not protected from human habitation or farming in the way that wilderness has been preserved in New Zealand, Australia and North America. Nonetheless, there is much to be said for a hot meal, cold beer and warm indoor fireplace in the trekking lodges of the Alps at the end of the day! My quiet tip in Europe is to go to the Julian Alps of Slovenia—it is quiet, cheap and every bit as beautiful as anywhere else in the high country of Europe.

Since that adventure of 2001, we have continued to get out and hike often, wherever and whenever we can. I grew up on the edge of Sydney’s Royal National Park and that became a delightful place to amble from forest to beach and back, or along the coastal path gazing out over the Pacific Ocean from the sandstone cliffs. Those reading from New Zealand (or the Tolkien fans) will perhaps be familiar with the epic scenery to be found there, and especially so on the South Island. It’s a ‘tramping’ paradise. I’ve walked Tasmania’s beloved Overland Track, rightfully the jewel in Tasmania’s bushwalking crown (if a little crowded sometimes) and all of these can be enjoyed most of the year with a little sense of adventure.

In my opinion, time spent outside makes one an infinitely better physician. In this age of ‘Nature Deficit Disorder’, the quiet reflection and sense of timeless perspective on a trail in the mountains can be wisely called upon when handling the busy demands of the practising paediatrician (or the fractious two-year-old at home).

And so, where to next? I now do endocrinology outreach clinics in Alaska and that is very high on the list. South America has stunning hiking in places like Patagonia and the otherworldly landscape of the Altiplano. A long-held goal of ours is to walk the trail from the Atlantic Ocean to the Mediterranean Sea along the spine of the Pyrenees. The Bibbulmun track in Western Australia is apparently fantastic, but I’ve yet to walk that trail. The beauty of it all is there is always a trail to hike, somewhere.

To return again to John Muir ...

Keep close to Nature’s heart ... and break clear away, once in awhile. Climb a mountain or spend a week in the woods. Wash your spirit clean.

Craig Taplin FRACP
Paediatric Endocrinologist
Seattle Children’s Hospital
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