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Emperor penguin parents and chicks at Auster Rookery, 50 km east of Mawson Station in the Australian Antarctic Territory.

Cover photo by Gary Dowse, Public Health Physician, who works in communicable disease control in the Department of Health, Western Australia.

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Emperor penguin parents and chicks at Auster Rookery, 50 km east of Mawson Station in the Australian Antarctic Territory.
As an exclusive relationship, we are also developing closer working relationships with other Colleges, both nationally and internationally.

Following the appointment of new senior members of staff at the College, the CEO, Jennifer Alexander, has established a very capable and enthusiastic Senior Leadership Group (SLG). Among the various activities being undertaken by this group is the review of all the By-laws of the College. Following the Governance Review, By-laws were developed for most but not all College committees. The expectation was that an overhaul would be necessary after a year or two to ensure harmony and consistency across the College, to embrace changes that had become necessary and to reflect more accurately the activity of the committees.

At its next meeting the Board will consider the new By-laws for the Board and the Board Executive as well as the generic By-laws that will apply to all committees of the College (unless specified otherwise). Importantly, this body of work will include the development of By-laws for State and Territory Committees. It is my hope that these will reflect the appropriate devolution of activities to these very important committees of the College. It is clear that the delivery of educational programs is heavily dependent on local commitment and leadership.

In addition, there are ‘local’ issues in which it is appropriate for our Fellows to be engaged. Increased appreciation of the important roles of State/Territory Committees is reflected in plans for the upgrading of offices as well as the appointment of Medical Education Officers (MEOs) and staff with Policy & Advocacy skills to the State offices.

In 2009 the Board of the College developed a Statement of Strategic Intent (SoSI) that outlined the College’s strategic initiatives for 2009–2012. In July the Board and the SLG met to review and refine the SoSI. Even in a year in which the College continues to develop policies and procedures for usual College activities, and in which there have been a number of issues that have demanded immediate attention, it was pleasing to reflect on the progress that has been made in a number of these important areas during the last year. The revised SoSI will be available on the College website.

In June, the Dean, Professor Kevin Forsyth, advised that he would be leaving his current role at the end of December 2010. Serving close to five years as Dean and Director of Education since 2006, Kevin has made an enormous contribution to education and to the College as a whole. When Kevin was appointed, the College was facing enormous challenges in the form of the AMC accreditation process and the need for education in the College to conform to medical education best practice. The changes in education introduced by Kevin have been characterised by innovation, academic underpinning and a coordinated and comprehensive approach. Kevin instilled a culture that strives to ensure that our education standards are the highest possible and that we maintain our focus on world’s best practice. He has moved the College to the ‘cutting edge’ of vocational education. Initially, the major focus was on PREP; the current focus is on PREP AT while acknowledging that the major focus now needs to shift to CPD and the need to address challenging issues such as revalidation and assessment of competence. Aspects of these new programs, including but not limited to the Professional Qualities Curriculum, the integrated PREP program, instruments such as the Professional Qualities Reflection, and the establishment of an academic SAC, have drawn highly favourable comments within Australasia and internationally.

At various meetings, it has become very clear to me the enormous respect that exists for Kevin’s opinions and the high esteem in which he is held in the field of medical education. Initially the changes in education that took place within the College were not embraced by all, with some taking the view, ‘if it ain’t broke, don’t fix it’. Hopefully now, all can appreciate the enormous benefits of the new education programs, although the barriers that Kevin had to overcome in these early times should not be underestimated. The fact that he addressed and overcame these difficulties with tolerance and good grace is testament to the strength and quality of his character. Under Kevin’s leadership, the Education Deanery has increased considerably in size and, commensurate with this, the education output has increased enormously. Although Kevin will remain in his current role for a number of months, it seems appropriate to recognise his enormous contribution at this time and the fact that the College and its Fellows owe him a great debt. I am sure you will wish to join with me in sincerely thanking Kevin and wishing him every success in the future.

John Kolbe
President
LONG-TERM WORKLESSNESS: HEALTH RISK EQUIVALENT TO SMOKING 10 PACKS OF CIGARETTES A DAY

‘Long-term worklessness,’ Professor Sir Mansel Aylward said during his recent visit to Australasia, ‘is one of the greatest known risks to Public Health. It has a health risk equivalent to that of smoking ten packs of cigarettes per day. After six months out of work, the suicide rate in young men is increased forty times.' For longer term worklessness, the general suicide rate is increased six times. Worklessness has a health risk and life expectancy reduction greater than many ‘killer diseases’. And worklessness is actually riskier than most dangerous jobs, including construction and working on the North Sea. Sir Mansel, a prominent UK health reformer, was here as a guest of the Australasian Faculty of Occupational and Environmental Medicine (AFOEM), under the auspices of the Royal Australasian College of Physicians, to launch AFOEM’s Position Statement, Realising the Health Benefits of Work. The Position Statement was launched in Sydney on 18 May 2010 and in Auckland on 25 May 2010. The launches were attended by business groups, unions, workers’ compensation authorities, rehabilitation providers and other stakeholders. In both Australia and New Zealand there was enthusiastic support for the message of Realising the Health Benefits of Work, and considerable interest in affecting meaningful change. For Dr David Beaumont, Co-chair of AFOEM’s Position Statement Working Group, "The highlight of the Auckland launch was the coup of having Sir Mansel present the keynote and official launch of the Position Statement—he is absolutely passionate about the agenda, and spellbinding in the way he gets the messages over. We had some great feedback afterwards, including statements such as "I could have listened to him all day!"

Not all work is good for all people; and work must be safe. With these provisos, Realising the Health Benefits of Work makes recommendations for treating practitioners, employers and government, based on the idea that work, in general, is the most effective means of improving the wellbeing of individuals, their families and their communities.

Despite the enthusiasm of key stakeholders, the message that ‘work is generally good for health’ does not yet seem to have achieved widespread acceptance in Australia and New Zealand. In fact, according to the Return to Work Monitor, a survey of workers with work injuries that provides an annual snapshot of return to work trends, over the last three years return to work rates have declined in Australia and over the last two years in New Zealand. Last year, 28% of injured workers surveyed in Australia and 25% of workers in New Zealand were not in paid employment six months after lodging a workers’ compensation claim in Australia or an accident compensation claim in New Zealand.9

This is particularly worrying given that work absence tends to perpetuate itself: that is, the longer someone is off work, the less likely they become ever to return. If the person is off work for:

- 20 days the chance of ever getting back to work is 70%
- 45 days the chance of ever getting back to work is 50%, and

Research demonstrates that unemployment has a significant negative impact on physical health and mental health, and results in increased mortality rates. Conversely, research demonstrates that not only do the beneficial effects of work outweigh the risks, but the health benefits of work are even greater than the harmful effects of long-term unemployment or prolonged sickness absence.8

Suitable work has been shown to benefit people suffering from a wide range of psychiatric conditions … anxiety, depression, bipolar disorders and schizophrenia.

AFOEM now says with confidence that work, in general, is good for health and wellbeing.

Despite this compelling evidence, in both Australia and New Zealand more and more people with mild to moderate musculoskeletal and/or mental health problems are being classified as unfit for work.9

Realising the Health Benefits of Work states that we can begin to address these issues by shifting popular perceptions of common health problems.
Studies have shown that in most cases an early return to work (or remaining at work) is beneficial for health and wellbeing, and that people with musculoskeletal conditions who are helped to return to work enjoy better health than those who remain off work. Suitable work has also been shown to benefit people suffering from a wide range of psychiatric conditions. These conditions include anxiety, depression, bipolar disorders and schizophrenia. The potentially negative impacts of work on mental health must be balanced against awareness that unemployment may also have serious consequences for mental health.

The medical community has a special responsibility to take the message of Realising the Health Benefits of Work on board: the evidence shows that the long-term negative consequences of advising a patient to remain away from work or to take time off work, or agreeing with them that time off work is a potentially helpful course of action, are often greater than those of the original health problem.

The key recommendations of Realising the Health Benefits of Work are that:

1. The medical community develop a consensus statement regarding the positive relationship between health and work and the negative consequences of long-term work absence and unemployment.

2. The education of treating practitioners incorporate training in workplace occupational health and vocational rehabilitation, and sickness certification practices, and that the medical community provide leadership on these issues.

3. Health professionals responsibly promote the health benefits of work to their patients.

4. Governments obtain and publicise accurate data about the level of work incapacity in Australia and New Zealand.

5. Governments launch public health campaigns, directed at employers, workers, medical practitioners and the general public to promote the message that 'Work, in general, is good for health and wellbeing.'

6. Employers move beyond legislative requirements to embrace the spirit of inclusive employment practices, workplace safety, health and wellbeing, and best practice injury management.

Work has already begun on the first of these recommendations, the consensus statement. Indeed, due to stakeholder enthusiasm for the project, the consensus statement is now likely to be endorsed by business groups, unions, some workers’ compensation authorities and other relevant parties, as well as the medical community.

Dr Mary Wyatt, Chair of the AFOEM’s Policy and Advocacy Committee, is determined to maintain the momentum established by the positive reception of Realising the Health Benefits of Work.

‘AFOEM now hopes to further the conversation about how the health and wellbeing benefits of work can be intensified,’ she said. ‘Our next position statement will examine the evidence about the relationship between health and productivity in the workplace.’

AFOEM is also seeking financial partners for an Australasian cost–benefit analysis of investments in workplace health and wellbeing. International studies indicate that such investments yield excellent returns, in terms of both value for money and health outcomes.

Both unions and business are behind this agenda. In Australia, Geoff Fary of the Australian Council of Trade Unions suggested approaching the Treasurer Wayne Swan for funding for such a cost–benefit analysis. In New Zealand, Paul MacKay of Business New Zealand reiterated the need for action. ‘More of this,’ he told the audience at the launch. ‘And fast!’ In fact, as Mary Wyatt and Robin Chase were leaving the Sydney launch at the Sofitel, as if on cue Wayne Swan appeared and as quick as aflash Mary had provided the Treasurer with a copy of the Position Statement and a 30-second doorstep on why this was such an important issue.

For more information about Realising the Health Benefits of Work, or to assist AFOEM with the agenda outlined above, please contact Andrew Messner on 02 9256 9602 or go to the AFOEM website: http://afoem.racp.edu.au/page/media-and-news/realisng-the-health-benefits-of-work.

Dr David Beaumont and Dr Mary Wyatt
Australasian Faculty of Occupational & Environmental Medicine

References


Towards a Sustainable, Affordable and Fit-for-Purpose New Zealand Health Workforce

The New Zealand Health System, then, is both financially threatened and threatening (to all other agencies of the State).

Third, our nexus with Australia is problematic and primarily serves Australia’s interests. The level of emigration of doctors and nurses to Australia is unsustainable for us; remuneration differences in regard to some of the less popular-to-work-in Australian states is certainly part of the problem, but vocational discomfort is far more complex and multi-factorial than pay, car parks and locker considerations alone.

Fourth, and related to the item above, New Zealand has a consequential and similarly unsustainable reliance on immigrant health workers.

Fifth, shortages of key health workers such as doctors, midwives, dentists and nurses are exaggerated by these workforces being poorly distributed against need by way of discipline, ethnicity, culture, demography and geography.

Sixth, despite being ‘submerged’ in data, most of our health planning has not been and is not well informed by intelligence. To date, we have found more than 500 agencies and so on which are engaged in some way in health workforce planning and or training!

Seventh, there is a schism between the governors of the New Zealand health system and the health workforce. There are a number of local drivers of this dislocation that are beyond the scope of this review, but the workforce is demonstrably segregated and tribal. A guild model best explains most recent behaviour.

Eighth, there is an aggregate of other interactive and confounding and complex factors that are germane to this discussion, including our Health Act not requiring the public health system to attend to the training of the health workforce, the nature of our largely publicly funded but privately and publicly delivered health system, along with the extraordinary reality of 20 district health boards and more than 80 primary health organisations (for a country with the population of the State of Victoria) and funding of undergraduate health worker students by an education commission that is not imbedded in the health system or in health system planning.

The New Zealand Health System, then, is both financially threatened and threatening (to all other agencies of the State).
The New Zealand health system has to become increasingly New Zealand need-centric and there are many lessons for us to learn from how Canada ‘survives and relatively prospers’ ...

Second, healthcare will be largely delivered by way of healthcare teams that are integrated and multi-professional and where team leadership is both contextual and values-based. All health workers will have clinical and corporate leadership responsibilities. The hidden curriculum of apprenticeship should be used to develop the broader domains of professionalism and an Institute of Health Leadership will almost certainly be needed.

Third, disruptive innovations of service configurations and models of healthcare will become business as usual. Nevertheless, role substitution and scope extensions should be sensible in the context of what are the values, skills, knowledge base and culture of the to-be-extended health profession. Remunerative and other barriers to rationalisation of services and models will need to be identified and addressed without favour.

Fourth, the private health sector derives both direct and indirect benefit from Vote Health and consequently must also contribute to the broader domains of the New Zealand health service.

Fifth, the New Zealand health workforce should look as much as is possible like the community it serves. Selection processes need to be accordingly attentive and both affirmation and immersion schemes will be needed. The New Zealand health system has to become increasingly New Zealand need-centric and there are many lessons for us to learn from how Canada ‘survives and relatively prospers’ alongside a bigger and more affluent country that has a relatively greater health expenditure.

addressed by way of a far more modest 40% increase in funding. To avoid the system substantially failing through differential decreasing access to health services, the conundrum presented here will need to be addressed by health workers doing many things very differently.

The second and third drivers of urgency relate to the understandable expectation of the health workforce for meaningful reform of what are often both archaic and arcane service configurations and models of care (as compared to the churn in governance models) and to our Government’s expectation that clinical leadership is at the core of any solution that will result in a fit-for-purpose health service. My concern here is not the logic of clinical leadership in either a clinical or a corporate sense, but the ability of health workers to meet this leadership challenge. Our emphasis on professionalism for some time has been heavy on ethics and communication and light on education and leadership.

The way ahead involves both a structural change in health system governance that establishes the correct relationship between a dog (health need) and its tail (services and models of care, and consequential workforce, IT and capital planning), and diversification of the health workforce through intelligence, innovation and clinical leadership. The former is underway and our Minister of Health has formed Health Workforce New Zealand (HWNZ), initially as a business unit in the Ministry of Health that reports directly to him, to consolidate activity and to lead the planning, funding, training and deployment of the health workforce. The mission of HWNZ is to ensure a fit-for-purpose and sustainable health workforce. There is a determination to consolidate activity and to lead the planning, funding, training and deployment of the health workforce. The planning cycle we are using is illustrated in Figure 2 and our process of service review is shown in Figure 3. In addition to a requirement to meet a best-guess 100% increase in demand over the next decade, but to constrain any funding increase over this period to 40% or less, we have agreed some other planning values and principles.

Figure 2: Planning cycle for reform of health services

First, healthcare must be patient and not practitioner centred. Most often we are using an aggregate of ‘idealised patient-journeys’ to develop and evaluate services and models for 2020. A broad application of a care-navigator scheme that operates across all social agencies and is known in New Zealand as whanau ora is intended.

Figure 3: Process of service review

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Sixth, the New Zealand Health System has to be sustainable and affordable. Given this principle and the intrinsic uncertainty in health planning, ‘slow to train’ and expensive health workers should be retained in general scopes of training and practice as much as and for as long as is possible. The health workforce needs to be incentivised in ways that encourage good practice and we must invest in and value career progression, training and status. This will help to distinguish New Zealand as a desirable place to study, learn and work. We are in the process of enhancing apprenticeships, have introduced a 3-R scheme (retain, repatriate and recruit) and are trialling very new models of employment that underpin a focus on career progression and training.

The two major training packages are Voluntary Bonding, which is for the early postgraduate trainee, and Special Engagements, which are for the Advanced Trainee, and they will provide support both in New Zealand and overseas. Details on these schemes are available on our website <www.healthworkforce.govt.nz>.

In summary, the challenge we face is to ensure a national birthright of universal access to excellent healthcare for the future generations of all New Zealanders. It will be deliberately clinically led, intelligently informed and very innovative.

Professor Des Gorman AFOEM
Executive Chairman of Health Workforce New Zealand

Fulfilling the promise

The great promise of the medical profession is to heal and care for people, ease pain and suffering, prevent disease and mitigate risk. The Australian medical profession now finds itself facing a challenge to deliver on this promise as structural impediments are imposed by critical shortages and maldistribution of medical workers.

A shifting target

Critical shortages of workers are driven by a tight supply of medical workers, but also by an unpredictable and exponential rising demand for services. Workforce planning is fraught with difficulty because the health policy aims of governments are in conflict. On the one hand is the objective for better health, as the careful and responsible management of the wellbeing of the population is a key responsibility of government. But on the other hand, this responsibility must be weighed against the many other responsibilities of government, and healthcare is indeed a costly and labour-intensive business. The workforce is by far the largest cost to the health system; in 2008 Australia spent 53% of its total healthcare spending on the clinical workforce (see Figure 1). It is also the responsibility of government to contain those soaring costs.

Largely as a result of this tension, successive governments have sought to first reduce the number of medical graduates by limiting intakes into medical schools and then to limit the number of practitioners allowed to operate independently by separating Medicare entitlements from medical registration. Furthermore, changing patterns of workforce participation have also sought to reduce the supply of available medical workers as the weekly working hours for both men and women in Australia is in decline (45.4 to 43.7 hours from 2001 to 2005). For example, women and younger workers tend to work fewer hours, on average, than their older male counterparts, resulting in fewer productive hours per medical worker.

Possibly as a consequence of these policies, Australia has struggled to address its workforce shortage and maldistribution of workers, particularly in outer metropolitan, rural and remote areas. An overseas trained workforce has duly provided services to these parts of the community. Australia is a net receiver of medical workers from the international marketplace, with 25% of doctors working in Australia overseas trained, up from 19% in 1996 (44% in New Zealand). Many of these fully trained workers are from the developing world, which takes advantage of poorer source countries and potentially leaves them with a worker shortage.

Faced with this reality, Commonwealth governments have made a complete policy reversal with a recent impetus to massively expand the numbers of new graduates by deregulating the medical marketplace for higher education, creating new medical schools and removing the cap on full-fee paying international students. This will have the effect of dramatically increasing supply over the next decade, but is unlikely to abolish our reliance on an overseas trained workforce, nor adequately meet rising demand.

Growing older and wider

Workforce shortages have been compounded by increased demand, which has been unprecedented. This is a result of four main factors: demographic change, epidemiological transition, improved technology, and changing community expectation.

Australia’s population is both growing and ageing. The population is expected to increase from 18.3 million people in 1996 to 25.6 million by 2021, a 2.7% increase. People aged 70 years and over...
are projected to account for 12.1% of the total population by the year 2021 (compared to 8.3% of the population in 1996). The growth rate of those aged 85 years and over is projected to be even more significant. Between 2006 and 2016 alone, the number of people over 85 years will have grown by over 60%. The changing age profile of the population has clear implications for the nature of the burden of disease the workforce must respond to. Already Australia has seen a transition to chronic and ‘lifestyle’ diseases; the current top three burdens of disease for Australian men are ischaemic heart disease, anxiety and depression, and type 2 diabetes. This is partly driven by an epidemic in obesity (see Figure 2).

**A crowded waiting room**

As the proportion of the population ages, there will be an increase in the chronic degenerative diseases seen with age such as dementia, osteoarthritis and heart failure. New technologies, treatment modalities and pharmaceuticals may change the specific burden of disease in ways that are unpredictable. For example, minimally invasive techniques such as coronary angioplasty have reduced the demand for bypass surgery, but what is certain is that there will be significantly higher numbers of elderly people to be cared for, with ever more complex care needs. Augmenting that demand in ways not yet clear are the community expectations for treatment. With increasing knowledge and wealth, individuals have become more demanding when it comes to their health needs. Popular media are encouraging people to take more control of their health, and the fear of losing health and independence has led to high demand for screening modalities. The Australian public have shown little patience with surgical waiting lists and emergency department waiting times, demanding ever more from their health services.

**Leadership required**

With critical shortages across the medical workforce now and into the future, the workforce will need to become more productive to maximise performance—that is, producing the best health services and health outcomes possible by reducing waste of staff time and skills. This will have an immediate impact on the delivery of services and will be associated with better motivation.

There are several ways that the health system can support medical workers to be more productive:

- **Team building and clinical leadership.** Teamwork can improve wellbeing of workers and improve quality of care. Clinical leadership can provide vision, encourage innovation, and create a culture of benchmarking and comparison. Teamwork can improve performance, job satisfaction and motivation by providing mutual support, education and feedback on good performance.

- **Workload management.** Workforce planning and rostering must take into account the competing demands on the time of medical workers to ensure workers are reasonably capable of meeting those demands while also caring for their own health and wellbeing. Productivity is sacrificed as workload approaches a breakpoint.

- **Continuous professional development.** Medical workers need up-to-date knowledge to perform well. Rapid increases in knowledge and changing health systems reinforce the need for a systematic, ongoing, cyclical process of self-directed learning. The system should structure professional development for all workers through formal feedback, mentoring and secondment.

- **Remuneration and incentives.** Remuneration can distort medical worker and health system performance. Gross disparities in remuneration between procedural and non-procedural work in Australia is driving medical workers to take up higher remuneration specialties leaving ‘low status’ areas, such as aged care, mental health and Indigenous health, in shortage. Remuneration should be brought into line to recognise the value of consultative medicine and the epidemiological transition to complex care.

- **Infrastructure.** The physical environment as well as services and technologies available to workers can improve performance. Essential support might include information technology such as portable wireless devices, electronic decision support, electronic health recording and prescribing.

- **Task liberation and new cadres.** This involves the optimal deployment of available workforce skills. A doctor is a highly skilled practitioner with unique ability to make a diagnosis and recommend a plan of management. These complex tasks should remain the focus of the doctor’s work, where the doctor can be liberated from other tasks. It might involve creating new cadres of workers to take on new roles with limited and specific training in the area of their work, which might include simple procedures or care coordination. This could extend health system performance and improve job satisfaction and motivation.

**Health promise into health action**

Medical workers are the human links that translate health promise into health action. But it is difficult to match the supply of workers with demand for services, because the challenges faced are constantly changing. With demographic change and epidemiological transition, demand...
International Medical Graduates (IMGs) are an incredibly important part of the Australian and New Zealand workforce, with 20–30% of medical positions in both countries being held by people who have completed some part of their training abroad. Ensuring that IMGs and their supervisors are supported and that IMG assessment processes are fair, robust and transparent is a priority for the College.

It is incredibly daunting for anyone to move to another country, but add the fact that your partner and young children may be moving with you, that English may not be your native tongue and that registration in Australia and New Zealand is a very complicated process, with many stakeholders involved, and it is easy to see how stress levels would be extremely high.

For supervisors and peer reviewers also, supporting IMGs can create some very specific challenges. It is never easy to coach team members on cultural and communication issues, especially when these are things that we have learned just by growing up in a particular environment.

Moving forward, there are several ways in which the RACP is seeking to support and inform IMGs and their supervisors. With assistance from the Department of Health and Ageing, the RACP has developed an OTP Orientation Module. The module is designed to familiarise applicants with the Australian healthcare environment, preparing them for practice in Australia. It focuses on professional qualities such as ethics and communication, as well as giving an overview of Australian cultural issues. The module is now a requirement for all Overseas Trained Physicians (OTPs) undergoing Specialist and Area of Need assessment and is open to all RACP trainees and Fellows to use.

We will also be rolling out peer review workshops in 2011 similar to our supervision workshops but specifically for Fellows involved in peer reviewing OTPs. These workshops will seek to assist Fellows in understanding our policies and procedures in this area as well as addressing specific issues that may come up for IMGs and their supervisors during review.

The RACP is also in frequent contact with the Australian Medical Council, the Medical Board of Australia and other key stakeholders seeking ways to improve the assessment process for IMGs and OTPs while still ensuring patient safety, which is of course our primary responsibility.

In 2009, the RACP Australian Division OTP Sub-committees assessed 175 new applications for Specialist and Area of Need assessment, and progress was considered for an additional 71 OTPs. The Faculties and Chapters of the RACP assessed 14 OTPs in the same period. The RACP also supported 142 Specified Training applications for IMGs (previously known as OTVs), and 25% of Basic Trainees completed their medical degrees overseas.

The five most common countries for Specified Training applicants were India (31%), the United Kingdom (12%), Malaysia (9%), Germany (8%) and the Philippines (6%). The five most common countries of origin for OTPs applying for assessment in Australia were India, the UK, South Africa, Germany and the Philippines. Switzerland and Sri Lanka also featured prominently. Estimates from the Australian Medical Council state that the majority of OTPs assessed are resident in Queensland (21%) and New South Wales (20%) at the time of application. The hospitals that possess the highest number of IMGs in Specified Training are Children’s Hospital, Westmead; Sydney Children’s; John Hunter; Royal Children’s, Victoria; and Royal Brisbane & Women’s.

The RACP OTP and Workforce Expert Advisory Groups are the policy-making bodies in this area and always welcome feedback on how policy and processes can be improved and how we can further support OTPs and their preparation for workforce change.

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References
Did you know that the Healthcare Identifiers Bill was recently passed in the Senate? It happened the day after the changeover of PM so it didn't get a lot of media coverage. Here is what you need to know.

The healthcare identifier is a 16 digit electronic health number that every Australian will get (no opt out) with a gradual rollout from 1 July 2010. This number will store each individual's name, address and date of birth. No clinical information will be stored with this number.

All healthcare providers, including hospitals, specialists, general practitioners and pathology departments, will use this unique number for each patient, which will make communication between providers easier.

However, the information stored on each provider's desktop will stay there and will not be seen by other providers.

For example, the pathology organisation doing blood tests for your patients will not be able to see what is stored on your computer or on hospital computers.

What is a shared electronic health record?

This is now referred to as a Personally Controlled Electronic Health Record (PCEHR) to emphasise the fact that there is in fact more enhanced privacy and control of access with the electronic system than the current old-fashioned paper record system.

Although everyone will get a Healthcare Identifier number, not everyone is compelled to have a personal electronic health record. Those interested (hopefully most Australians) can opt in to this system by registering online from 2012.

eHealth Survey

Complete the five-minute Physicians & IT in the Workplace Survey and win a prize! Keep your eye out for an email with a link to the online survey that will be sent to a sample of physicians and trainees. There is an increasing demand for clinical information to be exchanged between specialists and other healthcare providers and health departments. The recent eHealth reform changes have largely been made without specialist involvement. Information gathered from this survey will enable the College to act on behalf of the Fellowship so that specialists have a stronger voice in the development of future information technologies.

Please contact Alexandra.Lipman@racp.edu.au for more information regarding the survey.

Dr Steven Bollipo FRACP
Chair of the RACP eHealth Expert Advisory Group

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If you have aspirations to be the next Wordsworth, Whitman, Wright or Wilde, send in the poems you have buried in that bottom drawer to racpnews@racp.edu.au. We will consider all entries for publication.

Something like this, maybe?

Love set you going like a fat gold watch.
The midwife slapped your footsoles, and your bald cry Took its place among the elements.
Sylvia Plath, from *Morning Song*, *Colossus*
TAKE UP THE CHALLENGE:
Indigenous Health
and Chronic Disease

Join us for the RACP Congress 2011 in spectacular Darwin from 22 – 25 May 2011. Held at the Darwin Convention Centre, the Congress will examine the challenges of indigenous health and chronic disease over a 4-day program.

RACP Congress 2011 will incorporate:
- RACP Graduation Ceremony and Reception
- AFOEM Annual Training Meeting (ATM, 21 – 22 May 2011)
- RACP Trainees’ Day
- Joint Adult Medicine Division / Internal Medicine Society of Australia and New Zealand Annual Meeting
- Paediatrics & Child Health Annual Meeting
- Australasian Faculty of Occupational & Environmental Medicine Annual Meeting
- Australasian Faculty of Public Health Medicine Annual Meeting

Take the opportunity to participate in what promises to be an exciting Congress and take some time to discover the natural beauty of the Northern Territory.

For more information and to register your interest in the Congress visit www.racpcongress2011.com.au

Or contact the Congress Secretariat at WaldronSmith Management
61 Danks Street Port Melbourne VIC 3207 T : 61 + 3 9645 6311 F : 61 + 3 9645 6322 E : racpcongress@wsm.com.au
PHYSICIAN READINESS FOR EXPERT PRACTICE (PREP): ADVANCED TRAINING

FROM THE DEAN

The College is developing Advanced Training programs using a framework that outlines the broad set of standards and elements of training that will apply to all PREP: Advanced Training programs. The combination of these elements makes up the basic structure for the development of all subspecialty PREP: Advanced Training programs across the Divisions, Faculties and Chapters of the College.

The PREP: Advanced Training Framework includes:
- curricula
- formative assessments
- teaching and learning
- programmatic requirements
- online environment
- supervision
- site accreditation
- certification of training.

Curricula

We are developing subspecialty Advanced Training Curricula to outline the broad concepts, related learning objectives, and the associated knowledge, skills, attitudes and behaviours required and commonly utilised by graduates of each training program.

All Advanced Training Curricula are to be used in conjunction with the Professional Qualities Curriculum (PQC), which spans the life of the PREP program.

Table 1 lists the 38 curricula that have been completed or are in development. Many of these curricula combine the objectives for adult and paediatric training pathways within a single document. Completed curricula are available on the College website. Figures 1 and 2 represent the status of curriculum development for each subspecialty.

Table 1: Curricula completed and in development

<table>
<thead>
<tr>
<th>Completed (13)</th>
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<tbody>
<tr>
<td>Cardiology (Adult)</td>
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<tr>
<td>Cardiology (Paediatrics)</td>
<td>Respiratory Medicine (Adult)</td>
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<tr>
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<td>Respiratory Medicine (Paediatrics)</td>
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<tr>
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<td>Rheumatology (Adult)</td>
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<td>Medical Oncology (Adult)</td>
<td>Sleep Medicine (Adult)</td>
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<td>Neonatal/Perinatal Medicine</td>
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<td>Occupational and Environmental Medicine</td>
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<table>
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<tr>
<td>Addiction Medicine</td>
<td>Intensive Care Medicine</td>
</tr>
<tr>
<td>Adolescent Medicine</td>
<td>Medical Oncology (Paediatrics)</td>
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<td>Nephrology</td>
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<tr>
<td>Gastroenterology</td>
<td>Public Health Medicine</td>
</tr>
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<td>Rehabilitation Medicine (Adult)</td>
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<td>Rehabilitation Medicine (Paediatrics)</td>
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<td>Geriatric Medicine</td>
<td>Rheumatology (Paediatrics)</td>
</tr>
<tr>
<td>Immunology/Allergy</td>
<td>Sexual Health Medicine</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1: Divisions curricula

Figure 2: Chapter and Faculty curricula
Formative Assessments

The PREP: Advanced Training Framework includes a range of formative workplace-based assessments to be introduced as part of PREP: Advanced Training. The assessment methods in this framework are in accordance with international best practice. The respective Advanced Training Education Committees are considering how the PREP: Advanced Training assessments will be integrated into their curricula.

Case-based Discussion

Case-based Discussion is one assessment method that will be widely introduced as part of PREP: Advanced Training. It has already been incorporated into a number of international postgraduate medical education courses.

Purpose

A Case-based Discussion encounter aims to evaluate the level of professional judgement exercised in clinical cases by the trainee. Case-based Discussion is designed to:

- guide the trainee’s learning through structured feedback
- help improve clinical decision making, clinical knowledge and patient management
- provide the trainee with an opportunity to discuss their approach to the case and identify strategies to improve their practice
- be a teaching opportunity, enabling the assessor to share their professional knowledge and experience.

Overview

A Case-based Discussion encounter involves a comprehensive review of clinical cases between an Advanced Trainee and an assessor. The trainee is given feedback from an assessor across a range of areas relating to clinical knowledge, clinical decision making and patient management.

A Case-based Discussion encounter takes approximately 30 minutes.

Cases for discussion

Cases for discussion are chosen by the assessor. A variety of cases in which the trainee has had a significant role in the clinical decision making and patient management can be used. The discussion can focus on a single complex case or a series of cases that cover a wide range of clinical problem areas. The discussion should reflect the trainee’s level of experience and be linked to the relevant Advanced Training curriculum.

The trainee is responsible for ensuring that adequate encounters are completed and that all assessable areas outlined in their respective Advanced Training curriculum are covered.

Areas for assessment

- Record keeping
- History taking
- Clinical findings and interpretation
- Management plan
- Follow-up and future planning

Trainee responsibilities

- Arrange a Case-based Discussion encounter with an assessor.
- Confirm the case(s) chosen by the assessor.
- Provide the assessor with a copy of the standardised RACP Case-based Discussion form.
- Complete tasks after the encounter, including entering data into the online Case-based Discussion tool and emailing the completed form to the assessor.

Assessor responsibilities

- Choose the case(s) for discussion.
- Use the RACP Case-based Discussion form to rate the trainee.
- Provide constructive feedback and discuss improvement strategies.
- Provide an overall judgement on the trainee’s clinical decision-making skills.

A number of Advanced Training supervisors recently volunteered to take part in a trial of Case-based Discussion with trainees in their workplace. The feedback collected from the participants of this trial regarding their experiences using this assessment method will be evaluated and reported on. (See the first report from Associate Professor Benny Katz on page 17).

Input from this user group is invaluable in guiding the College’s resource development and informing the implementation plans of the Advanced Training Education Committees, and we offer our gratitude to all those who volunteered their involvement.

A video showcasing a Case-based Discussion encounter will be available on the College website in the coming weeks.

Development and implementation of PREP: AT programs

Advanced Training Education Committees are working in partnership with the Education Deanery to develop subspecialty Advanced Training programs within the PREP: Advanced Training Framework. This involves matching appropriate formative assessments to the curricula and planning the introduction of resources to support teaching and learning in the program.

Part of this process will also involve a systematic review of current programmatic requirements and processes to ensure that they are relevant in the context of PREP training. A review of programmatic requirements is an important step to enable the College to prepare for the influx of trainees in the future, and to ensure that consistency and alignment between College training programs are achieved.

Transparent requirements for training will be documented in specialty-specific training program handbooks. These documents will be developed through consultation with Education Committees and Specialty Society representatives and will provide clear information to trainees, supervisors, committee members, College staff and the general public.

It is anticipated that implementation of all of the elements within each subspecialty PREP: Advanced Training program will be a gradual process over a number of years. Advanced Training Education Committees will plan the implementation of programs and set transitional arrangements that will be practical and achievable for trainees and supervisors in the context of the workplace.

Kevin Forsyth FRACP
Dean
Susi McCarthy
Curriculum Development Officer
Education Deanery
NEW! ADVANCED TRAINING IN ACADEMIC MEDICINE

Although the College has excellent training programs, most fellows and trainees would be aware that the emphasis on training is for high levels of clinical competence. An entirely appropriate question would be: in its training programs does the College support and foster trainees to become medical academics? A further question may be: why would the College even be interested in such a matter?

Our health system relies on a variety of health professionals, and medical academics play a critical role in the health system in numerous ways:

- They generally head major clinical departments.
- They have a significant role in fostering research and undertaking research themselves.
- They contribute to and often lead medical education.
- They contribute in a major way to the development of health policies and are called on by governments and agencies for advice around health matters.

There is clear recognition across Australia and New Zealand that there are insufficient numbers of medical academics in our health system. In light of this, and because the College wants to support and foster scholarship, research and innovation in medicine, we are developing a process whereby trainees can be supported to train in research and medical education and clinically through the physician training programs. This will enable them to be fully equipped as medical academics.

The Specialist Advisory Committee (SAC) in Academic Medicine will be overseeing the training of College trainees who wish to become medical academics. These trainees will be high-calibre candidates who develop specific skills and competencies in not only clinical aspects of medicine, but also in research, medical education and knowledge of academic environments, for example, grant writing, policy development and leadership.

Hence we are seeking a small number of trainees for the 2011 academic year who are interested in training under the SAC in Academic Medicine. To be eligible, trainees must have successfully completed the written and clinical examination and be in their final year of Basic Training. Interested trainees should first inform the College of their intention to pursue this path. For information, please email Libby Newton, AcademicMedTraining@racp.edu.au.

Prospective trainees should identify an Educational Supervisor and a Professional Development Advisor from within medical academia. During the latter half of the year in which they complete Basic Training, they would commence development of a biomedical or educational research proposal with the support of their Educational Supervisor and an appropriate university or research institute. They may also begin a literature review and consider research methodologies. Candidates should then submit their research proposal (along the lines of a grant application) to the SAC in Academic Medicine for approval in the November of the year preceding commencement of their Advanced Training.

It is the responsibility of the trainee and their Educational Supervisor to link with the relevant university or research institute for the purposes of the PhD or equivalent (e.g. Doctorate or perhaps Masters in Medical Education). The trainee must meet the local university or research institute’s award and administration requirements. The SAC in Academic Medicine will verify that these requirements have been completed satisfactorily and will oversee the academic and clinical training throughout the trainee’s four or more years of Advanced Training. However, the university is the body responsible for the research/medical education higher degree.

It is anticipated that trainees would then graduate with a combined PhD and FRACP (for the Divisional programs). Additionally, during the four years of Advanced Training, the trainees would need to fulfil a number of medical education and medical academia competencies. There will be some taught elements of this course, including aspects around leadership, running a department, research grant writing and obtaining research funds.

Key requirements of application process for Advanced Training in Academic Medicine

1. Prospective trainees must be in their final year of Basic Training and have successfully completed written and clinical examinations.
2. Prospective trainees must register their intention to join the program and obtain further information by emailing Libby Newton at AcademicMedTraining@racp.edu.au.
3. Prospective trainees must identify an Educational Supervisor and Professional Development Advisor.
4. Prospective trainees must submit a research proposal (developed in conjunction with a university or research institute) by November of the year preceding commencement of Advanced Training.

The College is keen to ensure that there are synergies through this process, in that the research and medical education time the trainees spend will enhance and strengthen their clinical training time and vice versa. It is by building these synergies, as well as a program around specific medical academia competencies, that this combined program will be strengthened.

It is considered that the Advanced Training period for these Academic Medicine trainees would be a minimum of four years, comprising two years of subspecialty clinical training and two years of academic medicine training. It is hoped that the research and clinical work would be undertaken conjointly and that the clinical training path and the research program would have a considerable degree of overlap.

The College intends to begin this process with an intake of trainees for the 2011 academic year. It should be stressed that we will take only a small number of trainees initially.

In addition to having a small number of medical academic Fellows who serve on the SAC, it is also intended to establish a short-term steering committee, drawn from a broad range of Fellows, to assist in the development of this academic training stream. Such a steering group will consist of Fellows from research institutes, academic departments, universities and health departments.

Any Fellow who is interested in the development of this SAC in Academic Medicine is welcome to contact me at Kevin.Forsyth@racp.edu.au.

Kevin Forsyth FRACP
Dean
INTRODUCING PREP INTO ADVANCED TRAINING: A TRIAL OF FORMATIVE ASSESSMENT IN ADVANCED TRAINING IN GERIATRIC MEDICINE

The emphasis on improving the processes, quality and standards of physician training has until recently been focused on Basic Training with the introduction of the PREP program. As these trainees move into Advanced Training from 2011, the focus will shift to this level of training.

The Geriatric Medicine Training and Education Committee deliberated upon the feasibility of introducing the PREP program into Advanced Training in Geriatric Medicine, in particular, the formative assessment components. At present, trainees in Geriatric Medicine undergo summative assessment based upon supervisors’ reports and two projects, reflecting what the trainee has learned in the past. In contrast, the PREP program includes formative assessments such as mini-CEX and Case-based Discussion. These focus on identifying future training needs.

Issues of concern included the relevance of formative assessment to the practice of Geriatric Medicine, the selection of suitable instruments, and the willingness of physicians and trainees to accept them. To address these concerns, a trial of formative assessment in Advanced Training in Geriatric Medicine was carried out between February and May 2010.

Three of the formative assessment instruments suitable for non-procedural specialties were selected for the trial. The mini-CEX was chosen as it requires the supervisor to directly observe the trainee in a real clinical interaction. The second instrument selected was Case-based Discussion. This focuses on the cognitive processes involved in clinical practice and the application of medical knowledge. The third instrument was the Multi-Source Feedback. This focuses on professional qualities of the trainee, particularly around communication, working in teams, ethics, quality and safety, which may not be directly observed by the supervisor.

All Advanced Trainees in Geriatric Medicine in Australia and New Zealand were invited to participate in a trial. Participants were asked to undertake one assessment with each of the three instruments and then complete an online survey. Geriatricians and Advanced Trainees who did not participate in the trial were asked to complete a modified online survey.

Results

1. Participation. In 2010 there are 134 Advanced Trainees (ATs) in Australia and 27 in New Zealand; 155 individuals participated in this study, comprising 63 who participated in the trial (trialists) and 92 who did not (non-trialists). The trialists comprised 36 ATs and 27 supervisors. The non-trialists comprised 22 ATs, 65 supervisors and 5 who did not indicate whether they were trialists or non-trialists. The participants were widely distributed throughout Australia and New Zealand. Victoria was overrepresented in the trial group with 56% of participants. There was good representation of all three years of AT in both groups. Trialist supervisors tended to be more experienced than non-trialist supervisors, with 67% having previously supervised more than five ATs, compared with 40% of non-trialists.

Non-participation in the trial was more likely to be due to not having an Advanced Trainee in 2010 than to time constraints, 48% versus 42%.

2. Prior experience with the three instruments. More than half of all supervisors and trainees reported not having any prior experience with any of the instruments. The majority of those who had prior experience reported having used them on five or fewer occasions.

3. Ease of use. Mini-CEX was reported as easy to use by 91.8%, Case-based Discussion by 81.5%, and Multi-Source Feedback by 74.7%.

4. Time requirements. The majority of respondents reported that the Multi-Source Feedback session could be completed in 20 minutes, the mini-CEX in 30 minutes and the Case-based Discussion in 45 minutes.

5. Do the formative assessments help identify future training needs? Eighty-three percent of trainees and 96% of supervisors reported that the formative assessments in this trial had helped to identify future training needs. In addition, 77% of trainees and 74% of supervisors reported that they had helped improve the supervisor-trainee relationship.

6. Should these formative assessment instruments be introduced into Advanced Training? Eighty-three percent agreed that the mini-CEX should be incorporated into Advanced Training, 70% supported Case-based Discussion, and 76% supported Multi-Source Feedback.

7. Will they be easy to implement in your workplace? Of trialists, 65% reported that these formative assessment tools would be easy to implement in their workplace. Non-trialists were less certain about this question, with 38% reporting it would be easy and a further 41% being undecided.

8. Optimum frequency of assessments. There was strong consensus between the trialists and non-trialists about the frequency with which these instruments should be used. The preferred numbers were two mini-CEXs, two Cased-based Discussions and one or two Multi-Source Feedbacks per year.

9. Making formative assessment more effective. There was agreement about the need for more training with these instruments (42% trialists, 63% non-trialists), with a stronger response in favour of the need for more experience using these instruments (90%).

Discussion

In future, assessment of Advanced Training will require both summative and formative assessments. The high participation rate in this trial reflects favourably on the enthusiasm of geriatricians and trainees to improve Advanced Training. There was strong support for their ongoing use in Advanced Training. A number of trainees have elected to voluntarily continue formative assessment after this trial concluded.
Geriatricians and trainees reported having little or no prior experience with these instruments. A reliable assessment of the performance of a trainee requires multiple encounters with formative assessment instruments. Kichu Nair and colleagues (MJA 2008) reported that 8 to 10 encounters were required using the mini-CEX. This study found that even a single encounter with these instruments enhanced the supervisor–trainee relationship and helped identify future training needs. There was strong agreement in this trial that the process of formative assessment would improve as participants gained more experience.

The new PREP Basic Training requirements have already increased the workload on supervisors. A phased introduction of formative assessment will result in supervisors taking longer to gain experience and confidence with these instruments, but is less likely to face resistance. In the UK, trainees in Geriatric Medicine have up to six mini-CEXs and six Case-based Discussions per year. Trainees are expected to take increased responsibility for their Advanced Training. Formative assessments should be driven by the trainee rather than the supervisor. The current Basic Trainees are more experienced with these assessment tools and are likely to have higher expectations of their use than our current trainees.

Associate Professor Benny Katz
Benny.Katz@svhm.org.au

Benny Katz is the Lead in Assessment for the RACP Specially Training Committee in Geriatric Medicine. He is a consultant geriatrician at St Vincent’s Melbourne and the Director of the Victorian Geriatric Medicine Training Program. He is an adjunct Associate Professor at The Australian Centre for Evidence Based Aged Care at Latrobe University.

**SUPERVISOR WORKSHOPS**

In 2010, the College’s Education Deanery is organising a suite of Supervisor Workshops to help equip and support our supervisors throughout Australia and New Zealand.

The Medical Education Officers are delivering PREP: Basic Training Supervisor Workshops, which cover topics such as the mini-CEX, Learning Needs Analysis, Basic Training Portal, and the College’s Supervision Structure.

In conjunction with the relevant Advanced Training Committees, the Education Deanery is also running Advanced Training Supervisor Workshops tailored for each specialty within the College. These workshops are preparing supervisors for PREP: Advanced Training by covering such topics as the new assessment tools (e.g. Case-based Discussion, Direct Observation of Procedural Skills), new Advanced Training Curricula, and dealing with trainees in difficulty.

Regularly updated calendars for all Supervisor Workshops can be found on the RACP website under ‘Supervisor Support’: www.racp.edu.au/page/educational-and-professional-development/supervisor-support.

To register for a workshop, please email Supervisor@racp.edu.au with the name and date of the workshop you wish to attend.

Briony Bounds
Executive Officer, Physician Educators Education Deanery

**UPCOMING ADVANCED TRAINING SUPERVISOR WORKSHOPS**

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**EDUCATION POLICY**

The following Education policies have been ratified by the College Education Committee in 2010:

- Learning Needs Analysis Tool (LNAT) Policy
- Significant Incident Analysis Tool (SIAT) Policy
- Mini-CEX Policy (amended)
- Recognition of Prior Learning Policy

Keep up to date with Education policy development by visiting the College website: www.racp.edu.au/page/education-policies.
WHAT ARE OUR TRAINEE PHYSICIANS TELLING US? INSIGHTS FROM THE 2009 BASIC AND ADVANCED TRAINEE SURVEYS

As a part of quality assurance of our training programs, the College’s Research and Evaluation (R & E) Unit in the Education Deanery has been involved in continuous monitoring and evaluation of Basic and Advanced Training programs by means of surveying trainees’ experience and perceptions of the training environment and identifying gaps in the training programs. In 2008, the R & E Unit conducted its first run of the trainees’ survey, which was sent to then 2nd Year Basic Trainees enrolled in the previous (pre-PREP) training program. The data from this survey provided us with a baseline to compare trainees’ views on the PREP program in subsequent evaluations. The second run of the Basic Trainee survey was conducted in November 2009. We also surveyed 2nd Year Advanced Trainees to obtain similar baseline data. These surveys were undertaken keeping in view the following questions:

- How satisfied are trainees with their overall training experience?
- How do trainees perceive their training environment?
- How well prepared are trainees for expert practice?
- Based on trainees’ perceptions, what are the barriers and enablers within a work-integrated clinical environment?

Adapted from standardised measures of clinical learning environments (DREEM² and PHEEM³) and in consultation with various stakeholders, the 2009 online surveys were sent to 750 Basic Trainees and 683 Advanced Trainees in the second year of their training across Australia and New Zealand. Of these, 407 (54.3%) Basic Trainees and 421 (61.6%) Advanced Trainees participated in the survey.

Key results

It is encouraging to see that of those who responded to the survey a vast majority of trainees in both the training levels expressed satisfaction with their overall training experience, but concerns did emerge in specific areas of the training programs. This article highlights these gaps in the programs as perceived by the respondents.

Supervision, feedback and support were the key areas of weakness as indicated by the data. Nearly a third of Basic Training respondents indicated that they rarely/never met with their educational supervisors (Figure 1). With regard to Advanced Trainees, we found that a quarter indicated meeting rarely with their supervisor whereas nearly 40% indicated having monthly meetings with their supervisor.

Meetings with the director of training programs, i.e. DAT, DPE (DPT/DPPT)⁴, were perceived to be the least useful learning setting by both the categories of respondents. Furthermore, a large number of Basic Training respondents disagreed that their DPE (DPT/DPPT) discussed strengths and weaknesses and set clear expectations with them.

Respondents reported receiving inadequate feedback in most of the Professional Qualities Curriculum domains. Even in the core clinical skills such as clinical examination, approximately a quarter of respondents indicated receiving insufficient feedback (Figure 2).

These findings corroborate with the respondents’ perceived lack of preparedness for Advanced Training or expert practice in several skills related to the Professional Qualities Curriculum, such as ethics and legal issues, leadership and administrative skills, and research skills. Basic Training respondents also reported that the quality of their training experience, including the level of preparedness for practice, was dependent upon their experience in different rotations.

The Advanced Training research project was another gap area identified by the survey. While respondents were satisfied with support, supervision and feedback on the project, more than half were dissatisfied with the time available for research and ease of incorporating the research conducted into practice.

Absence of protected educational time, lack of support for trainees in difficulty and inadequate opportunities for career advice were areas of concern collectively raised by the Basic and Advanced Training respondents.

To summarise, the survey results have helped us gauge specific strengths and weaknesses in our training programs. The results have provided us with baseline data to compare with subsequent evaluations of the PREP programs. The results have also rendered insights into the dynamics of work-integrated clinical learning environments. A major challenge in such environments is to maintain equilibrium between providing clinical services and simultaneously engaging in teaching–learning activities.

Figure 1: Frequency of meetings with the supervisor (Basic Trainees)

Figure 2: Areas/skills reported as receiving none/not much feedback
Increased emphasis on patient safety has further added to the pressure on healthcare professionals towards better training outcomes. While the College is working towards reengineering the training programs, designing a new structure of supervision and drafting needs-based policies for trainees, these evaluations, coupled with our future plans for qualitative studies, will continue to add value towards further development and improvement of our training programs.

Professor Kevin Forsyth FRACP, Dean
Dr Priya Khanna, Research Officer, Research and Evaluation Unit
Ms Gillian Sliwka, Research Officer, Research and Evaluation Unit
Education Deanery
Research and Evaluation Unit, Education Deanery
Contact: evaluation@rACP.edu.au

References
1. PREP (Physician Readiness for Expert Practice) is a new training program launched in 2008 initially for Basic Training. It is being extended to Advanced Training.
4. Acronyms: Director of Advanced Training; Director of Physician Education; Director of Physician Training; Director of Paediatric Physician Training.

WHAT ARE YOUR MYCPD CREDITS REALLY WORTH?

The number of MyCPD credits that Fellows can gain from participation in RACP activities has initiated much discussion over the past year. This will be the first in a series of articles giving examples of how to articulate your activities into CPD points. This article looks at the number of MyCPD credits a Clinical Examiner can claim. Credits can be claimed under the following categories:

Examiner day (8 hours)
Total credits for 1 day = 12 credits
- Category 5 (Practice Review & Appraisal) – 3 credits/hour for long and short case reviews, e.g. 2 hours in one day = 6 credits
- Category 1 (Educational Development, Teaching & Research) – 1 credit/hour for any reflective comments. Reflection is rather a clumsy word in so many ways. What is being sought is evidence of thoughtful behaviour, considered thoughtfulness on the part of the participant undertaking the CPD activity.
- Category 1 is capped at a maximum of 50 credits per year; however, bonus credits can be gained for every reflective comment and these remain uncapped.

**For those Fellows involved in practice exams and assisting candidates with preparation for the clinical exam, credits are claimed under Category 6 (Other Learning Activities) at 1 credit/hour (up to a maximum of 50 credits per year).**

Special thanks to Professor Mike South for the initial collating of these points.
EASY ACCESS TO NATIONAL PRESCRIBING CURRICULUM MODULES FOR TRAINEES AND FELLOWS

The Royal Australasian College of Physicians

Featuring 25 modules covering a range of clinical areas from cardiology to endocrinology to psychiatry, the National Prescribing Curriculum (NPC) modules are available to all trainees and Fellows via the CPD Member Resources page of the RACP website (there are additional links from the RACP Basic Training Portal and Therapeutics page under Policy and Advocacy). These modules were developed by the National Prescribing Service Limited (NPS) in collaboration with Australian medical schools and the Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists (ASCEPT).

The modules are easily accessed through a self-sign-in process and can be viewed anywhere, at anytime. Each module is authored and reviewed by experts in the clinical area and each one is designed to be used in a self-paced mode.

The NPC modules mirror the decision-making process outlined in the World Health Organisation’s Guide to Good Prescribing; this process involves setting therapeutic goals for a patient, deciding on a therapeutic approach (drug and/or non-drug options), choosing and checking the effectiveness, safety and appropriateness of the chosen therapy, writing a prescription if required, monitoring treatment and providing the patient with information and instructions. Learners receive comprehensive peer-to-peer and expert-to-learner feedback throughout each module, and have access to independent, evidence-based resources, including NPS publications, the Australian Medicines Handbook and Therapeutic Guidelines.

The modules have been identified as a valuable resource for Fellows undertaking continuing professional development (CPD), and those Fellows wishing to participate in the course for the purposes of CPD can apply for credits under Category 3 ‘Self-Assessment Programs’ of the MyCPD categories framework.

To access the modules, visit the CPD Member Resources page of the RACP website. Once there:

1. Click on the ‘Sign up here’ link below the login box.
2. Enter the required information in the first seven fields.
3. Select RACP from the ‘Institution’ drop down box.
4. Select RACP Fellows from the ‘Course’ drop down box.
5. Enter the course key in the ‘Course Key’ field racpCpd.
6. Click on the ‘Register’ button.
7. A welcome screen will be displayed.
8. Click on the ‘Click here’ link.
9. Enter your user name and password in the login fields.

For more information, you can view a quick animated tour of the NPC on the NPS National Prescribing Curriculum website <http://www.nps.org.au/health_professionals/online_learning/national_prescribing_curriculum> (click on Virtual Tour in the right column). Alternatively, you can contact the National Prescribing Service Educational Design and Support team on 02 8217 8642 or at npcinfo@nps.org.au.

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SPECIALIST TRAINING PROGRAM

In 2010, the Department of Health and Ageing (DoHA) announced the newly branded Specialist Training Program (STP). STP is an amalgamation of several Commonwealth funded programs, including the Expanded Specialist Training Program (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.

The aims of STP are to:
- increase capacity in the health and education sectors to train specialists
- increase the number of specialists arising from the increase in the number of trainees and Specialist International Medical Graduates (SIMGs)
- better train specialists with education that matches the nature of demand and reflects the way health services are delivered
- address maldistribution of medical speciality services, in particular, issues arising from geographic location and the need for generalists
- develop networks of training posts across a broad range of settings beyond traditional teaching hospitals, including a range of public settings (e.g. regional, rural and ambulatory settings), the private sector (hospitals and practices), community settings and non-clinical environments
- support medical specialist trainees rotating through these networks
- complement medical specialty training initiatives in the states and territories.

For the 2011 STP round of funding, DoHA received over 340 applications for funding of physician posts; of these applications, 187 were shortlisted for funding. This is an increase from the 115 places that were funded in 2010.

In determining the STP-funded posts, applications were assessed and ranked by DoHA, the State Health jurisdictions and the RACP according to the following criteria:
- provides a training opportunity not currently available (or not often available) within existing funded training positions in the health service, which includes primarily public teaching hospitals
- provides training in rural or remote locations, with General Medicine and Community Paediatrics being given top priority
- provides training in areas where there is exposure to Indigenous health issues, or health issues of the particularly needy, underprivileged or minority groups in the population
- provides significantly new and innovative training paths for trainees
- has a physical infrastructure, a critical mass of supervisors and a clinical support
program which is accredited by the RACP
• has a strong imperative and infrastructure for education and for support of the trainee.

For details of the facilities/training sites that have been shortlisted for specialty post funding in 2011, please visit: www.


Trainees interested in these training posts, please contact the training site for more information.

For further information about the Specialist Training Program, email stp@racp.edu.au.

The October issue of RACP News will contain a feature article on the role of RACP in STP.

Davy Loo
Business Manager
Education Deanery

DARWIN AND ALICE SPRINGS PREP ROADSHOW

After the four and a half hour flight from Brisbane, I arrived in Darwin to be greeted by a lovely sunny warm afternoon (apparently the dry season had commenced just for me). As soon as I climbed into the taxi at the airport, George, my taxi driver, launched into a robust discussion about the state of rugby league in Australia. As an avid football spectator and lover of warm weather, I suspected I had found my new spiritual home.

Fired up from my talk with George, I arrived at Darwin Hospital ready for the PREP workshop with the Adult Medicine trainees and consultants. The session was one of the best I have run. The level of engagement from the attendees was fantastic and made for a really enjoyable and productive evening. It was particularly pleasing to meet a handful of trainees who were interested in commencing physician training in 2011 and were keen to find out more about the RACP and the PREP program.

Bright and early Tuesday morning, I met with the DPE for Paediatrics, Dr Carolyn Maclennan, and later in the week held a workshop for the consultant and trainee Paediatricians. Although significantly smaller than the Adult Medicine department, the group from Paediatrics were just as involved as their Adult Medicine counterparts and shot some first-rate questions in my direction. I concluded the session feeling like the program was in very good hands indeed.

Other highlights of the Darwin leg included a fantastic presentation on Rheumatic Heart Disease during the Adult Medicine Grand Rounds and tagging along with Dr Emma Spencer’s team for some of the morning ward rounds (after appropriate consent had been obtained). The most poignant meeting for me occurred on my last day at Royal Darwin. Dr Spencer and I met with the Clinical Nurse Consultant to discuss issues specific to the region concerning cultural competency and Indigenous health. It was an eye-opening conversation, highlighting some of the difficulties faced by consultants, trainees and patients in the Territory. We are now looking at developing more specific cultural competency information and teaching aids for the Territory and North Queensland to help ease some of these complications.

This initial visit to the Northern Territory was designed to spread the PREP word and get the program moving forwards. Dr Spencer and I believe we achieved this goal.

I was fortunate to meet individually with Dr Steve Brady, DPE for Adult Medicine, and Dr Rose Fahy, the DPE for Paediatrics. As is the case in Queensland, there are significant differences in the two programs and it was invaluable for me to learn more about the current state of affairs in Alice Springs.

This initial visit to the Northern Territory was designed to spread the PREP word and get the program moving forwards. Dr Spencer and I believe we achieved this goal.

I feel very privileged to have been given the opportunity to see first-hand the training and education that takes place at our sites. It has given me a much greater understanding not only of the challenges faced by the departments, but also of how we as a College, and PREP, can assist our Fellows and trainees.

I must say a special thanks to Dr Spencer, without whom the trip would not have been such a success. Thank you also to Dr Carolyn Maclennan, Dr Steve Brady and Dr Rose Fahy for your time and insight. As I am sure is obvious, I thoroughly enjoyed my trip to the Territory and very much look forward to heading back in a few months to build upon the foundations we have laid.

Lauren Davies
Queensland Medical Education Officer
Online Medical Education
Community of Learning

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I n 2008, we wrote an article in RACP News (October/November) outlining progress in refugee child health. The article detailed the launch of the RACP Refugee Child Health Policy, Medicare access for asylum seekers in New South Wales, and the RACP submission to the Inquiry into Immigration Detention in Australia in July 2008. We stated then that no children had been in detention centres within Australia since 2005, but noted that current legislation did not preclude this happening again. At the time, there were almost no children in immigration detention.

Who is an asylum seeker?
An asylum seeker is a person who has sought international protection and whose claim of refugee status has not yet been determined.

How effective has advocacy in refugee child health been?
The RACP Refugee Child Health Policy is a detailed document that was widely distributed. The policy-writing group sent the document to Australian and New Zealand Federal, State and Territory Ministers and responses were received from three Federal Ministers and eight State and Territory Ministers. Most of these responses outlined, in meticulous detail, the various programs and support services available to refugees. They included information on some innovative and creative strategies in health and dental care in the various jurisdictions, and there was widespread support (but no specific resources) for national research. If the purpose of a policy is to impact on practice and to inculcate a sense of accountability in those working in the area, can we argue that our policy has had some effect?

What has happened since the policy was released?
On the positive side, there has been progress in a number of areas:

- There have been significant policy shifts relating to asylum seekers at the Federal level in Australia, with the dismantling of the Pacific Solution in early 2008 and the abolition of the Temporary Protection Visa system in August 2008.
- After extensive lobbying by a number of groups, several medications necessary to treat common conditions in refugees have been listed on the Australian Pharmaceutical Benefits Scheme (PBS). In 2009, both

   praziquantel (for schistosomiasis) and atovaquone-proguanil (for Plasmodium falciparum malaria) were listed on the PBS, and in 2010 the authority indications for albendazole were extended to include hookworm and strongyloidiasis.
- The Australasian Society for Infectious Diseases Guidelines for the diagnosis, management and prevention of infections in newly arrived refugees were published in 2009.
- The recently proposed Department of Immigration and Citizenship tender for Humanitarian Settlement Support Services for new refugee arrivals will require case managers to arrange and accompany all newly arrived refugees to comprehensive health assessments, and to link all children under five years with early childhood centres for developmental screening and immunisation.
- All Australian states and territories now have either specialised refugee health clinics, or systems for refugee health assessments in primary care. New Zealand continues to use a central reception service model, providing holistic healthcare for their smaller quota of refugees.
- Uptake of the (Australian) MBS item number for refugee health assessments by general practitioners has increased though problems persist.
- There are now two accredited RACP Advanced Training positions in refugee child health, in Victoria and Western Australia.
- There have been two Australasian conferences on refugee health, with strong representation in the field of refugee child health.
- A network of refugee health providers from all Australian states and territories has formed—the Refugee Health Network of Australia (RHeaNA); this includes College Fellows.
- Despite these advances, once again there are large numbers of children in immigration detention in Australia, there have been shifts in asylum seeker policy, and long-standing issues in refugee healthcare persist:
- Department of Immigration and Citizenship statistics show that 342 children (under the age of 18 years) are currently in immigration detention on the Australian mainland and Christmas Island. Although children are no longer held in immigration detention centres on the Australian mainland (such as Villawood), there are 151 children in ‘Immigration Residential Housing’ and ‘Immigration Transit Accommodation’ on the Australian mainland. Immigration Transit Accommodation facilities are locked facilities; currently there are 74 children in locked detention in Melbourne and Brisbane. There are a further 191 children in community detention on either the mainland (24) or Christmas Island (167).
- In late 2009, two boats carrying 325 Sri Lankan asylum seekers, including over 40 children, were intercepted at the request of the Australian Government and remained on board for several weeks.
- On 9 April 2010, the Government announced they would suspend protection visa processing for asylum seekers from Sri Lanka (for three months) and Afghanistan (for six months). At the end of the period, the suspensions would be re-evaluated, based on the latest country security assessments from UNHCR. This could mean prolonged, or even indefinite, detention for some asylum seekers. Children are not exempt from this possibility.
- The remote Curtin detention centre in Western Australia reopened in April 2010.
- The leader of the Opposition has stated that the Coalition would bring back Temporary Protection Visas, previously abolished in August 2008.

The issues outlined in the 2008 update and the RACP Refugee Child Health Policy have not yet been fully addressed. These include:

- Increasing coverage of health assessments, so timely health assessments are provided for all refugees shortly after arrival
- Defining and evaluating optimal models of care within each state and territory, whether this be mainstream general practitioners as initial screeners, specialised refugee services with later transfer to primary care, or other models
- Establishing ongoing support for training positions in refugee health to increase the capacity of the workforce in this area
- Increasing the uptake of language services, including the free telephone interpreter services provided by most states for private practitioners
- Developing a national approach to the collection and collation of data to
Facts and figures on asylum seekers

• During 2009, 377,200 people fled persecution in their homelands to seek asylum in industrialised countries.

• In 2009, 6200 people sought asylum in Australia, an increase of 29% on the preceding year. This represents 2% of asylum applications in industrialised countries and ranks Australia 16th in the industrialised world.

• The countries receiving the largest number of asylum claims in 2009 were the United States (with 49,000), France (42,000), Canada (33,300), the United Kingdom (29,800) and Germany (27,600).

• The 2009 Australian figures are well below those observed in 2000 (13,100 claims) and 2001 (12,400).

• Ranked by the number of asylum seekers per 1000 population, the top three receiving industrialised countries were Cyprus, Malta and Sweden with 30, 22 and 14 applicants per 1000 inhabitants. Australia received 0.3 asylum-seeker applications per 1000 inhabitants.

• New Zealand asylum-seeker claims have remained stable at 300 new claims per year for the past five years.

• France experienced a 43% increase in asylum-seeker claims in 2009 (42,000) compared to 2007 (29,400), attributed to higher numbers from Serbia and Armenia.

• Of the 40 main countries from which asylum seekers originate, numbers increased from 23 of these source countries in 2009. Afghanistan became the main country of origin, with 28,600 Afghans requesting refugee status, a 45% increase on 2008 (18,500 claims). Of these claims, 940 were lodged in Australia in 2009, representing 3.5% of all asylum claims by Afghans.

Did you know?

Australia accepts relatively few of the world’s refugees and asylum seekers. The United Nations High Commissioner for Refugees (UNHCR) estimates there were 42 million forcibly displaced people worldwide at the end of 2006, including 10.5 million refugees under the UNHCR mandate, with 8.4 million of these hosted in developing countries. By comparison, Australia accepts 13,500 Humanitarian Program entrants annually.

Australia is the only Refugee Convention treaty country to routinely detain asylum seekers and illegal immigrants until deportation or visa acceptance, rather than allowing community placement until immigration decisions are made.

Australia’s Humanitarian Program is tightly controlled, such that if there are more boat arrivals, fewer people are accepted as part of the offshore arrival program, so total Humanitarian Program numbers remain constant.

There is now a large body of evidence to suggest that prolonged detention, particularly in isolated locations, poor access to health and social services and uncertainty of asylum seeker claims can have severe and detrimental effects on health and psychosocial wellbeing, especially in children and people who have experienced torture or trauma.

Concerns about the combination of mandatory detention, suspension of asylum claims, with no maximum limits on duration of stay, geographical isolation of detention facilities and absence of any binding legal standards have been raised by various advocacy groups and professionals. These include the United Nations special rapporteur on health, Anand Grover, the UNHCR Regional Representative, Richard Towlie, and the Detention Health Advisory Group (DeHAG). DeHAG is an independent expert advisory body to the Federal Department of Immigration and Citizenship made up of professionals from health and consumer organisations.

The College has been a strong advocate for refugee children and their families in the past, proactively aligning with like-minded professional bodies and coming up with an ambitious policy and implementation plan for the wellbeing of refugee children and young people in Australia and New Zealand. Unfortunately, in terms of advocacy, in the current climate, there is still a long way to go.

Karen Zwi FRACP, Shanti Raman FRACP, Mary Osborn, David Burghner FRACP, Georgie Paxton FRACP

References are provided on page 33.
The RACP recently joined key peak organisations working with children and young people to respond to the Australian Government’s document, *A National Health and Hospitals Network for Australia’s Future: Delivering the Reforms*. This is an extract of the response, the full text of which can be found on the College website at: www.racp.edu.au/page/policy-and-advocacy/paediatrics-and-child-health.

The continuum of care provided in children and young people’s services spans health promotion and primary care to tertiary inpatient care through multiple services, structures and initiatives in government and non-government agencies. The continuum recognises the importance of the social determinants of children’s and young people’s health and acknowledges the particular emotional, social and physical needs encountered.

Policy disconnections and the imperative to establish a National Commissioner for Children and Young People

This section highlights apparent disconnections between existing policies affecting the health, development, wellbeing and safety concerns of children and the lack of cohesion in the delivery of suitable health services. The absence of a Commonwealth department, agency or commission that carries responsibility for assessing the impacts of national public policy on children and young people is glaring. Clearly, an independent Commissioner for Children and Young People would identify any policy disconnection and address the issues arising more effectively, as canvassed in the *National Child Protection Framework* (COAG 2009). This proposal echoes the Human Rights Commission, which has been consistently calling for the establishment of a Federal Commissioner in this area.

It is anticipated that the establishment of an independent Commissioner would bring about considerable benefits such as:

- Place children and young people firmly on the national agenda
- Supporting the development of an evidence-based National Framework for the Health and Wellbeing of Children and Young People, facilitating partnership arrangements between all governments and peak bodies working for children and young people
- Aligning with accepted strategies in the COAG paper, ‘Protecting Children is Everyone’s Business’.

Disconnection in service provision

Potential disconnections between acute, subacute, ambulatory and primary healthcare services for children and young people might result from the governance arrangements proposed. It is cautioned that integrated approaches to children’s health and wellbeing would be at risk if community-based services for children were separated from acute services and placed in such governance structures as the Primary Health Care Organisations (PHCOs). The preference is for community-based services for children to sit within a Local Hospital Network (LHN) or within a state-wide Functional Health and Hospital Network with responsibility for the policy and planning of acute, paediatric, child health and ambulatory services. This would facilitate links between the various services provided and would be in line with the *National Early Childhood Development Strategy: Investing in the Early Years*, which envisages integration between health, care, education, welfare and early intervention services provided by the states and territories in child and family centres.

Reducing the apparent disconnection between the COAG Agreement and children and young people

The COAG Agreement gives little specific attention to health services for children, young people and their families. These represent 22% of the population. The health and wellbeing of children affects lifelong health, education, employment and relationship trajectories.

Every level of government must recognise that the success of supporting children’s health is predicated on the provision of services that engage in health promotion, prevention and early intervention. It remains important to develop a framework for the health and wellbeing of children and young people aged 0–24 years that recognises needs across a developmental and service delivery continuum, to identify key areas of child development and to set national targets to achieve a level for children’s health that meets community expectations.

Strengthening the place and recognition of specialist ambulatory care services for children and young people in relation to the COAG Agreement

The Health and Hospital Reform Agreement appears to take no account of the third stream of services for children and young people—specialist multidisciplinary ambulatory care—provided in a range of non-inpatient settings. This stream has been expanding in size and complexity over the past 50 years, as a result of changing patterns of children’s health needs and care. This stream bridges acute and primary care services, as it ranges from providing hospital-style acute illness care in an outpatient setting through to other services provided in community settings. Most operate out of an acute care framework, that is, hospital rather than community based, but with increasing links and liaison with primary and community care.

Specialist ambulatory healthcare services should be recognised and maintained in a single governance stream rather than be distributed between LHNs and PHCOs as we believe such a distribution would disrupt the pathway of care and impact on care outcomes.
Aligning the governance of Maternal, Family and Child Health services with other specialist services for this population

The decision on the governance arrangement for Maternal, Family and Child Health services has been deferred to December 2010. There appears to be an assumption that Maternal, Family and Child Health services are part of primary healthcare. If so, it seems possible that responsibility for them would be transferred to PHCOs and the role of Maternal, Family and Child Health services in supporting families and promoting early childhood development might be lost. There is also a risk of losing the focus on improving support for parents, childhood prevention and early intervention in favour of primary care treatment services for disease management.

The current governance arrangements for child and family health services differ between and within the states and territories. The COAG agreement noted the importance of linkage between health services for vulnerable children and other government agencies (education, child protection, disability services), but failed to acknowledge reform proposals in other COAG documents that would promote stronger collaboration and partnership between services for children provided by government agencies or NGOs funded by them.

There is a serious risk to integrated approaches to children’s health if acute and community-based services for children are placed in different governance structures. The best governance arrangement for Maternal, Family and Child Health seems therefore to be in maintaining and building upon the current service model. Management autonomy within these services has enabled a focus on the core business of prevention and early intervention for young children. It has also allowed a population-based health approach based on universalism, with targeted and intensive services for those with additional needs.

The cogent argument for casemix funding formulas to reflect the real cost of providing care to children and young people

Children’s Hospitals Australasia’s (CHA) study, ‘Costing Kids Care: a study of the health care costs in Australian specialist paediatric hospitals’ (2008), shows that the higher costs for specialist children’s hospitals and paediatric units compared with the costs of adult units reflect both the greater dependence of children on adults for their care and the co-morbidity that is frequently present in children admitted to hospital. There is a concern that if the new funding models were based on generic casemix formulae, the true cost of children’s healthcare would not be taken into account. The cost pressures experienced by specialist paediatric hospitals and paediatric units in treating a population with hidden complexity should be recognised in future funding models. The redesign of the AR-DRG system to accommodate diagnosis codes with age affected co-morbidity and complication levels and a range of other changes is overdue.

Improving the emotional wellbeing and mental health needs of children and young people

Almost one in five young people have one or more mental, emotional, behavioural (MEB) disorders at any given time. Among adults, half of all MEB disorders were first diagnosed by age 14 and three-quarters by age 24.

The current situation reveals that inpatient, subacute and specialised community mental health care is under-funded. Access to primary mental health care has improved but continues to be inequitable for vulnerable groups of children. Access to specialist child and adolescent mental health services (CAMHS) continues to be a gap in comprehensive mental health care delivery.

The Longitudinal Study of Australian Children (2007) and the Australian Early Childhood Development Index (2009) highlight the increased risks to the social and emotional development of young children in families who live in lower socioeconomic conditions and who may experience multiple risk factors in their lives.

Over the past four decades, strong connections have been well established between mental illness among parents and increased lifetime psychiatric risk for their children. However, mental health and drug and alcohol services for adults who are parents are generally not equipped to promote mental health for families or address the children’s wellbeing.

An integrated model of care increasing the availability of coordinated services for children and their families which reflected the cost and complexity of providing mental health care to infants, children, adolescents and their families would address their needs across the developmental spectrum.

The benefits of such a model would comprehensively cascade accessible services across primary and specialist community-based and inpatient care; and it would bring a national system of prevention, supported by funding incentives to promote mental health and reduce the morbidity of child and adolescent mental health problems, especially those that have continuity with adolescent and adult mental health problems.

The implementation of National Standards for the Care of Children and Young People in Health Services

There is clearly a role for the new Australian Commission for Safety and Quality in Health Care (ACSQHC). However, there are grave concerns about the narrow focus on measuring adverse events and the timeliness of healthcare delivery. A ‘balanced scorecard’ approach that monitors whether care is delivered in the right place, with the right staff, at the right time, in the right way is preferable.

The Association for the Wellbeing of Children in Healthcare’s (AWCH) survey (2004) of public hospitals revealed a number of critical issues that deserve national attention. The Government is strongly urged to adopt and implement the National Standards for the Care of Children and Adolescents in Health Services. These National Standards were developed collaboratively over two years ago by the AWCH, CHA and the Paediatrics & Child Health Division of the RACP but have yet to be implemented. They are relevant to all areas of the health service where children and adolescents are attended to and specifically define the need for a range of healthcare and social support. These Standards can be accessed at: www.racp.edu.au/page/policy-and-advocacy/ paediatrics-and-child-health.

Associate Professor Graham Reynolds FRACP
President
Children’s Hospitals Australasia
THE ROLE OF NON-PECUNIARY INTERESTS IN MEDICAL DECISION MAKING: EXCERPT FROM A CONVERSATION

Since 1992 the Royal Australasian College of Physicians has provided guidelines advising members about their relationships with the pharmaceutical industry. As with other guidelines on this subject, the emphasis has been on pecuniary interests. It has become increasingly recognised, however, that non-financial interests are also important influences on the behaviour of scientists and clinical practitioners, although the understanding of non-financial interests, and the most appropriate ways to deal with them, remains limited.

This is a key issue that is being addressed in the current revision of the RACP Guidelines. As previously, the process of revision is being guided by a series of consultations involving both the Fellows of the College and the wider public. At a recent meeting of the working group, the issue of non-pecuniary interests was discussed. To provide readers with an idea of some of the complexities associated with this topic, and to stimulate comments and responses, an edited fragment of this conversation is reproduced here.

Sanjeeda: The principle we have been working with is that every social role has attached to it interests or moral imperatives. It is a condition of modern life that we occupy simultaneously several—sometimes many—different roles: I may be a physician, a scientist, a teacher, a parent, a member of a company board, the secretary of the local tennis club, etc. Usually, there is no conflict between the various interests we serve in our different roles—we can keep all the balls in the air at once. But occasionally they conflict simultaneously and we find ourselves pulled in different directions. When this happens—that is, when there is a ‘conflict of interests’—we need to do something about it. A conflict of interests is, therefore, not a state of mind or a moral error: it is a sociological fact of life.

This schema is a general one. However, it’s interesting that nearly all the literature on conflicts of interest focuses exclusively on financial interests, as do all the guidelines from professional associations—including those of the American, British and Australian Medical Associations, the RACP and the Institute of Medicine. There is occasional passing acknowledgement of the importance of non-financial influences but no systematic analysis and no guidance for individual practitioners struggling to understand how they make—or should make—their own decisions.

Kim: I think this is a real deficiency. Despite all the discussion about the role of the drug companies and the corrupting influences of financial rewards, it is the non-financial interests that are often the more powerful. Certainly for myself—and I am sure for many of my colleagues—what drives me is not the prospect of making $100 or $1000 or even $10,000: it is the underlying values I hold to be important, together with the prospect of recognition, status and professional success. It may sound a little vain, but I am being honest: I do a lot of what I do because I think it is important and may benefit someone one day. But I also do it because I enjoy the status and the respect and recognition from colleagues that comes from making such a contribution.

I am sure that this is true in general. To academics, building a reputation and a career is more important than immediate financial reward. In any case, what would a few extra dollars mean to a surgeon who’s already making $300,000 a year? What he wants is not more money but public acknowledgement that what he is doing to make all that money is publicly valued!

Lee: That’s an interesting point. Even when someone—like your surgeon—is rewarded in monetary terms, what motivates him—or her—is primarily not the money itself. Money is often just a marker for other values, some good and some bad.

Sanjeeda: There seem to be several points we need to bring out. The first is that the interests that motivate doctors and scientists are much broader than just money. The second is that the non-monetary drivers can be multiple, and interrelated in complex ways. The third is that identification of non-financial values can be difficult, in part because the individuals concerned often do not themselves understand what is influencing their decisions. This makes it very difficult to regulate non-financial interests. I mean, given all this complexity, how are we going to ensure that people declare their interests and take steps to make sure that they do not distort their judgements.

Thuy: I guess it raises the additional question of how important it is to do so anyway. Why do people need to know whether they are being motivated by a desire to advance scientific truth, to improve medical treatments, or a quest for recognition, fame and power, so long as their professional practice is conducted with honesty and integrity? If a scientist produces a result that’s true and of benefit to humanity, what does it matter what motivated him or her to conduct the experiments in the first place?

Before we go any further I think that we should decide whether there is a genuine problem to be solved here. Maybe it is enough to focus on pecuniary interests. After all, that is what concerns the public and it is what we can respond to.

Kim: I agree with Sanjeeda that there is a problem. The whole point about pecuniary interests is that they influence behaviour. This is the lesson from 20 years of research in this area. Physicians always deny that the prospect of financial rewards changes their decisions, but whether they like it or not—or know it or not—the evidence shows that their judgements are affected. The entire structure we have established, including the five steps that need to be taken—the declaration of interests, review by a relevant body, assessment of whether there is a conflict and whether something needs to be done, development of a management strategy that separates the conflicting social roles, and effective communication of the outcomes—reflects the understanding that interests change decisions in spite of the conscious intentions of the decision makers.

There’s no reason why exactly the same shouldn’t apply to non-pecuniary interests. If I am motivated by socially beneficial values, that is fine. However, if what motivates me is a series of potential rewards extraneous to the interests of my patients or the broader public, I think that risks are posed that need to be identified and managed.

Sanjeeda: For example, if a surgeon is driven by a desire to become Australia’s Christian Barnard, he might be prepared to take risks that he would not take if he was acting in accordance with more modest aspirations. If a doctor is conducting a trial involving his or her own patients, it’ll be important to clarify the fact that there are different interests and values driving his or her decision making at different times. And if a researcher is seeking to prove that her new discovery really cures cancer, she’ll need to separate her excitement, her pride, her dreams of fame and fortune from the mundane process of patient recruitment and data collection.
Professor Carolyn Sappideen

The recent decision of the High Court in Tabet v Gett (see illustration 3 below) rejected a negligence claim brought on behalf of a young brain-damaged child who was admitted to the hospital complaining of continuing headaches and vomiting. A consultant paediatrician was found to be negligent in not promptly ordering a scan which would have shown a brain tumour and secondary hydrocephalus. However, the negligence was not a cause of the brain damage as it was likely (more than 50% probability) that the child would have suffered brain damage anyway. But did the negligence cause the child a different type of damage—the loss of a valuable chance of avoiding or reducing the severity of brain damage? The High Court held that, in the circumstances, the child would not have had a claim against the negligent physician for a loss of a chance of a better medical outcome where that chance was speculative and at best a 15% chance of reducing or avoiding brain damage.

A person bringing a claim for negligence must show that the defendant’s negligence caused the claimant’s harm, as illustrated in the cases below.

**Illustration 1: No causation**

[UK: Barnett 1968]

Two nightwatchmen accidentally drank poison. They were brought to the hospital but the attending medical officer refused to come and treat them. They died of poisoning. Even if the medical officer had attended promptly and treated them, they would still have died. The doctor’s negligence made no difference to the outcome and was not regarded as causing their death.

**Illustration 2: All or nothing rule**

[UK: Hotson’s case 1987]

A young child fell out of a tree and injured his hip. There was a negligent delay in treatment and the child developed avascular necrosis of the hip. Even if he had been treated promptly, there was a 75% likelihood that he would still have suffered the necrosis. The child’s claim failed because there must be better than a 50:50 chance of avoiding the injury before damages can be awarded. The child could not recover 25% of damages on the basis that he had a 25% chance of avoiding that harm. If the chances were better than 50:50, the child would have recovered full damages. This type of case is one where the risks resulting from delayed treatment have ‘played out’: the child has avascular necrosis.

**Illustration 3: Loss of chance**

[Tabet v Gett 2010]

A young child was admitted to hospital complaining of headaches and vomiting. The consulting paediatrician was found to be negligent in not ordering a CT scan promptly which would have diagnosed a brain tumour with secondary hydrocephalus. The child suffered
permanent brain damage. It was argued that there was a chance that if the CT scan had been done promptly early treatment might have either avoided or diminished brain damage. The chance of a better outcome was largely speculative and at the very best could not be put higher than 15%. Since the child had less than a 50:50 chance of recovery, the child’s claim failed and no damages were recovered.

This was the issue in the recent High Court case of Tabet v Gett (2010) available at: www.austlii.edu.au/au/cases/cth/HCA/2010/12.html.

Tabet v Gett—the High Court decision

The key question before the High Court was whether it was possible to bring a claim for damages for loss of a chance for a better outcome when a better outcome was improbable (less than 50%). The High Court held that there was no claim if the chance was less than 50%.

The reasons

The High Court agreed that if there was no claim for loss of chance, this would result in an all or nothing position. If the claimant’s prospects for recovery were greater than 50%, the claimant would get full damages even if there was some uncertainty about causation. But if the chance of a better outcome were less than 50%, the claimant would get no damages at all.

Patients may see this as ‘rough justice’ where there has been negligence and no damages have been recoverable for the loss of a chance of a better outcome which is significant and important to them. It was argued in Tabet that a loss of a chance of recovery should be regarded as actual damage. If loss of chance of a better outcome were so regarded, then it might be possible to show that it was more probable than not (more than 50%) that the practitioner’s negligence caused that damage (loss of chance). The value of that chance would then be assessed in proportion to that chance. So if there was a 40% chance of a better outcome, the claimant should get 40% of their total damages. It was also argued that allowing claims for loss of chance was important in maintaining professional standards and that it was inconsistent to allow recovery for a lost commercial opportunity but not to allow a patient’s claim for a loss of chance of a recovery. The High Court rejected these arguments. The maintenance of professional standards had to be balanced against the costs of defensive medicine.

The High Court also noted that there would be serious consequences if a loss of chance of a better outcome was regarded as a claimant’s relevant loss and recovery allowed for the value of that chance. For example, it would mean that if there was a negligent delay in treatment which reduced the patient’s prospects for recovery, the patient could still recover for loss of that chance even if at the time of trial the claimant had fully recovered. There is the further difficulty that it may be pure speculation what the chances for a better outcome might be. For example, in a case where a GP delayed 9 months in treating a patient’s cancer, the statistical model used by experts assessed the chances of survival at 42% if the patient had been promptly treated; the delay reduced this to 25%. Survival was defined as 10 years from the date of commencement of treatment. The patient was still alive 8 years after initial treatment and at the time of trial and subsequent appeal so that it was not clear that the delay in treatment had, in fact, caused the patient the loss of chance of surviving 10 years.

The High Court’s refusal to allow a claim for loss of chance in personal injury claims recognised that to allow a claim would result in serious consequences for insurers and the public health system. Whilst the High Court decision appears to have decisively rejected claims for loss of chance of a better outcome in personal injury claims for negligence, does this permanently close the door on all claims for loss of chance? There are some features of the Tabet v Gett case which militated against a claim for loss of chance. First, this was a case ‘where the factors present in that chance have played themselves out when physical injury or death occurs’. The risk had eventuated: the child had suffered permanent brain damage. In this type of case the claim was to be tested on the orthodox rules requiring a greater than 50% chance of a better outcome (see illustration 2 above). Second, the child’s chance of recovery or better outcome was speculative, put at its very highest at 15%. It was not a case where there was extensive expert evidence of the progression of a disease and its various stages. Third, in the hospital setting, a public patient does not have a contract with the treating physician. This left no room to argue that a claim for negligent breach of the agreement to treat (contract) could give rise to a claim for loss of a chance. A claim for loss of commercial opportunity is available in a claim for breach of contract. These factors suggest that it is just possible that in a suitable case the High Court might re-examine the question of whether a claim should be available for loss of chance of a better medical outcome. So in a failure to diagnose a case where there is stable statistical evidence and where the risk has not ‘played out’, a claim for loss of chance might be possible.

What are the chances? The diagnosis is uncertain.

Professor Carolyn Sappideen
Medico-Legal EAG

A THANK YOU

Meg Carroll has been with the College for over a decade and during that time she has built the foundations of the Queensland office. Her loyalty and commitment to the College and its Fellows are well recognised and have been the backbone of a great deal of the success of the College in Queensland. Meg has been a delight to work with: serious when needed, lighthearted and relaxed when not, but always the professional. Her depth of knowledge of the College and all of its interconnections and relationships has been a saving grace on many an occasion. Working with the aid of this knowledge of history and context has made the roles of those on the State Committee and within the office immensely more effective than they could ever have been.

We are happy to say that Meg will be remaining with the College in a part-time capacity so her value to the College, the State Committee and the Queensland office will not be lost.

Meg, we wish you all the best and please do enjoy your well-earned (semi) retirement.
I’m now three months into working for management! My dual training. So much for change-General Medicine at the John Radcliffe. Now I’m a Specialist Registrar in Acute New Zealand (and the CTC!) behind.

On a plane with my husband leaving time at World Congress, then jumped up my FRACP testamur, had a brilliant work as a locum consultant, picked training in December last year, started T

Postcard from Oxford

Two thousand and ten has been a rather surreal, topsy turvy experience so far. I finished gastroenterology Advanced Training in December last year, started work as a locum consultant, picked up my FRAC testamur, had a brilliant time at World Congress, then jumped on a plane with my husband leaving New Zealand (and the CTC!) behind. Now I’m a Specialist Registrar in Acute General Medicine at the John Radcliffe Hospital in Oxford, England, to finish my dual training. So much for change management!

I’m now three months into working for the NHS, which has also been surreal—so familiar, yet so very different. The NHS acronyms alone deserve a postcard of their own. One difference is how medical training has devolved from the Colleges and been given to (yet another acronym) the NHSE—suffice to say I think the RACP is on the right track. One really positive thing over here is that junior doctors take responsibility for their own learning. Computerised assessment tools for mini-CExs, SIATs, MSFs et al. actually work, so take heart trainees and Fellows!

I can’t sign off without thanking all the trainees and Fellows of Australia and New Zealand, especially the NZTC and CTC committee members, for your support during my tenure as CTC Chair. If any of you out there have thought about joining up, just do it. The RACP takes the voice of trainees seriously, and there are so many committees that need representation—take it from me, we do make a difference.

Hope you’re enjoying YOTT,

Zoë (Raos)

Procrastination—our enemy and friend

I found myself googling ‘procrastination’ the other night while I was avoiding writing up a project which I was due to send my supervisor. Seeing as this is an activity which I spend a significant proportion of time doing (this statement could apply to both googling and procrastinating; in fact one does tend to beget the other), I thought that 11 pm on a Wednesday night was the ideal time to start learning about the motivations for my habitual avoidance of that which has a deadline. From the outside it doesn’t make much sense—my whole life I have engaged in activities with deadlines and due dates, from high school debating to pursuing a career that involves exams, exams and more exams. With stress levels at a constant high, I often fall right off the end of the Yerkes–Dodson curve into paralysing inaction, at least with reference to the task at hand.

The psychology of procrastination has been studied at length; however, it did not give me much heart to read (in an article I found after an extensive review of the literature on pubmed—another great procrastination tool) that ‘continued research into procrastination should not be delayed, especially because its prevalence appears to be growing’. It filled me with a sense of dread for two reasons: (1) I have the uneasy sense that the procrastination researchers are procrastinators themselves, and (2) the prevalence is growing. Like other scary epidemics (obesity, pertussis, wearing leggings as pants), procrastination has taken hold of our society and soon will result in large-scale public health campaigns to curb its impact. If anyone gets around to it that is.

Procrastination does, however, have its benefits. I find my house full of the smell of baked goods around exam time, my washing always done, my ironing basket empty, my plastics drawer reorganised (so many lids, not enough containers). And I write endless to do lists, which actually make me feel as though I have achieved something.

If you are a procrastinator, and have not put off reading this article, I have some ‘facts’ about procrastination which should make you feel much better:

- There are lots of famous procrastinators—Leonardo da Vinci, Douglas Adams and Samuel Taylor Coleridge. Having said that, had Douglas Adams not procrastinated, he might have finished ‘The Salmon of Doubt’ which I could have read the night before my last assignment was due.

- Being a procrastinator is partly genetic. This means you can partly blame your parents for it. Everybody’s doing it—the prevalence in college students of procrastination behaviour is 80–95%!

- Ninety-five percent of procrastinators want to reduce their procrastination but will do it next week once they have arranged their sock drawer.

- Procrastinators tend to be impulsive, distractible and lacking in self-control. Therefore they are far more entertaining than other people.

Just remember fellow procrastinators, if it wasn’t for the last minute, nothing would be achieved.

Reference


Dr Jemma Anderson
Macquarie Street offices open to all

The College Head Office remains in its heritage building at 145 Macquarie Street, Sydney. But now with the relocation of the various Divisions, Faculties and Chapters from Macquarie Street to 52 Phillip Street, the Macquarie Street offices will have much more available space, including more readily available meeting room and workplace space, to meet the needs of visiting Fellows and trainees of the College.

The Macquarie Street office is already home to the extensive library facility which includes many historical publications.

The College welcomes and encourages its Fellows and trainees to utilise the various College facilities available, and we look forward to providing you with professional and efficient support, as required.

The Deanery and the IT team now at 70 Phillip Street

Due to the expansion of education operations across the College, the Education Deanery has been relocated to a larger office at Level 5, 70 Phillip Street.

The College has leased 1087 square metres of fully fitted out floor space, within 100 metres of the Macquarie Street offices. This new office is now home to the IT team and the Education Deanery (except CPD staff).

Having the entire Deanery on one open plan floor plate will remove fragmentation, maximise interaction and ensure knowledge sharing, to benefit and service all RACP trainees.

The IT department has been strategically located alongside the Deanery so that all of the information technology education initiatives and related roll-out can be managed with maximum efficiency. This will ensure the education tools being continually developed and provided to trainees are leading edge from both a technological and an educational perspective.

The office building at 70 Phillip Street is also tenanted on other floors by the Federal Government and includes the Sydney office of the Prime Minister and the offices of several senior Government Ministers. So the College is certainly in proximity to people in high places. We will have to wait and see if this transpires into better health outcomes for the nation. Here’s hoping!

An official welcome involving the CEO, Dr Jennifer Alexander, and staff from other sections of the College occurred on Monday, 28 June 2010.

The Education Deanery and the IT team are very happy in their new home.

Divisions, Faculties and Chapters combine forces in their new location

All Sydney-based staff in the various Divisions, Faculties and Chapters (DFaC) relocated on the weekend of 9–10 July to Level 7, 52 Phillip Street.

This move will be of enormous benefit to the entire College. Having the entire DFaC staff together will ensure much closer integration, cross-collaboration and sharing of ideas and, of course, much greater efficiencies. As a result, the College will be strengthened, improved, and more effectively positioned to deliver its outcomes to its various stakeholders.

We know the DFaC staff will enjoy the more modern facilities at 52 Phillip Street, although they have taken with them fond memories and more than a little nostalgia for Macquarie Street.

All RACP Sydney offices—145 and 147 Macquarie Street, 52 Phillip Street and 70 Phillip Street—are located within 100 metres of each other and this proximity ensures all parts of the organisation will remain close.

The entire property project has been successfully managed over the past few months by Siobhan Geraghty of Resources Global Professionals and we are indebted to Siobhan for delivering such great outcomes for the College across the property portfolio.

Dr Jennifer Alexander officially opened the new Sydney DFaC office on Tuesday, 13 July.

CEO Jennifer Alexander and staff of the Divisions, Faculties and Chapters at the official opening of the new DFaC offices.
A very well-respected and esteemed Fellow of the College stepped down from the position of New Zealand President on 21 May 2010. Dr Geoff Robinson FRACP FAcChAM was farewelled by 28 of his closest friends and colleagues on 22 June 2010 in what proved to be a very special occasion for everyone. Guests included younger and older Fellows, the College President and New Zealand President and past presidents and trainees, as well as past and current staff.

The evening was full of laughter, memories of past achievements and misdeeds, and much praise for Geoff’s constant and longstanding commitment to the College, its Fellows, trainees and staff. Over a meal of salmon, beef, salads and a multitude of desserts, guests chatted and shared stories of the past. Towards the end of the evening, Dr Leo Buchanan, Chair of the College Māori Health Committee, acknowledged Geoff’s significant leadership and mana in the College before Dr Johan Morreau, the new New Zealand President, presented Geoff with a very special gift—a greenstone toki, as a token of the esteem in which New Zealand Fellows hold him.

Geoff was New Zealand President from 2008 to 2010, a member of the College Board and the College Finance Committee, and is a senior member of the Australasian Chapter of Addiction Medicine. He has previously been Chair of the New Zealand Board of Censors and Board of Education, Chair of the Physicians Training Committee, and a member of the New Zealand Clinical Examinations Committee and the New Zealand Grants Advisory Committee. He was a key contributor to the development of the College’s response to the Review of the Sale and Supply of Liquor Act, and led the development and presentation of the College’s submission on Tobacco to the Māori Affairs Select Committee. Geoff remains Chair of the Board of the Medical Research Institute of New Zealand and is a significant contributor to the research activity of the Institute having authored over 70 publications. He is currently Chief Medical Officer at Capital and Coast District Health Board, a general physician and an acknowledged expert in alcohol and drug addiction medicine.

References from Broader protection, not just border protection


4. Citizenship NSW, Health NT, Multicultural Affairs QLD, Health QLD, Health SA, Health TAS, Health VIC, Citizenship & Multicultural Affairs WA.

5. In the ‘Pacific Solution’, detainees, including children, were held in detention on Manus Island and Nauru while their asylum claims were processed.


The College extends its warm congratulations to all Fellows who were honoured on the Queen’s Birthday this year.

New Zealand
Dr Francis Agnew MNZM, FACHAM was appointed a member of the New Zealand Order of Merit, for services to the Pacific Islands Community.
Dr John Richard Delahunt Matthews QSO, FRACP was appointed as a companion of the Queen’s Services Order, for services to medicine and the community.
Dr Teuila Percival QSO, FRACP was appointed as a companion of the Queen’s Services Order, for services to the Pacific Islands community.

Australia
Member (AM) in the General Division
Professor Louise Alison Baur AM, FRACP (NSW), for service to medicine, particularly in the field of paediatric obesity as a researcher and academic, and to the community through support for a range of children’s charities.
Emeritus Professor Felix Bochner AM, FRACP (SA), for service to clinical pharmacology in Australia as an academic and researcher, and to a range of professional associations.
Professor Peter John Collignon AM, FRACP FRCPA (ACT), for service to medicine, particularly as a practitioner and educator in the fields of clinical microbiology, infectious diseases and infection control.
Emeritus Professor Laurence Basil Geffen AM, FRACP (Hon) (QLD), for service to neuroscience as a clinician and researcher, and to medical education.
Dr John Francis Gunning AM, FRACP (NSW), for service to medicine as a cardiologist, and through senior roles with a range of professional organisations.
Dr John Hurley AM, FAFRM (VIC), for service as a leader and innovator in geriatric medicine through the development of best practice and quality improvement programs in aged care.
Professor Alan Frank Isles AM, FRACP (QLD), for services as a hospital administrator, medical educator and specialist in the field of paediatric respiratory medicine.
Professor Arumugam Manoharan AM, FRACP (NSW), for service to medicine as a haematologist, particularly as a researcher in the field of tumours and as an educator.
Professor Telk Ewe Oh AM, FRACP (WA), for service to medicine, particularly through the development of protocols for the specialties of anaesthesia and intensive care, through leadership roles in clinical and academic practice, and with professional bodies.
Dr Trevor Ernest Olsen AM, FRACP (QLD), for service to medicine as a clinical haematologist, and as an advocate for advances in the management and treatment of leukaemia.
Dr John William Tapsall AM, FACHSHM (Hon) (NSW), for service to medicine and to public health microbiology, particularly through contributions to the understanding of gonococcal and meningococcal disease.

Dr Ingrid Alida van Beek AM, FAFPHM FACHAM (NSW), for service to public health and community medicine through the promotion and provision of primary care for people affected by mental health issues, substance and physical abuse, and HIV/AIDS, and to medical education.
Dr Alexander David Wodak AM, FRACP FAFPHM FACHAM (NSW), for service to medicine and public health, particularly in the area of drug and alcohol dependency treatment, through legislative reform, and to medical education.
Dr Lindsay Ian Worthley AM, FRACP (SA), for service to medical education, particularly in the area of intensive care medicine, as a clinician, mentor and educator, and through contributions to professional associations.

Medal (OAM) in the General Division
Dr Sadanand Nagesharao Anavekar OAM, FRACP (VIC), for service to medicine, and to the Indian community of Victoria.
Dr Ian Kenneth Bailey OAM, FRACP (NSW), for service to medicine as a cardiologist.
Associate Professor Harry George Mond OAM, FRACP (VIC), for service to medicine in the field of cardiology.

Public Service Medal (PSM)
Dr Judith Ann Williams PSM, FRACP (QLD), for outstanding public service to the Wide Bay region as the director of paediatrics at the Bundaberg Base Hospital.
“Being entrusted with this research and supported in this way brings much responsibility. I hope that both the research I will undertake overseas and the skills learned there will hold me in good stead to continue to foster research, teaching and community service back in Australia in the near future.”

Dr Andrew Jabbour, Vincent Fairfax Family Foundation Research Fellowship 2010 recipient

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For more information, visit our website at: www.racp.edu.au
Closing date: 30 August 2010

Jacquot Research Entry Scholarship ($30,000)
To provide salary for younger Fellows or Advanced Trainees in Nephrology for one year to undertake a higher research degree. Projects may be in basic, clinical, epidemiological or public health aspects of Nephrology.

Jacquot Research Establishment Award ($90,000)
To assist establishment of a career in Nephrology research for a Nephrologist at any early stage in their career who has a postgraduate research degree in an area of relevance to Nephrology. The award is normally intended to provide laboratory costs or salary for a Research Assistant, but may also be used for part-salary for the applicant. The award is usually for one year with the option of renewal.

Don & Lorraine Jacquot Fellowships ($90,000–$100,000)
To provide opportunities for Nephrologists who have completed a postgraduate research degree and are still at an early stage in their research career, to help develop independent research programs to advance knowledge in the treatment of renal disease. The Fellowship is primarily intended as salary support or part salary support for the applicant.

For further information, please go to www.racp.edu.au/page/foundation and click on The Jacquot Awards, or contact foundation@racp.edu.au.

FELLOWS WELCOME TO SUBMIT ARTICLES TO RACP NEWS
If you are keen to let readers of RACP News know of any exciting developments or issues in your particular area of medicine, or in the health system more generally, please send your article to the editor, Kathryn Lamberton, at RACP.News@racp.edu.au.

A one-page article is 850 words; a two-page piece is 1700 words. Photographs submitted with articles need to be high resolution (300 dpi). Graphs and other illustrative material need also to be of reproducible quality.

All articles will be considered for publication by the Editorial Board as to their interest to the readership and appropriateness to the mission of the College journal.

We look forward to receiving your submissions.

FELLOWS COMMENDED IN VICTORIAN PREMIER’S MEDICAL RESEARCH AWARDS

A Victorian infectious diseases physician whose investigation into the powerful superbug, golden staph, is likely to change the way the bacterium is treated received a commendation in the 2010 Premier’s Award for Health and Medical Research. Dr Benjamin Howden received $8000 and a certificate for his work from the Premier of Victoria at a ceremony at Government House.

Dr Howden has been investigating how and why Staphylococcus aureus, commonly known as golden staph, has become resistant to antibiotics, including the powerful antibiotic vancomycin.

The bacterium is now a big problem in most large Australian hospitals, infecting intravenous lines, catheters and wounds after operations.

Using a combination of techniques, including high throughput whole genome sequencing, Dr Howden has shown that resistance can occur in patients being treated for serious golden staph infections by the bacteria developing only minor genetic changes. He has also found that the bacteria are developing ways to evade the human immune system.

The findings are resulting in the development of new patient management strategies to improve outcomes in the treatment of serious golden staph infections.

Dr Howden, a Fellow of the Royal Australasian College of Physicians and the Royal College of Pathologists of Australasia, is an infectious disease physician at Austin Health and an Honorary Senior Fellow in the Department of Microbiology and Immunology at the University of Melbourne. He is establishing his own staphylococcal research group at Austin Health and within the Department of Microbiology and Immunology at Melbourne University.
A LEADING PHYSICIAN ALLAN KERR GRANT
AO, RFD, ED, MB BS, DUNIV (ADEL), MRACP FRACP, FRCP, FRCPE, FACP, MD (FLINDERS), 1924–2009

Allan Kerr Grant was the third son of Professor Kerr Grant (later knighted), the well-known Professor of Physics at the University of Adelaide from 1911 to 1948. He was educated at St Peter's College where he matriculated early, thus allowing him to have a further school year and the chance to take on the responsibilities of a senior student. Leaving school in 1941, he started medicine the next year and graduated MB BS in 1947. After completing his internship at the Royal Adelaide Hospital, he then spent two years training in gastroenterological units in London, followed by a further several years of work at the Royal Adelaide Hospital and the University of Adelaide.

He joined the staff of the newly developed Queen Elizabeth Hospital (TQEH) in 1959, and five years later he became the director of its Gastroenterology Unit, the first such unit in South Australia. To cap this, he was elected president of the Gastroenterological Society of Australia in 1969.

A staunch supporter of the Royal Australasian College of Physicians, he became its president in 1981 and, during his tenure in office, was a superb ambassador (with his wife, Mary) for Australian medicine overseas. He was also the medical director of SAPMEA (South Australian Postgraduate Medical Education Association).

In 1984, he retired from the staff of TQEH after the completion of 25 years’ service, and this was a retirement much to the regret of all his associates, medical, nursing, clerical and others. However, this did not mean any reduction in work, as he quickly launched into positions at Flinders Medical Centre and Flinders University, while carrying on with commitments to the Medical Board of South Australia (he became a member in 1982) and SAPMEA.

It should be mentioned that work at Flinders was not new to Allan. Following the establishment of Flinders University in 1966, he had been involved, with the vice-chancellor, Professor Peter Karmel, in the planning and creation of the medical school, and was asked to participate in the teaching of students in the medical wards, once they had been established.

The training of students and young doctors was ever dear to his heart and he had long believed that juniors in hospital employment did not get the mentoring and continuing education necessary to ensure happy and successful careers. So it was a great satisfaction that the Medical Board, stimulated by Allan, approved the creation of a Council for Early Postgraduate Training in South Australia in 1995. This Council, which has been invaluable, has now become a statutory body answerable to the Minister for Health.

Allan gave much time over many years to the Citizen Military Forces (CMF), culminating in three months spent in South Vietnam (from December 1968 to March 1969) as the leader of the medical team supporting the Australian troops at Vung Tau.

It is not surprising, therefore, that during these years of outstanding service in so many fields he received substantial recognition—an Efficiency Decoration for military service (1970), the degree of Doctor of the University of Adelaide (1985) and the degree of MD Flinders (1996) for his work in postgraduate education, and the award of Officer of the General Division of the Order of Australia (1991) for his contribution to the nation.

Two years after graduation, while still in Adelaide, he married Mary Hone, a daughter of Dr Ray Hone, one of Adelaide’s most respected physicians. They subsequently had three sons and a daughter, all now established with their families.

Life for Kero was a continuous study of the world and its inhabitants, so it is appropriate to talk of his extra-curricular pursuits. He was an enthusiastic player and supporter of university rugby, social tennis in the summer and periodic rounds of golf at Mount Lofty. He would readily admit failing to reach ‘Blues’ standards, but the enjoyment he got and the enjoyment he provided his fellow players was memorable and usually hilariously funny. His feat of hitting three successive balls off the 9th tee into a creek, the last drive associated with the loss of his driver on the follow-through, was Guinness Book of World Records material. In later years, fishing became his great interest, and it didn’t matter whether it was casting from the beaches or reefs of Robe, or from a boat in American River, Coffin Bay, or Ceduna.

Ornithology, combined with photography, also fascinated him. The Adelaide Ornithologists Club was the beneficiary of a lovely collection of his pictures of birds taken in Australia and in the UK. Botany, too, was a great interest and under Mary’s guidance Allan became a successful propagator of plants at their home in Balhannah, and then Stirling.

The development of Alzheimer’s disease, followed by its inexorable progress, was a cruel and tragic event for one previously so exuberant and generous. As a consequence, Allan spent the last period of his life in the War Veterans Home. To Mary and her four children, who bore the brunt of all these changes, we can only imagine the stresses that they suffered, but we can hope that they will take much solace from the memory of Allan’s incredible medical achievements, his friendliness, and his great sense of fun. He will be missed by many.

Dr Hugh Douglas
Dr Hugh Douglas was a friend of Dr Allan Kerr Grant. This obituary is based on the eulogy given at his memorial service. Reprinted from medicSA, the AMA (SA) magazine, with permission.

Addendum
I am indebted to Dr Hugh Douglas and Allan’s wife, Mary, for the above obituary for Allan. Allan was the President of the RACP from 1981 to 1983 and was one of the College’s most outstanding presidents. During his tenure as President, he spent considerable time visiting all the states and New Zealand, engaging with the Fellows and trainees. He was a remarkable educator and a great mentor and I had the pleasure of being taught by Allan both as an undergraduate and as a physician trainee at the Queen Elizabeth Hospital in Adelaide in the 1960s. In his later years, as a member of the Medical Board of South Australia, he introduced an education program for interns, which was adopted Australia-wide.

Allan’s interests extended well beyond medicine. As Mary indicated to me, ‘Allan’s bird photography was superb, he was the best propagator of rhododendrons in South Australia and he was an avid supporter of opera and ballet’.

Professor Napier (Nip) Thomson
President RACP 2006–2008

Reviewing a book like this for a medical audience will cause some degree of scepticism, especially when the words ‘overcoming’ and ‘recovery’ are used in the title with reference to a disease like multiple sclerosis. However, this scepticism is allayed to some extent by thoughtful referencing to current evidence-based research in MS and a respect for current medical treatments. The book, of course, has been written primarily for an informed lay MS audience and that has to be taken into account. The author’s first book, Taking Control of Multiple Sclerosis: Natural and Medical Therapies to Prevent Its Progression, was written in 1999. His new book, similar in content, has been expanded to include current research and many more scientific references.

Since the first book was written, despite discussion around the virtue or otherwise of the promoted scientific argument on diet, there has been no evidence to the contrary. The evidence emerging since the first book has been more to support what was originally written.

Professor George Jelinek was diagnosed with multiple sclerosis 11 years ago while working as Professor in Emergency Medicine in Perth. He was Editor of the Journal of Emergency Medicine at the time and therefore understood the critical thinking involved in scientific evaluation of evidence and had written many papers on his area of specialty. He now devotes a lot of his time outside his emergency medical work to helping others understand MS and teach the effect of diet, exercise, lifestyle change, wellness, appropriate sun exposure and mind–body balance on the progression of multiple sclerosis.

This book is a much more relaxed, confident and open book than the first one. In large part this is due to the author being able to discuss his emotions, frustrations and desperation at not knowing how to help his mother who he was very close to and who eventually died of MS when he was in his twenties and working as a Resident Medical Officer. As he says, ‘repressed emotions and unresolved grief and conflict can trigger or worsen serious illness’ and therefore have a negative effect on a healthy immune system. It was important for him, therefore, that this chapter was added along with up-to-date evidence-based research on MS.

The first part of the book is about the disease itself and the adverse effects of saturated fats on the nervous and immune systems. The focus of the author’s management of MS is around diet. The diet he advocates is a very low saturated fat diet (less than 20 grams of fat per day) with no dairy and little or no meat. He argues that very low saturated fat diets have shown significant reductions in relapse rates and slowing of disease progression in MS. Much of this research was based on the work of Roy Swank, a Professor of Neurology in Oregon, who followed in detail 144 patients (out of the original 150) for 34 years in the immediate post-war period and who demonstrated, using historical comparative data, that the outcomes were better for those who followed a very low saturated fat diet. This was an extraordinary effort. Swank’s study was not randomised or controlled and therefore was not accepted by the medical profession at the time as evidence of the effect of diet on MS. To replicate such a study today would not only be difficult to do but impractical to randomise and control, because of the difficulty in asking people to stay on a special diet for such a protracted period of time.

The author recommends that the diet be supplemented with essential fatty acids of 17–23 g/day, either in supplements or food (fish). The supplement is usually in the form of omega 3 fatty acids. B Group vitamins, especially vitamin B12, are also advocated.

The health benefits of sunlight and supplementation of Vitamin D are advocated, too, along with annual Vitamin D checks to keep the serum level of Vitamin D to around 150 nmol/L. The evidence for the association between Vitamin D deficiency and MS has increased significantly since his first book was published.

The second part of the book discusses the importance of lifestyle change and the ‘mind–body connection’. Lifestyle adaptation and change are often advocated by treating physicians of MS. Exercise has been shown to improve fitness and wellbeing, while stressful life events have been shown to be associated with an increased risk of relapse in MS. Depression affects around 50% of people with MS. Smoking has been shown to increase the risk of developing MS and to increase the risk of progression. So it is of no surprise that these lifestyle factors and changes are advocated with great zeal and passion by the author.

The mind–body connection and being in a state of ‘wellbeing’ are central to the author’s beliefs. The control of the mind over the body is part of his teaching. Professor Jelinek encourages people with MS to express grief and difficult emotions, keep a diary, see a professional counsellor if required, attend an MS group and engage in some form of meditation for 20 minutes a day to improve their health.

In regard to the medical treatment of MS, the author supports the use of the traditional forms of steroid therapy and immunotherapy but cites evidence questioning the effect of interferons in reducing the rate of progression of MS. Other newer forms of therapy are also discussed.

Overall, the book is easy to read and respectful of current accepted treatments for MS. The aim of the book is to give people with MS a wider view of how to manage their MS and open their minds to other research.

The aim of the book is to give people with MS a wider view of how to manage their MS and open their minds to other research.
A charming autobiography by a good Fellow


Dudley William Carmalt Jones (1874–1957) was the Professor of Systematic Medicine, University of Otago (1920–1939), and in 1938 a Foundation Fellow and first New Zealand Vice-President of the RACP. A humble and self-effacing man, of modest talent, this aptly titled autobiography is an extraordinarily interesting account of British medicine in the twilight of the Empire and the emerging of the specialist physician in the Antipodes. Brian Barraclough has done a wonderful job compiling and constructing the book. The footnotes and postscripts are informative, the illustrations intriguing, and the binding elegant. It is a lovely book to hold and read.

Carmalt Jones was raised in affluent, professional upper middle class England, public schooled and educated at Oxford and St Mary’s. The dominating event of his life was the Great War (1914–1918). Having trained in the London hospitals, clerked at Queen’s Square (where Hughlings Jackson was still in practice) and worked in Sir Almroth Wright’s ‘vaccine’ laboratory, his medical experience was enviable and private means allowed him to pursue his interests as he wished. His career as a physician was ‘simple opportunism’. He had just commenced a private practice, as a physician was ‘simple opportunism’. He had just commenced a private practice, and the casual warmth of Australasians. His most worthy publication was on war neurasthenia (Brain, 1919). It is a rather pedestrian account of psychiatric illness induced by warfare, and no doubt influenced by the viewpoint of his domineering contemporary, Gordon Holmes. However, his sonnet adorning The Soldiers’ Memorial high on the Otago Peninsula, poignantly captures the tragedy of his generation—it begins ‘In trench-kit and steel helmet there he stands, For pride and protest, till the Judgement Day, Who flung his gallant spirit in the fray, His bones in Flanders mud or Sinai sands’. As a child of Dunedin, this haunting monument certainly alerted me to my great-uncle’s sacrifice.

Carmalt Jones retired home and at that point ended his autobiography. He wrote a history of the Otago Medical School and no doubt enjoyed the comforts of family and country until his death in 1957. The substance of this book is confessional, it would seem to have been a successful work of self-therapy, and because of this it is informative and instructive. It is a pleasure to read. On arrival in 1920 there were only 12 MRCPs practising in New Zealand! One senses today Carmalt Jones would be proud of his College in Australia and New Zealand.

A. D. (Sandy) Macleod Christchurch

The book is available for loan from the History of Medicine Library. Loans are posted free of charge to Fellows.

A rare find


Ms Sabine is to be congratulated on finding and presenting this antique compendium of popular medical advice while researching a box of solicitor’s papers in the Mitchell Library. As I have not seen the manuscript, I trust that her transcription is accurate and her editing judicious.

Dr Bell

William Bell’s qualifications were MRCS (London) and Lic Midwifery (Dublin), lately surgeon of the Windsor District Hospital, Resident Medical Officer Carcoar NSW. Bell first practised in his home town of Newry, Ireland. He reached Australia in 1839, serving as surgeon-superintendent on the ship. He practised briefly in Sydney before moving to Parramatta and investing in a shop, but became insolvent in January 1841 and spent five months in debtors’ prison. Bell then returned to Sydney and was licensed to practise by the Medical Board. In 1842 he moved to Windsor. In 1848 he assisted in an operation in which chloroform was used as an anaesthetic, but the patient was given too much and died!

Bell now had seven children, and not enough patients to provide sufficient income. He borrowed money to pay some debts, and gave the manuscript of his intended book to a solicitor as collateral for the loan.

In January 1850 he moved to Carcoar, but the town was almost deserted the following year when the gold rush started in nearby districts. He then moved to Orange, providing medical attention by horseback to the central western gold fields and frequently acting as a witness in coronial cases. He was appointed postmaster in Sofala in 1855 and took up the position...
A further response
In the last edition of RACP News, Nordin and Prince repeated several criticisms of our work on calcium supplements, finishing by stating that our conclusions (that calcium supplements when used without vitamin D have marginal anti-fracture efficacy and increase the risk of cardiovascular events) are ‘alarmist and almost certainly without substance’.

We have previously addressed most of these criticisms in peer-reviewed journals.1–3 We believe that data from randomised controlled trials (RCTs) should inform and guide clinical practice, and do not support Nordin and Prince’s view that data from observational studies or per-protocol analyses of RCTs should be afforded greater importance than intention-to-treat (ITT) analyses, because of the potential for confounding in both of the former situations.

There is no single RCT of calcium supplements without vitamin D that has adequate power to address the issues of anti-fracture efficacy and cardiovascular safety. When data from individual RCTs of calcium supplements without vitamin D are pooled in meta-analyses, the relative risk of any fracture with calcium is 0.90 (95% CI 0.80–1.0, P=0.052, n=9 studies, n=6517 participants), of hip fracture is 1.50 (95% CI 1.1–2.1, P=0.02, n=3 studies, n=5574 participants), and of myocardial infarction is 1.27 (95% CI 1.01–1.59, P=0.038, n=11 studies, n=11,921 participants).6

Meta-analyses of RCTs also show that there is no statistically significant reduction in risk of all fractures or hip fracture with calcium and vitamin D co-supplementation in community-dwelling individuals.7 Our own analyses (manuscript submitted), which were discussed in RACP News, suggest that vitamin D supplements do not mitigate the increased risk of cardiovascular events from calcium supplements.

We share Nordin and Prince’s view that these data are troubling and, consequently, we suggest that a review of the role of calcium supplements in osteoporosis management is justified. Such a suggestion is neither alarmist nor without substance.

Dr Mark J Bolland Associate Professor Andrew Grey Professor Ian R Reid Department of Medicine University of Auckland

References
LABYRINTH BUILDING
A NEW DIMENSION TO WALKING IN CIRCLES

My busy working life as a full-time staff specialist in paediatric oncology was enriched dramatically and surprisingly when labyrinths, as it were, found me out about me! During the year 2000, my wife Margaret and I were attending a weekend seminar on spirituality, given by a visiting American Franciscan priest, Fr Richard Rohr. He mentioned in passing that the Center for Action and Contemplation in Albuquerque, New Mexico, which he founded in 1987, has a labyrinth in its gardens. I was puzzled, and that evening, looked up ‘labyrinth’ on the internet. I was staggered by the amount of information available. I noticed immediately that I was enjoying reading about labyrinths, and was finding the topic really interesting. It felt as if a powerful engine that had been dormant within me had suddenly started up, and was now idling, ready to go. Soon afterwards, I began drawing labyrinths, and experiencing an irresistible urge to build them, which has stayed with me ever since. I see the passing landscape through new eyes now, quietly on the lookout for good sites for labyrinths.

It turns out labyrinths have been around for at least three thousand years. Their origin is unknown. They have shown up spontaneously—arguably, at times of need—in different ages and in far-flung parts of the world (e.g. the Mediterranean, Scandinavia, England, Europe, south-western America).

When people first hear about labyrinths, they often picture getting lost in a maze. A labyrinth is a type of maze, but it is the difference between a labyrinth and all other kinds of mazes which makes the labyrinth so fascinating, and so potentially valuable as a meditative and spiritual tool. The difference is that a labyrinth is unicursal—it has only one path, without any branches or dead ends. Labyrinths are usually flat—typically, a pattern marked on the ground. Evident within the pattern is a path which begins at an entrance on the ground. Evident within the pattern with my arms out, as if flying—authentic play for the spiritual child within! By the way, children love walking labyrinths—they usually ‘get it’ straightaway!

A common approach to a walk is to divide it into three phases. The first phase, from the entrance to the centre, is used to let one’s mind quieten and become more attentive to one’s inner self. In the second phase, time can be spent at the centre in quiet contemplation. During the third phase, the return from the centre to the entrance, one can continue to reflect on thoughts, images or feelings which may have surfaced in earlier phases of the walk. I invariably experience my return from the centre to the entrance as a time of mounting joy and excitement—these feelings have become so strong when walking some of my own beach labyrinths that I run through the final circuits of the pattern with my arms out, as if

The modern resurgence of interest in labyrinths began in the United States around the late 1980s, and is spreading slowly to other countries, including Australia. There are now more than a thousand labyrinths throughout the United States, including at least 170 in hospitals (e.g. Mid-Columbia Medical Centre, The Dalles, Oregon; Marianjoy Rehabilitation Hospital, Wheaton, Illinois; Johns Hopkins Hospital, Baltimore, Maryland) where they serve the spiritual needs of patients, visitors and staff. As yet, there are only a few labyrinths in Australia.

A few months after beginning to learn about them, I traced my first full-sized labyrinth in the sand at Seven Mile Beach, Gerroa, in New South Wales. Our prayer group was visiting the Jesuit Villa at Gerroa for a weekend. I plucked up courage and began work on the beach below the villa, while the others watched from time to time with some curiosity from the villa above. Slowly the 11 lanes of the Chartres pattern began to appear in the sand. Margaret was asked, ‘What’s in that canvas rucksack he’s hung on the centre pole?’ ‘Secret labyrinth-building tools, probably,’ she replied, tongue in cheek. There was much laughter when a can of chilled beer was produced from the sack when the task was completed. Labyrinth-building is thirsty work! At the beach, the finished
After Hours

Labyrinth at Kerever Park, Burradoo NSW, 2008: opening ceremony—building community!

pattern is always gently erased by the incoming tide a few hours later.

A bemused fisherman walking by on one occasion paused and, shaking his head, said, ‘Mate. That’s nice. But it’ll be gone in a couple of hours!’ A powerful metaphor for life itself, if you reflect.

Margaret and I have visited Chartres Cathedral in France, which has a superb Christian mediaeval labyrinth over 12 metres in diameter in its nave (be sure you visit on a Friday—that’s the one day each week the cathedral lifts the chairs off the labyrinth!), and Grace Cathedral in San Francisco (two labyrinths installed by Dr Lauren Artress, leader of the modern labyrinth movement). We have undergone training with Lauren Artress in Portland, Oregon, to assist us in introducing the concept to others. I’ve helped master labyrinth builder Robert Ferré build a permanent labyrinth in Livermore, California, visited John Ridder, another leading American labyrinth builder, in Indianapolis, Indiana, and purchased a 36-foot canvas labyrinth to conduct workshops for hospital staff and others. So far we’ve also acquired two wooden finger labyrinths, a tapestry, and 27 books and counting. Fortunately, Margaret and our four now-grown-up children have tolerated all of this bemusedly and with a generous degree of interest and support. A passion is so much more fun when you can share it with loved ones!

In 2007, Margaret and I were put in touch with Penny Sturrock, who informed us that Kincoppal-Rose Bay School had obtained funding to have a permanent labyrinth built the following year at its rural retreat, Kerever Park Spirituality Centre, as a project for World Youth Day. Kerever Park and Kincoppal-Rose Bay are works of an international order of Catholic women, the Society of the Sacred Heart. Kerever Park is a place of peace, reflection and renewal for people who are searching for meaning and deepening their understanding of their spirituality. It is set in spacious wooded grounds in Burradoo, near Bowral, in the picturesque Southern Highlands of New South Wales.

Over the 12 months leading up to the two weeks of World Youth Day in the winter of 2008, I spent a great deal of my ‘after hours’ consulting with stakeholders and deciding on materials and construction techniques that would be affordable. On the floor of a church hall, using a horizontal compass made from dowelling rods, I drew the pattern of a full-sized Chartres labyrinth onto a composite sheet of white cardboard 15 metres square, made up of 150 large sheets of white card laid out side by side on the floor. I cut out the patterned part on each sheet to leave behind a stencil. (Yes, I did remember to number each card!)

In July 2008, the big day finally arrived. With the professional assistance of Packman Landscapes (our son-in-law Nick Packman, and his leading hands Jason and Ben), the circular site at Kerever Park was excavated and levelled, and a foundation of basalt road base applied. We laid out the template, sprinkled cement dust liberally over the entire pattern, and moistened the cement dust to set it. This transferred the pattern securely onto the underlying road base. With the assistance of 20 young and highly enthusiastic World Youth Day pilgrims visiting Australia and Kerever Park from Vietnam, Paraguay and France, we laid and cemented several thousand granite cobbles over the pattern over six long and bitterly cold working days, to create the path dividers and other parts of the pattern. On the morning of the final day, we filled in the paths between the cobbled pattern with crushed granite aggregate, to create a beautiful permanent full-sized Chartres labyrinth.

What a joyous occasion on the final evening, when family, the pilgrims, the wonderful nuns of Kerever Park, and a hundred or more helpers and friends of Kerever Park from the local community gathered to bless the labyrinth and walk it together for the first time!

This labyrinth can be found in the grounds of Kerever Park, on the lawn adjacent to the roadside on Hurlingham Avenue, Burradoo, just south of Bowral. Members of the public who wish to walk the labyrinth may do so any day of the week during daylight hours without appointment.

I realised early on that a labyrinth in the grounds of The Children’s Hospital at Westmead would benefit patients, families, visitors and staff. In 2001, I obtained approval to have a labyrinth built in the hospital’s grounds, and a beautiful site was reserved. Funds sufficient for the project have been available now for some time. The hospital recently completed a master plan for future development. Under the plan, the earlier site is now reserved for construction of new buildings. However, a new site in the grounds is currently being negotiated, which will actually be nicer than the earlier one. Can you discern an ongoing labyrinthine process here? I remain hopeful this much-needed labyrinth will be built soon.

Now, where was that terrific site for a labyrinth I noticed yesterday …?

Michael M Stevens AM, FRACP
michaels@chw.edu.au
CALL FOR ABSTRACTS

Regulations
Abstracts and all presentations of NT research are welcome, including original research, case reports, reviews and hypothesis development.

Maximum 250 words
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Content of abstract
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  authors outside Australia and New Zealand are requested to include country.

Body of abstract
The following headings should be included in the abstract in bold upper and lower case:
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It is not satisfactory to state ‘results will be discussed’ or ‘data will be presented’.
Text may be replaced by 1 or 2 graphics, but abstracts must remain within 1 A4 page. Abbreviations may be used, but words must be spelled in full at the first mention, followed by the abbreviation in parentheses. There should be a maximum of two references.

Abstract submissions to: The Conference Secretariat, events@rACP.edu.au; telephone 02 8247 6240.
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