Canberra 2016

AAAPC was a key collaborator and contributor to the success of the 2016 PHC Research Conference.

Grant Russell and Claire Jackson delivered a powerful message of resilience and optimism during the AAAPC Plenary. As Claire noted in her presentation, primary care is now truly front and centre of the Australian health care system. This is accompanied by a shift in priorities towards research that is increasingly about productivity, relevance and partnership. It is a time of change – a time to honour our legacies and focus on our opportunities to contribute across the health system. It is a time to be proactive, aware of the ‘Big Questions’ and to build broader partnerships outside academic circles. Cassandra Goldie, CEO of ACOSS underscored these messages with her support for a strong evidence base to help improve health outcomes in Australia – and the importance of enlisting the voice of the people on the ground as part of the research process.

The Conference certainly offered many of those opportunities. Tailored as a knowledge exchange event, the conference theme of ‘Reform and Innovation’ attracted researchers and research users from across the PHC frontline. While a large proportion of the 315 delegates were researchers (31%), there was strong representation from CEOs/Managers/Directors, potentially reflecting the focus this year.
on broadening networks to engage more effectively with Primary Health Networks (PHNs), the private sector and industry. There was also significant engagement with delegates from policy backgrounds and general practice. It was pleasing to see developing connections with consumer representatives and students as well as nurses and allied health practitioners. This diversity in the delegate profile encouraged networking and collaboration across the breadth of the system. This is reflected in the following indicative responses to the evaluation:

\[\ldots\text{meet up with others from a PHN and network and find out what others are doing and where the opportunities are to be incorporating research more into our day to day work}\]

I was able to get involved in areas I have not experienced before. I found this useful for my learning and also stimulating for my research ideas. Thank you

\[\ldots\text{explore current research, thinking and innovation in PHC}\]

\[\ldots\text{reconnect with interstate colleagues for ongoing collaborations, be introduced to new potential colleagues, learn from others’ research journeys, hear up to date high quality project presentations}\]

\[\ldots\text{form new collaborations}\]

\[\ldots\text{meet with other researchers and clinicians, broaden my understanding of the health system and inspire new and further ideas}\]

Plenary talks were particularly enlightening – not thought of the place of private health companies in this discussion

Another now familiar aspect of the Conference was our strong focus on Research Higher Degree students, the face of our future research workforce. Elements included the Knowledge Exchange workshops for students as well as a separate workshop for mid-career researchers that emphasised the importance of knowledge exchange thinking in a contemporary PhD to prepare students for careers in either industry or academia. The ECR networking/mentoring lunch was as popular as ever!


Dr Christina Hagger, Conference Convenor;
Dr Lynsey Brown, Co-Convenor

Editorial

Welcome to our winter edition of the AAAPC newsletter. I am writing this from my desk in Cambridge (above) where I have been spending time as part of the AAAPC Travelling Fellowship – more about that in the next newsletter. Thank you again to all the members for their contributions to the newsletter and for Kitty Novy for coordinating the newsletter so expertly. This edition highlights the recent Primary Health Care Conference in Canberra, and includes articles from our two AAAPC prize winners, John Furler for his Most Distinguished Paper award and Erin O’Hare for her AAAPC Best First Time Presenter award. We celebrate the successes of many of our members: Kelsey Hegarty who was appointed the first Chair of Family Violence Prevention and deservedly won the Charles Bridges-Webb medal, and Nick Zwar’s appointment as the Dean of Medicine at the University of Wollongong, Ronny Gunnarsson who won the NAPCRG prize, and Kyle Eggleton who was the ‘Larry Green visiting Scholar’. We also celebrate the important work done by Helena Britt and Ellen McIntyre.

As usual we have international primary care news, from Saudi Arabia and New Zealand. We also have articles from new committee members, our re-elected President and new members. On a sad note, we acknowledge the passing of Amanda McBride who died recently. Thank you to Christine Bennett for her kind words.

Thanks again for all the members’ contributions.

Jennifer Walker
President’s Report

I was honoured to accept the nomination as President of the Australasian Association of Academic Primary Care for a second year. What follows is my President’s report for 2015/16 it is taken from my oral report to the AAAPC Annual General Meeting in Canberra in June.

In a few short years AAAPC has changed from being a GP focused organisation to one embracing primary care and incorporating NZ members. These major changes have coincided with some major external pressures on the primary care academic community. All reading this would be aware about the dismantling of Australia’s PHCRED strategy over the last six months. APHCRI was defunded from the end of 2015. PHCRIS has received a six-month stay of execution after a decision for it not to be funded beyond June 30, 2016. Only one of APHCRI’s Centers of Excellence will be functioning by mid 2017. Lack of Federal Government support has led to the closure of BEACH, the world’s longest running study of general practice and the mothballing of AAAPC’s own APCReN, the liaison organisation for 23 PBRNs in Australia.

These issues have dominated the activities of AAAPC during the last 12 months. We received considerable support from primary care professional colleges and from the North American Primary Care Research Group and the Society for Academic Primary Care, each of whom made representations of concern about the funding insecurity. Many others have rallied to the cause. We have liaised with the primary care colleges, gained media advice and presented our message in outlets including the Canberra Times, the Sydney Morning Herald and The Age. Some members have used our briefing information material to assist with discussions with Members of Parliament, and their own media pieces, while the Australian Heads of Department of General Practice made a presentation to senior Federal Departmental staff.

As well as our lobbying, during the year we provided written submissions to the Senate Standing Committee on Chronic Disease Management and to the Medical Research Future Fund. The MRFF submission was important in that it seems likely that the MRFF is going to become a substantial source of future Australian research funding support. Our proposal (soon to be available on our website) advocates that an early priority of the MRFF be to rebuild the capacity of Australia’s PHC research sector to help foster an evidence base for the delivery of high quality, equitable and accessible primary care. We prioritised investments in data, individual research capacity development and in Practice Based Research Networks.

During the year we consolidated arrangements for reciprocal conference awards with SAPC and NAPCRG. Our 2016 winners of both awards have been announced Jennifer Walker for SAPC and Ronny Gunnarsson for NAPCRG. Both awards will assist in the winners being able to present at the sponsor organisation’s Annual Research Meeting. AAAPC is faced with a couple of additional challenges as we transition from an organisation that was for many years focussed on Australian general practice. We need to make ourselves more relevant to our New Zealand members and begin to embrace other PHC disciplines. As such New Zealand membership on our executive has been expanded to 4 members.

One of the things that has become clear this year is that AAAPC has a unique and important position in Australian and New Zealand academic primary care. However I am not sure that our present structure is ‘fit for purpose’. We need to make ourselves relevant to both NZ and to non clinician researchers and non GP primary care professionals, and importantly be able to shape rather than simply react to the changing environment in which we work.

AAAPC has a responsibility on behalf of our Australian and New Zealand primary care academic communities to meet our potential and manage the demands upon us. Hence I believe that its time to invest in a process of reflection for AAAPC. We need to grow our membership, transition into an organisation with a broader focus and become more efficient – for many years the burden of keeping AAAPC working falls on a very small number of people. As such, and as a clear outcome of the Annual General Meeting, we will be consulting members for their opinions prior to holding an all day face to face planning day later in the year. This will be preceded by a ‘survey monkey’ type poll. There are many people that keep AAAPC running as an organisation. Kitty Novy has been her usual enthusiastic tower of strength during the year, going far beyond the call of duty regularly. I am keen to acknowledge to optimism and hard work of NZ executive members Sue Pullon and Ngaire Kerse, both of whom have been patient in providing advice in a year dominated by Australian funding issues. In addition, I wanted to sincerely thank those on the Executive who have gone beyond the call – reviewing, helping draft submissions, presenting our case to politicians and their staff. Particular thanks go to Nick Zwar, Kirsty Douglas, Phyllis Lau, Sarah Larkins, Ellen McIntyre, Dimity Pond and administrative staff of the University of Melbourne and Monash University. Finally I wanted to send good wishes to our 2015 Treasurer Suzanne MacKenzie who has been seriously unwell. She has our warmest thoughts.

Grant Russell, President AAAPC
Distinguished Paper Award
John Furler

Many thanks to the AAAPC for the Distinguished Paper award and for the chance to present our paper at SAPC in Warwick next year. Our study is a collaboration between researchers at the Universities of Melbourne, Deakin, Latrobe, Southampton, Monash and Nanyang Technological University in Singapore and UniSA in Adelaide.

Our study was a pragmatic cluster randomised controlled trial of a new practice nurse-led model of care to support insulin initiation and up-titration as part of routine care for people with type 2 diabetes being managed in General Practice. This step in treatment intensification is not done well in primary care in Australia, for a range of reasons. Our aim was to address both system and clinician barriers to starting insulin and to try to overcome this ‘clinical inertia’, and change clinical practice. The ‘Stepping Up’ trial compared the new model of care, (practice system change, an enhanced role for the practice nurse (PN) and a Registered Nurse-Credentialed Diabetes Educator (RN-CDE) playing a mentoring role to PN and GP, rather than providing direct patient care), with usual care. We developed the intervention through a series of qualitative and pilot studies as well as using Normalisation Process Theory to think about how the model of care would work in practice. Our aim was to develop a model of care that really fit with the ‘work’ of diabetes care and insulin initiation, work that both health professionals and patients are involved in. We wanted to ensure our intervention did not disrupt the ongoing clinical routines in general practice. We hypothesised that HbA1c would improve among participants in intervention arm practices, facilitated through timely insulin initiation, compared to the control arm.

General practices with at least one PN were eligible to participate. We introduced the new model of care to the practice staff through an on-site training session, covering the re-designed clinical roles and simple clinical tools to assist with insulin dosing. Patients were eligible to participate if they had an HbA1c ≥7.5% (ie at least 0.5% above a general target of 7.0%) and were on maximal oral therapy. As a pragmatic and inclusive trial we also allowed the treating GP to decide if insulin was clinically appropriate even if not on maximum oral therapy. We chose a meaningful clinical primary endpoint, change in glycated haemoglobin (HbA1c) from baseline to follow up at 12 months.

74 practices and 266 patients in Victoria participated with a mean (range) cluster size of four (one to eight) patients. At 12 months significantly more patients in intervention practices had commenced insulin compared to patients in control practices. HbA1c improved in both arms but there was a clinically and statistically significant between-arm difference favouring the intervention. Of note, depressive symptoms reduced in the intervention arm. No severe hypoglycemia was reported amongst participants.

We concluded that with appropriate supports and clinical system redesign, clinical inertia can be overcome to improve important health outcomes. T2D affects 387 million people. Globally, up to 15% of national health budgets are spent on diabetes. Between a quarter and a half of this is for control of high blood glucose concentrations. The problem of how to effectively, efficiently and safely achieve target glycaemic levels for people with T2D to prevent downstream complications is of concern. Our study is an example of working smarter with existing resources to achieve better outcomes for patients. Health economic analysis is underway, as is an analysis of 24 month follow-up data.

We learnt a lot about the need for the model of care to be flexible. While some practices, GPs and PNs adopted the model easily, rapidly becoming autonomous in the clinical work of insulin initiation, others required much more RN-CDE support over a longer period of time. From a research perspective, that suggest the need
for trial designs that allow for such ‘non-standardised’ interventions, but also raises the question of how much to accommodate this variation and still generate meaningful evidence. For the perspective of policy makers, this flexibility is important when implementing the model of care more widely. We are working with PHNs and the Victorian Department of Health to explore wider implementation.

Thanks again to the AAAPC community for the award.

Charles Bridges-Webb Medal Recipient 2016
Kelsey Hegarty

I was very honoured to be awarded the 2016 Charles Bridges-Webb medal for several reasons. Firstly and most importantly, I thought Charles Bridges-Webb was a very thoughtful academic so it is really great to be given this named award. I remember nominating people and never thinking that my area of research domestic violence would be seen as mainstream enough to qualify for this general award. However, domestic and family violence has hit the front pages and certainly research in this area is expanding and is seen as very relevant to primary care. Finally, I hope that I can be a role model for others who work part time, particularly women as I have worked half-time all my academic career (until the last 6 months). I firmly believe that achievement is possible for women, although I think there is often still a glass ceiling for those who seek to hold high academic office.

The first time I saw Charles was in 1995 at a General Practice Evaluation Program conference in Canberra at University House. I had received a GPEP fellowship and was presenting on prevalence of domestic violence and barriers to disclosure in general practice. It was the year he retired from University of Sydney at the early age of 60. At the time, he looked quite old to me, although of course I would not currently think that now. I remember him as sharp, intelligent and kind. That day he asked me a very clever question and then on my way out he said ‘good work’. A statement I treasured for some time.

I recently read his memoirs on the RACGP website and he started in country general practice in Traralgon the year I was born. He described that year:

Another dramatic day of practice started at 4.30am with a caesarean section and finished with a patient who I knew well shooting his wife dead outside the children’s home where the couple’s child was in care. The tragic event arose out of a sad and difficult situation for which it was hard to see any solution, but the home staff accusingly felt that either I or the police should somehow have prevented the violence outcome, would that we had done. Later I had to go to Melbourne to give evidence in the man’s trial for murder.

Charles and I never spoke of this event but he was always encouraging and often was down the back over the many years at conferences, still asking good questions and being supportive. Often I was presenting on the last day in the last session with all the other awkward topics (disability, SIDS, refugees, child sexual abuse). This award as a researcher into domestic and family violence I think brings to light how much we have changed in the way we think about these complex, sensitive topics. Current primary care pays attention to these issues which underlie a lot of the physical and mental health burden in our society.

Finally, I would like to thank the people who nominated me, those who judged the award and I thank Charles Bridges-Webb for being a great academic and a role model for us all.
AAAPC First-Time Presenter Award
Erin O’Hare

It was an honour to be awarded with the AAAPC first time presenter award at the Primary Health Care Research Conference in Canberra 2016. This has been the first time I have undertaken research, much less presented it, so it was a fantastic surprise to be acknowledged.

I am in my final year of the Doctor of Medicine program at the University of Melbourne, and over the years of my medical and nursing training I have developed an interest in skin cancer. I consider myself fortunate that I was able to complete my Scholarly Selective research term in the area of melanoma risk prediction with the Department of General Practice. My aim in the future is to undertake General Practice training in the regional/rural setting, and hopefully specialise further in the area of skin cancer. Obviously, it would also be nice to graduate from medical school first!

I presented my research ‘The MelaTools-Q Study: Identifying the prevalence of risk factors for melanoma in an Australian Primary Practice population’, on behalf of myself and my supervisors, Professor Jon Emery and Dr Jennifer Walker. This project aimed to identify the prevalence of risk factors for melanoma, and the prevalence of patients at risk of melanoma in an Australian general practice using the MelaTools-Q electronic risk calculator. My supervisor Professor Emery is a member of the MelaTools research group from the University of Cambridge’s Primary Care Unit. The group developed an electronic risk tool, the ‘MelaTools-Q’ that utilises a self-assessed risk model [the Williams model (Williams et al, 2011)] to identify whether patients are at increased risk of melanoma. The aim is to aid stratified screening for melanoma in the general population.

865/948 (91%) patients and companions agreed to undertake completion of the risk tool whilst in the waiting room of a suburban Melbourne general practice. We obtained 804 completed surveys for analysis over the six-week recruitment period. Using various cut-off scores from the Williams model (Williams et al, 2011), we calculated between 3.7% and 16.2% of the population to be identified as higher-risk, and those groups would contain 29% and 61% respectively of those likely to develop melanoma.

We demonstrated the MelaTools-Q risk calculator is a feasible method for identifying patients at increased risk for melanoma, suggesting a single risk-stratifying approach could be implemented across Australia in the future.

Further research will focus on different Australian practice populations and larger sample sizes. Participants who are identified as ‘higher risk’ will be followed up with interventions for self-monitoring screening as part of the MelaTools research program. I am very grateful to have been a part of this exciting research.
Dr Khawla Alsawaf is a family doctor working at the Al Hamraa Primary Care Centre in Jeddah in the Kingdom of Saudi Arabia. Khawla works with a team of health professionals delivering comprehensive primary health care services to the members of her community. I recently visited Saudi Arabia as a member of a World Health Organization mission. We had been invited to review primary health care across the country. This visit allowed me to witness the changes underway in a country that has firmly adopted a policy of strengthening primary health care through a family practice model.

Following governmental commitment to the Declaration of Alma Ata in 1980, the health system in Saudi Arabia has been reformed to deliver comprehensive, cost-effective primary care services to all members of the community. Family Medicine was introduced as an academic discipline at the College of Medicine at King Faisal University in 1980, and at King Saud University in 1982, and postgraduate training in Family Medicine was introduced in 1983. In recent years that there has been strong government-level commitment to the role of the family physician in leading the delivery of primary health care services in Saudi Arabia.

The primary health care services provided by the Saudi Ministry of Health are delivered through an extensive national network of 2,500 primary care centres, based in both urban and rural communities. Other providers of primary care services in Saudi Arabia include university hospitals, the military, the National Guard, and the private sector.

Saudi Arabia is one of many nations in the Middle East taking the role of family medicine very seriously. Family medicine is seen as the solution to ensuring universal health coverage, health care for all people. This was highlighted at the recent WONCA Eastern Mediterranean Region Conference, held in Dubai in March, in the United Arab Emirates.

WONCA’s Eastern Mediterranean Region runs from Morocco in the west through to Afghanistan in the east. The regional conference saw the welcoming of new WONCA member organisations from Afghanistan, Algeria, Kuwait and Morocco, and the Department of Family and Community Medicine at the University of Gezira in Sudan was welcomed as a new academic member. The WONCA Eastern Mediterranean Region also includes Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria and the United Arab Emirates,
with a number of other countries in the region, including Iran and Tunisia, currently in the process of seeking membership of our global organisation.

One of the highlights of our Eastern Mediterranean Region Conference was a special panel session hosted by leaders from the World Health Organization’s Eastern Mediterranean Regional Office (WHO EMRO), including Sameen Siddiqi, Hassan Salah and Mohammad Assai. This session highlighted many of the challenges facing family medicine development in nations of the region, including lack of government-level support, inadequate investment in facilities and support for primary health care, and severe shortages of trained family physicians and other primary health care professionals.

These are, of course, challenges that affect many countries around the world. But the WHO EMRO has a plan to scale up family practice in all nations of the region, including high, middle and low-income nations, and nations affected by serious crises. With support from WONCA, the WHO EMRO is working with each country’s Ministry of Health to gain political support and strengthen capacity in family practice. Programs have been established to introduce and scale up the training of specialist family physicians, and to support further training of general practitioners without postgraduate qualifications. Our family medicine colleagues from the American University of Beirut in Lebanon, and from Kuwait, among others, have been actively involved in working with WHO EMRO in supporting the training of colleagues from across the region.

It is impossible to visit the Eastern Mediterranean Region and not be aware of the crises affecting the people of several nations and especially the plight of the many people who are refugees fleeing violence in their home countries.

I commend to you the Istanbul Statement, released by WONCA Europe last October, calling for all people who are refugees to have access to equitable, affordable and high-quality health care.

WONCA’s global special interest groups (SIGs) are also active in this area, including our SIG on Migrant Care, International Health & Travel Medicine, led by Maria van den Muijsenbergh from the Netherlands, and our SIG on Conflict & Catastrophe Medicine, led by Professor Rich Withnall from the United Kingdom.

Several of our member organisations have produced resources to support family doctors working with migrants, refugees and people seeking asylum, including these guidelines from the Royal Australian College of General Practitioners.

We judge the nature of a community by the way it treats its most vulnerable and marginalized members. We are being judged as a global community by the way we respond to refugee crises around the world. As family doctors we play a role in ensuring health care for all people in our local communities. By working together we have a powerful voice as effective advocates for ensuring access to health care for all people.

Michael Kidd, President
WONCA
The rise and fall of the Family Medicine Research Centre, University of Sydney.

As many AAAPC members will have heard, in April 2016, after 18 continuous years the BEACH program stopped data collection. We received an informal email from DoH on 7 April:

Regrettably, there are no further funds to meet your request for ongoing and additional funding. It is advisable that you commence planning for transition to either an alternative business model, new funding arrangements or move to project closure.

It would have been handy if we had been told this six months earlier when we first approached DoH for funding for 2016-17. It would have given us time to seek ‘new funding arrangements’, rather than ‘move to project closure’.

We had no choice but to close the BEACH program. Officially, the program closed on the 30th of June, after completion of contracted deliverables for 2015-16 funding agreements.

We thank you all, as an organisation and individual members, for your support over the last few months. I guess the ‘wake’ period is a funny time in life, because it is a time when people recognise what they have lost. In particular it has been most rewarding to see that so many GPs were horrified to lose BEACH. They clearly see the value of the BEACH program to individual GPs, but even more so, to the profession. Thanks for all the support.

So, we go back to the 80s, with no reliable data source about general practice.

MBS data tells us little more than how many people see GPs, how many times they visit and how much it all costs Medicare.

The PBS tells us about the 40% of prescribed medications they now pay for and it doesn’t tell us what they were prescribed for. The other 60% is ignored because we pay for them ourselves.

The NPS using data drawn from EHRs, with no standards, data definitions, mixed coding and classification systems, and loads of free text. That makes it very hard to turn data into reliable information. Hopefully they read our Deeble Institute Issues Brief last week so they can develop an action plan to improve the data over the coming years.

BEACH has been the only continuous national study of general practice in the world which relies on random samples of GPs, links management actions to the exact problem being managed, and provides extensive measurement of prevalence of diseases, multimorbidity and adverse medication events (to name just a few subjects
of the many SAND sub-studies conducted in the BEACH program).

In the early ’90s, Rosemary Knight (DoH) said: ‘. . . runs on the board Helena – that’s what it’s all about. That’s how you get more funding. Get the runs on the board.’

OK Rosemary the FMRC got a lot of runs on the board:

- 39 BEACH books (+ 2 in press)
- 7 other books
- Contributions to 10 other books
- About 178 refereed articles in recognised journals (with 3 in press, 5 under review and more about to be submitted)
- 140 unrefereed articles in recognised journals
- 71 papers in other journals/publications (e.g. ’Byes from BEACH’ FMRC web site; Conversation; etc.)
- 16 theses and treatises (including 5 PhDs).
- 223 SAND sub-studies on a wide range of topics (abstracts on the FMRC website)
- Hundreds of conference presentations
- Over 1000 bespoke reports for stakeholders, researchers, governments and industry.

But clearly that just wasn’t enough runs!

The work of the Family Medicine Research Centre at the University of Sydney was concentrated around the BEACH program, and primary care terminologies and classification. The two streams of work have been intimately en-twined. So it was inevitable that the demise of BEACH would result in the closure of the Centre, which began as a research unit of the Department of General Practice about 26 years ago.

I have been in general practice/primary care research for 39 years and have watched the research in primary care grow from infancy. What breaks my heart most about the closure of our Centre, is the loss of the equivalent of 200 years of general practice research experience in the team.

The future

Employment of all FMRC staff was severed on 30 June 2016.

Supported by funding from the University, most members of the BEACH team are working on a casual or honorary basis, to prepare the GP activity report from 2015-16 BEACH data, and the Decade of General Practice reports. These up to date BEACH resources will soon be available for free download, or print on demand from Sydney University Press, so the GPs efforts of that year are not wasted. Our web site will remain, as it provides or links to, a vast amount of information.

The 18 years of BEACH data remains an enormously valuable source of information about general practice so we have made arrangements to provide continued access to specific subject reports from the BEACH database by researchers, industry, and Government. It will soon be in the hands of the Menzies Centre for Health Policy, University of Sydney.

The Centre’s Classification and Terminology work has already been transferred to the National Centre for Classification in Health (University of Sydney).

Requests for analyses of BEACH data: Christopher Harrison, The Menzies Centre for Health Policy, University of Sydney, Mid August 2016. Contact details will be put on FMRC website in mid August.

Classification and Terminology (ICPC-2, ICPC-2 Plus, SNOMED etc): Julia Leahy, National Centre for Classification in Health (NCCH) Cumberland Campus University of Sydney. Phone Julia Leahy, 9351 9408

Any subject, any time: Helena Britt currently on 12 months LSL, redundancy 1 July 2017, then Honorary, Mid August 2016. Mobile: 0411 197938

Any subject, any time: Graeme Miller, Honorary A/Prof, Mid August 2016. Mobile: 0412 465585

Best wishes for the future to all members of the AAAPC. May this organisation continue to thrive in these challenging times.

Helena Britt
A new study has shown that a rural health professional program on the East Coast of the North Island of New Zealand near Gisborne is highly successful for students, patients and the local community.

The study just published in BMC Medical Education demonstrates the enormous strengths and benefits of the Tairāwhiti Interprofessional Education (TIPE) programme. Run by the University of Otago, Wellington and others, the TIPE programme has now been going for nearly five years. Associate Professor Sue Pullon, Director of the TIPE programme and study leader, says these findings are critically important, because they show that rurally based inter-professional education in New Zealand can successfully meet multiple objectives within the five-week programme, more so than traditional education within each individual profession.

Dental, dietetic, medical, nursing, pharmacy and physiotherapy students together gain rich practical experience working closely with Māori patients and whānau, and contribute to the community with their education projects, says Associate Professor Sue Pullon, from the University of Otago, Wellington.

In the study, TIPE students were surveyed before and after participating in the programme, and compared to a corresponding group of classmates who did not attend the programme. TIPE students were significantly more able to work well with each other, understand rural health and Hauora Māori (a unique philosophy of health and wellbeing) and were more confident in caring for people with chronic long term conditions.

In today’s health care world, learning to practice collaboratively, and work in a wide variety of health care settings, are essential clinical skills, and this programme equips senior students to transition successfully to their new health practitioner roles, says Dr Pullon.

These senior health professional students not only enjoy their experiences in the TIPE programme, but also learn practical skills for working in health care teams in rural New Zealand, she says.

Funded by Health Workforce NZ, TIPE is a joint programme run by the University of Otago, Eastern Institute of Technology and Hauora Tairāwhiti DHB, in conjunction with its Whakatane-based counterpart.
OBITUARY

(University of Auckland, Bay of Plenty DHB). TIPE has been running since 2012.

By the end of 2016, 312 final year students from eight health professions will have come together in successive 5 week rotations to complete the TIPE programme.

Dr Patrick McHugh, local academic TIPE leader and co-author of the study, and long-time champion for the rural health workforce, says he is delighted to see an increasing number of TIPE graduates return to the region to work in intern positions or permanent roles.

Reference:


For further information contact:
Dr Sue Pullon <sue.pullon@otago.ac.nz> Associate Professor, Department of Primary Health Care & General Practice University of Otago, Wellington Mob: 027 436 8621

www.otago.ac.nz/wellington

For a list of Otago experts available for media comment, please go to: www.otago.ac.nz/mediaexpertise

Vale Associate Professor Amanda McBride (1955-2015).

A tribute to Amanda’s amazing life and achievements has been prepared by her friend and colleague Dr Christine Bennett below.

Over Amanda’s career, and specifically over the last eleven years in helping establish and develop the School of Medicine in Sydney, she gained our admiration, respect and love as a gifted clinician, committed academic, courageous advocate and compassionate friend to all.

In response to approaches from staff and students from across the School, and indeed from beyond the School, we are establishing a perpetual prize - The Amanda McBride Award for Excellence in Primary Care and Prevention - which will be awarded to the graduating student from the School of Medicine, Sydney who presents the best MD Project in the fields of general practice, primary health care, preventive medicine and/or primary care policy. To support this annual award in perpetuity we are providing opportunity for colleagues, students, alumni and friends of Amanda to contribute to the establishment of the award at Notre Dame. For further information please contact Michelle Scandrett on michelle.scandrett@nd.edu.au or +612 8204 4454.

This Award celebrates Amanda’s life and work in general practice, medical education and health policy.

I’m sure you will all join me in celebrating Amanda’s life and contribution and remember Amanda and her husband Peter in your thoughts and prayers.

Professor Christine Bennett, Dean School of Medicine, Sydney
A new challenge
Professor Nick Zwar

On 12th October this year I will be taking on the role of Dean, School of Medicine, University of Wollongong. This is an exciting opportunity to contribute to teaching, research and service at the University of Wollongong. The four year program at the UoW Graduate School of Medicine commenced in 2007 and has a focus on training doctors to work in regional, rural and remote areas of Australia. A unique feature of the program is the longitudinal experience for students in rural and regional hospital, primary care and community health facilities. I will be joining at an exciting time as the medicine program makes the transition from MBBS to MD, starting in 2017.

The School of Medicine is a multidisciplinary group with a range of undergraduate and postgraduate course offerings in the fields of Indigenous Health, Medical and Exercise Science, Medicine, Nutrition and Dietetics. This creates opportunities for interdisciplinary teaching and learning as well as collaboration in research. Another interesting aspect of the UoW School of Medicine is that it sits within a broader Faculty of Science, Medicine and Health led by the Executive Dean, Professor Alison Jones. This structure is still in its early stages and provides a platform for extensive cross disciplinary collaboration in research as well as in teaching and learning. There is the opportunity for me as Dean of the School of Medicine to make a significant contribution to the development of the Faculty. This includes building research collaborations with the Illawarra Health and Medical Research Institute, the Illawarra and Shoalhaven Local Health District, the Primary Health Network, local clinicians and the Illawarra and Shoalhaven community.

In the process of exploring and then applying for this role I have realised how many GPs are now Deans of Australian medical schools or health science faculties – Nick Glasgow at ANU, Michael Kidd at Flinders, Richard Murray at James Cook and Richard Hays at University of Tasmania. The current Dean at University of Wollongong Ian Wilson, who has chosen to step down to return to focussing on medical education research and development, is also a general practitioner.

Is this because GPs are broad thinkers who value diversity and understand the need for even-handed and consistent management? Or is it that we are one of the few disciplines mad enough to take on the role. Time will tell.

Ellen McIntyre
This (fortunate) career

While a good career requires hard work by the individual, it cannot be achieved without the support of others. And I have certainly had that. Starting with a Commonwealth scholarship in 1971, I followed my interest in physiology by completing a Master’s Degree in neurophysiology at Adelaide University. During this time I was fortunate to be awarded a summer scholarship at ANU following a chance meeting with an ANU professor at a conference meet and greet session. This led to my first peer review publication in 1975 and, in using the ANU network I was able to link to others in this field including a team in Cambridge where I worked for several weeks resulting in two more publications; one having now been cited over 300 times.

Fast forward to 1986; mothering two sons gave me a new interest: breastfeeding. This also became my next career move. From breastfeeding counselling for the Australian Breastfeeding Association (ABA) to lactation consultancy and...
education, I became immersed in finding ways to help health professionals become more effective when helping mothers and babies breastfeed. This focus led to my being appointed chair of the international exam board for lactation consultants. Unbeknownst to me, my peers nominated me for an OAM which I received in 2005; such an amazing award.

During my PhD on environmental barriers to breastfeeding, I was fortunate to work with key people at ABA which this led to the development of two very practical initiatives (promoting breastfeeding in public & combining breastfeeding and work). These were subsequently implemented with funding from the Commonwealth and continued support from ABA.

In 2001, I joined PHCRIS. This fortunate opportunity enabled me to expand my interests in sharing information (I had already been a journal and newsletter editor), building capacity (the lactation courses for health professionals had been growing since 1986), facilitating engagement (I had convened several conferences by this time) and research. In each case, this was only possible with the support of the PHC sector. Getting to know so many dedicated researchers, policy makers, managers, practitioners and consumers in the primary health care sector and working with them to improve health care has been a wonderful experience, something that cannot be done on one’s own.

I thank each and every one for the support you have given me throughout my fortunate career. It has come in so many shapes and forms.

You may not even know you have done this, but it has been very much appreciated. THANK YOU.

Professor Kelsey Hegarty

First Chair of Family Violence Prevention appointed by The University of Melbourne and the Royal Women's Hospital (Victoria).

Kelsey Hegarty has been appointed as Australia’s first Chair of Family Violence Prevention. It will be a joint appointment by The University of Melbourne and the Royal Women's Hospital.

The Minister made the announcement at the first Strengthening Hospital Responses to Family Violence (SHRFV) forum in Melbourne on May the 30th 2016.

This came as the World Health Organisation adopted a global plan of action at the weekend to strengthen the role of the health system to address interpersonal violence, in particular against women and girls and against children.

Australia was one of 44 Member States that adopted the resolution at the 69th World Health Assembly. The new Chair of Family Violence Prevention will work closely with the WHO over coming months as an expert advisor.

Professor Hegarty is a leading voice at The University of Melbourne and researcher on the role of the health system in preventing family violence in Australia and globally.

Minister Hennessy said hospitals and primary care settings were uniquely placed to provide women and children with a safe place to disclose that they are suffering family violence and need help.

‘The appointment of this Australian first Chair of Family Violence Prevention is an important step in strengthening the role of our health system in responding to and preventing family violence,’ she said.

‘We are working with The University of Melbourne and our hospitals, supporting them to take the lead in preventing women and children from suffering any more harm.’

Professor Geoff McColl, Head of The University of Melbourne Medical School said: ‘The Chair further develops an important element of our work as part of the new Melbourne Research Alliance to End Violence Against Women and their Children, building on existing research strengths within the University’.

Chief Executive of RWH, Dr Sue Matthews said the aim of the Chair was to alleviate the burden of family violence through research, training, clinical practice and patient care across the health sector.

Professor Hegarty said she was honoured to be made Australia’s first
Chair of Family Violence Prevention, and pleased that it would unite the research efforts of The University of Melbourne and The Royal Women’s Hospital.

‘This will give me the support and resources to continue researching how health practitioners and the holistic health care system can support women and children facing family violence,’ Professor Hegarty said.

‘We know family violence is incredibly complex and so often the victims are isolated, so we need to tap into new technologies and ensure that doctors, nurses and the health care system are supported to assist families where violence is occurring.

‘This position will form the focus for the two organisations to work together to find pathways for the safety and well-being of women and their children.’

The new Chair will:

• Lead the development of more effective early intervention strategies, protection and support for those affected by family violence
• Oversee integrated research programs, utilising the existing connections of the Melbourne Research Alliance to End Violence Against Women and their Children
• Develop new models of care for women and families, bringing together the strengths of hospital health professionals and community generalists to deliver outstanding patient care

• Drive a research program that the University believes will complement its missions, aims and strengths, as well as those of the Women’s Hospital new Violence against Women Strategy.

Professor Hegarty is an academic general practitioner who co-chairs the Melbourne Research Alliance and leads an Abuse and Violence research program in the Melbourne Medical School’s Department of General Practice. Her current research includes the evidence base for interventions to prevent violence against women; educational and complex system interventions around identification of family violence in health care settings (including men who use violence) and responding to women and children exposed to abuse through health care and through the use of new technologies.

For over a decade Professor Hegarty has contributed at both national and international levels to the family violence field, advising the World Health Organisation on guidelines for health practitioners and health systems change. She has developed a program of research in family violence, which began when she developed the Composite Abuse Scale, which has been used extensively globally as an outcome of intervention trials and is available in 10 languages.

Professor Hegarty played a lead role in the development of the Royal Australian College of General Practitioner’s White Book on Abuse and Violence and an online learning module. She has developed innovative family violence curriculums for health practitioners and regularly teaches to undergraduates and postgraduate health practitioners.

Professor Hegarty has been the Chair of the governance group of the Domestic Violence Resource Centre Victoria for many years. She is also Director of the postgraduate Primary Care Nursing Course. She continues to work in general practice.

WHO said its plan of action provided a strong mandate to address violence against women and girls as a global and urgent public health problem.

The WHO plan recommends actions under four strategic directions:

• Strengthening health system leadership and governance
• Strengthening health service delivery and health workers’/providers’ capacity to respond to violence, in particular against women and against children
• Strengthening programming to prevent interpersonal violence, in particular against women and girls, and against children
• Improving information and evidence.
NAPCRG Winner
Ronny Gunnarsson

I am very grateful to the AAAPC for awarding me a travel bursary to present my abstract ‘Etiologic predictive value of a rapid immunoassay for detection of group A streptococcus antigen from throat swabs in patients presenting with a sore throat’ at NAPCRG in Colorado Springs US in November 2016. This is the first year that I have had the opportunity to attend NAPCRG and I am very excited about presenting at this large international conference.

The abstract presents the result of a prospective cross-sectional study comparing prevalence of group A streptococci among children with a sore throat comparing them with children without any sign of infection.

Context: A sore throat is a common symptom mainly caused by virus but also by a variety of bacteria such as group A beta-haemolytic streptococci (GAS) often resulting in unnecessary antibiotic prescribing. Combinations of symptoms and scores are not specific enough to accurately sort out aetiology. Rapid diagnostic antigen tests (RADT) have demonstrated high sensitivity and specificity in detecting presence of GAS.

Objective: Establish the probability that finding of GAS in a RADT shows a true link between symptoms and GAS while considering carriers of GAS ill from a virus.

Design: Cross-sectional study comparing two groups.

Setting: Emergency department (ED) also managing primary health care cases in a remote rural town with 22,000 residents.

Patients / Participants: 101 consecutive children aged 3-15 years attending for a sore throat as the main complaint and 147 consecutive children of the same age attending the same ED for other reasons than an infection.

Main and Secondary outcome Measures: Positive and negative Etiologic Predictive Value (EPV).

Results: Positive EPV was 98% (88-100%). Negative EPV was 98% (97-99%). The positive EPV depends on setting and findings in this study and may not be transferable to other settings. It was mathematically shown that negative EPV found in this study is valid in all other reasonable settings and hence can be transferred to any other setting.

Conclusions: The evaluated RADT (Alere Test Pack+Plus With OBC Strep A) is always useful to rule out GAS infection in patients with an uncomplicated sore throat. It is often, depending on setting, useful to rule in a GAS infection in these patients.

Data were collected in Mt Isa and the study has been done in collaboration with Ulrich Orda, Sabine Orda, Mark Fitzgerald, Geoff Rofe and Anna Dargan. The study has been published after submission of the conference abstract: http://dx.doi.org/10.1016/j.ijid.2016.02.002

Kyle Eggleton
Larry Green Visiting Scholar Program

Once a month the Robert Graham Center, in Washington DC, hosts a visiting scholar. In May I was lucky enough to be the Larry Green Visiting Scholar. The Robert Graham Center is the research and health policy unit of the American Academy of Family Physicians. It conducts research on a range of issues that impact on primary care within the US. The major areas of focus, of the Center, include payment remodelling, workforce issues, needs assessments and geospatial health mapping. Each Larry Green Visiting Scholar spends the month working on an original research project of mutual interest to both the Robert Graham Center and the scholar with the intention of generating a nationally significant publication.
I am interested in health disparities, indigenous health and quality of primary care. In Washington I spent my time analysing the recently introduced Merit Based Incentive Payment System (MIPS) that forms the new pay-for-performance programme for family physicians treating Medicaid patients. The intent of my research was to determine if the introduction of MIPS would create further inequities for marginalised populations. With the help of Robert Graham Center academics we developed a taxonomy of the performance measures of MIPS and subsequently submitted a paper for publication.

While undertaking research in a supportive environment was one benefit of being the Larry Green Visiting Scholar the other benefits were the opportunities that existed by being in Washington. I spent a lot of time interviewing and meeting American Indian health care leaders, in relation to my projects; presenting at an international symposium; and exploring the sights of Washington and New York. More information on the Larry Green Visiting Scholar programme is found at this link: http://www.graham-center.org/rgc/scholars-fellows/scholars-program/about.html

We know there is some fantastic research being conducted across the AAAPC community and we'd like the world to know! Do you have a new publication? Send us the link and we'll share it online using the new hashtag #AAAPCAuthors! To exchange ideas, research and articles across a wider audience follow @AAAPC_ANZ on twitter OR When sending material across the AAAPC mailing list include ‘for social media’ in the subject line and we will share this for you.
Dr Oliver Franks

I have been a GP in the northern and north eastern suburbs of Adelaide since 1979, from 1988 to 2009 as a partner in a practice. I exchanged practices twice with GPs in England, first in Nottingham in 1993-1994 and then in Bristol in 1999, which provided insights into the workings of the British NHS.

I had had an interest in teaching and research for some years before enrolling part time in 1998 for a PhD. I was quite surprised some years later to read advice to prospective higher degree students that they should spend some time thinking about they wanted to research, because after my many years of clinical experience, I had already worked out in detail exactly what I wanted to research, because after my many years of clinical experience, I had already worked out in detail exactly what I wanted to research, because after my many years of clinical experience, I had already worked out in detail exactly what I wanted to research, because after my many years of clinical experience, I had already worked out in detail exactly what I wanted to research, because after my many years of clinical experience, I had already worked out in detail exactly what I wanted to research.

My PhD was based on a randomised controlled trial that I designed of on-screen prompts during consultations to GPs about preventive activities that were due to be performed. I was interested in whether and which characteristics of patients, GPs, consultations and preventive activities influenced the likelihood of opportunistic performance of those preventive activities, and found that every one of 13 such characteristics was independently associated with performance. Because many of those characteristics are known before the consultation starts, we can prioritise the reminders according to each preventive activity’s likelihood of being performed in the consultation.

For a range of reasons, the response to the on-screen reminders was small to moderate. Subsequently it occurred to me that we might do better by giving the person with the greatest interest, namely the patient, the same information a time when the patient can act on it with a minimum of extra time, effort and cost. I worked with Dr. Anton Knieriemen, a Melbourne GP who is the author of the Doctors’ Control Panel software, to develop technology that when patients arrive for consultations generates targeted relevant information for them to read just before they see their GP or practice nurse. We have piloted the use of these opportunistic information sheets for reminders about prevention, care of patients who have or who are at risk of osteoporosis, and to recruit patients for clinical trials.

Spending about half of my time in clinical practice and about half in research enables me to span the boundaries of these worlds and to pursue and combine my clinical and academic interests in prevention, health informatics, quality care and health services, with my activities in each sphere stimulating and reinforcing each other. As part of this, I serve on a number of regional, State and National professional and government committees and boards in my areas of interest.

I belong to AAAPC because I believe that general practice and primary care need to demonstrate their current value and their potential as the most cost-effective and therefore the most important part of the health care system. A big issue for general practice is explaining to others the following apparent paradox. GPs don’t ‘own’ any disease such as diabetes, any organ such as the heart, or any sub group of the population such as the elderly or refugees. Instead, it is the fact that GPs provide long term care, including preventive care, for all people in all states of health for all of their health problems, concerns, needs, questions and issues that makes GPs so valuable and so cost-effective, and that makes investment in training for general practice and support for the provision of high quality care a national priority.

Anything that I can do towards this is time well spent, and I look forwards to serving with Professor Richard Reed from the other university Discipline of General Practice in South Australia on the committee of AAAPC.
Dr Phyllis Lau, Treasurer

I am a Senior Research Fellow at the University of Melbourne Department of General Practice. I co-lead the Diabetes and Cardiometabolic Disease Research Group in the Department. I am also the Graduate Research Coordinator of the Department. I am on the committee of the Victorian Research Network (VicReN), a member of ACCESS Primary Health Care Network Steering Committee and a member of the University of Melbourne Teaching and Learning Quality Assurance Committee (TALQAC).

I have been a member of AAAPC for about 10 years, the last two years as the Victorian representative. I am looking forward to continuing my contribution in my new role as Treasurer. I would like to pay tribute to Associate Professor Susan McKenzie, previous Treasurer, who has left AAAPC with a healthy balance sheet. I hope to continue her good work and that of previous executive members in building AAAPC’s capacity to promote and develop academic general practice and primary care. My warmest wishes to Sue for her health and for the future.

Professor Tim Stokes

A new representative on AAAPC from New Zealand (Dunedin School of Medicine, University of Otago)

Tena koutou! I moved to New Zealand from the UK (University of Birmingham) two years ago to take up the Elaine Gurr Chair of General Practice at the Dunedin School of Medicine, University of Otago. Since February of this year I have also been Head of Department and am enjoying (or perhaps ‘bearing up to’ is better!) the challenges of juggling the needs of our four masters: research, teaching, service and being ‘just a GP’. On the GP front, it was a real privilege to be awarded FRNZCGP and full registration with the Medical Council of NZ earlier this year after a very thorough practice assessment visit from a censor of the College and I will be delighted to receive my Fellowship at our College conference in Auckland at the end of July.

Since coming to NZ, I have been successful in gaining local and national research funding in my area of interest (implementation research). This includes a locally funded study on GPs’ and practice nurses’ views on managing multimorbidity (presented at this year’s PHCRIS conference in Canberra), a Health Research Council Partnership grant on delivering better care for people with COPD, and a NZ Health lotteries grant on assessing the Fairness of Decision-Making in the NZ Health Sector. It has also been a pleasure to recruit great new research staff including Dr Lauralie Richard from the University of Melbourne who is now based in our department, working in Invercargill.

When I worked in the UK I was an active member of the UK’s Society for Academic Primary Care (SAPC) and their annual research conference was a staple fixture – both to present high quality research and to grow and sustain academic primary care. Coming to NZ I was aware we have a much smaller academic mass than the UK and so was very keen to get involved with AAAPC and build links with our sister departments across the ditch. Having got a taster of AAAPC and PHCRIS last year in Adelaide it was great to return to Canberra this year – both to present a research paper and to reconnect with Australian colleagues. It really is a great research conference – along with SAPC and NAPCRG. I hope that my and NZ’s growing involvement in AAAPC will lead to the development of joint trans-Tasman research projects and, in due course, NZ’s academic departments hosting the research conference.
Dr Lauralie Richard

Lauralie is a new addition as New Zealand representative to the AAAPC executive committee. She is an early career researcher with a PhD in Nursing from Université de Montréal (Canada) and postdoctoral research fellowship experience in Primary Health Care and has an ongoing honorary contract with the Department of General Practice at the University of Melbourne. Lauralie now holds a Research Fellow position with the Department of General Practice and Rural Health, Dunedin School of Medicine, and is based in Invercargill (Southland, NZ). She is developing a research programme around access to primary health care for vulnerable families, with a particular interest in innovative service models built on strong alliancing strategies with families and community participation. Her involvement as member of the AAAPC executive committee, in collaboration with other NZ representatives, is driven by a commitment to support further representation of New Zealand primary health care issues and foster discussions with colleagues from across the Tasman - learning from each other and sharing knowledge and successful strategies to pinpoint promising solutions to address similar root causes and challenges faced by the primary health care sector, despite differences in health systems. Lauralie is looking forward to continuing her engagement with AAAPC colleagues in the future.

Linda Slack-Smith

I am a teaching and research academic and co-ordinator of Research in the School of Dentistry at the University of Western Australia. I am President of the Australasian Epidemiological Association, President of the International Association for Dental Research ANZ Division and was Scientific Committee Chair for the Public Health Congress in Hobart in 2015. I lead a multidisciplinary team looking at overcoming disparities in oral health in marginalised groups, focusing on three streams - epidemiology (Big Data), qualitative research (perceptions) and policy - the team have a focus on capacity building, stakeholder engagement and translation. Our work is strongly driven by social justice.

I was attracted to academic primary care by the opportunities for improving oral health afforded by engaging in primary health care research and working with the wonderful networks of people in this area. I enjoy the intellectual challenges from research but equally important is the insight from working with many people in the community and many truly amazing colleagues. Our work is driven by social justice. We need to continue to form strong collegial and collaborative networks of primary health care researchers. Support and capacity building are not only for the young and early-career researchers (although they are very important) but may be better thought of as a learning circle where we all learn from each other: researchers and stakeholders, all those involved in research. Follow an area you are passionate about and make a difference. How can we say we live in a just society when the aged aren’t getting adequate dental care or refugee children or Aboriginal children or so many other groups. Find an area you want to commit to and build your research environment with wonderful colleagues. I hope for some of you that is oral health.

Dr. Jill Benson

Jill has been a GP for over 30 years. She has been a Senior Research Associate in the Discipline of General Practice at the University of Adelaide since 2006. She has a diverse research and supervision portfolio spanning refugee health, Aboriginal
health, mental health, infectious diseases and medical education. As well as working in mainstream General Practice, she has been involved in Doctors Health SA since 2000, with the Australia Medical Council since 2004, and has worked in rural and remote Aboriginal communities since 2002. She has also worked in Vanuatu as a WHO consultant for the Pacific Islands Mental Health Network and until recently worked for 15 years in refugee health. She is an active member of the WONCA mental health and refugee health working parties. She has recently joined GPEX, the South Australian GP Training Organisation, as a Medical Educator in Aboriginal health and for the Academic skills posts. In 2012 she was granted an Order of Australia (AM) for her work in Aboriginal health, refugee health and mental health.

Ca-PRI Meeting, Boston April 2016

I was fortunate enough to attend the Cancer in Primary Care Conference ‘Ca-PRI’ in Boston in April. Ca-PRI is a relatively small meeting which makes it easy to meet with many international delegates specifically involved in cancer in primary care. The annual conference focuses on the role of primary care in cancer prevention, screening, diagnosis and management of survivors and presents the best evidence and state of the art models of care. Highlights included a visit to the Dana-Farber Cancer Institute in Boston and a lunchtime talk from Professor Howard Koh who was a previous Assistant Secretary of Public Health in the US. Dr Christine Campbell from Edinburgh University convened a workshop exploring the different health services comparing cancers screening strategies and the role of primary care including the Australian context. Professor Danielle Mazza and I were the only Australians there and the other delegates were interested to hear about the Australian population cancer screening programs (colorectal, breast, cervical etc). The workshop provided an opportunity for further collaborative work to explore screening disparities within the different health systems. The Ca-PRI delegates enjoyed a night at the House of Blues as well as a baseball game at Fenway Park where we all had to sing ‘Sweet Caroline’ for some inexplicable reason. The next Ca-PRI meeting will be held in Edinburgh, Scotland in April 2017.

Photo: Danielle Mazza and Jenny Walker at the Boston Red Sox game

Jill Benson and the Desert Hawks (local footy team about to drive over 1000km to a footy game) photo from Tjuntjuntjara.
AAAPC TRAVELLING FELLOWSHIP 2017

Our TRAVELLING FELLOWSHIP aims to:

- Provide assistance to members of AAAPC to undertake study leave within Australasia and/or internationally
- Enhance Australasian academic primary care including allied health, community & nursing in a community setting
- Foster collaboration between Australasian academic primary care researchers, and between Australian, New Zealand and international primary care researchers
- Foster collaboration between academic departments where primary care research is conducted in order to initiate or continue a joint research or teaching project
- Undertake a mutually beneficial critical appraisal of the host department’s teaching research programs
- Deliver a teaching or research program in collaboration with the host department

To be eligible, the applicant must:

- be a current financial member of AAAPC & have held membership for at least 1 year before applying
- be actively involved in primary care research or teaching
- have a written letter of offer from the Head of the host institution
- have a letter of support from the Head of their own institution/department
- not have held an AAAPC Travelling Fellowship for at least 4 years

Cambridge UK

I am very grateful to have been awarded the AAAPC Travelling Fellowship to travel to Cambridge to begin a collaborative research project to develop the colorectal cancer risk prediction tool (CRISP) to include validated models for breast cancer and melanoma. The Department of General Practice has a close association with the Cancer Prevention and Early Diagnosis Group at the University of Cambridge, UK through many years of collaboration between Professor Jon Emery (my supervisor) and Dr Fiona Walter (Cambridge). The aim of the collaboration is to build on the existing program of systematic reviews of cancer risk models for melanoma and breast cancer and implement them into CRISP to develop a broader tool - 'CRISP-Plus'. The inclusion of other common cancers into the CRISP-Plus tool is the logical next step in our research in the Department of General Practice and will complement the work that the Cancer Prevention and Early Diagnosis Group and the Primary Care Cancer group are doing on tailored cancer prevention and screening. I am aiming to use this visit to develop funding applications for an international trial of CRISP-Plus between Cambridge and the University of Melbourne.

My visit to Cambridge will include a meeting with Professor Elizabeth Murray (University College London) who is one of the world leaders in implementation science research. We are planning to collaborate on a "conversation analysis" of the video footage of the simulated consultations with Dr Fiona Stevenson (University College London) to better understand the impact of CRISP on the interactions between the GPs and the "patients". I will also be attending the SAPC conference in Dublin where I am presenting the AAAPC Most Distinguished Paper based on the qualitative research our group has done to examine the useability and acceptability of the CRISP tool in general practice.

APPLICATIONS MUST INCLUDE:

- Name and contact details
- Location of proposed study trip
- Offer of invitation from host institution
- Letter of support from Head of your institution
- Plain language summary of proposed study trip (up to 300 words)
- Itinerary (include day by day account)
- Budget - include travel and accommodation costs
- Outcome (300 words) - explain how your proposed fellowship will benefit you, your institution and the wider community
- Curriculum vitae - no more than 6 pages
- Referees - 2 professional referees

APPLICATIONS MUST BE TYPED IN BLACK
Minimum font size of 11 point
Signed original plus 2 copies
Submitted by 30 September 2016 to:
AAAPC Secretariat - Ms Kitty Novy
knovy@unimelb.edu.au

ASSESSMENT PROCESS:
1. Short listing by Secretary using following criteria -
   eligibility and purpose of trip
2. Peer Review and assessment -
   short listed applications will be reviewed by 3 members of the AAAPC committee
   - applicants will be assessed on the basis of the purpose, itinerary and anticipated outcome of the trip, track record, and demonstrable commitment to Academic primary care and their future potential.
3. All applicants will be notified of their outcome by 30th October 2016.

APPLY NOW!
Up to $3000 awarded
Closing date: 30 September 2016