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Perspectives

1 Six principles of development
The Diamantina Health Partners (DHP) will work towards:
1. A joint governance structure promoting a coordinated effort towards better health care. The DHP governance structure is based on a partnership — a non-incorporated joint venture. This structure enables partners to honour obligations to other entities. Functional integration is supported through joint appointments and creation of joint activity streams.
2. Jointly determined key performance indicators (KPIs) in patient care, education and research. Traditional measures of research focused on publications and of teaching based on student assessment were felt not to provide an ability to measure relevant contributions to health outcomes or “quality”.
3. A jointly agreed strategy for improving health care, focused on health and wellbeing.
4. Administrative processes aimed at accelerating dissemination of research-based evidence into clinical practice.
5. Collaborative use of public resources with public accountability. Cost-effectiveness is part of DHP strategy. Collaborations that ensure the best use of public resources and public accountability are encouraged. Reporting towards KPIs that relate to measurable health improvements will be introduced.
6. Common drivers encouraging development and improvement of clinical innovation, training and health policy. Proven strengths on the DHP campuses will be used as exemplars for setting aims and employment standards at an international level.

university and hospital levels will facilitate achievement of the vision. Initially, we will align the strategic goals and plans of DHP stakeholders with expectations of patients using DHP services, for which we established six principles of development (Box 1).

Planning coordination is pivotal to the success of the DHP, and we believe education of clinical staff in research will encourage critical evaluation and application of new ideas and therapies in clinical care — skills to improve hospital performance in key performance indicators relating to efficient use of health care infrastructure (Box 2). Staff discussions about joint appointments facilitating teaching, research and clinical services are underway between the partners.

Current situation
One of our most pressing problems is engagement and representation in the DHP, which we are using our committee structure, reporting system, discussion groups and user groups to address. Early success in engagement is evident in collaboration on draft proposals and in facilitation of clinical research (by building clinical trial enrolments into performance indicators of service providers and departments). Engagement success is also seen in the teaching of medical, allied health and nursing students about clinical research methods, and by facilitating encounters between clinicians and basic researchers. Engagement is important from the strategic and survival perspectives of the DHP, and various strategies to benefit health and working environments are being planned. The ability to address new barriers is also crucial to success.

2 Clinical issues that could be improved with better linked education and research
- Role of emergency department for multiple attenders and for people with chronic conditions
- Bottlenecks in internal medicine discharges and the primary–secondary health care interface
- Providing health care for areas of high medical need, such as bariatric surgery versus a proliferation of obesity clinics in tertiary hospitals
- Use of expensive pharmacotherapies that have not been proven to meet clinically relevant end points, and which may cause high rates of adverse drug events
- New research tools such as genomics for predictive management of disease or response to drug therapies, streamlined by information gained from health services research in a particular health district

Another issue is that although the DHP board needs to have strategies in the best interests of the DHP, some partner representations on the board will be necessary, at least initially. The long-term aim is to have the right mix of people and skills acting in the interests of the DHP. An appropriate policy for membership of the board and its committees is being developed, as is a structure for successful implementation of DHP strategy into practice. Clear governance lines between the board and the partners will be necessary. Lastly, board diversity needs to be considered. The increasing number of women who are clinical academic leaders in Queensland will help achieve a balance of sexes. Care must be taken not to change organisational structure unless changes are clearly linked to improving health outcomes.

Areas under consideration include harmonisation of job descriptions and salaries between employment agencies, transparency of data and information technology services, and standardisation of intellectual property and commercialisation management. Setting research and policy priorities is underway.

An evident failure to deliver the vision espoused in the original 2010 proposal for health reforms threatens the existence of AHSCs, as federal funding for research, education and health remain separated. It is expected that the DHP will be politically independent and the board will be accountable for policy delivery and efficient use of public funds. The outstanding issues to be resolved by the DHP board are engagement; structural and policy “levers” it can use to influence institutional strategies; and ensuring strong alignment between the DHP and its individual components.

Summary
Many have asked “what is the benefit of the DHP over the current situation?” We believe that the responsiveness of research to community health needs and the balance of research and teaching outcomes in academic institutions can be improved, and stronger incentives to integrate research outcomes into clinical practice can be provided. The DHP is thus set up differently to a clinical research centre. The aim of our DHP is to improve health outcomes by means of coordinated excellence in teaching, research and clinical care.

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clinical, research and teaching initiatives are underway, and plans are being developed to teach future clinical staff the science of clinician-directed, rational use of medical resources. These include pathology, imaging services, pharmaceuticals and patient referrals, assisted by published expert guidelines. There are significant administrative and personnel issues to surmount, but planning for integration has begun, and plans for turning research outcomes into clinical care plans are already emerging.

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Stamps of greatness

Sir William Osler (1849-1919)

SIR WILLIAM OSLER, the son of a minister, was born at the parsonage in Bond Head, Tecumseh, Canada, on 12 July 1849, and entered Trinity College in Toronto, in 1867, to prepare for the ministry.

But he soon changed to the study of medicine and graduated from McGill University, Montreal, in 1872. After two years of postgraduate studies in various centres in Europe, he returned to Montreal in 1874 to become Professor of the Institutes of Medicine at McGill.

In 1884, he was appointed to the Chair of Clinical Medicine at the University of Pennsylvania, in Philadelphia, where he pursued his clinical and clinicopathological studies. He often referred to these years as the most instructive of his career.

In 1889, he became the first Professor of Medicine at the newly founded Johns Hopkins Medical School in Baltimore, where he became one of the famous four (along with Welch, Kelly and Halstead), who were immortalised in Sargent’s celebrated portrait. There he reintroduced to American medicine a true bedside method of instruction, teaching in the wards, where the students spent most of their time.

In 1904, he became Regius Professor of Medicine at the University of Oxford and was the leading British physician until his death in 1919. He was knighted in 1911.

His textbook The principles and practice of medicine (1892) established a new standard in medical texts, presenting at first hand a broad, yet fresh, store of information. It went through nine editions in his lifetime and it was the leading one-volume textbook of its time, if not of all time, and was translated into many languages. He was the founder and editor of the Quarterly Journal of Medicine (1908) and also edited Modern Medicine (1910).

His name is eponymously associated with Vasquez–Osler disease, or polycythaemia vera, and Osler’s nodes.

Osler bequeathed his extensive medical library to his alma mater McGill.

He has been well treated by his biographers, Harvey Cushing and Maude Abbott.

Osler died of pneumonia in Oxford on 29 December 1919, and was honoured by Canada on a stamp on the 50th anniversary of his death.

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Gerhard Henrick Armauer Hansen (1843-1912)

ARMAUER HANSEN WAS BORN IN BERGEN, in the north of Norway, on July 29, 1841. He studied medicine at the local university and received his degree in 1866.

Since leprosy was endemic in Bergen, he became immediately interested in it and was on the staff of the Leprosy Institute there. His efforts were rewarded and, in 1897, he discovered the causative organism, known as Hansen’s bacillus or Mycobacterium leprae.

He died in Flora, Norway, on 12 February, 1912.

He was postally honoured by Cuba on the occasion of the International Congress of Leprosy, Havana, in 1948 and subsequently by Brazil in

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