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Welcome to the first issue of RACP Quarterly for 2018.

This will be the last issue in which I write as President, as our next president, Associate Professor Mark Lane, takes over in May. It has been a great privilege to serve the College, and you as our members.

Before I reflect on the past two years, I need to acknowledge and apologise for the disruption and distress caused by the cancellation of our Computer Based Divisional Written Examination for Basic Trainees. We moved to this form of testing in keeping with the times, and requests to hold the exam more than once a year. However, there were many issues, not just the technical ones, and the Board and I deeply regret the stress caused to our trainees, our Supervisors and our Directors of Physician Education, as well as Health Services and District Health Boards. College staff worked around the clock to hold two alternative paper based exams. I thank them and our Education and Examination Committee members, and all who supported our trainees. We have refunded examination fees, and are holding an inquiry to address the examination problems and our responses.

Over the last two years we have achieved an enormous amount. I am very proud of the high public profile we have maintained in both Australia and New Zealand; our Fellows speaking out as experts on the health implications of inequities in housing, employment and mental health; refugee detention; alcohol advertising to children during sports broadcasts; the harms of codeine; and our advocacy for equal marriage rights in Australia. These are just some of many issues on which we have advocated on behalf of our patients and communities.

We have also spoken out about our own health and wellbeing. Changing our working environments and our profession’s attitudes and assumptions about our own physical and mental health is a multi-year, multi-agency task. But as I step down, I am confident we have started a movement that will not stop.

Our Indigenous Strategic Framework is charting a course to employ more Aboriginal, Māori and Pasifika specialists, as well as improve access to healthcare for Indigenous peoples.

With Medically Assisted Dying legislation being passed in Victoria and due to come into effect in 2019, this topic remains contentious for many physicians in both Australia and New Zealand. On page 21 we provide some insight into our members’ thoughts as part of the deliberative forums RACP held in both countries in November last year.

Many of us may feel we need to learn more about cultural competency. But some of our members have gone to great lengths to do so. The inspiring story of one senior Fellow, Professor Don Campbell, on page 18 is one of personal realisation and ongoing commitment in outback Australia. If you are a trainee, I especially encourage you to read it.

On page 9 you’ll find a story about our recent attendance in Suva at the signing of an agreement with Fiji National University to support a Pacific Medicine program at their College of Medicine, Nursing and Health Sciences.

This is a wonderful initiative that marks the launch of our International Strategy to support specialist training throughout the South Pacific.

Finally, the RACP has been proudly represented in this year’s New Zealand New Year and Australia Day Honours lists; notable among those recognised being our immediate past President, Laureate Professor Nicholas Talley, and Professor David Kissane who both received Australia’s highest honour, being made Companions of the Order of Australia. Turn to page 6 for the full list.

I hope to see many of you at this year’s RACP Congress in Sydney, where I hand over to Associate Professor Lane, who will serve your College well, and will continue the important work we do to “Serve the Health of our People.”

Dr Catherine Yelland
RACP President
A message from
The Board

Since the last edition of *RACP Quarterly*, your Board has met on Friday, 8 December 2017 and Thursday, 15 March in Sydney.

December 2017
Board meeting
On Friday, 8 December the Board met for its final meeting of 2017. The items of interest to the membership included:

**RACP Indigenous Strategic Framework**
The Board approved the Indigenous Strategic Framework for the College, with key priorities being to:

- contribute to addressing Indigenous health equity differences
- grow the Indigenous physician workforce
- equip and educate the broader physician workforce to improve Indigenous health
- foster a culturally safe and competent College
- meet regulatory standards and requirements from the Australian Medical Council and the Medical Council of New Zealand.

This was developed by the RACP Aboriginal and Torres Strait Islander Health Committee and the Māori Health Committee, with assistance from RACP staff, other Fellows and Associate Professor Wendy Edmondson, a Badimia Amungu Aboriginal woman, with broad experience in education, management and health.

The Framework will be made available on the RACP website when finalised.

Te Tiriti Ō Waitangi Clause for the New Zealand Committee By-law
On the recommendation of the New Zealand Committee, the Board approved the following clause to be added to By-laws of committees in New Zealand:

*The New Zealand Committee acknowledges Te Tiriti Ō Waitangi/The Treaty of Waitangi and the foundational principles of bicultural partnership, participation and protection it guarantees. We therefore commit that all our policies will give consideration to the impact on the wellbeing and mana of Māori as tangata whenua and ensure that these policies uphold the above principles.*

Congress 2018 update
Congress 2018 will be held at the International Convention Centre in Sydney from Monday, 14 May to Wednesday, 16 May 2018 and will focus on Disruption for Healthy Futures. Key themes are:

- Disruptive conversations and disruptive technologies
- Climate change
- Mental health
- Patient centred care/ integrated care.

VIP and Early Bird registrations closed on Sunday, 18 February 2018.
International partnerships update

The RACP International Strategy is focused initially on the Small Island Nations of the South West Pacific. These countries need backing and support from more developed nations and are a priority for both the Australian Department of Foreign Affairs and the New Zealand Ministry of Foreign Affairs.

Election update

2018 is an election year, in the two-yearly cycle, Board Directors, many Divisional and Faculty Office Holders, and members of the New Zealand Committee, College Trainees’ Committee and Chapter Committees will complete their terms at the Annual General Meeting on 14 May 2018.

Note the dates for nominations and elections:

- The Call for Nominations opened on Monday, 4 December 2017 and closed on Friday, 2 February 2018.
- The College elections opened on Monday, 5 March 2018 and close on Tuesday, 3 April 2018. Voting will be managed electronically by Computershare. Members are also provided with the option to vote by hardcopy ballot paper and return it by post if they so choose.
- Following the changes made to the RACP Constitution, the Members to be elected to the Board are:
  - President-Elect
  - three Member Directors
  - one Trainee Director.

The current President Elect, President Elect of New Zealand and up to three other appointed persons will also be on the Board.

Chief Executive’s report to the Board

The College’s Chief Executive Officer highlighted the following achievements:

- All strategic initiatives continue to be on track with significant progress in many areas.

March 2018

On Thursday, 15 and Friday, 16 March 2018, your Board held its first meeting of the year.

Directors were briefed on the successful 2 March staging of the alternative exam for the cancelled Divisional Written Examination, and preparations for the second alternative resit on 23 March.

All trainees who attempted the cancelled 19 February exam should now have been refunded their examination fees. The Board also heard about additional support being provided to trainees, as results for this year’s exam are released to them and to Directors of Physician Education.

The Board has appointed Ferrier Hodgson to conduct an independent investigation into events on and preceding 19 February. Ferrier Hodgson will be speaking with relevant RACP staff and Fellows, and reviewing all the relevant documentation.

The investigation will take approximately six weeks, after which a compiled report will be provided to the Board. Directors will decide when and how to publicly release the report and its recommendations.

Chief Executive’s report to the Board

The Chief Executive Officer noted the following achievements:

- All strategic initiatives continue to be on track with significant progress in many areas.
- The first draft of the 2018 Work Plan for the Physician Health and Wellbeing Strategic Roadmap and Action Plan is complete. The College met the NSW Ministry of Health to discuss implementing their JMO Wellbeing and Support Plan. We also provided feedback on the Australian Medical Association’s National Forum on Reducing Risk of Suicide in the Medical Profession.
- The College Learning Series (CLS) is now live with 34 presentations from 2017 and all 2017 Physician Education Program (PEP) content available. Lectures for 2018 are currently in production and the Paediatric series planning and development begins during this quarter.
- Fellowship Marks have been widely adopted by the membership following launch in December.
- Policy & Advocacy achievements included the Federal Government abandoning drug testing of welfare recipients, up-scheduling of OTC Codeine, adoption of many RACP policy recommendations in the Draft National Alcohol Strategy, and the 2018-2019 Pre-Budget submission was the subject of seven media releases.
- The Working Party on Medical Assistance in Dying has developed a position statement, which is being circulated to Members via eBulletin.
- The Memorandum of Understanding with the Fiji National University was signed with extensive media coverage in Fiji.
Annual accounts 2017
The 2017 Annual Accounts have been prepared for the year ending 31 December 2017 and audited by Grant Thornton, ahead of the accounts presentation to Members at the RACP Annual General Meeting on 14 May 2018. The notice of meeting will be dispatched to all Members in April 2018.

Whistleblower report
The Board considered in detail a 70-page document containing a whistleblower report alleging instances of bullying and financial mismanagement, as well as mishandling of these complaints. These matters have been raised on many previous occasions with both the current Board and the preceding Board. The current Board again found no substance to any of the allegations and rejected a call for an independent inquiry. The Board also notes the timing of the re-tabling of these allegations during College elections, but remains focused on support to trainees, physician health and wellbeing and placing members at the centre of everything we do.

Technology strategy
The Technology Strategy 2018-2020 was presented for noting. It enables technology support for Member facing and RACP business objectives, while increasing overall effectiveness and efficiency of our IT systems.

Guidelines for Ethical Relationships between Health Professionals and Industry
The Board approved the formal adoption of the RACP Guidelines for Ethical Relationships between Health Professionals and Industry as ‘Guidelines’ for Members of the College.

Relationship between the RACP Australasian Faculty of Occupational & Environmental Medicine (AFOEM) and the Hong Kong College of Community Medicine
The Board accepted the recommendation of the AFOEM Council to extend the arrangement between the HKCCM and College, including the provision of the AFOEM Stage B Written Examination and external examiner for a further five years.

Consumer Advisory Group
The Board was advised that expressions of interest have been invited to establish a Consumer Advisory Group, with its first meeting scheduled for May 2018. The Group’s Terms of Reference and Selection and Appointment Policy were both approved.

Next meeting
The next meeting of the RACP Board is on Saturday, 12 May 2018, ahead of the College Ceremony on Sunday and the beginning of Congress on Monday, 14 May.

Dr Catherine Yelland
RACP President
We would also like to congratulate the two Fellows who were state Australian of the Year recipients.

These awards highlight the outstanding work RACP members do and the importance of their work in local, national and international communities.

**New Zealand New Year Honours**

**Officer of the New Zealand Order of Merit**

Professor Edwin Arthur Mitchell FRACP
For services to children’s health.

Dr Renee Wen-Wei Liang FRACP
For services to the arts.

**Australia Day Honours**

**Companion (AC) in the General Division**

Professor David William Kissane FACchPM
For eminent service to psychiatry, particularly psycho-oncology and palliative medicine, as an educator, researcher, author and clinician, and through executive roles with a range of national and international professional medical bodies.

CONGRATULATIONS

to the 27 RACP Fellows recognised in the 2018 Australia Day and New Zealand New Year Honours lists.
Professor Nicholas Joseph Talley
FRACP, FAFPHM
For eminent service to medical research, and to education in the field of gastroenterology and epidemiology, as an academic, author and administrator at the national and international level, and to health and scientific associations.

Officer (AO) in the General Division
Professor Suzanne Marie Garland
FAChPH
For distinguished service to medicine in the field of clinical microbiology, particularly to infectious diseases in reproductive and neonatal health as a physician, administrator, researcher and author, and to professional medical organisations.

Professor David Joshua Handelsman
FRACP
For distinguished service to medicine, particularly to reproductive endocrinology and andrology, as a clinician, author and researcher, to the science of doping in sport, and to medical education.

Professor Jonathan Myer Kalman
FRACP
For distinguished service to medicine, particularly to cardiac electrophysiology as a clinician and academic, and through roles with a range of national and international heart rhythm societies.

Professor Creswell John Eastman
AM, FAFPHM, FRACP
For distinguished service to medicine, particularly to the discipline of pathology, through leadership roles, to medical education, and as a contributor to international public health projects.

Member (AM) in the General Division
Professor Fiona Mary Blyth
FAFPHM
For significant service to medical research and education in the field of public health, pain management and ageing, and to health policy reform.

Professor Susan Leigh Elliott FRACP
For significant service to education as an academic administrator, as a clinician in the field of gastroenterology, and to educational institutions in the Asia-Pacific.

Associate Professor Nerina Susan Harley FRACP
For significant service to medicine in the fields of intensive care and nephrology, as an administrator, and to medical research and education.

Dr Peshotan Homi Katrak FAFRM
For significant service to rehabilitation medicine as a practitioner, to medical education and professional organisations, and to the Zoroastrian community.

Professor Frank Oberklaid FRACP
For significant service to medicine in the field of clinical paediatrics, child development, and public health policy, as a researcher and academic.

Dr Vanita Rajul Parekh FACHSHM
For significant service to medicine as a specialist in the fields of sexual health and forensic medicine, as an educator and clinician, and to professional associations.

Dr Peter Creighton Pigott FRACP
For significant service to medicine in the prevention and treatment of HIV and tuberculosis as a clinician, researcher and mentor.

Professor Barbara S Workman FRACP
For significant service to geriatric and rehabilitation medicine, as a clinician and academic, and to the provision of aged care services.

Medal (OAM) in the General Division
Professor William Robert Adam
PSM, FRACP
For service to medical education, particularly to rural health.

Associate Professor Christopher Roger Ashton FRACP
For service to medicine, and to medical education.

Adjunct Professor Agnes Bankier
FRACP
For service to medicine as a geneticist, and to medical education.

Dr Leonard Brenner FRACP
For service to medicine as a general practitioner.

Dr Richard Arthur Cockington
FRACP
For service to medicine as a paediatrician.

Dr Barry Peter Hickey FRACP
For service to thoracic medicine.

Dr Fred Nickolas Nasser FRACP
For service to medicine in the field of cardiology, and to the community.

Dr Katrina J R Watson FRACP
For service to medicine, particularly to gastroenterology.

Dr Anthony (Tony) Paul Weldon
FRACP
For service to the community, and to paediatric medicine.

Medal (OAM) in the Honorary Division
Dr Friedbert Kohler FAFRM
For service to rehabilitation medicine.

Public Service Medal
Professor Maria Crotty FRACP
For outstanding public service in the rehabilitation sector in South Australia.

Australian of the Year
Dr Bo Remenyi FRACP
Paediatrics cardiologist
Northern Territory Australian
of the Year
Professor Paul Zimmet AO,
FRACP, FAFPHM
Scientist and diabetes specialist
Victorian Senior Australian
of the Year
WEB-BASED
Dictate and receive reports from anywhere at any time

ACCURATE
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MoU garnering international collaboration

Specialist medical training and expertise will be strengthened across the Pacific region as a result of a new Memorandum of Understanding (MoU) between the RACP and Fiji National University (FNU) which was signed in January 2018. The intent of the MoU is to facilitate capacity and capability building of postgraduate teaching in-country in Fiji.

Individual Fellows have had a long affinity with supporting the development of a postgraduate training program at the College of Medicine, Nursing and Health Sciences (CMNHS) at FNU. As one of many Fellows with a strong interest in global healthcare, who was a member of the RACP Pacific Working Group, Dr Kimberly Oman proudly supports the objectives of the College’s new MoU with FNU.

“Many Fellows do very good work on the international front so it’s great to have the College start to formally recognise this through mechanisms like the MoU,” she said.

“I think what’s really great about the MoU is the fact that it was developed in response to needs articulated to us by our colleagues in the Pacific.

“Before the MoU was drafted, the Working Group included Pacific colleagues, who spoke to physicians, trainees and graduates in Fiji. We asked them what they wanted and are pleased that the RACP used that information to inform its strategy.”

Dr Oman says feedback indicated that the high-volume of clinical, teaching and administrative work meant that Pacific physicians are often in ‘survival mode’ from day-to-day.

“Local specialists are often very busy and have limited resources,” she said.

“Because of these challenges, it’s hard for physicians to access or find time for professional development opportunities and that’s where RACP Fellows can assist.”

The MoU will see the RACP share learning resources, curriculum materials and eLearning assets with FNU’s CMNHS.

RACP Fellows will be invited to mentor and provide support on teaching practices and assessment processes in Fiji. In the future they may also offer locum support to local physicians so they can attend international conferences and professional development opportunities.

Dr Oman believes the MoU will give RACP Fellows access to exciting and rewarding learning opportunities.

“We can learn so much from our colleagues in the Pacific and continue our own professional development,” she says.

“It’s also particularly rewarding to be able to go into a lower income country, provide a higher income country perspective and have discussions about what should or

WAYS THE RACP WILL SUPPORT FNU:

- staff capacity building and development
- exchange of academic and administrative staff
- sharing of teaching resources and curriculum.
shouldn’t be incorporated into local healthcare settings. That can be very challenging, as the best approaches are not often known.

“You’re taught more than you teach’, is a saying I live by and in this case, I think it sums up why many RACP Fellows are supportive of the MoU with FNU.”

On the ground in Fiji, the MoU has been praised by local specialists, trainees and the healthcare community.

The FNU Vice Chancellor, Professor Nigel Healey, believes the MoU supports the University’s efforts to ensure Fiji and the South Pacific have the specialist skills they need to sustain their growing healthcare sector.

“This new partnership with the RACP is designed to support FNU as we expand our range of medical and clinical specialties,” says Professor Healey.

“This MoU is an affirmation of our intention to foster genuine and mutually beneficial collaboration.”

RACP President Dr Catherine Yelland travelled to Fiji for the signing of the MoU and says it will enhance many activities undertaken by our own physicians, colleagues and organisations working in the region.

“Internationally, our focus is on health education and research, as well as building capacity among educators, academics, physician specialists and their institutions within our region,” explained Dr Yelland.

“We look forward to building stronger ties with FNU and working together on postgraduate education, training and research opportunities.”

The MoU will remain in place for five years and forms part of a new international engagement strategy, which the RACP is currently developing.

The MoU enables CMNHS to identify their top priorities. There are several core areas of potential delivery and the aim of the international strategy at the RACP is to create sustainable processes that deliver on these needs over time. This allows the College to develop systems and processes to support the ongoing relationship with FNU.

Internally the International Strategy will also be supported through the Memorandum of Collaboration (MoC) framework the RACP is establishing with specialty societies. Fellows and trainees will be notified of opportunities through RACP communications.- RQ.
Left: Dr Gyaneshwar Rao, Fiji Ministry of Health, RACP President, Dr Catherine Yelland and Dr Jioji Malani, CMNHS.

Source: College of Medicine, Nursing and Health Sciences, Fiji National University, Fiji
Immunotherapy: The next frontier in cancer treatment

Dr Craig Gedye FRACP is a physician scientist, dual-trained as a medical oncologist and a basic researcher, now at the Calvary Mater Newcastle and the Hunter Medical Research Institute in NSW. He is a significant figure in immunotherapy and an enthusiast.

Immunotherapy is the first cancer treatment that focuses on empowering patients to fight their disease themselves. It does this by boosting their immune system. Given that one in three Australian men and one in four women will be diagnosed with cancer before the age of 75, there is considerable interest in this new frontier in treatment.

\[Australian\ Financial\ Review,\ 26\ December\ 2017\]

Hepatitis A outbreak confirmed in Victoria

Gay and bisexual men will be eligible for free hepatitis A vaccinations following confirmation of almost 30 cases in Victoria.

Deputy chief health officer Dr Brett Sutton FAFPHM says 27 men have recently contracted Hepatitis A, while another 12 cases are being investigated.

\[The\ Australian,\ 12\ January\ 2018\]

How big data could help combat heart failure

Mining a wealth of untapped health data could reveal new insights into how we age – and help tackle one of the biggest killers of older Kiwis.

A new study, led by medical specialist and Otago University researcher Dr Hamish Jamieson FRACP, will trawl through a sprawling national health database to look for clues to combating heart failure.

Heart failure was the most common cause of hospital admission in older New Zealanders.

\[New\ Zealand\ Herald,\ 15\ January\ 2018\]
GPs could be banned from prescribing addictive painkillers
General practitioners could be banned from prescribing strong painkillers in an attempt to prevent Australia following the United States into an opioid overdose epidemic.
Accidental drug overdoses are now far more likely to be caused by pharmaceutical drugs than illegal drugs.
Matthew Frei FACChAM, clinical director of drug and alcohol service Turning Point, said many Australians had come to believe they should not suffer from any pain at all, and a cultural change was needed from consumers, doctors and regulators.
"Unfortunately, I think this storm has aligned itself in North America and Australia at a time these drugs were marketed and promoted for non-cancer pain very strongly by the pharmaceutical industry," Dr Frei said.
"I think we are in a very concerning situation."
*Sydney Morning Herald, 26 January 2017*

Child specialist a welcome addition to Cairns Hospital’s ICU
MORE seriously ill children will be able to be treated in the Far North with Cairns Hospital hiring its first paediatric intensive care specialist.
Dr Vijay Palaniswamy FRACP is one of two new ICU specialists starting work at the hospital this week. A third is due to join the team next month.
*The Cairns Post, 13 January 2018*

Vaccinations urged for high-risk age group
Three Aboriginal children have been diagnosed with meningococcal in Kalgoorlie since November last year, prompting an urgent call from health experts for the vaccination of those aged two months to 19 years.
According to the WA Country Health Service, the three cases, all of serogroup W of the disease, indicate a much higher than usual attack rate in the Kalgoorlie-Boulder population.
WA Country Health Service Goldfields public health physician Clare Huppatz FAFPHM said the recent rise in cases was the same strain that was associated with an outbreak in Kalgoorlie in late 2016 and in central Australia in mid-2017.
"In both outbreaks, the majority of cases occurred in Aboriginal children," Dr Huppatz said.
*The West Australian, 8 January 2018*
Members in the media

Doctor: Make euthanasia drug available in pharmacies for over 18s

An Auckland medical specialist argues making a drug to assist dying available in pharmacies would be far easier to manage than bringing in legislation.

Dr Stephen Child FRACP has spoken to NZH Focus about his view on ACT MP David Seymour’s End of Life Choice Bill that passed its first reading in Parliament in December.

It will legalise assisted dying in cases where individuals have a terminal illness that is likely to end his or her life within six months.

Dr Child says the conversation isn’t really as much about opposed or supportive of euthanasia but whether it can be a perfectly written piece of legislation that gives the rights to those who want to end their life, without causing harm to people.

*New Zealand Herald, 17 January 2018*

Gold Coast medicos to get the latest in flu test after the region goes through worst season ever

TWO local hospitals will benefit from cutting-edge technology and other new measures to prevent another horror flu outbreak on the Gold Coast — the worst in the city’s history.

Gold Coast Public Health staff specialist Dr Paul Van Buynder FAFPHM said a new test to be introduced at Gold Coast University Hospital and Robina Hospital would enable doctors to detect A and B strains of influenza within 30 minutes.

The city will also get improved vaccines and local children will get them free next year as part of a statewide blitz on flu.

*Herald Sun, 12 November 2017*

Preventable diseases on the rise throughout the region

NORTH Queensland has experienced a spike in three vaccine-preventable diseases prompting health authorities to conduct an urgent immunisation program.

Over the past six months, the Townsville Public Health Unit (TPHU) has seen a rise in the number of mumps cases, mainly in remote communities in western Queensland and around Mount Isa.

In 2017, the TPHU recorded 242 cases of mumps compared to just two in 2016. Last year also saw a spike in the children’s gastro rotavirus with 131 cases compared to 43 in 2016 and chickenpox (varicella), 592 and 555 cases respectively.

TPHU registrar Dr Julie Mudd, trainee physician, said an outreach team was sent into these western Queensland communities to deliver catch up MMR (measles, mumps and rubella) vaccinations to more than 500 children and adults.

*The Daily Telegraph, 9 January 2018*
The 2017 flu season in Australia was indeed a bad year. In a conversation with Dr Brett Sutton FAFPHM, Deputy chief Health Officer – Victorian Department of Health and Human Services, we explore some of the reasons why it was such a bad year and the importance of prediction, prevention and preparedness plans.
Last year Australian health services recorded among some of our highest number of notifications of the influenza (flu) virus.

General Practitioner (GP) consultations increased, as did the pressure on primary care providers and hospital emergency departments.

Public health physician Dr Brett Sutton says it was a severe season for a number of reasons.

“The main reason was that somewhat unexpectedly H3N2, a subtype of the influenza A virus, was the predominant strain, with half of recorded cases,” he says.

“It was not well covered by the vaccine, leading to more hospitalisations than normal.

“The effectiveness of the vaccine also varied depending on factors such as flu strains and age demographics. Overall, we saw a low to moderate effectiveness of the vaccine.

“There are a lot of definitions of what the ‘worst season’ means, but in terms of notifications and therefore the spread of the infection, 2017 was a severe year. We were actually seeing more than double the notifications we normally see.”

“Another possible reason for notifications being so high was the shift from serology testing to respiratory swab collection and testing, which is easy and simple. I think more swabs were taken in those presenting with influenza-like illness so this contributed to more recorded flu cases than previous years,” Dr Sutton explains. “Although the exact number of people affected is hard to know, hospitalisations across Australia were 2.3 times above the five-year average for 2012 to 2016. Severity in terms of percentage presenting to emergency departments actually requiring hospital admission was average, and in terms of Intensive Care Unit (ICU) admissions it was on the lower end.

The season resulted in over triple the number of flu-related deaths of previous seasons, with young children and the elderly being particularly vulnerable to the virus.” Children
aged between five and nine were more affected last year than in a normal year and we saw a higher notification rate for our elderly population.

“Prediction of influenza is the Holy Grail but it is a rough tool. We do not have reliable models that have passed the validity test or tools to predict accurately what strains will emerge and how severe the symptoms will be,” says Dr Sutton.

This is the main reason why H3N2 was not predicted as the predominant strain and this predominance contributed to the overall effectiveness of the vaccine being poor, leading to a prolonged and dire season.

The vaccine is developed based on the viruses that circulated in the previous season. In 2017, the match was reasonable but the effectiveness of the vaccine against the H3N2 strain was limited. The severity of the season was better understood as the season progressed. It was clear the season was shaping up to be a severe one by looking at the data such as the number of notifications from GPs, hospitalisation rates, facility outbreaks and fatalities.

When it comes to limiting the severity and spread of the flu, most public health physicians agree immunisation is key.

“A lot can be done to improve some of the preventable aspects of the flu, I think we can do more in terms of uptake of the vaccine,” says Dr Sutton. “A critical point of herd immunity is when you lessen transmission, shorten the season or impact the peak of the season by increasing immunisation coverage.”

Some barriers to immunisation are often associated with personal experience of the vaccine, the cost or accessibility. To address the issue of access, for instance, pharmacist immunisers have been explored as additional providers of influenza vaccine.

Emphasising the importance of improved methods of mitigating flu consequences, Dr Sutton says there are other measures that health services should consider.

“We need better real-time national surveillance coordination to detect trends early in the season so that we can make necessary adjustments in a timely fashion,” he says.

“The uptake of the vaccine was good in some vulnerable groups such as elderly people in nursing homes. However, under 65-year-olds considered at risk; and those with a pre-existing condition such as diabetes, was not good enough. We need to improve the uptake in these groups.

“Other groups we need to focus on include children under five years of age and Indigenous people up to the age of 15. Under 65-year-olds considered not at risk should also be encouraged to get the vaccine. Uptake of the vaccine for these groups may help change the dynamics of transmission and have positive repercussions in terms of reducing the peak of the season.”

Creating awareness amongst vulnerable groups and improving immunisation coverage for other conditions that are prevalent during the flu season – such as pneumococcal pneumonia that peaked during the last influenza season – should also be a priority for health professionals.

“Doctors should recommend sick leave for affected people to mitigate the spread of the epidemic,” Dr Sutton explains. “And employers should make it their policy to encourage their employees to take sick leave in order to limit the spread of the flu. It also goes without saying that individuals should do their best to limit contact with others once they suspect or know they have the flu.

“Appropriate communication and awareness campaigns targeting the most vulnerable groups is key in curbing the spread of the disease. We also need to understand what the enablers and barriers are in terms of immunisation uptake to address them and come up with other innovative solutions.”

RQ
From Monash to Alice

Professor Don Campbell can recall the exact moment when he decided he needed to learn more about cultural competency and Indigenous issues. "I saw the look on Adam Goodes’ face when that young girl called him a monkey, and I turned to my wife and said, ‘I get it.’"

For non-Australian readers, the reference is to a notorious incident at the MCG in 2013 during an Australian Rules Football match, when a 13-year-old female supporter in the crowd racially abused well-known Aboriginal player Adam Goodes on the field.

Her subsequent removal by security after Goodes pointed her out, and the ensuing debate polarised Australia over the next two years – some saying it was harmless ‘sledging’ and booing Goodes at subsequent matches; others being outraged at what they saw as underlying racism still endemic in Australian society.

For Don it was a defining moment, after which many might have committed to doing a course or some reading to start to try and understand Indigenous issues and discrimination. But the Professor of Medicine and General Physician at Monash, a former IMSANZ President and senior RACP Fellow decided he needed to go much further. "I called up Dr Stephen Brady, the head of General Medicine at Alice Springs Hospital, and said ‘Can I come and do a locum?’"

The slightly surprised response from the Director of Medical Services in Alice Springs was, “...yes.” It’s not often that a very senior general physician calls up out of the blue from Melbourne 2,200 kilometres away, and offers to come to the outback to help with general medical inpatient consultations.

“...I did a two-day recce, looking around,” said Professor Campbell, “and then a year went by.”

After further thought he finally decided to follow up, and made his journey. “That was in June, two years ago. It blew my mind,” said Professor Campbell. “I was really impressed by the quality of care, and the operation run by Dr Samuel Goodwin, the Executive Director of Medical and Clinical Services with the Central Australian Health Service.”

“I would strongly encourage trainee physicians to consider working at Alice Springs Hospital for part of their training. They will have the medical experience of a lifetime and be strongly supported in doing so by a great team of physicians and an enlightened medical administration.”
“Seventy to eighty per cent of the patients I saw were Indigenous. For at least 30 per cent, English is not their first language.” For a physician who describes his practice of medicine as “…swimming between the flags…” it was a profound experience. So much so that he contacted doctors Goodwin and Brady afterwards and asked “…can I do it again?”

“Yes,” came the reply, “but if you come back, you’ve got to commit.”

That’s how the initial trip to Alice turned into a regular rotation for Professor Campbell; two weeks in January last year, another two weeks in June, and at the time of being interviewed for this article, he had just completed another four weeks.

He’s valued appreciating the real meaning of culture, kin and country to Australia’s first people, as well as an “…earthy sense of humour!”

And learning new words. “There are nine Aboriginal liaison officers who work at the hospital. I’ve been in a room with our registrar and resident and nine family members, completing an Advance Care Plan for a patient, and the patient has asked a question of the liaison officer. “’What did she say,’ I asked?”

“She said ‘what does the Tjilpi think?’ referring to me.”

“What does Tjilpi mean?”

“Depending on context it means, old man, respected elder, or white hair!”

Professor Campbell’s experience contradicts the perception that many may have of primary and secondary care in the outback being universally lacking.

“Alice is a town of around 29,000 people with another 15,000 living in the surrounding area, and the hospital catchment takes in everyone in a 500 kilometre radius. I’ve been very impressed with the quality of clinical care, the level of proactive medicine, but also the degree of responsibility the clinical team take for integrating their patients back into the wider community. I have access to MRIs the same day. Two phone-calls and via the Royal Flying Doctor Service we can medivac a patient to Adelaide or Darwin.”

Professor Campbell has a recommendation for those beginning the journey to become a physician.

“I would strongly encourage trainee physicians to consider working at Alice Springs Hospital for part of their training. They will have the medical experience of a lifetime and be strongly supported in doing so by a great team of physicians and an enlightened medical administration.”

“Having the support of such senior physicians like Don for remote and Indigenous Australia is incredible,” said Dr Samuel Goodwin. “He’s taking time out from his busy metropolitan practice, and its fantastic role-modelling for trainee physicians. Our message to trainees is to take the chance; come out here and see both the challenges and the incredible medicine that’s being practiced.”

Professor Campbell intends to continue his outback locum visits, quoting another College Fellow also well-known for his work in the outback, infectious diseases physician Dr Lloyd Einsiedel.

“We learn so much more than we can ever give back.”

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Professor Don Campbell on the bike trail out to Simpsons Gap.
RACP Trainees’ Day is taking place on Sunday, 13 May 2018. It is an opportunity for Basic and Advanced Trainees to meet and discuss critical topics around their profession and training pathway.

Connect with peers and hear from experienced physicians on topics such as:

- The global refugee crisis: it is our responsibility
- Australian refugees: stand up and be counted
- How can we advocate for a brighter future?
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Keynote speaker
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Powerhouse of Presidential knowledge
Paediatrics & Child Health Division President - Dr Sarah Dalton
Adult Medicine Division President - Associate Professor Grant Phelps

Trainees’ Day
Sunday, 13 May 2018
8.30am to 2.30pm
Venue: RACP
52 Phillip Street, Sydney

Trainees’ Dinner
Sunday, 13 May 2018
6pm to 10pm
Venue: Blackbird Café, 201 Sussex Street, Cockle Bay Wharf, Darling Harbour, Sydney
Cost: $59 per person

Due to the generosity of our sponsors Trainees’ Day registration is only $50 this year.

Registrations open. Go to the Trainees’ Day tab on the Congress website www.racpcongress.com.au
Medical assistance in dying is a complex issue that is exercising the hearts and minds of specialists, especially in Victoria, where it will become law next year.

The RACP has established a working party to develop a position on medically assisted dying, in consultation with our members. Members of the working party have expertise in areas including ethics, adult internal medicine, paediatrics, aged and extended care, disability care, palliative care and end-of-life care.

*RACP Quarterly* talks to two members of the RACP’s working party, Dr Danielle Ko and Dr Jim Howe, about the conversations doctors are having on this issue, the patient experience and the significant challenges that some specialists will face in their clinical practice when medical assistance in dying is legalised in Victoria.

**Where we are and where we’re heading**

**The patient experience**

In the United Kingdom, Dr Howe was trained in neurology and geriatrics. Currently based in Victoria, he works in the Statewide Progressive Neurological Disease Service, mainly in the Motor Neurone Disease clinic, and he is also helping to care for people living with other conditions, particularly Huntington’s Disease.

“In the course of our work, we have quite a few people ask about medical assistance in dying,” Dr Howe says. “Patients with Huntington’s Disease talk about how they want to kill themselves before they become helpless and are so cognitively impaired they can’t ask others for help. These patients need good end-of-life care that extends over a number of years.

“The suffering they have is not generally pain, it’s existential suffering, the suffering that comes with being helpless, not being able to breathe or swallow. When cognitive impairment comes, they lose their executive function, to be able to think ahead or plan. Communication becomes difficult.”

Dr Ko is a palliative medicine physician and former lawyer, with a background in clinical ethics. Like Dr Howe, Dr Ko is a practising clinician in Victoria where the new legislation will come into effect.

She explains that for patients considering assisted dying, the experience and issues raised will be unique to each individual patient and their family, and will inevitably be influenced by their relationship with their treating physician and their views.

“In my experience, the reason patients make a request for medical assistance in dying is often complex, dynamic and multi factorial. What might be identified as the primary reason at one point may become less relevant as time goes by and another factor may in fact be unmasked as the driving motivation all along,” Dr Ko explains.

Dr Ko says patients who tend to request medical assistance in dying are generally more likely to be well-educated and used to being in control.

“For the majority of patients who request a hastened death, it’s usually not about uncontrolled symptoms. People want to have control and make decisions about the end of their life and sometimes, there is a real fear of future suffering. If you’re used to having control in most aspects of your life, the uncertainty and loss of control as one faces the prospect of death can be extremely challenging,” she explains.

Dr Ko has also encountered patients requesting a hastened death and found, particularly amongst elderly female patients, their reasoning is they don’t want to be a burden.

“One of my patients told me that if it was a legal option, she would feel obliged to explore it so as not to be...
a burden on her children. This does make me worry, and this patient’s words have motivated me to never forget the importance of taking the time to explore what might, at first instance, seem like a straightforward voluntary decision.

“As a physician, you need to have an in-depth non-judgemental discussion, where you explore motivations with a real curiosity. Over a series of conversations and with good palliative care, the majority of my patients get enough relief, support and reassurance so that they no longer desire a hastened death. But for a small minority, that wish persists.”

Challenges for specialists and the profession

Some specialists feel that medical assistance in dying is likely to affect their practice significantly. Dr Howe explains some of the challenges that lie ahead for specialists, particularly for those who work in neurology.

“Progressive neurological disease is going to make this a difficult process because cognitive impairment is so subtle,” he says. “The biggest challenge for neurologists is that we are likely to be asked to make a decision on a patient’s competence, and often this is not a decision we can make alone. Psychiatrists, neuro psychologists, may need to be involved in determining competence, if there is any conflict around the decision.”

In jurisdictions where medically assisted dying is legal, doctors have had conversations similar to the ones being had in Australia and New Zealand.

“When Oregon’s legislation came out, doctors working in Motor Neurone Disease (MND) clinics told me that they were very concerned and didn’t want to do it. However, when patients asked, some did prescribe, unhappy as they were. Dutch neurologists I have talked to seem a lot more comfortable with the idea, perhaps because it has been possible in The Netherlands a lot longer.”

Dr Howe says he has talked to doctors where medical assistance in dying is legal, and has heard that the experience can be positive for the patient and their family.

“Some physicians say that when medically assisted dying is done well, it can be done really peacefully and beautifully. A patient takes the overdose and they die with the support of their family, but there are reports of difficulties, when things do not always go smoothly.”

When medical assistance in dying becomes legal, there will be personal moral challenges for physicians, regardless of their stance.

“For those who participate, the emotional impact of the process and the stress of managing relationships with other people who disagree with the practise will be a big challenge,” Dr Ko explains. “For those who don’t support medical assistance in dying, there will also be a need to reconcile one’s right to conscientiously object while delivering patient-centred care. If you don’t support medically assisted dying, you may feel like you are abandoning your patient, because you can’t go that extra step.”

Dr Ko says that specialists will also be navigating other barriers, including a lack of suitable services for some patients at the end of life.

“For patients with only a short number of months to live, there is a service gap. They are not sick enough to stay in a palliative care unit, and not well enough to go home. For these patients, they often need to go to an aged-care facility and many patients say they would rather die than go into aged care,” Dr Ko explains. “This is going to be a difficult situation which medical practitioners are going to face and it is important to consider this issue before the legislation commences next year.”

Dr Ko sees one challenge that may be unique to palliative care. “The palliative care ethos is that we care for patients and their families. If families don’t agree with a patient’s decision for assisted dying, I can foresee that there may be a lot of angst as we try and balance our duty to our patients while considering the families, as they come to terms with their loved one’s illness as well as future bereavement. This issue will highlight the difficulties we face as we try and balance these two sometimes competing interests.”

There are different views in the medical community on whether patients should be able to access medical assistance in dying but Dr Ko highlights that respecting differing views and allowing practitioners to conscientiously object will be key.

“For all specialists and their workplaces, the challenge will be working out how one supports and protects those who want to engage as well as those who want to conscientiously object, or what to do when there are cases where there are conflicting views on whether a patient meets the criteria.

“Differing views are inevitable and the focus should be on creating a culture of respect and maintaining good working relationships with colleagues who have different views on medical assistance in dying or on a particular case at hand.”

RACP consultations

The RACP Working Party has been consulting and engaging with RACP members on many of the key issues raised by legislation in Victoria as well as proposed legislation in New South Wales and New Zealand.

Dr Howe, who has engaged in College consultation including discussions with members and Victoria’s lawmakers, describes the spectrum of views.

“We have had a wide range of views where specialists aren’t afraid to say what they think and this has been a real strength,” he says. “I hope they don’t ask me to give the prescription or do the injection because I don’t think it should be part of my job – is a very common response. We have
“In my experience, the reason patients make a request for medical assistance in dying is often complex, dynamic and multi factorial. What might be identified as the primary reason at one point may become less relevant as time goes by and another factor may in fact be unmasked as the driving motivation all along.”

members who say we should be in full support of this and help Fellows and their patients to do this properly.”

Dr Ko describes the variety of views that exist within the RACP Working Party.

“Even within the RACP Working Party there is no agreement on the ethical validity of medical assistance in dying but there was strong consensus regarding the importance of providing good care to patients nearing the end of their lives.”

The way forward

Dr Howe and Dr Ko agree that patients, their families, carers and health professionals must be provided with appropriate support services and protected by a rigorous framework of data collection and monitoring that addresses every stage of the process for patients requesting medical assistance in dying.

“None of us have done this but there is a feeling of inevitability and an acceptance that this is something we need to be prepared to talk about,” Dr Howe says. “The RACP has started the process of supporting physicians with College consultations and a discussion paper which was well received.”

“It would be great if it was a coordinated effort and a central body was established in Victoria to provide education, support and training for specialists, and to collect data and monitor the process. There is still plenty of work to do before the legislation commences.”

“During consultations, it’s clear physicians want practical support and guidance,” Dr Ko says. “There is thought being put into what educational resources may help and there needs to be a coordinated effort between the Victorian Government and the health sector to identify where the gaps are and to avoid doubling up.”

It is also essential that Commonwealth and State Governments ensure that all terminally ill patients have access to quality end-of-life care, by increasing access and further funding for specialist palliative care services.

Dr Howe wants to see a greater investment in end-of-life care for people with neurological disease.

“There isn’t enough community care for people with Huntington’s disease in my opinion. These patients need physical and psychological care and yet they are not candidates for hospice care and their end-of-life care can go on for a long time. Currently, they don’t get the support they deserve.”

“We need a greater investment in palliative care,” Dr Ko says.

“Victoria is about to bring in assisted dying and it’s important that when patients choose this option, a lack of availability of high quality palliative care is not a contributing factor. We need to expand and ensure better co-ordination of existing services to meet the needs of a growing population who will access these services.”

The RACP will continue to support members now that the legislation has passed and is helping specialists in Victoria prepare for the legislation when it commences in June 2019.

Following a series of deliberative forums and online consultations with members, the RACP is finalising its position statement. The College will continue to engage with members and policymakers both in Victoria and other jurisdictions where legislation is being considered, to advocate for our members and patients and monitor the impacts of the scheme.

Members on the RACP Working Party include Dr George Laking (Chair), Associate Professor Andrew Cole (Deputy Chair), Dr Clare White, Dr Jonathan Gillis, Dr Christopher McKinlay, Dr Jim Howe, Dr Danielle Ko, Professor Paul Komesaroff, Dr Linda Sheahan and Dr Anthoulla Mohamudally. RQ.
The World Medical Association (WMA), at their 2017 annual General Assembly in Chicago, approved a revised version of the Declaration of Geneva. The Declaration was first adopted by the WMA in 1948 and is referred to as The Physician’s Pledge.

The Pledge is intended as a modern affirmation of physicians’ commitment to the humanitarian principles of medicine. For the Pledge to maintain this modern standing it has been amended three times (1968, 1983 and 1994) and previously revised twice (2005 and 2006).

“I have on occasion looked for references for what it means to be a ‘good doctor’ and I think that the revised Pledge provides good written guidance,” says RACP Fellow Dr Sarah Dalton.

“It begins a point of reflection for individuals and can promote conversations for doctors”. The latest revision of the Declaration contains small wording changes throughout as well as the inclusion of three completely new clauses:

- I WILL RESPECT the autonomy and dignity of my patient.
- I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare.
- I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard.

Having not been reviewed for a decade Dr Dalton welcomes the recent revision and reflects on the changes and progress we have seen across medicine.

“The recent additions are very helpful. I think that over the years (and centuries) medicine has been able to move from curing disease, to preventing disease, to promoting wellness, and that it is the paradigm within which we currently work. ‘Health’ is about so much more than the absence of disease, and I think it is really important that we prioritise this for our patients.”

The introduction of a clause specifically focused on physician self-care is particularly noteworthy. It brings the Pledge up to date and reflects the growing awareness of physician health and wellbeing and the changing expectations placed on doctors.

 “Some of the old language suggested that doctors should dedicate their lives to serving their patients above all else. While there are truths to this principle, I think the phrase ‘above all else’ has meant some doctors have felt a reinforcement that their own lives and health are not as important as their patients, which ultimately puts their own health at risk,” explains Dr Dalton.

“I think it is timely that we remember ourselves in this equation. Perhaps there is some synergy with the old saying ‘Physician Heal Thyself’. In paediatrics we always remind parents that in order for them to care for their children, they must ensure that they themselves are as healthy as they can be – this should be the same for doctors.

“Ultimately it is about changing the culture of medicine so that we look after our patients as well as ourselves, and the earlier we start to embed this into the minds of students and trainees the better,” says Dr Dalton.
As a member of the medical profession:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.
Could saliva be the main driver of gonorrhoea transmission?

Dr Vincent Cornelisse, a specialist in sexual health medicine, talks about the connection between saliva and gonorrhoea when it comes to transmitting and preventing the spread of this infection. Dr Cornelisse also discusses why gonorrhoea rates are going up and the latest gonorrhoea prevention research.
Recent research by the team at the Melbourne Sexual Health Centre, led by Professor Christopher Fairley, suggests that gonorrhoea is transmissible in more ways than only penetrative sex, including oro-genital sex and oro-anal sex. This suggests that gonorrhoea can be transmitted when people are exposed to saliva during sex. 

“The link between oro-genital sex and gonorrhoea transmission has previously been demonstrated, and in a recent cross-sectional analysis we demonstrated an association between receptive oro-anal sex and anal gonorrhoea,” says Dr Cornelisse.

Professor Fairley has hypothesised that tongue kissing may be driving most incident cases of gonorrhoea and this is supported by a mathematical modelling.

“Whether tongue kissing can transmit gonorrhoea has been more difficult to demonstrate in studies, at least partly due to significant collinearity between sexual practices and kissing,” explains Dr Cornelisse.

“We suspect that the per-act probability of transmission of gonorrhoea is lower for kissing than it is for penetrative anal sex, for example. However, people tend to kiss more often and kiss more people than they have anal sex with, so this potentially makes transmission by kissing more important epidemiologically. This is important, because our traditional public health strategies, such as the promotion of condom use for penetrative sex, are not going to be effective to prevent the transmission of gonorrhoea by kissing.”

While studies on the relative importance of different modes of transmission are ongoing, some parts of the community appear to be more susceptible to gonorrhoea than others and in recent years the epidemic has grown.

“Gonorrhoea disproportionally affects gay and bisexual men who have, on average, a higher rate of partner change than their heterosexual peers. However, we’re now starting to see an increase of gonorrhoea among women and even a few cases in neonates.

It is also important to highlight that gonorrhoea rates are disproportionately high in remote Australian Indigenous communities. The epidemic in remote communities is likely to be different than among gay and bisexual men, as it is likely a result of lack of access to culturally appropriate healthcare in those communities,” says Dr Cornelisse.

There are several possible explanations as to why gonorrhoea rates are increasing. Dr Cornelisse suggests the shift may be related to changes in sexual practices that go in tandem with a higher rate of partner change.

“Younger gay and bisexual men kiss a larger proportion of their sexual partners and tend to contract gonorrhoea more than older members of the community. Similarly, among young heterosexual people, oral sex is now more commonly practised than it was a couple of decades ago. If kissing and oral sex are significant drivers of gonorrhoea transmission, then such changes in sexual practices may account for some of the rise in gonorrhoea diagnoses.”

Dr Cornelisse says that if people frequently change sexual partners, then gonorrhoea may be passed between several partners before one of them develops symptoms.

“It is possible that the advent of smartphone dating applications is allowing people to more easily find sexual partners, and this could be contributing to the rise in gonorrhoea rates. To compound this issue, our research has shown that gay and bisexual men who use dating apps also kiss a greater proportion of their sexual partners compared to those who don’t use these apps.

“Theoretically, the increase in gonorrhoea diagnoses could also be due to an increase in virulence of gonorrhoea strains, but we have no evidence to indicate that this may be occurring.”

As research evolves, the concept of ‘safer sex’ will evolve too. While using condoms for penetrative sex is still recommended to reduce the risk of many STIs, and is a very effective method to prevent the transmission of HIV, it is unlikely to eliminate the risk of transmission of bacterial STIs. In addition to using condoms, doctors still recommend regular STI screening, at least every three months for those with multiple sexual partners, early treatment and the use of commercially available lubricant for penetrative sex instead of saliva. Other new developments include the development of an antiseptic mouthwash to reduce the risk of pharyngeal gonorrhoea and research around a possible vaccine.

The research team at the Melbourne Sexual Health Centre, led by Dr Eric Chow, is currently running a large randomised controlled trial of a mouthwash to prevent pharyngeal gonorrhoea, after it was shown to be effective in vitro, and showed some promising results in a small in vivo pilot study.

Dr Cornelisse says it is too early to recommend this as an effective prevention strategy, although the only side effects of this intervention are healthy gums and fresh breath.

“There is renewed research interest in vaccination against gonorrhoea. A few years ago, New Zealand experienced an outbreak of meningococcal infections among young people, prompting a large-scale immunisation program. A subsequent case-control study of sexual health clinic attendees aged 15 to 30 years, found that people who had been immunised against Neisseria meningitides had a 31 per cent lower incidence of Neisseria gonorrhoeae compared to people who had not been immunised. Further vaccine investigation is planned.”
Why you’ll feel **invigorated, challenged** and **excited** after attending Congress 2018

Disruption is rapidly impacting physicians across all specialities, their patients, colleagues and workplaces. RACP Congress 2018 explores the many ways healthcare has changed, is changing and will need to change as a result of the far-reaching disruption taking place.

How disruption directly impacts physicians, how it affects their day-to-day practice and how physicians can talk to their teams and colleagues about this are just some of the questions Congress delegates can expect answers to.

That’s according to Congress 2018 Lead Fellow Dr David Beaumont. He and the Congress Program Committee have put together an inspiring and thought-provoking program that includes engaging sessions, workshops, demonstrations, exhibits, video presentations and social functions.

All are aiming to drive discussions and debate about emerging issues, as well as those that physicians have frequently encountered over the years.

“Disruption in healthcare is big picture stuff but we’ve been really careful to make sure Congress 2018 is relevant to coal-face physicians,” explains Dr Beaumont.

“That’s the day-to-day stuff that we’re all encountering.

“We’re a very diverse College so we’ve taken really good care to make sure that in every session we’ve got something for everybody so that it is of relevance to physicians and their practice.”

Dr Beaumont says physician and patient perspectives are embedded throughout Congress — giving delegates a unique opportunity to learn from experts in their fields at one event.

“Congress 2018 is ready to go. We’ve had great fun putting the program together.”

Disasters and mental health

THOUGHT PROVOKING TOPICS YOU CAN HEAR MORE ABOUT AT CONGRESS

Medically unexplained symptoms

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Medical assistance in dying

Artificial intelligence and other disruptive technology

Disasters and mental health

Indigenous child health

Medically unexplained symptoms

Disasters and mental health

Climate change and health
Mental health now ranks as the number one concern among young people, findings of the latest Mission Australia Youth Survey show.

Almost 24,000 young people aged 15 to 19 took part in the survey, which saw the number of youths ranking mental health as their biggest worry more than double since 2015 and triple since 2011.

Growing community awareness of mental health is a key reason behind the rising concern, according to paediatrician and adolescent medicine physician Dr Andrew Kennedy.

“Awareness of mental health issues has increased significantly amongst young people over the last decade or more, in part through organisations such as beyondblue, Reach Out, Headspace and others,” he says.

“With increased awareness comes increased recognition, so young people are more able to recognise things they are experiencing and seeing amongst friends and peers.”

A possible increase in the incidence of anxiety, depression and other mental health issues among adolescents could also be a reason behind the growing concern identified in the survey, Dr Kennedy says.

“The impact of mental health on overall health is significant.

“I see mental health and physical health as being inextricably linked, especially in the teenage years.

“Mental health problems such as depression, anxiety or even eating disorders can affect things like nutrition, exercise levels, sleep, school attendance, resilience, pain tolerance, relationships and self-esteem.

“They can also lead to risk taking behaviour including substance use and self-harm.”
Youth Survey

24,055 young people's values and concerns.

In 2017 Mission Australia conducted its 16th annual survey of young people aged 15-19. The survey is distributed nationally through schools and organisations and aims to identify young people’s values and concerns.

Equity and discrimination

Mental health

Alcohol and drugs

From 2015 to 2017 the proportion of those indicating mental health as a national concern rose from 14.9% to 33.7%.

Top issues identified in Australia today all have increased since 2015.

Top 3 barriers

Over half (51.6%) indicated that there would be barriers to achieving their study or work goals after school.

Academic ability

Finanical difficulty

Mental health

Young people who took part in the survey ranked alcohol and drugs as their second biggest concern, with the number of youths worried also rising since the previous survey.

“This indicates to me more young people are feeling stressed,” Dr Kennedy says.

“I suspect it [the survey finding] reflects increased knowledge of alcohol and drugs as potential health issues.

“Also, if young people are exposed to alcohol and drugs, or seeing others experiencing problems then they’re likely to be concerned.”

Pressure to do well at school or with further study is a key driver of mental ill health in young people, Dr Kennedy believes.

“In the patients I see, who are stressed and recognise their stress, the vast majority say pressure to do well at school or in exams is a major contributor.

“The level of stress rises with each school year and, in my experience, has increased significantly over the last few years.

“This stress leads to mental health issues such as anxiety and depression.”

Dr Kennedy says bullying, social exclusion, family stress and body image issues all contribute to the growing mental health concern among young people.

“Increased awareness and knowledge is a good thing and in itself helpful, but young people need to know how and where to seek help and know that resources are actually there and that they will get help in a non-judgmental and confidential way,” he explains.

“In terms of managing their own mental health, I think it can mostly be done by positive things such as ensuring good levels of exercise and sleep, coupled with good nutrition.

“Young people could and should be taught basic stress management strategies. However I think it is more important they are encouraged to seek professional help rather than put pressure on themselves by believing they should manage it on their own.”

Mission Australia Chief Executive Officer James Tomey said the organisation shares survey results to inform the development of policies, services and programs that have the needs of young people at their core.

“If we better understand the hopes, fears and everyday realities that young people face, we will be better equipped to celebrate their achievements with them, support them through difficult times and help them realise their aspirations as they make their journey into adulthood and independence,” he said. RQ.
Doctors have published a new guide on pregnancy in the workplace to provide advice for pregnant women and mothers returning to work and to help medical practitioners and employers understand and meet their responsibilities.
The Guide to Pregnancy and Work, developed by the Australasian Faculty of Occupational and Environmental Medicine (AFOEM), a Faculty of the Royal Australasian College of Physicians, highlights the benefits of a supportive workplace.

Dr Caron Jander is an occupational health physician who led the development of the Guide with Dr Robin Chase. Dr Jander’s research started in the early 1990s when she was doing a sports medicine qualification and her thesis for her doctorate was in sports medicine and the effects of exercise on breastmilk production.

Her research began to look more broadly at the impacts of returning to work and possible health hazards.

“When you’re pregnant, you’re not sick but you’re not healthy either and there are factors you need to consider to make the pregnancy easier,” Dr Jander explains. “You have the worker, the workplace and the work, and you’re trying to match the environment as you’re transitioning during pregnancy and when you’re returning to work.”

Fear is a common emotion experienced during pregnancy and when a woman is pregnant there can be consequences.

“There’s a lot of uncertainty in that period. They’re facing the consequence of the pregnancy, the initial fatigue, the initial uncertainty of whether their pregnancy will go to term,” Dr Jander says.

“When we walk into the office, our subconscious doesn’t go away. Some people ask: ‘Do I tell people? How much work involvement should I have?’ If you work in a factory and your job is physically demanding, do you mention you can’t work as close to a conveyor belt if you have a pregnant belly? Flying for executives is an issue.

“These issues can have an impact on the ability, capacity and sometimes desire to continue to work.

“There’s the emotional side of pregnancy as well as the physical demands to consider. Is it a pregnancy that is precious, have you been through IVF? Is it an unwanted pregnancy? These issues often have an impact.”

It’s important for pregnant women and their employers to have realistic expectations during pregnancy, Dr Jander explains.

“During pregnancy, more than ever, you need to trust your instincts if something doesn’t feel right. I can’t emphasise enough the importance of listening to your body, working with your body, knowing your body and when in doubt, ask.

“There comes a point when doing certain things, is no longer advisable. I’ve been a doctor in a rugby team, whilst pregnant, and at some point, running onto the field became difficult. You need to find a balance, you are growing a baby that is depleting you from within, you need to have realistic expectations and this can be quite hard for ambitious women.

“Pregnancies can be unpredictable where things don’t go according to plan, and it’s important to know asking for help is not a sign of weakness.”

She said it was important employers offered an accommodating environment by making necessary adjustments to support a healthy pregnancy.

“If you’re an employer, look at a general workplace and the ergonomics. Consider using upstanding desks to increase circulation and ensure a cool environment. Consider altering rest breaks to accommodate a pregnant worker.”

Expectations may also need to adjust in relation to an employee’s productivity.

“Perhaps you need to look at key performance indicators as they can change during pregnancy

“A healthy baby, comes with a healthy mind and a healthy mum. We talk about the health benefits of work, the need to keep skills up and social interaction. You may have a transition phase where you don’t go back to a high powered corporate role and during this time it’s important that transitional roles are offered.”
Encourage transparent and open communication so that people aren’t afraid to stick their hand up if they need help. The workplace needs to be supportive, not punitive.”

She says it’s essential that employers provide a safe space for breastfeeding mothers.

“One of the most common reasons that women stop breastfeeding is because they need to return to work, so employers need to provide a safe environment for women to express breast milk and cool environments to store breast milk,” she says.

Employees and employers should devise a realistic transition back to work and a return to work plan.

“A healthy baby, comes with a healthy mind and a healthy mum. We talk about the health benefits of work, the need to keep skills up and social interaction. You may have a transition phase where you don’t go back to a high powered corporate role and during this time it’s important that transitional roles are offered. This could mean more flexibility during school hours, or working three days a week.”

Employees also need to have realistic expectations of themselves.

“Parents need to realise that pregnancy is not like an aspirin to water,” she says. “The whole road is unpredictable and for working women who are so used to being in control of their world, suddenly their sleep patterns can get turned upside down and it’s hard to adjust.

“A child doesn’t come with an instruction manual. Be aware that your entire home environment changes. You also have a lot of people giving advice and the confusion is enormous because everything you knew before has changed.

“Children are lent to us for such a short period of time and as parents we should enjoy them. It’s all about balance and it’s only as hard as we make it.

“A workplace is more than just a place of work, but also a social place where the pregnant mum can not only benefit from the support and collective wisdom of peers, colleagues and management but also continue to live an important element of her ‘before children’ life. It is also an opportunity for the employer to demonstrate its nurturing side and to walk the talk of its people value statements and policies: what support can be expected when one’s personal circumstances change?”

The Guide to Pregnancy and Work supports Health Benefits of Good Work, an AFOEM initiative that is based on compelling Australasian and international evidence that good work is beneficial to people’s health and wellbeing.

In addition to giving practical advice, the Guide outlines workplace policies and procedures regarding pregnancy at work that are non-discriminatory, flexible and comply with relevant legislation.

It has been endorsed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
RACP New Zealand Trainees’ Day 2018

Get connected
Be inspired

Saturday, 7 April 2018
The Heritage, Queenstown

www.nztraineesforum.org.nz
‘Challenging’ is a term that often first comes to mind for many specialists considering careers in regional Australia. But for Associate Professor Sophia Couzos, ‘rewarding’ is a more accurate description of living and delivering specialist healthcare in regional communities.

Working in regional or remote communities as a graduate was something Associate Professor Couzos knew she wanted to do when she was an undergraduate medical student in Melbourne. “I completed my Fellowship in Broome and now practice in Townsville,” she says. “These were easy decisions to make because my professional interests were primarily about reducing health inequities.”

Training in metropolitan and rural hospitals, and working for an organisation based in Canberra whilst still living in remote Australia reinforced her decision to practise outside metropolitan areas, Associate Professor Couzos says.

“I don’t see any challenges working in a regional setting but when asked if I do, I encourage people to reverse the question and ask themselves ‘what are the challenges you might face if you worked in a metropolitan setting?’”

“I found the sense of isolation is much greater in metropolitan environments as are limitations to the scope of practise and of health problems that are managed.”

Associate Professor Couzos now works as a public health physician and academic general practitioner with the College of Medicine and Dentistry at James Cook University. She believes regional and remote environments foster a greater sense of teamwork and professional
satisfaction that comes with managing diverse health issues.

“There is tremendous scope for innovation and a professional incentive to exercise more patient-centredness and engagement when working with regional and remote populations.

“Deciding to work in remote and regional Australia was one of the best decisions of my life.

“It’s been 30 years since graduation and I couldn’t imagine an alternative future in the city that could have been more professionally and personally rewarding.”

Passion, purpose and experience always prompts Associate Professor Couzos to ask trainees she meets to seriously consider careers in regional areas.

“Trainees unsure where they should look for jobs should consider moving away from big cities,” she says.

“A short visit to a regional or remote community does not make you informed about local health needs, community or socio-political issues.

“The career scope in regional and remote Australia is limitless and hugely satisfying.”

Associate Professor Couzos’s sentiments are shared by Dr Louis Baggio, who works as Director of Rehabilitation at the Wagga Wagga Rural Referral Hospital.

“I began my medical career as a GP and have been in Wagga Wagga since 1986,” he says.

“I was approached to consider a career change to rehabilitation medicine in 2004. So, began my training and four years later I was a rehabilitation physician.

“While geography and workforce, particularly recruitment of clinicians, can be challenging – the lifestyle working in sub-acute medicine in regional Australia suits me.

“Specialists working in regional communities are exposed to, and ultimately have to manage a diverse range of clinical scenarios”, Dr Baggio says.

“We have many opportunities to work outside our comfort zone and increase our skills.

“I would encourage every trainee to consider undertaking a rotation in regional or remote Australia.”

HOW EVENTS ARE SUPPORTING EDUCATION EFFORTS

Training orientation days, forums, workshops, meetings, conferences and award competitions are some of the events RACP regional office teams deliver for members across Australia and New Zealand.

By managing these events, the regional offices are giving specialists the opportunity to gather together, learn from each other and promote ongoing professional development.

Major events happening in 2018 include:

- Northern Territory Annual Scientific Meeting
- Tasmanian Physicians’ Conference
- Western Australia Rural Physicians’ Workshop.

Visit racp.edu.au to see a full list of upcoming events.
Until now, much of the publicity about health and wellbeing in medicine has concerned trainees and junior medical officers in general. But the RACP continues to look at the potential of other points during an entire career that can put pressure on a specialist’s emotional health and state of mind.

As background, a concern with physician health and wellbeing at the RACP in fact predates much of the media focus over the last 18 months concerning bullying, harassment and arduous working conditions across the entire medical profession.

As early as 2013 the RACP released its Health of Doctors position paper developed by the Australasian Faculty of Occupational and Environmental Medicine.

We’ve actively participated in the biannual Doctors Health Conference over many years, and considered the implications of beyondblue’s research into the mental health of doctors.

Active conversations about this issue continue in our Fellowship Committee, Trainees’ Committee, our Board, and the Tri-nation Alliance as well as the Council of Presidents of Medical Colleges.

As a result, multiple resources have been developed to support members’ health and wellbeing: https://www.racp.edu.au/fellows/resources/physician-health-and-wellbeing. Recently, the RACP held its first Physician Health and Wellbeing Reference Group meeting, with senior Fellows from all Divisions, Faculties and Chapters, and College staff attending.

With the College’s Health and Wellbeing Strategy signed off by the Board, the Reference Group is now putting it into practice.

“We’re building on the wellbeing work underway at the College, but also ensuring the strategic road map and action plan for health and wellbeing are implemented,” says Dr Alasdair MacDonald, Reference Group Chair.

“This group aims to influence the development of a culture which recognises early that a doctor needs support and provides appropriate support.”

One of the key themes that has emerged concerns career transition points.

“Health and wellbeing is not just an issue for trainees, there are other transition points during a Fellow’s career where wellbeing is important,” Dr Kate More, Director Fellowship Relations, told the meeting.

In a 2013 beyondblue study, conducted in Australia with nearly 50,000 medical professionals, male doctors as an occupational group exhibited three times the levels of psychological distress as the general population, with female doctors citing psychological distress at nearly double the rate of the general population. Female doctors were particularly prone to being diagnosed with depression.
The beyondblue data shows that middle-aged doctors have significant difficulty maintaining their wellbeing. There are stressors associated with setting up a practice, having a family and childcare that have an impact on how people cope at work.

Transitions such as admission to Fellowship, setting up a practice and transitioning to retirement, are times when practising specialists say they need help championing their health and wellbeing.

Current medical workplace cultures and dynamics can impose additional pressures on practising Fellows at these points according to consultant psychologist Sal Lauder, who briefed the meeting.

“The workplace is now more competitive and less collegiate than in the past, and doctors no longer have the same support networks and opportunities to debrief,” she explains. As healthcare services and training programs have increased in size, some peer support systems and integration of training programs have been lost.

Fellows who attended commented that doctors’ denial about the state of their own health and wellbeing, and reluctance to seek help, can also pose a risk to patient safety.

This is an important issue in the 65 to 75-year-old age group because, as people age, they lose cognitive flexibility not just physical procedural ability.

Physician health and wellbeing from Basic Training through to transition to retirement will continue to be highlighted by our College during the coming year.

Further collaboration with other colleges through the Committee of Presidents of Medical Colleges, as well as organisations like the Black Dog Institute and beyondblue, are being considered by the Reference Group.

The subject also formed the theme of the March meeting in Sydney of the International Medical Symposium titled Mauri ora: connecting health professionals’ wellbeing and quality care, where more than 200 delegates from a range of medical disciplines attended. RQ.

“In such environments, she highlighted leadership as having an impact on the preparedness of doctors to seek help.

Good medical leaders should be vulnerable and be able to demonstrate success despite vulnerability. Trainees should also be able to show that they are not impervious to stress. Local champions are important from the perspective of trainees and medical students.

“Health and wellbeing is not just an issue for trainees, there are other transition points during a Fellow’s career where wellbeing is important”
Mark your calendars and apply for leave as the RACP New Zealand Trainees’ Day is a professional development opportunity not to be missed. If you are an RACP trainee, this event is for you. Whether you are a Basic or Advanced Trainee, we have designed an inspiring program relevant for wherever you are in your training journey and whatever your specialty.

Saturday, 7 April 2018
The Heritage, 91 Fernhill Road, Queenstown
Various costs apply
www.nztraineesforum.org.nz

AFOEM ATM in conjunction with the RACP Congress each year. Trainees of the Faculty come together to learn, share, and network. The ATM provides trainees with invaluable experience and knowledge, and will be held across three days. The ATM is an integral part of the AFOEM training program with breakout sessions at this year’s ATM tailored to all stages of training.

Friday, 11 May to Sunday, 13 May 2018
RACP, 52 Phillip Street, Sydney
$660

This workshop has been designed to assist supervisors with creating a culture for learning, and delivering effective feedback, particularly in difficult situations.

Saturday, 12 May 2018
Dexus Place, 1 Farrar Place, Sydney
Complimentary to registered RACP Supervisors

RACP Trainees’ Day 2018 is an important event on the calendar for all trainees. The program will focus on you, your issues and issues that will affect your future career and practices.

Sunday, 13 May 2018
RACP, 52 Phillip Street, Sydney
$150
www.racpcongress.com.au
**Chapter of Community Child Health Satellite Day**

Sunday, 13 May 2018
Karstens, 111 Harrington St, The Rocks, NSW, 2000
Various costs apply

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**New Fellows’ Forum**

Making the change from being a trainee to a Fellow offers a number of opportunities to continue learning and building positive relationships.

Join us at the New Fellows’ Forum, taking place the day before RACP Congress 2018, where you can not only meet other specialists who are entering the world of being a consultant, but also participate in sessions that will provide you with tips to assist you in your career.

Sunday, 13 May 2018
RACP, 52 Phillip Street, Sydney
Free

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**Supervisor Professional Development Program workshop 2: Teaching and learning in healthcare settings**

The main themes of the workshop include dealing with the many challenges supervisors face: lack of time, pressure from the increasing number of trainees, and balancing service commitments with teaching. This workshop then focuses on a range of teaching strategies to deal with these challenges including planning for learning and teaching multi-level groups.

Sunday, 13 May 2018
Dexus Place, 1 Farrar Place, Sydney
Complimentary to registered RACP Supervisors

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**Supervisor Professional Development Program workshop 3: Work-based learning and assessment**

The workshop covers goal setting and gathering evidence about trainees using the PREP tools in order to give the trainee feedback on their performance. The challenges for supervisors to integrate work-based learning and assessment into the workflow are addressed along with practical strategies that can be used to help this become part of practice.

Sunday, 13 May 2018
Dexus Place, 1 Farrar Place, Sydney
Complimentary to registered RACP Supervisors

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**RACP Congress 2018 – Disruption for Healthy Futures**

As the premier annual event on the RACP calendar, Congress includes the College’s Convocation Ceremony as well as a diverse program with topics that span the breadth of the medical industry.

RACP Congress 2018 will be faster with more interactive stream sessions using TED style talks, workshops, video presentations and new technologies.

Monday, 14 to Wednesday, 16 May 2018
International Convention Centre Sydney, 14 Darling Drive
Various costs apply
www.racpcongress.com.au

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2018 scholarships, fellowships and grants
The RACP Foundation would like to acknowledge and congratulate the following award recipients.

**Career Development Fellowship**

These fellowships are intended to encourage and support established researchers who completed their research higher degree over seven years ago.

<table>
<thead>
<tr>
<th>AWARD RECIPIENT</th>
<th>AWARD</th>
<th>AWARD VALUE</th>
<th>PROJECT</th>
<th>INSTITUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Peter Psaltis</td>
<td>RACP Fellows Career Development Fellowship</td>
<td>$100,000</td>
<td>A novel role for Adventitial Macrophage Progenitor Cells (AMPCs) in providing a local source of macrophages in atherosclerosis</td>
<td>South Australian Health and Medical Research Institute</td>
</tr>
</tbody>
</table>

**Research Establishment Fellowships**

These fellowships are available to Fellows and trainees who wish to establish themselves as researchers and who are either within seven years of having completed a Masters, PhD or equivalent higher research degree, or who have a research higher degree and are within two years of returning from working or studying overseas.

<table>
<thead>
<tr>
<th>AWARD RECIPIENT</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Dr Craig Wallington-Beddoe</td>
<td>The Servier Staff “Barry Young” Research Establishment Fellowship</td>
<td>$50,000</td>
<td>Targeting sphingolipid metabolism to re-sensitise proteasome inhibitor resistant multiple myeloma</td>
<td>The University of South Australia</td>
</tr>
<tr>
<td>Dr Mark Ng Tang Fui</td>
<td>Endocrine Society of Australia (ESA) Research Establishment Fellowship</td>
<td>$50,000</td>
<td>Effects of testosterone treatment in men on bone microarchitecture, bone turnover markers, bone density and regulation of fat-derived genes</td>
<td>Dept. Medicine, Austin Health, University of Melbourne</td>
</tr>
<tr>
<td>Dr Kathleen Morrisroe</td>
<td>RACP Australian Rheumatology Association (ARA) and DEV Starr Research Establishment Fellowship</td>
<td>$50,000</td>
<td>Quantifying the burden of cancer in systemic sclerosis: A data linkage study</td>
<td>St Vincent’s Hospital, Melbourne</td>
</tr>
<tr>
<td>Dr Christopher Moran Croxon Research Establishment Fellowship for Alzheimer’s Disease Research</td>
<td>$75,000</td>
<td>Alzheimer’s Disease, Type 2 Diabetes and Neuroinflammation</td>
<td>Monash University</td>
<td></td>
</tr>
<tr>
<td>Associate Professor Jake Shortt</td>
<td>The Robert Maple-Brown Research Establishment Fellowship on Haematology</td>
<td>$60,000</td>
<td>Single-cell genomic interrogation of poor-risk Hodgkin lymphoma to annotate intraclonal heterogeneity and evolution at relapse</td>
<td>Monash University</td>
</tr>
<tr>
<td>Associate Professor Thomas Snelling</td>
<td>RACP Fellows Research Establishment Fellowship</td>
<td>$75,000</td>
<td>AuTOMATIC: Adaptive Trial of Messaging to Improve Vaccine Coverage</td>
<td>Telethon Kids Institute</td>
</tr>
<tr>
<td>Professor Cassandra Szoeke</td>
<td>Robert Maple-Brown Research Establishment Fellowship</td>
<td>$60,000</td>
<td>The influence of timing and duration of exposure to midlife risk factors on late life cognition</td>
<td>The University of Melbourne</td>
</tr>
<tr>
<td>Dr Sant-Ryan Pasricha</td>
<td>Cottrell Research Establishment Fellowship</td>
<td>$75,000</td>
<td>Effect of Iron Supplements and Multiple Micronutrient Powders on intestinal microbiota and health in young children: A sub-study of an RCT in Bangladesh (BRISC-Microbiome)</td>
<td>Walter and Eliza Hall Institute of Medical Research</td>
</tr>
<tr>
<td>Dr Rishi Kotecha</td>
<td>The Kids’ Cancer Project Research Establishment Fellowship</td>
<td>$180,000 (over 2 years)</td>
<td>Combinatorial therapeutics in high-risk infant acute lymphoblastic leukaemia</td>
<td>Telethon Kids Institute</td>
</tr>
</tbody>
</table>
Discovering ways to help children with kidney disease live longer and healthier lives is what Dr Anna Francis hopes to achieve as part of her PhD studies at the University of Sydney.

“We know that children with end stage kidney disease have a 30 times higher annual risk of mortality, when compared to children in the general population,” said Dr Francis, a paediatric nephrologist and 2018 RACP Jacquot Research Entry Scholarship recipient.

“These children also experience a range of other adverse health and psychosocial effects.”

Dr Francis said her research aims to identify modifiable risk factors for mortality and decreased quality of life.

“We’re hoping this will lead to decreased morbidity and mortality for this vulnerable group of children,” she said.

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**AWARD RECIPIENT** | **AWARD** | **AWARD VALUE** | **PROJECT** | **INSTITUTION**
--- | --- | --- | --- | ---
Dr Helen LG Barrett | Diabetes Australia Research Establishment Fellowship | $50,000 | Maternal and infant microbiome in women with pregnancies complicated by type 2 diabetes mellitus | The University of Queensland
Dr Bridget Barber | AstraZeneca Research Establishment Fellowship | $60,000 | The effect of regularly dosed paracetamol on renal function in Plasmodium knowlesi malaria | Menzies School of Health Research
Dr George Au-Yeung | RACP GlaxoSmithKline Research Establishment Fellowship | $40,000 | Investigating the immune landscape and gene expression profile of end-stage high grade serous ovarian cancer | Peter MacCallum Cancer Centre
Dr Ada Sau-Zhu Cheung | Vincent Fairfax Family Foundation Research Establishment Fellowship | $60,000 | Bone and metabolic health in trans and gender diverse individuals receiving testosterone or oestrogen as cross-sex hormone therapy | The University of Melbourne
Dr Kate Markey | *RACP Research Establishment Fellowship | $50,000 | The influence of the microbiome on outcomes of bone marrow transplantation | Memorial Sloan Kettering Cancer Center, New York
Dr Priya Sumithran | *RACP Research Establishment Fellowship | $50,000 | Identifying biomarkers of excessive gestational weight gain | The University of Melbourne
Dr Nay Min Htun | *RACP Research Establishment Fellowship | $50,000 | Innovative methods for detection and stabilisation of unstable atherosclerotic plaques | Baker Heart and Diabetes Institute

* One of three new Fellowships made possible thanks to the generosity of College members and Life Fellows

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Dr Anna Francis FRACP

Discovering ways to help children with kidney disease live longer and healthier lives is what Dr Anna Francis hopes to achieve as part of her PhD studies at the University of Sydney.

“We know that children with end stage kidney disease have a 30 times higher annual risk of mortality, when compared to children in the general population,” said Dr Francis, a paediatric nephrologist and 2018 RACP Jacquot Research Entry Scholarship recipient.

“These children also experience a range of other adverse health and psychosocial effects.”

Dr Francis said her research aims to identify modifiable risk factors for mortality and decreased quality of life.

“We’re hoping this will lead to decreased morbidity and mortality for this vulnerable group of children,” she said.
Dr Mark Ng Tang Fui FRACP

How testosterone treatment reduces fat mass and affects bone fragility in obese men is the focus of research being undertaken by Dr Mark Ng Tang Fui. A clinical trial involving more than 1000 men – the largest of its kind in the world – forms the basis of his research.

The inaugural RACP and Endocrine Society of Australia Research Establishment Fellowship has made Dr Ng Tang Fui’s work possible.

“This builds on an initial randomised controlled trial I conducted as part of my PhD,” Dr Ng Tang Fui said.

“I hope to publish the findings of my work in high impact journals in the field of obesity, diabetes, bone health and internal medicine.

“The findings of my work will be directly applicable to patients under my care at the Men’s Health Clinic, Austin Health and other clinicians managing men with low testosterone levels.”

The Jacquot Awards

These awards are jointly administered by the RACP and the Australian and New Zealand Society of Nephrology. They are offered to further research in the field of nephrology.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Dr Anna Francis</td>
<td>RACP Jacquot Research Entry Scholarship in Nephrology</td>
<td>$45,000</td>
<td>Improving the long term outcomes of children with chronic kidney disease</td>
<td>The University of Sydney</td>
</tr>
<tr>
<td>Dr Prasanti Kotagiri</td>
<td>RACP Jacquot Research Entry Scholarship in Nephrology</td>
<td>$40,000</td>
<td>A biomarker and pathway discovery program in autoimmune renal diseases</td>
<td>University of Cambridge (England)</td>
</tr>
<tr>
<td>Dr Amali Mallawaarachchi</td>
<td>RACP Jacquot Research Entry Scholarship in Nephrology</td>
<td>$45,000</td>
<td>Molecular Pathogenesis of Inherited Kidney Disease</td>
<td>The Garvan Institute of Medical Research</td>
</tr>
<tr>
<td>Dr Ankit Sharma</td>
<td>RACP Jacquot Research Entry Scholarship in Nephrology</td>
<td>$40,000</td>
<td>The impact of de novo donor specific antibodies and eplet matching in kidney transplantation</td>
<td>The University of Sydney</td>
</tr>
<tr>
<td>Dr Michael Collins</td>
<td>Jacquot Research Establishment Fellowship</td>
<td>$90,000</td>
<td>The BEST Fluids Study: Better Evidence for Selecting Transplant Fluids</td>
<td>Auckland District Health Board</td>
</tr>
<tr>
<td>Dr Andrew Mallet</td>
<td>Jacquot Research Establishment Fellowship</td>
<td>$90,000</td>
<td>Bringing genomics of inherited tubulointerstitial and cystic kidney diseases into clinical practice in Australia</td>
<td>The University of Queensland</td>
</tr>
<tr>
<td>Dr Natasha Rogers</td>
<td>Jacquot Research Establishment Fellowship</td>
<td>$90,000</td>
<td>Investigating new molecular pathways in acute kidney injury that are regulated by CD47</td>
<td>Westmead Institute for Medical Research</td>
</tr>
</tbody>
</table>
### Research Entry Scholarships

These scholarships assist Fellows and trainees who are at the start of their research careers and who are enrolled or about to enrol in a Masters, PhD or equivalent higher research degree.

<table>
<thead>
<tr>
<th>Award Recipient</th>
<th>Award</th>
<th>Award Value</th>
<th>Project</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Sara Hungerford</td>
<td>RACP Fellows Research Entry Scholarship</td>
<td>$45,000</td>
<td>Comparison of minimally invasive mitral valve replacement with percutaneous mitral valve replacement and open mitral valve replacement for the correction of severe mitral regurgitation</td>
<td>The University of New South Wales</td>
</tr>
<tr>
<td>Dr Annie Wong</td>
<td>New Zealand Odlin Research Entry Scholarship</td>
<td>NZ$45,000</td>
<td>Novel Biomarkers for melanoma immunotherapy</td>
<td>University of Melbourne</td>
</tr>
<tr>
<td>Dr Emma Foster</td>
<td>Vincent Fairfax Family Foundation Research Entry Scholarship</td>
<td>$10,000 shared funding</td>
<td>First Seizure Assessment and Management</td>
<td>Monash University</td>
</tr>
<tr>
<td>Dr Kajal Hirani</td>
<td>Vincent Fairfax Family Foundation Research Entry Scholarship</td>
<td>$20,000 shared funding</td>
<td>The medical and psychosocial health of adolescent refugees resettling in Western Australia</td>
<td>University of Western Australia</td>
</tr>
<tr>
<td>Dr Michelle Scoullar</td>
<td>Basser Research Entry Scholarship</td>
<td>$45,000</td>
<td>Newborn Health in Papua New Guinea</td>
<td>Burnet Institute</td>
</tr>
<tr>
<td>Dr Samantha Herath</td>
<td>Arnott Research Entry Scholarship in Cancer Research</td>
<td>$45,000</td>
<td>Randomised controlled trial comparing the diagnostic yield of CT guided transthoracic biopsy vs. cryobiopsy (via the radial endobronchial ultrasound guide sheath) in parenchymal pulmonary lesions suspected of lung cancer (CT CROP)</td>
<td>The University of Sydney</td>
</tr>
<tr>
<td>Dr Karen Chia</td>
<td>RACP AFRM Research Entry Scholarship</td>
<td>$45,000</td>
<td>The effect of an outpatient exercise training rehabilitation program on haemodynamics and cardiac magnetic resonance parameters of right ventricular function in patients with Pulmonary Arterial Hypertension (PAH)</td>
<td>The University of New South Wales</td>
</tr>
</tbody>
</table>

### RACP National Health & Medical Research Council Awards for Excellence

The National Health & Medical Research Council (NHMRC) and the RACP have partnered to support the top young clinical researchers with an Award for Excellence, as part of a shared commitment to nurture the next generation of medical researchers. Each recipient will receive $10,000 per annum for up to three years in addition to the NHMRC Scholarship.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Dr Anastasia Phillips</td>
<td>RACP NHMRC JJ Billings Scholarship</td>
<td>$10,000</td>
<td>Population-level vaccine safety monitoring: risk assessment and policy implications</td>
<td>The University of Sydney</td>
</tr>
<tr>
<td>Dr Anoop Koshy</td>
<td>RACP NHMRC CRB Blackburn Scholarship</td>
<td>$10,000</td>
<td>Cardiovascular Dysfunction in Advanced Liver failure &amp; after Liver Transplantation</td>
<td>University of Melbourne</td>
</tr>
<tr>
<td>Dr Lironne Wein</td>
<td>RACP NHMRC Kincaid-Smith Scholarship</td>
<td>$10,000</td>
<td>Incorporating genomics into breast cancer management</td>
<td>The Peter MacCallum Cancer Centre</td>
</tr>
<tr>
<td>Dr Robert Anderson</td>
<td>RACP NHMRC Woolcock Scholarship</td>
<td>$10,000</td>
<td>A prospective multicentre randomized study to evaluate the impact of OSA treatment with CPAP on atrial electrical and structural substrate and on long term maintenance of sinus rhythm following catheter ablation of atrial fibrillation</td>
<td>Royal Melbourne Hospital</td>
</tr>
</tbody>
</table>
New global research being undertaken by RACP Fellow Dr Simon Crouch is examining how countries manage emerging infectious disease risks such as Middle East respiratory syndrome.

Analysing and comparing preparedness and response approaches adopted by Australia and the United States of America (USA) is the core focus of Dr Crouch’s work.

To inform his research, Dr Crouch will travel to the USA in July for a four-month placement at the Centers for Disease Control and Prevention (CDC) — a world leader in developing policies and guidance around communicable disease threats.

“I have been offered a guest researcher position with the National Center for Emerging and Zoonotic Diseases at the CDC,” Dr Crouch, a Fellow of the Australasian College of Public Health Medicine, said.

“The time I spend at the CDC reflecting on how we currently prepare for emerging infectious diseases and learning from their experiences will further strengthen our response, protecting the health of Australians.”

Dr Crouch said a Robert and Elizabeth Albert Travel Grant from the RACP Foundation “demonstrates the importance of the project and helps colleagues at the CDC to see that this work is supported by one of Australia’s leading medical colleges”.

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### 2018 Research Development Grants

These grants provide funding for smaller projects undertaken by Fellows and trainees.

<table>
<thead>
<tr>
<th>AWARD RECIPIENT</th>
<th>AWARD</th>
<th>AWARD VALUE</th>
<th>PROJECT</th>
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</thead>
<tbody>
<tr>
<td>Dr Paul Leong</td>
<td>RACP NHRMC Dixon Award for Excellence</td>
<td>$10,000</td>
<td>Pulmonary artery pulsatility as a predictor of survival following hospitalised exacerbation of Chronic Obstructive Pulmonary Disease</td>
<td>Monash University</td>
</tr>
<tr>
<td>Dr Katherine Frayman</td>
<td>RACP P&amp;CHD NHMRC Scholarship</td>
<td>$10,000</td>
<td>Long term outcomes following early infection and inflammation in cystic fibrosis lung disease</td>
<td>Murdoch Children’s Research Institute</td>
</tr>
<tr>
<td>Dr Lani Shochet</td>
<td>RACP Jacquot NHMRC Award for Excellence</td>
<td>$10,000</td>
<td>Defining the pathogenesis of PR3-ANCA associated vasculitis</td>
<td>Monash University</td>
</tr>
<tr>
<td>Dr Emily See</td>
<td>RACP Jacquot NHMRC Award for Excellence</td>
<td>$10,000</td>
<td>Long-term sequelae of acute kidney injury: identifying the optimal model of care and intervention to enhance patient outcome</td>
<td>University of Melbourne</td>
</tr>
<tr>
<td>Dr Kate Robson</td>
<td>RACP Jacquot NHMRC Award for Excellence</td>
<td>$10,000</td>
<td>Regulatory T Cells and HLA Associations in Autoimmune Renal Disease</td>
<td>Monash University</td>
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<th>AWARD RECIPIENT</th>
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<tbody>
<tr>
<td>Dr Louise Tofts</td>
<td>RACP AFRM Research Development Scholarship</td>
<td>$10,000</td>
<td>Changes In Physical Function Of Young Persons With Longitudinal Fibular Deficiency</td>
<td>Kids Rehab The Children’s Hospital at Westmead</td>
</tr>
</tbody>
</table>
Dr Angela dos Santos, Advanced Trainee

Support offered through the RACP Foundation’s Indigenous Health Scholarship is assisting Dr Angela dos Santos while she is undertaking Advanced Training in neurology.

A term at the Wagga Wagga Rural Referral Hospital in early 2017 gave Dr dos Santos a fantastic opportunity to conduct a study on stroke risk factors among Indigenous Australians.

“There are many articles that address stroke and stroke risk factors, potentially hundreds. But in my literature review the articles that correctly address all the potential factors did not identify Indigenous Australians,” Dr dos Santos says.

“We know the commonest cause of stroke in non-Indigenous people is age, so if Indigenous people die 10 years younger than non-Indigenous people then surely this statement cannot be true for Indigenous Australians.

“Correctly identifying the commonest risk factor and potentially instituting medical interventions to prevent or cure this factor could curb the Indigenous stroke risk,” she explains.

The Scholarship also enables Dr dos Santos to attend the upcoming 2018 RACP Congress in Sydney. She hopes to use this opportunity to connect with like-minded people and further her research ideas.

2018 Travel Grants

These grants support short periods of research or study. They may be used to cover travelling or re-establishment costs for those taking up a postdoctoral fellowship overseas, or fees for those wishing to pursue further education.

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<tr>
<th>AWARD RECIPIENT</th>
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<th>AWARD VALUE</th>
<th>PROJECT</th>
<th>INSTITUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Pierre Qian</td>
<td>Bushell Travelling Fellowship in Medicine or the Allied Sciences</td>
<td>$30,000</td>
<td>Intramural Mapping and Ablation of Ventricular Tachycardia Substrate in Patients with Cardiomyopathy</td>
<td>Brigham and Women’s Hospital, Harvard Medical School</td>
</tr>
<tr>
<td>Dr Simon Crouch</td>
<td>Robert and Elizabeth Albert Travel Grant</td>
<td>$10,000</td>
<td>A comparative analysis of emerging infectious disease policies in Australia and the United States of America: a case study of Middle East respiratory syndrome coronavirus preparedness</td>
<td>Victorian Government Department of Health and Human Services</td>
</tr>
<tr>
<td>Dr Olivia Kemp</td>
<td>Richard Kemp Memorial (Travelling) Fellowship</td>
<td>$5,000</td>
<td>The Transplantation Infectious Disease and Compromised Host Fellowship Program</td>
<td>Massachusetts General Hospital</td>
</tr>
</tbody>
</table>

2018 Indigenous Health Scholarships

The RACP Indigenous Health Scholarship Program encourages medical graduates in Australia and New Zealand, who identify as being of Aboriginal, Torres Strait Islander or Māori heritage, to undertake specialist training.

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<tr>
<th>AWARD RECIPIENT</th>
<th>AWARD</th>
<th>TRAINING</th>
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<tbody>
<tr>
<td>Dr Angela dos Santos</td>
<td>College Indigenous Health Scholarship</td>
<td>Advanced Trainee Neurology</td>
</tr>
<tr>
<td>Dr Matthew Mackey</td>
<td>New Zealand Indigenous Health Scholarship</td>
<td>Advanced Trainee Cardiology</td>
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</tbody>
</table>
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Emeritus Professor Frederick Ehrlich OAM, MB BS, MA, PHD, FRCS (ENG), FRCS (ED), MRCPSYCH, DPRM (RACP), FAFRM, MACLM

Frederick Ehrlich, who passed away in early November at the age of 85, was a most remarkable person, truly one of a kind.

He was born in 1932 in Czernowitz (Chernivtsi), then in Romania, but now part of Western Ukraine. As a penniless young survivor of the Holocaust, Fred came to Sydney in late 1947 with minimal English language, and with just two years of schooling at North Sydney Boys High, he left school as Dux, and gained a scholarship entry to Sydney University Medical School. In the course of hospital experience in Australia and in England, Fred met his wife Shirley, and completed his orthopaedic and general surgical training within ten years of first arriving in Australia. Fred always called this time his miraculous decade.

To his surgical Fellowships, Fred later added qualifications in psychiatry and rehabilitation medicine. Active in medicolegal practice until his last illness, Fred most recently helped establish the Australian Medical Legal College, of which he was Foundation President.

Strongly orthodox in Jewish faith, Fred was an active member of Sydney’s Great Synagogue, living a short walking distance away in Woollomooloo, across Hyde Park. Fred’s very many and varied social contributions to his community were especially strong in the areas of teaching and learning. A lifelong learner with an extraordinary breadth of knowledge in many fields, Fred worked to support school and residential college development, and university scholarships, as well as being a Board member of numerous community organisations.

Following working in NSW State Psychiatric Services, Fred was Principal Adviser (Geriatrics and Rehabilitation) to the then NSW Health Commission, and a member of the Ethnic Communities Council of NSW. With his 1990 appointment to the UNSW Chair of Rehabilitation, Aged & Extended Care based at St George Hospital, Fred became very involved in teaching at UNSW and in our Faculty more generally. Fred was a member of the NSW/ACT Committee of the AFRM between 2001 and 2007.

In his medical work, Fred was always very concerned to understand an individual person’s needs for total care in a very holistic way, not considering just their physical and psychological needs, but also to understand the social and spiritual areas of people’s lives.

Decades ago, Fred was very clear on the importance of maintaining mobility in the elderly in hospitals, at a time when many were simply allowed to persist with unsupervised bed rest, whilst their medical problems were treated.

Fred’s surname in English translation conveys a range of meanings, including being honourable and upright. To recall a Biblical image especially appropriate in Australia’s drier lands, Fred flourished in all parts of his life, like a tree planted beside streams of water, ongoingly fruitful and evergreen.

We extend our sincere condolences to Fred’s wife Shirley and their extended family.

Associate Professor Andrew Cole
President Faculty of Rehabilitation Medicine
James Dennis Wilson (known as Dennis) was born on 4 August 1946, in Ballymena, Northern Ireland. He sadly died in Sydney, Australia on 29 January 2018.

Dennis was the second child of William and Jane Wilson of 'Kildrum', in the village of Kells. He attended Carnaughts Primary School, Ballymena Academy and Queen's University Belfast. At Queen's, he was awarded a Bachelor of Science in Physiology with First Class Honours and the University Medal. He graduated with a Bachelor of Medicine, Bachelor of Surgery and Bachelor of Obstetrics with Honours in 1972. Dennis married Audrey in 1974.

Dennis completed his training as an endocrinologist (MRCP – UK) at the Royal Victoria Hospital in 1979. He completed a MD at Queen’s that same year and moved to Melbourne as a Clinical Fellow at the Medical Research Centre, Prince Henry’s Hospital. He was awarded Fellowships with the Royal Australasian College of Physicians in 1983 and the Royal College of Physicians in 1997. Dennis was appointed Staff Endocrinologist at the Woden Valley Hospital (now The Canberra Hospital), Canberra, in 1980. He became Clinical Director of Endocrinology from 1990, continuing in that role until 2016. From 1983, he was involved in diabetes research as a Visiting Fellow at the John Curtin School of Medical Research at the Australian National University (ANU). Dennis was awarded academic title of Clinical Associate Professor in Medicine, University of Sydney 1995 to 2006 and Associate Professor in Medicine, ANU from 2002.

Professionally, Dennis will best be remembered for his contribution to patient care as a clinical endocrinologist in Canberra and the surrounding region of NSW. As Director of Endocrinology, his greatest legacy is a long list of endocrinology trainees he supervised, now consultant endocrinologists, including five who now work as endocrinologists in Canberra. He highly valued the nursing and allied health staff working alongside him within the service. He contributed in so many other ways, including as President of the Australasian Diabetes in Pregnancy Society 1990 to 1994, Chairman, Royal Australasian College of Physicians (ACT Branch) 1990 to 1994, Senior Vice President Diabetes Australia (ACT) 1982 to 1989 and Chairman of the Medical Staff Committee, Woden Valley Hospital 1992 to 1996.

Dennis and Audrey raised their three children in Canberra, and he was very proud of his grandson. Whilst separated by distance, he remained close to his extended family in both Ireland and abroad. He was curious about different countries, their people, history and culture. He travelled to 93 countries across the world and on every continent. He visited over 50 of these with his partner Kirsti.

Dennis will be sadly missed as a colleague and friend of many within the field of endocrinology and medicine in Australia and abroad. We will miss his sharp wit, the odd Irish tale, his kindness and generosity. He enriched all our lives.

Dennis is survived by his partner Kirsti Sirkiä, daughters Helen and Sharon, son Michael, son-in-law Robert, daughter-in-law Rebecca and grandson Matthew.

Professor Chris Nolan FRACP
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