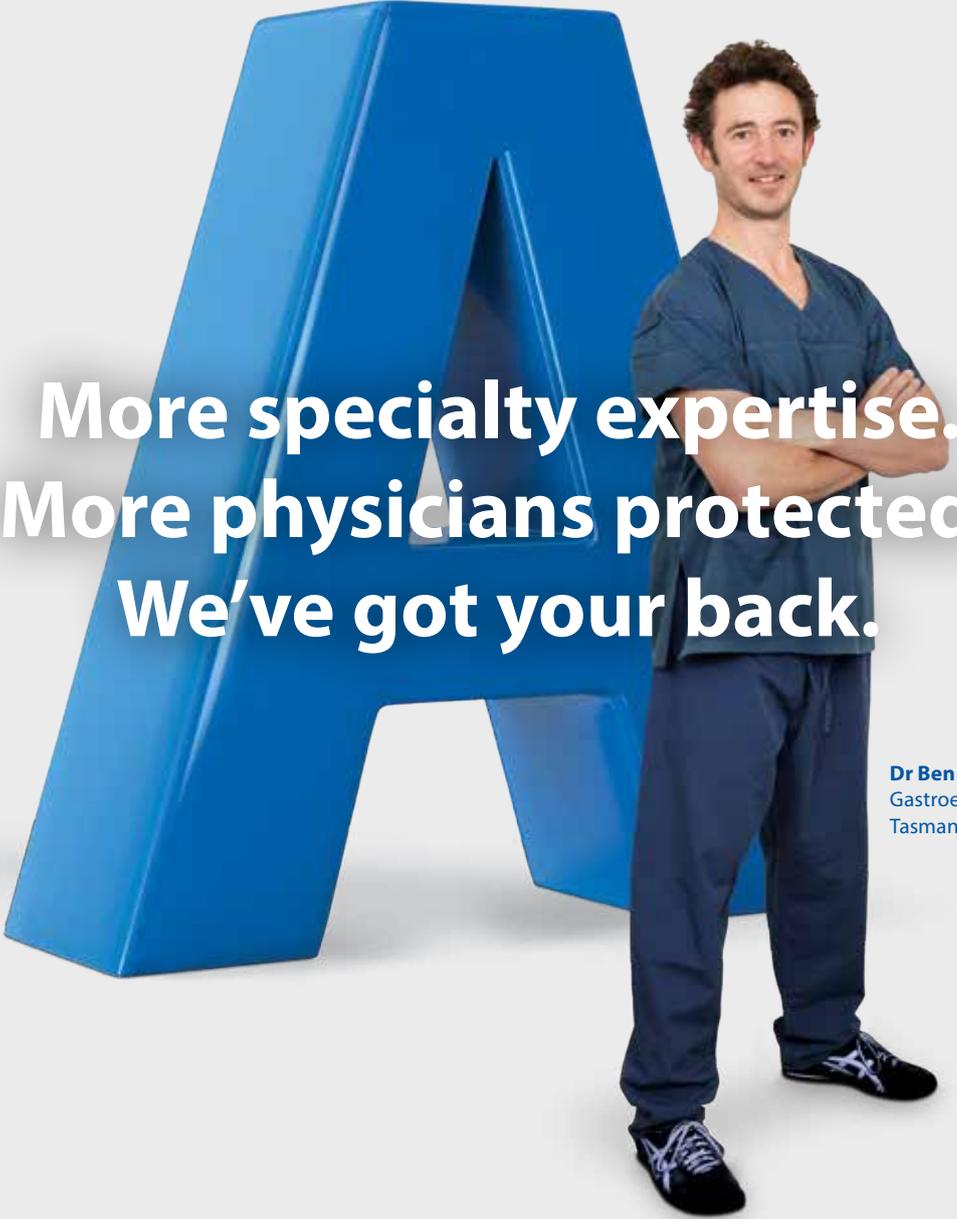


RACP Quarterly

December 2019/January 2020





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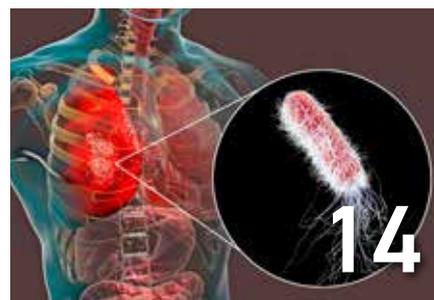
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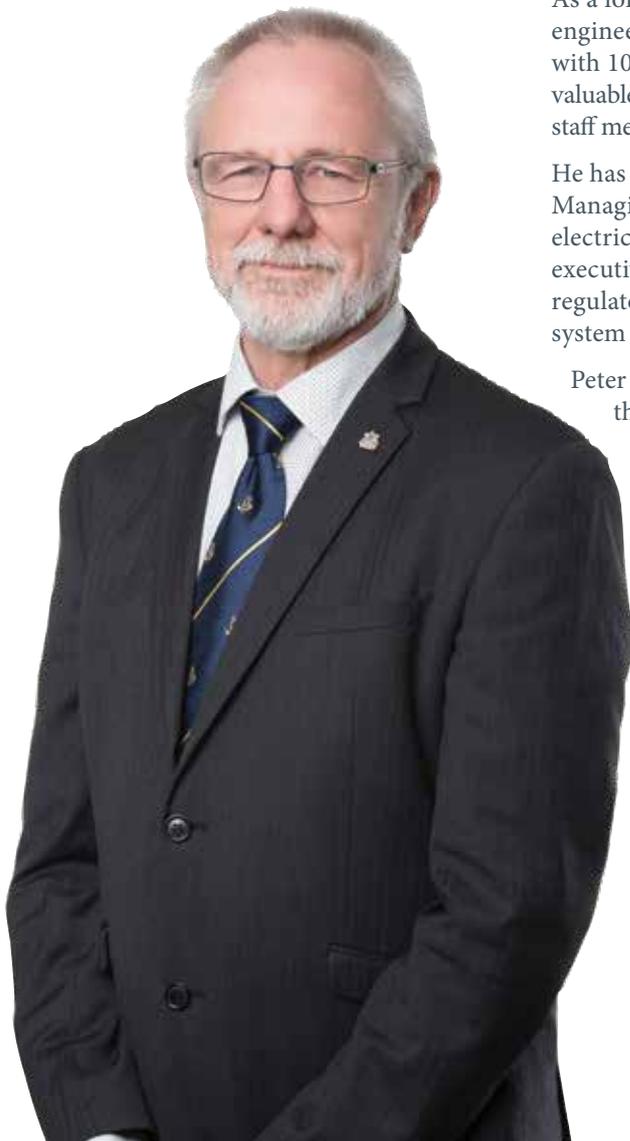
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A message from Your President

Welcome to the final edition of
RACP Quarterly for 2019.



In this final *RACP Quarterly* for the year, we close out 2019 with a welcome to our new College Chief Executive Officer Peter McIntyre.

Some readers may have already met Peter; he's been very busy meeting as many members and staff as possible since beginning his role in late October. Peter has already travelled to New Zealand, attended the Māori Health Hui and has rapidly come up to speed in grasping the complexity of our College, and the issues we face.

As a long-time Fellow of peak engineering body Engineers Australia, with 100,000 members, Peter brings valuable insights from both a Fellow and staff member perspective to the RACP.

He has held Board Director and Managing Director positions in the electricity industry as well as senior executive positions ranging from regulatory strategy to electricity system operations.

Peter is a past Deputy Chairman of the Energy Networks Association and past Chairman of Grid Australia.

He holds a BSc in physics and a BE (Hons) in electrical engineering from UNSW, an MBA in technology management from Deakin University and is a Chartered Professional Engineer and a Fellow of the Australian Institute of Company Directors and the Australian Institute of Energy.

Both the Board and I would also like to thank Interim Chief

Executive Officer Duane Findley for delivering our College through a busy and challenging period and wish him the best for the future.

It has been an eventful twelve months for all of us.

In the last quarter, the Board has worked closely with the Australian Charities and Not-for-profits Commission (ACNC) to improve Board governance processes, and that will continue through 2020.

Something that also may not be immediately obvious but will benefit you in future is the significant progress made this year in updating the hardware and software infrastructure we use to support you every day.

Since January 2019, we've made major strides in starting to unwind the spaghetti of custom-built and in some cases fragile legacy information technology systems behind the scenes that drive our many RACP online interactions with you.

But there's a lot more to do.

By the time you read this, the Board will have signed off on significant investment allowing us to start rolling out contemporary, stable, personalised and flexible services over the next few years, where and when you need them, on your device of choice.

Education is an area where rapid digital changes are taking place. We already have a working version of software that will allow trainees to access curricula material and record their learning and supervisor assessments – all on mobile devices.

Given the breadth and depth of specialties we encompass and the technical challenges, this is a complex project, but our Education, Learning and Assessment teams have made rapid progress this year and are on track for a limited pilot rollout in 2020.

This past year we've had wins in getting policy and decision-makers to enact rapid and meaningful healthcare change.

The biggest was driving the establishment of a national silicosis register in Australia, following a co-ordinated campaign by our AFOEM colleagues and their peers from the Thoracic Society of Australia and New Zealand.

Accelerated Silicosis is blighting the lives of stonemasons on both sides of the Tasman – and our College highlighted the issue.

On television, on radio and online in both countries, we've been heard loud and clear on many other critical healthcare issues in 2019; pill testing at music festivals, healthy rental housing standards, gun-control after March's tragedy in Christchurch, childhood obesity, abuse of children in custody and defence of Australia's medevac laws.

It is a list we should celebrate, which leads me to another end-of-year thought.

We often lose sight of just how significant our College is.

Our postgraduate student numbers are equivalent in size to those of the Australian National University, or

19 per cent more than those of the University of Auckland – New Zealand's largest. We were training nearly 10,000 Basic Trainees and Advanced Trainees as at September 2019.

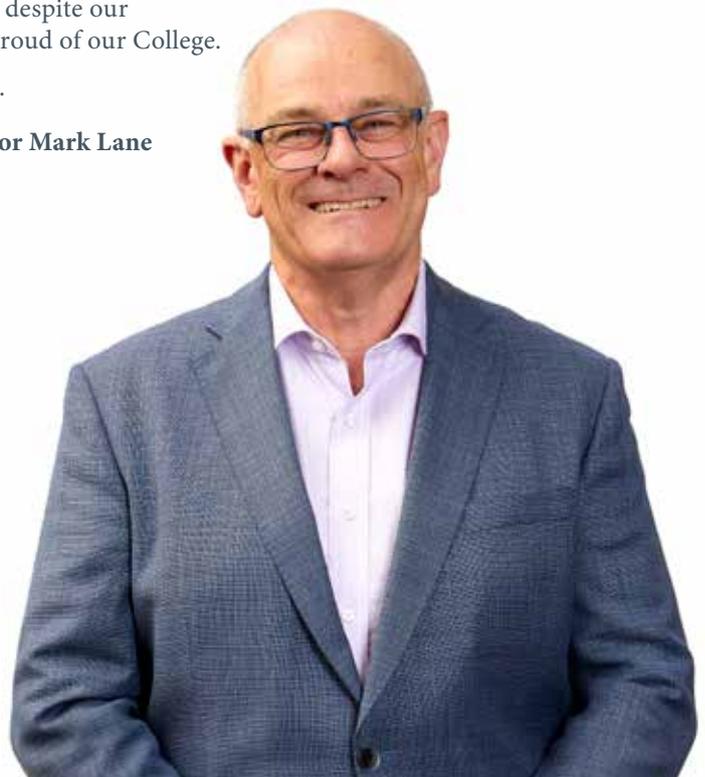
We have over 5,100 training supervisors across Australia and New Zealand. In comparison, Harvard Medical School has around 5,000 full and part-time instructors at its 14 affiliate hospitals across Boston.

We are accredited to train in 38 different specialties, via 63 different training pathways, across over 450 training sites, awarding seven different types of post-nominal. We organise over 4,000 events for our Fellows and trainees every year.

As we finish 2019, despite our challenges, I am proud of our College.

I hope you are too.

Associate Professor Mark Lane
RACP President



Peter McIntyre,
RACP Chief
Executive Officer



A message from **The Board**

Since the last edition of *RACP Quarterly* your Board met on 13 September 2019 and 25 October 2019.

September 2019

Your Board is committed to improving communication with you.

The Board was joined for the whole September meeting by James Beck and Rob Newman from Effective Governance.

They have been engaged by the Board to help deliver the various obligations under the ACNC Compliance Agreement signed by all Directors.

Ian Parry and Melissa Tan, representing the ACNC, also joined the meeting for part of the morning session.

In the Board meeting itself, the Board was briefed on the RACP's financial position at the end of July 2019.

This report showed a strong year to date operating surplus against budget, which was largely the result of the delay to the start of significant College IT infrastructure upgrade projects and other key projects which will begin during the second half of the year.

This increased project activity and expenditure are expected to significantly reduce the current

operating surplus and bring it back closer to budget by year end.

The surplus includes a one-off sum of \$1.8 million in additional revenue from prudent management of Foundation funds, on advice from our funds manager, and some timing adjustments on spending on upgrading IT systems for the College.

We discussed RACP Congress 2020, including pricing and structure, and noted further detailed planning work, led by Lead Fellow Professor Don Campbell, and by the Congress and Fellowship Committees.

We approved a proposal to extend the Tri-Nations Alliance in two stages, firstly within existing Tri-Nations countries, Australia, New Zealand and Canada, and secondly to seek to extend it to other regions including potentially the United Kingdom, Europe, USA and Asia.

Wider Tri-Nations Alliance membership would enhance opportunities to enable sharing of leading adult learning approaches to improve curriculum development, education and training, assessment and professional development.



We endorsed a strategy for a carefully phased transition to Computer Based Testing developed with guidance from the College Education Committee.

A detailed communication plan, giving members as much information and advance notice as possible, is under development. The College is undertaking a thorough and carefully risk managed approach to the re-introduction of Computer Based Testing and will ensure the system is robust and fully tested prior to implementation.

We also considered the draft College Strategic Infrastructure Investment Plan 2020-2025 presented by Director, Development, Brian Freestone. Further discussion of this initiative will be held at the October Board meeting.

Additional reports noted included an update on the work now underway to upgrade and improve the College website, which will come back to the Board for decision at a later meeting.

October 2019

For the Board meeting held in Sydney on 25 October 2019 we were again joined by Effective Governance, the organisation we have contracted to review governance in the College.

The previous day all Directors participated in a feedback and workshop session facilitated by Effective Governance.

This meeting was also attended by the ACNC.

The RACP's financial position at the

end of September 2019 showed a strong year to date operating surplus, partly because key projects are still getting underway and we expect a small end-of-year surplus.

In order to better plan for larger projects, we are introducing longer term budget projections, out to 2025.

The College needs significant IT upgrades and these are underway in current and future budgets.

Given the suitability and leasing issues for RACP offices and member facilities in Wellington and Perth, these offices will be relocated to more modern and appropriate facilities.

The Board approved a new Whistle-blower Policy to ensure we met legislative obligations introduced during the year.

Congress remains an important College activity, and to better support member involvement in planning, the Board delegated more of this role to the Fellowship Committee.

We have approved online publication for the *Internal Medicine Journal*, the *Journal of Paediatrics and Child Health* and *RACP Quarterly* publications. For those who wish to continue to have paper copy options, print-on-demand is being explored.

This follows a review of publication costs, readership statistics and our policy commitment to mitigate climate change and is estimated to save around half a million dollars, as well as 17,000 tonnes of equivalent carbon emissions per year. There will be more

communication about this early next year.

Revisions to the Conflict of Interest Policy were approved. Further work to finalise this will be carried out by the Governance Committee.

The culture within our College is an important influence on both our governance and experiences of members and staff. Significant attention has been paid to improving our culture, such as a Culture Action Plan, and this will remain a priority in future.

This Board meeting was the last for interim CEO Duane Findley. The Board thanked Duane for his contribution to the College during a time of great uncertainty and welcomed new CEO Peter McIntyre.

Our next meeting is scheduled for Thursday, 5 December 2019, followed by a joint meeting with the Board and the Aboriginal and Torres Strait Islander Health Committee (ATSIHC) and the Māori Health Committee (MHC) on Friday, 6 December 2019.

Associate Professor Mark Lane
RACP President

Showcasing Aboriginal, Torres Strait Islander and Māori cultures

In early 2018, the RACP finalised its first Indigenous Strategic Framework (ISF). The framework is 10 years in duration, focuses on Aboriginal, Torres Strait Islander and Māori culture, and aims to improve contributions by the College in achieving health equity for Indigenous people in Australia and New Zealand. During the ISF journey, we recognised the need to have an appropriate visual language recognising Aboriginal, Torres Strait Islander and Māori cultures as part of the process of incorporating Aboriginal, Torres Strait Islander and Māori health into the RACP's core business.

'Healing Place' By Riki Salam of WeAre27Creative



The RACP commissioned an Indigenous artwork to use on a range of documents and materials to demonstrate our commitment to Aboriginal and Torres Strait Islander health and the celebration of Aboriginal and Torres Strait Islander cultures.

The College's Policy and Advocacy team worked closely with the Aboriginal and Torres Strait Islander Health Committee (ATSIHC) in this undertaking. WeAre27Creative was engaged for the bespoke artwork as their colours, motifs and stories conveyed in their works resonated with ATSIHC and RACP staff.

Riki Salam, Principal, Creative Director and artist of WeAre27Creative consulted with ATSIHC and RACP staff on their views and hopes for the artwork and the College's ISF. Riki developed initial concepts that incorporated and expressed the RACP's values and how these values aligned with Aboriginal and Torres Strait Islander culture, values, practices and messaging through the lens of healing.

"Once a vision and direction were established, the next stage was to do more research on what a physician is; what they do and the historical definitions of 'physician'. And then put it into the context of not only a contemporary-based physician but also looking at it from an Indigenous perspective of who a physician is and what a physician does.

"We looked at traditional healers, we looked at the definition of what a healer is and then married up not only from a traditional point of view but also a contemporary point of view. We do this because we look at the aspect of two-way learning, especially with the Reconciliation Action Plan, there are two worlds coming together and how do we connect first of all, and how do we start to speak the same language to have the same understanding, to have positive outcomes," explains Riki.

"And so, these are all considerations we take on board with the initial research and we try to bring together the overarching concepts. This all leads to a visual language which we put into the artwork. We looked at the College



The artwork was launched by ATSIHC at their bi-annual face-to-face meeting on 18 November 2019 and will be used on a wide range of materials.

as a physical building, a physical place of learning, and we wanted to represent that in the artwork itself, we also wanted to recognise the people within the institution, the supervisors, the trainees and the staff who make it a functioning institution. And then taking it back to the traditional context, we looked at how traditionally we, Aboriginal and Torres Strait Islander people, go about healing and what some of the aspects are that we used to actually heal ourselves and heal one another. This meant looking at traditional healing and the practices that came with it, the bush medicine and knowledge of the environment and the landscape and

how we use these to actually make our people better. From that literal language I translate it into a visual language. I then started to connect the written language into symbols and looked at how they come together, and looking at the structure of the artwork, pulling all those symbols together to actually tell the story of the College and how Aboriginal and Torres Strait Islander people and other Indigenous people are associated with the College within the artwork,” said Riki.

ATSIHC are thrilled to see the artwork and messages come to life. “We have great respect for the process Riki

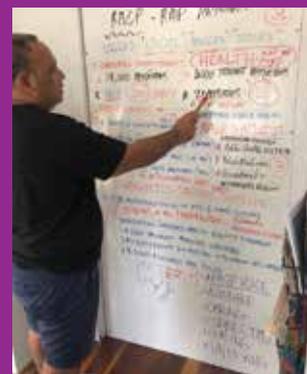
undertook to understand and envision the alignment between the RACP’s values and Aboriginal and Torres Strait Islander cultures, values, and practices. The development of this artwork is a pivotal moment in the history of the RACP, as the RACP now has a visual language to demonstrate our respect of and commitment to Aboriginal and Torres Strait Islander people. Riki was able to beautifully express this through the symbols and multiple narratives encapsulated in the artwork.”

The College hopes the artwork will be recognised as the RACP’s commitment to achieving significant improvements to the health and wellbeing of Aboriginal and Torres Strait Islander people. Fellows and trainees are encouraged to see the artwork in the reception area of the RACP office at 145 Macquarie Street, Sydney.

ABOUT THE ARTIST – RIKI SALAM

The College recognised the importance of working with an artist who had connections to both Aboriginal and Torres Strait Islander cultures. Riki Salam is the Principal, Creative Director and artist of WeAre27Creative. Riki has connections to Torres Strait and Kuku Yalanji peoples on his father’s side and the Ngai Tahu people of the South Island of New Zealand on his mother’s side.

As Riki also has Māori heritage, we valued Riki’s expertise and understanding of how the RACP, as a cross-Tasman organisation, aims to develop and implement strategic initiatives that effectively contribute to improved health outcomes for Indigenous people in Australia and Aotearoa New Zealand. In early 2020, Riki will create a cross-Tasman artwork that incorporates the Aboriginal, Torres Strait Islander and Māori artworks.



Tāne Mahuta Carved by Ihaia Puketapu

Tāne Mahuta is the first piece of Toi Māori (Māori art) commissioned by the College. Working in ways that upheld tikanga Māori values and kaupapa Māori practices was incredibly important to the Māori Health Committee (MHC), the Aotearoa New Zealand Committee and staff. This meant the project was not only driven by the Committee, but that the development of the ideas was conducted by whakawhanaungatunga (building of relationships), with manaakitanga (kindness and support) and mōhiotanga (information-sharing). Some time was spent distilling the Committee's values, history and priorities, such as commitment to the articles of Te Tiriti o Waitangi / The Treaty of Waitangi



and goals of health equity for Māori into information that could be given to the artist Ihaia Puketapu. In November 2018, Ihaia met with Dr George Laking, Chair of the MHC, Carmelita Edmonds (former Aotearoa NZ Manager) and Harriet Wild (Senior Policy and Advocacy Officer, Aotearoa New Zealand) to discuss the commission.

The MHC considered several key themes for the pou (carved wooden pole), which also feature in the ISF – the most significant of these being the drive for equity for Māori and the growth of the Māori physician and paediatrician workforce. Toi whakairo (carvings) often depict a pūrākau – an ancient Māori legend whose narrative may have points of resonance with a contemporary kaupapa (purpose) or theme. For the MHC, this was one of the pūrākau about Tāne Mahuta, God of the Forest and Living Things, where he ascended to the highest of the twelve heavens, Te Toi-o-ngā-rangi, climbing up spiders' webs to obtain three kete (baskets of knowledge). Tāne then planted the knowledge in the earth, where it could be discovered by humankind.

Together with the pūrākau, the MHC had been looking – perhaps unconsciously – for an appropriate way

to acknowledge and honour the work of the Committee's founding Chair, the late paediatrician Dr Leo Buchanan. The pou includes a figure representing Leo at its base. Leo's hands are interlocked with Tāne's feet, unified through their talon-like forms, which are features of the Te Atiawa carving style. Leo has returned to the RACP and the Committee in the form of the carving, and Dr Buchanan's photograph now hangs alongside Tāne Mahuta.

Tāne Mahuta now resides on the public floor of the RACP's Wellington office – it is one of the first things visitors to the College will see when they enter the space. This area used to house old medical instruments on shelves – these archaic tools are behind glass double doors. Tāne Mahuta has a warmth and life that was absent from the objects that were held in this space, and he has a real presence in the office. The pou is a point of pride for RACP members and staff, with committees meeting in the Wellington office being talked through the meaning and narrative of the work by College staff.

The work provides a powerful and very apt metaphor for the College's own journey through the ISF. While the presence of Toi Māori can signify acknowledgement of the

ABOUT THE ARTIST – IHAIA PUKETAPU

The MHC were unequivocal that the work should be designed and crafted by an artist with whakapapa (genealogical connections) to Te Atiawa, who are the mana whenua (tribal group with authority over a particular area) of Te Upoko o Te Ika a Maui, the Mouth of the Fish of Maui, or the Wellington region¹.

Ihaia Puketapu, who carved Tāne Mahuta has produced many carvings around Te Whanganui-a-Tara and of Te Upoko o Te Ika a Maui, notably the Waharoa on Matiu/Somes Island, and a series of pou at the Te Aro Pā Papakāinga (a collective model of housing) at Greta Point. This was a fortuitous link – as the Papakāinga was a project Leo Buchanan was heavily involved in as part of his trustee role with the Te Aro Pā. It was very significant, then, that Ihaia had a connection with Leo and had worked with him.

¹ How the land was shaped

<https://teara.govt.nz/en/whenua-how-the-land-was-shaped/page-2>

tangata whenua (people of the land, Indigenous people), Tāne Mahuta alludes to transitions and the pursuit of knowledge through Tāne's acquisition of the three kete of knowledge – moving from darkness to light and the pursuit of knowledge sought by humankind.

In late September 2019, the MHC, together with current and former RACP staff, held a hura pou (unveiling of the pou) with 20 members of Dr Buchanan's whānau, including his wife Mary, six of his eight children, his brother, cousins and grandchildren. This was a very powerful and moving ceremony, observing tikanga Māori practices, and was underscored by the generosity of the Buchanan whānau. The MHC learned about Dr Buchanan as a father and grandfather, and Dr Buchanan's whānau learned of his professional life, and of the Māori doctors he inspired. The hura pou was conducted largely in te reo Māori and attendees were seated in the formation that would be used on the marae, but within the reception area of the Wellington office. It was significant that not only did the RACP commission a piece of Māori art for its office, but that a ceremony such as the hura pou could be conducted at the College's office.



Members of Leo's whānau, RACP staff Charlotte Baird and Harriet Wild and Māori Health Committee member Dr Sandra Hotu with the pou.

THE RACP'S INDIGENOUS STRATEGIC FRAMEWORK HAS FIVE PRIORITIES:

- 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 the regulatory standards and requirements of the Australian Medical Council and the Medical Council of New Zealand.

The College also has two very active Indigenous committees, the Aboriginal and Torres Strait Islander Health Committee and the Māori Health Committee, who provide strategic leadership and advice to the College on Indigenous health initiatives and increasing the Indigenous physician workforce.

Learn more at www.racp.edu.au/news-and-events/media-releases/racp-releases-indigenous-strategic-framework

A PIECE ABOUT DR LEO BUCHANAN BY HIS ELDEST CHILD, DR RACHEL BUCHANAN PHD

In the last weeks of his life, Dad carefully wrote me a list of his 'particular medical honours'. I said this information would be useful but I left the purpose vague. Perhaps he already knew I had been asked to give his eulogy.

It was not easy. I knew Dad's creativity would come into it. "Medicine is an art that uses science for its own purposes", he wrote in a letter to Lily Arapera, my daughter, his oldest mokopuna.

I wanted to acknowledge Dad's many achievements but I also wanted to express that without Mum, nothing. Mary and Leo had eight children and two foster daughters. Mum did everything at home.

I asked Mum what it was like being married to Dad. Mary is living with dementia, a cruel disease, but a clear image arose from the fog.

Leo was stubborn, she said. He was absorbed and very thorough in his relationships. We sat together in silence for a while then Mum said: "The closed door."

The closed door was what I saw of Dad when I was a toddler. He was always studying behind one. He worked very hard and in 1970, he got the highest mark in Australasia in the paediatric specialist admission examination to the Royal Australasian College of Physicians. This major achievement was especially sweet because the Royal Women's Hospital had refused to renew his appointment the year before saying he was "not up to it".

Even in retirement, the closed door ruled as Dad continued his tireless work to improve the health of Māori children. He was the initiator and founding chairman of the Māori Health Committee of the Royal Australasian College of Physicians (2005 to 2013) and in recent years his obsession was to increase rates of breastfeeding among Māori women. He was also working on the detection and prevention of fetal alcohol syndrome, a terrible condition that plagues a disproportionate number of Indigenous babies on both sides of the ditch.

Then, as chronic illness (cancer for Dad, dementia for Mum) stripped away many parts of Mary and Leo, all that remained was the essential services.

For Dad, these were a sense of humour, a love of ceremony and theatre, a determination to be in charge and many, many Latin words. Dad retained a grip on the medical language of power right to the end of his life. Doped to the eyeballs, slurring, unable

to walk, unable to eat, in pain, Dad could still do a ward round on himself, seemingly stepping out of his skin to deliver a diagnosis to the district nurse, to his wife, to any other family members who happened to be there. The medical oration was enhanced by the tokotoko that leaned against his chair. Dad had decided to use it as a walking stick.

He hated being in a hospital room high off the ground with a window that could not open. The smells, the heat, the shared facilities of a hospital, all of it was torture. And yet he had chosen to work in hospitals. When I was a kid, he seemed to spend more time at the hospital than he did at home. This was a shame, because when he was at home, dad was such good fun.

After training in Whanganui, Invercargill, Melbourne and Sydney, Dad was the first paediatrician appointed in Taranaki and he set up the neonatal intensive care unit at Base Hospital in New Plymouth. We lived there from 1972 to 1983.

Dad was medical superintendent in chief of Masterton Hospital and secretary to the Medical Superintendent's Association of NZ from 1983 to 1987.

He was foundation community paediatrician to Waikato Hospital Board from 1987 until 1992 – and held regular clinics in places like Tokorua, Taumaranui and Huntly. From 1992 until he retired, Dad was a paediatrician at Hutt Hospital.

Dad was appointed a member to the Ministry of Health Child Review of Child Health Services in New Zealand in 1979, 1999 and in 2013. He was awarded the Royal Australasian College of Physicians John Sands College Medal 'for outstanding service to the college'.

Since Dad has died, we have learned more about him and the impact of his work. The unveiling of the pou was a chance to meet some of the young Māori medical specialists that Dad mentored and encouraged and also colleagues he had worked with at the College office. Mum was able to come along and speak about Dad. It was very special.



Build your cultural competence

The RACP recognises the evidence that the health and wellbeing of Indigenous peoples in Australia and Aotearoa/New Zealand have been adversely affected as the result of colonisation, and that physical and spiritual health outcomes have been and continue to be compromised leading to a gap in life expectancy and health outcomes between Indigenous and non-Indigenous peoples. The RACP is fully committed to making a positive difference.

As a part of our Indigenous Strategic Framework we've developed the Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence online course.

This course has been designed to support the provision of culturally competent and culturally safe, best practice medicine for Aboriginal, Torres Strait Islander and Māori patients by enabling you to reflect on your own cultural values and recognise their influence on your professional practice.

The course covers:

- Reflection on how your own cultures and belief systems influence your professional practice as a physician
- An understanding of your own cultural competence and cultural safety within social, cultural and clinical environments
- An awareness of how cultural competence and cultural safety principles may be applied to improve Indigenous patient health outcomes and experience of care.

The course features a mix of in-depth content, video scenarios and reflection

and discussion activities, as well as recommended supporting materials.

Thank you to our Working Group who helped develop the course content, including Dr Has Gunasekera MBBS DCH MIPH (Hons) FRACP PhD, Dr Sandra Hotu FRACP, Dr Joseph Lee FRACP FAANMS MBA PGDipClinUS, Janelle Speed, Dr Rajanikar Tota FRACP.

The content was also developed in consultation with Associate Professor Wendy Edmondson who has worked in the fields of Aboriginal health and education for 40 years, as well as consultants from the National Centre for Cultural Competence and from Mauri Ora Associates. RACP Online Learning Resources are free for members and count towards Continuing Professional Development (CPD) requirements.

To complete the course visit elearning.racp.edu.au.



Members in the media

Kids risk permanent damage as juvenile arthritis is misdiagnosed

A shocking lack of medical expertise and resources across NSW is leaving children with arthritis in pain and at risk of permanent joint damage.

There are about 3,000 children with arthritis across the state but only two part-time paediatric rheumatologists are employed across the children's hospital network.

Dr Christina Boros FRACP, chair of the Australian Paediatric Rheumatology Group, said that was seven times less than other states.

"These children can't be seen in an appropriate time frame due to insufficient physician workforce in NSW," Dr Boros said.

"If these children can't get seen in a timely manner, they risk permanent disability from their arthritis."

The delay in diagnosis is also leaving children in pain.

The Daily Telegraph, 29 September 2019

World-first HIV positive sperm bank launches in New Zealand

Today New Zealand launches the world's first HIV positive sperm bank in a bid to remove the negative stigma experienced by those living with the virus.

It comes ahead of this year's World Aids Day, on Sunday, December 1.

Sperm Positive are working with a number of fertility clinics who will act as the middle-person between the donor and patients. It will be made clear to people looking for a donor that they have HIV but are on treatment and have the blood tests to show their virus is undetectable.

Auckland District Health Board infectious diseases physician Associate Professor Mark Thomas FRACP, who has been working with people living with HIV for more than 30 years, said more than a decade ago the World Health Organization confirmed HIV treatment prevented transmission, even through sex without a condom and childbirth.

"This was life-changing for many people living with HIV, but due to the negative stigma, it's still not widely understood – even among doctors."

The NZ Herald, 27 November 2019



Lung cancer and leukemia treatments to be added to PBS

Some lung cancer and leukaemia patients will have access to "game-changing" drugs under additions to the Pharmaceutical Benefits Scheme announced today.

The treatment options for non-small-cell lung cancer and early stage acute lymphoblastic leukaemia will be available from 1 December.

More than 2,200 patients with that form of lung cancer will be able to access pembrolizumab – an immunotherapy medicine that supercharges the body's own immune system to fight cancer cells.

Peter MacCallum Cancer Centre oncologist Professor Ben Solomon FRACP said the treatment had already dramatically improved outcomes for his lung cancer patients.

"People live longer, survival is doubled. It costs in excess of \$6,000 a dose, up to \$60,000 a year for the treatment," he said. "That was out of the reach for most patents – now we can offer it to everyone."

The Daily Telegraph, 19 November 2019

Doctors 'obliged to speak on climate risk'

Doctors have a responsibility to speak out about the dire health impacts of climate change, an expert says, as bushfires burning across NSW create hazardous air pollution in Sydney.

Air quality was hazardous in northwestern Sydney on Tuesday morning and between very poor and hazardous in central and eastern Sydney.

Public health physician Dr Kate Charlesworth FAFPHM says the medical profession has an obligation to discuss the link between climate change and poor health.

"From a health perspective, refusing to talk about these bushfires is like refusing to talk about smoking and lung cancer," she told AAP.

"There's a proud history of health professionals standing up on issues of importance – think of asbestos and tobacco control – that is our role."

The Daily Telegraph, 19 November 2019



More tradies warned about the danger of silica

Tradies have been warned that engineered stone is not the only product that contains potentially dangerous levels of crystalline silica, meaning the emerging health crisis could extend beyond the stonemasonry industry.

Respiratory and sleep physician Dr Ryan Hoy FRACP said products such as tiles, bricks and concrete could also contain enough of the substance to cause an occupational lung disease. However, for those tradies, the onset of silicosis could take some time.

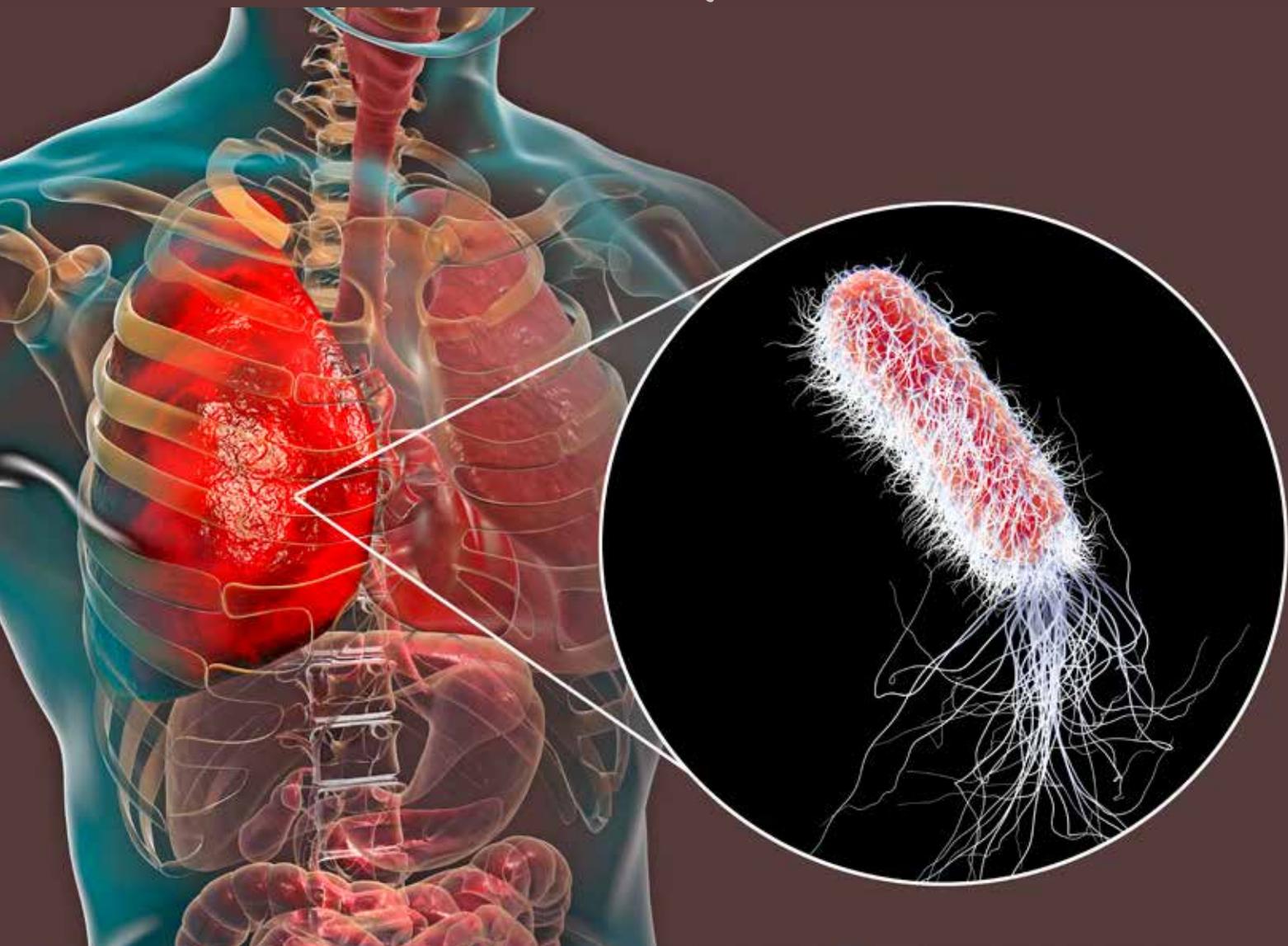
"I think there has been major complacency about the potential respiratory health effects of silica exposure for many years now, and certainly not just concern relating to workers with artificial stone," Dr Hoy said.

"For professional tradespeople that are on construction sites for a number of years, day in day out, for their whole career, there is a significant level of silica exposure."

The Sydney Morning Herald, 23 October 2019



The future of cystic fibrosis



Since the discovery of the cystic fibrosis (CF) gene in 1989, there's been tremendous advances in the understanding of the condition across the globe. Professor Scott Bell FRACP, a principal investigator on numerous pivotal cystic fibrosis transmembrane conductance regulator (CFTR) modulator trials, shares what the future holds for CF care.

Professor Bell co-led an international group of leading experts in CF care and research who contributed to the Lancet Respiratory Medicine Commission's report into the future of CF care. According to the report, there are now over 2,000 variants of CF discovered globally. What was thought to have been a global CF population of around 90,000, that number alone is now likely equal to the number of a whole undiscovered CF population in China. It is estimated that, in the next decade, the CF population will increase by 50

per cent with the majority of growth being adults.

"Over the course of the last 30 years, there's been a marked increase in the median survival of people with CF (now approaching 50 years of age in Australia). It is now a rare event for a child to die with CF, and older patients who are in adult life are living much longer than previously. That's certainly a good news story and is accompanied by challenges," says Professor Bell.

New and emerging complications of CF are being seen more commonly in the

“ In the latter third of my career, I want to ensure that our clinical and research teams are well trained to really look at delivering excellence in multi-disciplinary CF care that keeps the patient at the centre. The research questions we address need to bear in mind what the CF patient population needs and incorporate the patient perspective.”

older CF population. Classic diseases of the ageing population that weren't seen previously, such as metabolic syndromes, obesity, heart disease and increased risk of colorectal cancer, have led to newer clinical CF complications that require a different way of delivering care and the expertise to support care delivery.

“As a consequence of the increasing survival, what we are seeing is huge growth in the need to provide specialist care for adults with CF across the world. CF adult centres have grown tremendously. For instance, The Prince Charles Hospital in Queensland had 100 patients in the mid-90s and now has more than 300 patients, and that's not including those patients who have undergone lung transplants who are also surviving much longer post-transplant.

“In terms of how we manage younger children is also changing enormously, because they are much healthier than previously. Monitoring disease is an important aspect of it. As patients are healthier, we need to look at more evasive testing for monitoring, such as novel approaches to monitoring lung function (e.g. lung clearance index),

airway microbiology (e.g. induced sputum and even bronchoscopy) and extent of lung disease progression (e.g. CT and lung MRI scans),” explains Professor Bell.

The report also examines emerging treatments with highly effective CFTR modulators. Ivacaftor was the first to be made available, being introduced to Australian patients about six years ago resulting in very significant improvements in lung function, quality of life and especially reducing exacerbations of lung disease in patients with the G551 mutation, the second most common in the Australian CF population. “This was the first CFTR modulator available for patients, though a relatively small proportion (eight per cent) of Australians with CF,” explains Professor Bell.

“Since then, there have been two moderately effective combinations of drugs for the more common mutations (e.g. those homozygous for the most common CF mutation – F508del). These combination drugs (including lumacaftor/ivacaftor and recently tezacaftor/ivacaftor) have had moderate impact on patients' lung function,

quality of life and especially reducing exacerbations of lung disease.”

Ongoing drug discovery continues, with industry, clinics, patients and academia strongly collaborating to deliver effective treatments.

“The most recent development has been in the triple combination therapies (elexacaftor/tezacaftor/ivacaftor) which have demonstrated marked impact of lung function, quality of life and especially reducing exacerbations of lung disease as reported with ivacaftor for patients with the G551D mutation. Importantly this combination was not only seen to be effective for patients who were homozygous for the F508del mutations (50 per cent of Australians with CF) but also to those who had only one copy of the F508del mutation.

“The results of the international studies were published in late October 2019 in the New England Journal of Medicine (NEJM) and Lancet. Now we have the potential for highly effective treatments for the basic defect of CF for greater than 80 per cent and approaching 90 percent of the Australian CF population, although, approval and funding for

THE FUTURE OF CYSTIC FIBROSIS CARE: A GLOBAL PERSPECTIVE

The Lancet Respiratory Medicine Commission, led by Scott Bell and Felix Ratjen, reviews the latest research advances and identifies challenges and opportunities for progress in the care of CF patients globally.

Find out more at www.thelancet.com/commissions/cystic-fibrosis-care.

triple therapy is not likely to be available within the next two years.”

One of the challenges for these sorts of drug discoveries is balancing the investment by industry to discover such drugs and to take them through clinical trials ultimately to the clinic is high risk and requires long-term investment. Thus, the pricing of these therapies is very high. The impact on health may be substantial, but there's also the opportunity cost that all governments need to consider in delivering such therapies, particularly as therapies are likely to be delivered to very young children and lifelong in association with enhanced longevity.

“This is certainly one of the key challenges that the Lancet Respiratory Medicine Commission examines – delivering highly effective treatment for up to 90 per cent of the CF population, but in a sustainable and an accessible way globally.

“CFTR modulators are readily available in the United States of America, but if you live with CF in low-middle income countries, the high costs are out of the realms of feasibility. We need more therapies for more patients and we need them globally available without substantial delay. We also need to consider how to deliver the standards of care including early and accurate diagnosis and treatments such as pancreatic enzymes, nebulised therapies and antibiotics to patients living in low-middle income countries. This is extremely important so that the delivery of basic care becomes the norm

for patients in developing countries,” says Professor Bell.

The most important aspect for CF healthcare professionals is approaches to enhance patient engagement and the patient experience. Longevity is one thing but enhancing the patient's quality of life is also vital.

“The CF population is highly engaged in its care through close contact with the multidisciplinary team and lay organisations. They are highly expert in their understanding of the disease, sometimes more so than the healthcare professionals delivering the care.

“We are probably on an unsustainable pathway in delivering care in the way we have in the past particularly with the growth of the adult CF population, so this is an opportunity to use mobile health (mHealth) techniques and telehealth and use ‘wearable technologies’, for patients to be monitored in an unconventional yet equally effective way. These are the sort of approaches to care our patients are keen to adopt because if we deliver better and more effective treatments, they don't have to, nor do they want to, spend half their life in the clinic, especially if they could be monitored and managed more remotely, at least for a component of their care.

“In the latter third of my career, I want to ensure that our clinical and research teams are well trained to really look at delivering excellence in multi-disciplinary CF care that keeps the patient at the centre. The research questions we address need to bear in

mind what the CF patient population needs and incorporate the patient perspective.”

Highly effective treatments are well on the way for patients with CF, and certainly for healthcare professionals such as Professor Bell.

“It's all about maintaining the wellbeing and lowering the burden of treatment, and how as healthcare providers, we can try to optimise the lives of people with CF.” RQ

AOTEAROA NEW ZEALAND TRAINEES' DAY 2020

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Tackling the diabetes epidemic in rural and remote communities

In remote communities across Australia, Indigenous Australians are suffering from an extreme form of Type 2 diabetes at devastating rates. In the town of Ampilatwatja, 300 kms north-east of Alice Springs, 50 per cent of the community are burdened with a malignant, aggressive type of the disease.

RACP Fellow and diabetes expert, Associate Professor Neale Cohen, who has spent over a decade working in Ampilatwatja and the communities around it, says that the particularly nasty form of diabetes that is engulfing these communities requires a new, tailored approach to patient treatment and care.

“This sort of prevalence of Type 2 diabetes can be found in other first-nations groups around the world, so sadly, this problem is not unique to Australia. But when I first visited these communities in 2010, I was completely shocked at how aggressive this form of diabetes was, compared to the types of diabetes patients you would find in our metropolitan clinics.”

Twice a year, Associate Professor Cohen and his medical team travel through communities across Central Australia to provide critical treatment for diabetes patients. Sadly, the disease is so rapidly progressive in these communities that many individuals have been going from metformin to insulin in a matter of years, with significant numbers going on to develop renal failure.

Associate Professor Cohen says that “This diabetes isn’t your average Type 2 – it’s not a scenario in which lifestyle factors play a major role in the high prevalence and progression of the disease in these areas.

The impact of diet and exercise as we might prescribe in Caucasian populations is small, and the need for complex therapeutics, including insulin

and other injectable agents, is high.

“Genetics are a large factor for these communities, and I think it’s really important that both the medical community and the public have a better understanding of why people in our Indigenous communities suffer from diabetes at such alarming levels.

“We are seeing a large number of young patients ending up on kidney dialysis, which is horrific. Kidney dialysis is essentially just a form of palliative, end-of-life care. It’s unusual for a kidney transplant to be considered for patients living in remote communities, so we want to prevent as many people ending up with kidney failure as possible,” explains Associate Professor Cohen.

While the availability of kidney dialysis treatment has increased, making it more accessible for patients with kidney failure, Associate Professor Cohen says that for every patient using a bed, there’s at least two other patients waiting to get access.

But there is still some hope.

A new diabetes drug, exenatide-LAR, has improved treatment of diabetes through its once-a-week application. Instead of daily injections, Indigenous Australians in these remote communities, and diabetes patients around the globe, now have the option to have a once weekly glucose lowering injection. Associate Professor Cohen said this improvement in treatment is making an enormous difference in the consistency of care and treatment.

“While the new treatment makes it

Ampilatwatja,
300 kms north-east of
Alice Springs

50%

suffering from
diabetes

Right: Associate Professor Cohen with a local child at the Urupuntja Health Service.

Below: Associate Professor Cohen and his medical team travelling through communities across Central Australia.

much easier for patients with diabetes to control their blood sugar levels, this treatment alone is not likely to achieve adequate glycaemic control, particularly in this population.

“For this reason we conducted a trial in remote Central Australian communities to measure the outcomes of 38 diabetes patients, looking at those taking exenatide-LAR in addition to having weekly nurse visits, to a model of care in which patients received weekly nurse visits alone.

“The results of the clinical trial are yet to be formally published – but the results clearly demonstrate that the weekly nurse visits in addition to the drug treatment had a positive impact on blood glucose levels for patients.

“The trial demonstrated that caring for patients in these remote communities requires more than drugs alone – it’s about forming an effective model of care that is acceptable to clinicians and patients in communities. The clinics in these areas do their best with chronic disease management, but for the most part, their capacity to manage complex chronic disease is limited. Sadly – the scope of resourcing in these areas makes it very difficult for clinicians to deliver the care that so many patients need.

“The diabetes epidemic in these communities is at critical level – and without a shift in resourcing and improved models of care – it’s not going to get any better,” says Associate Professor Cohen. ^{RQ}



“ Genetics are a large factor for these communities, and I think it’s really important that both the medical community and the public have a better understanding of why people in our Indigenous communities suffer from diabetes at such alarming levels.”

Member Satisfaction

RESPONDING TO MEMBER FEEDBACK

The results of RACP's 2019 Member Satisfaction Survey (MSS) have shown a decrease in member satisfaction since the last survey in October 2016, but many initiatives are already underway across the College to improve member engagement and satisfaction.

The MSS is a longitudinal study of member satisfaction across five key areas: overall satisfaction; satisfaction with representation to the Government, the regulator and other bodies; satisfaction with the College's policy and advocacy activities; and satisfaction with the level of College communication. The 2019 survey also sought members' feedback on a range of additional measures including College service principals, member involvement with the College, online communities, online resources, health and wellbeing, RACP Congress, Continuing Professional Development (for Fellows) and future focus for the College. The 2019 study was run by Woolcott Research & Engagement from Monday, 25 February 2019 to Monday, 18 March 2019.



Key opportunities

The broader results identified key opportunities for the College to improve members' experience with a focus on the way we communicate and our online resources.

We need to:

- **communicate** more effectively with our members – so you know what we are doing and what we are offering to support you.
- **showcase our online learning resources** – these are developed by expert Fellows in collaboration with College staff and feature rich video case studies, tools and frameworks you can use in your everyday practice.
- **improve the College website** – so that it's easier for you to access information and services.

What we are doing

There are several activities being implemented across the College that are creating positive change and benefits for our members, including:

- Indigenous Strategic Framework 2018-2028
- Health and Wellbeing Strategy 2019-2021
- International Strategy.

A key area of change and progress is through the Education Renewal Program:

We are redesigning, developing and implementing 40 curricula across the Basic Training and Advanced Training programs. This follows a competency-based medical education framework through a co-design approach with targeted reviews, digital feedback and expert committees.

We are developing new software, Tracc, to improve Fellows' and trainees' experience when accessing curricula material, recording learning and supervisor assessments. Tracc will be piloted with our early adopter sites across 2020 and 2021.

Our activities to improve member engagement are guided by an improved understanding of member needs, defining stages in a member's career journey and adopting service principals that reflect the experience members have told us they want in their interaction with us.

The 2019 results are guiding us on this path, with work already done behind the scenes by Committees and staff to improve members' experience with their College. This will become more visible to the wider membership in 2020.

Work is well underway in response to the survey results which are informing the development of our new Member Engagement Strategy. This will help guide and assist us in monitoring how we improve your experience with your College and demonstrate the value of your membership. [RQ](#)

3,393 respondents.

34 per cent increase on respondents to the 2016 Member Satisfaction Survey.

Key results:

- Overall satisfaction decreased from 54 per cent in 2016 to 40 per cent in 2019.
- Satisfaction with representation to the Government, the regulator and other bodies decreased from 45 per cent in 2016 to 35 per cent in 2019.
- Satisfaction with the College's policy and advocacy activities decreased from 57 per cent in 2016 to 32 per cent in 2019.
- Value for money decreased to 21 per cent in 2019, down from 29 per cent in 2016.
- Satisfaction with the level of communication is down from 54 per cent in 2016, at 44 per cent in 2019.

- Members in the Faculties and Chapters were more satisfied than those in the Divisions.
- New Zealand and overseas members were more satisfied than Australian members.
- Regional and rural members were more satisfied than those in metro areas.
- Late career and retired Fellows were most satisfied.
- Trainees were least satisfied, with Basic Trainees slightly more satisfied than Advanced Trainees.
- Males were generally more satisfied than females on most measures.
- Members who participate on College committees were significantly more satisfied.



Cancer treatment just a video call away

For many patients, undertaking chemotherapy can be daunting, let alone when you are about to embark on this treatment away from home, family and friends.

A new TeleChemotherapy (TeleChemo) trial in the Pilbara region of Western Australia is giving locals access to metropolitan treatment via video link, removing the stress and burdens of travelling to Perth for each treatment.

Dr Wei-Sen Lam, WA Country Health Service Clinical Lead for Medical Oncology and Medical Oncologist at Esperance and Fiona Stanley Hospital, can already see the benefits of introducing TeleChemo to our largest state.

“A lot of our patients have to travel long distances, for instance if you’re in the East Kimberley, sometimes it takes a couple of days to get to Perth for your treatment. The flight time from Broome is two and a half hours, but to get to Broome for your flight you might also need to take a car and a bus,” says Dr Lam.

“It’s a long journey and it’s quite exhausting for a patient to be on treatment and to travel these long distances. Some people take three, four, even five days out of their usual lives just to receive one treatment or to have an appointment.”

For people in country WA, the further they are away from the metropolitan area, the poorer their outcomes when diagnosed with cancer. Country people have reduced rates of participation in screening programs, are diagnosed at a later stage and are less likely to complete treatment, and this is affecting survival.

“The difference with TeleChemo is that patients will ‘see’ a specialist from a metropolitan site via video conference. Treatment is delivered by a TeleChemotherapy nurse in the patient’s regional area, supervised by a senior chemotherapy nurse.”

“Life shouldn’t stop just because you’re receiving cancer treatment.”

While some patients may have to travel to Perth for initial testing and diagnosis, their ongoing treatment can be provided locally.

Determining whether a patient is suitable to have their treatment locally is based on a number of eligibility criteria aimed at providing a safe, quality service with regional capacity in mind.

“At the moment we’re using low risk chemotherapy and anti-neoplastic treatments such as immunotherapy. Patients who have low risk for toxicity and complications and meet the eligibility criteria can be treated in regional areas.

“Some patients won’t fit this criteria, however we want to make sure that the patients that require additional support and care can be treated in the most appropriate place, and at times that will still be the metropolitan area,” explains Dr Lam.

TeleChemo has previously been provided in rural areas of New South Wales and Queensland, which Dr Lam credits to the work of many, including physicians Professor Sabe Sabesan and Dr Florian Honeyball. While the Pilbara region is the first in WA to

implement the service, Dr Lam hopes this will quickly grow across the state.

“The pilot project is really designed for upskilling in the regional areas. Over time as the capacity and the experience improves, then they’ll be treating more and more patients and we hope to expand to future regional locations.”

The grand vision is not only to extend the service geographically, but to other specialties so that more patients are able to access support for a range of health issues locally. This again comes down to upskilling nurses in regional areas so they’re comfortable in delivering different treatments and upskilling hospitals so they’re comfortable in managing the complications of these treatments.

“It’s not just about the treatment, it’s about the holistic care of patients. If you have patients who live and work regionally they lose income because they’re away from home, but they are also away from their family and support system. To be able to change that is really big for our patients.

“Life shouldn’t stop just because you’re receiving cancer treatment,” says Dr Lam. [RQ](#)

Balancing medical science with humanity



RACP Congress is our flagship event which brings physicians and paediatricians from all specialties together to discuss the issues and topics that impact their work.

With the theme 'Balancing medical science with humanity', RACP Congress 2020 will explore how breakthroughs in science and research are constantly transforming how we approach our practise. We will explore what it is to be good medical citizens in this rapidly changing world.

"Retaining humanity and empathy in what we do makes us better scientists for our patients and for each other," says Congress Lead Fellow, Professor Don Campbell.

"We can learn from each other, from our patients and from the past, so we are better prepared for the future."

Ms Evelyn Culnane, who leads transition to Adult Care at the Royal Children's Hospital (RCH) Melbourne is leading a session that explores the challenges we face when transitioning patients from paediatric to adult care. Joined by Dr Jeremy Lewin, Medical Director of ONTrac at Peter Mac Victorian Adolescent and Young Adult Cancer Service, Dr Susie Gibb, Medical Lead of the Complex Care Hub at RCH and Dr Natasha Cook, a nephrologist from Austin Health, the panel will discuss the impact of transition in care to the most complex patients, especially those with multiple comorbidities and those with

severe developmental, behavioural and/or mental health concerns.

The healthy futures / healthy cities session asks the question; how do we design cities that are good for people's health? Urban density, climate change, digital networks, ageing, vulnerability and loneliness are all issues to consider in the design for health in cities. Director at Monash University's Sustainable Development Unit, Professor Tony Capon, Mr Rupert Lee, General Manager Partnerships and Clinical Use at the Australian Digital Health Agency (ADHA) and Dr Lucy Gunn, Research Fellow at the RMIT University Centre for Urban Research will open the floor to questions as they explore this big issue.

The microbiome describes the genome of all the microorganisms that live in

or on vertebrates. Emerging research and evolving technology focuses on the intestinal ecosystem and body surfaces in general. In the Emerging role of the microbiome session we will explore how our environment influences the expression of the microbiome and how the microbiome influences human health and disease.

These are just some of the shared sessions at RACP Congress 2020 aimed at uniting and energising all physicians from all specialties.

Whilst the shared sessions focus on some of the big issues that face all physicians and paediatricians, there is also an opportunity to contribute and learn through the specialty streams.

For the full program and to register visit the Congress website.

www.racpcongress.com.au



Presenting the Congress 2020 plenary orators

**Priscilla Kinkaid-Smith
Oration**

Ms Pat Anderson AO

Pat Anderson is an Australian human rights advocate and health administrator, an Alyawarre woman from the Northern Territory, she is well known internationally as a social justice advocate, advocating for improved health, and educational and protection outcomes for Aboriginal children.

Redfern Oration

Professor Tony Capon

Tony Capon directs the Monash Sustainable Development Institute (MSDI) and holds a chair in Planetary Health in the School of Public Health and Preventive Medicine at Monash University. A former director of the global health institute at United Nations University (UNU-IIGH), he is a public health physician and authority in environmental health and health promotion. His research focuses on urbanisation, sustainable development and population health.

George Burniston Oration

Associate Professor Adam Scheinberg

Adam Scheinberg is State-wide Medical Director of the Victorian Paediatric Rehabilitation Service (VPRS) and Head of Department Paediatric Rehabilitation at the Royal Children's Hospital. With over 20 years' experience in the care of children and adults with disability and an interest in technology, he has worked with engineers at Swinburne University to develop a humanoid robot to assist with post-operative care. His focus is on growing, living and ageing with a disability.

Ferguson-Glass Oration

Professor Michael Shanahan

Michael Shanahan currently works at the Department of Rheumatology, Southern Adelaide Local Health Network. Michael does research in internal medicine (general medicine), rheumatology, musculoskeletal medicine, occupational medicine and medical education.

Cottrell Memorial Lecture

Professor Des Gorman

Des Gorman (Ngati Kuri and Ngapuhi) is a Professor of Medicine in the Faculty of Medical and Health Sciences at the University of Auckland. From 2005 to 2010, he was the Head of the University's School of Medicine. He was awarded two doctorates for in-vivo brain injury research. His non-clinical interests include health system design and funding, and health workforce planning and development.

Howard Williams Medal Oration

Professor Louise Baur AM

Louise Baur is the Professor and Head of Child & Adolescent Health at the University of Sydney as well as Head of the Children's Hospital Westmead Clinical School. She is a senior consultant paediatrician at the Sydney Children's Hospitals Network where she is an active member – and former Head – of Weight Management Services. Louise has worked in many clinical, public health and policy aspects of paediatric obesity and nutrition. Louise is currently Director of the NHMRC Centre of Research Excellence in the Early Prevention of Obesity in Childhood.



Introducing **playtime** to **improve** the health of **older** Australians

A social experiment at the heart of the ABC's Australian Academy of Cinema and Television Awards nominated program 'Old People's Home for 4 Year Olds' has shown the positive health impacts for older Australians who spend time with our younger generations.

The documentary series paired a group of older retirement home residents with a class of pre-schoolers. Over seven weeks, the eleven older Australians and ten pre-schoolers came together in a specially designed pre-school within a retirement home for daily activities including lunches, arts, dance, mental and physical challenges as well as excursions.

The social experiment was run by a team of experts in geriatric medicine and an early childhood expert, who monitored the progress of both groups throughout, tracking quantifiable changes in the older group, and correspondingly, the developmental growth of the children.

Dr Stephanie Ward, a staff specialist at the Prince of Wales Hospital, Sydney

and a Senior Research Fellow at the University of New South Wales' Centre of Healthy Brain Ageing, came on board as the experiment's geriatrician.

"It was a no brainer for me because I'm also the mother of a six-year-old, so it was really fresh in my mind just how beneficial, and beautiful, it is when older and younger family members interact. In geriatrics, it's something that I love to see, but, equally, often don't see enough of," says Dr Ward.

Working in nursing homes as part of her hospital's outreach service, Dr Ward sees a lot of loneliness and isolation, and wasn't surprised by the initial testing.

"At the beginning, four of the 11 participants screened positive for depression. In residential aged care



Dr Stephanie Ward, Prince of Wales Hospital, Sydney



settings, over 50 per cent of people have depression symptoms. Many members of the group were inactive, were weak, had slow gait speed and poor balance, and were what we would term “frail”. The majority had experienced falls, and were very fearful of further falls, which is also very common amongst the patient group cared for by geriatricians.

“At the end we repeated the measures. Of the four people who had screened positive for depression, only one person remained in that category. That person was absent for a lot of the experiment as he had to take time out for a knee replacement. Overall 80 per

cent improved on their first score.

“Ninety per cent were more active, 80 per cent improved on gait speed and grip strength, and 50 per cent improved in balance. Overall the changes were really impressive.

“In the beginning I was hopeful that the experiment would be beneficial, but I was also concerned that not everyone would enjoy it, that it might have been too much for some and, like many of the participants, I was also mindful of the risk of falls. So, I guess I was really surprised that everybody enjoyed being part of it, nobody regretted it and for some participants it was an incredibly transformative

experience. I think it was even more beneficial than I thought it would be,” says Dr Ward.

Since filming the experiment, many of the relationships that were formed have continued. Parents of a few of the children bring them in to see their older friends and many of the residents have also formed friendships with each other.

The experience has also prompted the residents to look at new opportunities, with a couple of the participants now regularly visiting the onsite preschool.

Dr Ward explains that the show has had an impact on viewers too.

“What’s been incredible is that it has sparked such enthusiasm in the community for exploring and promoting intergenerational contact. Intergenerational playgroup registrations have doubled since the show aired. I’ve been contacted by local schools wanting to start visiting residential aged care people, and parent groups asking what they can do. Aged care providers are increasingly interested in co-location of residential aged care facilities with early childhood services.

“I think it’s [the show] reminded everybody just how amazing older people are. As a geriatrician, I see this every day and that’s why I love my job. Spending time with older people is enlightening, and humbling, and I think that a lot in our community just don’t get that opportunity to interact with older members of the public.” ^{RQ}



Images courtesy of Endemol Shine Australia Pty Ltd and ABC TV.

More information about intergenerational play and how to get involved is available at www.agelessplay.com.au

How Mangatjay McGregor became the first Yolngu doctor

In 2018, Mangatjay McGregor graduated on the stage of Flinders University, becoming the first person from the Yolngu people to receive a medical degree.

Dr McGregor grew up in Milingimbi, an island community off Arnhem Land in the Northern Territory. With both his parents very young – McGregor's grandmothers on both sides of the family played a key role in raising him and providing him with the inspiration to pursue an education and achieve his dream of becoming a doctor.

Dr McGregor said that seeing his fellow classmates in school become sick with a variety of illnesses always caused him concern. “I remember seeing my classmates endure diseases like diabetes or heart problems and I thought it just wasn't normal for so many young people in my community to be suffering like this. I knew that I had to do something to help improve the health outcomes in my community.”

At that stage Dr McGregor didn't know he would then go on to become the very first doctor from the Yolngu community – in fact it was only after he was awarded the degree in 2018 that he realised he might have been the first.

After graduating, Dr McGregor had a range of conversations with people from the Yolngu community who confirmed they didn't know anyone in their community or their ancestors to ever receive a medical degree. At the same time the ABC was writing a feature piece on Dr McGregor, so they put in a range of calls to universities to see if anyone of Yolngu background had ever graduated with a medical degree. After a series of calls and emails, it's safe to say that Dr McGregor is the first from the Yolngu community ever recorded as receiving a medical degree.

Next year Mangatjay McGregor will be travelling to Alice Springs to gain more experience with other Aboriginal communities as a Resident Medical Officer (RMO), as he takes

his next steps towards dual training in paediatrics and child psychiatry.

We asked Dr Mangatjay a few questions to find out a bit more about how he went from growing up in a remote community in the Northern Territory to graduating from university and treating patients at the Royal Darwin Hospital.

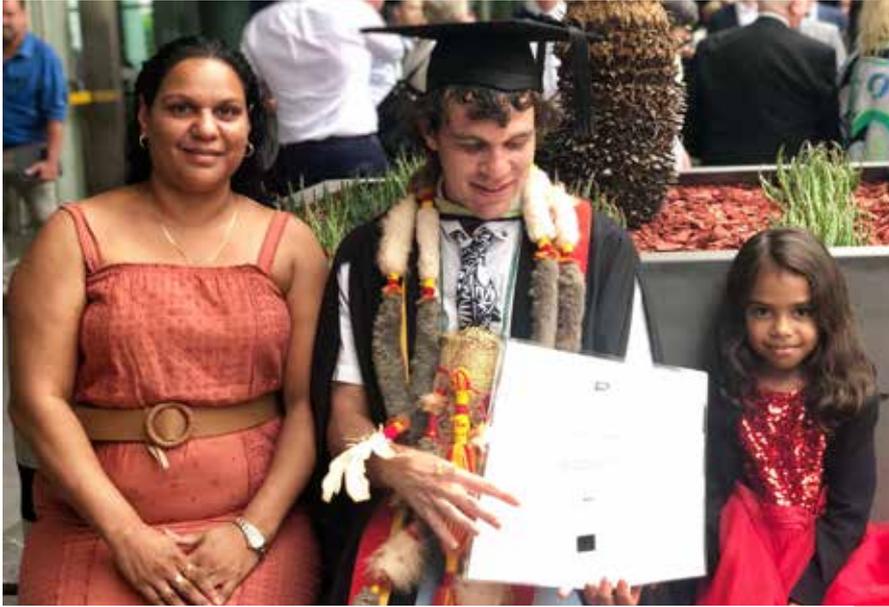
What inspired you to become a doctor?

“I can't really remember ever wanting to be anything else. My mum said that as I was growing up she always knew I'd be a doctor. As a kid I always really enjoyed helping people and I was moved by seeing suffering in others. I remember a classmate had to be flown interstate to get heart surgery – and she was only seven or eight years old – and I was shocked.

“I knew that the illnesses in my community and this level of suffering wasn't normal. I felt the need to do something to intervene, and for me, that was becoming a doctor.”

What factors made the biggest difference in your journey to become a doctor?

“One of the reasons why I thought it was possible for me to go through the education system was because of my two grandmas – my Aboriginal and Caucasian grandmas. Both my



“ I knew that the illnesses in my community and this level of suffering wasn’t normal. I felt the need to do something to intervene, and for me, that was becoming a doctor.”

Left: Mangatjay outside the Adelaide Convention Centre with his mum Sabrina Gurruwiwi and cousin Marley.

Right: Mangatjay in a classroom at Nhulunbuy primary school giving a talk and reading a book in Yolngu Matha that the children created.

grandmas were heavily involved in education and I think that made a really big difference.

“My paternal grandma, my Momu, was a teacher at Millingimbi – that’s how my mum and dad met. She eventually moved up into a principal role.

“My other grandma, my Māri, had been involved in education for a very long time and is still teaching. Having my grandmothers as these amazing two role models was crucial. I don’t know if I would have gone to university or even finished high school without them.”

What was the toughest part of your journey?

“The toughest part of my journey was definitely the first year of university. Moving from my community in Millingimbi to Adelaide and adjusting to the new environment was really

challenging and being away really compounded some of my pre-existing mental battles.

“The first year of university was pretty consumed by depression and my grades weren’t anywhere near what I would normally get, so I knew something was wrong. I decided to get help from a counsellor and that made a big difference. I was able to put in a plan to manage the depression I was going through. I also discovered meditation which made, and still makes, such a big difference to my mental health. It’s hard to put into words how useful meditation has been.

“Because I reached out for help and developed some good tools to manage my mental health, I was able to cope much better throughout the rest of my degree. There were still ups and downs but definitely the first year of university was the hardest part.”

What advice would you give to other young people who want to become a doctor?

“To know who you are and where you come from. Knowing this is such a powerful thing.

“Remembering where you are from and connecting with that is such a constant source of strength and empowerment.

“Connecting with your sense of belonging and your community is a different journey for everybody – for some people it might come easier than others. I was lucky growing up with my Aboriginal family as I always had that sense of who I was and where I was from. The problem is, a lot of people don’t get that.

“While it was really tough at times, I can say it is definitely a journey worth taking.” *RQ*

Providing care to underserved populations

Planning is now well underway for the Tri-nation Alliance International Medical Symposium (IMS) to be held in March 2020 in Sydney. IMS brings leaders from the medical profession, educators, regulators and policy makers together to address big-picture subjects from across the sector.

cementing the strong historical relationships between the medical professions of Canada, New Zealand and Australia, a formal agreement between The Royal College of Physicians and Surgeons of Canada, The Royal Australasian College of Physicians, The Royal Australasian College of Surgeons, The Australian and New Zealand College of Anaesthetists and The Royal Australasian College of Psychiatrists created the Tri-nation Alliance. Now in its ninth year, IMS is an annual event that reinforces this alliance, allowing sharing of knowledge and expertise.

The IMS theme for 2020, 'Providing care to underserved populations', allows for the exploration of underserved populations in our three countries, noting this can be due to isolation, geographical location or many other social determinants. There are parallels, for instance, in the Canadian and Australian experience, the obvious one being vast rural distances and isolated and Indigenous communities.

Dr Anne Cunningham, PhD FRACP, Interim Dean of the Royal Australasian College of Physicians, is leading the working group which is planning the upcoming event.

"The challenge for the speakers will be to draw out how we best train and prepare our medical specialists to care for these communities and how we sustain their expertise and enthusiasm throughout their different career stages, from selection into medical schools to continuing professional development as mature doctors," she says.

IMS will also explore how innovative technologies such as Artificial Intelligence and Telemedicine are applied to enhance access to underserved populations and how this will change future practice.

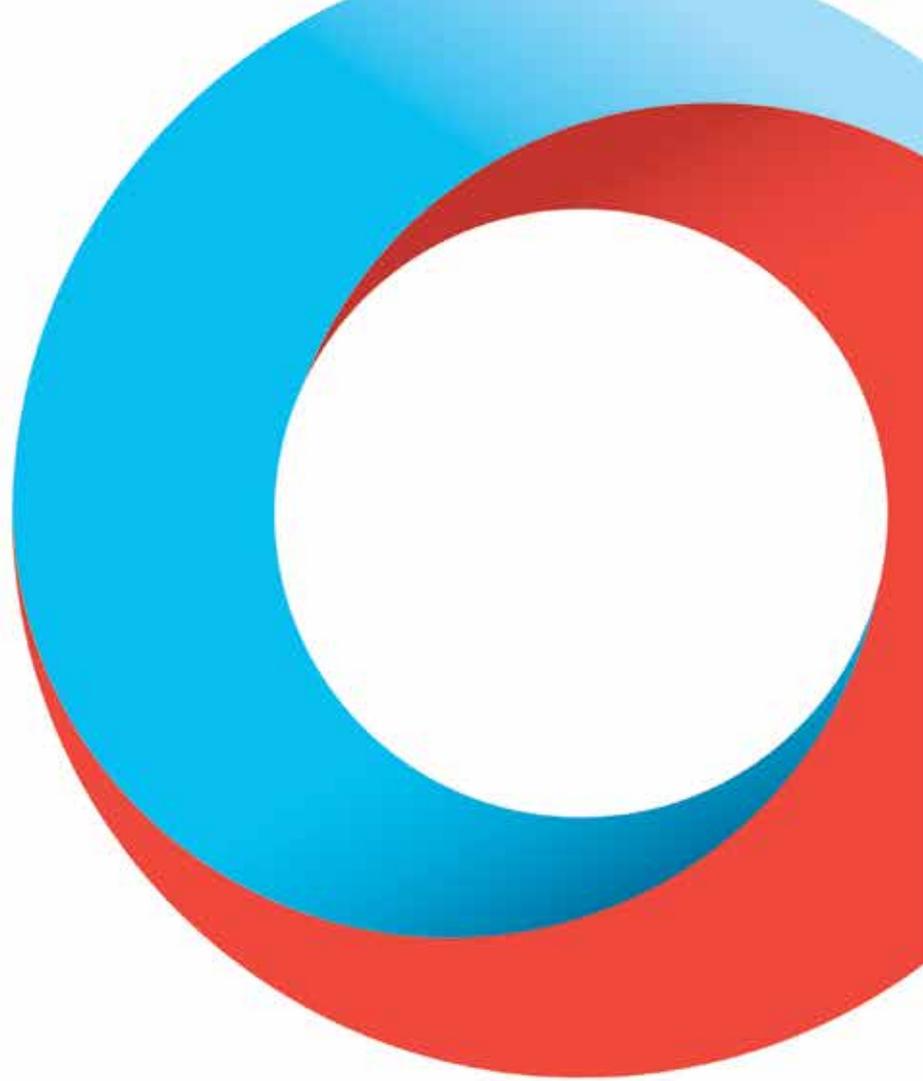
"IMS is a great opportunity for us to come together from around the world to share the latest insights in higher medical education," says Dr Cunningham.

"We all face similar challenges in meeting the educational needs of our members, whether it's specialist training or continuing professional development. The doctors of the future will need to be increasingly flexible and adaptable and embrace lifelong learning. We can share the experiences of other colleges and countries to help provide the best outcomes for our trainees and Fellows as well as the patient populations they serve."

Expert global speakers are being invited to share their knowledge with delegates, including keynote speakers Professor Roger Strasser, formerly Dean of the Northern Ontario School of Medicine, an expert renowned for promoting the importance of socially accountable medical education to serve communities; Professor Diane Sarfati, a public health physician and cancer epidemiologist from the University of Otago with expertise in the area of ethnic disparities in disease outcomes, particularly those affecting Indigenous peoples; and Dr Belinda O'Sullivan, a researcher leading international scale studies on rural health systems, from the University of Queensland Rural Clinical School.

Anyone who has an interest in this area is invited to attend. Registrations are now open, visit www.internationalmedicalsymposium.com.au to register. Friday, 20 March 2020, Amora Hotel, Jamison Street, Sydney

Sydney
20 March

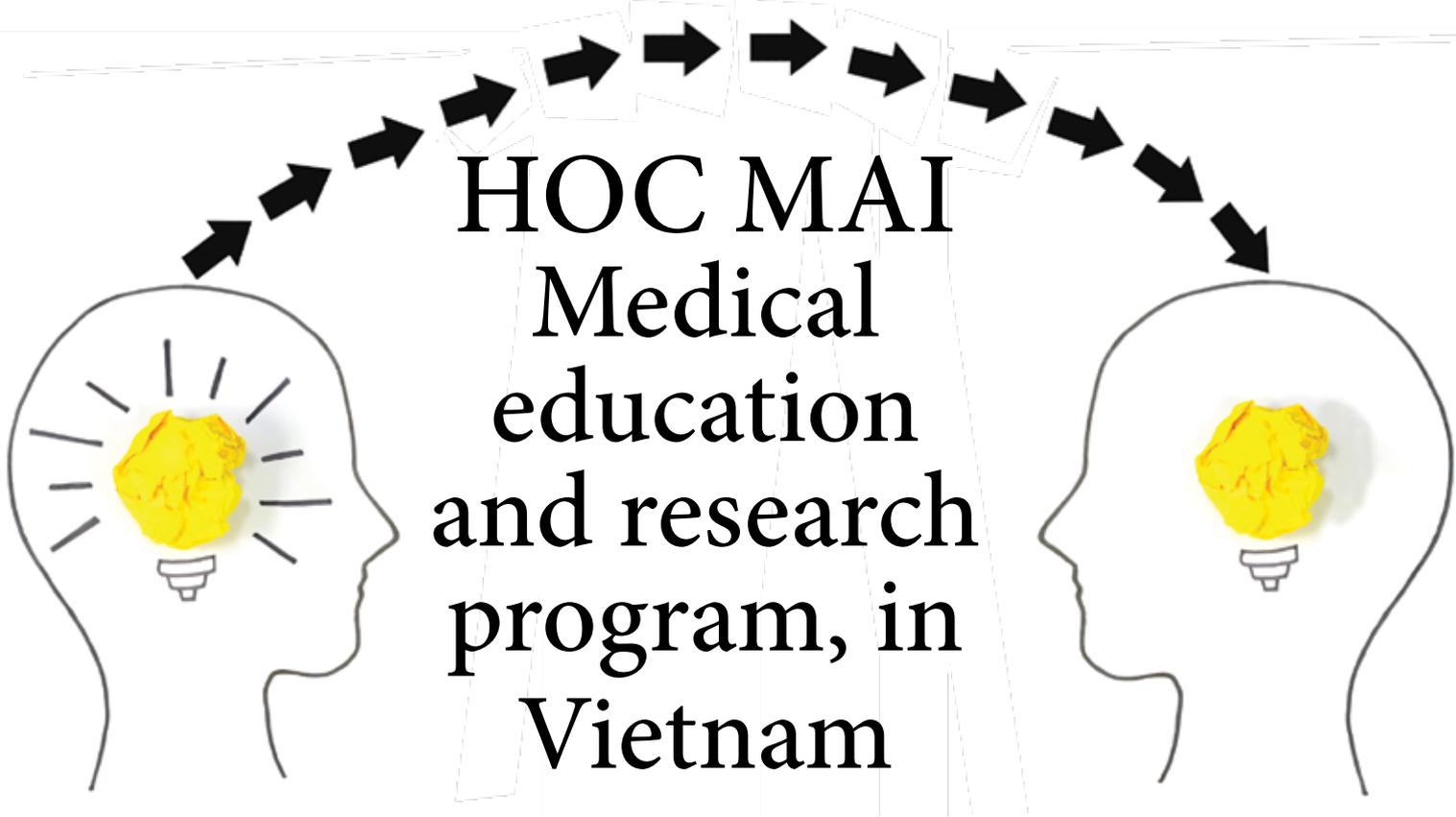


INTERNATIONAL MEDICAL SYMPOSIUM 2020

Providing care to
underserved populations



Register at www.internationalmedicalsymposium.com.au



HOC MAI Medical education and research program, in Vietnam

The Hoc Mai Foundation (Forever learning) was formed in 2001 to foster learning between Vietnamese and Australian medical practitioners, nurses and allied healthcare professionals.

The Foundation's inception resulted from a meeting in 1998 between Professor Kerry Goulston and Professor Ton That Bach, a cardiothoracic surgeon and Rector of Hanoi Medical University. Initially based at the University of Sydney, the Foundation has recently moved to the Royal North Shore Hospital. From the outset, the aim was to learn from each other. With regard to the Medical Education and Research Program, a group of volunteers, each of whom pay their own expenses, go to Vietnam twice a year, visiting hospitals and universities. The teachers include doctors (general practitioners and specialists), nurses, school teachers, former politicians, lawyers, Vietnam veterans, administrators and social workers.

Teaching takes many forms, from practising English to sharing knowledge on up-to-date treatments, through ward rounds, lectures, workshops and seminars, generally in an interactive manner. Subjects have included patient safety, smoking cessation, medical care of the elderly, family medicine, leadership, palliative care, ethics and hospital management.

There is also a well-established nurses program and a medical English club for students and doctors. In addition, regular weekend teaching is undertaken up to eight times a year for a select group who are chosen as potential future leaders in Vietnamese healthcare. From this cohort of 40–50, up to 30 are selected to come to Sydney for four weeks of intensive lectures and clinical attachments, with the costs being covered by Hoc Mai. Selection is based on interviews, references and curriculum vitae. These scholarships are highly regarded and very competitive. To date, over 200 Vietnamese have been recipients of these Hoc Mai scholarships.

Apart from the Medical Education and Research Program, the Hoc Mai Foundation, currently chaired by Professor Bruce Robinson, also arranges research seminars in both North and South Vietnam as well as student exchanges between Australia and Vietnam. In addition, there are well-established Paediatric, Obstetric, Psychiatry and Radiation Oncology research and clinical programs.

Hoc Mai is a not-for-profit organisation with funding being completely dependent on donations and volunteers paying for themselves. In the past, grants were awarded from the Department of Foreign Affairs and Trade, although these unfortunately ceased a few years ago. The trips are extremely rewarding and enjoyable. [RQ](#)

If anyone is interested in coming, would like to learn more about the program or make a donation, please contact one of us.

Associate Professor Christopher Pokorny –
cpokorny@ozemail.com.au

Professor Kerry Goulston –
kerry.goulston@sydney.edu.au

Professor Kim Oates –
kim.oates@sydney.edu.au



Gastroenterologist Dr Robert Read discussing a case at the bedside of a patient at Bach Mai Hospital, Hanoi.

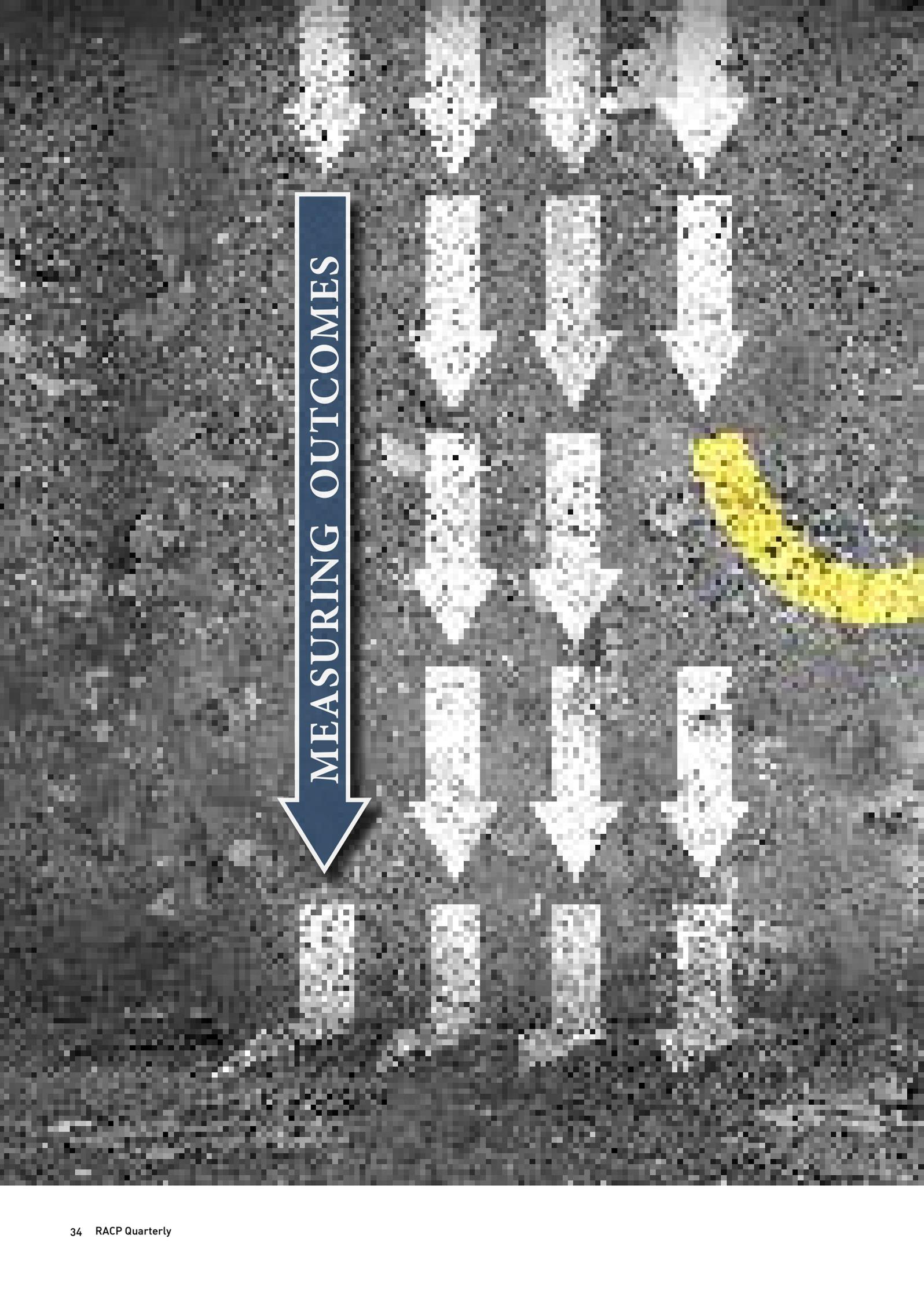
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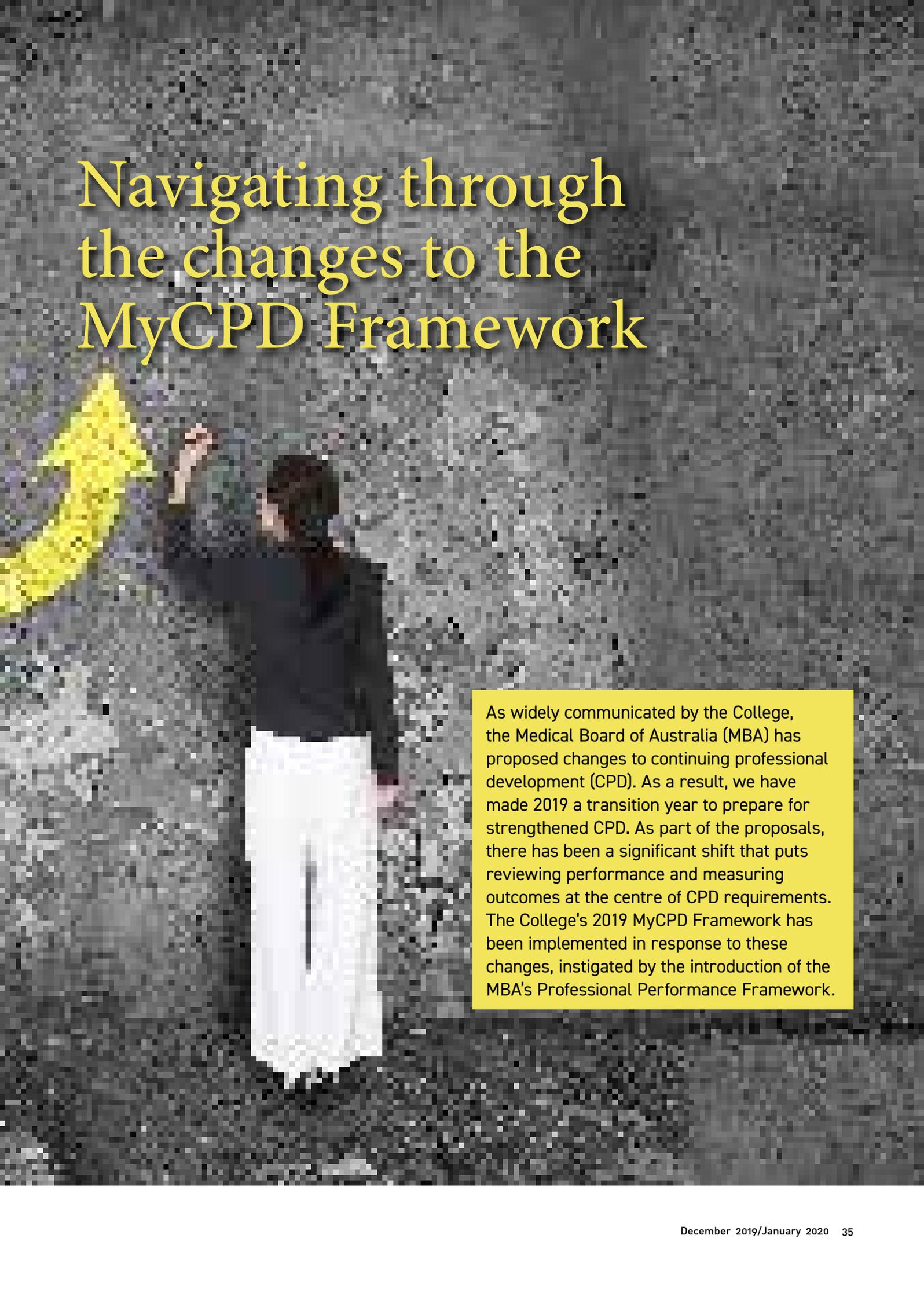
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MEASURING OUTCOMES

Navigating through the changes to the MyCPD Framework

A woman with dark hair, wearing a black long-sleeved top and a white skirt, stands in a dark room. She is pointing her right hand towards a large, glowing yellow arrow that points upwards and to the right. The arrow is mounted on a dark, textured wall. The overall scene is dimly lit, with the primary light source being the glowing arrow.

As widely communicated by the College, the Medical Board of Australia (MBA) has proposed changes to continuing professional development (CPD). As a result, we have made 2019 a transition year to prepare for strengthened CPD. As part of the proposals, there has been a significant shift that puts reviewing performance and measuring outcomes at the centre of CPD requirements. The College's 2019 MyCPD Framework has been implemented in response to these changes, instigated by the introduction of the MBA's Professional Performance Framework.

Your College is trying to facilitate and support you to understand the new CPD requirements as well as provide tools and resources for reviewing performance and measuring outcomes. We want to support you as you review and potentially improve your practice.

To help you navigate through the changes to the MyCPD Framework, we spoke with Associate Professor David Smallwood, Director of General Medicine at the Austin Hospital. Associate Professor Smallwood has an interest in general respiratory conditions such as asthma, chronic obstructive pulmonary disease, interstitial lung disease, cough and breathlessness, and the diagnosis of lung cancer.

www.racp.edu.au/fellows/continuing-professional-development

Why do you feel measuring outcomes activities is an important part of CPD?

“It’s important for us to review our practices, as we want good outcomes for patients. To do so we need to undertake best practice.

“Fellows work in many different contexts – solo, private, large teaching hospitals, transitioning into retirement, returning from paternity leave etc. To ensure the best outcomes for our patients, we must be fit for practice. Not only must we undertake education activities, but we should also review and measure our performance. In the past, as a profession we have not been as explicit about our requirements in assessing performance, which is why this aspect of CPD can appear quite confronting.

“I am fortunate that my work environment allows for my peers to assist in reviewing my practice on a regular basis. In addition, they allow me to identify ways of planning and implementing improvement. It is not a threat, but an opportunity to improve – and the benefits are rewarding. The challenge is to understand what is required and to find the time to do it.

“An example of how we measure outcomes is through our data sets. For example, performing audits on hand hygiene. We can respond appropriately if our department and hospital are not measuring up to the standard, as determined by the data sets.”

What impact can measuring outcomes have on your practice (and potential impact on patient outcomes)? What are the potential value and benefits?

“We are not particularly good at having an overall understanding of our performance. Having an external lens on how we practise can benefit us. It will help us further understand how we impact our patients and the community.

CASE STUDY: PROFESSOR PETER PROCOPIS FRACP

One example of an activity that meets Category 3 (measuring outcomes) requirements is audit. Participation in institution led audits will meet these requirements as will completion of a small self-audit of your own practice. An example of a self-audit is outlined briefly below. While it draws on a specific Evolve recommendation, any of the Evolve recommendations or other approved standards could be used in the same way. It is essential the audit you choose is meaningful in the context of your practice.

IDENTIFY THE AREA OF PRACTICE AND/OR AUDIT QUESTION YOU WANT TO ANSWER AND THE STANDARDS YOU WILL USE

Avoid medication-related harm in older patients (over 65 years) receiving five or more regularly-used medicines by performing a complete medication review and deprescribing whenever appropriate.

COLLECT AND ANALYSE THE DATA

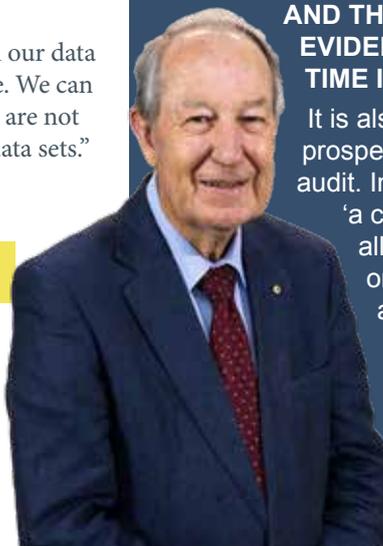
Review the case notes of a minimum of 10 of your most recent patients over 65 to identify the number of medications they were on, and how often you have done a complete medication review.

IDENTIFY ANY CHANGE IN PRACTICE, PLAN A RE-AUDIT

The audit may suggest a change in practice or a need for further investigation.

KEEP THE PLAN OF YOUR AUDIT AND THE RECOMMENDATIONS AS EVIDENCE IN MYCPD AND LOG THE TIME IT TOOK FOR CPD CREDITS

It is also possible to complete a prospective, rather than retrospective audit. In this case you may decide to do ‘a complete medication review’ of all patients over 65 receiving five or more regularly-used medicines and then track their progress to identify any impact. It is also important to identify if there are cultural or health equity issues in the audits you complete.



“We can turn to our peers and other healthcare professionals for help. We all want to do our best to help our patients’ life and this is one way of reflecting on the work we do for our patients.”

Can you describe specific examples of how you use measuring outcomes activities and the positive impact they have had?

“In heart failure we recognise our readmission rates have been higher than our peers, so we have specifically tried to promote an outreach service that will assist community members e.g. daily weights. We are now trying to do more benchmarking to see what success is for our peers.

“In my jurisdiction we do a lot of teaching as there are a lot of trainees. A recent survey we conducted discovered trainees had concerns about over-time and rosters. This affected their willingness to work at our organisation, which led to a change in resources/rostering. The change led to an improvement in wellbeing.

“It is important for us to survey the needs of fellow clinicians. It is particularly important for locums who fly in and fly out. It is just as important for them to know they are meeting the needs of our community.

“I understand all of this takes time and resources. However, any of these undertakings do not need to be large, but some targeted reviews should be possible in most contexts. The College is doing its best to provide resources to assist all its Fellows in this sort of review process.”

How is the College responding to Fellow concerns about the new CPD requirements?

“We’ve received a lot of feedback from Australian based Fellows and we respond to all of them. We’ve been grateful for the feedback.

“There will be further opportunity to provide feedback to the MBA as they undertake the consultation process on the revised registration standard for CPD. The College has been advocating strongly on behalf of members and will submit a response to this consultation. Members are encouraged to provide an independent submission to the MBA’s public consultation, which is currently open until 14 February 2020. Members can find further information on the AHPRA website.

“Although we have been making changes to respond to the proposed future regulatory requirements that will be coming, we are still trying to shape it so it’s meaningful and achievable for Fellows.

“While we are encouraging all Fellows to work within the new CPD Framework, for those that are unable to meet the new requirements for 2019, you will be required to do the CPD transition course which will be released this month.” ^{RQ}

CASE STUDY: LOCUM CPD

The College recognises that regulatory changes to CPD are likely to impact groups of physicians differently. One group that may find it more challenging to complete some Category 2 and 3 requirements are physicians working predominantly in locum roles. In conversation with a physician who has many years experience working in New Zealand as a locum, the following emerged as suggested activities to meet the requirements of categories 2 and 3:

Record CPD activities as you go. This enables you to more easily add reflections if you think the activity will change or influence your practice.

If possible, create a peer review group with two or three others in your field. While others may or may not be locums, it will be important to have the opportunity to review cases/incidents. It is likely this peer review will need to happen virtually (via teleconference or videoconference) but it can become a rich source of reflection on your practice.

- Ask for feedback from the Clinical Director or your colleagues as another form of peer review. There will be limitations to doing this as a locum, but it can provide a source of useful feedback.
- Consider gathering feedback from patients. This can be done in several ways, but if you do this via a multisource feedback tool it can provide a rich source of information that may influence your practice. It doesn’t matter that this may take longer for you to complete than those in full-time positions and you can draw the feedback from patients in different locations. The College strongly recommends you include a debrief of your multisource feedback report.
- For clinic audit, choose a condition you see often and look for any guidelines (such as the Evolve recommendations) or review articles about the condition. Try measuring one aspect of your practice against the guideline. In paediatrics this might be common conditions like bronchiolitis, asthma, eczema, ADHD, etc. It is possible to also complete a prospective audit, i.e. if you identify a new treatment option from your education activities you may find it valuable to document how implementing that option impacts your practice.
- Another rich vein for audit is checking records of consent/discussion before a procedure is carried out on a patient.

ACROSS

- 1 Semi-circular middle thumbs stretch and bend around (10)
- 6 See 7-down
- 10 It keeps doctors buzzing when tardy holding the first tablet (5)
- 11 Interval covers enteric coating with charged particle excision (9)
- 12 Catch ice, mishandle first cadaver of ill health (9)
- 14 Collect sound inverted in acoustician nipple (5)
- 15 Infiltrator unit (4)
- 16 Screwed up note containing centre fundus cord (6)
- 17 Very resistant to three quarters of an acre (1,1,1)
- 19 Burn clause trump created to query meningitis (6,9)
- 21 Constricts screws (8)
- 23 Blemish coarse rubies (6)
- 25 Small baby made tea after gas (7)
- 26 Do without antibody mark (7)
- 27 A type of mutation, no French taste? (8)
- 28 Groovy, small and healthy (5)

DOWN

- 1 A part of the protocol I concocted gave me wind (5)
- 2 Trice confused, you heard half of the asylum network (9)
- 3 Channel true ER shambles (6)
- 4 Emergency workers are the number one concerning initial skills and reasons (5,10)
- 5 To diagnose pancreatic cancer or part of an ileus (1,1,1)
- 7, 6-across
Can a stranger help when you can't control your limb? (5,4)
- 8 A specialty caught in time has teeth (7)
- 9 Uncus cut tapir's disorganised needle givers (14)
- 13 Fish on small triplets (6)

DOWN (continued)

- 15 Regulates sleep when afflicted by no ailment (9)
- 17 Gristle from rickshaw I left over time (9)
- 18 Cut wrapper and wrapped overturned pie (8)
- 20 Hard-nosed Capone, a notch! (7)
- 22 Love shown by a smile or perhaps private parts? (5)
- 24 Tumultuous era gathers sound (3)

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2020 Howard Williams Medal winner announced

Congratulations to Professor Louise Baur AM, FRACP who has been announced as the 2020 Howard Williams Medal winner for her outstanding contribution to improving the health of children and young people in Australia and New Zealand.

Professor and Head of Child and Adolescent Health at the University of Sydney as well as Head of Children's Hospital Westmead Clinical School, Professor Baur is also a senior consultant paediatrician at the Sydney Children's Hospitals Network where she is an active member, and former Head of Weight Management Services.

Professor Baur has worked in many clinical, public health and policy aspects of paediatric obesity and nutrition. She has made extensive research contributions to the prevention of obesity, especially in early childhood; the impact of food marketing to children; the antecedents of obesity and the metabolic syndrome in young people; the complications of obesity; the management of obesity and related disorders in a variety of clinical settings; and the measurement of body composition, dietary intake and physical activity in young people. Professor Baur is currently Director of the NHMRC Centre of Research Excellence in the Early Prevention of Obesity in Childhood.

Professor Baur is a Founding Fellow and member of the Council of the Australian Academy of Health and Medical Science.

In 2010 Professor Baur was made a Member of the Order of Australia (AM) for service to medicine and to the community.

An edited transcript of Professor Baur's oration will be published in an edition of *RACP Quarterly* following RACP Congress 2020. RQ



Join us at RACP Congress 2020 to hear Professor Louise Baur AM deliver the Howard Williams Oration on the topic 'Tackling the complexity of child and adolescent obesity'.

Register now at www.racpcongress.com.au

Meet your 2019 CPD requirements with this new online course



The 2019 MyCPD Framework changed to three categories: Educational Activities, Reviewing Performance and Measuring Outcomes. You are still required to record 100 credits but a maximum of 60 credits can come from each category.

We understand change takes time and not all Fellows completing CPD in 2019 may be aware of the changes to the 2019 MyCPD Framework. To help you adjust to these changes that support future requirements of the Medical Board of Australia, we have developed a transition course to assist compliance.

If you complete the Online Learning course, CPD: Applying the New Framework, you can still record all your 100 credits from Category 1: Educational Activities.

This educational course:

- Guides you through the background and requirements of the MyCPD Framework
- Offers recommendations on planning, completing and recording CPD in clinical and non-clinical practice
- Takes approximately one hour to complete.

Once you complete the Online Learning course and record 100 credits, you will receive a MyCPD certificate of completion confirming you have met the transition requirements.



This transition course is for 2019 only. From 2020 onwards, you will be expected to complete and record CPD against the most current version of the MyCPD Framework.

The RACP History of Medicine Library

“To acquire by purchase, donation or otherwise, a library of scientific works and to maintain and from time to time extend and improve such library”

Memorandum and articles of Association, 1938

In 1938, the Foundation Council of the RACP was very keen that a library be part of its new learned institution. The Library (later renamed The History of Medicine Library) has been subject to fluctuating fortunes ever since, but it is pleasing to report that after an extensive remediation program in 2018, the Library has now re-opened in a much improved format. The collection, which includes a library of over 25,000 books, extensive archives, a small assortment of medical artefacts, and numerous photographs – is an extraordinary resource for anyone exploring the past. To assist, there is now a readily accessible online catalogue from which to find these ‘treasures’. (<http://racp.intersearch.com.au>)

Originally the Library had a clinical focus and concentrated on the acquisition of contemporary medical texts and journals. However, in 1954, the Royal College of Physicians of London donated a remarkable collection of some 30 books which dated from 1500-1800 and Professor (later Sir) Edward Ford took over as Librarian Curator in 1958. This marked a change in focus from the contemporary to the historical.

In the mid 1960s, the Library faced an uncertain future. However, at the AGM held in Adelaide in 1966, Dr Bryan Gandevia, Chairman of the Library Committee, spoke passionately to the Fellows and members, who provided



Bookplate of A.E. Mills Foundation by noted artist Lionel Lindsay.



Some items from the collection of Dr. Cotter Harvey, FRACP, from his time spent as a prisoner of war in Changi

overwhelming support for the Library. Ms Alison Holster (1969-1985) accepted the position as the Library's first professional librarian to support and encourage research activity.

In 1978 Edward Ford presented over 2,500 items from his personal collection of 19th and 20th century medical Australiana and on his death in 1986 he bequeathed a further 250 books published before 1800. The Library now held an outstanding record of Australasian medical history and in 1982 the collection was renamed 'The RACP History of Medicine Library'.

Once again, in 2000, the Council questioned the value of the Library and requested that the Library Committee explore the possibility of its relocation to another institution. Writing in the *RACP News*, January 2001, Dr Stan Goulston AO MC FRACP described the Library as the 'jewel in the crown', emphasising its financial value in addition to its intellectual and heritage significance, concluding that 'to deny the importance of history is to deny

our past and jeopardise our future'. Fortunately, the Council decided to retain this great resource for future generations of Fellows and for the community of historical researchers.

Today, the collection is spread across several rooms of the College but much of it is housed at 147 Macquarie Street in the former surgery of the original owner Sir Herbert L. Maitland, who died in situ in what is now known as the Reading Room. This room also houses the medical Australiana collection donated by Sir Edward Ford in 1978. This space will become a dedicated research area for Fellows and researchers who wish to use this splendid facility to delve into the history of medicine in Australasia. This fabulous collection of books, papers, archives, photographs, artefacts, pamphlets and so much more is looking resplendent and ready to be extensively used for serious historical research.

Fellows are welcome to visit the RACP's extraordinary collections and buildings at Macquarie Street to learn more of the

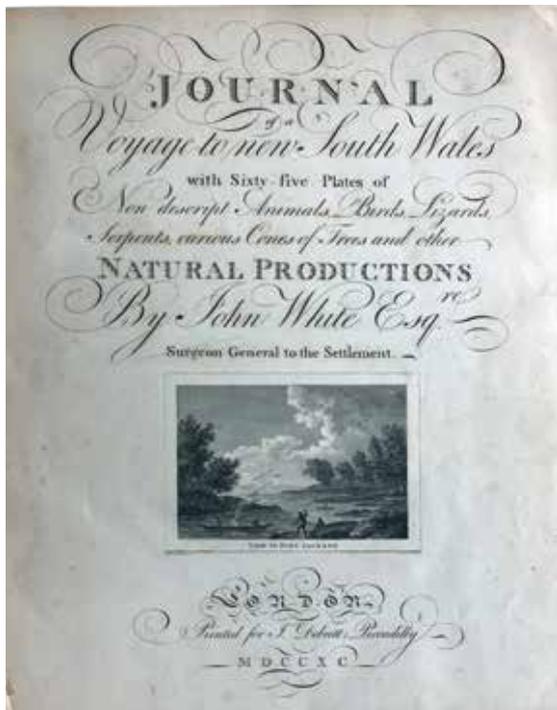
history of the College and Fellows, or to use the facility to undertake historical projects. [RQ](#)

Catherine E Storey OAM
MB BS MSc FRACP
Clinical Associate Professor
University of Sydney

Karen Myers
RACP History of Medicine Librarian



This urine testing set, purchased and used by Dr Lindsay Dey in the 1930s, was donated to the College History of Medicine Library by Dr David Dey. Dr Lindsay Dey was a former president of the Royal Alexandra Hospital for Children and the British Medical Association in Australia.



Title pages from "Journal of a voyage to New South Wales" (1790) by surgeon John White and "Some account of New Zealand" (1807) by surgeon John Savage, the first book written about New Zealand since James Cook's account. The College's version features the rare green tiki drawn by the author.

Vale Emeritus Professor Alex Cohen AO



Former Chancellor and Clinical Professor of Medicine Alex Cohen has been remembered by his family, friends, former students and colleagues as a compassionate, hard-working and popular man with a great sense of humour.

Unable to study medicine in Perth because the University of Western Australia (UWA) did not have a medical school until 1957, Professor Cohen obtained his medicine degree at The University of Adelaide. He went on to train as an endocrinologist with a focus on diabetes mellitus.

Professor Cohen was awarded the Australian Medical Association (WA) Award in 2013 for his outstanding contribution to diabetes research in Western Australia.

He also received an Order of Australia medal in 1995 for his efforts in improving diabetes research and care in the State.

Professor Cohen was instrumental in setting up the Centre for Diabetes Research at UWA. The Diabetes Research Foundation WA now honours Professor Cohen's contributions in the field with a scholarship set up in his name.

The Alex Cohen Scholarship was created for the purpose of providing top-up scholarships to students awarded an Australian Postgraduate Award to conduct research in all forms of diabetes.

Professor Cohen served as Chair of the Finance and Investment and Resources Committees at UWA, Director of Clinical Training at Hollywood Private

Hospital and Director of Postgraduate Medical Education at Sir Charles Gairdner Hospital.

He also held many positions within the community as Convenor and Chair of the Specialist Medical Review Committee for the Commonwealth of Australia's Department of Veteran's Affairs, Director of the Risk Management Program for the Medical Defence Association of WA, President of the Diabetes Research Foundation of WA and Director of the National Board for Diabetes.

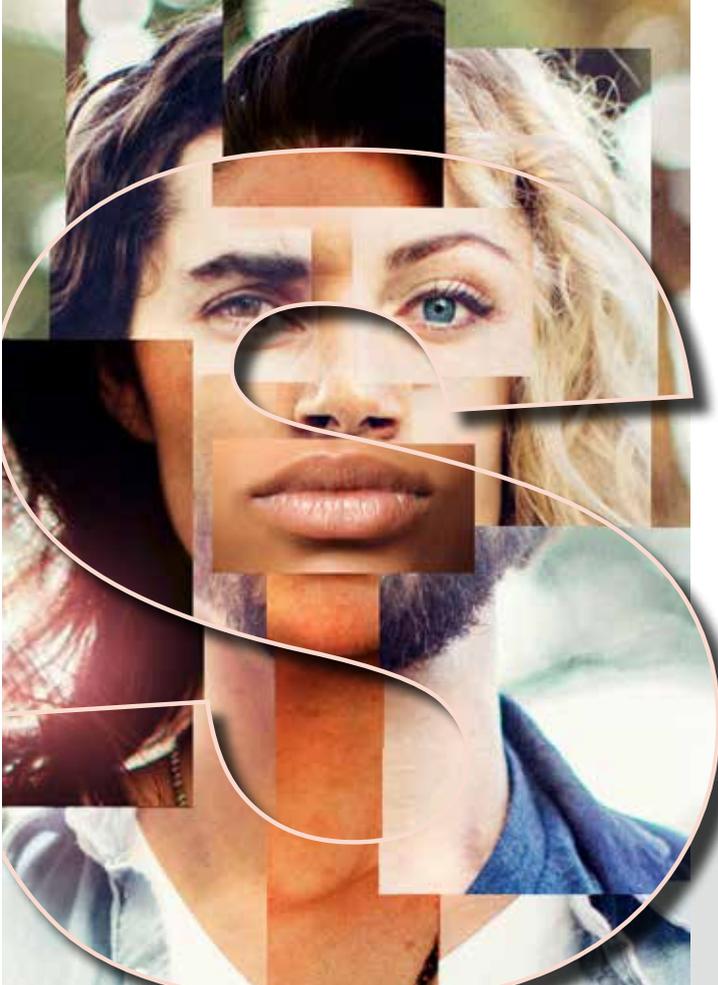
He was President of the Royal Australasian College of Physicians and of the Australian Medical Association (WA), Emeritus Consultant Physician and Endocrinologist at Sir Charles Gairdner Hospital and Royal Perth Hospital, a Fellow of the Australian Medical Association and Wolfson College Oxford, and a past Research Fellow of Harvard University Medical School.

UWA awarded Professor Cohen an Honorary Doctorate of Letters in 2002. Professor Cohen was also a great friend of the Convocation of UWA. He delighted in annually presenting the prestigious Alexander Cohen Postgraduate Research Travel Award to an outstanding student.

We offer our sincere condolences to his family and to all those whose lives were touched by this remarkable man.

Vale Emeritus Professor Alexander Cohen.

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Supervisor Professional Development Program Workshop 2 – Teaching and learning in healthcare settings

‘Teaching and learning in healthcare settings’ provides a range of teaching strategies to manage and overcome challenges supervisors face in a complex healthcare setting. These strategies include planning for learning, differentiated instructions for multi-level groups, and using teaching techniques such as questioning.

This workshop explores some cultural aspects that may impact on learning, including the hidden curriculum, tribalism and the need for effective role modelling.



Friday, 7 February 2020



Clinical School (Level 1), Joondalup Health Campus,
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Complimentary for registered RACP members



www.racp.edu.au/news-and-events/all-events

20
FEB
2020

Supervisor Professional Development Program Workshop 1 – Practical skills for supervisors

‘Practical skills for supervisors’ incorporates the overarching themes of developing trainee expertise and using coaching techniques to improve feedback practice.

This workshop focuses on delivering feedback using two frameworks, the GROW model and the four areas of feedback. By using these models, supervisors can facilitate change and growth in trainees towards expert performance.



Thursday, 20 February 2020



Canberra Hospital, Yamba Drive, Garran ACT



Complimentary for registered RACP members



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22
FEB
2020

Aotearoa New Zealand AFRM Symposium 2020

The Australasian Faculty of Rehabilitation Medicine invites Fellows and trainees to the annual Symposium. A platform to discuss up-to-date rehabilitation subjects, the event will also provide networking opportunities, research and case presentations.



Saturday, 22 February 2020



RACP office, 99 The Terrace, Wellington



Complimentary for registered RACP members



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2
MAR
2020

Overseas Trained Physicians interviewer training sessions 1 and 2

As part of the Overseas Trained Physicians (OTP) Assessment process, the OTP Unit relies on the knowledge and availability of RACP members to assist with the assessment of applicants through the interview stage.

The OTP Unit works to improve the robustness and consistency of this process by providing training to existing and new OTP interviewers. These sessions will cover tips to broaden your knowledge of this process.



Monday, 2 March 2020 (Session 1) and Tuesday, 3 March 2020 (Session 2)



RACP GMT2, Level 19, 1 Farrer Place, Sydney NSW



Complimentary for registered RACP members



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20
MAR
2020

International Medical Symposium – Providing care to underserved populations

Now in its ninth year, IMS is an annual event that reinforces the strong historical relationship between medical professions from Canada, New Zealand and Australia.

The IMS 2020 theme, ‘Providing care to underserved populations’ is relevant to health professionals from all member countries. With a focus on higher medical education, delegates will explore how specialist training can support and enhance access to healthcare for critical populations experiencing difficulties in accessing healthcare, potentially due to location or isolation, social determinants or other specific issues.



Friday, 20 March 2020



Amora Hotel Jamison Sydney, 11 Jamison Street, Sydney NSW



Various costs apply



www.internationalmedicalsymposium.com.au

21
MAR
2020

AChSHM Annual Scientific Meeting

The Australasian Chapter of Sexual Health Medicine invites Fellows, trainees, general practitioners, nurses and allied health professionals to the Annual Scientific Meeting themed ‘Sex, syndemics and special populations.’

Topics will include:

- syphilis outbreaks in Aboriginal and Torres Strait Islander communities and Māori communities
- the intersection of chemsex and sexual health among men who have sex with men
- sexual health of trans and gender-diverse people.



Saturday, 21 March 2020



RACP GMT1, Level 19, 1 Farrer Place, Sydney NSW



Various costs apply



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4
APR
2020

Aotearoa New Zealand Trainees’ Day 2020

If you are an RACP trainee, this event is for you. Whether you are a Basic or Advanced Trainee, adult medicine or paediatrics, the Trainees’ Day will be inspiring and relevant for wherever you are in your training journey.



Saturday, 4 April 2020



The Heritage Hotel, 91 Fernhill Road, Queenstown



Various costs apply



www.racptraineesday.org.nz

4
MAY
2020

RACP Congress 2020 – Balancing medical science with humanity

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.



Monday, 4 to Wednesday, 6 May 2020



Melbourne Convention and Exhibition Centre, VIC



Various costs apply



www.racpcongress.com.au

RACP CONGRESS 2020



4 – 6 May 2020
Melbourne

www.racpcongress.com.au



AUSTRALIAN ASSOCIATION
OF CONSULTANT PHYSICIANS

Join the AACCP

The Australian Association of Consultant Physicians (AACCP) works to support the sustainability of consultant physician and paediatrician (CPP) practice, focusing on improved items for consultative medicine.

MBS items 132 and 133

MBS items 132 and 133 – the mainstay of CPP practice – were negotiated by AACCP. Now the MBS Review has recommended the deletion of 132 & 133 and introduction of the same fully time-tiered structure for all specialists and CPPs. The AACCP opposes this change. If 132 & 133 are important to your practice, please support the AACCP by joining now.

Join online at www.aacp.org.au

For a 15 % DISCOUNT use promotion code: Q42019
Or email: secretariat@aacp.org.au for an application.

The medical cryptic crossword solution

C	I	R	C	U	M	F	L	E	X		H	A	N	D
O		E		R		I		U		A		L		E
L	A	T	T	E		R	E	S	E	C	T	I	O	N
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RACP
CONGRESS

**Balancing medical science
with humanity**

4-6 MAY 2020

Melbourne Convention and Exhibition Centre



RACP
Specialists. Together
EDUCATE · ADVOCATE · INNOVATE

Register now
racpcongress.com.au

December 2019/January 2020

RACP Quarterly

