

RACP Quarterly

June/July 2019



Congress 2019: Connecting cultures, from paediatrics to palliative care.

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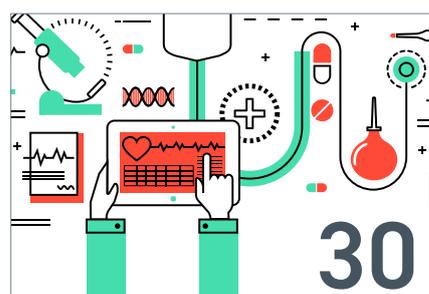
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CORRECTION: On page 17 of the March/April print edition of *RACP Quarterly*, within the article 'Blood stem cell therapy brings hope to people living with Multiple Sclerosis', the sentence "At the moment we think that perhaps the sinus, which is a gland in the chest, makes new cells in the immune system like a baby" should have referenced the thymus not the sinus: "At the moment we think that perhaps the thymus, which is a gland in the chest, makes new cells in the immune system like a baby." We apologise for the error.

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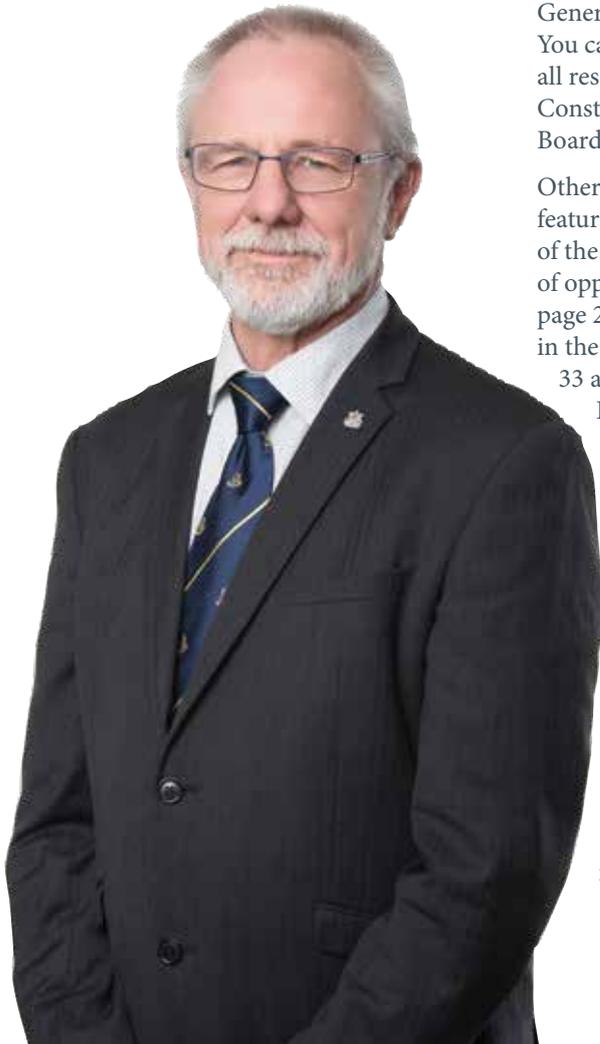
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A message from The President

Congress 2019 in Auckland during May can quite rightly be described as an outstanding success.



I've had a lot of feedback from many of you who attended about the positive atmosphere, how seamlessly and sensitively Māori culture and language were integrated into the program, and the success of our inaugural Fringe Experience, showcasing doctors' non-medical talents.

A personal highlight for me was the humble but powerful opening keynote address by Sir Mason Durie on lessons he has learned from patients and the importance of Indigenous knowledge in his approach to healthcare. You can read a summary of his speech on page 18.

Of note also was our Extraordinary General Meeting held during Congress. You can read about the outcome of all resolutions to amend the College Constitution in the message from the Board on page 5.

Other highlights from Congress featured in this issue are the importance of the first 1000 days of life as a window of opportunity for long term health on page 22, the significance of partnerships in the future of integrated care on page 33 and the closing plenary 'Physician Heal Thyself' on page 30 which features the latest research on physician burnout, as well as trainee and Fellow stories about balancing patient care with their own health and wellbeing.

We congratulate the 39 Fellows who were recognised in the 2019 Queen's Birthday Honours. You can read the full list on page 6. We also prominently feature the RACP Foundation Prize Winners recognised at Congress and their research.

In other features, we profile the College's new partnership with highly regarded Australian mental health charity The Black Dog Institute and the University of New South Wales to develop tools to support physician and trainee health and wellbeing. You can learn more about this interesting and topical project on page 28.

At Congress we featured two healthcare consumers as both presenters and award judges. This is an important milestone in highlighting how the College is now integrating a consumer perspective into its work and programs across the board. You can read more about our Consumer Advisory Group on page 16.

Finally, I would like to re-emphasise that I welcome the Australian Charities and Not-for-profits Commission's (ACNC) assistance to improve Board Governance and culture.

I know our recent announcement regarding the Commission will be of concern to members, but I assure you our written and clinical examinations, training setting accreditation cycles, and education renewal programs will continue as normal. As the Board also stated at our Annual General Meeting at Congress, the College remains in a sound financial position.

I undertake to update all of you as the Board works with the Commission.

Associate Professor Mark Lane
RACP President

A message from The Board

Since the last edition of *RACP Quarterly* your Board met on 1 March 2019 in Melbourne and 3 May 2019 in Auckland prior to the start of the RACP 2019 Congress.

There were a number of matters for Board consideration, and in summary the following were discussed or agreed.

1 March 2019 – Melbourne

The Board approved the RACP Audited Financial Statements for the 2018 financial year – with an unqualified audit opinion by Grant Thornton showing the College to be in good financial health, reporting a comprehensive income of \$1.7 million and remaining debt free with sufficient reserve funds to cover more than six months of operating costs.

We initiated a strategic review of fees and operating costs including benchmarking to comparable organisations to provide us with better understanding of the activities and cost structure of the College. This project is being led by the Honorary Treasurer and includes a review by the Finance and Risk Management Committee.

We reviewed the College Risk Management Report and Framework including scheduling a Risk Strategy Workshop to be attended by the Board and the Senior Leadership Group on 11 July 2019.

We approved the appointment of two Community Directors to the RACP Board to fill the two vacant positions.

Monica Schlesinger has significant board and senior management experience and her areas of expertise include company turnaround,

cybersecurity governance and health checks, mobile app and large package software development and cross sector healthcare market knowledge.



Rob Stewart is a former National Managing Partner of Minter Ellison, one of Australia's leading law firms, with extensive experience at board level as both Chair and Director. Both Rob and Monica have been appointed for a three-year term commencing at the end of the Annual General Meeting (AGM)



on 6 May 2019. We approved the appointment of an independent Chair of the Governance Committee, Mr Rob Ryan, for a term of two years. He is currently working with the President to select four RACP Fellows from expressions of interest received to appoint to the Governance Committee.

As soon as the members of the Governance Committee have been formally approved work will start on the priority work plan, including a review of the College Constitution, Code of Conduct procedures and By-laws covering the RACP elections, ahead of the 2020 election cycle.

We reviewed the revised Conflicts of Interest Policy and approved the implementation of a consultation process involving the key Board sub-committees, after which the Board will review the final policy for formal approval.

We also approved award of the College Medals based on recommendations from the Fellowship Committee, and the establishment of the College Journals Committee, and a relevant By-law.

Directors approved a five-year IT Services Agreement with BPAC NZ to support the College technology upgrade program including the current key Basic Training Curricula Renewal project.

In parallel, we reviewed the status and timelines for the various interrelated projects to be delivered over the next five to six years under the Education Renewal Program to meet the Australian Medical Council (AMC) and Medical Council of New Zealand's (MCNZ) accreditation standards.

A short additional Board meeting was held on Friday, 5 April 2019 at the end of a two-day Board Strategy workshop. The Board:

- reviewed the Fellowship Committee Discussion Paper, Future of Congress, and noted the ongoing work of the Fellowship Committee
- reviewed a detailed briefing paper concerning a 'safe and respectful working environment' with a discussion on opportunities to raise the profile of the College and to establish safe and respectful working environments for all Fellows and trainees
- reviewed and approved the draft Notice of Meeting and Explanatory Memorandum for the Extraordinary General Meeting of the College to be held at the conclusion of the Annual General Meeting on 6 May 2019 to consider the four resolutions received from the requisitioning members concerning proposed amendments to the College Constitution.

3 May 2019 – Auckland

Directors received formal notification from the Australian Charities and Not-for-Profits Commission that the RACP is being investigated by the Commission. The Board has committed to enter into a voluntary compliance agreement with the Commission in relation to improvement of Board culture and governance.

Directors approved amendments to the By-laws concerning the process and criteria for awarding the John Sands Medal and College Medal, following recommendations from the Fellowship Committee.

We also approved a change of name of the NZ Committee to the Aotearoa New Zealand Committee and signed off on the Work Plan for 2019 to 2020 of the Consumer Advisory Group and the College Policy and Advocacy Council Work Plan for 2019, as well as approving publication to members of the 2018 RACP Progress Report to the AMC.

A detailed review of the results of the College Staff Culture survey was held with guidance from an external facilitator.

Directors reviewed questions received from members and drafted responses ahead of the Annual General Meeting

and Extraordinary General Meeting held on Monday, 6 May 2019.

The next Board meeting will be held on 12 July 2019 in Sydney.

Annual General Meeting and Extraordinary General Meeting on 6 May 2019 – Auckland

The RACP AGM was held on Monday, 6 May during the lunch break of day one of Congress 2019 and was attended by 121 members and the College Senior Leadership Group plus members who took advantage of the live web stream available through the RACP website. After opening the meeting the President introduced the Honorary Treasurer Tony Tenaglia who reported on the 2018 financial year key financial performance, followed by the President's report on the work and achievements of the College over the past year. The President and Honorary Treasurer then responded to member questions, primarily concerning details from the audited financial statements published in the 2018 Annual Report.

The Extraordinary General Meeting (EGM) commenced immediately after the AGM with the items of business contained in the formal

Notice of Meeting and Explanatory Memorandum which had been sent by mail and email to all members prior to the meeting and was also available to download from the RACP website.

The outcome of the members' votes on the four resolutions received from the requisitioning members was published on the RACP website the day after the meeting, reporting that all resolutions had failed to attract the required votes and consequently there had been no changes to the College Constitution resulting from this meeting.

The Board had previously noted in the EGM Notice of Meeting and Explanatory Memorandum that a broad review of the College Constitution and key By-laws would be undertaken as a priority with guidance from the Governance Committee and consultation with members prior to being submitted for formal approval by members at an AGM or EGM called at the appropriate time.

Queen's Birthday Honours 2019

Congratulations to the RACP Fellows recognised in the 2019 Queen's Birthday Honours.

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

The New Zealand Order of Merit

To be Dame Companion of the said Order:

- **Dr Susan Nicola Bagshaw** FACHSHM, CNZM, of Christchurch. For services to youth health.

To be Officers of the said Order:

- **Dr Marie Claire McLintock** FRACP, of Auckland. For services to haematology and obstetrics.
- **Dr Christine Mary Roke** FACHSHM, of Auckland. For services to sexual and reproductive health.

AUSTRALIA

Companion (AC) in the General Division

- **Professor Ruth Frances Bishop AO FRACP (Hon)**. For eminent service to global child health through the development of improved vaccines for paediatric gastroenteritis, and to medical research.
- **Professor David James Burke AO FRACP**. For eminent service to neurophysiology, to innovative treatments for spinal cord and brain trauma injuries, and to professional medical organisations.

Officer (AO) in the General Division

- **Professor Lex William Doyle FRACP**. For distinguished service to medicine, and to medical education, as a neonatal paediatrician, academic, author and researcher.
- **Professor Christine Julie Kilpatrick FRACP**. For distinguished service to medicine through senior administrative roles, to the promotion of quality in health care, and to neurology.
- **Professor Christina Anne Mitchell FRACP**. For distinguished service to medicine in the field of haematology, to medical education and research, and to academic leadership.
- **Professor Richard George Pestell FRACP**. For distinguished service to medicine, and to medical education, as a researcher and physician in the fields of endocrinology and oncology.
- **Associate Professor Tilman Alfred Ruff AM FRACP**. For distinguished service to the global community as an advocate for nuclear non-proliferation and disarmament, and to medicine.

Member (AM) in the General Division

- **Professor William MacEwan Carroll FRACP.** For significant service to neurological medicine, and to people with Multiple Sclerosis.
- **Clinical Professor Peter Thomas Bye FRACP.** For significant service to medicine, particularly to cystic fibrosis, and to medical education.
- **Professor Ian James Cook FRACP.** For significant service to gastroenterology, and to medical research.
- **Professor John Patrick Edmonds FRACP.** For significant service to rheumatology, and to medical research.
- **Associate Professor Jonathan James Ell FRACP.** For significant service to medicine, and to medical education and research.
- **Professor Michael Lindsay Grayson FAFPHM, FRACP.** For significant service to medicine in the field of infectious disease.
- **Professor Winita Hardikar FRACP.** For significant service to medicine, particularly to paediatric liver disease and transplantation.
- **Professor Constance Helen Katelaris FRACP.** For significant service to medicine in the field of immunology and allergy.
- **Professor Steven Anthony Krilis FRACP.** For significant service to medical research in the areas of inflammation, thrombosis and allergic disease.
- **Dr David Alexander McCredie FRACP.** For significant service to medicine in the field of paediatric nephrology.
- **Dr Prudence Joan Manners FRACP.** For significant service to medicine as a paediatric rheumatologist.

- **Associate Professor Michael John Murray FRACP.** For significant service to geriatric medicine as a clinician and educator.
- **Professor Clare Nourse FRACP.** For significant service to medicine in the field of paediatric infectious diseases.
- **Emeritus Professor Anthony James Radford FRACP, FAFPHM.** For significant service to medicine, to medical education, and to global health.
- **Dr Nicholas Saltos FRACP.** For significant service to medicine, and to education.
- **Professor Malcolm Ross Sim FAFOEM, FAFPHM.** For significant service to occupational and environmental medicine.
- **Professor Leon Abraham Simons FRACP.** For significant service to cardiovascular medicine, and to education.
- **Associate Professor Richard James Stark FRACP.** For significant service to neurological medicine, and to professional associations.
- **Professor Carolyn Mary Sue FRACP.** For significant service to medicine, particularly to mitochondrial disease.
- **Professor James Leonard Wilkinson FRACP.** For significant service to medicine, particularly paediatric cardiology.

Honorary Member (AM) in the General Division

- **Professor Jacob George FRACP.** For significant service to medicine as a gastroenterologist and hepatologist.

Medal (OAM) in the General Division

- **Dr Christopher James Cunneen FAFOEM.** For service to medicine as an occupational and environmental physician.
- **Dr Malcolm Douglas Dobbin FAFPHM.** For service to medicine.
- **Dr John Dacre England FRACP.** For service to medicine as a cardiologist.
- **Dr David Everett FRACP.** For service to medicine as a paediatrician.
- **Dr David Thomas McDonald FRACP.** For service to medicine as a paediatrician.
- **Associate Professor Georgia Armat Paxton FRACP.** For service to community health, and to refugees.
- **Dr George Louie Williams FRACP.** For service to medicine in the field of paediatrics and developmental disability.
- **Dr Gordon Eustace White FACHSHM.** For service to medicine, particularly sexual health.

RACP CONGRESS 2019



Impacting health along the life course. From paediatrics to palliative care. As Specialists. Together

This year Congress took an in-depth look at the range of ways physicians, as specialists together, impact patients' lives from birth to death, from paediatrics and child health to palliative care.

Impacting health along the life course, the theme of RACP Congress 2019 brought over 900 delegates together in Auckland, New Zealand.

“There is so much I could say about this Congress – Impacting health along the life course. For me the thrilling bit is that absolutely every speaker referenced health along the life course. The theme has absolutely been threaded throughout the whole of Congress,” said Congress 2019 Lead Fellow, Dr David Beaumont.

Over the course of the three-day Congress there were 142 presentations within 42 thought-provoking sessions. Big questions were asked, and big conversations were had across a wide variety of issues spanning the breadth of the medical world.

Emeritus Professor Sir Mason Durie's opening keynote, 'Indigenous knowledge and science: Doctors at the interface', stimulated and invigorated delegates for the sessions ahead.

Sessions covering the first 1000 days, the life course paradigm, obesity, medically unexplained symptoms, chronic disease and integrated care, rural and remote populations and health, the search for value in what we do, populism and public health, transitioning from paediatric care into adult medicine, the opioid epidemic and physician heal thyself

raised awareness of issues impacting physician and patient health along the life course.

Congress 2019 also introduced an exciting new initiative, the Fringe Experience, which showcased the different interests and talents of our healthcare professionals and incorporated health and wellbeing into the program. Art and photography by healthcare professionals was displayed, main stage performances were enjoyed, morning workouts jogging around Auckland and yoga energised delegates for the day ahead and mindful activities allowed delegates a break from the educational content.

“I've really enjoyed wrapping up our creative sides into the conference. For example, this morning we had three fantastic orations in the plenary session, lots of science, lots of really solid stuff, fabulous learning and at the end a cardiologist stands up and sings 'I did it my way'. It's just really gorgeous, so you come out of the session feeling really upbeat, everyone's chatting and there's lots of energy, so fabulous. Good on the conference organisers for making such an effort with our creative side,” said Dr Margaret Young FAFPHM.

Tikanga Māori – the Māori way of doing things featured extensively during Congress. This theme flowed through the whole Congress and was a key takeaway for RACP President, Associate Professor Mark Lane.

“The more we understand the Māori way of doing things, or the Aboriginal and Torres Strait Islander way, we start to understand and



ask questions about why. About why Indigenous children are more likely to be malnourished? Why is this family living in substandard accommodation? Why are asylum seekers being treated like criminals?

“Why do we invest money in heroic interventions at the end of life when intervention at early life could make so much difference? Important questions that were asked this Congress and we must keep on asking difficult questions.”

Also drawing on the theme of Tikanga Māori, Dr Beaumont spoke in his closing remarks of the sub-theme he introduced in his welcome speech: kotahi tātou – we are one.

“For me this has resonated throughout Congress, particularly the relationship we have with our patients and the fact that we are actually one with our patients.”

Closing off Congress 2019 Associate Professor Lane said, “I hope this Congress has broadened your thinking, it has certainly broadened mine.”

Presentation videos of selected sessions from RACP Congress 2019 are now available on the RACP YouTube channel:

www.youtube.com/user/RACP1938.

You can also view many of the presentation slides. Selected sessions and slides have only been released where approval has been given by the presenters, visit

www.racp.edu.au/fellows/resources/congress-historical-resources. RQ

WHAT DELEGATES HAD TO SAY ABOUT CONGRESS 2019

“I’m looking forward to this afternoon when we’re going to have the release of the policy of the first 1000 days. These are of critical importance to the whole of medicine and I think will actually change the way our society views health and social factors together and that’s going to be really really really important in taking things forward,” Dr Cathy McAdam FRACP.

“I enjoyed the talk by Lex Doyle and the history of neonatal and retrolental fibroplasia, I found it very interesting from the point of view of an older physician who treats older patients,” Dr John Mathew FRACP.

“There was a performer this morning and that was fantastic. Just seeing some of the different talents of medical professionals,” Ms Josephine Davies.

“As a paediatrician I think it’s very essential that we remember that a lot of the determinants of health outcomes in adults start from early childhood,” Dr Biola Araba FRACP.

“The first session about science and culture and doctors at the interface, I thought it was a very interesting talk and it was very realistic from a Pacific background,” Dr William May.

“Some of the thoughts we saw here are going to be the foundation for internal medicine for the coming generations and one of the things that I see as very important is physician wellbeing, not just in terms of looking after your patients but also to heal yourself,” Dr Krishnakumar Kalpurath FRACP.

“Having the Māori input all the way through and Sir Mason Durie’s plenary bringing Indigenous knowledge and scientific knowledge together was just wonderful and I can get a copy of it to spread the news to my colleagues back home,” Dr Margaret Rowell FRACP.

“I think what is coming through from almost every speaker whether they are local, international, they’re saying the same thing. That if we don’t connect to people at their level, we are not accessing them,” Dr Sornalingam Kamalaharan FAFOEM.



148 Presenters

911 Delegates



RACP CONGRESS 2019





584 Downloaded the app



42 Sessions



52 Posters



Members in the media

Lack of sleep ‘same as drink driving’, finds Federal inquiry

The importance of a good night’s rest has been laid out following a Federal inquiry into sleep health awareness, with one WA professor saying the dangers of sleepiness can no longer be ignored.

Telling your boss you can’t come to work because you’re too tired could soon be as acceptable as being bed-ridden with the flu.

And new drivers could be educated about the dangers of driving “under the influence” of sleep deprivation.

That’s some of the suggestions to come out of the Federal inquiry into sleep health awareness, with a parliamentary committee this week releasing its report, *Bedtime Reading*.

University of WA’s Centre for Sleep Science Director Professor Peter Eastwood, who took part in the inquiry, said the Federal Government now needed to follow through on the inquiry’s top recommendation that sleep health becomes the “third pillar” of health, alongside diet and exercise.

Sir Charles Gairdner Hospital’s head of Sleep Medicine Department Professor Bhajan Singh FRACP said more education was needed for the community and health professionals about sleep apnoea, with about four out of five people unaware they had it.

Professor Singh said it was also important to improve access to treatment for sleep apnoea which was not funded through Medicare.

News.com.au, 14 April 2019



Study to probe gut health link to autism

QUEENSLAND adolescents with autism are being recruited for a pilot drug trial testing the controversial theory that poor gut health contributes to behavioural and mental health problems.

Paediatrician Honey Heussler FRACP, of the Queensland Children's Hospital, said the experimental drug was designed to bind to toxins in the gut, preventing them from being absorbed by the body and reaching the brain, where they could potentially cause symptoms.

Associate Professor Heussler said although significant numbers of autistic children experienced gastrointestinal problems, such as diarrhoea, it was too early to say whether gut health contributed to their autism.

The Daily Telegraph, 28 April 2019



Australia recording weekly flu deaths before peak winter season

AUSTRALIANS are dying on a weekly basis from the flu, as experts advise the population to get vaccinated.

NSW-based virologist Bill Rawlinson FRACP predicted Australia could see “a couple of million” cases of the flu this year – about eight per cent of the population.

Professor Rawlinson said he was worried this year may be a worse flu year than 2017 in Australia, with laboratory proven cases running at about three times the five-year average for this time of the year. Asked about how many influenza deaths had occurred in Australia during 2019, he said: “Certainly, we’re seeing them on a weekly basis”.

The Daily Telegraph, 7 May 2019



Members in the media

FAST FACTS



Acute Rheumatic Fever and Rheumatic Heart Disease are **PREVENTABLE**

MORE THAN 6000 PEOPLE ARE ON RHD REGISTERS ACROSS AUSTRALIA

& 40% of them are under 24 and at risk of premature death or disability.¹



RHD IS A DISEASE OF **SOCIAL DISADVANTAGE**

YOUNG PEOPLE AGED 5-14 YEARS

ARE AT HIGHEST RISK OF A FIRST EPISODE OF ARF



94%

of the ARF reported in Australia is among Aboriginal and Torres Strait Islander people.³



59 PER 100,000



The incidence of ARF is approximately 59 per 100,000 among Aboriginal and Torres Strait Islander people and less than 1 per 100,000 for other Australians.⁴

6x MORE



Aboriginal and Torres Strait Islander people are more than 6 times more likely than other Australians to be hospitalised for ARF and RHD.⁵

20-55x MORE



Aboriginal and Torres Strait Islanders are between 20-55 times more likely to die from RHD than non-Indigenous people.⁶

GOOD NEWS

ARF and RHD can be controlled through improved living conditions, reduced overcrowding, access to health care and antibiotics. Policy and research initiatives to better understand and reduce the burden of RHD are underway.



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2. Australian Institute of Health and Welfare 2016. Better Cardiac Care Measures for Aboriginal and Torres Strait Islander people. <http://aahw.gov.au>
3. Australian Institute of Health and Welfare 2015. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2015. Cat. No. 873. Canberra: AIHW.

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Rheumatic fever: An entirely preventable disease that kills

Trishanne Miller, 15, is a “germophobe”. At the Sydney Royal Easter Show last week the promising young soccer player refused to drink from the bubblers. Hand rails were also off limits.

She has reason to be wary. Trishanne is the third generation in her family, Gudanji people from Borroloola in the Northern Territory, to have contracted the life-threatening disease rheumatic heart disease (RHD).

Known to previous generations as scarlet fever, the disease is caused by untreated strep which results in a sore throat and body sores. It has been virtually eradicated from non-Indigenous communities.

Arnhem Land, though, has the highest rate in the world. The rate is about 122 times higher among Indigenous Australians than non-Indigenous people, and it kills two young Indigenous people each week.

In Maningrida, NT, a pilot program that tested every single child – more than 600 – for the disease in March and in November using hand-held heart scanners found 10 per cent had rheumatic heart fever or rheumatic heart disease, said cardiologist Dr Boglarka Remenyi FRACP.

Two thirds of children who were diagnosed with rheumatic heart disease hadn't been previously diagnosed with rheumatic heart fever. Following the scans, three children were evacuated for emergency open heart surgery, according to preliminary results expected to be published soon.

The Sydney Morning Herald, 21 April 2019

Only 1 in 10 psychotropic drugs used for aged care patients justified

Only about one in 10 prescriptions for psychotropic drugs currently prescribed in aged care facilities are justified, the Royal Commission into Aged Care Quality and Safety was told on Tuesday.

A cultural change among GPs working in aged care facilities was needed to change this, the Australian Government's Chief Medical Officer Professor Brendan Murphy FRACP said.

“Eight to nine out of 10 cases probably didn't need and shouldn't be using those drugs,” Professor Murphy conceded under questioning.

Senior Counsel assisting the commission Peter Gray said an expert committee was convened this year which suggested that only about 10 per cent of antipsychotics prescriptions could be justified as effective.

The Age, 14 May 2019



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A black and white photograph of a hand holding a glowing lightbulb. The lightbulb is the central focus, with a bright white circle inside it containing the title text. The hand is positioned around the bulb, with fingers visible on the left and right sides. The background is dark, making the glowing bulb stand out.

A healthcare consumer's insight

"Healthcare is focused on those who provide the care, not the patients and consumers." It was a provocative statement by RACP Fellow Professor Des Gorman at Congress 2019 during a session on Māori healthcare (see page 25).

But the observation highlights a growing view in healthcare worldwide that consumers and patients can offer valuable perspectives in shaping the system and the care it provides. As a College, we formally recognise the importance of consumer engagement, and that it needs to be genuine and not tokenistic.

In an important milestone signifying that patient and consumer views are now taken seriously by the RACP, two healthcare consumers, Ms Debra Letica and Mr Hamza Vayani, attended RACP Congress in Auckland as award judges and presenters.

Both have considerable expertise in giving a community perspective on healthcare initiatives, particularly

from the perspective of social inclusion of people with multi-cultural backgrounds, and physical or mental health challenges.

Hamza shared a personal perspective of a carer in the session ‘Transitions from paediatric care into adult medicine’. Debra presented at the integrated care session as a feature presenter on ‘The future state of Australia’s healthcare system’.

For Hamza, attending and presenting at Congress was hard to do given his personal experience caring for a daughter with a chronic medical condition. “It is raw, but I summoned the strength to do it... as a parent of two children, one with complex care needs, it was a fantastic opportunity to attend and great to hear physician presentations and research, particularly around the first thousand days of the child and perinatal infant health.” His presentation to attendees made a powerful impact, with a physician involved in caring for his daughter remarking afterwards that a colleague had commented unprompted on the valuable carer’s perspective Hamza provided. You can read more about this session on page 52.

Debra says she enjoyed every moment of Congress. “I felt welcomed and met some amazing passionate people, all who just happen to be doctors. Congress provided the opportunity for everyone attending to network. Having informal conversations with members of the College, with their Consumer Advisory Group (CAG) enabled us all to learn from each other and share experiences from both perspectives. It’s difficult to understand how it is to walk in someone else’s shoes, sharing stories of lived experiences creates empathy and a deeper understanding of the importance of integrated care.”

Hamza and Debra are both part of our CAG. They are two of six community members, all with a background in health consumer affairs, representing a wide variety of patient and consumer groups across Australia and New Zealand.

Established 12 months ago and led by Chair Associate Professor Nick Buckmaster, the group advises us on improving consumer engagement and patient centred care across professional standards and education, as well as policy and advocacy.

They’re also tasked with supporting understanding of the shared role of patients and carers in clinical decision-making, as well as promoting the importance of cultural competency and how this is supported and assessed in the workplaces of our trainees and their supervising physicians.

“By convening the Consumer Advisory Group, the RACP is shining a light for all other medical training colleges across Australia and New Zealand at the importance of engaging with consumers and carers in the design and delivery of healthcare,” said Debra. “Congratulations to the RACP.”

CAG members are now actively involved in several peak RACP Committees and Councils. These include: College Education Committee (Henry Ko), College Policy and Advocacy Committee (Debra Letica), College Council (Hamza Vayani) and the Aotearoa New Zealand Committee (Ezekiel Robson), as well as joining sub-committees of interest such as the Integrated Care Committee

(Debra Letica) and the Podcast Editorial Group (Melissa Cadzow).

Their views are sought when our College makes policy submissions such as a recent paper to the Royal Australian and New Zealand College of Radiologists (RANZCR) on *Ethical Principles for Artificial Intelligence in Medicine*.

The CAG has now added another member, who’ll contribute an Indigenous Australian perspective on our work. Terry Williams is an Aboriginal Community Elder who has worked as an Indigenous Community Outreach Worker and in the Consumer Advocacy Group at Caboolture Hospital, as well as at Queensland Health and the Institute for Urban Indigenous Health.

All members of the CAG are looking forward to being further involved across the College during the remainder of this year and into 2020. **RQ**

“ By convening the Consumer Advisory Group, the RACP is shining a light for all other medical training colleges across Australia and New Zealand at the importance of engaging with consumers and carers in the design and delivery of healthcare.”

Lessons from a koroua

“You can always tell when a physician's in trouble. The patient's tests have come back negative, the drugs aren't working; so, they ask for a psychiatrist's opinion!”



With that quiet, wry doctor's in joke, revered New Zealand psychiatrist Sir Mason Durie had a laughing Congress keynote audience in the palm of his hand. Well known in Aotearoa, Emeritus Professor Sir Mason Durie, KNZM, FRSNZ, FRANZCP, has been instrumental in transforming Māori healthcare.

Alongside a demanding many decades long clinical career in psychiatry and then in academia, he has served on many Māori health committees, and on many influential community and national bodies.

In the initial minutes of his opening address, he ranged from Galileo's contradiction of faith based teaching, and final papal recognition in 1992; "...a long time to wait for your thesis to be marked!" to the folly of Cartesian dualism and its influence on New Zealand's nascent mental health system.

But it was one humble, insightful and at times moving story that showed why he quietly commands such widespread mana, the Māori word for respect, throughout Indigenous healthcare, and many different areas of the public sector in New Zealand.

And it's from early in his career – 1964 – that this compelling story comes.

He told the assembled Congress of a koroua, a Māori grandfather, who had driven his hallucinating 14-year-old granddaughter to a hospital in a regional New Zealand city, convinced there was more to her condition than a diagnosis of mental illness by a local doctor.

"There, they came across a young, knowledgeable, but not very wise house surgeon," he states, gently smiling. "The eventual diagnosis was viral encephalitis [an inflammation of the brain caused by a virus], and she was admitted."

Each day, the grandfather, a shearer, brought flowers and, most notably, fresh green leaves for the gravely ill teenager and sat with her, asking if the

leaves could stay in the room at night.

"No koroua, the leaves make carbon dioxide at night; that's bad for the patient..." said the young house surgeon, repeating the prevailing wisdom of the time "...but why? Will they make her better?"

"Doctor, they are part of her," the old man said.

The young house surgeon was speechless.

The leaves were from her tribal homeland.

The tests eventually came back, and the surgeon's diagnosis of encephalitis was confirmed. "What do you think caused this illness?"; the young surgeon asked the old man. "A kanga; a curse," the koroua replied. "Her mum ran away to Australia with another man – so the child was cursed. Why doctor, what do you think caused this illness?"

"I don't think it was a curse. I think it was a virus," said the young surgeon.

"A virus. Can you see it?"

"No."

"Can you touch it?"

"No."

"Then doctor, I admire your faith in things you cannot see or touch!"

The experience shaped the young house surgeon's early thinking on the importance of cultural and environmental dimensions in Māori health and wellbeing, which he shared with Congress – 55 years later.

Sir Mason spoke of the interconnectedness of the broader physical environment and health, drawing an analogy with the coexistence of physical symptoms and mental illness.

He compared Indigenous knowledge with scientific knowledge: the former being holistic, amalgamative, with accepted truths handed down, with outwards facing or centrifugal thinking, older practitioners and knowledge being enhanced by time.

In contrast, he said, scientific knowledge is analytical and breaks things down, is sceptical, based on measurement, uses centripetal thinking, often has younger practitioners, and that time aged science.

Neither the Indigenous or scientific approach to knowledge is inherently right or wrong, they are simply different ways of looking at an issue.

Sir Mason also spoke of the relevance of land and environment in Indigenous knowledge systems.

He used an example from Māoridom – when a person is welcomed onto a marae, it is their iwi or tribe, their land, rivers and mountains that are welcomed, not just the individual themselves.

But, he contended, we miss a great deal if we don't also consider the broader physical and social environment our patients live in: "...we use the microscope a lot in medicine, but we should also use the telescope."

All these years later, he still reflects on lessons he learnt from the koroua: mental health and physical health are inextricably linked, always consider the environmental determinants of health, whānau, or family, are an important part of that picture, spirituality needs to be recognised as part of the journey to wellness work between different cultures and bodies of knowledge.

Sir Mason concluded by saying the 14-year-old female patient at the heart of this story made a truly remarkable recovery, considering the prognosis for viral encephalitis patients in 1960s New Zealand.

The koroua said makutu, the curse, had been lifted.

The young house surgeon never forgot those five lessons, and went on to an internationally recognised and eminent career, thanks to a grandfather, a teenager – and some fresh green leaves. RQ

HONORARY FELLOWSHIP AWARDED

At that evening's Congress Gala Dinner Sir Mason Durie's keynote address was acknowledged by RACP President Mark Lane as one of the highlights of Congress 2019, "...because he has walked the path our College now needs to walk – improving health and wellbeing through the combination of medical and Indigenous knowledge."

Associate Professor Lane said there are many names for this combination of the environment a community lives in and the health of its people; holistic, Indigenous, Tikanga Māori, which translates as Māori culture.

"Here's another word for it: wise... I want to thank Sir Mason for sharing his wisdom with us."

In recognition of that wisdom, his long and distinguished career and contributions to Māori healthcare, the Royal Australasian College of Physicians has awarded an Honorary Fellowship to Sir Mason Durie.





Join Us

Paediatrician/s required

North West Private Hospital, Brisbane QLD

North West Private Hospital has an exciting opportunity for up to three Paediatricians wishing to establish a private practice. This opportunity presents as some existing mature Paediatricians seek to expand further into full time community private practice. In addition to providing general paediatric services to the local community, the hospital requires Paediatricians to take referrals from Obstetricians and be available for deliveries, both elective and emergency. The right candidate/s will be available to care for neonates admitted to the Special Care Nursery and participate in the Paediatric On Call Roster. We would also be interested to speak with Qld Health staff Specialist Paediatricians who have an interest in transitioning to private practice.

North West Private Hospital has:

- More than 1300 births per year
- A Level 2 Special Care Nursery
- Consulting suites available onsite
- Ability to assist with marketing to GPs and other Specialists to establish your referral base

About Us:

North West Private Hospital is a 101-bed surgical, medical and maternity acute care hospital. It is situated in the leafy Northern suburb of Everton Park. North West Private Hospital has been serving Brisbane and the local community for over 35 years.

North West has recently commenced a major expansion that among other changes will increase beds to 150, relocate our successful mother baby - Brisbane Early Parenting Centre into a new ward tower, increase theatres from 7 to 9, commission an Intensive Care Unit, increase Oncology from 6 to 10 chairs, and establish a Day Rehabilitation service. This exiting expansion will be completed by mid-2020.

The hospital is well positioned geographically just 14km north west of the Brisbane CBD and is easily accessed via major arterial roads and tunnels.

Minimum Requirements:

Candidates must have FRACP(Paeds), hold specialist registration with AHPRA and are eligible for an unrestricted Medicare provider number.

We look forward to welcoming you to the team at North West Private Hospital.

For further information, please contact:

Chris Murphy, Chief Executive Officer

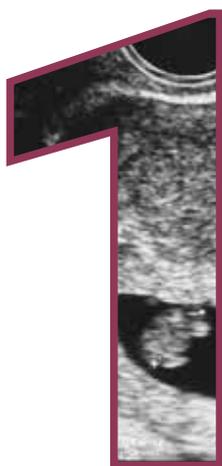
North West Private Hospital

(via Amber Leathwick, PA to the hospital Executive):

T: (07) 3246 3105

E: leathwicka@ramsayhealth.com.au

FIRST



DAYS

The window of opportunity for long term health

All children, no matter where they live or who they are, should have the same opportunity to fulfil their potential. Many children who experience inequities in health are also disadvantaged in accessing healthcare, leading to problems now and into the future. What are the origins of adult disease and how do epigenetics affect

pre and post-natal epigenetic profiles? What does the Dunedin study show us? How do we address these inequities in our communities?

These are the questions a shared session at RACP Congress 2019 set out to answer. It also explored how we can address and make

positive changes to what could be the most important years of patients' lives. The session was chaired by Dr Patrick Tuohy with captivating and enlightening presentations delivered by Professor Richie Poulton, Dr Johan Morreau and Dr Matire Harwood.



Welcoming delegates to the session Dr Tuohy, a specialist paediatrician with a particular interest in community child health, spoke of this topic as a paradigm shift in child health. “Following 20 years of research into the developmental origins of disease and the new science around epigenetics we now have a lot of information about how the early years affect the long term life course.

“Long term conditions and chronic disease in adulthood are some of the big challenges for the health sector right now. And it seems to me paediatricians, at long last, are going to be playing a very important role in prevention of these sorts of conditions and uniting with our colleagues in adult medicine to address this particularly troublesome and intractable problem.”

Professor Poulton, Director of the Dunedin Multidisciplinary Health and Development Research Unit, spoke about what the science says of the importance of the first 1000 days. But not just the first 1000 days. Professor Poulton also focused on conception through to preschool as at 1001 days the importance of development doesn't automatically go down a notch.

He presented on studies his team has done, drawing on data from the Dunedin Multidisciplinary Health & Developmental Study (Dunedin Study for short, run by Professor Poulton's Unit) which has been going for over 40 years and is one of the most detailed and cited studies of human development ever undertaken. It is an ongoing longitudinal study of the health, development and wellbeing of a general sample of New Zealanders. The researchers recorded over 1000 births in Dunedin in 1972 and have followed these people ever since, even though only a third have remained in New Zealand.

The studies show the importance of the early years, going back as far as age

three. They show that the early years meaningfully predict what happens down the track: “they predict important life outcomes not just from one particular area, but multiple important life domains and that prediction withstands control for all the usual suspects: distribution across social strata, cognitive measures, IQ and the like. It applies equally to men and women and it doesn't result from the extremes driving the association,” said Professor Poulton.



One of the studies was about childhood self-control, something useful to study in this modern day and age where there's really tempting distractions around us all the time. The study used the composite measure; if you composite via multiple measures from multiple sources you reduce the overall error. All the findings presented are from the composite, but Professor Poulton assures “that if you just use the age three measure, three decades later you can predict significantly the outcomes we're talking about, and the pattern is exactly the same.”

The study found a pattern is created from age three onwards and your level of self-control during childhood has an impact on your health in later years. It found that those with lower self-control in their early years showed the highest rates of instance in their later years across the following areas (compared to lower instance for those with higher self-control in their younger years):

- poor physical health
- drug and alcohol dependence
- lower socioeconomic status
- crime conviction
- single parent child-rearing
- welfare benefit use.

Following on from Professor Poulton's presentation, Dr Morreau presented on the impact of deprivation in early childhood on brain development.

He explained that early experience builds a brain. “Genes are the blueprint but experience is the carpenter, together they build a brain from the base up. Building a brain is like building a house – depending on the quality of experience a child grows a weak or a strong foundation.

“This foundation is critical for the later development of executive skills, including cognition, empathy and the ability to self-control and manage a life.”

According to the Harvard Centre on the Developing Child, 90 per cent of a child's brain growth happens before age five.

“Neurons in the brain build in early and then middle childhood, but if we're not using them then they get pruned away, and with a brain it's almost impossible to get them back later. A mature brain doesn't grow new neurons like a young one. The window of opportunity is when the child is very young,” explained Dr Morreau.

“Development occurs when a baby, infant and child and somebody else interact – somebody who is crazy about the child and gives them time. Through observing, playing and interacting with others a young child's brain grows and they develop their ability and their identity.”

Therefore, if a child is deprived of interaction, this will impact negatively on their development. If in addition they are exposed to a range of toxic



stressors, for example neglect or abuse etc, and don't receive the needed support from caregivers then prolonged activation of stress response systems will occur and these can seriously derail healthy brain growth and development.

"This stress response can impair the development of neural connections, especially in the areas of the brain dedicated to higher order skills, empathy, ability to control emotions and later cognitive skills – creating lifelong problems in learning, behaviour, and physical and mental health.

"A lack of a satisfactory first 1000 days (starting from conception) explains why in NZ we continue to have one of the highest rates of youth suicide, why we have such a high rate of incarceration and why we are seeing increasing numbers of children and adults with a range of preventable metabolic related conditions," said Dr Morreau.

Dr Morreau believes we know what needs to be done, "Invest in our workforce, especially those social workers, kaitiaki with the skills (cultural and personal) to engage with the families. Start with supporting pregnant women, early in pregnancy and follow through supporting the child and family until the child is at least school age."

The last speaker in the session, Dr Matire Harwood, a general practitioner, spoke passionately about the health and social issues affecting children and whānau (families) and urged delegates to believe that "addressing inequalities, particularly in the areas of Indigenous health is not overwhelming and that it can be done."

From all speakers in this session it was clear the early years, from pregnancy through to at least school age is of high importance for the development of the

child and that the experiences of the child in these years can have a lifelong impact on their health. Investment is needed during these early years in order to prevent increased investment in the later years.

If you are interested in hearing more about this session you can listen to the Pomegranate Podcast episode 46, visit www.racp.edu.au/podcast.



EARLY CHILDHOOD: THE IMPORTANCE OF THE EARLY YEARS

Launched at RACP Congress 2019 by RACP President, Associate Professor Mark Lane, the RACP policy position statement, *Early Childhood: The importance of the early years*, offers 47 policy recommendations for improving early development and child health.

"There are moral and ethical arguments for investing in children, children make up one fifth of our population, they make up 100 per cent of our future," said Associate Professor Lane, quoting the statement.

The President of the Paediatrics and Child Health Division, Professor Paul Colditz, said "investing in the early years of children's health, development and wellbeing is the most cost-effective means of tackling long-term health conditions and health inequity.

"Investing in the health of our youngest members of society makes sense on every level – it fulfils a basic human right, ensures a healthy and educated future workforce and reduces the burden of disease."

The statement puts forward a number of recommendations for the Government with a strong focus on parental and infant mental health, nutrition, early childhood education and social welfare.

The full policy statement can be accessed at www.racp.edu.au



Morals, ethics and Māori health

It was a simple but profound and pointed question posed by a Māori panellist in a wide-ranging session at Congress.

When it comes to medical morals and ethics in relation to Māori healthcare, whose morals and ethics are we talking about?

Indigenous health outcomes remain an intractable problem in many jurisdictions worldwide.

New Zealand has made progress in areas such as Indigenous medical trainee parity with Indigenous general population numbers; around 15 per cent of medical school students now identify as Māori.

But despite this, Māori health outcomes lag behind those of the general population in areas such as smoking, obesity and psychological distress, along with access to GPs and prescriptions because of cost.

And that, it was argued, is in part due to physicians not acknowledging or recognising their own biases as well as deep systemic bias and unfairness – and using their privileged position to advocate for change.

In the session ‘Exploring the impacts of health services on Māori health through key moral and ethical principles’, high profile Clinical Director and GP Dr Rawiri Jansen mounted a case from an ethical-legal perspective.

Unlike many nations purely colonised by force, he pointed out that, as a nation, New Zealand was established by formal agreement between Māori and Pākehā under the Treaty of Waitangi, signed on 6 February 1840 by the British Crown and Māori rangatira, or Chiefs of some tribes.

He and others argue that formal agreement has been legally breached.

That contention is now the subject of a formal Treaty case known as WAI

2575, bringing together over 200 health related claims to the nation’s Waitangi Tribunal, and the subject of an inquiry examining how New Zealand’s health services have failed to deliver appropriate health outcomes for Māori.

In an intriguing example, he spoke of an expectation that Māori could have of good governance of their health under the Treaty.

Yet evidence of this today is scant – in areas such as the Bay of Plenty where 50 per cent of the population identify as Māori, logically half of the Board of the local Health District should be as well.

Dr Jansen spoke of an Anglo-centric policy of assimilation and integration that persisted in New Zealand until the late 1960s, almost extinguishing Māori culture – and that continues to affect the health system today.

His message to physicians was direct. “Explore your own moral views of what is right and what is wrong and understand how these views have formed. Recognise the privileged position that you are in. Accept that you have a personal role to play in Māori health.”

He argued that, ethically, fairness in health access should not be about everyone getting the same thing but should be based on need.

While citing the success stories of Māori oncologists, renal physicians and public health specialists as well as increasing numbers of trainees, he also used the example of children still being raised in the back of cars in

Papakura where he practises. A decline in acute rheumatic fever among Māori in Auckland was promising, he said, but it was warmer, dryer housing that was the driver.

The responsibility to fix inequities lay with the broader physician community. “If you can help, get busy now – if you can’t, get out of the way.”

His final rallying call to those in the room was powerful.

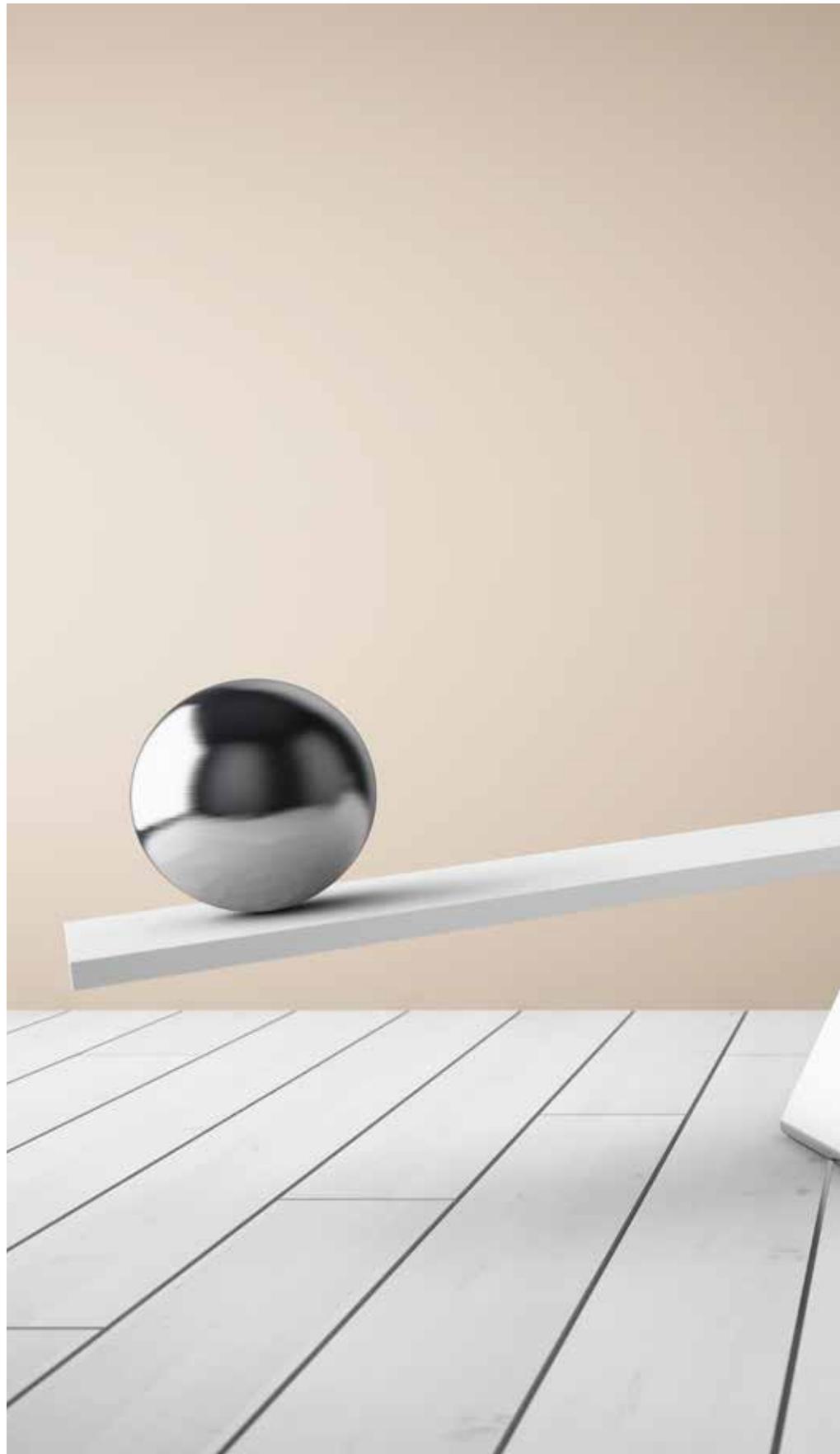
“If you want health equity for young Māori who turn 21 in 2040 – that’s all the babies born this year – we need to start now! For those Māori turning 65 in 2040 – we need to start addressing diabetes and chronic obstructive pulmonary heart disease now!”

RACP Fellow and Professor of Medicine and Associate Dean of the Faculty of Medical and Health Sciences at the University of Auckland Professor Des Gorman posed another question – why is the New Zealand health system so recidivist in terms of Māori health outcomes. He cited the non-closure of the absolute gap between Maori and Pākehā life expectancy since 1971 as an example. His assessment was scathing and blunt. “In fact the health system hasn’t changed since 1938 (when New Zealand’s first social security scheme was introduced).

“Savage (New Zealand’s first Labour Prime Minister) wanted to introduce universal healthcare, and the British Medical Association told him to piss off.” General Practice, he said, is a scaled-up cottage industry.

“It’s a colonial system, and there has only been in-system tinkering since. Healthcare is focused on those who provide the care, not the patients and consumers.”

He said today’s healthcare systems were examples of mathematician John Nash’s famous equilibrium, where all participants in a system are so interconnected and interdependent that one cannot change strategy without all changing strategy.





Professor Gorman said the pain created by the status quo had to be equal for all participants to effect system-wide change. He used the example of a Māori relative dying in the South Waikato of myeloma, struggling to access palliative care, whereas Pākehā New Zealanders in urban centres did not face the same degree of challenge.

“Unless we confront the realities,” he said, “...we’ll see more in-system tinkering and will be litigating this issue again in years to come.” ^{RQ}

“ Explore your own moral views of what is right and what is wrong and understand how these views have formed. Recognise the privileged position that you are in. Accept that you have a personal role to play in Māori health.”



RACP partners with Black Dog Institute to develop a physician health and wellbeing program

News that junior doctors have significantly higher levels of psychological distress compared to other doctors further along in their career may not come as a surprise. To date, interventions for doctors have focused on the individual. There is growing recognition, however, that strategies also need to be implemented at an organisational level to provide better support.

The RACP is excited to announce a new partnership with the Black Dog Institute and the University of New South Wales to design and develop an online education program for physician supervisors. This program will take a holistic approach to providing support by equipping supervisors to better manage the mental health and work environment of trainee physicians. The program will have a strong focus on building supervisor confidence so they can support the mental health needs of trainees.

Other expected benefits of the project include better mental health literacy, reduced stigma and more accepting attitudes towards mental health matters. Supervisors will also pick up techniques that are likely to have a flow-on effect, resulting in a mentally healthy workplace.

The Black Dog Institute is drawing on research about how managers can positively affect staff wellbeing, the results from previous evaluations and information gathered through consultation interviews with current physicians and supervisors.

The program will delve into topics including common mental illnesses, how to support trainees you're concerned about and how to minimise mental health risks at work.

A pilot of the program will be held soon with a randomised controlled trial, to examine the efficacy of the program, scheduled later this year. The College will provide further details throughout the year and will be in touch with members who are eligible to be a part of this trial.

Following the trial, the final program is set to be released in 2020. It will be mobile phone responsive so you can



**Black Dog
Institute**

For more details please contact
wellbeing@racp.edu.au



access it anywhere and completing the course will count towards your Continuing Professional Development (CPD) credits. For more details please contact wellbeing@racp.edu.au.

The wellbeing of all members, particularly trainees, is a priority of the College. Results from the 2018 Physician Training Survey have provided invaluable information on trainee and supervisor concerns about both their workplace and their training. The 2019 Physician Training Survey will be conducted later this year and all trainees and supervisors are encouraged to voice their opinions. We hope that actions resulting from member feedback, like the program

being developed with the Black Dog Institute, will continue to have a bold impact on member wellbeing.

If you are currently experiencing distress, the RACP support program is a free, fully confidential and independent helpline to support you with work, training and personal issues.

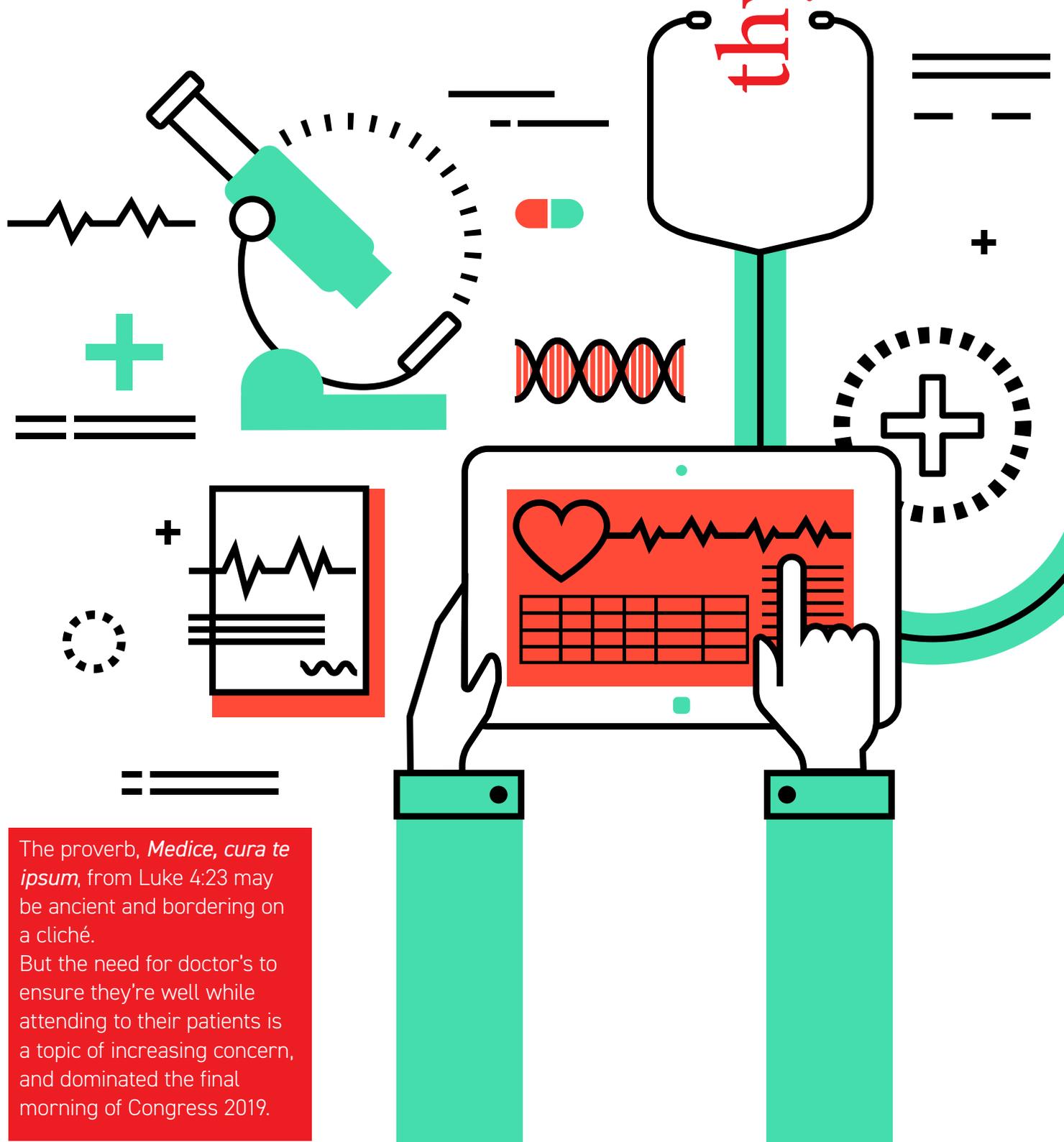
The College has partnered with Converge International to ensure this helpline is available 24 hours, seven days a week for Fellows and trainees. Any information you supply to Converge is completely confidential between you and your consultant and will not be passed onto the RACP or your employer.

You can arrange to speak directly with a consultant face-to-face, over the phone or via the internet on a number of issues, for both workplace and personal issues. These may include work-related stress and overload, interpersonal conflict and tension, bullying, harassment and grievances, as well as your mental health, including depression and anxiety.

If you would like to make an appointment or speak directly with a consultant, call
1300 687 327 (Australia) or
0800 666 367 (New Zealand). RQ

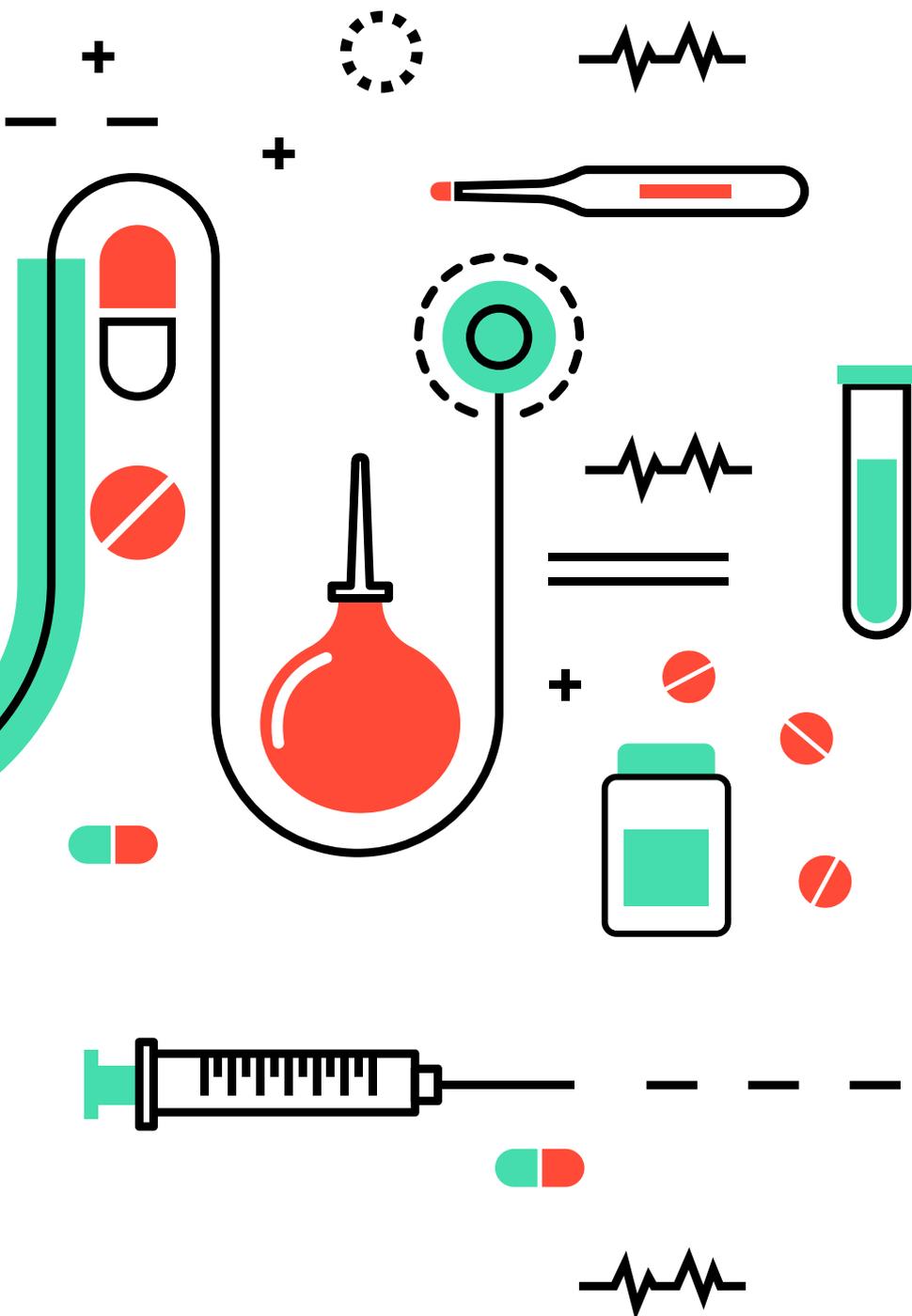
Physician **HEAL**

thymself



The proverb, *Medice, cura te ipsum*, from Luke 4:23 may be ancient and bordering on a cliché.

But the need for doctor's to ensure they're well while attending to their patients is a topic of increasing concern, and dominated the final morning of Congress 2019.



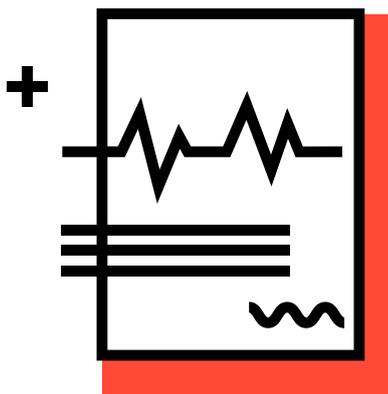
There was the opening address by Matt Beaumont, a first-year house officer, who spoke of the importance of sharing at least one sit down meal a week in his flat (that's a share-house to you Australians) with other young doctors as a form of therapy and support. His observation that hospital was a bizarre place with bizarre people, both sick and salaried drew laughs, but regardless, he said he is now a final year doctor, looking forward to 50 years more.

Dr Tait Shanafelt from Stanford Medicine, a leading US expert in physician burnout, joined by video. A Chief Wellness Officer, he spoke of at least 50 per cent of New Zealand physicians experiencing at least one symptom of occupational distress in the last year – a rate similar to that in the US – even after adjusting for hours worked. The consequences were similar across jurisdictions; broken relationships, alcohol abuse, major depressive or mood disorders and even suicide. Dr Shanafelt noted the considerable literature correlating occupational distress with poor patient care and satisfaction. He described seven domains of causes, primarily grouped under:

- workload
- inefficiency
- loss of control
- problems integrating work and personal life
- erosion of meaning in work
- isolation and loss of connection to colleagues
- value misalignment between medical altruism and healthcare business practices.

Professor Anthony Scott from the *Medicine in Australia: Balancing Employment and Life Survey (MABEL)* reported that the problem is increasing over time, but much more data needs to be gathered through MABEL across Australia to gauge the true extent

of the problem. Dr Margaret Key from the Australian Doctors Health Network reflected that no one has really taken ownership of the issue in work environments and observed that doctors in general only know they don't want to work with other impaired doctors, because they have to be reported.



This provided an interesting segue to the investigators themselves – Lynne Urquhart of the Medical Council of New Zealand's Council Health Committee. She dryly described herself "...sadly as a bureaucrat..." but gave a very relatable presentation on how the New Zealand regulator actually handles cases where doctors have been mandatorily reported under New Zealand legislation which covers all 21 allied health professions.

She said contrary to fears, 'will my career be ended?' the answer was usually, 'No.'

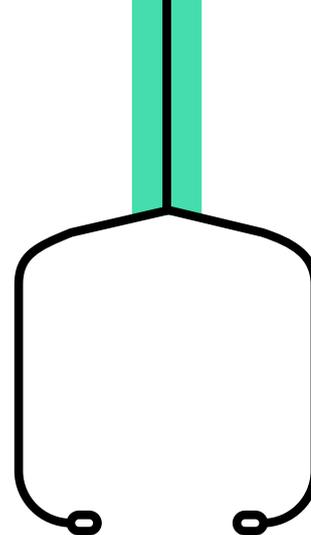
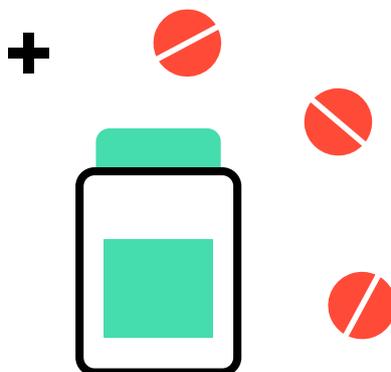
Ms Urquhart stepped through the entire process in New Zealand from notification to outlining the reasons for referral – which are primarily significant mood disorders, but also encompass substance and alcohol abuse, obsessive compulsive disorder and personal or professional crises.

She stressed that the key to a successful resolution was "...a decent level of insight and openness..." Privacy was of course a major concern, but couldn't always be

guaranteed as the Council may need collateral information from the workplace. She also observed that doctors, like their patients, often drip-fed information about their own issues, but emphasised that information could not be gathered without consent, and that the Council was obliged to act with consideration of the *New Zealand Privacy Act*. In certain cases, a monitoring regime may be required involving tests such as regular bloods. Surprisingly, she said some practitioners found the Council's intervention a welcome one and had asked to stay with the Council for the remainder of their professional careers.

Doctors Alexandra and Carl Muthu provided an interesting perspective on a medical marriage. Carl, a vascular and transplant surgeon, spoke of the implicit understanding another doctor had of long and odd work hours, bad patient outcomes and complaints. However, Alexandra, an occupational physician, maintained the support of families, friends and a nanny were critical, acknowledging that they had the privilege of being able to afford childcare and outsource household tasks. This was particularly important during training, study and exams, when each partner's schedule needed to be staggered.

Congress Lead Fellow Dr David Beaumont, father of Matt who opened the morning session, contributed a personal story of health and wellbeing, after transitioning from being a GP



to specialising in occupational and environmental medicine.

At 41 years of age, during a time of stress, on return home from work one evening in November 2004, his wife remarked he didn't look particularly well. 'Should I call a doctor?' she asked.

'I think you better call an ambulance,' he replied.

Then the crushing central chest pain set in.

Rushed to hospital he was diagnosed with a Non-ST Myocardial Infarction. Discharged with no procedure needed, but 'the usual cocktail of drugs', after six weeks off work his supervisor visited and remarked that they wanted to get him back to work but were worried about his state of mind.

As is common with cardiac patients – the psychological road to recovery is much more difficult than expected. Dr Beaumont shared that it took him five years to feel he was fully back to normal, and a significant part of that was finding a new meaning and purpose in life.

Ultimately, a personal health crisis and subsequent experience of doctor as patient revitalised his whole appreciation of medicine and led to him embracing a much more holistic practice and model of medicine. [RQ](#)



INTEGRATED CARE
The future
must be about
partnerships

The health needs of patients are changing, and for those living with chronic or complex health conditions, the health system can be an overwhelming place to navigate. Integration of care plays a vital role in ensuring a better experience for both consumer and clinician.

The experience and role of the consumer and primary healthcare and secondary care services were explored in this Congress session.

Treating the patient not just the condition

Ms Debra Letica has experienced both ends of the scale when it comes to dealing with the health system.

“Navigating both health and social care has perhaps been one of the most difficult things I’ve had to do.”

When Ms Letica’s mother-in-law ended up in an emergency department, both the hospital’s social worker and psychiatrist came to chat.

“They asked about mum’s health, how she used to be and how everyone was coping. She was diagnosed with dementia and they encouraged us to put a care plan in to ensure she got the care she needed in the future. They spoke with us about what she needed and what could be best for her. We were told about an aged care home down the road and how they could support mum.”

Ms Letica reflected on how this was a good experience for her and her family. Various facets of the health system came together and partnered with her family to get the best outcome.

“On the other hand was my experience as a carer for my brother who suffered an injury at birth resulting in an intellectual disability,” said Ms Letica.

A few years ago, the family was told he had Leukodystrophy, a genetic, degenerative condition that damages white matter in the brain. The experience of her brother’s diagnosis was far different to that of her mother-in-law’s.

“I was told by health professionals that I was being too passionate and that I asked too many questions, even though my brother couldn’t advocate for himself.”

Debra’s experience is invaluable as a member of the RACP Consumer Advisory Group (CAG). This body represents a wide variety of patient views from across Australia and New Zealand.

“[The CAG] is a shining light for the recognition of the importance of partnering with consumers in the design and delivery of healthcare so that we can all learn from each other.”

The medical home

“There’s great interest in primary care and how important this is in our health systems. Strong primary care in a health system is associated with reduced system costs, better outcomes and reduced social inequalities of health impacts,” said Dr Andrew Knight.

“A recent study in the US found 10 additional GPs per 100,000 population saw a 51.5 day increase in life expectancy. Ten additional physicians saw a 19.2 day increase.”

“The Patient-Centred Medical Home (PCMH) is a vision or an idea that we can all buy into,” said Dr Knight.

At the centre of the PCMH is the patient and their family. This is ‘the home’. Dr Knight and his colleagues then join patients and families in the next layer.

“There’s a relationship between the home and the primary clinician. This is the medical home which includes GPs, nurses and allied health and care coordinators.

“At the next level there’s community services including pharmacy, ambulatory care, community nurses. The final level of the PCMH is for tertiary care including hospitals and their services. This model becomes the medical neighbourhood all working together.

“It might start simply with your relationship with your GP but at times you’ll need to extend that to other members of the practice team. You may need a dietician or a psychologist or you are part of a population that needs extra care.

“Sometimes you’ll need people in the community and sometimes you’ll need to go to the hospital. We’re not doing hand over here, we’re extending and contracting the team as required by the patient as part of the medical neighbourhood,” explained Dr Knight.

The PCMH model is having a significant impact on policy. In NSW one of the pillars of NSW Health is Navigating the Healthcare Neighbourhood, a process to build networks, while nationally there’s the Healthcare Homes Trial.

Ninety per cent of people in Australia also have an online record as part of the My Health Record.

“Suddenly there’s an opportunity for informational continuity. In my view in the next five years this will make a difference. In my area, Nepean/Blue Mountains, we were one of the first trial sites to use this record. We’re finding people reporting they’re now getting information they didn’t get before,” said Dr Knight.

“We’ll see what happens. There’s risks and challenges but it seems to be having an impact”.

Levels of integration

When it comes to integration of care, Dr Peter Jones explains there are several layers.

“Much of what people talk about is clinical integration at the service level (meaning multi-disciplinary teams). Then there’s professional integration where you might have a service which is organised around a particular disease state or organ system. Then there’s a third level which is about system level integration.”

Multidisciplinary teams, which do not have to be doctor-led, are usually formed to deliver a set of services to people with a particular condition or who form a demographic group.

“There are community-based models designed to maximise the use of limited clinical resources while improving communication between the primary and secondary healthcare providers. These have their problems including limited capacity for primary care to support the model and poorer access to services for hospital clinicians, but could be a model for delivery of ambulatory care,” said Dr Jones.

System level integration is more complicated with numerous organisations coming together, feeding in and out of each other – a complex adaptive system. “You cannot control the system, you can only seek to understand and learn,” said Dr Jones.

“In New Zealand, District Alliances between District Health Boards and Primary Healthcare Organisations are the key to system integration. They are responsible for implementing system level measures

for quality improvement, placing the needs of healthcare consumers at the centre.

“Where we want them to go is to have more inclusive membership, beyond general practice to include ambulance, lead maternity carers, pharmacy, well child services, district nursing, public health and consumers. We want everybody at the table thinking about quality improvement and what collectively could be done to improve patient experience and outcomes.”

Consumers driving the future

The Consumers Health Forum of Australia grew from a group of community organisations who wanted consumer input into health policy development. Their vision is a healthcare system which shifts the approach from illness to wellness.

Consumers want to wield their choice to determine how services are developed. They want to be partners, shared decision makers and active managers of their own self care.

Advances in technology are opening up exciting opportunities to empower consumers in their health management. Technology could be used to integrate systems, provide data sets and capture the patient experience so that systems are designed around the patient and service offerings are determined by local needs and preferences.

A round table at a consumer health forum on primary care in 2018 also came up with a number of patient centred initiatives. This included empowering consumers with complex chronic diseases by providing an individual funding package, similar to the National Disability Insurance Scheme, to give patients choice and control of their healthcare providers. Another idea was a consumer portal to bring together literacy, resources, and self-management and decision-making tools.

To realise this future state the current primary healthcare structures will need to change. This doesn’t necessarily need to be an overhaul of the whole healthcare system, but everyone implementing the changes when they can. [RQ](#)

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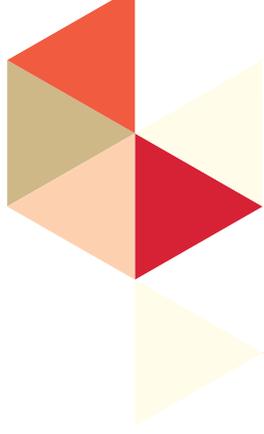
AOTEAROA NEW ZEALAND TRAINEES' DAY 2020

Developed by trainees for trainees

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,
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Balancing medical science with humanity

RACP Congress 2020

4 – 6 May 2020

Melbourne

With 86 per cent of RACP Congress 2019 attendees saying Congress gets better every year and more than half rating RACP Congress as their go-to educational forum, we are excited and energised for RACP Congress 2020.

Recently announced by RACP President, Associate Professor Mark Lane, our new Lead Fellow for Congress is Professor Don Campbell. Professor Campbell is a recent Past President of the Internal Medicine Society of Australia and New Zealand (IMSANZ) and is currently President-elect of the Adult Medicine Division.

With his interest in and commitment to health system design and fostering

medical leadership, Don regards Congress as a unique annual opportunity for College members to meet and be stimulated and challenged to continually strive to achieve better health outcomes for all New Zealanders and Australians.

Congress 2020 will explore how quickly medical science is developing and we will tackle some of the big questions. How can we predict where we will be in five or ten years? How do we keep up when science is changing so rapidly? How do we design a system that puts the patient first? How do we retain the humanity and empathy in what we do; for our patients and for each other?

These are just some of the things you will discover at Congress 2020.

This is your opportunity to come together as specialists, celebrate our diverse membership, engage with your peers and contribute to the generation of new ideas.

RACP Congress 2020 is being held at the Melbourne Convention and Exhibition Centre from Monday, 4 May to Wednesday, 6 May.

Register your interest in
RACP Congress 2020 at
[www.racpcongress.com.au/
register](http://www.racpcongress.com.au/register)

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The **DO'S** and **DONT'S** of recruitment

The Advanced Training selection period is fast approaching before Basic Training recruitment later in the year. Here's a reminder of what you should and shouldn't do when it comes to interviewing applicants.

Do

- Predetermine interview questions focusing on the requirements of the position and the training program. The questions should allow interviewers to assess the skills and abilities of the applicant and how these will relate to their performance of the requirements of the role.
- Ask all applicants the same core questions.
- Base interview questions on selection criteria and then, wherever possible, as a past behaviour question (PBQ). The aim is for the applicant to demonstrate that they have exhibited the selection criteria through past behaviour. Examples of a PBQ include:
 - What is your understanding of cultural competence and cultural safety? Could you give an example of how you have utilised this understanding in your role(s) to date?
 - Could you please give us an example of a time when you had to provide feedback to a junior colleague, peer, senior colleague or other health professional?

- Use the situation, action, result (SAR) approach. Ask the candidate to describe the situation, outline what they did (as opposed to what others did) and then detail the outcome of their action.
- Hold information sessions which are open to all potential applicants.
- Review your plan to ensure all applicants have an equal opportunity to participate in the interview and selection process.
- Include an independent member on the interview panel.
- Be consistent and fair in the way each applicant is treated.
- marital status
- pregnancy
- political opinion
- sexual orientation
- carer duties.
- Make assumptions based on the person's behaviour or body language that may be because of a disability or their cultural background.
- Seek irrelevant personal information.
- Hold pre-interviews which potentially disadvantage some applicants.

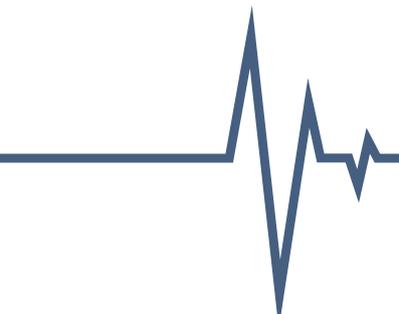
Don't

- Ask questions of a personal or discriminatory nature. This includes anything related to:
 - religion
 - race

Remember, if in doubt, contact your local Human Resources department.

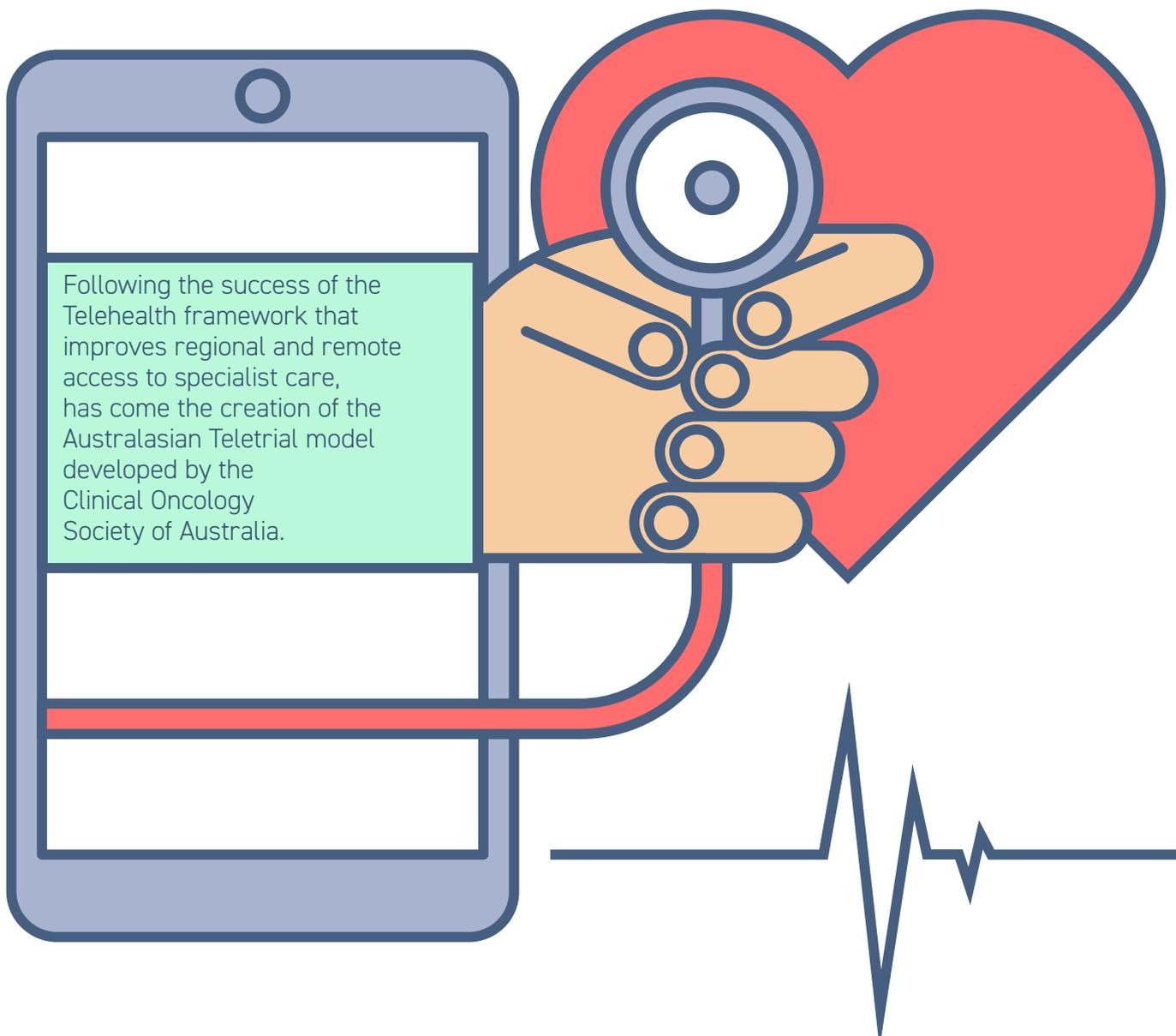
RACP has recently published a poster, guidelines and website information containing tips, tools and case studies to support this selection cycle. These resources are available now at www.racp.edu.au/selection.





TELETRIALS

Bringing regional and rural access to clinical trials closer to home



Following the success of the Telehealth framework that improves regional and remote access to specialist care, has come the creation of the Australasian Teletrial model developed by the Clinical Oncology Society of Australia.

The aim of the Teletrial model is to enhance regional and rural access to clinical trials (not limited to cancer care) by linking smaller centres with larger centres using telehealth. This model facilitates a system where patients at smaller centres take part in trials without travelling to larger centres, and where trial capabilities are enhanced at smaller sites due to formal collaboration with larger centres.

“For me, living in a regional place looking after rural people and seeing how they travel long distances, experience the cost of relocation and travel, and seeing the disruption to family life, I felt as doctors we need to come up with new models of care,” says Professor Sabe Sabesan, Co-Chair of the Australasian Teletrial Consortium (along with Co-chair Professor John Zalcberg of Monash University).

Professor Sabesan, Director of Medical Oncology at Townsville Cancer Centre and James Cook University, has been a driving force behind this important initiative and was troubled by the rate of enrolment in clinical trials being considerably lower than is expected of international recommendations and benchmarks.

“The problem is a lot of smaller centres or regional and rural sites, will never be able to do clinical trials because of limited workforce capabilities and distance.

“That’s where Teletrials come in. It

allows patients and clinicians to take part in the trials at their centre as part of teletrial clusters, without going to the bigger centres.”

Evidence suggests that patients who take part in clinical trials have better health outcomes in many fields of medicine. This is particularly important for cancer patients, as cancer clinical trials are considered the best option for cancer clinical care.

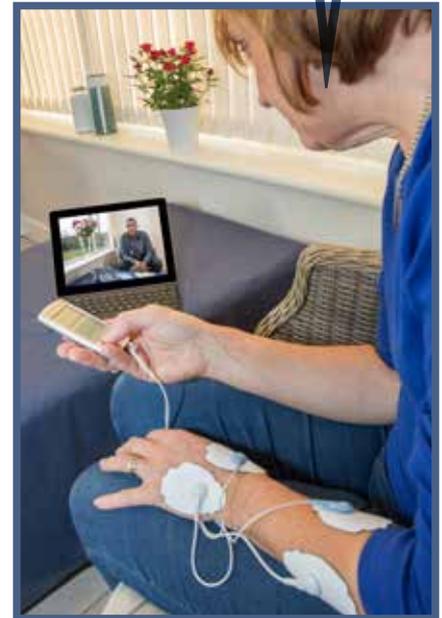
“This is because they are monitored much more closely and there is a protocol that the clinician must follow, which minimises variation in standard practise.

“To implement the Teletrial model across Australia, we need to have reforms at many layers of the health system from federal government to the frontline workforce.

“The current clinical trial models are site specific. They are not collaborative models and their approval processes are labour intensive,” says Professor Sabesan.

Some of the reforms include the development of standard operating procedures (incorporating Teletrials) by health departments, streamlining of ethics and governance approval processes for teletrial clusters and development of new contract processes.

In the last two years, Queensland Health has made reforms in many areas to facilitate the implementation across the state and several



pharmaceutical companies have activated many regional and rural sites that have never conducted clinical trials previously as satellite sites to major centres for their clinical trials.

Following the success in Queensland and North Queensland cancer centres, several states have established teletrial steering committees and many cancer centres across Australia have begun adopting Teletrial as a mechanism for enhancing rural and regional access to clinical trials closer to home. Professor Sabesan says that for this model to be sustainable it needs to be endorsed and adopted by peak national research bodies and state departments of health using incentives, resources and key performance indicators. [RQ](#)



Professor Sabe Sabesan

“ To implement the Teletrial model across Australia, we need to have reforms at many layers of the health system from federal government to the frontline workforce.”

Health issues in rural and remote populations



Supporting physicians in rural areas, as well as the community, was discussed as a part of the Australasian Faculty of Public Health Medicine's (AFPHM) stream at Congress 2019.

Approximately 15 per cent of New Zealand and 20 per cent of Australian populations live in rural or remote areas. While on the decline, they still make up almost one fifth of the population. With the ageing of these populations, a further decrease in the number of youth is expected over the next 20 years.

Professor Ross Lawrenson from the University of Waikato has been involved in research exploring the health outcomes for rural vs urban communities in New Zealand.

The Rural Health Survey (2002) highlighted health trends for genders in urban and rural areas. Women in urban areas were more likely to be diagnosed with arthritis and osteoporosis while there was a higher prevalence of spinal disorders in men from rural areas.

There were also a number of trends for Māori living in regional areas. Rural Māori have higher mortality than those living in urban areas and female Māori in rural areas had higher mortality rates for breast cancer.

"We've done another study looking at the number of general practitioners (GPs) per 10,000 population in our rural communities in the Waikato and Midland region compared to urban. There are 13 GPs per 10,000 in our urban centres, seven in our rural areas. So there's an access issue for rural patients," said Professor Lawrenson.

Dr Margot McLean is a Medical Officer of Health in a remote area of New Zealand that often feels like it is ignored by urban areas. Most of the community sit in the most deprived quintile and there are high rates of health issues including mental health problems, smoking, diabetes, family violence, bronchiolitis and rheumatic fever.

"If we want to promote meaningful change in remote and rural areas we have to be thinking well beyond our usual approaches to health and illness. Respect the Indigenous world view which encompasses the environment as well as human health."

The development of culture including language, sport, connection to the land

as well as to others creates a sense of belonging and community which has had a big influence on wellbeing in the region.

"Decolonise your institution. Small steps for example, have karakia to open and close any meeting.

"Recognise importance of whakapapa (genealogy) and whānaungatanga (relationships). That's incredibly important in this region. You need to introduce yourself properly to explain where you come from and where your ancestors come from to build relationships before launching into the mission," said Dr McLean.

"Learn te reo and be curious about history and culture. Mentor and support local staff, particularly Māori, who are from here and will stay here."

This continuity of care is something patients in rural areas continue to identify as a priority for their healthcare. They also want time to get to know their healthcare provider and for them to get to know the patient.



“ If we want to promote meaningful change in remote and rural areas we have to be thinking well beyond our usual approaches to health and illness. Respect the Indigenous world view which encompasses the environment as well as human health.”

Both of these factors not only assist the patient, but they reduce costs from new practitioners coming in and ordering unnecessary tests or by taking the time to dig deeper to find out that the test is irrelevant.

The key to delivering this is retention of staff.

“I’m dreaming of reaching the point where people ask themselves ‘where is my rural practice? Where it’s seen as the place to be,’” explains Dr Martin London.

Building a supportive professional environment is one of the key things that has kept Dr London in rural practice in New Zealand for over 30 years.

“A supportive professional environment means such things as good facilities, effective technology, and access to CPD, but above all it is about the relationships within the team and with the wider professional environment. If you have a team that wants to stay together they will. You also need employers who know and care about their workforce as well as strong relationships between primary and secondary services.”

Dr Douglas Lush spoke about the challenges he has experienced as a part time sole practitioner in a rural area. Recruitment and staffing levels present issues, for example, Dr Lush

has limited clinical support and there’s little back office staff to help with administration.

“There’s a variety of reasons why people move to rural areas and sometimes these don’t align with the community which can be difficult when it comes to recruitment. There’s also a lack of roles for spouses which can make it difficult for couples to move,” said Dr Lush.

There are opportunities to better support rural organisations though.

“I think we need more flexible jobs, maybe joint placements and a bit of creativity around what the role of a GP might look like.”

“Look at non-financial incentives. There’s plenty of reasons for living in these settings, the extraordinary sense of community, achievement, and living with the ‘unworried unwell’ is much better than what you can experience in an urban setting.

“Also, remove staff who aren’t team players with the organisation because it can be difficult to recruit when it’s known that it’s not a happy place to be.”

A survey of trainees and supervisors conducted by the University of Queensland in partnership with the College identified that training pathways for rural areas can be complex and it is often difficult for trainees to take that path.

Associate Professor Linda Selvey said other issues highlighted by the survey included the high workforce turnover which led trainees to feel like there was no continuity in their training. Some responders believed there was less access to support in rural areas and were unsure if they had the skill level needed to work in a less supported area.

Possible solutions to this are the Rural Focused Urban Specialists (RUFUS) and rural based clinical schools programs in New Zealand. RUFUS are specialists employed to go out to rural areas, understand the area and engage with the teams that provide care. They provide education on their visits and are available to the primary care practitioners for consultation out of hours. Rural based clinical schools disperse teaching to rural areas, not teaching ‘rural health’ but ‘core curriculum in a rural setting’.

“You have students of different specialities creating interdisciplinary teams, so you can get an education that is as good, if not better than that in an urban setting,” said Dr London.

“Both of these programs can help to develop a supportive professional environment, clinician retention, continuity of care and security of rural health services.” ^{RQ}

RACP Congress 2019 spotlights Indigenous health issues

Indigenous concepts of health and healthcare were under the spotlight at RACP's Congress in Auckland in May, with a number of sessions focusing on how to best ensure Indigenous frameworks underpin healthcare provision for Aboriginal and Torres Strait Islander and Māori peoples.

Despite the ocean separating the two countries and the very distinct histories and culture, Indigenous people in Australia and Aotearoa New Zealand unfortunately share a similar story of colonisation and dispossession which has direct consequences for inequality and poor health outcomes.

In both countries, Indigenous peoples suffer from lower life expectancy and higher rates of maternal mortality, infant mortality and mental health conditions than their non-Indigenous counterparts.

The gross inequities in health outcomes between Indigenous and non-Indigenous populations in Australia and Aotearoa New Zealand is a significant human rights issue and is unacceptable.

In Australia, Aboriginal and Torres Strait Islander peoples see specialists about 40 per cent less often than non-Aboriginal Australians, even though Indigenous Australians are currently experiencing a burden of disease and illness 2.3 times the rate of non-Indigenous Australians.

Access to timely, high quality, culturally safe and appropriate specialist medical care is absolutely essential to closing the gap between Indigenous and non-Indigenous populations' life expectancy and overall health outcomes.

Indigenous health featured heavily at this year's RACP Congress, including Sir Mason Durie's keynote address and sessions on the decolonisation of health services, the impact of health services on Māori health through key moral

and ethical principles, and the role of Indigenous leadership in transforming medicine.

In Sir Mason Durie's address he incorporated tikanga Māori into his ideas about health and wellbeing. That has evolved to his ideas of 'health as a house' – or 'Te Whare Tapa Whā', with four sides: Taha tinana – our bodies; Taha hinengaro – our minds; Taha whānau – our relationships; Taha wairua – our meaning and purpose. You can read more about the address on page 18.

In the session 'Exploring the impacts of our health services on Māori health through key moral and ethical principles', Dr Rawiri Jansen, Professor Des Gorman and Mr John Whaanga discussed the role of Waitangi Tribunal's WAI 2575 Health Services and Outcome Inquiry in addressing Māori health issues. More about this session is on page 25.

In the session 'Decolonising health services', Dr Sandra Hotu, Professor Noel Hayman and Dr Lance O'Sullivan explored ways of increasing cultural safety in health services and addressing a number of health inequalities which have been highlighted through a Waitangi Tribunal Inquiry to date.

In her presentation, Dr Sandra Hotu shared the methodology and findings from her study on applying a person and whānau centred approach to address health inequity for Māori with chronic airways disease.

Dr Hotu explored the myriad of reasons behind the health inequalities which



persist in the Māori population, namely, the legacy of colonisation, including marginalisation and normalisation, and the racism which is embedded into structures and practices in our society.

The study involved semi-structured interviews with 17 Māori with chronic airways disease and their whānau, and a series of focus groups with patients, nurses, physiotherapists and general practitioners.

Dr Hotu concluded that in order to mitigate the severe health inequalities which currently exist, practitioners and policy makers need to practise 'critical consciousness' whereby they recognise the role of colonisation in Māori health inequities and the mismatch that exists between Māori culture and the ideologies and assumptions underlying mainstream health structures and practices. Furthermore, clinicians should understand they have an ability to transform their own clinical practices

and the healthcare structures which perpetuate health inequity.

Congress 2019 saw practitioners, policy makers and specialists come together to discuss the systemic and institutional racism that persists in both Australia and Aotearoa New Zealand. It was an important opportunity to workshop solutions using Indigenous frameworks to address the inequities and close the gap between Indigenous and non-Indigenous populations.

Immediately preceding Congress, there was an historic meeting between members of the Aboriginal and Torres Strait Islander Health Committee and the Māori Health Committee to discuss their shared experiences, goals and objectives. Members from both Committees expressed the mutual positive support from the meeting and affirmed their commitment to the College's Indigenous Strategic Framework.

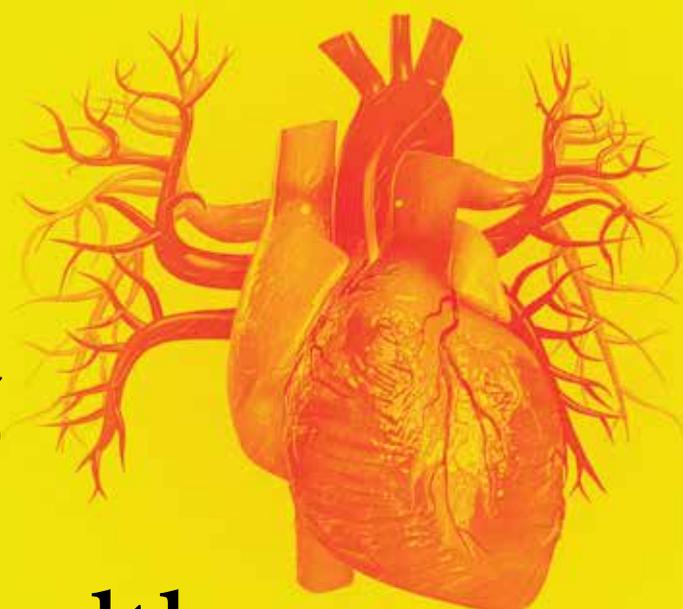
The insights gleaned from the sessions on Indigenous health will shape and inform the College's ongoing policy and advocacy in this area.

Within the RACP, the Indigenous Strategic Framework commits us to the following priorities:

- contributing to address Indigenous health inequities
- growing and supporting the Indigenous physician workforce
- educating and equipping the physician workforce to improve Indigenous health and provide culturally safe clinical practice
- fostering a culturally safe and competent College
- meeting the Australian Medical Council's accreditation standards.

Access the Indigenous Strategic Framework at www.racp.edu.au. RQ

Heart health researcher named a rising star by NSW Minister for Health



RACP Fellow, Associate Professor Aaron Sverdlov, was the recipient of the 2018 Ministerial Award for Rising Stars in Cardiovascular Health. Associate Professor Sverdlov is the Director of Heart Failure at the University of Newcastle and is a Clinical Lead of Heart Failure Services for Hunter New England Local Health District. His heart failure and cardio-oncology research was acknowledged when he received the award at the NSW Cardiovascular Research Network's (NSW CRN) annual 'State of the Heart' Showcase in Sydney on 7 November 2018.

The Hon Brad Hazzard MP, NSW Minister for Health and NSW Minister for Medical Research, hosted the event and presented the accolade to Associate Professor Sverdlov, the first winner outside of a Sydney-based institution.

The CRN's annual showcase provides an opportunity to formally recognise and acknowledge the enormous contribution NSW researchers do to fight cardiovascular disease – a major cause of death in Australia. It also highlights some of the innovative work currently being done in the cardiovascular disease space.

Cardiovascular disease (CVD) is a major cause of death in Australia. According to the Australian Bureau of Statistics, it claimed the lives of 43,477 Australians in 2017 and accounts for almost 30 per cent of all deaths, killing one Australian every 12 minutes.¹

Associate Professor Sverdlov was interested in a medical career during

1. Australian Bureau of Statistics 2018, Causes of Death 2017, ABS cat. no. 3303.0, September.

“ My vision is to establish, grow and lead a comprehensive research program aimed at improving outcomes for patients with heart failure.”

childhood and became passionate about improving heart health during placement. “With the increasing rate of cardiovascular diseases in our community and associated high burden of mortality and morbidity, I felt more could be done to help people clinically and by doing more research into mechanisms and new therapies,” says Associate Professor Sverdlov.

A core focus of Associate Professor Sverdlov’s research is heart failure. He has received research funding from the Heart Foundation to investigate mechanisms underlying heart failure due to obesity, novel biomarkers for early detection of cardiac abnormalities, and whether an intensive weight-loss program leads to improved outcomes in heart failure patients. Although he’s made great advancements in morbidity in heart

failure, Associate Professor Sverdlov says “arrhythmias are still one of the most expensive chronic conditions, costing Australia \$3 billion in healthcare costs alone.

“The main reasons for this failure to improve outcomes is increasing prevalence of heart failure with preserved ejection fraction or diastolic heart failure. The mechanisms for it are not understood well, which further contributes to the lack of therapeutic options. This is generally due to obesity, metabolic disease, ageing and hypertension – all of which are on the rise in our society.

“No medical or device therapy has yet been conclusively proven to be effective. The prevalence is now close to 50 per cent of all heart failure in the western world,” explains Associate Professor Sverdlov.

Associate Professor Sverdlov aims to use his research program to create a better understanding of the pathophysiology of heart failure and develop more personalised approaches to the diagnosis, prognostication and management of patients.

“My vision is to establish, grow and lead a comprehensive research program aimed at improving outcomes for patients with heart failure.”

Associate Professor Sverdlov believes biomarkers (whether for screening, diagnosis, or prognosis) are emerging to be an important tool to enhance the ability of the clinician to optimally manage the patient.

“Assessment of cardiovascular disease risk supported by biomarker analysis is a primary requirement to stratify those at high-risk. While there are current multiple biomarkers such as cholesterol levels, troponin, brain-natriuretic peptides (BNP), their predictive values and risk stratification in the era of personalised medicine are of only limited usefulness.”

In medicine in general, but especially in the field of cardiovascular medicine, prevention and early identification of disease states lead to early treatment with improved outcomes, patient satisfaction, reduced healthcare costs, morbidity and mortality.

“Biomarkers have potential to change the diagnostic and management pathway for many patients by risk stratifying them further and improving delivery of healthcare. The most promising biomarkers are ones that closely correlate with the early pathophysiological process of the disease,” says Associate Professor Sverdlov.

This research program ties in with both heart failure and cardio-oncology programs and aims to develop a personalised and individualised multi-marker strategy for diagnosis, risk stratification and prognostication in a wide range of cardiovascular conditions. [RQ](#)

ABOUT THE NSW CARDIOVASCULAR RESEARCH NETWORK

The NSW Cardiovascular Research Network (CVRN) is a collaboration of some of the state’s most eminent researchers working in the fields of heart disease, diabetes, stroke and kidney disease. The Heart Foundation facilitated the establishment of the network, alongside the support of the NSW Department of Health.

The CVRN combines its expertise to improve health outcomes for patients, while reducing the financial burden of cardiovascular disease on our health system.

Comprising 13 umbrella member organisations and more than 50 affiliated research institutions, the network is committed to cardiovascular research and supporting the research workforce in NSW. The CVRN offers its network potential and power through leverage and interaction, while working together to improve heart health.

FINDING VALUE IN WHAT WE DO: health advocacy and reform

RACP Congress welcomed three pioneering speakers on finding value in their profession. Their experiences ranged from improving equity in Māori health outcomes to preventing nuclear winter, showing the breadth of opportunities for values-based health advocacy in local and international spheres.

Addressing inequity in health outcomes

Dr Teresa Wall was previously the Deputy Director General of Health for Kete Hauora (Māori Health) and Ministry of Health Policy Unit. Now Dr Wall works to improve equity in the health system through her consultancy.

“The spread of value-based healthcare is changing the way physicians provide care,” Dr Wall told Congress. “New healthcare models stress a team-oriented approach and the sharing of patient data, so that caring is co-ordinated and outcomes can be measured easily.

“One of the tenets of value-based care is that benefits accrue across the whole healthcare system... society becomes healthier while reducing overall healthcare spending,” said Dr Wall.

However, Dr Wall pointed out that the current models of value-based care, such as Choosing Wisely and Evolve, are silent on the matter of equity. “I suspect that there is an assumption that doing things better will lead to equity, but this is usually not the case. Generally, the system will work more effectively for those it currently serves well.

“It’s not rocket science,” Dr Hall insists. “It’s about being able to look at things and ask the question: ‘Is what we’re currently doing increasing inequity or is it addressing equity?’”

Humanitarian advocacy for nuclear disarmament

Professor Tilman Ruff is a public health and infectious diseases physician and international and Australian Chair of the International Campaign to Abolish Nuclear Weapons (ICAN). Professor Ruff discussed finding value through “evidence-based advocacy and efforts by physicians to mobilise and harness evidence in ways that have political traction.”

Disarmament has gone backwards as nations race to increase their nuclear capacity. Professor Ruff outlined how nuclear weapons pose the most existential threat to humanity, as even a limited regional nuclear war involving less than 0.5 per cent of the global arsenal would abruptly cool the climate and imperil global food supplies.

“All of the nuclear armed states, all nine of them, are investing massive amounts, over \$105 billion US dollars every year projected over decades, in not just maintaining but in modernising those weapons with new capacities – more useable, more flexible, more accurate,” Professor Ruff said.

Health advocacy has been instrumental to disarmament talks and the establishment of ICAN, an organisation which won the Nobel Peace Prize in 2017 and of which Professor Ruff is a co-founder. “The idea was a broad civil society coalition focused on the humanitarian evidence, not the politics and security arguments, with the very clear goal of a treaty to ban and eliminate the world’s worst weapons,” he said.

Health advocates were instrumental in getting the International Court of Justice to review the obligation to disarm enshrined in the Nuclear Non-proliferation Treaty in 1996, advising unanimously that negotiations for disarmament in good faith were not sufficient, but must be brought to a conclusion.

At present, 70 nations have signed the United Nations treaty to ban nuclear weapons, with 23 ratifications.

Measuring the value of human life and the value in health outcomes

Dr Curtis Walker is Chair of the Medical Council of New Zealand and serves on the board of the Māori Medical Practitioners Association. With the premise that “Physicians can promote peace, love, understanding, and heal the world,” Dr Walker argued for reframing attempts to quantify the fiscal value proposition medical practitioners offer.

“We can come up with the cost of things, but what about the value of things?” Dr Walker asked. “Many of the things we measure are not valued, or valuable, and many of the things that are valuable are not measured. And I think that’s a big challenge as we talk about what is value-based healthcare.”

Dr Walker proposed that the value of a human life, reduced to the sum of its physical parts, is worth \$16.38 NZD, while the cost of producing a physician is well over \$500,000. The value of each, of course, cannot be measured.

Dr Walker’s argument was that we should strive for health outcomes of real value to patients, rather than focus on health inputs (such as the number of hip operations or chemo treatments we are able to deliver). This is increasingly being done in Australasia, even in the public health system, where open competition and choice for patients are not readily available. Values based-healthcare must also be equitable healthcare.

“Maybe one day, in the same way we have the first generation of ‘digital natives’, we will have doctors who are ‘values-based equity natives.’” RQ



SPDP workshops leading the way for supervisors

Teaching the teachers

Training is a vital part of every physician's journey, and one that doesn't stop after graduation. Our supervisors are integral to the development of each trainee, so it's imperative they receive the same support in their role.

RACP's Supervisor Professional Development Program (SPDP) is designed specifically for the role of supervisor. This free three-part program is a facilitated workshop, conducted with assistance from the Supervisor Learning team and Member Support Officers.

There are a number of opportunities to participate in a face-to-face workshop. They can be held at a local healthcare setting, at Annual Scientific Meetings or the RACP office in your state, or you can complete the SPDP workshops online.

SPDP equips you with the skills and tools needed for your role as a supervisor and you can earn up to three Continuing Professional Development credits per hour for attending SPDP workshops. Once you've completed SPDP you can further upskill to become an online or face-to-face facilitator. As a SPDP facilitator you can ensure the program continues to be relevant and focused on supervisor needs. As a physician you're best placed to deliver training to your peers. The skills you'll learn as a facilitator will also benefit you in a range of other professional areas.

What do Fellows say about SPDP?

Participants consistently praise the supervisor workshop series. Over 3,500 feedback questionnaires have been completed for the three SPDP workshops from 2014 to May 2018.

“The interaction and sharing of experiences and ideas was really helpful and constructive,”
SPDP participant.

SPDP 1: Practical skills for supervisors

The first supervisor workshop is designed to introduce supervisors to overarching themes such as coaching techniques and delivering feedback to trainees. This workshop focuses on delivering feedback using two frameworks, the GROW model and the four areas of feedback. By using these models, you can facilitate change and growth in trainees towards expert performance.

Most supervisors agree the:

- training was relevant to their needs
- the materials in the workshop were helpful
- the length of time was sufficient for training
- the workshop facilitator was effective.

“Very helpful. In my 20 years of medicine I have never been given the opportunity to discuss this integral part of our profession,”

SPDP 1 participant.

SPDP 2: Teaching and learning in healthcare settings

Workshop two furthers your understanding of teaching strategies so you can manage and overcome challenges supervisors face in a complex healthcare setting. Strategies include planning for learning, differentiated instructions for multi-level groups, and using teaching techniques such as questioning.

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

Most supervisors agree that:

- training was relevant to their needs
- the materials in the workshop were helpful
- the workshop increased their knowledge
- their confidence as a supervisor increased
- their recognition of the cultural environment increased
- their confidence in teaching through adverse events increased.

“I valued the opportunity to reflect on my practice as a supervisor,”

SPDP 2 participant.

SPDP 3: Work-based learning and assessment

Work-based learning and assessment is a complex and necessary part of physician training. The challenges of undertaking work-based learning and assessment amidst the complexities of the healthcare environment are many and varied. Workshop three offers techniques and solutions to these challenges that will be vital in your role as a supervisor.

Most supervisors agree that:

- training was relevant to their needs
- the materials in the workshop were helpful
- the workshop had good content
- questions were welcomed
- the workshop contained clear instructions
- the workshop met their expectations
- the length of time was sufficient for training
- the workshop facilitator was effective.

“Very interesting discussion and great to hear the experiences of colleagues in other disciplines. Nice to know problems I encounter are common elsewhere. Also, interesting to hear how they manage them,”

SPDP 3 participant.

All three workshops are held throughout the year in various locations in Australia and New Zealand as well as online. The course is flexible to suit your work and personal arrangements – you can complete the courses in whichever order suits you and you can switch between the face-to-face and the online option for each course as you progress through the program. [RQ](#)

Transition from paediatric care to adult medicine

Transitioning a patient from paediatric to adult care can be a complex and often challenging task. At the recent RACP Congress 2019 in Auckland, the Paediatrics & Child Health Division (PCHD) and Adult Medicine Division (AMD) combined in an expert presentation encompassing the paediatric and adult medicine spheres. Chaired by Dr Richard Sullivan, speakers were Lead Clinician for Paediatric Endocrinology Dr Fran Mouat, Adult Transplant Hepatologist Dr Rachael Harry, Developmental Paediatrician Dr Colette Muir and RACP Consumer Advisory Group member Mr Hamza Vayani. The thought-provoking session explored different methods on how to create a smooth process for patients, their families, carers and medical teams.

The session highlighted the many challenges of transition, and specifically that each child requires a tailored care plan to meet their differing needs. Dr Mouat quoted the American Society for Adolescent Medicine, “transition is a multi-faceted, active process that attends to the medical, psychosocial and educational/vocational needs of adolescents as they move from child to adult-centred care.” Based on a study done by the Department of Health in the UK, Dr Mouat explained that the transition has challenges.

“The transfer of young people from child to adult services requires special attention. Evidence shows this is generally poorly handled.”

Confidentiality was identified by adolescents as one of their biggest concerns. In a UK study of more than 1,000 students, almost 60 per cent of participants reported health concerns they wished to keep private from their parents. The study also found that 25 per cent of participants would forgo healthcare in some situations if their parents found out.



The barriers for care are even more pronounced for young people with developmental disabilities, as explored by Dr Muir. Dr Muir highlighted that young people living with developmental disabilities experience a high risk of unmet mental healthcare needs, risk taking behaviour and are more likely to not receive transition services. She discussed a UK study published in the *Lancet*, which said “you are likely to die 13 years earlier if you have an intellectual disability.”¹ She continued by explaining Julian Trollor’s work, which states “if you have an intellectual disability you have a 38 per cent chance you’ll die from a preventable reason.”²

The barriers surrounding transition are not just for the patient, physicians also face many during the process. According to Dr Mouat, providers find the process challenging, time-consuming and expensive and that they require further

training. She reported only one third of doctors (paediatric and adult) like working with adolescents. Although working with adolescents can often be challenging, Dr Harry shared that this work has been the most rewarding part of her career.

“We have the opportunity to develop meaningful relationships with young people and their families.”

Connecting adolescent patients with community supports was identified as another main hurdle when running hospital-based services for young people. Dr Harry described hospital teams as a metaphorical island surrounded by water as a barrier to the land or community. The challenges of connecting young people with the services that are in their communities was discussed.

“All of the good stuff for young people is out there in their community, not in my hospital,” expressed Dr Harry.

“Sometimes that feels like such a long way away, that the water around the island may as well be filled with sharks.” She reflected that if she wants to achieve the end goal of young people receiving integrated care, then “we need to build bridges around the water by partnering young people with the many services in the community that serve them.”

This session demonstrated the importance of transition of care and the benefits it has across the spectrum of healthcare. The common message amongst speakers was to start out small and do what you can, to make a big difference in your patient’s life.

As Dr Harry recommended, “start where you are, use what you have and do what you can.”

If you are interested in hearing more about this session you can listen to the Pomegranate Podcast episode 47, visit www.racp.edu.au/podcast. ^{RQ}

1. McCallion, P, McCarron, M. Deaths of people with intellectual disabilities in the UK. *The Lancet*. Volume 383, ISSUE 9920, P853-85

2. Trollor J, Srasuebku P, Xu H, et al Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data *BMJ Open* 2017;7:e013489. doi: 10.1136/bmjopen-2016-013489

A PARENT’S PERSPECTIVE

When dealing with transition of care, it’s important to focus on the patient’s care and the implications on their family across health and other support services such as education and welfare. Mr Vayani, who works in health policy and in partnering healthcare consumers with carers, shared his personal story about his 12-year-old daughter’s long stay in hospital and transition back home to the Gold Coast, a 70km trip away.

Mr Vayani said working with transition is “messy and not a linear process.” His daughter has experienced a long battle with her health, which has caused Mr Vayani and his family to experience, first-hand, the process of transition between care settings and preparing a pathway for transition to adolescent care.

Challenges they faced include his wife deferring her university studies in order for her to live opposite the hospital, and Mr Vayani needing to reduce his work hours, resulting in a significant pay cut.

Mr Vayani shared the importance of integrated care with doctors, care providers, patients and their families. This approach enables person-centred healthcare to facilitate recovery, quality of life and the best opportunity for families to rebuild. This design of a healthcare and social system enables families and their loved ones to be supported, equipped and empowered in a position where they can live a full life. It allows them to maintain optimum health and wellbeing, social inclusion, lifelong learning, community based civic participation and economic independence.

STEPPING-UP DAY

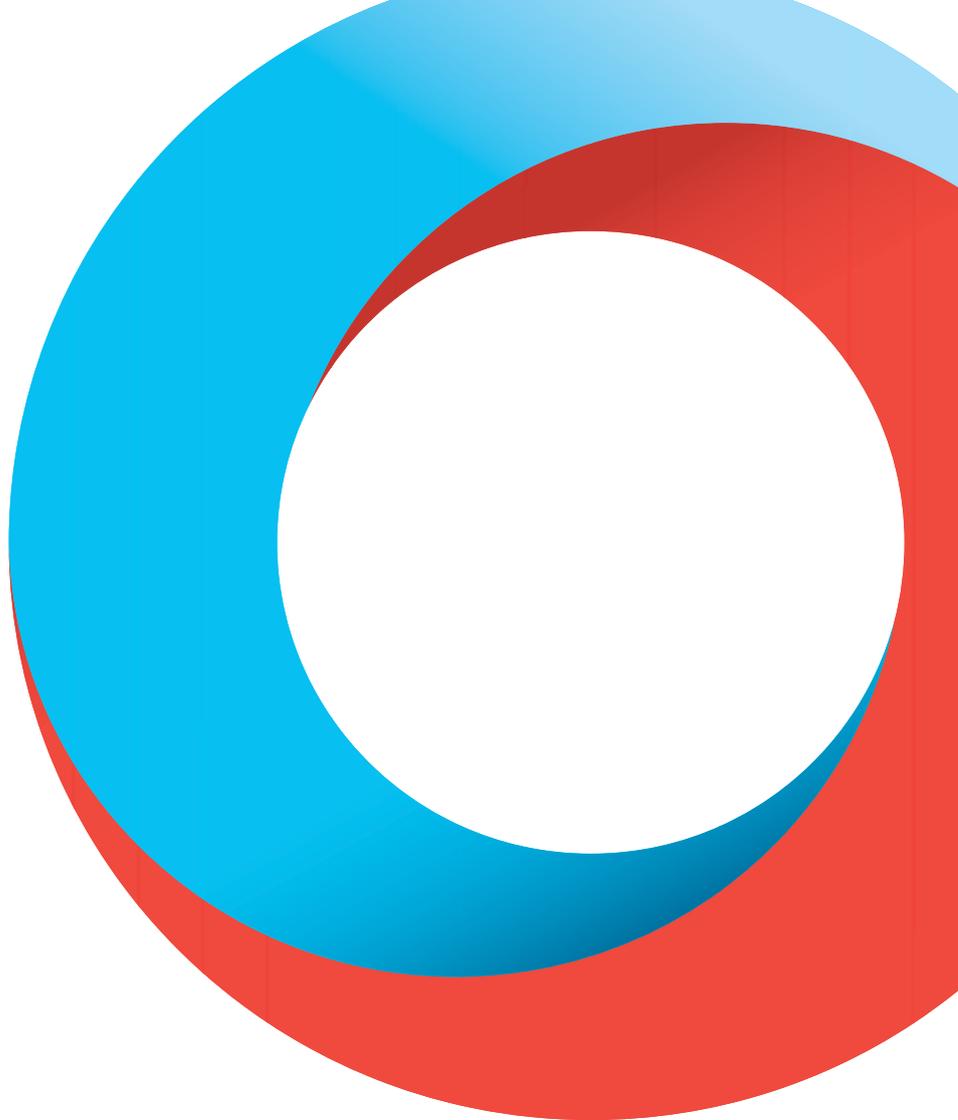
An interactive event ‘stepping-up day’ was used by Dr Mouat as a real-life example of how to help young people understand and get involved with their transition. This initiative was introduced because a lot of the education is for parents, but this initiative focuses purely on the child.

This fun and educational event sees all 13-year-old patients invited to an interactive day at a local YMCA. Staffed by paediatric endocrinologists, diabetes nurses, a psychologist and a sports person from the community, it brings together young adults living with diabetes and provides an opportunity for them to talk about their personal experiences.

Dr Mouat said Stepping-up Day gives adolescents the opportunity to anonymously ask their burning questions via a question box. At the end of the day, the adults form a panel at the front of the room and answer all the questions.

The event is an example of a way to help involve children, meet others with similar issues and learn more about their transition of care.

Sydney
20 March



INTERNATIONAL MEDICAL SYMPOSIUM 2020

Providing care to
underserved populations



Save the date

Thomas H. Hurley

AO, OBE, MD, FRACP, FAMA



Tom Hurley FRACP (1961) died on 10 May 2019 at the age of 93 years. He had been a member and a Fellow of the College for over sixty years and had served as examiner and councillor (1954 to 56, 1960 to 62).

He had a long association with the Royal Melbourne Hospital (RMH) where he had trained as a medical student followed by residency years. His subsequent 40-plus year association with RMH was interrupted only by periods of service in The Australian Navy Reserve (1943), The British Commonwealth Occupying Forces (BCOF) in Japan (1949) and time at Hammersmith Hospital, London (1953) and Cleveland Hospital (Western Reserve University) Ohio (1953 to 1954).

At the RMH he served as out-patient physician, in-patient physician, head of unit, Chairman Division of Medicine, Vice Chair of senior medical staff and eventually President of the RMH Board of Management.

His greatest achievement at RMH was, together with John Sullivan (FRACP) and Richard Bell (FRACP), establishing

a specialist haematology – oncology unit at the RMH to deliver a newly available chemotherapy regimen that became available in the late 1960s.

He served extensively as either a member or more often chair of numerous committees, boards or councils outside the RMH.

For example:

- The Research Committee for the NHMRC (Chair, 1975–1981)
- The Executive Committee, Anti Cancer Council of Victoria (Chair, 1980-1986)
- The Commonwealth Serum Laboratories (CSL) (Chair, 1986-1988)
- The Walter & Eliza Hall Institute (Board member, 1966-1985)
- There were numerous other committee appointments

He was awarded a FAMA (1979) for services to the AMA.

He was awarded an OBE (1980) for services to medicine.

He was awarded an AO (1989) for services to medicine.

His career trajectory emulated that of his father, Sir Victor Hurley, from a generation before. Other members of the extended family were physicians (uncle, nephew, son), pathologists, anaesthetists or general practitioners. Several medical and non-medical members of the family had professorial appointments.

The preceding merely skims an extensive lifetime CV.

What might it have been like to be a physician in the 50s, 60s and 70s? These were challenging times to

practise the art and science of being a consulting physician. The technology of the time was primitive.

His children remember this time and many hours spent as passengers in the car as he toured the various hospitals around Melbourne to provide second opinions. To illustrate the technological limitations of the time, the car sound system was a Sanyo that sat on top of the dashboard only to fall off as the car turned sharp corners. The only in-car entertainment for the children during many hours spent in the hospital car park was the car cigarette lighter.

This was an era before ultrasound let alone CT or MRI imaging. Even the interpretation of a blood test for thyroid function required a triple think.

Each diagnosis was hard won out of a fog of uncertainty.

On the other hand, the pharmacotherapy was arcane and patient's length of stay was measured in weeks rather than days.

As you can imagine, his ability to inspire confidence and good humour to the patient whilst the diagnosis might be a work-in-progress was a key selection criterion for a consultant physician. Tom Hurley's services were in demand.

These broad skills of a physician were honed over decades of honorary public hospital and teaching appointments. Even to establish a private practice required a considerable financial investment in rooms, staff and good will. In this he was supported by his wife of 70 years, Yvonne.

**Associate Professor James Hurley
FRACP (son of Tom Hurley)**

RACP

upcoming events

For more comprehensive information on the latest events visit
www.racp.edu.au/news-and-events/all-events

4
AUG
2019

Supervisor Professional Development Program Workshop 3 – Work-based Learning and Assessment

Work-based learning and assessment is a complex and necessary part of physician training. The challenges of undertaking work-based learning and assessment amidst the complexities of the healthcare environment are many and varied. This workshop offers techniques and solutions to these challenges that will help supervisors in their vital role.



4 August 2019



Michael Fowler Centre, 111 Wakefield Street,
Wellington, New Zealand



Complimentary to registered RACP members



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

20
AUG
2019

South Australian New Fellows Forum

Join us at this free event to hear about experiences, tips and important information for new Fellows and Advanced Trainees moving into Fellowship.

Learn about CPD requirements, medico legal, private practice versus public and working across multiple sites.



20 August 2019



RACP South Australia office, Level 2, 257 Melbourne
Street, North Adelaide.



Complimentary to registered RACP members



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

21
AUG
2019

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.



21 August 2019



Museum of New Zealand Te Papa Tongarewa,
Wellington, New Zealand



Complimentary to registered RACP members



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

3
SEP
2019

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.



3 September 2019



Adelaide Convention Centre, North Terrace,
Adelaide SA



Complimentary to registered RACP members



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

28
OCT
2019

AFOEM/ANZSOM Annual Scientific Meeting 2019

The Australian and New Zealand Society of Occupational Medicine (ANZSOM), together with the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) as scientific partner, invite you to the Occupational Medicine Conference of 2019.

The theme for the event is 'Making it Work' and will deliver an exciting educational event. 'Making it Work' offers networking, collaboration and education, with a focus on practical aspects of occupational medicine.



28 to 30 October 2019



The Playford Hotel, 120 North Terrace, Adelaide SA



Complimentary to registered RACP Supervisors



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

30
NOV
2019

2019 South Australian Annual Scientific Meeting

The South Australian Regional Committee are delighted to invite you to the 2019 South Australian Annual Scientific Meeting (ASM).

This year, 'Specialists. Together.' is the focus of the ASM. The event will provide networking opportunities, engaging speakers and educational experiences. Trainees will also present their research as part of the RACP Trainee Research Awards for Excellence.



30 November 2019



Adelaide Convention Centre, North Terrace, Adelaide SA



Various costs apply



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



4
MAY
2020

RACP Congress 2020

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

14th Annual Meeting
LEURA Critical Care ECHO
The Fairmont Resort, LEURA

- Doppler Theory
- Hands on Doppler-Cardiac Output
- Pulmonary Artery Pressures
- TDI Valve Assessment
- Heart-Lung Interactions
- Septic Cardiomyopathy
- Diastolic Dysfunction in critically ill
- Live Streaming (from Nepean Hospital ICU)
- Case Reviews, and more!

SAVE THE DATE: 14th - 17th September 2019

These courses are designed for the physician dealing with acutely ill, deteriorating patients. Advance your skills and knowledge in the use of Echocardiography.

- **RACEplus 2 Full Days BEGINNERS**
Rapid Assessment by Cardiac Echo (14th and 15th) [BASIC]
Highly recommended course for the Physician starting out in critical care echo.
- **Haemodynamic Evaluation**
By Echocardiography
2.5 days (15th, 16th and 17th) [ADVANCED]
Suitable for those undertaking EPEC-DOL. For those seeking to enhance their knowledge and skills in critical care echo.

International Speaker:
Prof Philippe Vignon, Intensive Care Medicine, Limoges, France

National Speaker:
Dr Faraz Pathan, Cardiology, Sydney, Australia

FOR FURTHER INFORMATION PLEASE CONTACT:
www.niccer.org.au
Noveca Riley: 02 47 342 480

RACP Awards and Prizes

The recipients of prestigious RACP awards and prizes were recently announced during RACP Congress 2019 in Auckland.

We acknowledge the generous donations from RACP members which help make these awards, administered by the RACP Foundation possible.

Applications for RACP awards and prizes for 2019 and 2020 are now open. Interested Fellows and trainees can visit www.racp.edu.au/foundation for more information.

College and Fellowship Awards

Award and prize	Recipient
College Medal	Associate Professor John "Will" Cairns Professor Stephen Clarke Dr Jurriaan de Groot
RACP Medal for Clinical Service in Rural and Remote Areas	Dr Peter Goss
RACP International Medal	Dr Christine Sanderson
The Eric Susman Prize	Professor Ranjeny Thomas
RACP Mentor of the Year	Dr Jeremy McAnulty
RACP Trainee of the Year	Dr Te Aro Moxon, Dr Cameron Gofton
RACP President's Indigenous Congress Prize	Miss Kapowairua Stephens

Examination prizes

Award and prize	Recipient
AMD Bryan Hudson Medal	Dr Nicholas Montarello
Paediatrics and Child Health Examination Medal	Dr Frances Gehrman
AFRM Basmajian and Györy Prize	Dr Matthew Tuminello
AFOEM Deane Southgate Award	Dr Hui Ting Ooi
AFPHM Sue Morey Medal	Dr Laila Parvaresh

Dr Anna Francis

2017 and 2018 recipient of the Jacquot Research Entry Scholarship in nephrology



Dr Anna Francis is a paediatric nephrologist at Queensland Children's Hospital. She completed her PhD with The Centre for Kidney Research at the University of Sydney. Her research focuses on the long-term outcomes for children with chronic kidney disease, with a particular focus on cancer after kidney transplantation and quality of life. She was awarded a Churchill Fellowship to explore models of transition to adult care and is a co-founder of the Young Adult Kidney Transplant Clinic at the Mater Hospital.

The Jacquot Research Entry Scholarship enabled Dr Francis to concentrate on her PhD. "My research revealed that children with kidney transplants have an eight times higher risk of cancer than children in the general population, with viral-related cancers and skin cancers the most common," says Dr Francis.

"As well as cancer, disease recurrence may occur post-transplant, with the most common disease (focal segmental glomerulosclerosis) recurring in around one third of transplant recipients and causing graft loss in half of those affected. The burden of illness in children with end stage kidney disease extends beyond medical issues. Psychosocial complications are common with quality of life worse for those on dialysis compared to those with transplants or early stage chronic kidney disease."

Adult Medicine Division awards

Award and prize	Recipient
Best Poster Prize in Adult Medicine (Fellow)	Dr Dharmenaan Palamuthusingam
Best Poster Prize in Adult Medicine (Trainee)	Dr Budhima Nanyakkara
RACP Trainee Research Awards (Adult Medicine)	Dr Jack Yu, SA recipient Dr Nathan Klose, QLD recipient Dr Karen Waller, NSW recipient Dr Michael Thompson, TAS recipient Dr Sam Salman, WA recipient Dr Jessica Fairley, VIC recipient Dr Johanna Birrell, NT recipient Dr Brian Corley, NZ recipient

Paediatrics & Child Health Division Prizes

Award and prize	Recipient
Howard Williams Medal	Professor Lex Doyle
Trainee research awards (Paediatrics)	Dr Valentina-Maria Milosescu, QLD recipient Dr Cathryn Poulton, WA recipient Dr Natalie Morgan, VIC recipient Dr Martin Hansen, NT recipient Dr Aaron Ooi, NZ recipient
Rue Wright Memorial Award	Dr Peter Vuillerman
Best Poster Prize in Paediatrics & Child Health	Dr Elaine Zaidman

Australasian Faculty of Occupational and Environmental Medicine

Award and prize	Recipient
AFOEM President's Awards – Policy and Advocacy	Dr Graeme Edwards
AFOEM President's Awards – Education, Training and Assessment	Dr Ilse-Marie Stockhoff
AFOEM President's Awards – Trainee Commitment	Dr Rosemarie Knight
AFOEM President's Awards – Ramazzini Prize	Dr Bianca Cheong

Australasian Faculty of Public Health Medicine

Award and prize	Recipient
AFPHM President's Award	Professor Lynne Madden
Gerry Murphy Prize	Dr Elizabeth Peach (VIC)
John Snow Award	Ms Sabrina Yeh



Dr Samuel Chan

Trainee Research Award – 2016 adult medicine recipient and Best Poster Prize (Adult Medicine Division trainee)

Current recipient of the 2019 National Health and Medical Research Council (NHMRC) Research Scholarship and the 2019 RACP NHMRC Jacquot Award for excellence

Dr Samuel Chan is a fulltime PhD student with the Australasian Kidney Trials Network at the Princess Alexandra Hospital in Queensland. He graduated with First Class Honours in pharmacy and medicine at The University of Queensland in 2011 and completed his Fellowship of the RACP in nephrology in 2018. He is a Nephrology Staff Specialist at the Metro South and Ipswich Nephrology and Transplant Services, as well as a Senior Lecturer at The University of Queensland, where he leads the nephrology curriculum of the MD program. Samuel's clinical research interests focus on clinical epidemiology and population health, and he is currently studying the epidemiology, predictors, outcomes and prevention of infectious complications of kidney transplantation as part of his PhD studies.

“The funding allows me to evaluate the role of the gut microbiome in infections complicating transplantation,” says Dr Chan.

“I ultimately aim to reduce infectious complications, improve quality of life and decrease transplantation healthcare costs. I am indebted to the three years of RACP support awarded to me both as a trainee and now as a Fellow/ PhD student. It has been a humbling journey allowing me to secure a foundation of developing sound research skills which will be of great value for my future career as a clinician-scientist.”



Dr Angela Titmuss

**Paediatrics & Child Health Division recipient
2016 NHMRC Scholarship
2016 RACP NHMRC Award for Excellence**

Dr Angela Titmuss is a paediatric endocrinologist and general paediatrician at the Royal Darwin Hospital. She is completing her PhD through the Menzies School of Health Research and previously held the RACP NHMRC Award for Excellence Woolcock Scholarship. Dr Titmuss is a lead investigator in the NHMRC Hot North collaboration, which explores the prevalence and experience of diabetes in Indigenous children and young people across northern Australia and is Deputy Chair of the RACP Aboriginal and Torres Strait Islander Health Committee.

“The scholarship provided me with financial support to undertake my PhD through the Menzies School of Health Research in Darwin,” says Dr Titmuss.

“My PhD has explored the association of hyperglycaemia in pregnancy with growth, developmental risk, and cardiometabolic profile of two to five-year-old children living across the Northern Territory.

“Unfortunately, in the NT, we are seeing many young people with poor metabolic health, and that risk is being transmitted across generations. This has far reaching implications for the health and wellbeing of Aboriginal and Torres Strait Islander people.”

Australasian Chapter of Sexual Health Medicine

Award and prize

Recipient

Penelope Lowe Prize 2019

Dr Melissa Kelly

Jan Edwards Prize 2018

Dr Ei Aung

Australasian Chapter of Addiction Medicine

Award and prize

Recipient

Research Project Prize 2018

Dr Xiu Qin Lim

RACP Indigenous Health Scholarship Program

Scholarships for 2019

Recipient

Advanced Training in General Medicine and Infectious Diseases

Dr William Naughton

New Zealand Scholarship for Advanced Training in Dermatology

Dr Monique Mackenzie

Aboriginal and Torres Strait Islander Scholarship for Advanced Training in Endocrinology

Dr Lisa Bichard

Paediatrics and Child Health Scholarship for Advanced Training

Dr Elkie Hull

Occupational and Environmental Medicine Scholarship

Dr Brett Shannon

Pacific Islander (NZ) Scholarship for Advanced Training in Nephrology

Dr Amelia Tekiteki

Pacific Islander (NZ) Scholarship for Advanced Training in Paediatrics and Child Health

Dr Simone Watkins

Join Us

Paediatrician required Part-time

Cairns Private Hospital, North QLD



Cairns Private Hospital has an opportunity for a Paediatrician to join the Hospital's existing team of Specialists/VMOs. This role is primarily to accept referrals from VMO Obstetricians for private deliveries, both elective and emergency.

The Paediatrician must be available to care for neonates admitted to the Special Care Nursery (for sick or premature babies greater than 32 weeks gestation). With three birthing suites we have a current birth rate of around 450+ babies per year. The hospital has a fully equipped 12 bed maternity unit with a Level 4 special care nursery. This opportunity would ideally suit a recent New Fellow looking to establish their referral base through in-patient consultations or an established Paediatrician. This is a salaried part-time position of approximately 20 hours per week plus on-call.

Minimum Requirements:

Candidates must have FRACP(Paed), hold specialist registration with AHPRA and are eligible for a Medicare provider number.

Further information is available at ramsaydocs.com.au or contact:

Ben Tooth, Chief Executive Officer, Cairns Private Hospital on (07) 4052 5213 or email: ToothB@ramsayhealth.com.au

 ramsaydocs.com.au



AUSTRALIAN ASSOCIATION OF CONSULTANT PHYSICIANS

Help AACCP to support you

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

The AACCP negotiated the introduction of MBS items 132 and 133, the most significant change in MBS items for CPPs in 20 years.

If you use these items and wish to support further AACCP campaigns that address CPP interests, then

Join the AACCP today, visit
www.aacp.org.au



AACP
AUSTRALIAN ASSOCIATION
OF CONSULTANT PHYSICIANS

MEDICAL STUDY TOURS 2019 & 2020

Medicine in China

5 – 19 October 2019

Tour Leader: Associate Professor Vicki Kotsirilos

Learn of China's history, medicine and culture on a tour and Yangtze cruise.

www.jonbainestours.com/chinamed

History of Medicine along the Nile

15 – 27 November 2019

Tour Leader: Dr Carole Reeves. Speaker: Prof. Rosalie David

Cruise along the Nile with medical historical lectures from a world renowned expert.

www.jonbainestours.com/nilehmed

Paediatrics & Child Health in India

13 – 27 February 2020

Tour Leader: Dr Nicki Murdock

Visit Delhi, Jaipur, Agra, Mysore and Kerala on this fascinating study tour.

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