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Associate Professor Remo Russo and Professor Ian Cameron at the AFRM/NRZA Combined Rehabilitation Meeting 2015

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First and foremost, we are an educational institution.

In 2015 we had a substantial pipeline of over 7,000 new trainees and thanks to the pro-bono generosity and commitment of our Fellows, over 4,500 supervisors who will guide those trainees through their elected training pathway.

Medical Colleges are often portrayed by external commentators as conservative and risk-averse. To counter that, I would highlight several examples of innovation during 2015.

In the space of six months we relaunched our website, based on your feedback. We re-authored, simplified and redesigned many hundreds of pages and documents. Although it is an improvement on the old website, we know there is still work to do. We will continue to listen to your feedback and refine the user experience to make the new site and its various portals more streamlined, easier to use and improve the accessibility of information.

We started podcasting at the same time the website was relaunched. There have now been five ‘pomcasts’ produced by physicians, for physicians. They are regularly among the most clicked links in our electronic news bulletins to Divisions, Faculties and Chapters, and are linked to our Twitter feed, where the College is highly active.

We launched the online MyCPD tool, and recognising the explosive popularity of mobile devices, the mobile MyCPD webapp.

We also continue to lead innovation in optimising the everyday practice of medicine. In 2015, 18 of our affiliated societies began work on our EVOLVE initiative, with physicians themselves identifying overused, inappropriate or ineffective procedures and medical interventions. Read more about the EVOLVE initiative on pages 32 and 33 of this issue.

At a fundamental level, innovation in medicine is driven by research. We continued to be a strong supporter of medical research in 2015, awarding nearly $3 million in research grants, prizes and scholarships.

Our advocacy work on behalf of you and your patients during 2015 was highly visible.

The College had over 2,300 mentions in print, broadcast and online media in Australia, New Zealand and internationally. There were substantial advocacy results this year. We united 13 peak health bodies to fight the Australian Government’s attempts to ban doctors speaking out about immigration related operational matters. We advocated for a National Health Rehabilitation Strategy in New Zealand, and saved specialty training programs in Australia from being cut.

We were lauded as taking an international leadership position by campaigning to recognise the health effects of climate change – a campaign that is still running as the year draws to a close.

Looking ahead, we are already advanced in plans to introduce our new member service database, which will progressively improve, streamline and add new functionality to your online experience with your College.

I look forward to working with you all again in 2016.

Laureate Professor Nicholas Talley
RACP President
Dear Colleagues

The fifth and final Board Meeting for the 2015 calendar year was held in Sydney on Thursday, 3 and Friday, 4 December 2015; and was followed by a regional convocation ceremony held on the afternoon of Friday, 4 December.

Strategy

Prior to the formal Board meeting commencing, Directors held a strategy session considering the following matters:

- international strategy
- physicians of the future
- results of the recent Member engagement survey
- RACP Congress
- the College’s role in advocacy and activism.

Bullying, Discrimination and Sexual Harassment

The Board working party convened on this issue has presented its report. The report found the College has sound mechanisms in place for dealing with the issue, particularly in its setting of standards of professional and lawful conduct and behaviour. The College also has a range of high quality training modules that address this issue.

However improvements can be made in taking a cross College approach to bullying, discrimination and sexual harassment, from trainee entry across all physician training pathways. The report made a number of recommendations. These were endorsed by the Board and the report has now been referred back to the Chief Executive Officer to develop a project plan.

In due course the working party’s findings will be published on the RACP website.

The Board reiterates the College’s position – the RACP has zero tolerance for bullying, discrimination and sexual harassment.

Model of Collaboration

The Board approved the Model of Collaboration for distribution to specialty societies who are affiliated with the College. The foundation of the Model has been built by the Adult Medicine Division Council, in collaboration with their Paediatrics & Child Health Division, New Zealand and Faculty colleagues both at a Board and Committee level. The next step for the Model of Collaboration is implementation through negotiation with each specialty society.

Re-appointment of Directors

The Board re-appointed Associate Professor Charles Steadman as Honorary Treasurer. Associate Professor Steadman was appointed as Honorary Treasurer from May 2015 and has fulfilled that role admirably.

The Board also re-appointed the current Community Directors, Mr Peter Martin and Ms Susan Tiffin for a further two years. Mr Martin and Ms Tiffin have contributed greatly to the Board since joining the Board in December 2014.

All of these appointments are effective until May 2018.

Next meeting

The next full Board Meeting will be held on Thursday, 11 and Friday, 12 February 2016 in Perth.

Laureate Professor Nicholas Talley
President
Fossil Fuel Divestment

The Finance Committee has overseen the College’s divestment from those investments held in companies identified as being directly and materially involved in fossil fuel activities. Those investments were estimated to be worth about $2.3 million out of approximately $90 million in total.

Since the RACP is a health organisation with an objective of improving the health of our population, divestment is an important action to lead to reduced carbon outputs and achieve our health objective i.e. to ensure better health outcomes for our patients into the future.

2016 Budget

The Finance Committee reviewed and endorsed the College’s operating budget for 2016. The College is in a strong financial position and importance has been placed on ensuring a sustainable future for the College while also delivering quality for members.

Subscription Exemption Criteria

The Committee reviewed and refined the criteria for exemptions for Members of all or part of their subscription fees to ensure consistency and equity for Members.

Next meeting

The next Finance Committee meeting will be held on Tuesday, 1 March 2016

Associate Professor Charles Steadman
Honorary Treasurer
2015: SETTING THE STANDARD FOR SPECIALTY SOCIETY COLLABORATION

The Adult Medicine Division (AMD) collaborated with many of the College’s affiliated specialty societies in 2015 and a Model of Collaboration (MoC) to guide and enhance the relationships between the College and societies has been developed.

Specialty societies are an important aspect of many Fellows’ professional careers, with many Fellows enjoying dual membership of the College and at least one specialty society. The College and the societies benefit from the collaboration arising from this common membership.

Throughout the year the Division and specialty societies have successfully collaborated on a number of initiatives including:

- the Australian Medical Council and New Zealand Medical Council reaccreditation review which saw the College being accredited for the maximum term of six years.
- education governance reform which has resulted in significant improvements in our training programs. This has placed the College in a strong position to manage the changing healthcare environment and the associated regulatory requirements placed on specialist training bodies such as the College. This has allowed the role of specialty societies in Advanced Training Committees to be clarified and better articulated.
- consulting on the College’s capacity to train, and maintain, high value and high impact training standards. Discussions focused on the development of a Selection into Training Policy with a policy for Basic Training initiated.
- an improved relationship between the Division and the specialty societies in regards to Advanced Training Selection and Matching activities.
- assisting the Australasian Chapters of Addiction Medicine, Palliative Medicine and Sexual Health Medicine and associated specialty societies to interact in areas of mutual benefit, and support their contribution to policy and advocacy.
- encouraging specialty societies to be the lead organisation on policy and advocacy matters where appropriate.
- refining College and specialty society collaboration on workforce analysis.
- contributing to the multidisciplinary National Fracture Prevention Forum being convened by the Australian and New Zealand Bone & Mineral Society, which brought together a number of other Adult Medicine specialty societies through common interest and purpose.

The process of developing the MoC has been an opportunity for the AMD Council and the specialty societies to reflect on how they already interact and provides a clear understanding of the roles and responsibilities of each organisation. We are looking forward to the MoC being finalised and in operation with specialty societies early this year.

The Division has plans for several exciting projects in 2016 that will continue to deliver opportunities for specialty societies and the College to collaborate and increase the Division’s capacity to drive policy and advocacy initiatives.

I thank AMD Councillors and our specialty societies for their contribution to our activities over the course of 2015, and look forward to an even more productive and collaborative 2016.

Professor John Wilson
President, Adult Medicine Division
PAEDIATRICIANS CONTINUE TO ADVOCATE FOR CHILDREN IN 2015

The end of 2015 was a time to reflect not just on the year personally but also as President of Paediatrics & Child Health Division (PCHD). It was a chance to review those things I said I would undertake when I took up office.

Almost inevitably the undertakings I thought would be easiest have turned out to be the most difficult and the issue I said I wouldn’t touch has turned into the most likely to succeed.

I stated quite clearly I was not interested in the move to set up a separate college, for many reasons. However the governance reforms in the College meant that we needed a ‘stand alone’ society for paediatrics in Australia.

Working with Past-Presidents and officers of the PCHD the concept of an Academy of Paediatrics has been developed, and a proposed business case for its development has been endorsed by the PCHD Council. The College Board has received a request for funding, which would support the Academy’s development, for consideration at the December meeting.

Meanwhile 2015 was a very busy year, with various people representing members and the College at different meetings. I attended the Australian Research Alliance for Children & Youth Annual General Meeting in April, Dr David Thomas attended the Australasian Society of Clinical Immunology and Allergy’s primary immunodeficiency resource development meeting in March, Dr Terry Donald, Protecting Australia’s Children: Third Action Plan round table in April, Dr Kerri-Lyn Webb, the National Community Child Health Council in May, Dr Janice Fletcher, the College Newborn Bloodspot Screening Consultation Workshop and Dr Anne Kynaston very kindly presented to the Senate Hearing into the ‘No Jab, No Pay’ legislation.

We have co-signed two position statements, ‘Intentional Self Harm in Children and Young People’ and ‘SOGII Gender Identity Report’, both of which influenced Australian Human Rights Commission reports.

We have campaigned against holding children in detention, we have created a media presence and are very supportive of the direct action by Royal Children’s Hospital Melbourne and echoed around the country. We were pleased to be invited to the launch of the Children’s Rights Report 2015.

Looking to the future we are lining up some interesting sessions at the RACP Congress in Adelaide in May. I think you will be pleased with the changes we have made, leading two days of double paediatric streams. A whole day will be devoted to Paediatric Patient Safety lectures and workshops, and the other day will explore the latest developments and innovations in paediatric care and support.

I look forward to seeing you at Congress in 2016, and of course have a dance at one of Adelaide’s great dining venues.

Dr Nicki Murdock
President, Paediatrics & Child Health Division
PAEDIATRICS & CHILD HEALTH COMMITTEE
ACHIEVEMENTS IN 2015

Adolescent and Young Adult Medicine Committee (AYAMC)
The AYAMC was established to explore ways in which support for young people's health could be furthered within the College — with relevance for both the Adult Medicine Division (AMD) and the Paediatrics & Child Health Division (PCHD).

In 2015 the AYAMC determined to focus on establishing a training pathway for AYAM at the College rather than actively seeking specialty recognition for AYAM in Australia. The RACP Board, the PCHD and AMD Councils, College Education Committee, PCHD and AMD Education Committees and other College bodies have given their support to this direction.

The AYAM Advanced Training Committee developed a training pathway model for dual training within the College, with general paediatrics and community child health to commence in 2016. It is intended that this training will be extended to other specialties in the future. Training sites will be invited to take part in the trial period of the AYAM training pathway. Sites will need to be able to meet curriculum requirements and flexibility will be required to ensure that interested trainees are able to take part.

Chapter of Community Child Health Committee (CCCHC)
The CCCHC supports members of the Chapter and provides advice and direction about education in Community Child Health, including programs for trainees and Continuing Professional Development for Fellows. The CCCH also provides input into health policy, professional affairs and other matters relevant to Community Child Health through the Division Council.

In 2015 the CCCH Advanced Training Committee supported the Community Child Health Entrustable Professional Activities (EPA) pilot and will review the feedback and continue to be involved in improving content as well as ongoing improvements to the training pathway.
Through the work of the CCCHC, the Chapter has now formalised a relationship with the International Society for Social Pediatrics and Child Health (ISSOP) which will provide opportunities for collaboration.

The CCCHC is already planning for the 2016 CCCH Satellite Day, an annual event focusing on child development and behaviour, child protection and child population health, which will be held immediately prior to RACP Congress on Sunday, 15 May 2016.

Paediatric Policy & Advocacy Committee (PPAC)

Improving the health of children and young people is a priority for the Paediatrics & Child Health Division (PCHD). The PPAC contributes to this by planning and overseeing policy and position statement development, maintaining advocacy on key issues in line with PPAC/PCHD annual plans and by supporting or participating in the PCHD’s responses to emerging and important child health issues.

This year, three position statements led by the PPAC were launched by the College:

- Protecting children is everybody’s business: Paediatricians responding to the challenge of child protection position statement launched by Dr Terry Donald in Auckland in April 2015.
- Newborn screening in Australia position statement launched by Dr Nicki Murdock, PCHD President and Dr Jim McGill at the RACP Congress in May 2015.
- Sexual and reproductive health care for young people position statement was launched by Dr Andrew Kennedy and Dr Sarah Martin in Melbourne in November 2015. Read more about this position statement on page 27.

Thank you to the Lead Fellows and working groups who worked on developing these position statements. They are complex and time consuming and reaching a consensus on these important issues can be challenging. Releasing three position statements in one year is a great achievement.

PPAC members are currently developing the following position statements:

- The role of paediatricians in mental health care of children and young people, led by Dr Chris Pearson. We hope to launch this policy at Congress 2016.
- Inequities in child health, led by Dr Sue Woolfenden and Associate Professor Sharon Goldfeld.
- The PPAC together with the Māori Health Committee (MHC) and Aboriginal and Torres Strait Islander Health Committee (ATSIHC) will begin work on a new policy on the health of Indigenous and Māori children this year.

PPAC will also work with the College on updating the existing breastfeeding policy and undertake the development of an early childhood policy in 2016.

PPAC continues to be involved in advocacy work and has contributed to a number of key areas such as refugee child health, Aboriginal and Torres Strait Islander children and families, the National Disability Insurance Scheme, the third action plan for protecting children and female genital cosmetic surgery.

Paediatricians are also making valuable contributions to whole of College work, including the effects of alcohol on neonatal development and consequent impacts on the health of children and adolescents, end of life care and the use of medicinal cannabis.

Your suggestions for policy activities are most welcome. Please contact Paed@racp.edu.au with any questions or ideas.

Dr Jacqueline Small
Chair, Paediatric Policy & Advocacy Committee

Paediatric Research Committee (PRC)

The PRC liaises with the Journal of Paediatrics and Child Health and research groups affiliated with the Division (including the Australian Paediatric Surveillance Unit, Australian Paediatric Research Network and the Paediatric Research Society of Australia and New Zealand) to improve and deliver strong research programs and initiatives.

In 2015 the PRC considered workforce issues and recommended to the RACP Workforce Working Party that workforce profiling captures the academic credentials of members including higher degrees.

The PRC have agreed that support for early career researchers is vital (as per the RACP Health and Medical Research Strategic Plan 2014–18) and is continuing to scope ways to partner with universities and Australian State Health Departments and is liaising with relevant research institutes.
2015 saw the Australasian Faculty of Rehabilitation Medicine (AFRM) achieve a number of goals and progress several key long term projects.

These achievements are only possible through the dedication of those Fellow and trainee members who voluntarily participate in committees, workshops and projects or act as supervisors of our trainees. I would like to thank all our Faculty members who have participated in these activities throughout the year.

I would also like to thank the members of the Faculty Council for the support they have provided to me, and all Faculty members, throughout 2015. I always look forward to our meetings and the positive outcomes that they yield. To the Members of Faculty Council, I am fortunate to have such a great team to work with. In particular I wish to thank Associate Professor Andrew Cole, Professor Timothy Geraghty and Associate Professor Christopher Poulos for their support and advice as part of the Faculty Council Executive.

**Key achievements in 2015**

**AFRM/NZRA Combined Rehabilitation Meeting**

This successful event co-hosted with the New Zealand Rehabilitation Association (NZRA) attracted 320 delegates and speakers, including 200 Faculty members.

Held in Wellington, the event themed ‘Building an Enabling Society’ was an excellent opportunity to explore the latest developments in our field and how society can further improve outcomes for those living with disability.

I would like to acknowledge the Organising Committee, led by Associate Professor Will Taylor, for their dedication to creating an event that was a rewarding learning experience for all Faculty members who attended as well as the broad representation from Allied Health professionals.

Read more about the AFRM/NZRA Combined Rehabilitation Meeting on page 13.

**Launch of the Call for a New Zealand Rehabilitation Strategy**

The Call for a New Zealand Rehabilitation Strategy (the Call), developed by the Faculty with NZRA and key stakeholders was launched at the AFRM/NZRA Combined Rehabilitation Meeting.

Read more about the Call and the continued work members of the Faculty in New Zealand are doing to continue to raise the profile of this area of need on page 15.

**Faculty involvement with National Disability Insurance Scheme (NDIS)**

The AFRM Executive continued to liaise with the National Disability Insurance Agency throughout the year and this relationship has resulted in increased Rehabilitation Physician involvement in decisions on resource/care provisions as well as participation in pilot projects on National Disability Insurance Scheme participation in acquired brain injury (ABI) and spinal rehabilitation discharge planning.

**2015 AFRM Annual Trainee Meeting (ATM)**

The 2015 AFRM ATM held on Saturday, 14 and Sunday, 15 March 2015 at Gold Coast University Hospital was extremely successful, with 70 trainees attending. Feedback highlighted the importance of these structured teaching opportunities for our trainees, and the planning of future ATMs are a faculty priority. My thanks and congratulations go to the Organising Committee for their efforts.

Planning for the 2016 ATM is underway and will be held in March in Melbourne. This annual event is a priority for the Faculty as an opportunity to provide a valuable and educational experience for our trainees and a chance for the training experience to be shared.

**AFRM policy work**

Important pieces of policy work are under development at the time of writing this:

- **Guiding Principles for Rehabilitation Medicine in Telehealth Settings**
- **Maintaining People’s Health – the Role of the Rehabilitation Physician in Integrative and Preventative Community Care**
The Rehabilitation Medicine Trainee of the Future Report

The Rehabilitation Medicine Trainee of the Future Report, authored by Dr Shari Parker, aims to stimulate discussion and decision making about the future of training in Rehabilitation Medicine in Australia and New Zealand.

A summary of the report was disseminated to AFRM members last year and the AFRM Council will work on strategic next steps based on the finalised report.

Regional AFRM members’ meetings

I was privileged to be able to attend the majority of regional Annual Members’ Meetings in 2015. I valued the opportunity to not only be able to provide updates, but also to receive feedback and advice from our membership, the diverse environments in which we work and to understand the various challenges our membership face in different areas.

It is also encouraging to witness the enthusiasm our members have across the regions to continue working in the policy space and at the local level to improve patient outcomes.

Dr Stephen de Graaff
AFRM President

Delegates at the AFRM/NZRA Combined Rehabilitation Meeting held in Wellington, New Zealand in October 2015.
The Australasian Faculty of Rehabilitation Medicine (AFRM) and the New Zealand Rehabilitation Association (NZRA) co-hosted the AFRM/NZRA Combined Rehabilitation Meeting 2015 from Tuesday, 13 to Saturday, 17 October 2015 in Wellington, New Zealand.

With 320 delegates from across Australia and New Zealand representing rehabilitation physicians, researchers and Allied Health professionals, the event themed ‘Building an Enabling Society’ was a fantastic opportunity to share ideas, re-think assumptions, and discover new ways of helping individuals attain the health and social outcomes that matter the most to them.

The 2015 George Burniston Oration was delivered by Professor Derick Wade from the United Kingdom and the Norrington Lecture by Associate Professor Barbara Gibson from Canada.

Professor Wade’s presentation was on ‘Healthcare disables people, rehabilitation can change the culture of healthcare and thus reduce societal disability’. In this inspiring presentation, Professor Wade challenged all conference participants to change the culture of healthcare and decrease societal disability. As editor of Clinical Rehabilitation he was well placed to also deliver a breakfast session on Writing for Publication.

Professor Barbara Gibson discussed novel and challenging concepts on the values attributed to modes of physical functioning, particularly mobility. In this presentation she questioned the need for therapists to constrain their interventions by notions of ‘normality’ and encouraged the audience to consider the goals of people living with disability more creatively.

AFRM and NZRA have also collaborated on the development of the Call for a New Zealand Rehabilitation Strategy and it was fitting that it was launched at the event co-hosted by the two organisations. Read more about the launch on page 15.

Boasting plenary sessions, scientific updates, workshops and breakfast sessions, the event successfully provided a program that met the needs and interests of the diverse crowd. A number of experts delivered presentations throughout the scientific program that included a wide range of topics ranging from enabling recovery after non-catastrophic injuries to a well-received session on rehabilitation following natural disasters.

The highlight of the social program was the Gala Dinner held in the historic Old St Paul’s, a former cathedral. Attendees were awed by the incredible architecture of the venue, and the opportunity to enjoy a meal in a very unique setting. Dr Maria Paul and Dr Hima Venugopal performed a wonderful traditional Indian dance for the crowd.

I would like to thank all members of the organising committee; Dr Cynthia Bennett, Dr Richard Seemann, Dr Shaun Xiong and our NZRA Colleagues Professor Kathryn McPherson and Associate Professor Nicola Kayes. Your hard work and dedication to the organisation of this event is greatly appreciated.

From 2016, the Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ) will take over the organisation of the Annual Scientific Meeting (ASM). The first RMSANZ ASM will be held from Sunday, 16 to Wednesday, 19 October 2016 at the Crown Promenade Melbourne.

Associate Professor Will Taylor
2015 AFRM/NZRA Combined Rehabilitation Meeting Organising Committee Chair

2015 AFRM/NZRA Combined Rehabilitation Meeting Organising Committee Chair

Associate Professor Will Taylor
Dr Louisa Ng, Professor Peter Disler, Professor Zaliha Omar

Dr Maria Paul and Dr Hima Venugopal performed a traditional Indian dance at the gala dinner

Associate Professor Barbara Gibson delivers the 2015 Norington Lecture

Professor Derick Wade delivered the 2015 George Burniston Oration
REHABILITATION SPECIALISTS LEAD THE CALL FOR A NEW ZEALAND STRATEGY

The Australasian Faculty of Rehabilitation Medicine (AFRM) in collaboration with the New Zealand Rehabilitation Association (NZRA) and key stakeholders have developed the Call for a New Zealand Rehabilitation Strategy (the Call), which was launched at the AFRM/NZRA Combined Rehabilitation Meeting in October 2015 in Wellington.

The Call identifies the current disparities in the availability and provision of disability and rehabilitation services and calls for the immediate development of a New Zealand-wide rehabilitation strategy to improve patient outcomes and reduce preventable disability through fiscally responsible and sustainable healthcare for those living with disability.

A comprehensive New Zealand rehabilitation strategy will identify current services, providers and programs; identify unmet needs and inefficiencies; and will help determine opportunities for streamlining, strengthening and increasing collaboration in provision of rehabilitation. The strategy will ensure alignment of current services and provide the framework for development of future services and healthcare planning.

New Zealand was among the first signatories to the United Nations Convention on the Rights of Persons with Disabilities (the Convention) in 2007, which identifies rehabilitation as a human right. The Convention provides clear standards for signatory states to follow in order to establish rehabilitation services and support for people living with disability in the areas of housing, education, social engagement and in the workplace. New Zealand has made some progress, but a more strategic approach is required to ensure those requiring rehabilitation services have access to the right service at the right time.

There is now a consensus amongst health and political leaders that New Zealand is moving towards an unsustainable health and social support system.

Rehabilitation physician and AFRM NZ Branch Committee Chair, Dr Cynthia Bennett, said rehabilitation is an integral component of healthcare, yet many New Zealanders do not have access to skilled, specialist rehabilitation.

“Our population is growing, as is the percentage of New Zealanders living with disability,” she said.

Between 2006 and 2013, the number of New Zealanders living with disability increased by seven per cent. Māori and Pacific peoples make up a higher proportion of this population. In addition, Māori and Pacific peoples generally have lower rates of access to rehabilitation services.

“There are great disparities in the availability of rehabilitation services, the skill of the service providers, equipment provision, funding of environmental modifications and available social supports across the country due to geographical location, age and whether the disability is due to illness or injury. A national strategy is crucial to improving the health, wellbeing and functional abilities of New Zealanders who live with a disability,” said Dr Bennett.

“Extensive international evidence confirms that timely and skilled rehabilitation leads to improved patient outcomes and healthcare savings.

A coordinated approach to rehabilitation services in New Zealand will have a positive impact not only on individuals and their families/whānau, but on the overall healthcare budget.”

The aims of the Call for a New Zealand Rehabilitation Strategy are to:

- guide policy and practice of health care for people with disability
- improve the health, wellbeing and functional abilities of New Zealanders who experience disability from illness or injury
- reduce the individual and family/whānau burden of impairment and disability
- enhance functional ability and independence, thus reducing the need for community support for personal care and societal cost of disability
- improve participation outcomes and the person’s ability to contribute to family, the community and the economy by encouraging return to life roles and work force participation
- create equity in rehabilitation service accessibility and provision across New Zealand
- promote leadership in health care and rehabilitation reform.

The AFRM NZ Branch will continue to collaborate with individuals and organisations to raise awareness of the Call, its key messages and the need for a New Zealand Rehabilitation Strategy.

Download the Call for a New Zealand Rehabilitation Strategy at www.racp.edu.au/fellows/resources/new-zealand-resources
GETTING GOOD WORK RIGHT

A new report highlights the importance and value of ‘good’ work and its positive effect on workers’ mental health.

The report, Realising the health benefits of work – An evidence update, produced by the Australasian Faculty of Occupational & Environmental Medicine (AFOEM) reviewed current and emerging evidence. It found the evidence continues to reiterate that work can contribute to optimising people’s health and wellbeing while prolonged work absence due to illness or injury may result in adverse physical and psychological effects.

The report also says that poor quality work can be as negative as unemployment in terms of health outcomes for workers.

AFOEM’s What is good work? statement describes ‘good’ work as “balancing the interests of the individuals, employers and society in order to deliver performance, engagement and fairness”.

With increasingly knowledge based economies, workers in Australia and New Zealand perform more sedentary work than physical labour.

AFOEM President Dr David Beaumont said that globalisation has also changed workplace conditions in terms of workforce casualisation, short term agency work, outsourcing and reduced job security, all of which impact employees’ psychological health and job satisfaction.

The World Health Organization’s Commission on Social Determinants of Health 2008 report Closing the gap in a generation – Health equity through action on the social determinants of health showed:

- temporary workers have shorter life expectancies compared to those with permanent roles
- poor mental health outcomes are associated with unstable work arrangements
- workers who perceive work insecurity experience significant detrimental effects on their mental health

Poor mental health is prevalent and costly in terms of lost productivity with work related stress costing Australian employers $8 billion per year. Growing numbers of workers are developing mental health conditions leading to a rise in absenteeism and presenteeism (lost productivity when employees come to work but perform below par due to illness).

Even in the absence of a diagnosed medical illness, poor mental health is linked to delayed return-to-work, increased sickness and reduced work productivity.

The report recommends the development of guidelines and protocols to assist all health professionals’ management of mental health claims and improve return to work outcomes for patients.


The latest report builds on the Realising the health benefits of work position statement released by AFOEM in 2010 and two companion position statements released in 2013 – What is good work? and Improving workforce health and workforce productivity. The Health benefits of good work consensus statement was released in 2011 and has been signed by 192 organisations across Australia and New Zealand.
PART TWO – SUPPORTING TRAINEES IN DIFFICULTY AND THEIR SUPERVISORS

In the previous edition of RACP News, Stage 1 of the policy was explained. Here we explore scenarios for the end of Stage 1 and what happens when a trainee progresses to Stage 2 of the pathway.

A new policy and pathway to support trainees will come into effect in January 2016. They have been introduced by the College to assist trainees who encounter work-based difficulties which disrupt their ability to meet and complete their training requirements and to provide a framework for supervisors to ensure appropriate and timely support is provided.

Evaluating progress and next steps

The focus of Stage 1 is on the development of an Improving Performance Action Plan (IPAP), which allows the supervisor and trainee to work together on strategies for the trainee to meet their training requirements.

The IPAP is planned and implemented collaboratively and sets clear measurable goals and strategies to achieve these goals. An important part of developing an IPAP is to specify timeframes for reviewing and assessing progress towards achieving these goals.

At the agreed time, the IPAP and the trainee’s progress is assessed by the supervisor and discussed with the trainee. At this point the supervisor has two options:

1. Advise the trainee that they have successfully met the requirements of the IPAP and the issue is resolved. In this instance the trainee can now return to the standard training pathway.

2. Advise the trainee that they would benefit from further support and will progress to Stage 2 of the support pathway.

Case study – Two scenarios that take a look at Stage 1, or progression to Stage 2

This fictional case study gives an example of how a supervisor can evaluate a trainee’s progress through Stage 1 or the process if the supervisor feels the trainee will require further support by initiating Stage 2.

Background

Adam went onto the Training Support Pathway when his supervisor received a complaint from one of his patient’s caregivers and she observed some negative interactions between Adam and his colleagues.

Liz and Adam developed an Improving Performance Action Plan (IPAP) together that set out clear tasks, goals and timeframes for Adam to improve his performance in patient communication and relationships with colleagues.

Adam’s IPAP included completion of RACP e-learning communication modules and additional Physician Readiness for Expert Practice tools specifically focused on interpersonal skills.

At the end of the IPAP period Liz and Adam meet to discuss his progress against it and what the next steps are.
(Fictional) Trainee in difficulty: Adam
Age: 32
Training stage: Advanced Trainee in General Paediatrics
Training stage: Completed three years of Basic Training in Paediatrics and Child Health with no reported difficulty
Issue identified: Difficulty communicating medical information to patients, their families and caregivers, and a lack of awareness of how his behaviour impacts others including his colleagues

Fictional scenario one – exiting at Stage 1
Adam’s (trainee’s) perspective
After my supervisor, Liz, spoke to me about her concerns and we worked together to develop my IPAP I thought a lot about how these issues arose. I didn’t realise that in some areas I was lacking confidence and was compensating in ways that were negatively impacting my relationship with my patients, their caregivers and my colleagues.

I felt that I had successfully worked through the tasks set out in my IPAP and my interpersonal skills had improved. I have also noticed a positive change in my interactions with my colleagues.

I was also able to explain some of my personal difficulties that have contributed to the issues I was having to Liz and I am grateful to her for raising the issues that were impacting my ability to deliver quality patient care, and the support she gave in resolving them.

Liz’s (supervisor’s) perspective
Throughout the period Adam has been working through the tasks in his IPAP I have noticed substantial improvement in all of his performance issues and his interpersonal skills. I could see that he was making a lot of effort to work on these problems. I was glad that I took the time to provide the extra support to him.

When I met with Adam to go through his IPAP and his progress, he said that he thought he was going really well and had successfully completed all the tasks. I suggested we go through each item and the evidence that it had been done. I agreed with Adam that he had completed all the tasks and the outcomes have been positive and noticeable.

Due to his willingness to work through the identified issues and achieving the outcomes set out in the IPAP I explained to Adam that he would be able to leave the Training Support Pathway and resume normal training, without any further action or having to notify the College.

Fictional scenario two – moving to Stage 2
Adam’s (trainee’s) perspective
I completed all the tasks that were set out in my IPAP to improve my communication with my patients and their caregivers. I have been making an effort to explain things to my patients and their caregivers in everyday language and I have noticed the difference that has made.

I feel that the only reason interpersonal skills with colleagues was on my IPAP is because they are jealous of my knowledge and success so I didn’t think that it is worth me doing any of the tasks set for this.

When I met with Liz and we went through the IPAP, she agreed that I had completed the tasks on communication with patients and their caregivers. She also agreed that she had seen an improvement in my performance in this area.
Fictional scenario two – moving to Stage 2 (Continued)

I explained to Liz that I didn’t think I had to complete the tasks on my interpersonal skills with colleagues. Liz tried to explain that this was just as important an area for me to work on and that because I had not successfully completed the IPAP I would have to move to Stage 2 of the Training Support Pathway. This sounded like it would taint my training record and I tried to explain to Liz that I didn’t think it was necessary.

Liz said that progressing through the pathway was not a punitive measure and would help me succeed as a paediatrician so I felt reassured.

Liz’s (supervisor’s) perspective

Adam has the potential to become a capable paediatrician, but after monitoring him over the IPAP period I am concerned and frustrated that he has not made progress in all of the identified areas.

I have seen some improvement in the way Adam communicates with his patients and their caregivers, however he continues to use unnecessary technical language when speaking with his colleagues and does not appear to have completed all of the tasks in his IPAP.

When I met with Adam to go through the IPAP and his progress he said that he thought he had successfully met all the goals set out.

I suggested we go through each of the tasks of the IPAP and the evidence of completion. We started with the issue of communicating with patients and their caregivers. Adam said that he thought he had successfully completed all of the agreed actions, but as we went through them and the evidence of completion wasn’t there Adam admitted he hadn’t performed all the tasks.

When we got to the issue of his interpersonal relationships with colleagues, Adam was adamant that there was no issue and he should not have to complete the tasks. So I went through the outcome statements for the tasks in the IPAP with him and he agreed that these outcomes would be beneficial to his performance as a paediatrician, his colleagues and ultimately patient care.

Adam said that he would put more effort into improving his interpersonal skills in the future. However, he had not successfully completed the IPAP and I felt he would benefit from further monitoring so we discussed proceeding to Stage 2 of the Training Support Pathway.

Adam protested this at first, he believed it was not necessary and was fearful that going to Stage 2 would tarnish his name as the Training Committee would be involved in monitoring and review. I explained to him that this was not the case, and that the pathway is there to support trainees and progressing to the next stage will help him improve his performance and get back on track with his training.

The next steps

Liz sent her final Supervisor Report to the College advising that Adam is not performing at the expected level. The Training Support Unit (TSU) then got in touch with Adam to coordinate and monitor the process.

The TSU explained all the requirements to Adam and a dedicated case manager was allocated who is available to Adam, Liz and supervisors who Adam works with in the future to assist with any queries throughout Stage 2.

Adam will develop a new IPAP to work through in the coming period of training, to ensure that he has access to regular feedback on his training performance, and that he has structured, achievable learning objectives to enable him to reach the expected standard.

The relevant Training Committee has been advised, and Adam will submit three-monthly reports completed in conjunction with his supervisors, on his progress against his new IPAP. Adam’s progress will be reviewed by the Committee after all documentation is submitted at the end of the agreed period of Training Support, to see if the expected level of performance has been met and he can return to the standard training pathway.

The next issue of RACP News will explain what happens in Stage 3 of the Training Support Policy.
ENHANCING MEMBER VALUE

What is the purpose of Congress, and how might it change to suit your future needs? How can messaging be developed to further unite our diverse membership and increase shared understanding of our College’s purpose? How can we increase the engagement of College members in every jurisdiction?

These are some of the issues grappled with by one of our newer College bodies – the Fellowship Committee – and they made considerable progress in 2015.

Chaired by RACP New Zealand President, Associate Professor Mark Lane, the Committee is made up of members representing all Divisions, Faculties and Chapters as well as New Zealand, trainees, and specialty societies.

It is the peak body responsible for developing and overseeing a broad range of College-wide initiatives that enhance the value of membership for Fellows and future Fellows.

The health of physicians themselves under the ‘Fellows in Difficulty’ (FiD) program was one of the Committee’s early projects this year. Highlighting the multiple personal and professional stressors faced by career physicians, FiD has led to ongoing discussions with peer medical Colleges and healthcare organisations. These conversations stress the need to advocate for the support of Fellows who are facing difficulty in a professional setting, and to assist all members in maintaining good health through proactive and preventative measures.

The re-design and launch of the new College website was a major Committee project in the first half of 2015.

Part of an extensive digital program of works, the first phase was completed in just six months. The new site, driven by principles of user design with input from a cross-section of the membership, streamlines and improves the member experience while also introducing new functionality.

Improvements to the new site are continuous, and a second phase offering members better access to high value content and digital interactivity is planned for 2016.

Although not directly Fellowship Committee projects, the introduction of clinical updates via Continuing Professional Development (CPD) podcasts titled ‘Pomegranate’ and the launch of the mobile responsive myCPD website were also projects to improve member experiences which were welcomed by the Committee.

Both are recognition of the need to not only keep pace with broad communication trends but also reflect our members’ increasing use of mobile and smart devices in their daily professional practice.

In Australia, the Fellowship Committee and Fellowship Relations oversaw inaugural regional convocations this year in both Melbourne and Sydney. Designed to enable more members to celebrate their admission to Fellowship and create local opportunities for networking, collegiality and fellowship, these ceremonies were an addition to Congress convocation. This opportunity will be extended to Auckland in 2016.
The Committee is continuing to examine the purpose of Congress, investigating different models and options to ensure this premier event remains relevant and compelling to Fellows and trainees in years to come.

Member research was commissioned and will be presented to the Committee, which will feed into the planning of future congresses. Recommended models will be tested amongst the membership this year.

Globalisation is already affecting medical practice and education, a phenomenon that will only increase in future. The Fellowship Committee oversaw the first stages in the development of a College international strategy during 2015 via its International Strategy Working Group, chaired by Dr Steve De Graaff and Pacific Working Group, chaired by Dr Johan Morreau.

One area with significant healthcare challenges likely to be affected by such a strategy is the Pacific Islands. In 2015 the Fellowship Committee also oversaw the Pacific Working Group – tasked with developing a plan for the support of College Fellows in the Pacific Islands.

The future of our flagship College event, RACP Congress, is a Board priority steered by the Fellowship Committee and Fellowship Relations professional team.
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The College was proud to host a Q&A session with one of the world’s leading health experts Dr Ezekiel J. Emanuel on Wednesday, 9 December 2015.

Dr Emanuel is regarded as an ‘architect’ of the United States’ Affordable Care Act, or ‘Obamacare’, which is transforming health services in the United States.

Dr Emanuel also raised the need to transform medical education and the rise of digital medicine.

“The single most important thing most doctors should have that we don’t do now – process improvement and learning how to lead teams. Those are two skills that are going to be essential,” he said.

He said that by training doctors in digital and telemedicine forms of healthcare patients outside of hospitals will be kept healthier, patients with chronic illnesses could be monitored and early intervention facilitated. It can also reduce unnecessary emergency department visits and hospital admissions, he said.

A video of the event can be viewed on the College’s YouTube channel at www.youtube.com/user/RACP1938.

RACP President, Laureate Professor Nick Talley, said Dr Emanuel is a global health expert and to have him visit and share his thoughts on megatrends in health and medical education with College members was a fantastic experience.

“He predicted the expansion of digital medicine, the end of health care inflation and dramatic changes to medical education. It was fascinating to discuss the relevance of these trends to Australia and in particular the work of the College,” he said.

Award winning broadcaster Dr Norman Swan hosted the evening that was attended by over 80 members and guests.

Dr Emanuel also discussed his role in the introduction of Obamacare sharing his side of the story, including the highs and lows of the reform.

“I think to the shock of most people it’s been more successful than most of us expected,” Dr Emanuel said.

“We have seen a big drop in the number of people uninsured in America and the number of readmissions. And it’s had no negative impact on the economy.

“Healthcare reform is a continuous process – you have to constantly be adjusting and looking for problems and solving problems. We are not done with healthcare reform we need to now be on healthcare 2.0 in America.”

Dr Emanuel also raised the need to transform medical education and the rise of digital medicine.

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Dr Norman Swan and Dr Ezekiel Emanuel
LEADING HEALTH EXPERT

Paediatrics & Child Health Division President-Elect Dr Sarah Dalton

Dr Ezekiel Emanuel

Rheumatologist Professor David Kandiah

RACP Chief Executive Officer Ms Linda Smith, RACP President Laureate Professor Nicholas Talley, Dr Ezekiel Emanuel, RACP President-Elect Dr Catherine Yelland, Dr Norman Swan
RACP ETHICS COMMITTEE

The new RACP Ethics Committee was formed in 2015 with the purpose of providing advice to the RACP Board in areas that raise ethical considerations in the context of policy and advocacy, education, research and financial investment.

The Committee was established following a 2014 review of ethics at the College conducted by independent expert in medical ethics, Dr Jeff Blackmer. The review concluded that “ethics is a key consideration for the College, a core mandate for the organisation, and needs to be integrated across the continuum of all of its activities and undertakings”.

The Committee’s work plan for its first year includes: the development of a model which transparently details its role, structure and priority setting processes; publication of the Guidelines for ethical relationships between health professionals and industry (Fourth Edition); and scoping of a number of future projects. The Committee will also provide input on ethical issues to other RACP committees and working groups as needed.

Members of the RACP Ethics Committee

Dr Greg Stewart FAFPHM FRACMA, Chair of the RACP Ethics Committee, Australasian Faculty of Public Health Medicine President

Dr Greg Stewart is a health manager and public health physician and is Director of Primary and Integrated Health for South Eastern Sydney Local Health District (SESLHD).

He has a long standing interest in clinical and research ethics and has been involved in governance, strategic and operational aspects of health ethics since his early public health and management career.

He completed the Monash University Intensive Bioethics Course when he realised he lacked a sound foundation in ethical theory, principles and practice, after he was appointed to a Human Research Ethics Committee in 1990. This led to a life-long interest in bioethics by people such as Peter Singer, Max Charlesworth, Helga Kuhse and Tony Coady who taught at that course. In recent years he has been very influenced by ‘virtue ethics’. When he was Chief Health Officer of NSW in the early 2000s, Dr Stewart established the NSW Health Clinical Ethics Advisory Panel, an influential group of senior ethicists, clinicians, consumers and others which provides high level bioethics advice to NSW Health. He was Chair of the panel for close to 10 years until 2013 and is still a member. He is also a member of the SESLHD Clinical Ethics Committee.

Dr Alina Iser FRACP

Dr Alina Iser is a paediatrician at Alice Springs Hospital with extensive experience in Indigenous child health. She has a Masters in Professional and Applied Ethics from Melbourne University’s Centre for Applied Philosophy.

She feels privileged to be part of this Committee, to promote and support ethical decisions and discussions across our College. She believes striving for ethical interactions is fundamental to all areas of medicine even when it is challenging, especially in cross-cultural settings or if time or resources are limited.
Professor Ian Kerridge FRACP FRCPA (Haematology)

Professor Ian Kerridge is a staff haematologist and bone marrow transplant (BMT) physician at Royal North Shore Hospital. He is also Professor of Bioethics and Medicine at the University of Sydney and from 2003-2015 was Director at the Centre for Values, Ethics and the Law in Medicine, University of Sydney.

Professor Kerridge conducts research in both haematology/BMT and ethics. His ethics research focuses on the philosophical, moral and socio-cultural concepts and issues that underpin health, health policy and biomedicine and explores such topics as public health, stem cells, end of life care, the experience of illness and survival, synthetic genomics, organ transplantation, cord blood and tissue donation, research, drug policy and the pharmaceutical industry.

Dr Danielle Ko FRACGP

Dr Danielle Ko is a palliative care advanced trainee at St Vincent’s Hospital, Melbourne. She also trained as a lawyer and General Practitioner in Australia before completing fellowships in both medical ethics and palliative medicine at Harvard Medical School.

Dr Ko has a strong interest in the intersection of medicine, law and clinical ethics as it relates to end of life care and co-wrote a chapter on withholding and withdrawing life sustaining treatment in the ethical issues section of Oxford Textbook of Palliative Medicine Fifth Edition (2015).

She believes that given physicians are increasingly required to make difficult ethical choices, contributed to by many factors including medical technology advances, an ageing population, increasing healthcare costs and growing inequity in healthcare, it is imperative that the College provides Fellows and trainees with robust and comprehensive ethics education, including practical skills in ethical decision-making.

Dr Ko said she is very excited to be part of the Ethics Committee and is looking forward to considering the many interesting ethics issues that confront Australian and New Zealand physicians and the College.

Dr Alastair MacDonald FRACP

A retired renal physician, Dr Alastair MacDonald is now a clinical ethics advisor. He is involved in the formation of a clinical ethics network in New Zealand. He said the fundamental issue that influences his involvement in ethics is that “clinical ethics is everyone’s business”. Although many people agree with this statement, clinical ethics has not yet become one of the pillars of good healthcare, said Dr MacDonald.

His appointment to the RACP Ethics Committee is an important part of his work in ethics.
Associate Professor Jillian Sewell AM FRACP FAICD

Paediatrician, Associate Professor Jillian (Jill) Sewell is Deputy Director of the Centre for Community Child Health and Clinical Director of the Children’s Bioethics Centre at the Royal Children’s Hospital, Melbourne. She is a Past-President of the RACP.

Associate Professor Sewell has 30 years’ experience as a specialist in developmental and behavioural paediatrics. Her interests include early childhood development, training in community paediatrics, medical education, health service delivery, and medical regulation.

She has been involved in clinical and research ethics for many years and is keen to assist the College to address issues such as ethical investment of College funds and the relationship of physicians with industry.

She was made a Member of the Order of Australia for her services to child health in 2005.

Dr Linda Sheahan FRACP FACHPM

Dr Linda Sheahan is Clinical Ethics Consultant for South Eastern Sydney Local Health District, a Conjoint Lecturer with UNSW Medical School, and an Honorary Associate with the Centre for Values, Ethics and Law in Medicine, University of Sydney.

As a palliative care physician, Dr Sheahan sees first hand how ethics and healthcare come together in a clinical setting. Her research interest is in exploring the interface between end of life care and physician assisted suicide/voluntary euthanasia.

Linda is keen to be involved in building ethics capacity at the College, promoting ethics as a key component of professionalism, and in the education and assessment of trainees.
POLICY & ADVOCACY

YOUNG PEOPLE NEED BETTER ACCESS TO SEXUAL HEALTH CARE

The Sexual and Reproductive Health Care for Young People position statement was launched in November 2015 to encourage appropriate access to sexual and reproductive health care outcomes for all young people including Indigenous, gender diverse, same-sex attracted and young people who live with disabilities or long-term conditions.

Despite the generally good health enjoyed by young people in Australia and New Zealand, rates of sexually transmitted infection, teenage parenthood, homophobic and transphobic abuse and bullying, and domestic and sexual violence remain significant concerns for the health and wellbeing of many young people in Australia and New Zealand.

In 2014, one fifth of all chlamydia diagnoses were in 15 to 19 year olds, and it is likely that many more young people have undiagnosed infection. Young Aboriginal and Torres Strait Islander and Māori populations in particular have high rates of both chlamydia and gonorrhoea.

Sexual health physician Dr Sarah Martin said accessible, timely and targeted sexual and reproductive health care is essential, and it is imperative that relationships and safe sex are discussed in relation to same-sex as well as heterosexual intimacy.

A 2013 survey showed almost 25 per cent of Australian Year 10 students and 50 per cent of Year 12 students were sexually active. A 2012 New Zealand survey found almost 25 per cent of students surveyed were sexually active, yet less than half always use condoms when they have sex.

Dr Martin said it is essential to maintain a focus on education and prevention that is relevant to all young people at risk.

“Getting the right knowledge about sexuality, relationships and the right health care is essential for young people to be able to make appropriate and healthy decisions that will affect their adult lives.”

In 2013, 50 per cent of young people were dissatisfied with their sex education at schools based on irrelevant material, a lack of relationship advice and a lack of discussion of same-sex issues.

The position statement outlines the need for information, education and clinical care that supports healthy sexual development and informed choices.

The recommendations include:

- promoting young people’s right to confidential and non-judgemental sexual and reproductive health care
- ensuring physically and financially feasible access to sexual and reproductive health care, with options for free health care
- specific services for young people who may face increased discrimination or vulnerability
- including the needs of young people in planning, service delivery and guideline development
- sexuality and relationships education curricula are accurate and evidence-based.

The position statement was developed by a Working Group of the Paediatric Policy & Advocacy Committee in consultation with the Chapter of Sexual and Reproductive Health Care for Young People Working Group member, Dr Phil Bergman with the Working Group Chair, Dr Sarah Martin

Health Medicine and the Adolescent and Young Adult Medicine Committee (AYAMC).

References
A YEAR IN POLICY & ADVOCACY

2015 was a very busy year in policy and advocacy. The College Policy & Advocacy Committee (CPAC) oversaw a broad range of projects as identified in its work plan, as well as issues that arose throughout the year. Here are a few highlights of CPAC’s achievements demonstrating the diversity and complexity of the topics tackled.

E-cigarettes – a gateway to smoking or a path from tobacco?

There has been a dramatic increase in the prevalence of e-cigarettes since they first appeared on the global market in 2004. It is estimated that 13.1 per cent of the New Zealand population and 8.4 per cent of the NSW population have tried an e-cigarette with, until recently, little regulation or scrutiny.

Are e-cigarettes a gateway to smoking for the young? Will they undermine our hard-won gains in reducing smoking? Will they prolong the habit for smokers as they enable an easier nicotine fix? Or, are they a useful tool in our move away from the toxicity of tobacco? Could they play a role in harm minimisation and provide an effective pathway for those seeking to quit smoking? What regulatory approach is needed, and what in fact do we need to regulate: their quality and safety, their promotion and sale, their use?

There is a limited, and often conflicting, evidence base to answer these questions, there is however a diverse range of opinions.

Throughout 2015, the College called for more research to understand the consequences of these products and has welcomed laws introduced in NSW limiting the sale of e-cigarettes to minors.

E-cigarettes will directly affect a number of specialties including: oncology, respiratory medicine, public health, and addiction medicine and the College’s E-cigarette Reference Group has been examining the evidence and consulting widely to develop a policy and position statement.

Refugee and asylum seeker health

The College launched the Refugee and Asylum Seeker Health policy and position statement at RACP Congress in May 2015 and advocacy has continued throughout the year.

The need to improve access to healthcare for refugees living in the Australian community, and calling for an end to immigration detention due to the clear evidence of the harm this causes to people’s physical and mental health has been the focus of this activity.

The Australian Border Force Act (2015) (the Act) has had profound implications for our physicians and paediatricians, and we continue to call for the secrecy provisions to be repealed. The threat of up to two years imprisonment for doctors who reveal information about the conditions or services within immigration detention centres has further eroded the little transparency there was, and compromised doctors’ ability to advocate and care for their patients.
Throughout 2015 the College raised its concerns with Parliamentarians from all sides of politics, as well as with representatives from the Department of Immigration and Border Protection including the Department’s Child Protection Panel.

Our members’ concern for the impact of detention on their patients was brought into sharp focus by the gatherings held around Australia by hospital-based health professionals in October and November 2015. The College was proud to support its members in the media as they stood up to protect and care for this vulnerable patient group.

The College will continue to lead on this complex and important healthcare issue in 2016, maintaining a strong stance on the need for better strategies to improve refugee and asylum seeker health, both within detention and in the community.

**College advocates for government reforms to deliver high-value, patient-centred care**

Both the Australian and New Zealand Governments are undertaking a number of reviews and reform activities in the quest to deliver improved quality, safety and efficiencies in healthcare. The College has been closely involved with a number of these policy discussions, including the Primary Health Care and Medicare Benefits Scheme Reviews, Senate inquiries into chronic disease and Indigenous health services in Australia, and the New Zealand Health Strategy Review.

Our own work on integrated care and the EVOLVE initiative has been an opportunity for the College to provide clear input to these reviews.

The College is advocating for a broad cross-sector perspective to be taken, and that new models of integrated care should be supported by multidisciplinary health teams, appropriate payment systems, improved use and uptake of technology, and appropriate governance.

**Telehealth**

The Telehealth project is continuing, with the RACP Telehealth website (www.racptelehealth.com.au) updated in October 2015 with improved content including new articles and links to other relevant sources of information.

Following the success of Telehealth workshops held at RACP Congress in May, and more recently at Port Macquarie and Hobart, several State Committees are looking at options for holding state-based interactive Telehealth workshops in 2016.
End of life care

The End of Life Working Party was established in May 2014 to lead the College’s work around end of life care and promote best practice in this area in Australia and New Zealand through education and training.

In 2015 the Working Party conducted a survey of RACP Fellows and trainees to assess knowledge, attitudes and practice in end of life care and advance care planning, the results of which were presented at Congress in May 2015. The survey (while drawn from a limited sample) found that the Fellows and trainees sampled felt comfortable and confident in discussing end of life issues and Advanced Care Plans, but want to continue to improve their skills in these areas. The responses to the survey, however, also indicate that many patients nearing the end of life are provided with treatment that is inappropriate or against their wishes.

A position statement and recommendations on good end of life care are being finalised.

The Working Party is working with the College’s Education Services and Continuing Professional Development (CPD) Unit to discuss ways best practice end of life care can be integrated into the education and CPD curricula.

Medicinal cannabis

State governments around Australia are supporting clinical medicinal cannabis trials and reviewing laws around its use.

The College sought to influence new legislation on the availability of medicinal cannabis through a submission to, and appearance before, the Senate Inquiry into the Regulator of Medicinal Cannabis Bill 2014. The submission highlighted members’ concerns for patient safety if the Therapeutic Goods Administration approval process was bypassed for cannabis-based medicines. The College also made a submission to the Victorian Law Reform Commission.

There is a strong possibility that medicinal cannabis will be legalised in Victoria in 2016. This change will impact our members who may be asked to authorise use of medicinal cannabis for certain conditions. The College has written to the Victorian Minister for Health outlining members’ concerns about the lack of quality evidence to support its use while also emphasising a willingness to contribute to the initiative, should the law change, to ensure safeguards are in place.
Overprescribing of opioids for pain relief

Fellows are concerned about the dangers of long-term opioid use – especially for chronic non-cancer pain – and opioid misuse. To support appropriate use and prescribing of opioids, the College has supported proposed amendments to the scheduling for codeine medications.

In May 2015, College representatives attended the Post-market Review of Authority Required Pharmaceutical Benefits Scheme Listings’ Opioid Roundtable, advocating for the establishment of a national system for real-time prescription monitoring to reduce ‘doctor shopping’. This campaign is supported by several medical colleges and pharmacy groups.

Adolescent and young adult health

The College’s Sexual and Reproductive Health Care for Young People position statement was launched in November 2015.

The statement emphasises that appropriate access to sexual and reproductive health care will improve health outcomes for all young people. It argues for young people’s right to confidential and non-judgemental sexual and reproductive health care.

Read more about the position statement on page 27.

Drawing on the expertise of the AYAM Committee, the health of adolescents and young people was the focus of a submission the College made to the Australian Human Rights Commission’s report Resilient Individuals: Sexual Orientation Gender Identity & Intersex Rights 2015.
EVOLVING WITH THE TIMES

EVOLVE is the College’s flagship policy and advocacy initiative and it is progressing in leaps and bounds. Through EVOLVE 18 specialty societies have partnered with the College to create and disseminate ‘Top 5’ lists of interventions in their specialty that offer little or no benefit to patients and in some cases may even cause harm.

By actively participating in EVOLVE, which was launched in March 2015, physicians and paediatricians are leading the evolution of high value patient care and partnering in an opportunity to make substantial improvements to patient care where warranted.

Two specialty societies, the Australasian Society of Clinical Immunology and Allergy (ASCIA) and the Australasian Society for Infectious Diseases (ASID), have published their lists and a further five are in the final cross-College consultation stages (see Table 1).

EVOLVE provides an opportunity for the College to take a leading role in framing the ongoing healthcare reform debate, and has proved invaluable in supporting our input to both the Federal Government’s Primary Health Care and Medical Benefits Schedule Reviews.

Lead Fellows from various specialties have presented on EVOLVE at a number of conferences and scientific meetings throughout the year; including RACP New Zealand President, Associate Professor Mark Lane, at a meeting of the New Zealand Council of Medical Colleges, Paediatrics & Child Health Division President-Elect, Dr Sarah Dalton, at the Paediatric Society of Queensland’s Annual Scientific and Educational Meeting, and myself at the Internal Medicine Society of Australia and New Zealand conference.

I am also pleased that we have been able to support a stand-alone website for EVOLVE that will be launched this year. The website will not only house completed EVOLVE ‘Top 5’ lists, but also enable cross-specialty consultation, as well as providing a platform for the latest research on the global movement to reduce low value practices.

Laureate Professor Nicholas Talley
RACP President
What our specialists say about EVOLVE

“Many medical professionals and consumers aren’t aware of this evidence, and this may lead to delays in getting the right treatment. EVOLVE will lead to improved knowledge and changes in clinical practice that will benefit patients and ensure they get the treatment they need, when they need it.”

Australasian Society for Clinical Immunology and Allergy (ASCIA) President, Dr Melanie Wong speaking on one of its recommendations to not use antihistamines as first-line treatment for anaphylaxis, as evolving evidence demonstrates that the appropriate treatment is actually adrenaline.

“EVOLVE gives the Royal Australasian College of Physicians and specialist societies such as the Endocrine Society of Australia, the opportunity to identify tests and treatments that may be in common use but without evidence for any real benefit for patients. Not only will avoiding these tests and treatments save the country millions of dollars per year but also reduce patients’ time, discomfort and expense.”

EVOLVE Lead Fellow for the Endocrine Society of Australia, Associate Professor Warrick Inder

Table 1: Status of EVOLVE ‘Top 5’ lists for each participating specialty as at December 2015

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<th>Status of ‘Top 5’ list</th>
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<tr>
<td>Published</td>
<td>Australasian Society of Clinical Immunology and Allergy</td>
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<td>Australasian Society for Infectious Diseases</td>
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<td>Final draft</td>
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In all, the team completed 31 submissions and seven endorsements, covering a broad range of topics from Antenatal Corticosteroid Guidelines through to Principles and Guidance for the Last Days of Life.

It also made three significant submissions to Parliamentary Select Committees to advise Members of Parliament on issues such as improving the tracing of people who may have an infectious disease, or may have been exposed to one, as well as increasing the range of infectious diseases that are notifiable.

Arguably, the highlight to its contribution to healthcare policy during 2015 was its December contribution to the refresh of the Ministry of Health’s New Zealand Health Strategy – *All New Zealanders live well, stay well, get well.*

Reflecting the views of many New Zealand peak committees, the submission calls out important strategic themes which physicians wish to see across future healthcare. It seeks to reduce the power imbalance between healthcare providers and consumers, advocates more integrated care initiatives, stresses the importance of multidisciplinary teams and calls for the need to properly manage the rollout of future IT health technologies so they do not unintentionally amplify current patient inequalities.

In other areas of focus, ensuring current training volumes and specialties take into account future workforce needs and demographic projections is a high priority for the College in New Zealand as well as Australia.

To address this, during the year the Committee provided advice to Health Workforce New Zealand, the Government agency which works with educational
bodies and employers to ensure that workforce planning and postgraduate training aligns with the needs of current and future service delivery.

Separately, working with the Council of Medical Colleges, Committee members also met with the Ministry of Health and the Medical Council of New Zealand to identify requirements for workforce data sharing.

The Committee stressed that any data shared publicly on the performance of medical practitioners should take place in the context of continuous quality improvement. This is the systematic approach used across many areas in the New Zealand healthcare sector to collect and review data or information in order to identify opportunities to improve team-based operations, rather than just targeting an individual’s performance.

Healthcare consumer engagement is one of the RACP Board’s 12 strategic projects, taking into account the trend worldwide of viewing patients as the ultimate end consumers of healthcare education, rather than physicians.

In this regard, New Zealand Government healthcare agencies sought to work with the College during the year, in an effort to progress efforts on healthcare consumer engagement.

One such agency, the New Zealand Health Quality and Safety Commission works with clinicians, providers and consumers to improve health and disability support services. It met with the Committee to further understand how its resources could support the RACP with its work to progress consumer engagement.

Towards the end of the year, the contentious topic of euthanasia was also brought sharply into focus in New Zealand with extensive media coverage of the case of prominent lawyer Ms Lecretia Seales, who petitioned the High Court for the right to die following diagnosis of an inoperable brain tumour. Ms Seales sought to have doctors treating her granted immunity from prosecution if they chose to assist her in dying.

A New Zealand submission on euthanasia and physician assisted suicide has been prepared to allow all New Zealand Committees to voice their concern on this issue to the Parliamentary Health Select Committee.

Looking ahead, while obesity is an increasing problem across many western nation populations due to dietary and lifestyle factors, New Zealand has its own special characteristics. According to the New Zealand Ministry of Health, the country has the third highest adult obesity rate in the Organisation for Economic Co-operation and Development (OECD), and its rates are rising. Almost one in three adult New Zealanders (over 15 years) is obese, and one in ten children. New Zealand Fellows are now seeking to lead a Trans-Tasman initiative to combat increasing obesity levels in both New Zealand and Australia.

All New Zealand Committee Chairs have agreed to work towards a common goal – a College-wide obesity initiative to reduce the impact of obesity, with a special focus on children in particular. New Zealand Policy & Advocacy Committee Chair Professor Chris Bullen is leading this work.

In a promising early sign that this initiative is attracting attention, the New Zealand Minister of Health, Dr Jonathan Coleman asked to meet with the College to discuss its obesity campaign and how it could contribute to the New Zealand Government’s overall obesity strategy. The aim is for the obesity campaign to become Trans-Tasman in 2016, beginning with the College Policy & Advocacy Committee, then filtering across the College’s other Australian committees. The vision for those working on the obesity campaign is to create the space for a movement – much in the same way as climate change.
PHYSICIANS AND PAEDIATRICIANS PRACTISING IN ISOLATION: DISCUSSION DOCUMENT LAUNCHED

The specialist workforce in New Zealand is not large with many specialties having small numbers of actively practising physicians and paediatricians. The challenges many NZ specialists have relating to their professional or geographical isolation is the subject of a recently launched discussion paper.

The Physicians and paediatricians practising in isolation in New Zealand discussion document 2015 was released in November 2015 and examines aspects of professional and geographic isolation as well as identifying opportunities to ameliorate these challenges.

Isolation may be felt by physicians and paediatricians practising in rural and remote settings, in highly specialised fields or based primarily in private practice. Clinical practice can be impacted by isolation in many ways including:

- fewer opportunities to discuss complex and challenging cases in the same or related fields
- hospital information technology and telemedicine facility limitations restricting participation in, or access to, online activities
- lack of support for research and access to peer review opportunities
- Continuing Professional Development (CPD) activities based in metropolitan centres not structured in ways (e.g. half or full day sessions) that facilitate attendance by rural clinicians
- alternative staffing arrangements being inadequate for attendance at CPD or Continuing Medical Education (CME) activities.

The experiences of Fellows working in the regional and rural areas of New Zealand highlighted that there was an opportunity to explore ideas such as the responsibility of employers, the establishment of regional networks to improve connections for physicians working in isolated areas and the role of District Health Boards (DHB) in supporting physicians in isolation.

“Provincial DHBs may be willing to support their physicians attending peer review and training sessions in tertiary centres, but relevant opportunities sometimes don’t exist, or staffing commitments make it too difficult to take time out,” said NZ Adult Medicine Division Committee Chair-Elect Dr John Gommans.

This discussion document broadens the scope of the original document that was initiated by the NZ Adult Medicine Division Council and released in 2012.

Since then recognition that issues of isolation are relevant to a wider audience including paediatricians, Fellows in private practice and those working in highly specialised fields in major centres has increased.

The health landscape in New Zealand has changed significantly with new challenges, opportunities and different arrangements in health care.

Solutions to the issues facing physicians and paediatricians in isolation can be complex and involve a range of contributors and technologies.

The target audience for the discussion paper includes individual physicians, clinical networks, specialty societies, other Colleges, DHBs and other health employers, health sector organisations and government.

The discussion document is available at www.racp.edu.au/fellows/resources/new-zealand-resources.

Comments and feedback can be sent to policy@racp.org.nz.
MĀORI HEALTH COMMITTEE HUI 2015

RACP Fellows and trainees and guests representing Indigenous health professionals in New Zealand, Australia and the Pacific joined the Māori Health Committee at their Hui/meeting in November 2015.

The Hui was an opportunity to refresh the Committee’s strategic direction, in partnership with its friends and in the context of the relationship with the Medical Council of New Zealand and the College’s six years of training reaccreditation from the Australian and New Zealand Medical Councils.

The Hui was structured by the five principal objectives of the Committee:

1. Assist in the education and training of physicians and paediatricians in facilitating their understanding, knowledge and skills when dealing with Māori patients.

2. Contribute to the development of College policy relating to cultural competence in training, educating and assessment.

3. Play an active role in the development of all College policies in respect to Māori health.

4. Inform and advise the College of the inequalities that exist with indigenous populations and ensure that the College works towards promoting the highest standard of Indigenous Health in Aotearoa/New Zealand and Australia.

5. Promote an increase in Māori participation and retention in the New Zealand physician and paediatric workforce.

Sessions were led by members of the Committee and topics such as indigeneity within RACP, the place of Te Tiriti o Waitangi/Treaty of Waitangi and indigenous trainees and workforce development were explored. The Hui also featured a forum on cultural competence.

Each session generated a wealth of discussion, ideas and engagement from participants. Targets and long term goals were identified and will provide an anchor point for the development of an Indigenous forum within the RACP combining Māori, Aboriginal, Torres Strait Islander and Pacific voices.

The Hui was held at Tai Wānanga Tū Toa Campus in Aokautere, Te Papaioea/ Palmerston North and attendees learned a waiata/song, ‘Purea Nei’ which they performed for the tangata whenua/local people of Tai Wānanga Tū Toa during the closing of the Hui.

Dr George Laking
Chair, Māori Health Committee
Royal Australasian College of Physicians

Attendees at the Māori Health Committee Hui
AUSTRALIA AND ANTIBIOTICS

The latest episode of Pomegranate, the College’s Continuing Professional Development (CPD) podcast, is based on a research paper featured in the Internal Medicine Journal, ‘Antibiotic resistance: are we all doomed?’. The research found that despite Australia’s high antibiotic use, bacteria resistance rates are among the lowest in the world.

However, the study warns, with high per capita antibiotics usage, Australia has been lucky and must remain vigilant if it is to maintain current levels of low antibiotic resistance.

The research by infectious diseases physician Professor Peter Collignon shows that low resistance rates are particularly present in the use of critically important or last-line antibiotics.

“The information on Australia’s resistance rates could help keep rates low and possibly help control antibiotic resistance internationally,” Professor Collignon said.

With most of the world already moving into a ‘post-antibiotic’ era, Professor Collignon said it is important to understand why Australia’s bacteria resistance rates have occurred in this way.

His research highlights the role of Australia’s stringent infection control and the prohibition of some antibiotic classes in animals used for food.

The paper states that while transparent data are often not available, it is likely that 80 per cent or more of the total volume of antibiotics used in the world is used in food animals.

Australia is the only country that never allowed fluoroquinolones to be used in food animals. This has resulted in Australia having almost no fluoroquinolone-resistant bacteria in food animals or food derived from these animals.

“Importantly, we also know that when antibiotic usage is stopped or severely curtailed, then rising antibiotic resistance rates will usually stabilise and often will fall,” added Professor Collignon.

There are two factors that drive antibiotic resistance, both of which can be controlled:

• the volumes of antimicrobials used
• the spread of resistant micro-organisms and genes encoding for resistance.

In the podcast Professor Collignon is joined by infectious diseases physician and clinical microbiologist Dr David Looke who says that physicians can ask their local pathology services for statistics from their own areas to know what the rates of resistance are and where impacts are greatest.

Dr Looke notes that not only is it getting harder to find new antibiotics, but modern regulatory systems are far more stringent – requiring close to 100 per cent guarantee of safety.

“We all say quite often that penicillin would never get up now if it was put on the market under the current regulations, because a certain proportion of people, five percent of people, are allergic to penicillin,” he says.

New Zealand does have similar issues to Australia, and have a national taskforce on antibiotic resistance. Their national reference laboratory is The Institute of Environmental Science and Research Ltd (ESR), which has put out data on resistance patterns, said Dr Looke.

‘Antibiotic resistance: are we all doomed?’ was published in the November edition of the Internal Medicine Journal (IMJ) and the podcast is available at www.racp.edu.au/pomcast and on iTunes.
Access the *Internal Medicine Journal* (IMJ) online

The *Internal Medicine Journal* is the official peer-reviewed publication of the Adult Medicine Division. It is produced 12 times per year.

RACP members have full access to IMJ at www.racp.edu.au/fellows/resources/journals/internal-medicine-journal.

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**Log your Continuing Professional Development with the MyCPD webapp**

The MyCPD mobile app allows Fellows to record their Continuing Professional Development (CPD) on the move and can be accessed by navigating to www.racp.edu.au/mycpd on any internet-connected mobile device.

The webapp offers many advantages – it is immediately accessible with no download requirement, compatible over multiple devices and cost-effective for the College to upgrade and maintain.

CPD activities for 2015 must be lodged by Thursday, 31 March 2016.

If you have any questions on CPD or using the app please contact the CPD Unit on MyCPD@racp.edu.au or MyCPD@racp.org.nz.
PAEDIATRIC TRAINEE RECEIVES REGISTRAR OF THE YEAR AWARD

Advanced Trainee in Paediatrics Dr Tessa Davis was named the 2015 NSW Minister for Health/BOQ Specialist Registrar of the Year.

Dr Davis has demonstrated expertise and prominence as an online medical educator and is a notable leader in the field through her blog and social media presence.

The award was presented at the Australian Medical Association (NSW) annual Doctors-in-Training Awards held in October.

Dr Davis is founder and creator of paediatric medicine educational website www.DontForgetTheBubbles.com, widely regarded by the medical community in Australia and internationally. The site is read by more than 1,000 people per day.

Dr Davis also created www.GuidelinesForMe.com, a crowd-sourced database of clinical treatment guidelines.

Her nomination stated: “Dr Davis rapidly acquired skills to manage a very broad cohort of matters, including aggressive children, sensitively delivering a disability diagnosis and working with other community chronic care providers. It has been extremely satisfying and inspiring to observe how she has undertaken her training. Her professionalism and strong work ethic are regularly on display.”

Her colleagues commented: “She is a shining example of the selflessness of the medical profession, a role model for modern medicine, and she has undoubtedly made a significant difference to the health and medical services of the Aboriginal community.”

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RACP UPCOMING EVENTS

For information on all RACP events, please visit www.racp.edu.au/news-and-events/all-events

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| 27 February 2016 | **Hot and Steamy in Brisbane**  
AChSHM Annual Scientific Meeting 2016  
27 February 2016  
Hotel Grand Chancellor Brisbane  
**Cost of registration**  
Full registration: AU $300  
Trainees and Allied Health Professionals registration: AU $225  
**Contact:** www.sexualhealthmedicineasm.com.au |
| 11 March 2016 | **INTERNATIONAL MEDICAL SYMPOSIUM 2016**  
Future Challenges for the Medical Profession  
**Cost of registration**  
Full registration: AU $495  
Trainee registration: AU $200  
**Contact:** www.internationalmedicalsymposium.com.au |
| 19 March 2016 | **NEW ZEALAND TRAINEES’ DAY**  
Making good decisions: at work and at home  
**Saturdays, 19 March 2016**  
The University of Otago, Christchurch School of Medicine, Christchurch Hospital  
**Cost of registration**  
NZ $250 (includes dinner)  
**Contact:** [www.racp.edu.au.nz-trainees-day-2016](http://www.racp.edu.au.nz-trainees-day-2016) |
| 16–18 May 2016 | **EVOLVE EDUCATE ENGAGE**  
RACP Congress 2016  
**Contact:** www.racpcongress2016.com |

All events are eligible for MyCPD credits. Points can be claimed under Category 2 at a rate of 1 point per hour and supervisor workshops can be claimed under Category 4 at a rate of 3 credit points per hour.
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RACP Congress 2016 / Adelaide Convention Centre 16 - 18 May 2016

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