Focus: New RACP Board and President

NZ Budget casts shame on Australian counterpart

What we learn from the drawings of children in detention

Addressing health inequities for Australian and New Zealand Indigenous peoples

End of life care – a challenge for Australian governments
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Welcome to my first Communiqué as the new President of The Royal Australasian College of Physicians. I am deeply honoured to lead the College over the next phase of growth and development.

As I begin my Presidency, I have been reflecting on many things; however, I keep returning to one question. What will be my driving force over the next two years? The answer is: our College values. Professionalism. Excellence. Advocacy. Collaboration. These values will be my highest priority and at the heart of everything I do during my Presidency.

I will be a strong advocate for physicians, patients and our communities across Australia and New Zealand and I will build on the strong foundations laid down by our 38 past Presidents. I would like to acknowledge Associate Professor Leslie Bolitho AM for his leadership over the past two years.

New Board

I’d like to extend a very warm welcome to our new and continuing RACP Board members, including our new President-Elect, Dr Catherine Yelland, and our New Zealand President, Associate Professor Mark Lane.

The new Board and I are committed to ensuring the College has an effective, flexible, responsive and cost-efficient structure capable of sustaining the essential work of the College and its members well into the future. This will allow us to make the greatest contribution to improving the health and wellbeing of communities across Australia and New Zealand.

I strongly encourage all Fellows and Trainee Members to contact Board members via the appropriate channels to discuss matters regarding the College.

RACP Congress

We are all very busy with our clinical practice, family life, research and teaching. While we all lead busy lives, we also share a strong belief in our profession and its capacity to do good.

Pausing and reflecting on our professional practice and the profession more broadly are important. RACP Congress is one forum that allows us that opportunity. As such, I was pleased to see many of you from our College at the recent Congress in Auckland, New Zealand.

I enjoyed the debates and discussions about the critical healthcare issues facing New Zealand and Australia and hearing about the latest advances in medical research and internal medicine.

It was also inspiring to meet some of the 686 Australian and 99 New Zealand Fellows recently admitted to Fellowship. These Fellows are from such diverse backgrounds and are the modern face of our College.

Governance Reform

With more than 14,800 Fellows and over 6,000 Trainee Members, our College is larger and more complex than ever before. We are also operating in a more highly regulated environment across two national jurisdictions.

The Board recognises its responsibility to continually review governance structures and to evolve the College to keep up with, and anticipate, real and strategic change.

As we undertake major organisational and governance reforms at the College, I encourage you to be part of this change and engage with the College as these reforms progress. It was pleasing to see so many of you at the Governance Reform member forum at Congress.

There are opportunities to have your say during every phase of this multi-phased consultation process including at forums across Australia and New Zealand in the coming weeks. You can read the views of other Fellows about our governance reforms on our Noticeboard, located on the homepage of the RACP website.
**Education and Training**

Educating the physician of the future is the College's core business, and one of my key priorities will be to ensure we continue to invest in strengthening our educational services, providing first-class training and education for Australasia’s future physicians and supporting supervisors. A UK report focusing on the qualities of the 21st century doctor got it right when it said:

... health and medicine attract the most dynamic thinkers in the world, many of whom come with a love of science and art, a yearning to improve health and well-being and an appreciation for thinking differently.

That report prepared by the King’s Fund goes on to say:

The potential to adapt to an unknown future should be put at the heart of medical education and training, underpinned by the ability to practise safely and respond to patient needs.

Leading and nurturing the intergenerational transfer of knowledge; passing on both the art and the science of clinical practice to the physicians of the future — this is the essence of our profession and our College.

Recognising that the delivery of healthcare is changing and the numbers of new trainees has dramatically increased, particularly in Australia, the College must make sure that teaching and training are protected. We will train and inspire future physicians who will become the leaders in clinical practice, health systems reform, medical education and research.

**Policy and Advocacy**

What unites every physician is our commitment to improving patient care. We also share a strong belief in social justice because we know that equity and good health go hand in hand.

You, our members, are uniquely placed to help shape the policy debate to benefit patients and the broader community and to improve our healthcare systems. It is vital for the College to be an active and influential voice on future health policies as our health systems undergo significant changes.

I am committed to ensuring the College continues to promote and protect the rights and the health of all in our community. To do this, we need to have a strong voice — the strength of this College voice comes from the active engagement of our members and your wide-ranging expertise.

We will continue to speak out on key issues including:

1. Protecting the health of refugees and asylum seekers
2. Improving care for the terminally ill by advocating for improvements in end of life care
3. Reducing the harmful effects of alcohol, particularly on young people
4. Advocating for solutions that acknowledge the social determinants of health
5. Promoting the need for much greater integration of care
6. Working at all levels to improve the health of Māori and Aboriginal and Torres Strait Islander people.

The College’s Policy Reference Group provides every Fellow and Trainee Member the opportunity to contribute your skills and expertise to help drive the College’s policy and advocacy efforts. I strongly encourage you to get involved by contacting: policy@racp.edu.au.

Thank you for the honour to represent you for the next two years as President. Let’s work together to serve the health of our people. Hominum servire salutis.

Professor Nicholas Talley
RACP President
2014–2016
As I begin my Presidency, I’d like to share with you a few stories about those who inspired me to enter medicine, leaders who have challenged me during my career and the learning environments that have shaped it.

As many of you would know, I am a practising gastroenterologist. What most of you wouldn’t know is that this career path nearly didn’t happen, based on my ambition to distinguish myself from, as one of my esteemed colleagues once told me, the ‘real Nick Talley’, also a gastroenterologist, Dr Nicholas Alexander Talley, OAM. My father is a great storyteller, but his own story is most remarkable; the loss of his father (who himself was a distinguished respiratory physician) to the Nazis, how he escaped from communist Hungary and how he all alone put himself through medical school in Sydney. He has been an inspiration throughout my career and continues to be.

I didn’t want to be a gastroenterologist (I thought two Nick Talleys in gastroenterology would be rather confronting, especially for me). I thought about neurology, but then I was offered a research position at Royal North Shore Hospital, Sydney, with one of the Australian ‘fathers’ of gastroenterology, the late Professor Doug Piper, and I took a chance. Doug was a towering figure in both teaching and research, and was also an inspiring leader because he saw the need for change, the need for a new area of specialisation, and he took steps to make that a reality.

I spent four very happy years at Royal North Shore Sydney completing Advanced Training and a PhD. I learnt how to do first-rate clinical and population-based research, then decided to move to the United States to join an outstanding expatriate Australian, Professor Sidney (Sid) Phillips, for further mentorship and training at Mayo Clinic. I expected to stay a year but instead spent seven years in Rochester, Minnesota, rising to the rank of Associate Professor before returning home.

At the age of 37 and with virtually no administrative experience, I was charged with the daunting task of developing teaching, research and clinical departments at Nepean Hospital, Sydney. As Foundation Professor, the next nine years were very exciting and flew by!

In 1998, I was invited to move back to Australia to become the inaugural Dean of the Faculty of Medicine at the University of Newcastle, where I have been striving to make a positive difference in terms of research and education across the health faculties and in the country.

In 2010 I decided to move back to Australia to take up the post of Pro Vice Chancellor and Dean (Health and Medicine) at the University of Newcastle, where I have been striving to make a positive difference in terms of research and education across the health faculties and in the country.

I now begin one of the most exciting challenges of my career, leading The Royal Australasian College of Physicians.

I look forward to hearing from many of you over the next two years. I encourage you to share your insights so that we may be inspired by and learn from each other.

Source: www.amsj.org/archives/325

**FINANCE COMMITTEE COMMUNIQUÉ**

**APRIL 2014 MEETING**

The College’s Finance Committee held its third meeting for 2014 on Tuesday, 29 April. This meeting focused on a number of general business matters, including:

- Review of Q1 financial accounts – the College recorded positive results for the 1st quarter of the year.
- Consideration of the Specialist Training Program – Government funding for this program will cease at the end of 2015 and the Committee is considering the financial risks to the College if the program is not continued to be managed by the College. In addition, the Policy & Advocacy team are working hard advocating on behalf of the College for future funding and management of the program past 2015.
- Alignment of Australia and New Zealand professional fees – the Committee is considering options for how, and in what currency, the College should charge its subscription fees.
- Amendments to the financial delegations schedule – the Committee approved a number of changes to the delegation schedule as a result of changes in reporting lines and new positions at the College.

- Progress of OSCAR – the Committee received a progress update on activities of the project since its last meeting in March.
- Applications for Honorary Treasurer – a number of applications had been received for the position of Honorary Treasurer and the Committee is currently reviewing these with interviews expected to take place shortly.

As this was the last meeting I chaired as Honorary Treasurer, I would like to thank staff, Fellows and non-Fellows of the College for their contributions and successful management of the Finance Committee.

The Committee’s next meeting will be on 24 June 2014.

Michael Hooper
Honorary Treasurer and Chair of the Finance Committee
Dear Fellows and trainees

As part of the Board’s commitment to keep our membership informed, monthly I will communicate matters discussed at the Board meeting and decisions made.

Ethics is a strong focus. At the May meeting we received and discussed a report from Dr Jeff Blackmer, following his review of ethics within the College. The Board decided to establish an Ethics Review Working Party comprising of Dr Catherine Yelland (Chair), Associate Professor Mark Lane, Dr Jim Newcombe and Dr Greg Stewart to consider the report in more detail and seek feedback from members. The report is on the College website and I encourage you to read it and provide feedback to the Working Party, which will update the Board at the July meeting.

The College has made considerable progress in meeting the standards and criteria set by the regulators since it was last accredited in 2008. The process of reaccreditation enables us, as an important specialist medical educator and trainer, to keep providing high-quality training and care for our profession. A detailed presentation was given to the Board on the processes the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) will undertake to reaccredit the College. A comprehensive 2014 Reaccreditation Report to the AMC/MCNZ, which underpins the reaccreditation process, was also approved by the Board.

Of interest to many members, amendments to the College’s indemnity (2011), which covers members who undertake activities in a voluntary capacity for and on behalf of the College, were approved by the Board. The indemnity document and explanatory letter provided by legal advisers King & Wood Mallesons is on the College website.

The Board also approved a Balanced Scorecard for the College to assess the College’s performance against a number of agreed measures. I look forward to keeping you updated on the College’s performance.

Board Announcements

The Board is pleased to announce the appointment of Dr John O’Donnell as the new Honorary Treasurer of the College for a two-year term. Dr O’Donnell is the past-President of New Zealand, acted as Assistant Honorary Treasurer for the past year, and has been a Board member and member of the Finance Committee since 2010.

Dr O’Donnell replaces Clinical Associate Professor Michael Hooper whose final term expired in May. The Board is grateful for Clinical Associate Professor Hooper’s dedication and service.

Dr Alexandra Greig was confirmed as Chair of the College Trainees’ Committee. Dr Greig also joins the Board as one of the two Trainee Representatives, replacing Dr Simone Ryan whose term had expired. Dr Jim Newcombe remains as the second Trainee Representative on the Board.

The Board approved changes to the composition and tenure of office for members of the Fellowship Committee. The terms of membership have been staggered so that committee momentum and knowledge are not lost every two years. The revised By-Law will be posted on the College’s website.

In other administrative matters Board approval was given to the New Zealand Committee, Fellowship Committee, College Trainees’ Committee, College Policy and Advocacy Committee and College Research Committee 2014 Work Plans.

Briefing Session

Incoming Directors were briefed on current matters being overseen by the Board, including Board Governance Reform, policy development, research activities, Pro Bono Workforce/Specialty Societies, and the Tripartite Alliance with the Royal College of Physicians and Surgeons of Canada and the Royal Australasian College of Surgeons.

Next Meeting

The next Board Meeting will be held in Brisbane on Friday, 25 July 2014.

Professor Nicholas Talley
President
The Annual General Meeting of members of the College was held in Auckland on Monday, 19 May 2014, with some 50 members in attendance.

This year, there were no resolutions to be voted on by members; however, the College’s constitution requires the Board to hold an Annual General Meeting every year. The business of the meeting included the following items:

1. Report of the Board
2. Approval of the financial statements for 2013
3. Declaration of results of the election of members to the Board in place of those retiring.

The President spoke to the Report of the Board, noting that in 2013 the College celebrated its 75th anniversary, which is a significant milestone for the growing membership of the College. In 2013, the College welcomed 526 new Fellows. In 2013, the College began implementing a number of changes to ensure its members remain well supported in education, training and professional practices for today’s environment. These changes included the reforms to the structure of Education Governance to provide greater transparency and accountability to the delivery of the College’s education services.

The College received a number of questions from members prior to the Annual General Meeting. Answers to questions received are published on the College website under the Annual Report section (www.racp.edu.au/page/racp-annualreport).

The Honorary Treasurer presented the 2013 financial statements to the members noting the College was in a healthy financial position. The College’s CFO and external auditors were available via telephone to answer questions from members regarding the financial accounts. Answers to these questions are also published on the College website under the Annual Report section.

Welcome to the new RACP President and the members of the Board

The current President, Associate Professor Leslie Bolitho, retired at the conclusion of the AGM. Associate Professor Bolitho was pleased to confirm that Professor Nicholas Talley would assume the Presidency of the College, together with Dr Catherine Yelland as President-Elect.

Professor Bolitho confirmed the appointment of the new members of the Board as follows:

<table>
<thead>
<tr>
<th>New Appointments to the Board</th>
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<tr>
<td>Dr Catherine Yelland RACP President-Elect</td>
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<td>Dr David Beaumont AFOEM President</td>
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<td>Associate Professor Nick Buckmaster AMD Appointment</td>
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<td>Dr Jonathan Christiansen New Zealand President-Elect</td>
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<td>Professor Paul Colditz PCHD Appointment</td>
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<td>Dr Stephen de Graaff AFPHM President</td>
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<tr>
<td>Dr Alexandra Greig Trainee Appointment</td>
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<td>Dr Greg Stewart AFPHM President</td>
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<th>Continuing Board Members</th>
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<tr>
<td>Professor Nicholas Talley RACP President</td>
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<td>Associate Professor Mark Lane New Zealand President</td>
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<td>Dr Nicola Murdock PCHD President</td>
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<tr>
<td>Dr Jim Newcombe Trainee Appointment</td>
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<tr>
<td>Associate Professor Grant Phelps AMD President-Elect</td>
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<tr>
<td>Dr Helen Rhodes AMD Appointment</td>
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<tr>
<td>Professor John Wilson AMD President</td>
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<tr>
<td>Dr John O’Donnell Honorary Treasurer</td>
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The President thanked the following retiring Board members for their valuable contribution to the work of the Board and the further development of the College over the past two years:

<table>
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<th>Retiring Board Members</th>
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<tr>
<td>Associate Professor Leslie Bolitho</td>
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<td>Dr Charles Guest</td>
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<td>Clinical Associate Professor Michael Hooper</td>
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<td>Dr Alasdair MacDonald</td>
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<td>Associate Professor Susan Moloney</td>
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<td>Associate Professor Christopher Poulos</td>
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<td>Associate Professor James Ross</td>
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<td>Dr Simone Ryan</td>
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In 2013, Dr Yelland was awarded the John Sands College Medal for outstanding service to the College. She has extensive experience in clinical practice, healthcare policy and politics, as well as physician training, at basic and advanced levels.

**Associate Professor Mark Lane**  
MBBS, FRACP  
President, New Zealand 2014–2016  
Associate Professor Lane is currently a senior medical officer in the Department of Gastroenterology and Hepatology at Auckland Hospital. He was Clinical Director of this Department for 17 years before stepping down from the role in 2008. His subspecialties include inflammatory bowel disease, coeliac disease, colon cancer screening and therapeutic endoscopy. Other roles held previously include secretary and President of the New Zealand Society of Gastroenterology. Within the College he has held various roles including Chair of the Specialist Advisory Committee for Gastroenterology in New Zealand, Chair of the Specialties Board and more recently Chair of the New Zealand Adult Medicine Division Committee. In this role he has been actively involved with the New Zealand Adult Medicine Education Committee and the New Zealand Policy and Advocacy Committee, and has sat on the Joint Executive (now the New Zealand Committee).

**Dr Catherine Yelland**  
MBBS FRACP  
President-Elect  
Dr Yelland is a Geriatrician and General Physician and the Director of Medicine and Older Persons Service at the Redcliffe Hospital in Queensland. Dr Yelland was President of the College’s Adult Medicine Division from 2010 to 2012 and served on the College Board from 2009 to 2012. Dr Yelland is also a past President of the Australian and New Zealand Society for Geriatric Medicine.

To introduce new and continuing Board Directors, biographies or interviews will be profiled in upcoming issues of *RACP News*. In this issue we feature the new President, Professor Nicholas Talley, President-Elect Dr Catherine Yelland, New Zealand President Associate Professor Mark Lane and New Zealand President-Elect Dr Jonathan Christiansen.

**Professor Nicholas Talley**  
MBBS (Hons)  
(MS (Med Sc (Clin Epidemiol)) MD (NSW), PhD (Syd), FRACP, FAFPHM, FRCP ( Lond), FRCP (Edin). FACP, FAGAF  
**RACP President 2014–2016**  
Professor Talley is Pro Vice-Chancellor and Dean of the Faculty of Health and Medicine at the University of Newcastle. He has published over 700 original and review articles in peer-reviewed literature, and he is considered one of the world’s leading authorities in clinical research on the stomach.

Professor Talley was formerly Chair of the Department of Internal Medicine at Mayo Clinic in Jacksonville, Florida, where he held the rank of Professor of Medicine and Epidemiology at the Mayo Clinic College of Medicine, and was the Foundation Professor of Medicine at the University of Sydney, Nepean Hospital for nearly a decade.

Professor Talley serves on a number of prominent editorial boards, and currently holds adjunct research appointments as Professor at Mayo Clinic, University of North Carolina, and the Karolinska Institute. He is a Fellow of the Royal College of Physicians (both London and Edinburgh) and the American College of Physicians. He was recommended for appointment as an initial Fellow of the Australian Academy of Health and Medical Sciences in April 2014.

**Dr Catherine Yelland**  
MBBS FRACP  
President-Elect

Dr Yelland was awarded FRACP in 1982 and his post-Fellowship training was in Auckland as Gastroenterology Research Fellow at Auckland Hospital (1982–83) and in...
Birmingham, UK, as a Fellow supported by the Ileostomy Society of the UK (1984–86).

**Dr Jonathan Christiansen**

*BHB MBChB MD FRACP FACC FCSANZ*

**New Zealand President-Elect**

Dr Jonathan Christiansen is a cardiologist working at North Shore Hospital in Auckland. He graduated from Auckland Medical School and trained in Tauranga and Auckland, before moving to the USA, undertaking Fellowships at the Universities of Virginia, and Rochester in New York.

Dr Christiansen’s clinical practice is general cardiology, with a clinical and research focus on non-invasive imaging, including cardiac MRI, CT coronary angiography and nuclear perfusion imaging. He is currently Head of Division of Medicine at Waitemata District Health Board and maintains a keen interest in medical education.

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**WELCOME TO OUR NEW HONORARY TREASURER**

The College’s AGM is similar to New Year’s Eve – when we say goodbye to the old and welcome in the new. In my case, as I wrote in my April column in RACP News, I have completed my six-year term as Honorary Treasurer and it’s time to bring in the new. I would like to thank you all for your support and the generous way you have given your time and expertise.

I am delighted that the RACP Board has appointed Dr John O’Donnell as the next Honorary Treasurer and I pass on the baton of this important College role with great confidence as I know John will continue to maintain and improve the financial governance of the College.

Whilst John is based in Christchurch, New Zealand, I am sure he will not let distance interfere with this role.

As many of you know, John is the immediate past New Zealand President, has been a Board Director for four years, chairs the College Research Committee and has been a Clinical Examiner. John has also been on the Finance Committee for three years and has held the role of Assistant Honorary Treasurer, stepping in to take on the Honorary Treasurer role when I have not been available.

As Honorary Treasurer, John continues as a member of the College Board, where he has been a strong supporter of the governance changes for the College. John brings to both the Board and the Finance Committee continuity, corporate knowledge and the views of the broad Fellowship.

The Finance Committee welcomes Associate Professor Charles Steadman as a Fellow member. Charles has extensive experience as a Board Director and in the financial and investment side of organisations. He is currently a Board Director of MIPS, a Medical Defence Organisation, and is also a member of its Investment Committee.

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My time as a Board Director and Honorary Treasurer has been rewarding, but the commitment would not have being possible without the support of Jenny, my wife, and my family.

I will now have more time to indulge some of my favourite pastimes as a grandfather, as an occasional, not very successful but keen fisherman, as a camper and as a traveller.

**Michael Hooper**
A TALE OF TWO BUDGETS

Two very different national health budgets were announced in May 2014. On the one hand was the New Zealand Health Budget, with its centrepiece of free prescriptions and GP visits for children under 13, and a focus on increasing help for vulnerable children. On the other hand there was the Australian Health Budget – putting in place new charges for GP visits and pathology and diagnostic imaging tests, ripping an initial A$2 billion, and then a further A$18 billion, from the public hospital system, and walking away from commitments on preventive and Indigenous health.

Although there was the promise in Australia of the savings being redirected into the Medical Research Future Fund – and a long-term commitment to properly funded research should be applauded – funding future cures and treatments is the responsibility of the entire nation, not just those who need to see their doctor today.

It is not in question that we need to improve many aspects of the Australian health system. The steady rise in healthcare expenditure is an issue that needs addressing and we have all seen instances where patient care isn’t what we want it to be. The fragmentation of services, in particular, causes expensive duplication and wastage, means patients don’t always receive optimal follow-up or recuperative care, and promotes poorer outcomes for those burdened with chronic diseases.

However, this Budget isn’t addressing those needs. Indeed, it seems to be heading in the opposite direction; stepping back and saying that hospital care is solely the responsibility of the States and Territories.

What is needed is greater collaboration not less. We need to be moving to a more connected and efficient system of care that drives the very best patient outcomes. Erecting cost barriers will impact people’s ability to seek care at an early stage, particularly those most vulnerable, including Aboriginal and Torres Strait Islander people, the aged and unemployed. It will be harder for families to make sure their children are immunised and have the early childhood health checks that they need.

The two health systems vary greatly in size and funding models so comparisons need to be considered in the broader context, but from an equity perspective they seem to be heading in opposite directions, with more to be commended in the New Zealand Budget and much to be questioned in the Australian Budget. The New Zealand Health Budget includes an additional NZ$1.8 billion over four years, to improve ‘front line’ health services by funding more elective surgery and reducing waiting times. It also includes measures to improve the oral health of children and adolescents, support aged care (including for people with dementia), improve cancer screening and treatment and launch a preventive Healthy Families NZ health campaign to encourage New Zealanders to eat healthier and exercise more.

In contrast, the Australian health budget cuts more than A$2 billion from public hospital funding over the forward estimates period (to 2018) – cancelling the public hospital funding guarantees and abandoning the National Partnership Agreement on Improving Public Hospital Services. The move to abandon activity-based funding from 2017 means a return to the old funding model based on inflation and population growth alone.

This model has no mechanism to account for demographic changes and increasing chronic disease. The implications of these changes for patient care and the delivery of teaching and training are significant and present challenges for the College and its members.

Despite the assurance of continued commitment to closing the health gap, over the next five years more than A$500 million will be cut from Indigenous programs, including over A$160 million from health.

Although detailed information remains scant,
there is concern that many of the cuts will affect support services such as early childhood development centres and a range of preventive health services. Also noticeable in its absence is the lack of long-term investment in the community-controlled health sector. We know that community involvement in developing and delivering health services significantly improves their effectiveness, and delivers broader economic and social benefits. We need a commitment to invest and grow the capacity of this sector if we are to make real advances in closing the gap for Australia’s first peoples.

The Australian Government is also pushing the retirement age up to 70 years. For Australians to work right up until their 70th birthday they will need to have a health system that is designed to keep them healthy; one where preventive health is a priority. Yet, with the exception of some measures such as the commitment to national bowel cancer screening, prevention has been downgraded in this Australian Budget. The A$367.9 million National Partnership Agreement on Preventive Health has been terminated and the Australian National Preventive Health Agency closed and its work transferred to the Australian Government Department of Health.

Other agencies, including Health Workforce Australia (HWA), are also being closed and their functions taken back into the Department of Health. Since it was established, HWA has made significant progress in improving the quality of health workforce data and evaluating workforce models and programs, which is fundamental to making the right policy and planning decisions. A national coordinated approach must be central to this. We urge the government to make sure that transparent mechanisms are in place that will ensure that this cross-jurisdictional perspective remains central. National leadership is crucial to ensuring that Australia has the health workforce it requires to meet future needs.

This Australian Budget was a Budget of lost opportunity. Taxing alcoholic drinks according to their alcohol content is one simple measure that would be a win–win for preventive health and for fiscal sustainability. However, this wasn’t considered. A recent Australian study found that just by taxing wine based on alcohol content rather than wholesale price, the government could raise an additional A$1.3 billion a year in revenue while saving A$820 million in lifetime healthcare costs for the Australian population.

The Australian Budget has accelerated the need for the medical profession to strategically lead the policy work required to deliver sustainable and equitable healthcare. Both nations need a vision for how primary, community and acute care can work together to keep people healthy and engaged in the workforce for a much longer period of their lives. The College is committed to working in the policy and advocacy space to provide this leadership.

Professor Nicholas Talley
RACP President

### BOTH NATIONS NEED A VISION FOR HOW PRIMARY, COMMUNITY AND ACUTE CARE CAN WORK TOGETHER TO KEEP PEOPLE HEALTHY AND ENGAGED IN THE WORKFORCE FOR A MUCH LONGER PERIOD OF THEIR LIVES.

### BUDGET RESPONSE

**STP FUNDING FOR 900 PLACES RETAINED IN THE 2014 FEDERAL BUDGET**

The College was pleased to note that funding for the existing 900 Specialist Training Program (STP) places had been retained in the 2014–2015 Federal Budget, with continued funding for positions allocated across the forward estimates to 2017.

The College administers the funding for 356 STP places, providing opportunities for over 500 RACP trainees in settings outside of the tertiary hospital system. The College views the STP program as crucial to ensuring the Australian health system is able to accommodate and adequately train the growing numbers of specialist trainees, and supports the move to increasing training opportunities outside the public hospital environment.

Moving forward, the College will be exploring ways to ensure the continuation of the STP program.
The RACP Strategic Directions for 2012–2015 propose six goals for our College including shaping the health policy and medical workforce agendas and continuing to be a robust and effective College. The enormous voluntary contributions of members will help these goals to be realised.

The entire College benefits from the expertise of office bearers who pursue outcomes in the interest of Fellows and trainees. Office bearers come from all specialties and Divisions, Faculties and Chapters and share a motivation for wanting to give something back to the profession and the College by contributing their diverse experience. Serving and past-serving Fellows have found volunteering highly rewarding and have gained from the opportunities to network and further develop their skills.

Committee membership and College leadership positions also provide an opportunity to gain skills and expertise in areas outside of clinical work and research: for example, in developing and implementing organisational strategic and operational plans; gaining a greater understanding of budgeting and financial management processes; policy development; and improving communication and negotiation skills.

RACP News spoke to three Fellows to find out what they gained from serving on College committees and the Board.

**Dr Stephen Inns FRACP**

Gastroenterologist and General Physician. Co-chair, interim NZ Trainees’ Committee; NZ Honorary Treasurer; Member NZ Committee; Member College Finance Committee; Member NZ Clinical Exams Committee; Member NZ Grants Committee; Member College Foundation Steering Group

RACP News: What interested you in becoming a Committee/Board member?

**Dr Inns**: When I passed the clinical exam, I looked around me to see what those physicians whom I respected and who seemed to be doing well in their careers were doing, and found that many were active in the College. One was then the NZ President. My interactions with the NZ office of the College as a basic trainee had always been very cordial and productive and I was encouraged to join the soon to be formed NZ Trainees’ Committee. It was a great privilege to be received and inducted into the workings of the College by senior Fellows and staff members, and I greatly enjoyed the interaction with my peers on that committee. We were listened to and did achieve a number of our objectives. It was always in my mind to re-join a College committee once I returned from completing my research degree overseas, and that’s what I did.

RACP News: What have been the most challenging and rewarding aspects of being a committee/Board member?

**Dr Inns**: Being a junior member of a committee composed of distinguished and experienced physicians can be daunting, especially when you find you are the Chair! But I have always been supported in my roles; there is always a kind and encouraging word to be had from the most senior of people. It is this collegiality, and the chance to meet fantastic people who you would otherwise never interact with, that makes the College such a great organisation to be a part of.

RACP News: What is the one thing you would like to see the College do that we are not doing today?

**Dr Inns**: We have to involve our Fellows more, make the College a living entity that everyone feels a part of. That means getting people involved young, as trainees and young Fellows. Sometimes I hear
my colleagues talk about the College as though it were a corporate entity that decided our fates from above. I really don’t see it that way. For me, the College is made up of people: Fellows, staff and many others, who give generously of their time so that our profession might be well maintained, progress and be well represented. I am amazed by the number of brilliant lay people whom we have sitting on College committees. That they would give so freely of their valuable time in pursuit of a better College is proof that the College continues to have something to offer our communities.

RACP News: In your opinion, what is the most meaningful skill you have picked up or gratifying part of being involved in the College?

Dr Inns: The ability to interact, listen and guide in a committee environment. To see that by careful discussion, thought and consensus, much can be achieved.

RACP News: Do you have any words of encouragement to those members who would like to become College office bearers?

Dr Inns: Just do it! Look for a position that will be achievable in the time you have to give. There are many roles in the College; most are not a massive commitment but all give great personal returns. Senior College committee members and College staff will be able to guide you as to what sort of commitment each position might entail. The only risk is that once you start you might enjoy it so much you want to do more and more.

Associate Professor Susan Moloney FRACP

Director of Paediatrics, Gold Coast University Hospital. President-Elect, Paediatrics & Child Health Division (2012–2014); Member RACP Board (2012–2014); Chair RACP Risk Management Committee; Member Fellowship Committee

RACP News: What interested you in becoming a Committee/Board member?

Associate Professor Moloney: I became a Board member as I was the President-Elect of the Paediatrics & Child Health Division (PCHD) four years ago. I had been an elected member of the PCHD Council in 1999–2000 and was a Divisional representative on the Board from May 2010 to May 2014.

RACP News: What have been the most challenging and rewarding aspects of being a committee/Board member?

Associate Professor Moloney: The College has many challenges ahead. We do need governance reform to allow more autonomy for the Divisions and Faculties. While on the Board, it was my honour to chair the College Education Committee (CEC) and lead the Educational Governance Review. This was a great way to gain an understanding of the College committees and to allow better delineation of decision-making processes. There was no doubt change was required to allow better and fairer decision making and to engage Fellows on time-limited working groups rather than the evolution of more committees and groups with no clear roles or delegation. It was brave of the Board to enact such change and I have no doubt we have a stronger and more robust College as a result.

RACP News: What is the one thing you would like to see the College do that we are not doing today?

Associate Professor Moloney: As a paediatrician, advocacy is a cornerstone of our practice. This term has many meanings to different people and is a constant source of unease between groups in the College. More autonomy to the Divisions and Faculties would allow some of these tensions within groups about our public messages to be less problematic.

RACP News: In your opinion, what is the most meaningful skill you have picked up or gratifying part of being involved in the College?

Associate Professor Moloney: The College makes a significant investment in Board Directors. This is required to enable effective stewardship of the Board and the College as a whole. I have been lucky to have had training in Board governance, financial reporting and media and communications and have learnt a number of leadership skills from those around me, both those on the Board and those working within the College.

RACP News: Do you have any words of encouragement to those members who would like to become College office bearers?

Associate Professor Moloney: Becoming involved in the College is very rewarding. You meet an inspirational and amazing group of Fellows and trainees across the breadth and depth of the College. If you are serious about change within the organisation, then being part of the process is the most effective means of achieving this.
Clinical Associate Professor Michael Hooper FRACP


RACP News: What interested you in becoming a Committee/Board member?

Clinical Associate Professor Hooper: I consider that the relationship between the College and the Specialty Societies is crucial for the future of the College. For the past 30 years, I have been involved in the development of the field of bone and mineral metabolism in Australia and New Zealand and was elected Honorary Secretary of the Australian and New Zealand Bone & Mineral Society on its foundation in 1988, a position I held until 1993. I was a past President of the Australian and New Zealand Bone & Mineral Society and was elected as an Honorary Life Fellow in 2014, the Society’s highest honour.

I was active in the College for several years as the Australian and New Zealand Bone & Mineral Society’s representative on the RACP Adult Medicine Council and previously on the Specialties Board, as chair of the Adult Medicine Programme Organising Committee for the RACP ASM, as well as other committees including the Adolescent Medicine Committee and the NSW State Committee.

RACP News: What have been the most challenging and rewarding aspects of being a committee/Board member?

Clinical Associate Professor Hooper: Balancing good financial governance with the desires and requests of staff and Fellows.

RACP News: What is the one thing you would like to see the College do that we are not doing today?

Clinical Associate Professor Hooper: Continue to improve the engagement with the Specialty Societies and Fellows.

RACP News: In your opinion, what is the most meaningful skill you have picked up or gratifying part of being involved in the College?

Clinical Associate Professor Hooper: Financial governance.

RACP News: Do you have any words of encouragement to those members who would like to become College office bearers?

Clinical Associate Professor Hooper: If you feel that changes need to be made in how your College functions, you need to be involved and take ‘ownership’ of the decisions that are being made.

The Pricing Working Group, established by the RACP Finance Committee, has reviewed the processes for managing late continuing professional development (CPD) submissions and submissions by alternative means, and has agreed to set new fees for these services, as below.

Late submissions
The College provides three months after the end of the CPD year for participants to complete their CPD submission, then closes the program so that certificates of completion can be issued. From 31 March 2015, a fee of $100 (plus applicable GST) will apply to the processing of submissions received after the program closing date. The fee will cover the cost of processing late submissions so that it is not borne by members in general.

Alternative (paper-based) CPD submissions
The College recommends MyCPD online to all members as the best way to track CPD participation. Alternative methods of submitting CPD were previously only available in exceptional circumstances on application to the College. In 2014, alternative paper-based submissions will be processed by College staff on your behalf for a fee of $200 (plus applicable GST). Providing this service will simplify CPD participation for some members. The fee will cover the cost of this service so that it is not borne by members in general. Please note that the CPD program requirements (categories and credits) are the same for members submitting by paper as for those submitting online.

Please contact the CPD Unit if you have any questions or require assistance with any aspect of CPD (MyCPD@racp.edu.au or +61 2 8247 6201).

John O'Donnell
Honorary Treasurer
While continuing professional development (CPD) comes naturally to most physicians, documenting it does not. You stay up to date with journals, but don’t formally summarise your reading. You spend hours preparing an abstract for submission, but never note the time in your diary. As hard as it may be to prioritise, documenting CPD serves an important purpose.

Physicians’ professional ‘contract’ with the community demands not only competence in current professional requirements but demonstration of that competence. This is why the Australian Medical Council insists that educational providers (such as the College) audit CPD activity, and why the Australian Health Practitioner Regulation Agency (AHPRA) is now following suit. Ensuring you have good source documents for your CPD makes it easy to comply with standards and provides you with ready evidence if audited. So why do so many Fellows continue to struggle with the task?

Feedback from physicians indicates that there is a strong commitment to CPD, but a lack of planning and supportive infrastructure makes it difficult to maintain consistent records. In response, the College is planning a major upgrade to its online administration system, and in the interim has introduced a number of smaller changes, such as quick links, to simplify the process. Many Fellows, however, may still be accustomed to documenting only the ‘easy targets’: publications, presentations and conferences. These activities produce a paper trail that can be quickly filed and uploaded, but rarely represent the full scope of ongoing learning. By using some of the strategies below, you can make it easier to document your CPD which – like most things in life – doesn’t come with a certificate of completion.

**Take notes**

One of the easiest ways to create source material is to take notes. Notes can document CPD activities that would otherwise be invisible, such as teaching on the wards. The most straightforward method is to dedicate a notebook to CPD that you take to conferences, journal clubs, meetings, rounds, and other activities. Note taking doesn’t need to be extensive, but it will be most helpful if you focus on what you have learned and how to apply those insights in your practice.

You can also employ a note-taking app, such as Evernote, on your mobile phone or tablet (see ‘How apps can be used for effective information management’, *RACP News*, October 2013), or use your entries in MyCPD as a de facto catch-all. Regardless of your approach, once you have a note-taking system in place it can become your CPD repository.

**Keep a journal diary**

Journal reading is a regular part of physician life, but proof of subscription does little to demonstrate engagement or learning for CPD. Some Fellows find it helpful to keep a journal diary to reflect on their reading, and often do so as part of a larger note-taking strategy (see above). Pen and paper obviously work well here, in addition to electronic bibliographies such as EndNote or Zotero.
Downloading a paper into EndNote, however, doesn’t demonstrate that you have learned anything. Instead, you can annotate papers you have read (electronically or otherwise) as evidence of your involvement with the material as well as a way of consolidating your understanding.

Use social media
Most conferences now create a specific Twitter hashtag for the event (see #RACPcongress, for example). Tech-savvy Fellows can use the hashtag to tweet their comments on sessions and panels during the day. This has the advantage of potentially initiating discussion with other Fellows on Twitter – and it is always exciting if you are re-tweeted! Tweeting doesn’t have to be for public consumption, though. You can use tweets to yourself as a way of keeping contemporaneous notes.

Update your calendar
The simple habit of annotating your calendar (whether on Outlook, Google Calendars, or your pocket diary) can provide you with a daily record of CPD activities and the time you allocated to them. Blocking out time for CPD, particularly activities outside your routine or comfort zone, also makes you more likely to complete it. Many calendar programs allow you to assign categories to activities – so create a tag for CPD and at year’s end you can view and print everything you’ve classified in a complete list.

Time activities
For CPD that defies any of the documentation strategies above, consider just keeping track of your hours. Beyond a stopwatch, there is a range of apps and time-management programs available. Toggl, for example, is a free cross-platform timer that lets you enter with a few clicks what you are doing, when you start, and when you stop. It then generates automatic reports. You can use it to track and report on CPD activities (or time spent on Sudoku).

Upload files to MyCPD
MyCPD has the capacity for you to upload documents, providing the College with source materials in case of an audit. If you are saving a lecture or a paper, consider uploading it at the time into MyCPD to save having to document it later.

There is a risk that the burden of documenting CPD takes away from its purpose of improving practice. But simple strategies exist to minimise the amount of time spent on documentation, provide strong sources if you are ever audited, and allow you to get back to learning and getting on with life.

Dr Matthew Links FRACP
Chair, CPD Committee
Anne Fredrickson
Project Officer, CPD Unit, Office of the Dean

Reference
The Royal Australasian College of Physicians Congress 2014 – Future Directions in Health, held in Auckland from 18 to 21 May, was a great success, attracting nearly 900 delegates.

The College Graduation Ceremony and Congress Welcome Reception were fitting events to officially launch the RACP Congress 2014. Over 200 trainees graduated at the ceremony to become new Fellows of the College, with nearly 800 people attending the Ceremony. The Ceremony also marked the ceremonial handover of the College Presidency from Associate Professor Leslie Bolitho AM to Professor Nicholas Talley.

The outgoing President, Associate Professor Bolitho, gave a poignant speech in which he asked delegates to reflect on the qualities that are asked of physicians in their professional commitment and practice, and screened a video titled ‘Empathy: the human connect to patient care’ developed by the physicians at the Cleveland Clinic, a multispecialty academic medical centre located in Cleveland, Ohio. The Cleveland Clinic is currently regarded as one of the top four hospitals in the United States.

This year, the College was honoured to have Professor Sir Peter Gluckman present the Arthur E Mills Oration on the topic of ‘Science and public policy – reconciling two cultures’. Sir Peter Gluckman was the founding Director of the Liggins Institute and is one of New Zealand’s best known scientists. In July 2009, he was appointed as the first Chief Science Advisor to the Prime Minister of New Zealand. In this role, he is internationally respected for his work promoting the use of evidence in policy formation and the translation of scientific knowledge into better social, economic and environmental outcomes. Sir Peter Gluckman’s oration focused on the relationship between science and policy in addressing many major issues confronting governments and the associated link with physicians in the professional elements of knowledge and expertise, values and beliefs, and understandings of risk and trust.

During the Congress Ceremony the College conferred Honorary Fellowship on two persons of international eminence who have made major contributions to the College, Mr Geoffrey Laurence and Professor Ron Paterson.

The Plenary Session on Monday was well attended, with Dame Silvia Cartwright providing the Opening Address and officially opening the Congress (see Dame Silvia’s abridged address on pages 29–32). Associate Professor Richard King, Head of Medicine at Monash Health in Melbourne, delivered the Priscilla Kincaid-Smith Oration on ‘Evidence-based introduction of health technology and disinvestment – two sides of the same coin’.

Delegates who attended the opening plenary on Tuesday, 20 May heard from Professor Jane Harding, Deputy Vice-Chancellor (Research) of the University of Auckland and a researcher in the Foetal and Neonatal Physiology research group of the Liggins Institute, who delivered the Howard Williams Oration on the topic of ‘The life-long legacies of perinatal management’, followed by Dr Richard Heron, Vice-President Health and Chief Medical Officer at BP, delivering the Ferguson-Glass Oration on ‘Standing on the shoulders of giants – can we see further?’. The College was honoured to have Professor William Ivan Glass in attendance at the Plenary.

Dr Rhys Jones, a public health physician and Senior Lecturer at Te Kupenga Hauora Māori at the University of Auckland, delivered the Redfern Oration on 21 May on ‘Decolonising medical education and practice to advance indigenous health’ (see Dr Jones’ abridged oration on pages 20 and 21). The final oration for Congress 2014 was the Cottrell Memorial Lecture delivered by Dr James Ross, Professor William Ivan Glass and Dr Richard Heron.
by Professor Rod Jackson, a professor of epidemiology at the University of Auckland who has over 30 years of research experience in cardiovascular disease epidemiology. Professor Jackson’s oration was titled ‘The death of diagnosis?’.

Aside from the Plenaries, the informative and thought-provoking program included eight parallel streams including Physicians as Medical Experts, as Advocates, as Educators, as Professionals, as Physicians in the Workplace. Revalidation attracted significant interest at Congress with a half-day session including panel discussions covering the what, why and how of revalidation and recertification, which already stands in place in New Zealand and may potentially in the future impact on our Australian membership.

Australian Medical Council representatives held five open sessions at this year’s Congress engaging directly with College trainees, supervisors, Directors of Physician Education and College committee members in asking them to have their say and share their views on the College. They sought feedback on several topics ranging from the strengths and weaknesses of the College’s education and training activities and Continuing Professional Development program, how well College policies work in practice, and challenges facing the physician profession and practice. (Turn to page 41 for further information on College reaccreditation.)

The social program was a hit again this year with the Welcome Reception held on the Monday night. It provided the perfect opportunity for delegates to renew old friendships and make new acquaintances. The Faculty and Division dinners were held at some of Auckland’s best restaurants giving delegates a chance to sample Auckland’s fine cuisine. The 75th Anniversary Gala Dinner took place on the Tuesday night. The Gala Dinner was the highlight of the social calendar, held at one of Auckland’s most prestigious hotels, The Langham. The evening included the presentation of awards and prizes received during Congress and was the perfect occasion for guests to relax and celebrate their successes together.

RACP Congress 2015 – Future Directions in Health will be held in sunny Cairns, Queensland, from 24 to 27 May 2015. We look forward to seeing you there.
Indigenous health in Australia and New Zealand is characterised by inequities in health outcomes, in the determinants of health, in access to and quality of healthcare, and in representation in the health workforce. These inequities are unacceptable and represent a breach of the right to health for Indigenous peoples.

Health inequalities between Indigenous and non-Indigenous populations are not natural or inevitable; they are created and maintained by our societies' structures, systems and institutions. As people who operate within these systems and institutions, it's important that we ask the difficult questions – about the roles we play in perpetuating health disparities, but also about the roles we can play in reducing and eliminating them. Examining these questions highlights the need to decolonise medical education and practice, which in turn requires us to decolonise ourselves.

Healthcare disparities

It is evident from a wealth of international literature that racial and ethnic disparities in healthcare are widespread. In New Zealand, for example, Māori patients tend to receive poorer care than non-Māori patients – shorter consultations, fewer referrals for investigation and management, and less effective treatment. This is despite generally having much greater need for healthcare, due to a substantially higher burden of disease, and facing greater barriers to achieving optimal healthcare outcomes.

Research shows that racial and ethnic inequalities in healthcare can be attributed to characteristics of the health system, patient or population differences, and health professional factors. In other words, while other factors also play a role, health professionals contribute to unequal outcomes for Indigenous patients. When confronted with evidence of our contribution to disparities, the response is often denial: ‘But I treat all my patients the same.’ While we may be quite happy to admit that there is a problem, we’re generally much less willing to admit that we might be part of the problem.

So how do we account for this gap between perception and reality? What explains the discrepancy between our intent (to treat all patients as well as we can) and the outcome (some patients receiving better care than others)?

Implicit and explicit bias

The key to explaining the divergence between intent and outcome is recognising the role of unconscious processes and how they can influence our practice. It has been shown that unconscious biases and stereotypes can affect our thoughts and actions irrespective of how egalitarian our conscious attitudes are. A theoretical model developed by US researchers shows how clinician factors, patient factors and characteristics of the setting and wider society interact to ultimately produce different quality care based on the patient’s ‘race’ or ethnic group.

None of us are immune to implicit biases – our perceptions and judgements of others are shaped by social values, beliefs and discourses from a very young age. In settler societies like Australia and New Zealand, representations of Indigenous peoples can be traced back to colonial ideologies about Western superiority and Indigenous inferiority. We internalise these associations, which are then reinforced through medical education and training.

So, going back to the comment, ‘I treat all my patients the same’, based on the preceding discussion our default assumption should be that we will treat patients inequitably. That is, unless we do something fundamentally different.
What does this mean for us as healthcare practitioners?
The fact that biases and stereotypes are the result of social conditioning (that affects everyone) does not absolve us of the responsibility to do something about them. There are tools that can help us to identify areas where we may have ‘blind spots’ – in other words, where implicit bias may betray our overt attitudes and beliefs – such as the Implicit Association Test (IAT). Being aware of our own biases is important because it allows us to do something about them. In the short term, we can correct for or consciously override potential biases. In the longer term, there are strategies that can help us ‘rewire’ cognitive connections that result in the expression of bias.

In order to address biases, experts suggest that we should be engaging in lifelong, transformative ‘unlearning’ processes. A really important message is that we can’t do this alone – if we only reflect in the solitude of our own thoughts, we will only ever come up with analyses and solutions from our own (biased) frame of reference. This highlights the need for social reflective processes.

What does this mean for medical education and training?
Medical curricula need to be redirected away from cultural ‘awareness’ or ‘sensitivity’ towards much more transformative educational processes. The objective of the exercise is not to learn about Indigenous culture(s); it is to learn about ourselves and our positioning with respect to Indigenous peoples. We should be aiming for what Kumagai and Lyson describe as ‘critical consciousness’: ‘the continuous critical refinement and fostering of a type of thinking and knowing – a critical consciousness – of self, others, and the world.’

What does this mean for medical colleges?
In the pursuit of ‘critical consciousness’, medical colleges need to provide opportunities for trainees and Fellows to engage in transformative processes that can address the effects of implicit and explicit biases. Further, these activities must be established as part of the formal curriculum during training and continuing professional development. They are critical for the development of core competencies and therefore cannot be left to individuals to engage in based on personal motivation. The implication is that such activities need to be explicitly incorporated into teaching, learning and assessment processes throughout the educational continuum.

But modifying the curriculum is only one part of the answer; in order to truly become part of the solution, systemic change is required. Medical colleges themselves need to engage in decolonisation – identifying colonial baggage and engaging in reform to address factors that perpetuate disparities. This requires systematic monitoring and assessment of equity, formally identifying and addressing structures and processes that limit Indigenous health development, introducing proactive policies to improve Indigenous participation and success, and training and performance monitoring for staff, supervisors and assessors. Importantly, none of this will succeed if Indigenous stakeholders are marginalised in the process; effective governance arrangements are needed to give expression to Indigenous aspirations and solutions.

Summary
As health professionals, whether or not we like to admit it, we contribute to healthcare inequities between Indigenous and non-Indigenous populations in Australia and New Zealand. This happens in part due to the way social environments shape our psychological makeup, manifesting as implicit and explicit biases. To achieve equity, we need to decolonise ourselves – by engaging in lifelong, social, transformative ‘unlearning’ processes. We also need to decolonise healthcare organisations and medical education institutions including medical colleges. A fundamental ingredient for success is Indigenous partnership at all levels – not simply involvement or consultation, but genuine structural reform to ensure that Indigenous voices drive solutions.

Albert Einstein noted that ‘no problem can be solved from the same level of consciousness that created it’. If we are to make real differences to Indigenous health outcomes, we are not going to do it with the same thinking and structures that got us to this point. This requires a warts-and-all decolonisation process – not only for us as individuals but also for our educational institutions and healthcare organisations.

Dr Rhys Jones (Ngāti Kahungunu)
FNZCPHM

Reference
MEDALS AND PRIZES AWARDED

Warm congratulations to all of this year’s recipients of Royal Australasian College of Physicians medals, prizes and awards.

College Ceremony 2014 – Medal, Prize and Award Winners*

John Sands College Medal 2014
This medal is awarded for outstanding service to Fellows of the College, its Divisions, Faculties and Chapters who, in the opinion of the College Board, have significantly contributed to the welfare of the College but who have not attained the office of President of the College.

Awarded to: Dr Stephen Buckley for his longstanding service and commitment to the College and the Australasian Faculty of Rehabilitation Medicine (AFRM), through committee roles, as AFRM President and RACP Board Director (2008–2010) and for his contributions to a wide range of education, training and health policy matters.

Awarded to: Dr David Burke. Dr Burke has specialised in Rehabilitation Medicine for over 40 years, predominantly in the fields of spinal cord rehabilitation and brain injury rehabilitation. Throughout this time he has also taken a prominent role in the development of AFRM and the teaching and mentoring of trainees.

Awarded to: Dr Ki Douglas for her major contribution to the development and refinement of the Faculty of Occupational and Environmental Medicine (AFOEM) training and certification programs. Dr Douglas is widely respected by her peers for her practical advice and encyclopaedic knowledge of Occupational and Environmental Medicine issues.

Awarded to: Dr Paul Frankish for his ongoing involvement in the College’s medical examination, physician training and overseas trained physicians committees (New Zealand), and his continued commitment to the training and supervision of trainees.

Awarded to: Professor George Rubin. Professor Rubin served on the Faculty of Public Health Medicine Council for six years, as President of the Faculty of Public Health Medicine from 2007 to 2010 and as an RACP Board Director. Professor Rubin has continued to serve as an active member of the Faculty Policy and Advocacy Committee and College Expert Advisory Groups.

Awarded to: Dr Roger Tuck for his substantial contributions to College policy and advocacy matters across a broad range of paediatric and child health issues in New Zealand, and his ongoing service and commitment to Paediatric and Child Health physician education and training.

Awarded to: Dr Johan Morreau. Dr Morreau has contributed significantly to College policy submissions, held the position of New Zealand President and RACP Board member from 2010 to 2012 and has been a key member

* Listed in order of presentation

John Sands College Medal 2013
Awarded to: Dr Leo Buchanan. Dr Buchanan has been a driver in bringing both Māori health issues and Te Ao Māori perspectives into the College’s arena. He has represented the College at Parliamentary Select Committee hearings advocating on behalf of Māori children. Through his work on the Māori Health Committee he has mentored Māori physicians and doctors.

Medal for Clinical Service in Rural and Remote Areas 2014
This medal is in recognition of Fellows who have provided outstanding clinical service in rural and remote areas.

Awarded to: Adjunct Associate Professor Gabriel Shannon

Associate Professor Shannon has practised as a General and Renal Physician in Orange since 1980 and has worked tirelessly to improve the quality of healthcare services in rural New South Wales as well as ensuring medical students are trained to the highest standards. After being appointed Sub-Dean of the Orange Campus of the School of Rural Health, University of Sydney, Associate Professor Shannon has ensured that the Orange campus continues to shine as an excellent model of rural medical training.

Associate Professor Shannon has continually advocated for improved clinical care, safety and quality in health services. His dedication and drive to enhance rural clinical services has contributed to the excellent reputation of Orange Base Hospital in demonstrating strong local clinical leadership.
Eric Susman Prize 2013

This prize recognises the best contribution to the knowledge of any branch of internal medicine. The contribution must have appeared as a published work in the two-year period preceding the award.

Awarded to: Associate Professor Diane Fatkin

- Faculty member at the Victor Chang Cardiac Research Institute
- Honorary Medical Officer, Cardiology Department, St Vincent’s Hospital
- Professor Faculty of Medicine, University of New South Wales

Nominated for her contribution to research into understanding the genetic basis of two heart diseases, familial dilated cardiomyopathy and familial atrial fibrillation.

Honorary Fellowship of The Royal Australasian College of Physicians

Awarded to: Mr Geoffrey Laurence

Mr Geoffrey Laurence has tertiary qualifications in industrial engineering and commerce. He is a member of the New Zealand Institute of Accountants and leads his own financial investment company.

On the basis of his business acumen and his experience in the not-for-profit sector, in 2008 he was invited by the RACP Board to be the first ‘community’ Board Director. As a Director, he brought a depth of financial experience and knowledge to the Board to address the challenges confronting the College. His participation and contribution was integral to the financial restructuring within the College.

Mr Laurence was a joint founder of the College Finance Committee and remains a member. He retired from the College Board in 2013 having served five years as a Director. He continues to chair the fundraising arm of the RACP Foundation. The College is greatly indebted to him for his contribution to the College Board and his significant commitment to the College.

Awarded to: Professor Ron Paterson

Professor Ron Paterson is a New Zealand Parliamentary Ombudsman and Professor of Law at the University of Auckland. He was New Zealand Health and Disability Commissioner, from 2000 to 2010. With law degrees from Auckland and Oxford Universities, Professor Paterson has held Fulbright and Harkness Fellowships in biomedical ethics and health policy.

He was Chairman of the New Zealand Banking Ombudsman Scheme (2010–2013) and a Non-Fellow Board member of the RACP Board (2010–2013). Professor Paterson has chaired several major health quality reviews in New Zealand and Australia. He was made an Officer of the New Zealand Order of Merit (ONZM) for services to health in 2011.

Arthur E Mills Memorial Oration and Medal

The late Arthur Edward Mills of New South Wales was a Foundation Fellow of the College and an outstanding physician, medical administrator and teacher. The Arthur E Mills Oration was endowed in 1950 by his widow and established within the College for the promotion and encouragement of medical education and general culture. The Arthur E Mills Oration was delivered by Professor Sir Peter Gluckman.

Bryan Hudson Medal 2013

The Bryan Hudson Medal is named in honour of the late Dr Bryan Hudson AO FRACP, President of the College 1982–1984. Dr Hudson was an outstanding physician, teacher and administrator who had a major influence on training and assessment for Fellowship. The Bryan Hudson Medal is awarded for the best overall performance in the Adult Medicine Division Written and Clinical examination.

Awarded to: Dr George Heriot

Examination Medal in Paediatrics & Child Health 2013

The Examination Medal in Paediatrics & Child Health is awarded for the achievement of the best overall performance in the Written and Clinical examination.

Awarded to: Dr Christine Marie Mincham

Adrian Paul Prize 2013 (AFRM)

Established in 1986, the Adrian Paul Prize is awarded in memory of the late Dr Adrian Paul, Director of the Department of Rehabilitation Medicine of the Royal Prince Alfred Hospital for the best scientific paper or poster presented at the Australasian

Continued on page 26
Outgoing AFRM President, Associate Professor Chris Poulos congratulating Dr Siang Siang Naik on receiving the Basmajian Prize and Merit Certificate.

Left to right: Outgoing President Associate Professor Leslie E Bolitho AM, Dr Bradley Gardiner, Dr Elizabeth Liow, Dr Rita Upreti and outgoing Adult Medicine Division President, Associate Professor Alasdair MacDonald.

Outgoing President, Associate Professor Leslie E Bolitho AM presents Dr Roger Tuck with the John Sands Medal.

RACP Honorary Fellows, Mr Geoffrey Laurence and Mr Ron Paterson.

Outgoing AFRM President, Associate Professor Chris Poulos congratulating Dr Kimly Holton, recipient of the Adrian Paul Prize.

John Sands College Medallists
Back row (left to right): Dr Johan Morreau, Dr Leo Buchanan and Dr Stephen Buckley. Front row, left to right: Dr Paul Frankish, Professor George Rubin, Dr David Burke and Dr Ki Douglas (Dr Roger Tuck pictured at right).

RACP NEWS / JUNE 2014
Outgoing Adult Medicine Division President, Associate Professor Alasdair MacDonald and Dr George Heriot, recipient of the Brian Hudson medal

Outgoing President, Associate Professor Leslie E Bolitho AM presents Eric Susman Prize recipient Associate Professor Diane Fatkin with her medal

Outgoing AFOEM President, Associate Professor James Ross with Dr Andrew Lingwood who received the Deane Southgate Award

Outgoing Paediatrics & Child Health Division President, Associate Professor Susan Moloney with Dr Christine Marie Mincham, winner of the Examination Medal in Paediatrics & Child Health 2013

Outgoing President, Associate Professor Leslie E Bolitho AM with RACP Mentor of the Year, Dr Peter Roper

Outgoing President Associate Professor Leslie E Bolitho AM and Ms Cara Lucas, winner of the RACP President’s Indigenous Congress Prize
Faculty of Rehabilitation Medicine Annual Scientific Meeting or for the best scientific paper published in a refereed medical journal.

Awarded to: **Dr Kirrily Holton**

**Basmajian Prize and Merit Certificate 2013 (AFRM)**

The Basmajian Prize has been named in honour of Professor John Basmajian, an Honorary Fellow of AFRM who donated an annual book prize for over 10 years. AFRM annually awards a Merit Certificate and the Basmajian Prize for the most outstanding candidate in the Fellowship Clinical Examination.

Awarded to: **Dr Siang Siang Naik**

**Deane Southgate Award 2013 (AFOEM)**

The Deane Southgate Medal is awarded to the graduating Fellow with the highest aggregate mark for The Australasian Faculty of Occupational and Environmental Medicine Stage B Written and Practical Exams.

Awarded to: **Dr Andrew Lingwood**

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**RACP CONGRESS 2014 – AWARD AND PRIZE WINNERS**

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<td>RACP Mentor of the Year</td>
<td>Dr Peter Roper</td>
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<td>RACP President’s Indigenous Congress Prize</td>
<td>Ms Cara Lucas</td>
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<td>RACP Trainee Research Award for Excellence in the field of Adult Medicine</td>
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<td>Dr Elizabeth Liow</td>
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<td>Best of Grand Rounds – Wiley Publishing Award for Clinical Excellence</td>
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<td>Rue Wright Memorial Award</td>
<td>Dr Caroline McMahon</td>
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**PHOTOGRAPHY SERVICE FOR THE COLLEGE CEREMONY 2014**

All images taken at the College Ceremony are now available.


Choose the relevant year under the gallery heading, select the RACP icon.

Choose the relevant folders for the College Ceremony and portrait studio images as indicated on the card you would have been given by your photographer.

You can purchase images as prints and/or digital downloadable files.

**Enquiries/Orders**

Larry Pitt Photography Australasia

Website: www.ourphotographer.com.au

Email: ourphotographer@mac.com
Dr Jones was followed by Dr Anne O’Donnell, who gave an excellent talk on breaking bad news, including tips that all of the attendees found very useful.

The day continued with a series of workshops, with three sessions running concurrently: attendees had to choose three out of the nine workshops. While some found this difficult, some sessions were relevant only to certain trainees, for example, ‘Approaching the Exams’ was for Basic Trainees and ‘Becoming a Consultant’ was for trainees at the end of their training.

Our final presenters were the Children’s Commissioner, Dr Russell Wills and Dr Lucille Wilkinson on another of her ‘Dealing with … scenarios’, this time focusing on dealing with patients and when it all goes wrong. The day came to a close with an address by the delightful, Dr Tony Fernando, who talked about mindfulness and compassion training.

Our workshop presenters included incoming NZ President-Elect Dr Jonathan Christiansen, who talked about mentoring and difficulties in training; Dr Amin Sheikh and Dr Cheryl Johnson who spoke on ‘Planning your training pathway’ from both a paediatric and adult medicine perspective; Dr Harry McNaughton, whose address was ‘Volunteering – experiences in India’; Dr Marie-Louise Stokes on ‘Effective feedback’ – how a trainee can make the most of feedback they receive; Dr Nicola Smith and Dr Richard Smiley who spoke on ‘Becoming a consultant’; Dr Anne Roche and Dr Jenny Butler on ‘Balancing training/part-time training’; Dr Zoe Raos and Dr Cheryl Johnson who gave tips on ‘Approaching the exams’; Dr Rob Bevan and Dr Karen Tsui on ‘Fellowships – the USA and Australia’; and Dr Richard Smiley who spoke on ‘Rural training’.

We concluded our day with a fabulous dinner at Cibo, where we were well looked after by the owner, Jeremy, and his staff. Many of the presenters also attended, along with outgoing NZ President, Dr John O’Donnell.

We were delighted to announce the recipient of the RACP Trainee of the Year award – Dr Jim Newcombe.
Award, Dr Jim Newcombe, Deputy Chair of the College Trainees’ Committee. We would like to thank incoming NZ President Associate Professor Mark Lane for presenting the award to Dr Newcombe.

We would also like to sincerely thank all the presenters who gave their time freely, on a Sunday, some travelling from as far away as Christchurch for the day. Without them, this day would simply not have happened.

Carolyn Lill
Senior Education Officer, New Zealand
**ETHICAL PROFESSIONAL PRACTICE – AND ITS MANY DILEMMAS**

The Honourable Dame Silvia Cartwright delivered the opening address at the RACP Congress 2014 Future Directions in Health. Dame Silvia shared her insights as a trial judge on the United Nations Tribunal investigating war crimes in Cambodia. She also spoke about the many ethical issues around trials of mass crimes, including medico-legal dilemmas arising from the age and rapidly deteriorating mental and physical health of the very elderly accused. This is an abridged version of her address.

Some of you will know my name from over a quarter of a century ago when I conducted an Inquiry into medico-legal issues centred on New Zealand’s foremost obstetrical and gynaecological institution, National Women’s Hospital. Much to everyone’s surprise, the report that I wrote so laboriously all those years ago, before we had easy software and electronic search systems, became influential in changing clinical and ethical practices here and in other parts of the world. No one could have been more surprised than me. My earlier experiences of providing advice to government had been more typical: a polite meeting with the relevant Minister, and the subsequent ‘filing’ of the report in the rubbish bin.

Of course, as I had no medical training, I was carefully scrutinised by the medical profession (and others), and many have tried to find some personal or political agenda, given that my findings were a little embarrassing to many and disastrous for a few, as well as for the patients they had encountered during their many years of research. Such scrutiny is to be expected when a report has any impact on the community, but it misunderstands the role of a judge which is to examine facts, make impartial findings and reach a balanced conclusion. There is no agenda, and usually a judge quickly forgets the case he or she worked on. Sadly, I have been unable to do this, as year in and year out my findings are referred to or critiqued, at least in New Zealand.

Since then, I have not often been called on to decide medical/scientific or ethical issues, but my notoriety endures and occasionally, as today, I am invited to speak to medical audiences as well as to those concerned with the ethical dimensions of the practice of medicine and the law. My recent experience as a trial judge in the Extraordinary Chambers in the Courts of Cambodia (ECCC), colloquially known as the Khmer Rouge Tribunal, has involved many ethical issues around trials of mass crimes, as well as some interesting medico-legal dilemmas arising from the age and rapidly deteriorating mental and physical health of the very elderly accused. I cannot indicate my views of the evidence or the accused, as the verdict in the current trial is still to be delivered. However, I want to give you a flavour of the sorts of matters a judge faces as part of their day-to-day work, albeit in the difficult area of international trials of mass crimes.

Without discussing the problems that face the court daily, I can only say that the word ‘Extraordinary’ has never been more aptly applied to a court. The Court has two parallel administrative processes, operates in the European civil law system and has a trial bench comprising three Cambodian, one French and one New Zealand judge representing both civil and common law traditions, with two reserve judges who participate throughout the trial in case one of us drops dead. We operate in three languages so there is translation of all documentation (which runs to millions of pages) into Khmer, English and French and in-court interpretation. The court has also introduced a comprehensive system of participation by victims.

But now let’s turn to the events which led to charges against, so far, five accused, of Crimes Against Humanity, genocide and war crimes.

**Political background to the trials**

The factual background is predictably tragic. Many of you will recall something of the period in the 1970s when Cambodia was ruled by the ruthless Khmer Rouge, a Manist group led by a man called Pol Pot. It is estimated that at least 17 million people from a population of more than 7 million died through execution, starvation, disease, or overwork in the 3 years, 8 months and 20 days of the regime. Khmer Rouge ideology required that the country become self-sufficient. Allegedly, there was to be no
conventional economy or formal education, and no modern technology. The cities were to be emptied of inhabitants so the entire population could work in the rice fields or in building infrastructure. A reversal of the social order was imposed. Poor peasants were to become the elite and ‘new’ people or city dwellers – the educated, intellectuals, those who had studied or worked abroad, or anyone who might oppose this theory – were to be eliminated as actual or potential enemies. Ironically, the country was renamed ‘Democratic Kampuchea’.

After the Khmer Rouge gained control of the capital Phnom Penh in April 1975, it is alleged to have forced out, at gunpoint, approximately 2 million people, killing anyone who resisted. Families were separated, the elderly, sick and young perished immediately, and many starved or succumbed to illness en route to the rural areas. Once there, the survivors were put to work tilling the fields using equipment usually pulled by oxen, planting rice, and building canals and dams with their bare hands. Not surprisingly, as the regime consolidated its power, there was a terrible death rate.

The people on trial
There have been two trials to date. The first was of a man with the revolutionary name ‘Duch’. He is a well-educated, highly intelligent former teacher who excelled academically, particularly in mathematics. Duch was appointed to head S-21, one of about 190 similar security prisons scattered through Cambodia. Under his leadership, of 12,000–20,000 detainees, about 5–8 survived, albeit under constant threat of death. Other detainees were shackled to a common iron bar, toileted on the floor still shackled, fed starvation rations, hosed down, bitten by mosquitoes and tortured until they confessed, often to being members of the CIA or KGB, organisations many had never heard of, or until they died. Those who survived were put to death in a field near Phnom Penh.

The second trial in which the evidence has just concluded is of four remaining senior leaders, only two of whom are left on trial. They are both in their late 80s and in fragile health. The third died last year, and the fourth, his wife, was diagnosed as suffering from advanced dementia (probably Alzheimer’s) at the beginning of the trial three years ago and severed from the proceedings. Among the allegations against them are forced evacuation of the cities, enslavement labour, enforced communal living, forced marriages and many other inhuman initiatives. The regime was incredibly secretive and no one caught up in it knew who the leaders were until after the regime fell, nor did they usually know why they were singled out for punishment or death. It has been described as a nightmare which lasted for almost four years, suffered in a country later described as one huge concentration camp, and killed approximately a quarter of the population.

Cambodia has been crippled by these events, leaving a nation with at least two generations illiterate or semi-literate and burdened with severe physical, mental and psychological trauma. In this context, victims must be at the forefront of attempts to achieve justice.

Victim participation at the ECCC
Role of victims in criminal justice systems
In recent years, there has been an increasingly vocal demand in most countries, to focus more intensely on the victim experience, with calls for justice or revenge often made from public platforms from which victims’ suffering can be dramatically articulated. Increased prison terms are demanded and harrowing stories are paraded before vast public audiences. I have always doubted that victims thus displayed gain anything positive from the experience of so publicly discussing their tragedies, and my recent experience in Cambodia has done nothing to change my mind.

At trial, the part played by a victim who gives evidence can be pivotal. In the French civil law system upon which the Cambodian judicial system is based, a victim, called a civil party, has a right to participate at all stages of the criminal process in order to assist in the ascertainment of the truth, and to seek reparation for injury caused by the offending. Throughout the whole process, the victim may offer evidence and have access to all the confidential material collated. The system is designed to put the victim in a central position during the criminal process.

This model has been adapted for use by the ECCC in its trials. In Duch’s trial, 93 victims participated actively and in the current trial of senior leaders, almost 4,000 victims have been registered. All are entitled to legal representation, in itself a major logistical exercise that has required a fundamental re-think of the way in which they can best participate.

What the victims hope to achieve
One of the features of the Cambodian tragedy is that the events and the people have been examined exhaustively by hosts of scholars, social scientists, and psychiatric, psychological, legal and medical experts. Survivors of the Khmer Rouge regime who have been surveyed ask for a variety of outcomes from these trials: ‘justice’, reconciliation, an opportunity to articulate their experiences, sorrow and anger publicly, revenge, or simply to find out what happened to a relation or friend.

A trial attempts to give justice and provide accountability but it is by no means the perfect process. Choices must be made such
as who to indict and try, and which charges to bring. At trial, factors such as the availability of relevant evidence, the reliability of witness memories, the fitness of the accused, which dictates the speed at which the trial can proceed, the balancing of the rights of accused, victims and witnesses, all play a part in determining what can be considered by the judge or jury.

Justice is also a subjective concept. For the accused it is a fair trial, in itself a whole topic, with an appropriate sentence if convicted. For the victim it is to hear all the information about the incident in which he or she was involved. The victim may also hope there will be an opportunity to confront the accused, to seek information, to assuage suffering, extract a pound of flesh, or tell the world about their suffering. Only some of these objectives can or should be achieved.

Reconciliation is unlikely in the tense atmosphere of a trial. Catharsis may occur, but a trial, even with the full participation of victims, does not and cannot offer therapeutic outcomes.

A witness can certainly tell the world about their suffering, but depending on the world’s interest in the particular trial, this may be to a limited audience. In a domestic criminal trial, unless there are features which ensure the media will cover it, no one outside the courtroom will listen. At the other extreme, in the ECCC, the 500-capacity public seating is usually full, and at least in Asia and Europe there is extensive coverage. I have serious doubts about the therapeutic value to the victim of such wide coverage and in a few instances the fact that they would be on television has encouraged a victim with an agenda to give evidence.

Venting anger and threatening revenge is a topic all of its own, but a fair trial is not the venue for this. The desire for revenge is a fundamental human emotion but it is a court’s responsibility to ensure accountability for crimes in an atmosphere that is calm, and compassionate, but fair.

Finding out what happened and why can rarely be achieved in cases such as this. Senior leaders will seldom have the details a victim craves. Where the accused has processed up to 20,000 people through their prison or led a country of 5–7 million enslaved labourers for almost 4 years, they will seldom have the details sought by an individual victim. A parallel process may be helpful, one which involves a wide range of lesser participants who may have more direct information that may be useful for a victim who is unable to resolve his or her emotions.

Every victim of a crime wants to be reinstated to the financial position they were in before the crime was committed. At the ECCC, for various reasons, reparation is limited. Even if an accused had massive resources, how could one put a price on the loss of an entire family, all their property or an education? And at the destruction of physical or mental health?

Broader issues

A civil party has full, privileged access to material gathered during an investigation and trial. Much is deeply personal and confidential. In Cambodia, while there were many victims who were enslaved or pressed-ganged into service, equally there were many who voluntarily chose to be perpetrators, or effectively had no choice. The Cambodian people soon understood that noble gestures were useless – if you refused to become an executioner, then you and your whole family would very likely die. So the line between victim and perpetrator in such instances is very unclear. Also, there are massive ethical issues in protecting confidential information so that witnesses or other participants can be kept safe.

In employing the model which limits criminal justice to a criminal trial, we may be confusing the objectives of a fair and expeditious trial which at its end imposes a balanced sentence on any person convicted, with the human rights’ impetus to learn the wider truth of why an event has occurred and to find a resolution that might prevent a recurrence. The absence of a clear line delineating justice from the human rights’ objective can lead to confusion and disappointment.

Who are the victims?

In contemporary Cambodia there has been a tragedy in every family. Thirty-five years after these events, simply chatting to a tuktuk driver on the street teaches you this. Early in my time in Cambodia, I spoke to a man whose brother, a doctor, working in the countryside along with thousands of others, seeing a young Khmer Rouge soldier fall from a tree ran to help him. Until then the doctor had successfully hidden his educated status. The Khmer Rouge guards did not listen to his plea to be allowed to help, and shot him. The young man then died.

Many have had a personal impact on me as well as on the judges with whom I have worked every day for over six years. All experienced life under the Khmer Rouge, yet survived to gain a legal education and help lead their country as it struggles to overcome the legacy of those years. They have an enormous responsibility, given that the notion of the independence of the judiciary is not strong in Cambodia. As one judge said, ‘When the foreign ship sails we have to contend with the ongoing consequences of our work.’ I can come home to a comfortable retirement – they cannot.

Conclusion

Few, if anyone, listening today will have suffered the terror, deprivation and indignities experienced by the hundreds of victims I have met. So we remember why trials for mass crimes are convened often well after the events: it is crucial to hear the victims’ experiences. These have been described to me in harrowing detail during my time as a trial judge.

The victims deserve the right to tell their stories, to have at least some of their questions answered and their desire for retribution assuaged. But so far no mechanism for achieving this has been wholly effective and the terrible thing is that the cry of Holocaust survivors ‘never again’ has been far from realised.

I recognise that much of what I have described is far removed from your worlds of medicine unless some of you have worked in post-conflict societies as many Australian and New Zealand doctors continue to do in Cambodia – often at great personal expense. It is the
same for the lawyers and judges from our respective countries who work there. Those of us who have had that privilege live stimulating and rewarding professional lives, seeing and dealing with many issues that our colleagues, friends and neighbours will never experience.

Although most doctors and lawyers work in an environment less dramatic than what I have spoken about, we all face many ethical dilemmas. The skill is to recognise them, to confer with and learn from each other, and to continue to serve our communities professionally and to the best of our abilities.

As former NZ Health and Disability Commissioner Ron Paterson said when delivering last year’s Arthur Mills Oration entitled ‘The good doctor: competent, fit and safe’: ‘Ideally, professionalism is a commitment by members of a profession (individually and collectively) to maintain high standards and serve the public, in return for the privileges accorded to practitioners.’

This Congress gives you all a chance to build on your knowledge and skills and exchange information with colleagues both in and outside your area of specialty. Your presence here today also indicates that you recognise your roles as health professionals and specialists in shaping the future directions of our healthcare system in both New Zealand and Australia.

I wish you all every success as you confer, and enjoy each other’s company.

Tena koutou katoa (Greetings to all)

Postscript: The verdict in the current trial will be announced on 7 August 2014.

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**CLINICAL LEADERSHIP NEEDS GOOD ‘FOLLOWERSHIP’**

The two hours spent in the Clinical Leadership for Improvement Workshop, facilitated by incoming President-Elect Paediatrics & Child Health Division Dr Sarah Dalton and incoming President-Elect Adult Medicine Division Associate Professor Grant Phelps, for me was thoroughly rewarding. A somewhat clinically eclectic group of attendees, ranging from the brand new Fellows (who had stood receiving their accolades only three days previously) to the ‘old-and-bold – been there, seen that, done it’ merchants like me; I believe we were all positively motivated. The workshop consisted of both a well-facilitated presentation of current ideas and the discussion of a very real change scenario. It was clear that Sarah and Grant not only have clinical and leadership credibility, but the drive and enthusiasm to impart this knowledge to their colleagues.

Of particular interest were the two specific ideas explored throughout the session. First, the ‘ladder’ analogy – a manager is the person who places a ladder, but a leader is the person who says where the ladder is to be placed. This analogy was then extended (excuse the pun) into the second concept of ‘followership’ – a good follower being eager to climb the ladder, and perhaps report what a good view they have from the top? The first follower turns the ‘lone nut’ with a vision into a leader.

The Congress plenary orations had a common theme that we, as physicians, should continue to question current dogma and recognise the important role we play as servants to our communities. The Clinical Leadership for Improvement Workshop presented ideas on how we might go about this, particularly how we might address and implement change and culture shifts in our practices.

A pivotal aspect of the workshop was the continuing need we all aspire to achieve: the improvement of our care for individuals. Only by effective leadership and followership can we expect to attain change that subsequently means something to the communities we serve. It can only be lauded that the College supports such activities. The College has the responsibility to encourage excellent health and wellness care, and it is through ongoing activities such as these that we can develop the skills to manage and lead change.

Dr Guy Vautier
RACP’S 75TH YEAR AWARDS

In recognition of 75 years of promoting health, The Royal Australasian College of Physicians is acknowledging outstanding Fellows in each state/territory in Australia and in New Zealand for their significant contributions to the field of health through philanthropic, research or educational activities.

Northern Territory – Professor Bart Currie

Professor Bart Currie has made an immense impact on the health and wellbeing of the local community during his many years of clinical service in the Top End.

Professor Currie is Professor of Medicine at Flinders and Charles Darwin universities and is acknowledged as one of the leading authorities on infectious disease in Australia, with 25 years’ experience as an Infectious Diseases and General Physician at Royal Darwin Hospital.

To date he has published almost 400 peer-reviewed articles and 40 book chapters, establishing himself as a pre-eminent authority on melioidosis and envenomation as well as producing seminal work on staphylococcus infection, rheumatic heart disease and a spectrum of tropical diseases.

Dr Asha Bowen, Catherine Marshall, Steven Tong, Nicholas Anstey and Ric Price nominated Professor Currie for the award. They said:

Bart’s passion for his work, compassion for his patients, clinical acumen and expansion of the boundaries of medical knowledge exemplifies what a good physician should strive for.

Tasmania – Dr Alistair McGregor

Dr Alistair McGregor was the first infectious diseases physician in Hobart and played a key role in the development of the Royal Hobart Hospital’s infectious diseases department and infectious disease services throughout Tasmania.

Dr McGregor was also instrumental in the establishment of refugee health programs in Hobart and Statewide Refugee Health Services, which continue to provide all humanitarian arrivals with free, high-quality healthcare for both adults and children.

During the meningococcal outbreak in 2001–02, Dr McGregor fought tirelessly for the introduction of a meningococcal vaccination, which was paramount in halting the outbreak.

He also played a key role in the recent discovery of the emergence in the southern hemisphere of the serious infectious disease, tularemia (rabbit fever).

In nominating Dr McGregor for the award, Dr Alison Ratcliffe said:

His interest, curiosity and engagement in the science and art of medicine are sought out by many, and he remains so humble despite his amazing achievements.

New Zealand – Dr Geoffrey Robinson

Over a 40-year career, Dr Geoffrey Robinson has sought to improve health for all by advocating for and developing health and social policy, which has contributed to reform in the fields of alcohol and drug abuse, HIV and prisons.

Translational research, with its potential to improve clinical practice, has been a feature of Dr Robinson’s career, during which he has also made an outstanding contribution to medical research, with over 90 publications.

As a physician, Chief Medical Officer of the Capital & Coast District Health Board and former NZ President of the RACP,
Queensland winner of the RACP 75th Anniversary award, Professor Janet Hardy, with the Governor of Queensland, The Honorable Ms Penelope Wensley AC.

Left to right: Nominator of winner Dr Alison Radcliffe, Tasmanian winner of the RACP 75th Anniversary award Dr Alistair McGregor, Governor of Tasmania The Honourable Peter Underwood AC and Chair of the RACP Tasmanian State Committee Dr Geoff Kirkland.

Left to right: Incoming NZ President Associate Professor Mark Lane, Outgoing President Associate Professor Leslie E Bolitho AM and New Zealand winner of the RACP 75th Anniversary award Dr Geoffrey Robinson.

Queensland winner of the RACP 75th Anniversary award, Professor Janet Hardy, with the Governor of Queensland, The Honorable Ms Penelope Wensley AC.

Dr Robinson has worked tirelessly to bring together physicians for their common benefit and to raise professional standards.

In nominating Dr Robinson for the award, Professor Richard Beasley said:

*Dr Robinson’s contribution to medicine and the community has been substantive and he has been selfless in his service to the College.*

**Queensland – Professor Janet Hardy**

Professor Janet Hardy is Palliative Care Director at Mater Health Services, Brisbane.

An internationally respected leader in palliative care, Professor Hardy has been a pioneer in undertaking studies that in the past had been regarded as impossible – in particular, her research with patients with life-limiting diseases that may not help them directly but will be of benefit to future patients by improving the evidence base for the optimal management of pain and symptom relief.

Professor Hardy has also made significant contributions to the supervision and education of College trainees at various levels and given her time to educate and train other health professionals and medical students in palliative care.

In nominating Professor Hardy for the award, Associate Professor Helen Liley said:

*Professor Hardy is a gifted teacher, a leading researcher and a dedicated clinician who has committed more than 20 years to the challenging field of palliative care.*

Award winners from other states will be featured in a future edition of RACP News. For further information about the RACP’s 75th Anniversary Awards, please contact the Manager, RACP Foundation at foundation@racp.edu.au.
Australians are ageing better and living longer, mainly through not smoking, exercising regularly, eating a healthy diet and avoiding obesity. They also experience multiple diseases needing regular medical attention: diabetes, osteoarthritis, dementia, cancer, high blood pressure and arterial disease, with the risk of stroke or heart attack. These are conditions we live with, rather than see cured.

The success of modern medicine has encouraged high expectations that any illness can be cured or kept at bay with better, newer treatment. We elderly consume, for our diseases, a high proportion of the nation’s health budget. Our numbers are increasing rapidly, so the costs we generate will also increase.

Governments cannot maintain current spending models as elderly numbers increase. Individuals and families will shoulder greater responsibility for their own care through savings and superannuation, but living longer means these funds risk being exhausted well before death.

There is a cultural shift taking place, with more discussion of end of life care. State and Territory legislation supports the preparation of Advance Care Directives, and encourages any person to set down, preferably with family support, wishes for care in any foreseeable change or crisis in health status. Precision is difficult, but a wish to avoid the futility and isolation of death in intensive care can be discussed and written in simple English, establishing values to guide care when an individual is unable to make decisions. Advance Care Directives are a key component of end of life care and should be advocated in all Australian health facilities.

Most elderly persons look not for mere prolongation of life, but for quality in the life that remains to them, with an emphasis on comfort, respect and dignity. The challenge is to find, in considering Advance Care Directives, the balance between very useful medical interventions that may sustain life and the community cost of such measures, plus the fact that often they seem uncomfortable and futile.

Can we do better? Can governments work towards a more frugal but sustainable system of healthcare for the elderly that will help individuals and families achieve that appropriate balance between medical cost and end of life quality?

The emphasis on comfort and quality that palliative care teams have demonstrated in hospice and home care is appreciated as of high value. It must accompany the Advance Care Directive opportunity, so that professional expertise ensuring dignity and comfort supports any decision to avoid expensive and possibly uncomfortable treatments.

This need not be in a hospice. Our relatively few hospices accept patients with the most difficult discomforts, and undertake crucial teaching and research. Care for dying persons too often occurs in an acute hospital; far better to take place in a home or a Residential Aged Care Facility (RACF).

The current delivery of care to the aged is unsatisfactory. Care at home is preferred, but home visiting by family doctors is much reduced, and RACFs also suffer from inadequate medical supervision. The result is that RACF residents and those still at home risk sudden transfer to an acute hospital when some discomfort or crisis ensues, and many die there.

Coordination of care at a community level should replace the present fragmentation between specialties, hospitals, homes, RACFs and community services, which would reduce costs. If RACFs could offer a full range of both residential and home care that embraced all major categories of elderly need across local communities, they would promote the healthiest balance between more treatment and dignified care.

The creation of a ‘Community Hub’ that includes a comprehensive medical team based within the RACF needs to be investigated. By boosting the clinical

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WHY GOOD COMMUNICATION SKILLS ARE IMPORTANT

Award-winning author and medical oncologist Dr Ranjana Srivastava discusses with RACP News why fragmentation of treatment and poor communication by doctors make end of life decisions difficult for both patients and their families – and what measures can be taken to address this situation.

**RACP News:** What is your most recent book, Dying for a Chat, about?

**Dr Srivastava:** Dying for a Chat is a short book about a vital topic in modern medicine: the communication breakdown between doctors and patients that leads to all-round dissatisfaction, pain and suffering, as well as a waste of precious resources.

**RACP News:** What/who inspired you to write this book?

**Dr Srivastava:** A collection of everyday patient experiences and reflections from doctors, patients and their families prompted me to write a book that has been in gestation for some years. Sometimes it seems that our good intentions regarding patient-centred care are not necessarily reflected in our actions at the bedside, and this led me to ask why.

**RACP News:** A key message that comes through in the book is that patients may be undergoing risky or unnecessary procedures. Why is this so?

**Dr Srivastava:** As a fortunate and rich Western country, we are blessed with an endless line of modern medical interventions and drugs, so it is probably natural to want to apply them to our patients in the hope of doing good. But as every clinician knows, it is not uncommon to end up treating the test rather than the patient. Patient expectations continuously rise, too, without necessarily an understanding of the implications of treatment.

**RACP News:** Doctors/specialists clearly do remarkable things for their patients, but what you appear to be saying in your book is that talking is not one of their strong points?

**Dr Srivastava:** Talking to patients in a meaningful way to convey complex medical information is not the same as having an ordinary conversation. Conversations around breaking bad news, delivering a serious prognosis, stopping active treatment and recommending palliation are emotionally intense and ethically challenging occasions for many – if not most – doctors. These conversations require skill and training. If medical students and doctors were taught these skills early on, we would create future doctors who were comfortable having these conversations. Many doctors want to be able to engage meaningfully with their patients, but find that they don’t really know how, so they either avoid the challenge or don’t manage it well.

**RACP News:** In your book you say that good communication skills should be as important to healthcare as medical breakthroughs. But they’re not – why not?

**Dr Srivastava:** I actually think, as a profession, we do understand the value of good communication because, after all, doctors are also patients and we know from our own experience the difference that good doctor–patient communication makes. But we have always assumed that communication skills are intrinsic and there is not much one can do to change this. We have thus developed skewed norms of communication based on our assumptions.

However, we are now beginning to rethink this and realising that, while an aspect of communication skills may be intrinsic, we can provide tools and checklists to encourage all doctors to become more able communicators. The best organisations around the world are investing in communication training because it has widespread benefits – from improved morale to perceived wellbeing.

**RACP News:** What about doctor–specialist communication? What are the implications of poor communication between health professionals? For the patient? For the health system?

**Dr Srivastava:** You only have to talk to a patient to appreciate the widespread frustration caused through poor communication between different clinicians, which leads to confusion and duplication of tests and interventions, which in turn increases the cost of care. With increased subspecialisation in all fields of medicine, it is common for patients to consult many doctors, so communication between all parties has never been more important.

**RACP News:** What do you believe are the key communication skills needed by medical specialists?

**Dr Srivastava:** Every doctor (not only a specialist) should possess a toolset that
allows him or her to do the following tasks with a degree of sophistication, sensitivity and integrity: breaking bad news, stopping active treatment, discussing views on resuscitation and advance care planning, having an informative family meeting and discussing uncertainty about a range of things from diagnosis to prognosis. Having a toolset to approach difficult conversations allows even the less confident clinician to engage with the patient and learn from experience.

**RACP News:** I read in your book that you would like to see mandatory teaching of communication skills to all Australian doctors. Would you expand on this? How can this be achieved?

**Dr Srivastava:** The medical profession is answerable to the needs of the society it serves, and our patients are increasingly demanding clearer, better communication. It is important that medical education and early hospital training recognise and address this need. This can be done via a formal communication skills program designed as a vital pillar of modern medical education rather than an optional extra. We also need continuing medical education and training of the generations of clinicians who were not exposed to this type of thinking during their own training which took place decades ago. It is important that healthcare organisations show leadership in this area.

Ultimately, for all the good intentions, there will always be jostling for funding and it takes visionary leadership to think through how best to allocate a finite budget. In my humble opinion, better communication training has the potential to redefine the doctor–patient relationship.

**RACP News:** Innovations in medicine and technology mean that many patients (and the patients’ families) expect to receive ‘cutting-edge’ treatment for any illness. Knowing that medical intervention may not always be the answer, how can specialists manage their patients’ expectations for treatment?

**Dr Srivastava:** The individual clinician must appreciate the implications of suggesting or performing an intervention or prescribing a drug. The Australian education system produces sound, well-educated graduates. The challenge then is to know how to transmit that sophisticated knowledge to the largely health-literate patient. The key to managing patient expectations often has to do with knowing how to communicate complex information in simple language while not forgetting empathy and sensitivity. It is not an easy task, but it can be done well with training.

Patients repeatedly tell us that they want us to be honest when it comes to end of life care planning. At the same time, they may also expect miracles. But the mismatch of expectations can almost always be addressed with unhurried, considered and compassionate communication. Sure there are outliers in every clinician’s experience where the best intentions and deeds seem to misfire, but it’s important that we recognise them as outliers and learn from the many other experiences where good communication has been the best therapy.

**RACP News:** The introduction of legislation in many Australian states supports the preparation of Advance Care Directives. In what way do you think this will change/improve shared decision making between patients (and their families) and their specialists?

**Dr Srivastava:** I am very hopeful that the legislation will provide an impetus for patients to discuss complex illness and its implications with doctors at an earlier stage than they currently might. People who understand their illness will want to have a say in how best to navigate it too. They might realise that their care is fragmented and attempt to unify it. If a patient expresses a desire to limit care or think more carefully about future interventions, conversations about quality of life versus prolonged, futile care are somewhat easier to have.

Conversations about one’s own mortality are never going to be comfortable and we should not expect overnight change in the attitude of society as a whole of preferring to disregard the inevitability of death. But patience on our part and a wider belief in the value of advance care directives will lead to change.

Dr Srivastava received the Australian Human Rights Commission Literature Prize in 2013 for Dying for a Chat: The Communication Breakdown between Doctors and Patients (Penguin Australia eBook).

**Continued from page 35**

expertise in aged care, psycho-geriatrics and palliative care within RACFs, the standards of care would improve with flow-on benefits for training. The Hub would enrich community life by providing outreach support for those at home, plus activities to encourage health in the ageing and respite opportunities for tired carers. Care for our elderly could then continue at the individual’s preferred site, and inappropriate hospital transfer could be replaced by compassionate and effective end of life support.

Shifting end of life care services away from acute hospital wards does mean spending more money in the primary care area, but this will result in a better experience for the patient, reflect their needs and preferences and, in the long term, deliver savings to the health system. In this current environment of reviewing and reducing healthcare costs and spending, this will be a challenge for Federal and State governments, but one that needs to be prioritised to ensure all Australians receive the end of life care they deserve.

Emeritus Professor Ian Maddocks AM, FRACP FAFPHM FACHPM
We spent a week on Christmas Island as medical consultants – we were shocked by the pervasive sadness, the despair in children and in adults, and the lack of dignity offered to detainees.

The recent announcement that most Australian detention centres will close and all asylum seekers will be transferred offshore to Nauru and Manus Island confirms the fears of children currently detained on Christmas Island. In March, we spent a week on Christmas Island as medical consultants to the Australian Human Rights Commission’s (AHRC) President, Professor Gillian Triggs, to Christmas Island. Dr Zwi visited Christmas Island as a representative of The Royal Australasian College of Physicians. The visit was part of the AHRC’s inquiry into children in immigration detention. Dr Zwi and Dr Mares also gave evidence at the AHRC’s first public hearing in April. In this article they share some of what they saw.

Earlier this year, paediatrician Dr Karen Zwi and child psychiatrist Dr Sarah Mares accompanied the Australian Human Rights Commission’s (AHRC) President, Professor Gillian Triggs, to Christmas Island. Dr Zwi visited Christmas Island as a representative of The Royal Australasian College of Physicians. The visit was part of the AHRC’s inquiry into children in immigration detention. Dr Zwi and Dr Mares also gave evidence at the AHRC’s first public hearing in April. In this article they share some of what they saw.

The UN convention on the rights of the child, which Australia ratified in 1990, can be described in shorthand as identifying that children need:

- **Provision** (of food, shelter, education)
- **Protection** (from harmful and traumatic experiences, including abuse, torture, exploitation, arbitrary detention)
- The chance to **participate** in decision making about their lives. How this should occur depends on a child’s age.

These rights seem clear and unarguable and are largely enacted in policies and services for children living in Australia. What we saw on Christmas Island suggests that immigration detention impacts on adequate provision for, protection of and participation by children at all ages and stages, from birth to 18 years old.

Childhood adversity and exposure to violence, trauma and parental despair disrupt normal development and are well documented to impact on children’s outcomes. The gravest impacts come from cumulative and prolonged adversity which are not balanced or mitigated by protective experiences and relationships. Positive learning environments – such as quality childcare, or meaningful activities with supportive adults – are protective for children facing adversity.

Immigration detention on Christmas Island is an impoverished and harsh environment with little opportunity for safe play and exploration, education, physical exercise or for nurturing family time. Most children had very little schooling and many had only been for three hours a day for 10 days out of the eight months they were detained.

Detention has been shown to be harmful for children in Australia and in many other...
countries, with worse impacts the longer the detention continues. Offshore detention with increased isolation in remote and harsh circumstances exaggerates that adversity.

It also increases the difficulties and the costs associated with providing health and educational services. It is impossible for providers, however well resourced and intentioned, to ever balance or mitigate the damaging impact of detention itself. And parents, no matter how committed or competent they are, cannot adequately provide for, or protect their children in this environment.

Most shocking about our visit was the pervasive sadness, the despair in children and in adults, and the extreme fears about the future. Many children are symptomatic, anxious and unhappy; some were withdrawn, had begun wetting the bed, and parents were concerned about delays in their children’s speech or recurrent games about drowning or playing at being ‘officers’. Some younger children were biting themselves or hitting their heads in distress, many had disturbed behaviour and sleep.

Powerlessness is reinforced for parents in daily humiliations. Families line up in the sun or rain (there is little shelter) and wait, then show ID cards for food (holding their own issued plastic cup, plate and cutlery), for medicines to be handed out, or to see the nurse or doctor. For parents with little ones there is additional lining up for nappies, baby wipes and scoops of formula – only three are dispensed each time.

Use three nappies or make up three bottles of milk and you need to line up all over again. And at 11 pm and 5–6 am there are knocks on the bedroom door, entry of an officer with a torch and roll calls. This adds to the disturbed sleep in children and adults, which is very common.

The way that decisions about family separations are made and enacted is another source of great fear and distress. Transfers of family members for medical reasons to the mainland sometimes result in prolonged family separation, including of children from parents. The ‘ageing out’ of boys (the term for turning 18) means they can be moved suddenly to the adult camp or to Manus Island, and some families have been suddenly ‘extracted’ to Nauru. These transfers often occur in the early hours of the morning and with no warning (for ‘operational reasons’) and are big contributors to the pervasive fear and anxiety.

For children in asylum seeking families who are detained on Christmas Island and will be moved to Nauru or Manus, the adversities are cumulative. They include past as well as current trauma. The children show in their drawings the issues that concern them and how this makes them feel. They are eloquent about the impact on their feelings about themselves, about life and about the future. What we see and what the drawings show is children who are scared, sad and disillusioned.

If they are moved to Nauru or Manus their circumstances are likely to be even worse.

**Dr Sarah Mares FRANZCP**
Senior Staff Specialist, Karitane Jade House and Toddler Clinics
Conjoint Senior Lecturer with the UNSW School of Psychiatry
Senior Research Fellow at the Centre for Child Development and Education, Menzies School of Health Research, Darwin

**Dr Karen Zwi FRACP**
Community Paediatrician and Head of Department of Community Child Health, Sydney Children’s Hospital Network
Clinical Director of Community, Ambulatory, Rehabilitation, Population and Allied Health (CARPA), Sydney Children’s Hospital Network
Conjoint Associate Professor with the UNSW School of Women’s & Children’s Health

Footnote: The RACP’s submission to the AHRC’s inquiry to children in immigration detention can be found on the RACP website under ‘Policy and Advocacy – Submissions’. The AHRC is expected to deliver its report later this year.

NEXT YEAR’S TRAINING PROGRAM
REQUIREMENTS AVAILABLE NOW

In 2014, the Australian Medical Council (AMC), in partnership with the Medical Council of New Zealand (MCNZ), is undertaking a reaccreditation review of the education, training and continuing professional development programs of The Royal Australasian College of Physicians.

2015 Program Requirements

Program requirements are the components of a training program that a trainee must complete in order to progress through and complete the program. They comprise requirements such as particular training rotations, learning activities and assessments.

To ensure that its program requirements remain relevant, achievable and in accordance with educational best practice, the College annually reviews the requirements for each of its 61 training pathways. This revision process includes consultation with stakeholders including trainees and supervisors.

The College Education Committee, which has oversight of all College training programs, has published the confirmed 2015 program requirements in summary form on the College website: www.racp.edu.au/page/2015requirements. This will allow trainees and supervisors to become familiar with the requirements before they come into effect at the start of the 2015 training year.

2014 Program Requirements

The program requirements for this year are set out in the 2014 PREP Program Requirements Handbooks. These handbooks contain the essential information about every College training program and are a must-read for trainees and supervisors, as well as an excellent source of information for prospective trainees.

The PREP Program Requirements Handbooks for all College training programs are now available in a new look web browser at: http://handbooks.racp.edu.au. The web browser has been enhanced to provide readers with:

- improved navigation for easier browsing
- an enhanced full-text search function
- ‘quick links’ on each handbook’s landing page for fast access to important information.

The web browser is easy to view on mobile devices such as tablets and smart phones, and now contains both the 2014 and 2013 editions of the handbooks.

Go to http://handbooks.racp.edu.au today to access your handbook.

For more information about program requirements or handbooks contact: handbooks@racp.edu.au.
In 2014, the Australian Medical Council (AMC), in partnership with the Medical Council of New Zealand (MCNZ), is undertaking a reaccreditation review of the education, training and continuing professional development programs of The Royal Australasian College of Physicians.

The purpose of the 2014 reaccreditation review is to ensure that the College meets the AMC standards and the MCNZ criteria, and will continue to meet these from 2014 onwards.

The College is on track with reaccreditation, with a number of activities occurring in the last few months as part of the review.

In May, the College submitted the comprehensive 2014 Accreditation Submission to the AMC addressing our progress since 2008 against the AMC standards and MCNZ criteria. This report can be viewed on the RACP website at: www.racp.edu.au/page/about-racp/australia/.

The AMC conducted College-wide online surveys and hosted a number of open sessions at the RACP Congress 2014 in New Zealand to collect feedback from College trainees, supervisors of training, Directors of Physician Education (DPEs) and committee members about the College’s training programs and processes. Prior to Congress, members of the AMC reaccreditation panel attended the RACP Board meeting in New Zealand to provide Board members with an update on the accreditation process.

Future reaccreditation activities

Between June and October this year, the AMC panel will visit a number of training sites around Australia and New Zealand to evaluate the variety of training experiences offered by the College. From 29 September to 3 October, the College will host a series of meetings between the AMC and a range of senior College Fellows, staff and trainees involved in education.

The College has made significant progress since our original 2008 accreditation in the areas of education policy, curricula, assessment supervision and eLearning. As we celebrate the end of the College’s 75th year, we look forward to developing our education, training and continuing professional development programs to provide our members with the best in specialist medical education.

AMC reaccreditation activities at Congress

In May, representatives of the AMC reaccreditation panel attended the RACP Congress 2014 in New Zealand to speak with College members. Key topics included the strengths and weaknesses of the College’s policies, education and training activities, the College’s communication methods and the challenges facing the physician profession and practice.

The AMC sessions provided an ideal opportunity for College members to provide feedback on the education and governance improvements to date and to assist the College to set the agenda for further improvements to education training programs. AMC reaccreditation panel members in attendance included Deputy Chair of the AMC panel Dr Andrew Connelly FRACS, Dr Simon Martel FANZCA and Dr Elnike Brand, Advanced Trainee, RANZCP.

Five open sessions were held at Congress for trainees, supervisors and DPEs. Sessions were also conducted for Congress delegates involved in the Paediatrics and Child Health Committee, Advanced Training Committee, Continuing Professional Development Committee and Adult Medicine Committee.

The AMC will present results from the Congress feedback sessions, along with the results of the recent College-wide surveys and the final stage of the accreditation review.

Julie Gustavs
Manager, Education Development, Research and Evaluation

Eloise Birbara
Executive Officer, Education Policy and AMC Accreditation
ADVANCED TRAINEE SELECTION AND MATCHING

In 2014, the RACP will again be facilitating the online coordinated selection of Advanced Trainees for some specialties. The online Advanced Trainee Selection and Matching (ATSM) program is a coordinated process of Advanced Trainee selection provided by the RACP, comprising an online documentation and preferencing system that electronically matches trainees to available Advanced Training positions.

This year, nine matches will be conducted. Details of those specialties/states involved are listed in Table 1. Trainees looking for information on specialties/states not currently involved in the ATSM process should contact the Specialty Society Group (SSG) of those specialties direct as listed under ‘Advanced Training Specialties’ on the RACP website.

Table 1: Matches involved in ATSM online process and key dates*

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Applications open</th>
<th>Applications close</th>
<th>Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory &amp; Sleep Medicine VIC/TAS Continuing Trainees*</td>
<td>7 July 2014</td>
<td>18 July 2014</td>
<td>23 July 2014</td>
</tr>
<tr>
<td>Infectious Diseases VIC Continuing Trainees*</td>
<td>28 July 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AFRM QLD First Year and Continuing Trainees*</td>
<td>14 July 2014</td>
<td>4 August 2014</td>
<td>26 August 2014</td>
</tr>
<tr>
<td>AFRM SA First Year and Continuing Trainees*</td>
<td>7 July 2014</td>
<td>4 August 2014</td>
<td>26 August 2014</td>
</tr>
<tr>
<td>Endocrinology VIC/TAS First Year and Continuing Trainees*</td>
<td>24 July 2014</td>
<td>8 August 2014</td>
<td>15 August 2014</td>
</tr>
<tr>
<td>Cardiology VIC/TAS &amp; NSW First Year Trainees*</td>
<td>24 July 2014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Correct at time of printing

Table 2: Specialties involved in the Multi-Specialty Match for positions commencing in 2015

<table>
<thead>
<tr>
<th>Specialty</th>
</tr>
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<tbody>
<tr>
<td>Nephrology (VIC) (first year positions)</td>
</tr>
<tr>
<td>Medical Oncology (VIC/TAS) (first year and continuing positions)</td>
</tr>
<tr>
<td>Respiratory and Sleep Medicine (VIC/TAS) (first year positions)</td>
</tr>
<tr>
<td>Rheumatology (VIC) (first year and continuing positions)</td>
</tr>
<tr>
<td>Rheumatology (ACT/NSW) (first year and continuing positions)</td>
</tr>
<tr>
<td>Gastroenterology (NSW/ACT) (first year positions)</td>
</tr>
<tr>
<td>Gastroenterology (VIC/TAS) (first year positions)</td>
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<tr>
<td>Gastroenterology (SA) (first year positions)</td>
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<td>Gastroenterology (WA) (first year positions)</td>
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<tr>
<td>Gastroenterology (QLD) (first year positions)</td>
</tr>
<tr>
<td>Infectious Diseases (VIC) (first year positions)</td>
</tr>
</tbody>
</table>

The Multi-Specialty Match combines several specialties into one match. The opening and closing dates are the same for each specialty within the Multi-Specialty Match.

How to apply

Applications for available positions in the 2014 online ATSM matches are via the RACP website. Applicants should follow the process for applying for positions in the ATSM Trainee Handbook. This is available on the RACP website at www.racp.edu.au/page/coordinated-selection-of-trainees. It provides step-by-step instructions to guide you through the registration and preferencing process.

Continued on page 43
For the third year in a row, trainee physicians in the Specialist Training Program (STP) administered by the College have highly rated their training experience. From the responses to the 2013 STP trainee exit survey (89% completion rate), analysis showed that 97% of respondents rated their STP training experience as ‘good’ or better and 94% of respondents would recommend STP training to colleagues.

In results that were similar to those in 2012 and 2011, the majority of respondents said they developed breadth of experience and were given appropriate responsibility. They felt STP provided a good balance between workload and training/learning and an understanding of the range of community services that contribute to health. Analysis of STP supervisor surveys in 2013 found similar opinions from those supervisors, with the majority agreeing that STP trainees are exposed to a wider variety of case mix compared to non-STP trainees.

STP provides salary contributions of $100,000 per annum for training posts in non-traditional settings, such as rural and remote settings, private hospitals and non-hospital organisations. The program is funded by the Commonwealth Department of Health and is administered by the specialist medical colleges, with the RACP currently administering 376 posts. Additional funding is available for posts in private hospitals and rural Australia. In 2014, 55% of RACP posts are in rural settings, 50% in private and 62% in non-hospital settings (posts can be in more than one of these kinds of settings).

The trainee exit survey found the most useful aspects of an STP position included exposure to different settings (community, rural, aged care, Aboriginal) and more variety, responsibility, autonomy, independence and leadership development. There was also more experience with outpatients, the chance to develop enhanced communication skills, exposure to more specialties and protected learning time.

The survey was implemented by the College to assess the quality of training and supervision in STP posts nationwide. For the full survey report and for reports from previous years, visit the STP website at www.racp.edu.au/stp/#Evaluation.

The RACP encourages trainees to consider rotations to STP posts as a way of gaining a different, yet valuable, training experience.

*Dominique Holt*
Manager, Faculties
(formerly Program Coordinator, STP Unit)

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**WHAT STP TRAINEES SAID**

- Magnificent to experience the ‘real’ world paediatrics during training.
- STP position is a great opportunity to expand knowledge and understanding.
- Vastly different to anything my training has provided to date and yet so much more appropriate in terms of skill development.
- Offers a big scope for independent decision making outside the ‘protected’ hospital setting, offers exposure to challenging ethical and moral aspects of medicine.
- Unique opportunities afforded by the rural and culturally diverse setting of Central Australia.
- The private system functions very differently and is somewhat enigmatic when you have spent your entire training in the public system. This rotation helps fill a large void in experience by letting you experience first-hand what happens in the private sector.

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**To be considered for a job in NSW (in the NSW specialties listed on page 42) all applicants MUST apply via BOTH the RACP website AND each training hospital via the NSW Health ‘HealthJobs’ website: www.health.nsw.gov.au/jobs/recruitment/jmo.asp.**

Trainees are encouraged to begin the application process as early as possible as the deadlines are fixed. Online applications can be made by entering your personal information, completing the online CV and lodging your preferences.

Interview schedules are organised independently by each specialty. For information on interviews, please see the RACP website or contact the Specialty Society Group coordinator. Contact details are available on the RACP website.

**Match results**

The results of the matches for each specialty will be released firstly to the State Specialty Group (SSG) coordinators, who will in turn inform the Head of Department for each position before results are released to applicants. The College will not be releasing match results directly to applicants.

**Further information**

For more information on the online ATSM application process, please visit: www.racp.edu.au/page/coordinated-selection-of-trainees.
LETTER TO THE EDITOR

I wish to express my views about the proposed Board reforms. I was a Board Director from 2010 to 2012, so have had direct experience of the difficulties inherent in the current Board structure. In general terms, I support reform: I have seen first-hand that the large College Board is cumbersome in its workings, and is subject to inefficient factionalism. The two-year terms create power differentials between the Board Directors with longer terms/management and the rest of the Board. All of this impacts on board effectiveness, and is ultimately unhealthy for the organisation.

Notwithstanding my general support for a reformed Board, the overall details of the reforms as outlined in the initial consultation paper are insufficient for me. Specifically, before these reforms are put to the Fellowship in May 2015, I would like to see a draft Board charter, by-laws for Board committees, and for College bodies and New Zealand and State committees, which articulate the stated intent of decentralisation and the diminution of the ‘command and control’ approach which has, in my opinion, been prevalent over the last five years. If Divisions, Faculties and Chapters are indeed to be abolished, this strategy should be made explicit – College bodies are currently specified in the College Constitution, and so structural change will also require Constitutional change. I would also like to see draft terms of reference or by-laws/terms of reference for a Finance committee and details on the extent to which the Senate will have a role in operational matters, for example, decisions about education delivery and content, and policy and advocacy.

A skills-based board, with some positions put up for election by a Board nominations committee, is proposed in the reform. Others have previously raised concerns about the power of this proposed Board Nominations Committee. Having had the experience of chairing a Board nominations working party to select a non-Fellow Director for the RACP Board in 2012, I have very significant concerns about the potential for the Board Nominations Committee to be influenced by the CEO or other non-committee Directors. I also have concerns that those who disagree with the Board, or who speak out publicly in disagreement about a matter, have the potential to be selected out by the Nominations Committee. If the Nominations Committee is put forward again as part of the final reform proposition, I recommend that there should be very stringent guidelines, overseen by independent legal process, to ensure that the Nominations Committee does not enforce censorship, nor censure Fellows, by prohibiting dissenters, or those perceived to be ‘on the outer’, to stand for election. The governance experts consulting to the College should be asked to identify specific strategies and instruments from other successful nominations committees in the not-for-profit sector which can reassure the membership that a nominations committee can implement a transparent, non-discriminatory and unbiased process.

Constitutional reform is likely to be sequential and in relatively small steps, the first steps being to address the size, skills and structure of the Board. However, given the impact of centralisation in College decision making and operations over the past five years, I am of the view that there need to be safeguards in the Constitution and Board Committee charters/by-laws, to ensure sufficient and clear delegations to Board committees and College bodies, consistent with the promised devolution of operational decision making away from the Board. Further, may I suggest that, hand in hand with Board reform, there needs to be an open and concurrent discussion about the purpose of the College, its values (led by the Board, with input from the members) and the nature of ‘fellowship engagement’. In particular, a revisiting of the view I have heard on countless occasions that Fellows wish to go back to being more closely involved in the operations and decision making of the organisation through Councils and their sub-committees, NZ and State committees, policy and advocacy committees, and expert groups rather than only having ‘member services’ provided for them. These discussions have to occur simultaneously with Board reform. A governance reform in the absence of an associated analysis of how better to address culture, values, trust, strategy and the relationship between management/Board and management/members will not sufficiently address the ‘modernisation of the College’ that this reform is, I believe, earnestly attempting to achieve.

Leena Gupta
Hands on roles, our Doctors get to do more
Registrar – Alcohol and Drug Service

The Department of Health and Human Services-Tasmania invites you to consider a career in the Alcohol and Drug Service. Opportunities exist for interested and experienced people who wish to become part of a dynamic and professional team.

Tasmania offers a lifestyle that will revitalise your senses. Our pristine environment and spectacular scenery may be the healthy change you need. Tasmania offers a great range of opportunities for you and your family, with affordable living, access to a range of recreational activities and first class produce unique to the state.

Entry to the Advanced Training in Addiction Medicine can be gained through either:
1. Fellowship of one of the following Colleges, Divisions or Faculties:
   - Anaesthetics (FANZCA)
   - Emergency Medicine (FACEM)
   - General Practice (FRACGP and FRANZCGP)
   - Adult Medicine Division (FRACP)
   - Paediatrics & Child Health Division (FRACP)
   - Pain Medicine (FFPMANZCA)
   - Psychiatry (FRANZCP)
   - Public Health Medicine (FAFPHM)
   - Rehabilitation Medicine (FACRM)
   - Rural and Remote Medicine (FACRRM)
   - Obstetrics & Gynaecology (FRANZCOG)

   NB: Overseas trained doctors (including general practitioners) must have been considered by the relevant Australasian medical college

Or
2. Completion of RACP Basic Training and success in the Written and Clinical Examinations

And
3. Appointment to an accredited Advanced Training position.


Some of the many advantages of living and working in Tasmania:
- Varied and stimulating caseloads, you'll develop strong practical skills
- Great access to Consultants and ongoing support
- Attractive salary packaging options
- Assistance with relocation and registration may be provided
- Short distances make it possible to live in rural tranquility or by the beach while commuting to a city job.

Contact
Dr Adrian Reynolds
Clinical Director Alcohol and Drug Service
Email: adl-clinicaldirector@dhhs.tas.gov.au
Phone: (03) 6214 5706

Apply online: www.dhhs.tas.gov.au/careers/junior_docs/current_campaign

An appropriate and attractive package will be negotiated based on the candidate’s special qualifications and experience.

You will:
- Receive enthusiastic and skilled clinical teaching, supervision and mentoring from a team of Addiction Medicine and other medical specialists.
- Become skilled in undertaking clinical assessment including risk assessment and providing appropriate expert advice and clinical interventions for patients with broad ranging substance use and related medical (e.g. pain, mental health, pulmonary) and psychosocial problems.
- Be supported in taking every relevant internal and external learning opportunity.
- Be trained and authorised as an opioid pharmacotherapy prescriber in Tasmania.
- Provide direct care to patients admitted to the inpatient withdrawal unit or attending outpatient psychological counselling services and treating patients with opioid dependence often with co-occurring mental health and chronic pain problems, in the opioid pharmacotherapy unit.
- Develop knowledge and skills in alcohol, tobacco and other drug policy as it impacts on population and public health.
- Develop advanced clinical and related critical thinking skills, judgement and confidence to apply those skills in a clinical and policy leadership role in the future.
- An appropriate and attractive package will be negotiated based on the candidate’s special qualifications and experience.

Your choice of Rewards program
- Choose to earn in Membership Rewards Direct and receive 3,500 Membership Rewards Bonus Points
- Choose to earn in Diners Direct and receive 4,000 Diners Points

Terms and Conditions apply. Minimum spend applies. Please visit partnersamericanexpress.com/professionalsgold14 for full details.

MEMBER ADVANTAGE

RACP NEWS / JUNE 2014 45
If you treat veterans with mental health issues, DVA’s At Ease Professional website is your one-stop source for evidence based assessment and outcome tools, treatment options and the latest research in military mental health.

Developed in partnership with the Australian Centre for Posttraumatic Mental Health.

www.at-ease.dva.gov.au/professionals

The Commonwealth Fund invites promising mid-career professionals — government policymakers, academic researchers, clinical leaders, senior hospital and insurance managers, and journalists — from Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, and the United Kingdom — to apply for a unique opportunity to spend up to 12 months in the U.S. as a Harkness Fellow in Health Care Policy and Practice. Fellows are placed with mentors who are leading U.S. experts to study issues relevant to the Fund’s mission to support a high performing health care system—insurance coverage, access, and affordability; health care delivery system reforms (e.g. bundled payments, accountable care organizations, innovative approaches to care for high need/high cost patients); cost containment; and other critical issues on the health policy agenda in both the U.S. and their home countries. The Commonwealth Fund brings together the full class of Fellows throughout the year to participate in a series of high level policy briefings and leadership seminars with U.S. health care leaders.

The Fellowship awards up to U.S. $119,000 in support, with an additional supplemental family allowance (approximately $55,000 for partner and two children up to age 18).

For more details about eligibility, the project, or the application process, please visit www.commonwealthfund.org/fellowships

APPLICATION DEADLINE

SEPTEMBER 15, 2014  Australia and New Zealand
DVA has smart phone apps for health professionals to use as an adjunct to treatment of veterans.

PTSD Coach Australia helps your patients manage symptoms using CBT tools, and progress treatment between appointments.

ON TRACK with The Right Mix helps patients track their alcohol consumption and review the impact on their wellbeing and fitness.

DVA apps are FREE from the App Store and Google Play

www.at-ease.dva.gov.au

Call practice manager on 0407 224 537 to inquire or email accounts@swsgi.com.au

Sessional rooms available at Private Medical Centre. Clean, light and professional rooms with friendly staff available for specialist consulting sessions, conveniently located next to Bankstown Hospital. Option to bring own receptionist or utilize existing for meet and greet. Consulting room includes computer, printer, scanner, telephones, internet. Excellent set-up for paperless practice. Fees on sliding scale according to support required.

Medical Study Tours 2014/2015

<table>
<thead>
<tr>
<th>Medical Study Tour</th>
<th>Tour date</th>
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<tbody>
<tr>
<td>Paediatrics in Vietnam</td>
<td>13 – 24 Sept 2014</td>
</tr>
<tr>
<td>Travel Medicine in Nepal, Bhutan, India</td>
<td>3 – 19 Nov 2014</td>
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<tr>
<td>Medicine and Society in Ethiopia</td>
<td>3 – 16 Nov 2014</td>
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<tr>
<td>Medicine and Society in Cuba</td>
<td>22 Jan – 2 Feb 2015</td>
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<tr>
<td>Cancer Care in China</td>
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<td>Palliative Care in South Africa</td>
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<td>History of Medicine with John Pearn in Greece and Turkey</td>
<td>May 2015</td>
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info@jonbainestours.com.au
Tel: 03 9343 6367

www.jonbainestours.com

Australian Government
Department of Veterans’ Affairs

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plenary | networking | gala dinner
Cairns Convention Centre, Queensland, Australia

FUTURE DIRECTIONS IN HEALTH

RACP CONGRESS 2015
24–27 May
SAVE THE DATE

Cairns Convention Centre
Hall A, Plenary Session
Cairns Lagoon at night