Focus: Child, adolescent and young adult health
Spotlight on AFRM Annual Scientific Meeting
Conversation with London bombing survivor Dr Gillian Hicks MBE
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Dear Colleagues

Welcome to the October issue of RACP News. With more than 2800 paediatricians and 1500 paediatric trainees, the Paediatrics & Child Health (PCH) Division is an important and significant part of the College. In this issue, we explore a number of key paediatric, child and adolescent health topics such as children in detention, paediatric outreach services for Aboriginal children, a Community and Child Health Advanced Training pilot study and important child health issues in New Zealand. We will also hear from PCH President Dr Nicki Murdock on the key priorities for the Division. Please turn to page 13 to read more about this important work.

As part of my President’s Communiqué, I would like to share an abridged version of the presentation I gave at the Internal Medicine Society of Australia and New Zealand (IMSANZ) Annual Scientific Meeting on healthcare reform. As physicians and paediatricians, we play a vital role in the health system and it is up to us, both as individuals and as part of a professional member body, to not only provide the highest quality patient care but to advocate for and have influence on the health system we want and need now and into the future.

Physicians first and foremost

Physicians have much to offer the health system. We are the leaders in our Specialties and, together, as part of an integrated team we have frontline experience across the breadth of our health system – from large teaching hospitals in metropolitan centres to remote Aboriginal community controlled health services in the Northern Territory. In all these settings you will find physicians and paediatricians working together as subspecialists and generalists, to provide the very best of care in their field of expertise.

We also see and experience the great and the not so great of our health system, and in my view we should be more influential than we have been. The challenges our health system faces demand, more than ever, that physicians come together and lead, to create the right teams of subspecialists and more general physicians for the benefit of our communities. A College representing nearly 15,000 physicians and over 6600 trainees across Australia and New Zealand has real authority, but we must have the strategic commitment to exercise it.

Leading for the benefit of our communities

Our physician practice has become more and more specialised and our healthcare system more and more focused on individual episodes of care – two trends that arguably are the exact opposite of what many in the growing cohort of patients with chronic and complex conditions are saying they need.

Excellence in education

The College’s commitment to excellence means we are committed to educating highly skilled specialists capable of delivering the most advanced medical treatment. The College is also committed to doing things better and strives to match our training programs with patient needs, train the future leaders in our system and advocate for a health system that promotes optimal care.

Specialists

We all want the best outcomes for our patients. Yet patients with multiple and complex conditions face referrals to multiple specialists who may have little interaction with each other. Far from receiving integrated care, they often experience disintegrated care. The College has influence and is committed to advocating for truly person-centred care. We are committed to a more integrated system that values specialists but also promotes the role of the general physician in better managing patients with multiple morbidities.

Advocacy for General Medicine

The first step is to ensure our own house is in order and this includes increasing the number of general physician trainees. This has been an IMSANZ (Internal Medicine Society of Australia & New Zealand) and College priority for over a decade and much has been achieved.

The College has been a strong advocate to the Australian government – both at State and Commonwealth levels – for the development of policies and programs that support both General Medicine and dual training, and we will continue to be.
Health policy makers are increasingly acknowledging the benefits of the whole-person focus that general physicians can deliver. This recognition is demonstrated in initiatives like the Specialist Training Program and dual training programs, which support training positions in settings outside of the traditional urban public hospital. This is invaluable to training General Medicine physicians, so these aspiring physicians have early experience of providing generalist care to patients and understand the different styles and forms of medical practice.

Trainees who have had training rotations in community settings say that spending time in the community has helped with developing strong interprofessional relationships. It has also improved their understanding of the patient journey through the health system. These professional qualities are essential for the modern physician working in multidisciplinary teams.

**Growth in Generalists**

In Australia, to build the professional workforce we need, we are working closely with the Australian government and other colleges to shape the Specialist Training Program so that it encourages the development of a larger generalist medicine workforce.

There is also strong support from Australian State Health jurisdictions to establish more General Medicine and dual-training pathways, and further develop existing ones. We have been encouraged that employers are recognising the importance of these training positions and the need for structured training programs.

In recent years, the number of General Medicine trainees has been steadily increasing. Data from the Medical Training Review Panel (MTRP) shows there were six times the number of trainees in a General Medicine specialty in 2013 than in 2009.

Although the numbers of trainees undertaking dual training in Australia is still not at the levels observed in New Zealand, we are seeing a steady increase. In 2013, 14.8% of Adult Medicine trainees were completing dual training and 49.5% of Basic Trainees eligible for Advanced Training in 2014 indicated they were “very interested” in undertaking dual training.

A 2013 survey of Basic Trainees eligible for Advanced Training in 2014 revealed that the most common Adult Medicine specialty preference was General and Acute Care Medicine (23.3%). Furthermore, the General and Acute Care training program has the highest number of enrolments within the Adult Medicine Division, with 27.3% of all Adult Medicine trainees in 2014 undertaking training in General and Acute Care Medicine.

**Patient-centred integrated care**

Modern medical care focuses on rapid investigation, diagnosis, treatment and cure, but the system often fails patients who most need integrated longitudinal care such as the elderly with complex, multisystem disease.

Our patients need us to form stronger partnerships with general practitioners and improve communication between us. Electronic health records are part of the solution, but communication takes time and our funding models don’t recognise or support this component of integrated person-centred care.

If we embrace the concept that we are a College committed to advancing the community’s needs then we must start these conversations.

Here, in Australia, the establishment of the new Primary Health Networks provides an opportunity to place integrated care front and centre in their remit and embed mechanisms to make it happen.

Culture change is essential and culture change starts with leadership. We must model that change, build trust, and demonstrate a commitment and desire to collaborate across clinical groups.

**The College – greater than the sum of its parts**

I believe most physicians want an externally focused College acting in the best interests of the community and engaged in the big health debates of our time.

A College that is at the leading edge of physician and paediatrician education and continuing professional development.

A College that positively influences the delivery of high-quality patient-centred care.

A College that strives to be a community benefiting organisation.

A College that is greater than the sum of its parts.

**Professor Nicholas Talley**

RACP President
The College Finance Committee, chaired by Dr John O’Donnell, meets regularly to discuss the College’s financial activities. A number of important matters were discussed at the fifth meeting of the Finance Committee held on Wednesday, 30 July 2014.

**Financial performance**
The Finance Committee reviewed the half-year financial accounts to 30 June 2014. I am pleased to report that the College remains in a sound financial position. At the time of the meeting, budget preparations for 2015 had commenced and in September were approved, subject to some amendments, by the RACP Board.

**Indigenous Health Scholarship**
The Committee approved the RACP Indigenous Health Scholarship within the Indigenous Health Scholarship Program. These training scholarships will provide a funded pathway through either Basic, Advanced, Faculty or Chapter Training in Australia or New Zealand to those who identify as being of Aboriginal, Torres Strait Islander or Māori heritage. For more information on these scholarships, please refer to page 33 of this issue.

**RACP Travel Guidelines and Policy**
The RACP Travel Guidelines and Policy has been updated to include hotel internet charges which may be incurred by Fellow and Trainee Members travelling on College-related business. The College will cover reasonable internet charges, incurred by the traveller. If arrangements with the hotel have not been made and a member travelling on College business pays such charges this expense will be reimbursed directly to the individual by the College on submission of approved receipts. For more information on the College’s Travel Guidelines and Policy, please visit the Member Services section of the RACP website.

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**Training and subscription fees**
The Committee also reviewed the payment of training and subscription fees by instalments. The College will continue to offer an instalment plan to Australian-based Fellows and trainees. Trainees who opt to pay their fees by instalments will not be charged an instalment plan application fee.

The Finance Committee will report on the items discussed at the next meeting in the December issue of RACP News.

Dr John O’Donnell
Honorary Treasurer
Chair of the Finance Committee

**IN THE NEWS**
In September and October the College continued its strong advocacy efforts on behalf of members. This has resulted in several significant pieces of media coverage. RACP President Professor Talley has spoken out on children in detention, e-cigarettes and medicinal cannabis. The College also received coverage in the Guardian online on some of the barriers to seeing specialists experienced by Aboriginal and Torres Strait Islander patients. The adjacent page captures some of our key highlights in the media in September and October.

**RACP Media Releases – September/October**
- Medical cannabis clinical trial a win for all Australians
- Tighter controls needed for smoking “gateway” products
- A national approach needed to improve access to specialist care for Aboriginal and Torres Strait Islander peoples
- Rehab physicians – helping Australians regain a quality of life after serious injury or disability
- Opinion piece – Standards of care in offshore detention a cause for concern
- World-leading rehab medicine experts converge on Adelaide
- NSW Government must broaden its approach to reduce harm from alcohol
- Infant formula marketing must be regulated to protect breastfeeding
- Opinion piece – Medicinal cannabis – healing or harming? A doctor’s dilemma
If e-cigarettes are not properly regulated, they will lead to young people, lots of young people, taking up the habit.”

Professor Nicholas Talley, on ABC’s 7.30 program

“A framework for better care should look at well-established medical specialist services in some communities that were working well and resulting in improvements to the health of Aboriginal and Torres Strait Islander peoples.”

Dr Tamara Mackean
Dear Colleagues

The third meeting of the RACP Board was held in Sydney on Thursday, 25 and Friday, 26 September 2014.

Strategy

Day one, the Board Strategy day, focused on creating a Strategic Plan for the College. This included consideration of the strategic framework in which we operate, some of the major uncertainties that could impact on the future of the College and ways to measure the value of the strategies pursued, starting with the College’s current Balanced Scorecard.

As a Board, we collectively work for the common good of the College and our Fellow and Trainee Members. As such, it is important that we can communicate what we need to achieve over the next 12 to 18 months. A clearly articulated strategic plan that serves the best interests of our members means that we can continue to meet and exceed our strategic goals and build a College for the future.

College Governance Reform

Governance Reform at the College continues to be a majority priority for the Board as we prepare to commence Phase 2 of the member consultation process. As Fellow and Trainee Members, you will once again have the opportunity to provide feedback at member consultation forums in the States, Territories and New Zealand, submit written feedback to the Noticeboard and/or participate in an online forum on the RACP website.

A College Reform Working Party has been convened to oversee Phase 2 of the consultation process. Four Board Directors – President-Elect Dr Catherine Yelland, President, Adult Medicine Division Professor John Wilson, Chair, College Trainees’ Committee Dr Alexandra Greig and I have been appointed to this Working Party and an expression of interest process to appoint three additional non-Board Director members will commence shortly. I encourage anyone with an interest in College Reform to apply.

Board and CEO recruitment

On behalf of the Board I would like to sincerely thank Dr Jim Newcombe for his dedicated service as a trainee appointed Director of the Board. Following Dr Newcombe’s resignation, I am pleased to advise that the Board has accepted the appointment of Dr Evan Jolliffe who will serve as one of the trainee appointed Directors of the Board.

The recruitment of up to three community representatives to fill current vacancies on the Board and the permanent Chief Executive Officer role continues. I look forward to updating you on the progress of these appointments in upcoming Board Communiqués.

Other key items

The Board and the College has the best interests of our Fellow and Trainee Members at heart and we are always looking at ways to improve our support to members. This extends to ensuring support for Fellows seeking to undertake post-fellowship training. As such, the Board approved the establishment of a Working Party to consider an appropriate way forward.

In 2015, the College will hold ceremonies to welcome and congratulate new Fellows to the College. As part of this pilot project, ceremonies will be held in States, Territories and New Zealand, in addition to the ceremony held at RACP Congress in Cairns in May 2015.

Effective and relevant communication with our fellowship is absolutely important to the Board and the College, and is an area that can be strengthened. The approval of the RACP Communications Strategy will streamline the College’s communications function through the delivery of best practice corporate publications, centralised and consolidated messaging and improved use of traditional and digital communication channels.

The Board also considered and approved the RACP 2015 Budget. Further information will be communicated to members once the budget has been finalised.

Other matters discussed include the establishment of an Ethics Committee as a Board Committee which will be supported by the Office of the President and CEO. An expression of interest will be issued shortly for membership of this committee.

Next meeting

The final meeting of the Board for 2014 will take place on Thursday, 4 December and Friday, 5 December in Sydney.

Professor Nicholas Talley
President
COLLEGE REFORM – START OF PHASE 2 MEMBER CONSULTATION

“

The health landscape is changing and the College must change too if it is to continue to respond to meet the needs of members and the community.

Structures that reflect the diversity of our membership and support the delivery of high-quality physician education and training programs and health policy leadership are needed.

The College’s structures must adapt to meet and lead this change.”

Governance reform is a key priority of the RACP Board. As part of the Board’s commitment to renew consultation with our Fellow and Trainee Members, I am pleased to announce the beginning of Phase 2 consultation on College Reform.

The Board has not decided on, nor is it fixed on, a particular model for College Reform. The model that is being presented in the Discussion Paper is based on the detailed discussion from Phase 1 consultation on Board Governance Reform with members. I would like to thank Fellows and trainees who participated in our first phase of consultation and encourage all members to take an active role in the second phase. I would also like to reiterate that the Board is open to all comments and suggestions from the membership on College Reform.

As part of Phase 2 consultation, a face-to-face consultation program has been put together, as well as a new online Discussion Forum, where you can chat with colleagues and post your views. Simply click on the “Have your say” and “Noticeboard” buttons on the RACP website home page, which will take you to the new RACP Board webpages where you can read more information.

I encourage every Fellow and trainee to visit these pages. I also invite you to encourage your colleagues to participate and maintain the momentum in this important discussion about our College’s future.

Professor Nicholas Talley
RACP President
In the June and August issues of RACP News we introduced you to a number of RACP Board Members. Here we complete our introductions.

**RACP BOARD DIRECTOR PROFILES**

**Associate Professor Grant Phelps**

BMBS MBA FRACP FRACMA GAICD FAIM

Adult Medicine Division President-Elect

Associate Professor Grant Phelps is a physician executive and healthcare consultant. From 1991 to 2012, he was in gastroenterology/general medicine clinical practice in Western Victoria, in both the public and private sectors. Associate Professor Phelps’ consulting interests include clinical leadership, clinical engagement and clinical quality improvement. He has had a longstanding involvement with the RACP as a member of the former Committee for Physician Training, a Director of Physician Training and a National Panel examiner. More recently, he chaired the Quality Expert Advisory Group and co-chaired with Dr Sarah Dalton the College’s recent work in developing the Supporting Physicians’ Professionalism and Performance (SPPP) framework. This work grew alongside Associate Professor Phelps’ interest in supporting the performance of doctors within the organisational context and stemmed from work he undertook for the Victorian Department of Health in developing a meaningful and engaging performance development process for senior doctors.

Associate Professor Phelps provides medical leadership to the Tasmanian Health Department’s Safety and Quality program. The opportunity to be front and centre at this time has been fundamental in driving his view of the need for clinicians to be equipped with the management and leadership skills required to drive change in a way which adds value at every level of the system, but particularly to their patients. Associate Professor Phelps sees this as a major task for the College, and it was one of the reasons he qualified as FRACMA and took on a part-time academic appointment with Deakin University’s Medical School where he coordinates a Masters program in Clinical Leadership.

**Professor Paul Colditz**

MBBS FRACP FRCPCH MBiomedEng DPhil (Oxford)

Paediatrics & Child Health Division Representative

Paul Colditz is Professor of Perinatal Medicine at the University of Queensland and a neonatologist at the Royal Brisbane and Women’s Hospital. He is Director of the Perinatal Research Centre, which focuses on multidisciplinary approaches to the prevention and treatment of perinatal brain injury and the optimisation of health outcomes for mothers and babies. He is Deputy Director of the University of Queensland Centre for Clinical Research.

Professor Colditz has fulfilled various roles at the College including Chair of the Paediatric Scientific Program Committee, member of the Aboriginal Health Working Party and member of the Policy and Advocacy Committee. Within the Paediatrics & Child Health (PCH) Division, he is currently Chair of the Research Committee and a member of the PCH Council and Executive.

Professor Colditz brings to the Board broad experience in College affairs, as well as expertise in research, research training, research translation and entrepreneurship. He has past and current experience as a member of national not-for-profit Boards and is a member of the Australian Institute of Company Directors.
Associate Professor Nick Buckmaster is a General and Respiratory Physician at the Gold Coast Hospital and Health Service and an Associate Professor at Griffith University Medical School. He has held many leadership roles in many areas of his profession, reflecting his passion for engaging with productive change to the health system.

Recent roles include presidency of the Internal Medicine Society of Australia and New Zealand, where he drove the reinvigoration and recognition of General Internal Medicine. He is also Clinical Leader of the Gold Coast electronic Medical Record (eMR) project, which introduced a direct entry eMR across all areas of the Gold Coast acute sector, a change which is probably a first for hospital inpatient services in Australia.

Associate Professor Buckmaster has had a long involvement in medical education and training, previously as Director of Clinical Training at Caboolture Hospital for 10 years and now as a member of the Department of Health Medical Training Review Panel and Chair of its Data Subcommittee.

Associate Professor Buckmaster is a member of the SAC for General and Acute Medicine and has been an elected member of the RACP Adult Medicine Divisional Council for four years and a member of the AMD Executive Committee for the last two years.

As President of Australian Salaried Medical Officers Federation Queensland over many years and Secretary of the corresponding federal union, he understands the importance of appropriate human resource management in supporting system reform. He has also held offices within AMA Queensland, including as Chairman of AMA Queensland Council.

Associate Professor Buckmaster welcomes his appointment as a Member of the RACP Board as an opportunity to work toward improving engagement with the College membership and strengthening College governance efficiency. He is also interested in work to further raise the profile of the College as a trusted source of impartial advice to government on strategies to improve the efficiency and safety of our health systems.

Dr Helen Rhodes is a Renal Physician at Fremantle Hospital and for the past five years has also been Director of Physician Training there. In addition, she works as a visiting Renal Physician and Director of Haemodialysis at St John of God Hospital in Bunbury in the south-west of Western Australia.

Prior to this, Dr Rhodes spent two years as Area Medical Educator for the Northern Sydney Area Health Service, combining this with regular locum work as a Renal and General Physician in the Blue Mountains.

Dr Rhodes has been a member of the Adult Medicine Division Council for the past four years and was invited to join the Board two years ago as one of its representatives. She is also a Board Representative on the WA RACP State Committee.

Since commencing work at Fremantle Hospital in 1996, Dr Rhodes has been actively involved in a wide range of teaching and educational activities, including Facilitator Training for Teaching on the Run Workshops. She has also been involved in postgraduate Medical Council activities in WA and for three years was a Director of Clinical Training at Fremantle Hospital.

Being invited to remain on the Board presents an opportunity to further develop her role as a physician educator and mentor, and to contribute to the College and her colleagues.
Dr Alexandra Greig is a Public Health Registrar in the Population Health Division of ACT Health in Canberra. She is an Advanced Trainee in Public Health Medicine with the Australasian Faculty of Public Health Medicine (AFPHM).

Dr Greig is the Chair of the College Trainees’ Committee and also sits on the Faculty Education Committee and the National Trainees’ Committee of the AFPHM.

Dr Greig is a graduate in medicine from the University of Auckland. She completed a Masters in Public Health (Health Policy) as a Fulbright Scholar at Harvard School of Public Health in 2011. Her research interests include health systems reform and health policy related to HIV/AIDS and disability.

Dr Evan Jolliffe is an Advanced Trainee in Neurology and General Medicine in Wellington, New Zealand.

Dr Jolliffe is the Deputy Chair of the College Trainees’ Committee, Co-Chair of the New Zealand Trainees’ Committee and a member of the RACP New Zealand Committee. He served as the lead trainee for the inaugural RACP Australasian Trainees’ Day.

Dr Jolliffe’s current research interest is the integration of primary and secondary care models for atrial fibrillation and stroke prevention.
KEY PRIORITIES FOR THE PAEDIATRICS & CHILD HEALTH DIVISION

Paediatrics & Child Health (PCH) President Dr Nicki Murdock recently spoke with RACP News about her new role, the current and future priorities of the Division and the debate around the establishment of a separate College for paediatricians.

**RACP News:** Congratulations on your appointment as President of the Paediatrics & Child Health Division (PCHD). What does being President of the Division mean to you?

Thank you. Being President is a chance to contribute to the health of all children in Australia and New Zealand. I hope to use the time to achieve change in government policies that potentially affect all children within our borders, be they Indigenous Australian or Māori or not, be they Australian, New Zealander or children who aspire to join our countries. That change will be achieved by impactful advocacy so that the issues we all feel strongly about are brought to the attention of the community and our politicians.

**RACP News:** What is the role of the PCHD and how does it represent our paediatric Fellows and trainees?

The role of the Division is one currently being debated by the College, the PCHD Council and Fellows and trainees. Some Fellows have re-presented the issue of forming a separate college. As Council members, we have debated this issue recently and posed the following questions:

1. What is driving people to want to break away?
2. Will those issues be addressed within currently proposed governance reforms?
3. Does the latest proposal by the group, led by Professor Kevin Forsyth – an Academy of Paediatrics – fulfil the desire for separate advocacy and greater influence over certain aspects of being a paediatrician?

The PCHD Council recognises we need a future sensitive to all members’ needs, and members should be consulted and apprised of what is involved. A substantial amount of work is needed to effectively assess the option, and serious consideration would need to be given to many things, including the provision of high-quality education accredited by the relevant bodies in Australia and New Zealand, the willingness of hospitals and training settings to work with another College and the establishment of a strong voice with governments and stakeholders.

In my view, the PCHD Council has many functions, but overall lies the remit to ensure that paediatrics and the health of children and young people are considered in all parts of the College, be that education, CPD, policy or advice to those who ask for it, such as governments.

**RACP News:** As President of the PCHD, what are your key responsibilities?

The President has scope to determine the strategic direction of the Division with input and support from the Council. The key objective of the Division’s strategy is to improve the health and wellbeing of children and young people. I see it as my role to represent paediatricians and trainee paediatricians within the greater environment of health in both Australia and New Zealand. The latter is a greater challenge for me as an Australian paediatrician; however, next year I intend to travel to New Zealand to meet with paediatricians in the South Island and also with others at the Paediatric Society of New Zealand meeting.

**RACP News:** What do you hope to achieve during your term as President?

I want to make our advocacy more effective and get some fire into it, whilst still maintaining our status within the community.

I’d like the College to offer more CPD activities, not just count points; this includes ensuring that revalidation is designed to be workable. I will be discussing sharing CPD with the Royal College of Paediatrics and Child Health (UK) during my visit to the United Kingdom. Most importantly, I would like to have a well-considered discussion about the future of paediatrics within the College to improve the way the College works for all Fellows and trainees, including paediatricians. As part of that, I support the work being done to look at the structure of the College.

Continued on page 14
FRUITFUL MEETING WITH NATIONAL CHILDREN’S COMMISSIONER

On 4 September, PCHD President-Elect Dr Sarah Dalton, Senior Policy Officer Alex Lynch and I met with [Australian] National Children’s Commissioner Ms Megan Mitchell to discuss a range of areas for promoting the health and wellbeing of children. The meeting with the National Children’s Commissioner was a welcome opportunity to discuss multiple child health issues on which the RACP and the Australian Human Rights Commission (AHRC) share common views and goals.

High on the agenda was a discussion around asylum-seeking children in detention. The RACP has called for the immediate release of every child in detention and we discussed how the AHRC might assist us in continuing to strongly advocate this position with government.

Also canvassed was the idea of strengthening Australia’s position against the physical punishment of children through Early Childhood Australia’s

Supporting young children’s rights: statement of intent (2015–2018). Action on this issue remains a key goal for the College. Australia lags behind many other developed nations in addressing this; New Zealand, for example, introduced children’s rights legislation in 2007.

Progress was made on the idea of campaigning for the introduction of an [Australian] National Chief Paediatrician and we will continue to develop this in the coming months.

The Australian Paediatric Endocrine Group guidelines on the treatment of adolescents with disorders of sex development (DSD) were raised in this meeting as well. There is currently no strong consensus amongst paediatricians on best practice in treating infants with DSD. I advised Ms Mitchell that I am currently examining the feasibility of holding a session on intersex children at the College’s 2015 Congress.

I welcome further opportunities to engage the National Children’s Commissioner and look forward to strengthening the Division’s partnership with the AHRC during my time as President.

Dr Nicki Murdock
PCHD President

Continued from page 13

RACP News: What are some of the key priorities of the Division for the next 12 months and beyond?

Key priorities for the Division include improving advocacy, particularly for those most vulnerable amongst the children of Australia and New Zealand, for example those with a disability or in detention, and improving the governance of the College to better meet the needs of our Fellows and trainees.

The PCHD Council recently met to develop the PCHD Plan for 2015; at the time of writing this requires approval from the Board. The draft is available on the Division webpage.

Finally, I am interested to hear members’ thoughts, so please contact me at paed@racp.edu.au.
RACP News: What has PPAC been working on this year?

This year, PPAC has continued its work in a number of really important areas as well as establishing new work priorities. We are in the process of finalising a revision of the College’s Child Protection Position Statement Protecting Children is Everybody’s Business. This has undergone a major review and will reinforce the role of paediatricians in protecting children. We have been really fortunate that a number of colleagues on the Committee have brought insights from major national initiatives in both Australia and New Zealand to inform our approach.

Physical punishment of children was a major policy launched last year and our advocacy work on that position continues. This was an important position statement as it brought clarity to colleagues around the harms associated with physical punishment and raised awareness of effective alternatives to bring about change in children’s behaviour. We also discussed this at our recent meeting with the National Children’s Commissioner, Ms Megan Mitchell (see article on page 14).

RACP News: What new projects are underway?

We have established two new areas of work this year. One is recommendations for newborn screening. Currently, there is a rather ad hoc approach to newborn screening around the country. We will recommend a comprehensive national approach to newborn screening and call on it to be properly funded. Developments in screening for new genetic and other diseases are becoming available all the time and we want to ensure a systematic and considered approach to their implementation. This project has also benefited from the expertise of paediatricians with established expertise and interest in the screening of newborns for metabolic and other conditions.

We are also hoping to finalise our policy on adolescent access to sexual health services shortly. It’s a complex area: as adolescents become more able to meet their own healthcare needs, issues of confidentiality and consent emerge. Adolescence is both a very important and a very vulnerable period in a young person’s life. Using our colleagues’ adolescent sexual health expertise to develop position statements like these has been very important. The issue of consent can be a challenge both for a practitioner who may be used to working with younger children and for parents.

Another position statement will examine the role of paediatricians in the care of children with mental health problems. Data suggests that around one-third of paediatric practice involves care for such children, and in some practices it’s a far larger percentage. Yet strategic plans from governments often overlook the role that paediatricians play in identifying and treating these children. To develop better care models for them and their families, we firstly need to recognise the role of paediatricians and then develop models of care that have a life-course approach across disciplines.

RACP News: Does the PPAC benefit from its multidisciplinary approach?

Absolutely! This is a vibrant group of people who are committed to doing what they can to improve the health and wellbeing of children. We also benefit from the great insight our consumer representative brings to our discussions. We regularly consider how we should involve young people themselves, and have recently attempted to do that as part of a working group.

RACP News: What’s ahead for the PPAC?

Paediatricians involved in our advocacy efforts want to recognise the needs of disadvantaged children: children in out-of-home care, socioeconomically disadvantaged children and children in regional and remote areas. We know that in order to improve the health of the population as a whole, we need to improve the health of disadvantaged groups particularly.

There is a range of other issues of interest or for which the expert opinion of paediatricians needs to be sought. Breastfeeding is one; the impact of media on the health, development and wellbeing of children is another. These are really important areas, with growing research highlighting their importance and relevance for health and wellbeing.
Paediatrician Dr Josh Francis writes with great compassion of the devastating health and psychological effects of confining already traumatised children in detention centres for extended periods.

Post-traumatic stress disorder (PTSD) seems a particular tragedy when it presents in those whose few years of life seem too short to have been exposed to sufficient trauma for the condition to manifest. I will never forget the young teenager whose mother said of him, “My son has suffered a lot and is now a broken-hearted child and anger is taking him”. I met him in a refugee clinic, and I am sure the little I knew of his story barely scratched the surface of the atrocities he had experienced first-hand. His trauma, gratefully, has passed, but the psychological sequelae remain. His situation is a stark reminder to me of the devastating impacts of persecution, famine and war that continue to afflict children the world over, as well as the potential our country has to be a true haven for young people fleeing such perils.

Last month I met another boy whose family similarly escaped the very real dangers of their home country, in hope of new life and opportunity in ours. This child is barely half the age of the other boy, but nevertheless the marks of PTSD are undeniable. He has developed secondary nocturnal enuresis, and more recently has been incontinent during daylight hours. His sleep is poor, postponed by unspoken fears and interrupted by nightmares. He startles easily and has trouble engaging with peers his age. He comes across as a thoughtful boy, all too aware of the anxious thoughts that plague his parents and the uncertainty of his own future. Like many other families, his has been moved between detention centres in Perth, Darwin and Christmas Island with minimal notice or explanation. Their most recent transfer to the mainland came about because of his younger brother’s chronic illness. For this child, the traumatic experiences of a desperate flight, a shipwrecked boat and the untimely deaths of close family members are compounded on a daily basis by the ongoing trauma of life in an Australian detention centre.

Pleadingly, I wrote in his notes, “Needs release from detention”. The very next day brought a glimmer of hope with an announcement from the Government regarding the release of children from detention. My heart leapt, momentarily. Unfortunately for this family, they arrived in Australia after 19 July 2013 and the Government’s decision specifically excludes those children and families who have been moved to mainland detention centres for health reasons. And so he will continue to live behind locked gates; he will continue to witness escalating mental health issues and associated self-harm; I expect he will continue to wet his bed. What hope can there be of addressing the effects of PTSD in a child whose trauma is ongoing, propped up by seemingly immutable legislation in one of the freest countries on earth?

The decision to provide bridging visas to some children and families who have been living in detention admits the significant harm that the detention environment causes children. And yet, for children who are over 10 and for those who arrived in Australia after 19 July 2013, indefinite detention is an ongoing reality, without regard for the devastating impact it has on many of them.

Current immigration policy has gone some way towards “stopping the boats”. But at what price? The measures that have been pursued to achieve this end include the deliberately cruel treatment of already traumatised and vulnerable people in order to deter others from seeking asylum here. Surely this is neither just nor merciful.

Children and young people around the world suffer inordinately at the hands of those whose responsibility it is to care for and protect them. That they suffer as a direct result of Australian immigration policy is appalling.

Dr Josh Francis, member of the RACP Health of Asylum Seekers and Refugees Working Party

“Children and young people around the world suffer inordinately at the hands of those whose responsibility it is to care for and protect them. That they suffer as a direct result of Australian immigration policy is appalling.”
The College’s New Zealand Paediatric and Child Health Division Committee (NZ P&CHDC) has expressed concern at the increasing use of “gummy” multivitamins among children, compounded by advertising campaigns for these products targeting children and their parents. The Committee has formally written to the Royal New Zealand College of General Practitioners, Plunket and the Pharmacy Guild of New Zealand to outline its concerns and encourage a multi-organisational approach to inform the public about the potential for misuse of multivitamins by children.

Worldwide, companies have begun to produce multivitamins in a chewable gummy, rather than as a tablet or capsule, and often in the shape of an animal or cartoon character. These products have the appearance, taste and texture of a lolly and, combined with brightly coloured packaging, are designed especially to appeal to young children. Associate Professor Susan Moloney, Immediate Past President of RACP’s Paediatrics & Child Health Division, has noted that Parents need to be vigilant, as there is a risk that a young child could overdose on a product that looks and tastes very much like a lolly.

Children may also experience unpredictable reactions as a result of excessive multivitamin use, including swelling and pressure around the brain, which can lead to prolonged medical treatment. Moreover, research shows that children most likely to be given a multivitamin are least likely to require one to combat any lack in essential vitamins and nutrients.1,2

As with multivitamins, the advertising in New Zealand of sports and energy drinks through the incorporation of colours and recognisable branding is designed to appeal to children and young people. These drinks are often high in sugar and some contain large amounts of caffeine.3 Campaigns for these products may be tied in with particular events or sportspersons, creating an association in children’s minds that equates physical activity with a perceived “need” for a sports or energy drink. A recent study from the University of Otago4 found that a child exposed to sports and energy drinks in the context of sport would equate these sugar-sweetened beverages with “providing the energy [needed] for playing sport [or] hydration or [with quenching] thirst.”5

The NZ P&CHDC believes that children and parents, on their children’s behalf should be encouraged to make healthy choices and recommends they consult the Ministry of Health’s Food and Nutrition Guidelines for Healthy Children and Young People (Aged 2–18 years)6 or the Australian National Health and Medical Council’s Australian Dietary Guidelines.7 The College supports further research into the uses of complementary medicines in Australia and New Zealand and improved regulation to ensure vitamin products demonstrate evidence to support the claims made for them.

“Research shows that children most likely to be given a multivitamin are least likely to require one to combat any lack in essential vitamins and nutrients.”

References
5. ibid.
WATER FLUORIDATION IN NEW ZEALAND – A MAJOR PUBLIC HEALTH ISSUE

The College has been active in Australia and New Zealand advocating for an evidence-based approach to public health measures that could have positive outcomes for more vulnerable groups in the community. This article focuses on the urgent need for fluoridated water to be available to all communities in New Zealand, particularly in view of recent telling evidence.

The addition of fluoride to population centres’ water supplies in New Zealand has been subject to debate in the mainstream media and communities over several years. New Zealand has very low levels of naturally present fluoride in its water supply. The addition of fluoride to community water supplies to raise levels to between 0.7 and 1.0 mg/litre has positive outcomes for the oral health of all people, and particularly for a number of vulnerable groups within communities, including children, the elderly, those in lower socioeconomic groups and Māori. Oral health is an essential part of overall health and wellbeing; poor oral health can result in long-term consequences for an individual’s health and wellbeing, as well as their appearance, which in turn can adversely affect self-esteem. Decay is irreversible and often cumulative: individuals experiencing tooth decay at a young age will likely suffer extensive tooth loss later in life.

In New Zealand, water reticulation (the monitoring, treatment and supply of drinking water) is the responsibility of the local regional or district council. It is estimated that 56% of the New Zealand population receives fluoridated drinking water via reticulated water supplies. Of the major centres, Christchurch, New Plymouth and Tauranga are the only cities which currently do not have fluoridated water. In the last three years, the councils of Hamilton, New Plymouth and Waipukurau in Central Hawke’s Bay District renewed discussions around fluoridation, with all three councils voting to remove CWF. However, following a referendum in 2013, the Hamilton City Council reinstated CWF in July 2014.

The College’s contribution to the debate

The College has contributed significantly to the fluoride discussion in New Zealand and Australia, advocating strongly for an evidence-based approach that confirms the broad public health benefits of CWF. The College’s 2012 position statement, “Oral health in children and young people”, acknowledges the importance of lifelong oral health and recommends “supporting cost-effective public health measures that have a proven impact on child oral health, such as public water fluoridation”.

In 2013, the College’s NZ Paediatrics and Child Health Division Committee (NZ P&CHDC) wrote to the Minister for Local Government, the Hon. Chris Tremain, strongly supporting the arguments for municipalities to continue CWF and registering concern at the growing influence of the anti-fluoride lobby. The NZ P&CHDC maintained that central government has a responsibility to actively educate and inform the public on the facts of water fluoridation, particularly as a safe, cost-effective and equitable process contributing to improved health status for New Zealanders.

Erena Browne, a fifth-year medical student from the Faculty of Medicine and Health Sciences, University of Auckland, was awarded the 2013–14 Summer Studentship offered jointly by the College and Te Ohu Rata o Aotearoa (Te ORA), the Māori Medical Practitioners’ Association. Erena’s research project, “The relationship between fluoridation and oral health outcomes for Māori children” is a comprehensive examination of the relationship between access to CWF and incidences of dental caries and decayed, filled or missing teeth in Māori children. The study used data collected via the Ministry of Health’s oral health statistics, sourced from District Health Boards’ Community Oral Health Services.

Erena Browne’s results indicated that while both Māori and non-Māori showed positive responses to fluoridation, “Māori children show a relatively greater impact from the introduction of fluoridation compared to non-Māori. This implies that not only will the introduction of national water fluoridation improve health outcomes for all children, it is also likely to narrow the ethnic disparities that currently exist.” Ms Browne’s research report will be made available to the Ministry of Health’s Oral Health unit and Te Aō Marama, the Māori Dental Association.

Prime Minister’s Science Advisor and Royal Society of New Zealand Report

The potential for positive health outcomes is confirmed in an exhaustive review of the scientific evidence on CWF, commissioned by Auckland City Council on behalf of several other local government organisations.

“While both Māori and non-Māori showed positive responses to fluoridation, Māori children show a relatively greater impact from the introduction of fluoridation compared to non-Māori.”
The panel of experts was led by Sir Peter Gluckman, the Prime Minister’s Chief Science Advisor, and Sir David Skegg, President of the Royal Society of New Zealand. The report, *Health effects of water fluoridation: a review of the scientific evidence*, details the scientific issues around the safety and efficacy of fluoridation of water in decreasing incidences of dental caries. While acknowledging concerns regarding safety and efficacy of fluoride, the review’s findings did not consider there were any significant philosophical or ethical issues around fluoridation.

The report concludes that “water fluoridation is an effective preventative measure against tooth decay that reaches all segments of the population, and is particularly beneficial to those most in need of improved oral health”. By extension, the cost to the taxpayer of CWF is minimal, but the cost of not implementing CWF is far greater when the associated dental costs are included. A range of claimed side-effects of consuming fluoridated water, including increased incidences of some cancers and lower IQ in children, are not supported by the evidence.

The review process analysed the findings of a large number of studies and systematic reviews and the report found conclusively that, from a medical and public health perspective, “water fluoridation at the levels used in New Zealand poses no significant health risks and is effective at reducing the prevalence and severity of tooth decay in communities where it is used”. The report also noted that the Ministry of Health is preparing further studies of the efficacy of CWF, particularly around cost-effectiveness in relation to the size of the community.

The report’s conclusions that CWF is both safe and effective should be encouraging to local government bodies considering reviewing fluoridation of community water supplies. The benefits of reduced caries and improved oral health for vulnerable sectors of the community, including children and the elderly, make CWF a viable public health intervention.

NZ Paediatric and Child Health Division Committee
Māori Health Committee

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1. The review by Sir Peter Gluckman and Sir David Skegg notes that natural concentrations of fluoride in New Zealand’s drinking water are ~0.1–0.2 mg/litre. Gluckman P, Skegg, D 2014. *Health effects of water fluoridation: a review of the scientific evidence*. Wellington: Royal Society of New Zealand and the Office of the Prime Minister’s Chief Science Advisor. August.
9. ibid.
Dr Nigel Stewart, Rural Paediatrician

**RACP News:** How long have you been practising as a paediatrician in Port Augusta?

I have been in Port Augusta just over 21 years.

**RACP News:** What drew you to the area?

I came on a two-year contract and stayed.

**RACP News:** How have your experiences in regional practice differed from your experiences in city/metro practice?

Port Augusta is the last place on the sea and I could not bear to live away from the sea, and at the time 300 km to the next paediatrician seemed about the right distance for me and my colleagues. Living in a community rich in Aboriginal culture and with a Royal Flying Doctor Service base seemed reasonably exotic to a New Zealander.

In a city/metro practice, call is intense but short lived and you can hand over to colleagues. Call in a rural community can be long and relentless, with low-level demands and periods of extreme urgency and the need for high performance. In the city, a sick child has a cast of thousands providing care and individual performance does not matter as much. In a regional setting, you are often the only person with paediatric experience and need to firstly manage yourself and exhibit leadership. Failure to do so is very concerning to other team members.

**RACP News:** As a regionally based paediatrician, what challenges do you face?

They are infinite and varied. They include looking after your own health, getting life in balance and at times minimising relentless demands. There is a balance between engaging with the community, being part of the community and sometimes having to be apart from the community, and tolerating personal criticism. In a city of a million people or more these are small issues, but in a small town they are very real.

The biggest challenge is a lack of understanding. This occurs on many different levels, both locally and at a distance. Commitment to rural specialists is minimal, but action from the Australian system has been even smaller over the 21 years I have been here, with some notable exceptions. Preserving, maintaining and expanding regional services in the face of administrative, clinical and political frameworks is extremely challenging. The more one is alone and isolated, the more difficult this becomes. My answer to this is small team structures.

**RACP News:** What are the benefits of being a regional paediatrician?

The benefits of being a regional paediatrician include becoming a much better clinician, developing good decision-making pathways and diplomacy, and becoming embedded in your community.
The community does indeed provide emotional sustenance and support. I am largely happy as I have friends, family and a little money to spend with friends and family. Do I need anything more?

**RACP News:** What do you think it takes to commit to a long-term career in rural/regional practice?

In the past, people had a bit of a focus on heroic figures. What is needed these days is people who are well trained and appreciate good evidence-based medicine, but are flexible and come to the rural service with a modicum of emergency skills, excellent community skills and some leadership and management skills to take a crowd of people along with them. The people with these skills mostly want to work in a small team environment. Small teams, in my experience, can be one of the most positive parts of practice.

**RACP News:** A number of challenges face hospitals and health networks when it comes to attracting and retaining doctors in rural and regional areas. What can be done to encourage/entice paediatricians into rural/regional practice?

The RACP could do much more to encourage people into rural practice. This includes knowing where the workforce demands are in Australia, supporting training and placement models that give young practitioners confidence to move into rural practice, and providing advocacy and support for the important social structures that are needed locally and the incentives that are necessary to live in places where most Australians don’t wish to live or work. These then need to be ring-fenced and not simply reallocated at the next election to outer metro areas due to short-term political decisions. I came from an urban area and a high-intensity environment in New Zealand. It is very different in a regional area, but the pressures and stressors are actually at times not a lot different. Working with small teams, and much closer to the community, places one much closer to the fabric of society.

Support helps, both collegial and administrative, both rural and urban. I have been fortunate largely to have had both.

**RACP News:** What would you say to others to encourage them to work in a regional area?

Regional work provides an opportunity to become a much better generalist and general paediatrician. It also provides huge opportunities for personal insight and growth. I would encourage all young general paediatricians to consider spending a period of their life in regional practice. They and their families would be the richer for it. My life and family have been enriched immeasurably by the experience.

**Dr Khurram Noori, Paediatric Registrar**

**RACP News:** How long have you been based at the Northern Regional Paediatric Unit?

Approximately 10 weeks.

**RACP News:** Have you enjoyed the experience? Why/why not?

I am really enjoying my rural experience. It is a more hands-on experience. I manage not just paediatric medical patients, but also review and manage paediatric surgical, ear, nose and throat, orthopaedic and neonatal presentations to the Emergency Department. I have also been given the opportunity to make independent evidence-based decisions on patients’ management with an option of discussing them with the consultant as required, which I think is crucial for an Advanced Trainee.

**RACP News:** How has your training experience at a regional hospital differed from your training experience in metropolitan hospitals?

As mentioned above, there is a vast range of exposure at a regional hospital. I also do day clinics at Whyalla and Roxby Downs hospitals on a regular basis. Even within General Paediatrics, I have seen a good variety of cases in the short time I have been here. It has enhanced my experience and exposure from my General Paediatric training. It has also helped me grow both on a personal and a professional level.

**RACP News:** Once you finish your training, do you intend returning to rural/regional practice? Why/why not?

I have not made any concrete plans at this stage, but this is something I would definitely consider.

**RACP News:** What would you say to others to encourage them to work in a regional area?

I would recommend a minimum of six months in a regional area for all trainees as this experience is very different from that of a metropolitan hospital. We don’t have the luxury of other specialties reviewing our patient immediately and we attend to and stabilise the patient first hand. This is a really good term to brush up on emergency skills as well, which you may not be required to use as a paediatric physician trainee in a metropolitan hospital unless you are doing a term in the Emergency Department. This experience teaches you to perform at your best with limited resources at hand.

**RACP News:** What do you like most about living and working in Port Augusta?

I haven’t been in Port Augusta for very long, but I have really enjoyed it. The best part is working with the fabulous paediatric team at Port Augusta. The entire medical, nursing and admin staff is very approachable and helpful. All the paediatricians are very flexible and have a family-friendly approach, which has helped me settle in very quickly and make Port Augusta a home away from home.
IT’S TIME TO CURB YOUNG DRINKING

Alcohol is very much an accepted part of Australian and New Zealand culture. It is consumed by most adults and makes a significant contribution to our economies. As a recreational drug, it confers some benefits in facilitating relaxation, socialisation and conviviality. It is seen as a natural, and by some an essential, part of celebrations.

Yet we need also to take account of the negative impact of alcohol and the harm it causes. This is estimated to cost Australia approximately 3000 lives and $15 billion each year, while in New Zealand the cost of the harms of alcohol are estimated at almost $5 billion a year. In reality, however, these figures are an underestimate as they don’t include all of the costs stemming from harm to others.

As physicians, we see the health impacts every day in emergency departments, in clinics and on the wards. In particular, though, we should be concerned about the impact of our drinking culture on our young people.

Almost one-fifth of 14–19-year-old Australians and 40% of 18–19 year olds are weekly drinkers, and a third of those aged 18–19 drink at levels which place them at a lifetime risk of alcohol-related harm.

We know that heavy drinking during adolescence is associated with poorer cognitive functioning and possible brain response abnormalities. We also know that young people have a propensity to combine high-risk drinking with other high-risk activities, which amplifies their risk of harm or even death.

Young people are commonly harmed through the drinking of their parents and other adults. It’s time we did something to address this. In particular, it’s time to take concrete steps in both countries to change our culture of drinking so that our young people can enjoy a healthier life.

Exploitation of loopholes in alcohol advertising restrictions

The advertising and marketing of alcohol is highly pervasive. It goes beyond traditional media such as television, print, radio and billboards, and extends into sponsorships and social marketing strategies; the latter rapidly growing in importance. It is clear from the research that alcohol advertising encourages underage people to take up drinking and makes regular young drinkers more prone to harmful and binge-drinking patterns.

This is why we have restrictions on the times when alcohol advertising is allowed on TV. However, these regulations to reduce exposure to young people do not apply to live sports broadcasts or to sponsorship arrangements. Every weekend we have alcohol brands shown for hours during TV sport. We have page after page in our newspapers, with alcohol brands emblazoned across the chests of our sporting heroes and even our Premiers.

This exemption clearly provides a significant loophole for the alcohol industry. Not surprisingly, sporting events are the second most important form of advertising for alcohol after television. According to one estimate, the alcohol industry in Australia spends $50 million a year on sponsorship of major sporting events.

There is significant support in the community for the abolition of this loophole, with a recent Australian survey showing 67% of the public thought it was time to phase out sponsorship of sport by the alcohol industry.

Harms of drinking for teenagers

There is a substantial body of evidence that shows a strong negative relationship between the minimum drinking age and the rate of hospital presentations for young people, notably resulting from traffic accidents. For example, when New Zealand reduced its drinking age from 20 to 18 in 1997, this led to significant increases in hospital presentations of intoxicated people aged under 20 and rates of traffic accidents among 15–19 year olds.
We know that early drinking increases the risk of suffering from alcohol use disorder and drug use disorders in adulthood(12), so increasing the legal drinking age is vital.

These findings suggest that we need a public debate about the potential benefits of raising the current legal drinking age, as well as community discussion on the trade-offs for keeping our young people safe versus some curtailment of their freedom.

The impact of drinking and driving

In Australia and New Zealand it is an offence for any motorist to drive with a blood alcohol concentration (BAC) of 0.05% or greater (a zero level is required for learners and "P plateers"). We know that alcohol affects driving ability, with those with a BAC level of 0.05 twice as likely as before they started drinking to have an accident.

Our drink-driving laws have been a major public health success. However, research suggests that reducing BAC limits even further would continue to yield reductions in fatal crashes related to drink driving(16), including among younger drivers. For instance, there was a 10% reduction in fatal crashes related to drink driving in Sweden after it reduced its BAC limit to 0.02.

Education and mandatory treatment interventions for drink drivers and the incapacitation of vehicles through the use of ignition interlock devices have also been found to be effective means of increasing compliance with licence suspension and reducing recidivism. Ignition interlock programs require people convicted of drink-driving offences to install an alcohol ignition interlock on their vehicle.

Time for action

The prevailing culture of drinking in Australia and New Zealand does no favours for our young people. It needs to be addressed, and three tools that could potentially drive this culture change are phasing out alcohol industry sponsorship of sport, reducing the BAC limit for drivers and increasing the legal drinking age. These measures have been shown to be effective and have growing community support. It is time we had more open and informed public debate on whether Australia and New Zealand should take some of these steps to reduce the often devastating harms caused by alcohol, especially its impact on our young people.

Professor Paul Haber
Co-chair, College Alcohol Working Party
Clinical Director, Drug Health Services, Sydney Local Health District
Head, Discipline of Addiction Medicine, Sydney Medical School,
University of Sydney

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2. Ibid.
11. Kypros K et al., op. cit.
ADOLESCENT & YOUNG ADULT HEALTH

DANGER OF IGNORING ADOLESCENT AND YOUNG ADULT HEALTH NEEDS

Chair of the Adolescent and Young Adult Medicine Committee Dr Andrew Kennedy writes of the measures physicians and paediatricians can take to improve the lives of all of our young people.

Adolescence presents an opportunity for health professionals to positively influence the health of young people in a way that will best support their physical and mental health over the course of their lives. Unfortunately, our current health system is not seizing this opportunity and many young people face a health system that is confusing and often ill-equipped to meet their specific health needs.

The World Health Organization defines “adolescence” as 10 to 19 years and “youth” as 15 to 24 years. The terms “young people” and “adolescent and young adult” cover this overlapping range of 10 to 24 years.

The challenge

Today’s adolescents and young adults face new health and social challenges, including the earlier onset of puberty and different societal and peer expectations. It is also an influential period in a person’s life when risk behaviours emerge that can affect health, such as alcohol consumption, smoking, substance use and sexual activity. It is a time when eating habits and sedentary lifestyle patterns may become established, leading to obesity. In addition, many mental health issues present for the first time during adolescence.

Delivering the best healthcare to this age group can require different approaches and particular skills. This means physicians and other health professionals need to be trained so that they are confident communicating with and providing services to adolescents and young adults. Extensive and clearly defined systems are in place to address the unique health needs of children and the elderly in our society. In contrast, the absence of a recognised focus on adolescent and young adult health needs puts young people and especially those with complex conditions at risk of falling through cracks in the health system.

CASE STUDY PART 1

Jane, a 17-year-old patient, was recently transferred from a paediatric hospital to an adult hospital. She has a cleft palate, probable obstructive sleep apnoea, morbid obesity and recent onset type 2 diabetes. She found school attendance challenging and also had low mood, thought to be due primarily to the recent death of her severely disabled sister. At the children’s hospital she was under the care of a general paediatrician and a respiratory physician and was seeing the plastic and ENT surgeons. She also received counselling regarding her recent bereavement. Her transition to the adult service was poorly conceived, simply involving a transfer from the paediatric diabetes team to the adult one. Her mother – despite being a nurse – was unable to advocate effectively for a more comprehensive transition process.

CASE STUDY PART 2

In Jane’s case, the adult diabetes team requested a consultation from the adolescent medicine team that, fortunately, exists in their hospital. The adolescent medicine team was able to assist in helping the other health professionals involved to evaluate and understand Jane’s care needs, thus facilitating the process of transition and transfer to adult care. Recommendations included arranging a mental health review, along with liaison with her school in an effort to re-engage her in education.

Dr Andrew Kennedy Chair of the Adolescent and Young Adult Medicine Committee

For young people with a chronic illness, the transition from paediatric to adult health services is often not handled optimally. Poor transition processes represent missed opportunities to build self-management skills in young people, and can cause negative experiences and lead to poorer health outcomes, especially in those who disengage from care as a result.
The ability to identify and advocate for a young person’s particular needs and to provide consultation and support to other specialist teams is one of the hallmarks of Adolescent and Young Adult Medicine.

The need for engagement

There is a clear need for ways to improve interaction between the various points of contact that young people have with the health system. General practitioners should be aware of their options for accessing specialist advice directly and the services that are available for referring patients. Physicians and paediatricians need to take ownership of their patients’ transitions between services, particularly those of young people of a vulnerable age. They are able to bridge gaps in existing healthcare and during periods of transition, and can offer support to other health professionals.

A Melbourne-based study found that receiving training sessions in adolescent health allowed general practitioners to deliver more effective care to young patients.1

The need to engage where possible in patient-centred, family-focused care is often overlooked. Parents and carers can and should be involved in discussions about the health services that are most appropriate for their children or adolescents at their particular age. This improves the health literacy of both the patient and their family. For example, physicians can routinely spend part of their consultations with young people alone as they enter adolescence. This helps build self-management skills and autonomy around their healthcare in a gradual and developmentally appropriate fashion. Such small steps prepare young adults for negotiating the adult health system far better than an unplanned and often sudden shift to adult services.

Bringing about change

Physicians and paediatricians can give voice to the difficulties our young people face in accessing care and navigating the health system. Indeed, the health community should be engaged in discussions regarding the impact that educational, cultural and social environments have on adolescents and young adults. The health of young people is not simply a clinical issue. Physicians and paediatricians should be involved in public discourse around issues that affect their young patients, especially as a means to improve community-based preventative health efforts. Issues that need to be tackled include the impact of changing social norms on young people’s mental health, sexual health, attitudes to drugs and health risk behaviour.

The RACP and other professional associations and training bodies must prioritise Adolescent and Young Adult Medicine as an integral part of all medical and health specialties. All clinicians are involved in the care of adolescents and young adults and must therefore be able to look beyond single-organ diagnoses and screen for other emerging health risk behaviours or issues.

Australians aged 15 to 24 years is unique health challenges. However, the absence of a specific focus on the health of young people aged 10 to 24 years is contributing to the lack of progress in health outcomes for this demographic.

The medical world increasingly recognises that adolescents and young adults face unique health challenges. However, the absence of a specific focus on the health of young people aged 10 to 24 years is contributing to the lack of progress in health outcomes for this demographic.

**Dr Andrew Kennedy**
Chair, Adolescent and Young Adult Medicine Committee

**Resources**


**References**


Left to right: Mrs Elyn Stubblefield, international speaker Dr Michael Stubblefield, Australian television journalist Mr Ray Martin AM and AFRM ASM Organising Committee Member Dr Gerry McLaren

Left to right: AFRM President Dr Stephen de Graaff with AFRM Immediate Past-President Associate Professor Chris Poulos at the official handover of the Presidency ceremony.

Left to right: Professor Ian Cameron, AFRM ASM Convenor Professor Maria Crotty and invited speaker Professor Richard Osborne

Dr Miranda Jelbart presenting at the Cancer Rehabilitation plenary session

Founding Fellow (AFRM) Dr Richard Jones at the Annual Members’ Meeting

RACP staff member Krista Recsei speaking with a Fellow at the AFRM booth

Invited speaker Mr Ray Martin AM presenting “Reflections about remote challenges” at the opening ceremony
The Mortlock Chamber of the State Library of South Australia was a stunning venue for the AFRM ASM Gala Dinner.

Left to right: Immediate AFRM Past-President Associate Professor Chris Poulos presenting Professor Ian Cameron with the George Burniston Oration Medal

Associate Professor Steven Faux asking a question at the AFRM Annual Members’ Meeting

AFRM President-Elect Associate Professor Andrew Cole during a panel discussion on cancer rehabilitation

AFRM ASM Organising Committee Member Associate Professor Ruth Marshall at the Annual Members’ Meeting

Left to right: Dr Steven Faux, with special guest Dr Gillian Hicks MBE, RACP staff member Phillipa Affleck and AFRM President Dr Stephen de Graaff

Senior Research Fellow (University of Wollongong) and Manager of the Australasian Rehabilitation Outcomes Centre (AROC) Ms Frances Simmonds presenting on using AROC data on older people in private and public rehabilitation units

Left to right: Ipsen Group Product Manager Gavin Assauw with the AFRM Ipsen prize winner for best trainee presentation on neurological rehabilitation, Dr Bensy Mathew, and AFRM President Dr Stephen de Graaff
AFRM ANNUAL SCIENTIFIC MEETING ATTRACTS SIGNIFICANT ATTENDANCE

Close to 400 participants, including 250 world-leading Australian and international rehabilitation physicians, gathered in Adelaide for five days in September for the Australasian Faculty of Rehabilitation Medicine (AFRM) 22nd Annual Scientific Meeting (ASM), “Rehabilitation: off the grid”. The conference kicked off with pre-conference workshops, including a hands-on introduction to disabled sailor classification and a delegate sailing race! The workshop was kindly sponsored by Port Adelaide Sailing Club and was thoroughly enjoyed by all who attended – even inspiring some to contribute to and encourage the sport of disabled sailing.

The first day concluded with a networking reception where AFRM President Dr Stephen de Graaff welcomed delegates to the conference. Attendees were given the opportunity to socialise with colleagues, peruse the exhibition area and talk to attending sponsors in a relaxed setting.

The conference was officially opened on the second morning by ASM Convenor Professor Maria Crotty and an insightful and inspiring address, “Reflections about remote challenges”, by award-winning television journalist Mr Ray Martin AM. This provided an excellent start to the three-day program, which consisted of morning and afternoon plenary sessions, breakfast sessions and key AFRM orations, including the George Burniston lecture given by Professor Ian Cameron and Norington lecture given by Professor Rob Herbert.

In a well-developed scientific program, rehabilitation experts from Australia and overseas presented on many topics, including emerging therapies and technologies such as telerehabilitation, osseointegration, myoelectrics and new orthoses, transcranial magnetic stimulation, Gaming Therapy, Music Therapy and Cognitive Rehabilitation Therapy.

The conference highlighted special populations in presentations on cancer rehabilitation and older people’s rehabilitation, while challenging clinical areas of rehabilitation practice including pain, contractures, neuromuscular control of joint stability and differentiating hip and spine pain were given deserved prominence. The conference also addressed complex policy issues such as the National Disability Insurance Scheme (NDIS), Indigenous health and disability, and private versus public rehabilitation.

The Hypothetical Debate, facilitated by Mr Ray Martin, was a highlight, focusing on the NDIS with special emphasis on remote injury and the realities of re-entry to remote Indigenous communities in Australia. The Hypothetical was based on a grand round case presentation by AFRM Fellow Dr Gerry McLaren on catastrophic injury in an Indigenous elder in Central Australia to a panel of experts, with lively audience participation and questions.

At the Telehealth Group Lunch, Professor Patrice (Tamar) Weiss provided the keynote address via video link from Israel on “Telerehabilitation technologies and research: a well-balanced approach”, stressing the potential of telehealth to assist rehabilitation patients.

A number of social events complemented the academic program, including “Off the eaten track”, which provided delegates the opportunity to choose from a selection of local restaurants and meet up with other delegates, and the “Rural & Remote” dinner at Concubine restaurant.

But the highlight was the Gala Dinner held in the spectacular Mortlock Wing of the State Library. We were honoured to have Dr Gill Hicks MBE, a survivor of the July 2005 London bombings, as our guest speaker. Her story of survival from catastrophic injuries and her rehabilitation was truly inspiring to all in attendance (see a precis of Dr Anastassiadi’s interview with Dr Hicks at this event on pages 27 and 28).

Overall, the event was a wonderful opportunity for those working in Rehabilitation Medicine to meet, network and discuss topical issues and future directions for the profession with fellow physicians. The diverse and considered program was well received by all and left attendees excited to attend the 2015 Annual Scientific Meeting in Wellington, New Zealand, 13–17 October 2015, for which organisation is well underway.

My sincere thanks to all members of the organising committee for their hard work and dedication to the conference, in particular the leadership of Professor Maria Crotty as Conference Convenor.

We look forward to meeting again in Wellington next year.

Dr Peter Anastassiadis
AFRM ASM Organising Committee Member
IN CONVERSATION WITH GILL

On 11 September 2014 (the 13th anniversary of the 2001 New York terrorist attack), Dr Gill Hicks MBE spoke to Dr Peter Anastassiadis at the Australasian Faculty of Rehabilitation Medicine (AFRM) Annual Scientific Meeting (ASM) Gala Dinner in front of a captive audience. Gill Hicks is well known as one of the bilateral lower limb amputee survivors of the 2005 London bombings. This is her story.

She described rallying to choose survival in order to fulfill the firm conviction formed in those moments that she would make a difference and contribute to her fellow human beings. It was not until weeks later that she was to learn the circumstances of her injuries – a terrorist bombing.

Gill calmly described her immediate observations in the tube carriage. She recalled seeing her lower limbs as an anatomical dissection drawing of exposed flesh, vessels and sinews and both her feet barely dangling by tendons. She was able to act quickly to use her scarf to fashion two tourniquets to tie around both thighs. She elevated her legs and focused on her wrist watch, and reduced her breathing to maximize her body reserves. Subsequently, she lost consciousness.

Gill's account of the paramedics and the cardiac arrest resuscitation that ensued is extraordinary. She was fortunate to be attended to by a highly prepared (perhaps the most highly prepared) extreme adventure and environmental injury paramedic at the scene of the accident. The paramedic immediately arranged for ice from a nearby hotel to pack her neck and body. Gill can remember being given a “Priority 1” designation and feeling relieved and encouraged that she was on the “worthy to save” list.

Gill had a prolonged resuscitation. She lost 75–80% of her total blood volume. She had three cardiac arrests in total and reported having a “flat line (ECG) duration for 28 minutes.” Gill recounted that the resuscitation team at St Thomas' Hospital worked for a prolonged period, and that when the senior doctor advised that it was time to end resuscitation on a dead body, somehow the resus team achieved a consensus that they should go on for another 3 minutes and 30 seconds. Between that final 3 minutes and the end of the next 30 seconds, Gill’s heart responded and cardiac output was established.

Gill was locked in state for a period of time and unable to communicate verbally. Her
identity was “One Unknown”. A detective spoke to her and fortunately used the alphabet as a technique to find out her name. He asked Gill to blink as he arrived at the letters that spelt her name. She recalled being relieved at having such a short name!

Gill was also fortunate to have a highly expert vascular surgeon on site on the day of her arrival at St Thomas’. Her surgeon was able to salvage her limbs and preserve her lower limbs below the knee, whereas anywhere else in London – she was to learn – she would have had life-saving surgical amputations above the knee. In addition to the traumatic lower limb amputations, Gill suffered blast and explosion injuries to her head and chest, burns and eardrum injuries with deafness.

Gill has met all those responsible for saving her life: her rescue worker, paramedics, police officers and detectives, nurses and doctors, and rehabilitation therapists.

Gill had an extended period of rehabilitation and learning how to walk. She described in her husky jazz voice that, when her prosthetic prescribers were measuring her arm span to determine her height, she insisted – more likely demanded – that this was now her once in a lifetime opportunity to increase her height from 5 feet to 5 feet 7 inches by lengthening the prostheses that were to be fitted.

Since that time, Gill has continued along her extraordinary life journey. She has worked industriously as a philanthropist and for charitable foundations. She completed the 475 km “Walk the Talk” between Leeds and London in one month, raising awareness of the need for peace and for friendliness in community neighbourhoods among different ethnic and religious groups.

Gill has many friends who have lost loved ones as a result of terrorism and many friends with injuries who survived the London bombing. She commented that the actions of the terrorists on the immediate victims were not justified. Her philosophical conclusion about what happened and her being at the scene was that it was a random event from which she received a lottery winning ticket for survival. She also said that she was shielded and saved by a fellow citizen who did not deserve their fate in the circumstances that occurred.

Gill left her career in architecture and design to dedicate her life to peace building and working with extremists to try to overcome terrorism. She is Founding Director of M.A.D., an organisation based on the principles of the cell network adopted by some terrorist/extremist groups, but with the important difference that its focus is peace. She has been awarded Fellowship of the Royal Society of Arts and a Medal of the British Empire for her services to charity. Her acclaimed book, One Unknown, was shortlisted for the Mind Book of the Year 2007.

Gill has recently become an Ambassador for The Repat Foundation (based at the Repatriation General Hospital, Daw Park, South Australia) and is keen to contribute further to the rehabilitation and disability arenas. She is now training to do a climb in 2015 for the 10th anniversary of the London bombings.

Thank you, Gill Hicks, for your incredible story and life.

Dr Peter Anastassiadis FRACP FAFRM

To find out more about Gill Hicks and the work of her organisations, go to: www.gillhicksspeaking.com/; www.madnests.com; www.cease2hr.com.
It was a great honour to attend the RACP Foundation Cocktail Reception on 18 September 2014. Being a fortunate recipient of the RACP National Health and Medical Research Council (NHMRC) J J Billings Scholarship, a top-up scholarship to my NHMRC grant, I had the opportunity to meet members of the College, benefactors and fellow recipients and to briefly share with them what my research was about, what I had achieved and what lay ahead.

Adenocarcinoma of the oesophagus has become the fastest growing solid-organ malignancy over the past three decades, with a seven-fold increase in incidence in the West. Barrett’s oesophagus is the most common precursor to oesophageal adenocarcinoma. Pre-cancerous Barrett’s and early oesophageal carcinoma used to be treated by surgically removing the oesophagus – a procedure with high morbidity and long-term impacts on swallowing and digestive health. In the past decade, removing such lesions by endoscopy has become an acceptable treatment.

However, there are still many unanswered questions, such as identifying which particular patients are likely to progress from Barrett’s oesophagus to cancer, what the optimal endoscopic removal technique is and how the removal techniques can be made safer and more effective for our patients.

Having developed a passion for advanced endoscopy during my physician and gastroenterology training, I decided to contribute to the pool of knowledge through completion of a PhD. By my second PhD year, I had helped set up a large Australian multicentre registry of endoscopy referral centres, recording their experiences of evaluation and management of Barrett’s oesophagus. I have also researched novel ways of reducing oesophageal narrowing (stenosis) following endoscopic resection of Barrett’s tissue and have helped to determine which patients are most likely to progress to cancer. A highlight thus far was the opportunity to visit a state-of-the-art endoscopy and oncology centre in Dusseldorf, Germany. Observing their work has helped with furthering scientific ideas, learning about effective project management and fostering collaborative research between two similarly minded endoscopy centres.

Through the PhD, I have come to appreciate the importance of research, the logistic gaps in theory and successful practice of projects, and the importance of teamwork.

Investment in Australian research is truly vital and I strongly believe that it pays dividends. In my speech on the night of the Cocktail Reception I could not emphasise enough how grateful I was to receive such generous support from the Foundation. I strongly encourage fellow trainees to support the Foundation — it will inevitably assist us all at some point.

Dr Farzan F Bahin Endoscopy Research Fellow Westmead Hospital and University of Sydney
On Thursday, 19 September 2014 the RACP Foundation hosted a Cocktail Reception to acknowledge the 2014 award recipients and Foundation donors from New South Wales, Queensland and the Australian Capital Territory.

Twelve award recipients gave a short presentation about their research endeavours and had the opportunity to meet some of the College’s corporate, institution and private donors.

If you would like to attend an RACP Foundation event in the future, please contact the RACP Foundation at foundation@racp.edu.au
Over the past two years, the RACP Foundation has been consulting with different units of the College to develop an Indigenous Health Scholarship Program to encourage indigenous medical graduates to take up physician training.

There has been consultation with Division, Faculty and Chapter committees and councils, as well as with the Māori Health Committee, the Aboriginal and Torres Strait Islander Health Advisory Committee, the New Zealand Grants Advisory Committee, and College units such as Policy & Advocacy, Education Services and Business Services. Consultation has also been conducted with existing donors, Siggins Miller and Professor Noel Hayman, who initiated and funded the Aboriginal & Torres Strait Islander Scholarship 2008.

The outcome has been a coordinated program to provide funded pathways through Basic, Advanced, Faculty and Chapter training. Scholarships will be offered for three or four years and recipients will be required to provide evidence of progress at the end of each year. Part-time training will be allowed. The scholarships cover all training and examination fees, attendance at Congress in each year of training, and a small cash component to cover costs of IT equipment (hardware and software) or additional training.

**Application process**

A single scholarship form ensures that all applicants are considered on an equal basis and provides facility for an indigenous resident of one country to apply for a scholarship to be taken up in the other country.

It also allows the best candidates to be ranked on merit and funding to be allocated to the highest ranked candidates.

Applications will be reviewed by an Award Review Panel including cultural representatives (Aboriginal and Torres Strait Islander and Māori) and members of the relevant Divisions, Faculties and Chapters to which an applicant has applied for training, as well as a member of the Grants Advisory Committee and the New Zealand Grants Advisory Committee. The Award Review Panel will therefore reflect both the interests of the applicants and the interests of the relevant Divisions, Faculties and Chapters.

**Value of scholarships**

Dependent upon the training pathway, these scholarships are valued at up to $40,000.

**Scholarships available**

**College Indigenous Health Scholarship**

*The scholarship is made available by the Fellows of the RACP.*

**Aboriginal & Torres Strait Islander Health Scholarship**

The scholarship is funded by a grant from Siggins Miller, the Royal Australasian College of Physicians, an anonymous benefactor and Associate Professor Noel Hayman. The scholarship was first offered in 2008.

**New Zealand Indigenous Health Scholarship**

*The scholarship is made available by the Fellows of the RACP, New Zealand.*

**Indigenous Health Scholarship for Paediatrics and Child Health**

*The scholarship is made available by the Paediatrics & Child Health Division.*

**Indigenous Health Scholarship for Occupational & Environmental Medicine**

*The scholarship is made available by the Fellows of the Australasian Faculty of Occupational and Environmental Medicine.*

**Indigenous Health Scholarship for Rehabilitation Medicine**

*The scholarship is made available by the Fellows of the Australasian Faculty of Rehabilitation Medicine.*

**The John McLeod Indigenous Health Scholarship (AFPHM)**

*The scholarship is made available by the Australasian Faculty of Public Health Medicine and is in memory of the late Dr John McLeod. Dr McLeod was renowned both nationally and internationally for his work in public health and his significant contribution towards improving indigenous health status.*

The RACP Foundation would like to thank Siggins Miller, Professor Noel Hayman and the Fellows of the College for supporting this initiative as well as those who contributed to the consultation and discussion process.

Applications are now open for these scholarships. For more information please contact the RACP Foundation at foundation@racp.edu.au or go to the RACP website.

“Naku te rourou nau te rourou ka ora ai te iwi’. In the words of the proverb, with your basket and my basket the people will live. The Māori Health Committee welcomes the RACP Foundation Indigenous Health Scholarships, and looks forward to meeting the talented trainees who will follow this path into physician careers.” – Dr George Laking FRACP
PAEDIATRIC OUTREACH SERVICE IN THE TOP END

RACP Aboriginal and Torres Strait Islander Health Advisory Committee member Dr Paul Bauert took some time out to answer a few questions about the Service and the importance of improving access to specialist medical care for Aboriginal and Torres Strait Islander children.

**RACP News: How long has the Paediatric Outreach Service been running in the Northern Territory?**

**Dr Bauert:** We [Royal Darwin Hospital] have been running the Service since it was established by the late Dr Alan Walker OA in the late 1960s. We now make over 250 remote visits every year and all 10 full-time equivalent paediatricians are involved in the outreach programs. We now cover most communities in the Top End, but it would be good to have the resources and coordination to provide paediatric care completely across the Territory and in coordination with the other specialties.

**RACP News: How is the Paediatric Outreach Service managed?**

**Dr Bauert:** We coordinate the outreach service through a central office here in Darwin. We liaise closely with the regional hospitals, Aboriginal Community Controlled Health Services and other remote health services and take into account that each town and community manages their health needs differently.

Our physicians coordinate with the larger base hospitals, particularly the Royal Darwin Hospital, Katherine and Gove, to get children transferred for care as needed. Having consistent follow-through is very important.

We undertake a mix of primary and acute care in our Service. It is essential that primary and specialist medical care providers work cohesively to provide equitable care.

**RACP News: What are some of the challenges the Service faces in delivering paediatric care to remote Aboriginal communities?**

**Dr Bauert:** There are a number of challenges we face in delivering paediatric care. Firstly, as we cover such a large geographical area, we face issues around sourcing adequate transport for our physicians. For example, we prefer to have our physicians fly in no less than twin-engine, turbo-propelled light aircraft to ensure a decent level of safety, comfort and preparedness for what are often extremely busy clinics. This is increasingly important as we are accompanied by trainees and often by students. I feel strongly that the safety of Fellows and trainees conducting outreach is something that the College should strongly advocate for within the work currently underway to improve access to specialist care for Aboriginal and Torres Strait Islander peoples.

Secondly, outreach programs like ours would benefit from having experienced coordinating nurses, who would not only assist with the regular clinics but also maintain chronic disease registers. Unfortunately, there are very few options to be able to fund this capacity. We manage to make do, but our Service would benefit from this extra level of coordination.

Another challenge is Information Technology (IT). Although great gains have been achieved in having the several different electronic clinical record programs “talk” to each other, there is quite a way to go to improve the use and uptake of patient records systems, particularly in ensuring they are kept up to date and accurate, that they’re used to improve the efficiency of running clinics and that patient privacy is always considered.

**RACP News: The College recently hosted a Specialist Access Roundtable. What role does the College play in improving access to specialists and assisting programs like the Paediatric Outreach Service?**

**Dr Bauert:** I was pleased to be involved in the College’s Specialist Access Roundtable in August this year. It is well acknowledged that Aboriginal and Torres Strait Islander people are not receiving the specialist medical care they need – despite the many efforts of our Fellows and others around the country.

The College has an important role to play in supporting specialist medical outreach programs. Particularly important is ensuring adequate pathways of training for those trainees wanting to join regional paediatricians in their profoundly satisfying role of providing the highest quality care to Australian kids, no matter where they choose to live.

I think the College is well placed to advocate for a national system that coordinates specialist medical care across the country so that no one misses out on the care they need.

**Note:** The RACP Specialist Access Roundtable Consensus Statement can be found on the RACP website at www.racp.edu.au/page/policy-and-advocacy/indigenous-health.
There is substantial evidence that Australia’s First Peoples experience a greater burden of disease than their non-Indigenous counterparts. For example, in 2010 the prevalence of lung cancer for Aboriginal and Torres Strait Islander peoples (80.8 new cases per 100,000 population) was nearly double that of other Australians (44.2 per 100,000). Yet, despite this, data shows that they access MBS-rebated specialist care at a lower rate than non-Indigenous people. This low use of specialist services is a contributing factor to the health gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. According to the latest “Close the Gap” report, the life expectancy gap remains close to 10 years irrespective of living in a city or a remote community.

Some excellent work has been done by organisations and individuals to try and redress this situation: for example, the Paediatric Outreach Service in the Top End, discussed in the interview with Dr Paul Bauert on page 38, which has been in operation for around 50 years. Still, an overarching problem remains the lack of a nationally coordinated scheme to ensure specialist medical coverage across Australia. Too often, timely access to effective specialist medical care services is reliant on relationships between key people, so that when one person moves elsewhere, the system falls apart or ceases altogether.

It is this sporadic and ad-hoc approach that needs to be addressed. What is needed is a systematic and comprehensive national approach that ensures comprehensive coverage of access to specialist care across the country. Dr Tamara Mackean, Chair of the Specialist Access Working Party, says: “The diversity of populations, locations and health services requires flexibility of service and funding models.”

**RACP LEADS ON IMPROVING SPECIALIST ACCESS FOR ABORIGINAL AND TORRES STRAIT ISLANDER AUSTRALIANS**

**Strong support for the College’s proposal for a national framework**

On 27 August, the College, led by its Aboriginal and Torres Strait Islander Health Advisory Committee (ATSIHAC), hosted a roundtable, which was attended by over 30 leading experts in Aboriginal and Torres Strait Islander peoples’ health. The wide range of participants from across the country included representatives from the National Aboriginal Community Controlled Health Organisation (NACCHO), the Australian Indigenous Doctors’ Association (AIDA), Aboriginal Health Services, the Australian Government and State Health.

The Specialist Access Roundtable participants strongly supported the College’s proposal that Australia needs a framework to underpin a nationally networked, coordinated and consistent system to support appropriate access to specialist medical care, with complete geographical coverage across the country.

The roundtable participants devised some broad principles on which a national framework would be based and that...
would inform community-led development of appropriate models of care. These principles highlight the importance of Indigenous and community leadership; the need for strong integration across primary healthcare, specialist services and acute care; the crucial role of the Aboriginal Community Controlled sector; and the necessity for culturally safe services and settings.


What’s next?
The College and the ATSIHAC will continue to collaborate with key Indigenous health stakeholders to draft the proposed framework and ensure it has input and support from a broad range of agencies and organisations, as well as exploring other ideas that emerged from the roundtable.

The Australian Government is currently supporting the development of an Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan, and the College is liaising with the National Health Leaders Forum and the Government to ensure specialist access is prioritised within this process.

There isn’t a short-term fix to this problem. However, the College is committed to continuing work on and advocacy for ongoing improvements to the way specialist medical care is provided to Aboriginal and Torres Strait Islander people, aiming for health equity as we close the gap.

“...The diversity of populations, locations and health services requires flexibility of service and funding models.”

References
The College established its Health of Asylum Seekers and Refugees Working Party earlier this year in recognition of our obligation to advocate for protection of the health of people seeking asylum and of refugee background. The Working Party is comprised of eight College members representing the specialties of Paediatrics, Public Health, Infectious Diseases and General Medicine.

We have begun by updating the previous College position statement and broadening it to cover both paediatric and adult health advocacy issues. We aim to cover four themes related to the health of people seeking asylum and of refugee background, including: (1) access to healthcare services; (2) health assessments and screening processes; (3) optimising long-term health in settlement; and (4) the impact of detention. Table 1 contains more information about the specific issues that will be covered in the position statement.

In addition, we have prepared the College’s submission to the Australian Human Rights Commission’s (AHRC) Inquiry into Children in Immigration Detention 2014. I also joined AHRC President Emeritus Professor Gillian Triggs and the AHRC team as the College representative on AHRC visits to the Darwin and Christmas Island detention facilities as part of the Inquiry.

The Working Party has been involved in developing College media statements advocating for better healthcare for this vulnerable group. Key issues include ongoing lack of transparency in detention oversight (“Expert immigration advice needed now more than ever”), supporting doctors working in the detention environment to speak out in the best interest of their patients (“Doctors’ duty of care to people seeking asylum must be
respected”) and advocating for children in detention (“Immigration Minister must release every child from immigration detention”). These and other recent media statements can be found at www.racp.edu.au/page/asylum-seekers.

The College’s statements have been picked up by mainstream media. College spokespeople have been interviewed for print, radio and TV by media outlets including Fairfax Media, ABC TV and radio, Sky News and The Guardian. Members of the public have written to the College to relay their appreciation of the College’s public advocacy efforts. The College will continue its advocacy with the goal of effecting change to immigration policy to ensure the health of people seeking asylum is not at risk.

We aim to have a draft position statement for internal consultation later this year. College members interested in reviewing the draft statement are encouraged to register their interest with Emily Ofner at policy@racp.edu.au.

Conjoint Associate Professor Karen Zwi, UNSW
Community Paediatrician,
Sydney Children’s Hospitals Network
Chair, Health of Asylum Seekers and Refugees Working Party

Table 1: Outline of proposed content of position statement

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<tr>
<th>Issue</th>
<th>Considerations</th>
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<td>Access to healthcare services</td>
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<td>Health assessments and screening processes</td>
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<td>Optimising long-term health in settlement</td>
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<td>• Settlement support services</td>
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<td>• Community support</td>
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<td>• Offshore detention</td>
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<td>• Length of detention</td>
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<td>• Children and families in detention</td>
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<td>• Unaccompanied children</td>
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AMC AND MCNZ ACCREDITATION – COLLEGE VISIT AND 2014 WRAP-UP

Throughout 2014, the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) have been undertaking an assessment of the RACP and its education and training programs. The primary objective of the AMC and MCNZ accreditation process is to provide external assurance of the quality of specialist medical education programs by assessing them against nine explicit accreditation standards.

The College presented its Accreditation Submission to the AMC in May 2014. This provided a detailed written account of how the College is meeting the AMC/MCNZ accreditation standards and criteria. Evaluation activities, such as surveys of College trainees and supervisors and observation of a range of College meetings and events, including Congress and the Divisional Clinical Examination, then continued throughout the year.

In September, members of the AMC Assessment Team spoke with trainees, supervisors and hospital staff in 18 RACP accredited training settings across Australia and New Zealand about the College's education programs.

The assessment process culminated in the AMC and MCNZ Assessment Team visiting College headquarters in Sydney from 29 September to 3 October for a week of meetings with over 100 Fellows, trainees and College staff to discuss both strengths and challenges of the College education and training programs. These discussions built on the content of the College’s accreditation submission and evidence gathered through evaluation activities and site visits.

Throughout November and December, the Assessment Team will be compiling a comprehensive report on the College’s assessment. Following review by the AMC’s Specialist Education Advisory Committee in February 2015 and Board of Directors in March 2015, the AMC will provide advice to the Medical Board of Australia and the report will then be sent to the College and made available as a public document.

On behalf of the College, we would like to acknowledge the very valuable contribution of the many Fellows, trainees and College staff who were involved in this important process during 2014. Continued support from College members plays a vital role in the success of RACP education and training programs and we look forward to sharing the assessment report, which will inform our focus moving forward. The College also extends a warm thanks to the Assessment Team (pictured above) for their significant contribution to the success of the process.

Dr Jonathan Christiansen
Chair, College Education Committee

Dr Marie-Louise Stokes
Director, Education Services
One of the goals of the Education Governance Review is to achieve greater alignment between Australia and New Zealand in relation to training requirements. During the consultation process conducted early in 2014, a number of proposed governance models for trans-Tasman alignment were put forward to each of the specialties for consideration.

The criteria for the proposed models included that the program requirements and standards would be aligned across the two countries and that there would also be trans-Tasman calibration of operational decisions regarding trainee monitoring.

In late September, the RACP Board approved three models of governance for the Trans-Tasman Advanced Training specialties.

Governance Model 1: One Australasian Advanced Training Committee

This model has governance and operational oversight over both Australian and New Zealand trainees under a single Australian and New Zealand Committee and will apply to the following specialties: Clinical Genetics, Clinical Pharmacology, Community Child Health, Neonatal/Perinatal Medicine, Neurology, Nuclear Medicine, Paediatric Emergency Medicine, and Palliative Care (see Figure 1).

Governance Model 2: Advanced Training Committee and New Zealand Subcommittee

One Advanced Training Committee will oversee governance across both Australia and New Zealand. This committee will also be responsible for the operational oversight of Australian trainees. Under this committee will be a local operational oversight subcommittee – the New Zealand Advanced Training Subcommittee. This model has been chosen by the following specialties: Cardiology, Gastroenterology, Geriatric Medicine, Medical Oncology, Nephrology, Respiratory & Sleep Medicine, and Rheumatology (see Figure 2).

Figure 1: New Governance Model 1
One Australasian Advanced Training Committee

Division Council
(FRACP signoff)

Division Education Committee
(AMDEC/PCHDEC)

Advanced Training Committee in SPECIALTY

Division Council
(Australian trainee FRACP signoff)

Division Education Committee
(AMDEC/PCHDEC)

Advanced Training Committee in SPECIALTY

NZ Committee
(NZ trainee FRACP signoff)

NZ Education Committees
(NZ AMDEC/NZ PCHDEC)

Indicates a close relationship with NZ AMDEC but not a formal ‘reporting’ line. Also, RRA process for RACP NZ trainees will go up to NZ AMDEC and sign off for FRACP for NZ trainees will be undertaken by NZ President.

Figure 2: New Governance Model 2
Training Committee + NZ Subcommittee
CASE STUDY: NEUROLOGY ADVANCED TRAINING COMMITTEE

The alignment of the Neurology New Zealand Specialist Advisory Committee and Neurology Specialist Training Committee seemed a logical move, with the existence of a single trans-Tasman specialty society, the Australian and New Zealand Association of Neurologists (ANZAN). The development of the neurology curricula for adult and paediatric neurology trainees also provided the perfect opportunity to harmonise training requirements between the two countries. This makes the practicalities of merging the two committees impractical. In this model trans-Tasman alignment will occur through cross-committee membership and the committees will convene regular joint meetings to review standards and program requirements.

With the models now approved by the Board, the committee alignment is on track for completion by May 2015, with most new committee structures to be finalised by the end of 2014 (see Figure 3).

**Figure 3: New Governance Model 3**
Separate Advanced Training Committees (Australia & NZ)

Professor Alan Barber  
Chair of the SAC and STC during the alignment project

**Governance Model 3: Separate Advanced Training Committees (Australia & New Zealand)**

Under this model, there are separate Advanced Training Committees in Australia and New Zealand. This model has been chosen by General Medicine and General Paediatrics as these specialties have large trainee numbers and a number of operational and regulatory differences across the two countries. This makes the practicalities of merging the two committees impractical. In this model trans-Tasman alignment will occur through cross-committee membership and the committees will convene regular joint meetings to review standards and program requirements.

With the models now approved by the Board, the committee alignment is on track for completion by May 2015, with most new committee structures to be finalised by the end of 2014 (see Figure 3).

**Figure 3: New Governance Model 3**
Separate Advanced Training Committees (Australia & NZ)

Division Council  
(Australian trainee FRACP signoff)

NZ Committee  
(NZ trainee FRACP signoff)

Division Education Committee  
(AMDEC/PCHDEC)

NZ Education Committees  
(NZ AMDEC/NZ PCHDEC)

Advanced Training Committee in SPECIALTY (Australia)

Advanced Training Committee in SPECIALTY (NZ)

NB: Chair (or delegate) of each AT Committee will sit on other country’s AT Committee as an ex-officio member, to ensure alignment and calibration across the two countries.

Professor John Wilson  
President, Adult Medicine Division  
Chair, Education Governance Implementation Working Group

Dr Marie-Louise Stokes  
Director, Education Services

**CASE STUDY: NEUROLOGY ADVANCED TRAINING COMMITTEE**

The alignment of the Neurology New Zealand Specialist Advisory Committee and Neurology Specialist Training Committee seemed a logical move, with the existence of a single trans-Tasman specialty society, the Australian and New Zealand Association of Neurologists (ANZAN). The development of the neurology curricula for adult and paediatric neurology trainees also provided the perfect opportunity to harmonise training requirements between the two countries.

The most positive benefit of the merger of the two committees has been the significant increase in contact NZ trainees have had with their Australian counterparts. This includes attendance at the monthly College-facilitated Brain School, as well as required attendance at weekend EEG, EMG and neuropathology workshops. Trainees are also able to undertake core training in either country and apply for positions via the “Neurology Match”.

Although there was some concern early on that the concerns of NZ trainees might be lost amongst those of the larger number of Australian trainees and that issues unique to NZ would be overlooked, this has not been the case. The fact that two of the last four trainee representatives on the current Specialist Training Committee (STC) are from NZ indicates how well the Kiwis have been accepted by their colleagues. The new Advanced Training Committee (ATC) will have NZ representatives who will deal with the occasional NZ-specific issues that will inevitably arise.

There are a number of factors that have aided our success. Neurology has just over 100 trainees, so that the numbers under supervision aren’t large. There is a single trans-Tasman specialty society, ANZAN, which has helped drive the alignment. The College, both in Australia and New Zealand, has been supportive at every step of the process. Overall, the experience has been very positive.

**The last NZ SAC meeting will be in November 2014 with a single trans-Tasman ATC to commence operations in early 2015.**

Professor Alan Barber  
Chair of the SAC and STC during the alignment project
This year 761 Adult Medicine and 239 Paediatrics & Child Health trainees undertook the RACP Clinical Examination. Organising this examination is an enormous task and many Fellows contribute their time generously to the process. The largest burden borne by any individual during the Clinical Examination is that taken on by the Local Examination Organisers at the hospitals involved. Many of us have done this over the years and understand how much effort goes into providing a high-quality experience for anxious candidates on the day.

The Clinical Examination Committee would like to express our gratitude to the Regional Examiners and Local Examination Organisers at each of the hosting sites for their invaluable contribution to this essential process. We also acknowledge the role played by many others including trainees, residents, medical students, and administrative and nursing staff who contributed to the smooth running and success of the examination.

### Adult Medicine

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Regional Examiner</th>
<th>Local Examination Organisers</th>
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<tbody>
<tr>
<td>Austin Health</td>
<td>Dr Simon Lam</td>
<td>Dr Nicholas Jones</td>
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<tr>
<td>Ballarat Base Hospital</td>
<td>Associate Professor James Hurley</td>
<td>Dr James Cameron</td>
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<td>Bankstown Hospital</td>
<td>Professor Shannugara Rajendra</td>
<td>Dr Sharon Paul</td>
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<td>Bendigo Base Hospital</td>
<td>Dr Patrick Cooney</td>
<td>Dr Megan Kwong</td>
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<td>Blacktown Hospital</td>
<td>Associate Professor Lukas Kairatis</td>
<td>Dr Jaime Lin</td>
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<tr>
<td>Box Hill Hospital</td>
<td>Professor Chris Giffilani</td>
<td>Dr James Fulforth</td>
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<td>Caboolture Hospital</td>
<td>Dr Mukhslesur Rahman</td>
<td>Dr Ni Ni Khin</td>
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<tr>
<td>Cairns Base Hospital</td>
<td>Dr Murty Mantha</td>
<td>Dr Amt Nigam</td>
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<tr>
<td>Calvary Mater Hospital Newcastle</td>
<td>Dr Michael Hayes</td>
<td>Dr Sudesh Wijethilaka</td>
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<tr>
<td>Campbelltown Hospital</td>
<td>Dr Rohit Rajagopal</td>
<td>Dr Rajini Jayaballa</td>
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<td>Caulfield Hospital</td>
<td>Dr Anne Powell</td>
<td>Dr Kristy Siostrrom</td>
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<td>Concord Repatriation General Hospital</td>
<td>Associate Professor Alvin Ing</td>
<td>Dr Erica Meggitt</td>
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<td>Dandenong Hospital</td>
<td>Dr Andy Lim</td>
<td>Dr Alexander Dunn</td>
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<td>Epworth Hospital</td>
<td>Associate Professor lan Fraser</td>
<td>Dr Devaki Chembolli</td>
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<td>Dr Jayantha Rupasinghe</td>
<td>Dr Inas Ahmed</td>
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<td>Fremantle Hospital</td>
<td>Dr Tony Ryan</td>
<td>Dr Simone Fritschi</td>
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<td>Dr Neel Heerasing</td>
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<td>Dr Fahid Hashehn</td>
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<td>Dr Sheenaz Mazid</td>
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<td>Dr Joanne Campbell</td>
<td>Dr Krishna Kalipurath</td>
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<td>Professor Jeremy Wilson</td>
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<td>Lyell McEwin Health Service</td>
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<td>Dr Satish Pillai</td>
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<td>Maroondah Hospital</td>
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<td>Dr Usman Mushtaq</td>
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<td>Dr April Win</td>
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Paediatrics & Child Health

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<td>Dr Tony Lafferty</td>
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<td>Dr Noha Soliman</td>
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<td>Dr Megan Corp</td>
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<td>Dr Peter Morris</td>
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<td>Dr Michelle Williams</td>
<td>Dr Upasana Kapoor</td>
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<td>Dr Katherine Klima</td>
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<td>The Children's Hospital at Westmead</td>
<td>Dr David Lester-Smith</td>
<td>Dr Irene Chiu Joe Chuah</td>
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<td>Dr Shalija Singh</td>
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<td>Dr Sithambaram pillai Sivayoganathan</td>
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<td>Dr John Wong</td>
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<tr>
<td>Wollongong Hospital</td>
<td>Dr Susie Piper</td>
<td>Dr Vishal Malhotra</td>
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Professor Michelle Leech FRACP  
Chair, Adult Medicine  
Clinical Examination Committee  

Dr Mike Starr FRACP  
Chair, Paediatrics & Child Health  
Clinical Examination Committee  

ONLINE ADVANCED TRAINEE SELECTION AND MATCHING IN 2014

Facilitated by the College, the Advanced Trainee Selection and Matching (ATSM) online process, which allows employers to advertise positions and trainees to indicate their interest in the positions advertised, has now been completed for the 2015 training year.

This year, eight matches were run covering seven specialties across six states in Australia, as well as a separate ‘multi-specialty’ match covering six specialties across seven states for both continuing and first year Advanced Trainees.

The specialties and states involved in the matches this year were: Gastroenterology (Vic/Tas), Nephrology (Vic), Endocrinology (Vic), Infectious Diseases (Vic), Cardiology (Vic/Tas, NSW/ACT), Medical Oncology (Vic), Rheumatology (Vic, NSW/ACT) and AFRM (Qld, SA). The first match was opened for trainee registrations on 1 July and the final match was run on 10 September.

A total of 521 trainees applied for 364 positions and, of these, 318 trainees were matched with registered positions. The results of each match were released by the College to the Specialty Coordinators on the same day.

If you would like more information relating to the ATSM online matching service, please email atselection@rACP.edu.au.
Supervisors make decisions based on trust every day when working with trainees. We decide if and when trainees are capable of independently performing their various tasks. Entrustable Professional Activities, or EPAs, are a relatively recent innovation in medical education, with the potential to transform our training programs. While the title may sound like educational jargon, it is really quite descriptive – these are the essential work activities that we need to be able to entrust our trainees to carry out.

The use of Entrustable Professional Activities within the College context will be evaluated over 2015–2016 through pilot studies in Basic Training for Physicians and Paediatricians and in Advanced Training in Community Child Health.

The Community Child Health pilot aims to make four key changes to our current educational approach:

1. Focus learning and assessment more keenly on the core activities trainees need to be able to perform independently at the completion of Advanced Training in Community Child Health (through the use of Entrustable Professional Activities)
2. Streamline the workplace-based learning and assessment process
3. Improve the collection of evidence on trainee progression by focusing existing formative assessments on EPAs
4. Improve certification decisions by ensuring that learning goals are more clearly defined at the outset of a training rotation, are reviewed midpoint and are checked at the conclusion of the rotation.

An example of an Entrustable Professional Activity for Community Child Health is: Assessment in Developmental–Behavioural Paediatrics

Performs a comprehensive assessment of a child's development, behaviour, learning and emotional state, taking into account biological, psychological and social environmental factors.

This is an activity that is central to what we do in Community Child Health and captures a number of components of professional practice, such as clinical knowledge, communication skills, cultural competence, ethical behaviour, and quality and safety.

Additional EPAs have been developed across the three Community Child Health subspecialty areas: Developmental–Behavioural Paediatrics, Child Protection, and Child Population Health. A group of EPAs encompassing general Community Child Health Professional Skills has also been developed.

The pilot will run across Australia and New Zealand from December 2014 to August 2015. The input of the supervisors and trainees taking part in this pilot is essential to us in designing the most effective Advanced Training program we can deliver for Community Child Health.

I am really looking forward to the outcome of these pilots. It is an exciting time to be involved in education and training within the College!

Dr Mick O’Keeffe FRACP
Chair, Community Child Health Entrustable Professional Activities Pilot Working Group

Entrustable Professional Activities
A critical part of professional work that can be identified as a unit to be entrusted to a trainee once sufficient competence has been reached.

Ten Cate 2005

- EPAs represent real-life, practical aspects of job performance
- Provide a focus for workplace-based assessments
- Are essential work activities. Supervisors need to be able to entrust their trainees with these important tasks.
- Are certified by a supervisor when a trainee can be trusted to perform the activity without direct supervision
- Are a key feature of competency-based medical education.

For further information, please visit www.racp.edu.au/page/cchepapilot.

Reference
ELEARNING@RACP

An online collection of interactive learning resources for trainees, supervisors and Fellows

eLearning@RACP hosts a range of self-directed learning resources for RACP members, including online courses on Australian Aboriginal Child Health, Indigenous Child and Adult Health, and Young People and Addiction.

Australian Aboriginal Child Health modules (2012)
The modules in this short course focus on a range of issues from common diseases in Aboriginal children, including respiratory, ear, nose and throat, skin and eye diseases, rheumatic heart disease and post-infectious glomerulonephritis to determinants of child development, including factors which impact child behaviour and cognitive development. Case studies include specific examples from the Fitzroy Valley, Western Australia, and other Australian settings.

Indigenous Child and Adult Health modules (2013)
Developed by College Fellows and Advanced Trainees, this series of modules begins by exploring the concept of cultural competence and the unique determinants of health for Aboriginal and Torres Strait Islander peoples. Two modules then refer specifically to Aboriginal child health, reviewing developmental problems and diseases and illnesses commonly related to poverty.

Young People and Addiction modules (2013)
Developed by members of the Australasian Chapter of Addiction Medicine Online Modules Advisory Group, this resource assists addiction medicine practitioners in increasing their knowledge and skills to effectively manage young people with addictions and their families through specific approaches. The modules cover mental health issues associated with adolescent substance abuse, parent and family interventions for adolescent substance misuse and approaches to assisting families recover from youth substance problems.

To access eLearning@RACP visit: http://elearning.racp.edu.au. To access the resources, log in with your RACP MIN and password.
The College has recently updated the Privacy Policy for Personal Information. Information about members is collected in the normal course of College activities, including names, contact details and a great deal of other information, often relating to training and assessment. The updated College Privacy Policy reflects the College’s commitment to protect that information and to comply with Privacy laws in both Australia and New Zealand.

At the heart of the legislation in both countries is the concept of informed consent: that an individual should know that their information is being collected and for what purpose, and should give their consent to the information being used for that purpose or any other.

The College’s Privacy Policy, which is available on the College website (click on “Privacy” at the bottom of the College home page to download a copy), sets out the type of information that the College is likely to collect and how it will be used. Generally, we will not seek further approval from you for these uses, or uses which can reasonably be expected to flow from them.

Occasionally, the College may receive a request for information and it will seek your permission before releasing your personal information.

This means that, while the College will confirm your Fellowship of the College, or that you are enrolled as a trainee, it cannot, as a rule, without direct authorisation from the person or persons concerned, give out telephone numbers and contact details or provide lists (including mailing lists) of members or groups of members.

The College can explore other options with you, such as advertising your event in College publications and e-bulletins, or placing a link on the College webpage.

The College may take the details of a person seeking to contact a Fellow or trainee and forward them to the person concerned on their behalf. This prevents personal information being disclosed and means the Fellow or trainee being contacted has the option of deciding whether to respond.

You can request a copy of the information that the College holds about you and you can request corrections to that information at any time (within certain limits). The College will need to confirm the identity of the person requesting the information before releasing records.

For further information, please refer to the Privacy Policy, email privacy@racp.edu.au, or call the privacy officer on 02 9256 5491.

Changes to MyCPD in 2014 – Fees for Late and Alternative Submissions

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).

Dr John O’Donnell
Honorary Treasurer
From 24 to 27 May 2015, the Royal Australasian College of Physicians (RACP) is holding its annual Congress in the stunning tropical setting of Cairns, North Queensland. In 2015, we are building on the past theme of Future Directions in Health, and moving forward to reinvigorate Congress and challenge delegates to “break boundaries and create connections”, making RACP Congress 2015 an event not to be missed.

Call for abstracts
The RACP is now calling for abstracts and award submissions for Congress 2015.

The three key topics for the 2015 Congress are:
- Gender Identity
- End of Life Care
- Refugee Health

To speak at the largest annual multidisciplinary internal medicine meeting in Australasia in 2015, submit your abstract now at: www.RACP Congress 2015.com.

Visit the new RACP Congress website at www.racp.congress2015.com to register, submit your abstract and obtain further updates for RACP Congress 2015.
## RACP UPCOMING EVENTS

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<tr>
<th>Event name</th>
<th>Date</th>
<th>Location</th>
<th>Who should attend</th>
<th>What are the key learning outcomes and benefits</th>
<th>What is the cost of registration</th>
<th>How to access detailed program and registration information</th>
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<tbody>
<tr>
<td>Facilitator Training: Teaching and Learning in Health Care Settings</td>
<td>17–18 November 2014</td>
<td>The Mint, Sydney, NSW</td>
<td>Any Fellow with an interest in medical education and facilitating skills-based workshops</td>
<td>Increased supervision capacity Personal skill development</td>
<td>No cost. RACP will cover travel and accommodation costs for workshop participants</td>
<td>Email: <a href="mailto:supervisor@racp.edu.au">supervisor@racp.edu.au</a> or visit <a href="http://www.racp.edu.au/page/facilities">www.racp.edu.au/page/facilities</a></td>
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<tr>
<td>Facilitator Training: Teaching and Learning in Health Care Settings</td>
<td>27–28 November 2014</td>
<td>The Hilton Hotel, Auckland, New Zealand</td>
<td>Any Fellow with an interest in medical education and facilitating skills-based workshops</td>
<td>Increased supervision capacity Personal skill development</td>
<td>No cost. RACP will cover travel and accommodation costs for workshop participants</td>
<td>Email: <a href="mailto:supervisor@racp.edu.au">supervisor@racp.edu.au</a> or visit <a href="http://www.racp.edu.au/page/facilities">www.racp.edu.au/page/facilities</a></td>
</tr>
<tr>
<td>Australasian Chapter of Sexual Health Medicine Annual Scientific Meeting</td>
<td>6 March 2015</td>
<td>Sydney, NSW</td>
<td>Fellows and trainees of the Chapter of Sexual Health Medicine and any members with an interest in sexual health medicine</td>
<td>Presentation and dissemination of research to inform effective sexual health care and service delivery</td>
<td>TBC. Check the conference website for updates</td>
<td>Visit <a href="http://www.racp.edu.au/page/australasian-chapter-of-sexual-health-medicine/">www.racp.edu.au/page/australasian-chapter-of-sexual-health-medicine/</a></td>
</tr>
<tr>
<td>International Medicine in Addiction Conference</td>
<td>20–22 March 2015</td>
<td>Melbourne Convention Centre, VIC</td>
<td>Any Fellow or trainee from the Australasian Chapter of Addiction Medicine and other Fellows and trainees with an interest in addiction medicine</td>
<td>Latest addiction research and clinical approaches Interactive learning experiences Workshops on themes related to common clinical challenges</td>
<td>TBC. Check the conference website for updates</td>
<td>Visit <a href="http://www.racgp.org.au/education/courses/imia15/">www.racgp.org.au/education/courses/imia15/</a></td>
</tr>
<tr>
<td>RACP Congress 2015</td>
<td>24–27 May 2015</td>
<td>Cairns Convention Centre, QLD</td>
<td>All Fellows and trainees</td>
<td>Participate in workshops, learn about the latest cutting-edge clinical updates Attend the Australasian Trainees' Day</td>
<td>TBC. Check the conference website for updates</td>
<td>Visit <a href="http://www.racp.congress2015.com">www.racp.congress2015.com</a></td>
</tr>
<tr>
<td>Australasian Faculty of Rehabilitation Medicine Annual Scientific Meeting</td>
<td>13–17 October 2015</td>
<td>Intercontinental Hotel, Wellington, NZ</td>
<td>All Fellows and trainees of the Faculty of Rehabilitation Medicine</td>
<td>TBC</td>
<td>TBC. Check the conference website for updates</td>
<td>Further information to come</td>
</tr>
</tbody>
</table>

All events are eligible for MyCPD credits. Points can be claimed under Category 2 at a rate of 1 point/hour.
Your RACP member benefits can help you plan the perfect getaway, with great discounts on hotels, car hire, dining and much more.

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