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Occupational medicine in the mining and oil and gas industries
College action on climate change
Dr Eric Susman – A legacy lives on
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RACP Past-President Professor Priscilla Kincaid-Smith
AC CBE FRACP

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THE CLIMATE CHANGE CHALLENGE

Dear Colleagues

**Working Party on Climate Change and Health**

Our College is committed to leadership on the health impacts of Climate Change. Our newly formed Working Party on Climate Change and Health held its inaugural meeting in early August.

The Working Party will lead the College’s advocacy campaign in the lead-up to the UN Convention on Climate Change (COP21) in November. The College intends to make Monday, 12 October a ‘Day of Global Action’ highlighting the health impacts of Climate Change. Engagement and collaboration is being sought from Australasian medical Colleges, Specialty Societies, as well as medical Colleges from around the world for a Global Consensus Statement on the need to act to combat the negative health impacts of Climate Change. Our colleagues in the UK have already agreed to endorse the statement.

An online campaign is being developed to garner the support of medical professionals around the world to add their voice to the call for leaders to take action to mitigate the impacts of Climate Change.

**College Position**

As specialties continue to evolve and the health landscape develops and diversifies, our College needs to continually review and refine its purpose. We need to ensure we remain a contemporary and vibrant professional organisation that is relevant to our members, and the many other stakeholders we serve.

We are undertaking a research project to review different stakeholders’ perceptions of the College’s role and function in an ever-changing environment. This will help us refine our communication and strengthen the College’s position and reputation into the future.

The findings will be shared with members as this project progresses.

**Past-Presidents’ Portraits Unveiled**

I recently had the privilege of recognising the contributions of two Past-Presidents, Professor John Kolbe, President from 2010 to 2012, and Associate Professor Leslie Bolitho, who served from 2012 to 2014, at an unveiling of their portraits.

These two works, which hang in 145 Macquarie Street, Sydney, have been painted by renowned South Australian portrait artist, Robert Hannaford. Mr Hannaford has painted numerous distinguished Australians over the years, including Donald Bradman, and former Prime Ministers Paul Keating and Bob Hawke, and has been a finalist in the Archibald Prize every year his works have been submitted, as far back as 1991.

Our two Past-Presidents spoke of the technical skill of Robert Hannaford and the process of their portraits being developed. We hope that you will enjoy viewing the portraits in the Fellows’ Room on your next visit to our College’s 145 Macquarie Street offices.

I would also like to acknowledge our Past-President Priscilla Kincaid-Smith. I encourage you to read more about Professor Kincaid-Smith in the article on her life, and contributions to medicine, on page 8.

Laureate Professor Nicholas Talley  
RACP President
Dear Colleagues

Your Board’s third meeting for the 2015 calendar year was held in Sydney on Thursday, 23 and Friday, 24 July 2015. The main outcomes of this meeting are summarised below.

**Medicare Benefits Schedule (MBS) Review Working Party**

The Federal Government’s MBS Review established earlier this year has considerable implications for the many and varied types of healthcare services we deliver.

The Board has established a Review Working Party to coordinate a consistent strategic response to the health policy issues that may arise.

The Working Party will consider the findings and recommendations of the Government’s Review Taskforce, then consult across the College and other stakeholders to coordinate a strategic response.

It will also develop communication and engagement strategies, including representing the College at related events. Where necessary, the Working Party will recommend the appointment of College representatives to relevant committees or meetings.

An Expression of Interest process for members interested in joining the MBS Review Working Party has been issued.

**Admission to Fellowship Process**

Over the next few months we will be implementing changes to the Admission to Fellowship Policy and Process.

Following a scheduled review, we have identified ways to improve the process, while still maintaining the stringent requirements needed to ensure that candidates with the appropriate skills are admitted to Fellowship.

**RACP International Medal**

A new ‘RACP International Medal’ has been established by the Board to acknowledge the significant contribution some of our members make to areas outside Australia and New Zealand. This work is vital to many communities around the world, particularly in developing nations. The Medal will be awarded for the first time at the College Ceremony to be held in conjunction with RACP Congress 2016, which will be held 16–18 May 2016 in Adelaide.

**RACP Congress**

We have approved member research to evaluate our annual Congress (members’ motivations, barriers, enablers, needs etc.) and develop a framework for future Congresses that resonate with members and grows attendance.

As the College’s flagship event, and preeminent medical conference in Australasia, RACP Congress needs to continue to evolve to provide interest and value to large and diverse groups of physicians and paediatricians.

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**Next meeting**

The next full Board Meeting will be held on Friday 25 September 2015 in Melbourne, following the inaugural College Council Meeting being held on Thursday 24 September 2015.

There will be a Board question and answer session on Wednesday evening; if you are in Melbourne and interested in participating, I invite you to come along.

Professor Nicholas Talley
RACP President
### RACP UPCOMING EVENTS

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

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<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Event Description</th>
<th>Cost of Registration</th>
<th>Contact</th>
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<tbody>
<tr>
<td>13–17 October 2015</td>
<td>Auckland NZ</td>
<td>Building An Enabling Society AFRM/NZRA Combined Rehabilitation Meeting 2015</td>
<td>Full Faculty registration: NZ$1275</td>
<td>Email: <a href="mailto:tamzin.luafalealo@racp.org.nz">tamzin.luafalealo@racp.org.nz</a></td>
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<td>9 October 2015</td>
<td>Auckland NZ</td>
<td>SPDP Workshop 2: Teaching and Learning in Healthcare Settings</td>
<td>This is a free event</td>
<td>Email: <a href="mailto:tamzin.luafalealo@racp.org.nz">tamzin.luafalealo@racp.org.nz</a></td>
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<td>This is a free event</td>
<td>Email: <a href="mailto:tamzin.luafalealo@racp.org.nz">tamzin.luafalealo@racp.org.nz</a></td>
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<td>14 October 2015</td>
<td>Wellington NZ</td>
<td>SPDP Workshop 2: Teaching and Learning in Healthcare Settings</td>
<td>This is a free event</td>
<td>Email: <a href="mailto:tamzin.luafalealo@racp.org.nz">tamzin.luafalealo@racp.org.nz</a></td>
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<td>15 October 2015</td>
<td>Sydney NSW</td>
<td>Consultation workshop: Patient-centred care and consumer engagement</td>
<td>This is a free event</td>
<td>Email: <a href="mailto:evaluation@racp.edu.au">evaluation@racp.edu.au</a></td>
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<td>16 October 2015</td>
<td>Wellington NZ</td>
<td>SPDP Workshop 3: Workplace-based Learning and Assessment</td>
<td>This is a free event</td>
<td>Email: <a href="mailto:tamzin.luafalealo@racp.org.nz">tamzin.luafalealo@racp.org.nz</a></td>
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<td>20 October 2015</td>
<td>Gold Coast QLD</td>
<td>Consultation workshop: Patient-centred care and consumer engagement</td>
<td>This is a free event</td>
<td>Email: <a href="mailto:evaluation@racp.edu.au">evaluation@racp.edu.au</a></td>
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<td>22 OCTOBER 2015</td>
<td>Consultation workshop: Patient-centred care and consumer engagement</td>
<td>Adelaide, SA</td>
<td>This is a free event</td>
<td>Email: <a href="mailto:evaluation@racp.edu.au">evaluation@racp.edu.au</a></td>
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<td>22–23 OCTOBER 2015</td>
<td>Workshop 3: Facilitator Training Forum</td>
<td>Sydney, NSW</td>
<td>This is a free event</td>
<td>Email: <a href="mailto:supervisor@racp.edu.au">supervisor@racp.edu.au</a></td>
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<td>27 OCTOBER 2015</td>
<td>SPDP Workshop 3: Workplace-based Learning and Assessment</td>
<td>Adelaide, SA</td>
<td>This is a free event</td>
<td>Email: <a href="mailto:supervisor@racp.edu.au">supervisor@racp.edu.au</a></td>
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<td>1 NOVEMBER 2015</td>
<td>SPDP Workshop 2: Teaching and Learning in Healthcare Settings</td>
<td>Perth, WA</td>
<td>This is a free event</td>
<td>Email: <a href="mailto:supervisor@racp.edu.au">supervisor@racp.edu.au</a></td>
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<td>17 NOVEMBER 2015</td>
<td>SPDP Workshop 1: Practical Skills for Supervisors</td>
<td>Christchurch, NZ</td>
<td>This is a free event</td>
<td>Email: <a href="mailto:tamzin.luafalealo@racp.org.nz">tamzin.luafalealo@racp.org.nz</a></td>
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<tr>
<td>28 NOVEMBER 2015</td>
<td>Continuing Education Workshop</td>
<td>Melbourne, VIC</td>
<td>This is a free event</td>
<td><a href="http://www.racp.edu.au/news-and-events/all-events">www.racp.edu.au/news-and-events/all-events</a></td>
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<tr>
<td>11 MARCH 2016</td>
<td>INTERNATIONAL MEDICAL SYMPOSIUM 2016: FUTURE CHALLENGES FOR THE MEDICAL PROFESSION</td>
<td></td>
<td>Full registration: A$495</td>
<td>Trainee registration: A$200</td>
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All events are eligible for MyCPD credits. Points can be claimed under Category 2 at a rate of 1 point/hour.
PROFESSOR PRISCILLA KINCAID-SMITH (1926–2015)
REMEMBERING A LEADER IN MEDICINE

The Royal Australasian College of Physicians (RACP) remembers the pioneering spirit of Past-President, Emeritus Professor Priscilla Kincaid-Smith.

Professor Kincaid-Smith was the first female President of the RACP (1986–1988) and played a crucial role in the advancement of medicine in Australia. A renowned specialist in kidney disease, she forged a career in Nephrology at a time when there were very few women in medicine.

Her passing is a loss for medicine, the College, her family, friends, and the people whose lives she touched through her medical work.

There were many firsts for Professor Kincaid-Smith: she was the first female Professor at the University of Melbourne; first female President of the Royal Australasian College of Physicians; first female Chair of the Australian Medical Association and the first female President of the World Medical Association (she was also the first Australian to hold the position).

With three children of her own, she laid the groundwork for generations of female medical practitioners to come, demonstrating that women could have both a family and a successful medical career.

Professor Kincaid-Smith was born in South Africa and graduated in Medicine from the University of Witwatersrand in 1950. She moved to London in 1953 and trained in pathology and cardiology.

Professor Kincaid-Smith relocated to Australia in 1958, encountering, and overcoming, the gender discrimination common in Australian medicine at the time.

In the 1960s she famously established the causal link between headache powders and kidney damage, campaigning strongly against their use. Professor Kincaid-Smith also made substantial contributions to research on the link between the kidneys and high blood pressure.

In 1975 she was appointed Commander of the order of the British Empire "for services to medicine"; and in 1988 she was awarded the Companion of the Order of Australia. She also served on the Council of the Royal Australasian College of Physicians for 12 years.

Professor Kincaid-Smith was widely published, authoring more than 480 papers in refereed scientific journals, authoring three textbooks, contributing chapters to another 103 and editing a further 10.

The prestigious ‘Professor Kincaid-Smith Oration’ was established in 1993 in recognition of her contributions to medicine and to the College, and is delivered at the RACP Congress every year by an orator of international standing.

Her drive and commitment to the success of the College is an example to all.

Professor Kincaid-Smith will be remembered as a medical leading light for many generations to come.
HIGHEST QUEEN’S BIRTHDAY HONOUR
FOR PROFESSOR SIR PETER GLUCKMAN
KNZM FRSNZ FMEDSCI FRS FRACP

Fellow and world-renowned health adviser, Professor Sir Peter Gluckman, has received the highest 2015 New Zealand Queen’s Birthday Honour, the Order of New Zealand. Sir Peter joins an exceptional group, limited to 20 New Zealanders at any one time.

As an international advocate for science, Sir Peter’s honour is the culmination of a lifetime of dedication to the field of health research.

He has received many accolades, including New Zealand’s top science award, the Rutherford Medal in 2004 and a knighthood in 2009.

He is one of only 42 New Zealand-born scientists to be honoured as a Fellow of the Royal Society in London since its establishment in 1660.

Sir Peter studied paediatrics and endocrinology at the University of Otago followed by a Doctor of Science degree at Auckland University. Sir Peter soon realised that his great passion lay within the field of research, and 40 years later this remains his first priority. Sir Peter’s research encompasses paediatric endocrinology, the developmental origins of health and disease, the evolutionary-developmental biology interface, and evolutionary medicine.

In 2009 Sir Peter became the first Chief Science Advisor to the Prime Minister of New Zealand, and in 2014 was appointed by the World Health Organization to co-chair the Commission on Ending Childhood Obesity.

Sir Peter acknowledged the recognition that the order of New Zealand brought to his colleagues:

I was somewhat taken aback by the honour but obviously feel considerable satisfaction in seeing a career in medical research, and more latterly in applying science for the country’s benefit, so recognised. I am convinced that the more New Zealand understands the importance of science, the more it will thrive. I hope the award gives some pleasure to the many colleagues, fellows and students, both in New Zealand and internationally, who have worked with me over many years – so much of what we do in science has to be built on collaboration and collegiality.

Sir Peter believes that science has a central role in our future, and can help transform New Zealand into a stronger nation – socially, environmentally and economically. He encourages children to see science in their future: “keep an open mind and pursue things you are interested in” is his advice to aspiring young scientists and doctors.
GETTING THE BALANCE RIGHT: SPECIALIST OUTREACH IN THE OUTBACK

Researchers are using data from the College-endorsed Medicine in Australia: Balancing Employment and Life (MABEL) survey to establish how to provide essential specialist services in rural and remote areas efficiently and effectively.

FIFO (Fly In Fly Out) is a buzzword often associated with mining workers, but its most pressing application in a country the size of Australia is in the health sector. Only 15 per cent of medical specialists, compared with 31 per cent of the population, live in non-metropolitan — rural and remote — areas, as such, health policy in Australia faces a unique challenge. How does it accommodate vast distances, low population density and limited infrastructure in rural and remote communities to ensure adequate specialist services?

It is a challenge that has required governments to acknowledge the pivotal role of outreach specialists who are prepared to travel regularly to deliver healthcare services in these communities for a few days at a time.

Outreach has a long tradition in Australia, where it has been fundamental to combating the tyranny of distance. But we currently have little idea about how common it is, or where these outreach services are provided.

“There have been lots of descriptive local-level studies validating that outreach probably works, but none showing us about current workforce patterns and key drivers,” says outreach expert Belinda O’Sullivan, a PhD candidate who heads up a unique program of research in this field. “So while we have a policy and we should be planning, there is very little information to go on.”

Ms O’Sullivan is using the data compiled since 2008 by the MABEL survey to determine how a national outreach workforce might be properly coordinated and subsidised to provide vital services where they are most needed. Coordinated outreach can manage patients in place, mitigating the considerable costs of transferring them to large tertiary hospitals.

Outreach healthcare needs national coordination. Some specialists need to be in the same place at the same time, as a part of team-based care – surgeons and anaesthetists, for example – and they need to be there when they are required. To coordinate a workforce, it is essential to have a reasonable idea of who they are, where they come from and what might compel them to become involved.

According to Ms O’Sullivan, specialists are willing to provide outreach – one in five specialists already do so. “The workforce dynamics for outreach are different to the factors driving permanent recruitment,” she says. “Most participants have had no experience of growing up in a rural or remote area. If they have leeway in their normal job, they are more likely to participate.”

Participation also varies by specialist types. General specialists, who have a wider scope of practice, are more likely to provide outreach services. “The exact motivations of individual specialists have not been pinned down yet, but there is more driving specialists than simply earning a living,” Ms O’Sullivan says. “There’s interesting medicine; there’s practice diversity.”

One of the ongoing challenges is to evenly distribute remote services.

Only around 41 per cent of all services are provided to outer regional or remote locations. Specialists providing services to outlying areas tend to be more experienced, which makes sense given that they are more likely to have to work solo and that the community disease profile is likely to be more complex.

But government policy and organisational planning can do more to promote remote services by taking a role in supporting the costs of longer travel and specialists’ time away from their normal practice. “Our evidence indicates that the national Rural Health Outreach Fund policy plays an important role in doing this,” says Ms O’Sullivan. “But there is a limited pot of money and other ways to provide adequate financial support will also be needed.”

The travel preferences of specialists also need to be taken into account in coordinating services. Specialists living in metropolitan areas are more likely to provide remote-area services because they have better access to flights. They also make up the majority of all outreach providers. But a higher proportion of all rural specialists participate overall – perhaps travelling by different means.

Ms O’Sullivan explains: “There is a need to recognise that both metropolitan- and rural-based specialists add different value to the mix, but there is a critical need to coordinate doctors providing services from different
locations for the benefit of rural and remote communities.”

In acknowledging the complexity of outreach as a model, it is important not to place the burden of service coordination with any one policy, structure or unit, but to use a multi-level approach that accommodates current workforce patterns and incentivises where needed.

Ideally, service coordinators would foster collaboration between specialties and services from different locations and link services to local needs. But it is important that the success of outreach does not eclipse the focus on local community specialists. “One of the challenges for the future will be to work out how to optimise outreach as a strategy without compromising the growth of permanent regional specialist services,” Ms O’Sullivan concluded.


To coordinate a workforce, you need to have a reasonable idea of who they are, where they come from and what might compel them to become involved.

Coordinated outreach can manage patients in place, mitigating the considerable costs of transferring them to large tertiary hospitals.
WORKPLACE HEALTH AND SAFETY CHALLENGES IN THE MINING AND OIL AND GAS INDUSTRIES

Associate Professor Euan Thompson is an Occupational Physician (OP) with particular expertise in the Western Australian mining and oil and gas industries. RACP News spoke to him about workplace health and safety (WHS) in these industries and some of the challenges consulting on oil rigs, ships and mine sites.

RACP News: How did you get into the mining and oil and gas industries?
Associate Professor Thompson: I grew up in Scotland, studied medicine at Edinburgh, trained and worked in Aberdeen, initially gaining GP qualifications and thereafter in Occupational Medicine. In Aberdeen, you can’t really get away from the oil and gas industry – it is largely what modern Aberdeen has been built up on.

I then immigrated to Western Australia in 2009 and continued my work as an OP within the oil and gas industry, and diversified into mining. I also have more general interests in healthcare, retail and transport.

Despite it often being the same companies, working in the Australian oil and gas industry can be quite different to working in Aberdeen. In the UK there is no Workers’ Compensation – injured workers are cared for via the National Health Service, which then creates a different dynamic, for example, in the UK there can be less enthusiastic active case management, and it can be more challenging to access some services.

RACP News: What is it like to be an OP in these industries?
Associate Professor Thompson: In this job you have to be prepared to get your hands dirty! We visit workplaces and get a feel for the working environment and job tasks (sometimes even trying them for ourselves), and listen to the workers and management. This leads us to visit oil rigs, ships, mine sites, trains, factories, laboratories, warehouses, and more. If you don’t do that, you don’t really get a comprehensive view. The rest of the time I’m in the clinic or office, either consulting or in discussions on more strategic issues.
Perth is the main hub in WA, that’s where the majority of OPs are based, but we tend to like to get out to the worksites as regularly as we can.

**RACP News: Can you give us a bit of background on the current state of health in the WA mining and oil and gas industries?**

**Associate Professor Thompson:** One of my colleagues has best described it as “a period of readjustment”. The WA economy has been going great guns on the back of the mining boom but mining and gas construction is, in the main, coming to an end. The industries are entering a more stable phase of production and there are a lot of companies, particularly mining companies, tightening their belts. This has had hard knock-on effects; there have been many redundancies.

Similarly, around the world the price of oil has dropped dramatically. This has meant a reduction in staff numbers in some of the oil companies, which has resulted in increased demands upon the remaining workers.

**RACP News: What are your biggest health and safety concerns in the industries?**

**Associate Professor Thompson:** Year-on-year fatality rates have been dropping in mining, except for 2013–2014 when there was a small increase. There is controversy about whether this was a ‘blip’ due to small numbers or whether it is a trend. In June this year the Western Australian government published their findings and recommendations on mental health and suicide rates in fly-in fly-out (FIFO) workers.

**RACP News: Is it true that the mining industry has one of the highest occupational rates of serious injury and fatality?**

**Associate Professor Thompson:** Of the most dangerous industries, mining does rank highly: according to Australian Bureau of Statistics, it’s amongst the highest, behind commercial fishing, trucking and farming. Interestingly, police and armed forces are ranked as less dangerous than mining.

However, this ranking doesn’t specify whether it is mining construction or production. Across industries, construction has been associated with a higher risk of serious injury and fatality than production.

**RACP News: What are the most common health issues you encounter from these industries?**

**Associate Professor Thompson:** Physical complaints are the most common: back pain, lifting incidents, slips, trips and falls, and hand injuries, but now mental health is becoming increasingly recognised – it’s becoming culturally acceptable to admit to these issues.

[In terms of mental health] many companies now have an employee assistance program, to which workers can make anonymous calls for initial support, and OPs can become involved if the matter isn’t resolved.

**RACP News: How effective do you think the industries are at reducing risk/risk management?**

**Associate Professor Thompson:** Both the mining and oil and gas industries recognise the inherently hazardous nature of their industries, and in most companies there are enthusiastic efforts to understand and quantify risk, and then to control it. The current philosophy is increasingly to try to adopt a systemic approach to incident investigation, as very often it is not a single-point failure that leads to an accident, rather contributions from many sources.

Incident investigations are used as learning points; learning is also shared throughout the industry, even between competitors.

Amongst other controls, there is increasing automation, even trains and truck driving! I think that a lot of the “physical contributors” are gradually being engineered out – I think a more difficult challenge is the behavioural contributors.

**RACP News: In terms of WHS, what measures would you like to see the industries implementing/moving towards in the future?**

**Associate Professor Thompson:** It’s difficult to predict the future! Forward workforce planning would be a prudent long-term plan – over the next few decades, people are likely to work longer and longer, so we need to recommend that companies engage longer term thinking about the health of their employees, and how to cater for older workers. Already I am seeing diseases of ageing starting to affect some workers, and I anticipate that this will probably grow.

Health promotion and early identification of potential medical issues may allow a “pre-emptive strike” – an intervention before it results in them being unable to work.

**RACP News: How do you think the future of WHS will look in the mining and oil and gas industries?**

**Associate Professor Thompson:** By and large, there is a relatively low rate of fatalities and accidents; however, longer term personal health issues (for example, mental health and obesity) and unfitness for work as a result are likely to far overshadow accidents.

As such, I think that increasingly there are gains to be made in prevention.

**RACP News: How supportive are mines/companies of Workers’ Compensation?**

**Associate Professor Thompson:** Generally, excellent.

In a small proportion of organisations and sectors, there’s still a certain stigma often unfairly attached to Workers’ Compensation. In that environment, workers can feel judged, worry about their employment prospects, and may be hesitant to make a claim, sometimes even arranging treatment privately.
INNOVATIONS IN STROKE REHABILITATION

RACP News spoke to Professor John Olver, Past-President of the Australasian Faculty of Rehabilitation Medicine (AFRM) and Professor of Rehabilitation Medicine at Monash University, about the latest treatments and technological developments revolutionising stroke rehabilitation. Professor Olver will host a Clinical Update Session on Innovations in Stroke Rehabilitation at this year’s AFRM/NZRA Combined Rehabilitation Meeting, 13–17 October.

**RACP News: What attracted you to rehabilitation medicine?**

**Professor Olver:** Rehabilitation medicine appealed to me because it focuses on the patient as a whole. It is a holistic and patient-centred approach to treatment.

It looks beyond the medical issues, to assess the effect of the impairment on the patient in their lifestyle and function.

It is also team-based. We work with multiple disciplines (such as physiotherapists, occupational therapists and speech pathologists) to develop a program which delivers the best outcomes for patients.

**RACP News: Throughout your career, what would you say have been some of the greatest developments in the treatment of stroke patients?**

**Professor Olver:** New technologies and treatments are always emerging in the area of stroke rehabilitation. The first of three current examples is the emergence of botulinum toxin to treat spasticity (muscle tightness or stiffness) after stroke. Up to 30 per cent of patients who have suffered a stroke experience muscle spasticity. The ability to manage this problem has improved significantly through the use of botulinum toxin, which is injected into the tight muscles to facilitate movement or relieve pain.

The second is the advent of robotics to help patients walk and move their arms after stroke. With robotic assistance, patients with paresis in muscles can practise tasks repetitively (like moving their arms). One of the keys to neuroplasticity and the brain continuing to heal is this repetition of specific tasks. The advancement of such mechanics has been quite dramatic over the last 10 years and is continuing. For example, a treadmill with body-weight support and a mechanical interface to the patient can simulate walking and enable patients to do several hundred steps per day to encourage recovery of walking.

The third development is the use of virtual reality environments as part of rehabilitation. Virtual reality environments can simulate tasks relevant to the patient and allow them to practise the skill in safety.

It is hoped that the use of these innovations (in combination with traditional therapy) will give patients a more rapid recovery (in terms of regaining independence in daily function) than traditional therapies on their own. It’s important to note that all of these advancements are currently an adjunct to traditional therapy.

**RACP News: How do you believe technology will aid in improving the functionality of stroke patients, particularly the 50 per cent of patients who are not currently independent?**

**Professor Olver:** It’s often referred to as the rule of thirds: one-third will get almost everything back (after a stroke), one-third will regain some function and for the final third, the chance of regaining independence is unfortunately slim.

It is hoped that use of robots in therapy could help the first group gain greater improvements in recovery and achieve them faster, and the other two-thirds might respond more to this type of assisted therapy and achieve a better outcome than they would have without robotics.

It’s important to note, however, that at this point more evidence-based research is needed to prove the theory.

**RACP News: How does the treatment of stroke and traumatic brain injuries in Australasia compare to the rest of the world?**

**Professor Olver:** Australia is right up there with the rest of the world. We can always learn from the different approaches of other countries, for example the US and Japan are leading the way in robotics, but our programs in Australia are high quality and we can be happy with our progress.

International trials like the recently completed A Very Early Rehabilitation Trial (AVERT) looking at early therapy intervention after stroke was led by Australian researchers.

To register for the AFRM/NZRA Combined Rehabilitation Meeting in October, please visit the conference website at www.afrm-nzra-rehabilitationmeeting.com.
WORLD-CLASS PALLIATIVE MEDICINE COMMUNICATION SKILLS WORKSHOP

Originally developed in 2008 for the Australasian Chapter of Palliative Medicine (AChPM) by expert communication skills facilitators from the US, New Zealand and Australia, the workshop has to date trained more than one hundred palliative medicine registrars and Fellows.

Twenty trainees and five Fellows from Australia and New Zealand attended this year’s three-day workshop held in Sydney in July. Dr Robyn Thomas, the current chair of the workshop group, was supported at the event by other facilitators who were part of the original workshop development group. These included Dr Jonathan Adler, Dr Anne O’Callaghan, Dr Josephine Clayton and Dr Jennifer Hynson, as well as Dr Jennifer Philip, Dr Derek Eng, Dr Amy Waters, Dr Sarah Thompson and Dr David Brumley.

Each day of the workshop started with a brief presentation on evidence-based communication skills, followed by a demonstration role play. The participants then separated into small experiential learning groups with clinically relevant simulated patients (actors). Each participant had the opportunity to practise ‘the tough stuff’ in a safe and supported environment, providing a personalised learning experience. The groups provide the participant with positive and constructive feedback, reflection opportunities and general moral support. The practice gained in this safe, small-group environment and the ability to discuss different approaches to the more difficult scenarios were considered particularly valuable by attending trainees.

Communication skills are core to the work of physicians. It is the one skill set that all physicians require, and it is one of the ten domains of the College’s standards framework. The Professional Qualities Curriculum (PQC) also includes specific competencies related to communication. The revised Basic Training Curriculum, which will be distributed for consultation in the near future, consolidates these frameworks and includes themes highlighting the importance of communication.

The resources required for running small-group learning sessions, in terms of both facilitators and logistics, limit the number of attendees for each workshop. However, the workshop group is considering options on how to expand the course.

TESTIMONIALS

“Outstanding opportunity to safely practise new communication skills and extend your repertoire in difficult conversations in a very supported environment.” – Dr Christine Edwards

“The Palliative Care Communication Skills Course provided not only the techniques for dealing with challenging conversations but also a safe and supportive environment in which to practise these new skills. I would highly recommend this course to not only palliative care trainees and specialists but all medical professionals looking to improve their communication skills.” – Dr Dean Fourie
The College hosted the Australasian launch of the UCL-Lancet Commission’s Report on Health and Climate Change in June. This gave Fellows and trainees the opportunity to hear not just from Professor Anthony Costello, one of its preeminent authors, about the findings of the report and the process they undertook, but also from colleagues around Australia and New Zealand.

The UCL-Lancet Report and the wealth of available evidence highlights that climate change is, beyond any doubt, a health issue. If climate change goes unaddressed, extreme weather events, disease, disruptions to food and water supply, loss of livelihoods and threats to human security will all be exacerbated.

The UCL-Lancet Report presents the facts on how climate change is impacting human health. The overriding message of the report, however, is one of hope: “Tackling climate change could be the greatest global health opportunity of the 21st century.”

The College is committed to getting this message out and communicating the benefits of tackling climate change. Our newly formed Working Party on Climate Change and Health recently held its first meeting, mapping out its work and identifying the key areas where our voice, as physicians, can most effectively contribute to efforts to curb the health impacts of climate change.

The Working Party will preside over the College’s ‘Day of Global Action’ on Monday, 12 October 2015, calling for meaningful action on the health impacts of climate change at the upcoming United Nations Climate Change Convention of Parties (COP21). This ‘Day of Global Action’ will focus on a digital campaign, ‘Doctors for Climate Action’, which will give doctors around the world the opportunity to add their voice to the call for leaders to show true leadership at COP21 and agree to meaningful and concrete actions to tackle climate change.

At the international level, tackling climate change offers the opportunity to curb some of the most devastating health impacts. Without leaders committing to action at COP21, a huge opportunity will have been missed. Through the ‘Day of Global Action’ and the digital campaign, we have an opportunity to use our influence as physicians to stand up for the health of the planet and the health of our patients, and call for meaningful action.

The College, through the Working Party, is also promoting a ‘Global Consensus Statement’, for which we will seek endorsement from medical colleges and other health and medical organisations around the world. This statement will highlight the importance of climate change as a health concern, and once again will call on leaders to address the concerns of the global medical community on this pressing issue.

Climate change could be seen simply as a looming catastrophe, but the College has chosen to accept the challenge set out by the UCL-Lancet Report to highlight the opportunities. Fellows and trainees are all encouraged to keep an eye out for ‘Doctors for Climate Action’ and add your name to the campaign.
MAKING SMALL FOOTPRINTS

Emeritus Professor Ian Maddocks AM challenges all Fellows and trainees to take action on climate change by reducing their carbon footprint at home, in their practice, in their hospital and in the wider community.

The recent UCL-Lancet Report on Managing the Health Effects of Climate Change is a sobering reflection on a threat to personal, community and global health that many would prefer not to recognise or address. But if doctors cannot accept its message and act on it, who will?

The message of the UCL-Lancet Report is direct and brutal. Whatever the global community does from this point, a rise in the world mean temperature of 1.5 degrees Celsius is inevitable, and its consequences are becoming evident from well-authenticated rises in sea levels and the extent of days of extreme heat. And, as our responses prove inadequate, each further degree rise in temperature will bring new incidences of extreme weather, displacement of populations, spread of insect vectors, famine and conflict. Every part of the earth is set to become a far less healthy place.

In our own interests, and in those of our family, our community, our nation and our world, we are challenged to accept personal and professional responsibility to lead by example, teaching and research, so that this undeniable threat may be ameliorated successfully.

Can you lessen the footprint of carbon you leave on the earth with each step you take?

Will you eat less meat and recycle waste in your home, walk, cycle or travel by public transport and replace unnecessary travel with telecommunication?

Will you lessen energy usage and waste and the pollution associated with your practice of medicine? Will you be careful to avoid unnecessary or inappropriate hospital admissions, investigations and poly-pharmacy? Will you explain to your patients that their health and your health depend on working together to reduce our footprints, and therefore your practice is committed to a careful husbanding of energy and resources?

Will you urge your hospital to advertise that it is seeking to reduce its footprint? Cities are major generators of global warming, and large urban hospitals make their own significant contribution. Will your hospital strive to be a healthy place, careful to eliminate as much pollution, waste or overuse as possible?

Does your hospital accept its role as a centre of advocacy, so that its staff, patients and their families may be confronted with their individual opportunities to reduce their footprint? If we are to hold back what is increasingly recognised as a major threat to human health, even human survival, all will need to be challenged – including our politicians – to join what must become a universal change in attitude and practice.

I propose that informed and responsible medical practitioners wear a badge in the form of a small naked footprint, to say, in effect:

For global health, I am seeking to lessen my footprint – what are you doing?

A large footprint can appear in my practice, and a larger one at the entrance of my hospital. But it is the many smaller footprints that mark the path ahead to secure the future we dream of.

I have spread my dreams under your feet; Tread softly, because you tread on my dreams.

WB Yeats, ‘He wishes for the Cloths of Heaven’
Medicine shortages are an international issue with potentially significant implications for physicians and their patients. Over the years, shortages of essential medicines have become increasingly common in Australia. For example, we have recently seen shortages of medicines such as flucloxacillin, amoxicillin, ampicillin and cabergoline.

Medicine shortages are a cause for concern for Australia’s Therapeutic Goods Administration (TGA) and shortages can have a negative impact on public health and put pressure on clinicians to find alternatives.

There can be a number of reasons for medicine shortages in Australia. Often medicine shortages can be caused by the unavailability of raw and bulk materials, the effects of pharmaceutical industry consolidation, disruption to centralised manufacturing processes, changes in product manufacturer and drug discontinuations.

It is worth noting that being listed on the Pharmaceutical Benefits Scheme (PBS) does not guarantee a continued supply in Australia of those medicines. Under the current pharmaceutical legal framework, pharmaceutical companies are not obligated to supply medicines listed on the PBS. There is also no regulation to mandate that companies advise the TGA if particular medicines are discontinued in Australia.

To assist clinicians in dealing with the issues surrounding medicine shortages, the TGA launched a Medicine Shortage Information Initiative website (www.tga.gov.au/medicine-shortages-information-initiative) in May 2014.

The initiative serves as a central platform to provide clinicians with up-to-date information on shortages of prescription medicines in Australia including current drug shortages, anticipated shortages, and resolved shortages, based on the information provided voluntarily by sponsors.

The TGA also has an alert service for medicine shortages (www.tga.gov.au/medicine-shortages-alert-service). Clinicians can subscribe to the alert service to receive the latest medicine shortages information as it is reported to the TGA.

Associate Professor Shane Hamblin FRACP
COLLEGE-WIDE INITIATIVE ON CONSUMER ENGAGEMENT

The College has initiated a collaborative research project with peak consumer body Health Issues Centre to develop a College-wide strategy for patient-centred care and consumer engagement in healthcare.

Why focus on consumer engagement?

Many organisations are engaging consumers, including patients and community groups, in their governance, education and policy activities to become more patient focused.

Consumer engagement and patient-centred care have been identified by the RACP Board as key strategic priorities. Both nationally and internationally there is an increased focus on the patient experience, patient outcomes and the quality of care provided by health services.

In medical education, ensuring that training approaches are patient focused is arguably the next significant paradigm shift, whereby success of postgraduate training programs is measured not just by trainee performance but by the impact of training programs on patient outcomes. In this model, the patient is the end user of education and training, rather than the trainee. Similarly in policy and advocacy, the focus is on the endpoint of how policy transforms care for the benefit of the patient and of the community.

What are the aims of the project?

1. To engage more actively with consumer groups and progress the College’s goal of being more outward looking and collaborative in its work.
2. To ensure that education and policy approaches contribute explicitly to improved patient-centred care.
3. To facilitate consumer input into decisions regarding educational change and, broadly, the purpose of the College.
4. To demonstrate the link between RACP training programs and improved patient outcomes.

What is being done?

The College is working closely with Health Issues Centre on:

- Development of a framework to inform the College strategy for consumer engagement and patient-centred care in education, policy and advocacy, and governance.
- Development of a strategy document including recommendations for consumer engagement at the College.

How can I get involved?

During September and October 2015, a series of consultation workshops, open to all Fellows and trainees, will be held across Australia and New Zealand to identify member perceptions of consumer engagement and patient-centred care.

A survey will also be conducted in October to allow the broader membership to participate in the project.

For more information on this project, please contact the Education Policy, Research and Evaluation Unit at evaluation@racp.edu.au.
PAST-PRESIDENTS’ PORTRAIT UNVEILING

Professor John Kolbe with his wife, Mrs Anne Kolbe

Associate Professor Leslie Bolitho AM with his wife, Professor Rosemary Calder AM

Laureate Professor Nicholas Talley (centre) with RACP Board Trainee representatives Dr Evan Jolliffe (left) and Dr Alexandra Greig
PORTRAIT UNVEILING

Left to right: Laureate Professor Nicholas Talley, Professor John Kolbe and Associate Professor Leslie Bolitho AM

Left to right: Mrs Anne Kolbe and RACP Board members Professor Paul Colditz, Associate Professor Nicholas Buckmaster and RACP President-Elect Dr Catherine Yelland
This year, 776 Adult Medicine and 232 Paediatrics & Child Health trainees sat the RACP Clinical Examination in Australia. Organising this examination is an enormous task and many Fellows contribute their time to the process. The largest burden is borne by the Local Examination Organisers at the hospitals involved. The College recognises examiners and the effort required to provide a high-quality exam experience for candidates.

On behalf of the Clinical Examination Committee, we would like to express our gratitude to the Local Examination Organisers and Regional Examiners 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.

Professor Michelle Leech FRACP
Chair, Adult Medicine
Clinical Examination Committee

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

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### 2015 RACP CLINICAL EXAMINATION AUSTRALIA

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<td>Angliss Hospital</td>
<td>Dr Evan Newnham</td>
<td>Dr Kwee Chin Liew</td>
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<td>Austin Health</td>
<td>Dr Simon Lam</td>
<td>Dr Ahmed Al-Kaisey</td>
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<td>Associate Professor James Hurley</td>
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<td>Dr Dov Degen</td>
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<td>Associate Professor Lukas Kairaitis</td>
<td>Dr Darshika Christie-David</td>
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<td>Dr John Lubel</td>
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<td>Dr Joshua Hanson</td>
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<td>Calvary Hospital, Canberra</td>
<td>Dr Arnagretta Hunter</td>
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<td>Dr Michael Hayes</td>
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<td>Dr Rohit Rajagopal</td>
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<td>Associate Professor Anne Powell</td>
<td>Dr Jonathan Zimmerman</td>
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<td>Greenslopes Private Hospital</td>
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### Adult Medicine

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<td>Dr Robert Kim</td>
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<td>Dr Duncan Cooke</td>
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Paediatrics & Child Health

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Despite sustaining several battlefield injuries during World War I, Dr Eric Susman became a renowned neurologist whose contribution to medicine in Australia continues to be recognised, with a library and annual award named in his honour.

The Susman Library at Sydney’s Royal Prince Alfred Hospital is familiar to many medical specialists and students. But the majority of people who use it daily are unlikely to appreciate the achievements of the pioneering Australian neurologist, teaching physician and World War I veteran after which it is named.

Like many of his generation, a young Eric Susman volunteered for service in World War I. In his case, Susman did so even though he was medically unfit. Diagnosed with Diabetes Insipidus (DI) at the age of ten he had also suffered from a bout of life-threatening measles during his teenage years.

Aged 18 he enlisted as a Lance Sergeant in the 13th Battalion of the First Australian Imperial Force (AIF) in September 1914 and was part of the contingent which made the historic landing at Gallipoli during World War I.

Susman’s service with the AIF involved heavy fighting and his recurring illnesses also impeded his performance at the frontline. The initial period of combat was especially harsh for Susman as he sustained numerous wounds.

Despite this, Susman persevered and risked his life to recover a water bottle from a dead soldier in the midst of a battle. He continued fighting even though he had sustained severe leg injuries. Towards the end of the war, he also suffered a relapse of his childhood DI.

Susman’s severe injuries at Gallipoli rendered him unfit for war and he returned home, graduating with a medical degree from the University of Sydney in 1921. Appointed briefly as a Resident Medical officer at Sydney Hospital and Royal Prince Alfred Hospital (RPAH), he then moved to London where he had the opportunity to specialise in neurology at the National Hospital for Nervous Disease. He was made a Fellow of the Royal College of Physicians in 1924 and discovered his innate passion for neurology.

Eric Susman’s wealth of medical knowledge and expertise was immediately recognised when he returned to Sydney and he was appointed as an Honorary Assistant Physician to RPAH in 1926, remaining there for the rest of his life.

It was at RPAH where Susman became renowned for his substantial contributions to the medical field in Australia. He was one of the first neurologists in Sydney and a pioneer in the setting up of neurological clinics at RPAH and the Royal Alexandra Hospital at a time when specialisation was not favoured.

His lectures and medical papers were meticulously prepared and reflected his original ideas and hypotheses. He was respected by his patients and admired for his compassion and dedication. Eric Susman did not possess the slightest interest in building up a busy private practice which entailed both neurology and general medicine.

Instead, he harboured the belief that it was more important for him to expand his collections of neurology journals, explaining it was imperative for future neurologists to have ready access to a vast repertoire of neurology literature so that they would have a firm grounding in this specialised field.

Susman was a versatile, well rounded physician with diverse talents. He took the initiative to organise and conduct Sunday morning medical rounds which eventually laid the foundation of the post-graduate school in medicine at RPAH.

He also devoted a large part of his professional life to teaching, appealing even to the least interested student. He was not only able to simplify mundane and sophisticated medical concepts but also utilised powerful analogies to illustrate a theory so that students would have a clear understanding of the
The Susman Library in the 1970s

subject. As an example, Susman likened the atrophic brain of a dementia patient to a “shrivelled walnut in its shell”.

His outpatient sessions were beloved by students. When queried on what his secret recipe to being a successful teacher was, Susman claimed that one must be “half a Socrates and half a clown”, and he was a concoction of both.

On his retirement, Susman donated the then substantial sum of £5000 to establish the library at the RPAH that bears his name today.

Towards the end of his life, Eric Susman was plagued by diseases such as trigeminal neuralgia and terminal cardiac illness.

However, these terminal illnesses did not dampen his naturally cheerful temperament and Susman did not reveal that he was suffering from these illnesses as he did not want his friends to worry about him.

Susman passed away suddenly on 10 June, 1959. But his legacy continues to live on.

The Royal Australasian College of Physicians established the Eric Susman Prize with the help of a generous endowment from Susman’s estate. First awarded in 1962, the prize is a prestigious award presented annually to a Fellow of the College for the best contribution to the knowledge of any branch of internal medicine as adjudged by the Council of the said College.

Recipients must be nominated by another person who is able to provide a succinct account of the nominee’s valuable contributions to clinical medicine. Visit www.racp.edu.au/racpfoundation for more information.
AWARDS OPEN – APPLY OR NOMINATE A COLLEAGUE

The prestigious RACP awards season has begun. Applications are sought for six medals/awards which recognise excellence and outstanding achievement, including the newly endorsed RACP International Medal which recognises the significant contributions of those undertaking vital healthcare work in developing countries.

See the RACP website (www.racp.edu.au/about/racp-foundation-awards/college-congress-prizes) for eligibility criteria and to submit your application or nomination.

A new RACP award – The International Medal
The RACP International Medal is a new initiative to recognise the significant contributions made by Fellows or trainees who are either resident or undertake voluntary or philanthropic work in developing countries.

Members of the RACP are invited to nominate a Fellow or trainee to be recognised for their contribution to improving the welfare of communities in disadvantaged areas.

Award of the medal will be based on the nominee’s clinical and public service contribution, their promotion, collaboration and advocacy of health improvements, and their commitment to education and training, either in a developing country, or working for an international aid agency overseas as outlined in the full eligibility and requirements.

The John Sands College Medal
Awarded to a Fellow in recognition of a significant contribution to the welfare of the College.

RACP Medal for Clinical Service in Rural and Remote Areas
Recognises Fellows who have provided outstanding clinical service in rural and remote areas of Australia and New Zealand.

RACP Mentor of the Year Award
Acknowledges the leadership qualities of a Fellow who has mentored a trainee or provided a high level of support and guidance throughout their training.

RACP Trainee of the Year Award
Celebrates the achievements of a trainee who has made an outstanding contribution to College, community and trainee activities.

The Eric Susman Prize 2015
A prestigious award offered by the College for the best contribution to the knowledge of internal medicine. Read more about Dr Eric Susman in the article on pages 26 and 27.

The RACP Foundation acknowledges the contributions of all donors and supporters that allow the College to offer these awards and prizes.
This year the Australasian Chapter of Addiction Medicine (AChAM) offered trainees and medical students the opportunity to attend the International Medicine in Addiction Conference, held in Melbourne in March. These awards are funded through the Chapter’s endowment fund, administered by the RACP Foundation. This year’s prize recipients speak of their experiences at the conference.

### 2015 AChAM Essay Prize

**Awarded to: Dr Patricia Collie**

I was fortunate to receive the AChAM Essay Prize for this year, which was kindly funded by AChAM, through the RACP Foundation. This enabled me to attend the International Medicine in Addiction Conference held in Melbourne in March.

This unique conference is co-convened by three Colleges – the Royal Australasian College of Physicians, Royal Australian and New Zealand College of Psychiatrists and Royal Australian College of General Practitioners – allowing a diversity of input that enhanced the content and provided perspectives on management from a broad range of clinicians.

Each of the three days was centred on a theme – alcohol, prescription drugs and emerging drugs and their management. The speakers came from both clinical and research backgrounds, allowing a blend of opinions, research and ideas. Leaders in the field from overseas such as Professor David Nutt, Dr Andrew Kolodny and Dr Adam Winstock provided a global overview of current issues and trends in drug and alcohol use. The presence of the Victorian Coroner and sports physicians broadened the discussion.

This conference directly related to my training in addiction medicine and provided an opportunity to enhance my learning and networks with colleagues. I plan to attend the next conference and hope that it will be as informative and enjoyable.

### 2015 AChAM Indigenous Prize

**Awarded to: Mr Andrew M Sampson**

Through receiving the AChAM Indigenous Prize, I was given the honour of attending the 2015 International Medicine in Addiction Conference in Melbourne where I had the opportunity to learn from international experts in the field of addiction. Not only did my attendance at the conference give me the opportunity to be a part of some truly interesting talks and sessions, it also provided me with the chance to meet and network with many wonderful people from multiple specialties with an interest in addiction.

The opportunity to attend this conference has deepened my interest in addiction medicine, and through meeting many of the people in attendance, I know this is certainly a rewarding field I would like to work in.

**Awarded to: Mrs Anika Tiplady**

It was a fantastic honour to be awarded the AChAM Indigenous Prize to attend the International Medicine in Addiction Conference held in Melbourne earlier this year.

As a medical student from New Zealand, it was a fantastic experience, not only to expand my understanding of addiction medicine, but also to network within the RACP environment.

Conference highlights included the opening plenary by Professor David Nutt, a discussion on the liver transplant selection criteria debate and a small group workshop on tips for sensitive practice with lesbian, gay, bisexual and transgender (LGBT) people regarding their substance use. Visiting the Melbourne Cricket Ground for the conference dinner was also a highlight. My wife and I thoroughly enjoyed the evening!

I would like to thank the RACP Foundation for providing me this opportunity and I look forward to future interactions with the College.
CONTINUING COMMITMENT TO INDIGENOUS HEALTH IN AUSTRALIA AND NEW ZEALAND

The RACP Indigenous Health Scholarship Program was launched in 2014 with the aim of encouraging medical graduates and doctors of Indigenous heritage to undertake specialist medical training, and to provide additional support to current Indigenous trainees.

Considerable research and two years of consultation with different groups, both within the College and externally, has resulted in a coordinated Scholarship Program which offers funded pathways through Basic, Advanced, Faculty and Chapter training.

There are now eight scholarships available through the program, with each scholarship offered for three or four years, depending on the training pathway. Valued at up to A$40,000, they cover all training and examination fees, and attendance at the RACP Congress each year.

Applications are now being accepted for 2016 for the following scholarships.

**College Indigenous Health Scholarship**
The scholarship is made available by the Fellows of the RACP.

**Aboriginal & Torres Strait Island 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.

**New Zealand Pacific Island Health Scholarship**
This year the RACP is pleased to announce the addition of the NZ Pacific Island Health Scholarship to its Indigenous Health Scholarship Program. This new scholarship is available to those medical graduates and doctors resident in New Zealand who identify as being of Pacific Island heritage.

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 & 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.

For more information about these scholarships and how to apply, please visit the RACP website or contact the RACP Foundation office by email at foundation@racp.edu.au or phone +61 2 9256 9639.

Laureate Professor Nicholas Talley and 2015 New Zealand Indigenous Health Scholarship recipient Dr Myra Ruka
MEDICAL EXPERTISE ESSENTIAL IN ASSISTING DOCTORS IN DEVELOPING COUNTRIES

Dr Jennifer Tan writes about the achievements, the frustrations and the highlights of working as a teaching fellow in Laos and passionately encourages others to take up similar opportunities.

I went to Laos for six months at the start of 2013 as a Clinical Paediatric Teaching Fellow. The role had been created as part of a collaboration between the Centre for International Health, University of Melbourne, and the University of Health Sciences of Lao PDR and is currently supported by the Planet Wheeler Foundation.

I was based in Vientiane, the capital of Laos, working with paediatricians and paediatric residents in the three tertiary referral hospitals. Laos is a low-resource country. The health system is user pays. There is a local medical school and a postgraduate paediatric residency program, the quality of which is limited by the availability and experience of clinical teachers.

Do students learn anything in a medical school clinical attachment standing six people back from a tiny patient where they can neither hear nor see what is going on? As a newly graduated doctor in these circumstances, would you learn best practice, or would you learn to do what the person next to you does? How easy would it be to aim for more, when a few years back there were no medical texts written in the Lao language and no system of continuing medical education?

One of the highlights for me was transferring the skills and knowledge I’d gained in my own training and seeing the light bulb moment of understanding in the paediatric residents when I’d made something finally make sense.

My day was spent supervising and supporting ward rounds, modelling good practice, doing clinical and bedside teaching and spontaneous consults, and working with the paediatricians to prepare lectures and clinical skills workshops. By the time I left, the residents were pre-empting my questions: “Why is there [insert clinical sign]? Why this? Why that?” “How will you know if your shocked patient is better? When will you review them? In 20 minutes? In three hours after lunch? Tomorrow?”

“This child presents with dengue shock, undetectable pulse and blood pressure 80/0. How do you give enough fluid to resuscitate the child, balance continuous capillary leakage and not end up with cumulative fluid overload and respiratory failure 48 hours later?” There was a nationwide dengue epidemic that year. I had great respect for the doctors. They were challenged and doing their best to manage the influx of these often critically ill children, learning the hard way the need for repeated assessment of this dynamic illness, without a good grasp of the physiological concepts, and with limited resources and support.

We hold our clinical teachers in high esteem, and remember their passion – they are the doctors we would like to grow up to be. We don’t realise the way we learn to clinically reason until we try to impart these lessons to others who have not grown up being taught in this system: interrogating the reasons why, considering the evidence base, and working from first principles based on an understanding of physiology.

I became much more appreciative of the training we receive and the quality improvement and accreditation systems we have in Australia. In Laos I had to rely much more on my own clinical skills without the luxury of expensive investigations. Who would have thought I’d ever be so thankful for having been put through the written and clinical exams!
I had to re-evaluate what “patient-centred care” really meant in the context of public health and what the family could afford, and truly consider which tests would change my management approach and if these would change the patient’s outcome. Parents frequently took their children home to an expected death as they did not have enough money for hospital tests, treatment and antibiotics. Often there was a history of money spent on tests and treatments of little value or indication of improvement in the patient.

The clinical teaching role has broadened since its inception in 2013. There are now opportunities to get involved in research. I did my Advanced Training project for the General Paediatric SAC whilst in Laos, a prospective cohort study looking into the effect of a pilot low-cost oxygen concentrator system for Laos. Subsequent Advanced Trainee Registrars have provided technical and implementation support for the Essential Early Newborn Care initiative driven by the World Health Organization, and helped with local research into the pneumococcal vaccine project through the Murdoch Children’s Research Institute.

It is easy to feel wonderful about the things that you are doing. But short, unsustained interventions have limited long-term effect. One of the great strengths of the collaboration in Laos has been the ongoing relationship that we have been able to build through successive Trainee Registrars going to Laos each year, reinforcing the same messages and building energy for growth and change.

The capacity to plant a seed of excitement about learning, improving and changing is addictive. The frustrations are many. You cannot go with preconceptions of grandeur and plans for achievement, but the things you do achieve are immensely rewarding. You may change, or you may reflect more within yourself than on what you have achieved. The country has wormed its way into my heart and I’ll be going back next year.

There are many of us who have always thought of doing something to contribute to international child health. Nearly everyone I speak to tells me the same. Don’t let your doubts hold you back. Keep an open mind, and do it!

Dr Jennifer Yan
Current General Paediatric and Infectious Diseases Fellow
Monash Children’s Hospital
Yan.jen@gmail.com

The Lao Clinical Teaching Fellow position is part of a program of work aimed at improving human resource capacity for child health in Laos through medical education capacity building and interventions to improve quality of care in hospitals. It is overseen by Dr Amy Gray (Paediatrician, Royal Children’s Hospital Melbourne and senior lecturer in the Centre for International Child Health/Department of Paediatrics, University of Melbourne). Subsequent fellows include Michelle Hendel, Melinda Morpeth, Annie Kilpatrick and Penny Wittick.

The Centre for International Child Health (www.rch.org.au/cich) also has other projects with partners in the Pacific region, with opportunities for interested trainees to become involved.
MEDICAL HUMANITIES: BENEFITS FOR PATIENTS AND PHYSICIANS

Basic Trainee Dr Abhijit Pal discusses how the methods of the medical humanities can reinvigorate and humanise clinical practice.

The term “medical humanities” is difficult to define. A useful definition by Gordon (2005) sees it as being concerned with “the science of the human”, bringing the perspectives of disciplines such as history, philosophy, literature, art and music to understanding health, illness and medicine. It is an academic field that is studied in many university departments and centres across the world, and is the focus of international conferences and several peer-reviewed journals (e.g. Medical Humanities). Due to being a relatively new field, and its interdisciplinary nature, there is still some academic debate as to its boundaries and goals and objectives (see Viney et al. 2015 for a thorough discussion). But leaving these more academic questions aside, below is a sampling of activities that fall within the scope of medical humanities:

- the study of illness narratives (e.g. The diving bell and the butterfly by Jean Dominique Bauby)
- poems by doctors about the practice of medicine (e.g. Selected poems by William Carlos Williams)
- plays about the patient experience of medicine (e.g. Wit by Margaret Edson)
- analysis of how different illnesses are represented in culture (e.g. HIV in the film Dallas Buyers Club or dementia in the film Nebraska)
- applying cultural theory and sociology to medicine (e.g. Illness as metaphor by Susan Sontag).

Medical schools across the world have responded to the growing prominence of medical humanities by incorporating materials such as the above side by side with the teaching of basic and clinical science. Rita Charon, Founder and Director of the Narrative Medicine program at Columbia University and one of the pioneers of narrative medicine, a subfield of medical humanities, writes: A scientifically competent medicine alone cannot help a patient grapple with the loss of health or find meaning in suffering. Along with scientific ability, physicians need the ability to listen to the narratives of the patient, grasp and honor their meanings, and be moved to act on the patient’s behalf.

Similarly, another prominent physician involved in the medical humanities, Dr Rafael Campo, poet physician at Harvard University, writes: I don’t want a supercomputer like IBM’s Watson telling me I have lymphoma because I entered in my twelve symptoms and that’s what the algorithm spits out. I don’t want a doctor who’s a robot. I want a doctor to be present with me as she tells me, “You have cancer and this is what we’re going to do next.”

These two quotes set the scene for medical humanities as a method through which practitioners can reflect on, learn from and improve upon the patient–doctor relationship. The scientific evidence base for medicine is fundamental to its practice, but it is also vital to know how to use it, how to deliver that information to patients, and how to be with patients while the various technologies (blood tests, investigations, medications, procedures) of medicine are being delivered to them. This latter part requires an understanding of the patient, their cultural background, their personal history, their values, wishes and desires, and engagement with the arts can assist this process by supporting empathy, broadening understanding and deepening compassion. Engaging with the arts also provides a space where medical practitioners can reflect on, and gain some perspective on, the enormous tracts of suffering and loss they bear witness to, reclaim their own humanity, and be less vulnerable to the emotional exhaustion and depersonalisation that threatens medical practitioners at every stage of their career.

Benefits for patients

Patients come to doctors for relief from suffering from an as yet undiagnosed condition, but as any doctor knows, different patients will cope differently with their diagnosis. There will be different levels of engagement, different levels of distress and different levels of coping – and it is here that medical humanities can offer a range of creative techniques to target the stigma
and opacity that illnesses often bring to patients. As a simple example, cancer is a diagnosis that is commonly feared and misunderstood and triggers a tremendous amount of distress and stigma. In Cowards get cancer too, journalist John Diamond takes us through his experience with cancer and tackles and debunks the myths that cancer is a battle to be fought and success requires “courage”. In Cancer made me a shallower person, Miriam Engelberger makes fun of her experience of breast cancer through cartoons and finds the humour in the various parts of her cancer experience without compromising the reality of cancer. In doing so, she destigmatises the experience of cancer and moves the cancer patient away from the gaze of pity. These tools allow doctors and patients to challenge social models of suffering and enable creative methods of responding to diagnoses and disease symptoms.

Benefits for physicians

Medicine is a challenging profession by any standards – the nature of the work, the length of training, the hours of working – and signs of burnout (e.g. emotional exhaustion and depersonalisation) are all too common. Many enter medicine because they view having the skills and training as a doctor to assist another human being who is suffering as an extraordinary privilege, but it is easy to forget this. The medical humanities is one method of reigniting this passion for medicine.

The challenges and joys of being a doctor are explored in classic texts such as House of God by Samuel Shem and Arrowsmith by Sinclair Lewis. These texts offer the physician an opportunity to reflect on their own practice and more than likely find many of their private thoughts echoed, hopefully providing at least a degree of comfort. While initially seeming like an unappealing choice after a busy clinical day, reading illness narratives (e.g. The diving bell and the butterfly, which describes the experience of a journalist with locked-in syndrome) is another excellent way of remembering that each patient is a human being with his or her own history, identity, family, friends, hopes and fears; a simple fact easy to forget for a busy registrar or clinician.

The medical humanities is an invaluable adjunct to medical education and practice, and has the potential to enrich the experience for both patient and practitioner. Jack Coulehan, one of the pioneers of medical humanities, writes eloquently about its benefits in medical education for students, but his ideas are easily transferable to doctors:

Medical humanities also points the way toward remedial education in habits of the heart. Nowadays, our culture disvalues liberal education, is skeptical of virtue, and, in particular, glorifies self-aggrandizement over altruism. Thus, today’s medical students usually lack a liberal education and often a belief in virtue. These factors make them more vulnerable to a culture of medicine that reinforces egoism, cynicism, and a sense of entitlement. Medical humanities (whatever it is) may assist students in resisting these negative forces by opening their hearts to empathy, respect, genuineness, self-awareness, and reflective practice.

Dr Abhijit Pal
Basic Trainee
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Suggested links for exploration

Medical Humanities (peer-reviewed international journal) – http://mh.bmj.com/
New York School of Medicine Literature, Arts and Medicine Database – http://medhum.med.nyu.edu/

Durham University Centre for Medical Humanities – www.dur.ac.uk/cmh/
Intima, a journal of Narrative Medicine – www.theintima.org/

References

RACP FELLOW TAKES ACTION ON BEHALF OF AYSLUM SEEKERS AND THEIR CHILDREN

Professor John Ziegler AM was so shocked by the attack on Professor Gillian Triggs, President of the Australian Human Rights Commission, he was compelled to bring community attention to the human rights violations taking place in Australia’s asylum seeker detention centres.

The media coverage of the parliamentary attack on Professor Gillian Triggs, President of the Australian Human Rights Commission (HRC), galvanised Professor John Ziegler into action to support Professor Triggs and the work of the HRC.

“I saw the Abbot Government’s attack as unfair since she was obviously in an invidious position of having to criticise senior political figures to mount a complete defence,” said Professor Ziegler, Department of Immunology and Infectious Diseases at UNSW.

Professor Ziegler started a petition calling on the Abbott Government to stop attacking Professor Triggs and to instead address the treatment of children in detention and the associated violations of international and national law.

“I thought the assertions of partisanship on the part of the HRC were wrong. Unfortunately Australia’s shameful treatment of asylum seekers has bipartisan support,” he said.

“Apparently the philosophy driving the harsh treatment of asylum seekers, including children, is to discourage others to seek the services of people smugglers.”

Professor Ziegler said the trickle of people into Australian waters on boats pales into insignificance compared to the influx into Europe from North Africa and other regions of conflict such as Syria.

“Compared to the numbers of would-be-immigrants who have arrived by plane but don’t have currently valid entry visas, the number arriving by boat is small,” he said.

“One can’t help wondering what is driving the malicious attitude to those arriving by boat without entry visa and to those such as Professor Triggs, who speak out against the Government’s actions.”

Recent legislative changes now make it a criminal offence for health professionals to report mistreatment of children in offshore detention. Professor Ziegler said this is of enormous concern.

“Doctors are legally obliged to report knowledge or strong suspicion of emotional, physical or sexual mistreatment of children,” he said.

“It isn’t surprising to learn that colleagues have declared a willingness to risk gaol rather than fail to uphold their professional and moral obligation to report mistreatment.

“This draconian legislation is hard to get your mind around. It’s reminiscent of the behaviour of totalitarian regimes.”

Since the petition went live on Change.org, more than 550 people have given their support by signing. Professor Ziegler says the overall feedback had been extremely positive. “It appears that most people who have read the petition support it. I have received only one objection to the sentiment expressed in the text.”

Well on the way to meeting its target of 1,000 signatures, the petition’s main purpose is not to bring about a change in government policy and methodology, but to show support for the HRC.

“I’m not so naive as to expect that [government action] will happen, given the unfortunate support that the government knows it has from both sides of the parliament, and the fact that the Australian public has been subjected to considerable xenophobia on this issue. The petition is meant to show Professor Triggs and her colleagues working for the HRC that she has support from the medical profession and others in the community who are sensitive to the plight of asylum seekers, and that...
there are people who oppose all forms of child abuse, and who are very disturbed by the virtual imprisonment of children and the associated impact on their physical and mental health and their education.”

While this is Professor Ziegler’s first foray into online activism, he hopes the petition reaches his RACP colleagues and other sections of the medical and healthcare professions.

“The feedback suggests that there is probably a majority of Australians who are appalled by the treatment of children in detention and would support the statements in the text if given the opportunity to do so,” he said.

Petition respondents to date include paediatricians and other medical practitioners, refugee workers, parents, children of refugees and immigrants from all parts of Australia and many from overseas. Reasons for support vary from the shame caused by the government’s actions to a sense of obligation to fight for the health and wellbeing of other human beings.

Most of Professor Ziegler’s family and his wife’s family perished in the Holocaust. Their parents were able to escape their home countries through the use of people smugglers.

“I can see why desperate people fearing or experiencing persecution will resort to such measures,” he said.

To view the petition, please see the Change.org website and search Triggs.

SENATE REPORT CONFIRMS THAT NAURU DETENTION IS NO PLACE FOR CHILDREN

The Senate Select Committee report on allegations relating to conditions and circumstances at the regional processing centre in Nauru was released on Monday, 31 August.

The RACP welcomed the Senate Committee recommendation to release all children from immigration detention in Nauru.

RACP President Laureate Professor Nick Talley said the Senate report confirms once again that children do not belong in detention.

The RACP will continue to call on the Government to respond swiftly to the Senate report and remove all children and their families into the Australian community.

The RACP particularly supports the following recommendations of the Committee:

- The complete removal of asylum seeker children and their families from detention on Nauru (Recommendation 11)
- A comprehensive audit of all allegations of sexual abuse, child abuse and other criminal conduct at the detention centre (Recommendation 13)
- New laws requiring mandatory reporting of any reasonable suspected unlawful sexual contact, sexual harassment, unreasonable use of force or other assault against asylum seekers (Recommendation 14)

The RACP will continue to advocate for urgent amendments to the newly introduced Australian Border Force Act.
LISTEN IN FOR END-OF-LIFE CARE ON POMEGRANATE

Pomegranate, the RACP’s CPD podcast, has released the final instalment of its series on end-of-life decision making.

The episode, titled ‘Law at End-of-Life’, explores the complexity and jurisdictional variations of law in this space.

For the majority of dying patients, their families and their medical staff, most decisions are reached without contention.

However, there are risks, both legal and physical, to doctors and their patients if a doctor has knowledge gaps around end-of-life care and the law.

In this episode Professor Ben White, from the Australian Centre for Health Law Research at Queensland University of Technology, and Associate Professor Colin Gavaghan, from the Faculty of Law at the University of Otago, discuss the legal frameworks for end-of-life care in Australia and New Zealand, and how they differ when a patient lacks capacity.

The first episode of this series, ‘Recognising Death’, discussed the difficulties involved with end-of-life decision making conversations with patients. The episode features palliative care physician, Dr Amanda Walker, and intensive care specialists, Dr Charlie Corke FCICM and Dr Peter Saul FCICM.

In the second episode, ‘Cultural Humility’, paediatrician Dr Andrew Watkins and Dr Peter Saul discuss the role of family and religion at end-of-life and strategies for cross-cultural communication, examining why these may sometimes clash with a professional preference for autonomy.

Made by physicians for physicians, Pomegranate is a monthly, peer-reviewed podcast featuring Fellows from across specialties and divisions, speaking on issues that matter to them.

The next episode of Pomegranate will feature clinical haematologist and pathologist Professor John Rasko from the Royal Prince Alfred Hospital, Sydney. Professor Rasko will present an update on stem cell research.


You can subscribe to Pomegranate by visiting the iTunes Store or Subscribe with Android. The podcast can also be downloaded for other podcast apps by searching for ‘Pomegranate’.
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