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As physicians I am sure many of us would like to think we practise patient centred care, and are probably confident we understand what the concept means. Even so, there are a number of different definitions and understandings of what is meant by this term and the broader, related concept of consumer engagement which drive so much of our thinking at the College, as we renew our curriculum to educate the next generation of physicians.

As many of you will know, we are in the midst of a slow, international groundswell of change in the way
medicine is practised. Like many other medical professions, specialists are no longer the sole expert in patient care, but rather the ‘influencer in chief’ when it comes to treatment.

Better informed patients are just one facet of a move towards ensuring patients and their families or loved ones are at the centre of all care-related decision making.

This concept of a collaborative partnership extends to the idea of ensuring healthcare consumers, such as patient advocate groups and other community stakeholders, are included in healthcare system decision making.

Your College is already factoring patient centred care and the broader principles of consumer engagement into the way it educates physicians, advocates for the health of patients and communities, and practises innovation in medical research.

You can read more in our lead story on pages 10−12.

On a less positive note, I’m sure that like me many of you will have been profoundly disturbed recently to see images and read stories of young people, many of them Aboriginal and Torres Strait Islanders, hooded and shackled in Australia’s Don Dale Youth Detention Centre in Darwin, as part of a supposed disciplinary regime.

Some were subjected to tear gassing, beatings, were stripped or were held in solitary confinement.

No person should be treated like this. The damage to young people is permanent. With these revelations of harm, it is little wonder that we see the poor social and health outcomes for Indigenous Australians in detention.

As context for our New Zealand and international colleagues, this documentary and the subsequent reaction have prompted the announcement of a Royal Commission of Inquiry by the Australian Prime Minister.

The RACP immediately issued a statement supporting the Royal Commission, as well as a further media release from Paediatrics & Child Health Division President Dr Sarah Dalton calling for the inclusion of health measures for Indigenous Australians in the terms of reference and for a broadening of the Inquiry’s remit to a national level.

Sarah has personally authored a heartfelt opinion piece on this issue – and I would encourage you to turn to page nine and read it.

As a College we will not stay silent on this topic and intend to advocate strongly, make a submission, and seek to give evidence to the Commission.

Recognition of Māori, Pasifika and Indigenous Australian cultures and promotion of Indigenous health and wellbeing are key RACP priorities, ably assisted by the vital work of our Aboriginal and Torres Strait Islander Health and Māori Health Committees.

We have dedicated paediatric Fellows who work not only in the Northern Territory, but across Australia to support disadvantaged Indigenous children and youth. They are all deeply concerned by what they have seen.

Our first thoughts should be for the young people who have been treated in a humiliating, harmful and inhumane way that we did not think could ever happen in Australia.

But our paediatric colleagues also deserve our recognition, support and our backing as a College for the tremendous work they do, and for their courage in standing up and speaking out for the young and vulnerable.

Dr Catherine Yelland
RACP President
A message from the Board

Two Board meetings have been held since the last edition of RACP Quarterly. On Thursday, 21 and Friday, 22 July 2016 the Board met in Auckland and held a regional convocation ceremony, and on Friday, 2 September, the Board met in Brisbane.

College strategy
The Board held a Strategy Day on Thursday, 21 July. The main topics discussed were:

- the implementation of the changes to the Constitution that were approved by members at the 2016 Annual General Meeting
- Education Renewal: Next Generation Learning for Physicians
- Towards Equity: a strengths-based approach for a new RACP Indigenous Strategic Framework
- the RACP International Strategy.

College accreditation
The Board discussed the RACP’s accreditation progress report that will be submitted to the Australian Medical Council in August.

The College received the longest possible accreditation of six years from the Australian Medical Council and MCNZ in 2015.

As part of the ongoing requirements this report will be submitted to show progress against the conditions and recommendations provided by the Australian Medical Council in its accreditation of the College.

Ethics Committee
The Board approved the continuation of the Ethics Committee. The Ethics Committee was established in 2015 for an initial period of 12 months. Over that period the Ethics Committee has developed a plan of activities, defined its purpose and demonstrated the need for it to continue as a committee of the Board.

State Committee report
At its July 2015 meeting, the Board requested that the College Council provide guidance and recommendations on the role and functions of the State Committees.

A Council working group developed five recommendations that were endorsed by the College Council at its May 2016 meeting.

The Board approved all recommendations which cover the role of State Committees, the recommended membership of the committees, and improved reporting and cooperation structures to support State Committees.

Indigenous representation on College Council
The RACP has a key role in strategically and positively impacting the health of our Indigenous peoples. This is achieved through policy and advocacy activities, ensuring that the broader membership is equipped with the required clinical and cultural competencies, and in working to grow the Indigenous physician workforce.

To ensure representation of these groups on key College committees in September the Board approved the addition of two positions on the College Council – one for an Aboriginal or Torres Strait Islander representative and one for a Māori representative.

Implementing the changes to the College Constitution
At the RACP’s 2016 Annual General Meeting held in May, members voted to change the Constitution in relation to Board composition.

To ensure the successful implementation of these changes, the Board has established a working group to oversee the required activities, and any resulting changes in College structures, By-laws, policies or processes in the intervening two years until the new Board structure takes effect in May 2018.

Board Committee appointments
As July was the first meeting of this Board a number of appointments to Board committees were made:

- Dr Jonathan Christiansen was re-affirmed as Chair of the College Education Committee for a further term.
- Dr Helen Rhodes was appointed Chair of the Fellowship Committee.
- As RACP President-Elect, Associate Professor Mark Lane will be Chair of the College Policy & Advocacy Committee.
• Professor Paul Colditz was re-affirmed as Chair of the College Research Committee.

• Dr Jeff Brown and Professor Lynne Madden were appointed to the College Finance and Risk Management Committee. They will join Associate Professor Grant Phelps and Mr Peter Martin as Director members of the committee; and Associate Professor Charles Steadman, Honorary Treasurer, will continue as Chair. Other positions reserved for non-Directors are in the process of being filled.

• Professor Paul Komesaroff was appointed as a member of the Ethics Committee. The Ethics Committee will recommend one of its members to be Committee Chair for the Board’s approval.

Minutes of the RACP’s 2016 Annual General Meeting

The Board approved the minutes of the RACP’s 2016 Annual General Meeting. They are now available on the RACP website at www.racp.edu.au/about/racp-board-and-governance/annual-reports.

College Council

The Board established the College Council in 2015 for an initial term of one year. Throughout that first year the College Council has met three times and contributed to important topics within the College, including:

• Capacity to Train
• Consumer Engagement
• Role and Responsibilities of Australian Regional Committees
• Governance Reform
• Bullying, Discrimination and Sexual Harassment
• Congress
• Workforce Planning
• Revalidation
• Selection into Training

The Board considers the College Council an important representative body within the College whose contribution will increase over time, especially as the changes to the Board composition come into effect in 2018. In light of this, the Board has made the College Council an ongoing committee of the Board.

Revalidation

The Board discussed the Medical Board of Australia’s recent interim report and discussion paper on revalidation. The interim report and discussion paper are part of a consultation program by the Medical Board of Australia and the discussion paper poses a number of questions on which they are seeking input from the profession and the community.

Revalidation is an important issue for the College and our members. The College will submit a response to the discussion paper, and will continue to be engaged in the ongoing conversation regarding revalidation.

RACP Foundation

The RACP Foundation supports exceptional Fellows, trainees, medical graduates and medical students through various awards, grants, scholarships and prizes. As the College’s philanthropic arm the Foundation funds important research and education.

The Board discussed opportunities to enhance the Foundation’s impact through increased engagement with members and the community.

Next meeting

The next Board Meeting will be held on Friday, 14 October in Melbourne, following the College Council Meeting being held on Thursday, 13 October.

Dr Catherine Yelland
RACP President
Revenue, expenditure and finance are words one typically would not expect to read about in the latest issue of *RACP Quarterly.*

However, in an era of increasing regulation and scrutiny, it makes sense that the College focuses on transparency and regularly opens its books for Fellows and trainees.

Of course this is not a new thing for the RACP to do. In fact, whenever an annual report is sent out, the figures are there to see for members and the public alike (page 43 in the most recent annual report). Financial details are also available via the Annual General Meeting (AGM) and reports from the Finance Committee.

As Honorary Treasurer and Board member I chair the Finance and Risk Management Committee that drives the financial direction of the College by advising the Board regarding decisions and strategies relating to good financial and risk management.

Fellows and trainees are always encouraged to contact the Finance and Risk Management Committee with any suggestions or questions they may have.

The Board and Finance and Risk Management Committee appreciate that as Fellows and trainees pay annual fees to the College, many are interested in finding out what this money goes towards. It is important for us to be transparent so Fellows and trainees can understand the sources of College income and where it is being spent.

From an ethical standpoint it is also important for members and the public to understand that the College is not compromised in its advocacy work. If we are going to be advocating for change on health issues, it is important for Fellows and trainees, and the broader public, to understand that we are not conflicted by donation or financial support.

If someone looks at our financial revenue, it is easy to see that member fees and admissions, training and examinations drive the majority of our revenue.
### HOW DOES THE COLLEGE PROVIDE VALUE FOR MEMBERS?

<table>
<thead>
<tr>
<th><strong>202</strong> Fellow and trainee led committees and working parties</th>
<th><strong>One</strong> podcast released every month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost <strong>A$2.6 million</strong> in scholarships, fellowships, grants or prizes allocated through the RACP Foundation in 2015</td>
<td></td>
</tr>
<tr>
<td><strong>In 2015, 19,149</strong> calls were taken from members and assistance provided</td>
<td><strong>Two thirds</strong> of College specialties engaged in EVOLVE – an initiative to identify and reduce low-value clinical practices and interventions</td>
</tr>
<tr>
<td><strong>61</strong> different training pathways</td>
<td><strong>4,574</strong> supervisors</td>
</tr>
<tr>
<td><strong>2,331</strong> clinical and written examinations facilitated last year</td>
<td><strong>1,053</strong> attended RACP Congress and ancillary events in May</td>
</tr>
<tr>
<td>Over <strong>40,000</strong> medical history items available for members at the College library</td>
<td><strong>One 24/7 professional and confidential counselling service, available to all Fellows and trainees</strong></td>
</tr>
<tr>
<td><strong>97</strong> per cent of Fellows recorded credits on MYCPD</td>
<td><strong>More than 90</strong> media releases distributed in 2015</td>
</tr>
</tbody>
</table>

Advocates on **many** issues important to members including immigration detention, the harms of alcohol, end-of-life care, Indigenous health, adolescent incarceration, infant formula, childhood immunisations, adolescent sexual health and climate change

| **15** curated content resources supporting professional standards | **Two** Qstream courses – Modern Ethical Challenges and Diagnostic Error |
In 2015, total revenue for the College was A$54,404,859. This included:

- 53 per cent on training and exams
- 34 per cent on subscriptions
- 9 per cent on investment income.

In 2015, total expenditure for the College was A$48,167,804. This included:

- 25 per cent on education – trainee
- 15 per cent on governance
- 14 per cent on administration, including IT, finance, human resources and commercial services.

The day-to-day activities of the College also include the RACP Foundation, which derives income from its investments (2015 total income A$1.9 million). The majority of this income, as well as further donations from members and donors, is used to fund research awards of scholarships, fellowships and grants. In 2015, the RACP Foundation allocated almost A$2.6 million in research awards.

Associate Professor Charles Steadman
Honorary Treasurer

Charles Steadman
I wasn’t proud to say I am Australian, but I do have hope:

*a letter to all those who stand up for and protect our children*

In a scholarship interview once, I was asked to nominate the one movie that I thought best represented what it meant to be ‘Australian’. Not a question I was prepared for. How could I answer that? Should I highlight our history with Gallipoli, our stereotype with Crocodile Dundee or our beautiful outback with Red Dog?

In fact I said the first thing that came to mind – *The Castle*. After a laugh from the panel, I went on to explain that I thought this movie demonstrated many Australian truisms in the most Australian of ways, with humour. To me it’s about a fair go for the underdog, standing up for what is right, the importance of family and the importance of land. And I’m proud of that.

But recently I was not proud to say I am Australian. The horrific revelations about the treatment of young people in the juvenile justice system in the Northern Territory made me want to turn off the television. How could this happen in my backyard? In my name?

Along with our now customary poor treatment of asylum seekers, Australia is turning its back on our own and the world’s most vulnerable people. How is that the Australian ‘fair go’ I thought I knew?

I do wonder how many people turned off the television. Looked away. These children and many like them are the ‘great unseen’. People who face trauma and turmoil on a daily basis and we don’t, can’t, won’t see them. But as a paediatrician that is not what I was taught to do. We are trained to look out for and look after vulnerable children and do everything within our power to put things right.

I am proud to be a paediatrician, and so proud of my exceptional paediatric colleagues who have dedicated their professional lives to standing up for children like those in Don Dale Youth Detention Centre in the Northern Territory.

As I shake my head in the shame of what has happened, I also shake it in amazement and gratitude for all the people who have come forward to offer support for the children, their families and their communities. Perhaps there is a chance to get things right.

Don’t ask me what it means to be Australian. Ask the people who have been here for 60,000 years. They too might wonder which ‘face’ of Australia you want to see. There are many aspects of our history and our country that do not make us proud, but at the same time seeing the compassion and commitment from so many gives me hope. We can all play a part in changing things. Thank you to all those Australians who do.

Dr Sarah Dalton
Paediatrics & Child Health Division
President
Patient centred care and consumer engagement

How is your College involved?
They are commonsense ideas, but ones that turn traditional concepts of medical education, training and practice upside down.

Patient centred care is an approach to the planning, delivery and evaluation of healthcare that is grounded in mutually beneficial partnerships among healthcare providers, patients, families and communities. It is a many decades-long international megatrend in medicine and is driving research, consultation and may ultimately influence medical curriculum redesign by some of the RACP’s lead educators. In fact the Australian Medical Council has mandated that the College focus on this issue in the near future.

The idea of increasing patient power and knowledge is not new. Over the past 20–30 years the evolution of the internet and consequent sharing of medical knowledge has led to much more informed patients presenting for consultation, often briefed by Doctor Google. But the RACP’s Patient Centred Care and Consumer Engagement Project proposes taking the concept of an informed and involved patient much further.

Rather than the specialist as sole expert, the RACP’s Patient Centred Care and Consumer Engagement Project is investigating how a truly collaborative care relationship might be established between physician and patient, as well as the community groups and organisations that advocate on the patient’s behalf. The RACP is also investigating how this collaborative relationship may function at the system level by listening to and incorporating consumer perspectives into RACP strategic priorities.

A College Council Working Party is investigating this deep and far-reaching issue. The thinking behind patient centred care in particular is much more than the latest educational trend or even political correctness – it is tied to empirically documented medical results. Better coordination of care, and better communication have been proven to drive better clinical outcomes for patients. They exhibit decreased mortality, lower readmission rates, fewer healthcare acquired infections, reduced lengths of stay, improved adherence to treatment regimes and improved functional status.

Ultimately, under a proposed patient centred care framework, the physician is still the subject matter expert, but under this model the specialist adopts the role of ‘influencer in chief’. The nature of the relationship fundamentally changes, and patients are allowed to value their own judgement, or feel they are able to challenge a decision or diagnosis. More broadly, healthcare consumer groups can also contribute, as part of a wider

Associate Professor Andrew Cole and patient collaborating on healthcare options.
pool of ‘critical friends’ or advisors to help shape physician training.

Genuinely embracing this idea as a core principle of physician practise and healthcare system design has profound implications for ongoing medical education, and for the next generation of physicians the RACP will train, as well as the way our College conducts its policy and advocacy and funding of medical research and innovation.

Even defining exactly what ‘patient centred care’ means can be problematic. In collaboration with peak consumer body, Health Issues Centre, the RACP has undertaken a broad international literature review, key stakeholder interviews and extensive consultation with physicians and various healthcare consumers. At least 80 per cent of participants showed a clear understanding of the concept, namely placing the patient and their family at the centre of care. In all, 61 per cent of specialists surveyed said they were confident they understood the concept and already practised it.

However day to day reality in many current healthcare systems can be very different. Specialists cited lack of senior leadership, cultural resistance, limited patient knowledge and competing demands as barriers. Built up over decades of “…the doctor always being right…” current healthcare structures often do not support the practice of patient centred care. At a basic level, families may not always be welcome to be with patients, visiting hours may be restrictive, large hospital or healthcare complexes may be intimidating and difficult to navigate.

Even defining exactly what ‘patient centred care’ means can be problematic.

Internationally, the imperative to introduce more comprehensive patient centred care has been highlighted by the Royal College of Physicians in London who concluded that there is a case for change in primary healthcare due to the ageing of the population and the increasing number of people affected by chronic illness.

Other peer Colleges in the United Kingdom, the United States and across Australasia, as well as secondary healthcare providers such as hospitals, are all now also paying attention to the concept, but haven’t yet deeply embedded it in practice.

Our College is similar. References to communication, holistic care and integrated care are dotted throughout education and training materials and there are two skills based community Directors who sit on our Board. But there is always room for improvement.

A College framework will ensure the consumers’ voice shapes our education, advocacy and innovation to provide patients, families and communities highly competent specialists delivering the best care possible.

Physicians themselves consulted as part of the project noted they “…haven’t always been good role models… and so if you’ve never seen it, you’ve never experienced it yourself, you won’t understand it.” Others commented “…we’re not very good at understanding the consumer or patient view of the care we provide at a training context… it’s hard to measure how well someone actually engages with a patient.”

The time has come for a joined up approach and the Fellow-led College Council Working Party in conjunction with the Health Issues Centre has developed the Framework for Improving Patient Centred Care and Consumer Engagement.

The framework is a set of simple high level principles embracing respect and dignity, shared information, excellent clinical care, participation and collaboration. These feed up into and drive the College’s three key purposes, to educate, to innovate and to advocate.

A College Council led Working Party will be working on a communication and implementation plan for this framework over the next two months and will report back to the College Board in December.
RACP Framework for Improving Patient Centred Care and Consumer Engagement

**Goal**

Excellent healthcare experience and healthier communities

**RACP Strategic Priorities**

- **Educate**
  
  Patient centred care is embedded in the College’s professional standards, training programs and the lifelong learning of its physicians and trainees

- **Innovate**
  
  Key partners are engaged in the College’s governance, strategic planning, and implementation of the framework, enabled by a culture which values their voices and perspectives

- **Advocate**
  
  Key partners influence and inform the College’s policy and advocacy work, including best practice patient centred care

**Principles**

- Shared information
- Respect & dignity
- Excellent clinical care
- Collaboration
- Participation
- Indigenous health as a priority

**Partners**

- Physicians & trainees
- Patients, families & carers
- Healthcare teams
- Consumers & communities
- Health related organisations & government

*A draft diagram of the RACP Patient Centred Care and Consumer Engagement Framework, used for illustrative purposes only. The Framework may undergo further refinement before being formally rolled out.*
The traditional definition of health as we know it is: Health is a complete state of physical, mental and social wellbeing and not merely the absence of disease or infirmity.

For most doctors the absence of disease or infirmity is our aim, but it seemed to me, dealing with a very deprived population, that the complete state of physical, mental and social wellbeing was something positive that we should pursue.

There was something inherent in the people I was dealing with in the East End of Glasgow that was absent – the capacity to be well – and I concluded that wellness was not the opposite of illness, there was a positive set of attributes that led to wellbeing.

Wellbeing – what is it? what causes it? how do we create it? why do we need it?

In the British Medical Journal a few years ago [a group] decided to try to redefine health and the conclusion is, I think, very appropriate: Just as environmental scientists describe the health of the earth as the capacity of a complex system to maintain a stable environment within a relatively narrow range, we propose the formulation of health as the ability to adapt and to self manage.

They proposed that health should contain some notion of the ability to adapt to external circumstances.

So, I wanted to try and understand that in the context of Scotland’s health. This is what we’re told about Scotland’s health – we’re incredibly unhealthy and it’s because we smoke too much, we eat the wrong kind of food, we drink too much and if only we would do the right thing we’d be as healthy as anyone.

Well, the fact is, when we look at Scotland’s data, only one of those statements is true – the one about the drinking.

So, are Scots unhealthy? Well, 160 years’ worth of life expectancy data from 16 Western European countries shows that for most of that time Scottish life expectancy was in the middle of the European league.

However, since the 1950s the gap in life expectancy between the richest 20 per cent of the population and the poorest 20 per cent is increasing. The fundamental problem has been the widening growth in inequality since the 1950s. If the gap that existed in the 1950s had been maintained all the way through to now, Scottish life expectancy would be up around the middle of the European pack.

It’s not cigarettes that’s doing this. A World Health Organization (WHO) study of smoking rates in 15 year old teenagers in countries in the European region of the WHO shows that Scottish teenagers are the fifth lowest smokers in Europe.

And what about diet?

In Finland in the 1960s heart disease mortality for Finnish men under the age of 75 was particularly high and they decided to do something about it.

They took subsidies away from dairy farmers to discourage the production of milk, butter, cream, cheese and so on. They gave the subsidies back if farmers switched to growing fruit and...
vegetables, and free fruit and salads were made compulsory in all schools and workplaces.

The Finns took radical action to change their diets, and saw a decrease in mortality.

But, the Scots did absolutely [nothing] to change their diet and got the same result, because it wasn’t anything to do with the fatty foods in the diet.

Men gave up smoking at a huge rate in the 1960s, the introduction of new therapies like statins and so on had a significant effect, and every Western country saw the same fall.

They confused association with causation, as we do all the time in epidemiology.

So, we began to look for different ways to show light on what was driving this inequality and one of my colleagues in Glasgow, Professor Alastair Leyland, really began to clarify this when he started looking at a calculation called the Slope Index of Inequality.

It’s not in old people that you see the greatest inequality in mortality, in teenagers it rises from age 15, it’s at its peak at age 20 to 30 and it starts to decline at age 45.

Inequality in mortality in the Scottish population, and in any other population that I’ve been able to find data for, is essentially property of teenagers and young working people, and they are not the people who die of heart disease and cancer.

So what is it?

It’s suicide, drugs, alcohol and violence.

We’re not going to fix that by reducing the saturated fat content of the diet. These are psycho-socially driven causes of death and the answer is to explore what it is in the psychology and sociology of the population that’s causing that.

Just to spend a moment on alcohol, because there is a problem with alcohol. Data from 16 western European countries going back to 1950 shows that until 1970 Scotland had one of the lowest alcoholic liver disease mortalities in Europe, rising until 1990 but remaining below the European average. But from 1990, that’s what happened, in the space of a decade and a half we went from being one of the lowest to being the highest mortalities in Europe.

The culture in the 1950s all the way up to the 1990s was that men drank, they drank beer, they drank at the end of the working week and they drank it in the pub. But from 1990, the culture changed, because now everybody drinks, they drink everything, they drink everywhere and they drink all the time. It’s completely changed, from teenagers all the way through to working men.

What happened in the 50s, 60s, 70s that changed Scotland’s relationship with alcohol was a catastrophic loss in employment. In the 50s and 60s hundreds of thousands of men in the west of Scotland were employed in heavy industry – then all those jobs disappeared. Jobs that gave meaning and purpose to men’s lives disappeared and they were never rediscovered, and no industry came into the west of Scotland to replace those jobs.

And at the same time the jobs were going, housing was changing. In post war years there was a plan to make the housing more livable and communities that had been close were broken up and people were just sent to places across the west of Scotland, often given no choice where they went, friends of 20, 30 years, you would never see again.

So at the time we were entering poverty, the housing and communities were being broken up and what we’ve been seeing ever since are the health consequences of that.

Aaron Antonovsky, an American sociologist, spent most of his career working in Israel and studied the health of adults who, as children, had been in concentration camps. He interviewed hundreds of these people and concluded that those who were successful – in mental and physical health terms, socially and economically – had acquired, as children, before they entered the concentration camps what he described as ‘a sense of coherence’.

They saw that the world, the environment around them was structured, predictable, explainable. They felt they had the internal resources to meet the challenges they faced and they saw those challenges as something they wanted to overcome, they wanted to meet the challenge and win. They had a sense of purpose and meaning in life to survive and they did what it took to survive.

I remember reading Antonovsky’s book at the time because he went on to say that unless you saw the social and physical environment as comprehensible, manageable and meaningful you would experience chronic stress.

What he was saying was, the social circumstances we endure as children can switch on our stress responses permanently.

What would that do in physical health terms, what is the impact of that for a whole range of systems that we rely on to live happy and healthy lives?

Canadian data looking at salivary cortisol levels in children in orphanages shows there’s something chronically stressful to a child through not having a single significant adult to attach to.

A really interesting study was carried out by an American, Susan

“I concluded that wellness was not the opposite of illness.”
“The poor are being disadvantaged in all sorts of ways that we don’t appreciate because we don’t look for it.”

Everson, who went to Finland to examine the health of men at higher risk of heart disease. She measured everything you can think of including hopelessness; she had a hopelessness scale that allowed her to split men into three groups – men who were very very hopeless, men who were moderately hopeless and men who were just a little bit hopeless. What she discovered in adjusting her data for all the conventional risk factors like tobacco, alcohol, educational status and all these kinds of things, was that psychological negativity was an independent predictor of adverse outcome – coronary heart disease, cancer, other causes of death were all higher in the psychologically negative group, so we’re beginning to see a real link between psychological drivers of adversity and lack of wellbeing and physical ill health.

If you’re living with no money coming in, if you live with fear of your children being approached by drug pushers or social workers coming to take your children into care you are not in control of your life, other people are.

**Early indicators**

So, I was still in pursuit of the link, the biological link, between not having consistency in childhood and having these adverse events occur. The best way I’ve got of explaining it is to describe an experiment I saw in the psychology department of a New York university.

They essentially made baby monkeys depressed. The way they made the baby monkeys depressed was all down to the way they let the mum feed the baby. In one half of the animal house, food was lying out so when the baby indicated it was hungry, the mother could just bend down pick up the food and feed it. The other half of the animal house was taken a long way away and when the baby was hungry, the mother had to leave it, go away from it for a long time, she was hassled because she had to fight with other mothers to get access to the food.

And if I were to ask you which group of babies do you think became depressed – was it the ones where mum found it easy to feed baby or the ones where mum was away from baby for a long time and stressed by the experience, I guess you would say naturally it was in that second group that the babies became withdrawn.

It made no difference.

It was the group where the babies feeding pattern was randomly changed from one day to the next that became depressed. It wasn’t mum being there or not being there, it was the baby not knowing what was going on that caused the problem.

And if you think about what the first stressor in any human baby’s life is, it’s hunger, so what does he do, he cries, so what happens, mum picks him up, talks to him, feeds him, stress resolved. And by the time that sort of exchange goes on 500, 1000 times, the brain growth is laying down this pattern that says to the baby ‘yeah this is okay’ if I feel something wrong I do the crying thing, this nice person picks him up and it becomes more active in the stressed babies.

So the babies who experience stress are more emotionally labile, more likely to be anxious, fearful, aggressive, they’re less well able to learn inappropriate behaviour because the prefrontal cortex hasn’t developed so much and they’re much less able to learn at school because the hippocampus hasn’t developed so much and that’s what leads to problems.

And it’s the hippocampal change that leads to the chronic elevation of the stress response.

The poor are being disadvantaged in all sorts of ways that we don’t appreciate because we don’t look for it.

The reason cortisol levels are so high in these people is that they don’t develop the mechanisms necessary to suppress cortisol. Dr Michael Meaney from McGill University in Montreal has shown the relationship between serotonin (5-Hydroxytryptophan (5-HTP)) and epigenetic activation of the glucocorticoid receptor gene.
When you hug babies you release 5HT into the bloodstream, it activates a transport mechanism in the cell wall, it’s transported into the nucleus where in chromosome number five, the glucocorticoid receptor gene is activated and it produces GC receptors in the hippocampus.

If you don’t hug babies, if you don’t nurture them, they are unable to suppress the stress response as a result of epigenetic means.

We are seeing epigenetic mechanisms emerging as the cause of problems in a lot of places.

Öerkalix, in northern Sweden had an oversupply of food in the late nineteenth century which caused increased problems with heart disease in people who were boys at that time – they were more likely to die prematurely, but their sons and grandsons are also showing the same kind of effects. The epigenetic switching is inherited.

Rachel Yehuda, a psychologist in New York showed that babies who were in utero at the time of 9/11 have abnormal stress responses now if their mother showed signs of post-traumatic stress disorder.

There was an amazing study done by a colleague in Edinburgh who traced a lot of children who had been born in Scotland in the 1950s and their obstetrician essentially put all their mothers on an Atkins diet during pregnancy – it was bizarre at the time, but their children and grandchildren are all hypertensive, so we’re beginning to learn a lot about the biological consequences of what happens in very early life.

Children who had four or more of those adverse events in early life were eight times more likely to become alcoholics and about eleven or twelve times more likely to become narcotics misusers than children who had no adverse events in early life.

Boys who experienced physical violence at the hands of an older male were eight times more likely to engage in partner violence, four times more likely to be arrested for carrying weapons.

An English study recently published by Professor Mark Belis looked at adverse childhood events in a population in the north of England. Thirty-five per cent of those who have no adverse events will have a chronic disease by the age of sixty, for those who have four or more adverse events, it’s double that.

So the biological consequences parallel the psychosocial consequences in the population.

We’re seeing an intergenerational cycle of adversity. What the adverse childhood events study showed was that by the age of 32, almost half the victims of neglect had been arrested for a non-traffic offence. What we are seeing is a cycle of alienation occurring in the population. What we see is chaotic early years in a group of the population, leading to mental health problems, exclusion, failure at school, failure in offending behaviour, increased risk of ill health leading to loss of any sense of control, loss of sense of self-efficacy, leading to worklessness and poverty.

Poverty doesn’t cause health inequalities, health inequalities cause poverty.

We need a global response

It’s not just the west of Scotland, a study in California of 17,000 middle class Californians examined for nine different types of adverse events in early life: physical/sexual/emotional abuse; neglect (physical/emotional); domestic substance abuse; domestic violence; parental mental illness; parental criminality.

Dr Bruce McEwan has been looking with others in the United States at the kinds of events, the kind of interventions we can use to reverse some of the brain changes: physical activity, use of mindfulness and meditation – strongly evidenced based – and giving these people strong social connections, mentors that will help them learn to navigate life.

The World Bank has looked at population growth, by the end of this century the population will be 10 billion. Europe will constitute less than seven per cent of the world’s population and a third of Europe’s population will be over the age of sixty.

They’re projecting six cities in the world that will have a population greater than thirty million, can you imagine a city with a population greater than thirty million, the logistics of keeping them fed. And those six cities are in places like Democratic Republic of Congo, Nigeria, the Indian sub-continent. At present the deprivation, the chaos in those cities is enormous.

A third of urban dwellers across the world live in slums where they lack rights, they lack any kind of security, it’s only going to get worse unless we tackle this issue of inequality in our society and the consequences it has for the brains of young people.

“Poverty doesn’t cause health inequalities, health inequalities cause poverty.”

Sir Harry Burns’ talk in full at www.racp.edu.au/fellows/resources/congress-presentations

WATCH
Imagine you’re a junior doctor and you have just seen a 10 month old girl who presented with fever, tachypnoea and wheeze. She looks unwell and has a strong family history of atopy. After suctioning, a trial of ventolin, some blood tests and a chest x-ray you wonder, should she also have antibiotics just in case? You may decide she should because ‘that’s the way we do things at this hospital’ or because you know that when you ring the Paediatric Registrar that’s what they will ask for, or because that’s the way the last consultant you worked with did things. It may also be because you are willing to try anything that might help improve the child’s condition.

These are all very real considerations, but what you really need is easy access to good evidence to help guide your practice. It’s hardly surprising that busy clinicians don’t always hold the most recent papers in their heads. After all, the sheer volume of literature and the speed of developments outpace even the finest minds in medicine. And it means all doctors, not just trainees, face this dilemma.

We’ve all been in the position of not knowing exactly what the most recent evidence says, making us vulnerable to responding in the same way as this junior doctor might – doing something because it’s the way we or others have always done it. And sometimes this means doing something that may not ’add value’ to the patient’s care; wastes their time and yours, wastes resources, and sometimes inadvertently does harm. It also goes a long way to explaining why, even in the twenty-first century, patients still don’t receive consistent care from practitioner to practitioner.

**Variations in care**

In a landmark 1938 study on variations in care, British surgeon J Alison Glover found tonsillectomy procedures in children varied substantially across different regions in the UK. He noted in particular that boys and wealthier children were more likely to have tonsillectomies.

Nearly eight decades later researchers are still identifying seemingly unwarranted variations in care around the world. The 2015 *Australian Atlas of Healthcare Variation* points to significant differences in asthma medications and admissions, psychotropic medication and tonsillectomies for children and young people.

Not all variation in care is bad of course. Some may be warranted due to increased burden of disease in a given population, different patient circumstance or practice innovation in particular areas.

At the same time, it is also highly likely that some of the observed variations are unwarranted and due to factors such as inequities of access (i.e. under-treatment of some populations) and in other cases overuse of interventions with questionable value.

It is therefore not surprising that a recent study of 16 common paediatric conditions found that the use of electronic order sets and awareness of clinical practice guidelines were two factors effective in reducing unwarranted variation.

**Questioning paediatric clinical practices and the RACP Evolve initiative**

The RACP Paediatrics & Child Health Division is actively working on the RACP’s Evolve initiative and developing a ’top five’ list of questionable clinical practices in general paediatrics such as the use of chest x-rays to diagnose asthma.

The Evolve initiative identifies low-value medical practices across a range of specialties and supports specialists and other healthcare providers to deliver high quality, contemporary care to patients.

One of the more interesting challenges that emerged in this process was defining the scope of general paediatrics – paediatricians may do quite different work depending on their practice and location.

The release of our final ’top five’ list later this year will mark the beginning of our ongoing work to raise awareness of low-value interventions in general paediatrics.

There is still some way to go in improving the appropriateness of care for children, but with the help of Evolve we are looking forward to taking these important steps.

Adapted from a presentation given by Paediatrics & Child Health Division President Dr Sarah Dalton at an Evolve workshop for general paediatrics at RACP Congress 2016.

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All in a good night’s rest

Associate Professor Harriet Hiscock is passionate about sleep. This however is not a story about a Fellow having their slippers under the bed by nine o’clock.
Associate Professor Hiscock works tirelessly to make a positive impact on thousands of Victorian households every evening. Her work has been described by thankful mums and dads as “lifesaving” and “marriage saving”.

Sharing her time between Melbourne’s Royal Children’s Hospital, Murdoch Children’s Research Institute and The University of Melbourne, Associate Professor Hiscock is the ultimate ‘Sleep Doctor.’

“Sleep disorders are very treatable,” she explained. “With only brief interventions, paediatricians can achieve great outcomes for their patients.

“The potential benefits to the child are significant – both in terms of improving behaviour and better quality of life. Plus this has a hugely beneficial flow on effect for mums and dads.

“I have seen first-hand how sleep disorders not only impact a parent’s relationship with their child, but also their partner. It can become a health issue for parents as everyone is exhausted and cranky”.

Associate Professor Hiscock’s doctoral research saw her provide parental one-on-one support to parents with baby sleep problems. The study proved so successful it was rolled out across Victoria via 1,200 maternal and child health nurses, helping thousands of sleep deprived mums and dads across the state. Its educational materials have also been translated into eight languages and a training program in the intervention is available online to practitioners throughout Australia and internationally.

“My sleep program is now the intervention for the eight-month Victorian Maternal and Child Health visit. It is very rewarding for me to pass on the skills I have learned as part of my research to others.”

It is little surprise that Associate Professor Hiscock has been recognised multiple times by the RACP Foundation – first with a Young Investigator Award in 2001, the 2009 Rue Wright Memorial Prize, the 2012 Fellow’s Contribution Award and the Best Poster Prize in Paediatrics & Child Health at RACP Congress 2016.

Her 2012 Fellow’s Contribution Fellowship, which involved a $150,000 grant, went a long way to helping secure the future of another of Associate Professor Hiscock’s initiatives – the Australian Paediatric Research Network (APRN).

APRN brings together more than 500 paediatricians from across Australia who are keen to contribute to new research relevant to both public and private practice. It focuses on common, high impact child health conditions seen by paediatricians in community settings.

“It’s a platform which allows us to reach out to paediatricians who may not have the time to do research but want to contribute. We run projects, surveys, audits and the response to each has been very positive.

“We now have data on more than 15,000 patients. This provides a unique window to analyse what is really going on.

“Since it was formed in 2007, we have had a significant impact in driving change in clinical practice. We are very fortunate that we have engaged members with excellent ideas and the financial backing of organisations like the RACP.”

Among the list of APRN achievements are: helping to prepare for paediatricians to get a Medicare rebate for complex patients; multiple research grants for sleep, attention deficit hyperactivity disorder (ADHD) and autism; and a new model of care for food allergies.

Associate Professor Hiscock’s involvement in APRN is only one of a growing list of commitments.

“There will always be more work. Currently I am heavily involved in the College’s Evolve program to focus on reducing unnecessary care. Although our lists are yet to be finalised it’s likely to include unnecessary x-rays and blood tests.

“I am also focused on researching ADHD and autism. We know that there is a connection between sleep disorders and kids with ADHD and autism – 70 per cent are identified as having sleep issues.

“Along with my former PhD student, Dr Jon Quach, we have developed an intervention for students in their first year of primary school with sleep problems stemming from worry, anxiety or a lack of parental limit-setting. We are now in the process of trialling this with the school nursing workforce.”

Associate Professor Harriet Hiscock FRACP
GOLDEN RULES FOR KIDS’ SLEEP

- Establish a bedtime routine – so children know what to expect and have time to wind down.
- Keep bedtime consistent (within 30 mins), even on the weekends – big variations can disrupt their body clock.
- Make sure they fall asleep in their bed – snoozing off on the couch or in front of the TV can affect their routine and make them less likely to want to sleep alone.
- Remove all TVs, computers and mobile devices from their bedroom – the light stimulation alone will make it harder for them to settle down.
- Avoid caffeinated foods and drinks after 3pm – caffeine is a stimulant which is likely to keep young bodies awake.
- Have a wind-down period yourself – show kids that a bedtime routine is important for the whole family.
Indigenous doctor dedicated to Indigenous health

Worimi doctor Marlene Kong was “pleased, yet semi surprised” when she was announced as the recipient of the RACP’s Indigenous Congress Prize.

“I’d always viewed the College as a conservative organisation. But I think this is a reflection of positive change and that doors are beginning to open.”

The closed “doors” that Dr Kong refers to are racial stereotypes and prejudices she has faced throughout her career – both as an Indigenous Australian and as a female.

“I remember during my university days that many of my peers had never met an Aboriginal person before,” explained Dr Kong.

“Many had stereotypes of an Aboriginal person being lazy, drunk and reliant on government handouts.”

Since graduating in medicine, Dr Kong also feels there is an assumption by others that she had received her tertiary education for free through an Indigenous scholarship, which is not true.

“I worked hard like everyone else. And I graduated from university with a HECS debt that I had to pay off, like everyone else.

“My grandfather told me stories of how in his day, cinemas had a roped off section for Aboriginal people for standing only; while non-Aboriginal people got to sit down.”

Dr Kong still feels segregation is an underlying agenda of modern Australia.

“Racial discrimination is still very much entrenched in our communities, institutions and our politics.”

The adversity that the Worimi doctor has faced and seen to this day is alarming, and she stresses that it is the main reason why completion rates of medical degrees for Indigenous Australians are low.

When talking to Dr Kong one can’t help but admire her steely resolve that firstly helped her overcome these challenges to graduate from university and then later become a health advocate for her people. Currently, she is the Program Head Aboriginal & Torres Strait Islander Health Program at the Kirby Institute.

“My mother was a great role model and she always instilled in her children the importance of a good education in order to get a good job.

“Mum is a community nurse and midwife who is motivated to help others and she could do this through health. Naturally, her three kids gravitated towards this idea as well.”

Remarkably, Dr Kong is one of three children who have all gone on to excel in the health sector. Dr Kong’s twin sister, Dr Marilyn Clarke, is a Fellow of The Royal Australian and New Zealand College of Obstetricians and Gynaecologists and younger brother Kelvin is Australia’s first Indigenous doctor dedicated to Indigenous health.

We must do better, there is so much more we can do. Good intentions are not translating to good outcomes.
“Decisions are not always made in the best interests of Indigenous Australians and they are usually made by non-Indigenous Australians. Indigenous doctors are needed for Indigenous health issues.”

Surgeon Dr Kong and Dr Clarke became the first Indigenous women to graduate with a Bachelor of Medicine and a Bachelor of Surgery from the University of Sydney in 1997.

The three siblings and mum grew up in a modest fibro two-bedroom home in NSW's Shoal Bay. From humble beginnings, all three have gone on to make significant contributions to Indigenous health and all have ideas for real positive change.

“We must do better, there is so much more we can do. Good intentions are not translating to good outcomes,” she adds.

“Politically, there are too many layers of bureaucracy to make anything more than minor progress.

“Decisions are not always made in the best interests of Indigenous Australians and they are usually made by non-Indigenous Australians. Indigenous doctors are needed for Indigenous health issues.”

“I currently work within an Indigenous health program at the University of NSW, yet I am only one of two staff who identify as being of Aboriginal and Torres Strait Islander descent.

“I understand that we are only small in numbers and therefore thin on the ground. We will therefore always need the help of non-Indigenous health professionals to assist in tackling the burden, however I believe our health system can learn a lot from Aboriginal doctors and traditional healers.”

Currently, three per cent of the population identify as being of Aboriginal or Torres Strait Islander heritage. And the number of those who are doctors is estimated to be approximately 260 – an under-representation given the burden of disease affecting Aboriginal people.

“If we are going to make significant progress in closing the gap, we need to recognise and remove discrimination and have social equity at all levels.”
Skilling up at supervisor workshops

Since they began in 2013 the RACP Supervisor Professional Development Program (SPDP) workshops have become a popular and valuable opportunity for Fellows and Advanced Trainees who are keen to gain insight into, and learn from, the experience of others about the rewarding role of supervisor.

There are three SPDP workshops, each with a specific theme: Practical skills for supervisors, Teaching and learning in healthcare settings, and Workplace-based learning and assessment. Facilitator workshops are also run to build the skills of the enthusiastic Fellows who facilitate the SPDP.

Whakatane-based paediatrician Dr Stephen Robinson has been involved in facilitating SPDP workshops since 2013. "Having always had a particular interest in teaching, the workshops struck me as something really useful," he said.

Having initially trained in the United Kingdom before arriving in New Zealand in 2004, Dr Robinson says facilitating the workshops has given him a great perspective about the differences and, more importantly, the similarities in training.

"One aspect that stood out to me was that supervisors had not had any training. The supervisors were as helpful as they were able to be, however this was no substitute for training. I saw the SPDP workshops, and facilitating them, as a real opportunity to gain skills, and then share those skills," he said.

Dr Robinson’s initial training included teaching skills and although he says this was definitely helpful, he considers the most important quality in a supervisor as being enthusiastic.

Auckland-based paediatrician Dr Gregory Williams also facilitates SPDP workshops and was involved in the development of the third workshop – Workplace-based learning and assessment.

"There was a clear need for tangible support for supervisors. I saw that the first two workshops were developed using sound educational methodology, and designed to be practically useful. I was also aware of the increasing focus on formalising workplace-based assessment. For these reasons I was keen to be involved in the development of the workshop," he said.

The workshop development process was thorough, says Dr Williams. "It was hugely beneficial to have the help of RACP staff who undertook a comprehensive literature review of the field, which provided a solid foundation on which to build the workshop. From there, we collaborated with a number of Fellows and brainstormed possible scenarios. A key aspect was the ‘fabulous’ role-playing put together for the videos used in the workshop to effectively demonstrate examples of workplace interactions."

"Our aim was to give examples of how to use the learning and assessment tools to best effect in the real world, and even more importantly look at how to integrate the tools into the overall training experience. We wanted to encourage supervisors and trainees to
focus on using the tools as a means of achieving good outcomes and reaching goals,” said Dr Williams.

Advanced Trainees are also welcomed at the SPDP. “We all want the same thing – a better training experience. As trainees progress through their training program they will be training and assessing junior staff. Learning the skills that are focused on in SPDP workshops helps everyone: the trainees, junior staff and supervisors, not to mention the patients we are all looking after. Learning to teach, assess and supervise is just as important a part of medicine as the medicine itself,” said Dr Robinson.

Dr Williams agrees that the skills are equally valuable for Advanced Trainees and Fellows. “Advanced Trainees often have supervisory responsibilities, and this continues when they become a Fellow.”

A valuable aspect of the workshops is hearing feedback from physicians in a variety of different specialties, says Dr Robinson. “I’m a paediatrician so I usually attend events with other paediatricians, whereas SPDP workshops have doctors from many specialities so the differences and similarities in experiences are really interesting.

“Each workshop provides its own unique experience. Although some themes recur the individual stories vary greatly. I think that everyone attending, including facilitators, learns something new each time.”

Feedback from the workshops has also proved valuable for incorporation into successive workshops. “This was apparent from the start”, says Dr Robinson, “there is a really individual aspect to the feedback and it is obvious if a presentation or concept doesn’t resonate with the group”.

Asked for a key learning that he would like workshop participants to take away, Dr Robinson said the practical nature of teaching and assessing in a normal working environment.

“It really should be part of the normal day-to-day activity. I believe that work-based teaching and learning has always been how medicine should be, if we look back at the old apprenticeship approach to medicine as it was in the beginning, that is what would have happened,” he said.

Dr Williams hoped participants would come away from the workshops seeing the value in having an overall plan: “How they and their trainees set goals and go about achieving them – and seeing how much more satisfying this can make the experience for both parties.”

As the popularity of the workshops continues to grow, participation in online workshops is now also gaining momentum. Dr Robinson says online and face-to-face workshops both have their merits. “The face-to-face environment is definitely conducive to robust interactive discussion, and an obvious benefit of the online workshops is the increased accessibility they provide.”

Find out more about the Supervisor Professional Development Program (SPDP) at www.racp.edu.au/fellows/supervision/supervisor-professional-development-program.
Still putting others first after 60 years in the profession

After 60 years of practising Occupational Medicine and advocating for the occupational health rights of workers, 85 year old Dr Bill Glass says he still gets a ‘buzz’ out of helping workers get a fair deal, and currently has no plans of retiring.

“I’ll keep working as long as I am able and feel useful. If your passion is still there, your training is up to date, and your mind is still sharp – then why not?,” said Dr Glass.

When New Zealand based Dr Glass started practising medicine in 1957, there was no specialist qualification in occupational medicine in New Zealand, so he had to go to London. While working his way over as a ship’s doctor, he experienced his first occupational medicine role, noise and asbestos in the engine room, sunstroke when the captain insisted on playing deck tennis against a much younger first mate in the midday sun and of course regular penicillin injections for crew members who had spent the overnight stay at Curacao in the local brothels.

Over the course of his career, Dr Glass has seen a lot of changes to both the composition of workplaces, and to the specialty of occupational medicine.

"Workplaces have changed a lot; they are more complex and constantly developing. One can see how new technology impacts on social relations at work, disrupting them so that short term contracts, casualisation, job insecurity and uncertainty have replaced permanence and a ‘job for life’. This has had a big impact on people’s health and wellbeing," said Dr Glass.

“Thats what keeps you going; you get great satisfaction helping workers who have suffered illness through work get justice and a fair deal.”

While estimating the cost of absenteeism and presenteeism is complex, overseas figures suggest that the combined cost to industry of workplace accidents and diseases isn’t as big as the cost of general employee health and wellness issues.

If this is the pattern for the future, it will raise the question of whether industry needs to provide more primary healthcare services at the place of work. An issue one of the early Presidents of the Australian and New Zealand Society of Occupational Medicine Dr Darryl O’Donnell raised in the 1970s.

“A healthy workforce equals a healthy economy. Employees who are happy, healthy, and are treated like humans thrive – and as a result you get good productivity.”

"As one employer told me years ago – 'If you look after your staff, productivity looks after itself' – it may not be that simple but it is not a bad starting point,” said Dr Glass.

Speaking to Dr Glass, what stands out is his humanitarian approach to workers and their needs and a belief that workplaces provide an opportunity to improve population health.

"Workplaces provide an opportunity to access small groups of people and influence their health and wellbeing – through health education, and encouraging healthy lifestyle choices and behaviours.”

"Having a job in itself is a contributor to wellbeing and can bring health benefits – pride, self-esteem, identity and dignity. That’s what we as a specialty advocate for – healthy and safe work for all,” he said.
In his almost 60 years of practice, Dr Glass has worked with countless employers, workers, unions, regulators, academics and governments, across a variety of industries, but one episode in particular stands out for him.

"In the 1970s a union organiser contacted me on behalf of a group of school dental nurses in Auckland. As part of their job they had been melting copper mercury in tea spoons over a Bunsen burner to form amalgam fillings – often in enclosed rooms and – in the winter with the heaters on. Their clinic rooms were bathed in an ambient air of mercury. I arranged to interview ten of the nurses one afternoon in my rooms.

“When I met with the young women their stories astounded me. I remember one said – ‘I have only just got married and the other evening I threw all the kitchen crockery and smashed it – that’s not like me’. They were showing early signs of mercury poisoning.”

“The dental nurses were well organised. They used the media to mount their campaign against their employer, the Department of Health, and they won. The Department was forced to change the use of copper mercury to an encapsulated silver mercury form. Tests showed between one winter and the next their urinary mercury levels had fallen to barely measurable levels.

“That’s what keeps you going; you get great satisfaction helping workers who have suffered illness through work to resolve the problem themselves. Your role is that of the facilitator,” said Dr Glass. Dr Glass is adamant that the only way health professionals can truly understand workers’ health issues is to go into the workplace.

“There is no way you can understand the situation by sitting in your office. Our primary goal as occupational medicine specialists is to look after the health of the workers. If there were no workers, there would be no need for our specialty, I think sometimes we forget this,” said Dr Glass.

Dr Glass is currently Professor of Occupational Medicine at the Centre for Public Health Research, Massey University, and a Principal Advisor in Occupational Medicine to Worksafe New Zealand.

While he says his age doesn’t hinder his ability to work, he is aware of his limits.

“With older physicians comes a lot of experience. In our Faculty (AFOEM) we have to keep our training up-to-date to remain registered – so from that perspective I don't think there are any issues. What changes though, are your limits, they are narrower. These days I work about four days a week instead of five or six and I do less worksite visits. The energy levels are not the same.”

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**THE FERGUSON-GLASS ORATION**

The Ferguson Glass Oration is presented each year at the RACP Congress by a person who has made a significant contribution to the field of Occupational and Environmental Medicine.

The oration is named after Professor David Alexander Ferguson AM and Professor William Ivan Glass ONZM. Both Professor Ferguson and Professor Glass are considered the founding fathers of academic Occupational Medicine in Australia and New Zealand.

They were pioneers of the discipline of Occupational Medicine in Australia and New Zealand, first through the Australian and New Zealand Society of Occupational Medicine (ANZSOM), then the Australasian College of Occupational Medicine and finally the Australasian Faculty of Occupational and Environmental Medicine.

Professor Bill Glass delivered the Ferguson-Glass Oration at the RACP Congress 2016, becoming the first person to deliver an oration after which they were named, at the event.
With the ageing of Australia’s population we are facing an epidemic of dementia. The incidence climbs from five per cent at age 65 to 25 per cent at age 85. It is a diagnosis many fear more than death.

This phenomenon is particularly evident in smaller rural towns where younger people move away for work or study. In most urban centres the proportion of the population aged over 70 is approximately 12 per cent however it climbs to over 25 per cent in some towns such as Manilla, Barraba and Bingara in the New England region of north-west New South Wales.

There is much work to be done in improving rates of diagnosis and management of dementia, particularly in rural areas where access to specialists such as geriatricians is limited. Accurate diagnosis is essential to appropriate management, education of carers and advanced care planning.

One of the cognitive tests that I do routinely because it is quick and helpful is the clockface test where I ask patients to draw a time on a clock. I have occasionally convinced doubting carers or staff that something is seriously wrong by showing them an abnormal clock drawing.

The work can sometimes be very stressful. Issues such as driving cessation, accepting services or even family support, and moving into a care facility cause the most distress.

In rural areas driving is often essential to maintain independence due to the vast distances involved and the lack of alternative transport options. This is particularly difficult in patients who lack insight, which is common, but even more difficult if the family lack insight.

I recall seeing a patient who had clipped his cattle truck against a wide...
oncoming load because he failed to move over like all the other traffic had on the Newell Highway and continued without stopping into Moree. When I advised his daughter that I would have to cancel his driving licence as his cognitive testing revealed he had major problems with attention, vision and executive function she pleaded with me not to as it would destroy his livelihood and independence.

One needs to be able to communicate the diagnosis of dementia quite sensitively to rural people, many of whom have access to guns, as the issue of whether they are safe to continue to hold a gun licence is another consideration.

I have had several older people both with and without dementia suffer serious injuries on their properties handling cattle and driving farm machinery. So I always enquire about these activities.

Despite the challenges, working with patients with dementia in rural areas is extremely rewarding. The relief on carers’ faces when someone explains to them that their concerns are real and that simple things can be done to help them is palpable.

A lot of dementia management is about educating carers and there is good evidence that caregiver interventions can improve behavioural and psychological symptoms of dementia and prevent premature institutionalisation.

Many carers come seeking cholinesterase inhibitors to give them some hope of stabilisation of symptoms. I usually give them the oxygen mask analogy where airline cabin crew tell passengers to put their oxygen mask on before helping young children. They need to look after their own health first to be effective carers.

It is important to speak to carers separately to obtain accurate corroborative history, to be able to have a frank discussion with them about the road ahead, and to preserve the dignity of the patient especially during cognitive testing (as well as reducing distractions and interference).

I have developed a keen interest in Dementia with Lewy Bodies patients who present quite differently to those with Alzheimer’s disease. Their short term memory is relatively preserved but they are often extremely muddled with unusual illusions, delusions and hallucinations. Farmers with this condition seem to see small animals. They often have a sense that others are present in their home. They can respond at times quite dramatically to cholinesterase inhibitors.

I had a patient who thought their image in the mirror in her bedroom was an intruder who would not speak to her but had the same name as her. Medications did not relieve her distress but removing the mirror did.

Another patient was stunned to arrive at mass on a Saturday to find there was no mass. He demanded to speak to the priest who advised him that mass was always held on a Sunday. The man was incensed that the calendars had all been printed wrong as it was definitely Sunday. While investigations can help to rule out alternative diagnoses or confounding factors, dementia is still predominantly a clinical diagnosis. Some recent studies have shown promise in the development of a reliable biomarker such as a simple blood test for diagnosis of Alzheimer’s pathology. Hopefully within our lifetimes we will see an effective treatment.

**“Despite the challenges, working with patients with dementia in rural areas is extremely rewarding.”**
College supports global health targets

The World Health Organization’s (WHO) sixty-ninth World Health Assembly approved a number of new resolutions including a WHO guidance on ending the inappropriate promotion of foods for infants and young children and the introduction of global targets for the reduction in hepatitis C cases and related deaths.
WHAT IS THE WHO WORLD HEALTH ASSEMBLY?

The World Health Assembly is the decision-making body of WHO. It is attended by delegations from all WHO member states and focuses on a specific health agenda prepared by the Executive Board. The main functions of the World Health Assembly are to determine the policies of the WHO, appoint the Director-General, supervise financial policies, and review and approve the proposed program budget.

Some of the other health issues discussed at the sixty-ninth World Health Assembly were:

- tobacco control
- road traffic deaths and injuries
- access to medicines and vaccines
- integrated health services.

Read more about the WHO World Health Assembly at www.who.int/mediacentre/events/governance/wha/en/

WHO guidance on ending the inappropriate promotion of foods for infants and young children

The guidance clarifies that, in order to protect, promote and support breastfeeding, the marketing of ‘follow-up formula’ and ‘growing-up milks’ – targeted for consumption by babies aged six months to three years – should be regulated in the same manner as infant formula for nought to six-month olds.

The RACP has previously expressed concern over the regulation of marketing of infant formula in Australia, including labelling of infant formula products.

Paediatrics & Child Health Division President, Professor Sarah Dalton, said that the Marketing in Australia of Infant Formula’s (MAIF) Code of Conduct is voluntary and self-regulated.

In its current state, the MAIF code does not sufficiently address the provisions of the WHO International Code of Marketing of Breast Milk Substitutes and the College will be advocating for it to be brought in line with the WHO guidelines.

"Mothers are inundated with incorrect and biased information through advertising and unsubstantiated health claims. All reasonable steps should be taken to ensure infant formula marketing does not distort the critical role breastfeeding plays in infant health outcomes," said Professor Dalton.

First global targets for viral hepatitis

Globally, 1.4 million people die each year from viral hepatitis, with a further six to ten million new cases of hepatitis each year. There are 230,470 people living with chronic hepatitis C in Australia and 50,000 in New Zealand.

The global strategy is the first to be released by the WHO to fight viral hepatitis, with targets that include an 80 per cent reduction in hepatitis C infections and a 65 per cent reduction in hepatitis related deaths by 2030.

Hepatitis is a global public health threat, comparable to other major communicable diseases including HIV and malaria, yet it has often been ignored as a global health priority.

The WHO report also focuses on the need for increased childhood vaccine coverage, safe injections, and greater prevention measures for mother-to-child hepatitis transmissions.

Locally, from 1 March 2016, the Australian Government made a number of new and more advanced hepatitis C medications publicly available on the Pharmaceutical Benefits Scheme.

From 1 July 2016, two new hepatitis treatments were funded through the Pharmaceutical Management Agency in New Zealand.
Influencing health policy debates in Australia

As the forty-fifth Australian Parliament gets underway, the RACP will be visible and vocal, working to put the health of all Australians first and securing a strong, sustainable national health system.

The College strongly advocated for the RACP’s policy priorities and proactively sought to shape key debates throughout the recent Australian Federal election campaign.

In the lead up to the election, the RACP released its election statement, *Time for Action on Health Policy*, urging the incoming government to act on key issues, including:

- concerted and sustained action to improve health outcomes for Aboriginal and Torres Strait Islander people

**FELLOWS IN PARLIAMENT**

Members will be interested in the appointment of Dr David Gillespie FRACP as Assistant Minister for Rural Health. The RACP has previously liaised with Dr Gillespie on our advocacy to secure the future of the Specialist Training Program (STP) and looks forward to continuing our relationship to promote the health of Australians living in regional and rural communities.

The House of Representatives also has another doctor amongst its members, with Dr Michael Freelander FRACP elected as the member for Macarthur. Dr Freelander has worked as a paediatrician in the south west Sydney region for over 30 years and is now turning his attention to politics as an advocate for community healthcare and preventive health.
leading a national awareness-raising campaign encouraging conversations about end-of-life care
restoring a national focus on preventive health
measures to reduce alcohol-related harm, including action to reduce inappropriate access to cheap alcohol, protecting children from exposure to alcohol advertising during sport, and investing in and expanding treatment services
the immediate release of all asylum seekers from held immigration detention and the urgent repeal of the secrecy provisions of the Australian Border Force Act 2015
strategies to ensure immunisation programs are delivered consistently across Australia and that immunisation schedules are completed

 Already, the policy work of the RACP has been picked up by major political parties – informing their health policies and election platforms. The RACP/RANZCP (Royal Australian & New Zealand College of Psychiatrists) joint Alcohol Policy, for example, was quoted in the Australian Labor Party’s Building Healthy Communities and Preventing Chronic Disease factsheet and the Greens’ Alcohol Ads are not Child's Play initiative.

The RACP’s contributions to the policy debate reflect its reputation as a trusted authority, clinical leader, and source of evidence-based policy. Policymakers recognise the expertise of College Fellows.

With the election over and parliamentary uncertainties resolved, the RACP continues to influence policy to improve the health and wellbeing of all Australians.

In the coming months, RACP President Dr Catherine Yelland will lead discussions with decision makers in Canberra on RACP policy priorities. College Council Chair Associate Professor Alasdair Macdonald will help steer Health Care Homes trials as a member of the initiative’s Implementation Advisory Group. The College will continue to call on federal, state and territory governments to reduce alcohol-related harms.

We will be working with the new Australian Digital Health Agency to ensure physicians’ needs are recognised and their clinical leadership is engaged in the move to better use digital technologies and electronic patient records. We will raise awareness of the health impacts of climate change in many ways, including a series of position statements, and seek to have them incorporated into health policy. The College will maintain its commitment to the Specialist Training Program (STP) and the need for confirmed details for 2017 and beyond. And, as the rollout of the National Disability Insurance Scheme (NDIS) progresses, the College will continue to collaborate with the National Disability Insurance Agency (NDIA) to influence and support the rollout and promote the health needs of people living with disability.

There is much more work to be done to make the RACP election statement a policy reality. For example, securing long-term funding to advance the Implementation Plan for The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 is critical to improving health outcomes and realising the Close the Gap targets. Big conversations need to be had about better integration of primary and specialist care, as well as coordinated end-of-life care.

Preventive health strategies are long overdue given increasing rates of non-communicable, chronic diseases, as well as smoking, obesity and risky alcohol consumption. RQ.

MINISTERS ACKNOWLEDGE RACP/RANZCP ALCOHOL POLICY

Early in March, a copy of the RACP/RANZCP Alcohol Policy was sent to federal, state and territory health ministers, as well as other key government and opposition figures.

Responses received have been encouraging, with Ministers acknowledging the important role held by the RACP in advocating for alcohol policy reforms and welcoming the policy as a timely contribution to efforts to curb the harms of alcohol.

Some Australian jurisdictions are implementing measures to reduce the harms of alcohol. For example, the NSW Ministry of Health is developing a Drug and Alcohol Plan which will focus on prevention, early intervention, specialist treatment services, and accessible integrated care; while in Victoria, $192 million over two years will be invested in prevention and treatment strategies. In the ACT, Calvary Hospital is participating in a nationwide research project which aims to use emergency department data to reduce alcohol-related harm.

We welcome these locally based initiatives, however we will continue to call for a nationally coordinated and comprehensive strategy, which evidence demonstrates is the most effective policy approach.

Upcoming opportunities include consultations on the revised South Australian Alcohol and Other Drug Strategy, review of the Victorian Liquor Control Reform Act 1998 and ongoing conversations with the federal Department of Health ahead of the release of the National Alcohol Strategy 2016–2021.
After nine years commuting between Adelaide and Sydney (then later Canberra), Professor Chris Baggoley has no fixed plans after his tenure as CMO ends and says it will just be nice to be back at home.

In speaking with him his passion for his work and his post is clear.

“My responsibility as CMO was to provide clinical advice to the Health Minister, other senior Ministers, and occasionally the Prime Minister, as well as head up the Office of Health Protection, which was a huge job and has been a real privilege.

“One of the most reassuring aspects of this role is that I have always been surrounded by incredible people looking to get the best outcome for the community,” he said.

Prior to his appointment as CMO Professor Baggoley was Chief Executive of the Australian Commission on Safety and Quality in Health Care, a former CMO to the South Australian Department of Health and had a distinguished clinical career in emergency medicine.

In reflecting on his time in the role, Chris said there was no ‘regular day’.

“Just like in an emergency department where you never know what is going to come through the door, you never know what is going to be in the next phone call, next text or, next email. You can prepare for likely emergencies but at the end of the day you really just don’t know.”

One of his early standout experiences as CMO and a testament to this fact was grappling with the problem of community concern about suspected faulty breast implants.

“At the time there was great concern among women that there might be some issues with the industrial grade silicon.

“I was able to call together a range of specialists to get their feedback and ultimately it was determined that the fears weren’t borne out by the facts,” he said.

Chris’s advice to aspiring CMOs is true to his experience, saying it is “not a role that you plan for”.

“The post comes up once every five years. For me it was a series of circumstances that all lined up. I’d encourage anyone interested in pursuing the role to get in touch with a past CMO and I am including myself there.”

He further added that having a great network within the industry and a broad range of experiences would position someone well to succeed in the role.

He hopes that whatever he does next he will have the chance to continue to contribute to the health industry.
Life doesn’t always go exactly as we might plan, in the case of the incoming CMO, nephrologist Professor Brendan Murphy however that hasn’t been a bad thing.

“I wouldn’t have thought for a minute that I would end up in hospital management,” he says.

“I thought that I would spend about 40 years as a specialist physician and researcher, and retire in my late 60s from a clinical role.”

Appointed as the Head of his clinical department at an early age, Professor Murphy spent 15 years working as a clinician and researcher. After butting up against some of the problems associated with working inside a big hospital he decided it was time for a change.

“I was a bit frustrated at the time and not wanting to stay too long in the role. I thought to myself instead of criticising from a far why don’t I give management a go?

“Even though it might seem an unusual career move I’ve never looked back and enjoyed my management role immensely.”

Entering the third distinct ‘phase’ of his career Professor Murphy takes the reigns as the federal government CMO after spending the past 11 years as Chief Executive Officer of Austin Health in Melbourne.

“I am very excited to be working with the Government, as there are lots of opportunities to do new and exciting things.

“The chance to participate in national and international health reform and to be on the front line of some of the big challenges we’re facing is fantastic.

“For example, one of the many issues that the Commonwealth Department is tackling, in partnership with many local and international collaborators, is the growing problem of antimicrobial resistance”.

A passionate advocate of the medical profession Professor Murphy believes medical professionals should be taking on greater leadership roles in all aspects of the health system.

“I think if doctors who have had a successful clinical career are prepared to work in policy and in management they have such a lot to offer because they understand the clinical perspective,” he says.

His advice to future physicians is simple. Do what you love.

“Don’t choose a specialty because of its availability, or income, go after something that you’re really passionate about and be open minded about where this will lead.

“Don’t be dogmatic about your area of practice and do at least have a go at the most rewarding area of medical research. If you’re open to doing things differently and looking at new evidence you can play a substantial role in leadership”. RQ
The RACP membership: 16,000 Fellows, 7,000 trainees, from across 42 specialties.

A year ago we asked you, our members, about your aspirations for Congress. The answer was clear.

Both Fellows and trainees want the flagship event to deliver unique and collaborative conversations on big issues, provide specialist and cross-disciplinary clinical insights, showcase cutting edge examples of best practice, support opportunities for knowledge transfer, and deliver relevant professional development and skills building workshops.

The membership of the RACP is as diverse as our patients and the communities we work with. But, as members of the RACP we all share the common goal ‘to serve the health of our people’.

It is this common goal that brings specialists together and RACP Congress 2017 will be an ideal opportunity to be specialists together.

The Congress Organising Committee is developing a program for RACP Congress 2017 where you will have a chance to share your knowledge and build your skills as the big issues that impact healthcare for Australians, New Zealanders and those in the numerous other countries our members live and volunteer in are explored.

Medical knowledge, technology, clinical practice and patient expectations of engagement in their own care are always changing and RACP Congress 2017 will also feature the latest clinical updates and research presentations creating a rich and exciting event and learning opportunity.
learn about the latest clinical updates
join the conversations on the ‘big issues’ that are relevant to all physicians; obesity, disability, ageing, cognitive bias and end-of-life issues
attend high energy, cross-disciplinary think tanks
network with global thinkers and healthcare leaders, socialise with peers and forge new professional ties
getaway and explore all that Melbourne, Victoria, Australia has to offer.

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- network with global thinkers and healthcare leaders, socialise with peers and forge new professional ties
- getaway and explore all that Melbourne, Victoria, Australia has to offer.

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Rare books, lectures and an opportunity to connect – a night at the RACP
The occasion was a Fellow-led evening lecture on Herbals; the books that encapsulated medical knowledge of plants with medicinal properties, and an exhibition of texts up to 500 years old at the RACP's Sydney offices.

The event, supported by Board Director Professor Lynne Madden, coincided with the 200th anniversary of Sydney's Royal Botanic Gardens, and was organised with the assistance of the Library and Heritage Committee chaired by Clinical Associate Professor Cate Storey who spent three months curating the rare books on display.

In an hour long presentation, Professor Robert Clancy AM FRACP and retired pharmacist Christine Clancy covered the evolution of the use of plants for medicinal purposes across various cultures from 5000BC. They took the audience through to the advent of printing, and the compilation of influential herbal texts such as John Gerard's translation of Dodeon's Generall historie of plantes (1597) and Nicholas Culpeper's The Complete Herbal (1652–1653).

An audience of over 40 current and retired Fellows as well as guests and members of the public was taken on a journey through medical history. The lecture focused on the often competing roles of physicians and apothecaries in 17th century England, culminating in 19th century extraction of active agents such as the alkaloids morphine, strychnine and quinine, and the synthesis of urea, which revolutionised drug development, leading to today's pharmaceutical industry.

Guests then had a chance to actually see real copies of the valuable historical texts covered in the lecture. In a rare public opening of the RACP's Council Room, Library, Edward Ford Room and Fellows Lounge, they were invited to view 30 separate herbal texts on exhibition. Dating from the 1500s to the present day, the books were curated from the History of Medicine Library and Fellows' private collections.

There was also an opportunity to examine the many historical features of 145 Macquarie Street. The RACP's Sydney office is one of the city's few remaining grand terraces. It boasts many historically listed features and major restorations of the façade and staircase have recently been completed.

The occasion was a powerful reminder of times past for some, with one older Fellow overheard commenting with amusement “…the last time I was here was for my exams!” Many were delighted to revisit the RACP. “It was a really lovely event this evening and a great display of herbals,” said Professor Madden. “The presentations were terrific. It drew a great and diverse crowd as well.”

For several guests this night-time visit was the first time they had been back to their College in at least 25 years.
Regional healthcare gets a boost with dual training program

The RACP and the Victorian Government have announced the expansion of the Dual Physician Training Program following the success of the 2016 pilot in Bendigo. From 2017, new Advanced Trainee positions will commence at Ballarat Health, Bendigo Health, Goulburn Valley Health and Latrobe Regional Hospital. They will partner with metropolitan health services to deliver dual training in General and Acute Care Medicine and an additional specialty via a four year accredited training pathway.

When meeting with the Victorian Minister for Health the Hon Jill Hennessy and Member for Bendigo East the Hon Jacinta Allan at the announcement, Dean of the RACP, Professor Richard Doherty, said the program’s expansion was a positive step forward for the College, its trainees and regional community health.

“This is a special program for us. It demonstrates how we can expand regional training capacity, it helps address regional specialist shortages and it offers a model in terms of how the system commits to the training of selected individuals over the full period of training,” said Professor Doherty.

Minister Hennessy added: “This new training program will give our future rural physicians access to first class clinical education in Melbourne and help fill gaps in our rural communities.”

General and Acute Care Medicine and Gastroenterology Medicine trainee Dr Christopher Mills is an Advanced Trainee in the dual training program pilot.

“The dual training position at Bendigo fits perfectly with my career goals and aspirations.

“The position at Bendigo has also given me the opportunity to become engrossed in the local community, developing friendships and community partnerships to a degree not possible in metropolitan centres,” he said.
It was with great sadness that we said farewell to Emeritus Professor Rick Speare who was tragically killed in a car accident on Sunday, 5 June 2016. Rick was a medical practitioner, veterinary surgeon, public health physician, teacher, researcher, mentor and friend to many. He taught and inspired many rural clinicians from Australia and around the world who undertook public health and tropical medicine studies or research at James Cook University (JCU), where he spent most of his career.

He was awarded a PhD by JCU for his work on the human gut parasite Strongyloides, a neglected tropical disease that particularly affects remote Aboriginal communities. Rick became an internationally recognised leader in neglected tropical diseases among humans. Equally, he made important contributions to wildlife health. His higher doctorate of veterinary science was awarded by the University of Queensland for his research on amphibian disease.

Rick worked at James Cook University from 1988 until his retirement in 2012 and held many senior positions including Head of the School of Public Health, Tropical Medicine and Rehabilitation Sciences. He played a pivotal role in the establishment of the World Health Organization Collaboration Centre for the Control of Lymphatic Filariasis, Soil-Transmitted Helminths and other Neglected Tropical Diseases at JCU in 1996.

At JCU, Rick taught and supervised masters and doctoral students, as well as training hundreds through capacity building workshops in low income settings, particularly in Aboriginal communities, Africa and the Pacific. He not only formed professional partnerships with the people with whom he worked, but enduring friendships with many of them. Rick had the ability to see potential in people and supported them to realise their potential.

He had an insatiable curiosity that formed a wonderful basis for his research work, which spanned many countries, most notably Papua New Guinea, the Solomon Islands and the wider Pacific, South East Asia and South Africa. He played a key role in high-level responses to various emerging pandemic threats, as well as broader parasitic, ectoparasitic and infectious diseases over many years. He was highly regarded in the community for his work on trialling more effective treatment of scabies and head lice. He was a senior member of the team that was awarded the CSIRO Medal for the discovery of the fungal disease that was leading to the worldwide epidemic killing frog populations.

Rick published more than 250 papers in peer reviewed journals, as well as four books and 25 book chapters.

In 2013 Rick was awarded Membership of the General Division of the Order of Australia for his significant service to medical and biological research through leadership roles in the areas of public health and wildlife conservation.

Most recently Rick was working with the Atoifi Health Research Group in the Solomon Islands. His colleagues from Atoifi wrote a touching statement which really sums Rick up:

“Rick was a man of great humanity, wisdom and wit. Across his extensive professional and personal endeavours, his commitment was to make the world a better place. People across the globe will attest to his immense kindness, genuine humility and great intellect. Rick has been influential in so many of our lives.”

Our thoughts are with his many friends, colleagues and students among whom he will be greatly missed and especially with his wife Kerry, his two daughters, three sons and five grandchildren.

In accordance with his family’s wishes, a Rick Speare Memorial Fund has been established in his name, with funds raised to support continuation of his work in the Solomon Islands.

Prepared by Dr Penny Hutchinson FAFPHM, Professor David Durrheim FAFPHM, Dr Rod Davison FAFPHM with information provided by the Australian College of Rural and Remote Medicine and James Cook University.
Help solve the College art conundrum
Since its establishment in 1938, a number of paintings, drawings and sculptures have been gifted or bequeathed to the College. Among this extensive art collection are paintings by world renowned Australian artists, however the journey of two of these paintings to the College’s collection is unknown.

Although remembered most for his drawings, Lloyd Rees AC, CMG was also a prolific painter. Sailing – Sydney Harbour is one of those paintings. He was known for his obsession with light and depictions of ethereal scenes of Australian landscapes and despite the onset of blindness, still active at age 94 when he died in Hobart in 1988.

Best known for his stylised series of depictions of bushranger Ned Kelly, Sidney Nolan OM AC travelled Australia and the world extensively. Queensland Port was painted after travelling through Queensland in the late 1940s.

Works by Lloyd Rees and Sidney Nolan are held in public and private collections around the world. The College’s Rees and Nolan have significant value, both monetary and cultural, but there is no current information in any records or asset registers as to how they came to be held by us.

“We are wondering if the Fellowship can help,” says Clinical Associate Professor Cate Storey, Chair of the Library and Heritage Committee. “Both we and the Fellowship Committee were asked to make recommendations to the Finance Committee in regards to the future of these two artworks. It’s possible that one of our members knows how they came to us.”

If you know the story behind the acquisition of either one of these artworks RACP Quarterly would be delighted to hear from you, contact us at communications@racp.edu.au

The College’s art collection hangs throughout the College premises on Macquarie Street in Sydney. The collection also includes portraits of our Past-Presidents, many of which were painted by Australian artist Robert Hannaford, who has been an Archibald Prize finalist every year in which he has submitted works. RQ.
**NSW/ACT telehealth workshop**

Genetic Oncologist, Dr Hilda High and Ms Julia Martinovich, Implementation Officer, NSW Agency for Clinical Innovation will present at this free workshop on telehealth.

- **Date:** Tuesday, 25 October 2016
- **Location:** RACP 145 Macquarie Street, Sydney
- **Cost:** Free
- **Website:** [www.racp.edu.au/news-and-events/all-events](http://www.racp.edu.au/news-and-events/all-events)

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**Victorian telehealth workshop**

At this workshop find out about:
- what telehealth is
- what telehealth is used for
- guidelines and processes for telehealth
- doctor and patient experiences using telehealth
- setting up telehealth services and funding.

- **Date:** Wednesday, 2 November 2016
- **Location:** RACP Victoria, Level 2, 417 St Kilda Road, Melbourne
- **Cost:** Free
- **Website:** [www.racp.edu.au/news-and-events/all-events](http://www.racp.edu.au/news-and-events/all-events)

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**Supervisor Professional Development Program workshop 3: workplace-based learning and assessment**

This workshop will be held at the New Zealand Society of Gastroenterology Annual Scientific Meeting (ASM).

The objectives of the workshop are to:
- discuss the purpose and importance of workplace-based learning and assessment
- analyse the cycle of planning for learning and assessment
- identify the challenges and solutions associated with work-based assessment in a complex environment
- draw on evidence of learning and achievement to determine overall performance and progression.

- **Date:** Friday, 25 November 2016
- **Location:** Claudlands Events Centre, Hamilton, New Zealand
- **Cost:** Free
- **Website:** [www.racp.edu.au/fellows/supervision/supervisorworkshops](http://www.racp.edu.au/fellows/supervision/supervisorworkshops)
WA Rural Physicians’ Workshop 2016

The fifth annual Rural Physicians’ Workshop will be held at the RACP WA office.

The program, designed specifically for rural physicians and those with an interest in rural medicine, will include presentations in a range of topics including:

- respiratory medicine
- neurology
- a review of important journal articles from 2016.

Saturday, 26 and Sunday, 27 November
RACP Perth, 1–3/24 Leura Street, Nedlands, Western Australia

Free, optional dinner A$110 per person
Email racpwa@racp.edu.au to register.

2016 RACP Northern Territory Annual Scientific Meeting

This one day event with the theme ‘Access and Patient Centred Care’ event will feature:

- presentations and clinical updates from Fellows
- the Northern Territory RACP Trainee Research Awards for Excellence presentations
- the Northern Territory Australasian Faculty of Public Health Medicine Gerry Murphy Prize presentations.

Saturday, 26 November 2016
The Waterfront Lecture Theatre, Charles Darwin University and via videoconference

Various costs apply.
www.racp.edu.au/news-and-events/all-events


Join us at the largest annual multi-disciplinary internal medicine meeting in Australasia.

RACP Congress 2017 an opportunity for you to:

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- hear the latest clinical updates
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- network with global thinkers and healthcare leaders, socialise with peers and forge new professional ties
- getaway and explore all that Melbourne, Victoria, Australia has to offer.

Monday, 8 to Wednesday, 10 May 2017
Melbourne Convention and Exhibition Centre

Various costs apply.
www.racpcongress.com
The importance of words

Language, the greatest of all human achievements and as a result we think in words.

I prefer to be known as a ‘physician’ but the term is defined and in reality demeaned by the absence of surgery. The epithet of general physician provokes the comment ‘but I thought you were a specialist’ and indeed how can a generalist be a specialist?

The American term of ‘internal physician’ is unsatisfactory as it implies the exclusion of dermatology and the ability to recognise the external manifestations of internal disease. I have used the term Plenary Physician becoming the only one in the world with no-one being the wiser.

The importance of words is indicated by the fact that if there is no word for something, it might as well not exist. It would be difficult to write about physician-induced illness if the term iatrogenic did not exist. The classical Greeks had no lawyers and hence no word for them making the coining of a word to describe disorders provoked or made worse by legal processes difficult.

It is suggested that the deficiency is corrected by the word ‘dikogenesis’ or the adjective ‘dikogenic’. Words like dictator and diktat already exist and this addition to the dictionary would be a small corrective to the balance between those that do and those in the habit of sitting in judgement of them.

Dr George Crowe
FRACP

CORRECTIONS

1. On page nine of the June/July edition of RACP Quarterly the Queens Birthday honour descriptor for Associate Professor John Owen King was incorrect.

Associate Professor King was recognised in the Australian Queens Birthday honours list as Member (AM) in the General Division for significant service to medicine as a neurologist, to medical education, to Multiple Sclerosis research, and to professional organisations.

2. On page 48 of the June/July edition of RACP Quarterly Dr Matthew Pitman’s name was spelt incorrectly and research institute was incorrect, he works at the Peter Doherty Institute for Infection and Immunity.
REGISTRATION & CALL FOR POSTER ABSTRACTS OPEN

KEYNOTE SPEAKERS

Jane Ballantyne
University of Washington, USA
Opioids and chronic pain

Wim van den Brink
Academic Medical Center, University of Amsterdam, The Netherlands
Addiction and ADHD: genetics, neurobiology and treatment

David Forbes
Phoenix Australia Centre for Posttraumatic Mental Health, The University of Melbourne, Australia
Responding to trauma

KEY DATES

Call for poster abstracts close
- 31 October 2016
To submit your abstract please visit imia17.com.au

Early bird registration closes
- 12 December 2016

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TO REGISTER OR VIEW THE FULL PROGRAM PLEASE VISIT imia17.com.au
Pomegranate is a free monthly medical podcast created by physicians, for physicians. The show is produced by the RACP’s Learning Support Unit with physician input guiding every step of development – from deciding on an episode’s theme to peer review of the show’s final content. Episodes of the 20-minute program, along with all past Pomegranate episodes, are available to download or stream on both iTunes and Subscribe on Android.

NEW episodes of Pomegranate are released on the last Tuesday of every month.

Previous episodes have included:
- Law at end-of-life
- Antibiotic resistance – Are we all doomed?
- Obesity Inside Out
- Physician, Heal Thyself.
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