CANBERRA Doctor

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Telehealth: AMA says COVID reforms must be made permanent

Australian patients are overwhelmingly embracing telehealth as an important part of their health care management, making a very strong case for the Government to make the COVID-19 telehealth reforms a permanent feature of our health system.

AMA President, Dr Tony Bartone, said today that the AMA has been a strong telehealth advocate for many years and is delighted that patients are now reaping the benefits.

Dr Bartone said that around 10 million Medicare-funded telehealth services have been provided, either over the phone or via video, a significant majority of which have been provided by GPs and other specialists since the Medicare telehealth items were introduced in March.

"Telehealth is the norm in many parts of the world, providing patients with a convenient option to access care where they don't need a physical examination," Dr Bartone said.

"Telehealth is not and never likely to be a complete substitute for face to face visits to the doctor, but does provide a convenient and highly appropriate option that can supplement visits to the practice in person.

Telehealth has worked

"The initial decision to open up Medicare funding for telehealth services was driven by the need to reduce the risks of the transmission of COVID-19 and to protect vulnerable patients.

"However, it has also given us the opportunity to trial telehealth in the Australian context – with current arrangements due to expire in September.

"While there have been some important learnings along the way, the overall sense from GPs, other specialists, and patients is that it has been a tremendous success.

AMA President, Dr Tony Bartone.

"We must now turn to the task of seamlessly and fully integrating telehealth into day to day general practice and other relevant medical specialties, and ensuring continuity of care for patients – and that we follow best practice standards.

Integration

"Our very successful primary care system is built around the relationship between a usual GP and a patient.

"For GP telehealth consultations, we need to continue to follow this proven approach and ensure that future telehealth arrangements are built around this concept. We should also consider how to permanently implement telehealth across other relevant medical specialities.

"One suggested approach is to allow GPs or general practices to allow patients to voluntarily nominate a GP and/or a practice in order to be able to access telehealth services from their GP once the current interim telehealth arrangements are due to end.

"We need to avoid 'pop up' or purely 'virtual' opportunistic other models of telehealth that fragment care and, in some cases, blur the important distinction between the prescribing and dispensing of medicines.

"Most telehealth consultations to date have been by telephone rather than video, which reflects the speed at which telehealth has been rolled out and the limited preparedness of medical practices and patients to utilise video consultations.

"Both options can provide a quality service for patients, but the longer term may see a greater emphasis on video.

"Reliable, robust, and very fast internet across the country must be a priority to make telehealth work.

"And we must note that, for some patients, the phone is their only option, and they must not be discriminated against.

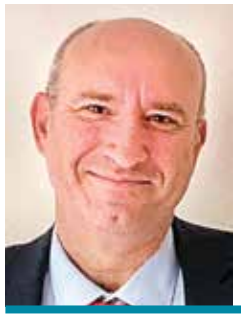
Funding for Practices

"The Government needs to support the profession through this transition with funding to augment and integrate practice infrastructure and the development of appropriate frameworks and guidelines and provide the stimulus for wider sector innovation.

"Health Minister Greg Hunt has already acknowledged the success of telehealth, and is actively considering how it can continue beyond the current interim arrangements.

"The AMA is working to provide the Government with advice on how to move forward.

"Telehealth is the way of the future, and must become another essential element of Australia's world class health system."



President's **Notes**

WITH PRESIDENT, DR ANTONIO DI DIO

As we see the immediate threat from COVID receding in most parts of the country, including Canberra, I wanted to pay a quick thanks to such a long list of people, it cannot be quick! But here goes – Leaders Federal and State, collaborative doctors and health workers, minister Stephen-Smith, Kerry Coleman, Bernadette McDonald, Vanessa Johnson, Imogen Mitchell, the team at ASMOF and VMOA, every worker bee and soldier, every wards staff and administration team and cleaner and doctor and physio and OT and nurse and individual who in just the act of showing up to work at a time of fear and panic demonstrated courage and community spirit that I will never forget or cease to be grateful for.

And while much more needs to be done, more on that later – I feel very confident that there is a structure and a set of people in place to get that done.

AGM and Annual Report

In normal circumstances, at this time of the year, we would have just held our annual general meeting and dinner; an opportunity to catch up with friends and colleagues, receive the annual report and review the activities of AMA (ACT) during 2019.

This year, of course, COVID has meant that our AGM was held online and I'm grateful to the members who participated, allowing us to successfully complete the meeting.

In brief, 2019 was again a busy year and we hit the ground running when the Final report of the Independent Review of Workplace Culture was handed down in early March. Of course it's also been an ongoing battle over the year to get a new salary deal for our hospital doctors and, while we've been able to achieve an excellent outcome, there's been hiccoughs getting it approved by the Fair Work Commission. As recently as last week we learnt that the FWC has sent the parties back to complete the final steps again.

On the membership side, we have a shown a steady increase in our member numbers, particularly with young doctors. This is a trend that needs to continue and it's important we encourage our senior colleagues to join too.

To that end, this year, I've been gratified that many very high quality and experienced doctors have taken the step to join us. The only way those people will continue to join our group is for them to see what we can do – what we can do for the profession, what we can do for the community, and what enjoyment and emotional reward we get ourselves.

For the full story of 2019, you can view the Annual Report on our website at https://act.ama.com.au/node/905

AMA (ACT) Elections

The recent AGM also saw the new AMA (ACT) Board take up their duties. Prof Steve Robson was returned as Secretary, A/Prof Andrew Miller continues as Treasurer, Dr Iain Dunlop and A/Prof Jeff Looi were also returned as Board members and Dr Rashmi Sharma continues on the Board as Chair of our Advisory Council.

In addition, Prof Walter Abhayaratna was elected as President-Elect and Dr Charles Howse as a Board member.

Congratulations to the successful candidates and I look forward to working with you over the next two years. On that note, I'm extremely grateful to be continuing as President.

I also wanted to express my thanks to Dr Suzanne Davey and Dr Balaji Bikshandi as they both leave the Board. Over this past term, Balaji has shown a remarkable energy and enthusiasm combined with an insightful view of the world and what our profession is facing over the coming years. I wish him all the best and hope this is not the last we see of his involvement with AMA (ACT).

In particular, I'd like to thank Dr Suzanne Davey for her more than 10 years' service on the Board of AMA (ACT). Her contribution has been outstanding and incredibly valuable, as a voice of general practice as well as her relentless pursuit of fairness, justice and compassion for all doctors and their patients.

I'd also like to thank Suzanne for her membership and contribution for many years as the AMA (ACT) representative to the AMA Council of General Practice and for her tireless advocacy of general practice in the ACT.

Finally, those of us who know Suzanne will understand when I say how much her warmth, intelligence, passion and compassionate articulation of GP issues at our Board meetings will be missed. Thank you Suzanne.

COVID

This remains a work in progress. In this issue you will see thoughtful contributions from Steve Robson and Jenny Ross, whose professional and personal insights will, as ever, bring forth their wisdom and wit. The AMA (ACT) remains integrally involved in many different aspects of the COVID response, working with pharmacy, health, hospital, and leaders at both state and Federal levels, ensuring that the youngest child here is raised like some fatherless Tarzan creature of the inner South, and the weekly subscription to the Phantom remains in the highly collectible but somewhat frustrating Unread/ Near Mint condition. I'd particularly like to mention our craft groups working together and solving differences with each other at this time, with many of our procedural specialist and GPs taking a huge hit to their income while, in some cases, an addition to their tasks, without a word of complaint.

The next six months and beyond

We know we have a lot of work to do over the next six months and beyond – even without COVID – our VMO members await the outcome of their contract determination, we have an ACT election that is still scheduled for October, we have the many unfinished areas around telehealth and General Practice, the MBS Review hovers around and believe it or not, once our hospital doctors' agreement is finalised, we will be back into the next round.

These reasons and more are why we need your ongoing support, along with that of your colleagues. I am proud and humbled to be here for another year, and would love to hear from you about what we are doing, if you'd like to help, how we can do better, how we can help you, and any policy or strategy advice you have. Every member's voice is important, and we are here to listen. Speaking of members, have a look in this issue for three of our most honourable AMA (ACT) family members celebrating 50 years in the organisation. If you want to see people who have given so much, look no further.

Now where's the latest Phantom? Ah, there it is, up a tree, in the clutched fists of my little Tarzan. If only he wasn't holding it upside down, I'd be even prouder! Best wishes, Antonio.

Public Hospital Doctors Enterprise Agreement delayed again

Despite extensive negotiations over more than two years, an overwhelming vote of doctors across the ACT public hospital systems and hearings in the Fair Work Commission, the FWC has declined to approve the new enterprise agreement.

In essence, the FWC decided that two practitioners who were separately represented during the negotiations had not been provided with an important document despite repeated requests for access. Consequently, the failure by CHS to provide the document had sufficiently disadvantaged the employees concerned that FWC found that could not have sufficiently understood the changes in the enterprise agreement.

It's important to note that the Fair Work Act is highly technical and it's not particularly unusual for an approval for an enterprise agreement to strike trouble. However, it's also not unusual for some matters to be resolved between the parties and the FWC, and the agreement is then approved.

On this occasion, the FWC determined that without access to an explanation of the changes, the two practitioners could not have 'genuinely agreed' to the agreement and the agreement must fail.

Pay rises intact

Although the FWC has not approved the new agreement, the pay rises currently in place are to continue while CHS considers the implications of the decision with CEO, Bernadette McDonald saying that, "in the interim the Territory will continue to honour its commitment to pay the enhanced rates of pay that were agreed in good faith with all parties."

While it's appropriate to consider the implications of the decision and make sure that the next approach to the FWC succeeds, the fact is that approval of the new agreement can't come soon enough.

The next round of pay rises were due at the beginning of June.

CHS CEO, Bernadette McDonald.

JMO education allowance delayed

For junior doctors, the major issue is the delay in accessing the new education allowance that AMA (ACT) and CHS have agreed. The new allowance puts money directly into the doctor's pocket, on a fortnightly basis, to be used for educational activities. The new allowance is paid as follows:

- Interns; $1040 p.a.
- RMO1, SRMO1, Jnr Reg; $3,000 p.a.
- SRMO 2, SRMO 3, Reg 1-4, Snr Reg; – $4120 p.a.

Until the new agreement is approved the old system of reimbursement through CHS continues in place.

Next steps

While CHS is considering its next steps, it's certainly likely that further discussions with the two practitioners concerned will need to take place. In addition, it's also likely that further information will need to be provided to some other staff specialists are covered by some of the private practice schemes.

It's also likely that the agreement will need to be re-submitted for another vote in the near future.

In the end, while AMA (ACT) is willing to assist with the process, the Fair Work Act mandates that employers are responsible for submitting enterprise agreements for approval to the FWC.

Leadership in the age of COVID

BY PROF STEVE ROBSON

The community of Canberra and its surrounds has been savagely battered over the last twelve months. A long-lasting drought ushered in a series of heatwaves and a bushfire season the likes of which few of us had ever experienced before. Summer's horrors were punctuated with a devastating hailstorm, then drenching rains that caused further chaos as floods inundated many of the towns around us.

Those 'horsemen of the apocalypse,' as severe as they were, served as but a warm-up act for the main horror – the COVID-19 pandemic. Seemingly out of nowhere, and just when Canberrans were beginning to see some brightness on the horizon, what began as an exotic viral outbreak in remote China exploded into an evolving global catastrophe the like of which few of us have experienced before.

For many Canberrans, emotional reserves are low. The pall of bushfire smoke that blanketed us over summer meant that we entered the COVID-19 crisis in a weary state of mental exhaustion. For many of Canberra's doctors the summer was one of restless overwork – our patients were anxious and on-edge. It was difficult for us to calm and reassure them, and fears were held for the elderly, mothers-to-be, and our children.

The leadership vacuum

In an article published in the *Harvard Business Review* in January this year, just before the COVID-19 pandemic took on its true significance, Mark Kramer and colleagues addressed the issue of how our global leadership should tackle the world's biggest problems. Their assessment was sobering:

"High-level global partnerships serve a useful purpose by garnering resources, generating knowledge, and focusing attention on the urgency and importance of the issue at stake. Unfortunately, the one thing these partnerships rarely do is actually solve these problems. Instead, these initiatives collapse under their own weight as partners become discouraged by the lack of meaningful progress for society or economic benefit..."

> May we all model our own behaviour on their selflessness and sacrifice as we help each other through this.

Many of us, both in the medical profession and more broadly across out community, have lost trust in the institutions that, in the past, seemed rock solid. The *Edelman Trust Barometer*, released earlier this year, reported that Australians were distrusting, sceptical, and critical of major institutions – they were viewed as incompetent or unethical.

The CEO of Edelman, Michelle Hutton, said that, "Australians no longer feel in control. The new decade marks an opportunity for our institutions to step up, take action, and lead on key issues that will unite Australians and instil hope for the future."

Trust is everything. The ABC's Australia Talks national survey rated doctors and nurses as the most trusted group in the community, trusted by an incredible 97% of respondents. At the bottom of the list? Politicians and celebrities, with corporate executive only just a nose ahead.

All politics is local

Kramer's *Harvard Business Review* article drew attention to something that now seems blindingly obvious:

"We have learned... to achieve economic success and social impact, collaboration must happen at a local level where all relevant actors in business, government, and civil society must be brought together to create systemic change. Getting everyone to work together effectively requires an approach, an approach [that] is far more work and far less glamorous than joining a global partnership, but it does generate tangible social and economic results."

Many of Canberra's doctors are experiencing the consequences of a perceived vacuum in leadership, something that has become obvious globally as the COVID virus infects and moves through our communities. Countries have been ill-prepared for the event, with global supply chains found severely wanting. Not only have Canberra's doctors had to contend with shortages of staples such as hand sanitiser and toilet paper at home, but with an inability to source critical protective equipment such as masks and gowns. To make matters worse, advice on clinical matters has seemed incomplete, sometimes contradictory, and changes rapidly making it hard to keep up to date.

Keep them close

As the accompanying economic crisis has worsened, doctors who own their own practices have faced many anxieties. The demands of high-level infection control, not normally a feature of most medical practices, have thrown patient flow and business into chaos. Many of us are concerned about the very financial viability of the practices that we have put our heart and soul into, just as so many other in the Canberra community feel as well.

Practice staff – the lynchpin of most busy medical practices – will have had little or no experience in dealing with a pandemic. Patients and their families are worried, and this makes people panicky and demanding. While our practice staff are used to some prickly patients or relatives, having large numbers of people bombarding the practice is disorienting and worrying. Our practice staff have their own concerns to deal with: will their own families stay healthy? Will their partners still have a job? Will elderly relatives fall ill?

How is it possible to juggle these competing priorities in a time of COVID? Canberra's doctors are naturally worried that they, themselves, might become infected and have to withdraw from work.

They worry about protecting their staff and their staff's families. They worry that some mistake in protocols might put other patients at risk or cause other harms. They worry about the economy, their friends and families.

A time for leadership

I read several wonderful Tweets this week, and they touched my heart:

"We owe a profound debt of gratitude to all our health professionals and everybody who'll be on the front lines of this pandemic for a long while. They're giving everything. May we all model our own behaviour on their selflessness and sacrifice as we help each other through this."

President Barack Obama (@BarackObama)

"A pandemic, or any disaster, highlights that healthcare is more than just a machine that helps ill people get better. Healthcare is an instrument of social cohesion, distributive justice, and even economic viability."

Peter Brindley in the BMJ blog (@docpgb)

And perhaps my favourite...

*"So society's *real* key workers have been revealed. Not the bankers. Not the traders. Not the elite hedge fund managers. It's the nurses. The doctors. The delivery drivers. The carers. The porters. The teachers. The shelf stackers. The check-out staff."*

Dr Rachel Clarke (@doctor_oxford)

It is clear to our patients and our communities that disastrous events – bushfires, floods, storms, infectious pandemics – reveal the true leaders. We're all in a position to provide leadership, comfort, support, and even inspiration to the patients we treat, the communities we serve, and the staff who support us in difficult times.

50 YEAR MEMBERS: BY DR JOHN DONOVAN

Dr David McNicol

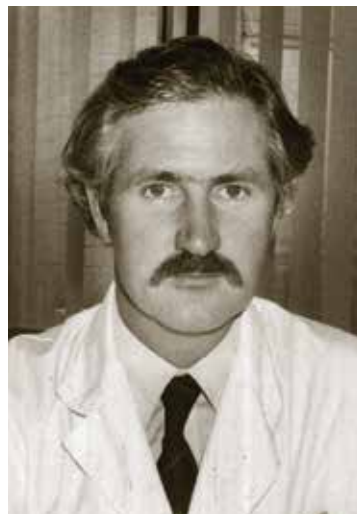
This year we celebrate the 50-year AMA membership of the founder of *Canberra Doctor*. During his Presidency of the Capital Territory Group of the AMA, as it then was, David McNicol had learnt that the NSW Branch had a monthly magazine, so why shouldn't we? He pursued the project with his usual determination, and we are still here 33 years later.

Thank you, David.

Early life and Career

Education at Canberra Grammar School and the University of Adelaide meant that David played two codes of football. However it was his conscription and service in Vietnam that inspired him to become an orthopaedic surgeon. Soon after leaving the Army he studied Anatomy at Cambridge, passed the Primary FRCS in London, then worked in Manchester before returning to Adelaide as a surgical registrar. That led him into Orthopaedic Surgery, and by the time he gained his RACS Fellowship in 1976, he had developed an interest in scoliosis management in teenagers.

A chance meeting led David to the Duchess of Kent Children's Hospital, Hong Kong, a world renowned Hospital for management of scoliosis and other spinal disorders. Later, he moved to a research position in the laboratories of the Shriners Hospital for Crippled Children in Montreal where he gained an MSc degree from Magill University, Department of Experimental Surgery.



Dr David Mcnicol in 1985, during the Doctors' Dispute.

David and family settled in Canberra in 1980 when he was appointed VMO in Orthopaedic Surgery to all three of its hospitals, additionally acquiring ANU research appointments in 1982.

President of AMA (ACT)

While President of the Capital Territory Group and later as Surgeons' representative on the Federal Council of the AMA, David played a major role in moving the Federal AMA office from Sydney to, Canberra. He rightly considers this achievement to have been significant in lifting the political profile of the AMA.

David McNicol.

During this time he had also been elected to the Council of the Australian Orthopaedic Association (AOA). Within the AOA, the ACT had till then been regarded as part of NSW, but he was able to remedy this so that the ACT had its own seat on the AOA National Council.

He became National President of the AOA in October 2001, and subsequently chaired AOA Orthopaedic Research and Orthopaedic Outreach. He was also Chairman of the Australian Branch of the Asia-Pacific Orthopaedic Association, sitting on its Federal Council for several years as Second Vice-President and Chairman of the Finance Committee.

David has now retired and is living in the Byron Bay hinterland. He says it has been a full life in every respect, and he is very conscious of and grateful for the opportunities that have come his way.

Much would not have been possible however without the support, love, understanding and steadfastness of his wife Jannine.

Dr Doug Rogers

As a student at the University of Sydney, Doug Rogers looked forward to summer long vacations. He fled Sydney for Quilpie in Western Queensland to work as a jackeroo on a property managed by his elder brother. There he could ride, not only well enough to play polo, but so well that the stockmen saddled for him whichever horse they could not handle!

Doug was attracted to a career in O&G during his residency at Royal Newcastle Hospital, but the long and irregular hours necessary to commit to training was too much for his family life at the time. Then a two-week locum in Molong in country NSW pointed him towards general practice.

In the end, he joined a five-partner general practice in West Ryde, relieving each partner in turn for three months, and at the end of 15 months a departing partner invited him to buy his share. He did that, and stayed for 27 years. For two years in the 1970s he was Secretary of the Kuringai District Medical Association, but he declined the offer of becoming President.

Life in Sweden

By then Doug had a Swedish wife and a stepson who was about to start school. They moved to Sweden. On weekdays he commuted 2½ hours each way by train to University in Linköping learning Swedish Language and Culture, then medical Swedish. After 16 months he was qualified to work, and four years later as a 'Specialist in General Medicine' again. He joined the Swedish Medical Association.

His first position was at a Medical Centre in Oskarshamn, where he worked for nearly 10 years. Then he did locums seeing the Sweden he had lived in but seen little of. The most challenging was 12 weeks in winter, 150 km north of the Arctic Circle in Malmberget, where he mixed with northern Swedes and the Sami people. Here he experienced overnight temperatures down to -35°, and no sun. But there was compensation: most evenings the Northern Lights were there for those who bothered to look up.

Back to Australia

After 14 years in Sweden, by which time he had three grandchildren here, Doug returned to Australia. He was initially looking for a position in the Southern Highlands but was fortunate enough to find one in Kaleen with Dr David Voon's practice, now part of Ochre Health in the University of Canberra grounds in Bruce. He remains fluent in Swedish, but has only had one Swedish patient in 8 years!

Dr Doug Rogers.

At 77, Doug describes himself as 'not quite ready to quit'. But for his grandchildren he would willingly head back to Sweden. So he stays here and visits there.

And as he says, it's a wonderful life if you just keep waking up ...

Dr Colin Andrews

"I have always wanted to be a farmer."

Wait on, Colin Andrews. We know you as a neurologist, in fact the first neurologist in Australia to practise outside the five mainland capitals. You arrived in Canberra in 1972 and were in practice until 2018. During that time you were President of the ACT Branch of the AMA for two years, Deputy Chairman and later Chairman for five years of the Medical Committee, and Chairman of the Hospital Board. We thank you for the time you gave in service of your colleagues.

Colin Andrews on the front porch at Jeir Station.

Colin had a research career before he moved into private practice. In 1973 he was awarded an MD for Experimental Studies on extra pyramidal rigidity and tremor. He participated in studies of the use of botox in migraine (2001) and later in trigeminal neuralgia (2005), and stem cell treatment of multiple sclerosis.

Back to the farm. Raised in Tottenham, Colin did his secondary schooling at Hurlstone Agricultural High School, and then completed one year of a Rural Science degree at the University of New England before transferring to Medicine II at the University of Sydney. His postgraduate training was at Prince Henry Hospital, by then affiliated with the University of New South Wales.

Within a year of arriving in the ACT, Colin had moved out to a rural property. Then in 1983 the Andrews family bought Jeir Station, once one of the largest landholdings in the district; Colin and his wife Kay are still there as empty-nesters. They live in a large heritage-listed homestead with a ballroom, alas no longer used. Adjacent to the homestead is an 1830 range of outbuildings where once there were a Post Office and a Cobb & Co change station. The storage barns house 60,000 bottles of Jirra wine, an A-model Ford, and a 1932 Ford truck, both in running order. The two sports cars with which some readers may be familiar have long since gone to a paediatrician daughter in Lismore. The surrounding 120 hectares include a vineyard and pasture for 50 head of Aberdeen Angus cattle.

Offsite Colin and Kay have 4000 hectares at Tottenham sown to wheat, barley, oats, and canola. Much more interestingly they have recently acquired Capital Wines with their Cellar Door at Hall. You are invited there for a tasting of both Capital and Jirra wines. AMA members will receive a 20% discount for the rest of 2020.

Annual General Meeting and Elections

The AMA (ACT) Annual General Meeting was held on Wednesday 20 May and, given COVID restrictions, was held 'remotely'. The meeting considered the annual report, including both the President's Report and Treasurer's Report from 2019.

The Annual Report can be found at this link: https://act.ama.com.au/node/905

In addition to the reports, the meeting recognised five new 50-year members, Dr Colin Andrews, Dr David McNicol, Dr Doug Rogers, Dr Heather Lopert and Dr Michael Flynn. Congratulations and thank you to all these members and particularly past-Presidents, Colin and David.

New Board

The conclusion of the AGM also saw the new AMA (ACT) Board take office, the members of the Board are:

President:
Dr Antonio Di Dio

President-Elect:
Prof Walter Abhayaratna

Secretary:
Prof Steve Robson

Treasurer:
A/Prof Andrew Miller

Board Members:
Dr Iain Dunlop
A/Prof Jeff Looi
Dr Charles Howse

Chair of Advisory Council:
A/Prof Rashmi Sharma

AMA (ACT) LIMITED

What makes specialist doctor trainees happy?

New research by UNSW medical researchers has shown that specialist doctor trainee satisfaction is most strongly linked to good supervision by specialists, enough study time, and overall healthiness.

The paper – published earlier this year in Medical Education – is the largest Australian study ever on specialist trainee satisfaction, paving the way for an evidence-based approach to improving satisfaction rates.

The pathway to becoming a specialist doctor is a demanding process that generally takes a minimum of 12 years of education from the start of medical school to the completion of fellowship.

Dr Matt Lennon from UNSW Medicine, a junior doctor in Wagga Wagga and the lead author of the study, said these findings were important, particularly given recent reports in both Australia and the UK of cumbersome workloads, burnout, trainee bullying, a lack of employment security and high rates of suicide.

"Ensuring that specialty trainees are professionally satisfied is important for trainee wellbeing – and it's also critical for the health systems to retain doctors," he said.

"Since 2015 there has been an intense focus on trainee distress and burnout. Despite this, we've seen little systematic research on specialist trainees and what contributes positively to their professional satisfaction.

The study

"In this study, we try to shift the focus of discussion away from halting trainee distress towards promoting trainee wellness, identifying key factors to build satisfaction." Dr Lennon said.

The study used the Medicine in Australia: Balancing Life and Employment (MABEL) survey and examined 4012 hospital-based specialist trainees.

"The three most important factors associated with professional satisfaction were feeling well supported and supervised by consultants, having sufficient study time and self-rated health status," Dr Lennon said.

"This confirms anecdotal and survey data that has pointed out that trainees feel least safe and satisfied when unsupported by supervisors."

Overworked trainees more likely to be dissatisfied

Risk Factors

The study also identified a number of groups who were particularly at risk of being unsatisfied with their work.

"Those that work more than 56 hours per week – which one in five respondents did – were 24% less likely to be satisfied than those working 45 – 50 hours per week, whereas those working between 51 and 56 hours a week were the most satisfied group.

"This highlights that the discussion around reasonable working hours doesn't have to be constrained to the traditional 40-hour working week, but we clearly need to identify a point at which trainees feel unsafe and unsatisfied.

The study also showed that male trainees, those more junior and those trained overseas were less likely to be satisfied. Conversely, rural and regional trainees were significantly more satisfied than those in metropolitan centres.

"To build pathways out of the current challenges with trainee wellbeing, peak bodies and hospitals should focus on ensuring good supervision, protecting adequate study time, providing controls around work hours and encouraging healthy life choices," Dr Lennon concluded.

The study can be found here: https://onlinelibrary.wiley.com/doi/abs/10.1111/medu.14041

Covid in Canberra: what just happened?

BY DR JENNY ROSS

Is anyone else feeling just a bit discombobulated??

March 2020. Autumn arrives and we farewell that horrible, sad, Summer. Years of crippling drought culminating in weeks of horrendous fires, heat, destruction, loss and smoke.

Social distancing takes on new meaning.

In Canberra we looked around as our neighbouring communities of Braidwood, South Coast, Snowy Mountains, Southern Highlands all burned. Our own borders were threatened. We prepared for the worst and watched on helplessly. All summer we sat glued to 24 hour news channels, mesmerized in horror at the images of the ravaging fires. The exhausted men and women in high vis orange suits and sooty faces. The tragic deaths, the lost properties and livelihoods. The animals incinerated as they tried to flee. We shared their pain. We breathed their smoke. The nation grieved.

The coming of COVID

Early March and we take a deep sigh of relief. It has rained. Canberra has turned on its best conditions. Benign temperatures, glorious yellow and red trees. Blessed clear blue skies and clean air. The green grass and paddocks a balm to our smoke weary souls.

But then another foe looms. More insidious. That virus in China we have watched with relative disinterest over summer is coming. People are sitting up and taking notice. I'm guilty of transient "Trump-esque" thoughts that it is all a blip and we should stop making a fuss.

It's now in Europe. It's now in in the U.K. It's now in Australia and the case numbers are rising exponentially...

13th March we have our first Covid case in Canberra and it is all systems go.

In a few short days the practice is changed. The toys and magazines are ditched. A barrier built at the desk to protect the staff. We are consulting by telephone. We start seeing our "sick" patients in the car park, dangling stethoscopes through the car window, poking swabs up their nostrils.

We assume every patient either has Covid or is carrying it. There is talk of asymptomatic transmission. We google how to "Don" and "Doff" the PPE. We go to Bunnings and purchase industrial face shields for safe Covid swabbing. We ditch the pearls, wear scrubs to work and shower as we walk in the door at night.

As someone "at the front line" I am suddenly a potential risk to my friends and family. What if I carry it home? Should I banish my husband to the spare room?

We are instructed to "socially distance" but you can't assess an acute abdomen, palpate a breast lump, excise a melanoma or examine an ear from 2 m. We take precautions and we get on with doing our job.

27th March and Canberra now has 62 cases. The curve is steep. There is no guesswork about what this could look like- we just have to watch the nightly news and see the images of Spain and Italy who are 3 weeks ahead of us. The hospitals and morgues overwhelmed. Stories of healthcare workers dying.

Boris is in ICU. New York is reeling.

We have our first "positive" Covid result at Yarralumla Surgery

This is not a drill....

And the changes keep coming

Our leaders -both federal and local -take expert advice and act swiftly.

A dedicated Covid hospital is commissioned. Retired doctors are enticed back to work. An email asking if we G.Ps would be prepared to work in E.D. to free up the more skilled doctors to work with ventilated patients. Testing centres are opened. A scramble for hand sanitiser and PPE. Is this really happening? Sleepless nights worrying about how to run the practice, how to care for our patients, how to keep our staff safe.

On the home front there is also rapid change.

The routines and rhythms of my rather simple but happy life disappear in a day.

A Thai meal in Manuka on Thursday night. Brumbies match on Saturday. Coffee with elderly parents on Sunday. Brunch with a girlfriend. A pedicure. A trip to Sydney catching up with the kids. All gone.

My 30th wedding anniversary spent – not on a boat in Croatia as planned – but at home with a takeaway. These losses feel like such a 'first world problem' as I watch my friend mourn her mother's death without the comfort of extended family and friends, but I'm guiltily still feeling sad.

Work from home, school from home, uni from home, yoga at home. No churches, gyms, playgrounds, pubs. Borders closed. Unemployment and financial hardship. I didn't hoard loo paper but admit to teabags and long life milk. The rug is pulled out from under us. We are shocked and breathless at the rate of change.

But actually we are OK

We are more than OK

It is mid-May now and the curve has flattened. It has worked. The country is stunned by its own success. Canberra has been Covid free for over a week. Will it return? Almost certainly, and living with this virus will be the new normal. Did all that fuss really need to happen? A glimpse at the news and events in the USA remind us of what a Plan B might have looked like.

The adrenaline level is settling. The restrictions lifting. The shops busier. The traffic thickening. Kids trickling back to school. Athletes trickling back to training. The patients trickling back to the waiting room. The Kiwis trickling back to Bondi...

For me personally there has been a silver lining;

I've witnessed, and drawn great strength from, the support, resilience, hard work, adaptability and humour of my staff and work colleagues to whom I'm deeply grateful.

I've had precious extra time with my daughter living at home / evicted from her residential college as she does her Uni online.

I've realised the reason I need to see my parents each week is not just for them, but for me.

I've had more people thank me and acknowledge our work as doctors than ever before. Strangers in my Yarralumla village delivering coffee vouchers and "Pinot for the PPE" to thank us for being there in a pandemic.

I have never felt so proud to be in the medical profession.

But I'm still feeling somewhat discombobulated...

A heightened awareness of life and death

The COVID-19 pandemic has altered the way people live and perceive mortality. This includes changes to the way in which people live, the way in which they work and even the way in which they die. Living with social distancing, working behind masks and shields, and coping with relatively random deaths that leave grieving families as well as health professionals wondering why an individual succumbed to this virulent virus.

A/Professor Kim Devery.

Deb Rawlings.

Of course, everyone dies and in normal circumstances everyone is touched by death during their lifetime. In most developed countries like Australia, deaths in recent times have been accompanied by old age and chronic complex illnesses that slowly and almost insidiously progress, limiting function and many, many years later causing death. These are the patients that are frequently seen and cared for in hospitals. People will also experience the occasional, unexpected death in their life that may include heart attacks, accidents, or perhaps following cancer.

What has altered is the highly contagious nature of the potentially lethal COVID-19 virus. This universal experience of living with the pandemic has heightened everyone's awareness of their own and their community's mortality and of the unpredictability of life. Frontline health workers are particularly at risk with the well documented occupational risks, with over 1000 resulting deaths worldwide

COVID and end of life care

Palliative care and end of life care has come to the forefront, as globally people are dying unexpectedly in large numbers in hospital. This is not something experienced by many health professionals, some not for decades and for some not at all. Precedents have been set in health arenas, such as the HIV/AIDS epidemic which emerged in the 1980's and in some countries is still the leading cause of death. However, HIV/AIDS is most often transmitted through sexual behaviour and needle or syringe use, and not simply via close contact (often incidental) with someone else – perhaps a more confronting consideration.

Due to COVID-19, health care professionals may have had to change their work specialty, or even workplace to accommodate care of those who are ill and those who are dying. The majority (aside from specialist palliative care) may have cared for dying patients sometimes, occasionally, or not at all. Undergraduate training does not prepare health care professionals for care of the dying generally, nor for what they have been asked to face in these times, and for the changes to practice that they have been asked to make. Never more than now has palliative care and end of life care mattered. Care of those at the end of life has come into everyone's thoughts and for health professionals has become everyone's business.

As we celebrate palliative care week let us all reflect on how transient our lives are and how important it is to think about good health, social and community care at the end of life.

The End-of-Life Essentials project provides free online education modules to assist doctors, nurses and allied health professionals working in acute hospitals in delivering end-of-life care.

The materials can be accessed at: https://www.endoflifeessentials.com.au/tabid/5195/Default.aspx

IMPORTANT SURVEY:

The GP contraceptive appointment: More than just a script?

The pharmacy guild argue chemists can safely prescribe the pill. We want to know what doctors do when a woman presents for the pill. Take our short anonymous survey and let us know. Results will be published. This project has ethics approval from ANU Human Ethics Committee. Lead investigators are ANU medical student Ms Courtney Donohue and Professor Julie Quinlivan.

To complete the survey go to: https://apollo.anu.edu.au/default.asp?pid=12186

Progress on cutting red tape for GPs

Legislation that is set to cut red tape and simplify recognition of General Practitioners (GPs) as specialists, streamlining access to higher Medicare rebates for patients has passed through the House of Representatives.

The Health Insurance Amendment (General Practitioners and Quality Assurance) Bill 2020 will simplify the recognition of a specialist general practitioner (GP) for the purposes of Medicare and come after sustained lobbying by the AMA to cut red tape for GPs.

The Australian Department of Health says that under the new arrangements, GPs' access to Medicare will be determined by their continued registration status with the Australian Health Practitioner Regulation Agency (AHPRA). Once a medical practitioner is awarded Fellowship as a GP, they will no longer need to make an application to Services Australia (formerly the Department of Human Services) to access Medicare Rebates.

The new process will allow Services Australia to use the AHPRA register of medical practitioners to determine access to GP rebates through an automatic data feed.

In addition, the definition of general practitioner in the Health Insurance Act 1973 will align with the Health Practitioner Regulation National Law.

GPs who may be affected by the changes

If a GP has gained fellowship with either the Royal Australian College of General Practitioners or the Australian College of Rural and Remote Medicine and are not currently registered as a specialist with AHPRA, they will need to apply to update their registration status. If a GP is unsure of registration status, it can be checked using AHPRA's public register.

If a GP has previously been listed on the Vocational Register and wishes to be re-instated on the Vocational Register and recognised as a GP by Medicare, they will need to complete an Application for Vocational Registration for General Practitioner form and submit it to Services Australia.

The implementation of the changes will follow the passage of the legislation through the Senate. Even then, there is likely to be a transition period between Royal Assent and commencement to ensure that all GPs can comply with the new simplified arrangements.

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1. Interim Report of the Disability Committee, Institute of Actuaries of Australia 2000. 2. Australia's Health 2015, Australian Institute of Health and Welfare, 2015. 3. Cancer in Australia, an overview, Australian Institute of Health and Welfare, 2014-2015

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Book Review: False Positive

By Theodore Dalrymple
Encounter Books, USA 2019
ISBN: 9781641770460

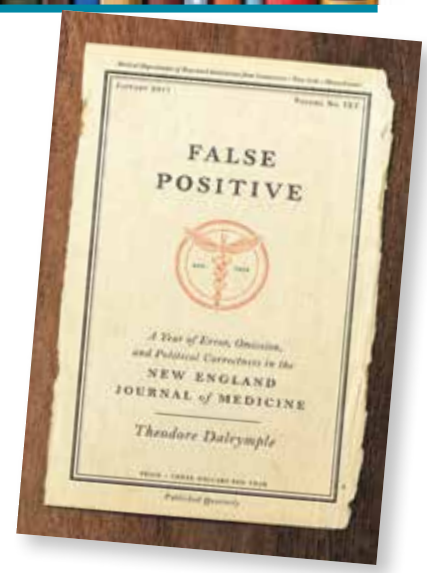
Theodore Dalrymple's *False Positive* exposes inept science and groupthink, writes Adjunct Professor Jeanette Ward, in the *New England Journal of Medicine*.

"Anyone as old as me will remember the nasty shock that typically occurred only after graduation when it became clear that sound clinical decisions required strong methodological skills. I recall my first encounters with the odds ratio, absolute risk, confidence intervals and numbers needed to treat. I remember with horror the trap for the unwary clinician of the single study and, instead, the welcome relief of a well-constructed systematic review.

Thankfully anyone younger than me will have benefited from the universal inclusion of these powerful intellectual foundations in their undergraduate education, courtesy of what, for a time at least was heralded a 'new era' of evidence-based medicine (EBM)

EBMs principals stand as steady compass points in daily practice to guide our profession no matter to which branch of medicine we have been drawn. My public health training first introduced me to the embarrassing litany of epidemiological and other research mishaps logged by Bjorn Andersen in his *Methodological errors in medical research* (1990). (Blackwell Scientific Publications, Oxford 1990.) This book was packed with sobering examples from multiple journals that had slipped through the process of peer review. It and another classic *Follies and fallacies in medicine* written by Skrabanek and McCormack (1989), (Tarragon Press, Glasgow: 1989) helped explain why randomized trials weren't needed to demonstrate the efficacy of appendectomy whereas, by contrast randomized control trials were always needed to substantiate claims that a *'wonder drug'* improved management of non-communicable chronic diseases afflicting the developed world.

Theodore Dalrymple's *False Positive: A year of error, omission and political correctness in the New England Journal of Medicine* (2019) is a new take on this tradition. Dalrymple is the nom de plume of Dr Anthony Michael Daniels, a prison Psychiatrist in the UK NHS.



Like all of us, Dalrymple once simply assumed the veracity and accuracy or articles in peer-reviewed journals. Recently retired and inspired by a question from his nephew, he sets about to read every issue of the prestigious, high impact *New England Journal of Medicine* (NEJM) from cover to cover, selecting one or two articles every week to reflect on scientific integrity, salience and sell-out.

The result is an eclectic and instructive collection!

Dalrymple's clinical experience and compassion expose inept science and groupthink. Quite some bitterness is reserved for the introduction of oral semisynthetic opioids for chronic pain. He reflects positively, however, on much that catches his eye but finds little comfort for example in articles about healthcare management and its contrary, contradictory fads. He revisits a longstanding truth about rheumatic heart disease: that the means to eliminate this disease is settled scientifically. So when and how do know we have enough evidence? Who decides? By professional daily habit, doctors are rarely inclined to change practice on the basis of one significant p-value alone. We remain rightly cynical of the celebrity endorsement. Twitter storm or media hype as admissible evidence. We also know that science can be used for political purpose.

Thoughtful respectful, elegant prose, False Positive is a reminder that medical expertise is a hard earned discipline of complexity and judgment premised on a combination of scientific vigilance and intellectual honesty focused on public good.

In this very readable book, Dalrymple chronicles enough examples to make readers wonder if we are at risk of dropping the intellectual standards with which we have been entrusted and for which we have become properly renowned.

This review has appeared previously in Medicus, the magazine of the AMA WA.

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Editorial:
Peter Somerville
Ph 6270 5410 Fax 6273 0455
execofficer@ama-act.com.au

Typesetting:
Design Graphix
Ph 0410 080 619

Editorial Committee:
Peter Somerville – Production Mngr
Dr Ray Cook
Dr John Donovan
A/Prof Jeffrey Looi

Advertising:
Ph 6270 5410, Fax 6273 0455
reception@ama-act.com.au

Articles:
Copy is preferred by email to execofficer@ama-act.com.au in "Microsoft Word" or RTF format, (not PDF) with graphics in TIFF, EPS or JPEG format.

2020 Directory of Medical Specialists, Directory of Allied Health Professionals and Directory of GPs with Special Interests

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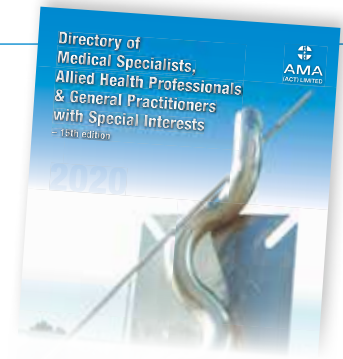

The Seventh edition of the directory of **Allied Health Professionals** and **GPs with Special Interests** will be published as a service to ACT general practitioners and distributed with the 14th edition of the **Directory of Medical Specialists** during Family Doctor Week in July 2020.

Entries must be on the form below and returned to the address below no later than 30 April 2020.

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Email: sdirectory@ama-act.com.au

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☐ **Directory of Allied Health Professionals**
☐ **Directory of GPs with Special Interests** (Select which Directory you would like to go in)

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Services offered:
(Please keep this brief and use only accepted abbreviations – eg: DCH, Diploma in Child Health)

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I am/am not interested in taking a display advert to accompany my listing in the directory.

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Note: In order to be included in this directory,it is mandatory that you are a medical practitioner currently registered with the Australian Health Practitioner Regulation Authority (AHPRA) (dieticians excepted)

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