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Time to hear from ANU medical students

For the final edition of the Canberra Doctor in 2015, we have invited medical students from the ANU Medical School to contribute a series of articles. The first of these is by Chris Wilder, the 2015 President of the ANU Medical Students Society and he reflects on the changing face of medicine and the changing expectations of medical students.

Two other contributions from Gabriella Charlton and Greg Threlfall appear further on together with an item from the "The Informant", an ad hoc publication from the ANUMSS that aims to engage with students on current advocacy issues affecting medical students, junior doctors, or the general health area.

Enjoy the holiday season and here's Chris Wilder's contribution and he's excited…

…I'm excited

New things nearly always excite the young people of today. New opportunities, new horizons, new dreams, if it's new it'll generally spark interest. Medical students may be no different in this regard. But I do wonder if the medical students and the medical world of today might be different to those of the past. I wonder if the medical students of today are stepping foot into different medical careers, I wonder if they are facing different expectations and are bounded by different limitations?

As a late-20s medical student in a post-graduate cohort, it would seem that I am living proof of some of what I claim. The thought of medicine entered not a single neuron until my early 20s and if it weren't for the graduate entry pathway I would remain sitting on a fit ball in a physio clinic (not to take anything away from the job I loved of course). The revolution of graduate entry programs has funneled in people from all walks of life. We have engineers, we have business consultants, we have nurses and lawyers and researchers. We are often older than the medical students of the past, but I expect that with our extra few years we bring additional experience. And yes we have much to learn and less time in which to do it, but with our previous lives and previous skills I believe we carry outside ideas and alternate perspectives.

Changing medical education

Those in charge of delivering our medical education often attest that it is also a vastly different medical education today. They cite the additional opportunity and the extra support and I would wholeheartedly agree with these statements. It might however, seem to the students of today that the world of medical knowledge is many times larger than what it once was. The rate of new information being acquired continues to accelerate, and with it so do the number of chapters in textbooks. With expanded knowledge of disease, the delivery and capability of modern medicine is astounding and exciting. I would be biased if I made a plea that there are different expectations, but I believe I can comfortably say that at times we do feel daunted by the volume, the details and the drug names.

Changing careers

Finally then to the medical careers we are entering. In what way are these different? To find this out we continually ask questions and absorb stories in order to paint pictures and make comparisons. From all the stories heard and all the pictures painted it would seem that the images of yesterday are immensely different to those of today. We hear stories of 72- or even 96-hour shifts. Stories of junior doctors facing isolation and expectation. We hear that male doctors once outnumbered their female counterparts. We even hear that there was once desperation for more medical graduates. So it would therefore seem that we are entering a fairer and more supported career that offers improved patient safety and better outcomes. Some might say then that the increase in competition for an intern place is a worthy price to pay.

I have spent these words highlighting differences and citing stories in the hope of

suggesting that we may well be in a different world. In highlighting differences, I must also acknowledge that for every difference there are likely dozens of similarities. We see similar patients, we learn about the same conditions, and we face equal challenges to those in years past. So yes, some things change and some things remain. But as I suggested at the top of the page, what's new is exciting. I'm excited.

Happy holidays.

This Issue

Capital Conversations with President, Dr Elizabeth Gallagher

I welcome you to the final Canberra Doctor for 2015 and trust that you enjoy the contribution that ANU medical students have made to this edition. By the time you read this column, the class of 2015 will have graduated and the new graduates will be close to their next major milestone – starting as interns.

I wish each of them well and welcome them to our profession.

With the end of the year rapidly approaching, it's worthwhile reflecting on where we are, where we've been and where we're going in 2016. As ever, it's been a busy and productive year with major change seemingly being the only constant.

Christine Brill

It's impossible to review 2015 without thinking of the retirement of Christine Brill as our CEO. Her contribution over more than 30 years was immense and it's a great tribute to her that the things she's started and the work she's done will continue to be influential long into the future. From a beginning as a "one woman show" through to the vibrant AMA (ACT) of today reflects well on the work Christine – and many Board members – have done over the years.

Typically though, Christine was barely back in the country after a well-deserved holiday before agreeing to do project work for the Federal AMA around careers advice for junior doctors. I wish her all the best for the holiday season.

In September, Peter Somerville stepped into Christine's shoes and I know he's been working hard to get up to speed on the many tasks that fall to the AMA (ACT)'s CEO. I have come to appreciate just how broad that role really is.

Federal scene

Nationally, the AMA has been kept busy with issues around the MBS review, the rebate freeze and the review of intern training. Career paths and training opportunities for junior doctors will remain a key issue as will longer-term workforce planning and ensuring they are trained and remain skilled to the standard we expect of our Australian doctors.

While both the MBS review and the rebate freeze will require the AMA to keep up a strong advocacy role on behalf of all members, I know that the Federal President A/Prof Brian Owler and his Federal office team have a good strategy in place. The politics of health require us, most often, to constructively engage with government. Sometimes, however, those same politics require us to oppose government action when we believe they have got it wrong. While that can be uncomfortable, in order to do the best we can for our patients and the profession, it's also necessary.

ACT issues

On the local scene, this year has witnessed a drawn out process that will eventually result in salaried hospital doctors getting a new enterprise agreement – hopefully it will be through by the time you read this. Pay increases have been delayed by almost a year and, with the next round of bargaining to commence in barely twelve months' time, it heralds a busy 2016. Meanwhile, our VMOs continue to slog their way through a slow process that will end in an arbitration in the first part of next year.

Of course, bullying and harassment have been on the agenda nationally, highlighted by work done on behalf of the Royal Australasian College of Surgeons by their Expert Advisory Group, and there's a report later in the Canberra Doctor on the RACS Action Plan. AMA (ACT) has also conducted a survey of ACT Doctors in Training and a report on the survey outcomes also appears in this edition.

The findings of the ACT (AMA) survey are sobering and ACT Health needs to rapidly come to grips with the issue and open up the resolution process to include AMA (ACT), the medical colleges and other stakeholders if we are to get a truly effective outcome. An internal ACT Health process will almost inevitably fail and I urge Health Minister Simon Corbell and Director General Nicole Feeley to reconsider their approach.

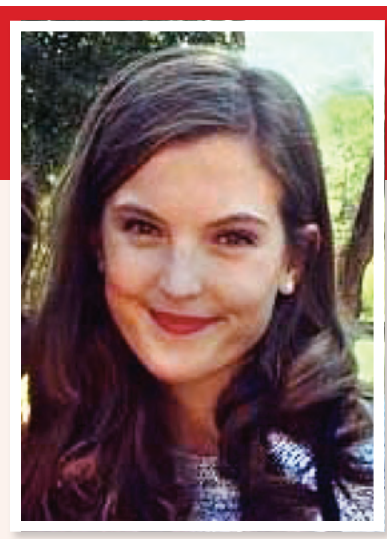
The AMA (ACT) stands ready to participate in an open, transparent and constructive process to deal with the issue.

Before I end for 2015, it's worthwhile considering that by this time next year we will have had both a Federal and an ACT election. Health is sure to play a key role in both elections and, already in the ACT, the parties are laying the groundwork with announcements expected early in 2016. While AMA (ACT) is not in the business of endorsing one political party or another we will acknowledge good policy when we see it and constructively engage to inform the debate and ensure the political parties and the electorate understand the issues that are at stake.

In my view, members expect no less.

Enjoy this final 2015 edition of the Canberra Doctor and I look forward to being with you again next year. All the best for the festive season and, on behalf of AMA (ACT), I wish you and your family a Merry Christmas and a Happy New Year.

Blood donations save lives – but at what cost?



By Gabriella Charlton, ANU Medical Student

October 3rd marked the end of 'Vampire Cup', the twelve-week blood drive between competing Australian medical schools. This annual drive aims to increase blood donations across Australia, and facilitate awareness about the constant need for blood. A combined effort by 20 medical schools saw 1,843 donations made within the period, resulting in over five and a half thousand lives saved by these blood products. As an aside, ANU put in a massive effort and came second, only narrowly beaten by Deakin University in Victoria.

Blood can be donated in the form of whole blood, plasma or platelets, and is used for patients with cancer, blood diseases, surgical patients, obstetric events, and trauma accidents. Currently, 1 in 3 people will need blood in their lifetime, yet only 1 in 30 Australians donate.

This drive was an augmented effort, encouraged by the competitiveness of medical students, and the glory of being crowned winners. However, on a daily basis, thousands of Australians generously donate whole blood, plasma and platelets of their own accord. These donations garner no reward for the donor aside from a free milkshake and muffin, and the sense of generosity.

But is this effort enough? The Australian Red Cross Blood Service states that a blood donation is needed every 8 seconds to maintain adequate supplies. Holiday periods such as Easter, Christmas and long weekends place enormous strain on supply levels, as the need for blood increases (particularly due to increases in motor vehicle accidents), and donors take time off to go on holidays.

Paying donors

Currently, Australia only receives voluntary donations of blood. This is in line with the International World Health Organisation and Red Cross policies, which support voluntary non-remunerated donations. However, some countries pay donors, including Russia, China, Germany and the USA. Britain supports voluntary donation, but since 2002, has commercially imported plasma from the USA, as a result of the bovine spongiform encephalopathy (BSE) outbreak and subsequent risk of receivers developing Creutzfeldt Jacob disease.

It may appear that offering financial gain in return for blood collection would improve stresses on supplies, and encourage more people to donate. However, this approach is not without significant risk.

Risks of commercialisation

Spread of blood-borne diseases is the primary threat with commercialising blood donations. Worldwide, the plasma trade carries a risk of rapidly spreading diseases such as hepatitis, HIV and Ebola between patients and donors that are dishonest about their risk factors, seeking only to make fast cash. Companies that run blood trades may cut corners in order to generate profit, and many scandals have been uncovered in the past. In 2006, a Chinese blood collection company was found to be selling plasma infected with hepatitis C. The donors were receiving 100 Yuan (approximately $15) per donation. Safety practices were non-existent, with traders using recycled needles, drawing blood from pregnant women, and injecting leftover blood back into donors. As a result, local Chinese health workers estimate over one million HIV positive people in one rural district alone.

Commercialising blood collection may also have negative impacts on donors' attitudes towards the service. A study in New Zealand found that potential changes to their national voluntary system resulted in individuals feeling less inclined to donate without payment, and more likely not to disclose health risks. The authors of the study discussed the benefits of preserving the 'gift relationship' values that are associated with voluntary donation, and concluded that many donors have reservations about the quality of products in a commercially driven collection.

Australian blood supplies are at best, always strained, and at worst, critically low. In November 2011, the Red Cross reported that it had less than three days supply of blood left across Australia, and pleaded with the public to donate. However, aside from a public appeal, there was little that the Red Cross could do to incentivise donations. Would a financial reward have been of benefit in this case?

There are many dangers and drawbacks to commercialising blood donations, but if the alternative is a lack of blood so severe that people begin to needlessly die, commercialisation may be a necessary avenue.

To donate blood, and save up the three lives, visit donateblood.com.au or call 13 14 95 today.

References for this article are available by contacting AMA (ACT) Limited.

2015 AMA indigenous health report card and scholarship

On 25 November at Parliament House, AMA President, A/Prof Brian Owler launched the 2015 AMA Indigenous Health Report Card. The aim of the Report Card is to highlight the health inequalities between Indigenous and non-Indigenous Australians. The specific focus of the 2015 Report Card was on the impact of incarceration on the health of Aboriginal and Torres Strait Islander people.

In launching the 2015 Report Card, A/Prof Owler said that, "The results of the Report Card are dire and of high concern for our Indigenous population and the Australian Government in addressing the failure of both the health and justice systems on the Indigenous and Torres Strait Islander people."

Key findings of the 2015 AMA indigenous health report card:

Aboriginal and Torres Strait Islander people comprise 3% of the Australian population but:

- Experience a life expectancy of 10 years less than non-Indigenous people;
- Are significantly over represented in custodial settings;
- Comprise 27% of all sentenced prisoners;
- Comprise 29% of people awaiting sentencing;
- Are 13 times more likely to be imprisoned than their non-Indigenous peers.

The future

In the period from 2013 to 2014, there was a 10% increase in the imprisonment rate of Aboriginal and Torres Strait Islander people and the future is even bleaker with projections of over 10, 000 Indigenous people in custody, including 1000 Aboriginal and Torres Strait Islander women in 2016.

"Of particular concern is the increasing number of young and adolescent Aboriginal and Torres Strait Islander people under youth supervision. Resources and real action are required to combat the increasing number of adolescents heading down the same path to future incarceration." Prof Owler added.

Health issues and imprisonment linkage

It is a clear indication in the 2015 AMA report card that the overall health and life expectancy of Aboriginal and Torres Strait Islander people are directly related to imprisonment. There are significant health issues predominant in the Indigenous population that are major potential precursors to imprisonment such as mental health issues, alcohol and drug abuse, substance abuse and cognitive disabilities.

"As a matter of social justice and human rights, we must dedicate resources to deliver culturally based solutions to these health issues in an effort to reduce Indigenous imprisonment rates." A/Prof Owler said.

Culturally diverse approach required

The needs of young Aboriginal and Torres Strait Islander peoples are significantly different to their non-Indigenous peers, and as such require focus on different areas such as suicide prevention in children and adolescents, health, wellbeing and diversion.

"It is apparent that the health and prison health systems have been failing our Indigenous peoples by not being able to respond to their specific needs effectively."

Closing the health and prison health gap

A/Prof Owler concluded by saying, "As a nation, we need to continue to work harder to close the health and imprisonment gap between Indigenous and non-Indigenous Australians. By decreasing the imprisonment rates of Indigenous Australians we can attempt to improve the overall health and well being of Aboriginal and Torres Strait Islander people, especially in children and adolescents and create a brighter future for generations to come."

Varicocele

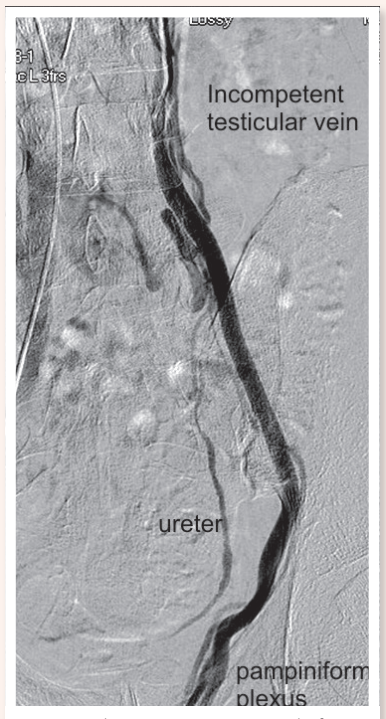
Varicocele is a common abnormality seen in 15-20% of males with a preponderance of occurrence and severity on the left side.

Classified by size ranging from the subclinical varicocele diagnosed on ultrasound alone to the visually evident varicose dilatation of the pampiniform plexus of veins in the scrotum. The most popular theory of causation is primaryvalvular incompetence with the anatomical difference in the confluences of right and left testicular veins with central veins dictating the left sided bias in severity. Rarely a varicocele may result from venous hypertension caused by venous obstruction of a testicular or the left renal vein. Symptoms range from concern about the appearance of dilated scrotal veins to a variety of dragging or aching sensations. Advanced cases may be associated with testicular atrophy. Diagnosis can usually be made clinically but ultrasound may be useful in confirmation or in the investigation of obscure symptoms.

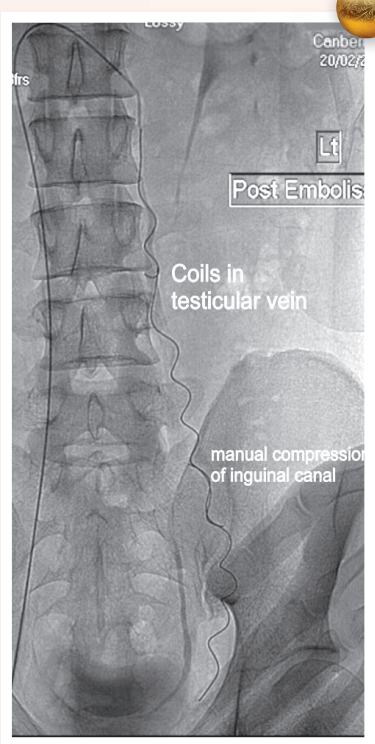
If blood refluxes from central veins to the scrotum the testes are warmed – potentially interfering with spermatogenesis. While this is true it is rarely the case that male subfertilityis altered by correction of a varicocele. That said treatment today is simple and rarely complicated and embolisation for subfertility could be considered.

Surgical treatment was for many years the only method of cure and traditionally this involved tying the testicular veins at the level on the internal inguinal ring thus severing the direct connection with intra-abdominal central veins. This involved general anaesthetic, an abdominal surgical incision and was accompanied by surgical complications and a significant recovery time. Today the vast majority are treated by the Interventional radiologists embolising and sclerosing the testicular vein. This is performed under conscious sedation as a day only procedure. Initially, testicular veins are catheterised from the right femoral or jugular veins to test the competence of the valves. Subsequently incompetent systems are catheterised to the level of the internal inguinal ring to allow deposition of sclerosant foam while thrombosis of the pampiniform plexus is prevented by gentle manual pressure on the inguinal canal. Fibred metal MRI compatible coils are deployed along the vein to prevent recanalisation. Recovery time is minimal and recurrence rates are equal to or better than surgery.

Dr Robert Allen
MBBS, FRANZCR, FRCR, DDU



A grossly in competent left testicular vein injected after selective catheterisation from the right groin.



Post treatment using Fibrovein foam and fibred metal MRI compatible coils.

2016 AMA scholarship for indigenous medical students

Applications are now open for the AMA 2016 Indigenous Peoples' Medical Scholarship with the successful applicant receiving $10, 000 per year for the duration of their course.

The scholarship highlights the fact that a highly skilled medical workforce that includes more Indigenous doctors and health professionals will work towards reducing health inequalities for Indigenous Australians.

The AMA Scholarship aims to help increase the number of Indigenous and Torres Strait Islander people in the medical workforce.

In announcing the 2016 scholarsip, the AMA Presdient, A/Prof Brian Owler said "The benefits include graduates continuing on to provide care in their own communities, thus increasing Indigenous access to quality health care and positive role models for their peers and younger generations.

"These wonderful doctors are now the pride of the medical profession and their communities, and role models for Indigenous Australians who want a career as a doctor or other health professional."

Applications are open until 31st January 2016. To be eligible, students must be enrolled at an Australian medical school, be in at least their first year of medicine and must be people of Aboriginal or Torres Strait Islander background.

To apply visit https://ama.com.au/indigenous-peoples-medical-scholarship-2016

Guys, we need to talk...

By Greg Threlfall, ANU Medical Student

The idea that women didn't have gender equity is (or rather was) foreign to me and largely seemed like a non-issue. Besides, it wasn't me contributing to any inequity, the best person always got the job as far as I was concerned. Right? I probably viewed the world this way because I am white and male. Also, because all of the workplaces I have worked in professionally, prior to studying medicine, were in the military and almost exclusively made up of, you guessed it, men. But gender equity is still a fantasy, especially in medicine, based on the statistics.

Despite the numbers of women and men entering Australian medical schools reaching relative parity in the late 1990s, only 37.9% of all medical practitioners are women. Women represent 25.4% of specialist clinicians and only 8.8% of all specialist surgeons (2012).

Yes, those statistics are poor, but fairness and human rights aside should we as men care? For one, men more than ever are valuing time with their family and men are becoming increasingly involved with parenting responsibilities. Like many fathers, I personally want a job in which I am able to strike a balance between work and family. The less of an issue this becomes for women, the less it will be an issue for me.

Happier, more productive workplaces

Secondly, there is a growing amount of research, including in Australia, that suggests that gender diversity and inclusivity correlates with significantly improved organisational productivity. The assumption is that productive workplaces are happier, healthier places to work that get more from their staff. If my previous professional life has taught me anything, it is that job satisfaction is attributable to a large extent to the team with which you work. I want to work in happy, healthy, satisfying workplaces. Doesn't everyone? Evidence suggests that such workplaces are also ones that value gender equity.

Look around you

The importance of gender equity and comparable representation from women in high level positions has been lost on me for many years. But consider this. If all you see around you, above you in the hierarchy, are different to you, it gives you the impression that the higher echelons are not for you. I'm not saying that this is an insurmountable barrier, there are plenty of women who have reached upper leadership roles despite this. However, people for the most part need role models to whom they can aspire in order to reach their full potential. That's not to say that women can't have male mentors and vice versa, but unless there is abundant proof of the capacity for people like you (other women in this case) occupying high level positions I imagine it would cast doubt over your abilities. I say I imagine, because I've never been there. I see an abundance of white men occupying lots of desirable positions and consequently, if I put in the work, all I see is a world of limitless possibilities. But this is not always so for women, who, to reach the top must not only work hard but overcome societal stereotypes and organisations that are set-up to make it harder for them to achieve the same things as me.

The recently released draft report by the Expert Advisory Group to the RACS indicated that 18% of respondents had experienced sexual discrimination and 7% of respondents had been sexually harassed. Granted, I'm not sure of the gender split in respondents but I would wager that a substantially higher percentage of women suffered these behaviours than their male counterparts. When it comes to workplace sexual harassment, in particular sexually oriented jokes, I have often thought, in a very male way, 'it's just a joke, grow a thicker skin'. But really, who am I, from my privileged position as someone who has never occupied a minority position within society or an organisation, to decide what causes offence to someone and what doesn't? But it's also not enough to stay silent on the issue. Only through men challenging these types of comments, made by other men, can real cultural change occur.

Time to reflect

After some time of reflection, I have reached the point where I'm beginning to understand the importance of gender equity. Many of you will ask, quite rightly, 'isn't it obvious'? I'm not even sure what has transpired to make me realise this. Maybe being married to a very confident and professional woman who earns more than me, maybe becoming a father, maybe changing careers into medicine which I assumed from the outside would be gender equal, but is anything but. Maybe the constant noise from the 'feminists' has swayed my view. Maybe I just took a look, critically at the evidence that I saw around me. Maybe it is all of the above. Despite the fact, that the evidence is everywhere, it did take me a while. I never claimed to be a fast learner. If you haven't done so already, maybe you can have a look around you and reach the same conclusion.

References for this article are available by contacting AMA (ACT) Limited.

Updating medicine ingredient names

The Therapeutic Goods Administration ("TGA") has recently announced that they will be updating some medicine ingredient names used in Australia to align with names used internationally.

Not all medicine ingredient names are changing. A list of medicine ingredient names that will be changing is available at: https://www.tga.gov.au/updating-medicine-ingredient-names-list-affected-ingredients

There will be a four year transition period for these changes, expected to start from April 2016.

What type of changes?

Some changes are minor, for example changing a 'y' to an 'i', and will not affect how the ingredient name is pronounced.

Some changes are more significant. For these products, medicine labels will need to use both the old and new ingredient name for an additional three years after the end of the transition period to help consumers and healthcare professionals become familiar with the new name.

For example, medicines containing lignocaine will need to be dual labelled as 'lidocaine (lignocaine)'.

Working together

TGA say they have released this information so health professionals, health educators, consumers, software companies and industry can begin to prepare for the changes.

Providing useful educational material and tools to support the medicine ingredient name changes is important to make sure that medicines continue to be used safely.

TGA are working with:

- pharmacists, medical colleges, health professional organisations and consumer groups to inform Australians about these changes.
- pharmaceutical, health and medication software industry bodies to implement these changes with minimal impact.
- the National e-Health Transition Authority and government agencies about how these changes will be implemented on health software and the Pharmaceutical Benefits Scheme.

In early 2016, TGA will be contacting the sponsors of affected products with information on next steps.

National Medicines Symposium 2016

Leading local and international medical experts and health professionals will converge in Canberra from 18-20 May 2016 to take part in the ninth National Medicines Symposium: *Making wise decisions about medicines, tests and technologies* (NMS 2016).

NMS 2016 will bring together some of the most influential people in the health sector to debate and discuss current quality use of medicines, medical tests and medical technologies issues for consumers, health professionals and the broader health landscape.

This year the scope of the symposium has broadened to health technologies beyond medicines which will encourage new conversations and insights as part of the program.

The theme of *'Making wise decisions about medicines, tests and technologies: co-designing policy, practice and priorities'* will centre on three program streams:

- **Foundations:** exploring issues relating to evidence, knowledge, access, quality, and safety
- **Sustainable systems** which will consider aspect like policy, regulatory, workforce and cost
- **In practice** will examine topics like models of care, health literacy and enabling best practice.

"Over the years NMS has gone from strength to strength and is now the leading symposium on advancing quality use of medicines," said NPS MedicineWise CEO Dr Lynn Weekes.

"NMS draws experts from across the health sector together and this combination of people and decision makers creates a truly unique event where cross-disciplinary conversations emphasise and enable solutions and contemporary thinking."

"The NMS 2016 Program Committee warmly invites individuals, organisations and/or consortia to make a submission to be part of the program. While in previous years we have invited traditional abstracts for oral presentations, this year is different with an open invitation to submit an abstract for one of the following:

NPS MEDICINEWISE

- Lightning talks (five minute plenary presentation)
- To host a panel discussion or workshop
- Pitching session (opportunity to 'pitch' an idea or innovation)
- Posters (for display at the symposium)."

The closing date for submission is Monday 29 February 2016.

Visit www.nps.org.au/nms2016 for more details.

AMA (ACT) DIT survey on bullying and harassment

The AMA (ACT) DiT Survey on Bullying and Harassment was conducted over two weeks in November and disappointingly, but unsurprisingly, reflected other national surveys conducted on the issues. The AMA (ACT) survey followed the release of a report undertaken by KPMG and commissioned by ACT Health, into the training culture at the Canberra Hospital and health services.

The release of the KPMG Review occurred the Health Minister, Simon Corbell, simultaneously announcing that he intended to implement all the Review's recommendations. The Minister proposed that the implementation be done though a newly created, internal ACT Health body known as the "Clinical Culture Committee".

The CCC was made up of selected ACT Health senior clinicians and managers including two junior doctors selected by ACT Health. AMA (ACT) was supportive of the need to take action but critical of the method selected by ACT Health and wrote to Minister Corbell in those terms.

So far, ACT Health has refused to open up the process and include independent bodies such as AMA (ACT), ASMOF, the medical colleges or registration authorities but, as the recent report of the Royal Australasian College of Surgeons' Expert Advisory Group shows, it is vital that there be a transparent process. Without that transparency and openness the CCC will almost inevitably fail.

In order to gain further insights into the issues and canvass the views of junior doctors the AMA (ACT) undertook its own survey and the responses to selected questions are set out below.

Position occupied:

- 18% interns
- 38% RMOs
- 43% Registrars

Working at the following hospital or hospitals:

- 88% TCH
- 23% Calvary
- 2% Goulburn
- 3% Bega

Over the previous twelve months, the following workplace issues were experienced (indicate all that apply):

- 74% felt expectations of undertaking unpaid overtime
- 63% perceived inability to raise issues of concern without recrimination
- 50% experienced bullying
- 44% experienced unsafe working hours
- 17% overt threats of not being reappointed.
- 4% experienced sexual harassment
- 10% other
- 10% none of the above workplace issues.

Do you believe there are adequate structures in place to allow you to report issues of concern?

- 58% – no
- 25% – yes
- 17% – don't know

Do you have a GP or other health professional you can talk to about such issues?

- 56% – yes
- 44% – no

What initiatives do you consider would improve the current situation?

A selection of responses:

"More interns to reduce workload and hours. Senior doctors need to support junior doctors and set a good example by insisting they go home on time etc., rather than encouraging or insisting on unpaid overtime. Teaching by humiliation has to stop – senior doctors need to learn more appropriate teaching techniques."

"An appointed senior clinician not involved in that team who actively seeks regular feedback regarding issues of this nature – at present, there are people who are a contact person for this sort of thing but it can be difficult to contact them, difficult to meet with them, and meeting with them will be noticed and assumptions made."

"In regards to trainees in our department – improve working hours which are unsafe… we need more staff desperately and a night shift as on call is far too onerous and unsafe. Due to excessive working hours training is suffering. We do not seem to have a voice in our department, no-one seems to care about how excessive our working hours have gotten due to the ever increasing work-load for the department."

"Improved culture. More women in positions of authority."

If ACT Health were to open up the CCC process, which organisations would you support being involved in an ACT-wide response to bullying and harassment in the medical workforce.

- 85% AMA (ACT)
- 77% The Canberra Hospital
- 69% Calvary Hospital and Health Service
- 60% Specialist Medical Colleges
- 45% ACT ASMOF
- 38% Registration Authorities

At the December meeting of the AMA (ACT)'s Council of Doctors in Training, the Council endorsed the AMA (ACT) writing to Minister Corbell and informing him of the outcome of the survey. Given those outcomes, the AMA (ACT) will again urge the Minister to reconsider the CCC process and institute immediate discussions with AMA (ACT) to consider a more open and transparent process for addressing the issues of bullying and harassment in the medical workforce in the ACT.

College of surgeons releases action plan for combatting bullying, sexual harrassment and discrimination

Earlier this year, the Royal Australasian College of Surgeons ("RACS") commissioned an Expert Advisory Group to examine the issues of bullying, sexual harassment and discrimination in the surgical workforce. The EAG's report found that nearly 50% of Fellows, Trainees and International Medical Graduates had experienced discrimination, bullying or sexual harassment.

The EAG recommended that "there must be a profound shift in the culture of surgery and an unwavering commitment to achieve this" and that the "longstanding traditions that had normalized unprofessional and sometimes illegal behaviours must be relinquished."

The EAG challenged RACS to be bolder, more transparent and more accountable.

In response, on Monday 30 November, RACS released *Building Respect, Improving Patient Safety: An Action Plan on Discrimination, Bullying and Sexual Harassment.*

Building Respect, Improving Patient Safety translates the EAG's recommendations into action with a simple message: **There is no place for discrimination, bullying and sexual harassment in the practice of surgery.**

The Action Plan as summarized below, details a comprehensive, long-term program designed to promote respect, counter discrimination bullying and sexual harassment in the practice of surgery. It is essential in providing better standards of surgical training and higher quality patient care and safety.

The Plan is divided into three key areas of change:

- Cultural Change and Leadership
- Surgical Education
- Complaints Management

A summary of the key goals in each area and the main actions to be taken to implement change are set out below.

RACS has committed to the implementation of the Action Plan (led by the College Vice President) being transparent in actions and outcomes and will help ensure its actions are subject to external scrutiny and input.

In a very encouraging sign, RACS has also committed to working with other organisations to ensure the success of the plan including public and private hospitals, medical colleges, universities, regulators and jurisdictions. AMA (ACT) looks forward to this opportunity and will likewise raise the matter with ACT Health.

A full copy of the Action Plan can be found at: www.surgeons.org/about/dbsh/

1. Cultural change and leadership

Goal	Action
1. Build a culture of respect and collaboration in surgical practice and education.	· Improve complaints management with external oversight. · Compulsory training in discrimination, bullying and sexual harassment (DBSH). · Improved training in DBSH for surgical educators. · Implement training in conjunction with the Royal Australasian College of Surgeons Trainees Association (RACSTA).
2. Respecting the rich history of the surgical profession, advance the culture of surgical practice so there is no place for DBSH.	· Establishing mandatory training in DBSH by 2017. · Holding Fellows accountable to their behaviour and providing support for behavioural change.
3. Build and foster relationships of trust and confidence on DBSH with employers, governments and their agencies.	· Publicly publish DBSH roles and responsibilities and pilot and evaluate multiple different approaches to DBSH initiatives. · Ensure surgical appointments are merit-based.
4. Embrace diversity and gender equity	· Develop and publish a diversity plan covering gender equity and workplace flexibility. · Work with universities and medical schools to encourage surgery as a career. · Create targets for women in leadership roles and ensure there are no gender-based barriers.
5. Increase transparency, independent scrutiny and external accountability	· Publish annual reports and activities. · Repeat DBSH survey in five years · Provide independent review for those Trainees on probation.

2. Surgical education

Goal	Action
Improve capability of all surgeons involved in surgical education based on respect, transparency and professionalism.	· Implement training for educators on performance feedback, DBSH and dealing with allegations · Establish standards for surgical educators and identify underperforming educators and provide adequate training to improve their skills.
Train all Fellows, Trainees and Graduates to build and consolidate professionalism including: · Fostering respect and good behaviour. · Understanding DBSH and legal obligations. · Encouraging calling it out and not walking past bad behaviour. · Resilience in maintaining professional behaviour.	· Revise accreditation standards for surgical training posts and develop and implement multi-source feedback options across all levels.

3. Complaints management

Goal	Action
Revise and strengthen RACS complaints management process to one that is transparent, robust and fair through additional external scrutiny.	· Review the RACS code of conduct to include explicit DBSH policies and consequences. · Include clear protection and confidentiality measures to protect those who make complaints.

Mental health in rural Australia

The facts

- **Mental health is more than just lack of mental illness.** It is defined by the World Health Organisation as "a state of wellbeing in which every individual realises his or her own potential, can cope with the stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"
- **Mental illness is common.** One in four Australian adults experience a mental health problem or substance use disorder each year
- **Suicide rates are higher in rural areas.** Although there is a similar prevalence of mental disorders in both urban and rural areas, there are higher rates of suicide in rural and remote areas, particularly in males. Men in remote areas are 1.7 times as likely and in very remote areas are 2.6 times as likely to die from suicide compared to men in urban areas
- **Rural life has unique stressors.** People living in rural areas face distinctive problems, such as unbuffered exposure to drought and other natural disasters as well as depressed agricultural commodity prices
- **Population decline is negatively impacting inland rural areas.** Although there has been population growth in many coastal and mountain towns, population decline has occurred in inland agricultural regions due to out--migration of young people. This is the result of centralization of the private and public sector (e.g. schools, banks, and hospitals) to urban areas. These events have caused increased unemployment, falling house prices and entrapment for those remaining in these rural areas who cannot afford to move elsewhere with the price they would get for selling their house
- **Poorer access to psychiatric help.** These conditions are combined with isolation from health services, with 91% of psychiatrists in Australia practicing solely in urban areas and only 12% of psychologists practicing outside urban areas
- **Fewer GPs, less people accessing them.** Even though people from rural areas depend more on GPs for mental health care, the number of GPs per capita plummets in rural and remote areas. People in rural and remote areas are also less likely to seek help from their GP for mental health problems, which has been proposed to be due to distance, financial barriers, stoicism, prevailing stigma around mental illness, and fear of gossip in smaller communities

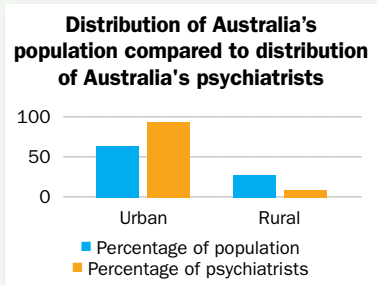


Figure 1: Distribution of Australia's population compared to distribution of Australia's psychiatrists. One third of Australia's population lives in a rural area but only one in ten psychiatrists practices in a rural area.

The opinions

Royal Australian and New Zealand College of Psychiatrists (RANZCP)

- Recommends a range of strategies that aim to give rural communities access to a full range of mental health services close to where they live
- These strategies include: increased numbers of medical students with a rural background through enrolment targets, investing in funding and training centres that allow psychiatrist trainees to undertake their training entirely in a rural area, more support to psychiatrist trainees in rural and remote settings, the funding of grants to improve the number of psychiatrists remaining in rural areas such as access to professional development and financial incentives, more flexible (fly--in fly--out) models of work, and greater resourcing for telepsychiatry.

Australian Medical Association (AMA)

- Any Australian with a mental illness should have access to quality mental health care
- Immediate priorities for government action include improved access to community--based mental health care services in rural communities, with the services customized to specifically meet local needs, as well as rural hospitals and general practices that have enough resources to give a timely and effective care to patients with a mental illness after hours
- A priority area is development of an MBS item for telehealth consultations

NSW Farmers' Association

- The NSW Farmers Mental Health Network Blueprint recognizes that pathways to health are needed to combat the pathways to breakdown occurring in rural farming communities.
- This includes improved access to drug and alcohol programs to combat alcohol misuse; mental health first aid training to combat lack of awareness of mental illness and services available; lobbying NSW Health to improve the number and quality of services available to rural NSW to combat clinical depression and other mental health disorders; and funding and public education about crisis lines to combat suicide attempts.

Royal Australian College of General Practice (RACGP)

- GPs and healthcare teams currently have to work with a number of different supports which are often narrow in their scope and work in isolation of other supports
- Priorities for action include integration of existing funding; a reduction of the distance burden in rural areas by investment in policy which facilitates innovative localized solutions; stronger investments in training the existing workforce; and a review of MBS item numbers for mental health

How you can make a difference

- Become involved in Blue Week to learn more about mental health
- Contact AMSA Rural Health https://www.amsa.org.au/initiatives/ruralhealth/) or the ANU Rural Medical Society (http://arms.asn.au) to find out about education and advocacy opportunities for rural mental health

World AIDS day shines a spotlight on the PrEP debate

World AIDS day was held on Tuesday, December 1 with the AMA (ACT) and our Federal AMA colleagues joining together over morning tea to mark the occasion. Peter Somerville, AMA (ACT) CEO said "It's an important day to remember those who've suffered both locally and globally but also to recognize the hard work that's gone into combatting HIV/AIDS through research and the safer sex message."

Staff of AMA (ACT) at the morning tea to mark World AIDS Day.

"Getting to zero new infections by 2020 is possible if we stick to the message of get tested, treat early and stay safe."

Coinciding with World AIDS Day was the announcement by the NSW Government and the AIDS Council of NSW (ACON) of the extension of the current Pre-exposure Prophylaxis (PreP) Trial to 3700 people at high risk of HIV transmission in NSW.

ACON CEO Nicolas Parkhill said that "ACON is thrilled to be involved in the historic trial, which is projected to bring about a dramatic reduction in new HIV transmissions."

"PrEP is going to be a game changer in terms of HIV prevention in NSW. In conjunction with high HIV testing rates among gay men and strong treatment uptake among people with HIV, it's helping revolutionise HIV prevention in Sydney's sister city, San Francisco."

"Here in NSW, the EPIC project will play a vital role in helping us realise our goal of eliminating HIV transmission by 2020. As a result of this initiative, 3700 people at high risk of HIV transmission will soon be much better protected from acquiring HIV."

AMA staff (l to r) Moe Mahat, Kirsty Waterford and Michelle Grybaitis at the morning tea for World AIDS Day.

"When we combine this with our increasing rates of HIV testing among gay men and stronger uptake of treatment among people with HIV, we have the potential to deliver the biggest reduction in HIV transmission rates in NSW for more than 20 years. This is an incredibly exciting development in terms of the HIV prevention landscape." Mr Parkhill said.

While the debate about the use and availability of PrEP in Australia continues, the efficacy of the antiretroviral drug Truvada in preventing new HIV infections has been demonstrated in clinical trials in both the UK PROUD study and the Canadian IPERGAY study. These trials, amongst gay men, transgender women, heterosexual men and women and injecting drug users, reported 86% reductions in risk of HIV infection in participants. Importantly, neither study found evidence of increased sexual risk-taking while participants were on PrEP.

Given these findings, combined with the recent announcement extending the PrEP Trial in NSW, it now seems both sensible and logical to commence, at the very least, a trial in the ACT.

When taken daily, PrEP works for those who are HIV-negative but considered at a high risk of acquiring HIV by acting to prevent new infections. If Australia is to reach a target of zero new infections by 2020, the use of PrEP is increasingly being seen as critical.

Truvada has been utilised as PrEP in the United States since 2012 and the argument for making it available to Australians seems compelling. The manufacturer of Truvada has submitted an application to the Therapeutic Goods Administration for a change in indication to allow Truvada to be prescribed as PrEP, but that application has yet to be approved.

Subject to that approval, and assessment of the cost-effectiveness of subsidising PrEP through the Pharmaceutical Benefits Scheme, it may not be too long before a further, effective weapon is available in the fight against HIV/AIDS in Australia.

Time for a national activity plan

Progressively, Australia has slipped from being an active nation to one of the least active nations in the developed world. Our decrease in physical activity and increase in sedentary activities has seen an increase in chronic diseases and obesity creating far reaching health, economic, environmental and social problems.

On 11 September 100 leading policy experts and stakeholders, joined by a further 200 professionals online, met at the National Physical Activity Consensus Forum in Canberra to discuss the key elements that might comprise a much-needed Australian national physical activity plan.

Despite 30 countries around the world having an implemented National Physical Activity Action Plan, Australia unfortunately falls behind the mark with no such plan in place.

The consensus from the meeting was that something needs to be done. A snapshot of where Australia is:

- Physical inactivity causes over 14 000 deaths per year
- Physical inactivity contributes to major Australian health issues – namely cardiovascular disease, type 2 diabetes and mental illness.
- More than half of Australians don't meet the physical activity guidelines.
- More disturbingly, 8 out of10 children don't meet these guidelines.
- Physical inactivity costs us as a nation $1.5 billion per year.

The Canberra Communique sets out the priorities agreed at the Forum and outlines nine action areas that together point to the basis for a formal National Physical Activity Action Plan.

All of this is aimed at achieving an active Australia and create a nation that move more and sit less.

The physical activity plan 9 key action areas:

1. **Active Seniors** – develop community and aged care policies and programs to keep our seniors active, fit and well.
2. **Active Children** – develop school and community based policies and programs to get our children moving
3. **Active Workplaces** – Develop workplace policies and programs to drive productivity through physical activity and reduced sitting
4. **Active Transport, Walking and Cycling** – Develop transport systems that encourage walking, cycling and public transport
5. **Active Cities and Neighbourhoods** – Implement urban design regulations to create livable and active neighbourhoods and cities
6. **Active Healthcare** – Ensure physical activity prescription is integrated into primary care
7. **Active Public Education** – Develop an integrated media and social media campaign and cohesive brand to promote an active culture to all Australians
8. **Active Clubs and Sport** – Focus on boosting participation in sport and recreation
9. **Active Communities** – Implement community-based programs that engage community networks

The National Heart Foundation, a key participant in the Forum, believes that the benefits of a National Physical Activity Action Plan are clear and far-reaching:

- Improved health of Australians with reduced chronic diseases
- Economic benefits with savings to our health budget
- Higher productivity, happier workers and lower absenteeism
- Reduced traffic congestion with more Australians seeking more active modes of transport.

Their message is simple, "We owe it to the future of our nation to push the focus of a healthy, active Australia to the forefront of Federal policy. The health of our nation depends on it."

DiT update

The AMA (ACT)'s Council of Doctors-in-Training met on Tuesday 8 December for its regular quarterly meeting. First and foremost on the agenda was a report on the AMA National Council of Doctors in Training meeting and update on a range of matters – from access to training and training places to the national internship review through to the latest on issues of workplace bullying and harassment.

After a discussion on enterprise bargaining and the imminent vote on the new ACT enterprise agreement, the Council discussed some specific issues around pay classifications – resident or registrar – and the reimbursement of professional development expenses. Importantly, the Council also heard about issues relating to access to leave. Workplace Manager, Andy Ozolins, will be following up on these issues.

Given that the next round of enterprise bargaining is due to commence in early 2017, it's going to be a busy twelve months.

AMA (ACT) CEO, Peter Somerville, outlined his plans for 2016 including a proposed joint membership agreement with ASMOF and closer working relationships with the Junior Medical Officers Association. Peter also stressed how important it was to get DiTs to join AMA (ACT) and become involved with us because the more members we have, the more influential we can be with ACT Health.

The next meeting of the AMA (ACT) Council of Doctors in Training will be in March 2016 so see you all then and don't forget to like AMA ACT on Facebook.

AMA (ACT) is now on Facebook!

AMA (ACT) has jumped into the wide world of Facebook so please get online and like us. It's a great way to find out what's going on quickly and keep up to date with events. Recent posts have featured the decision by Fair Work Australia to retain one agreement for ACT hospital doctors and the meeting with ACT Health Minister, Simon Corbell.

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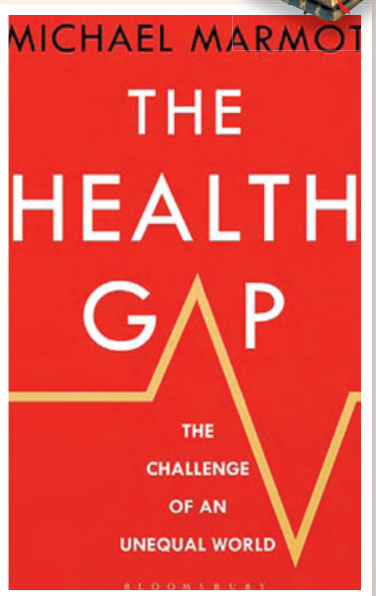
BOOK REVIEW:

The Health Gap.
The challenge of an unequal world.
By Michael Marmot.
Bloomsbury.
Hardback $35, paperback $29. ISBN 9781408858004



The fortieth anniversary of the dismissal has spawned reminiscences galore of the Whitlam era, including some of its more erratic ventures. Unfortunately they all missed one of my favourites, Clyde Cameron's wish that everyone should earn at least the average wage.

What? Nought out of ten for arithmetic of course, but suppose our fairy godmother did substantially increase wages of the very low paid, did sharply reduce unemployment and low-hours employment, did provide quality child care for all, and did increase welfare payments substantially.

None of these actions have any direct relation to health or health services. But if they somehow were instituted, would there be a rapid and substantial improvement in measures of health in the sectors of our population which presently have the worst health? Yes there would.

Now suppose you were told that it was not just the amount of money people had, rather what they could do because they had it. Would control over one's life affect health and wellbeing? Yes it would.

There are lots and lots of examples of these phenomena, but for simplicity let us consider only one measure of health, life expectancy. Over the last 50 years Cuban life expectancy has improved so much that it has overtaken that in the United States. Cuba is by any standard a poor country, and if there is equality, it could be said that this is because conditions are uniformly ghastly. Cuba emphasises education and social protection, and has a well-developed health care system, a system that operates with few resources. In contrast the US population is the wealthiest in the world, but this is on average. Its pockets of unemployment and other causes of poverty are enough to pull down its performance to below that of Cuba.

The ranting of a socialist? Not at all. Professor Sir Michael Marmot, British but educated in Sydney, has been President of the BMA and is now President of the WMA. His professional life has been devoted to reducing and removing inequality and its impact on health. If you are interested in how society and medicine interact, his book is worth reading.

John Donovan

Prime Minister's Summer reading list 2015

Every year the Grattan Institute releases a summer reading list for the Prime Minister. It recommends books and articles that the Prime Minister, or any Australian interested in public debate, will hopefully find both stimulating and cracking good reads. The Grattan Institute has recently announced this year's list:

Warrior: A legendary leader's dramatic life and violent death on the colonial frontier
– Libby Connors

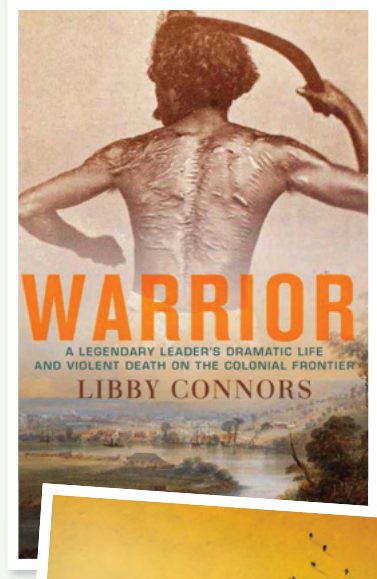
Coming of Age: Growing up Muslim in Australia
– Amra Pajalic and Demet Divaroren (editors)

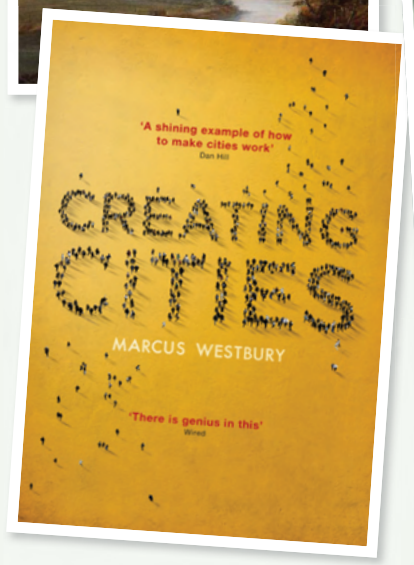
Creating Cities
– Marcus Westbury

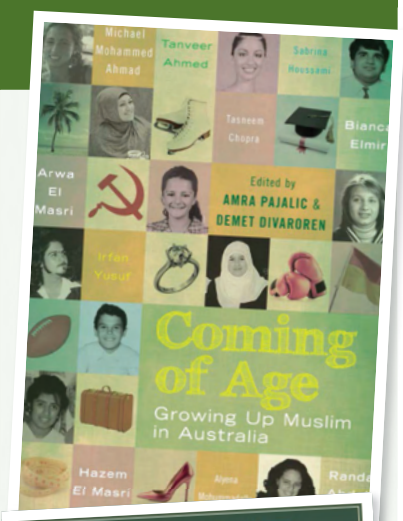
Other People's Money: Masters of the universe or servants of the people?
– John Kay

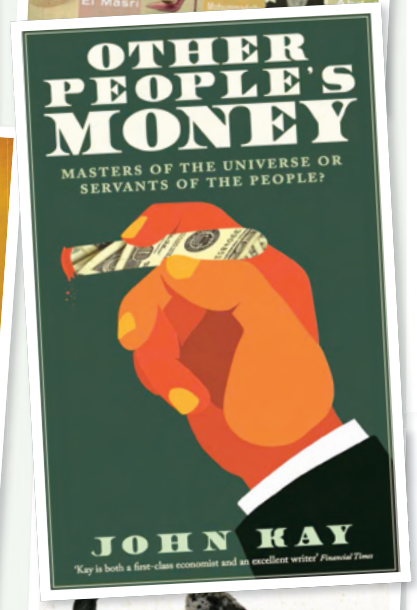
Rising Inequality: A benign outgrowth of markets or a symptom of cancerous political favours?
– Paul Frijters and Gigi Foster

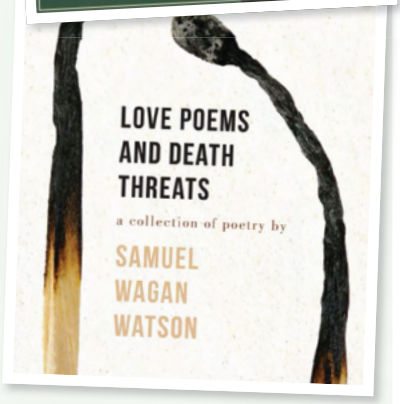
Love Poems and Death Threats
– Samuel Wagan Watson











faiths, to love and money. Stories about growing up Muslim in Australia, and early white settlers' attempts to coexist with Indigenous Australians are reminders of our shared humanity and of the lessons of history. The list includes original thinking about Australian cities and why they thrive or wither, and two compelling tales about money: one about the financiers who trade in its mysteries, the other about how Australia's super-rich made so much of it. There is also a new collection of incandescent and joy-filled poems from a remarkable Australian voice.

VALE

The President, Dr Elizabeth Gallagher, Board members and staff of AMA ACT extend their sincere condolences to the family, friends and colleagues of their late esteemed colleague,
Dr Philip Ikupu Toua

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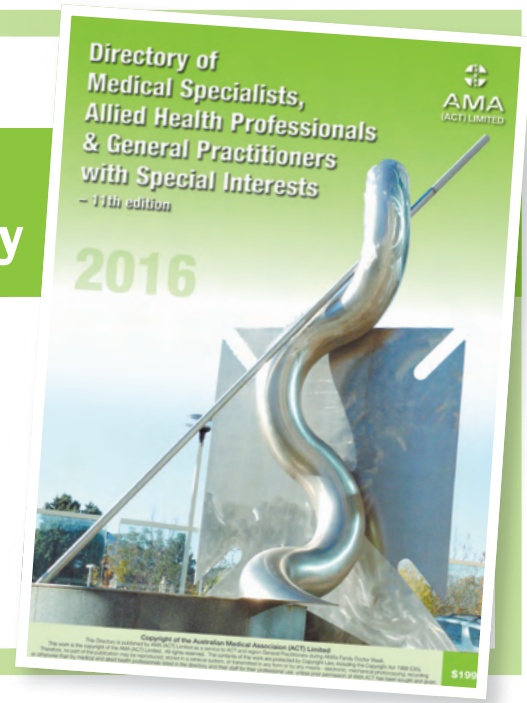

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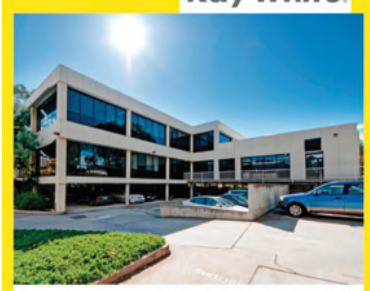

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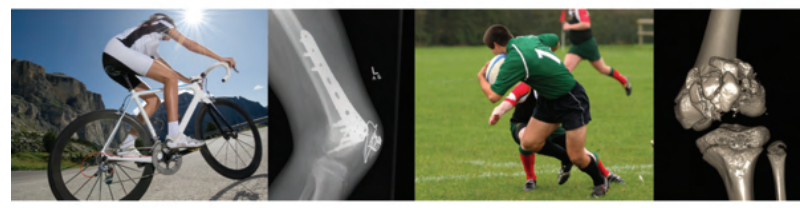

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