

# CANBERRA Doctor

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## Greg Hunt appointed Health Minister

AMA President, Dr Michael Gannon, has welcomed the appointment of Greg Hunt as Health Minister, saying that Mr Hunt's experience as a senior Minister in the Environment and Industry portfolios should prepare him for the demands of the Health portfolio.



Greg Hunt,  
newly  
appointed  
Federal Health  
Minister.

Dr Gannon said that Mr Hunt, who has been in Federal politics since 2001, faces many challenges from day one in his new job.

"The AMA would like to see Mr Hunt get off to a flying start by scrapping the Government's freeze of Medicare patient rebates, which is caus-

ing great hardship for patients and doctors," Dr Gannon said.

"The new Minister must also quickly get across the many reviews instigated by his predecessor, most importantly the review of the Medicare Benefits Schedule (MBS) and the review of Private Health Insurance, which are key to the sustainability of our health system.

"The ongoing issue of public hospital funding is another priority, along with Indigenous health, mental health, and prevention.

### AMA to meet with new minister

"The AMA will meet with the Minister at the earliest opportunity to

discuss the broad range of health policy issues that need urgent attention, especially in the context of the 2017 Budget in May."

Dr Gannon also congratulates Ken Wyatt on his promotion to Minister for Aged Care and Minister for Indigenous Health.



Sussan Ley,  
outgoing  
Health  
Minister.

### Sussan Ley

AMA President, Dr Michael Gannon, has also acknowledged the positive and collaborative contribution that Sussan Ley has made to the Health portfolio.

Dr Gannon said that, from her first day as Health Minister, Ms Ley made a genuine effort to engage with the medical profession.

"Sussan Ley became Health Minister at a very difficult time," Dr Gannon said.

"The Government was reeling from a comprehensively, negative response – both from the public and the health sector – to its various versions of a Medicare patient co-payment.

"It was Ms Ley's job to turn around this negativity, and it was not long into her tenure that the co-payment policy was scrapped.

"She then entered into genuine consultation with the AMA and other groups as the Government embarked on a range of reviews – including the MBS Review and the Private Health Insurance Review.

"Ms Ley also commenced the Health Care Home trial, which has received qualified AMA support.

"The AMA did not always agree with the policies announced by the Minister, especially the Medicare rebate freeze, but she was always prepared to hear our views and continue the broader discussions around health reform.

"The AMA thanks Sussan Ley for her friendly and engaging approach to dealing with the challenging Health portfolio, and we wish her success in her ongoing political career and beyond," Dr Gannon said.



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# Medical Musings

WITH PRESIDENT, PROFESSOR STEVE ROBSON

2017 – and the heat is on

Australia Day and the Australian Open tennis are over, and Canberra's children are back at school. Another heatwave spreads over the Capital. It must be the start of a new year. 2016 was a big year for Canberra's medical community. The ACT Legislative Assembly election was held, and health policy was front and centre – it is clear that health is now the most important issue for voters at both the Commonwealth and Territory level. Now that the election is over, the time has come for promises to be delivered. New Territory Health Minister, Ms Meegan Fitzharris, is coming to brief the AMA (ACT) Board in early February about her plans for Canberrans' health services – I will keep you closely posted.



about drug metabolism and potential interactions are necessary to ensure safe use. Lack of information is a major issue for doctors, who are used to writing prescriptions based on such guidance. Much of the drive for increasing access to medical marijuana has come with the advent of social media, which thrives on anecdotes.

Unfortunately, the evidence we have at the moment has not convinced many clinicians. A review of the evidence for 'medical marijuana' was published two years ago in JAMA: the review concluded that the evidence for many claims was weak, and that there was a risk of serious adverse effects. These findings worry many doctors, who want to offer the best to the patients they care for and caution will be needed to ensure that we do no harm. For those worried about a new wave of pot smoking, the World Health Organisation (WHO) reports showing that the legal status of cannabis does not seem to have any effect on community usage.

There are many more issues to deal with through 2017: the ACT Government's Health Workforce Plan needs updating, and despite nay-sayers about responsible alcohol use there is good evidence that 'lock-out' and 'last drinks' laws cut the rate of alcohol-fuelled violence in the community. I hope everyone has returned to work after a restful and refreshing break, ready for another year of hard work to keep Canberrans as healthy as possible.

The Australian Medical Association has a membership drawn from across the medical profession, a broad base that allows a unique perspective on the impact of health policy on both patients and the medical profession. However, it is impossible to keep everyone happy. Most of the major policy initiatives arise from discussion at the AMA Federal Council, and these reflect a broad consensus about important issues for the country. Some things just about everyone can agree on – lifting the MBS freeze is a good example. On other issues, such as policy on firearms legislation and euthanasia, it will always be impossible to please everybody. However the debate is the thing, and engaging doctors with the community and, indeed, with other doctors is an achievement in itself.

## Good – but could do better

Looking at the other states and territories, we in Canberra should be proud of the ACT Health system: we lead the way in many national indicators of good health.

Yet there are areas needing improvement, mostly notably access to primary care (especially after-hours care), reducing the pressure on emergency departments, and improving the efficiency of both Canberra Hospital and Calvary Public Hospital. These are the major challenges facing the ACT Government this year.

At Canberra Hospital, the 'SPIRE Centre' is being planned, and major changes are underway in the ACT Health bureaucracy to swing behind this effort. Large health infrastructure projects are important – Canberra has some creaking hospital facilities that are stretched to the limit – but just as importantly our excellent General Practitioners play a central role in patient care. Almost 85 per cent of Australians will visit a GP at least once each year, and family doctors are usually the first point of contact when Australians become ill. The vast majority of health problems are managed, and managed well, solely by GPs. When people have a trusted

family doctor it is good for their health: those with an ongoing relationship with their GP have been shown to experience better health outcomes.

## Working together for patients

The AMA (ACT) is keen to work with the ACT Government, the Capital Health Network, and other groups to support investment in general practice. In particular, established general practices need assistance for investment in costly items of equipment and infrastructure, providing services and staff and improving communications between general practice and hospitals.

With appropriate resources, many established general practices could provide more effective and economical doctor-led care over extended hours. It's a good time for the ACT Government to rethink its relationship with local practices and how they can play a part in solving our problems at the major public hospitals.

## The straight dope

So-called 'medical marijuana' is always in the headlines, for better or worse, and the Territory Government has established their *Medicinal Cannabis Medical Advisory Panel* to provide advice on such issues as conditions eligible for treatment, doses, form, mode of administration and strength. Another separate committee is being set up to provide advice to government on the broader economic, legal, and 'social' issues related to the introduction of Canberra's 'medicinal cannabis' scheme.

Australians are already the world's heaviest users of marijuana, an honour shared with New Zealand and the United States. Trials of 'medical marijuana' have been underway in Canada for a couple of years now and while Canadian doctors generally express cautious support, they are reluctant to prescribe it. Before a new medication can be approved for patient use, pharmaceutical companies have to provide detailed information about toxicity and safety. Data

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# AMA: needle and syringe programs needed to combat blood born viruses

The AMA has called for needle and syringe programs (NSPs) to be introduced in prisons and other custodial settings, to reduce the spread of Blood Borne Viruses (BBVs) including hepatitis B and C, and HIV.



AMA President,  
Dr Michael  
Gannon.

AMA President, Dr Michael Gannon, said that the prevalence of BBVs is significantly higher in prisons, yet custodial facilities provide a unique opportunity to protect the health of inmates.

## AMA position statement

Launching the *AMA Position Statement on Blood Borne Viruses 2017*, Dr Gannon said that with new BBV treatments, including hepatitis C direct acting antivirals, available on the subsidised Pharmaceutical Benefits Scheme (PBS), now is the time to identify people with undiagnosed BBVs.

"BBVs are a major health problem in our prisons, which is no surprise given that many people are in custody for drug-related offences in the first place," Dr Gannon said.

"All the evidence shows that harm minimisation measures, such as access to condoms and lubricant, regulated needle and syringe programs, and access to disinfectants such as bleach, protects not just those in custody, but prison staff too.

"It also reduces the likelihood of someone being discharged from prison with an untreated BBV, and spreading it in the outside community.

## NSPs as frontline approach

"The AMA supports NSPs as a frontline approach to preventing BBVs. Prison-based NSP trials have been shown to reduce the risk of needle-stick injuries to staff, and increase the number of detainees accessing drug treatment, while showing no adverse effect on illicit drug use or overall prison security."

The AMA Position Statement also calls for greater emphasis on prevention, reliable and affordable screening, immunisation, and treatment, with stronger referral pathways, and greater investment in specialist services.

## Criminal sanctions a last resort

It also warns against making transmission of a BBV a crime, arguing the BBVs are first and foremost a health issue, not a legal one.

"Criminal sanctions should be used only as a last resort for people who intentionally put others at risk of BBV infection," Dr Gannon said.

"There is no evidence that laws that criminalise BBV transmission either prevent or deter transmission.

"Indeed, such laws can be a barrier to the prevention and manage-

ment of BBVs by discouraging sex workers and injecting drug users from being tested and treated, or from disclosing their diagnosis.

"Doctors are at the front line of BBV diagnosis and treatment, and should therefore be well informed about legal issues, particularly their own legal obligations, to provide the best advice and support to individual patients." The AMA Position Statement also calls for specific resourcing and management of HLTV-1, a relatively unknown BBV that affects Aboriginal people in central Australia.

The AMA *Position Statement on Blood Borne Viruses 2017* is available at <https://ama.com.au/position-statement/blood-borne-viruses-bbvs-2017>.

*The Canberra Times featured this story in its 9 January edition. The following is an excerpt:*

## Calls for ACT to again lead prison syringe program debate

By Daniel Burdon

Calls for the ACT to return to leading the national debate on safe needle exchange programs in prisons have been reignited after the Australian Medical Association urged all governments to instigate such programs around the nation on Monday.

The territory government was seen as leading the debate on regulated

needle and syringe programs (NSP) in prisons after it pledged to trial a safe injecting room at Alexander Maconochie Centre in July last year after lengthy consultations on the ideal model.

But prison officers overwhelmingly rejected the proposal in an all-staff vote in September last year, leading to the government abandoning the idea weeks out from the ACT's October election.

AMA president Dr Michael Gannon told ABC Radio on Monday that while the ACT's approach to the issue was a "novel one", and prison officers' views were important, the evidence showed such programs were effective at reducing rates of blood-borne viruses among both inmates and officers.

The statement called for such programs to be used as a "frontline approach to preventing blood-borne viruses" and Dr Gannon said it "should not be seen as having a permissive attitude" towards drugs, instead arguing people should recognise the realities of drug use in prisons and "we should do what we can to reduce harm".

Hepatitis ACT executive officer John Didlick said the statement was a welcome addition to "the chorus of professional bodies and organisations calling for regulated access to sterile injecting equipment in Australia's prisons".

Mr Didlick said there was also no evidence that regulated NSPs led to an increased risk of needle-related attacks on prison officers, and overseas research had actu-

ally revealed the opposite – that it made prisons safer.

"On the contrary, illegal and unregulated NSPs that operate when there is no regulated program, recirculate a limited supply of unsterile needles that spread disease and create harms and risks for the prison and for the community more broadly," he said.

Similarly, the Penington Institute, which advocates for harm minimisation among injecting drug users, backed the AMA's position.

Institute chief executive John Ryan said prison officers were at higher risk of potential attacks in the current un-regulated system.

He said that prisoners may be "doing the time they deserved", but they "don't deserve to lose all their human rights" just because they were serving a sentence.

"We've been very engaged in the prison needle exchange issue for years, and what happens on the inside does actually affect everybody," he said.

"We've got a great system in the community, but we've completely [let down] those in our prison system.

"The leader (in this debate) was the ACT, until they outsourced it to the unions."

Corrections Minister Shane Rattenbury said he and the government "remain committed to reducing the spread of serious blood-borne viruses among detainees at the AMC".

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# AMA (ACT) welcomes new graduates

Immediately Prior to Christmas the AMA (ACT) held its annual Graduation Breakfast to celebrate the graduation of the 2016 ANU Medical School graduates. The breakfast was held at Double Drummer in Barton and, despite the somewhat inclement weather, was a successful day.

AMA (ACT) President Elect, Dr Antonio Di Dio welcomed the new graduates to the profession and wished them well for their intern year. Of course the Graduation Breakfast is a good opportunity to talk to the new graduates about AMA membership. Whether it's simply being part of an association of medical colleagues or accessing career advice or workplace relations advice, there are many good reasons to join up.

Thanks to our sponsors for a great day – BOQS, MIGA, MDA National and our rewards partners who donated prizes – Jirra Wines, Belluci's Restaurants and Crabtree & Evelyn. Thank you to all our sponsors.

## AMA (ACT) Prize for Student Leadership Awarded to Chris Wilder

The ANU Medical Ball, held in the Great Hall of Parliament House, took place on the evening of the Graduation Breakfast. The Ball marked one of the final events for Prof Nick Glasgow, as Dean of the ANU Medical School. During his address, Prof Glasgow announced that Prof Imogen Mitchell had been appointed to succeed him as Dean.

The 2016 AMA (ACT) Prize for Student Leadership was awarded to Chris Wilder. Congratulations Chris, a well-deserved award for four years of outstanding leadership.



ABOVE: Some of the tables at the breakfast.



AMA (ACT) Team (L to R) Anish Prasad, Dr Antonio Di Dio, Peter Somerville, Tony Chase, Karen Fraser and Alison Hosking.



AMA (ACT) President Elect, Dr Antonio Di Dio, with Prof Kirsty Douglas.



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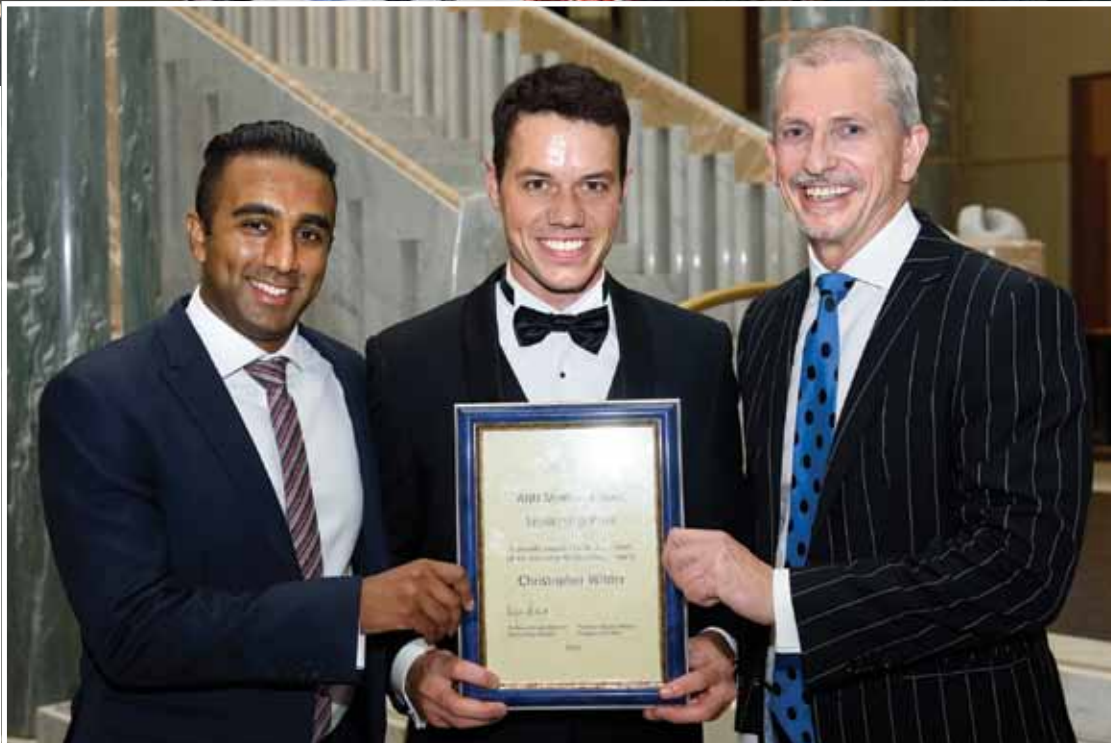
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Prof Nick Glasgow, outgoing Dean of ANU Medical School.



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# AMA pre-budget submission 2017-18: government must set new direction

The AMA has called on the incoming Health Minister, Greg Hunt, to change the Federal Government's direction on health policy, and to consign any links to the disastrous 2014-15 Health budget to history.

Launching the AMA's Pre-Budget Submission 2017-18, AMA President, Dr Michael Gannon said the key for the Government and the Health Minister is to look at all health policies as investments in a healthier and more productive population.

"Health is the best investment that governments can make," Dr Gannon said.

"The AMA agrees with and supports Budget responsibility. But we also believe that savings must be made in areas that do not directly negatively affect the health and wellbeing of Australian families.

## Consider health as an investment

"Health must be seen as an investment, not a cost or a Budget saving.

"There are greater efficiencies to be made in the health system and in the Health budget, but any changes must be undertaken with close consultation with the medical profession, and with close consideration of any impact on patients, especially the most vulnerable – the poor, the elderly, working families with young children, and the chronically ill.

"But the AMA urges caution – and care. The Government must not make long-term cuts for short-term gain. Patients will lose out.

"In this Pre-Budget Submission, the AMA is urging the Government to invest strategically in key areas of health that will deliver great benefits – in economic terms and with health outcomes – over time.

## Lift the freeze

"The first task of the new Minister must be to lift the freeze on Medicare patient rebates, which is harming patients and doctors.

"Primary care and prevention are areas where the Government can and should make greater investment.

"General practice, in particular, is cost-effective and proven to keep people well and away from more expensive hospital care. It was pleasing to hear Minister Hunt use his first health media conference to declare that he wanted to be the Health Minister for GPs.

"The Government must also fulfil its responsibilities – along with the States and Territories – to properly fund our public hospitals.



AMA President, Dr Michael Gannon.

"So too, the Government must deliver on its commitments to improve the health of Indigenous Australians.

"In this submission, the AMA provides the Government with affordable, targeted, and proven policies that will contribute to a much better Budget bottom line in coming years.

"More importantly, the AMA's recommendations will deliver a healthier and more productive

population to drive further savings into the future."

The AMA Pre-Budget Submission 2017-18 is at [https://ama.com.au/sites/default/files/budget-submission/Budget\\_Submission\\_2017\\_2018.pdf](https://ama.com.au/sites/default/files/budget-submission/Budget_Submission_2017_2018.pdf)

## The AMA pre-budget submission 2017-18 covers key areas including the following:

Medicare Indexation Freeze – immediately reverse the Medicare

indexation freeze and lift future indexation of patient rebates to levels that cover the true cost of providing high quality health services.

**Public Hospitals** – ensure that Commonwealth funding for public hospitals must, at a minimum, include an additional supplement for the period to 2020, having regard to the funding level that was planned to apply under the NHRA;

**Medicare Reviews** – ensure that clinicians continue to be consult-

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Incoming Health Minister, Greg Hunt, with predecessor, Sussan Ley.

ed throughout the entirety of the MBS review, including in policy implementation and changes to the MBS; use the review as the basis for improving, modernising, supporting innovation, and investing in the MBS, not as a budget savings measure.

**Pathology** – adequately support pathology services through realistic reimbursement of pathology services and investment in a sustainable pathology workforce.

**Indigenous Health** – the AMA calls on the Government to correct the under-funding of Aboriginal and Torres Strait Islander health services, increase investment in Aboriginal and Torres Strait Islander community-controlled health organisations. Such investment must support services to build their capacity and be sustainable over the long term identify areas of poor health and inadequate services

for Aboriginal and Torres Strait Islander people, and direct funding according to need.

**Mental Health** – the AMA calls on the Government to develop and implement a National Mental Health Plan and ensure that existing mental health programs, and eligibility for the NDIS for people with mental health needs, are quarantined until PHNs demonstrate they have the capacity to maintain and expand the services and access arrangements currently available

**Alcohol and Drugs** – the AMA calls on the Government to finalise the National Drug Strategy as a matter of priority. This strategy should coordinate and prioritise the various aspects of the response to drugs and alcohol and should be accompanied by sufficient funding to ensure those actions identified as a priority can be implemented quickly

Australian Medical Association  
Pre-Budget Submission  
**2017-18**

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# Why an analogue life is making a comeback

BY JANE SHILLING, TELEGRAPH LONDON

How do I love the internet? Let me count the ways. I love the way it makes me feel that all the knowledge in the universe is potentially mine to command.

The last person to feel this was probably the sprightly Jacobean polymath, Francis Bacon, who died of pneumonia acquired while stuffing a chicken with snow to see what would happen. No danger of that with Wikipedia.

Still, I am a child of my time, and the habits of a Sixties childhood are not lightly discarded. I like my newspapers and books to be tangible objects and shopping to be a real-life transaction. Whether I'm buying a cardigan or a cabbage, I want to know exactly what I'm getting. In this, I find myself unexpectedly ahead of the curve.

Vinyl records, print books and Moleskine notebooks are increasingly in demand.

A Canadian journalist, David Sax, has just published a book, *The Revenge of Analog: Real Things and Why They Matter*, which records the renaissance of physical objects that once seemed obsolete. Vinyl records, print books, the Moleskine notebooks carried by would-be creative types – all are experiencing a surge in demand, and it is the young who are buying analogue, not just the nostalgic middle-aged.

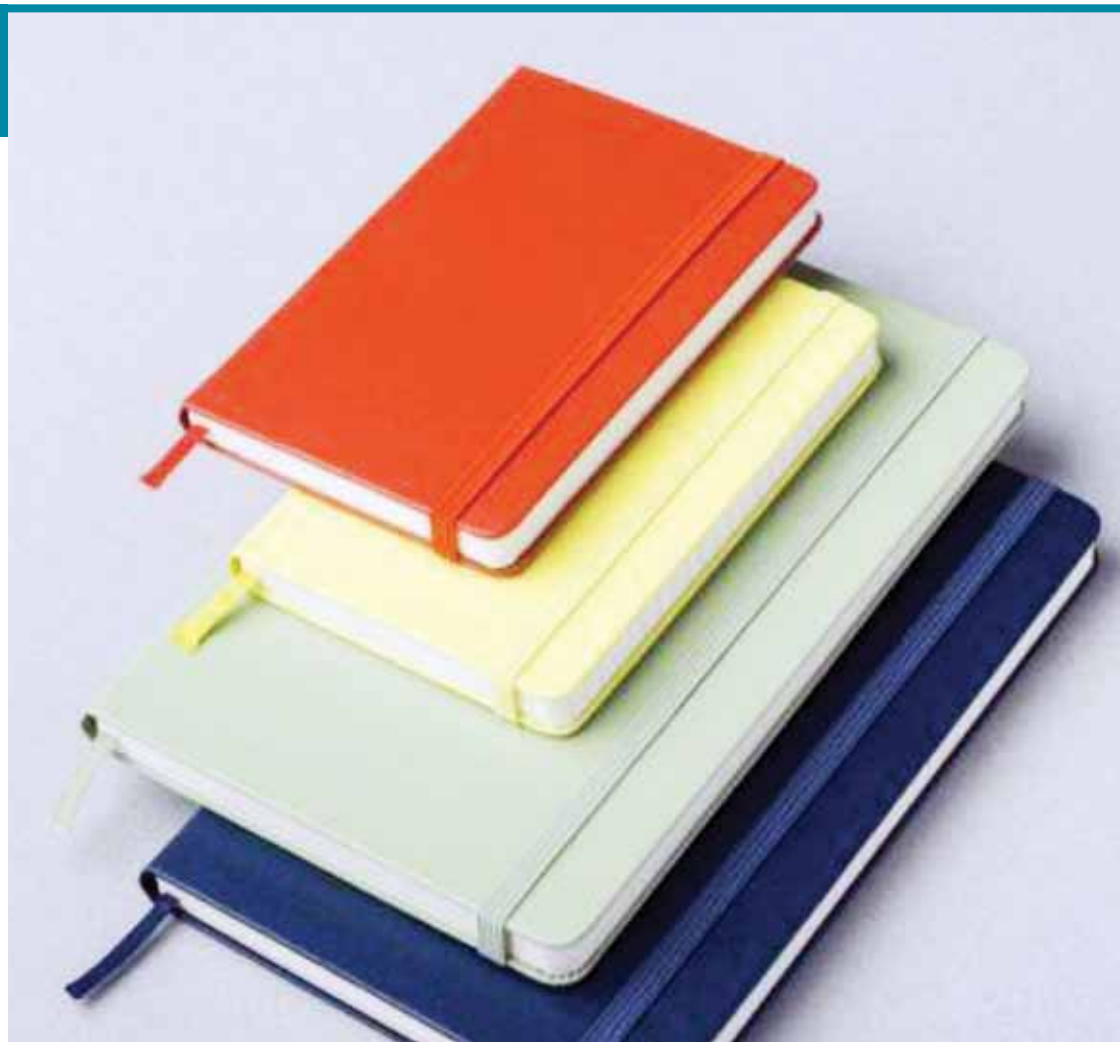
Once you start to look, the evidence is everywhere: Simon Rattle's new cycle of Brahms

symphonies with the Berlin Philharmonic, available only on vinyl; the return of Kodak's Ektachrome film, reversing a decision five years ago to stop manufacturing it; the newfound popularity of sewing machines, typewriters and board game cafes (Sax frequents one in Toronto called Snakes & Lattes).

And that's not to mention the Adobe Kickbox, a key tool at the software multinational Adobe Systems. It consists of a cardboard box containing things the electronic gurus find essential: chocolate, coffee, pens and a notebook.

In times when even truth has alternative versions, the unarguable "thingness" (not a lovely word, but if it's good enough) of everyday objects can feel tremendously comforting.

The photographer Jason Wilde has just published *Vera & John*, a photobook of notes scribbled on the backs of envelopes by his mother to his father. Brisk, mundane, often comic ("There's two mouses in the traps under the radiator cover. They are big. Get rid of them before I come home or I'm leaving"), they are as insignificant a part of the minutiae of daily life as the crumbs on a kitchen table.



If they had been text messages, they would have been deleted in due course. But their physical form – the press of biro on paper, the torn edges of the paper – lends them an arresting pathos

and intimacy. In the spaces between the words, an entire relationship is visible.

Like the board games at Snakes & Latte, or the coughs and dropped

programmes on Rattle's vinyl Brahms, Vera's scribbled notes distil the essence of the thing that can't be digitised: the lovely, imperfect reality of human contact.



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# Do's and don'ts of patient SMS communication

BY KATE GILLMAN, HEAD OF THE MEDICO-LEGAL ADVISORY SERVICE AND DR ROSA CANALESE, SENIOR MEDICAL ADVISOR, AVANT

Vanessa, a sixteen year-old patient, has attended your practice and returned a positive test result for HSV-2. After discussing the result with her over the phone, you prescribe an antiviral medication and leave the prescription at the front desk for Vanessa to collect.

Your practice receptionist sends Vanessa a message via SMS (text) stating that her "Famvir script is ready to pick up at reception." However, the receptionist failed to check Vanessa's patient registration form which clearly indicates that she did not consent to receiving any text communication from the practice.

The next day, Vanessa's mother rings your practice and demands to speak to you. She has read the text on Vanessa's phone after she left her mobile sitting on the kitchen bench. She is very concerned and wants to know why her daughter has been prescribed a medication for herpes.

Ultimately, Vanessa is very embarrassed that her mother has been privy to her confidential health information and makes a complaint to the Privacy Commissioner.\*

The use of text messaging for recalls and reminders is becoming routine in many practices and hospitals due to postage costs. Our Medico-legal Advisory Service (MLAS) has seen an increase in requests from members for advice on

the safe use of text communication to prevent patient privacy breaches like the one above. Organisations can face up to a \$1.7 million civil penalty and individuals \$340,000 for a privacy breach under the Privacy Act 1988. Doctors and practice staff can protect personal information when using text communication by taking a few simple steps.

## 1. Have a text messaging policy

It's a good idea to develop a text messaging policy in your practice or hospital to encourage consistent use of the system. The policy should cover:

- who is authorised to send/receive and respond to text messages
- how messages are included in the electronic health records
- what information may be included or not included in a text message
- how patient consent is obtained and documented
- whether text messages are sent offering goods or health services

- what checks are made to verify the patient's mobile number is up to date and accurate.

## 2. Obtain and document patient consent

Before any health information is sent via text you need to obtain and document patient consent. Your practice or hospital should inform patients that text messages are used as a reminder service for appointments and recalls through your privacy policy and/or the practice website.

Remember, just because patients have provided a mobile phone number, it does not automatically mean they agree to receive text messages.

Patient's consent to receive text messages can be obtained via:

- the patient registration form for new patients
- when confirming an appointment for existing patients
- an online appointment or registration portal.



For example, the wording in a patient registration form could be:

'Would you like to be contacted via SMS (mobile text message) for: appointment reminders, recall and other text reminders or medical services we offer? Yes/No.'

You should also confirm the patient's identification and verify the patient's contact details before any information is sent.

If a patient does not consent to being contacted via text messages, this should be clearly documented to ensure that text messages are not sent.

## 3. Limit information contained in text messages

Due to a higher risk of information inadvertently being seen by another person, doctors and practice staff should be mindful of protecting the privacy and confidentiality of the patient's health information when sending texts.

As illustrated in the scenario above, text messages should not contain sensitive health information such as a description of particular test results that need to be followed up or the results of tests, for example, pregnancy results (unless the patient expressly consents to this). The message should simply request that the patient contact the practice or hospital and if appropriate, indicate the level of urgency.

Reminders about preventative screening tests, for example, pap smears and skin checks can be sent via text message.

## 4. Document text messages in the patient's medical record

Text messages form part of the medical record, so any text messages to and from the patient should be included in the patient's

record. This also extends to texts exchanged between doctors in relation to a patient's care.

### Key lessons

When communicating health information to patients via text, remember to:

- have a text messaging policy in place at your practice or hospital
- obtain and document the patient's consent and verify their identification and contact details before any health information is sent via text
- not include sensitive health information or test results
- document any text messages to and from the patient or text exchanges between doctors regarding their management in the patient's medical record.

\*This scenario has been created based on Avant's experience.

For more information download our Risk IQ fact sheet Recommendations when using SMS messaging on Avant Learning Centre.

### Find out more

For more advice regarding the appropriate use of patient text communication, call Avant's Medico-legal Advisory Service on 1800 128 268.

Find out why we are advocating for continuing education to maintain privacy rather than a punitive approach of a mandatory data breach notification law underpinned by civil penalties in our submission to the draft Serious Data Breach Notification bill.

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# Silence is the enemy for doctors\*

BY AARON E. CARROLL

In my first year of training as a doctor, I knew something was wrong with me. I had trouble sleeping. I had difficulty feeling joy. I was prone to crying at inopportune times. Even worse, I had trouble connecting with patients. I felt as if I couldn't please anyone, and I felt susceptible to feelings of despair and panic.



Images by Jody Barton.

I'm a physician, and, if I do say so myself, a very well-trained one. Yet it took an "intern support group" and the social worker who ran it, close friends and my fiancée (now my wife) to convince me that I might need help. Even if I couldn't acknowledge it, they could see I was suffering from depression.

I wasn't alone.

Last month, a study in the Journal of the American Medical Association reviewed all of the literature on depression and depressive symptoms in resident physicians — those are doctors still being trained. They found more than 50 studies on the

subject. Research shows that almost 30 percent of resident physicians have either symptoms or a diagnosis of depression.

Physicians are in a position of needing to care for others continuously. That strain, coupled with difficulties in helping themselves, leaves both patients and physicians at risk. The studies that followed doctors over the course of their residencies found that the rate of depression symptoms increased more than 15 percent within a year of the beginning of training.



Physicians with moderate to severe depression had a decrease in work productivity and job satisfaction. They were also two to three times more likely to say that they

were worried about, or had difficulty getting, mental health care.

Sometimes that medication is appropriate, as with anti-depressants. Often, it is not. A 2012 study in JAMA Surgery found that more than 15 percent of the members of the American College of Surgeons had a score on a screening test consistent with alcohol abuse or dependence. Among female surgeons, the prevalence was more than 25 percent. Those who were depressed were significantly more likely to abuse or be dependent on alcohol.

Doctors have much easier access to drugs than most other people do. Because of this, they are more likely to misuse prescription drugs than the general population. Anesthesiologists have access to more drugs than other physicians, and their problems are even more common. A 2005 study of anesthesia residency training programs found that 80 percent of them reported experiences with impaired residents, and almost 20 percent had experiences with at least one abuse-related death of a doctor in training.

Unfortunately, depression and substance abuse can lead to further problems, including suicide. More than 6 percent of surgeons reported suicidal thoughts in the last year. Yet only one quarter of them sought any kind of help. Most who didn't seek help feared that doing so would affect their ability to obtain a license — even though they were also worried about killing themselves.

The problem is even worse among medical trainees. About 6 percent of them reported thinking about suicide in just the previous two

weeks. Those with a history of depression were almost four times as likely to report recent suicidal thoughts as those without.



It is estimated that about 400 physicians commit suicide each year. That's about three times as many doctors as were in my medical school class at the University of Pennsylvania. Meta-analyses estimate that the rate of suicide among male physicians is 140 percent that of the general population. Among female physicians it is almost 230 percent.

What makes this important to discuss is not the prevalence of depression in physicians and trainees, although it's clearly very high. The critical issue here is that too many physicians, especially trainees, suffer in silence, afraid to ask for help for fear that they will be punished professionally, and probably, personally.

I have always been very open about my time in residency, and how depression somewhat robbed me of a few years of my life. When I look back, I think the constant pressure to help others, coupled with frequent feelings of helplessness, weighed on me. A lack of sleep and being away from family and friends left me vulnerable. Seeing children I bonded with, and cared for deeply, suffer and die was often more than I could bear. I think some part of me, whether it be physical or behavioral, is also predisposed to depression.

But I'm lucky. Thanks to the support of those who love me, as well as two excellent therapists, I am no longer depressed. I remain vigilant, however, against a recurrence. It's important for me, and for all physicians, to stay on top of their mental health and not wait for a crisis to act

Many colleagues still recoil when I talk openly about therapy, or how I plan to go to a therapist for the rest of my life. I'm sure they will find this column disconcerting as well. But we can't avoid talking about this. Too many are suffering, and if they can't get help from others, they may try — and fail — to help themselves. Suicide is always a tragedy; a physician's suicide is a travesty.

*Aaron E. Carroll is a professor of pediatrics at Indiana University School of Medicine. He blogs on health research and policy at The Incidental Economist.*

*\*This is an edited version of a column that first appeared in the New York Times on 11 January 2016.*

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# No “undo” button for email

BY TONY CHASE, AMA (ACT) MANAGER, WORKPLACE RELATIONS AND GENERAL PRACTICE

The quick and sometimes spontaneous nature of email correspondence means that on occasions we may have sent an email and then thought better of it. In the contemporary workplace we may send and receive hundreds of emails in a working day, often without much consideration for the wording and content. There are instances where such communications can be subject to scrutiny and pose an evidentiary obstacle if discoverable in legal proceedings.

## When Does Privilege Apply?

In workplace related legal proceedings emails can be discoverable, just like other documents unless they are subject to legal professional privilege, or without prejudice privilege. Generally speaking, legal professional privilege cannot be claimed retrospectively or claimed over documents that were not created for the dominant purpose of obtaining legal advice or in legal proceedings. In practical terms, this means even if an employer subsequently seeks legal advice on a claim by a former employee, written communications that already exist between Directors/Managers and/or human resources personnel (even between co-workers) relevant to a decision to terminate an employee, may be discoverable.

There may be a requirement for workplace documents to be produced through a variety of processes. Under State and Territory workplace health & safety legislation, regulators have extensive powers to compel production relating to workplace health and safety risks. The Fair Work Commission (FWC) and courts, including the Federal Court, have broad powers to order disclosure and

inspection of documents. Additionally, the FWC is not bound by the rules of evidence and may elect to consider documents traditionally considered private, privileged or confidential. An example of this is where the employer has relied on the findings and recommendations of an internal workplace investigation to dismiss an employee. There are cases where the employer had assumed such investigations were privileged only to discover that this may not necessarily apply.

## “Without Prejudice” – Protection?

The use of the “Without prejudice” privilege allow parties to explore potential settlement opportunities without fear of any associated documents being used against them in future proceedings. This does not mean however, that simply using the words “without prejudice” will satisfy a claim of privilege.

The Fair Work Commission has determined, in some cases documents marked “without prejudice” should be produced as the documents would assist in the resolution of the matters before the FWC. This is a reminder that labelling a documents “without prejudice” may not necessarily prevent a doc-



ument from being discoverable in the event of legal proceedings.

## Access to employer’s internal documents

As well as the risk of documents being discoverable, there is also the possibility that these apparently innocent workplace communications may present other issues for an employer, particularly where allegations of an unfair dismissal or adverse action have been made. This scenario could result in other litigation. There are many cases where employers have experienced challenges when managing misconduct issues involving the use of internal email communication systems.

## Some tips to manage internal communications

- Adequately document discussions and decisions, but keep the language and tone of the communications appropriate and professional.
- Adopt the “newspaper test”, that is, refrain from putting anything in writing that you would not be comfortable in defending in a public forum or saying directly to a person
- When dealing with difficult workplace situations, avoid raising personal sentiments or concerns unless relevant to the issue at hand
- Performance-based feed-

back should be presented in a constructive and balanced manner, ideally in person at first then confirmed by email; and

- Before you send an emotionally charged or reactive email, consider asking a trusted colleague to review it or leave it in your draft folder for a period of time before a cooler re-evaluation is made to determine if it is appropriate to send.

The best way to avoid embarrassing exposure is to be proactive in your approach to training employees on document management and appropriate workplace behaviour.

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# JMO rostering in for a shakeup at TCH

In a move that's been cautiously welcomed by AMA (ACT), rostering for JMOs at Canberra Hospital is to be centralised in a newly created 'Centralised Medical Rostering Team for Junior Doctors'. The new team will be part of MOSCETU.

Of course, rosters are key in ensuring that both TCH runs efficiently and JMOs can have a degree of certainty in regard to their working hours. While changing operational requirements, seasonal fluctuations and occasional unforeseen circumstances will always arise, predictable rosters and work patterns are the goals.

Industrial problems associated with rostering across the health sector has always been an area of friction. The ACT's public hospital system is no exception but as ever, we live in hope that things will improve as we move towards a new workplace agreement for our public hospital doctors in 2017.

The establishment of the 'Centralised Medical Rostering Team for Junior Doctors' is a welcome initiative and a hopeful sign that things can and will improve.

In a nutshell, the idea is to centralise all JMO rosters, locum engagements, secondments and leave

management in order to release clinical staff from the administrative burdens of roster creation and maintenance. We hope that the administration of the new system will ensure more equitable rostering for JMOs, especially in light of ongoing concerns about the ability of JMOs to meet their training requirements and achieve a healthy work/life balance.

This new rostering system will be progressively rolled out from January 2017 with the goal to have it rolled out to all clinical units by the end of the year. We expect that current rostering practices remaining in place until the new system is rolled out.

The introduction of the centralised scheme will be carefully monitored by the AMA (ACT) Workplace Relations Team and reports of progress on its roll out will be sent to members. Likewise we would appreciate feedback on issues as they arise [organiser@ama-act.com.au](mailto:organiser@ama-act.com.au) or [industrial@ama-act.com.au](mailto:industrial@ama-act.com.au)



## 'We want to hear from you!'

**The ACT Government has commenced enterprise bargaining with Public Hospital Doctors.**

The AMA (ACT) is inviting all public hospital doctors employed by ACT Health to complete an 'EBA Survey'. The survey will shape the 'log of claims' we present to the ACT Government.

The EBA Survey is available online <https://www.surveymonkey.com/r/SZLNW78> and closes on the 14th February 2017 at 11pm.

If haven't been able to participate or would like to comment, please contact Anish via email on [organiser@ama-act.com.au](mailto:organiser@ama-act.com.au).



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# Council of DiTs for 2017

BY ANISH PRASAD, AMA (ACT)'S HOSPITAL ORGANISER

In late December, AMA (ACT) sought nominations for the Council of Doctors in Training (ACT) for 2017. It was hoped that with Enterprise Bargaining around the corner (for ACT hospital doctors) and a growing list of concerns, we would attract 2 or 3 Doctors in Training to the Council. In the end, 12 people put up their hands and are ready to contribute to their profession – indeed, it is very encouraging to see that so many are passionate about having their voices heard on a range of issues. We've already held our first meeting for the year and have a diverse group representing their colleagues from Canberra hospital, Calvary hospital, Goulburn/Bega hospitals and GPs in Canberra.



Anish Prasad.

## The role of the Council

The Council of DiTs (ACT) is a group of AMA (ACT) members from the Intern level through to Senior Registrar. Their role will be to work with their colleagues to identify issues affecting their lives and careers and advocate on their behalf on the 'hospital floor', and where necessary, with relevant decision makers. However, it is important that the wider group of DiTs from Canberra, Calvary and Goulburn/Bega recognise that the Council will need your help in identifying

issues and advocating for change. So if you and your colleagues have concerns – get in contact with the Council and start a conversation.

If the Council needs help advocating on an issue – speak up and talk to your colleagues about getting behind them. Without the support of the wider group of DiTs, achieving good outcomes in 2017 will be more difficult.

## What's next?

In late December, the ACT Government initiated enterprise bargaining with medical practitioners and other ACT Health workers. The AMA (ACT) Council of DiTs will spend the first few months of 2017 on these matters alongside the AMA (ACT)'s Manager of Workplace Relations, Tony Chase and myself.

A survey has been sent to AMA (ACT) members asking for feedback on current conditions and what DiTs would like to see in the agreement. This results of the survey will help formulate the 'Log of Claims' which will then be presented to the ACT Government, af-



ter which formal negotiations will commence.

## Info-sessions at TCH and Calvary

AMA (ACT) will hold two EA 'Info-Sessions' with DiTs at Canberra and Calvary hospitals on, for Calvary, 6pm Wednesday 22 February in the ACU Tutorial Room, Lewisham Bldg and for TCH, Auditorium in Bldg 4. The 'Info-Sessions' will provide DiTs with an opportunity to ask questions about the EBA

process, how they are affected, results of the survey, the log of claims to be presented and provide feedback on other industrial issues important to you.

Outside of the EA, if you and your colleagues have concerns or questions feel free to get in contact with the Council and/or Hospital Organiser.

## How can I help?

The best way to help the Council and your colleagues is to join the

AMA, participate and speak up! You can join online ([ama.com.au/join-ama](http://ama.com.au/join-ama)) or contact me at [organiser@ama-act.com.au](mailto:organiser@ama-act.com.au) Participate in the survey, attend an 'Info-Session' and speak up and have a conversation with your colleagues about your concerns and how the DiTs cohort can work together and have their voices heard.

Finally, if you'd like to find out what you can do to help Council and your colleagues, contact me.



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For further information or an application form please contact the ACT AMA secretariat on **6270 5410** or download the application from the Members' Only section of the AMA ACT website: [www.ama-act.com.au](http://www.ama-act.com.au)

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# Book review:

REVIEW BY ASSOCIATE PROFESSOR JEFFREY LOOI, ANU MEDICAL SCHOOL

Henry Kissinger, Penguin, 2015: ISBN-13: 978-0143127710

Henry Kissinger is uniquely placed to provide a primer and overview of international relations from the perspective of a pivotal figure in US Foreign Policy over half a century. He has crafted a book with a grand narrative sweep, ranging from the origins of the nation states and the Westphalian balance of powers, through the decades of the Cold War, to the current cut and thrust of realpolitik in a multipolar world.

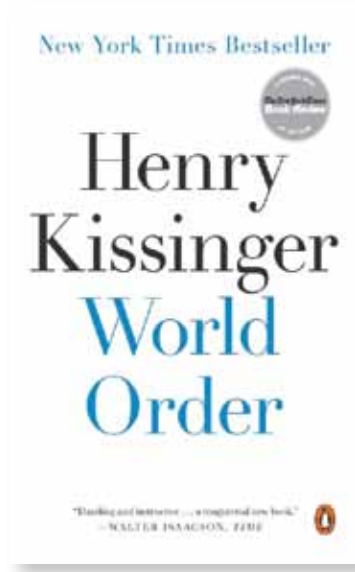


Kissinger's historical account provides an incisive context for the current international relations of the European Union, the Russian Federation and China. Given his key role in US Foreign Policy, it is appropriate that he articulates the worldview of the United States as a superpower, in the context of the nation's history and aspirations. He argues that the US must continue to balance vision with pragmatism.

Of course, such a primer cannot contain all: there is little on international relations in Africa, most of Asia, Middle and South America.

In his analysis of cyberspace, Kissinger is oracular in his ob-

servations that social media may promote emotionalism over reason in public discourse, as seems manifest in the rise of populism across the developed world. Eli Pariser, among others, in his book *The Filter Bubble*, has also written of the role that curated social media and information may play into human cognitive confirmation biases to reinforce what one believes and to discount differing views – leading to polarisation. In this context, the measured wisdom of Kissinger rings a sober note of caution for current international relations.



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The work of AMA (ACT) thrives on the contribution we get from our volunteers and helpers. Whether that be as an officer bearer or board member, member of our Advisory Council, Council of Doctors in Training, Canberra Doctor Editorial Committee or contributor to Canberra Doctor.

Opportunities have arisen for you to assist us on the AMA (ACT) Advisory Council and the editorial committee of the *Canberra Doctor*.

## AMA (ACT) Advisory Council

The Advisory Council, chaired by Dr Rashmi Sharma, is established by the AMA (ACT) Constitution to provide a forum for policy development and policy review and to provide advice to the AMA (ACT) Board on policy matters.

The format of the meetings usually sees a brief verbal report from the craft and special inter-

est group representatives and then a discussion on a particular policy issue or issues. With this being an election year in the ACT, the Advisory Council has been considering the issues relevant for AMA (ACT) to be pursuing in the lead up to and during the election period.

The Advisory Council is made up of representatives of the various craft groups, together with salaried doctors, medical students and doctors in training. In addition, the AMA (ACT) President is a member as are the AMA (ACT) representatives to the



Dr Rashmi Sharma, Chair of the AMA (ACT) Advisory Council.

AMA Council of General Practice, Council of Salaried Doctors and Council of Doctors in Training.

The AMA (ACT) Advisory Council usually meets three times a year on a Wednesday evening starting at 6.30pm at the AMA (ACT) offices in Barton. Dinner and refreshments are provided.

For more information or to join the Advisory Council please contact Peter Somerville on 6270 5410 or [execofficer@ama-act.com.au](mailto:execofficer@ama-act.com.au)

## Canberra Doctor Editorial Committee

The *Canberra Doctor* is produced in ten editions each year and is the primary means by which the AMA (ACT) communicates with the medical profession in Canberra and the surrounding region. With the recent resignation of the chair of the Editorial Committee, AMA (ACT) Board has called for expressions of in-

terest both as chair of the committee and for positions on the committee. Committee meetings are usually held on the second Thursday of each month from February to November with the meeting commencing at 6.30pm for about an hour.

Any assistance members feel able to contribute, either as a members of the committee or as a contributor to the *Canberra Doctor* would be most welcome.

For more information or to join the *Canberra Doctor* Editorial Committee or to contribute to the *Canberra Doctor* please contact Peter Somerville on 6270 5410 or [execofficer@ama-act.com.au](mailto:execofficer@ama-act.com.au)

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**Editorial:**  
Peter Somerville  
Ph 6270 5410 Fax 6273 0455  
[execofficer@ama-act.com.au](mailto:execofficer@ama-act.com.au)  
**Typesetting:**  
Design Graphix  
Ph 0410 080 619  
**Editorial Committee:**  
Peter Somerville  
– Production Mngtr  
Dr Ray Cook  
Dr John Donovan  
A/Prof Jeffrey Looi  
**Advertising:**  
Ph 6270 5410, Fax 6273 0455  
[reception@ama-act.com.au](mailto:reception@ama-act.com.au)  
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**AMA ACT membership entitles you to access this Member Reward Partner**  
**THE ESSENTIAL INGREDIENT**  
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**AMA ACT membership entitles you to access this Member Reward Partner**  
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Ph: (02) 6162 0808  
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Conditions may apply and you must produce your membership card to access these benefits.

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Ph: (02) 6163 1888  
– Accommodation only  
Conditions may apply and you must produce your membership card to access these benefits.

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You don't need to go to Tuscany for good Italian wines. Canberra has a climate very close to Tuscany's.  
Conditions may apply and you must produce your membership card to access these benefits.

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Ph: (02) 6295 0315  
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**Membership Rewards Program Partners ~ 10% discount\* See Page 13 for details...**  
\* conditions may apply.



# Orthopaedic Surgeon

PRACTICE LOCATION



## Dr Wisam Ihsheish

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**Knee arthroscopic surgery, hip and knee replacements and general orthopaedics**

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Fax 6109 0003

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56-58 Clifford St,  
Goulburn NSW 2580  
Ph 4823 0223  
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on 02 4471 5199 or 0438 130 053  
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#### Emphasis on Healthy Ageing

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- Cognitive Impairment/Dementia
- Medication Management
- Falls

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APPOINTMENTS 02 6285 1409

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[www.capitalmedacupuncture.com](http://www.capitalmedacupuncture.com)  
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Medicare Plus  
NDIS Provider  
Dietetic Clinic  
Physiotherapist  
Warm Water Exercise  
Strength and Balance  
Phone: 1800 011 041

## Dr Julie Kidd GP Hypnotherapist

Smoking, alcohol, binge-eating, stress, anxiety etc.

Canberra Complementary Health Practice  
Suite 4, Playoust Bldg, Hawker Pl, Hawker  
0425 300 233 | [www.canberrahypnosis.com.au](http://www.canberrahypnosis.com.au)

## Dr Muhammad Choudhry FRACP NEPHROLOGIST/GERIATRICIAN

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- Comprehensive geriatric assessment
- Cognitive assessment
- Home visits
- Residential aged care consultation provided
- Bulk billing

Suit 11/12 Napier Close, Deakin ACT 2605  
Phone 02 6154 5031  
Fax 02 6169 4437  
[MuhammadErfan.Choudhry@act.gov.au](mailto:MuhammadErfan.Choudhry@act.gov.au)

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endoscopic surgery  
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experienced care

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39 GREY STREET DEAKIN ACT 2600  
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### A. J. Collins MB BS FRACS

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#### Oncoplastic Breast Surgery – including:

- ▶ Immediate breast reconstruction and breast reduction techniques
- ▶ Breast Cancer surgery
- ▶ Sentinel node biopsy

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Phone: 02 6282 1191  
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For further information  
please call the practice on 02 6282 2033  
or email [reception@womenshealthonstrickland.com.au](mailto:reception@womenshealthonstrickland.com.au)



## Dr Sabari Saha

MBBS (Hons), FRACP

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- Falls assessments
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Deakin ACT 2605  
Phone: 02 6154 5031  
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## Dr Damian Smith Orthopaedics ACT

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- Hip replacement
- Knee replacement
- ACL reconstruction
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- Patella surgery for dislocations
- Tibial and femoral osteotomies for arthritis
- Multiligament surgery
- Achilles tendon repair

Patients do not need to have private health insurance to be seen by Dr Smith in his consulting rooms.

Phone: 6221 9321 | Email: [dsmith.admin@orthoact.com.au](mailto:dsmith.admin@orthoact.com.au)  
Level 2, 90 Corinna Street, Woden ACT 2606



### Dr Maciek Kuzniarz

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Comprehensive general ophthalmology services and oculoplastic surgery including:



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- ▶ AMD management
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