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Salaried doctors agreement in operation, VMO arbitration next

The ACT Public Sector Medical Practitioners Enterprise Agreement 2013-2017 has finally been approved by the Fair Work Commission with effect from 27th January 2016. The Agreement covers all medical practitioners employed by the ACT Health Directorate and Calvary Health Care ACT.

While much of the change contained in the Agreement focuses on salary and leave, there are, however, improvements to DIT conference leave and support for overseas activities.

Salary Increases

With the new agreement covering a period dating back to 2013, salary increases of 2%, 1.5% and 1.5% will flow through immediately and a further 1.5% from October this year. AMA (ACT) understands that these new rates should have been paid from 25 February.

Back pay should be paid on or by 24 March. Former staff who have resigned since 1 July 2013 will also be eligible for back pay.

Allowance rates will be increased in line with annual pay increases.

Changes to Leave

Several new or enhanced leave provisions are part of the new agreement with bonding leave extended and fostering, short time caring, adoption and permanent care arrangements amended. Domestic violence leave has also been introduced.

New provisions have been introduced to enable cashing out of annual leave and long service leave. The latter can be cashed out in full or partially, up to accrued credit. Some restrictions apply to the cashing out of annual leave.

Conference Leave

Reimbursement of conference leave expenses for DITs, Career Medical Officers and Post Graduate Fellows are to be indexed annually. The trade-off for this improvement is that the JMO Bonus has been deleted. Expenses for overseas conferences can now be claimed subject to travel being approved in advance.

Other Changes

In line with the Fair Work Act, employees may now seek flexible working arrangements based on caring responsibilities, disability and being over the age of 55.

The provisions for breaks following a period of seven consecutive days' duty or following a period of night duty have been amended from 24 hours to 1 day and 48 hours to 2 days, respectively. To avoid any ambiguity, a day is defined as the period from midnight to midnight.

If you have any questions, please contact Andy Ozolins: phone 6270 5410 or email industrial@ama-act.com.au

VMO Arbitration

Following the negotiating period that concluded in the latter part of 2015, the AMA (ACT), Visiting Medical Officers Association (VMOA) and ACT Health have produced an agreed statement of facts for presentation to the arbitrator, Mr Greg Smith. Mr Smith's appointment as arbitrator was made by Minister Corbell and notified to AMA (ACT) and the VMOA at the conclusion of last year.

The arbitration itself is set down for the first week of April.

The major areas of contention deal with ACT Health's claim for a "more flexible" contract with greater controls over VMO payments and the ability to vary the contract terms with minimal notice. ACT Health's claim includes a proposal to make any increase in rates subject to efficiencies gained from the new contract provisions.

The AMA's main claims are in regard to an annualised 2.5% increase in rates, payment for attendance at training and for supervisory purposes and additional VMO parking. The VMOA has similar objectives and we strongly support the VMOA proposal to have VMOs more involved in hospital and departmental-life.

We are similarly in agreement with the VMOA in opposing ACT Health's claims for a range of greater controls over VMO arrangements including termination rights and variation to workloads with very limited notice.

Submissions to the arbitrator are now being prepared with the hearing dates a little over a month away.

Capital Conversations with President, Dr Elizabeth Gallagher

Although it may seem a little late, with this being my first column of the year, I'd like to extend my best wishes for a happy new year to all the readers of the Canberra Doctor.

As I get older, it seems time, and life are flying past; my children have grown into young men in the blink of an eye, I'm already planning for 2017 and the biggest challenge continues to be simply to stop and smell the roses.

I have really enjoyed my time as AMA (ACT) President not least of which because of the range of issues that come across my desk. Working as a clinician is hugely rewarding but then being asked for public comment on or insights into medico-politics, service provision, budgeting, public health issues, integration of care and all to the deadlines of media can be quite daunting. It took me at least a year to feel comfortable and understand just how the media works and ensure the views of the medical profession are regularly part of the public debate about health.

Then only the other day, I realised my term as AMA (ACT) President comes to an end in about 10 weeks!

AMA (ACT) AGM and new President

On that note, the AMA (ACT) AGM and installation of Prof Steve Robson as the new President will be held on Wednesday 11 May at the Realm Hotel in Barton. This year, I invite all members to join us from 6.30 pm for drinks followed by a two-course dinner – all for $35 per head. If you can't make dinner please come along for the AGM commencing at 8pm.

Of course, I'm looking forward to making the AGM a more social event and am very keen to meet and talk with new members, catch up with colleagues and reacquaint myself with friends I may not have seen for some time.

A/Prof Brian Owler at TCH

Another date for your diary is Wednesday 30 March where AMA (ACT) is hosting the AMA President, A/Prof Brian Owler, at an Open Forum in the Auditorium of the ANU Medical School at Canberra Hospital. Come along and join us, with refreshments available from 6.30pm and the Forum to start at 6.45pm. Brian has kindly agreed to give a short update on issues the AMA is currently dealing with and then take questions from the floor.

If you can't make it to the Forum, please send us your questions and we'll pass the best of them on to Brian for an answer at the Forum. Don't forget – it's a free event and open to all medical practitioners and medical students in the Canberra region.

2015 AMA (ACT) Student Leadership Prize

Each year, AMA (ACT) through the ANU Medical School, funds a student prize for leadership. In 2015, Dr Lauren O'Rourke was the recipient with the award being made at the ANU Medical School Graduation Ball held prior to Christmas. Lauren has been an outstanding leader in the ranks of medical students and we are looking forward to working with her into the future as she progresses through her medical career.

On the morning prior to the graduation ball, AMA (ACT) hosted a breakfast for the graduates in recognition of their achievements and to welcome them to the medical profession. AMA Federal Vice-President, Dr Steve Parnis attended and spoke to the graduates along with AMA (ACT) President-elect, Dr Steve Robson and Board, members Dr Andrew Miller and Dr Suzanne Davey.

My thanks to Steve Parnis and the AMA (ACT) Board members and also to the new graduates and interns for helping us sign up more than 50 new members over both the breakfast and subsequent intern orientation. I want the interns and all the other existing and new Doctors in Training working with ACT Health in 2016 to know that you have the support of the AMA (ACT) both now and in your future careers.

Finally, on the list of recent events, I had the pleasure of hosting our annual "Welcome Drinks" for first year Medical Students during their "O Week" at the Uni Pub. Steve Robson and I had the opportunity to talk and mingle with the new class, learning a little about them and, in return, giving them a better understanding of the AMA. The current crop of students will enter into a far different workforce – and workplace – than even a few short years ago with significantly different opportunities and threats to their chosen careers.

A good reason to join

With the new term starting and membership renewals upon us, I'm always reminded that the AMA is one of very few organisations – or maybe the only one – that will be with you for your entire medical career. From students, through to new graduates, to Doctors in Training, fellowships and into specialist practice and even into retirement. While the AMA cannot be everything to everyone all of the time – if you do not have a voice, you will not be heard.

That's why your membership is vital.

2016 – The year of the election

A Perfect Storm of elections are brewing this year with both a local, ACT election and a likely double dissolution Federal election occurring in the second part of the year. The recent release of the AMA Public Hospital Report card highlighted that the quality of health care is not keeping up with demand and expectations and that the Federal Government, in particular, needs to come to the party on health funding.

As the ACT election approaches, we look forward to hearing from Labor, the Liberals and the Greens on their plans for healthcare. AMA (ACT) will continue to talk to all the parties and test their views against what we know of the health system, the needs of patients, and the concerns of doctors.

Finally, I'd like to congratulate Dr Rashmi Sharma on her Australia Day Award. Rashmi has been a hard working representative of our profession for many years, and the award is just recognition. Congratulations Rashmi!

Canberra GP Dr Rashmi Sharma awarded OAM

Well-known Canberra GP, educator and former Medicare Local chair, Dr Rashmi Sharma has been awarded the Medal of the Order of Australia (OAM) in the 2016 Australia Day honours for her service to medicine, and to professional organisations.

The Canberra Doctor and AMA (ACT) congratulates Dr Sharma on the award and acknowledge both her past service and her current roles as a board member of AMA (ACT) and the Chair of AMA (ACT)'s Advisory Council.

In addition to her current clinical practice, Dr Sharma is an Adjunct Associate Professor and GP supervisor with the Australian National University and a former senior lecturer and clinical skills tutor. Her history of involvement in vocational general practice training is extensive, having been a GP supervisor training GP registrars since 2003 and a medical educator with the former Coast City Country GP Training, the regional training provider.

Over the last 12 years, Dr Sharma has also played an important role in Canberra-based advocacy and health policy development. From 2007 until 2014 she was chair of the ACT Medicare Local (now the Primary Health Network) and prior to that a board member from 2004. She's also been chair of the Practice Principals Group, the GP Advisory Committee and Clinical Governance Committee.

Dr Sharma moved to Australia in 1993, after finishing med school in the UK where she was born, with her first job as a registrar in a small Queensland country town. She says it was a great start to her Australian life and she learnt quickly in a range of areas.

"Australia has one of the best health systems in the world and part of that is attributable to the high standards it demands of its health professionals. I had to sit the Australian Medical Council exams when I migrated from the UK."

"I agree the process of navigating the system to get through the relevant exams and get qualifications recognised can be complex, but I think people need to persevere, link into local help and see how they go."

Since then, of course, things have changed not only for Dr Sharma but in medicine more generally, "there are more women studying medicine in Australia than men, but I think the issue is the recognition of women in these senior roles,"

"We know that there is a lack of female representation in leadership and governance roles and I think this reflects on Australian society as a whole where we know gender equity is still an issue" Dr Sharma said.

With a busy life split between her northern NSW farm, Canberra and Sydney Dr Sharma feels that life's working out well, in a good place, "I live in Murwillumbah in northern NSW with my two, husband Stuart and my parents on my farm. I commute to Canberra for work and spend three days away from home, either at my surgery or on government-related work.

"I then spend four days at home where I head up GP training for the North Coast region. It's a bit nutty, but I enjoy it! I think I get the best of both worlds – a career I enjoy as well as a satisfying family life."

2016: A year of challenges for health policy

With the growing need to meet the challenges of 21st century healthcare, Stephen Duckett indicates change is on the horizon.

We start 2016 as we started 2015 – with big challenges for the health system and uncertainty as to how government will meet them.

The healthcare headaches in 2016 are, in fact, the same ones we faced a decade ago, albeit different in severity and symptoms. They include population growth, ageing and the rise of chronic disease; inequality in access to care and health outcomes; technological change (the good, bad and expensive); and the seemingly inexorable rise in health costs.

Circling for landing are three major reviews on primary care, low-value care and private health insurance. Their recommendations, and the government's response to them, are very much up in the air. Adding to the uncertainty is the broader review of federalism and its consequences for public hospital funding, along with speculation around the 2016 election date and what each party's Santa sack of election promises might contain.

Public hospitals

2016 will be a challenging year for public hospitals. Major reductions in Commonwealth funding for hospital admissions – which continue to grow – will kick in from 2017, and States are likely to start the belt-tightening early. The cuts far exceed the amount of fat in the system, so a reduction in services is likely. Efficiency may be improved somewhat by the ongoing expansion of activity-based funding to mental health and 'sub-acute' care.

Hospitals will also be under pressure to lift quality. Hospitals face increasingly stringent 'quality standards' with tougher monitoring covering a broader scope of issues, including access and timeliness. Meanwhile, the increasing array of publicly available data is putting variation in hospital performance under the spotlight more and more, with commensurate calls for greater accountability.

Medicare

Two independent reviews of Medicare are expected to land sometime in 2016.

The first examines primary care. It could address any number of challenges, including chronic disease management, 'six-minute medicine', co-payments, frozen rebates, and the growing corporatisation of practice.

Chronic disease management poses the main challenge. The rise of chronic disease is imposing big costs on a system that wasn't designed to provide the complex, continuous and coordinated care now needed. Government will have to consider far-reaching reform with only limited and equivocal evidence to draw on. Options include a shift in the balance of payments to practices, with less emphasis on payment for attendances (fee-for-service) and more emphasis on payment for care over the episode of illness or year (capitation payments).

There may be other changes in payment structures. The Government's longstanding desire to reduce perceived incentives for six-minute medicine may see a minimum consultation time imposed on the standard (Level B) fee. If sense prevails we won't see a resurrection of the GP co-payment policy zombie. We should, however, see an end to the freeze on medical rebates; the only question being when and with what trade-offs.

A further issue to be addressed is the shift toward practices owned by corporate chains that profit from referrals to and provision of diagnostic services. The implications of changed ownership structures for practice are not at the forefront of practice payment redesign but should be.

The second review looks at quality and cost-effectiveness of items on the Medicare schedule. The review got off to a rocky start with wild claims about 30% waste in the system, but is now getting into the hard grind of identifying what items in what circumstances are ineffective or over-used – issues much more complex than simply identifying useless items and removing them from the schedule.

The work on modernising the schedule will come to fruition in 2016. There will be individual and group losers in this process who undoubtedly will scream loudly with varying levels of effectiveness.

Conclusion

It isn't yet clear whether Minister Ley's appetite for reviews portends massive reform to the sector, or simply a politically judicious preference for treading water in a portfolio still reeling from tumultuous management by her predecessor. However, the auguries are good for the former. The scene for change has been set, at least with the medical profession. Respectable leaders are engaged and leading the option-identification process. 2016 may well be the year that the health system rises to meet the big challenges of 21st century healthcare.

Stephen Duckett is the Director of the Health Program at Grattan Institute. Reprinted courtesy of NSW Doctor.

AMA Public Hospital Report Card – ACT struggling

Earlier in February the AMA released its Public Hospital Report Card showing that there has been little, if any, improvement in public hospital performance in the four key areas reported. The four areas are – emergency department waiting and treatment times and elective surgery waiting and treatment times.

The AMA also reported on public hospital capacity – showing bed ratios being cut by more than 42% since 1993-94 and commonwealth funding.

The changing basis for Commonwealth funding of public hospitals adopted following the 2014-15 budget has been the focus of considerable debate with some state premiers urging an increase in the GST to cover the shortfall. More latterly, of course, the Australian Government has refused to consider that option and moved on to other areas of tax reform.

AMA (ACT) president Elizabeth Gallagher has called on the Australian Government to increase funding to the ACT and live up to the promises made by its predecessors to improve public hospitals.

"In the ACT in 2014-15, the results have been mixed with disappointing results on key Emergency Department indicators but improvements in some elements of elective surgery such that:

- Only 48% of urgent Emergency Department cases were seen within the recommended time of 30 minutes. This was a decrease from 50% in the previous year.
- In regard to elective surgery, waiting times have continued to reduce with the median waiting times now at 45 days
- The percentage of Category 2 elective surgery patients admitted within the recommended time frame of 90 days has gone backwards to 69% from the previous year's 74%."

"While the improvements in elective surgery are welcome, along with the recently announced new beds in the Emergency Department at Canberra Hospital, the fact is that ACT public hospitals continue to struggle to keep up." Dr Gallagher said.

Despite acknowledging significant improvements in the waiting times for elective surgery, the association described the performance of ACT emergency departments as "disappointing".

ACT AMA president Dr Liz Gallagher said hospital funding would be a key issue for both sides of politics, with a territory election scheduled for October 15.

"Health is always one of the hot topics in an election and both sides of politics know this is going to be a political issue," she said.

Substance use and addiction in primary care

Did you know that most people seeking help for substance use and addiction use their GPs as the first point of contact? GPs are well placed to assess these issues, provide brief intervention or refer for further treatment, as these things can take place within the context of a typical consultation session. Routine screening is recommended; but how do you know how to do an assessment, and what to do with the results? This article aims to help answer these questions.

Setting the scene

You really don't need to be told about the extent of alcohol and drug use in Australia, nor the significant harms caused to individuals, families and communities. Suffice to say, a significant proportion of the population consume alcohol and other drugs on a regular basis.

Substance use occurs on a continuum, from occasional use to dependence. Addiction is a pattern of use that is characterised by the syndrome of dependence in addition to compulsive substance-seeking behaviours and persistence, despite significant negative consequences. In general practice, it is likely you will see patients ranging across the entire spectrum.

Assessment is crucial

Assessment of the issues is the first important step in tailoring treatment, and this is where GP input is crucial, as the most common first contact.

So how do you do an assessment in primary care that optimises your chances of engaging the substance-using patient in treatment? First of all, always ask a patient if they are using alcohol or other drugs regularly. This is especially the case if they are presenting for mental health problems such as anxiety or depression. Sometimes their mental health problems can be due to the effects of substances, or they may be using substances to self-medicate for their mental health problems.

Remember that drugs can take many forms – illicit drugs of course, but also prescription drugs of abuse and dependence (Schedule 8), over the counter medications containing codeine, alcohol, tobacco and synthetic drugs such as synthetic cannabis (eg. 'Kronic', 'Marley'). Don't forget to ask about these, as many people don't consider prescribed or over the counter medications as drugs. Keep in mind that polysubstance use is the norm, so patients are probably using more than one type of substance.

Assessment can include standardised measures of use that measure quantity consumed and the presence of dependence – such as the AUDIT (Alcohol Use Disorders Identification Test). However patients may tend to understate their intake and frequency, so it can be more helpful to assess the impact substances may be having on a patient's life. I find it useful to use the acronym of HARM. Ask:

- Has your Health suffered as a result of your substance use?
- Has your ability to participate in your usual Activities been impacted?
- Are any of your Relationships suffering?
- Have you experienced any Money problems as a result of your substance use?

Answers to these questions may provide an indication as to what kind of intervention is required.

The stages of change

Any referral or intervention must be guided by the patient's 'stage of change' with regards to their substance use. When considering behaviour change, individuals move through predictable stages of change:

- precontemplation - not ready to change;
- contemplation - considering change as an option, gathering information;

- preparation – making a plan for change;
- action – making the change; and
- maintenance – after around six months of sustaining behaviour change.

Each patient's stage of change must be matched with the appropriate intervention for optimal chance of success.

Matching stage of change to your intervention is crucial

For those who are consuming substances at less than risky levels, who are experiencing minimal harms, or who are pre-contemplative about change, education is encouraged. Education about safe consumption levels, safe using practices, and the physical and psychological e ects of the substance may be useful. Providing information in the form of lea ets and websites is usually helpful. Try and 'leave the door open' for future consultation if they choose to change in the future.

For those who are consuming at risky levels, experiencing harms, or are contemplative about change, brief intervention and some basic motivational interviewing questions are required. Open questions about the negative impacts of substance use, coupled with an empathic, non-judgmental attitude can do wonders in helping a patient move towards change. Ask these patients if they are interested in the kinds of help available and if they are, provide them with details of their local AOD service or a psychologist experienced in treating substance use. You can refer to a psychologist under the Better Access scheme.

If a patient is dependent on or addicted to a substance, or experiencing significant harms, more intensive intervention is required, including detoxification. Some skillful motivational interviewing questions will be helpful here, as many patients may be unconvinced of the need to change. A team approach here works best. Referral to an Addiction Medicine Specialist would be helpful. Referral to a clinical psychologist with experience and skill in treating these issues is highly recommended. Other options include the local AOD service, residential rehabilitation (many require patients to already be detoxed – you'll need to check this). DirectLine (1800 888 236) is a fantastic resource if you're not sure of your client's local health service or closest rehabilitation service.

AA or NA?

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are support groups facilitated by community members who have experienced addiction themselves. They can be a great source of social support for patients, however they should not be used as a standalone treatment as they are not informed or monitored by any kind of professionals. If a patient wants to try AA or NA, encourage them to attend a few different meetings to get an idea of which kind of meetings suit them.

A final word: get ready to be in it for the long haul

Progress with this population of patients is often slow. However this does not mean there is something wrong with the patient, they are not trying hard enough, or interventions are not working. It can be disheartening and even frustrating when patients persist with behaviours that are harmful to themselves and others. However it's important to remember that most people make many attempts at changing any behaviour before they are successful, and even then, there are often slip ups. Individuals with substance use problems are no different. The best way you can help in general practice is to persevere despite setbacks, and to always leave your door open. You never know – this consultation could be the one that sets the scene for long-term change.

Article by Melissa Kent, MAPS, Principal Clinical Psychologist Melissa Kent Psychology, Substance Use and Addiction Program, Delmont Private Hospital – courtesy of VicDoc magazine.

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.

It's easy – just search for AMA ACT.

Important information for AMA ACT members

REMINDER

2016 SUBSCRIPTION PAYMENTS ARE NOW OVERDUE

To renew your membership please go to website: **https://ama.com.au/act**

Or contact membership officer: **membership@ama-act.com.au**

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FARE: The alcohol industry's dependence on Australia's heaviest drinkers

The Foundation for Alcohol Research and Education's (FARE's) latest research tells us that alcohol harms in Australia are extensive and well acknowledged: resulting in 5,500 deaths every year and a further 157,000 hospitalisations.

The alcohol industry's oft-cited defence to these statistics is to reference official per capita consumption which shows national alcohol consumption in decline to argue that Australia has become a nation of responsible drinkers.

FARE's recent research report, titled *Risky business*, shines a light on the industry's claims by revealing that the decline in the amount of alcohol being consumed as a nation in fact masks alarming patterns of consumption in significant segments of the population.

Outcomes

The findings contained in *Risky business* are drawn from an analysis of the study *Understanding recent trends in Australian alcohol consumption* by the Centre for Alcohol Policy Research (CAPR).

More than 3.8 million Australians average at least four standard drinks of alcohol per day or that's twice the recommended health guidelines.

Over 1.9 million Australians drink on average more than six standard drinkers per day, three times the amount outlined in the Australian Guidelines to Reduce Health risks from Drinking Alcohol. Just under a million Australians consume on average more than eight standard drinks a day, equivalent to more than four times the recommended health guidelines.

Risky business, which also comes as a video, exposes the alcohol industry's 'dirty little secret' – its economic dependence on these risky drinkers.

The 3.8 million Australians averaging more than four standard drinks of alcohol per day represent just 20 per cent of all Australians aged 14 and over, yet this group accounts for a staggering 74.2 per cent of all the alcohol consumed nationally each year.

The alcohol industry's reliance on risky drinking is brought into sharp relief when examining the economic impact of measures to encourage 'super consumers' to drink within the guidelines. If these 'super consumers' changed their habits to be within guidelines, the total alcohol consumed nationally would be reduced by 39 per cent.

The *Risky business* paper expands on the 'super consumer' story, providing greater detail on the alcohol consumption data, an overview of the Australian alcohol industry and an analysis of the impact on the industry if 'super consumers' where given the necessary support and encouragement to drink within the guidelines.

Recommendations

FARE's analysis of drinking patterns shows that a reduction in alcohol consumption by the top 20 per cent of Australian drinkers would have a dramatic effect on the alcohol industry's size, shape, viability, and overall profitability.

FARE says it is for this reason that public health researchers and advocates have refrained from working with the alcohol industry. FARE has now called on governments to do the same and cease co-operation with the industry.

For further information or to download or watch the Risky business materials go to http://www.fare.org.au and go to the Research tab.

New standards for CPD and recency of practice

The Medical Board of Australia has published revised registration standards for continuing professional development (CPD) and recency of practice.

The revised standards will take effect on 1 October 2016 with the MBA publishing them now in order to assist with a smooth transition. Registered medical practitioners must ensure they comply with the revised CPD and recency of practice registration standards from 1 October 2016.

Continuing professional development

Registered medical practitioners must ensure they comply with the revised CPD registration standard from 1 October 2016.

The revised CPD registration standard has not changed significantly. All registered medical practitioners must continue to participate in regular CPD activities.

Medical practitioners with specialist registration must continue to meet the requirements set out by their relevant college. Medical practitioners with general registration (who do not have specialist registration) must continue to complete a minimum of 50 hours CPD per year.

For medical practitioners with provisional registration or limited registration, the standard more clearly sets out the requirements to ensure their CPD is linked to their training position and/or supervision plan. The revised standard requires international medical graduates to complete a minimum of 50 hours CPD per year.

Recency of practice

The recency of practice standard has changed to the extent that practitioners will need to practise a minimum number of hours to meet the standard. The standard also explains requirements for returning to practice after an absence and requirements for changing scope of practice.

Practitioners must ensure they comply with the revised recency of practice registration standard from 1 October 2016.

To meet the standard, medical practitioners must practise within their scope of practice at any time for a minimum total of:

- four weeks full-time equivalent in one registration period, which is a total of 152 hours, or
- 12 weeks full-time equivalent over three consecutive registration periods, which is a total of 456 hours.

Full-time equivalent is 38 hours per week. The maximum number of hours that can be counted per week is 38 hours. Medical practitioners who work part-time must complete the same minimum number of hours of practice – this can be completed part-time.

The Medical Board says that most practitioners who are currently practising will meet the revised standard.

The change may affect practitioners who are currently practising infrequently, or who have had a recent absence from practice or who are currently taking a temporary break from practice. The MNA has advised that a key reason why the revised standard has been published well before it takes effect is to provide practitioners with enough time to prepare for the changes.

If a medical practitioner cannot meet the minimum hours of practice in the revised standard, this will not necessarily prevent them from returning to practice as a medical practitioner. The standard sets out the requirements for medical practitioners who don't meet the standard, including those with non-practising registration and medical practitioners who are not registered and wish to return to practice after 1 October 2016.

The new standards can be found at: http://www.medicalboard.gov.au/News/2016-02-02-recency-of-practice.aspx

2016 Directory of Medical Specialists, Directory of Allied Health Professionals and Directory of GPs with Special Interests

… a publication of the AMA ACT

AMA (ACT) LIMITED

The third edition of the directory of **Allied Health Professionals** and **GPs with Special Interests** will be published as a service to ACT general practitioners and distributed with the 11th edition of the **Directory of Medical Specialists** during Family Doctor Week in July 2016.

Entries must be on the form below and returned to the address below no later than 30 April 2016.

Mail: AMA ACT, PO Box 560, CURTIN ACT 2605

Fax: 6273 0455 Email: reception@ama-act.com.au

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

Name:
Speciality:

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

Practice Details (1)	**Practice Details (2)**
Phone:	Phone:
Address:	Address:
Fax:	Fax:
Email:	Email:
Website:	Website:

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

Signed: _____ Date: _____

AHPRA registration number: _____

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

NOT FOR PUBLICATION

Contact Phone: _____

A proof of your entry will be sent prior to printing. Please indicate preferred method to receive this:

☐ Fax number:_____ ☐ Email address: _____

Tomosynthesis breast biopsy

Breast tomosynthesis (3D mammography) acquires images of the breast at multiple angles. Individual images are reconstructed into a series of high resolution slices 1mm thick.

Tomosynthesis reduces the challenge of detecting invasive cancers in the presence of overlapping structures in the breast.

Compared with full field digital mammography, invasive cancer detection is increased by up to 40%, while false positives are decreased by 15-40%.

Breast compression is similar to that of standard mammography, and image acquisition is only a few seconds longer.

Radiation dose is well within accepted limits, particularly with synthesised 2D views.

Tomosynthesis guided vacuum-assisted breast biopsy has been available in the ACT since December 2015, enabling fast, accurate, minimally invasive tissue sampling of breast lesions seen on 2D and 3D mammographic imaging which are invisible on ultrasound.

Compared with previous stereotactic techniques, initial experience has shown reduced procedure times, a potential for reduced radiation dose, ability to biopsy lesions not seen on standard mammography, and successful sampling of low contrast lesions.

By Dr Brendan Cranney, MBBS(Hons), FRANZCR
Image courtesy of Hologic, Inc and affiliates.

Sexual abuse of doctors, by doctors: a narrative study

Contemporary attitudes to sexual abuse are changing. The Royal Commission into Institutional Responses to Child Sexual Abuse, the response of the Australian Defence Force to allegations of sexual abuse in the military and the work of the Australian Human Rights Commission around sexual harassment in the workplace all indicate a shift in community values.

Dr Louise Stone and her colleagues at the ANU believe that those changed attitudes have resulted in a shift in understanding of the nature and scope of professionalism including in the medical profession. Respected institutions have had professional failings exposed and it seems that few groups are immune. Existing codes of professional conduct have not protected colleagues or clients from toxic behaviour.

As a further step in this process the ANU group are involved in a study looking at the scope, impact and context of sexual abuse of qualified doctors in the medical workplace. Despite over a decade of research reporting that doctors, especially in the early part of their training, experience sexual harassment, it is not clear how best to respond to this issue. With surprising little literature on the issue, there can be little clinical or academic conversation around the support and treatment we can offer these traumatised doctors, and no organisational response to the culture that enables or tolerates this behaviour. There is also little written about the impact of sexual abuse on the career aspirations and professional decisions of doctors.

This qualitative study currently being undertaken is designed to explore how doctors understand their experience, seek help for the effects of sexual trauma and pursue their careers in the wake of this experience. The study is the first of its type internationally and is being conducted by a team of GP researchers from ANU. The research team is supported by an expert reference group with expertise in ethically sensitive research processes, organisational behaviour change, effective methodological design, appropriate dissemination and effective research translation.

Further information about the study, including links to register interest in participating in the research, can be found at ofdoctorsbydoctors.com or by emailing Dr Louise Stone at louise.stone@anu.edu.au. A notice also appears in this edition of Canberra Doctor.

Events...

Since the last edition of the *Canberra Doctor* we've had several events celebrating milestones for young doctors and medical students locally. The AMA's graduation breakfast featured at the end of last year where Federal AMA Vice president, Dr Steve Parnis and AMA (ACT)'s President-Elect, Dr Steve Robson, did the honours.

Later the same day, a very successful Graduation Ball for ANU Medical Students was held, with Dr Lauren O'Rourke being presented with the AMA (ACT) prize for student leadership by AMA (ACT) Treasurer, Dr Andrew Miller.

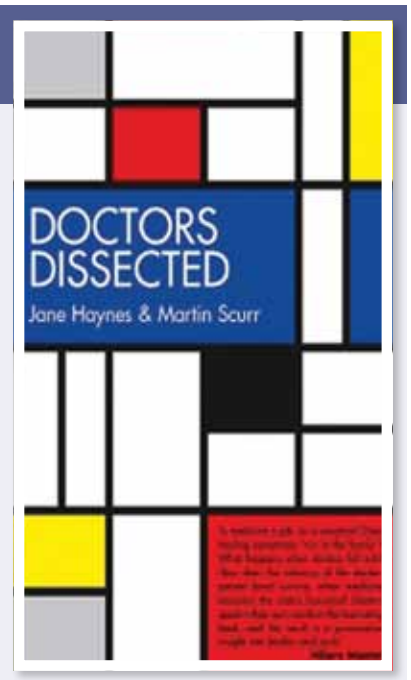
In early February, AMA (ACT) hosted a welcome for medical students at Unipub that saw some 80 first year students come along to share AMA ACTs hospitality and be welcomed by Dr Liz Gallagher, AMA (ACT) President, Dr Lauren O'Rourke and Jazmin Hawes, the AMA (ACT) student rep.

Graduation Ball

Student Welcome Drinks

Graduation Breakfast

BOOK REVIEW: Doctors Dissected



Jayne Haynes and Martin Scurr, Quartet Books, London, UK 2015: ISBN 978-0-70437-375-4, GBP 20

Jayne Haynes, a psychotherapist and Dr Martin Scurr, a GP present a series of interviews and reflections on life trajectory and career of a number of UK GPs and Scurr's son, Cosmo, an anaesthetic registrar. The book gives a view into the looking glass world of the UK general practice but is certainly not restricted to the NHS, as a number of the GPs describe work in the private medical sector. Haynes and Scurr both work in the Blue Door psychotherapy practice in London, which Haynes co-founded.

The diversity of the pathways into general practice is striking, in contrast to the current pressures upon young doctors in Australia to make haste into a speciality; but perhaps these tales mainly arise from the circumstances of previous era either in the forging of early experience or in the career, even in the UK.

There are stories from eight GP or GP trainees, including Martin Scurr, a junior doctor, and the story of Cosmo Scurr, as well as discussions into Martin Scurr's recurrent migraines, Hayne's irritable bowel syndrome and of course the mortality of the doctor. The richness here is in the depth of enquiry, which encompasses a lifespan history as well as career trajectory, viewed through the lens of Hayne's experience as a non-medical, formerly Jungian, now relational psychotherapist with considerable experience working with doctors.

Louring over all the stories, as the authors note are, as Raymond Tallis observed, the repeated re-disorganisations of the NHS. However, it is the thoughtfulness and honesty of the doctors in telling their stories that particularly shine a light on the experience of being a GP in the UK.

Certainly, there is vividness and depth in exploring personal stories that cannot be achieved solely by quantitative measurement or analysis. Whilst the psychotherapeutic lens is particularly useful in the one-to-one therapeutic setting, it is probably an over-reach to draw the threads together of the rich tapestry of the very different lives into summative psychodynamic conclusions without a systematic qualitative study. To be fair, the authors mainly seek to identify themes. However, when from such a small sample the authors observe that all female doctors acknowledged some depression in their lives, whilst male doctors described none and proceeded to draw conclusions from there, the authors are over-reaching.

Overall, this is a very thoughtfully written and considered book that encompasses many aspects of the personal experience of being a doctor recognisably common to Australia and the UK. The richly described uniqueness of the doctors' personal and career journeys is remarkable. Yet, the looking glass element of the NHS is omnipresent, casting a strange reflection upon all. The courage and honesty of all the participants, authors and interviewees alike, is a commendably great gift bestowed upon us via Haynes and Scurr. I hope that there are many other stories told from our vocation in the future, and similarly from my own profession such as Dr Christine Montross's Falling into Fire (reviewed previously in the Canberra Doctor).

Reviewed by Associate Professor Jeffrey Looi, Academic Unit of Psychiatry and Addiction Medicine, ANU Medical School.

Changes for the *Canberra Doctor*

Prior to Christmas we conducted a survey of readers of the Canberra Doctor to get your feedback and to look at ways of improving our content and production.

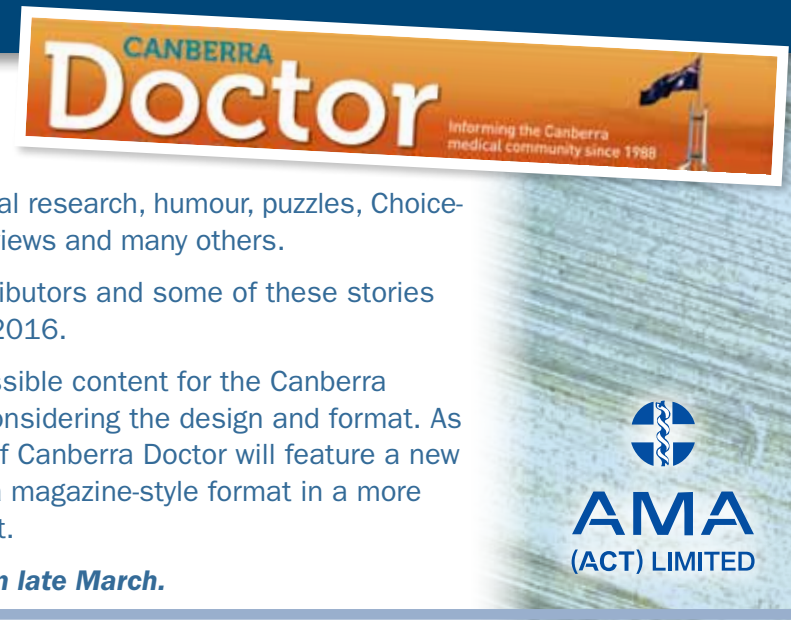
We also offered a prize for completing the survey and congratulations to Dr Thi Tran of Tumut on winning the $250 Coles Myer Gift card.

Overall, the survey revealed that most readers are satisfied with the current content and like the emphasis on local, ACT stories and news. We also asked for ideas on possible future articles, stories or other content readers would like to see. The responses, as you might imagine, were many and varied – features on local doctors, aboriginal health, reflections on Canberra life, reports from Canberra doctors working overseas, financial stories, insights from local doctors' lives away from medicine, information on local medical research, humour, puzzles, Choice-like medical equipment reviews and many others.

Our thanks to all the contributors and some of these stories will certainly appear over 2016.

As well as considering possible content for the Canberra Doctor, we've also been considering the design and format. As a result, the next edition of Canberra Doctor will feature a new design but also come as a magazine-style format in a more convenient size and weight.

Look out for that edition in late March.



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

Typesetting:
Design Graphix
Ph 0410 080 619

Editorial Committee:
Dr Jo-Anne Benson
Peter Somerville – Production Mngr
Dr Ray Cook
Dr James Cookman
Dr John Donovan
A/Prof Jeffrey Looi
Dr Ian Pryor
Ms Lara Whitbourne

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

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