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CANBERRA Doctor

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Local grads reject Canberra internships

ANU medical graduates are increasingly turning their backs on Canberra Health Services for internships, latest figures show, with a growing number of overseas graduates required to fill positions.

In the past, the vast majority of ANU graduates stayed in Canberra for their internship – a natural fit after spending two years in the ACT hospital system during their degree. In 2014, 84% of interns came from ANU. This fell to 74-77% between 2017 and 2021, before dropping to 62% in 2023.

This year however, ANU graduates represent only 53% of the CHS intern cohort, the lowest in a decade. The 2024 cohort comprises 51 graduates of ANU, 22 from other Australian medical schools and 23 from overseas medical schools.

National intern shortage

A spokesperson for CHS, who supplied the data, said at least four Australian jurisdictions, including the ACT, had exhausted the applicant pool of Australian graduates this year and so had to engage international medical graduates.

"The required number of interns across all Australian states and territories currently outstrips the number of domestic medical graduates," the spokesperson said, adding that the problem was "the subject of discussion nationally".

It's a stark reversal of the trend a decade ago, when a shortage of internship positions created a crisis for graduating medical students, only resolved at the eleventh-hour with the creation of more than 100 additional Commonwealth-supported positions across the states and territories.

An intern's market

Fast forward a decade, and it's an intern's market, with hospitals competing to fill places. Unfortunately for Canberra, CHS's reputation

Continued page 4

ANU grads represent only 53% of the CHS intern cohort in 2024, the lowest in a decade.

President's Notes

WITH PRESIDENT, **PROFESSOR WALTER ABHAYARATNA**

Professor Abhayaratna with students at AMA ACT's Student Welcome Drinks.

Like anyone deeply involved in Canberra's health system, I'm troubled to see Canberra Health Services struggling to attract and retain good doctors. From the growing number of ANU med school grads who forego internships in Canberra, to the struggle to fill senior doctor vacancies in Cardiology and Obstetrics, it's apparent that CHS's reputational problems are ongoing.

I wish I could say with confidence that CHS is turning the ship around. And yet, while there are signs of hope, I remain concerned.

Reasons for hope

The latest results from the Medical Training Survey suggest Canberra trainees had a better experience in 2023 than 2022, when the results were extremely disappointing. As someone involved with the physician training program at The Canberra Hospital, it's reassuring to see those trainees' satisfaction rates have climbed. Canberra's anaesthesia and surgery trainees were more satisfied than the national average in 2023.

Another reason for hope is the enormous resources CHS has recently poured into introducing a world-leading Digital Health Record, and creating new roles to support staff wellbeing. These two areas of investment have potential to alleviate some of the root causes of doctor burnout if they are done well.

However, unfortunately, those who've been in the system a while detect 'more of the same' in the way CHS is implementing these reforms.

More of the same

First, there is a lack of transparency.

It recently came to light that a glitch in the DHR led to more than 200 missed referrals in the first 6 months of the new system. Some of the referrals were missed for a period of up to 10 months and nine were urgent. However, the first that those doctors heard about this was in the media, months later.

The IT problem behind the glitch appears to have been fixed. Nonetheless, the fact that doctors were not told is deeply troubling for anyone who relies on the DHR – which is all of us.

Second, doctors are ignored.

On the wellbeing front, CHS has established a chief medical wellness officer. However, this person will not report directly to the CEO, despite strong evidence that this is essential to effect real change throughout the organisation. AMA clearly put this model – the Stanford Model – to CHS and stressed the importance of the chief medical wellness officer being resourced to collect data on doctors' experiences in order to develop wellbeing strategies that work for doctors. We had great hopes, because of the success of this model in the US and at RPA Hospital in Sydney.

Unfortunately, it often appears the ACT Government is not listening to what doctors are saying, whether it's about the DHR or doctor wellbeing or payroll tax or the needs of the different hospital units. It's hard to see how CHS can turn its reputation around with such a trust deficit among doctors.

Pre-election meetings

AMA ACT continues to meet with doctors and raise their concerns with CHS and with the ACT Government. Over the coming months we will be holding a number of meetings to find out the issues that matter to our members in the lead-up to October's ACT Election. All members are invited, and the discussions will inform our advocacy. Details about events can be found on the AMA ACT website.

Payroll tax

The ACT Government is standing by its intentions to impose a new payroll tax on general practices, despite warnings that it is making general practice increasingly unviable.

Over the coming months, AMA ACT will be seeking advice on a range of business models from the Revenue Office and feeding that back to our members to make sure practices do not inadvertently fall foul of tax law. Stay tuned for more information.

Australia Day Honours

Congratulations to Associate Professor Kathie Tymms, who received a Member of the Order of Australia (AM) award on Australia Day. Kathie's been a consultant in Canberra for 40 years, is a stalwart of the ACT's rheumatology service and is an AMA member. She has the relatively rare credentialling to have been able to serve both adult and paediatric rheumatology patients and she's also done some excellent multi-jurisdictional research on patients with rheumatological diseases. Kathie's made a great contribution to the understanding of biologic therapies, which have transformed the nature of rheumatological conditions and allowed many patients to return to normal function.

Vale Dr Angus McIntosh

I'd like to offer my condolences along with the AMA ACT Board's to the family and friends of Dr Angus McIntosh, who passed away in February. Dr McIntosh was a very well respected, long-serving paediatrician in Canberra and was AMA ACT president from 1978-79. He will be sadly missed.

Creating community

AMA ACT has held a number of successful networking events already this year, including the Student Welcome Drinks (pictured). These events are a great opportunity to meet peers in medicine and develop mentoring relationships. To find out more about upcoming AMA Events visit the AMA ACT website. ■

VALE

The President, Professor Walter Abhayaratna, Board members and staff of AMA (ACT) extend their sincere condolences to the family, friends and colleagues of

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Dr Annamma Dorai Raj

Training rotations improving at TCH: survey

Trainee doctors across a range of specialties at The Canberra Hospital have reported increased workplace satisfaction compared with one year ago, an independent survey shows, with the sharp exception of those in Obstetrics and Gynaecology.

Detailed results from the Medical Board of Australia's 2023 Medical Training Survey are now available online. They show that in 2023, trainees across a range of specialties were more likely to recommend their workplace as a place to train compared with trainees in 2022 (see box). Satisfaction rates among Anaesthesia and Surgery trainees at TCH were higher than the national averages.

Obstetrics and Gynaecology (O&G) experienced a steep decline in trainee satisfaction, although the sample size was small (see box).

A spokesperson for Canberra Health Services (CHS) said the overall improvement was the result of investments and changes CHS had made to better support junior doctors and provide them with high quality education and training. He pointed to the appointment of a psychologist in the JMO welfare team in the 2022-23 clinical year.

However, in relation O&G, the spokesperson acknowledged there was more work to do. "The O&G education team is working with the Director of Clinical Training to improve the training experience for junior doctors and the supports available to them in the workplace," he added. Efforts included improving resourcing and recruiting additional doctors in training, senior medical officers and administrative support staff, he said.

The number of survey respondents at North Canberra Hospital was too small to enable subgroup analysis of the results. ■

OVERALL SATISFACTION WITH TRAINING PLACE

"Would you recommend your current workplace as a place to train?" The Canberra Hospital

Rotation	2022 (respondents) YES		2023 (respondents) YES	
Physician Adult Medicine	**40%**	(48)	**66%**	(53) ↑
Emergency Medicine	**68%**	(44)	**78%**	(40) ↑
Psychiatry	**50%**	(12)	**86%**	(14) ↑
Anaesthesia	**71%**	(14)	**93%**	(15) ↑
Intensive Care	**68%**	(25)	**75%**	(24) ↑
Surgery	**60%**	(42)	**79%**	(42) ↑
O&G	**46%**	(13)	**14%**	(14) ↓

Source: medicaltrainingsurvey.gov.au

Share patient information to fix mental health crisis: GPs

Canberra GPs are calling for immediate changes to the way information about patients engaged in the ACT Mental Health System is shared, amid loud warnings the system is failing.

Deep End Canberra, a network of practitioners involved in caring for the most disadvantaged patients in the Canberra region, is behind the new report on what can be done to fix the territory's public mental health system.

With members including Dr Tanya Robertson, Dr Peter Tait and Associate Professor Louise Stone, they say an immediate priority is to overhaul privacy laws that impede timely information-sharing among a patient's care team.

"Transparency should be the default across everyone involved in the person's clinical care," the report states.

The report comes on the back of two workshops Deep End ran last year with the support of AMA ACT and Capital Health Network, and includes findings from a survey of GPs in the Canberra region.

The survey painted a grim picture of Canberra's public mental health system, with GPs lamenting that many patients were falling through the cracks. GPs expressed frustration that they were not consulted about decisions affecting their patients once they entered into the hospital system, and that their referrals to the ED for mental health issues were often not taken seriously.

Dr Peter Tait told *Canberra Doctor*: "Our core ask of mental health services is the establishment of a shared care model, in which primary and secondary parts of the system recognise they are both parts of the person's care system and have an integrated, mutually respectful approach to supporting people with mental illness."

The report calls on the public mental health service to routinely consider a broader set of inputs when assessing a patient, including recent and past history across relevant agencies, carers, primary care practitioners and community support agencies.

Other recommendations include:

- Design multiple ways to connect with people – phone, email, messaging including multiple languages
- Incorporate review of autonomy vs capacity regularly during assessment and treatment
- Make existing service intake criteria transparent and flexible, with a standardised intake form ■

For more information contact deependcanberra@gmail.com

COVER STORY

Local grads reject Canberra internships

Continued from page 1

for training lags significantly behind other jurisdictions. Only 73% of ACT trainees would recommend their workplace as a place to train, the most recent Medical Training Survey showed – the lowest proportion of any state or territory, although an improvement on previous years.

AMA ACT recently surveyed new medical graduates on their decision-making regarding internships and received more than 80 responses.

Those who chose CHS cited reasons including "always having intended to stay in Canberra", "guaranteed job and straightforward application" and "exposure to CHS throughout the degree".

Several graduates raised concerns about CHS's reputation among medical students. One commented: "Unfortunately CHS has historically suffered from cultural problems and received bad press for it, which impacts future interns perspectives."

A few respondents mentioned the "overly negative" impression created at a CHS recruitment seminar, in which students were told their internship would be the "hardest year of their life", and that they should not expect their leave requests to be granted.

Many graduates gave suggestions for how CHS could make itself more attractive to interns. These included:

- Easier application process
- Advertise earlier on the CHS website
- Improve recruitment seminar
- Allow preferencing of at least one rotation
- Give choice over whether to go rural
- Fewer night shifts early in the year
- Increased pay
- Free lunches
- Provide assurances of high-level training programs later in career, for instance Basic Physician Training
- Pay overtime consistently
- Guarantee leave
- Cultural change
- Protect teaching time
- Delay start date, and provide greater transparency on start date
- Mentoring

Source: AMA ACT Survey

AMA ACT President Professor Walter Abhayaratna said the graduates had provided valuable feedback, which will be shared with CHS.

"A major issue is the long-term training prospects for junior doctors at CHS," he said. "Students need to see an advantage from doing their internship in Canberra for getting into their preferred specialty program."

Professor Abhayaratna said he is encouraged CHS is supporting the development of structured training pathways for junior doctors, so they can distinguish themselves as researchers, teachers or clinical leaders.

"For instance, CHS is this year able to offer 15 physician trainees time to do research through a structured program with mentors in their specialty of choice," he said.

A CHS spokesperson said the organisation is committed to becoming a more attractive placement option for medical graduates. They noted the ACT Government recently allocated $8.5 million to further support the JMO workforce with extended contracts, additional learning positions and increased pastoral care and training development.

The spokesperson said CHS was undertaking several activities to attract medical graduates, including offering a $5000 relocation allowance, generous fortnightly education allowance and access to study and conference leave.

A med school for Canberra

Professor Abhayaratna said the latest intern figures had important implications for ANU's medical school, which has a responsibility to train doctors for the Canberra region.

"To fill the vacancies, CHS has had to take quite a few international medical graduates," he said. "This was an issue in the past, and was indeed a driver for starting ANU medical school two decades ago."

An important role of ANU's medical school is to produce doctors who will practice in Canberra. *Source: Australian National University medicalschool.anu.edu.au/contact-us, CC BY-SA 4.0.*

"It's therefore really important that the medical school takes responsibility for working with the hospital to ensure that the experience during medical school and in the early postgraduate years is so positive that people stay in the region."

Professor Paul Fitzgerald, Head of the School of Medicine and Psychology at ANU agreed that producing doctors who will practice in Canberra was an important part of the role of the medical school.

"If it does look like the numbers of graduates from ANU, staying locally, is genuinely falling, and it's not a random fluctuation, then I would be quite open to us looking at what we can do to address that, alongside CHS who have an important role in ensuring the service provides excellent opportunities for ongoing training," he said. "That could include looking at our entry criteria and thinking about whether we need to do more to promote local students into the course."

Professor Abhayaratna raised concern that some ANU medical students were getting less exposure to CHS throughout their degree because they go to the Sydney Adventist Hospital ('The SAN') for clinical placements.

An average of 15 ANU medical students will be on placement at The SAN at any point in time across the year, Professor Fitzgerald confirmed. Each placement lasts six weeks and students can do multiple placements there in succession. However, Professor Fitzgerald said students still had good exposure to CHS throughout their degree, and that the program, which is now in its third year, is expected to continue.

Call for more student places

ANU medical school currently has around 90 Commonwealth Supported Places (CSPs) and 15 international students each year, but Professor Fitzgerald would like to see those numbers grow.

He commented: "There has been resistance from the Federal Government over time to expand CSPs, but I think it's time for the Federal Government to expand CSPs to meet the local workforce needs, especially with the dramatic need for interns that will come with the North Canberra Hospital development in the next five years.

"In addition, there may be a role for the ACT government to financially support training places to meet future workforce needs, as is now happening in other places such as the Northern Territory," he added. The NT Government sponsors 12 graduate-entry places for domestic students each year, with successful applicants required to work in the NT for four years following graduation.

Professor Fitzgerald said further expansion of international student places at ANU's medical school is likely in the coming years. "This will be incremental, and assessed along the way as to its success," he said.

"It is important to note that generally there has been a high retention of international students from ANU in the ACT," he added.

The number of interns employed at CHS each year has not changed over the last decade, hovering between 95 and 98, despite Canberra's population growing by around 15% over that period. ■

VAD assessments must be robust: AMA

Efforts to introduce a voluntary assisted dying scheme for the territory are gathering pace, with the Labor-Greens Government determined to take its bill to the Legislative Assembly before October's election.

A select committee inquiry has been reviewing the draft bill, which allows people aged 18 and older access to voluntary assisted dying if they have an illness that is advanced, progressive and expected to cause death. A person must be "suffering intolerably" and have decision-making capacity, however the bill does not require an expected time frame for death.

The committee is due to report to the Legislative Assembly by the end of February, after which point the legislation will be brought into the Assembly, where heated debate is expected. If the bill passes, the scheme will come into effect 18 months later.

Heated debate

The committee inquiry received more than 80 submissions, including 58% in favour, 32% against and 10% neither for nor against. Both the Labor and Liberal party are allowing their members a conscience vote on the bill.

AMA ACT President Professor Walter Abhayaratna acknowledged the issue was a vexed one among medical professionals.

"A lot of people who go into medicine do not want to be thinking about contributing to the end of someone's life, but society has chosen that this is an option for people who are suffering and we as doctors need to be involved in the discussions," he said.

"Palliative care services need to be maximised so we know that the best care and pain relief can be delivered to support patients in pain, but in the absence of that, there needs to be a really good program that has sufficient safeguards that protect vulnerable patients but also the professionals who are going to be involved with the VAD programs."

Telehealth

In December, AMA Federal wrote to Attorney-General Mark Dreyfus about concerns doctors could be committing a crime by engaging in telehealth services to provide voluntary assisted dying services.

The AMA's request was made in response to a Federal Court determination that "suicide", as used in sections of *Commonwealth Criminal Code Act 1995*, applies to the ending of a person's life in accordance with the Victorian voluntary assisted dying (VAD) legislation. This effectively prohibits doctors from using telehealth services when participating in or providing VAD services throughout Australia.

The AMA's letter emphasised that the prohibition on the use of telehealth will potentially have a major impact on people living in regional, rural and remote communities. In addition, it also disadvantages patients who are physically unable to travel for face-to-face consultations.

Professor Abhayaratna commented: "Assessments for VAD should be robust, and anyone involved in assessing a patient's suitability needs to collaborate with the physicians who are looking after the patient.

"They cannot be making judgements without that information, otherwise they do not know the nature of the conditions that the patient has and what the treatment options would be."

Professor Abhayaratna said if people were unable to travel for whatever reason to have the consultations, telehealth may be reasonable.

"I could understand facilitating other means of consultation as long as there was very robust collaboration with the usual practitioners who look after the patients," he said.

"It's appropriate for nursing staff who have skills in palliative care to be involved in the decision-making process, together with a doctor," he added. ■

Dr Benjamin Mead wins student leadership prize

Dr Benjamin Mead with Dr Kerrie Aust, AMA ACT President-Elect.

Congratulations Dr Benjamin Mead for winning the ANU School of Medicine and Psychology's Leadership Prize for 2023.

Dr Mead graduated last year and was presented with his award at a ceremony at the university in December.

During his time at medical school, Dr Mead gained a reputation for being an innovative thinker and excellent communicator and was well-liked by other students and staff.

He was instrumental in setting up a Medical Education Stream for students with a passion for peer education under the leadership of Associate Professor Alexandra Webb. This involved training and supporting fellow students and recruiting educational speakers to provide structured learning and support. ■

Best practice ADHD care: what international experience shows

Canberra GP Dr Wee-Sian Woon has been researching how adult ADHD is diagnosed and managed around the world. Supported by a Churchill Fellowship, he conducted a study trip to the US, Sweden, Ireland, the Netherlands and the UK last year to understand global best practice. Speaking with *Canberra Doctor*, Dr Woon said upskilling and supporting GPs is essential.

Why did you want to do this research?

I did not receive any formal education on adult ADHD during medical school and GP training, so I was left quite sceptical of the increasing number of patients seeking ADHD assessment and management. However, my perspective shifted a few years ago when my sister was diagnosed with ADHD. Not only had I witnessed first-hand how the condition had affected her life but I saw that the diagnosis enabled her to better understand her strengths and weaknesses, and could empower her to leverage the former.

This personal experience, alongside my patients with ADHD, revealed significant gaps in care including financial barriers and prolonged wait times for accessing specialist appointments. Furthermore, some GPs have little knowledge about ADHD and are not aware of pathways for patients to seek help or were similarly sceptical towards diagnosis and management, leaving patients with little support.

There are significant social and economic impacts from untreated ADHD, including more lost workdays, unemployment, increased reliance on mental health services, increased substance use disorders and over-representation in the prison population. A report from Deloitte in 2019 estimated the total social and economic cost of ADHD in Australia to be $20.4 billion.

An Australian Senate inquiry last year highlighted the barriers patients face trying to access ADHD care. Are other countries facing similar problems?

Across the countries I visited, the challenges in accessing ADHD care mirror those in Australia, particularly with significant wait times for diagnosis and management. There's no perfect or universally accepted model of care internationally, however it is apparent there are not enough psychiatrists to cater for the 2-5% prevalence of ADHD in adults, with increased demand outpacing service capacity.

In the UK's NHS public system, wait times can exceed five years in some regions. Ireland's combined secondary and tertiary system, implemented two years ago, already grapples with lengthy public system waits. Private ADHD clinics, though available, also contend with substantial waiting periods and significant costs for patients.

In the United States, although wait times may be less significant than the other countries mentioned, access is largely determined by insurance coverage and by the level of interest and training of the practitioner. Diagnosis and treatment can be initiated by psychiatrists, family doctors, internal medicine doctors and psychiatric nurse practitioners.

How does the GP's role look different in each of the countries you visited when it comes to diagnosing and managing ADHD in adults?

In the UK, GPs play a central role after medication initiation, with NICE guidelines recommending routine prescribing transfer to primary care through shared care protocols once a patient is stabilised on psychostimulant medication. Unfortunately, this practice is not consistently observed in Australia. The transfer of routine prescribing to GPs is also seen in the Netherlands, Ireland and Sweden.

The United States and Canada allow GPs and family physicians to diagnose, initiate and prescribe psychostimulants, reducing the necessity for psychiatrist involvement. However, lack of training and education and confidence in the skillset of diagnosing and managing ADHD means that there is a tendency for GPs in these countries not to take on ADHD care.

Some experts have expressed concern about calls for GPs to take a lead role in ADHD-care, suggesting they lack the training, experience or time. Has your project shed any light on this concern?

While I agree with this concern, it's worth noting that some GPs in Australia are interested in upskilling, particularly those with personal or familial experience with ADHD. Pilot projects in other Australian states are exploring the feasibility of this approach. GPs offer longitudinal experience with patients over time, which enables them to gather crucial information. Additionally, GPs are capable of understanding the limitations and boundaries of their expertise.

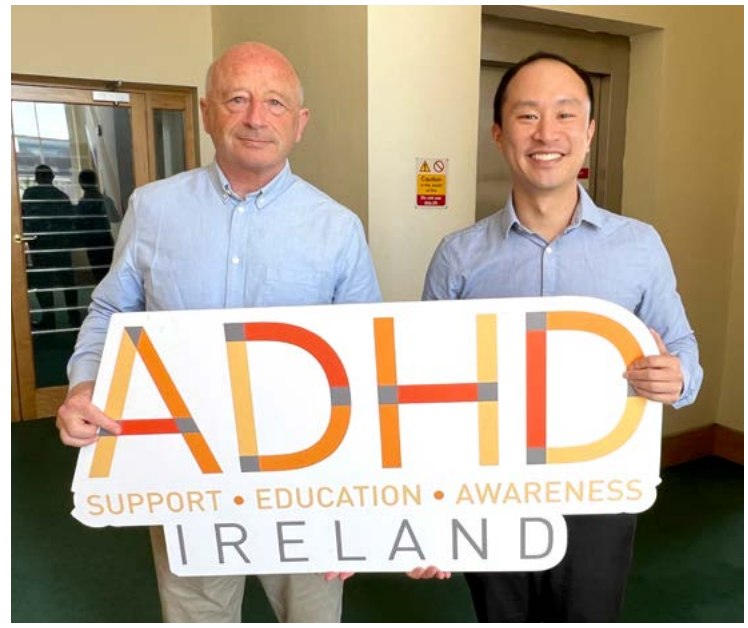
During my time in Ireland, I was able to observe the skillset of GPs providing initial assessment and ongoing titration management at the private GP-led integrated ADHD clinic named ADHDDoc , working alongside psychiatrists and other health professionals. GPs received training through the UKAAN (UK Adult ADHD Network) course and guidelines, with referrals to psychiatrists at the clinic when necessary or if the ADHD diagnosis was unclear.

In Canada, GPs have successfully initiated ADHD medication, viewing it as akin to managing conditions like diabetes or depression. However, this requires education, upskilling and support.

In response to long waiting lists, some adult ADHD services have shifted to nurse-led approaches with no psychiatrist involvement such as the Adult NHS ADHD Service in Warrington UK, with non-medical prescribers conducting assessments and GPs with Special Interests also involved in prescribing.

Dr Craig Surman, a psychiatrist associated with Harvard University, emphasised the importance of backup support for GPs due to the potential complexity of ADHD and co-occuring conditions. Complex adult ADHD cases, involving drug dependency, bipolar disorder and complex-PTSD for instance, should always be diagnosed and managed by psychiatrists.

Overall, while there are challenges, there's potential for better collaboration between GPs and specialists to improve ADHD care, provided there's adequate training and support in place.



Dr Wee-Sian Woon with CEO of ADHD Ireland, Ken Kilbride.

Would you comment on the potential for overdiagnosis of ADHD and how to reduce the risk of this occurring?

To address the concerns of overdiagnosis, it's crucial to ensure that ADHD diagnosis is conducted through thorough and high-quality assessments by well-trained clinicians. This entails evaluating not only ADHD symptoms but also co-occurring conditions, gathering informant and collateral history, and assessing the individual's overall functioning and impairments. Clinicians must receive adequate support and training, including supervision and adherence to recognised guidelines.

Organisations like UKAAN in the UK provide training aligned with guidelines, offering opportunities for clinicians of all types to upskill and enhance their diagnostic competency. Collaborative approaches, such as shadowing experienced diagnosticians and ongoing supervision, can also mitigate the risk of overdiagnosis.

What immediate steps should Australia take to reduce barriers to diagnosis and management of ADHD?

Ensuring equitable access to public clinics for adults with ADHD across all jurisdictions in Australia is crucial. As the senate inquiry proposed, pilot schemes supported by state and territory governments should be initiated to test various models of care tailored to diverse needs, with increased involvement of GPs and other health professionals. There's potential for GPs with special interests who have adequate training and support to diagnose and manage non-complex ADHD cases in primary care settings, while complex cases could be referred to and managed by psychiatrists.

Funding could support GPs with special interests to work in public paediatric and adult development services to enhance their skills. Moreover, integrating adult ADHD education and neurodiversity training into GP, medical and psychiatry training programs is essential. An organisation similar to UKAAN in the UK is needed to ensure evidence-based education delivery.

A holistic approach is needed, addressing ADHD not just as a medical issue but also considering its impact on workplaces, the justice system, and educational institutions. Providing support and accommodations for ADHD adults in these settings is vital for comprehensive care. ■

Dr Woon is currently writing up the Churchill Fellowship report, which will be available online.

He has also set up a new GP ADHD Special Interest Group within Canberra. If you are a GP in the Canberra region and interested in joining please email: w.woon@ochrehealth.com.au

'Australia needs a strong AMA'

Meet Natalia Centellas, Secretary General, Federal AMA

It's one year since Natalia Centellas became Secretary General of the Federal AMA. Affable and clear-sighted, Ms Centellas told *Canberra Doctor* she's thrilled to be working in a professional environment that is "intellectual, professional and kind".

What's encouraged you since you started working at the AMA?

It's a nourishing place to work. The AMA attracts clever, active doctors who are trying to do better for medicine and for society at large. The whole organisation has this vibrant vibe, with people from all generations, from many different countries, GPs and non-GP specialists, men and women, including women with young families who are in senior roles, just as I am.

You were previously CEO of the Royal Australian and New Zealand College of Radiologists, a role you held for eight years. How have you found the transition?

I've enjoyed it, for several reasons. Firstly, I know how complex medical organisations run; lots of committees, lots of doctors, lots of discussions. It's a familiar space for me to be working in a clinically led, but professionally managed organisation.

Secondly, I enjoy the fact that the AMA, federally, punches so hard in the political and the media sphere. While policy and advocacy is part of the work colleges do, it's a superpower at the AMA.

Since starting here, I've met a lot of people, both clinicians and staff, who are just outstanding in terms of their insight and ability to translate the bigger waves of political and public mood into something that AMA can use for the benefit of doctors and for the benefit of the health system.

Public advocacy on controversial policy issues can be challenging. How does the AMA navigate that?

The AMA is a genuinely broad church, with the data showing the organisation has similar penetration across different age groups, with younger generations of doctors coming in, and older generations staying on.

Diversity in views is what enriches the AMA's positions. Our Federal Council and our executives in policy and advocacy are very clear that the AMA's 'lane' is doctors, medicine, healthcare and the health of the Australian community. Being clear on that enables us to not stray into areas that are interesting but only peripherally relevant.

The AMA prides itself on producing very high-quality research papers and engaging doctors in the development of our positions, and so from a policy sense, we work hard on divisive issues to engage the full membership. Voluntary assisted dying is a example of an issue that is complex and can be very divisive. The ethos of the AMA is to engage and to understand our members on a topic, and then approach the issue in terms of what's best for medical professionals, for medicine and for patients.

Why does Australia need a strong AMA?

Doctors are highly skilled and they're the ones who take responsibility for what happens to their patients at the end of the day. But they're working in a world where evidence and authority are increasingly under attack, where government funding for medical care is always cut unless you argue, and where the number of voices arguing for additional investment and powers has exploded.

In this climate, Australia needs the AMA to be a strong and united voice to consistently argue for what's best for patients: evidence-based decision making, clinical autonomy and team-based care under medical leadership. A strong AMA is critical to ensuring Australia's healthcare remains strong into the future.

You're a proud advocate for Western Sydney University, of which you're on the board as an alumni member. Tell us about that.

Western's ethos and charter is about being a university that's not just about research grants or status, but one that will actually lift the community with it. Western prides itself on how many of its students are the first generation in their family to go to university, and how many are migrants, as I was when I undertook my Bachelor's degree there.

Despite its relatively young age, Western has become a very high calibre university and its board includes academic and commercial heavyweights such as Professor Peter Shergold and Jennifer Westacott. It is now a world-leading institution, but very much staying true to its work with the 'underdogs'. It's a tremendous social and ethical enterprise and that appeals to me.

You have a Masters in International Social Development, which you say has been strangely applicable when working with doctors. How's that?

It's a degree that equips you to work with underprivileged communities. While it would seem like that wouldn't apply to doctors, the thinking I did in my masters has helped me to appreciate the medical profession as its own community – one that respects its own leaders, has its own traditions and has its own language.

It's International Women's Day on March 8. What's one thing that continues to frustrate you about women's experiences in Australia in 2024?

Ever since I became a mum three years ago, I've been reflecting on how men need to be practically enabled and culturally encouraged to take the time and space to participate equally in the family. In medicine, it's so typical for a dad to go back to crazy shift work just a few weeks after the birth of their child. You can't support the women unless you support their partners to be at home with their families more. We need partners to be able to take appropriate leave to support the family transition.

AMA and Australian Indigenous Doctors' Association meet to sign their inaugural MOU in 2023. From left: AIDA CEO Donna Burns GAICD RN, AIDA President Dr Simone Raye, AMA Secretary General Natalia Centellas, AMA President Professor Steve Robson.

What are the AMA's priorities for 2024?

In 2024, we're launching our new strategic plan. As part of that, we are refreshing AMA's Vision for Australia's Health, which is our policy platform. That will cover issues affecting doctors right across the spectrum, including private health insurance, primary care, public hospitals and key public health issues.

We also want to turbocharge our focus on member engagement in 2024 through surveys and other tools, to get that voice from the doctors even louder inside the AMA.

We'll also see a lot more investment in digital assets at the AMA in the next 12 months, as you can't engage nowadays unless you engage digitally. ■

INTERNATIONAL WOMEN'S DAY MARCH 8

Women in medicine share their stories

To coincide with International Women's Day on March 8, *Canberra Doctor* asked some of our city's leading female doctors to write about their own experiences of the distinct challenges women face in a career in medicine, and reflect on how they forged a path through.

"I felt that I had to be to be better than my male colleagues to prove myself."

Dr Carolyn Cho

GENERAL, BREAST, RECONSTRUCTIVE AND CANCER SURGEON, CANBERRA

One of the challenges as a woman in medicine has been finding the right mentors. When I was going through my surgical training at John Hunter Hospital in Newcastle in the early 2000s there were very few female trainees, let alone female surgeons. In my whole training I only worked for two female surgeons and they were both fantastic and inspirational. This is very different now, where there are many more women in surgery.

How did I deal with the challenges of being a female surgical trainee?

As a female surgeon I felt that I had to be to be better than my male colleagues to prove myself to my seniors, and sometimes to the patients as well. There would still be patients who thought I was the nurse when I walked into the ward, rather than the doctor. Thankfully these attitudes are very different now. My attitude was to just do the work and let my results speak for themselves. That worked for me. Nowadays I find that patients come to see me specifically because I am female.

During my time as a surgical registrar, I have worked for surgeons who wouldn't let me operate, and I have no doubt it was because I'm female. I'd look after the patient, get them prepped in theatre, but then the consultant would take over to do the surgery. This was in contrast to the male registrars who would do their cases routinely.

I have a theory that it's because women surgeons approach surgery in a different, measured way and this can be misperceived as a lack of confidence or ability.

Having said all this, I would not have done surgery in the first place if not for many great male surgeons that I had the privilege of training under. One of these mentors used some subtle tricks to build my confidence. For example I'd ring him up and say 'I'm taking this patient to theatre' and he'd say 'you start and I'll put my head in' and he'd never come. He knew I could do it, which is what he always told me afterwards.

I think you achieve a lot more as a doctor if you're nice to people. It sounds obvious but creating a stress-free environment allows people to perform at their best and builds a better team. This includes not just other doctors and nursing staff, but wardspeople, clerks and technicians.

There's been a lot of progress over the years for female surgeons and there are many more support groups where you can find good mentors. The biggest reform priority remains flexible work and training hours, but it's not an easy problem to solve. For the surgeon, work-life balance is never going to mean always getting home at 4pm, but being able to distribute your time through the week so you can spend quality time with your family.

The flip side to this is that surgery is all about volume of cases - the more you do of any procedure, the better you're going to be as a surgeon. If it takes five years full time to become competent performing a particular operation, how much time does it take for the surgical trainee doing flexible training? It is imperative that surgical standards are maintained even as we strive to make training more flexible.

"I had support to refuse sexual propositions."

Associate Professor Karen Flegg

PRESIDENT, WORLD ORGANISATION OF FAMILY DOCTORS (WONCA)

I was gifted with a father who believed in university education, as much for female children as males – not always a foregone conclusion in the 70s. That's a hurdle for many women, that I did not have to overcome. I had two others for company, travelling to university from my home in a suburb that our uni colleagues had never heard of.

Having company that I can confide in and work with, has always been important – for me the biggest challenges have often been about aloneness and being perceived as young.

It was not so easy being a female registrar in a solo doctor town – which box did people put me in when I had a farmer husband? How did I get my only time (evenings) with him when townsfolk demanded routine evening clinics and I was already on call 24/7? I had support to refuse this and the sexual propositions from the elderly patient or hospital board member. And the anonymous letter demanding I not take holidays – my husband sorted that and we left the town!

I was the third woman on RACGP's board in the mid 1990s. My first meeting made me feel lost and I realised that I needed a mentor who knew about formal meetings and processes. I looked around the room and found my mentor. His challenge was to teach me in one year what it had taken 20 years to learn. One of the best strategies for all of us to overcome challenges – find a mentor!

At the interview for a medical management role I was asked about my personal plans (by a female colleague). I pointed out the lack of appropriateness in this and responded, but knew that meant no job. Ah well, when we want a role and don't get it, my belief is there is a very good reason and all will turn out for the best, but it may take some years to see that!

The biggest enemy has often been my own thoughts of inadequacy, my own feelings that I was being too emotional, or not knowing enough, or not having the right to an opinion.

In WONCA, as an international organisation, it's a very clear that as a white skinned woman from a first world country, I have nothing to complain about. Indeed, I feel any gender gaps are minor, even in Australia, compared to the much more widespread discrimination against colleagues on basis of colour and international origin, for example.

I've found the support I needed in mentors, like-minded colleagues and my family and medical family.

"I learnt skills as a new parent that made me a better doctor."

Dr Danica Vress

OBSTETRICIAN & GYNAECOLOGIST

AMA ACT BOARD MEMBER

I remember the jokes about the 'mandatory Mirena' on the first day of specialist training. But the joke quickly became awkward – turns out I was already pregnant. And at that time, the regulations stipulated I had to do my first year of training full time and continuously (no extended leave). My plan was to work until the last possible moment and then take the yearly allowance of 6 weeks off and come back to work to finish the year so I could then take leave in year 2.

'But who will look after your baby? What about breastfeeding?'. These were the questions asked by the same training college who had put those same restrictions in place. EXACTLY! It didn't sit right with me and I decided to question it. I received legal advice and we drafted an incredibly powerful letter to the CEO whilst I gathered allies across Australia through various committees and social media groups until a regulation change was put forward and succeeded! I had to work until 39 weeks to

see this through but was then able to go on leave for 5 months knowing my training time had counted.

Returning to work fulltime (this regulation hadn't changed then) had its challenges. Balancing the pumping gear whilst trying to answer the on-call phone; drinking my first water of the day, hours into my shift; and scrolling my photos to try and trigger a letdown, are memories I'm happy to forget.

I learnt so many new skills as a new parent that also made me a better doctor – how to maximally function with minimal sleep, multitasking, time management and conflict resolution. And I became involved in advocacy at every chance including being a trainee representative.

> "It didn't sit right with me and I decided to question it."

It is great to see that further changes have now been made more broadly within multiple colleges to make extended time off training and flexible training arrangements (for any reason, including parental leave) more accessible at every stage.

Going forward, I hope that we can consider the skills and experiences gained from outside of medicine as positives that can make our health care system better whilst also stamping out inequities that disproportionately impact women. As more women move into leadership positions, I think the future is looking brighter.

> "My title was noticeably absent."

Dr Marrwah Ahmadzai

OBSTETRIC AND GYNAECOLOGY REGISTRAR, THE CANBERRA HOSPITAL

A few years ago, I was featured in a newspaper article alongside a male medical doctor regarding an award we were both finalists for. Both our photographs and names appeared on the article. Next to his name was the title, 'doctor'. My title was noticeably absent next to my name.

"It's probably just a coincidence," I thought. Until I remembered all the other times it had happened in clinical practice. Small daily occurrences like when I had introduced myself as 'doctor' only to be asked later when the doctor was coming or was referred to subsequently as 'nurse' or 'midwife' despite the introduction.

But others had noticed too. Whilst I initially dismissed the incident, another female doctor shared the article on Twitter, and it made the rounds. The journalist noticed the post and acknowledged what had happened. She forwarded the criticism to her editorial team.

I later learnt that this a phenomenon called 'untitling', where one's title is omitted in a setting where it would be reasonable to expect its use. Female clinicians frequently experience untitling and it undermines their expertise. An observational study in the *Journal of the American Medical Association** demonstrated that female physicians were twice as likely to be identified by their first name compared to their male counterparts.

Untitling is the tip of the iceberg. It is a small indicator of the broader systemic challenges that women in medicine face, including but not limited to pay inequity, sexual harassment, and underrepresentation in medical and academic leadership positions. Women from cultural and religious minorities face racism and discrimination that compounds these challenges.

And yet women in medicine are crucial in overcoming the health issues we face as a society. Research has demonstrated that patients treated by female surgeons have improved outcomes compared to those treated by male surgeons after accounting for patient, surgeon, and hospital characteristics.

And there is a lot of work to be done.

Women spend 25% more time in poor health compared to men according to a report by The McKinsey Health Institute. Insufficient medical research to guide treatments for women, under-estimating of disease burden in women, underfunding of women's health conditions and barriers to accessing care are all root causes.

I hope that we can continue to acknowledge and dismantle the challenges we face as a profession to better support female doctors and achieve health equity for our female patients. ■

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Photo of Dr Marrwah Ahmadzai courtesy of Ross Townsend.

Society builds local community of women doctors

The Medical Women's Society of the ACT and Region provides networking, events and student mentoring opportunities.

They aim to foster communication between women in medicine, in the ACT and surrounding NSW towns.

Part of the Australian Federation of Medical Women (AFMW), the Society's members include GPs, specialists and registrars working in hospitals, private practice and in administration.

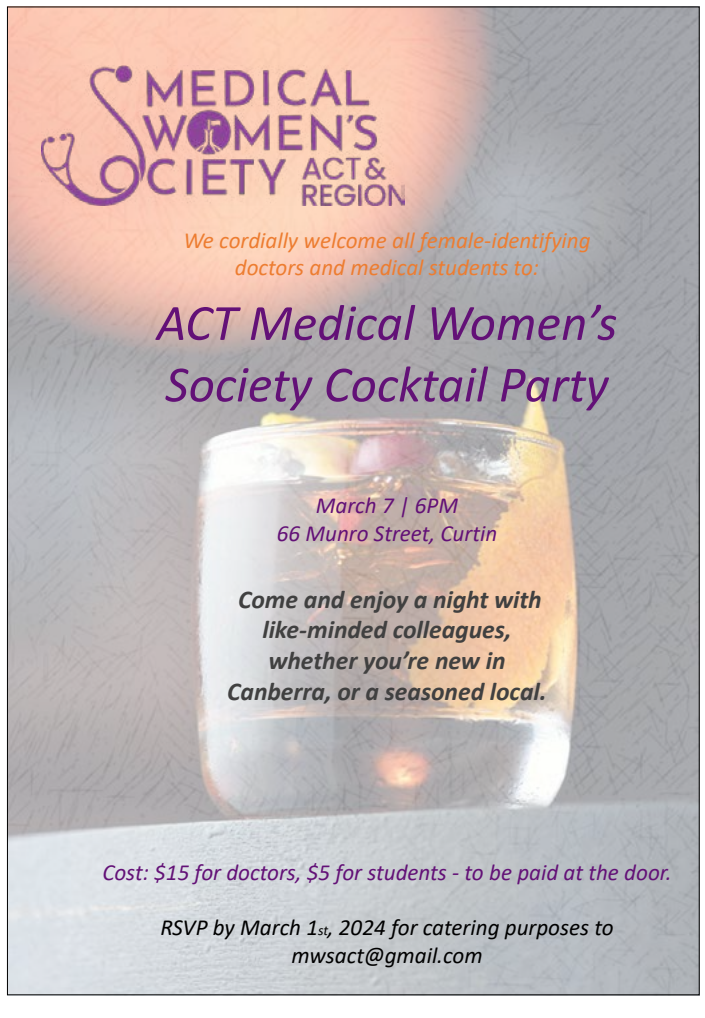
The Society has a strong link to the medical schools of ANU and Sydney University, with student representatives from each of these on their committee.

Some members are newly arrived in the region, wanting to meet fellow women medical professionals.

Running events is one of the core ways the Society helps to bring the community together.

They also have a focus on student support, offering a mentoring program. ■

To get involved visit act.afmw.org.au



SUPPORT FOR INTERNS

GREG SCHMIDT
Senior Workplace Relations Advisor, AMA ACT

Questions Interns Ask

One way the AMA supports doctors is by helping them understand their entitlements under the Enterprise Agreement*. We're happy to answer questions by email or phone, and to take matters up with the hospital hierarchy where necessary. Here's a sample of some employment-related questions interns have asked.

The AMA ACT's Workplace Relations Support Line is (02) 6270 5418 or email industrial@ama-act.com.au

How do ADOs (accrued day off) work?

The "typical" roster for a full-time employee will have them working 40 hours of ordinary time in an average week. Under the Enterprise Agreement, this employee will be paid for 38 hours of ordinary time, with the remaining 2 hours per week accruing in the employee's ADO bank. After 3 weeks of this roster cycle, the employee will have 6 hours accrued. In an ideal world, the roster for the 4th week of the cycle would have the employee work 32 hours and take a paid ADO (using the accrued 6 hours), thereby still being paid for 38 hours.

In the real world of hospital rostering, there will be many occasions when you cannot be released from duty to take your ADO. In these instances, the ADO remains available to be taken at another time. A maximum of 13 ADOs can be accumulated, although hospital administration would prefer to keep your balance of accumulated ADOs at 5 days or less. Any ADOs that remain unused when you cease employment will be paid out to you at ordinary time rates.

Should I get paid extra for working a Saturday/ Sunday/ public holiday/ after hours?

Because of the 24/7 nature of work at the hospital, Medical Officers can expect to be rostered to work "unsociable hours" for some of their ordinary time shifts. The Enterprise Agreement recognises this, and requires that a Medical Officer be paid their ordinary rate of pay, **PLUS**

- an additional 12.5% for work performed between 6:00pm and midnight on a weekday;
- an additional 25% for work between midnight and 8:00am on a weekday morning;
- an additional 50% for ordinary time work any time on a Saturday;
- an additional 75% for ordinary time work any time on a Sunday; and
- an additional 150% for ordinary time work on a public holiday

The above shift penalty payments don't apply to blocks of time which are paid at overtime rates.

How many days should I have off after night shift?

At least two calendar days free from any duty will be allowed following the end of night shift duties. Further, where operationally possible, additional days off should be rostered until the number of days free from ordinary duty equals the number of consecutive night shifts worked.

What is the maximum number of days that I can be rostered to work in a row?

Clause 19 of the Enterprise Agreement limits the number of consecutive ordinary duty days to seven, but it is possible that days of overtime duty could be required immediately after (or in between) ordinary duty days. This would be unusual, and both the Medical Officer and the hospital should try to arrange some days off to avoid the doctor becoming excessively fatigued.There is an absolute requirement (clause 19.16) that every Medical Officer will have at least two consecutive days in each fortnight free from all duty.

How do I dispute/ query a pay slip?

You will be paid fortnightly on a Thursday, and that payment will provide payment for your ordinary time hours up to the Wednesday evening including any leave usage that the Payroll team knew about in advance. Payment for overtime is usually made a fortnight later – that is, 15 to 28 days after the day that the overtime was worked.

If you think that you haven't been paid correctly, your first query should be through your Manager who signed off on your hours for the fortnight. MOSCETU can also help with pay issues. The AMA will also support and assist members who have not been paid correctly.

How long in advance should I receive my roster?

The Enterprise Agreement requires that Medical Officers be given *"at least 14 days' notice of rosters to be worked in relation to ordinary hours of work and also where practicable, in relation to additional (overtime) rostered hours of work"*. It then goes on to say that amendments to rosters can be made without notice to meet "emergent situations" such as emergencies and unexpected staff absences.

I want to raise an issue about my supervisor/rotation, but I'm worried that it might affect me passing internship. Should I be concerned about this?

Your supervisor should be your first point of contact for raising most issues about your training. However, if your supervisor *is the issue of concern* then you may be better served by approaching DPET or MOSCETU. Don't burn your bridges – it's important to maintain working relationships with the people that you are working closely with, especially supervisors whose job it is to assess your work. AMA ACT is available to support our members and assist in getting issues resolved for you. ■

*Most of the conditions of employment for ACT Doctors in Training, including pay rates, are set out in the *ACT Public Sector Medical Practitioners Enterprise Agreement 2021-2022*.

SUPPORT FOR INTERNS

Tips for new interns

You'll receive a lot of advice about your internship. The key thing to remember is to find what works for you and only you. Others have been through it before but no one has experienced it like you have yet, with all your own unique experiences in the lead up and all your unique things going on in your life as you head into this amazing year.

DR AKASH PATEL

Internship for me was scary, exciting, absolutely inspiring and insanely fun. You'll have the chance to put yourself on a learning curve unlike any other and when you look back you will be amazed by how far you've come.

The following three pieces of advice came from different mentors from different areas of medicine, but they truly stuck with me and changed the way I approached internship for the better. I hope they can help you too.

1. Own your own patients

As an intern it can sometimes feel like you're at the complete beck and call of your team. Depending on what that team's like it can be easy to fall in under them and take the backseat when it comes to making decisions and seeing yourself as someone in charge of that patient's care.

On after-hour shifts that all changes – you will have to test yourself clinically and make determinations about what is happening with the patient in front of you. Help is always nearby, but there is definitely more independent thinking that goes on.

The advice I received from a mentor that stayed with me was own all of your patients as if you were the one in charge of their care. They're your patients and their care is dependent on you and your decisions.

Don't leave things to chance or think that if something doesn't seem quite right that it's up to someone senior to you to figure it out. Think about what you would want from a doctor looking after your family— be thorough, fix problems (with help of course), but truly care for each and every person you're lucky enough to be looking after.

2. The (other) ABCs of medicine

An easy way to remember some of those things from above is to follow the slightly different and more cynical ABCs of medicine – Assume nothing, Believe nobody and Check everything. This advice from a different mentor made me pause and make sure that I was truly taking everything into consideration for each patient under my care.

It made me remember to check whether a patient's bloods had been done that morning and what needed to be done about them. It made me follow up on patients that had been flagged with me earlier in the day or overnight, and it made me always come back to confirming with the patient themselves that they felt cared for and heard.

3. The 3 Cs

I know... another acronym. We learn too many! But these 3 Cs of Curiosity, Courage and Compassion held true for me and I'm sure will continue to do so for a long time. This model came from a mentor who embodied these characteristics in everything they did and do.

1. Curiosity – Always stay curious to learn more; about yourself, about others, about your patient. Find those areas where you feel uncomfortable; be it in your knowledge or your skills.

2. Courage – Have the courage to move towards those uncomfortable things; picking up the phone and doing that difficult consult, having a go at that difficult cannula, asking a senior about how to manage a particular condition. These moments all add up. Seeking them out is the fastest way to learn.

3. Compassion – Have compassion for yourself when things go wrong and make sure you know who to go to when they do. Have compassion for your colleagues when they're struggling. Have compassion for your patients – remember they are why you're here.

You as a new doctor have the chance to use all of your knowledge and skill to make a difference in someone's life during a time that is probably amongst the worst. Take on that challenge and make the absolute most of your time this year – it'll go by before you know it. ■

Dr Patel was an intern in Canberra in 2023 and member of the AMA ACT Board. He has since moved to Darwin to work as an RMO.

School's back and so is avoidance: Tips for parents and GPs

DR MICHAEL HERD
Psychologist and Deputy Head of Training (Australia), Triple P International

With the school year now in full swing, GPs are likely seeing patients whose children are struggling. School refusal, anxiety and avoidance are common issues. Here are some tips to help you support parents, carers and kids in building confidence and resilience.

Positive role modelling

Research has shown parents' attitudes towards school and transitions can influence their children's experiences. While feeling a mix of emotions is normal, parents and carers can try to pay attention to their reactions and responses, and the tone they're setting.

Practice and preparation

Parents can think about what they can do to help their child feel comfortable in a new environment. For example, organising play dates and catch-ups with other families, meeting teachers and getting involved in school activities. The school might be able to assist with this, and it's a good idea for families to see what resources they have available.

Routines

Daily routines help children feel safe and secure, especially during times of change and adjustment. For families who might be struggling with routines, a simple step is to try to get bags, uniforms or lunches ready for school the night before. This can get the whole day off to a calmer and more positive start.

Genuine interest

Family life can get incredibly busy, but taking the time to give children our full attention sends a powerful message that they matter, and we care. Asking open-ended questions and listening without judgement can help kids to feel more comfortable in sharing their feelings. In turn, this can help families to work through challenges together.

Realistic expectations

It's normal for children to have mixed feelings about going to school. They may love it one week and dislike it the next. Parents can try to focus on what's going well, roll with the changes, and stay optimistic.

That said, if a reluctance or refusal to go to school becomes an ongoing challenge, it's important to know where to go for help. This can be a difficult and isolating time for parents, and seeking help is a sign of strength. Talking with your school and health professionals can be a good first step.

Free online parenting support

GPs can refer patients to free, online evidence-based parenting support from the Triple P – Positive Parenting Program, available 24/7.

With rising instances of anxiety in school-age children, **Fear-Less Triple P Online** supports parents to help children aged 6 and above who experience anxiety.

Triple P Online has practical strategies to manage everyday challenges, for parents and carers with children under 12 years old.

There's also a program for new and expecting parents, **Triple P Online for Baby**, which helps them confidently adjust to new parenthood.

Thanks to Government funding, these programs are now free across Australia, including the ACT. They help parents and carers raise happy, confident children who thrive at home, in school, and beyond. ■

Did you know?

GPs can get free promotional resources by emailing contact@triplep.net

Parents and carers can now access free online parenting programs at triplep-parenting.net.au

Vale Dr Susie Close

Long time Obstetrician and Gynaecologist, Dr Susanne Christine Close sadly passed away on 30th November 2023 after a long illness, which forced her early, and sudden retirement in 2015.

Susie was born in 1955 in Young, NSW, to Lorna and Allen Close of "Heathdale" Wirrimah NSW. She attended the local one-teacher primary school, then travelled by bus each day to the Young High School where she excelled in her HSC. Susie gained entrance to the Faculty of Medicine at the University of Sydney and took up residence at Santa Sophie College in 1973.

Susie soon began a relationship with Michael Tuite from St John's College next door. They married on 18 May 1974. She continued her medical studies, managing to have two children along the way. Susie completed her medical degree in 1979 and then commenced her medical career as an intern at Albury Base Hospital. She obtained her Diploma of Obstetrics at Alice Springs Hospital in 1982 and then commenced general practice in her hometown of Young, NSW. The following year, she came to Canberra and entered general practice, and during this time her third child was born. She then realised she wanted to extend her ability to care for women at all stages of their lives, so undertook specialty training in O&G.

Susie was a force of nature. Everything she did was at a fast pace, from her trademark clip clopping down the corridors in her high heels, to the way she approached her work with enthusiasm and determination. She earned the nickname of "Cyclone Susie" for good reason.

Susie was a strong advocate for women's health and women's rights and women in the medical profession. She was unconditionally supportive of her colleagues and trainees. She participated in the NSW Medical Women Society, Medical Women Society of the ACT, Australian Federation of Medical Women (including a term as President) and Medical Women's International Association, serving on the Scientific Committee and Ethics and Resolution Committee at several International Congresses. Even when her health declined, she stayed a part of the ACT Women's Medical Society, and the Australian Federation of Medical Women. She always spoke passionately about their work promoting causes that influenced the lives of women and women doctors around the world.

> "Susie was a force of nature. Everything she did was at a fast pace, from her trademark clip clopping down the corridors in her high heels, to the way she approached her work with enthusiasm and determination."

Susie loved her profession, loved bringing babies into the world, and helping women and their families. Absolutely, everything she ever did was with the absolute best of intentions, and her kindness and achievements will be remembered fondly by her colleagues and family.

Susie is survived by her husband Michael, children Chris and Elspeth, Sarah and Matt, Eileen and Jess, six grandchildren, and a large extended family. ■

By Dr Elizabeth Gallagher & Michael Tuite

Why you probably need more friends

NESH NIKOLIC
Strategic Psychology

Most adults are not in the habit of making new friends. Typically, our most social period of life is childhood, but as we get older, we start pruning our friendships, then friends move away or pass away. Some of us feel we're too busy to make friends, or to keep up friendships.

Yet there are strong reasons to prioritise friendships, and to be open to making new friends, whether you're 27 or 77.

Studies show that the more connections a child has when growing up, the more they thrive. A child with two parents, grandparents and other significant adults in their life is exposed to different perspectives and has many people they can lean on. What's more, those adults are able to be patient with the child because they're not alone in bearing their burdens.

The same is true with adult friendships. People who have strong bonds with others are better able to ride out life's most difficult seasons. Not only does a good friend bear another's burdens, they share their own – helping each other to build an acceptance that pain is a normal part of life. There is little doubt the absence of strong bonds is a factor in people turning to alcohol and other drugs to numb the pain of difficult experiences.

While having a spouse fulfils some of our deep human need for connection, no one person can be everything to another. That's why it's wise to keep putting effort into making new friends and maintaining existing friendships, whether you're single or partnered.

Indeed, even the most introverted people need friends. Watch an introvert with their closest friends, and they will appear quite extroverted, although they will need time to recharge their batteries once the party's over. Introverts may require less frequent catch-ups than extroverts, but they still need those support networks in their life.

While the basics of friendship might seem obvious, psychologists every day in Australia are seeing clients who are extremely socially disconnected.

A few basic tips on friendship are worth remembering:

Have regular connection points

If you only speak with or hear from your friends once in a blue moon, you're very socially isolated. Schedule regular catch-ups. If it can't be in person, make it on the phone, or at very least, send them a text. Social media might make you feel connected, but it's illusory. Communication needs to be one-on-one and direct.

Build each other up

Tell your friends what you love about them. Small but genuine compliments nourish a friendship. If you love spending time with someone because they're always laughing, or if they've always got a good book recommendation or a good story, tell them so.

Take a genuine interest in others' lives

It sounds obvious, but relationships need to be reciprocal. Take an interest in other peoples' lives in order to forge a closer relationship with them. Do things together. Be part of their story.

Remember the 'why'

Remind yourself why friendships are worth the effort even when life is busy. We're wired for relationships; you need that strong web of support around you; and in the end, no one looks back on their life and wishes they spent more time in the office. ■

AMA ACT EVENTS

Graduate Breakfast

AMA ACT's Graduate Breakfast at Hotel Realm to celebrate the graduating ANU medical students of 2023. Guest presentations from Drs4Drs ACT; Dr Luke Streitberg, DPET Canberra Hospital; Dr Akash Patel, AMA ACT Board Member; Dr Jason Gluch, CEO Capital Pathology.

Student Welcome Drinks

AMA ACT welcomed the first year ANU medical students at the start of February, at Lobby Bar Cultural Centre, ANU.

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Canberra's favourite season is here

Autumn is surely the best time of year in Canberra. The kids are back at school, the leaves are turning red, the footy's back at GIO Stadium and the looming long winter feels like a novelty after all that summer heat.

As if that weren't enough, it gets even better. **Enlighten Festival** returns to Canberra from 1-11 March, with stunning projections on Parliament House, the National Library, the National Gallery, Questacon, the National Portrait Gallery and the Museum of Australian Democracy at Old Parliament House.

This year's program includes 3-dimensional neon artistic reflections of the Canberra landscape, interactive projections, a VR swing experience, colourful fibre optics and kaleidoscopic animation of nightlife.

A range of exclusive events are also available including exploring the National Gallery after-hours, a Degustation Dinner at the Australian Parliament House and a lakeside moon walk as part of the Enlighten After Dark program.

The **Lights! Canberra! Action!** short film festival will showcase local talent on Friday 8 March. There's also **Symphony in the Park** with feature artist, Hoodoo Gurus supported by the Canberra Symphony Orchestra on Sunday 10 March. A charity focused **Canberra Day event** will be held on Monday 11 March at Commonwealth Park.

As the Enlighten Illuminations draws to a close, Canberrans can shift their focus from dusk to dawn as the **Canberra Balloon Spectacular** fills the sky with colour each morning from **9-17 March**. ■

For more information, ticketing and full program visit enlightencanberra.com

Canberra Balloon Spectacular runs 8-17 March.

Enlighten runs from 1-11 March.

Good listening

Doctorama with Professor Steve Robson

If you haven't caught AMA's new podcast, Doctorama, it's well worth a listen.

AMA President, Professor Steve Robson, interviews prominent Australians with a wide range of careers, all with health backgrounds.

Episode 11 is an interview with leading Canberra academic and GP, Associate Professor Louise Stone, whose work has always involved patients with complex mental health issues.

The pair discuss the relentless challenges in general practice and how Stone learnt not to drown in its complexity: working part-time in clinical practice and taking on additional work in teaching, policy or research.

Most of the interview is focused on the troubling issue of sexual harassment

in medicine: one third of female doctors in Australia have been subject to incidents of sexual harassment, and overwhelmingly the perpetrators are their own colleagues.

Stone talks about how she was compelled to research and write a book on the topic after looking after an intern who was sexually assaulted by her boss on the way back to her car after night-shift.

To hear the full interview and other episodes, you can access Doctorama on all streaming platforms including Spotify, Apple, and Google podcasting services.

WIN! Recommend a podcast and we'll send you an iconic Canberra scrub cap. Email editorial@ama-act.com.au

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