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Health to be an Election Issue

With ACT Legislative Assembly elections less than a year away and health likely to be a major issue, AMA (ACT) President, Dr Liz Gallagher, President-elect, Dr Steve Robson and CEO, Peter Somerville last week met with Health Minister, Simon Corbell.

While these meetings happen regularly, there do seem to be a whole series of important issues running at the present time.

Bullying and Harassment at TCH

It was no surprise that the recent KPMG Review of the Training Culture at The Canberra Hospital found there were significant problems of bullying and harassment amongst medical staff. If nothing else, the Review confirmed that the situation went beyond surgical training as identified by the Royal Australasian College of Surgeons Expert Advisory Group.

What was disappointing however, was Minister Corbell's response to the Review and his decision to commence an internal ACT Health-based process of implementing its recommendations. No attempt was made to consult with the AMA (ACT), the ACT Branch of the Australian Salaried Medical Officers Federation, junior doctors, the colleges (other than RACS) or registration authorities, before the Minister made his decision.

Following the Minister's response, AMA (ACT) and ACT ASMOF had written to Minister Corbell proposing he convene a round-table of stakeholders to decide on implementation priorities. Indeed, this has been the process undertaken in NSW. Unfortunately our approach was rebuffed.

If there's one thing the RACS EAG process demonstrated it's that the response to these issues needs to be open, transparent and fair. Instead, ACT Health has established a "Clinical Cultural Committee", made up of persons chosen solely by ACT Health, and commenced an opaque, internal process.

In our meeting with the Minster we re-stated these concerns and, while he listened politely, he was not willing to compromise.

The AMA (ACT) considers this issue to be a key one for all the profession and will continue to advocate for an inclusive process that is open, transparent and fair. Without this, in the words of Dr Gallagher, any attempt to address the issue by ACT Health "will almost inevitably fail".

Salaried Doctors Enterprise Bargaining

As ACT salaried doctors will be only too well aware, the current round of enterprise bargaining has been held up for more than six months while Fair Work Australia decides whether to split the current single bargaining process for senior and junior staff into two processes where seniors and juniors bargain separately.

With AMA (ACT) being a bargaining representative for junior staff, we are very aware that pay increases and back-pay are being delayed and that some junior doctors entitled to back pay will have moved away from the ACT and will be difficult to track down.

The good news, however, is that the Fair Work Commission handed down its decision on 13 November deciding to stay with a single agreement. The onus is now on ACT Health to move as quickly as they can to ensure junior doctors receive their salary increases and back-pay as soon as possible.

Minister for Health, Simon Corbell (centre) with AMA (ACT) President Dr Liz Gallagher and President-elect Dr Steve Robson.

Minister Corbell Guarantees Intern Places

In 2006 an agreement was reached at COAG where all states and territories guaranteed intern training places for domestic students. It now looks likely that South Australia will walk away from this agreement in 2016 and the unplaced graduates will have to find places elsewhere.

When this issue was put to Minister Corbell, he confirmed that all domestic ANU graduates who had requested an intern place in the ACT would have one. He also went a step further and confirmed that students who completed secondary school in the ACT and want to return after completing their medical degrees elsewhere will be able to do so.

VMO Contract Bargaining

With the VMO contract bargaining period having been underway for the past three months, remarkably little progress has been made. Disputes with ACT Health and the Visiting Medical Officers Association over threatened legal action, good faith bargaining and the identity of the arbitrator topped off with a walkout by ACT Health have made progress difficult.

We urged the Minster to act on the issue of the arbitrator and encourage ACT Health to continue discussions.

All in all a constructive meeting but one in which there is much to follow up on, particularly the issues of bullying and harassment, enterprise bargaining for DiTs and the VMO contract.

Capital Conversations with President, Dr Elizabeth Gallagher

As I write this column, I have just returned from spending two weeks working at Honiara's National Referral Hospital (NRH) in the Solomon Islands. This is the first time I've worked in a developing country and I found it one of the most challenging – yet, satisfying – things I've ever done.

Before I let you in on some of our experiences, let me firstly acknowledge the John James Memorial Foundation for their support and making our trip possible.

I travelled as part of a team of four – a fellow local O&G, Dr Tween Low, anaesthetist Dr Nicola Meares and Perioperative Nurse and midwife, Lesley Stewart from the Northern Territory.

O&G – Solomon's Style

The NRH has 5000 deliveries a year. Their busiest days have seen up to 48 babies delivered in 24 hours! The NRH has a first stage lounge, in reality a single room, where all labouring women are cared for until they are ready to have their babies. They are then transferred to one of three delivery rooms. Of the two postnatal wards, only one is attached to the labour ward and it has neither windows nor air conditioning. If this wasn't problem enough, there is only one shower and toilet for more than twenty labouring and postnatal women to share!

And Gynaecology…

Walking into the Gynaecology ward the first thing you notice is the mix of people. The ward is open plan and relatives stay day and night doing washing and providing meals for patients. The NRH provides neither food nor linen for general use.

The emergency gynaecology plus referrals from the outer provinces matches the obstetric workload although everything presents at the extremes… and late. Massive fibroids, massive ovarian cysts and most tragically, given the absence of screening programmes, advanced cervical cancers in very young women.

There is a trial of Gardisil in three provinces, and if they are able to introduce universal immunisations for HPV hopefully the incidence will fall. It really brought home how effective our screening programme is in Australia, and how dangerous it would be if we get complacent.

To say they saved the difficult cases up for us is an understatement! I was challenged at every turn and if the surgery was not difficult, the co-morbidities and anaesthetic risks kept Nicola on her toes! Luckily all our postoperative patients seemed to have made, or be making, uncomplicated recoveries. This was very reassuring, given the complexity of the anaesthesia and surgery.

We found the postoperative pain relief very poor. For the first two days, we turned up for our postoperative round to find none of our patients had even been given Panadol after they left theatre. We then did some educational sessions with the nursing staff, mindful that the local team will need to continue to implement and use the skills and knowledge we have brought. By the third day our patients were getting regular observations and pain relief, a legacy I hope will continue.

Training and Education

One of the key goals for our team was to providing training and education to our medical and nursing colleagues. With the O&G Department staffed by three local registrars (who are PGY2 or 3) and four interns (in addition to two specialists) we were all conscious of the importance of being able to teach skills that are sustainable once we had left.

Career paths for doctors are highly regulated by the Solomon Islands government. The interns may well end up as generalist doctors working in isolated locations on the outer islands.

Making Do

The availability of equipment and supplies in the hospital depends on what and when things are delivered. They reuse many things we throw away after a single use, including surgical drains and suction tubing. Much of the donated disposables are out of date but they use them without a second thought.

Some things seem to be in oversupply, while others simply run out. For example, when we arrived, the hospital had run out of xylocaine and the women in the labour ward were getting their suturing done without any anaesthetic! They have not been able to check creatinine levels as they ran out of reagent a few months ago, and they ran out of automated platelet counters the week before. Thyroid function tests and histopathology are sent to Brisbane and take up to 6 weeks for results to come back and pathology and radiology are only available in office hours.

Cats in the Belfry

Parts of the NRH date back to World War 2, others to the 1980s but either way, a new hospital is badly needed. There were rats using the plumbing to get from the ceiling to the tea-room and a cat in the theatre roof to catch them.

Discarded and broken equipment littered the hospital grounds and it brought home to us how important it is to donate equipment that is actually needed and teach the skills to be able to look after it.

So that is a small taste of my experience. It made me really appreciate what a great health system we have, and what high expectations we have. I want to send a big thank you to the John James Memorial Foundation for making it all possible.

Meanwhile back in Canberra

Finally, a quick update on some local issues to bring us back to reality. We met with Health Minister, Simon Corbell last week and I was personally very pleased to hear the Minister confirm the provision of intern places for all our local graduating students that want to stay, as well as students who completed high school in the ACT and want to return after completing their medical degrees elsewhere.

With the South Australian Government reneging on its guarantee of intern places we have to ensure this doesn't happen in the ACT.

The bargaining period for VMO contract negotiations is now over. The negotiations have been extremely unsatisfactory with most of the early meetings cancelled and ACT Health walking out half way through the third and final meeting. This leaves many more unsettled issues than we would have liked to go before the as-yet-undecided arbitrator.

With another issue of the Canberra Doctor before Christmas I'll talk to you again soon.

For more information on the John James Foundation please go to www.jjf.org.au

Almost 30% of girls turning 15 not fully immunised against HPV

Around 38,400 of the estimated 137,460 girls aged 15 in 2013 were not fully immunised against the highly contagious virus that can cause cervical cancer, with coverage rates as low as 56% in some areas, a new report from the National Health Performance Authority finds.

Human papillomavirus (HPV) is a common virus which for most people is harmless and without symptoms. However, for others the virus can cause a range of cancers, such as cervical cancer and other conditions such as genital warts. Four out of five people will have an HPV infection at some stage of their lives.

The new report shows HPV immunisation rates for girls who turned 15 in 2013 by two levels of geography – by 31 areas covered by the new Primary Health Networks (PHNs), and by more than 80 smaller areas that cover all of Australia, known as Statistical Areas Level 4 (SA4s) – the smallest areas for which HPV immunisation rates have been reported to date.

The report shows that out of the 137,460 girls estimated to be aged 15 in 2013, almost three-quarters of girls (72%, or 99,011 girls) were fully immunised against HPV. The report further reveals:

- The five PHN areas with the highest percentages of girls fully immunised against HPV had coverage rates between 78% and 89%, while the six PHN areas with the lowest percentages had coverage rates between 56% and 66%
- The five local areas (SA4s) with the highest percentages of girls fully immunised against HPV had coverage rates between 84% and 89%, while the five local areas with the lowest percentages had coverage rates between 56% and 60%.

National Health Performance Authority CEO Dr Diane Watson said today's report provided the most nationally consistent data by local area available on HPV rates.

"Communities now have the clearest picture yet on where HPV immunisation rates are high and low. This new information will assist to better target strategies to improve HPV immunisation rates," Dr Watson said.

"The National HPV Vaccination Program was introduced in 2007, to protect girls against infection by a virus known to cause cervical cancer."

The report also includes changes over time and state and territory level rates. The Healthy

Communities: HPV immunisation rates for girls in 2013, In Focus report can be downloaded at www.myhealthycommunities.gov.au

ACT Medical Careers Expo

By Lauren O'Rourke

The inaugural ACT Medical Careers Expo was held on Sunday 25 October and saw over 100 medical students and junior doctors explore future career choices. The expo provided participants with the opportunity to learn about postgraduate training pathways courtesy of representatives from ten of the different training colleges.

Unlike the more traditional careers fairs, participants rotated through stations in a "speed dating" type fashion, having dedicated time with each college. This gave them insight into pathways they may not have otherwise explored or considered.

In the afternoon session, representatives from the AMA (ACT), AMA DiT, JMOA, Bega and Goulburn Hospitals, as well as ACT Health's Medical Officer Support, Credentialing, Employment and Training Unit (MOSC ETU) passed on information specific to junior doctors.

The expo filled a fundamental gap in the ACT as similar careers expositions are currently held only at interstate conferences and events. The ACT Medical Careers Expo provided participants with the opportunity to gain information and tips for their future careers while also fostering the connection between junior doctors and medical students.

The event was organised by the Australian National University Medical Students' Society (ANUMSS) with support from the Australian Medical Association, ANU Postgraduate and Research Students' Association, Bank of Queensland, MIPS, and MDA National.

Lauren O'Rourke is a 4th Year Medical Student at the ANU Medical School.

DiT Matters

By Dr Catherine Greenshields

As another clinical year draws to a close, newly graduated medical students prepare for their transition to responsible professionals while doctors in training (DiTs) around the country look to the next step in their career progressions. It's an exciting time, with both groups sharing the common goals of education, gaining experience doing the best they can for patients and other users of our health system.

While those of us who work in the health system are usually thinking about what we can do for others, it's good to know that the AMA is there to give us the support we need. One important part of what the AMA does for DiTs is the AMA's Council of Doctors in Training (AMA CDT). The AMA CDT is a national organisation comprised of junior doctors from around Australia – interns, residents, registrars and fellows – that supports and advocates for DiTs on issues including training, education and workplace planning.

Workforce Planning and Training

That workforce planning and training issues affect DiTs is unlikely to be news to you. However, while there has been a substantial increase in the number of medical student places over the past decade, the lack of co-ordination with speciality colleges and state governments has created a training crisis that threatens the career trajectory of many DiTs. The AMA CDT continues to lobby key government and stakeholder groups regarding this issue, advocating for a more sustainable health workforce.

Guarantee of Intern Places

In addition to the bottlenecks in the system at the level of entry into vocational training and beyond, there is increasing pressure on graduating medical students to secure an internship. The 'intern crisis' has been expanding over recent years, and while to date it has been primarily international medical students who have borne the brunt of this failure in workforce planning, in the near future domestic students will also be affected. In 2006 states and territories were granted an increase in their federally funded number of medical school places, and through the COAG (Council of Australia Government) processes, agreed to guarantee medical internships to all Commonwealth funded domestic graduates. Projections have shown that by 2018, South Australia will be almost 40 internships short for their domestic graduates, and this blatant breach of their COAG commitments not only has the potential to cripple the medical career of those doctors who are affected, but also sets a dangerous precedent for other states and territories to disregard their obligations under COAG. AMA CDT and the wider AMA have been active in vocalising this issue at a national level, compelling South Australia to comply with their COAG responsibilities.

Following representations made to ACT Health Minister, Simon Corbell, the ACT Government has guaranteed intern places for domestic ANU medical graduates in 2016. We appreciate the Minister's assurances.

National Review of Intern Training

This is not the only issue facing our interns. A short while ago COAG commissioned an independent National Review of medical intern training. While an increase in education and support for doctors during their internship can only be seen as a positive move, this review has put forward an options paper with more dramatic changes. Various reforms were proposed, including a 2-year internship spanned over either the first 2 years following graduation or including the final year of medical school and internship as a combined 2-year internship. The AMA has spoken out strongly against such dramatic changes. While of course supporting evidence-based improvements in the supervision and education provided to interns, there is no evidence to suggest that the current model of internship is "broken".

Bullying and Harassment

Bullying and harassment in the medical work place has been pulled out of the shadows this year, both at a local and national level. AMA CDT has liaised with the Royal College of Surgeons (RACS), other speciality colleges and health departments to ensure that a safe work environment can be provided to all doctors. The KPMG review into the training culture at The Canberra Hospital identified many similar findings to the recent RACS report on bullying and harassment. While many individuals in management roles attended this review, there was only a small portion of DiTs present, and a lack of inclusion of key stakeholder groups in this process, including junior doctor organisations, the AMA ACT or ASMOF ACT. The findings suggested that there is generally little confidence in the organisations' ability to deliver timely and effective resolutions to reports of harassment in the workplace.

The next AMA ACT DiT forum will be held before the end of the year so please watch out for the date and come along.

Dr Greenshields is the President of the Canberra Hospital Junior Medical Officers Association and AMA ACT representative for the AMA Council of Doctors in Training.

ACT AIDS Action Council welcomes John Mackay as Patron

With November being ACT Testing Month, the ACT AIDS Action Council held its Annual General Meeting on 11 November electing local Canberra business identity, John Mackay, as their inaugural patron.

John Mackay's personal history with HIV and AIDS demonstrates the tragic interplay between disease and societal attitudes. The Canberra Times put it this way:

"When two of Canberra business magnate John Mackay's younger brothers succumbed to AIDS within six weeks of each other, the only bright spot was the way their friends and community groups gathered around to support them in their time of darkness.

"It was at a time when AIDS was very new to Australia, one of my brothers was in the first five or 10 people diagnosed in this country and people were terrified of it, they didn't understand it," Mr Mackay said.

"I think there was a fair bit of homophobia going on in Australia at that time, I think in some states if you were homosexual you could still be charged with a crime so it was a pretty tough time all around."

Now, the former Canberran of the Year will help steer Australia away from stigma in his new role as the ACT AIDS Action Council's inaugural patron.

ACT Testing month aims to get the message out that regular testing is just as much a part of staying healthy as awareness of blood borne viruses, access to effective treatments and safe sex. The ACT Government and a range of community health service providers are supporting the initiative.

For more information see the ACT Testing Month website at www.testingmonth.info or ask at any of the Testing Month partner organisations about extra testing events and dates during November.

The AIDS Action Council was formed more than 30 years ago and provides a variety of services, education programs and works to raise awareness of HIV and AIDS in the community via regular events and communications.

And for the AIDS Action Council please go to www.aidsaction.org.au

New CEO for Capital Health Network

Gaylene Coulton has started as the new CEO of Capital Health Network (formerly Canberra Medicare Local).

Before taking up her new position earlier in October, Gaylene was CEO of South Western Melbourne Medicare Local.

In her background as an RN Ms Coulton specialised in palliative care and community nursing, before moving into education and management in community nursing, aged care and social services.

Gaylene appreciates first-hand the importance of addressing the social determinants of health in order to improve health outcomes, from her years as a registered nurse and more recently as CEO of health organisations in fast growing and disadvantaged areas of Queensland and Victoria.

"I'm passionate about working to improve health outcomes through integrating the health care system and by addressing the social determinants of health. It's imperative that we take a holistic and comprehensive approach to our work,"

"We are in a unique and fortunate position in the ACT being one jurisdiction. I am keen to continue to build on our work in taking on a whole-of-government and whole-of-sector collaborative approach to ensure the social determinants of health are considered and addressed. This is essential to improve health outcomes for hard-to-reach groups and to successfully tackle issues such as mental health and chronic disease in a coordinated way," said Ms Coulton.

AMA ACT looks forward to working with Gaylene in her new role.

Preparing children for bushfire

As bushfire season approaches, psychologists from the Australian Psychological Society Disaster Reference Group have prepared some simple tips to support children who may be affected by threat of fire or by news and coverage of bushfires.

Psychologists suggest that carers can help children who live in vulnerable bush fire regions by:

- Involving them in physical preparations that helps them have a greater sense of control and assists them to manage their fears, e.g. develop a household plan with kids and practice it.
- The carer preparing themselves psychologically so that they feel more in control, and then teaching children the same skills (anticipate, identify, manage feelings and thoughts)
- Listening to children's concerns and correcting any thoughts or ideas that are exaggerated or inaccurate.
- Remaining positive and reassuring, saying things like "Remember the plan we have and the things we can do to help us all keep safe if a bushfire comes".

Key messages for carers of children who are experiencing anxiety about bushfires, or other threats, but may not be directly at risk

Carers can help children by:

- Monitoring media exposure (limit, or watch with them).
- Listening to understand how children are feeling and thinking (encouraging them to talk, but not forcing them, normalising their feelings, providing truthful but simple and thoughtful explanations).
- Providing children with opportunities to express their feelings.
- Reassuring children that they are safe and are being looked after and that nothing bad will happen to them personally.
- Being aware of how you talk in the presence of children.
- Paying attention to your own reactions.
- Video: Listen to Dr Susie Burke talk about mentally preparing children for bushfires. https://www.youtube.com/watch?v=wNeoKmYCnew.

OPINION:
We need to talk about Embryo Gene-Editing Technology*

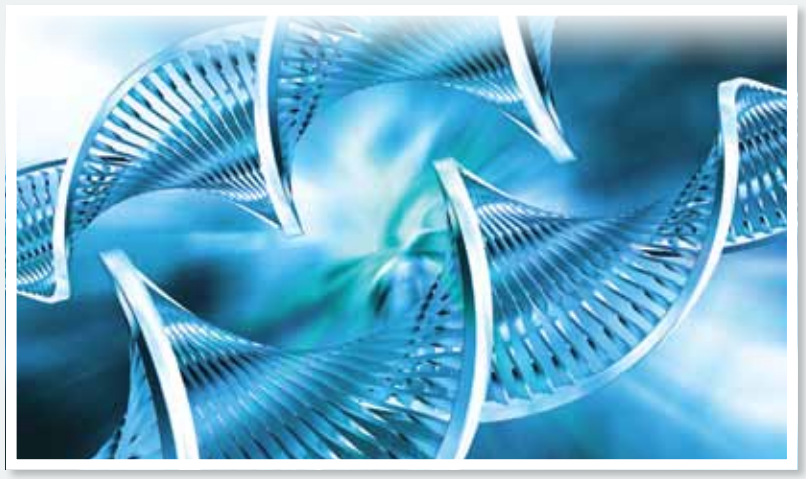
By Rebekka Jerjen,
ANU Medical Student

The conundrum of embryo genome editing has arrived at our doorstep carrying heavy bags filled with imprecise technology, ethical dilemmas, legal quandaries and international discordance – will we let it in? And if so, how will we unpack these bags over the decades to come?

The idea that we could deliberately rewrite precise areas of the human genome to remove disease-causing variants is powerfully frightening and simultaneously wonderful. Developing this ability in a safe, moral and efficacious manner has been the challenge of genetic engineering for many years. Recently, the debate over ethical and safety issues arsing from such technology has been powerfully reignited after a research group in China reported the use of genome editing in human embryo. The researchers used the CRISPR/Cas9 enzyme complex to edit the genome of unviable IVF embryos with aberrant β-globin genes (HBB gene) implicated in the aetiology of β-thalassemia. This same technology is currently being used to study gene functions and develop gene therapy but hasn't before been applied to human embryos. Although the experiments were predominantly unsuccessful, the report understandably raises many questions as to the safety, regulation and ethical implications of this technology and its use around the world.

Theoretically, the replacement of a variant ("bad") gene sequences with a wild-type ("good") copy either in adults with diagnosed disease or embryos with expected disease could significantly reduce the burden of genetic disorders and improve quality of life for these individuals. It is conceivable that this form of gene therapy can be effective for disorders with established, monogenetic causes such as cystic fibrosis (*CFTR gene*), Tay-Sachs disease (*HEXA gene*) or Huntington's disease (*Huntington gene*). The inheritance patterns of these disorders are well understood and their eradication would have significant beneficial impacts on individuals' and families' lives. Gene-editing could also be used for preventative changes; for instance, introduction of variant sequences into CCR5 and CXCR4 (HIV co-receptors) to reduce susceptibility to HIV infection.

Direct gene-editing can be viewed as an extension of existing genetic intervention strategies such as genetic counselling, where parents are advised as to the risks of diseases in their children and perhaps advised against having them; screening programs for pregnant women to identify Down's Syndrome or spina bifida and offer the possibility of abortion; and is very similar to pre-implantation genetic diagnosis (PGD) which enables implantation only of embryos which are genetically "healthy". Embryo gene-editing goes one step further and instead of selecting for a disease-free embryo, it can create one. All these methods aim to reduce the incidence of severe genetic abnormalities and associated impairments and disabilities in the population.



Whilst gene-editing offers many possibilities, the ideas that it will cure all disease, can be used to extend life expectancy, make intelligence a selectable trait or lead down the slippery slope to designer babies are far from true. The complex inheritance pattern and multifactorial nature of most diseases excludes gene-editing as a foreseeable treatment or preventative option since the genetic targets would be numerous or unknown. The role of genetics in many pathologies remains undefined and scientists are working to better understand potential gene candidates partly through analysis of the vast amounts of data produced through genome sequencing. Moreover, the role of the environment in producing complex traits such as intelligence and increasing life expectancy is arguably more important than a genetic basis and as such these traits could never be selected for or introduced. Furthermore, adequate regulation of genetic engineering technology can prevent the possibility of designer babies as it has for PGD.

Nonetheless, the article from the Chinese group has led to international uproar and ethical controversy. Journal giants *Nature* and *Science* both refused to publish the work and issued commentaries and advance warnings regarding their "grave concerns" around the ethical and safety implications of this research, calling for a moratorium of research in this field. Many scientists believe that genetically modifying human embryos has crossed an ethical line and should remain taboo. A key issue is that the effects of genetic modification of an embryo are impossible to predict and as such they pose unimaginable implications for gene diversity, long term effects on individuals and the adaptive and survival ability of populations. The Chinese researchers clearly concluded the application of this embryo gene-editing technology to clinical scenarios is premature, the technology is still in its infancy, it has low fidelity and specificity and potentially detrimental off-target effects (changes to DNA away from the intended site). Despite these conservative conclusions, the damage is done and their international colleagues are unimpressed.

Ultimately there are various arguments for and against the development of gene-editing technology but it seems inevitable that it will progress and the science cannot be stopped across the world. Australia needs to be prepared.

Currently, Australian law allows embryos to be altered in NHMRC Embryo Research licensed laboratories (of which there are 10 in Australia) as long as the embryos are destroyed within 14 days and not implanted into women. This regulatory framework is similar in the UK whilst the US has no law prohibiting genome editing of human embryos although the National Institutes of Health will not fund any research in this area. However, funding for such projects can be sourced from private companies and individuals thus there are alternative pathways.

It is internationally uniformly accepted that medical research and treatments should do no harm to patients and, in its infancy, gene-editing is undoubtedly more harmful than beneficial due to its imprecision and damaging "off-target" effects. But technology is

evolving rapidly and will continue to advance until it is potentially feasible to apply it to embryos in a beneficial way to relieve suffering and disease burden. China, with its more liberal regulatory approach to embryo research and different cultural views, will accelerate ahead to develop this technology.

In order for embryo gene-editing to be developed and performed in a responsible way, Australia's researchers and research funders need to discuss the ethics, regulation and implications of these technologies in order to prepare for and potentially participate in the inevitable advancement in this field and define restrictions as to its use to particular genes/disorders. Simply abiding to a moratorium and condemning the practice is unlikely to prevent progression of the technology and may instead encourage irresponsible and unregulated experimentation.

Australia needs to build a sound ethical and legal framework around the issue of human embryo genome editing in light of these new experiments and physicians should take a moment to consider their stance on the topic so as to appropriately inform patients and potentially advise families on gene therapy options in the (not-too-far-distant) future.

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

Breaking the silence

AMSA Vice President Brian Fernandes contends meaningful change to the culture of medicine must start by ensuring that medical students and junior doctors can raise their voice without fear of reprise.

I'm a final year medical student from NSW. Alongside my medical studies, I hold the position of Vice President (External) of the Australian Medical Students' Association. It's a rewarding role advocating for the interests of my peers at medical schools across Australia.

Earlier this year, I received a phone call from a fellow medical student. They called me to vent about a consultant on their medical team who had a reputation for bullying medical students. The medical student was concerned about the welfare of other medical students on future rotations and wanted to report their experience of bullying in the hospital.

The consultant rounded with the medical team at the start of every day and during this time, the whole team would be on edge. If the medical student got a question wrong, the fragile serenity of the hospital ward round would be broken. The consultant would castigate the medical student in front of the medical team, hospital staff and patients.

The medical student recounted one incident when they interpreted an ECG incorrectly and was berated in the corridor throughout the ward round by the consultant in between seeing patients.

This doctor's wrath wasn't only directed at medical students, but also hospital staff and even patients. There were stories that the consultant would scold patients when they didn't comply with the management plan, even bringing some patients to tears on the ward round.

I enquired if the hospital knew. The medical student said that while the hospital administration knew about the consultant's aberrant behaviour, no one was willing to lodge an official complaint for fear of retribution. Instead, they made a conscious effort to allocate male doctors under the supervision of this consultant as they were "more likely to withstand the bullying".

Becoming increasingly alarmed with this foreboding account, the medical student sought to reassure me, "But apart from the consultant, the rest of the team is lovely. After the ward round we get coffee, debrief on the hour of terror and laugh it off".

I suggested raising their concerns with the student's medical school. The medical student agreed, but lamented that the medical school had received several complaints about this doctor in the past, however the doctor still managed to retain their teaching appointment.

This story of bullying and teaching by humiliation is one of the many stories from medical students and junior doctors that have come to light in recent months. It sadly highlights a systemic failure in the traditional hierarchy of medicine that has fostered a wanton culture of bullying and harassment.

In an attempt to stave off reticence from junior medical officers that reporting would cause reprise, the secretary of NSW Health, Dr Mary Foley wrote an open letter in May reiterating that every report of bullying or harassment would be met with a zero tolerance response.

The AMA have taken a leading role in this space, by convening a sexual harassment roundtable to discuss the underlying culture of bullying and harassment within medicine. The AMA has also worked with the MBA to launch a national subsidiary that will streamline Doctors' Health Services around the country in an effort to improve the provision of services and support to doctors.

But despite movement in the sector, attempts to stamp out experiences of bullying and harassment will be in vain without lasting change to the culture of medicine. Medical students often struggle being caught between university and hospital bullying and harassment policies. Many find the prospect of escalating their legitimate concerns of bullying and harassment daunting and resign themselves to biding their time silently through their rotation.

But if we're serious about making meaningful change to the culture of medicine, then we must start by ensuring that medical students and junior doctors can raise their voice without fear of reprise.

Brian Fernandes is a final year medical student and the current Vice President (External) of the Australian Medical Students' Association.

This article was first published in "The NSW Doctor".

Budget benefits, are you taking advantage of the 2015 Federal Budget opportunities for your business?

The 2015-16 Federal Budget created opportunities for small business entities with an annual aggregated turnover of less than $2 million, and employers employing new workers.

The accelerated depreciation measure received the majority of the Budget media buzz. Small businesses can claim immediate tax deductions for as many assets they purchase costing less than $20,000 from the Federal Budget night (12 May 2015) to 30 June 2017. If the value of the pool or purchased assets is below $20,000 it can be immediately deducted too. This is the pool value at the start of the income year. As such, if the small business' pool balance is $20,000 or more at the start of the income year and then falls below $20,000 during that year, they will not be able to write off the pool balance for the year.

This is a huge increase from the previous instant asset write-off threshold of $1,000 and can benefit small businesses by reducing their tax bill or increasing tax losses which can be offset against profits in future years. You may want to consider timing planned asset purchases prior to 30 June 2017 when the threshold reverts back to $1,000; however don't buy things you don't need just to receive a tax deduction!

The fringe benefits tax exemption for small businesses will be extended to apply to all portable electronic devices used primarily for work purposes after 1 April 2016, removing the restriction that devices must have substantially different functions to qualify for an exemption.

Capital Gains Tax rollover relief will apply to small businesses when changing their legal structures but keeping the same owners. This measure recognises that a small business may have chosen a structure when they started and now find that their structure is no longer suitable. As such, consider taking the opportunity to review your business structure whilst your business is under the $2 million revenue threshold. The detail regarding the extension of the rollover concessions is yet to be released, as such any review will be subject to the detail to be released for this measure.

Professional fees, such as accounting and legal fees, relating to the set up of a new business can now be fully deducted in the year they are incurred, rather than having to be deducted over five years.

The Federal Budget also introduced employment initiatives targeted towards helping younger and older workers find jobs. Employers can participate in jobactive programs, which place jobseekers in supported work experience placements. Employers offering young job seekers ongoing employment may be eligible for wage subsidy payments of up to $6,500 over a 12-month period. An employer hiring a new employee who is over the age of 50, and who had been unemployed and on income support for six months or more, may be eligible for wage subsidy payments of $10,000 after 12 months.

Disclaimer: This article has been prepared as general advice and does not constitute personal financial advice.

Art In, Butt Out

The ACT Minister for Health, Simon Corbell, recently announced that Jack Witchalls was the winner of the 2015 Art In, Butt Out competition. The annual competition is an initiative of the AMA (ACT)'s Tobacco Task Force, which provides year 8 students with the opportunity to design an anti-smoking advertisement. The winning entry appeared on approximately 60,000 Canberra Milk cartons distributed across the ACT for a six week period.

Minister Corbell's announcement was attended by finalists from across the ACT, including Jack Witchalls, a student of Canberra High School. The Minister congratulated the students who took part, and commended the AMA (ACT) and Canberra Milk for their ongoing commitment to the competition. The Minister emphasised the critical role that educating young people about the dangers of smoking has played in reducing the smoking rate among secondary school students from its 1996 level of around 20 percent, to under 6 percent in 2011.

The majority of smokers take up the habit during their teenage years. Art In, Butt Out uses the effectiveness of peer-to-peer messaging to raise awareness among young people of the harms associated with tobacco use. The competition gives students the chance to use their design and marketing skills in a real situation and have their public health message seen by a wide audience. Participation in Art In, Butt Out encourages young people to think about their own health and wellbeing, as well as how they can support their friends and family members to make healthy choices more generally.

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.

Case Study – ACL Tears

By Dr Raymond Kuan

ACL tears are one of the most common knee injuries encountered. The ACL plays a major role in the stability of the knee joint and is comprised of 2 components, a smaller anteromedial bundle and a larger posterolateral bundle. The mechanism of injury is often related to deceleration coupled with cutting, pivoting and sidestepping manoeuvres.

X-Rays are commonly the first imaging test ordered and they may demonstrate a post-traumatic joint effusion (fig 1). Rarely, a Segond fracture (fig 2) or avulsion fracture involving the tibial footplate of the ACL (fig 3) may be present. The latter is usually only seen in the paediatric population. When these fractures are present, they are highly suggestive of an underlying ACL injury.

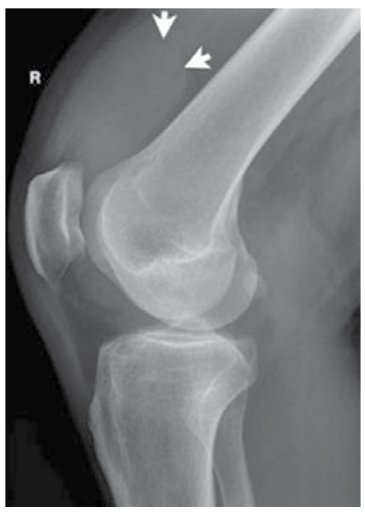


Fig 1

Ultrasound findings are non-specific, usually demonstrating a joint effusion and sometimes, an associated MCL injury. Being a deep intra-articular structure, the ACL itself is poorly visualised on ultrasound.

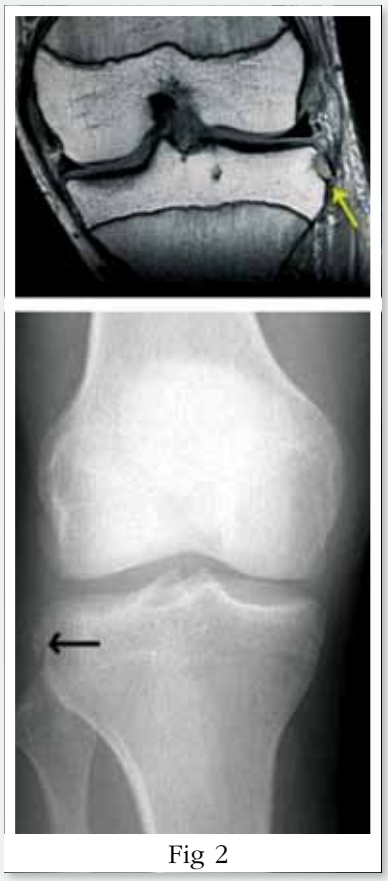


Fig 2

As such, ultrasound is not recommended for the routine assessment of ACL injuries.

MRI is the non-invasive imaging modality of choice for the assessment of ACL tears (fig 4a and 4b). Apart from assessment of the ACL, MRI allows for assessment of associated injuries which commonly occur

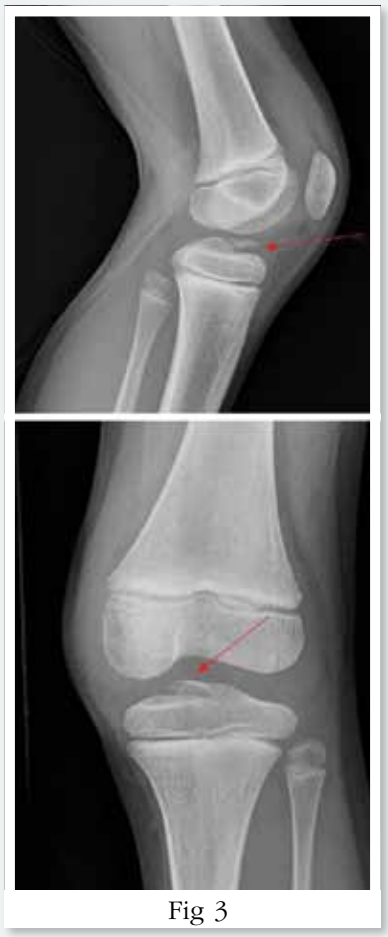


Fig 3

with ACL tears. These include bone bruising/fractures, meniscal and ligamentous injuries. ACL pattern bone bruising usually involves the subchondral region of the posterior aspect of the lateral tibial plateau and the lateral femoral condylar notch/sulcus (fig 5). Meniscal tears may involve either meniscus (fig 6). Associated ligamentous injuries include the MCL and FCL (fig 6).

In the setting of acute trauma, GPs may order Medicare rebatable MRs on certain approved machines if there is suspicion of an ACL injury. In the paediatric population (under 15), this must be preceded by plain radiographs to be eligible.

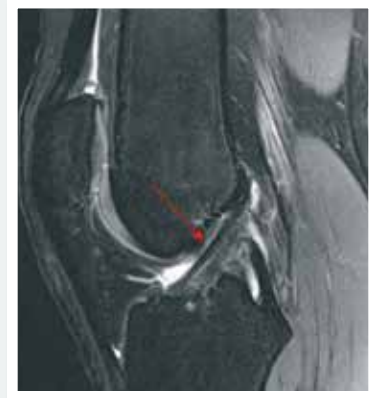


Fig 4a

Fig 4b

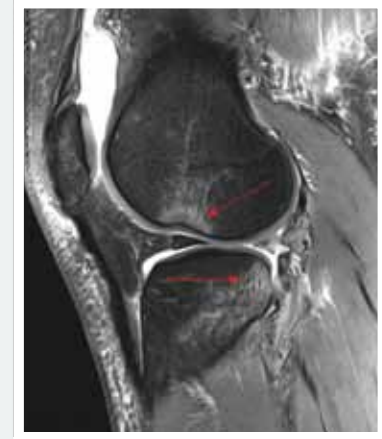


Fig 5

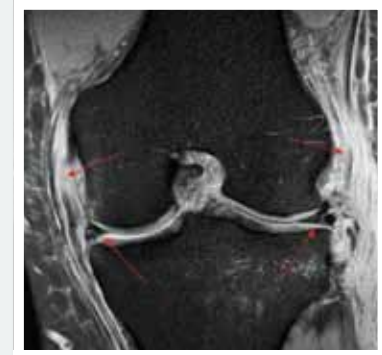


Fig 6

Employers face new rule for paying Super from 2016

With effect from 1 July 2016, the ATO will introduce new rules compelling small business owners with 19 or fewer employees to start paying super contributions and sending member information electronically through SuperStream.

The ATO says that SuperStream will enable employers to pay super to multiple super funds through one channel – "saving them time and money". Practices should have received information via email and text message about it and further information is available on the ATO website and by webinar.

The ATO's Philip Hind suggests that "The ATO's employer checklist is a great place to start, or speak with your service provider, whether it is your accountant, bookkeeper, payroll provider, clearing house or super fund, they can help you become SuperStream compliant."

"We're already hearing positive feedback from those that have already implemented SuperStream. Employers who previously had to make contributions to multiple funds are telling us what used to take hours has now been reduced to minutes." Hind said.

The ATO step-by-step checklist to help employers prepare can be found at www.ato.gov.au/SuperStreamChecklist.

SuperStream Ready
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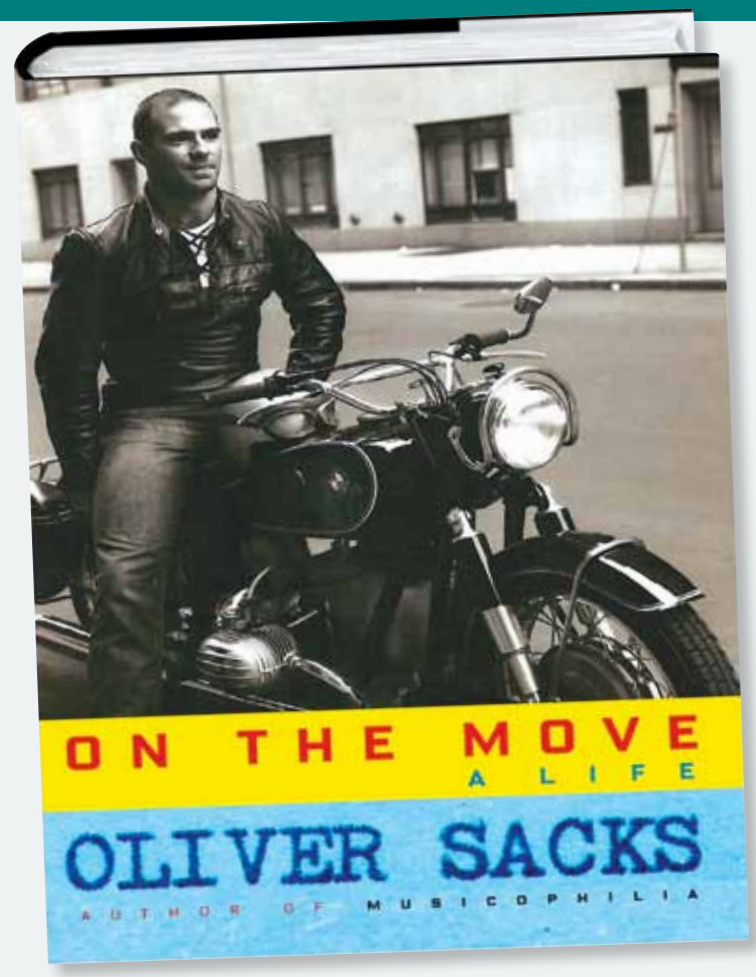
BOOK REVIEW: On the Move – A Life by Oliver Sacks

ISBN: 9781447264057
$34.99



Oliver Sacks played a big role in my career choices; over time I have grown to appreciate that reading his books had been a guide for me. So it was with a sense of wary but excited unavoidability that I brought home his autobiography *On the Move*. As enticing as gossip, but slightly sacrilegious, to find out his secrets.

By his own admission Sacks is '... a man of vehement disposition, with violent enthusiasms, and extreme immoderation in all my passions'. (*My Own Life*, in The New York Times 19/2/2015) This year, at the age of 81, he was diagnosed with metastatic melanoma, unexpected liver metastases years after treatment for ocular melanoma. Readers of *On the Move* may find themselves surprised that he survived his early risk-taking and made it to middle age, let alone 81. Born into a brilliant, Jewish, London medical family a few years before the Second World War, Sacks was separated from his parents and evacuated to a harrowing boarding school at the age of 6. As he has written before in *Uncle Tungsten*, intellectual excitement and curiosity kept him afloat in childhood and seem to have formed the raft that carried him through the storms that followed.

There is a sense, in reading his confessions, of an urgent need to get down on paper first, who he is, and second, what he has achieved. Perhaps, given his past books, we should have been expecting that *On the Move* would read more like a series of case studies of events in his life rather than a continuous narrative; it is only fair that he be exposed using the same methodology he used to describe his patients. As a far from disinterested reader I found *On the Move* to be fascinating.

Reviewed by Dr Philip Keightley, Consultant Psychiatrist and Academic Fellow, ANU Medical School

Erratum:
The October *Canberra Doctor* contained a Book review of First Fleet Surgeon by David Hill. Dr Paul Maguire contributed the review.

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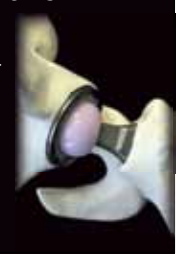

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