CANBERRA Doctor

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ACT Hospital doctors to start bargaining – again

By early December all ACT hospital doctors including DITs, Staff Specialists, Career Medical Officers and other employed doctors should have been notified of the ACT Government's intention to initiate bargaining for the next Public Sector Medical Practitioners Enterprise Agreement. While the agreement is not due to expire until 30 June 2017, the parties can commence negotiations from six months prior to that date.

Bargaining

The Fair Work Act establishes a clear framework about how to go about the process for a new agreement including rules about bargaining, what is included in an enterprise agreement and the process of completing an agreement. Employers, employees and their bargaining representatives are involved in the process of bargaining for an agreement and this is where AMA (ACT) steps up.

Dr Nushin Ahmed, Co-chair of the AMA (ACT)'s Council of Doctors in Training.

The first step in enterprise bargaining is developing our 'Log of Claims', which is a carefully constructed list of requests that our members, as employees, would like to make of ACT Health. It is essentially a list of those things that our members would like to see improved in the workplace and is then submitted to ACT Health for consideration.

ACT Health will also present us with their Log of Claims and we will use both logs as a basis for enterprise bargaining and the subject of debate between bargaining representatives, including AMA (ACT) and Act Health.

Early indications are that AMA (ACT) will be focussing on a range of industrial issues and training issues emphasising safe hours and associated working conditions.

A Separate DIT Agreement?

Many members will recall the lengthy delays and Fair Work Commission proceedings during 2014-15 which characterised the last round of negotiations. The AMA (ACT) is keen to ensure that we avoid the delays which so badly affected the finalisation of the current enterprise agreement.

The idea of a separate agreement for the Junior Doctors was seriously considered last time, but a single agreement was maintained. This time around the AMA (ACT) is consulting with its Junior Doctor members to decide whether the idea of a separate agreement for Junior Doctors, is likely to be of any real benefit to members.

Separate agreements for Junior Doctors operate in other jurisdictions notably in Victoria, which also operates under the Federal workplace relations regime.

Continued page 2...

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Medical **Musings**

WITH PRESIDENT, PROFESSOR STEVE ROBSON

With Christmas almost upon us and the New Year following that, I thought it worthwhile for the *Canberra Doctor* Christmas edition to, firstly, look back over the issues and events of 2016 and secondly, consider what lies ahead of us in 2017.

2016 kicked off with the salaried doctors' agreement finally being settled and the much-delayed pay increases being paid to senior and junior staff. In the end, some 18 months late, and featuring a vote that had to be re-run and subsequent litigation in Fair Work Australia, the delay in finalisation was a matter of some regret.

Somewhat ironically, given that the last salaried doctors' agreement was settled only earlier this year, the ACT Government has just issued notices advising that the next round of bargaining will commence early in 2017. The more things change . . .

Intern orientation and student welcome

One of the highlights for the year was the welcoming of a new groups of interns to Canberra, kicking off with our graduate breakfast and then intern orientation. For the first time in many years we asked interns to pay a fee to joining the AMA (ACT) and I'm pleased to say we were successful in recruiting more than half of 2016 interns as members; a great effort and one we're looking to repeat in 2017.

As ever, our welcome event for new medical students was held in February and I had the opportunity to meet many of the new first years. Eager faces, high expectations and unbound enthusiasm – quite a night at the Uni Pub and a great opportunity to meet the next generation of medical practitioners.

Dr Liz Gallagher

The AMA (ACT)'s AGM was held in May and this year we held meeting as a part of a dinner event at the Hotel realm that coincided with the launch of our new Mercedes Benz partnership.

The AGM also marked the end of Dr Liz Gallagher's term as AMA (ACT)'s President and I'd like to express the thanks and gratitude of the AMA (ACT) Board and members for a job well done. It's easy to forget that Liz took on the President's role at the time of the Abbott Government's 2014 budget and it really preceded an extremely busy two years. Thank you Liz.

VMO arbitration

This year's VMO arbitration produced a drawn out process that saw much toing and froing, false starts, threats of litigation and walkouts right up until the arbitrator delivered what was, more or less, a 'status quo' decision. Each side received a little and gave a little. The fact that ACT Health pursued a series of claims that would have seen VMOs' conditions and payments slashed was disappointing, to say the least but commonsense eventually prevailed.

We all know how important morale is in the public hospital system and, in my view, some fence mending would be welcome in 2017.

ABOVE: *AMA (ACT) President, Prof Steve Robson, with Mix 106.3's Kirsten and Rod at FARE's 'Pregnant Pause' launch.*

LEFT: *AMA (ACT) President, Prof Steve Robson, chatting with new medical students.*

The Year of the Election

2016 was certainly the year of the election; after a marathon eight-week Federal election campaign, that significantly featured health issues, we followed up locally with an ACT election that again saw both sides making extensive – and expensive – health-related promises. Both the Canberra Liberals and ACT Labor promised to redevelop significant parts of Canberra Hospital and AMA (ACT) intends to work with the re-elected Barr Government to ensure the promises that have been made are carried through in a timely manner.

One notable public policy failure during the year was the ACT Government's decision not to legislate '3am last drinks'. I've seen the type of injuries and effect alcohol-fuelled violence can have on individuals and their families and I'm determined to continue the AMA (ACT)'s advocacy in this area and do what we can to ensure evidence-based changes to liquor licensing laws.

And next year...

Recently, we've welcomed the appointment of Meegan Fitzharris as the ACT Minister for Health. Meegan has a strong commitment to the community and I'm confident we'll be able to work constructively with her. Her community background will be valuable as we come to terms with a number of major issues including how we continue to support Canberra's hardworking general practitioners.

We know that primary care is an effective and cost efficient part of ensuring the long-term health of Canberra's citizens but we need to work out how we support GPs to ensure they can continue to deliver that care. Issues around access to extended after-hours services, practice grants and innovative projects are being considered by AMA (ACT), the Capital Health Network and ACT Health.

While these developments are welcome, they need to be built on over the course of 2017.

Best Wishes for the Holidays

It's of course, timely to thank all of those people who've assisted us in the work of AMA (ACT) over 2016 including the members of the Board and Advisory Council and our AMA (ACT) staff. Of course, a special thank you to our members and other colleagues we work and interact with every day – stay safe and enjoy this special time of the year.

ACT Hospital doctors ...continued

...from page 1

While the workplace relations system can sometimes feel distant and as though it will have very little impact on you, enterprise bargaining is a great opportunity to have your say and raise your issues through AMA (ACT).

Further Information

Regular updates and bulletins on the progress of negotiations with the Territory Government and ACT Health will be a feature of coming editions of the Canberra Doctor. During this critical consultation stage Interested AMA (ACT) members are invited to contact Tony Chase, Manager, Workplace Relations and General Practice or Anish Prasad, Hospital Organiser to discuss any concerns with the current EBA. Both may be contacted on 6270 5410 or at industrial@ama-act.com.au

AMA on obesity: Australia's biggest public health challenge

The AMA has released a revised and updated position statement on obesity, with AMA President, Dr Michael Gannon, saying that obesity is the biggest public health challenge facing the Australian population. Dr Gannon called on the Federal Government to take national leadership in implementing a multi-faceted strategy to address the serious health threat that obesity poses to individuals, families, and communities across the nation.

AMA President, Dr Michael Gannon.

"The AMA strongly recommends that the national strategy include a sugar tax; stronger controls on junk food advertising, especially to children; improved nutritional literacy; healthy work environments; and more and better walking paths and cycling paths as part of smarter urban planning," Dr Gannon said.

National Strategy Needed

"A national obesity strategy requires the participation of all governments, non-government organisations, the health and food industries, the media, employers, schools, and community organisations.

"The whole-of-society strategy must be coordinated at a national level by the Federal Government and must be based on specific national goals and targets for reducing obesity and its numerous health effects.

"More than half of all adult Australians have a body weight that puts their health at risk. More than 60 per cent of adults are either overweight or obese, and almost 10 per cent are severely obese.

"At least a quarter of Australian children and adolescents are overweight or obese.

"Obesity is a risk factor for type 2 diabetes, heart disease, hypertension, stroke, musculoskeletal diseases, and impaired social functioning.

"Around 70 per cent of people who are obese have at least one established health condition, illness, or disease, which can increase the cost of their health care by at least 30 per cent.

Children and Adolescents

"The AMA recommends that the initial focus of a national obesity strategy should be on children and adolescents, with prevention and early intervention starting with the pregnant mother and the fetus, and continuing through infancy and childhood.

"We are urging the Federal Government to lead a national strategy that encompasses physical activity; nutritional measures; targeted interventions, community-based programs, research, and monitoring; and treatment and management.

"Governments at all levels must employ their full range of policy, regulatory, and financial instruments to modify the behaviours and social practices that promote and sustain obesity.

"Every initiative – diet, exercise, urban planning, walking paths, cycle paths, transport, work environments, sport and recreation facilities, health literacy – must be supported by comprehensive and effective social marketing and education campaigns," Dr Gannon said.

The AMA recommends that the Federal Government's national obesity strategy incorporates these key elements:

- greater and more sustained investment in research, monitoring, and evidence collection to determine which and individual and population measures are working;
- town planning that creates healthy communities, including safe access to walking and cycle paths, parks, and other recreational spaces;
- a renewed focus on obesity prevention measures;
- ban the targeted marketing of junk food to children;
- a 'sugar tax' – higher taxes and higher prices for products that are known to significantly contribute to obesity, especially in children;
- subsidies for healthy foods, such as fruit and vegetables, to keep prices low, especially in remotes areas;
- action from the food industry and retail food outlets to reduce the production, sale, and consumption of energy-dense and nutrient-poor products;
- easy to understand nutrition labelling for packaged foods;
- expansion of the Health Star Rating scheme;
- greater support for doctors and other health professionals to help patients lose weight; and
- local community-based education and information programs and services.

The AMA Position Statement on Obesity 2016 is at https://ama.com.au/position-statement/obesity-2016

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PRIDOC 2016 – indigenous doctors from around the Pacific Rim

BY CHARMAINE EARNSHAW, A PALAWA WOMAN FROM THE BRIM CREEK MOB IN TASMANIA

I recently went to the PRIDOC conference in Auckland, New Zealand. PRIDoC stands for Pacific Region Indigenous Doctors Congress. It provides an indigenous space, for indigenous doctors, medical students, health professionals, health researchers and medical educators from around the Pacific to discuss ideas, action and evidence that impact indigenous health. The theme for this year was transformation, specifically about medical education, the workforce, healthcare design and delivery.

Indigenous Doctors from around the Pacific rim

At the conference the Lancet, in collaboration with the Lowitja institute, presented a paper on "Indigenous and tribal peoples' health" which shows the similar health disparities across most indigenous populations. It was interesting to note the similar disease types across each country, although the size of the rate difference varies substantially. This study showed a 12 year age gap between Australian Indigenous and Non-Indigenous populations. The Sami people of Norway have banned all forms of research relating to themselves, which was reflected in this paper.

From the Western Pacific

I attended a number of talks from the native Taiwanese delegation. In Taiwan a number of Indigenous Health Services had only been recently set up. They had constructed a lessons learnt seminar and were also asking for advice. Some key advice points were to incorporate native Taiwanese and potentially Chinese medical methodologies, particularly for mental health, as the main treatment forms were from Western methodologies (the disease-deficit model). It was postulated that this model does not adequately address the main source of disease in Indigenous populations, namely the trauma of colonisation and loss of identity.

To Near Neighbours

Another key point from the conference was the line between intellectual property and genetic information. There have been a number of incidents where the Māori population of New Zealand allowed their tissue samples to be taken and experimented on in one study, but further explicit consent for use of the genetic sequences in other studies was not obtained before a new study was initiated. A new governance framework and consent form is being designed by Te ORA (a professional body representing Māori medical students and doctors) to prevent this in the future.

And on to the Eastern Pacific

Racism and devaluation of culture was a common theme in many presentations. In Hawaii, the use of their native land for cash crops and tourism instead of food, and turning traditional dances, instruments and carvings into "Tiki culture" has contributed to the decline in physical and mental health of the kānaka maoli (native Hawaiians).

The topics in this Congress were deep, and added to my own knowledge of identity and value systems. I learnt so much, and I got to meet some wonderful students and doctors. The sense of family and inclusion that goes with these environments cannot be compared.

Meeting Elders and Doctors who share the same goals as I do without compromising their beliefs or traditions energises me in my desire to follow the path they walk.

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The MBANSW is funded by your donations; please allow us to continue to provide support and assistance to your colleagues in need by making a donation to the Medical Benevolent Association Annual Appeal. Donations can be made visiting our website www.mbansw.org.au

If you are concerned about your own situation or that of a colleague, please contact the MBANSW Social Worker, Meredith McVey on (02) 9987 0504.

Removing uncertainty when issuing medical certificates

BY HARRY MCCAY, SENIOR SOLICITOR, AVANT LAW & DR PETER WALKER, A GP AND SENIOR RISK MANAGER, AVANT

A patient says he is stressed and anxious because of his work and requests a medical certificate for two weeks off work. A couple of days after providing the certificate, you are contacted by their employer who tells you the patient's Facebook page indicates he spent the last two days fishing at a resort. The employer asks if this is consistent with him being sick and unable to work. How should you respond? Could this mean trouble?

Medical certificates are powerful legal documents which can entitle a person to financial or other benefits. Therefore, doctors requested to complete medical certificates need to be mindful of their legal and ethical obligations.

How should you respond? Firstly, don't respond until you check the employer is who they say they are. Ask to see a copy of the medical certificate to ensure it is the one you issued and not fraudulently altered. If it is the same, simply confirm that you issued the medical certificate. Do not provide any personal medical information about your patient to the employer.

Could this mean trouble? That is not a simple question. Employers are much more inclined to challenge certificates than ever and to complain to medical boards or other regulatory authorities if they perceive a certificate has been issued improperly or inappropriately.

If a complaint is made, whether or not this becomes an issue depends on whether you:

- completed the certificate accurately and honestly
- examined the patient and determined whether their condition warranted time off work and the length of time off work that you specified
- kept detailed notes on the reasons why you issued the medical certificate
- referred the patient to a specialist or for further tests if indicated.

Make good notes

A medical certificate is best defended by good notes, and where appropriate, relevant investigations and referrals, and even the opinions of other health professionals. Your contemporaneous notes of the patient's visit should always record the diagnosis on which the certificate was issued, and the details of the history and examination findings supporting that diagnosis. We also recommend that you keep a copy of the certificate in their file.

If you do not honestly believe the patient has a medical condition which affects their ability to attend work or school, do not provide a certificate. If you do, or if you provide a certificate for longer than is reasonably necessary, you could be exposed to disciplinary, civil or even criminal action.

Stick to the facts

Unless required by a statutory scheme, such as WorkCover, private health information diagnoses should not be included in a medical certificate.

The content of certificates should be limited to the fact that the patient is unwell, is unable to work, and how long they will be expected to be unable to work.

Medical certificates are not a vehicle for advocating on behalf of patients.

In recent cases, adverse comments on medical certificates about workplaces or schools resulted in Medical Board complaints and even the threat of a defamation action.

Always be honest

One case that did end up in court, involved a patient given a certificate for two months off work. During this time he appeared as a contestant on a television show and advised the compere that he was in good health, resulting in a complaint by the employer against the doctor.

The GP believed the patient had adjustment disorder and stress-related symptoms which worsened when his employer moved his position interstate and changed the nature of his duties. The GP was of the opinion that the patient was well enough to be on the show and it might even improve his condition, but he was not fit for work-related duties.

The worker was dismissed by his employer but the court reinstated him. The court found that having referred the patient to a psychologist and basing his views on the psychologist's diagnosis the GP had honestly provided the medical certificate.

Can you issue post-illness medical certificates?

Providing a post-illness medical certificate depends on a relationship of trust between doctor and patient. In the absence of any physical findings, the doctor must believe on reasonable grounds, the patient's reported symptoms and condition prior to attending.

So, yes, you can certify that a patient required time off work before they attended your practice, however you must clearly identify:

- the date you saw the patient
- the period of time the patient had off work before seeing you
- that you support the need for the time off work because of their reported history and symptoms.

When should you not provide a certificate?

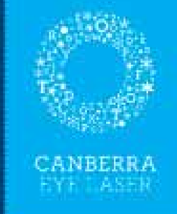
As a medical certificate is a legal document, a doctor should not provide one if they believe there is insufficient evidence that the patient's condition should preclude them from work. Breaching this rule may expose a doctor to civil, criminal or disciplinary prosecution. Doctors should be particularly cautious in certifying long periods without reviewing the need for further time off. Referring and obtaining additional expert opinion is prudent before certifying long periods of incapacity.

Appropriate signage and policies around issuing medical certificates can also help deter patients from making inappropriate requests for medical certificates and support doctors declining to provide a certificate in these cases.

Further information

Guidance about completing medical certificates can be found in Section 8.8 of *Good medical practice: a code of conduct for doctors in Australia* and in Avant's fact sheet, 'Medical certificates and you.'

If you have concerns about completing a medical certificate seek advice from Avant's Medico-legal Advisory Service – phone 1800 128 268 or email nca@avant.org.au



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Medical Benevolent Association of NSW – where did it all begin?

As the Medical Benevolent Association of NSW celebrates 120 Years of service to medical families, it's worth reflecting on its beginnings in the late 18oo's, a pivotal time in Australian medicine. Many modern medical entities had their beginnings during this period.

Dr Austin Nathaniel Cooper.

The British Medical Association of NSW, formed in 1880, was the heart of the medical community, with meetings held to discuss medical issues and unusual cases – many pivotal policies and future medical entities had their origins within this group.

Dr Austin Nathaniel Cooper was an active and trusted member of this medical fraternity, having migrated to Australia from Ireland. First registered in 1891, he practiced in Tamworth and was a member of the Sydney Medical Association at its first general meeting in April 1893, a scrutineer at the first elections of the newly formed Medical Defence Fund and was awarded the Association Gold Medal.

In 1893, he treated a boy, thrown from his horse, who sustained a fractured humerus. The lad claimed damages of £2000, alleging that, owing to want of skill on the part of the defendant 'the arm is stiff, has withered, and is useless.' The case concerned the medical fraternity, and a number of highly esteemed medical men of the time gave evidence at the trial, including Dr Philip Sydney Jones, President of the BMA (NSW).

The Judge presiding over the case did not agree with the action and explained to the Jury that 'a surgeon in the position of Mr. Cooper was only bound to use a reasonable amount of care, and bring a reasonable amount of skill .... indeed, evidence had been give that he (Mr. Cooper) possessed very high qualifications.' Unexpectedly, the Jury returned the verdict for the plaintiff of £200.

April 20, 1898.] THE AUSTRALASI.

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The donations received will be duly acknowledged in the *Australasian Medical Gazette*.

NEW INVENTIONS.

A NEW INSTRUMENT FOR AUSCULTATION.

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Our experience in the use of this instrument has been most satisfactory.

The Stethoscope arrives in Sydney.

Although Dr Cooper had been present in January 1894 where it was determined that the NSW Medical (Defence) Union be formed and a scrutineer of its first election of office-bearers, he was unable to avail himself of their assistance as the treatment had occurred just prior to the Medical Union being formed.

In order to defray the costs of an Appeal, in 1895, the BMA formed the Cooper Appeal Fund, which contained the sum of £133 8s 11d after settlement of trial costs. The BMA decided that this balance 'be devoted to the formation of a nucleus of a Benevolent Fund for the benefit of such members of the profession as may be deemed worthy of assistance.'

At a meeting of the subscribers in 1895, the first Executive was elected – Drs P Sydney Jones, R. L. Faithfull, M Martin, F. H. Quaife and Fiaschi – all executive members of the BMA. The objects of the Fund were 'to afford assistance to any duly qualified medical man, or widow, or orphan children of such, whom the committee deem worthy of assistance.'

From these accounts of the end of the 1890s, we see that the leading NSW medical men of the day were engaged together with many significant medical advances attributed to this group and during this important post-Colonial period, marked by the development of an Australasian and Intercolonial medical identity. This same united medical fraternity were responsible for the development of Sydney's first Hospitals, the first Medical School, first Intercolonial annual meetings and medical journals, Friendly Societies (to become Health Funds) as well as the formation of the Medical Defence Union and the NSW Medical Benevolent Fund.

With a proud history of helping medical families in need, we trust that the continuing support of the NSW and ACT medical communities, will enable us to continue to provide assistance for a further 120 years.

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From Country to Country

BY AMANDA STEELE

Born and mostly bred in Chicago, Illinois with my Mom's Polish American family I have always yearned to learn more about my Dad's Australian roots. As a Wiradjuri woman with mixed Australian decent I am on a journey to learn more about my culture. As a medical student I am on a journey to immerse myself in medicine and holistic health care.

The year of 2016 has been a very challenging, but an inspiring leg of the journey. Through the Rural Stream at ANU Medical School I was able to spend my third year of medical school working at the hospital and clinic in the rural town where my Wiradjuri ancestors originated, where my Irish ancestors were exiled, and where my parents live. Being able to blend family, spirit, and country into my medical year has been priceless.

On top of this, the medical community and culture made Cowra, NSW a very inspiring and special place to learn. The amount of one-on-one teaching with brilliant, empowering supervisors and the amount of hands on clinical experience could launch any student doctor into the depths of clinical medicine.

Walpiri Country

What propelled me even deeper into medicine and Aboriginal culture was my placement in the Northern Territory. The Indigenous Health Stream provides opportunities to submerse yourself in Aboriginal Australian culture throughout your four years at ANU Medical School. This year, I was honored to spend six weeks working at a remote health clinic on Warlpiri country.

It is difficult to put words to an experience that is so surreal – like a dream. Warlpiri culture is beautiful. I connected deeply with some of the community members. One old Warlpiri woman in particular stole my heart. She shared her stories of living on country with her parents when she was young 'before the white people came.' She shared her fire dreaming stories with me through song and her water dreaming stories through painting. She spent many afternoons teaching me Warlpiri, and we would paint, talk, and play with her maliki (dogs).

Language and art

The difference learning even just a few Warlpiri words made to connecting with Warlpiri patients in the clinic astounded me. Just saying 'hello, how are you?' in Warlpiri stimulated patients' smiles. Although, they could have been laughing at my pronunciation, it never failed to create connection.

The local artists and artworks that arise from the community are awe-inspiring. As an artist, I couldn't resist the urge to paint. Goanna dreaming is part of my Wiradjuri culture, and part of Warlpiri culture. The painting 'Goanna Dreaming' depicts my visit to Walpiri country.

Disadvantage and hope

This Warlpiri dream of mine did not come without its nightmares though. The medicine I learned in remote NT is invaluable, although, it saddens me that I am able to see diseases like scabies, impetigo, and rheumatic heart disease in children of our country. It saddens me to see the living the conditions that our fellow Australians endure. It overwhelms me that the issues in remote Australia are so complex and so numerous and so big.

Goanna dreaming.

Reflecting on the commitment and compassion of the health professionals I met working in this community is extremely inspirational. The community itself was an inspiration. The local Warlpiri community members decided to make it a dry community and I met many a patient that moved there to get away from the alcohol, and abstained successfully.

The community's elderly people and patients with early dementia were extremely well cared for through their 'Old People's Program', which provided showers, clean clothes, food, advocacy and social support.

I have only had a taste of remote Aboriginal Australia and remote medicine. As challenging and complex as it seems, it is refreshing to have met so many dedicated and compassionate Australians, Aboriginal and non-Aboriginal alike, overcoming such obstacles. I hope my journey takes me back to remote Australia someday, and I hope I can lend a hand in achieving better health outcomes for Aboriginal Australia throughout my career.

expert orthopaedics

Dr Yeong Joe Lau is an Australian trained orthopaedic surgeon with an interest in disorders of the lower limb. He has now returned to Canberra to start practice after completing local and international fellowships in foot, ankle, knee and hip surgery.

Joe operates at The Canberra Hospital, Canberra Private Hospital and National Capital Private Hospital. He consults from The Specialist Consulting Suites at Canberra Private Hospital.

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Behind the scenes: ANU Med Revue 2016 – Murder, She Prescribed

BY FIONA DíMELLO & ANDY HUA

Lightning flashed onstage. The oddly jovial staff of St Omen's Hospital screamed and ran away. A lone spotlight shone into the darkness behind the audience. Detective Grey emerged, sauntering down the stairs of the theatre as he began his investigation of the death of Nigel Black, a diabetic patient who decided to die overnight. But who could have killed him? Was it the surgeon who amputated his leg, or the anaesthetist who knocked him out? Was it the radiologist, or the diabetic educator nurse? Was it the overworked, incompetent intern? Was it his seemingly aggrieved widow? Or could it possibly have been suicide? Nobody could be certain, but that was what the Detective was determined to find out.

In November 2015 we had the privilege of being elected Directors of ANU Med Revue 2016. After spending the previous two years of medical school acting and singing in the Med Revue, we finally had the chance to take ourselves off stage and lead the production. Alongside our Producer, Jonathan Peake, we kick-started the process of writing an original script in early December 2015.

Twists and Turns

It was surprisingly difficult to come up with the intricacies of a whodunit and our scriptwriting committee dedicated portions of their summer holiday to writing *Murder, She Prescribed*. What kind of motives would each of the six suspects have? How could we provide enough twists and turns to keep the audience captivated?

Not only did we have to think of the script; there were songs to write, a soundscape for the band to create and learn, and dancing that needed to be choreographed. There were makeup and costumes that needed designing; sets and props that awaited construction and a crew to work on the microphones, the lights and the changes in sets and props.

It was not all doom and gloom, however. We poked fun at our experiences as medical students, at some of our lecturers and at pop culture. There was a ridiculous chase sequence and there were one-liners which were so bad that they were good.

Companion House

And it was all for a wonderful cause – we put on this show to raise money for Companion House: Assisting Survivors of Torture and Trauma. A charity that is close to the heart of ANU Medical School, and carries out such important work in the Canberra community. We had high expectations to live up to, *Into the Wards*, the 2015 ANU Med Revue, raised $9000 and we hoped to raise even more this time around. All the blood, sweat and tears paid off when we passed our $15 000 cheque to Dr Christine Phillips and Dr Katrina Anderson. Their surprise and gratitude was moving for all of us, and made the entire experience worthwhile.

Our Thanks

If there was anything we learned as Directors of ANU Med Revue 2016, it was that many hands make light work! It would have been impossible to go on this journey without every single person involved in the Cast and Crew. We would like to make a special mention of our Producer, Jonathan Peake, whose guidance and leadership made everything possible. The amount of creative capacity, passion and experience our Cast and Crew brought to the table was phenomenal. Their dedication and hard work, combined with an ability to have fun and put their hearts into a wonderful cause, turned it into an unforgettable experience.

We would also like to thank the Canberra community, as well as our friends and relatives from interstate, for coming out this year to support us. Seeing a full house every night, hearing our audience roar with laughter and applaud our performances was the best reward for several months of hard work. Thank you to all of the medical school staff who were willing to make fun of themselves by taking part in the Med Revue! It was lovely having some famous faces onscreen for our videos.

We would also like to thank our sponsors: the ANU Medical Students' Society, the General Practice Students Network, Teatro Vivaldi and Canberra Philharmonic Society.

And now, it's that time of the year where a new, original production will start coming to life from within ANU Medical School. Jonathan Peake, Hayden Aitken and Alexander Kary are the new leaders of ANU Med Revue 2017. We are confident that next year's show will be in excellent hands.

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Mandatory flu shots for healthcare workers?

BY PIP KNOWLER, MEDICAL STUDENT, ANU MEDICAL SCHOOL

Before commencing work, it is, at present, compulsory that healthcare workers (HCWs) prove that they are immune to numerous infectious diseases. This is in order to protect both themselves and their patients.

Rural 3rd Year Medical Students and future Health Care Workers.
L to R: Elyria Goldie, Patrice Albert-Thenet, Amanda Steele, Michael Stanisic, Anna Habeck-Fardy.

In contrast, vaccination against influenza by HCWs is currently voluntary, despite the fact that influenza is highly contagious and can cause severe disease. One reason for this is that the vaccine is only protective against the major circulating viral strains so does not offer complete protection. Also, due to slight variations in the genetic make-up of the virus that occur each year, individuals must receive a new vaccination annually. Despite all of this, the vaccine still remains the best form of protection available.

Why Vaccinate?

HCWs are an important group of people who should take all steps possible to ensure that they are protected from influenza to the best of their ability. The reason for this relates to patient infection. HCWs who are not vaccinated may contract the virus but not suffer any discernible effect on their health. Infected, they may unknowingly transmit the virus to their patients. Hospitalised patients are often immunocompromised and are unable to combat the virus effectively. This results in a higher incidence of patient morbidity and even mortality from influenza associated complications.

Studies that have looked into the rates of vaccination coverage amongst HCWs in various Australian healthcare institutions reveal that uptake rates are consistently unsatisfactory. In response to these poor statistics, numerous educational and operational strategies have been developed and implemented in an attempt to increase voluntary vaccination uptake by HCWs.

Improving education about the personal protective benefits of receiving the vaccination, the safety and efficacy of the vaccine and the severity of influenza has previously been a major focus. Other past strategies include increasing accessibility to the vaccine for HCWs at their place of employment and senior staff demonstrating stronger leadership to encourage other HCWs to receive the vaccine.

Whilst such strategies may have helped to improve vaccination uptake rates, they have not lead to complete coverage. It is crucial that HCWs work as a team and all receive the vaccine so as to effectively protect patients through the phenomenon of herd immunity. The only strategy that seems to lead to near-complete coverage is the implementation of a mandatory vaccination policy for influenza. For example, the introduction of such a policy in a hospital in Maywood, USA led to an increase in vaccine uptake rates amongst HCWs from 73% to 99% (3). It is suggested that without such a mandatory influenza vaccination policy, the consistently incomplete coverage seen in Australian tertiary institutes will persist indefinitely.

Advantages of a Mandatory Policy

The obvious benefit of a mandatory policy for influenza vaccination is that it would lead to almost complete vaccination coverage amongst HCWs. This would have side benefits for HCWs, principally the reduced risk of getting influenza themselves, which in turn would protect their family and friends. It would also result in economic benefits for the healthcare institution by reducing staff absenteeism from influenza related causes. Most importantly, it would diminish the rate of influenza transmission from staff to patients, thus leading to reduced patient morbidity and mortality.

Influenza, although often mistakenly likened to the common cold, is in fact, a severe and potentially fatal disease. History illustrates its devastating impact, the most severe example being the Spanish Influenza in 1918, which claimed more lives than were lost during the whole of World War One. As stated previously, hospitalized patients are more at risk of developing serious complications from influenza infection due to their already weakened immunological state. When all HCWs are vaccinated against influenza, this helps to protect vulnerable patients and afford them a greater chance of recovery.

Disadvantages of a Mandatory Policy

The main argument against a mandatory influenza policy is that it undermines HCWs' rights to their autonomy. Autonomy is a central pillar of medical ethics. Staff may choose not to get the influenza vaccination for many reasons, including cultural and religious ones, and their right to do so should be respected. A mandatory policy overrides this and in doing so suggests that the health of patients is more important than values and beliefs held by staff.

A mandatory vaccination policy also implies that the strategies used to increase voluntary uptake rates are ineffective. This may have unintended repercussions in the future and could result in a depletion of resources currently used to improve voluntary vaccine uptake (such as employing immunization nurses to run mobile carts).

Conclusions

Having considered both the advantages and disadvantages of a mandatory influenza vaccination policy, it would, on balance, appear necessary to implement such a policy if the strategies used to promote voluntary influenza vaccination are unable to increase the overall uptake rate to near complete coverage.

However as a forerunner to mandatory vaccination, it would be beneficial to continue to increase knowledge about influenza and implement operational strategies like improving vaccine accessibility so as to encourage staff to get the vaccination, which would, in turn, likely raise the overall uptake. This is supported by the findings of a study that was conducted at Alfred Health in Melbourne, Victoria, which demonstrates that the implementation of educational and operational strategies alone can lead to significantly, increased rates of vaccination on a voluntary basis (4). This would appear to be the best possible outcome as it preserves the autonomy of HCWs but simultaneously ensures that patients receive the best possible protection against contracting the influenza virus.

If such strategies were not able to bring coverage rates close to 100% within a few years after being initiated, then, in my view there would be no option but to introduce a mandatory vaccination policy. I have reached this conclusion after considering the four pillars of medical ethics: beneficence, non-maleficence, autonomy and justice and balancing the different requirements posed by each. By being vaccinated, HCWs comply with beneficence and non-maleficence as they are taking the best possible measures to protect their patients. A mandatory influenza vaccination policy ensures that justice is served to the patient, as patients have the right to expect the best possible standard of care from their health professionals. Although the autonomy of HCWs is infringed, this is balanced by the overall benefit to the patients. In this instance the needs of the patient should be prioritised over those of HCWs. Patients do not choose to be in hospital, but HCWs choose their profession and the responsibilities that accompany it.

As well as a moral obligation, HCWs also have a legal obligation to act in a way that ensures "public protection and safety" as outlined in the AHPRA National Law Act (2010). A mandatory policy ensures HCWs are vaccinated and that they are thus compliant with the law.

Finally, regardless of moral and legal responsibilities, it is my belief that HCWs inherently want, to the best of their ability, to help people – that is why they are drawn to their profession. Being vaccinated against influenza, even if only to ensure they comply with a mandatory policy, allows them to achieve this and through the concept of herd protection, enables the best possible patient care.

Disease caused by reasonable administrative action not compensable

Employers should not shy away from making decisions affecting employee's employment where they have a sound basis for doing so and can show the reasons for the decision.

Commonwealth Departments and agencies can be more confident in taking reasonable administrative action including performance management of their employees, following the High Court's decision in *Comcare v Martin* (2016) HCA 43.

This case has underscored that disease or injury caused by, or worsened by reasonable administrative action will not be compensable under the Safety, Rehabilitation and Compensation Act 1988 (Cth) – a position which has been thrown into some doubt by the Federal Court when it considered this case on appeal.

The reasonable administrative action and the disease

The employee in this case Ms Martin, did not have a good working relationship with her manager (her formal complaint of bullying had been unsubstituted following an investigation). She took a temporary acting position, reporting to another manager, and applied to be made permanent in that role. She was unsuccessful, and hearing that news, expecting to return to her previous manager, she "*broke down uncontrollably*" and immediately went home. She then sought medical treatment and was diagnosed as suffering from an adjustment disorder which made her unfit for work.

The High Court considered there was no question that she suffered from an compensable disease which had been aggravated following her unsuccessful application for promotion. The key issue is the causal connection between the decision not to award her the promotion and the prospect of returning to her substantive position, and whether that entitles her to compensation.

Carve-outs to compensation under the Commonwealth Act

Under the Safety, *Rehabilitation and Compensation Act 1988* (Cth), there is no compensation for a disease *"suffered as a result of reasonable administrative action taken in a reasonable manner in respect of the employee's employment"*.

Com Care contended that the decision not to promote Ms Martin was reasonable administrative action, and the deterioration of her condition was caused by it, so therefore she was not entitled to compensation. This was rejected by the Administrative Appeals Tribunal (AAT) and Com Care appealed the AAT decision to the Federal Court, which found the view of the AAT that the decision not to award Ms Martin the promotion was not taken in a reasonable manner, amounted to an error of law. Ms Martin appealed that decision to the Full Bench of the Federal Court.

On appeal the Full Federal Court found in favour of Ms Martin. It said that the Act required a common sense approach to causation, the news about her failed application preceded her breakdown, but that does not mean that it caused it.

"As a result" means reasonable administrative action was a cause.

The High Court unanimously overturned the Full Federal Court's decision saying that;

"an employee has suffered a disease 'as a result' of administrative action if the administrative action is a cause in fact of the disease which the employee has suffered"

The administrative action need not be the sole cause, as long as the employee's ailment or aggravation would not have been a disease without the administrative action.

In this case, Ms Martin's disease was worsened by the administrative action and what she perceived to be its consequences. This means it falls within the exclusionary powers of the Commonwealth's statutory compensation scheme.

Lessons for employers

This decision reaffirms that where employers take reasonable action in relation to a person's employment, including making decisions about whether an employee should be awarded a promotion, the employee's perceived consequence of that action is irrelevant, provided that the action is undertaken is reasonably.

The test for determining whether the employees' injury is caused "as a result of" action taken by the employer is to be assed objectively. It assumes a plain meaning and is not influenced by an employee's subjective reaction to the action taken.

The message here is that employers should not shy away from making decisions affecting an employee's employment where they have a sound basis for doing so and can clearly show the reasons for the decisions having been taken. Where there is an unresolved personal workplace grievance or complaint, employer's need to be mindful of ensuring they uphold their work health and safety obligations, to both employees and manager, by making reasonable adjustments where needed, This is particularly so in the context of potential reprisal action under the Public Interest Disclosure Scheme.

Article published on 28 November 2016 by Jennifer Wyborn and Lauren Haywood, Clayton Utz.

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A quick check-up to find the right accounting firm

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We are excited about our new office space as it allows us to grow and improve our systems and processes. We also hope it will provide our clients with a more manageable space to meet with us in terms of car parking, location and office resources.

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Common Rounds: Podcast Me

BY HAMED SHAHNAM & GAUTAM BHANOT, MEDICAL STUDENTS, AUSTRALIAN NATIONAL UNIVERSITY

When medical students enter a rotation in their clinical years, we are assigned a supervisor who is expected to take a role in our education. In fact, every clinician has a vital role to play in the education of medical students. The importance of teaching is as old as the medical profession itself. In the rapidly expanding treasure of medical literature; there has also been an improvement in the methods of teaching. One of these is the utilisation of novel media formats that could deliver content anytime and anywhere.

Co-author Gautam Bahnot, right, proving he has skills beyond podcasting.

On the basis of this concept, we began a podcast series focusing on medical education for medical students by medical students. We called it The Common Rounds (a take on the more auspicious Grand Rounds). Initially; our aim was to systematically cover general physiology and medical topics in a very summarised format. The idea was to break topics down into ten to twenty minute episodes focusing on delivering medical topics in a coffee table conversation format.

Mobile Learning

What is evident about medical students is the constant pursuit for experimenting and embracing new and innovative study modalities. After all, the rapid development of technology can help supplement the more traditional models of learning. The idea was to create an educational modality where the listener would be able to engage in educational activities without being confined to a table and the comforts of the study desk.

Other than the educational content, we interview guest speakers and discuss important medical topics ranging from ethics to medical careers. Last year, a student (current junior doctor) even spoke about his elective in Latin America. This segment of our project is called "Doctor Talks" and aims to continue to share the experiences, passion and insights of specialist and medical leaders to the audience. The idea is to give a podium to the rich bank of experience that is the Canberra community.

In the middle of 2015, the Common Rounds took part in a student-led protest against the controversial Border Force Act which effectively made it illegal for anyone to disclose government information; threatening the freedom to speak out against conditions in asylum seeker camps. The current project is to create video podcasts on YouTube to complement the audio podcast on iTunes and cater to those who are visual learners and prefer access to supporting notes.

Broadening our Horizons

When we first set out, the initial intention was to supplement the educational content provided by the Australian National University medical school. Just under two years since launching the podcast, in the last quarter we had approximately 20,000 unique downloads. Our audience has also expanded to countries outside of the Australian continent, far exceeding our expectations.

This podcast has been an exciting opportunity for all that have been involved. We have learnt immensely from the experience both from a technical and creative perspective, but feel that there is still more to be accomplished and many more topics yet to be covered. If you are reading this and are just as passionate about medical education and would like to collaborate or get involved we would love to hear from you.

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Which sports are best for health and long life? *

BY ZELJKO PEDISIC, SENIOR RESEARCH FELLOW, VICTORIA UNIVERSITY

Millions of people around the world, including nearly 60% of Americans, Australians and Europeans, participate in sports. A 2015 review found the available data on long-term health benefits of specific sport disciplines is limited, but a new study provides strong evidence participation in several common sports is linked with a significantly reduced risk of death.

Insufficient physical activity is estimated to cause more than 5 million premature deaths a year. To reduce the risk of heart disease, type 2 diabetes, cancer and a number of other chronic diseases, the World Health Organisation recommends adults and older people engage in physical activity for at least 150 minutes a week.

These estimates and guidelines are predominantly based on studies about outcomes of participation in any moderate- to vigorous-intensity physical activity. But does it make a difference which physical activities we do?

In recent years, there has been growing research interest in how specific domains (such as work, transport, domestic and leisure time) and types of physical activity (walking, cycling) affect health.

While, for example, walking and cycling were found to be associated with similar reductions in death risk, physical activity in the domains of leisure time and daily living seem to produce greater benefits than occupational and transport-related physical activities. This shows that, health-wise, it is not necessarily irrelevant which physical activity you do.

Which sports are good for health?

Adults participating in a high overall level of sports and exercise are at 34% lower risk of death than those who never or rarely engage in such activities. This generic evidence, however, does not imply all sports equally affect health.

The previously mentioned 2015 review summarised available data on health benefits of participation in 26 sport disciplines. It found conditional to moderately strong evidence that both running and football improve heart function, aerobic capacity, metabolism, balance and weight status. Football was additionally shown to benefit muscular performance. The evidence for other sports was scarce or inconsistent.

To strengthen the evidence on health benefits of six common sport disciplines – aerobics, cycling, football, racquet sports, running and swimming – we recently analysed data from 80,306 British adults. The study found 27%, 15%, 47% and 28% reduced risk of death for participants in aerobics, cycling, racquet sports and swimming, respectively.

Although we observed reductions in the risk of death associated with football and running (18% and 13%, respectively) in our study sample, the data did not allow us to draw conclusions about these effects across the whole population. These statistically "non-significant" associations should not be misinterpreted as "no association" or "evidence of no effect". We simply do not know whether the observed effects in the sample occurred by chance alone or reflect the true effects in the population.

Previous studies conducted among Americans, Chinese men and Danes found a significantly reduced risk (27%-40%) of death associated with running. The 2015 review identified a number of health benefits associated with football.

Should I play sports at all?

Annual injury rate among all recreational and professional athletes

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is around 6%, but incidence, types and severity of injuries vary significantly across different sports. Fortunately, experts advise that up to 50% of sports injuries can be prevented. The risk can be minimised by following Sports Medicine Australia's in-depth prevention guidelines in their Injury Fact Sheets.

More than 50 years ago, Winston Churchill was asked to reveal his secret of longevity. "Sport," he said. "I never, ever got involved in sport."

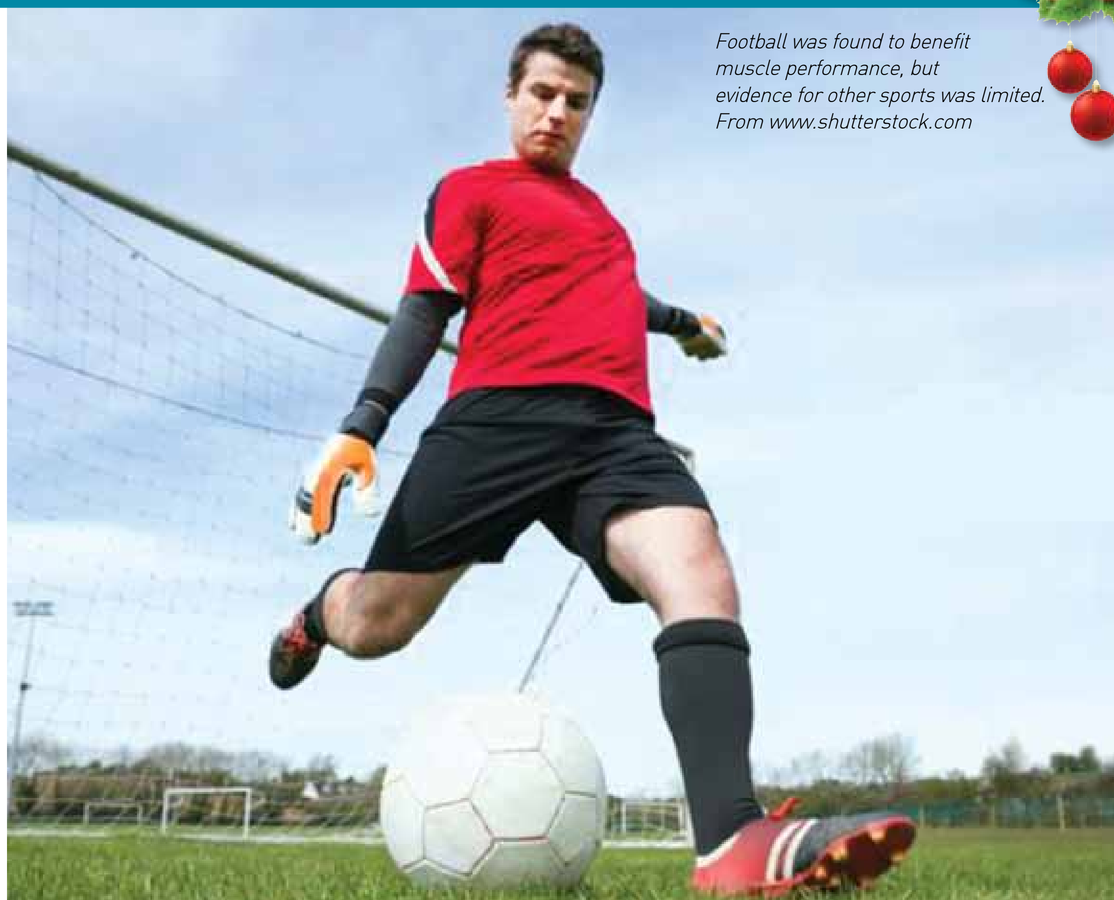
So should we follow Sir Winston's example, or act in accordance with the latest research evidence demonstrating health benefits of sports? Although a possibility of a sports injury or other sport-related negative health outcomes (such as sudden death during exercise) can never be ruled out, the potential benefits of sports far outweigh the risks.

Which sport to choose?

It may take decades until we reach definite conclusions about health outcomes of all types of sport. Should you in the meantime sit in front of the TV and wait for researchers to announce the final results? No. Follow your preferences and select an affordable and easily accessible sporting activity you enjoy doing, while trying to minimise the risk of injury.

This will increase your likelihood of staying sufficiently motivated and engaged in the activity long enough to reap substantial health benefits.

* This article was first published on *The Conversation* on 30 November 2016



Football was found to benefit muscle performance, but evidence for other sports was limited. From www.shutterstock.com

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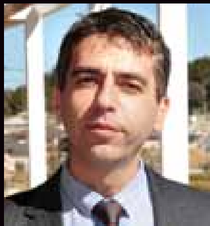

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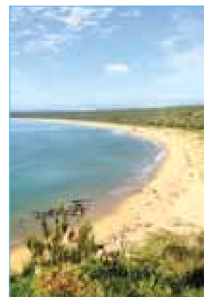

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