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The AMA ACT President,
Dr Elizabeth Gallagher, Board, Staff and
the Canberra Doctor Committee extend
Seasons Greetings to all
and best wishes for 2015

Seasons Greetings

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Capital Conversations with President, Dr Elizabeth Gallagher

Welcome to you all,
and I hope you enjoy this,
our final "Candoc" and
my final column for the year.
I have included a mix of local
and national tidbits for you and
I hope you enjoy the articles in
this edition on a range of
topical issues submitted by our
medical students.

This year celebrates the 10 year anniversary of the opening of the ANU Medical School. The end of the year has come so quickly, and I want to extend our congratulations to the graduating class of 2014. The AMA ACT is continuing its tradition of hosting a celebratory graduation breakfast ahead of the Graduation Ceremony and Graduation Ball. We look forward to meeting you then, and again next year as Interns. It seems not so long ago we welcomed this cohort to Canberra as new medical students.

Next week (as I write this) we farewell Dr Rashmi Sharma as she steps down after 10 years as the President of the ACTDGP and then ACTML. We would like to thank her for her contribution to the profession and the ACT community. A few years ago she received the AMA ACT President's award for her work. We wish her all the best for her future endeavours, which to our advantage includes joining our advisory council as the GP representative.

The Australian Government has finally announced it will formally support sending medical personnel to West Africa but has stepped back from taking direct responsibility. They have contracted the help through Aspen Medical to set up and run a hospital in Sierra Leone. At the time of writing it appears they are training the AusMat emergency response teams but withholding them from West Africa, in case there is an outbreak in the Asia-Pacific. One cannot help wondering though if it is best to control the disease at its source where the help is desperately needed now (primary prevention), rather than preparing to deal with the worst case scenario of world spread (secondary prevention). Food for thought …

The cannabis debate continues. At the recent COAG and Health Ministers' meeting the idea of a "national approach" was mooted. It looks as though this very sensible approach is moving forward with a number of states looking very closely with the NSW review and trial. Again though, the federal government, while expressing support for a national solution, has abdicated direct responsibility and left it to the states to come up with a plan. Hopefully we should have more information and proposals in the New Year. In any event, I encourage you to put your views forward on the current proposals of Green's Assembly Member, Mr Shane Rattenbury to introduce medicinal cannabis here.

We are still keen to try and see the introduction of some sort of needle and syringe program adopted within the Alexander Maconachie Centre on public health grounds.

Most detainees will return to the community and therefore it is important for both them and their families to minimise the risk of newly contracted blood borne diseases and also reduce the risk of reinfection while they are incarcerated. While prohibition and rehabilitation is the ideal, realism shows it is impossible to keep drugs out of the jails and therefore a backup plan needs to be put in place. As part of our education about the complex issues around trying to design a model that addresses issues raised by the government, and also the CPSU representing the prison officers, Christine Brill and I visited the AMC one Monday morning recently together with Dr Nadeem Siddiqui and Julie Tongs of Winnunga Nimmityjah AHS. The visit gave a new perspective on what models could be considered given the physical layout of the AMC and our colleague, Prof Michael Levy gave us a tour of the Hume Health Centre. My thanks to all who made this visit possible. It certainly highlighted the challenges for us as we think about "where to from here". We have supported the government in its endeavour to introduce a NSP and whilst we are aware of the issues for the CPSU and the corrections officers, we hope that we can move forward and agree a model which meets the needs of all concerned.

The other issue that has reared its head in the media recently, and I think I need to say something about, is the bullying allegations in the maternity unit at TCH. I acknowledge that this is an issue very close to me, as I work in the department, but I hope I am able to remain objective as well. The same department had issues back in 2010 which is one of the reasons why it has been singled out in the media. That said though, the issues are not the same despite media reports suggesting that they are a chronic problem area of the hospital.

…Continued page 4

Dr Yii Song Wong

Consistent with our ongoing commitment to imaging quality and service excellence, we are pleased to announce that Dr Yii Song Wong has joined the Partnership of Canberra Imaging Group.

Dr Wong is a dually trained Nuclear Medicine Radiologist who graduated from the University of Sydney and trained in radiology at The Canberra Hospital (TCH).

Dr Wong continued his Interventional Fellowship at TCH before moving to Melbourne to complete his Nuclear Medicine Fellowship at St Vincent's and The Alfred hospitals. During this time he honed his interest in cardiac and oncologic nuclear medicine including PET/CT.

On returning to Canberra he joined Canberra Imaging Group (CIG). During this period he has also completed a Visiting Fellowship with Proscan in Cincinnati, USA, furthering his musculoskeletal imaging skills.

We welcome Dr Wong's skills and expertise to the Partnership of CIG.

Dr Yii Song Wong
MBBS, FRANZCR

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Advice for GPs and their staff on Ebola

In a recent letter to AMA GP members, chair of the AMA Council of General Practice, Dr Brian Morton wrote:

"The AMA has worked hard to encourage the Government to do more to help tackle the growing Ebola outbreak in West Africa and make sure Australia is well prepared if the virus makes it to our shores. Last week, the Government responded and announced that it would significantly lift its contribution to the international effort.

"The AMA is also a member of the Chief Medical Officer's GP Roundtable, which has been working to ensure GPs have up-to-date advice on the outbreak, Ebola symptoms and how GPs can prepare.

"The Office of Health Protection (OHP) has now released updated advice on the evaluation of patients with possible Ebolavirus disease (Ebola). The advice also provides important reassurances on the chances of Ebola making it to Australia and on the current measures that have been put in place to contain any outbreak.

"According to the OHP, it is very unlikely that a febrile patient in primary care will have Ebola. The risk of infection is very low even in persons with a compatible travel history, unless there has been direct exposure to the bodily fluids of an infected person.

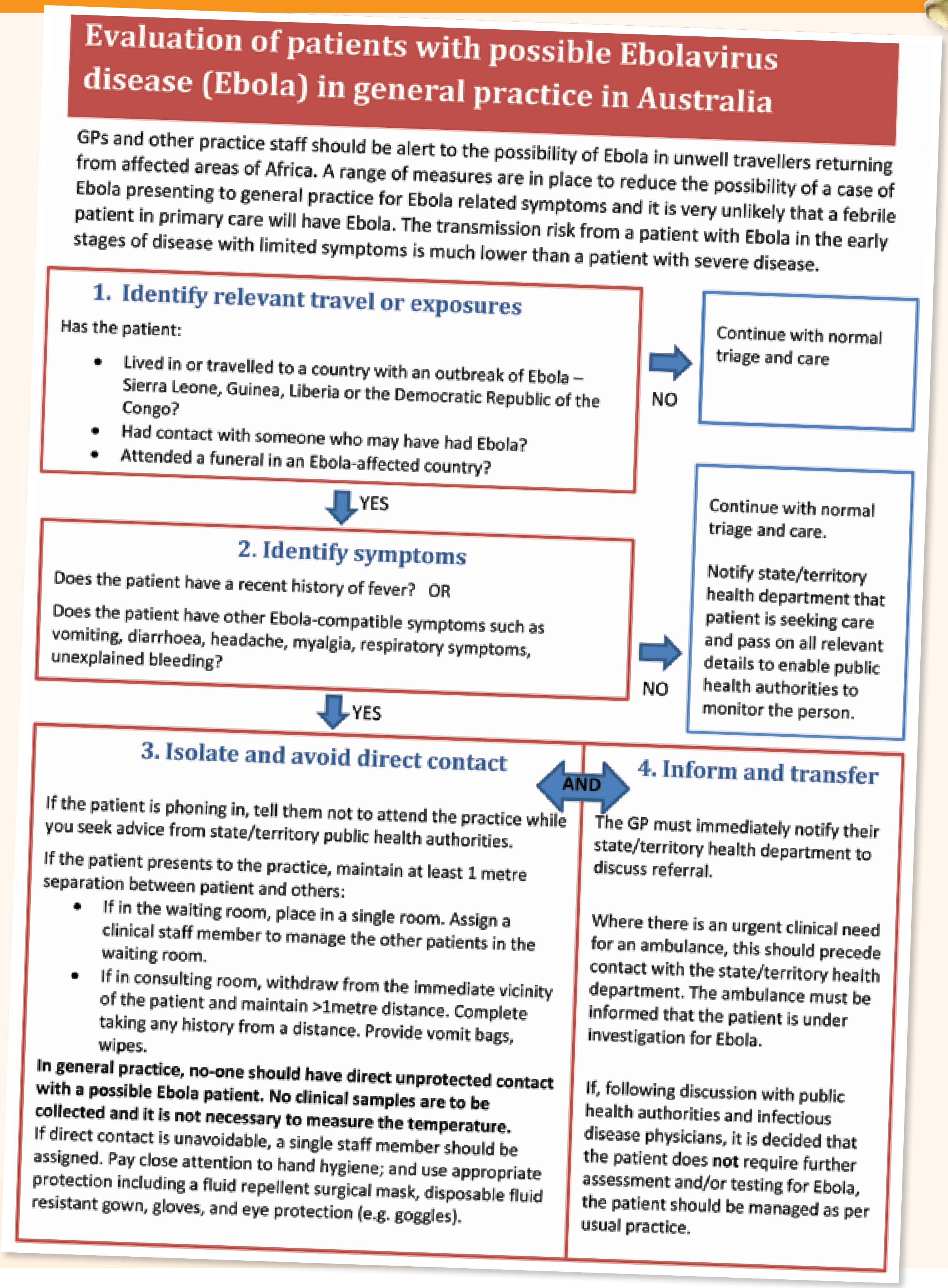
"Arrivals from West Africa number approximately 10 per week. All travellers will be given two new cards on arrival; one (Travel History Ebola Information) listing the West African countries involved and the second (Ebola Identified Traveller) alerting the traveller of any symptoms occurring within 21 days of arrival and advising the action/telephone numbers to call.

"For someone who has arrived from West Africa, they will be moved to a quarantined area, where their temperature will be taken and the risk assessed. Their details will be sent to the relevant Public Health Unit (PHU) for monitoring and follow-up.

"If a returned traveller develops symptoms after entry into Australia, they are advised not to contact their GP, but rather to call the dedicated national Ebola hotline, 1800 186 815. The DoH has developed material for GPs on the evaluation of patients with possible Ebola and advises that the GP must notify a suspected case immediately to their state/territory communicable disease branch/centre to discuss referral.

"The material prepared by the Department is important and provides a significant measure of reassurance for front line GPs about the risks of a patient presenting with the Ebola virus. It provides clear advice on the steps you need to take with a suspected case and all key practice staff should read it.

To download a copy of the latest advice, visit www.health.gov.au



Evaluation of patients with possible Ebolavirus disease (Ebola) in general practice in Australia

GPs and other practice staff should be alert to the possibility of Ebola in unwell travellers returning from affected areas of Africa. A range of measures are in place to reduce the possibility of a case of Ebola presenting to general practice for Ebola related symptoms and it is very unlikely that a febrile patient in primary care will have Ebola. The transmission risk from a patient with Ebola in the early stages of disease with limited symptoms is much lower than a patient with severe disease.

1. Identify relevant travel or exposures

Has the patient:

- Lived in or travelled to a country with an outbreak of Ebola – Sierra Leone, Guinea, Liberia or the Democratic Republic of the Congo?
- Had contact with someone who may have had Ebola?
- Attended a funeral in an Ebola-affected country?

NO → Continue with normal triage and care

YES

2. Identify symptoms

Does the patient have a recent history of fever? OR

Does the patient have other Ebola-compatible symptoms such as vomiting, diarrhoea, headache, myalgia, respiratory symptoms, unexplained bleeding?

NO → Continue with normal triage and care.

Notify state/territory health department that patient is seeking care and pass on all relevant details to enable public health authorities to monitor the person.

YES

3. Isolate and avoid direct contact

If the patient is phoning in, tell them not to attend the practice while you seek advice from state/territory public health authorities.

If the patient presents to the practice, maintain at least 1 metre separation between patient and others:

- If in the waiting room, place in a single room. Assign a clinical staff member to manage the other patients in the waiting room.
- If in consulting room, withdraw from the immediate vicinity of the patient and maintain >1metre distance. Complete taking any history from a distance. Provide vomit bags, wipes.

In general practice, no-one should have direct unprotected contact with a possible Ebola patient. No clinical samples are to be collected and it is not necessary to measure the temperature.
If direct contact is unavoidable, a single staff member should be assigned. Pay close attention to hand hygiene; and use appropriate protection including a fluid repellent surgical mask, disposable fluid resistant gown, gloves, and eye protection (e.g. goggles).

AND

4. Inform and transfer

The GP must immediately notify their state/territory health department to discuss referral.

Where there is an urgent clinical need for an ambulance, this should precede contact with the state/territory health department. The ambulance must be informed that the patient is under investigation for Ebola.

If, following discussion with public health authorities and infectious disease physicians, it is decided that the patient does **not** require further assessment and/or testing for Ebola, the patient should be managed as per usual practice.

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Universal Medical Imaging Welcomes Dr David Ashton for 2015

Dr David Ashton brings a wealth of clinical experience as a Neurologist, Radiologist and Neuroradiologist. He completed his advanced training in Neurology and Radiology at Royal Prince Alfred Hospital with a further Fellowship in Stroke, and Masters of Clinical Epidemiology at the University of Sydney. Dr Ashton later undertook a Neuroradiology Fellowship at the University of Toronto, Canada. He also trained in Head and Neck Oncology at Princess Margaret Hospital.

Dr Ashton is a Head/Neck Consultant at The Canberra Hospital and has commenced work at UMI as a Neuroradiology Consultant.

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Capital Conversations… *continued*

…From page 2

The AMA is well aware that it is not the only department within the hospital where there are "issues", or other occurrences that have impacted on staff wellbeing. We have been trying to address these as well – just not out in the public forum. Our place is to support our junior and senior medical officers, and work with management to resolve the issues. In this case, ACT Health has been aware of problems for many months, and I give them credit at having been working to support staff and deal with these in a supportive way while working to resolve the matters. This has accelerated since the RANZCOG training review and I feel confident that the training issues can be addressed. What is most important is to recognise the hard work and dedication of the staff in providing patient care in a safe way, even in a stressful environment. I'd encourage members working in this and any other area of the hospital to speak to the AMA ACT if they have concerns about patient care or colleague fatigue, inequity or workload and training issues.

On a lighter and brighter note, we are hosting some of our long-time members to lunch. These are indeed the "Timelords" and "Timeladies" of our association who have retained membership for many decades. Our Fellows and former Presidents will also be joining us at lunch as a thank you gesture for their contribution to the association and the profession locally.

Thank you so much to my Board and Christine Brill for their support in my first 6 months as President. It has been a very steep learning curve! I wish them, and you, a safe and happy Christmas and look forward to regrouping and continuing our journey into 2015.

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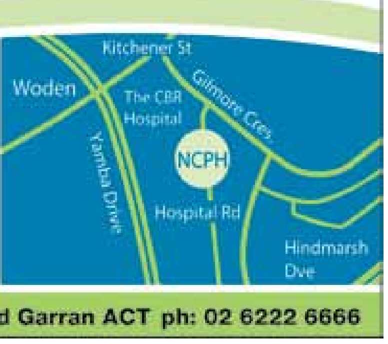

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Emergency department survey reinforces the need for national leadership on alcohol harms

AMA President, A/Prof Brian Owler, said recently that the latest survey of alcohol harm in hospital emergency departments is further proof that national leadership from the Federal Government is needed to change Australia's drinking culture.

The Australasian College of Emergency Medicine (ACEM) *'Enough is Enough'* Survey consulted more than 2000 emergency department doctors and nurses in Australia and New Zealand about their experiences with drunk patients.

A/Prof Owler said the survey results are disturbing, and illustrate the strain that alcohol-related behaviour and violence imposes on stressed hospital staff and resources, and the economic burden placed on the Australian health system.

"The survey lifts the lid on the alcohol-fuelled violence that doctors and nurses and other patients in emergency departments have to deal with," A/Prof Owler said.

"Emergency department workers have had enough of dealing with drunks being violent, disorderly, and offensive, and physically harming staff and other patients.

"A significant proportion of emergency department resources provide life-saving care to people who have consumed too much alcohol, or people who have been harmed by people who have consumed too much alcohol.

"If we can change the drinking culture to promote more responsible use of alcohol in the community, we will have fewer drunks and people injured by drunks in our emergency departments."

A/Prof Owler said that initiatives to address alcohol-related harms in the Australian community were discussed at last month's AMA National Alcohol Summit in Canberra.

"There is an urgent need in Australia for a whole-of-government strategy to coordinate and drive action to address alcohol related harms," A/Prof Owler said.

"Excessive alcohol consumption is having a widespread impact on our community and our health.

"Seventy nine per cent of Australians – 18.5 million people – have serious concerns with our drinking culture.

"We are calling on the Government to invest more in public education and campaigns, and to regulate the way that alcohol is advertised and marketed, especially in sport and to young people.

"One of the simplest and most cost-effective changes is to mandate labelling on alcohol products.

"The Australian Government must provide leadership to address the significant health and social impacts of alcohol misuse and abuse.

"More than half of Australian drinkers consume alcohol in excess of the recommended intake, and one in five Australians drink alcohol at a level that puts them at risk of lifetime harm from injury or disease.

"The health, social, and economic burden caused by alcohol in Australia is substantial and unacceptable. Alcohol-related violence, chronic disease, accidents, and deaths occur frequently.

"These incidents harm not only the individual drinker, but also families, bystanders, and the wider community.

"The range and extent of alcohol-related harms are alarming. Even more alarming is that the number of people harmed by alcohol is increasing.

"We need a National Alcohol Strategy to take a multi-pronged approach to stamping out the culture of excessive alcohol consumption in Australian society," A/Prof Owler said.

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"But at the heart of the solution is strong and committed national leadership. There is an urgent and unmet need for the Australian Government to tackle this problem with more robust and rigorous policy and regulation to supplement parental oversight and responsibility.

"Without that leadership, commitment and coordination, we at the frontline will continue to mop up the devastation caused by alcohol in Australia – the road fatalities, the victims of violence, and the children who suffer the effects of the drinking around them.

The Australian Government's new National Alcohol Strategy should:

1. Set out the role of the Australian Government in leading a consistent national approach to the supply of, and access to, alcohol.
2. Include the development and implementation of effective and sustained advertising and community-led public education campaigns that address the public's understanding of unsafe drinking and the harms of excess alcohol use. Campaigns should target a range of priority audiences, including young people and pregnant women.
3. Include the increased availability of targeted alcohol prevention and treatment services throughout the community, including: GP-led services and referral mechanisms; community-led interventions; safe sobering-up facilities; increased availability of addiction medicine specialist services; treatment and detoxification services at all major hospitals; and services for acute alcohol abuse at hospitals with emergency departments.
4. Include measures that specifically respond to the particular needs and preferences of Aboriginal and Torres Strait Islander people, and other culturally and linguistically diverse groups.
5. Include the development and implementation of statutory regulation of alcohol marketing and promotion, independently of the alcohol and advertising industries, with meaningful sanctions for non-compliance. Particular attention should be paid to sponsorship and promotion in the community and professional sporting industries.
6. Support research and evaluation and data collection to monitor and measure alcohol use and alcohol-related harms across the Australian community, and the effectiveness of different alcohol treatment options. Data collected by Government departments and authorities should be readily available to alcohol researchers and program evaluators.
7. Include a review of current alcohol taxation and pricing arrangements and how they can be reformed to discourage harmful drinking.
8. Ensure transparent policy development, with sufficient independence to avoid influence from industry.

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The program operates from 7:00am – 7:00pm, 7 days a week excluding public holidays. It has a range of vehicles available including a new wheelchair accessible vehicle.

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We believe a community approach is required to spread the word about available community transport options so that as a Community Transport provider, transport@bcs can open doors for people by providing them with access to social activities, health related activities and promoting community connectivity.

Referrals can be made to transport@bcs by the person themselves or someone acting on their behalf by phoning the team on 6251 2886 or via email to transport@bcs-act.com.au

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Bottle or Breast? Balancing the Milk Formula

By Maryon Jones

For years there has been heated debate over a woman's decision to breastfeed or give her child formula. Now more than ever, today's fast-paced society has meant women are under significant pressure to juggle work, life and care for their child.

The creation a breast milk substitute, infant formula, has given a woman the chance to decide about the sustenance she wishes to feed her young, but has simultaneously presented a moral dilemma – should a woman breastfeed or not, and if so, for how long? Yet, perhaps the ultimate question for any new mother is whether her choice will irreversibly harm the development and wellbeing of her child not just in the short term, but also in later life.

In Australia, 92 per cent of Australian babies are breastfed at birth. By one week of age, the rate drops to 80 per cent, and by one month, 71 per cent are fully breastfed, 11 per cent receive a combination of breast milk and formula, and 18 per cent receive solely formula. With each subsequent month, there is a sharp decline in the number of women fully breastfeeding their young. The Australian Dietary Guidelines and World Health Organisation recommend all babies are exclusively breastfeed up to six months at which point solid foods should be introduced. Tragically, at this 6-month mark, only 14 per cent of Australian babies are exclusively breastfeeding. Although breastfeeding rates have remained fairly static over the last ten years, breastfeeding rates do vary significantly between socioeconomic groups, with less educated women from low socioeconomic backgrounds least likely to breastfeed. Despite this, overall breastfeeding rates in Australia remain significantly higher than those in middle class Asia, particularly within China. In a country where 16 million babies are born each year, fewer than 16 per cent of Chinese babies are breastfed from birth. This has driven a booming market for infant formula, which reportedly grows by greater than 10 per cent each year. Dr Mu Li, an associate professor in international public health at Sydney University states that the rapid increase in family income, urbanisation, cultural resistance to breastfeeding in public, and infant formula symbolising 'privilege' has underpinned this demand. Indeed, financial analysts predict that baby formula consumption in Asia will likely reach $25 billion by 2016.

Research investigating the long-term health implications associated with formula use has yielded concerning results. In a study by Quigley *et al.* in 2007, donor breast milk was compared to milk formula in the feeding of premature low birth weight infants. The study found that although feeding formula resulted in a higher rate of short-term growth, it also caused a higher risk of the development of nectrotising enterocolitis. Formula-fed children have also been demonstrated to be at greater risk of childhood obesity, Type I and Type II diabetes, leukaemia, sudden infant death syndrome (SIDS) and impaired cognitive development compared to their breastfed counterparts.

Formula use has also been marred by contamination scandals. One of the major issues to reach the headlines was in 2008, when 59 babies in north-western Gansu province were diagnosed with kidney stones following consumption of locally produced formula. The formula had been contaminated with melamine, a toxic chemical that artificially increases the milk's protein concentration. The resultant investigation revealed that 22 dairy companies had produced formula containing the toxic chemical, ultimately causing 300,000 children to fall ill, and six children to die. Following the contamination scandal, authorities have reported a significant increase in demand for formula from Western countries. This has driven the price of formula to new heights. Purchasing one tin of formula within Australia reportedly costs approximately $20 AUD. In Asia, the same tin is worth up to AUD $70.

Breastfeeding by comparison, has a number of significant health benefits. Not only is it environmentally friendly, readily available and free, it is also an important component in establishing the initial emotional connection between mother and young. Additionally, it is positively associated with HDL cholesterol and lowers overall cholesterol levels and reduces obesity in later life. Breastfed babies are also less likely to contract respiratory diseases, gastroenteritis and otitis media, and are at reduced risk of chronic disease. Breastfeeding is also beneficial for the mothers: it promotes faster recovery from childbirth, return to pre-pregnancy weight, and reduces the risk of breast and ovarian cancer in later years.

One of the challenges associated with breastfeeding within Australia, is the social stigma associated with breastfeeding in public and at work. Here, women are permitted to breastfeed their child in public, yet a 2009 Newspoll study revealed a significant proportion of respondents believed it was illegal. Furthermore, 26 per cent considered it unacceptable to breastfeed in a café or restaurant, and 19 per cent believed it was unacceptable to breastfeed in a shopping centre. The Org-

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anisation for Economic Co-operation and Development (OECD) research has found that returning to work is one of the main reasons why women cease breastfeeding early, or never commence the process. Other environmental factors and societal considerations that have also been implicated include the attitude and education of the mother, attributes of the infant and key environmental factors such as hospital and healthcare access, home/family environment, work environment, community support and public policy.

Australia is fortunate to have a myriad of government and non-governmental programs that support, promote and protect breastfeeding. Perhaps the most significant is the implementation of the Australian National Breastfeeding Strategy 2010-2015 which was developed from sources including the Cochrane Collaboration, World Health Organisation (WHO) Global Strategy for Infant and Young Child Feeding and the United States Centre for Disease Control and Prevention. The strategy provides a framework for national and state/territorial governments to support, promote and protect breastfeeding within the wider Australian community so that breastfeeding can be viewed as the biological and social norm. Australia is also a member state of the WHO, and as such, has actively supported the International Code of Marketing of Breast-milk Substitutes (1981); WHO/UNICEF Global Strategy for Infant and Young Child Feeding (2003); and the 1990 and 2005 Innocenti Declarations. Australia also supports the Baby-Friendly Hospital Initiative – Ten Steps to Successful Breastfeeding (WHO/UNICEF, 1991, updated 2009) as well the United Nations Convention on the Rights of the Child and the Millennium Development Goals (MDG) aiming to reduce child mortality. States including South Australia, New South Wales and Queensland as well as the Australian Breastfeeding Association have also developed breastfeeding strategies/guidelines. Diverse strategies such as the Paid Parental Leave Scheme, development of human milk banks, and restriction on infant formula marketing (Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement (MAIF Agreement)) and Australian Dietary Guidelines have also been instrumental in supporting and encouraging breastfeeding within Australia.

Ultimately, whether to breastfeed, give formula, or utilise both depends on the mother's decision. Yet, as both Australia and middle-class Asia demonstrate, a woman's choice to breastfeed or feed formula is strongly dictated by her education, socioeconomic status, the current social and cultural norms and public policy.

Regardless of one's opinion or choice, it is difficult to refute the tenderness and peace of a woman breastfeeding her child. As Leo Tolstoy so eloquently wrote in War and Peace,

"No one could give her such soothing and sensible consolation as this little three-month-old creature when he lay at her breast and she felt the movement of his lips and the snuffling of his tiny nose".

Maryon Jones is a year 2 student at the ANU Medical Student.

References available upon request from the author.

Co-payments disastrous for people with serious mental illness: RANZCP

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has used a new report to call on all non-Government Senators to hold firm in their opposition to the Government's proposed Budget measures for the introduction of a $7 co-payment for GP visits and pathology.

"We already know that many people with mental illness struggle to get the care they need", RANZCP President Dr Murray Patton said today. "However it is clear from our analysis, that the proposed co-payments will make an already bad situation, much worse. We are concerned about the effects of these Budget measures on people with serious mental illness, particularly those who also have physical illness. In particular we are concerned that the impact of the pathology co-payment has not been thoroughly considered. We would welcome the opportunity to discuss with the Government the impacts of this reform on people with serious mental illness."

RANZCP is concerned that the gap between life expectancy in patients with a mental illness and the general population has widened since 1985. People with serious mental illness live between 10 and 32 years less than the general population. Around 80% of this higher mortality rate can be attributed to the much higher rates of physical illnesses such as cardiovascular and respiratory diseases and cancer experienced by this population.

"People who struggle with serious mental illness already face a range of barriers obtaining access to appropriate, high quality healthcare and we know that this impacts on their physical health. These new co-payments will be one more barrier. This will lead to other health problems not being identified or treated properly, leading to deterioration in patients' health." Dr Patton said.

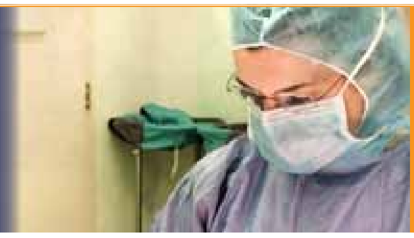
The report has highlighted a number of particular problems for people who have both mental and physical health issues:

1. A number of treatments for serious mental illness can cause side effects that, if left untreated, cause metabolic disorder, cardiovascular disease and diabetes, and a range of other serious health issues. The best way to diagnose and manage these side effects is through regular pathology testing. These tests will now attract a $7 co-payment for each test.
2. People who are not eligible for a healthcare concession card because their income is marginally too high 'fall through the gaps.' They are particularly disadvantaged by the new co-payment, as they will have to pay the full rate co-payment for pharmaceuticals, GP visits and pathology testing. These additional costs can amount to many hundreds of dollars each year for care that is related to managing both physical and mental health conditions.
3. Consumers, carers and psychiatrists consulted as part of this report all thought that the co-payment would change the way they used health services and medication and could put their health at risk.

"This new co-payment regime will be particularly difficult for people who need to take medication to manage a mental health condition, the medication puts them at risk for a whole lot of other conditions, and then they are slugged with additional costs if they try to manage those side effects. We have serious concerns about the health impacts of these co-payments for this most vulnerable group of consumers." Dr Patton said.

"We call on the Senate to continue to block the implementation of these measures. The College has a range of policy recommendations to ensure that healthcare remains affordable for people with serious mental illness. We would welcome the opportunity to work productively with the Government on a better package of reform for people with serious mental illness."

Dr Katherine Gordiev
Orthopaedic Surgeon
Shoulder & Upper limb
MBBS (Hons I) FRACS FAOrthA



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Dr Katherine Gordiev specialises in Orthopaedic treatment of shoulder, elbow, wrist and hand disorders.

After completing her Orthopaedic training, Katherine undertook an 18 month Shoulder Surgery Fellowship at The Cleveland Clinic, USA, between 2003 and 2004. This Fellowship was concerned with the management of shoulder arthritis, rotator cuff disease, instability and trauma, as well as elbow and wrist pathology. In 2005 she returned and settled in Canberra, with rooms in the National Capital Private Hospital. Katherine lives in Canberra with her two children.

To maintain skills and knowledge in current and emerging techniques, Katherine regularly attends conferences and surgical skills session, and visits Orthopaedic colleagues in Australia and overseas. For example, Katherine visited Shoulder and Upper limb units in France in 2008 and 2012, attended a Shoulder conference in San Diego in 2014 and will be attending courses in Melbourne and Switzerland in the coming months. Katherine participates in the teaching of AOA Orthopaedic trainees and ANU Medical Students through the Calvary Hospital. In addition to her other qualifications, Katherine is a member of the Shoulder and Elbow Society of Australia.

A detailed list of operations performed and conditions treated by Katherine can be found at www.katherinegordiev.com.au. A weekly fracture clinic enables timely care of trauma and urgent referrals. A faxed referral and imaging allow determination of the urgency of appointments. Please call 6260 5249, and Katherine's staff will be pleased to assist you. Queries are welcomed and can be emailed to mail@kathg.net.

After 10 years, Dr Rashmi Sharma steps down

Dr Sharma's thank you letter to the profession in the ACT:

"With just over a quarter of my life having been a board member of Canberra's 'primary healthcare organisation' in the form of the ACT Division of General Practice and then the ACT Medicare Local, I feel it is in the interests of good governance and my personal development to move on.

As Chair I have had the privilege of interacting with multiple facets of the health sector ranging from political, policy, consumer, clinical support staff and coal face clinicians.

As I have been preparing to step down I have been reflecting on the journey over the last decade and the lessons I have learnt…

- it is better to be 'in the tent' and engage in discussions even where you are philosophically opposed to the proposed outcome. The outcome may remain unchanged but you may have been able to influence it in some way.
- 'protection of turf' has very different meanings between public and private sectors and that loss of 'turf' ultimately lead to the demise of private primary healthcare if a short term view is taken when health policy decisions are made.
- 'we are all on the same side' – all of us engaged in health care, at whatever level are in it for the same ultimate outcome – better health for the community – so let's get over the traps of public vs private, artificial hierarchies within and between professions and work together and get on with it.
- 'death by committee' is a real clinical condition that needs an evidence based treatment to save the precious health dollar.
- the best idea in the world developed by policy makers will fall down if you do not get 'real clinical input' – input from those who currently do the face to face clinical care and have to implement any policy – if not, guess what – it will not work.
- getting a doctor direct phone number for clinicians to contact Canberra Hospital was harder than you think but do not underestimate the power of survey findings in health and there is 'no harm in asking'.
- clinicians are used to making on-the-spot clinical decisions and change behaviour immediately, so get frustrated in the long delays in system changes. To keep their engagement, progress needs to be demonstrable.
- General Practice is the 'backbone of the entire health system' – it is undervalued and under resourced – let us recognise it for what it does and can offer and ensure that we keep the standards high, it will be the most cost effective investment we make as a community.
- while there is always room for improvement we have to 'invest in evidence not ideology'. We enjoy world-leading health outcomes in the region so let us celebrate the work that is being currently done by our health workers – new is not always better or cheaper.
- it can be confronting sometimes to agree or embrace government policy regarding our professions. I too have had a degree of cynicism at times. However I do not believe in 'throwing the baby out with the bathwater' but rather making the most of what we have to work with and crafting it for maximum impact.

I remember setting a KPI for myself when I took over at the helm that people would notice if the Division /Medicare Local were to close overnight. Not sure if this KPI could ever be met but I do think that if most members were to reflect they would recognise that if they were not receiving support directly; eg, an education event, it may be behind the scenes; assistance with accreditation or chronic disease management, for example. Or even more removed: they may be benefiting from advocacy work undertaken; eg, better communication with the public sector.

One thing though is that we cannot be all things to all people, especially within budgetary constraints.

It is a time of extreme turmoil for those involved in health and I urge everyone to take an interest in their future by supporting their organisations that try to advocate on their behalf otherwise we will be the recipients of 'things done to us rather than with us.'

And so thank you to all of those who have supported, guided and mentored me along the way. It has been a tremendous journey and while we are again at the crossroads of uncertainty, I feel here is enormous opportunity to refocus and refine the work of the Medicare Local with a dedicated board, CEO and staff. I will stay involved and look forward to contributing in the future.

National residential medication chart released

A new national medication chart that can be used to prescribe and supply PBS medicines is now available free from the Australian Commission on Safety and Quality in Health Care at http://www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/nrmc/.

Doctors and pharmacists in the ACT, Tasmania, Victoria, Queensland, Western Australia and South Australia can now prescribe and supply most PBS medicines to residents of aged care facilities using this chart without needing to also write prescriptions. (Legislation is yet to be passed in NSW and the Northern Territory to allow the NRMC to be used for medicine prescribing and supply purposes.)

The National Residential Medication Chart (NRMC) has also been designed to provide a central point for information. 'Prescriptions' and the record of medicine administration are co-located, with the resident's details including their photograph and known adverse drug reactions visible from each page. Relevant pathology, doctors' instructions and special considerations are also included.

The NRMC was developed, tested and evaluated in 2013-14 by the Commission in over twenty residential aged care facilities in NSW (specially exempted from current NSW legislative restrictions). AMA members, Dr Brian Morton and Dr Richard Kidd, participated in the expert reference group providing advice.

The Commission found that the NRMC improved medication safety for residents as well as considerably minimising the administrative burden of prescribers, aged care staff, and pharmacists when ordering, administering and supplying PBS medicines.

While NRMC test sites provided very positive feedback and have chosen to continue using it, their experiences indicate that everyone involved initially needs training and support to move successfully to an NRMC model.

The next step is for commercial companies to develop electronic versions of the NRMC to streamline processes even further.

Use of the NRMC is a decision of the residential aged care facilities and is purely voluntary but AMA members may wish to encourage the facilities they work in to investigate its adoption.

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Disability and discrimination: why dollars do not equal solutions

By Christina Hodge

In 2012 I met a boy that changed the way I viewed my world. He had a bright, contagious smile with a manner that drew people to him and a sincere concern for the wellbeing of others. I clearly remember one day walking, frustrated, out of the counselling rooms where I worked to see him waiting with a smile at the ready.

This boy was 9 years old and had cerebral palsy. I had spent the morning working with the medical team to find a wheelchair that would fit on the bus and a teacher aid to assist him through the door and help him communicate his thoughts and ideas so that he, like every other child I worked with, could go to school. I was disheartened and upset to tell him that we were doing our best but, again, tomorrow would not be the day. The reason this boy had such a profound effect on me was that, despite the limitation society was placing on him through lack of resources, the response his brother relayed to me was “it’s ok, he knows you will keep trying”.

In Australia, the private, corporate and public sectors all assert a role in moulding the structure of our health system; how resources are distributed; how accessibility and funding are addressed; and how health equity is determined. It is the role of governments and these sectors to decide how finite financial and human capital is spread to best serve our communities’ needs while considering each individual’s circumstances, of which disability (whether a physical, sensory, intellectual or mental health impairment) is considered a component. In 2013 the Australian Government released a review of services provided under the National Disability Agreement, boasting a 6.7 billion dollar spend on disability support services. They noted the inclusion of 34 individual service types aimed at improving the lives of people with disability by providing opportunities for them to participate in the community. That seems like a lot of money, so why am I unsatisfied? It is justice and equity that are central to this argument about how disability is viewed by our society, not just monetary provisions.

I look first to the basic tenants of the World Health Organisations Constitutional description of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Similar understandings are expounded by the UDHR, ICESCR and the AMA Code of Ethics pronouncing the right of every human being to the highest attainable standard of physical and mental health. This suggests not just the opportunity for a person considered disabled to ‘participate in the community’ but recognition by society that disability is the result of an interaction between a person and an environment that does not appropriately cater for their needs. The social model of disability stresses that the context in which we live must change, not just physically, but attitudinally and socially to enable an equal, equitable standard of health for all members of our society. This paradigm shift has become internationally recognised by the United Nations Convention on the Rights of Persons with Disabilities (which Australia ratified in 2008). This move has given the Australian Human Rights Commission a platform on which to stand and say, the current aims of service provision, centred on a medical model of disability, are just not good enough.

In the words of Stella Young, a disability activist, MC and comedian, “disability is not a person’s identity”. For verification of that you need look no further than Sue Austin’s Ted Talk “Deep sea diving ... in a wheelchair: the value of difference”. Sue Austin is an artist that through her work exemplifies the value of diversity to society and tries to overcome the notion of ‘disabled’ as ‘other’. Her ideas are captured in the narratives of the film ‘Fixed’, which raises the question, “what is disability?” And conversely, “what is normal to you?” During this film Hugh Herr, head of the Biomechatronics research group at MIT and developer of the Rheo Knee and the world’s first powered ankle-foot prosthesis, asks “What does ‘disabled’ mean when a man with no legs can run faster than most people in the world?”. This question is followed by the remarks of Gregor Wolbring, biochemist and ability studies scholar, that “people should think of disability as another human experience that embodies qualities of human adaptability that are common to all people, whether they have a specific disability or not, and the experiences...have lessons for the community at large.”

In 1992 federal legislation, namely the Disability Discrimination Act, stated in its general principles that by law it is required we have “respect for difference and acceptance of persons with disabilities as part of human diversity and humanity with equality of opportunity”. Further, it states with direct reference to children that “State Parties take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children”. Why now, twenty years on, are we still not getting it right? Why am I, as a health care provider, still not able to give the boy I worked with adequate services to allow him to attend school and enjoy the basic human right of education. If our government has spent 6.9 billion dollars on disability support services and in a major city a basic child’s wheelchair comes with a waiting list then maybe we are thinking about disability the wrong way.

Christina Hodge is a year 2 student at the ANU Medical School.

References available on request from the author.

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BOOK REVIEW: A Doctor's Dream

By Dr Buddhi Lokuge and Tanya Burke

Allen & Unwin 2014,
RRP $32.99

When did you last treat a case of scabies? In Canberra this infestation is rarely seen, and easily treated. We view it as an occasional nuisance, and load our patients up with information and topical treatments which are likely to fix the problem.

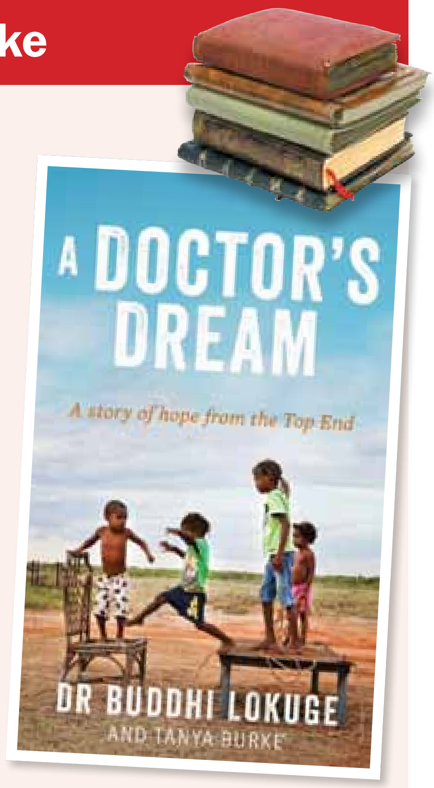
The situation is entirely different in remote Indigenous communities in the Top End, where seven in ten Aboriginal children will be affected by the disease before they turn one. Whole households and communities suffer from chronic scabies. The streptococcal infections that develop from scratching sores can lead to rheumatic heart disease and chronic kidney disease.

A Doctor's Dream is the fascinating story of the journey of a Canberra GP who struggled to find an approach to tackling the problem that actually worked. Staring down opposition from high-profile experts, he took the time to listen and work with communities and develop a partnership approach that delivered startlingly positive results.

Dr Buddhi Lokuge is a public health physician who has worked in general practice in Canberra, as well as for MSF in Africa and Afghanistan. He and his partner Tanya moved from Canberra to East Arnhem land in 2011 with their young family to run a multi-million dollar program to tackle scabies. The expert plan was to mass dose communities with ivermectin, an oral scabicide.

It soon became clear that this would not lead to a lasting solution. People would keep being re-infected unless crusted scabies, the most severe and debilitating form of the disease, dubbed by some as modern day leprosy, was controlled. People with crusted scabies hid themselves away, and had often had a lifetime of failed hospitalisations and medical intervention which further stigmatised them and increased their sense of distrust. Existing treatment protocols – and mass dosing regimes – were ineffective in remote settings, and did not take into account the priorities of the sufferers themselves.

By taking the slow road, listening to sufferers, and working with them family by family, Dr Lokuge and his team gradually developed a ground-up approach that ended up reducing scabies transmission and hospitalisation rates by around 80% in just three years.



The book is a rare story of hope and change from the often dispiriting coalface of remote indigenous health. It is also a fascinating insight into how effective start-up health programs are created, from dream to funding partnerships, from fieldwork trials to policy development, from chats on the verandahs of elders in Arnhem land to corporate boardrooms, public health conferences and social media campaigns. It reveals the challenges and satisfactions of remote area work, and the strains it places on individuals and relationships. It shines light on the often fraught relationship between white and black Australia 'a partnership dance that is still struggling to develop trust and mutual respect'. Most of all it brings alive the silenced voices of the local Yolgnu people. Their singular and moving stories are the heart of the book. In the end, like in all good medicine, it is about listening to people, and finding a way forward together.

You can link to the Medical Journal of Australia article on the scabies project: http://www.everyvoicecounts.org/scabies/

By Dr Joo-Inn Chew, GP at Interchange General Practice, and at Companion House Torture and Trauma Survivor Service.

New reports support AMA calls for greater investment in general practice

AMA President, A/Prof Brian Owler, said recently that the AMA welcomes the latest Bettering the Evaluation and Care of Health (BEACH) reports, which support AMA calls for greater Government investment in general practice.

A/Prof Owler said that the reports, *A decade of Australian general practice activity 2004-05 – 2013-14* and *Australian General Practice Activity 2013-14*, provide further evidence that general practice delivers the best value for money in the Australian health system.

"Significant investment in general practice is crucial to equip the health system to cope with the ageing population and more patients with complex and chronic diseases," A/Prof Owler.

"General practice keeps people healthy and out of hospital. It makes sense for the Government to invest heavily in primary care, and the most cost-effective quality primary care is provided by GPs.

"It is definitely not the time to be introducing disincentives – such as the Government's proposed model of co-payments for GP, pathology, and radiology services – that would deter sick people from visiting their GP."

A/Prof Owler said the reports show that if GP services were performed in other areas of the health system, they would cost both the Government and patients considerably more than general practice.

"GP services in the Emergency Department, for example, would cost between $396 and $599 each, compared to the average cost of a GP visit, which is around $50," A/Prof Owler said.

The BEACH reports highlight that general practice, over the period 2004-05 to 2013-14, has been doing more to keep Australians healthy than ever before, including:

- 68 million extra problems managed (48 per cent increase), of which 24 million were chronic conditions such as diabetes and depression;
- 35 million extra GP-patient encounters (36 per cent increase), 17 million of which were with patients aged 65+ (a 67 per cent increase);
- 10 million extra hours of GP clinical time (43 per cent increase); and
- 10 million extra procedural treatments (a 66 per cent increase).

The BEACH publications are available at General practice activity in Australia 2013–14 and A decade of general practice activity 2004–05 to 2013–14.

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The junk food crisis

Many years ago I wrote in an article that "we all know what we should and shouldn't eat". I no longer think that this is the case.

Food packaging is confusing people. Every aisle in the supermarket, except the first and last, is given over to processed food. With all the diets, food fads and misleading advertising I now have intelligent, educated patients telling me that "I don't know what to eat". The daily intake guides on the packets are next to useless, and so much defended by the food industry.

Poor diet is now the leading cause of death and disability in Australia, says Professor

Bruce Neal of the George Institute. A quarter of children and adolescents are overweight or obese and there are 400 new cases of type 2 diabetes per year among them. This is a public health crisis.

A recent national nutritional survey showed that our fruit and vegetable consumption has declined by 30% in the past 20 years. Over the past 50 years, sugar, salt and fat have been progressively added to processed food.

We have become used to highly flavoured food. We know that we develop a taste for these substances such that food can taste too bland without them. The food industry knows this and keeps inventing products to tap the addiction.

Over the same time, we have become time-poor, eat out often and move less. We grab the frozen dinner or packaged sauce rather than cooking from scratch. If I as a GP, and a health conscious person (without my glasses) can pick up a stir fry sauce, and on getting it home find that the second main ingredient in it, after water, was sugar, then how does everyone else fare?

In 2011, the AMA stated: "The facts are clear. The AMA believes that the government must mandate traffic light labelling on packaged food and drink products". In a victory for industry over the public good, the government of the day decided not to go ahead with that system even though it is clear, obvious and the most effective way to change buyer behaviour. What parent is going to pick up a lunch box snack for their child with a red light on it?

A front of pack Health Star Rating system, which rates foods on nutritional value from 1 to 5 stars, was proposed instead. For two years, federal and state governments, the food industry, public health experts and consumers worked on it.

In February this year, the Health Department's website to inform consumers and manufacturers finally arrived but was pulled down immediately by the Assistant Health Minister's then chief of staff, Alistair Furnival. Furnival, it has been reported, is a co-owner of a company that represents food industry opponents of the website and the alcohol industry. He also reportedly played a lead role in the startling decision to defund the Alcohol and Other Drugs Council of Australia.

Alarmed, the Public Health Association of Australia and 66 professors published a letter to government "obesity needs urgent action – it is causing diabetes, heart and kidney disease and cancer" and urged all ministers "to take whatever action is within their power" to reinstate the website and begin compliance as soon as possible.

Still, many in the current government believe that no intervention should take place, decrying it as "pure nanny state". Apparently neither the Health Minister nor Assistant Health Minister defended the HSR during internal debates. Finally, in June, the Federal Government buckled to pressure to re-instate the website.

We should be throwing everything at this. If doctors were in charge we would have the tried and true traffic light system, it would be mandatory and phased in quickly. Instead, we have a second best system, which is voluntary, to be phased in over 5 years – and still hasn't appeared online.

This week, the Health Department site "encourages the attendance of food companies" to a workshop about the new system. I do hope they wander along!

The only GP in Parliament, Senator Richard Di Natale, commented "The Federal Government is dragging its heels over the launch of the health star rating website. The fact that the George Intitute have been able to launch a functional online rating system begs the question, why the delay from the government?"

In Senate estimates this week the Assistant Minister for Health, Senator Nash, was asked about the delay. Her response was a masterpiece of obfuscation.

I have given up waiting. I'm now directing patients to the George Institute's website (www.foodswitchstars.com.au) which lists 55,000 items and compares products within each range. I was amazed to find that a Weight Watchers bar received only 1 1/2 stars out of 5. People need to be informed now about what they're putting in their mouths. We all do.

By Dr Julie Kidd, MB, BS.

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Economic sanctions and healthcare – an ethical dilemma?

By Zainab Ridha

Sanctions are tools of foreign policy that have been used increasingly since World War I. The main purpose behind sanctions is to punish states that refuse to conform to international norms, particularly when these states commit acts in violation of human rights. The senders of sanctions justify their policies on the basis of sanctions being an ethical alternative to the inhumane use of military force. Yet, deep consideration of the consequences on the people of the "punished state" raises an important question – are sanctions in themselves a violation of human rights?

The most common type of sanction applied in recent times has been the trade embargo, or economic sanction. The nature of these embargoes in the past was quite comprehensive and broadly affected societies to the point of humanitarian devastation, primarily through the decline of food and medical provisions. For example, US sanctions on Cuba from the 1960s till present have caused significant malnutrition, particularly in children, related to reduced food imports and a decline in local production. As a result, conditions like anaemia in underweight pregnant women and infectious diseases among the elderly were a significant burden on the Cuban healthcare system.

Yet no set of sanctions in history compares to those imposed on Iraq by the UN Security Council after Saddam Hussein's invasion of Kuwait. The embargo lasted for 13 years blocking nearly all imports/exports, freezing Iraqi funds and banning transport to and from Iraq. Even more so than in the case of Cuba, the Iraqi healthcare system was crippled facing a more than two-fold increase in typhoid, measles and polio cases. The inadequate availability of essential medical products like insulin caused more deaths from chronic diseases and, shockingly, the lack of anaesthetic agents forced surgeons to perform operations without anaesthesia. Entire populations were forced into semi-starvation and humiliation as they depended on a 1000 calorie/day government rationing system consisting of mainly rice and sugar. To make matters worse, the Iraqi sewage treatment system was also hit due to blocks on the importation of chlorine precipitated by fears it may be used as a chemical weapon. It is no wonder then that many children died from diarrhoea and other preventable illnesses related to lack of personal hygiene. In total, the UN estimated that approximately 1.7 million Iraqi lives were lost as a direct effect of the sanctions, with 500,000 of them being children.

However, following the humanitarian disaster of the Iraq sanctions, there has been a shift towards targeted sanctions over their comprehensive predecessors. These may involve trade embargoes on specific industries (e.g. weapons, oil), travel prohibitions, or sanctions aimed at limiting a state's financial freedom via restricting investments, freezing foreign assets or banning monetary transactions. The recent sanctions on Iran fit into this mould; directed by the US, EU, Canada, and several other countries including Australia, their main aim has been to stop the proliferation of Iran's nuclear program. Although the sanctions have exempted trade on food and medicine, the sanctioning of Iran's Central Bank and interruption of financial flows has led to a significant shortage in medical supplies. Even raw materials to support Iran's pharmaceutical industry have been cut-dry, which manufactures 90% of drugs available on the domestic market. This raises issues with long-term management of chronic diseases, like cancer, and has even resulted in the death of a haemophilia patient due to lack of required treatment. One may thus argue that targeted sanctions are not very different to their comprehensive counterparts due to the highly connected nature of global markets and dependence on financial flow.

Although the humanitarian impact of economic sanctions on ordinary civilians is undeniable, they continue to exist and be advocated for. Those in favour take a utilitarian approach to ethically justify sanctions, claiming that the greater good of political gain far outweighs the collateral damage of human suffering. However, history has shown us that this has rarely been the case. It may be true that sanctions significantly weakened Iraq's once-powerful army, yet they failed to overthrow Saddam Hussein by the frustrated masses and this was mainly due to his strong, hostile and heavily-protected political standing. More recently, in the case of Iran, the US-led sanctions on oil and gasoline trade have ironically created a bigger incentive for the Iranian government to enrich its nuclear energy program and meet the demands of its people.

It's an unfortunate reality that violations of human rights continue to occur on a daily basis, particularly in war zones and places with authoritarian regimes. However, what of institutions such as the UN Security Council, the US, EU and other sanction imposers that are signatories to international human rights agreements? According to the Universal Declaration of Human Rights, every individual has a right to life, medicine and shelter. Likewise the UN Covenant for Economic, Social and Cultural Rights guarantees that food, sanitation products and pharmaceuticals should be available to all. Yet in nearly all countries targeted by sanctions, civilians have been stripped of these essential rights. Attempts have been made in the past to correct for the damage, such as the UN's inadequate Iraq Oil-for-Food program, yet corruption and bureaucratic obstacles have hindered this affirmative action. In some cases, as in the 2012 Iranian earthquake, even NGO's were unable to transfer funds for emergency relief simply because no bank was willing to facilitate the transaction.

Economic sanctions may be a preferable method over military combat to discipline states that violate treaties or other nations' sovereignty. Also, policy modifications over the past decade may have slightly limited the humanitarian cost, but this is not enough. Even targeted sanctions impact on healthcare systems, which consequently affects the livelihood of multiple generations. It is thus the onus on the sanction imposers to ensure continuous monitoring of the targeted population's health status and implement mechanisms to maintain food stability, prevent water contamination and infectious disease spread. Only in this way will the benefits of sanctions outweigh the harms.

Zainab Ridha is a year 2 student at the ANU Medical School

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Tipping the scale in work-life balance

By Anna-Kristen Szubert

Two different presenters, two entirely different methods of entrancing their audience. Still, each audience was rapt.

One, taking his audience through a series of hilarious anecdotes of surgical life, delivering punchlines with whiplash timing, punctuated by bursts of laughter from sections of the audience as they eventually caught on.

The other lecture was somber. This man was humble in the way great men often are, which only engendered greater awe at his tales of high-risk surgery in the Antarctic, expeditions to landlocked villages, setting up makeshift operating theatres in developing countries. The photos of beaming children – bandages finally off – demonstrated how both men had done something truly extraordinary with their lives.

The medical students that made up the audience were intrigued. The lecture was opened for questions. The normal questions were asked – how long did it take them to gain their expertise? What was their greatest achievement? Then, another was asked – How did they handle combining their career and raising children?

It was there that these two lecturers found common ground. They both replied – one jokingly, another with a distinct twinge of regret – that they had not raised their children at all. Both relayed stories of having missed much of their children's lives. Both explained that without a stay at home spouse, they would not have been able to have children at all.

This reply was not unexpected. There was a distinct sense of annoyance from large portions of the audience – mostly female – who mentally crossed this career path off their lists.

In both lectures, the lecturer was peppered with questions about how they could possibly have done better, been more involved in their children's lives. Interestingly, both men and women were asking the questions. Even more interestingly, at both lectures, it was a man who had asked the original question.

From these two encounters – taken from two separate surgical symposiums in 2013 – we can make a few assumptions. People are more interested in surgery than ever. It is an exciting, ever changing field, presenting challenges and adventures for anyone who decides to push on down that path. More importantly, gender roles are changing. In 1975, 20% of medical graduates were female. Today that number is closer to 50%. Additionally, men are more interested in being involved in raising their children than ever before. The traditional nuclear family still exists – with a man as the sole breadwinner, and a stay at home mother working to raise the children – but it is only a percentage of a larger subset of families. Most families in Australia have both parents working full-time, and taking time off at times that suit their personal situations, not just their traditional gender roles. Additionally, the spreading wave of LGBT+ equality means that more gay and lesbian couples than ever are raising children of their own.

A 2014 report released by the Australian Human Rights Commission details the many ways that workers are penalised for childrearing. This includes discrimination relating to pregnancy, a lack of part time or flexible time options, cutting workers off from promotions due to their primary carer status. Workers are disproportionately penalised for taking time off from work to care for children. Even thirty years after taking a year off to care for a child, workers are paid far less than their counterparts who took no time off.

The pay rates for male and female medical graduates are equal. Despite this, soon the pay gap expands dramatically, with the average pay gap for doctors at 30.7%, 12% larger than the national average. 30-60% of the wage gap is due to differences in hours worked (which in itself is mostly due to the increased load of unpaid domestic work for women). 40-70% of the wage gap has been ascribed to fewer offers for promotion, performing fewer procedures on average than men, and an "unknown factor".

This is compounded by lower pay rates per hour for those on part time work, a lack of resources for re-training for those who take time off, a lack of daycare facilities, and workplace discrimination (conscious or otherwise) leading to fewer promotions and pay raises, high levels of burnout, and a lack of leadership opportunities. Intellectually, this makes sense – medicine is a demanding profession, and as such any decision to take on another high intensity job – that is, of raising children – will impact on that first job significantly. Medicine is traditionally very inflexible. Even so, it is important to remember that historically, medicine has gone through many changes despite heavy resistance – the introduction of handwashing is an excellent example – and challenges to the status quo can and should be encouraged.

Proposed changes to training are often met with concerns about affecting training quality and patient care. Yet the introduction of part time training in both internal medicine and paediatrics has been associated with improved personal wellbeing and clinical performance. There has been no evidence of compromised training quality or quality of patient care.

There is also a view that part time training demonstrates a lack of commitment. The evidence shows, however, that the ability to manage both the demands of a young family and part time training requires a high level of commitment and organisational skill.

The composition of the medical profession is changing, and our new graduates should not be made to adapt to a career style that stubbornly refuses to change. Having children is a desire common to many people, and if we as a profession purport to champion gender equality we should not dismiss the idea that one might combine a career and a family as something out of the ordinary. Currently, our profession and training is designed to serve a hypothetical entity who will never have any other commitment than medicine. As childrearing is a common thing to do, and women have traditionally been the primary carer, this resistance to change translates into discriminative workplace practices and a widening pay gap.

We need to recognise that today, people of every gender want to combine a career and raising a child. In our personal lives, we should take a page out of the book of our LGBT-identified co-workers and strive to designate childcare responsibilities equitably, not according to traditional gender roles.

Additionally, in our professional careers, we need to identify areas where we are perpetuating discrimination against parents, and where we can, implement policies such as flexible training and working opportunities that will help to turn the tide against gender inequality.

Someday, I hope to see another two lecturers – one male, one female – regale us with their stories of a fulfilling career. I hope that those people will be able to confidently answer that they spent a great deal of time with their children, and shared childcare responsibilities with their partners. I especially hope that the medical students of the future will be satisfied to know that every speciality is available to them, regardless of their gender or their responsibilities.

Anna-Kristen Szubert is a year 2 student at the ANU Medical School.

References are available on request from the author.

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Mental Health: Helping ourselves to help others

By Nicole Maitin-Casalis

The Hippocratic Oath stands at the very foundation of medicine, stating that "the health of my patient will be my first consideration". Yet, I argue that to uphold this doctrine, doctors must first take care of themselves.

In 2013 a world-first survey on the mental health of over 14,000 Australian medical students and doctors was conducted by BeyondBlue. As a medical student, the findings invoked an unbridled mix of alarm and disappointment.

Alarm at the statistic that almost a quarter of Australian doctors and medical students reported thoughts of ending their lives. That young doctors and female doctors particularly had the highest rates of mental health issues, reporting more severe work stress and a disconcertingly high rate of burnout.

Then came the disappointment. The survey revealed that stigmatising attitudes regarding mental health amongst medical professionals are running rife. Amongst medical students, 40% believed that doctors with a history of mental health conditions are less competent, and furthermore that doctors would encourage their colleagues to conceal any mental health problems. These views lined up with the attitudes held by current doctors, who reported the belief that mental health issues impede career progression due to the medical community questioning the competence of doctors who admit to a history of depression.

The burden of mental health is by no means restricted to medical students. Mental health is one of the leading contributors to non-fatal burden of disease and injury in Australia. Specifically, in 2007 the ABS Survey of Mental Health and Wellbeing revealed that almost half (7.3 million people) had a mental disorder at some time in their life. Most shockingly, this statistic is largely due to the young-adolescent group, where almost a quarter of people aged 16-24 years had a mental disorder in the previous year. The Australian Medical Students Association (AMSA) has recognised the critical nature of this issue, launching a campaign for increasing awareness and removing the stigma of mental health in youth.

Thus, as a medical community, we are to be credited for recognising and jumping to action regarding the pressing issue of mental health amongst our potential patients. These actions are in accordance with the requirements of the Health Professionals Act, to exercise professional judgement, knowledge, skill and conduct at a level that maintains public protection and safety.

Furthermore, in approaching patients with mental health issues, doctors uphold the ethical principles of autonomy, justice, beneficence and non-maleficence. They ensure the dignity of their patient is upheld, and that the patient's entitlement to fair treatment is fulfilled by ensuring their approach toward the patient's needs is not marred by a stigmatising attitude. In accordance with the principles of beneficence and non-maleficence, doctors do not ignore signs of depression in a patient, particularly where suicidal ideations occur. In doing so, the aim is to ensure that the patient's human right to the highest attainable standard of care as outlined in the UCESR is satisfied. These are the principles drilled into us as medical students, rote-learned and well-understood.

So why is it that we actively and selectively strip our own medical community of these rights and fail to uphold these principles when it involves our own peers and colleagues?

The endorsement of discriminatory attitudes toward mental health in the medical community will hurt not only those affected, but their patients too. Due to fears of stigmatisation, medical students are less likely to seek treatment, which will in turn result in greater burnout and fuel the growing mental health statistics. Moreover, these attitudes may hinder a doctor's ability to increase awareness about mental health issues and the importance of removing stigma in the general public.

To be effective, doctors must first take care of themselves. Yet in the current climate, doing so requires admitting the issue and seeking treatment – which is obstructed due to the perception that doctors will be viewed as incompetent BECAUSE they sought treatment. This self-perpetuating cycle must be stopped. To do so, we must strive to apply the same professional and legal principles to our own community as we will for our patients. Only then will doctors be able to fully commit to delivering the highest standard of care to patients. Only then will the health of the patient truly be the first and unimpeded consideration.

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It can be challenging for a doctor to be a patient

By Rachael Heath Jeffery

In order to contend whether or not it is challenging for a doctor to be a patient, it is important to provide the context within which doctors carry out their daily duties to meet their responsibilities and what, if anything, distinguishes a doctor's experience on the receiving end of medical treatment to that of his or her patients.

Research has shown that doctors, when compared to the overall population, have a lower standard mortality rate and are less likely to suffer lifestyle-related illnesses such as heart disease. However, research has also demonstrated that doctors experience similar rates of chronic illness and high levels of occupational stress and subsequent vulnerability to anxiety, depression and substance abuse. In addition, they have a higher than average suicide rate.

The stress factor plays a significant role in inhibiting the smooth transition from doctor to patient. Doctors are, in the main, dedicated and proficient and their profession comes with a great deal of responsibility. The life of their patients may depend on them making timely and accurate decisions. They are trying to achieve the best possible outcome for their patients and, in doing so, they may witness great suffering, not only with respect to the patient but those around them. The nature of illness and injury is such that doctors may have little control over events in their lives and, accordingly, demands on their time and skills can be unpredictable. Patients too can have expectations that their doctor will be available to them if and when required. All this would indicate that many doctors could struggle in achieving a work-life balance as well as avoiding depression and anxiety.

This difficulty in managing their work environment, together with the general reticence of doctors to consult on or even discuss their own health, especially mental health, would be exacerbated by the perception that, depending on the illness, they also feel they are unable to influence their own wellbeing. Due to the demands on their time and the volume of work, it may be convenient for doctors to ignore that they are sick, particularly in the early stages, or they give it such a low priority that they do not seek help until their illnesses are more severe or even critical. These are matters, which should be addressed throughout medical training so that doctors are better prepared to acknowledge that they need help, especially if they are to encourage responsible attitudes in their patients. Doctors in rural settings are particularly vulnerable because seeking help usually involves travelling long distances and therefore leaving their practices.

It has been suggested that systemic issues, such as long working hours may present more of a problem to doctors in accessing medical services than individual barriers, for instance personality traits. Confidentiality may also be perceived as an issue both for rural and urban doctors, when it relates to their own health and this would be particularly evident in relation to their mental health, including evoking feelings of shame, embarrassment and loss of face. A study found 71 per cent of doctors felt embarrassed when seeing another doctor. Rural doctors typically live in small communities where the benefits of familiarity may come at a cost of loss of privacy. Ironically, doctors who have experienced illness should subsequently be recognised and respected for having a greater insight to and appreciation of their patients' physical and mental symptoms. At the other end of the scale doctors may be dismissive of symptoms like fatigue because of their own exhaustion from overwork and stress.

Being exposed to the consequences of disease on a regular basis, means that doctors may become detached from or impervious to it in order to survive mentally. In some cases such detachment may extend to them not acknowledging that they may need medical treatment. This is despite being fully aware of the repercussions of not seeking help in the early stage of the disease. It is relevant in this regard that, in the first week of medical school, students are usually asked to dissect a cadaver. This prepares them at the outset for the long non-judgemental path ahead where it is the physiological and clinical aspects of the body that must preoccupy their mind in a professional capacity over the life's experience of the person who existed. The focus on the disease itself can be interpreted by anyone, especially those outside the medical profession, as being almost unnatural and it could be inferred that this depersonalisation of disease and illness may cause doctors to disassociate themselves from their own illnesses and therefore challenging for them to become patients.

Doctors often go through a complex process in choosing their own general practitioner with female doctors more likely to experience difficulty in this area but also more likely to be successful. This would indicate a difference between the sexes in procuring a doctor. The professional status of a doctor also is a factor in that the higher the status, the less likely they are to acknowledge they need help. It may be that their confidence in doctors of a lesser standing is lacking. Doctors are also more likely to consult other doctors informally than would a mainstream patient and it is reported that over a-third of doctors used 'corridor consultations'. This preference for informal consultation is evidence that doctors find it challenging to be a patient whether it is due to time constraints or resistance to the practice.

An extension of the reluctance to seek formal medical treatment from other doctors is the matter of self-treatment. This is a quick and cheap option with privacy assured and the problem of the doctor-patient relationship is circumvented. It follows that, depending on their training and experience, doctors may feel that they are better equipped to deal with their own medical issues. They are also aware of the limitations of medical treatment. Research has shown most doctors believe 'self-treatment' is acceptable, especially for minor illnesses. In this regard and as would be expected, self-treatment is shown to be more common for general practitioners than specialists. Doctors do not like to consume another doctor's time especially if they believe their illness may be trivial or related to a mental health issue. Unfortunately embarrassment with mental health matters is not only an issue with doctors but reflects prevailing community attitudes towards those illnesses exacerbating challenges for doctors to be patients.

Challenges for doctors to be patients are wide-ranging and relate to situations beyond their control such as the occupational stress increasingly associated with the demands placed on them by patients and society or their own expectations arising from their individual personality traits. The latter can be associated with doctors giving their own health issues a low priority perhaps due to their work ethics or a hesitation to consult other doctors due to embarrassment or concerns about confidentiality. Some doctors may believe that they are, or should be, better, able to deal with their own health issues, according to the perceived quality of health care available. These factors, together with the well-established practice of self-treatment, mean that it can be challenging for a doctor to be a patient.

Rachael Heath Jeffery is a year 2 student at the ANU Medical School

References available on request from the author

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Medicine and technology: challenges for patients and practitioners alike in the use of electronic health records

By Jessica Fardon

People are becoming increasingly reliant on their electronic and mobile devices, unable to function without them. Indeed, even within medical and health domains, a push exists to move towards electronic health records.

However the privacy and security issues arising from this increased use of technology are becoming increasingly apparent. Just recently, news headlines related to the hundreds of nude celebrity photos leaked online. This demonstrates the huge potential for misappropriation of online data of any nature, not excluding sensitive health related information.

Electronic health records (EHRs) are digital healthcare information stored in online databases to facilitate access across all disciplines of health care, across many different physical environments. Its purpose is to support continuity of care and to improve the efficiency and safety of health care delivery. Data from every conceivable aspect of a patient's health care is entered and stored digitally, providing a comprehensive collection of information. This includes demographics, general observations, lab tests and results, imaging and medication regimes from across the lifespan. As such, EHRs present a means by which practitioners may communicate more effectively with each other, with a full understanding of each other's contribution to a particular individual's care plan. A greater knowledge decreases risk of errors, thereby improving patient safety. EHRs also present the additional benefits of cost reduction via increased efficiency and decreased administration costs by eliminating the need to find and fax paper documents to relevant parties. The timely delivery of test results also allows for decreased waiting time. Despite these multiple benefits, wide spread utilisation of EHRs is yet to be implemented.

While there are issues relating to the cost of implementing the devices and training staff, there is a reluctance driven from fear of establishing a reliance on a system which may not be supported during power outages, computer crashes or system glitches. While valid concerns, the primary concern for both practitioners and patients is that of privacy and confidentiality.

The inherent difficulty of paper documentation and the time consuming "finding and faxing" processes required for cross-facility communication; while cumbersome, protects the nature of the data in the documents. Further to this, the relatively simple matter of ensuring safe storage of patient records by locking in a filing cabinet in a record room is no longer relevant. As such, security breaches are a major concern in the use of EHRs. This is particularly true considering the larger quantity of information available for misappropriation contained within EHRs, especially when compared with the previous paper based issues of one file at a time going missing or being misplaced.

A practitioner's ability to assure confidentiality is a cornerstone of practice, first documented in the Hippocratic Oath and later in the Geneva Declaration, outlining that a doctor should maintain patient confidentiality, only ever using the data for the purpose it was collected for, even after the patient's death. These principles have since been incorporated into the Australian Medical Council's Code of Conduct, and also indoctrinated into the Health Professionals Act (ACT). Electronic health records present a change from not only paper records, but the ability of a practitioner to fully assure the confidentiality of any discussion, with an appreciation for just how that confidentiality will be upheld. This issue presents the downstream effect of patients being reluctant to fully disclose details that may be necessary for diagnosis and appropriate management. This may be driven by many factors, including fear of future repercussions – to embarrassment, or even missed opportunities if employers or insurance companies were to gain access to the information.

Privacy laws such as the Privacy Act 1988 (Cth) and the Human Rights Act 2004 (ACT) state that everyone has the right to respect for his private and family life. Further to this, the Health Records and Information Privacy Act (2002) outline requirements for the processing, sharing and security of sensitive personal data. While these laws go some way in helping protect patient data through outlining how practitioners may use and store patient's health information, in many respects these laws are misaligned with the new technology of electronic health records. Until both the laws are updated and software improvements can vouch for the safety of information held within online databases, perhaps the current push to utilise EHRs should be slowed to ensure not just efficient health care delivery, but health care which fosters the doctor-patient relationship and respects the right of individuals even outside of the health care environment.

While there are huge potential benefits of electronic health records to health care efficacy, efficiency and safety, reluctance by both practitioners and patients driven by concern for confidentiality and privacy are so far impairing wide spread utilisation. Ultimately, greater security measures need to be implemented to protect not only our patient's privacy, but to protect the doctor – patient relationship and to prevent a fear of technology jeopardising what patients are willing to disclose to us. There is a need for electronic health records to promote efficiency and patient centred practice, but maybe for the moment, the technology is out stretching the ways we can control and protect the intrinsic rights of the patient. As practitioners and advocates for our patients, we need to ensure we educate ourselves as to how these electronic systems work and exercise a mode of caution when embracing this era of technology.

Jessica Fardon is a year 2 student at the ANU Medical School.

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It is cool, but is it right? The ALS Ice Bucket Challenge

By Camilla Bradshaw

For the past two months, logging on to any social media site had you bombarded by videos of people dumping buckets of ice water on their head, all in the name of charity.

Amyotrophic lateral sclerosis (ALS), better known as motor neurone disease (MND) in Australia, is a cruel and relentless disease; the average life expectancy after diagnosis is a mere 27 months. The ALS Ice Bucket Challenge has been hugely successful in increasing the international profile of this horrific disease, raising over $2 million for MND Australia to fund research and to support affected Australians and their families. Regardless of whether people participating in this challenge are doing so to follow a social media fad or because they genuinely want to contribute to finding a cure for MND, this is excellent news for the MND community. The dramatic success of this campaign highlights how a diverse range of factors can affect how successful a charitable or humanitarian organisation will be.

Firstly, the marketability of the target disease significantly influences how effective the charity's campaign will be. How 'sexy' or socially acceptable a disease is impacts hugely on disease awareness. For example, women who undergo a lumpectomy or mastectomy for breast cancer are celebrated as empowered survivors; however, the same cannot be said for people who lose their colon and have to live with a stoma and colostomy bag for the rest of their life. Most Australians will recognise the pink ribbon as the embodiment of breast cancer funding and research, but how many people recognise that the purple ribbon represents gastrointestinal cancer? Unfortunately, for sufferers of gastrointestinal cancer, the nature of the disease impedes the potential marketability of the disease. What is promising is that we have one of the highest rates of breast cancer survival in the world. If successful marketing has helped to achieve this impressive survival rate, there is no reason that it can't work for other diseases to improve care, therapy and survival.

The next significant issue is the practice of spending money to raise money. People will not donate to an organisation they haven't heard of; consequently, for a campaign to be successful it requires a catch phrase, fad or marketing 'hook' to grab attention. Consequently, charitable organisations must raise their profile through advertising, which can be very costly. Some charitable organisations are lucky enough to gain celebrity endorsement for their cause, either because the celebrity has been directly affected by the disease, as in the case of Lance Armstrong who publicly battled testicular cancer then formed the Livestrong Foundation, or indirectly because they personally have a strong connection to the disease, such as Elton John who is heavily involved with fund-raising for HIV/AIDS as a way of supporting the gay and lesbian community who have been disproportionately affected by this disease. Celebrity endorsement both raises the profile of the organisation and gives credibility to it, which assists in attaining donations.

Furthermore, there are numerous smaller organisations in Australia all raising money for the same disease, and in doing so, compete against each other and their own cause for attention. This raises the question of whether it would be more effective for each disease or condition to have one central organisation, rather than multiple smaller ones. Surely administration and advertising fees would be reduced if costs were managed by one organisation rather than by many small ones. Perhaps charitable organisations could also benefit by pooling their efforts and resources to raise the public profile of the disease, rather than compete with each other for fundraising. After all, they are all working towards the same goal.

Perhaps on a different note, it is interesting to consider whether the amount of funding allocated reflects or corresponds to how many people are affected by the disease. In 2011, more people died from lung cancer and gastrointestinal cancer than from breast cancer. However, breast cancer foundations receive more money ($21.7 million) than both lung cancer ($3.2 million) and gastrointestinal cancer ($5.1 million) combined. Centralising donations, then allocating them according to the financial requirements of the organisation's programs could address the disparity between allocated funding and disease burden.

Finally, there are diseases that have no survivors, such as MND, or that have survivors who are unable to advocate for themselves, such as survivors of paediatric cancer. Without survivors, there is no public face for the disease and consequently, fundraising becomes very difficult as there is the double challenge of firstly raising awareness of the disease's existence in the first place, then trying to convince the public of the worthiness of donating to this previous unknown cause. Prior to the ALS Ice Bucket Challenge, many Australians had never even heard of MND, despite the fact every day, two Australians are diagnosed with this devastating condition. Given approximately 625 Australian children are diagnosed with various paediatric cancers each year, this suggests that each of these cancers will need their own global social media fad version of the Ice Bucket Challenge or face poor public awareness and insufficient funding to meet the needs of the patients as well as research into finding effective treatment and cures.

In conclusion, the ALS Ice Bucket Challenge exemplifies a successful marketing campaign to raise awareness and money to support a devastating disease. Disappointingly, it also highlights a number of issues associated with how charitable organisations are forced to attain funding for their cause. Specifically, marketability of the disease, costly advertising and competition with other charitable organisations for limited funding all contribute to campaigning behaviour and ultimately, the outcome for those affected by the disease. As the public becomes more engaged with fund raising for charities, it may be timely to overhaul the current system for allocating funds to ensure equality in medical research and better outcomes for those with debilitating diseases, regardless of their public profile sexiness.

Camilla Bradshaw is a year 2 student at the ANU Medical School

References available on request from the author.

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Caught behind the shadow of stigma – medicinal marijuana

By Nicolas Grandjean-Thomsen

Cannabis (also known as marijuana) has been used for millennia as a source of food, fibre, medicine and infamously, as a recreational drug. Long stigmatised in modern society, it is only in the last couple of decades where its legitimate and legal use as a therapeutic product has been taken seriously.

Based on a groundswell of public support, the NSW and ACT governments are considering drafting legislation which would legalise its medicinal use. While it is important for an elected government to adhere to popular consensus, they must also ensure that any action is based on sound scientific evidence.

Medical marijuana has a broad range of therapeutic uses. This has been proven by many scientific studies and meta-analyses which demonstrate its ability to alleviate patients of spasticity from disseminated sclerosis, chemotherapy associated nausea, cachexia from AIDS and cancer, and chronic pain associated with cancer, rheumatism and neuropathy. The benefits have proven to be immensely life changing, with many patients now willing to break the law to procure the substance. As a future medical professional, I believe that forcing patients to resort to this practice is unethical. In reference to the Declaration of Geneva, we the members of the medical profession must protect and uphold public safety, and thus advocacy on our behalf is clearly required to alter this situation.

Despite the clear benefits of medical marijuana use, as with most medicines, there are adverse effects. Studies have shown modest increases in incidence of disorientation, disturbance in attention, depression, memory impairment, dissociation, feeling intoxicated and euphoric mood. For those of a particular genetic disposition, marijuana use has been found to increase the risk of an earlier onset of schizophrenia. It is clear that there are risks associated with cannabis use, however they must be weighed against the substantial beneficial effects that it can provide. Furthermore, with the appropriate control and dosing, many of the adverse events can be minimised. As a medical community we must look beyond our own moral views and base our decisions on evidence-based medicine and the desire of our patients.

The recreational use of cannabis is rampant in Australia and all over the world.

Opponents of medical cannabis claim that it will create addiction among patients and increase supply avenues to recreational users. Marijuana in Australia is already easily accessible via illegal means, with 92% of respondents to the 2012 Illicit Drug Reporting System Survey reporting that cannabis was 'easy or very easy' to obtain. Abusers are therefore unlikely to resort to medical means when access is already so readily available. Regarding patient addiction, several studies have found that abuse dependence only occurs in small proportions and that tolerance does not occur. Precedence with other narcotics already exists with opioid derivatives being widely used for essential medical pain relief, but at the same time being recreationally banned. Medical marijuana will be abused no more than other commonly accepted medications, and thus it should not be dismissed in fear of corrupting our social foundations.

The quality and dosing of medicinal marijuana can significantly affect its therapeutic benefits. Previous studies on the substance have used medicinal grade versions in institutionally approved trials. Current ACT legislation however, proposes to legalise the self-cultivation and medication of marijuana for selected patients. The use of 'street grade' cannabis and patient self-dosing is questionable in terms of its efficacy. In overseas jurisdictions, such as the Netherlands, medicinal grade supply is procured from an authorised supplier who follows strict European standards and quality control measures. It is then distributed by a qualified pharmacist via prescription who provides the patient with instructions on how to use the product.

Cannabis has been developed with only cannabidiol (the non-psychoactive agent of cannabis which contains many of its therapeutic affects) and no tetrahydrocannabinol (the psychoactive agent). This strain of cannabis has the potential to eliminate any potential problems related to abuse. With time and investment, the whole supply chain up to patient application can be completely controlled and standardised. This will result in the complete medicalisation of medicinal cannabis, and an almost complete disconnection to the problems of recreational use.

There has been a steady increase in support for the legalisation of medical marijuana throughout the western world. It has long been used in European countries such as Netherlands and Belgium, and is currently legalised in 23 states in the United States. In recent surveys, about 66% of Australians are in support of the legalisation of medical marijuana, which has led to serious pushes by medical bodies and some politicians to introduce legislation. Despite its overwhelming popularity, conservative political leaders have remained hesitant to introduce change. Stigma is a powerful entity, and it is our role as medical practitioners to counter it with our most effective tool – scientific evidence – to bring about change.

Overwhelming scientific evidence has shown that medicinal cannabis has many valuable applications. While some negative effects can occur, these are generally minor and of low frequency. By adopting the control and distribution strategies of other nations who have already implemented medical cannabis use, we can further minimise any adverse effects and regulate addiction and abuse. The Australian public has shown strong support for legalising medical marijuana, and it's time for the government to listen to the general and scientific community. We need to break free from unfounded stigma and evaluate this medical good like any other.

Nicolas Grandjean-Thomsen is a year 2 student at the ANU Medical School.

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An Exciting Update from NCDI

The NCDI Corinna Chambers Clinic is relocating to a new, state of the art clinic co-located with Orthopaedics ACT and Flex Out Physiotherapy Canberra. This will provide our patients with state of the art Diagnostic Imaging, Orthopaedic, and Physiotherapy services within the one centrally located building.

The NCDI Clinic, located on the ground floor, will be installing a new 3T MRI which will bring great benefit to the local community by reducing MRI waitlists and providing better access to diagnostic imaging services for the ACT. This MRI will have the only private, fully Medicare rebated license in Canberra attached to it. NCDI are also investing in a new state of the art CT scanner, as well as the latest in Breast Screening technology – Tommosynthesis.

New address: **Woden Specialist Medical Centre, 90 Corinna Street, Woden, ACT 2606**

Clinic open date: **15th December 2014**

Our Corinna Chambers Clinic will cease operation on Wednesday the 10th of December at 5pm with minimum referrer and patient disruption with our Tuggeranong, Deakin, and Geils Court Clinics available for all of your imaging needs.

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- **3D Breast Tomosynthesis** - a 3D mammogram which allows breast tissues to be examined in thin 'layers', meaning improved cancer detection and reduced call backs

INVITATION: On behalf of the NCDI Management team and staff we would like to warmly invite our referrers, their family and friends to our Clinic opening "Family Fun Day" on Saturday the 13th of December. The event will kick off at 10am, with tours of the new facilities available until 2pm.

The new clinic will be officially opened by the Chief Minister at 11:15am. There will be face painting and a jumping castle, a BBQ provided by Camp Quality, a pass the ball competition along with the opportunity for the public to have their photo taken with Brumbies and Raiders players.

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Walking in two worlds as an Aboriginal medical student

By Danielle Dries

In more recent times there has been increased discussion of the importance of recruiting and retaining Indigenous Australian medical students to improve health outcomes and close the gap in health inequality.

I find it astonishing that in one of the wealthiest countries in the world Aboriginal and Torres Strait Islander people, my people, continue to suffer poorer health outcomes than some developing countries. We have struggled for years in Australia to improve education and health outcomes for less than 3% of our population. I believe we have also failed in teaching graduating doctors how to be culturally responsive practitioners. Medical practitioners who are not culturally responsive can be destructive in the health care they provide to an individual, but also create barriers to access for future family members and communities.

For many years Indigenous health was not considered necessary to be taught in the medical curriculum. It is now a course requirement for medical degrees across Australia. However, it is a difficult subject to teach without the risk of stereotyping Aboriginal and Torres Strait Islander people. I truly believe that this issue can be overcome by increasing the number of Aboriginal and Torres Strait Islander medical and health students, and that this will be the bridge to improving health outcomes.

Nevertheless, in my experience, there are many challenges as an Aboriginal medical student which non-Indigenous students may not experience. These difficulties should be considered when assessing the recruitment and retention rates of Aboriginal students.

I am a proud Kaurna Meyunna woman from the Adelaide region, and these are my lived experiences as an Aboriginal woman and student in a non-Indigenous dominated world. The first question that came into my mind when I was accepted into medicine was "Did I only get in because I'm Aboriginal?" There has been a big push in recruiting more Indigenous doctors and this has helped create a perception of preferential treatment. Many people have assured me that they do not, and cannot, accept people who do not meet an acceptable standard.

I worry about preferential treatment because others do, because society has been led to believe that Aboriginal people as a whole have worse outcomes and cannot achieve the things non-Indigenous Australians are able to without help. It's like someone constantly telling you that you're ugly; eventually you might start to believe it. I have now been studying medicine for two years, and I'm not failing. I am actually doing better than the average in a cohort of medical students. So why do I feel like I don't belong? Really, the question should be, are the other people here because they are non-Indigenous? The first identified Indigenous graduate doctor was in 1983, before that medicine was a career that only seemed open for non-Indigenous people.

I also encounter continuous subtle racism that occurs on a weekly basis. Since I've started to become more open, I've noticed the racism everywhere. Most people do not realise that some of the things they say can be inappropriate and even harmful.

Questions like, "How much Aboriginal are you?" or statements like "You don't look Aboriginal" are far too common. I've learnt to suppress an emotional response and instead, most of the time I respond with answers which educate others on what you should and should not say. Sometimes I just ask them the question "Well, what does an Aboriginal person look like?" Most people have formed an idea of what every Aboriginal person looks and acts like, even if they understand that there are many different Aboriginal communities. Is it meant to be a compliment when someone says "Yes, but you're one of the good ones"?

The way that Indigenous health is taught at the university has not helped with the stereotypical picture of who Aboriginal people are. Many times in discussion of Indigenous health, rates are compared to that of non-Indigenous Australians. For example, smoking rates are 2.5 times that of non-Indigenous Australians, life expectancy is 12-20 years less than that of non-Indigenous Australians, diabetes, rheumatic heart disease, otitis media, the list goes on. I am not saying that it is a bad thing for people to realise the devastating inequality in health outcomes for our Aboriginal and Torres Strait Islander people, but it creates a nasty stereotype and generalisation. Is every Indigenous person that comes into your clinic going to be riddled with diseases? How could any Aboriginal person possibly come out of this situation and make it in life as a doctor?

There are not many Aboriginal students in medicine or at university in general. There are significant challenges with being one of the first and leading the way to inspire others to do the same. I am actively involved in promoting Aboriginal and Torres Strait Islander recruitment by attending high school visits, mentoring, promoting the Australian Indigenous Doctors' Association (AIDA) and also Indigenous Allied Health Australia (IAHA). I also have a personal goal to encourage non-Indigenous students to become interested in Indigenous health, which can be difficult and frustrating at times. Though I love doing all these things and the support that I have is amazing, it still puts me at risk of becoming burnt out. I have to balance my culture and the things that inspire me, with succeeding academically so that I am able to finish my degree.

It is true that overall Aboriginal and Torres Strait Islander people have poorer outcomes in education and health. An increase in Aboriginal and Torres Strait Islander doctors improves health outcomes by providing culturally appropriate health care. However, an increase in Aboriginal and Torres Strait Islander students helps to breakdown stereotypes and can improve a cultural awareness for other students. These are only some of my experiences and challenges as an Aboriginal student. Other students may have different experiences, but by increasing recruitment and retaining more students these challenges and burdens for each student will hopefully decrease, load will be shared and will eventually just be the norm.

By Danielle Dries, a year 2 student at the ANU Medical School.

References are available on request from the Author.

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The co-payment and its forgotten goal

By Peter Bennett

Would you be willing to pay $7 for each visit to your local GP so that you had shorter waiting times?

Would you spend it in order to increase the quality of health care provision?

Is it worth spending it now to save imposing a burden on future generations with an increasing budget deficit?

The co-payment has seen so much media attention focussed on its negative aspects. But how often do we consider the benefits that it would provide? Much of the media coverage has argued that a GP co-payment is not the solution. The Australian Medical Association president Brian Owler warned that the Federal Government's budget's $7 co-payment will hit the "working poor" the hardest, while stretching the states' hospital funding will negatively affect "frontline clinical services". A report by Jennifer Doggett released in 2014 pointed out the following reasons for rejecting the co-payment:

- Decreased access to health care (proportional to the size of the co-payment)
- The greatest impact is on the elderly and low income earners

The same study reported a survey finding that consumers already experience difficulty affording health care. This means that they fail to access health care or delay seeking health care. The co-payment would increase this burden. Furthermore, the budget proposal recommends freezing GP rebates paid by Medicare unless they charge the co-payment. This is designed to encourage GPs to charge the co-payment to maintain their incomes.

The Bettering the Evaluation And Care of Health (BEACH) study has shown there is an increasing burden on GP services. Demand has increased due to increases in the prevalence of chronic diseases and the aging of the population. However there has been no solution to the challenge of demand for services growth that does not rely purely on government expenditure increasing to cover the costs of additional supply. This becomes an increasing issue with an ageing population as the relative tax pool decreases. Health care needs to be considered practically. Growing health expenditure with lower tax receipts can only result in increased government debt to be paid off by future generations. The proposed co-payment, although not perfect, offers a solution to the budget issue and provides some positive changes to the health system, which are too often overlooked in public media.

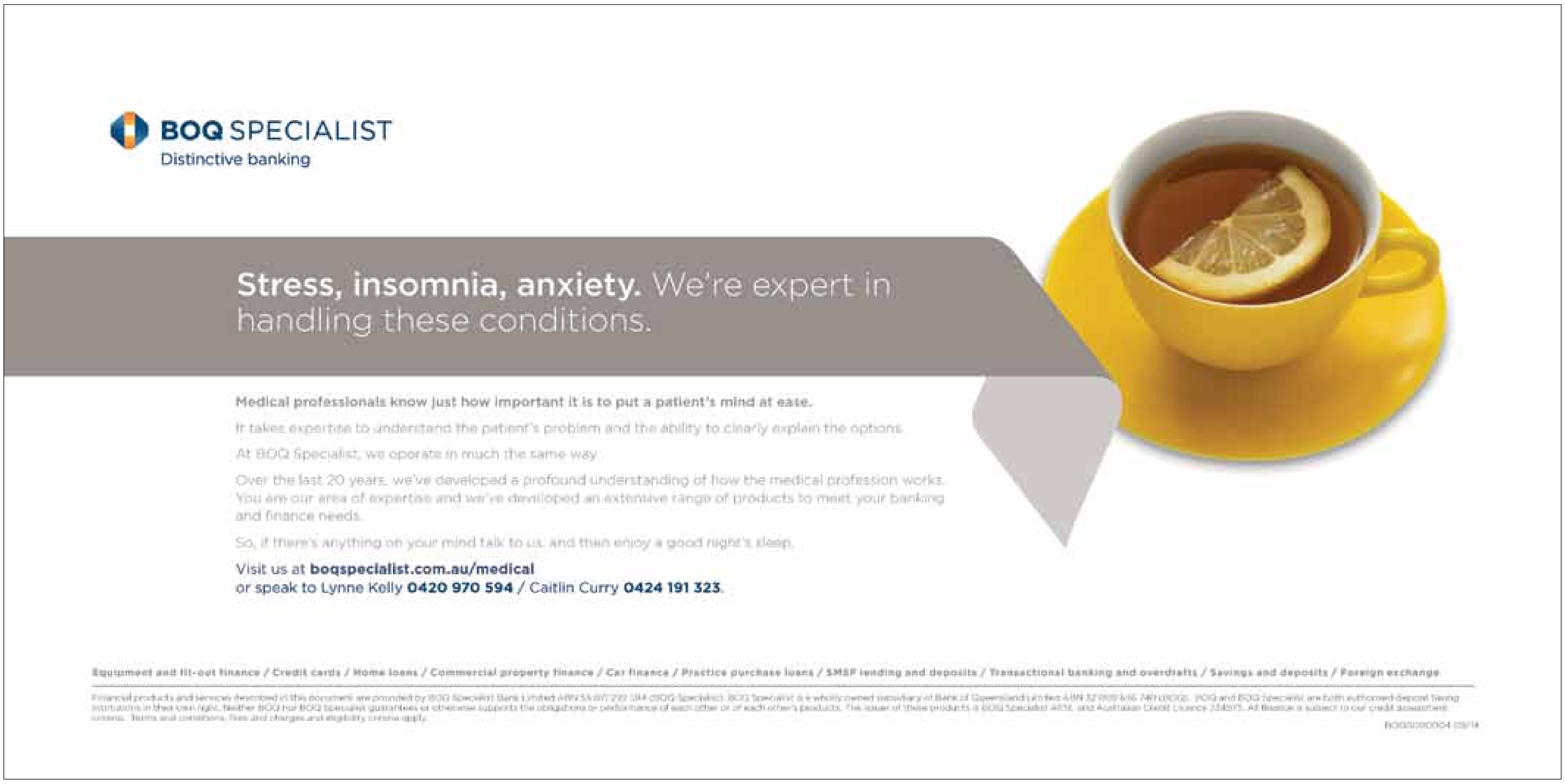
Let's consider the co-payment. It is a charge for a service rather a tax. The aim of the charge is to assist the funding of Medicare for which the government is currently funding through budget deficits. At the moment 25% of the demand on the health system comes from 4% of users, almost all of whom will be covered by the Medicare safety net. This means that their maximum excess over a year would be $70 given that the maximum number of times the co-payment can be charged is 10 per annum. This increased cost may appear large to the poorest in our community, however consider the potential for time saving and reduced hassles going to the GP with a decrease in demand. The additional $7 becomes less substantial in terms of real costs, as time spent working can be extended (for those on an hourly based income) due to less time wasted waiting for GPs. Furthermore the disincentive provided by the co-payment against going to the GP will mean consumers would have a new incentive to think twice about going to the GP with a minor complaint. They would look after their own health and, to avoid the co-payment, move to more healthy lifestyles.

The RAND Health Insurance Experiment (in the US) is the main source of evidence for the implementation of co-payments. This study ignored those over 65 years of age and those under 16 (arguably the most vulnerable age groups). Despite this it concluded that the demand reduction had "little or no measurable effect on health status for the average adult". In its defence, the RAND study admitted that those impacted the most were low income earners and those chronically ill, although in Australia this would be capped at $70 per annum. It did however conclude that those effects could be offset with a small cost. For instance a onetime blood pressure screen for low income adults achieved most of the gains that free care achieved. This study when applied to Australia's situation provides only a simplified view as Australia already has in place a complicated system of co-payments for things such as treatments and medicines, of which already provide a financial burden for those previously mentioned at risk of greatest impact.

The real issue about the proposed co-payment is how the vulnerable people can be protected from the financial burden that it will create on this minority of the population. So far there are no obvious solutions. One may be the exclusion of these people from the co-payment, or providing a 'means test' on the charge such that it becomes proportional to income. However the financial state of the health care system is such that there has to be a change. The idea behind the co-payment system is good however the implementation is too simplistic and the funds misdirected. It does not consider the complexity of the co-payment system that is already in place, and the funds raised are being put towards research where it should be fed directly back in to the Medicare system, for which it was designed to assist. For the vast majority of the population it will be beneficial. However the health system should not cater for the vast majority. It needs to cater for everybody. I support the idea of a charge for health services to assist the economic burden of the increasing health costs, however this co-payment has been misled and poorly instrumented. More thought must be put to protecting those who are at risk of increased financial burden.

Peter Bennett is a year 2 student at the ANU Medical School.

References available on request from the author.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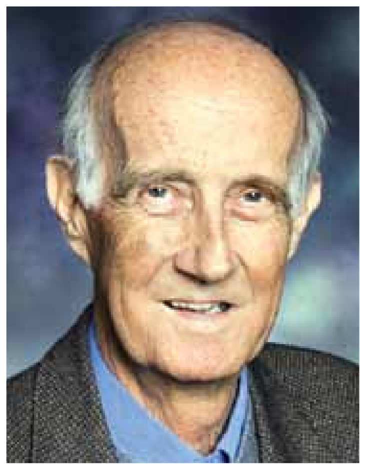
OBITUARY:
Anthony John McMichael AO, MB BS, PhD

Professor Anthony Mcmichael will be remembered as much for his warmth, generosity of spirit and dedication to his family as for his work in the fields of environmental epidemiology, public health and climate change science.



Professor McMichael, who died on 26 September 2014 at the age of 71 from complications related to influenza and pneumonia, was regarded as a leader of the pioneering generation of epidemiologists who brought the field to prominence in the 1970s and 1980s.

In his most recent publication for the MJA, Professor McMichael led a dozen prominent Australian medical practitioners and researchers as signatories to an open letter to the Prime Minister, urging action and inclusion on climate change (https://www.mja.com.au/journal/2014/201/5/open-letter-hon-tony-abbott-mp).

"I visited Tony in Canberra Hospital a week [before his death]", wrote Professor Stephen Leeder, Editor-in-Chief of the MJA (http://blogs.crikey.com.au/croakey/2014/09/27/paying-tribute-to-professor-tony-mcmichael-one-of-the-worlds-public-health-champions).

"We chatted about letters received at the MJA following publication of his (and colleagues') open letter … One letter suggested that we were scurrilous fascists and another Russian socialist lackeys. He found this entertaining."He was an active writer on environmental matters … the lines were clearly drawn for his outstanding career in environmental epidemiology and public health."

Professor Bruce Armstrong, currently working at the International Agency for Research on Cancer, said Professor McMichael was "a lovely, generous man".

"He had always been concerned with trying to have an influence and make a difference in the world", Professor Armstrong said. "I had the chance this year to work with him on a think tank on climate change and health. It was a wonderful opportunity to spend time with him, to see his influence on the people around him, and to experience the warmth and care of Tony."

Professor Bob Douglas, from the National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University, in delivering the eulogy, praised Professor McMichael's "nurturing of future leaders".

Professor McMichael worked at the University of North Carolina, the CSIRO Division of Human Nutrition, the University of Adelaide as Foundation Chair in Occupational and Environmental Health, the London School of Hygiene and Tropical Medicine, and the NCEPH as Director.

He was President of the Public Health Association of Australia in its early days, was a member of the National Better Health Commission, took a leading role in the Intergovernmental Panel on Climate Change and, with Professor Graham Vimpani, led research on lead poisoning that ultimately resulted in moves to lead-free petrol.

His 1993 book Planetary overload was considered groundbreaking.

"Tony drew together the threads of research across multiple disciplines, arguing that the human species now faced a new threat to its health and perhaps to its survival", Professor Douglas said.

Professor Colin Butler, one of Professor McMichael's closest colleagues over the past two decades, wrote: "If we are to survive as an advanced, wise and compassionate species, the work of people like Tony McMichael will increasingly be recognised as fundamental to the shift that we are engaged in" (http://globalchangemusings.blogspot.com.au/2014/09/aj-tony-mcmichael-champion-for.html).

His early mentor and supervisor Dr Basil Hetzel, first Chief of the CSIRO Division of Human Nutrition, wrote that throughout his distinguished career, "Tony was a very popular figure, readily available to colleagues, research students and the community".

Professor McMichael is survived by his wife Judith and two daughters, Celia and Anna.

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