VOL 11 - N 01 - JANUARY/FEBRUARY 2019

THE NSW doctor

THE OFFICIAL PUBLICATION OF THE AUSTRALIAN MEDICAL ASSOCIATION OF NSW

AMA NEW SOUTH WALES

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THE DIT EDITION

Solving unrostered overtime

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The Australian Medical Association (NSW) Limited
ACN 000 001 614
Street address
69 Christie Street
ST LEONARDS NSW 2065
Mailing address
PO Box 121, ST LEONARDS NSW 1590
Telephone **(02) 9439 8822**
Outside Sydney Telephone **1800 813 423**
Facsimile **(02) 9438 3760**
Outside Sydney Facsimile **1300 889 017**
Email **enquiries@amansw.com.au**
Website **www.amansw.com.au**
The NSW Doctor is the bi-monthly publication of the Australian Medical Association (NSW) Limited.

Printing by Immij Pty Ltd.

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Editor
Andrea Cornish
andrea.cornish@amansw.com.au

Designer
Gilly Bibb
gilly.bibb@amansw.com.au

Advertising enquiries
Andrea Cornish
andrea.cornish@amansw.com.au

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Cover: Dr Tahmina Lata, Deputy Co-Chair of The Alliance's Doctors-in-Training Committee

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TRANSFORMATION

A new year marks new beginnings and opportunities for change. Whether you're an intern starting your career, or a student learning to become a leader – you have the power to positively impact the health of our communities.

FIRSTLY – WELCOME TO A New Year, and welcome to our interns embarking on a new leg of the journey. There will be many memorable moments along the path, and the experiences will vary. But whatever comes your way, the association is here to be part of that journey.

Pivotal moments of transformation occur at many points in one's life – and I've had the pleasure of participating in a particularly impactful secondary school-based lifestyle and obesity prevention program called SALSA (Students As Life Style Activists). This is a peer-led education program where groups of Year 10 students lead classes of Year 8 students through a lifestyle optimisation curriculum during their PDHPE classes. It was developed in partnership between one local medical association, the public health unit of the WSLHD and Rooty Hill High School. It has subsequently expanded to 24 schools across Sydney. The evaluation results show 4-9% increases in consumption of recommended levels of fruit and vegetables, a 13% increase in physical activity, and a 6% reduction in sugary beverage consumption by the end of the program.

Its strength, however, lies not just in the results of the evaluation but the cultural changes across the schools. This is a program where university students from different schools ranging from public health to medicine, are educated as trainers. These trainers then travel to secondary schools to coach cohorts of Year 10 peer leaders, who then teach groups of Year 8 students. In time, those Year 8 students have become Year 10 students, and often peer leaders in their own right. The progression has continued for over 12 years and some of these students have completed the circle of coming back to be trainers of university students and leaders in their community.

Based on the social-ecological model, the program addresses multiple influences on behavioural change at multiple levels, harnessing the power of small groups and the strength of peer influence. In the SALSA program, student peer leaders enhance their leadership skills enabling them to influence cultural change within the school environment. The impact of these changes on the broader school community cannot be underestimated. The SALSA program has demonstrated the capacity to not only influence behaviour within the school, but also on the friends and families of students.

At the end of the year, the students are encouraged to identify and develop a local intervention to improve the health of the community. Suggestions have included measures such as adopting a local skate park and improving the appearance and family friendliness of the facility, as well as improving lighting in certain parts of the city. One year, program participants identified the disrepair of the carpark outside the local shopping centre as a barrier to healthy eating. Huge potholes in the carpark's surface were actually discouraging consumers from going to fresh food shops – especially where the fast food shops had clean and enticing carparks and exteriors. With support from their schools, and organisations such as the AMA, local councils were encouraged to remedy these defects, with each being a small step on the journey to creating an environment where it is easier to do the right thing.

Change starts with small steps and cultural change takes time. There is no end point but there is always a start. For many students at these schools, this was one of the points where they learnt they could make a difference.

To all new interns, and to all those who were once interns, the journey continues. dr.

President@amansw.com.au @KeansenglimLim www.facebook.com/amansw

Dr Kean-Seng Lim President, AMA (NSW)

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When one election is NOT NEARLY ENOUGH

The upcoming elections are important opportunities to make health a priority for both governments.

2019 LOOKS SET to be an interesting year in politics with a State and Federal election in the first half of 2019. The State election is, of course, fixed for Saturday 23 March 2019. The indications are that the Federal election will be held in May 2019, although as I write this column, there continues to be some media speculation about an early March election for the Federal Government. By the time you are reading this column, you will know one way or the other.

Despite the uncertainty about the timing, it is clear from the Victorian election and early polling that health will be a critical issue for both State and Federal politicians. As always, AMA (NSW) will be developing a comprehensive election policy to cover both the State and Federal campaigns. We see this as an important opportunity to call on both parties to put forward a vision for healthcare, not just a set of announcements and photo opportunities in front of hospitals.

Ongoing investment in health is key to the overall wellbeing and welfare of the community. We must continually strive for a system that is patient-centred, equitable, integrated and innovative.

Both State and Federal Governments have an opportunity to strategically invest in health at what is one of the most critical points in history – where the country's population growth intersects with an ageing demographic, that is increasingly at risk of chronic disease due to the prevalence of overweight and obesity. We must act now to adequately resource both preventive health and clinical treatment.

We will be calling on members to meet with State and Federal candidates in their local communities and to talk to them about what they want for their patients. We would like as many members as possible to take this opportunity because we know it makes a significant difference, both during the campaign and, more importantly, in the decision-making processes that come with whichever party wins government.

Our other priorities for 2019 will be to continue to inform patients about the true costs of healthcare and to support our members in their interactions with patients around fees. We have developed two resources - 'Why is there a gap?' and 'How much will it cost?' to help practices talk about fees, which you can find on our website at amansw.com.au. These can be provided to patients or used on practice websites.

We will build on these resources and develop further activities to support practices in 2019.

We look forward to a successful 2019 and appreciate your continued support. dr.

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Fiona Davies CEO, AMA (NSW)

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AMA NEW SOUTH WALES

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Northern Beaches Hospital VMO UPDATE

We have been working to address all of the issues raised before and after the opening of the NBH. AMA (NSW)'s Industrial Manager, Andrew Campbell explains...

QUITE A FEW CHANGES have happened at Northern Beaches Hospital (NBH) since the last issue of *The NSW Doctor.* In particular:

- NBH has an interim CEO in Mr Stephen Gameren;
- Healthscope Australia Chief Medical Officer Dr Victoria Atkinson is on the ground at Frenchs Forest to provide much needed medical leadership; and
- Senior Medical Staff have created an NBH Medical Staff Council (MSC) to complement the Medical Advisory Committee. (At the time of writing the second MSC meeting was about to take place.)

AMA (NSW) have noted a marked change in the engagement between Healthscope and stakeholders. Rolling weekly meetings have been taking place with representatives from Healthscope, AMA (NSW), ASMOF (NSW), Northern Sydney LHD, and the Ministry of Health. During the meetings, we discussed matters such as safety concerns, junior and senior medical workforce numbers, excessive workloads, night staffing, IT and communications issues, and the availability of policies and procedures. AMA (NSW) has attended a number of meetings with Junior Medical Staff to provide further context as to what is working at NBH and, more importantly, what needs to be fixed.

Recruitment is underway for a large number of JMO and Accredited Trainee positions, with some already accepting contracts for February 2019. This will provide welcome relief to all staff members who have worked tirelessly over the first few months ensuring optimal care for all patients in ED, theatres, wards and clinics. Junior doctors have, to date, reported that there has been no opportunity for education and training due to staffing levels, and the influx of additional staff should see to remedy this. AMA (NSW) is watching recruitment numbers closely and seeks feedback from members in real time.

Following continued lobbying by Physician VMOs, the ward-based model for General Medicine has been replaced with the desired team-based model, which has much more evenly distributed the workloads.

At the time of writing, AMA (NSW) was scheduled to host a Physician Dinner giving NBH Physician VMOs the opportunity to meet with AMA (NSW) President Dr Kean-Seng Lim and other Board members. The dinner is an opportunity for us to gain a clear picture of a patient's journey through the hospital, from ED to the wards, and a better understanding of areas to improve.

We encourage expressions of interest from other craft groups who may wish for us to hold a similar event for them.

A number of Public Patient clinics are now up and running, and AMA (NSW) is engaging with Healthscope to ensure that the payment method will not leave VMOs exposed to any 'double dipping' issues with Medicare. We encourage surgeons and other proceduralists performing consults in their private rooms to inform AMA (NSW) of how the arrangements are working.

Information sessions are scheduled to have taken place with the Healthscope CIO to ensure that any questions and concerns regarding the Electronic Medical Record and the Incident Management Systems have been addressed. Junior doctors reported problems with the communications devices issued and, hopefully, these will have been addressed by the time this edition is printed.

An external review of the operating theatres as supported by members of the Department of Anaesthesia is also scheduled to take place.

The Hospital received a fair amount of negative press in November and December 2018, in particular regarding safety concerns raised by doctors.

We can appreciate the overwhelming frustration borne from the perceived foreseeability of some of these issues. It is, however, important to note AMA (NSW)'s position that any safety or other concerns should be raised through the appropriate channels, whether that be through the IIMS notification system or via a head of department, hospital administrator, or MSC Chair. Should such channels fail to lead to a satisfactory outcome, AMA (NSW) would be comfortable to discuss additional pathways of escalation to appropriate audiences.

At the time of writing, AMA (NSW) is still working to resolve outstanding issues raised by members, including, but not limited to:

- Non-receipt of countersigned VMO contracts;
- Inability to submit monthly payment claims;
- Difficulties in transferring medical records from other NSLHD facilities;
- Inadequate consulting rooms and office accommodation for some specialties; and
- Delays in receiving imaging and other test results.

We trust that these outstanding issues will also be resolved in due course, and welcome feedback from both NBH VMOs and those following the story from other facilities who would like to ask any questions or offer their advice and support. dr.

HOSPITAL HEALTH CHECK 2018

The results are in from our second annual Hospital Health Check survey, which asked doctors-in-training to rate their workplaces. Did your hospital make the grade?

DOCTORS-IN-TRAINING gave three different hospitals a failing grade in reference to staff wellbeing or their management of rosters in this year's Hospital Health Check (HHC).

Westmead and Wollongong were both given Fs for wellbeing, and Canterbury received an F for overtime and rostering.

These are notable, not just because they are failing grades, but because they are the first Fs awarded by the HHC in NSW.

The wellbeing category includes questions relating to bullying, support for mental health issues, and reporting of inappropriate behaviour, while overtime and rostering deals with roster accuracy, overtime pay, and fatigue.

Each hospital was scored and graded in five categories with the results averaged to create an overall result.

While no hospital was given an F for its overall performance, three hospitals failed to rise above a D ranking, which is significant because the lowest overall grade last year was a C.

The hospitals awarded a D overall are: Blacktown and Mt Druitt, Canterbury, and Westmead.

The highest overall hospital grade given this year was a B.

This is the second year the AMA (NSW) / ASMOF (NSW) Alliance Doctors-in-Training Committee has conducted the HHC. It was encouraging to see an increase in respondents from year to

year, with 1351 doctors participating in 2018, compared with 1107 in 2017 – a testament to the growing awareness of the importance of this survey.

This represents more than a fifth of NSW's doctors-in-training workforce.

The increase in participation also allowed for 33 hospitals (or hospital groupings) to be graded this year, up from 26 in 2017.

Sixty-one per cent of respondents were female with 39% male, and the most well-represented hospital was John Hunter.

Comparing the results from the two surveys, there appeared to be a slide in performance in the wellbeing category from year to year.

About one-third of hospitals received a D in wellbeing in the 2017 survey compared with about two-thirds receiving a D or an F in 2018.

Additionally, four in 10 doctors-in-training reported experiencing bullying, and half said they had witnessed bullying of other staff.

And 62% of respondents said they thought there would be negative consequences for them if they reported inappropriate workplace behaviour.

These numbers were virtually the same as in the 2017 survey.

This is a disappointing result, considering the highly publicised attempts to reverse this trend by NSW Health since last year.

It was also interesting to note that there was a trend for the more senior doctors-in-training to more commonly report being bullied.

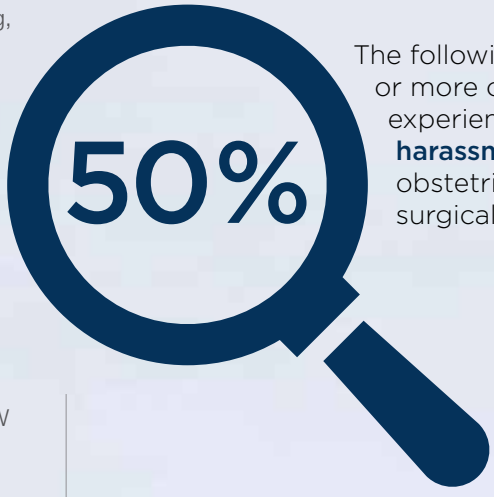
More than half of unaccredited specialty training registrar respondents reported being bullied in 2018 compared with just under a third of interns.

There were some improvements in terms of doctors-in-training reporting concerns over making clinical errors or about their personal safety due to fatigue.

That said, 65% of respondents this year were still worried about making clinical errors from fatigue due to hours worked and 60% had been concerned about their personal safety for the same reason.

1351 doctors-in-training responded to our 2018 HHC survey

75% or more of respondents at the following hospitals thought there would be negative consequences for reporting **inappropriate workplace behaviour**: Calvary Mater Newcastle, Nepean / Blue Mountains, Sutherland, and Wollongong



The following specialty training areas had 50% or more of respondents report they have experienced **bullying / discrimination / harassment** by staff: emergency medicine, obstetrics and gynaecology, psychiatry, and surgical training (sub specialty)

Intimidation, bullying, threats

from patients or staff left 50% or more of respondents at these hospitals feeling unsafe: Bankstown-Lidcombe, Blacktown / Mt Druitt, Canterbury, Lismore / Tweed, Sutherland

MORE THAN 50% of respondents at Belmont, Blacktown / Mt Druitt, Canterbury, and The Children's Hospital at Westmead said **none of their unrostered overtime was paid**

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In terms of the good news, the HHC awarded 12 As to hospitals in the remaining three categories: access to leave, education and training, and morale and culture.

The top three performing hospitals were: Wagga Wagga, Wyong, and Dubbo Base.

The best performing metropolitan hospital according to HHC 2018 was Royal North Shore, which ranked fourth overall.

Other hospitals to be awarded a B included Gosford, Mona Vale / Manly / Ryde, Orange and Bathurst, St George, Sutherland, and Tamworth.

Despite a downward trend on wellbeing, bullying was not what doctors-in-training reported as being their most urgent issue. The strongest demand from doctors-in-training was for payment of overtime.

Results from the survey reinforced what we already know about the gulf between overtime pay for surgical trainees and physician trainees.

Surgical trainees are much more likely to be paid for the overtime they work but even then, only 40% of them said they get paid for all of their unrostered overtime.

It should be noted, that this is much higher than the 16% of all doctors-in-training who said they got paid for all unrostered overtime.

The survey results also show that women are much less likely than men to even claim overtime (43% of women claimed no unrostered overtime worked compared with 33% of men).

Women are also more likely than men to not get paid for any overtime worked.

The second and third highest priority improvements requested by doctors-in-training are for more staff, and better and fairer rosters.

This is certainly reflected in the results for the overtime and rostering domain, with the three lowest-performing hospitals overall receiving a D or an F in this category.

While it narrowly escaped an F rating in overtime and rostering, Westmead respondents reported it had the rosters least likely to match the hours they were expected to be at work.

Of the bigger hospitals, Westmead and Liverpool also had the highest proportion of respondents working 25 hours or more of unrostered overtime a fortnight.

In terms of the access to leave category, nearly two-thirds of women who applied for maternity leave said their access to it was good or very good.

However, only about one-third of respondents said the same about access to paternity leave.

More than half of the doctors-in-training surveyed said they rarely or never take sick leave when they are too ill to be at work.

And touching on the morale and culture category, it was refreshing to note that more than 95% of respondents said they had not been asked any inappropriate or discriminatory questions in the interview process for their jobs at the hospital.

Additionally, there was only a small variation on the answer to this question when filtering the results by gender.

And while 899 respondents said they had never experienced discrimination from other hospital staff, 311 said they had been discriminated against based on gender, 142 on race, 34 on sexuality, 55 on marital status, 51 on pregnancy or being a carer, and 83 for other reasons.

This question allowed respondents to choose all categories that applied, so the numbers above do not add together to the total number of people who took the survey.

The HHC results in 2017 helped The Alliance guide its advocacy for doctors-in-training and achieve some great outcomes for them in the 12 months following their release.

We will be using the 2018 results to the same end and, as per the survey results, our number one aim is to improve rates of unrostered overtime pay for junior doctors.

However, clearly, there are many areas that need improvement and we will be working to improve life for doctors-in-training and their workplaces in a number of ways.

You can read the survey online at http://www.alliancensw.com.au/hospital-health-check-2018/. dr.

or more of respondents at the following hospitals said they had been **worried about their own safety due to fatigue:** Bankstown-Lidcombe, Belmont, Blacktown / Mt Druitt, Calvary Mater Newcastle, Campbelltown, Canterbury, Lismore / Tweed, Shoalhaven / Shellharbour / Milton-Ulladulla, and Westmead / Auburn

PARENTS-IN-TRAINING

Parenthood presents a unique set of challenges for medical professionals – particularly doctors-in-training. Dr Tessa Kennedy and Dr James Lawler share their experiences with their families about what is often seen as gendered-issue.

DR TESSA KENNEDY
AMA COUNCIL OF DOCTORS-IN-TRAINING CHAIR

THREE MONTHS AGO, I had my first baby, exactly four weeks after completing my general paediatric training. It's been simultaneously the most terrifying and awe-inspiring thing I've ever done, and very humbling for someone who thought they knew a thing or two about babies to feel completely at sea. (The first time he vomited out his nose I was packing the bag to bring him to ED for a clean catch urine, until a nonplussed grandmother brought me some perspective.)

It was perfect timing, they said – you're done! Except that finishing one program also marked starting another. Becoming FRACP is my gateway into paediatric intensive care advanced training, which kicks the can of consultant practice four to five years down the road. At least.

I have joked that I find myself turning down the opportunity to exit training at this juncture because I'm a masochist who has made poor life decisions. As colleagues would know, medical training is neither synonymous with flexibility nor thought of as terribly family-friendly. In addition, my Award wage is maxed out at Reg Year 4 and set to go down once I'm a Provisional Fellow. And further proof that I'm bent on self-punishment – I'm going from a generalist specialty that can be practiced almost anywhere, to a very narrow tertiary field in which "there are no jobs" (though this seems to be touted about every specialty but psychiatry at the moment).

On the contrary, to get here we made a series of carefully planned and calculated moves to meet training requirements, time conception, deliberations about when to do rural terms… I had sought to control as much as I could, even though on reflection it probably just made life more stressful.

The perennial question, "When is the best time to have kids?" is particularly vexing in the context of medical training and the subject of much debate among students and trainees alike trying to plan their personal and professional futures, which can be difficult to align.

It is increasingly anxiety-provoking because, with more postgraduate programs, the average age of medical graduates has increased, and with more medical graduates, the time – and in many cases, CV-buffing activities – required to get into vocational training has increased. As such, the possibility of sprinting to the finish line of fellowship before having kids can become a race against dwindling fertility and indeed stifle opportunities to get out there and meet a partner you want to have them with in the first place.

But then, opting to have kids during training also seems fraught, with rigid barrier exams at infrequent intervals; temporary employment contracts that may start or end awkwardly within a few days of a due date; the fact that most long daycare is made for people who work 8am till 5pm, not till 9pm, or from 8pm. Or a different kind of roster every three months with only two weeks' notice!

My carefully laid pregnancy plans nearly unravelled when my body threatened premature labour at 28 weeks and I was grounded from returning to my interstate rural term, four weeks shy of completion, with a fridge full of leftovers, my car and other belongings, not to mention a pile of unchecked clinic letters, left stranded. It was only the absolute magnanimity of my colleagues in both Sydney and Darwin and the General Paediatric team at the RACP granting me special consideration that meant I was lucky enough to complete my time close to home and a tertiary NICU, and before my contract allowing me to do so ended.

So, in the various tea rooms, social media forums and women in medicine events where this question is of perennial interest, I think the closest we get to a one-size-fits-all answer is that there is no good time or bad time – there is just your time. It would seem you're less likely to be disappointed with the outcome in either domain if you aim to consider them separately, acknowledging the inherent uncertainty of biology and the capacity of training to become more flexible than we might think or have let it be to date.

The reality is despite the most meticulous planning, it could take a while to fall pregnant. Even then 1 in 10 babies

Dr Tessa Kennedy, with husband Alex and son, Soren

is born prematurely, and even then my main parenting take-away thus far is to expect the unexpected – as soon as you think you've got this tiny human figured out they go and change it up again.

It's interesting though that while male and female trainees become parents at similar rates, this question of timing so often asked by female trainees doesn't seem to be asked by the men. It would seem they don't have to, because our current systems conflate the biologically imperative differences between our parenting roles with ageing societal expectations. I get it that I'm the only one in my house who has the equipment to give birth and breastfeed, but I'm calling it: everything else is fair game.

The NSW Hospital Health Check survey gathered insights from 1351 doctors-in-training in mid-2018. In the last 12 months, 8% female and 6% of male trainees reported that they had applied for flexible work (such as part time or other arrangements), though women were slightly more likely to be successful in their application. However, a further 58% of female and 35% of male trainees would consider doing so in the future. Our workforce is ready to change, but are our systems?

Frankly, the time for debate has come and gone – flexible work and equal participation is the new reality, and our systems need to adapt. It's critical to provide any semblance of work-life balance and mitigate the epidemic of burnout among doctors at all levels.

Now, I'm obviously only three months into this parenting gig so please forgive the n=1 anecdata, especially when I haven't even returned to work. I don't pretend to have all the answers. But from my collated vicarious experience through advocacy roles and many one-handed midnight hours learning from the 'wise hive' of medical mums and mums to be, there are some things I'd hope we can do to make the very personal decision to have children more compatible with our professional obligations.

We need to advocate to make parental leave more equitable and making flexible work options far more accessible for every trainee, removing outdated gendered assumptions and acknowledging that childbearing and rearing are not just an unavoidable reality in the lives of doctors-in-training, but deserve the time to be done properly. Conferences should have parents' rooms for feeding and changing to allow participation without disrupting everyone else, hospitals need to have after-hours childcare, and every training post should be available part time – only 20% of 1351 trainees didn't believe their current role or specialty training should be able to be undertaken less than full time.

I recently chaired a two-day face-to-face meeting of our AMA Council of Doctors-in-Training with a 10-week-old breastfed baby and presented twice at an interstate conference shortly after. From my partner and mother who travelled with us and entertained him between feeds, to my deputy chairs who directed the flow of conversation when I was directing the flow of milk; it took a village. But it was eminently possible, we just had to believe it. dr.

DR JAMES LAWLER
CO-CHAIR, AMA (NSW) / ASMOF (NSW) ALLIANCE DOCTORS-IN-TRAINING COMMITTEE

TWO YEARS AGO, my partner Elise and I made a bet.

At the time, Elise was in the penultimate year of her medical degree, while I was completing my internship.

Together, we had a vague plan for our future: finish medical school; finish our training; buy a house; have children. Neither of us are traditional enough to feel that those events needed to be in any particular order. But certainly our belief was, and the zeitgeist amongst junior doctors is, that the earliest we would consider having children would be after some or all of our training was done.

I had felt for some time we were ready to start our family, and Elise and I lamented our inability to do so before finishing training. But one day, Elise came home (as she tells it, having seen a particularly cute baby that day in Campbelltown paediatrician Andrew McDonald's clinic) looked at me and said, "We can do this."

At first, we spoke about it as an abstract concept, but we quickly realised there was little stopping us. Despite the dogma amongst my peers, I have never spoken to a senior doctor who said that waiting until after medical training is necessarily the best time to have kids. It may seem like there is no time in a training program to have children, but nor is it ideal to take time off after you've received your letters, when you want to be establishing yourself. After talking it through, we agreed to start a family.

Elise and I saw no reason for our contributions to raising children and managing a home to be unequal. We both grew up in regional areas, spent two years doing other things before entering undergraduate medical degrees – we even each spent a term as President of the Australian Medical Students' Association. Our lives have taken remarkably similar paths. An age gap of a few years is really the only differentiating factor in our career progression thus far, and we both have dreams and ambitions for the future.

However, an expectation of domestic equality isn't the norm for Australian heterosexual couples, as I learned when I read Annabelle Crabb's book The Wife Drought on Elise's recommendation. One of Crabb's main theses is that both

men and women nowadays often lack a "wife" to perform domestic duties at home since both partners are often working outside the home. Despite this, domestic and childcare duties still tend to fall to women. Crabb points to data from to the Australian Bureau of Statistics which shows that 76% of full-time working fathers have a spouse who is either not employed or working part time; however, only 16% of full-time working mothers are supported in the same way. On average, women are doing more housework per week than their husbands (regardless of each person's hours of paid employment), and as more children are added to the family, men do even less housework. The reasons for this may be that as more children are born, gender norms become more enshrined, or perhaps that the male "breadwinner" increases his time at work since there are more mouths to feed and (perhaps ironically) that his wife is no longer making as much income as before. Many of these factors won't change overnight in Australia. But they weren't acceptable to us, so Elise and I have tried to split our domestic responsibilities as evenly as possible.

However, one of the obvious structural barriers which entrenches gender inequality in the workplace and the home is how we allocate parental leave to men and women. Lo and behold when I searched my entitlements under the NSW Health Award, I found that whilst mothers (appropriately) are entitled to 14 weeks paid maternity leave, fathers are only entitled to one.

Knowing that Elise alone takes on the responsibility of pregnancy and childbirth, I would never suggest that I 'deserve' the same amount of leave as her after a child is born. However, Elise deserves an equal partner in the first weeks of parenting, and our children deserve a father equally present in the first months of their life. Placing so little societal value on a father's time with their newborn child only entrenches existing gender norms; if dad has no other way of making an income, he is likely to quickly return to work while

mum stays at home caring for the baby, often assuming additional responsibility for domestic tasks as well.

This is actually one of Ms Crabb's other propositions – that whilst many things have changed over the last century for women in terms of their rights and, in particular, how they access employment, very little has changed for men, which overall continues to enshrine stereotypes for both genders. Men are generally embarrassed to, or ridiculed for, working part-time in order to care for their children, and when they do ask for these arrangements they are often turned down. The NSW Health Public Medical Officers Award is a perfect example – if men are worth 1/14th of the value of their wives at home following the birth of their child, and are compelled to return to the workplace as a consequence, the system continues to compel women to assume the primary parenting role. Thankfully, NSW Health committed to working toward ensuring "equity in approach" around parental leave as part of the JMO Wellbeing and Support plan, and the work towards this goal so far has been positive.

> *"Whilst many things have changed over the last century for women in terms of their rights and in particular how they access employment, very little has changed for men, which overall continues to enshrine stereotypes for both genders."*

So the bet that Elise and I made was that we might be able to have our cake and eat it too – that we could maintain our aspirations but also work together to raise a family. It has been the best decision we have ever made; we were grateful to welcome a beautiful, healthy daughter into our lives in March of this year. I took my one week of paid paternity leave, strung it together with a run of nights and some annual leave and ADOs, and was lucky to have a workplace that supported me to do so. Elise has taken this whole year off from her studies – time I have committed to paying back to her one day, so she can reach her goals. I want my daughter to grow up to be proud of her amazing mother and all of the things she achieves throughout her career. And I'm looking forward to spending more time with my incredible daughter too. dr.

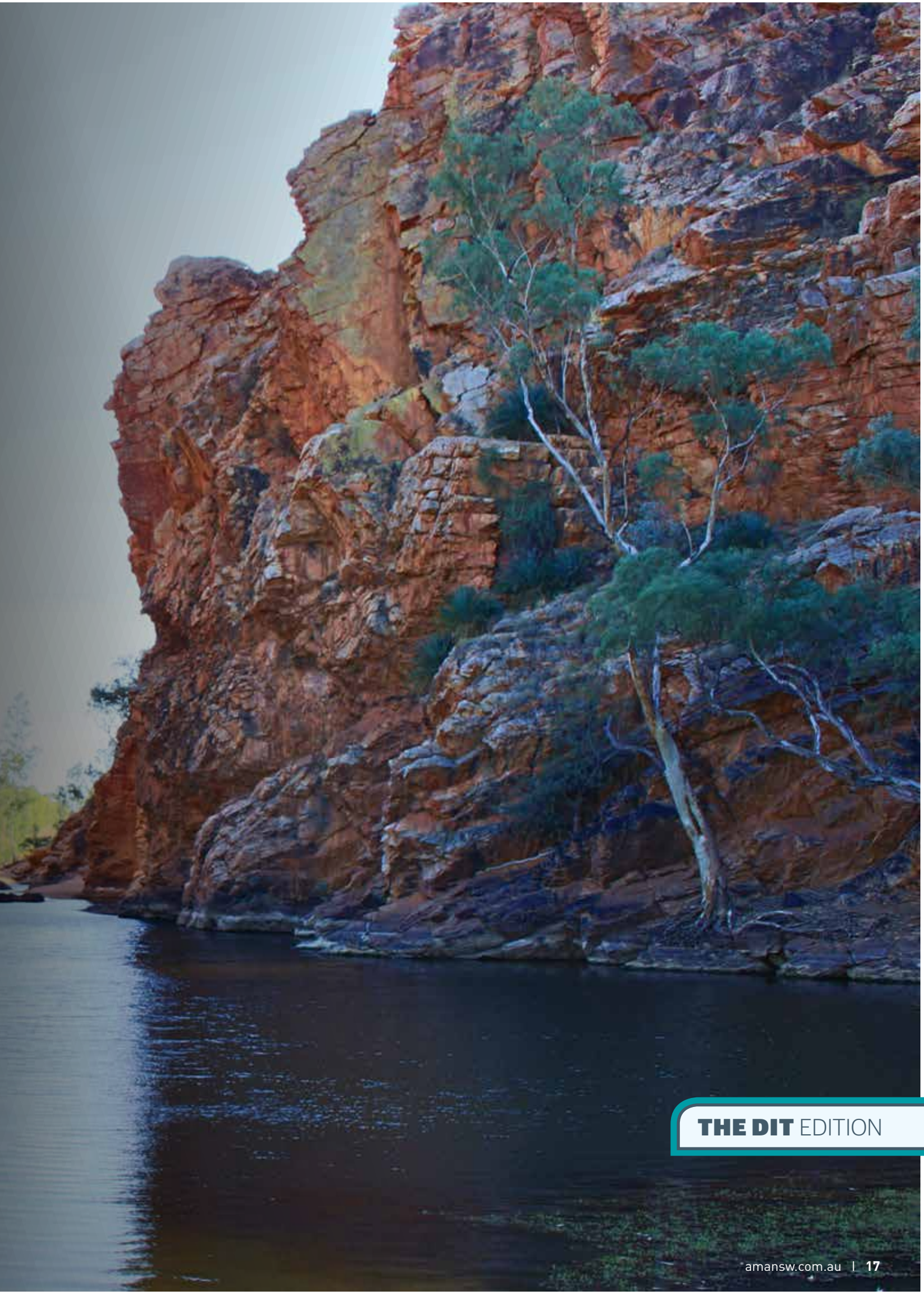
ACKNOWLEDGING Makarrata

Working in Alice Springs didn't give Dr Eliza Milliken all the answers to improving Indigenous health. It did, however, force her to ask some hard questions about the limits of a medical system that fails to acknowledge the impact of history.

ALICE SPRINGS is a town gated by a split of red rocks bisecting the West MacDonnell Ranges called "The Gap". Driving into town, the first thing that strikes you is that it's more beautiful than expected. The name "Red Centre" doesn't prepare you for the green-and-silver of the spinifex and the stark white and warm yellow of the ochre. In the morning, the mountains are rose-gold to compliment the rose-coloured sky. Around town you can watch birds of prey ride heated updrafts, and on the highway eagles as big as dogs refuse to move for approaching cars, protecting their lunch of broken kangaroo bodies. In the Desert Park out of town, functionally extinct species, such as the kitten-sized mala, live in tiny surviving colonies within the walls of their marsupial utopia, protected from the feral cats, camels and hunters.

Writing about working in the Northern Territory (or "The Territory" as locals call it) seemed liked a good idea during our week-long road trip in a rusty Subaru from Sydney to Alice. The basic concept: report back with some on-the-ground learning about bridging cultural divides to help doctors who see First Nations patients in the minority. However, driving North I remained under the illusion that we are unified in the goal of addressing inequality between First Nations people and new Australians. Malcolm Turnbull's rejection of the Uluru Statement of the Heart shows that we are not. This, and the fact that I realised that a suburban white girl has no real credentials to speak on the experience of First Nations Australians, made me worried I shouldn't comment. There are plenty of better informed First Nations doctors (and patients) who could say more useful things than I can and I don't want to suggest I have authority or speak for the experience of others.

Nevertheless, there are some good arguments for white-fellas (and white doctors especially) speaking up about the health of First Nations Australians. Firstly, the negative, racist responses my husband and I frequently received when telling people, white-like-me people, that we were doctors in Alice made me think that a little bit of dissent, even from a silver-spoon suburbanite, doesn't hurt. For example, the well-dressed older lady who informed me at a party that treating harmful alcohol use in Indigenous communities was "a waste of time because those people have traits", while in the next minute joking that I would need a crate of shiraz "smuggled in" into the dry town. A NSW-based farmer unleashed a string of racial slurs at us just hearing the words Alice Springs. Even a locum consultant in the town itself mumbled "well just think about where Aboriginal people would be if we white people hadn't come!" I was too taken aback to even reply – this, after all, was a person being exceedingly well renumerated with taxpayer dollars to care for Aboriginal patients. More pressingly, non-Aboriginal Australian doctors have an imperative to publicly reject the phenomenon historians call 'The Great Australian Silence'; a term denoting the refusal of British-descended Australia to acknowledge the reality of how this Nation was formed. At present, two opposing narratives exist. The term 'Frontier Wars' is used by historians to describe the violent ingress of European colonisers into this continent. Using primary sources, this narrative tells of the officially-sanctioned massacres, racist policies, and the Stolen Generation. There is another narrative, dubbed 'The Silence', which is a glib but often stringent dismissal of Australia's violent history – along the lines of John Howard's description of Australia as "formed without strife of warfare". This may seem irrelevant to the provision of individual patient care but it's not. This thinking, and the narrative that gets accepted by those in charge of research dollars and access to healthcare, informs the way we provide care at every level. The Great Silence underpins health inequality between First Nations Australians and new Australians.



THE DIT EDITION

THE DIT EDITION

Therefore, we must not be silent.

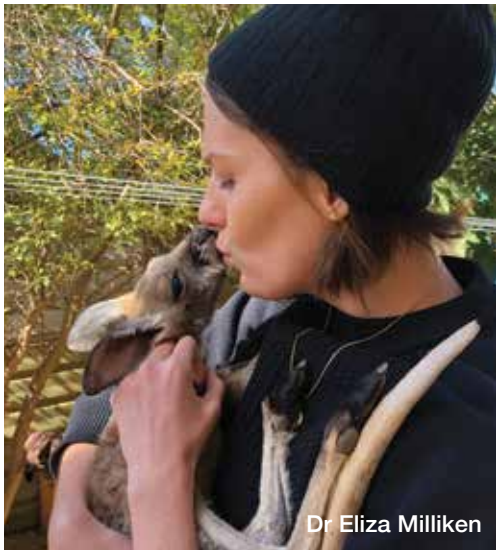
Despite breathless reports from some media outlets, racial tension is not an everyday reality, and Alice is not a tinder box waiting to ignite. It's a very pleasant place to wander around, get a nice coffee and visit the art galleries and the Megafauna Museum. Even better, to buy some art off the street from local artists. It would be wilfully ignorant to pretend racial tensions do not exist at all. Growing up in the beach suburbs of Northern Sydney you can live under the illusion that colonialism is a completed – rather than dynamic – process; but that's impossible in Central Australia. Official census data puts the Aboriginal population in town at under 50%, but most people living in and around Alice are First Nations Australians. This discrepancy comes from the fact that in addition to the Arrernte peoples who have lived in the centre for some 35 millenia, visitors from surrounding areas such Walpiri and Anangu travel to Alice for business and leisure, thus the population regularly expands and contracts. Despite the non-Aboriginal population having only been present for some 80 years, there is, for the most part, a huge inequality in the way the two groups live. First Nations people often reside in town-camps which can be poverty stricken, lack running water and electricity, and may become violent at night. Visitors to town often sleep on the dry Todd River bed and hypothermia is common in winter. Vandalism, a predictable form of civil disobedience, is commonplace. Long-term white inhabitants tend to refer to "Problems In Town" with a capital 'P' the way people in Ireland talk about "The Troubles", and with a lot less self-reflection.

Arriving in Alice, I was mostly ignorant to the healthcare needs of First Nations people. This shouldn't really have been the case considering medical schools have programs to ensure medical trainees get something of a clue before being unleashed on patients. Unfortunately, the teaching still isn't sufficient for adequate cultural understanding. For example, the NSW Health 'Indigenous Health' module (in my memory) required clicking through cartoons of Aboriginal people with hypothetical presentations. In one scenario an elderly woman presented "complaining of bilateral arm tingling", the eventual punchline; "you've missed a stroke!" It was unclear whether you were supposed to have missed a veiled presentation, or whether the well-meaning program designer thought this was a typical stroke presentation. Either way it sure didn't help me much the first time I did treat a stroke in Alice (end of bed hemiparesis – too bad the hospital isn't supported for thrombolysis or thrombectomy). Another hypothetical training case featured a woman wanting a bed towards the back of the ward to see the view outside. In the next scenario, the same patient is given the bed at the back but worries she's being put out of sight as a form of segregation. There was no right answer and in all fairness that's probably the only thing we can all agree on. With only this kind of training to go on I realised I had better upskill quickly.

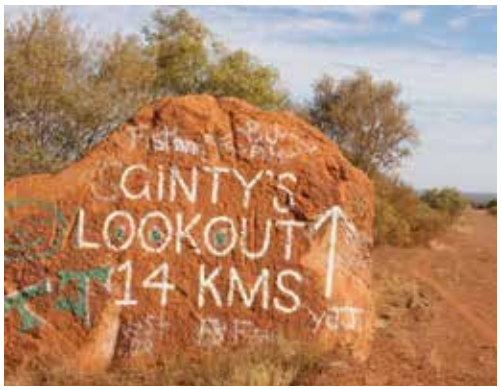
> *Working in Alice made me question how much we can really trust any decision we make as clinicians to be objective rather than cultural.*

Like everyone, I've been aware of the data about diabetes, hypertension, renal disease and alcohol-dependence in remote communities since medical school. Things I didn't know arriving in NT – my patients wouldn't speak English (as I'd been taught by media that First Nations languages were all dead or dying). I didn't know what a Ngankari (central desert healer) was, or the central role of singing to illness and healing. I knew the Government did not recognise Aboriginal people as full citizens with voting rights until 1967, but I didn't know that the last government-sanctioned massacre was only 41 years earlier in 1928 when 17 people from three different Nation groups were murdered near the Coniston Cattle Station. In fact, this was the last massacre considered to have occurred legally, but the killing didn't stop with the suspension of official state endorsement. The health impact of these historically-recent atrocities is not only intergenerational trauma (something I also learned when I got to Alice is an epigenetic, not a cultural concept), there is other sequelae too. For example, a place where one's family were massacred may become forbidden for descendants. Seeing a forbidden place may induce an illness that needs to be endured as punishment rather than treated. Cultural practices are often easily dismissed as "non-compliance". In the most fundamental sense, how likely is it that the same authority that less than a century ago sanctioned mass murder now accurately determines what is in the best interests of the next two generations? The Stolen Generation is the obvious example of why we as doctors should always be cautious of official policies claiming knowledge of "what's best" for people who had no say in the policies that affect, or more correctly, afflict them. Medical curriculums need to go further than population data and introduce notions of intergenerational trauma, the history of the Frontier Wars, and I would suggest The Names of Places; a multimedia map developed at The University of Newcastle, showing places and dates where First Nations massacres occurred.

This is not to say that progress towards health equality has not been made. Any consultant who has been in



Dr Eliza Milliken



Alice long-term will tell you about the Bad Old Days. There was the time of the "Rivers of Blood" when the bottle-o sold a cheap fortified wine that turned normal vomitus blood-red and indistinguishable from exsanguination. The floors of the emergency department "ran blood-red every night" and it was impossible to keep up with who needed a transfusion and scope and who was just pissed, or so the myth goes. The wine was eventually banned. There was also "Todd River Syndrome" or "Todd River Triad" which, depending on who you spoke to, involves a severe burn from falling forwards into a camp fire, a blunt force trauma from a closed fist punch and a GCS of three. The trick? Differentiating who needed urgent neurosurgical input and who was merely intoxicated, with no radiology available overnight. Anecdotally, this presentation lessened with stricter alcohol laws. By the same token, storytellers told me that the Territory Government suppressed the publication of data about patient outcomes to avoid bad publicity for the 2007 Northern Territory Intervention and that it had a negative impact on remote communities – an opinion supported by the Australian Indigenous Doctors Association 2010 Intervention Health Impact Assessment.

It's not white Australia that has been doing the hard work to push forward the Nation. In 2017, The Uluru Statement from the Heart called not for a massive redistribution of land or wealth, but simply a spirit of "truth telling" as a way forwards. Makarrata is a Yolngu word describing a complex multi-layered concept of conflict resolution, peacemaking and justice. It is derived from a ceremonial practice that seeks to even the scales when one party has committed a misdeed. The Uluru Statement suggested a Makarrata Commission to guide policy affecting First Nations people at the Federal level and guide progress towards a treaty, as Australia remains the only Commonwealth country without one. Unfortunately, this gave Malcolm Turnbull his excuse for an out-of-hand dismissal through the specious claim that the Commission would create "two parliaments". Turnbull's flat "no", without compromise or negotiation, sent a clear message: Australians of European descent still feel superiority and entitlement over and above First Nations People.

I think now I'm supposed to neatly summarise what I "learned" from working in Alice Springs. Unfortunately, I have no neat summary. Our role as caregivers and healers is problematised by our position as the fingers at the end of the long-arm of the Government. Even First Nations doctors must work within a system that does not often recognise and prioritise the health needs of First Nations Australians and a culture that refutes the reality of The Frontier Wars. Working in Alice made me question how much we can really trust any decision we make as clinicians to be objective rather than cultural. In fact, it made me question my very identity as an Australian woman and my government-sanctioned job as someone who heals people. If the Government today won't listen to the voices that represent First Nations people, as the rejection of the Uluru Statement from the Heart suggests, it seems doubtful that modern Australia, including our medical culture is making sufficient effort to understand and provide for the health needs of First Nations people. The negative health impact of suppression and silencing is complex, but it is also very real. As doctors, we need to acknowledge the social and historical conditions that created the absence of health if we hope to be effective and treat the wounds inflicted and also to be a part of Makarrata. dr.

IMPOSTER PHENOMENON

Studies suggest that at least a third of doctors-in-training feel like a fraud at some point in their careers. Dr Caitlin Weston shares her advice for managing imposter syndrome.

MANY OF US know the feeling – that nagging suspicion that despite all the things you have "achieved" in your lifetime, it's really just been a combination of good timing, help from other people, a lowering of standards, people liking or taking pity on you, and/or your painstakingly maintained façade of competence.

Imposter phenomenon (IP; also called imposter syndrome) was first described in 1978 by psychologists studying a group of high-achieving women apparently incapable of internalising their achievements despite considerable success and accolades. Those suffering from IP also have remarkable capacity to internalise and ruminate upon failures, and believe that only through good luck and smooth talking have managed to create a very positive but very inaccurate impression of themselves.

Others may see the imposter as a highly capable achiever, and ask more

and more of them, hoping to encourage growth and knowing they will do a great job on any task set for them. The imposter, trying desperately to maintain the façade of easy perfection, may take on more and more responsibility, downplaying the time and effort required to maintain their incredibly high standards. Alternatively, imposters may hesitate to apply for new opportunities or to evaluate themselves positively for fear that they will be exposed as failures, neither of which is helpful to career advancement or development.

Beyond merely being an unpleasant experience, these patterns increase the imposter's risk of burnout, dissatisfaction, distress, anxiety and depression, and can lead to an intense desire to escape their responsibilities, self-sabotaging behaviours like procrastination, and withdrawal from those around them.

Of course, the self-doubt that leads to imposter syndrome isn't all bad. Second-guessing our decisions, particularly as training clinicians, makes us safer and can provide us with increased opportunities for learning. People who never experience feelings of self-doubt exist in a much more sinister state known as sociopathy.

Imposter phenomenon is common. It's not a permanent state, but it visits most of us from time to time throughout our careers and beyond. An awareness of when these thoughts are likely to strike can help us recognise them as just thoughts when they do.

A recent review of imposter phenomenon in academia states: "IP is more often seen in those with advanced degrees, those who have the traits of conscientiousness, achievement orientation, perfectionistic expectations, and people who work in highly competitive and stressful occupations."

It probably won't escape your notice that that description fits just about everyone in medicine. Many (but not all) studies suggest a preponderance for IP among women (who are often taught that modesty is a virtue), but men experience it at high rates too (despite cultural norms teaching them to suppress feelings suggestive of vulnerability). Meanwhile individuals who are in a minority group in their discipline are at higher risk regardless of whether the divide is based on race or gender (this may well stretch to other demographic divides too).

In terms of timing, we are likely to have more IP-like thoughts as we face new roles or challenges, and especially in our first jobs. If you are reading this on the eve of your internship, fear not! Although this year is probably your peak risk time for experiencing frequent imposter syndrome, you will not be alone. The vast majority of your peers will feel the same way at some point.

You've handled it before: the thoughts are probably familiar from your first weeks of medical school, or your first few clinical placements. They will likely return as you rotate between terms, and each time you're called to take a step up in responsibility: supervising your first medical students, awaiting your first night shift, if you pursue a specialty and have to step up to the role of registrar, fellow, junior consultant, winding down to retirement, even outside of medicine: for example, as a parent.

The years ahead will provide you with plenty of opportunities to learn how to recognise your brain's script for imposter syndrome, understand what is likely to trigger it for you, and figure out how you can best keep it in check at a healthy level rather than letting it dominate you.

Tips for Managing Imposter Syndrome: Connect, Reflect and Grow

CONNECT

Nurturing and maintaining trusting relationships with colleagues and friends is one of the best things you can do to combat imposter syndrome. You will realise that everyone feels like a fraud sometimes, even those who look as though they have breezed through their entire life feeling confident.

1. Find a "coach" and be disciplined about catching up regularly. Whether you choose a mentor, a peer, an executive coach or a therapist, it's important that you are able to trust them and be vulnerable with them. You need to establish this habit early to maintain it when things get tough: It's much harder to reach out for support when you already feel like a fraud.
2. Join in with any organised peer support or debriefing groups offered by your hospital (Balint groups, Schwartz rounds, RMOA peer support sessions, even some well-run M&M meetings). These are good opportunities to see that everyone in healthcare is human and we share a lot of common experiences. If there are no groups locally, you can join the "Tea & Empathy" international junior doctors' peer support group on Faceboook (includes the option to post anonymously) or join in the conversation on #MedTwitter (in both cases, be aware of local social media policies).
3. If you are in a marginalised group, particularly within your workplace or speciality, seek out and connect with

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people in a similar situation. There are peer groups for women in orthopaedics, International Medical Graduates, doctors with disabilities, medical mothers and any number of other groups. If you can't find one locally, #MedTwitter is a great place to find a supportive international community.
4. Develop opportunities for informal peer support by spending time inside or outside of work with your colleagues and other social supports.
5. Lead by example in showing empathy and courage if someone else appears to be struggling. "I feel the same way" is one of the most powerful things you can say to someone, particularly if you are their leader or their peer.

REFLECT

Cultivating insight and self-compassion will serve you better in your career and life than almost any skill set.

1. Learn to recognise your imposter syndrome script. If you catch yourself thinking "I'm the only one here who doesn't know what they're doing" or "my patients don't even realise they've drawn the short straw having me at the end of the bed" and recognise these as imposter thoughts – the congratulations, that's half the battle! Once you get good at recognising imposter thoughts, remind yourself that they are just thoughts, not objective truths. Challenging them takes practice, but a good place to start is by taking a deep breath and examining the thoughts with a spirit of detached curiosity. You'll find there's lots of evidence that the thoughts are untrue.
2. Develop an awareness of high risk times for your imposter script to start playing. It's likely to strike when you start a new job or rotation,or when you're feeling under the pump or like you've been thrown in the deep end. Prepare as much as you can with the orientation resources available to you, but be aware that these are times to examine your thoughts and connect with your coach.
3. Reflective practices like journaling can help you untangle what's going on and can help you develop technical and non-technical skills.
4. Learn about self-compassion and how to cultivate and nurture it. Imagine what a friend would say if you said your imposter thoughts out loud.
5. Play to your strengths. Research has shown that understanding your "signature strengths" of character and finding opportunities to use them increases your happiness, productivity and work satisfaction. It can also help you decide on the career path most likely to inspire you.

GROW

Cultivating a "growth mindset"– a fundamental belief that your abilities can be improved with effort and persistence – will enhance your capacity for learning and increase your ability to bounce back from adversity and failure. Many people suffering from imposter syndrome experience evaluation anxiety, but feedback, appraisal, assessments and applications are an inherent part of our training system.

1. Teach yourself to recognise the difference between good and bad feedback. This is the difference between helpful, formative, constructive feedback and feedback that doesn't facilitate your learning, development or growth. Helpful feedback will be realistic, timely, specific (ideally with examples), direct, and focused on actions and behaviours. Feedback that is futile, vague, or personal is at best unhelpful, and at worst unprofessional.
2. Set yourself some challenging goals and reward yourself for effort rather than achievement. Decide on some personal and professional goals that are focused on skill mastery rather than performance and others' perceptions. Make a specific plan of where, why and how, and reward yourself for sticking with the plan. This will help you to remember you are the boss of your own life (which is more than just medicine).
3. Seek opportunities to fail in a safe environment. Stretching yourself is the best way to learn, so seek out opportunities for supervision and feedback. When calling for help or advice in a clinical situation, challenge yourself to present your corridor thoughts and plan to your supervisor.
4. Learn to own your successes and embrace your failures. Try to accept appropriate compliments and useful positive feedback with a simple "thank-you" rather than attempting denial or deflection. Keep a file of achievements and positive feedback, but also pay attention to constructive criticism. Mistakes are lessons learned and a failed attempt only means you haven't got there yet.

If you are a medical student or junior doctor, you form a part of a new generation in medicine, one that is more open than ever to showing vulnerability and emotional intelligence. This is something that should be celebrated, nurtured and encouraged.

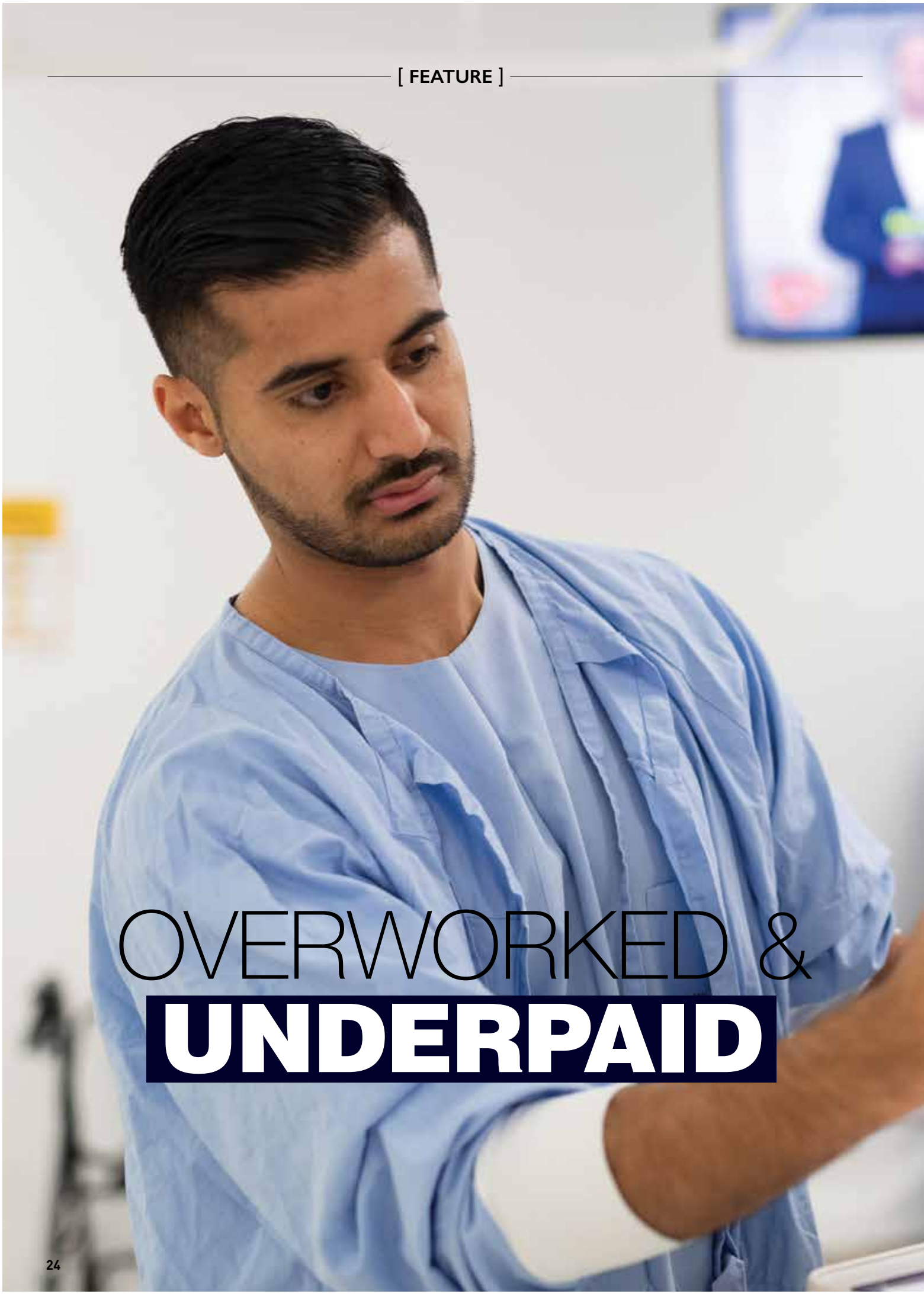
So let me tell you now that you are enough, that you are welcome here in the big wide world of medicine, that you have strengths that contribute to your patients and your team, and that you are not supposed to know everything. You are here to learn and will continue to do so for the rest of your life.

In turn, I hope that you will pass these concepts on to those who follow you as you make your way in the world. dr.

KEY REFERENCES AND RESOURCES:

- A recent review of imposter syndrome: Parkman, A. (2016). The imposter phenomenon in higher education: Incidence and impact. Journal of Higher Education Theory and Practice, 16(1), 51.
- Useful blog post on Organisational Psychology including articles on Imposter Syndrome and Growth Mindset, featuring adorable sketch-notes: https://halopsychology.com
- TED Talks: Brené Brown on vulnerability and shame and Amy Cuddy on Power Posing
- Headspace's free ten-day crash course on mindfulness and meditation, "Take 10" https://www.headspace.com/headspace-meditation-app
- Strengthsfinder: https://www.viacharacter.org/www/

Dr Caitlin Weston, CF
Non-Executive Director, Doctors Health Services Pty Ltd Wellbeing Project Lead at MedApps Pty Ltd AMA (NSW) Doctors-in-Training Committee



OVERWORKED & UNDERPAID

Are you clocking out on time? Probably not if you're anything like the doctors-in-training who answered our surveys. AMA (NSW)'s Victoria Patterson explains what the Alliance is doing to solve unrostered overtime.

THE ISSUE OF UNROSTERED overtime (UROT) is a recurring theme. More than 1100 doctors-in-training (DITs) participated in the 2017 Hospital Health Check (HHC) survey and the results demonstrated that it is unsurprisingly rare for respondents to work their 'standard' hours. The significance of this issue was further underscored during the JMO Safe Working Hours Workshop hosted by the Ministry of Health (MOH) in November 2017, where participants identified UROT as a contributing factor to unsafe working hours and poor mental health in JMOs.

The results from the 2018 HHC survey reveal that not much has changed.

Both surveys found that the top two reasons for respondents not claiming UROT was 'workplace cultural expectations' and/or their UROT 'generally doesn't fall under "approved" reasons'.

FACTORS THAT CONTRIBUTE TO JMOS NOT RECEIVING PAYMENT FOR UNROSTERED OVERTIME

1. **"Approved" overtime is narrowly defined in NSW Health policy and isn't consistent with the realities of the workplace.**
2. **The process for claiming overtime is extremely burdensome and arguably designed to dissuade.**
3. **Culture.**
4. **Insufficient funding of Hospital Departments. Top down pressure on budgets by executives and Ministry of Health.**
5. **Resourcing and increased pressures placed on the health system by expanding user base.**
6. **No process to accurately record hours.**
7. **Rostering practices.**
8. **Heavy emphasis on the individual advancing and claiming overtime. This exposes anyone 'speaking out'.**
9. **JMOs aren't always advised whether their overtime claim/s are accepted or denied. Also, particulars aren't given for denied claims.**
10. **Dispute process not effective (or at least perceived this way).**
11. **Fear of reprisal or victimisation.**
12. **Little repercussion for perpetrators of inappropriate conduct.**
13. **Other issues raised, like performance, if overtime is claimed.**
14. **Power imbalance between trainee and supervisor. JMOs are dependent on their seniors for career advancements, references etc. One bad word from any consultant is often enough to impede career progression, getting onto programs, or finishing training.**
15. **Job security – fixed term contracts.**
16. **Saturated employment market, ie. too many JMOs and not enough training positions.**
17. **The relevant Medical Colleges – adverse repercussions can occur via the College.**
18. **Requirements of training programs.**

THE DIT EDITION

The DIT Committee (DITC) resolved at the July 2018 meeting to form Industrial Working Groups (IWG) to investigate the main issues affecting DITS including UROT, Safe Working Hours and the JMO Award. The UROT Working Group had their inaugural meeting in September 2018. A robust discussion identified an exhaustive list of 18 factors that contribute to JMOs not receiving payment for unrostered overtime, including workplace culture, rostering practices, and insufficient funding of hospital departments, among other things.

These factors were grouped into three categories – policy, process and culture – to dissect the complex and multifaceted components of each factor and to identify which key stakeholders to engage to effect change.

POLICY

The UROT Working Group identified that the current Ministry of Health policy governing Employment Arrangements for Medical Officers in the NSW Public Health Service is inconsistent with clause 11 of the Public Hospital Medical Officers (State) Award 2018, which recognises the rights of JMOs to claim overtime for "All time worked by officers in excess of the ordinary hours specified in clause 6, Hours of Work".

Moreover, authorisation is automatically implied where the circumstances permit no other alternatives. This requires an analysis of every claim. Whilst there is support to expand the prescriptive 'pre-approved' list of reasons where unrostered overtime may be claimed without approval, it must be a non-exhaustive list.

The working group then identified that the Ministry of Health should aim to:

a.) Expand the list (which does not require prior approval) to include:

- Early/late ward rounds
- Completing outstanding/late discharge summaries
- Ongoing clinical care
- Excessive workload due to resourcing
- Staying back to finish duties due to education sessions

b.) Develop a comprehensive state wide UROT policy

c.) Assurance that all alleged misconduct will be investigated & dealt with appropriately

PROCESS

The UROT Working Group then identified the process for claiming UROT is onerous, complicated and excessive. They also acknowledged that anecdotal evidence from hospitals that have implemented expanded 'approver' lists has resulted in more UROT being claimed.

As a result, they decided the Ministry of Health should work towards getting approval from NUMs, registrars and other members of the relevant department to authorise overtime, as well as a commitment to implement electronic claiming across NSW Health.

CULTURE

The UROT Working Group also looked at the very real and historic issue of entrenched workplace cultural expectations within the hierarchies of hospitals from registrars up to senior staff specialists, JMO managers and even Heads of Departments that either implicitly or explicitly discourage and/or condemn JMOs claiming UROT.

To combat these entrenched workplace cultural expectations, it was decided doctors-in-training would develop a campaign targeted at Senior Doctors to identify champions that would be vocal in driving a 'cultural revolution' to actively encourage JMOs to claim their overtime.

In late September, the DITC were informed that the MOH – recognising the significance of the issue – were undertaking a review of both the policy directive and the claiming process itself.

Their preliminary findings / recommendations included:

1. A possible new / amended policy directive that can be implemented state-wide to standardise the process
2. The development of an eHealth portal to facilitate online claiming of UROT
3. Potentially expanding the criteria of reasons to claim UROT (although it was identified any list may be prohibitive and have unintended consequences)
4. Reviewing the need for departmental head approval (NUM approval, etc.)

The MOH advised that any proposed amendments to the current system will require consultation with JMO managers and workplace managers / hospital administrators. In addition, the MOH noted that any changes will require significant bolstering of auditing and monitoring practices in all sites throughout NSW. The MOH also acknowledged the entrenched cultural expectations impacting JMOs' willingness to claim UROT and agreed that the solution needs to include some element of enforceability at site level.

The Alliance wrote to the MOH in October, following a face-to-face meeting, asking the Ministry to agree to the proposed amendments to the current process as discussed at the meeting. These include:

1. A commitment to implement electronic claiming across NSW Health within a reasonable timeframe;
2. An expansion of the circumstances when a medical officer's UROT may be claimed without prior approval under Clause 9.2 of the NSW Health Employment Arrangements for Medical Officers in the NSW Public Health Service Policy Directive to include the following categories:
    a. Early/late ward rounds
    b. Completing outstanding/ discharge summaries
    c. Ongoing clinical care

   d. Excessive workload due to resourcing
   e. Staying back to finish duties due to education session
3. The ability to seek approval from registrars, nursing managers and other members of the relevant department
4. An assurance that all alleged misconduct will be investigated and dealt with appropriately where pressure is applied to a medical officer not to claim their Award entitlement
5. Further discussion to establish an appropriate dispute process for unrostered overtime

The MOH provided a draft package that included a revised Medical Officer Unrostered Overtime Form to be implemented across the State to address the variations in claiming forms to facilitate a more streamlined and consistent claiming process. The package also contained a draft with proposed changes to the policy directive to address the issues identified above.

Unfortunately, upon revision of the proposed changes, the Alliance did not believe the changes were sufficient enough to address the current factors impeding JMOs from claiming their UROT and by extension, effecting systemic change.

We will continue to work with the MOH to amend the current policy. dr.

2017 HHC SURVEY RESULTS

- **97% of respondents worked some amount of overtime**
- **47% worked more than 24 hours of overtime per fortnight; 46% of whom did not get paid for that overtime at all**
- **89% of respondents are paid less than the hours they accrue**
- **When asked about the reasons for not being paid, 589 people said that they didn't claim their UROT due to 'Workplace cultural expectations' and 559 said that it doesn't fall under 'Approved' reasons.**

2018 HHC SURVEY RESULTS

- **64% worked greater than 10 hours in addition to their rostered 80-hour fortnight with 6.7% of those respondents working in excess of 25 additional hours**
- **For those working UROT, 39.2% did not claim any compensation for those hours worked**
- **For those who did claim UROT, 51.42% reported that the entire amount was usually paid, and 17.22% responded that more than half of it was paid; which suggests that the failure in the system is the actual claiming versus hospital paying what is claimed**

THE JOURNEY THAT LIES AHEAD

On the cusp of starting internship, Dr Albert Vu takes a moment to reflect on life as a med student and the challenges in front of him.

Albert Vu
INTERN
WESTMEAD HOSPITAL

THEY SAY TO LEARN as much as you can while you are young since life becomes too busy later. To a final year medical student, that roughly translates to read Marshall and Ruedy's *On Call* while you can, since those patients discharge summaries aren't going to write themselves.

As one of over a thousand graduates looking forward to commencing internship in NSW this year, the last few weeks of 2018 offered a chance to reflect upon the journey of the past few years as a student. That journey has taken us from the lecture theatres and anatomy labs to the hospital wards and operating theatres. I think we all remember our first day on the wards as a student. For me, it was marked by mixed feelings of excitement, anticipation and privilege to see medical theory come to life which quickly made way for a sobering realisation of how much there was yet to learn. There will no doubt be a sense of déjà vu on the first day of internship – let's hope without breaking sterile field twice in one day.

For many of us, an integral part of that journey has been involvement with one of the countless student societies that colour university life. I was humbled to be elected to the executive body of the NSW Medical Students' Council (NSWMSC) as Treasurer. As medicine continues to grow, we are welcoming a broader range of students into the profession. My involvement with NSWMSC and other student societies gave me a chance to meet like-minded individuals. If I were to give one piece of advice to medical students starting out it would be to throw your hat in the ring and get involved in societies and causes that you are passionate about.

Despite medical schools increasingly shifting their attention to focus on workplace readiness, there will always be an element of the unknown when transitioning from being a student to a member of the workforce. As a future intern, I often worry that my inexperience will somehow let the team down. Worse still, what if my shortcomings are the cause for harm to patients? These doubts when it comes to workplace readiness are not unique to our profession. However, it is important to recognise that being asked to shoulder a high burden of responsibility with limited experience results in undue stress

The human consequences of our work make the predicament of a junior doctor unique and warrants appropriate support structures.

Internship represents an amazing opportunity if well managed. We are paid to learn and continue doing what we love whilst making a difference in people's lives. Our colleagues with whom we will be privileged to work alongside everyday embody vast amounts of knowledge and experience from which we can learn. Unfortunately, lived experience is often incongruent with this ideal, leading to junior doctors becoming disillusioned with their work and workplace. A supportive work environment can help realise this vision of internship as a program that prioritises the wellbeing of junior doctors and patients alike. Unlocking the full potential of new graduates will benefit both the hospital system and the young doctors that represent its future. It may be easy to forget, but every doctor was once an intern. That means everyone in our profession understands the demands placed on interns because at one point or another we were all here ourselves. That should be a comforting fact to all new interns; to know your colleagues and superiors have gone through the challenges that you face and that support is never far from hand.

As is often said, life will only get busier from here. Therefore, it is important for my colleagues to take stock and recognise how far we have come; to celebrate past victories and look forward to the journey that lies ahead. dr.

THE JMO AWARD: FIT FOR 2019?

Despite policy restrictions, the Alliance is working to create a safe and fair working environment for doctors-in-training.

Dr Sanjay Hettige
CO-CHAIR, AMA/ASMOF ALLIANCE DOCTORS-IN-TRAINING COMMITTEE

FOR THOSE OF US currently in unaccredited land, signing a new employment contract is an annual rite of passage for doctors-in-training in NSW. We see this as a formality that has to be carried out to continue our training, to make sure we have job security for another year. Few of us go through the contract line by line to read what we're signing and what terms of employment we're agreeing to.

For the vast majority, we're agreeing to the terms outlined in the Public Hospital (Medical Officers) Award, aka the JMO Award.

This document outlines our working conditions, how much we get paid, overtime and on call requirements, and leave allowances (including study leave). Unfortunately, it's also an outdated document, one that hasn't had major updates for around 30 years. It reflects employment practices of a past generation – not what we expect from a modern Award fit for 2019.

ASMOF (NSW) obtained industrial coverage of DITs in 2012 and through the AMA (NSW)/ASMOF (NSW) Alliance, started gathering information on what members saw as urgent changes that needed to be made to make the JMO Award fit for purpose. During this time, the NSW Government introduced a new wages policy which has severely restricted our ability modernise the JMO Award.

The changes in policy and regulation prohibit a public-sector organisation, such as the Ministry of Health, from changing conditions of employment which will increase salary-related costs by more than 2.5% without equivalent cost offsets.

This is a major barrier when you've got an Award that fails to create a safe and fair working environment for DITs. It's hard to trade-off employment benefits when you're coming off such a low base.

Adding to that, the independent arbiter – the Industrial Relations Commission of NSW – has its hands tied and is not allowed to change Awards or make orders which are inconsistent with this policy.

Though we have some major obstacles, the Alliance isn't giving up on getting the changes that DITs need to prosper in the workplace. We've identified these priority issues:

1) Unrostered overtime
2) Safe working hours
3) PGY 3 registrar issue
4) Remote on-call
5) Study leave provisions
6) Meal breaks

The industrial arena isn't the only avenue open to us and we've used advocacy tools such as the Hospital Health Check to start making gains on issues such as safe working hours and unrostered overtime. As a result of our advocacy, the Ministry of Health has recognised the need to make structural and cultural changes to create a safe working environment. We'll continue working with the Ministry in good faith to achieve these goals. While it's a start, we know we're still some way off achieving our ultimate goal and getting our Award up to a level that's comparable with other states in Australia.

The Doctors-in-Training Committee is committed to using local advocacy, political advocacy, the media and the industrial arena in tandem to come up with innovative ways to secure the changes we need in a time of a heavy-handed industrial relations framework. To carry on this momentum, we need to hear from all members on what other changes are needed or what local solutions may work on a state-wide level. Always feel free to get in touch with us via ditnsw@alliancensw.com.au, or come to the next Doctors-in-Training Committee meeting. dr.

A warm welcome to all of our NEW MEMBERS

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Dr Vanessa Lusink
Dr Victoria Grigor
Dr Vivek Arora
Dr Vivian Morian
Dr Wagdy Ashaia
Dr Wijaya Premaratne

The AMA (NSW) offers condolences to family and friends of those AMA members who have recently passed away.

Dr Henry Kellow
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WHAT DOCTORS ARE SAYING

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"Last year, I was successful in getting a position in Goulburn as Year 1 GP registrar. This year, I was successful in getting a job in Bowral. Thank you for your help with my interview preparations. I am more confident and calm during my interviews and I am enjoying the conversations." **GP Registrar Sydney**

AMA (NSW) Golf Society Calendar of Events 2019

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