

**21st PREVOCATIONAL MEDICAL EDUCATION FORUM
SPEECH BY HER EXCELLENCY
PROFESSOR THE HONOURABLE KATE WARNER AM
GOVERNOR OF TASMANIA
HOTEL GRAND CHANCELLOR
MONDAY 7 NOVEMBER 2016**

Good morning everyone and thank you for inviting me to open your 21st Prevocational Medical Education Forum.

I want to begin by paying my respects to the traditional and original owners of this land – to pay respect to those that have passed before us and to acknowledge today's Tasmanian Aboriginal community who are the custodians of this land.

I can see from your program that you have a diverse range of fascinating and stimulating topics to engage you throughout the course of your Forum.¹ Coming together over the next few days is a fantastic opportunity to not only hear the presentations being delivered, but also to meet and share your stories with others involved in medical training.

I must confess that I had to do some investigating to discover actually what prevocational medical education was, and have discovered that it embraces the first two years of postgraduate training after the basic medical qualification. And I also needed to google some of the topics in your program such as phlebotomy services to discover exactly that this is the surgical opening or puncture of a vein to take blood or introduce fluid, something I am sure I should have known!

So I guess prevocational medical education is the medical equivalent of articles of clerkship, the postgraduate training that I had to do before being admitted to legal practice. I well remember the sinking realisation when I started my articles that the law in the books had little to do with the law in action and that my legal education was just beginning!

¹<http://www.prevocationalforum2016.com/wp-content/uploads/2014/05/Draft-Program-12-October-2016.pdf>

My background as I have indicated is in law and it is often challenging when I am opening conferences in disciplines other than mine to say something that is relevant and neither boring nor superficial; to find an angle that has some relationship to the discipline. This is not always easy, and the other day at a conference for English teachers I resorted to starting with a grammar knock-knock joke. .. I did find a medical knock-knock joke, but it is so lame and predictable, I will spare you!

As Governor, I do not enjoy the same freedom of expression as other citizens, there are constraints and I can never, for example, speak publicly against government policy but I am free to speak about social issues provided I can do so in a way which is apolitical. Family violence is one of the issues I have chosen to speak about. In February this year I spoke at the opening of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists' Scientific meeting in Launceston, which was also attended by midwives. I was asked to talk about the role of front-line health care services for vulnerable populations. I spoke of how pregnancy and the period following birth are a time of increased vulnerability to spousal violence and of the relationship between pre-natal spousal abuse and post-natal trauma symptoms in a child. I made the suggestion that public hospitals in particular consider using a family violence screening device and perhaps routine screening together with introducing training for such screening and I referred to some research on the use of these tools.

A couple of months later, when we visited the Launceston General Hospital I heard that the midwives were looking into using a family violence screening tool after hearing my presentation to the College of Obstetricians and Gynaecologists. I followed this up by sending them a report which I had launched on improving men's awareness of the effects of family violence on children, highlighting the section which makes recommendations in relation to 'front-line' health professionals and the need for them to have a greater awareness of the latest evidence of the harms to children of exposure to family and domestic violence.²

The same issue is also of relevance to this group. I understand from an article in the Medical Journal of Australia's *InSight* that there are plans to widely implement screening for domestic violence across hospital emergency

² Peter Lucas et al, *Increasing Men's Awareness of the Effect on Children Exposed to Family and Domestic Violence*, 2016 (Salvation Army and University of Tasmania)

departments and general practice.³ It appears that routine screening for domestic violence in health services differs from State to State and from service to service. In emergency departments it seems that it is not routine but it is done on an ad hoc basis in some centres.

Associate Professor Dr Diana Egerton-Warburton, chair of the Australasian College for Emergency Medicine's Public Health Committee, conducted a survey of 800 ED clinicians, who were asked about the development of domestic violence screening tools. She reports that doctors were keen on the idea of screening but they had concerns: some related to a lack of time and resources to screen, some said they lacked the training to screen, while others felt it was an issue that they were not comfortable raising with patients.

Professor Egerton-Warburton has said it is particularly important to encourage the regular use of a routine non-invasive screening question in women's hospitals, such as 'Do you feel safe at home?' She recommends that the question be asked three or four times during a patient's stay in hospital, as they may not be comfortable in disclosing the information straight away. She also said that domestic violence screening should not be restricted to emergency departments, but should be extended to general practices 'because GPs already have a relationship with the patient.'

Professor Angela Taft, director of the Judith Lumley Centre at La Trobe University's School of Nursing and Midwifery was also interviewed by the author of the *InSight* article. She cautioned that there is no evidence yet that screening improves the lives of women because the support systems are not in place. She cites a 2013 Cochrane Review of 11 trials (mostly North American) on some 13 thousand women which showed that while screening increased identification rates, the rates of referral to support agencies were low.⁴ However, Egerton-Warburton argues that the recent increased media coverage and public discussion of the issue of domestic violence indicates that it is increasingly less of a taboo subject and that the time is right to act and that Australia is 'on an international level ... very behind in developing screening methods.'⁵

³ Charlotte Mitchell, 'Violence screening "complex"' 35914) *InSight* 14 September 2015, <http://www.doctorportal.com.au/mjainsight/2015/35/violence-screening-complex/> accessed 2 November 2016.

⁴ Angela Taft et al, *Screening Women for Intimate Partner Violence in Health Care Settings*, 2013, <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007007.pub2/pdf>

⁵ Mitchell, n 3.

It is certainly true that more attention is being given to family violence in Australia and efforts are being made to increase and improve the resources to intervene by both government services and those funded by NGOs. For example I have recently been invited to a graduation ceremony for participants of A Family Violence Champions Program, which is an intensive 12-week family violence training program for mental health professionals which trained participants to become leaders in the development of more responsive and appropriate service interventions to meet the needs of victims of family violence. This event will also serve as the launch of a guide for mental health professionals to assist Australian mental health professionals effectively support those affected by family violence. Both are initiatives of SHE, Support, Help and Empowerment, a Tasmanian community organisation. SHE also provides an excellent online tool for medical practitioners, the *Medical Practitioner Toolkit*.⁶ This notes that it is estimated that full-time GPs are seeing up to five women each week who have experienced some form of intimate partner abuse (physical, sexual or emotional).⁷ It provides information on risk factors, screening questions, referrals, note-taking and photographing injuries, advice when the patient is the perpetrator and so on. Other states have similar toolkits, with State specific information.

I commend these resources to you.

The second issue I wish to touch on relates to rural medical practice. From your program I can see that there are a number of sessions that deal with rural practice and rural placements. Recently, after addressing a fundraising function for Rural Alive and Well (RAW), I have become aware that overall suicide rates in Australia are higher in rural areas, when compared to urban areas. Suicide rates among farmers increased in the 1990s and in rural areas have continued to increase – with youth, males and indigenous people most at risk.⁸

Male vulnerability to suicide in rural areas appears to be linked to the traditional stereotype of what it is to be a rural male. Men in the country are expected to be physically and emotionally tough and strong, able to solve any problem and confront any obstacle. It has been argued that the need these days for many males on the land to rely their wife or partner to bring in off-farm income to keep farming can have negative impacts on the male sense of self – they are no

⁶ Medical Practitioner Toolkit, 2015, <http://www.she.org.au/resources/>

⁷ Medical Practitioner Toolkit, n 7, p 1.

⁸ Kairi Kolves et al, *Suicide in Rural and Remote Areas of Australia*, Australian Institute for Suicide Research and Prevention, 2012, 9.

longer the breadwinner, even if in other respects they are continuing to conform to all of the ideals of the rural masculine paradigm. So rural men can become locked into a fairly rigid role, typified by a stoic resistance to adversity and a rugged individualism that prevents help-seeking behaviour.⁹

In addition to the vulnerabilities attached to the ideal of rural masculinity, there are suicide risk factors which research has found are more uniquely linked to farmers. Running a farm can be an unrelenting workload; stress is only further exacerbated when financial and living situations do not improve despite all of these continual efforts. And a farmer's perceived lack of control over factors so intrinsically linked to his success or failure, such as the weather, can make him feel powerless during times of rural crisis such as drought or flood.¹⁰

This is where Rural Alive and Well (RAW) comes into the picture. They help rural families with mental health issues when times are tough. Outreach workers provide information, support and strategies to help and links with relevant services to assist such as referrals for financial counselling. Their workers seek to get under that stoic individualism and help-seeking reluctance to encourage rural people to talk about their problems and seek help to address them. They don't provide counselling but merely serve as a mate to talk to and can point you in the right direction to seek help. Rural Alive and Well is an organisation that should be known to doctors working in rural communities.

I understand that other States are considering creating similar services modelled on Tasmania's RAW.

After such grim topics, perhaps I should end with a joke after all:

A phlebotomist at a hospital entered a patient's room to draw blood. Noticing an apple on his bedside table, she remarked, "An apple a day keeps the doctor away, right?"

"That's true," he agreed. "I haven't seen a doctor in three days."

And I now declare open your 21st National Forum on Prevocational Medical Education, *Back to the Future: The Old and New of Medical Education*.

Thank you.

⁹ Kolves et al, n 8, 11.

¹⁰ Kolves et al, n 8, 12.