CANBERRA Doctor

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ACT Health Minister meets with AMA (ACT) Board

The April meeting of the AMA (ACT) Board saw ACT Health Meegan Fitzharris, MLA, join the Board for dinner and a wide ranging discussion on the state of the ACT Health system. In addition to Board members, representatives from AMA (ACT)'s Council of Doctors in Training and the ANU Medical Students Society were able to join Minister Fitzharris and Prof Steve Robson, AMA (ACT) President and give their perspectives on local issues.

ACT Health Minister, Meegan Fitzharris and AMA (ACT) President, Prof Steve Robson, listen intently to the discussion over dinner.

A large part of the discussion was given over to primary care and the challenges faced by general practitioners in the ACT. This is a key issue for both AMA (ACT) and the ACT Government as without adequate access to high quality general practice for local patients, the ACT's public hospitals face an increasing burden.

Primary care

There's no doubt that access to after-hours care and avoiding unnecessary presentations to public hospital emergency departments is a priority for the ACT Government. From AMA (ACT)'s perspective, it's equally clear that nurse-led walk-in clinics are not the answer to this issue. Instead, a combination of measures needs to be put in place and incentives found for general practices to be opened longer hours and able to see patients on a 'walk in' basis.

The AMA (ACT) has proposed that funding from ACT Health be made available to general practices, on a competitive tender basis, for additional nursing resources to facilitate extended after-hours care on a 'walk-in' basis. AMA (ACT) has undertaken to provide further information to the Minister on this issue.

On a similar theme, there was also significant discussion about the quality of specialist referrals and then need to properly triage those referrals. Similarly, the timeliness and quality of discharge summaries was a point of discussion. Given AMA (ACT)'s earlier discussions with the Capital Health Network on these matters, the prospect of joining with ACT Health and the CHN to move forward would be very worthwhile.

Area of need

ACT Health's 'Area of Need' policy, that permits employers to employ practitioners who would not otherwise be registrable in Australia, under certain conditions, is due for review in 2017. This has become an increasingly important issue for AMA (ACT) and our concerns were set out for the Minister.

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Medical **Musings**

WITH PRESIDENT, PROFESSOR STEVE ROBSON

Making a meal of things

I am writing this month's MM column from San Diego, where the ACOG Annual Meeting is in progress. However, any thoughts of enjoying the famed Southern California weather are gone – it has been grey and gloomy.

Being in San Deigo means that I have been away from the Australian Federal Budget circus, but I spent a great deal of the evening, into the early hours here in the US, following things online.

Overall, the budget will be judged as a disappointment for General Practitioners, with rumours of an immediate end to the MBS freeze proving, well, insubstantial. Although there is a hint of improvement, with indexation to be applied from July for bulk billing incentives, this will represent a Government spend of less than $10 million.

It seems that rebates for General Practice standard consultations, and attendance item numbers for specialists, will increase in line with indexation from the middle of next year. While the change is welcome, the fact is that rebates to patients will fall in real terms for another year. Specialist procedural item numbers will only be indexed from mid-2019.

Pathology rents were also dealt with, with allocation of almost $20 million over the next few years for 'audit and compliance' programs to make sure that General Practices fall in line with legal requirements that payments above a certain threshold are not made. What effect this will have on General Practices is not clear.

There were also delays to the roll-out of the Health Care Homes initiative, with only 20 of the registered 200 practices to receive block funding in October, presumably as a trial, and the remainder waiting until December.

The MyHealth Record, which seems to me a total white elephant in its current format, will receive even more funding – almost $400 million. Let's hope it finally achieves something useful to patients and doctors.

While there were no new budget announcements in regard to funding for after-hours visits, the MBS review will shortly publish recommendations on the issue.

More on the budget in the next issue of Canberra Doctor.

AMA
(ACT) LIMITED

The President, Prof Stephen Robson
Invites you to dinner
to be held prior to the AGM
on
Wednesday 31 May 2017
High Courtyard South, Hotel Realm
18 National Circuit, Barton
at 6.30pm

Doctors in Training: $25
Other members: $50

RSVP essential by Monday 26 May to 6270 5410
or reception@ama-act.com.au

Politics for dinner

Locally, the AMA (ACT) Board meeting in April saw us hosting Health Minister, Meegan Fitzharris, for dinner and a broad ranging discussion on the state of our local health system. The Minister was extremely generous with her time and listened intently to the range of issues raised by Board members and the invited DIT and medical student representatives.

A key part of the discussion with Minister Fitzharris was the central role Canberra's General Practitioners play in patient care. Not only are GPs a cost efficient means of delivering care but patients with an ongoing relationship with their GP have been shown to experience better health outcomes.

Given these matters, we particularly wanted to talk to Minister Fitzharris about ways to, firstly, improve access to primary care in Canberra and secondly, support our hard working local GPs.

Primary care

In particular, we discussed after hours primary care and how GPs might be assisted to extend practice hours as a complement to Nurse–led Walk-in clinics. For example, additional nursing resources could be made available to existing GPs via a competitive tender process on the basis that extended after hours primary care services are provided on a "walk-in" basis.

The AMA (ACT) believes placing nurses in primary care team setting would beneficial to GPs, nurses and, importantly, patients.

In addition, ensuring an efficient system of referrals from GPs to specialists would assist medical practitioners in providing high quality patient care. Our experience demonstrates that improvements can be made in the referral system in terms of triage, clarity and content of referrals.

AMA (ACT) would like to see suitably qualified and experienced practitioner reviewing and triaging, or clarifying, referral letters from GPs to specialists at the Canberra Hospital and Calvary Hospital. This position can also be a contact point for urgent referrals.

ACT Health Minister, Meegan Fitzharris with AMA (ACT) President, Prof Steve Robson.

The Minister listened with some interest to these proposals.

Other issues

The other issues discussed during the evening included the new clinical services framework, the ACT psychiatry workforce, dermatology services and current issues with new ophthalmology contracts.

Finally, I'd like to sincerely thank Minister Fitzharris for taking the time to join the Board both for dinner and the discussion that followed.

Salaried doctors start negotiations

We've recently seen the start of the negotiations for a new salaried doctors' enterprise agreement and our Manager of Workplace Relations, Tony Chase and Hospital Organiser, Anish Prasad, in concert with our Doctors-in-Training (DIT) representatives, have done an outstanding job in developing a comprehensive set of claims for our junior doctors.

The negotiations look like being protracted – as these things seem to be here – but the Industrial team have put together a strong case for improved conditions for both junior doctors and their senior colleagues.

Canberra Liberals

Recently, AMA (ACT) CEO Peter Somerville and I met with Ms Vicki Dunne, Canberra Liberals' Shadow Health Spokesperson to provide a briefing and a broader discussion on issues relating to the health portfolio. While Vicki has a hard act to follow in Jeremy Hanson, she's rapidly coming to grips with the portfolio. I look forward to further, regular catchups.

Canberra Liberals Health Spokesperson, Vicki Dunne with AMA (ACT) President, Prof Steve Robson.

Bargaining kicks off for salaried Doctors

Since the results of AMA (ACT)'s enterprise bargaining survey were released in February, the AMA (ACT)'s Council of Doctors in Training developed a 'log of claims' that was subsequently presented to ACT Health. Last week, the log of claims formed part of AMA (ACT)'s presentation at the first bargaining meeting for the next enterprise agreement.

In addition to AMA (ACT), other bargaining representatives present at the negotiating meeting included ASMOF, several medical practitioners in person and a legal representative for a group of staff specialists.

AMA (ACT)'s log of claims

While our log of claims deals mainly with issues relevant to junior staff, the agreement itself will apply generally to medical practitioners employed by ACT Health. In brief, our claim covers annual leave, ADOs, overtime, rosters, training and, of course, a salary increase.

A more detailed outline of the log of claims appears later in this edition of the Canberra Doctor.

First bargaining meeting

The first meeting saw some interesting developments including the fact that ACT Health would like to see an agreement "in place" by October 2017. While this is encouraging, it will also be a challenge for all the parties to agree on the new terms, have the agreement voted up and then approved by the Fair Work Commission within the timeframe.

This is particularly so given that ACT Health has yet to present their claims and their expected

ACT Chief Minister and Treasurer, Andrew Barr.

timeframe for doing so is the end of May.

As ever, the issue of backpay is a controversial one with no further pay increases available under the current agreement that ends on 30 June 2017. We understand that the ACT Government's position is that if there is not an 'in principle' agreement before 1 July 2017, they will not backpay any government employee. Given the delay by ACT Health in presenting their claim, it's a little rich to be ruling a line under backpay at this point.

New section 'B' for DITs

AMA (ACT) has proposed that a new and separate section 'B' in the new agreement be created to contain items relevant to JMOs only. This would mean the structure of the new agreement would see the creation of a Section B for DITs and other junior staff, a core conditions section applicable to all doctors and a new Section 'A' for Staff Specialists.

AMA (ACT) is seeking to simplify the current agreement

Next meeting

The next meeting will be on the first Tuesday in June from 4:30pm. An agenda will be circulated beforehand but the intention is to dedicate this meeting to what would be included in a restructured agreement – Core Conditions, Section A and Section B.

It's fair to say that the junior doctors are currently the only group that has a comprehensive proposal on the table and that's a great credit to the AMA (ACT)'s Council of Doctors in Training and our DIT members.

Outline of AMA (ACT)'s log of claims for salaried doctors

Rosters

- A **minimum** 28 days' notice of rosters (rosters should include ordinary hours of hours, rostered overtime and on-call)
- Include a clause to facilitate departmental-based specific rosters in the EA. Such rosters should take into account the service needs, adequate rest for practitioners and other relevant contingencies. Moreover, this proposal should be determined in consultation with ACTH, relevant Heads of Department and employee representatives (i.e. AMA, ASMOF)
- Rosters should reflect time required to complete work (time required for theatre preparation, ward rounds, clerical duties, clinical handover, administrative duties and education session).
- DiTs should not be rostered to work more than 7 consecutive days. If they are rostered to work more than 7 consecutive days, the relevant overtime loading will apply until a full two days free from duty is given.

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College of Surgeons open new ACT office

The new ACT office of the Royal Australasian College of Surgeons (RACS) on King Street in Deakin is now officially open, having outgrown its old space in Napier Close.

Cutting the ribbon, from left, ACT Health Minister, Meegan Fitzharris, RACS President, Phil Truskett AM, Federal Assistant Health Minister, Dr David Gillespie, Ngunnawal Elder, Agnes Stone and RACS ACT Chair, Sivakumar Gananadha.

Local surgeons were joined late last week by the ACT Minister for Health, Meegan Fitzharris MLA, Commonwealth Assistant Minister for Health David Gillespie, RACS President Phil Truskett AM, RACS Vice President Spencer Beasley, ACT Chair Sivakumar Gananadha and guests from a range of other Commonwealth and ACT agencies.

Ngunnawal Elder Agnes Shea gave an official Welcome to Country, followed by speeches from the ministers, before Mr Truskett noted RACS history in Canberra, with the first ever College annual general meeting held in 1928.

RACS and Canberra

RACS was given the opportunity to set up its national headquarters in Canberra in 1927, with a three acre site reserved near where the National Film and Sound Arc

Mr Truskett acknowledged the contribution of Mr Peter Brown who was hive in Acton now stands. However, with most of the inaugural Councillors being based in Victoria, RACS headquarters were established in Melbourne instead.

the first Chair of the ACT Committee in 1989, and other Committee members Mr Ray Newcombe, Mr Diarmid McKeown, Mr Richard Nugent and Mr John Buckingham.

RACS in Canberra

The Committee is active across a number of health forums and provides advice to both the RACS Council and ACT Government on issues affecting ACT surgeons and surgical trainees, and more broadly about issues affecting surgical practice across Australia and New Zealand.

Key issues that the Committee has been advocating for include improving surgical education in the ACT, establishing a better resourced and coordinated Trauma Service, and increased efforts to build respect within the medical profession and improve patient safety.

RACS President, Phil Truskett, left, with Federal Assistant Health Minister, Dr David Gillespie.

From left, Prof Nick Tally, Council of Presidents of Medical Colleges, Federal Assistant Health Minister, Dr David Gillespie and RACS President, Phil Truskett.

Are you concerned about revalidation?

Many medical practitioners and medical students will have heard about the Medical Board of Australia's plans for revalidation by now but maybe youíd like to know more or possibly youíve only heard part of the story. Join AMA (ACT) President, Prof Steve Robson and Dr Joanna Flynn, chair of the Medical Board of Australia for a free forum on revalidation to be held at AMA House in Barton from 6pm on Thursday 15 June.

This is a free event for all of Canberra's doctors and medical students and the AMA (ACT) invites you to attend and join us for refreshments.

What is revalidation?

In 2012, the Medical Board of Australia (MBA) started a started a process that aimed, in their words, 'to make sure doctors in Australia maintain the skills to provide safe and ethical care to patients throughout their working lives'. Since then the MBA has commissioned research to make sure that the way this is done is effective, evidence-based and practical.

An Expert Advisory Group was appointed to propose models for evaluation on the grounds of effectiveness, feasibility and acceptability. The Expert Advisory Group's interim report has been published on the Board's website at: www.medicalboard.gov.au/News/Current-Consultations.aspx.

Proposed revalidation models

The MBA has ruled out a UK-style revalidation and made it clear that doctors will not be required to re-sit their fellowship exams every five years. The EAG, which was established by the MBA to provide advice on options for revalidation in Australia, has recommended a model that combines strengthened continuing professional development (CPD) and the proactive identification and assessment of at-risk and poorly performing practitioners.

Consultation on the proposed models

Hundreds of doctors, community members and educators shared their ideas during the four-month consultation. They gave feedback on the proposal put forward by the Board's Expert Advisory Group (EAG) on what we should do to build a system for revalidation in Australia that is tailored to our health care context – and is practical, effective and evidence-based.

Dr Joanna Flynn AM, Chair of the Medical Board of Australia.

Feedback from consultation

The EAG is now analysing the submissions and other feedback from the consultation process. Some general themes have emerged including:

- wide support for improving standards and managing risk to patients, through strengthened CPD
- most specialist colleges are already in the process of strengthening their CPD programs, but there is variation between colleges in the types of CPD currently offered (that is, the balance of educational activities, outcome measurement and performance review activities)
- wide support for maintaining the supportive, educational and standards-focused role of specialist colleges
- the proposal to identify and manage at-risk and already poorly performing practitioners was more contentious, with some individuals unconvinced there is a problem to be solved
- wide support for better information and data sharing between health sector agencies, and demand for role clarity to prevent double handling and confusion
- a need for ongoing processes that offer remediation and support individual practitioners to return to safe practice, outside of the regulatory framework, and
- widespread concern that any new process should not increase the administrative burden on practitioners without demonstrable improvements in patient safety.

What's next?

The EAG met in February 2017 to review the submissions and comments, and start finalising its recommendations. The EAG will make its final report to the Board in mid-2017. The Board will then set a direction and propose what is needed so that doctors in Australia remain competent throughout their working lives.

Forum details

Join Dr Joanna Flynn AM, Chair of the Medical Board of Australia and Prof Steve Robson, President of AMA (ACT), from 6pm on Thursday 15 June to learn more about revalidation and how it effects you. The forum is free for medical practitioners and medical students.

RSVP to AMA (ACT) on 02 6270 5410 or reception@ama-act.com.au

CIG launches PET/CT Scanner

ACT Minister for Health, Meegan Fitzharris, has launched a new cancer scanner at Canberra Imaging Group's (CIG) Garran clinic, "marking a major advance in the diagnosis and treatment of cancer for the local community."

Health Minister, Meegan Fitzharris is shown the new scanner By Dr Yiisong Wong, right.

The new machine, a positron emission tomography-computed tomography (PET/CT) scanner, is the second of this type to be installed anywhere in the world.

CIG Chairman, Dr Rohit Tamhane, said the new machine, which represents an investment of around $3 million provides the ACT with world-best technology,

"Local cancer specialists have access to a powerful new tool which supports earlier detection and better targeted treatments; this means better health outcomes, less waiting time and patients no longer being forced to travel interstate for specialist scans," Dr Tamhane said.

A Major Advance

Canberra Imaging radiologist Dr Yiisong Wong said the equipment was a major advance on standard CT scanners, which show the location and extent of cancers, while the PET technology also showed radiologists the "behaviour" of cancerous cells.

Prostate Cancer Specialist Nurse Allison Turner said prostate specific PET/CT is an important addition to local health services.

"This kind of PET/CT is widely used in Europe but still relatively new in Australia and offers significant advances in the diagnosis and treatment of men with prostate cancer. One of the real benefits of this scanner is that it can detect the prostate specific antigen anywhere in the body allowing more targeted treatment," Allison said.

Improving Access

In officially opening the new facility, Health Minister Meegan Fitzharris said the scanner had already been used on the father of a friend of hers, and she believed having such equipment in Canberra had helped improve his quality of life, negating the need for trips to Sydney for such scans.

She said the family was "enormous grateful" to have such advanced equipment available in the capital and that the technology would complement the nearby regional cancer centre and other existing ACT health services.

While the scanner will initially be used mainly to treat cancer patients, Dr Tamhane says it is an amazing technology which offers unlimited opportunities.

"This is a field of medicine that will continue to grow, and CIG is proud to be at the forefront of the ongoing PET/CT revolution.

AMA PHI Report Card 2017: read the small print

The AMA is urging consumers to do their homework before purchasing or changing their private health insurance (PHI) policies.

AMA President, Dr Michael Gannon, wants to see improvements in PHI.

Launching the *AMA Private Health Insurance Report Card 2017*, AMA President, Dr Michael Gannon, said that people should thoroughly research and compare the various and varied policies on offer to ensure they are getting value for money and, more importantly, that they know exactly what they are covered for in the event of accident, illness, or injury.

"Australian families now contribute a substantial proportion of their household income towards private health insurance, so it is important they know exactly what they are getting from their investment," Dr Gannon said.

"Family budgets are under pressure with cost of living increases, which have been added to with this week's annual increase in PHI premiums.

Report card

"The *AMA Private Health Insurance Report Card 2017* provides consumers with clear, simple information about how health insurance really works.

"It shows that there are a lot of policies on offer, which provide significantly varying levels of cover, gaps, and management expenses. There are a lot of policies on the market that do not provide the cover patients expect when they need it.

"If people have one of these 'junk polices', the AMA encourages them to check their policy matches their current and anticipated health care needs. And, if not, dump it for better cover.

"Our Report Card will help people to understand their product, and allow them to make changes to get better cover and better value for money.

Varying benefits

"We show what insurance policies may or may not cover, what the Medicare Benefits Schedule (MBS) covers, and what an out-of-pocket fee may be under different scenarios.

"The Report Card also highlights that private health insurer benefits vary significantly between policies and insurance companies.

"Benefits vary State by State, so this year we've highlighted the percentage of hospital charges covered by fund in each State to help consumers better understand what they are buying.

"The percentage of services with no-gap are detailed State by State, and we reveal what each of the PHI funds has reported they spend on management and administration compared to what they pay out as benefits to patients.

"There is data on the level of complaints each fund receives, and we've also warned people about the dangers of doctor rating sites."

Beware of junk

Dr Gannon said that, although it is understandable that people are looking to save money, the AMA advises that they must not be deceived into downgrading to a junk policy.

"From the AMA's perspective, junk policies should not exist at all.

"We need private health insurance to be simplified, we need it to be more transparent, and we need it to also cover the real costs of treatment – including the theatre fees, equipment, consumables, hospital costs, and staff time.

"The funds must put the interests of their policyholders first and foremost, and stop pointing the finger at doctors or pushing increased out of pocket costs onto patients when their products do not deliver what patients expect.

"Benefits for doctors represent less than 10 per cent of the money paid out by Australia's biggest health insurer.

"We need to ensure that patients retain the right to choose the doctor that is right for them, and to have their treatment at a facility that suits them.

"Equally, we need to ensure that doctors can refer patients to the right specialist – not just the one that an insurer deems appropriate. Insurers do not know the difference between specialist and sub-specialist treatment.

US-style managed care

"We must not end up with US-style managed care where a clerk in an office on the other side of the country, not the patient and their doctor, decides what care is affordable.

"Sometimes, preserving that choice might mean treatment in a public hospital. Products must preserve flexibility. Some of our best, most highly-trained doctors work in public hospitals.

"And for those in rural areas, it is often only the public hospital that is available. They should be able to use their insurance product as they need to.

"These decisions – these patient rights – are far too important to be taken away by insurers in an effort to further bolster their profits.

"The AMA wants this Report Card to be a catalyst for greater transparency and clarity from the private health insurers about their products, and a signal to consumers to thoroughly know their PHI product before signing up," Dr Gannon said.

Since the release of the inaugural AMA Private Health Insurance Report Card in March 2016, the Government has established the Private Health Ministerial Advisory Committee to examine all aspects of private health insurance.

The AMA Private Health Insurance Report Card 2017 is at https://ama.com.au/ama-private-health-insurance-report-card-2017

ACT Health Minister meets with AMA (ACT) Board...*continued*

Ian McConnell-Whalan, representing the ANU Medical Students Society.

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In particular, AMA (ACT) is concerned about the lack of co-ordination between ACT Health, who approves an AON position, AHPRA, who has responsibility for registration and oversight of supervision and employers, who deliver the supervision. There is considerable potential for issues to 'fall between the cracks' and AMA (ACT) urged Minister Fitzharris to include AHPRA and employers in the upcoming policy review.

Clinical Services Framework

Minister Fitzharris raised the issue of the new Clinical Services Framework and was keen to ensure adequate consultation and communications with key stakeholders including AMA (ACT). With the new CSF providing the basis for delivery of clinical services into the medium term, it's important that it be developed collaboratively and transparently.

Medical workforce

A considerable part of the evening was taken up with discussing workforce issues most prominently, psychiatry and dermatology. The ongoing crisis in both access to mental health services and recruitment of psychiatrists is causing considerable distress. In particular, for child and adolescent services, where Dr Suzanne Davey, AMA (ACT) Honorary Secretary and long-time Canberra GP, outlined her concern and frustration at not being able to arrange an urgent psychiatry consultation.

Dr Andrew Miller, AMA (ACT) Treasurer and local Dermatologist, raised the issue of funding for dermatology trainees and urged Minister Fitzharris to look at ACT Health funding an additional training place.

VMO contracts

With new VMO contracts being rolled out this year and a focus on cost-savings across ACT Health, several issues in regard to both the renewal and content of VMO contracts have arisen.

Dr Iain Dunlop raised with the Minister the issue of VMO Ophthalmologists and ACT Health's last-minute offer to renew contracts on significantly inferior terms to those currently in place. Whether ACT Health's actions where negotiating tactics or simply a stuff-up, the effect was the same – a degree of anger and confusion over ACT Health's intentions and a loss of goodwill.

In summary

Our thanks to Minister Fitzharris for joining with the AMA (ACT) Board and participating in such a wide ranging discussion. We appreciated both her openness and willingness to take on board the wide variety of issues raised by Board members and DIT and medical student representatives.

With several issues to follow up, the next few months looks very busy indeed.

Dr Iain Dunlop, AM, AMA (ACT) Board member with Dr Suzanne Davey, AMA (ACT) Honorary Secretary.

Dr Rebeka Stepto, Co-chair of the AMA (ACT) Council of Doctors in Training makes a point during the discussion with Minister Fitzharris.

Robotic assisted joint replacement surgery

BY DR DAMIAN SMITH BSC MBBS FRACS ORTH

Robotics is a branch of science that combines the technologies of engineering and computer science. Robots have captured imaginations young and old for decades. A robot is a machine that is capable of performing a complex series of pre-programmed tasks automatically.

Robots have been used in the manufacturing industry replacing humans in performing repetitive and dangerous tasks. They've been used in search and rescue; in the military and law enforcement for such things as bomb disposal; and of course they have been used in various capacities in medicine. Robots have become commonplace in popular culture, with the concept of robotic autonomy giving rise to many sci-fi blockbuster movies and television shows.

Robotic surgery

The past decade has seen an explosion of interest, with a significant growth in the research and development of computer assisted surgery, and more recently robotic assisted surgery. The da Vinci robot (Intuitive Surgical, Sunnyvale, CA, USA) is a well-known fully automated robot that allows the surgeon to remotely control laparoscopic instruments with increased accuracy and precision.

More recently, we have seen exciting developments in orthopaedic robotic assisted surgery, with the Mako robot enjoying increased exposure. Orthopaedic surgery is highly compatible with robotic assisted surgery. The rigidity of bone allows for precise pre-operative planning through imaging and biomechanical assessments that provides what is effectively a precisely mapped plan that is tailored specifically for that patient. That plan can then be synchronized with the robot. The surgeon can make pre-operative and intra-operative adjustments to the plan to further customise the surgery to the individual patient's anatomy and soft tissues.

Computer assisted and robotic assisted surgery allows for less invasive surgery. It also facilitates a quantitative analysis of the operation. Studies are showing statistics that favour the precision and accuracy of computer assisted and robotic assisted surgery over conventional surgery. Improvements in the positioning of components are likely to lead to improvements in joint stability and longevity, bearing surface wear, and ultimately a longer time before revision surgery is necessary. A well placed joint replacement is more likely to become a more "normal feeling" joint and a "forgotten joint replacement". In short, the margins of error are reduced, the most

biomechanically correct position is more likely to be achieved, and the patient's experience is consequently optimised.

Automated systems

Robotic systems in orthopaedic surgery can be classified as fully automated, semi-automated and passive. Automated systems require surgical exposure and landmark registration from the surgeon. The robot then completes the bone resection and preparation autonomously. The ROBODOC (Think Surgical, Fremont CA, USA) is the only commercially available system of this type and has been in use since 1992, when the first patient had a femoral canal milled by this system. Further development has seen this system evolve for use in total knee replacement.

Semi-automated systems are the most utilised. This technology consists of robotic arm assisted devices and hand held navigated cutting tools. The Mako (Fort Lauderdale, FL, USA) robotic arm device was first used to implant a uni-compartmental knee replacement in 2006. Since then there have been over 80,000 robotic assisted joint procedures worldwide.

Mako robotic arm assisted surgery facilitates functional, patient-specific implant positioning. This promotes better functional and clinical outcomes. Systems such as these are designed to minimize the margin of error and enhance the accuracy and reproducibility of joint component placement. A randomised controlled study by Bell et al showed statistically significant improved accuracy in partial knee component positioning to the pre-operative plan with robotic arm assisted surgery compared to conventional methods.

Evidence also shows improved accuracy in the placement of total hip arthroplasty. A multicentre clinical trial has found that robotic arm assisted acetabular placement achieved greater accuracy in preparation and placement than conventional surgery. Studies have shown that 100% of the assessed robotic arm assisted acetabular cup placements fell within the "safe zone" as described by Lewinnek compared with 80% of conventionally placed acetabulum. Callinan subsequently revised the "safe zone", tightening the criteria – and 92% of the robotic arm assisted cup placements fell within that "modified safe zone" compared with 62% of conventionally placed cups.

Cadaveric studies indicate that robotic arm assisted surgery is accurate within one millimetre for leg length and offset, 5 times more accurate in acetabular cup inclination, and 3.4 times more accurate in acetabular cup anteversion. Patient outcome studies are finding that patients who have had robotic arm assisted joint replacements reported less pain post-operatively, had a shorter length of stay in hospital, and required less physiotherapy.

There is an increasing amount of evidence that supports the use of robotic assisted surgery in joint replacement procedures due to the improved accuracy and improvements in early patient outcomes. The capital outlay associated with purchasing this technology is currently borne by the hospital or institution involved. The broader health, social and economic costs will be evaluated over time, but with the anticipated benefits including improved functional outcomes and extension of the useful life of the prosthesis, this technology has vast potential to make a significant positive impact on both the patient experience and the direct and indirect public and private costs associated with growing numbers of joint replacements in an ageing society.

References available upon request.

Insurance premiums on the rise

BY RUSSELL PRICE, DIRECTOR AT SPECIALIST WEALTH GROUP

Have you had an increase of life insurance premiums over the past year or two? If so, you're not alone. Life Insurers across Australia have imposed premium rate increases at an alarming rate over the past few years, to the detriment of their policy holders.

Some Insurers have increased their premium rates as high as 30% (plus increases for age & inflation), leaving their clients with little alternative other than to absorb the increases, cancel or reduce their cover. Others have increased their rates twice in the short period of 2 years. With more insurers announcing in the past few months of upcoming rate hikes.

The cause for the significant increases cannot be put down to any one reason however the fact is that most Insurers are seeing an increase in claims. As a result, they need to remain profitable with significant losses in the industry.

What can you do?

While you it's difficult to avoid insurers increasing their rates, you can look to limit the increases on your own policy. This means setting up the right policy early on by means such as Level premiums.

A Level premium starts off more expensive but does not increase with age – remaining 'more level' over time. For younger policy holders, who have the intention of keeping their policies long term, the savings can be significant.

A good Financial Adviser will make sure they take the time every year to review your policy and ensure your cover is adequate – as an example, if it has been a few years since your cover has been reviewed, you may find your mortgage or debts could be lower than what they once were. Therefore, considering less insurance may be appropriate to your circumstances and a good way to reduce costs over time.

There's also ways to hold some insurances within superannuation to further reduce your out of pocket costs.

Many insurers are now also encouraging their customers to live a healthy and active life by rewarding them with discounts on all their insurance for doing so.

Review Regularly

If you have a life insurance policy which has seen recent increases, you should have your policy reviewed by a professional. You may be able to save a significant amount of money by doing so and at the same time, improve on the policy definitions and features.

Specialist Wealth Group specialises in providing financial advice and personal insurances for medical professionals. Most of our clients who are doctors are very time poor and haven't given much thought to their old policies, often set up many years ago, potentially outdated and rising in costs unnecessarily.

In addition, the life insurance industry continues to change with new competitors in the marketplace and existing insurers merging; there really is no better time to check the cover that you have is right for you.

Contact an adviser at Specialist Wealth Group on 1300 008 002 to discuss your insurance needs today.

SPECIALIST WEALTH GROUP

Winnunga extends clinic opening hours

Winnunga has announced an extension to clinic opening hours to operate from 9am - 8pm Monday to Friday. Please note doctors hours will remain 9am - 4.30pm Monday to Friday.

Winnunnga is located at:
63 Boolimba Crescent Narrabundah
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WINNUNGA NIMMITYJAH
ABORIGINAL HEALTH SERVICE

Providing medical information to a third party

BY AVANT MEDIA

When you arrive at the practice, you see Vicky*, the receptionist sorting a patientís file. On enquiry, Vicky explains that Jane*, a 32-year-old patient who is relocating to another town, called earlier to urgently request that her medical records are transferred to her new specialist in that town.

Vicky has already faxed several pages to the specialist. You ask her which medical records Jane has requested and to whom they are being released?

Vicky explains that she confirmed Jane's full name and current address, and has documented her verbal request for the transfer of her medical records in Jane's medical records, and the name of the specialist the medical records are being sent to. Vicky has also sent a cover fax to the specialist detailing Jane's request. After checking that this request has been documented in Jane's medical records and the pages being sent, you are happy to allow the remaining pages to be faxed to the specialist.

All doctors have an ethical and legal duty to ensure medical records are kept confidential. However, doctors receive requests for access to medical records and are often unsure of their responsibilities for sharing confidential information. Requests for access may come from the patient themselves, from another person or organisation, or via a court order.

You can share medical information with a third party if you have authority from your patient or you are required to by law.

In each instance, before sharing patient records, consider:

1. Requirements for consent

Ideally, the consent should:

- Be in writing, signed and dated by the patient
- If verbal consent obtained, document the details discussed
- Indicate which records and to whom they can be released
- Be reasonably current i.e. not more than 12 months old.

2. Your legal obligation

Examples where legislation requires you to share health information without express authority from the patient include:

- Public health requirements to report infectious diseases
- Summons or subpoena to produce medical records to a court or tribunal
- A police search warrant.

3. Which documents to supply

Read the request and the patient's authority carefully to ensure that you know:

- Which documents to include
- Which documents to exclude.

An insurer may request all the patient's medical records, but the patient may only authorise disclosure of records relevant to the insurance claim.

Consider confirming consent with the patient, particularly if the patient's records contain sensitive material as the patient may not have considered the implications of releasing this information.

Letters from specialists should be shared with the patient or third party even if the specialist has not provided specific consent, and even if the letter says it should not be disclosed to the patient or third party without the writer's consent. Such notifications do not overcome the legal requirement under privacy laws giving patients, subject to certain exceptions, the right to access to their health information.

4. Refusing to provide information

There may be occasions when you are concerned about providing records to a third party, even with appropriate authority or legal requirement. In certain circumstances, for example, a situation in which supplying the records may result in significant harm to an individual, it may be possible to withhold records from disclosure – contact Avant for advice if you have any concerns.

Key lessons

Document any conversations you have with the patient

- Carefully read the request for medical information and the patient's authority to ensure the correct documentation is shared and that it is within the scope of the patient's authority
- Understand that sometimes you are legally required to share information with a third party without express authority from the patient
- Know that you can refuse to provide records in certain circumstances

*This scenario has been created based on Avant's Medico-legal Advisory Service and claims experience. For more information, watch *"Managing requests for medical records on the Avant Learning Centre"*.

For more advice regarding sharing medical records, call Avant's Medico-legal Advisory Service on 1800 128 268.

Editor's note: *Practitioner's should also be aware of the ACT's Health Records (Privacy and Access) Act 1997 that grants patients additional access rights.*

Salaried Doctors...*continued*

...from page 3

Training

- Up to 5 **additional** hours of 'dedicated training time' (equalling 43 hours per week or an average of 43 hours per week over 4 weeks) for DiTs. This time should be used to complete college specific education training, ACTH mandated education sessions, including generic Intern teaching sessions, RMO teaching, accredited departmental meetings (Radiology, Pathology, General Medicine). This training time should not include case discussion for professional opinion. Dedicated teaching time would ideally be scheduled into JMO rosters. The object would be to facilitate JMO/RMO involvement in departmental case presentations.
- The 'dedicated teaching time' proposal will also be determined in consultation with the relevant college/ department and this time shall be free from clinical duties (except in medical emergencies or disaster situations).
- **3 days clear** from all duties prior to an examination.
- **Increase** the 'conference leave' allowance from the current amount ($3,062) to 12% of a DiTs fixed wage and be payable in each fortnightly pay. Moreover, this should reflect the genuine training requirements and costs for DiTs, including the increase in College fees.

Annual Leave

- An **additional** week of leave of annual leave for all Doctors who work five Saturdays or Sundays in a year.
- Leave applied for four (4) or more months in advance be approved in two or less weeks upon the request being made.
- ACTH work collaboratively with DiTs to accommodate their leave requests and ensure they have access to the leave they accrue.

ADOs

- **Reduce** the accrual of ADOs from 13 days to 6 days. Any additional day accrued past the limit be automatically paid out at time and a half.
- Where appropriate, ADOs be taken as two **'half-days'**.

Overtime

- A **review committee** (ACTH, AMA, ASMOF) to oversee the lodgement of overtime, approval process and compliance with enterprise agreement.
- Include the dates and hours of overtime worked in each **payslip** (Note: we've also proposed that penalty rates, on-call/call back be included)
- Ensure that Time-Off-In-Lieu (TOIL) of overtime is **readily available**.
- **Reduce** the amount of time ACTH has to rectify underpayments of overtime from 2 pay periods to 1 pay period. Interest shall be paid on underpayments and be calculated daily.

Separate section for DiTs

- A **separate section** in the EA for JMOs/DiTs be included in the new agreement. This would ensure the new agreement is easier to read and better suited to the needs of DiTs

FBT 'crackdown' on meal and entertainment expenses

BY ANISH PRASAD, AMA (ACT)iS HOSPITAL ORGANISER

Many of you are aware of the Meal Entertainment and Venue Hire (MEVH) card, but for those that aren't I'll give you a brief explanation of what it is.

The MEVH card is a benefit available to some employees of not-for-profit organisation; this includes public hospital Doctors in the ACT. Eligible employees are permitted to reduce their taxable income in return for non-cash benefits, in this case meal, entertainment and venue hire related expenses. Generally speaking, you may claim expenses such as food consumed in a restaurant and alcohol when it is consumed with a meal at a restaurant (Note: please check the ACT Health's 'MEVH Quick Reference Guide' for more details or the ATO website). Currently, you can claim up to a maximum of $2,550 (single gross-up cap of $5000) for expenses incurred in an 'FBT Year' (April 1st- March 31st).

Prior to the 2015 Federal Budget, eligible employees were able to claim up to $17,667 every FBT year. When it was announced, the AMA ('FBT CAP: We are not entertained', 1st December 2015), expressed the view that "[the] proposal to impose a $5000 cap on salary sacrificed meal and entertainment expenses that are eligible for fringe benefit tax exemptions would harm the ability of public hospitals and other not-for-profit health groups to attract and retain skilled medical staff...". Fair to say we still hold this view and believe any further reduction of this benefit will do more harm than good.

Oh and for those that haven't taken up this benefit, I recommend you get in contact with Shared Services (SalaryPackaging@act.gov.au)

Crackdown by ACT Health

In late December (December 23rd 2016 to be exact), ACT Health notified all staff that they were concerned that the MEVH card was not being used in accordance with their guidelines and recommended all staff to review their purchases to ensure they were compliant.

Fast forward to early-mid March 2017, and AMA Members were notified by Shared Services that they were conducting an 'audit' of sorts into their expenses and they were asked to provide proof of certain expenditures. Of those we spoke to, Members were concerned about the time provided to reply (in some cases as little as 4 days) and the 'merchant blocks' imposed on businesses such as Rodney's Nursery Café in Pialligo (we'll revisit the merchant blocks issue in a tick).

It is important to clarify that your employer (ACT Health) are within their right to audit and monitor MEVH expenses. Moreover, the ATO does monitor and audit salary packaging arrangements employers' offer to their employees (of which the MEVH card falls within).

However, for some Doctors, the time provided by Shared Service for proof of expenditures was unreasonable. The reality is hospital Doctors work long hours, are on-call, work night shifts, and work weekends. There is hardly enough time in a day, let alone a week, to find that Nike shoe box full of receipts! We did raise this with our friends at Shared Services and we sensed they recognised some Doctors did not receive adequate time to reply.

Merchant blocks

One way for ACT Health to ensure compliance with their guidelines is to have certain businesses blocked from purchases – think fast food outlets and grocery stores. The easiest way to determine whether business is say a grocery store or restaurant is to use the merchant codes supplied banks, this code identifies the type of business they are.

The issue here is that a number of AMA (ACT) Members have come back to us and said they have used their MEVH card at some businesses earlier in the FBT year and are now finding out the expense didn't meet ACT Health's guidelines.

Case in point: Rodney's Garden Café

We've been told that purchases at Rodney's café have been blocked and that Doctors are being asked to rectify any purchases made there. Admittedly, Rodney's is also a plant nursery, however, they also have a great cafe that is more akin to a restaurant than say a take-away shop (take-away shops are not allowed!). Indeed, Tony (Manager, Workplace Relations here at AMA ACT) says that "Rodney would be offended if you called his facility a café!"

Rodney's Garden Café

Rodney's is what you would call a 'Mixed Business' and if you look around, there are many businesses that have taken up this business model i.e. they have the facilities for sit down meal and say retail outlet.

Now, those at ACT Health do not have the time to go to each and every single business in the Canberra region and determine whether or not they would fit within their guidelines. Instead, they probably rely mostly on the merchant codes provided by banks and where necessary what their 'primary business' is and then move on to the next merchant.

Rodney's Garden Café is an example of a business that is blocked despite having the facilities for a sit down meal. Surely, it is reasonable for us to compile a list together of those businesses that are blocked but we believe fit within the rules, and provide this to ACT Health? I'll be proposing this to our local Council of DiTs and go from there.

Book review: Norse Mythology

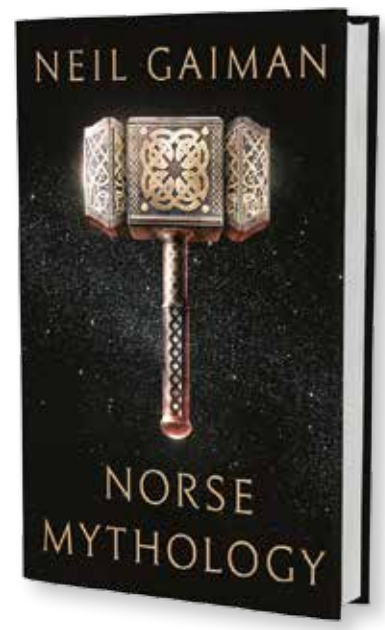
REVIEW BY ASSOCIATE PROFESSOR JEFFREY LOOI, ANU MEDICAL SCHOOL

Neil Gaiman, 2017
W.W. Norton
ISBN13 9780393609097

Mythology, true to its origins in the spoken word, or in this case, the skald's declamation, is enlivened by retelling. As Neil Gaiman acknowledges in his fond introduction, he has drawn upon the traditions and translations of the *Poetic Edda* and Snorri Sturlson's *Prose Edda*. In contemporary media, there have been lightning images of the tall-hatted Odin in the HBO series of The Vikings and more than an influence upon role-playing games such as Dungeons and Dragons. The literary worlds of Tolkein's Middle Earth and Martin's Game of Thrones arguably draw upon the Eddic traditions.

A grim stoicism is tempered into the sublime steelwork of sharp sword-like tales, burnished by Gaiman's melancholy lyric prose. For the English speaker, there is a tantilising sense of familiarity gifted us by the names of the days of our week – here drawn from modern Swedish: *Tyrsdag*, anglicised as Tuesday, we have the grim embodiment of the Norse god of Law; *Onsdag*, anglicised as Wednesday, for Odin the one-eyed Norse all-father; *Torsdag*, anglicised as Thursday, for Thor Norse god of thunder; and Fredag, anglicised as Friday, for Freya, Norse goddess of fertility. At the Karolinska Institute Huddinge, the neuroimaging research laboratory once had a computer server called *Freya* and another I think was named for *Fenrir*, the fierce son of the trickster god *Loki*.

Each retelling of the Norse myths has its own appeal, as in A.S. Byatt's nested Russian Doll tale of *Ragnarok* set in World War II. Gaiman's retelling of selected Eddic tales has its own typically Norse grim sardonic charm, golden and bloody as the draught of the mead of poetry.



Dr Dennis Wilson

We would like to inform you that Dr Dennis Wilson unfortunately has had to retire from private practice due to the recent onset of a serious illness. He has given over 37 years of valued service to Canberra and the region. Dr Aaron Simpson and Dr Rakesh Iyer have taken over his practice at John James Medical Centre. The contact details for the practice remain unchanged.

Dr Iyer and Dr Simpson would like to take this opportunity express their sincere gratitude to Dr Wilson for his continued support and mentorship.

New referrals to Dr Simpson and Dr Iyer can be made by fax 6281 7098 or post. Patients with existing appointments will continue to be seen as scheduled. Dr Rakesh Iyer will continue to provide Endocrinology outpatient services at Suite 9, Calvary Clinic for north Canberra residents.

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