CANBERRA
Doctor

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AMA calls for 'hidden waiting list' data

Waiting times for outpatient appointments are not publicly reported.

The AMA is calling for nation-wide transparency on the time it takes to see a specialist in a public hospital.

The period between referral by a GP and consultation with a specialist where the patient is often officially added to an elective surgery waiting list is known as the 'hidden' waiting list, a new AMA report explains.

The report says it's impossible for patients to make informed decisions about whether they will wait for surgery in the public hospital or go through the private hospital system without knowing how long they will wait for an initial outpatient appointment.

"For example, a patient waiting for a non-urgent knee replacement would be aware that they could be waiting a year or more for this surgery on the elective surgery waiting list, however may not be aware of the almost two year wait for the outpatient appointment," the report says.

Waiting in the ACT

The ACT Public Health Services Quarterly Performance Report for January to March 2022 showed 1,299 patients were overdue waiting for their elective surgery – 189 more than in the previous quarter (a rise of 17%).

However, how long patients wait to get on the waiting list is not publicly reported in the ACT, nor in NSW.

GPs in the ACT used to be able to see average waiting times for different specialists on the GP HealthNet portal. However, with that system no longer available, GPs and patients are left guessing how long the wait will be. Anecdotally, non-urgent Category 3 patients in the ACT wait years for an initial orthopaedic appointment, 12-18 months for an ENT appointment and 6-12 months for gastroenterology and cardiology appointments.

The ACT Government said it will provide Canberra Doctor with up-to-date figures on the wait for initial outpatient appointments, however it could not make our deadline of one week.

Victoria and Queensland

There is no nationally-consistent reporting of the issue. However, evidence from Victoria and Queensland shows patients are waiting far longer than waiting time targets, which are 30 days for urgent consults and 365 days for non-urgent consults.

For instance, in both states, patients typically waited more than 150 days for an urgent initial appointment with a gastroenterologist.

For non-urgent cases, waiting times came close to or exceeded 700 days for ophthalmology, orthopaedic and ear nose and throat appointments.

Tackling the backlog

AMA President Steve Robson commented: "It's little wonder our health system isn't coping when we are not counting the true number of people who desperately need care. It's like counting emergency waiting room times without counting the hours someone is waiting in an ambulance to get into the waiting room."

Professor Robson said while the Australian Institute of Health and Welfare was working with jurisdictions to include outpatient waiting data, a national plan was needed now to address the backlog.

"We need a plan to tackle the backlog of patients because this backlog is adding to the number of people turning up in droves to GP practices and often out of sheer desperation to emergency departments," he said.

The Commonwealth currently funds 45% of "efficient activity" in public hospitals, with the state and territory governments funding the remaining.

Under the National Health Reform Agreement, the Commonwealth in any given year will only provide up to an extra 6.5 per cent of funding, based on a measure of efficient growth.

The AMA is calling for a 50-50 funding split between the Commonwealth and the states and territories and removal of the 6.5% cap.

To read the report visit ama.com.au/elective-surgery-hidden-waiting-list

President's Notes

WITH PRESIDENT, PROFESSOR WALTER ABHAYARATNA

Your wellbeing

It's encouraging to see the ACT Government has announced a new $8.75 million fund to support the wellbeing of our health workers.

AMA ACT is gathering information that we hope will be the start of some significant work toward evidence-based investment in wellness.

We need to hear from doctors at all stages of practice – and medical students too – about the barriers they are facing as they try to provide the best care for their patients in ways that are personally sustainable.

There is no one-size-fits-all model for wellbeing. What works for doctors will be different to what works for nurses and allied health professionals. It will be different for those working in hospitals and those working in the community.

Effective solutions are far bigger than installing a water cooler or teaching doctors how to be resilient. Most doctors have fantastic levels of resilience, and yet they are still at significant risk of burnout.

Only when we have good data on what doctors, nurses and allied health workers in the Territory are facing can we come up with targeted interventions to improve the culture of our workplaces and remove some of the frustratingly inefficient aspects of practice that weigh us down.

If you haven't got a copy of AMA ACT's wellbeing survey, please contact the AMA ACT office. We'd also love to have as many doctors as possible at the next Safe Space event on October 15 where we'll be workshopping a model of wellness and hearing the evidence from around the world.

Mental Health in the ACT

I recently met with the Minister for Disability and Mental Health, Emma Davidson. I briefed her on the new Drs4Drs ACT service and the importance of mental wellbeing of medical practitioners and students, and she expressed her support for the service.

We spoke about the mental health workforce, especially the need to attract more psychiatrists to work in the ACT, and how some of the best mental healthcare in the Territory is provided by skilful and hard-working GPs. Our GPs need more support. We spoke about how the psychiatrist hotline is good in theory – enabling GPs to access telephone help on behalf of patients – but in practice, it's too hard to access. It's clear that more resources are needed to turn a good idea into an effective service for GPs.

There is much ground to cover in discussing what a good, effective, caring mental health service in the ACT would look like and how to get there. AMA ACT is planning a workshop for the near future that will bring together those working at the frontline to build momentum for reform.

Disability services

Minister Davidson and I also spoke about the baffling 151 days on average that patients with a disability spend in hospital when they require a change in their level of NDIS support. Sometimes it's because of the wait on home modifications, or the wait for a new home altogether, and sometimes it's the wait on assistance technology. I'm encouraged that the Minister is across this issue and is working with different stakeholders to improve the situation for some of our most vulnerable patients.

Prof Walter Abhayaratna, Dr Peter French and Dr Antonio Di Dio.

Paediatric early warning system

I want to congratulate those working with children and adolescents at Canberra Health Services for the work they are doing despite the challenges being played out in the media. In the last few weeks paediatricians, paediatric anaesthetists, ED and intensive care have all being working together to fine tune a paediatric early warning system. It's been a tremendous multidisciplinary effort and will save lives.

Enterprise agreement

As negotiations continue, AMA ACT remains confident that a package of improvements for our Doctors in Training can be secured. The package is aimed at better access to training and education, improving retention and recruitment, making it easier and simpler to get the benefits of paid leave and improving the information provided around pays.

Together with a decent pay rise – of course!

Timeframe on a potential end to negotiations is by the end of the year.

VMO contract negotiations

Once again, the VMO negotiations are about to kick off with a three-month negotiating period before an arbitration in 2023. The AMA ACT's claim centres on a catch-up increase in remuneration, better security of contract terms and ensuring VMOs remain a key part of the medical workforce in the ACT's public hospitals. The VMO contract negotiations are an important opportunity to ensure that the conditions under which senior medical staff work remain relevant to the changing demands of modern medicine. The last round saw AMA ACT winning a new 'Digital Recall' provision – only the second time in Australia such a key provision has been achieved.

Dr Peter French

I recently had the pleasure of presenting Dr Peter French with his Life Membership certificate and thanking him for his contribution to AMA ACT over many years. Well done, Peter.

Mid-term report: Labor-Greens govt hits the ground scoping

Remember all those promises made by Labor and the Greens at the last ACT election? A major expansion of Canberra Hospital by 2024, an elective surgery centre on the University of Canberra campus by 2025, a dedicated palliative care ward at Canberra Hospital, upgrades of the hospital's endoscopy rooms and five new walk-in health centres? As the ACT Government has just reached the half-way point in its four-year term, we thought it was time for a mid-term report.

It's been a tough period in office for the Barr-Rattenbury government, elected in October 2020 when we'd just emerged from the first wave of the pandemic, a Covid success story. Then came the second and third waves, decimating the workforce and disrupting supply chains. Nevertheless, how's it all going with those promises?

They've been very busy with their studies – feasibility studies that is. Struggling to meet some deadlines, though circumstances have been difficult. One thing's clear though, they'll need to work extra hard over the next two years to achieve their goals.

Here's what the ACT Government had to say about the implementation of its promises. If any of our readers have additional information about how they're going, let us know at **execofficer@ama-act.com.au**. We'll keep checking in with them to see how they're travelling.

Promise: Complete major expansion of Canberra Hospital by 2024, a Labor commitment from the 2016 election
Update: Early works for the $624 million Canberra Hospital Expansion project have been completed. The centrepiece of the Canberra Hospital Expansion project, the Critical Services Building remains on track.

Promise: Establish an Elective Surgery Centre on the University of Canberra campus by 2025
Update: Feasibility study is scheduled to be completed in late 2022.

Promise: Upgrade endoscopy rooms at Canberra Hospital by 2023
Update: Feasibility study and site selection process is scheduled to be completed in late 2022.

Promise: Establish a dedicated palliative care ward at Canberra Hospital by 2025
Update: Site selection and early concept design is scheduled for 2023.

Promise: Continue the planning and design work for a new northside hospital, with the aim to start construction by mid-decade
Update:

- The ACT Government invested more than $13 million to continue planning and design work for future hospital infrastructure in Canberra's north in the 2021-22 ACT Budget.
- Work is currently underway on the early planning including site selection and costs.
- The ACT Government has established a Northside Hospital project team and has appointed commercial, technical and legal advisors.

Promise: $15 million in more mental health support for young people
Update:
The ACT Government has invested more than $15 million in Community Youth Mental health programs over the last two Territory Budgets which includes:

- A Youth at Risk Program, which provides multi-disciplinary response to trauma and coordinated responses to young people with complex needs at risk of developing enduring mental illness ($4 million in 2022-23 ACT Budget)
- Funding to build on child mental health initiatives to improve access to multidisciplinary team care for children and their families ($4 million in 2022-23 ACT Budget)
- Funding to establish Youth Mental Health Programs, which includes a trial of the Moderated Online Social Therapy (MOST) program ($7.5 million in 2021-22 ACT Budget)
- Additional funding for the CatholicCare Youth and Wellbeing Program ($851,000 over four years in 2021-222 ACT Budget)
- Funding for Parentline ACT, a counselling and information resource for families ($169,000 over 4 years in 2021-22 Budget)

Promise: Expand the Police, Ambulance and Clinician Early Response (PACER) Program
Update: PACER has been expanded to two teams to service the North and South of Canberra 7 days a week.

Promise: Establish a psychologist subsidy scheme for young people and people on low incomes
Update: Given limited access to psychologists, the Government is instead focusing on other mental health initiatives for young people (according to a Green's spokesperson)

Promise: Build a second hydrotherapy pool in Canberra's south by 2023
Update: Subject to market conditions, construction on a new southside hydrotherapy pool at Tuggeranong Lakeside Leisure Centre is expected to commence in the second half of 2023, with the pool operational in the second half of 2024.

Promise: More services at the existing nurse-led Walk-in Centres (WIC) and establishment of an outpatient imaging service at Weston Creek WIC by January 2022
Update:

- Construction works for the new imaging services at Weston Creek began in August 2022 and are scheduled to be completed in February 2023. Services are expected to start in March 2023, subject to the delivery of specialist medical equipment. Covid-19 has affected the timeline due to impacts on workforce, supply chains and delivery of products.
- The Walk-in Centres have recently changed their scope of practice to allow treatment for children aged from 12 months. Prior to this, services were limited to children aged 2 years and above.
- Canberra Health Services is working to further develop the sexual health screening service at Canberra's Walk-in Centres, in partnership with the Canberra Sexual Health Service.

Promise: Establish five new local walk-in centres in South Tuggeranong, West Belconnen, North Gungahlin, Coombs and the Inner South between 2021 and 2025
Update:

- Canberra Health Services at Molonglo opened in April 2022. The Centre provides pregnancy care, maternal and child health services, women's health counselling and children's asthma care.
- The ACT Government is undertaking a feasibility study for the additional centres, with potential sites and services to be determined.
- The new centres will have a focus on prevention, early intervention and coordinated care for people with chronic illness.

Promise: 60,000 elective surgeries over the next four years, including an additional 2,000 higher complexity elective procedures
Update:

- In 2021-22, the ACT completed 14,031 public elective surgeries. While not reaching the target of 14,800, this is the second highest number of surgeries undertaken in a financial year in the territory, with the 2020-21 financial year being the highest. The 2021-22 figure included an additional 338 higher complexity elective procedures.
- The Canberra Hospital met 98% of its elective surgery target.
- Calvary Public Hospital Bruce achieved 90% of its target despite the impacts of Covid-19 and the suspension of non-urgent elective surgeries for some weeks in early 2022.

Covid-19-related workforce shortages and emergency surgery increases affected the delivery of elective surgeries, as did cancellation of appointments and procedures by patients who were unwell.

Promise: Employ an additional 400 doctors, nurses and allied health workers this term
Update: The ACT Government is ahead of schedule to employ an additional 400 doctors, nurses and allied health workers this term and expects to reach this target by the end of the 2022-23 financial year.

General Practice: A bleak future for quality and quantity

As a retired GP, I would like to fully endorse the excellent suggestions of Dr Katrina Watson, expressed in her recent article in the online journal *Pearls and Irritations*, to improve the current parlous state of General Practice in Australia.

DR SUZANNE DAVEY

To summarise, Katrina suggested that GP fees should be increased without any increase in out-of-pocket expenses to patients and these fees should be more aligned with specialist fees, given that GPs and specialists shoulder similar levels of responsibility. She suggested there should be financial support for GPs for their Continuing Professional Development requirements and subsidised childcare. She thought that GPs should work as part of a team with extra administrative support provided, consultation times should be lengthened and there should be regulation of working conditions for GPs working in corporate practices. She also had some great ideas as to how the education of GPs from the very beginning of their medical degree could be improved.

No longer viable

I recently retired after a deeply satisfying career in General Practice, in which I developed long-standing relationships with my patients. I always spent enough time with them to ensure that all their issues were addressed. To this end, I worked long hours and often ran late, but my patients rarely complained as they knew that I would spend time with them when their turn came. About one third of my consultations were "long" consultations. As a practice owner, I made a reasonable living and was able to bulk bill about 40% of consultations. Those who could afford to pay subsidised those who could not. I experienced great camaraderie with, and support from my colleagues and my workplace was a happy one.

This style of practice is no longer viable. The Medicare system of rebates rewards quick consultations rather than the long ones needed to address complex issues and mental health concerns. Unfortunately, there are strong incentives to write a script for an antibiotic rather than give a long explanation of why an antibiotic may not be necessary, and to write a script for a cholesterol-lowering medication without detailed dietary advice.

Corporatisation

Since the late 1990s there has been increasing corporatisation of General Practices in Australia. This certainly reduces the administrative burden of running a general practice, and there is no concrete evidence that outcomes for patients are any worse in corporatised practices. However, the corporate structure tends to result in patients identifying with a practice rather than with an individual GP. This tends to foster "episodic" consultations where patients are seen for one condition by a doctor whom they may not have seen before, and therefore who is not familiar with their family circumstances or detailed medical history. This contrasts with the concept of "continuity of care" where the doctor who knows the patient can put their complaint in context socially and historically and treat accordingly, whilst considering and advising the patient on their future preventative health care needs. There is also some evidence that in corporatised practices doctors are more likely to refer patients for pathology and radiology where these services are co-located and commercially related, in comparison to the rate of ordering of these tests by doctors in non corporatised practices.

Hairdressers, vets and GPs

The current General Practice "in surgery" Medicare rebates are $39.75 for a consultation

Dr Suzanne Davey

up to 20 minutes long, $76.95 for a consultation 20 to 40 minutes long and $113.30 for a consultation longer than 40 minutes. Since the inception of Medicare, these rates have been slowly eroded relative to increases in the costs of running a practice.

These rates should be compared with the prices charged by hairdressers, vets, dentists, and other allied health professionals. I contend that is impossible to run a viable practice providing a quality standard of service and still bulk bill all patients. There is strong evidence for this contention. Because so few doctors in Canberra bulk bill, the ACT government has embarked on a programme of setting up a series of Walk-in Clinics where the patient is seen by a nurse practitioner at no cost to the patient. This has proved to be a very popular service with patients. However, there is no such thing as a free lunch. This service costs the ACT Government about $200 per consultation to run, paid for by the ACT taxpayer of course!

The GP exodus

When I graduated in 1977, about 20% of medical students were women. This figure is now 50%. There has been great feminisation of the GP workforce. General Practice appeals to women because of the flexible hours and the ability for it to fit in with family responsibilities. However, as with their colleagues in the other altruistic, majority female professions of Nursing and Teaching, both male and female GPs are leaving their profession due to inadequate remuneration for very arduous work. Only 10 to 15% of medical graduates now want to go into General Practice, simply a totally inadequate number to sustain let alone increase the General Practice workforce to serve an ever-increasing ageing population with chronic health care needs. This will of course only exacerbate the current critical rural doctor shortage as the total GP workforce contracts.

Things will never improve whilst we have politicians talking of lower bulk billing rates as a disaster and an indication of doctors' greed, rather than addressing the simple fact that the current Medicare system is broken. A broken Primary Health care system just puts increasing pressure on an already severely squeezed Public Hospital System.

Australia spent 9.91% of its Gross Domestic Product on Health in 2019 according to World Bank figures, in comparison to USA (16.77%), United Kingdom (12.00%), Germany (11.70%), Switzerland (11.29%), France (11.06%) and Canada (10.84%). Maybe we need to increase our health care budget and the percentage of this budget spent on Primary Health Care (33.1% in 2019-2020), or else risk a continuing decline in Primary Health Care standards in Australia, and consequently the overall health, wellbeing, and longevity of all Australians.

Dr Suzanne Davey BSc (Hons) MBBS, DCH, DRCOG has been a long-term active member of AMA ACT and in 2021 she was made a Fellow of the AMA.

Dr Davey wrote this piece for the online journal, Pearls and Irritations, *in response to an article by Dr Katrina Watson on how to improve the parlous state of General Practice in Australia.*

GP corporate ditches bulk-billing model

A major provider of bulk-billed GP consults in the ACT has moved to mixed billing in recent months in response to inadequate rebates and looming payroll tax liability.

Trans-Ax owns five practices in the Canberra region

Over the past three months Trans-Ax Health Care, which runs medical centres at Tuggeranong, Weston, Crace, Belconnen and Queanbeyan introduced an out-of-pocket fee for standard consults for patients aged over 16, excepting concession card and DVA card holders during normal business hours.


Mr Peter Szekely

Director, Peter Szekely, told Canberra Doctor the move to mixed billing was a big change to the business model of the company, whose practices see around 1000 patients a day across the ACT and Queanbeyan.

"We've always targeted affordable healthcare and as such, bulk billing was important, but it becomes unsustainable in the current environment," he said. "Still, I don't think we've lost many patients over it as our fees remain relatively affordable."

"Operators who do not switch to mixed or private billing will be out of business within the next few years," he added.

In letters to patients, the company explained that Medicare rebates had failed to keep pace with inflation, while practice costs had risen 4-6% annually over the past 10 years.

Mr Szekely said his company has 30-35 doctors working on any given day in Canberra. Each sees an average of 33-35 patients a day, but with substantial variation between individual doctors, he added. Recruitment, electricity and communications costs have all increased in recent years, Mr Szeleky said.

Increasingly the company has had to recruit doctors from overseas – "a slow and expensive process", he said.

Another major pressure on the company is looming payroll tax, which he described as "a very heavy burden".

Uncertainty over payroll tax has become an issue for general practices since the Optical Superstore Case of 2019 when the Victorian Commissioner of State Revenue determined that payments to practitioners in a service-entity model constitute wages.

In 2021-22 Revenue NSW reported that it had doubled its tax audits, revealing a 75% liability strike rate on all health-related audits conducted, including allied health.

Mr Szekely commented: "Although NSW and Victorian Revenue Offices have been the first to target GP medical centres following the Optical Superstore Case other states will certainly follow suit."

Mr Szekely, an engineer whose wife is a GP, said his company has plans to double the size of its operations over the next three years and achieve performance that would allow public listing by 2026-27.

In addition to its Canberra and Queanbeyan practices, the company has two clinics in Victoria and one in Sydney, where it is headquartered. Plans to establish two new clinics in Victoria and NSW were cancelled due to Covid-19, he said.

Parents caught in the middle caring for adolescents with mental illness

Cleaning up her son Ravi's bedroom after he took his own life last year at age 23, Leigh Watson found a poorly photocopied brochure about the Way Back Support Service, which provides post-discharge care to patients following a suicide attempt.

For Ms Watson and her husband, Ashish Madan, it was a tragic reminder of how the territory's under-resourced and fragmented mental health services leave parents like themselves stepping in to fill the gaps, but without any support.

"Someone in the mental health service had given Ravi the brochure, but it wasn't even written for a patient," she said. "It was a corporate document, written for health providers and it was entirely inappropriate for Ravi."

Ms Watson and Mr Madan say that in trying to help their son after his initial suicide attempt, they encountered mistrust from mental health services and faced enormous barriers under privacy law.

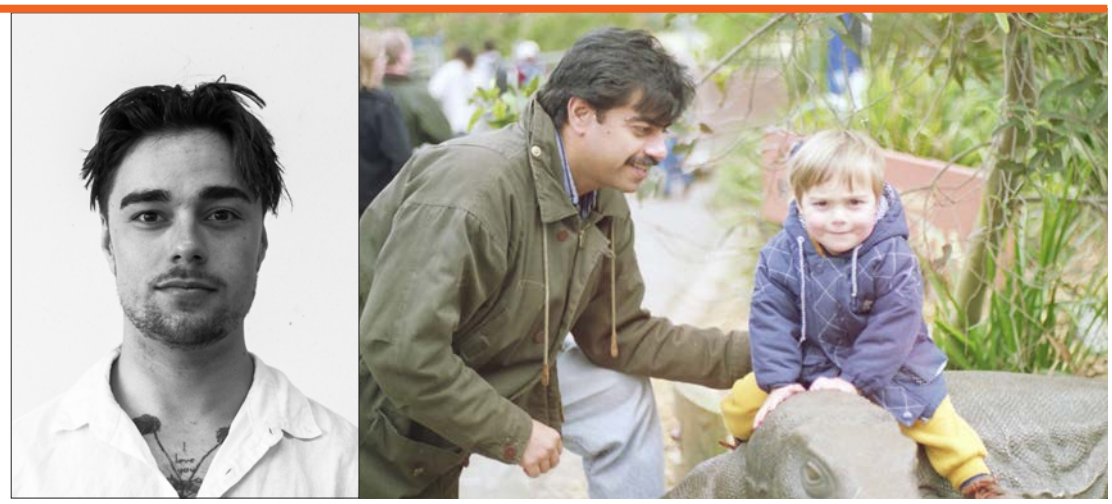
"I think staff were worried about breaching confidentiality because Ravi had not consented to sharing his medical information with us," Ms Watson said.

"We appealed to Ravi to accept our help, while also tiptoeing carefully around the privacy legislation."

Ravi lived with his parents, who organised his medical care, including various stints in residential mental health care facilities, and appointments with counsellors and behavioural therapists. They went searching for him when he made an attempt on his life in October 2019, finding him with the assistance of police.

Mr Madan said mental health workers would not give them basic information about Ravi such as his diagnosis, and were dismissive when the family raised concerns about his discharge from hospital.

"If anyone in mental health had been willing to engage with us they might have learned information that was useful to helping him," he said.



A recent photo of Ravi; Ravi as a child with his father, Ashish.

The law

Harry McCay, a solicitor at Avant Law said sharing health information with relatives of patients was a tricky area.

"Doctors are understandably cautious about providing information contrary to the patient's wishes," he said. "If unsure we always recommend the doctor speak with the doctor's MDO to get advice."

He said provisions of the Privacy Act and the Australian Privacy Principles establish the following requirements in relation to sharing information with relatives of patients:

If the patient has capacity, information can only be shared with the patient's consent, unless there is a serious risk to the life or health of an individual, in which case information can be shared in order to lessen or prevent the serious risk to the life or health of the individual

If the patient is either physically or legally incapable of giving consent to disclosure, the practice can disclose information to a person responsible for the patient that is necessary to provide appropriate care or treatment or for compassionate reasons.

Mr McCay said: "If there is a serious risk of self-harm this does allow for sharing information with a concerned relative in order to lessen that risk."

"If the doctor is unsure about the level of risk, the doctor should seek advice from a respected colleague with mental health experience and in the case of doubt should err on the side of caution."

Parents' plea

Ms Watson and Mr Madan are calling for an overhaul of the aftercare provided to young adults who have attempted suicide to provide proactive support for them and their carers. This would include:

- The appointment of a specialist suicide prevention support worker for the patient before they leave the hospital
- A peer support program worker for the patient's family or carers
- Coordination between these two programs to develop a plan for the patient's future, including creation of a case management team. If the patient decided not to be involved in case management this would be acknowledged as a risk by the team.

Mr McCay said having a support worker appointed to advocate for patients may be useful as consent is not required for sharing information for the primary purpose for which the person was seen – eg. if the patient was seen for mental health purposes and the support worker appointed for mental health purposes.

"This may allow the hospital team to share with the case worker, but that doesn't mean the case worker can share with the family unless the serious risk criteria is fulfilled," he said.

The minister's view

Minister for Mental Health Emma Davidson told Canberra Doctor there was "definitely more we need to do to improve access to the right services, at the right time".

She emphasised the government's primary focus on early intervention mental health services through the new Safe Haven and mindmap programs. The mindmap program includes Youth Navigators who can talk to young people or their families about their options and "hold the space and support young people" while they are awaiting their first appointment, she said.

She also specifically mentioned the Way Back Support service that supports people in the first few months following a suicide attempt, noting it is an initiative of beyond blue, funded by the Commonwealth Department of Health and ACT Health.

"We believe the person with the mental health experience has a right to make decisions about their discharge plans, including whether they would like a case worker and who should be involved in the decision-making process," Ms Davidson said. "Under the Mental Health Act 2015, the person's capacity to make decisions like this must be assessed by a psychiatrist."

Drs4Drs ACT: 1300 374 377
Lifeline: 13 11 14

NEWS
IN BRIEF

New MJA editor-in-chief

The *Medical Journal of Australia* has appointed Professor Virginia (Ginny) Barbour as its new Editor-in-Chief.

Professor Barbour is the Academic Lead, Office for Scholarly Communication at Queensland University of Technology (QUT) and Director, Open Access Australasia. Professor Barbour will start her new role as Editor-in-Chief on 23 January 2023.

Damian Smith, chair of the Journal's parent company, the Australasian Medical Publishing Company, said Professor Barbour was an outstanding choice for the role.

"Prof Barbour is one of Australia's foremost and experienced medical editors, someone with high integrity, superb judgement and a real affinity with the Journal and our purpose," he said.

Prof Barbour started her medical publishing career at *The Lancet*. She went on to be a founding editor of *PLOS Medicine*, the flagship medical journal of the open access publisher, Public Library of Science (PLOS) and she led medical publishing initiatives at PLOS for over a decade. She has a medical degree from Cambridge University, and a Doctor of Philosophy from the University of Oxford.

Professor Barbour said she has great respect for the heritage and history of the Journal which is over 100 years old.

"My predominant professional interest is improving scholarly communication, through increasing access to research for medical practitioners, researchers and the wider public, and enhancing the integrity, quality and reproducibility of the scholarly literature," she said.

Mr Smith said Professor Barbour takes over from Laureate Professor Nick Talley, AC, who will step down in January 2023, after a highly successful seven years in the role.

VALE

The President, Professor Walter Abhayaratna, Board members and staff of AMA (ACT) extend their sincere condolences to the family, friends and colleagues of
Dr Andrzej Rososinski

New RACGP president

The Australian Medical Association congratulates Dr Nicole Higgins on her election as the next President of the Royal Australian College of General Practitioners.

AMA President Professor Steve Robson welcomed Dr Higgins as RACGP President-elect, saying the AMA looked forward to working with her as both organisations strive to advocate for general practice, which is under increasing pressure.

"General practice is the cornerstone of Australia's health system and Dr Higgins is someone who we know is passionate about general practice and already enjoys a good relationship with the AMA," Professor Robson said.

"The AMA has always had a strong and respectful relationship with the RACGP and has worked closely with current President, Dr Karen Price.

"We have worked with the RACGP on the shared aim of improving the medical environment for doctors and we look forward to continuing this work with Dr Higgins," Professor Robson said.

Dr Higgins will officially take on the role at the conclusion of the RACGP's 2022 Annual General Meeting on Thursday 24 November.

NPS MedicineWise to cease

After 24 years championing the quality use of medicines in Australia, the NPS MedicineWise Board has made the difficult decision to cease the company's operations at the end of 2022.

This follows the decision by the Federal Minister for Health and Aged Care, the Hon Mark Butler, to proceed with the redesign of the Quality Use of Therapeutics, Diagnostics and Pathology (QUTDP) Program, as announced in the March 2022 Federal Budget. The Minister's decision follows a "rapid review" of the Budget measure by Deloitte Access Economics, in line with a pre-election commitment from the Labor Party after strong advocacy from NPS MedicineWise and the health community.

From 1 January 2023, NPS MedicineWise will no longer receive Federal Government funding to deliver Quality Use of Medicines activities, and existing functions will transfer either to the Australian Commission on Safety and Quality in Health Care or to new contestable funding arrangements.

Dr Andrew Knight, Chair of the NPS MedicineWise Board said: "NPS MedicineWise does not agree with the decision to proceed with the redesign."

"We believe it will prove to be a poor decision, and will make the safe and wise use of medicines in Australia much harder to achieve."

Drs4Drs ACT: access the best thinking on doctor wellbeing

Drs4Drs ACT is running its second Safe Space event of the year on Saturday October 15.

The day conference is an invaluable opportunity for doctors and medical students to confront the most stressful aspects of medical practice head-on, access support for their own wellbeing and be a part of changing the culture toward one that fosters wellbeing for doctors and medical students. A Safe Space is free to all doctors and medical students in the ACT, with morning tea and lunch provided.

AMA ACT President, Professor Walter Abhayaratna, said no subjects were off-limits at Drs 4 Drs events.

"At our inaugural conference, doctors talked honestly about mental health and other wellbeing issues in the profession and the fear of litigation," he said. "We need this kind of openness to support one another and improve the culture in our profession."

Professor Abhayaratna said there was now good literature on how to build professional fulfilment in the healthcare sector and avoid burnout.

"Contrary to what many have thought in the past, it's not all about building your own professional resilience, although that's important," he said. "There is a lot that can be done at the organisational level to create the kinds of healthcare environments where doctors can enjoy doing the work they were trained to do."

Speakers at the next event include:

- Dr Chandi Perera, rheumatologist at Canberra Hospital, who will be speaking on evidence and learnings about health practitioner wellbeing
- Dr Dana Phang, creator of the Junior Doctor's Corner podcast, who will be speaking on helping junior doctors thrive by building personal skills and influencing system change
- A panel of GPs and medical students led by Dr Michelle Barrett, who will discuss wellbeing for medical students
- Dr Paresh Dawda, GP and Palliative Care Researcher will lead discussion of a model of health practitioner wellbeing for the ACT

For those who missed June's conference, video-packages of the highlights are now available online, including legal advice on how to survive a patient complaint and a session with psychologist Nesh Nikolic on recognising the signs of burnout.

For more information and to register for the next Safe Space event visit ama.com.au/act

Training survey now open

The Medical Board of Australia's Medical Training Survey (MTS) is open now - giving trainees a platform to share their experience of medical training.

MTS is a longitudinal study, with most MTS questions consistent year on year to facilitate comparisons.

This year's survey asks questions again about the impact of COVID-19. It also asks about barriers trainees face in reporting bullying, harassment, discrimination and racism facing trainees, so we've added a question.

There are five versions of the survey, tailored to different groups of trainees; interns, prevocational and unaccredited trainees, international medical graduates (with provisional or limited registration), specialist GP trainees and specialist non-GP trainees.

MTS data from past years is already being used across the health sector to drive improvements in medical training.

For instance, the AMA Council of Doctors in Training (AMACDT) used data from the MTS for its second Specialist Trainee Experience Health Check, released in February 2022.

The results showed that while the quality of specialist medical education and training In Australia has weathered the COVID storm well over the past two years, supporting trainees to sit and pass examinations to progress to fellowship is a key area for collaboration and improvement.

MedicalTrainingSurvey.gov.au

Ode to a supervisor...

Dr Kerrie Aust, AMA ACT President-Elect gave the Plenary Speech at the GP Supervisors Australia Conference in September. Her speech explored her own training journey through the ANU medical school, Canberra Hospital and General Practice Training. Speaking with Canberra Doctor, Dr Aust laughed that her presentation should perhaps have been titled "A love letter to my supervisors".

AMA ACT President-elect, Dr Kerrie Aust

"While I wanted to highlight the challenges facing General Practice sustainability, I also wanted to reinforce that medical education is not possible without clinical supervisors," she said. "The impact of positive interactions from our supervisors shapes the doctors that we become and creates the supervisors of the future."

Below are a sample of her memories of some wonderful mentors in medicine.

"**The staff at ANU** saw the whole person and supported me as such. People were generous with their time, their knowledge, their stories of their failures and their skills. An ICU consultant offered to babysit my kids as exams loomed and the respiratory consultant offered extra tutorials when I struggled in respiratory physiology."

"With **Kirsty Douglas**, I was taught what true patient-centred integrative care can look like, with doctors working side-by-side Aboriginal Health Workers, dentists, midwives and psychologists."

"**Philip Gray** was tough, but he would hand me the loaded needle holder and tell me to sew up the hand laceration, correct my grip, remove the suture and let me try again. He encouraged me to back my instincts when I wasn't satisfied with the diagnosis of a patient. He told me to keep reading, keep advocating until the patient was sorted."

"**Perveen Aslam** was an exceptional educator. On my second day as an intern she took half an hour to sit down and teach me how to triage jobs effectively. She was always on the other end of the phone and always came if I needed her urgently. Knowing that you have that when you are looking after very sick patients keeps you safe as a doctor, and safe as a human."

"**Rashmi Sharma** gave me teaching that sometimes terrified my socks off but taught me so much. Role play sessions focused on very specific feedback – did I inappropriately reassure the patient before sending them for imaging? Was my safety net specific, clear, suitable?"

Canberra Doctor would love to publish more stories expressing gratitude to those who have generously invested in training the next generation.

Who can you thank for the support you received as a trainee? Share your memories by emailing sarah-colyer@ama-act.com.au

Doctors' health resources

Are you looking for a GP?

If you're a junior doctor or medical student and looking for a GP, please contact AMA (ACT) Reception on 6270 5410 and we will assist you to find a local GP.

Doctors' Health Resources online

Doctors for Doctors:

https://www.drs4drs.com.au/

DRS4DRS ACT

AMSA students and your doctors:

https://amsa.imiscloud.com/Web/Web/Committees/Mental-Health

amsa mental health

The Mental Health Guide is located at:

https://amsa.imiscloud.com/Web/Web/Publications/Guides/Mental-Health-Initiatives-Guide

Who's looking after you?

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ACT Helpline 1300 374 377 (24/7 days)
ama.com.au/act/drs4drsact

Don’t bequeath your super to the ATO

Who would you prefer your leftover super to go to?

If you were to die before you’ve had a chance to spend all your super, who would you prefer to receive what’s left over? Your loved ones or the ATO?

Many super accounts include a taxable component. So before it’s transferred to your beneficiaries, it may be taxed.

Unless, that is, you can take advantage of the re-contribution strategy. This involves withdrawing the taxable component from your super and then re-contributing it as non-taxable contributions. This strategy has saved some clients tens of thousands of dollars. But it’s not a no-brainer. Whether and when you’re eligible, the amount you can re-contribute and the way you do it, all require a great deal of technical expertise. That’s where we come in. ■

Should you need financial advice speak to the AMA Financial Services team on 1800 262 346 or email advice@amafp.com.au.

Case study: atypical Carpal Tunnel Syndrome

IGOR POLICINSKI

There are many ways a patient with carpal tunnel syndrome can present. The classic symptoms of tingling and numbness in the thumb, index and long finger at night are all well described, taught and recognised by doctors. It is the atypical carpal tunnel syndrome that is less known and recognised. Therefore, I would like to describe a patient that has recently presented to me, to help understand some of the less know symptoms that patients can complain of.

A 28-year-old female office worker presented with pain, sensation of swollen fingers and weakness, mainly on the right side but also occasionally on the left side, for more than 6 months. She reported difficulties using the keyboard at work, which persisted after changing to a more ergonomic set up. Her symptoms were usually worse after work and at night and would often wake her up. The pain was located generally through her wrist joint and radiated up to her elbow. She also reported dropping objects. She could not recall any trauma to her hands. She was otherwise well, played netball, didn't take any medications and was right hand dominant.

The patient tried work and activity modifications, which seemed to help, but did not resolve the symptoms completely. Her general practitioner started her on anti-inflammatory medication and requested an ultrasound (USG) of her wrist and carpal tunnel region.

Examination and tests

A clinical examination did not show muscle wasting. She had no loss of motion in the wrist or fingers. She had a negative provocative Tinel's test but a positive provocative Phalen's test. Her two-point discrimination was within normal range. There were no discrete tender points on her wrist or forearm. Her cubital tunnel was negative to Tinel's and compression. A nerve conduction study (NCS) was negative and the ultrasound did not show any major pathology apart from some median nerve flattening.

A cortisone injection in her carpal tunnel and trial of night splinting was recommended. Upon returning 6 weeks after the injection, she reported a partial relief of her symptoms.

Surgery and outcomes

After an extensive discussion, we elected to proceed with a carpal tunnel release despite the normal NCS. During the surgery, her median nerve was flat and synovitis of the flexor tendons was present.

At two weeks post operative follow up, symptoms on the right side had completely resolved, including wrist pain. The patient was also able to sleep through the night. Eight months later she returned with left side atypical symptoms, for which she also had a carpal tunnel release with complete resolution.

Lessons learned

This is one of many cases that I have treated for atypical carpal tunnel. It demonstrates the need for a detailed patient history, provocative clinical tests and the knowledge that sometimes not all tests will be positive for the diagnosis we are looking for.

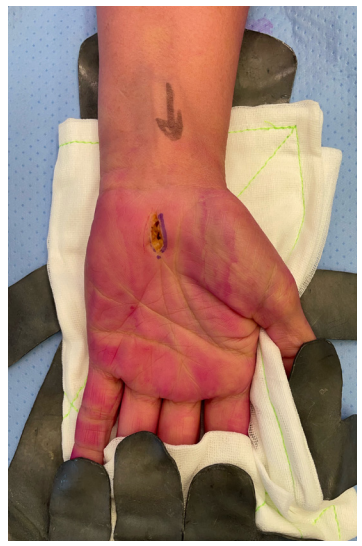
History of pain, swelling of fingers or difficulty with making a tight fist is not uncommon. Other symptoms of pain radiating to the shoulder, neck or even chest can happen and have been described in the literature.

Some patients also report tingling and numbness in anatomical distribution that are not classically supplied by the median nerve, but by the ulna or radial nerves. This occasionally can happen due to an anatomical anastomosis of the nerves in the forearm (Martin-Gruber anastomosis) or in the hand (Cannieu and Riché anastomosis).

Compression of the median nerve in other regions or other peripheral nerves can also occur, in particular the ulna nerve in the cubital tunnel region. These compressions can also be recognised with thorough medical history and clinically assessed at the time of consultations.

NCS can be false negative in some cases, especially in early carpal and cubital tunnel syndrome. USG can sometimes be helpful and show compression of the nerve. MRI can be very helpful but will also demonstrate incidental findings that could complicate the diagnosis.

A trial of a cortisone injection into the carpal tunnel can help to determine if the diagnosis is correct. However, if there is no response, that does not necessary eliminate the diagnosis of carpal tunnel syndrome.



Symptoms resolved after surgery.

Most patients with atypical carpal tunnel syndrome will have some response to night splinting and cortisone injections. A nerve conduction study and ultrasounds will help in establishing the diagnosis, but are not always positive.

Dr Policinski is an Orthopaedic Surgeon in Canberra specialising in conditions of the hand, wrist, elbow, shoulder and trauma.

10 challenges for healthcare governance

PROF JENNIFER MARTIN
AND DR SARAH DALTON

Governance in healthcare is usually assumed to include both corporate governance, that is, managing the organisation's business performance (including ethics, culture and stakeholder accountability); and clinical governance, which focuses on improving the quality and safety of patient care.

Clinical governance also focuses on performance in terms of the clinical outcomes of the health organisation. It is also a key pillar of corporate governance as business performance also impacts on the clinical governance aspects of patient care, practice processes, staffing quantity and quality, and healthcare flows, such as movement of patients throughout the different parts of the system. Health organisations need to serve the community's needs and to do so must meet compliance and regulatory obligations.

Health organisation leaders therefore have a dual-governance oversight role, with corporate governance activities focusing on regulatory and compliance risks, and clinical governance activities addressing patient safety. An awareness of the linkages and overlap between the two is vital, as is the use of appropriate technology to make that information available to the board.

The health system as a whole regularly has new issues to face. Good governance in the sector thus requires understanding of the complexity and dynamic position of new corporate and clinical governance challenges. Depending on whether the entity is public, private or a mix of both, the dual governance role also includes alignment with policy directives, accountability to funders, community, other stakeholders, and to different aspects of the healthcare system.

Into this complexity – and a longstanding lack of resources to meet our healthcare needs, particularly for the public sector – came the COVID-19 pandemic, now in its third year.

The strain on both primary care and aged care, with different funders and policymakers changing patient flows and bed priorities as the pandemic progressed, manifested issues for clinical governance. The chronic need for hospital beds for COVID-19 patients resulted in the cancellation of non-urgent services and surgeries. The result of these measures has seen increases in issues of late presentations of disease, and in staff issues of sickness, mental health and fatigue. It is increasingly apparent that without adequate numbers of healthy and appropriately credentialed staff, corporate performance is affected.

Corporate and clinical governance is complex and dynamic.

Healthcare governance has clearly been thrust into the spotlight and was selected as a session for discussion at the 2022 Australian Governance Summit (AGS) in Melbourne. The session identified the following issues for healthcare directors to consider for their organisations going forward. They apply at least equally to a strained aged care sector in need of urgent attention.

1 Workforce shortages

It is now evident that Australia as a whole, and particularly in specific areas, does not have adequate numbers of appropriately trained and credentialed nurses, doctors, specialists and allied health workers (among others), to undertake the current and future work of many health organisations.

Training and credentialing are key aspects undertaken both in health organisations and by external providers for which the healthcare provider may not have oversight, for example, in universities and community settings. Training a specialist doctor takes 12-16 years, so urgent replacement of specialists is not easy. Overseas-trained doctors are now not easily available to support our workforce gap. Although there is an immediate need in major

cities, the problem is magnified in regional areas, with some hospital services having to close.

2 Staff wellbeing

The "great resignation" has already been keenly felt in healthcare. Clinicians are accustomed to the high workloads and constant stress associated with burnout. However, the ever-increasing acuity, societal expectations and complex regulatory environment of healthcare provision have taken a toll on our workforce. This is potentially tied in with issue one (above), as all of these contribute to unexpected and large workforce issues. As more clinicians move away from patient-facing roles, or leave healthcare altogether, those who are left behind face mental health and wellbeing issues at great cost to themselves and the corporate goals of the organisation they work for. Healthcare boards must prioritise and protect the wellbeing of their employees as one of their greatest, and potentially scarcest, resources.

3 Occupational health and safety

A sufficient and healthy workforce is a key foundation for optimal organisational performance. Without an adequate workforce there are poor patient outcomes. It adds additional risks to patients and to clinical governance performance, in turn affecting total risk for the organisation. Boards must consider their risk-compliance appetite – what is their risk for inadequate staff levels, patient care and treatment delays? For private hospitals, reducing services is possible. However public hospitals must accept all patients needing admission and find them a bed. Yet if the referral system is not working well due to primary care pressures, this becomes a bed block in the hospital and a reduction in services. This has also seen the aged care sector unable to accept patients in a timely manner.

4 Culture

This is a difficult one because not only are there age-old cultural and behavioural differences between health disciplines, but also between and within roles in hospitals. Many senior healthcare workers on public hospital boards are appointed long after retirement from a clinical role and may not have the flexibility and speed to manage navigating all the issues that come up on a daily basis, particularly during a pandemic. There is a need to work cooperatively going forward - for example in IT, cyber, allocation of complex work and training staff requirements. We ask: where is the risk vs compliance or the innovation barometer now set on our boards for culture? Does this need to be reset for pandemic times? Do we even know or aim to predict what the health workforce is going to look like in the future, and how our teaching and training will need to adjust?

Issues where this was evident in the pandemic included the use of the same pre-pandemic systems for medical research funding processes, including, a reliance on large, long, expensive, randomised clinical trials, which were already being undertaken in other countries; lack of ability to use and link administrative data between Commonwealth and states, between states, within states and even within health districts and primary care; slow and tortuous ethics processes unaltered for the pandemic; difficulty with processes to physically move staff around to fill shortages; use of other digital services (for example, medical records are still paper-based in many hospitals); integration of new technologies to manage workload and measure care; and harnessing innovative spirit, creativity and decisions regarding infrastructure.

One major risk management issue is how clinical systems develop and support electronic medical records/consent processes, and how to navigate these processes and respect patient confidentiality.

5 Relationship between health and other entities

What are the clinical governance risk and compliance issues to be overcome? For example, for hospitals when their staff are trained by medical schools and universities, and their specialists by colleges, themselves accredited. And these subsequently accredit health workplaces for being able to deliver healthcare and train staff.

But how does the board provide oversight and monitoring here? How does the board navigate this? How does the healthcare organisation navigate through specialist college issues such as workforce shortages to ensure such requirements are met in a timely capacity?

Good healthcare governance cannot ignore climate change.

6 Role of state/federal governments in health governance

Australia needs to have a pandemic strategy for the next and subsequent pandemics; and health policies need to be developed to support health organisations. Issues where healthcare had difficulty navigating government policy during the first COVID-19 wave were seen in the personal protective equipment issue, our vaccine roll-out strategy, our strategy for medicine supply chain issues and the lack of a mRNA vaccine technology facility. Strategic planning for workforce sustainability is a critical element of the future of healthcare and must be recognised as a primary policy priority.

7 Climate change

COVID-19 hit at the same time as the natural disasters of fires and floods in Australia, causing an immense impact on the health and wellbeing of the population. How can issues around reduced wastage, sustainability and the effects of high temperatures on mosquito-borne viruses – which have added to the stress and sickness of our communities – be addressed at a health board level, for our important community stakeholders?

8 Supply chains and manufacturing

Lessons here are around agility in our research systems and research funding processes, for example, the UQ vaccine project, the lack of cooperation and national coordination across the health and medical research sector; inability to use and combine administrative data; and problems with data linkage across states, and between primary and secondary health.

9 Appointments to health boards

In most states, public hospital boards are appointed by and accountable nominally to the minister; process and vetting is done elsewhere. In situations such as a pandemic, should some board members have a risk-compliance meter that is set lower than the general board? Or requirements for personality traits of agility, flexibility and innovation. Who are health boards accountable to, not just in law or regulations, but morally and ethically? How does a board set the tone from the top on culture, wellbeing and ensuring clinical outcomes are priority?

10 Relationships with health system structures

Lastly, it is important to consider how the board is affected by Commonwealth/state health committees and their policies and directives. Are our health workers trained to the required standards and able to be retrained (perhaps by external providers) as the needs of the health system changes? Do we have enough to deliver our services at the levels expected of us by our stakeholders? What control do we have over patient flows into and out of our hospitals? And how do changes in government policy for our stakeholders, such as aged care, affect us being able to deliver our healthcare? We believe healthcare and its governance are at critical times.

In summary

COVID-19 has forced healthcare organisations to rethink their governance systems and approach to workforce sustainability and to test whether some aspects of performance are still fit for purpose. Governance in healthcare organisations must evolve quickly, so it can implement an updated system that links clinical and corporate governance effectively.

Both governance systems can better assess performance and clinical risks through compliance monitoring and regular review of board appointments and risk tolerance.

As a way forward, healthcare organisations could support putting in place governance training programs across leadership roles. This would assist employees to understand corporate as well as clinical risk management and the unique role of governance in their organisation. Healthcare boards could regularly listen to stakeholder voices, including those staff on the ground and the communities who use the facilities.

Prof Jennifer Martin is a practising physician and Royal Australian College of Physicians (RACP) board member and Australian Institute of Company Directors (AICD) NSW council member. Dr Sarah Dalton is an AICD graduate member, a practising paediatrician and previous member of the RACP board. This article was developed from preparation for AGS 2022.

This article was first published on the website of the AICD in May 2022.

Donations help restore doctors' livelihoods

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Floodwaters damaged the Lismore Skin Clinic.

It has been a busy two years for The Medical Benevolent Association of NSW(MBANSW) who help doctors in NSW/ACT in times of crisis.

Historically their work centred around common life stressors like illness, accident, loss, addiction and relationship breakdown but more recently, it has been directed towards helping doctors who have lost homes and livelihoods.

In 2020 during the Black Summer Bushfires, they assisted doctors and practices re-establish. Then COVID-19 came and doctors needed financial support due to lockdowns and the closure of elective surgery. With stress levels rising some succumbed to burnout and required support while they took a few months off.

The NSW floods

More recently the NSW floods have required MBANSW to assist 45 doctors with emergency funding including a few who lost their homes. MBANSW also provided grants to re-equip significantly affected clinics.

"We heard stories of amazing resilience – doctors putting others before themselves during these floods," said Ida Chan, MBANSWs Senior Social Worker. "Many had lost their family home and some their clinics. Yet these were the same doctors who were the first to deliver first aid and vital medicines to patients stranded by flood waters."

"We let them know we were here for them and gave them a safe, independent space to voice their own anxiety and exhaustion."

Executive Officer Louise Fallon said some doctors admitted to the MBANSW team they had less than $50 in the bank, after paying clinic bills and staff, despite their income stopping. "We knew that we needed to get money to them quickly and without unnecessary red-tape. In 90% of the cases, we took less than 3 days to do that and it was some of the first money to 'hit the ground'," she said.

To raise the funding needed, MBANSW launched a Flood Appeal. Ms Fallon would like to thank the many ACT and NSW doctors who donated to support their colleagues. They also received a $10,000 grant from CommBank. These funds, plus additional reserves were used to provide over $99,600 in flood relief.

Reach out

Ms Fallon welcomed all doctors to make use of MBANSW's free, independent and confidential support service.

"Doctors are not immune from life stressors and can experience stress for all sorts of reasons as well as those more unique to their profession," she said. "If anything is bothering or concerning to them then that's enough reason to reach out!"

MBANSW are also calling out for donations so they can continue their work. All donations are 100% tax deductible and can be made via their website at www.mbansw.org.au or you can send them direct to AMA-ACT.

If you, or a fellow colleague, are in need of support or financial assistance, please contact MBANSW for a confidential discussion on 02 9987 0504 or email support@mbansw.org.au.

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