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Workforce crisis steals election spotlight

Canberra's impressive new public hospital building has arrived just in time for the ACT election on October 19, but for doctors, the bigger issue is the territory's crumbling medical workforce.

The completion of the long-awaited Critical Services Building in Garran could not avert doctors' gaze from the crisis in the medical workforce at AMA ACT's second Politics in the Pub event in July. Panellists including Health Minister Rachel Stephen-Smith and Attorney General Shane Rattenbury faced questions from frustrated local doctors and medical students.

Doctors expressed feeling over-worked, under-supported and under-appreciated. They pointed to the territory's deep recruitment and retention problems, asking panellists to account for why ANU medical graduates are leaving Canberra in record numbers and why hospital departments struggle to fill vacancies. They expressed worry for their patients who face long waits in the public system.

AMA ACT President Dr Kerrie Aust told the panel many junior doctors were not coping and that culture problems persist at Canberra Health Services. "The more stretched the system is, the first thing that disappears is teaching and the second thing is civility," she said.

Recruitment and wellbeing

Health minister Rachel Stephen-Smith was keen to reassure doctors that the ACT Government has been making improvements in the areas of recruitment and staff wellbeing.

She highlighted the successes of the Government's new talent acquisition team which recently recruited four cardiac stenographers. "We were able to do that because we have a talent acquisition team that knows what it is doing," Ms Stephen-Smith said.

Ms Stephen-Smith acknowledged the long-running culture problems at CHS but said things were changing. She pointed to the Government's $8.5m investment in health practitioner wellbeing, which includes funding a staff psychologist and dedicated support staff for IMGs and unaccredited registrars.

JMOs angry over EA

Emotions flared as several JMOs in the audience confronted the Health Minister about the Government's pay offer in the latest Medical Practitioners Enterprise Agreement, which one doctor labelled "insulting".

The EA, which was voted on in July, would have given interns a pay rise of just 3.7% annually. Doctors overwhelmingly rejected the offer – with a response rate of 58% and only a 14% yes vote.

Canberra Liberals Deputy Leader Leanne Castley, Attorney General Shane Rattenbury, Health Minister Rachel Stephen-Smith and Independent candidate Thomas Emerson at AMA ACT's Politics in the Pub.

JMO Association President Simona Sarmiento claimed that despite Labor's pledge to ensure ACT health workers were the best paid in Australia, junior doctors in the ACT were "the third-lowest paid in Australia". Ms Stephen-Smith retorted: "They wouldn't be if the EA actually got up."

AMA ACT has fact checked these statements. While the rates of pay vary according to the classification of employment, ACT interns are the second lowest paid in Australia, after NSW interns. If the Government's pay offer had been accepted, ACT interns would be the fourth lowest paid. Second year residents by contrast would be comparatively well paid in the ACT, while senior specialists would be comparatively poorly paid. See box on page 7 for further details.

Continued page 7

President's Notes

WITH PRESIDENT,
DR KERRIE AUST

ANU Medical Students' Society Vice President Tally Golembiewski, AMA ACT President Dr Kerrie Aust, Health Minister Rachel Stephen-Smith and AMSA President Allan Xiao at Politics in the Pub.

As we count down the days to the ACT election, it's interesting to reflect on where the health system is at today compared to four years ago, before the last election.

The upsides

The introduction of the **Digital Health Record** in 2022 is a tremendous achievement. While the change has been uncomfortable for many doctors and was not without technical hiccups, we are already starting to see improvements when it comes to clinical handover within the hospital. Registrars I'm talking to love it, and the VMOs are getting increasingly used to it. We have feedback in private practice that communication on discharge and from outpatients is often faster. We want to see the technology utilised for improvements in data on waiting times and patient outcomes – the kind of transparency the AMA has long called for.

The opening of the long-awaited **Critical Services Building** is another obvious achievement. By all accounts, Canberra Health Services has done a terrific job preparing staff for the move to the new building. Visiting the place since its opening, there's a buzz among the staff, suggesting it's providing a much-needed morale boost. We can only hope this might translate into a recruitment boom. We hope to see the hospital address some of the concerns from doctors and nurses about spaces for confidential discussions and team meetings, access to computers, breastfeeding spaces and staff lockers in the coming months.

I'm really encouraged to see the Government's recent investments in **doctor wellbeing** at CHS – especially when it comes to our hard-working junior medical officers. There is positive feedback about having access to a staff psychologist and new senior staff to support unaccredited registrars and IMGs. AMA ACT is watching this space closely, to see that the new appointments translate into improved experiences for trainees and senior doctors over time. The results from the Medical Board's **Medical Training Survey** over the next few years will be the proof in the pudding. If you're a JMO, please take the time to complete this really important survey.

Overall, the dialogue between AMA and the Government is positive on many fronts. I was especially glad to hear Health Minister Rachel Stephen-Smith talking about the importance of GP-led integrated primary health care at AMA ACT's most recent Politics in the Pub event. And yet, there are some very fundamental problems with the ACT Government's big picture on health care that cannot be ignored. So let me come to the downsides about the last four years.

The downsides

It devastates me, as someone who knows the value of general practice from evidence and experience, to see the ACT Government increasingly reliant on **alternative attendance models** that push health practitioners to work outside of their scope of practice and fragment care. From nurse-led clinics to pharmacy-prescribing trials, the Government is increasingly ushering patients to non-medical practitioners for conditions that have traditionally been managed by a GP.

Many of these nurses and pharmacists are skilled colleagues and friends. Nevertheless, nursing and pharmacy training and experience are in no way equivalent to medical training when it comes to making a diagnosis. I too did some science units in my undergraduate science degree that did not lead me to be prepared for the complexity of diagnostic medicine. The result of this task substitution will be missed diagnoses, decreased efficiency and loss of continuity of care, as patients no longer go to their regular GP. All this will put more pressure on our hospital system.

The most cost-effective model of primary health care is GP-led integrated multidisciplinary care. That's for many reasons. A GP sees the whole patient rather than an isolated medical episode, and works with them on health priorities in a step-wise fashion, to prevent the development or worsening of chronic health disorders, to keep them out of hospital. A GP who knows the patient well orders fewer unnecessary investigations than a nurse working at the top of their scope, saving the health system money. The Primary Health Care pilot funded by the Federal Government (Page 8) is looking to be a great demonstration of this. This is where primary health care should be headed.

Instead, several of the ACT Government's policies in the last four years have undermined the viability of general practices. Not only must general practices in the ACT compete with government-funded Walk in Centres, they are now subject to an expensive **payroll tax**. Practice managers tell me they are running on the slimmest of margins and several general practices have closed their doors in the last four years.

It's not just the GPs who are feeling let down. Across the hospital system, many doctors tell me they feel like the Government doesn't appreciate doctors; that they're replaceable cogs in a service-delivery machine. This sentiment was recently reinforced with the Government's disappointing pay offer for doctors in the **Medical Practitioners Enterprise Agreement**. Only 14% of doctors voted in favour of it (with a 58% response rate).

Unfortunately, no candidate I have heard in the lead-up to election has cast the kind of big picture vision required to reverse the structural dysfunction in the ACT health system. The Liberal Party is offering a Royal Commission into the health system and promising to revoke the payroll tax. These announcements are welcome but fall far short of what is required.

So how do you rate the ACT Government's performance over the last four years? You'll get to tell them yourself on October 19.

AMA matters

I'm pleased to inform members that former AMA ACT president Dr Andrew Miller has taken on the role of board chair for the Federal AMA. Dr Miller has been a long-serving member of the AMA, and we wish him all the best in the new role. Dr Miller is continuing to see patients through his dermatology practice.

I've recently been out and about visiting different medical teams in Canberra to better understand the issues our members are facing. Recently I had the pleasure of visiting Dr Karyn Cuthbert and the Hospital in the Home Team (Page 13). Members are welcome to get in touch with our office if they'd like a visit. ■

Staff praised for 'enormously successful' hospital move

After much anticipation, Canberra Hospital's emergency department moved into the new state-of-the art Critical Services Building (Building 5) on August 17.

The new emergency department was activated about 7.30am, with Canberra Health Services CEO Dave Peffer cutting the ribbon for the first patient to be transferred across the clinical link bridge.

By about 4.30pm the move was complete, with more than 100 patients moved into the new building, as well as thousands of pieces of equipment. Over the weekend the new emergency department experienced more than 520 presentations.

Elective surgery and Cardiac Catheter Laboratory procedures had been progressively getting underway in the new building in the week before. Saturday 17th August also saw the opening of the new Helideck, Clinical Forensic Medical Unit, Intensive Care Unit, Operating Theatres, Cardiac Catheterisation Laboratories, Medical Imaging and Inpatient Units.

Health Minister Rachel Stephen-Smith praised hospital staff for their remarkable efforts to see the move go smoothly.

> "It's a credit to the teams that have undertaken all of the training, all of the scenario planning, all of the simulation to make this happen,"
>
> **- Rachel Stephen-Smith**

"It was an enormous logistical effort, but what we've really seen is that it's been an enormous success, and our teams are now settling into their new state of the art facility," Ms Stephen-Smith said.

AMA ACT has received positive feedback from hospital doctors about the move. AMA ACT board member Dr Clair Bannerman was one of the many doctors working on the day of the move, and said it went really well.

Dave Peffer, with the first patient to be transferred across the clinical link bridge, cutting the ribbon.

"Staff affected by the move have felt supported and informed," she said. "The planning for the move has been exceptional, including orientation tours and transition rostering."

The AMA is aware of concerns from doctors and nurses about a lack of spaces for confidential discussions and team meetings, access to computers, breastfeeding spaces, staff lockers and ride to work facilities at the new building. AMA ACT will continue its advocacy on these matters with the ACT Government. ■

Dr Adam Eslick in the new building.

The entrance of the new Emergency Department.

AMA reassured on IV fluid shortages

Federal, state and territory governments' recent coordination efforts on IV fluid shortages provide growing reassurance that patients will continue to be able to access care across the health sector.

AMA President Professor Steve Robson said media reports on the issue had caused concerns among patients and providers, however coordination efforts by governments meant steps were being taken to address the issue.

"The cross-jurisdictional response group established by Minister for Health and Aged Care Mark Butler is meeting frequently to share data; co-ordinate action on IV fluid usage and supply; establish forecasts for future needs; discuss logistics and issue clinical guidance and updates to our front-line healthcare workers," Professor Robson said.

"This effort should be comforting for Australian patients, no matter where they live, or where they are being treated."

The AMA will continue to monitor the situation closely and provide feedback through the cross jurisdictional working group, ensuing that clinician feedback continues to inform decisions being taken at the highest levels.

An ACT Intravenous Fluid Shortage Collaboration Network has been established which includes representation from all public and private health services, ACT Ambulance Service and Southern NSW Local Health Network. This group is currently meeting weekly to share information and ensure equity of supply.

ACT Chief Medical Officer Dr Jodi Glading said ACT is currently in a good position with expectations that supplies will continue.

"The ACT IV Fluid Shortage Collaboration Network continues to meet to ensure communication channel remain open and if things do change, we are able to respond quickly," Dr Glading said. ■

AMA will continue to monitor the IV fluid shortage and provide feedback.

AMA24 CONFERENCE

AMA welcomes new President and Vice President

Dr Danielle McMullen has been elected unopposed as the new AMA Federal President, with Associate Professor Julian Rait elected Vice President. They will commence their new roles on October 1.

Outgoing AMA President, Professor Steve Robson, praised Dr McMullen, who has been Vice President for the past two years and was President of AMA NSW before that.

"Having worked with Dr McMullen so closely I can confidently say I can't think of a better person to advocate for members, and all doctors on improvements to our health system," Professor Robson said.

"Dr McMullen is a strong but inclusive leader. She brings poise and vibrancy to the role of AMA President. The respect and recognition that Dr McMullen has around the country has translated into broad support of her candidacy for the AMA President role."

Dr McMullen said she was looking forward to representing all doctors across the health system, which is under strain in all areas.

> "The AMA is the voice of the medical profession and the only group representing all doctors across the country of all specialties and stages of career. I'm ready to take on the challenge along with my colleagues."
>
> **- Dr Danielle McMullen**

"There is an urgency and a readiness to take the best bits of our healthcare system and strengthen them; to support our excellent doctors and other health workers; to invest in prevention and early intervention; and to invest in general practice so that Australians have ready access to their doctor when they need them," Dr McMullen said. "While there are many threats to the health system, there are also great opportunities."

Associate Professor Rait, a specialist ophthalmologist who was President of AMA Victoria from 2018 to 2021, said he was looking forward to representing AMA members in his new role and advocating for a stronger health system for all.

"I am looking forward to working with Dr Danielle McMullen, an extraordinary GP who will be a fantastic President of this organisation," he said. ■

New Federal President, Dr Danielle McMullen.

ACT members honoured with fellowship

Congratulations to AMA ACT members, Associate Professor Jeffrey Looi and Professor Anthony Lawler, whose long-standing contributions to the AMA, the profession and the health system as a whole have seen them inducted into the AMA Roll of Fellows.

A/Prof Jeffrey Looi and Prof Anthony Lawler.

A clinical academic neuropsychiatrist, A/Prof Looi has provided invaluable insights and guidance into numerous topics of AMA mental health policy and advocacy over many years.

His contributions to the work of the AMA have been thoughtful and consistent, willingly contributing his time, knowledge and expertise. As an advocate for his workplace colleagues, office bearer, chair and committee member, A/Prof Looi has shown what it is to be a leader in the AMA.

Professor Lawler is currently Deputy Secretary of Health Products Regulation at the Department of Health and Aged Care and was previously the Tasmanian Chief Medical Officer. During the COVID-19 pandemic, Professor Lawler led the state's acute health system response.

Professor Lawler has been an active member of the AMA for almost 30 years and has held leadership positions at all levels, from Chair of the Council of DiT to Branch President and Federal Council and Executive member. ■

Canberra GP wins diversity award

Canberra GP Dr Clara Tuck Meng Soo is one of two doctors to have been specially recognised with a Diversity in Medicine Award at AMA24 on the Gold Coast.

Born in Malaysia, Dr Soo is known for her dedication to the LGBTIQA+ community. She believes it is important for a trans woman of colour to be seen and heard to increase the visibility of both trans people and LGBTIQA+ people of colour, and promote greater understanding and acceptance.

Dr Soo said she was honoured to accept the award. "The AMA's award for diversity in medicine sends a strong message about the importance of the diverse communities working in medicine and the diverse communities that we serve," Dr Soo said. "In giving me this award, I see it as the AMA acknowledging my work with the LGBTIQ community and in particular the trans community, and I am grateful for this powerful gesture of support."

Dr Dinesh Palipana, a Queensland emergency doctor living with quadriplegia, was also recognised with a Diversity in Medicine Award. He is a passionate disability advocate, dedicating his professional life to working, teaching and researching health.

Dr Clara Tuck Meng Soo.

AMA President Professor Steve Robson commented: "We'd like to honour Dr Soo and Dr Palipana for their commitment to providing compassionate and inclusive healthcare for all. Their compassion and empathy have made a profound difference in the lives of countless individuals and families across Australia." ■

Know the rules on VAD in NSW

The ACT Government is aware that some doctors have been receiving inquiries from patients about accessing voluntary assisted dying (VAD) in NSW. Doctors need to be aware of the legal restrictions that apply in these conversations. The following information comes from an ACT Government factsheet.

When does VAD become legal in the ACT?

The law has recently changed in the ACT to allow eligible people to access VAD, however this scheme does not come into effect until 3 November 2025. By contrast, VAD has been available in NSW since November 2023.

Can an ACT patient access VAD in NSW?

Eligibility to access VAD in NSW is limited to NSW residents of 12 months or longer. However, there is an exemption process available to people who can show a substantial connection to NSW.

Where an ACT patient can prove they have a substantial connection to NSW and there are compassionate grounds, the patient can apply to the NSW Voluntary Assisted Dying Board for an exemption from the residency requirement. For information visit health.nsw.gov.au/voluntary-assisted-dying.

Can an ACT patient access any stage of the NSW VAD process in the ACT?

No. Patients need to complete each step of the VAD process in NSW. The authorised practitioners must also be registered by the NSW Voluntary Assisted Dying Board and be physically located within NSW for each step of the VAD process. This is detailed in the NSW Voluntary Assisted Dying Clinical Practice Handbook.

Can an ACT registered health practitioner be a coordinating, consulting or administering practitioner as part of the NSW VAD process?

No. The NSW VAD legislation does not allow for ACT registered health practitioners to be eligible for any of these roles.

If a patient/family or carers want to know more about the NSW VAD process, what can I tell them?

You can only provide contact information about accessing VAD in NSW. You cannot discuss any content or general information about the NSW VAD process or legislation.

Providing more than contact information risks breaching the Crimes Act 1900 (ACT) as it may be considered aiding or abetting suicide, or attempted suicide, or inciting or counselling another person to commit suicide under the Act.

What information can I give?

- The NSW Voluntary Assisted Dying website: health.nsw.gov.au/voluntary-assisted-dying.
- The NSW Voluntary Assisted Dying Care Navigator Service: 1300 802 133, NSLHD-VADCareNavigator@health.nsw.gov.au
- The Translating and Interpreting Service (TIS National) on 131 450
- The Southern NSW LHD Voluntary Assisted Dying Coordinator: 0460 874 453, SNSWLHD-VAD@health.nsw.gov.au

What if I am asked to provide information about a patient to a NSW clinician who is assessing the patient's eligibility for VAD in NSW?

You are required to comply with

the Health Records (Privacy and Access) Act 1997. Where it is reasonable to do so, you should provide the requested personal health information and where practicable, seek the patient's consent for this personal health information to be shared with a NSW clinician who is assessing the patient's eligibility for VAD in NSW.

Where patient consent can be obtained, you should document this consent within the patient notes or file. You should not provide any views on whether the patient may (or may not) meet NSW VAD eligibility criteria. ■

Support

If voluntary assisted dying raises concerns for you, you can contact **Lifeline** on 13 11 14 or **Griefline** on 1300 845 745.

Abortion law changes in ACT

Health practitioners with a conscientious objection, who have been asked about abortion services by a client, are now required to immediately refer the client to another service provider.

The change recently came into effect in the ACT after the passage of the Health (Improved Abortion Access) Amendment Act 2024 in June. Previously, health practitioners were only required to inform the client that they had a conscientious objection. The new requirements align the ACT with other states and territories.

Conscientious objectors can either give information about how to locate or contact another health practitioner (or health service) who they reasonably believe can provide the abortion service; or transfer the person's care to another health practitioner (or health service) who they reasonably believe can provide the abortion service.

Under the changes to the Health Act 1993, prescribing rights are expanded so that suitably qualified nurse practitioners and authorised (endorsed) midwives are able to prescribe abortifacients. This accords with changes made by the Therapeutic Goods Administration in August 2023.

The amendments complement the ACT Government's accessible abortions scheme, which supports the provision of no-cost abortions and free long-acting reversible contraceptives at the time of abortion to ACT residents, including those without access to Medicare.

These no-cost services have been available through MSI Australia since April 2023, and more recently include participating general practices, pharmacies, pathology services and medical imaging services across the Territory. ■

For more information visit womenshealthmatters.org.au

Promises Checkpoint

As the October 19 election draws near, the major parties are grandstanding on their commitment to Canberra's health workers and making promises to fix the ACT's broken health system.

ACT Labor are promising to hire 800 more health workers if they are re-elected and say they will make sure Canberra's health workers are some of the best paid in the country. Their website makes the audacious boast that "only Labor invests in our healthcare system. And only Labor looks after those who work in it, and those who rely on it". It claims ACT Labor is making the biggest investments in free public healthcare in territory history, pointing to Labor's plans for the Canberra Hospital Expansion, the new northside hospital and new Walk-in Centres.

The **ACT Greens** are promising to establish four bulk-billing GP clinics across Canberra employing eight full time doctors 7-days a week, including after-hours. They're also offering four new mental healthcare centres across the ACT that will run on a 'Safe Haven' model. They're promising to make emergency ambulances free. And they say they'll give additional funding to GPs who provide bulk-billed care for mental health and musculoskeletal health.

The **Canberra Liberals** are promising to hold a Royal Commission into the health system. They also say they will abolish the GP payroll tax, establish a gynaecology oncology unit, engage contractors to reduce colonoscopy and endoscopy wait lists, explore retention measures for frontline health workers, develop a men's health plan and repeal the drug decriminalisation laws.

It begs the question, what became of all the promises Labor and the Greens made before winning the last ACT election in 2020? *Canberra Doctor* did some digging and found the Barr-Rattenbury Government has made good on many of its election commitments. Nevertheless, they haven't managed to meet all their deadlines and have quietly abandoned a few policies (see opposite). ■

Has the Government delivered on its 2020 promises?

On track or completed

Labor/Greens promise: Complete major expansion of Canberra Hospital by 2024.

Update: State-of-the-art Critical Services Building opened August 2024.

Labor/Greens 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 compulsorily acquired Calvary Public Hospital Bruce in 2023 and has commenced planning to develop a new northside hospital on the site.

Labor/Greens promise: More services at the existing nurse-led Walk-in Centres (WIC) and establishment of an outpatient imaging service at Weston Creek by January 2022.

Update: Imaging Services are now available at Weston Creek WIC. The scope of WICs has been expanded so they can now see children aged 1 and older.

Labor/Greens promise: Establish 5 new WICs between 2021 and 2025.

Update: The WIC concept has evolved to 'Community Health Centres' offering targeted, multidisciplinary services. The first such new centre opened at Molonglo in 2022, offering free pregnancy care and maternal and child health care. The 2024-25 budget includes money for the construction of new Community Health Centres in North Gungahlin (Casey) and the Inner South (Conder) and early design work for an additional centre in West Belconnen (Ginninderry). These will have a focus on chronic disease care.

Labor promise: Establish a new adolescent mental health unit.

Update: Adolescent mental health unit opened at Canberra Hospital in 2023.

Labor promise: Employ an additional 400 doctors, nurses & allied health workers this term.

Update: The ACT Government says it has met this target.

Labor promise: Introduce a Paediatric Liaison and Navigation Service to help coordinate patient care across the health system.

Update: PLaNS is up and running.

Greens promise: Expand the Police, Ambulance and Clinician Early Response (PACER) Program.

Update: The Government added a second PACER team. There have been calls to expand the program further.

Greens promise: Establish Safe Haven cafes for people at risk of a mental health crisis.

Update: A Safe Haven cafe has opened in Belconnen. Work is underway to establish the ACT's second Safe Haven in Garran.

Greens promise: Enhanced in-home and after-hours palliative care.

Update: In the 2021-22 Budget the Government invested more than $16 million over four years to expand inpatient beds and home-based palliative care services at Clare Holland House.

Greens promise: Legislate for Voluntary Assisted Dying.

Update: VAD legislation was passed in the ACT in June 2024. The scheme will come into effect in November 2025.

Labor promise: Establish a dedicated palliative care ward for Canberra Hospital by 2025.

Update: Construction of the 12-bed ward is expected to begin in late 2024.

Delayed or not delivered

Labor promise: Establish an Elective Surgery Centre on the University of Canberra campus by 2025.

Update: The Government dropped plans for the centre following early feasibility work.

Labor promise: Deliver the online platform 'MOST' for young people with mental illness.

Update: The MOST platform is being trialled but has not been expanded to the full promise, following a review.

Labor/Greens promise: Build a second hydrotherapy pool in Canberra's south by 2023.

Update: Early construction work has started and it is now expected to be completed mid-2025.

Labor/Greens promise: Deliver 60,000 elective surgeries over the next four years, including an additional 2,000 higher complexity elective procedure by 2024/25.

Update: The ACT Government still has another year to meet the deadline, and in the 2024 budget announcements the ACT Government renewed this commitment. Time will tell.

Greens promise: Introduce seniors' streaming at Emergency Department.

Update: This work is still in development, as part of the new Critical Services Building at the Canberra Hospital.

Greens promise: Establish a psychologist subsidy scheme for young people and people on low incomes.

Update: This promise was abandoned; deemed impractical due to limited access to psychologists.

Labor promise: Inject $16 million over three years to upgrade and expand endoscopy facilities at Canberra Hospital, to deliver an additional 5000 endoscopy procedures each year from 2023.

Update: This target has not been met. The redevelopment of endoscopy facilities in building 12 is not expected to begin until early 2025. In April this year, the Government completed a $1.467 million upgrade and expansion of the endoscopy suite at North Canberra Hospital.

The new Critical Services Building opened in August.

COVER STORY

Workforce crisis steals election spotlight

Continued from page 1

Ms Stephen-Smith said the Government was very disappointed in the EA outcome. "There is a lot of feedback about the pay offer itself," she said. "There is also feedback about professional development incentives and the broader feedback about people feeling valued in the workplace."

"I've been very clear with ASMOF [Australian Salaried Medical Officers' Federation] and AMA that the agreement is not fit for purpose in the way it's currently structured and if I'm still here next year I want to sit down and have a very serious conversation about what a new EA looks like that is fit for purpose for this jurisdiction, for our hospitals and for our health services that will succeed in attracting and retaining staff."

However, Canberra Liberals' Deputy Leader, Leanne Castley said after 23 years in power, Labor had already had more than enough time to develop a well-functioning enterprise agreement. "If the agreement isn't right, why isn't it right?" she said. "It must be addressed. We're losing people and we can't lose people… Senior doctors are leaving and junior doctors don't want to stay."

Calls for transparency and accountability

The Canberra Liberals have pledged that if elected, they will hold a royal commission into the health system. "We need to have the right governance model across our health system and I'm not sure that's happening," Ms Castley said.

The Greens are also calling for greater accountability and transparency. If elected, they are promising to establish an independent board for Canberra's health system, similar to what already exists in several states.

Board members would include carer, consumer and union representatives, the CEO of CHS and the Director General of the ACT Health Directorate, among other representatives. The board's strategic priorities would include integrated care, discharge processes, stewardship of public funds and evidence-based investments in staff wellbeing.

AMA ACT has long called for the formation of a well-structured and well-governed independent board for the ACT health system and welcomes the proposal.

Funding sustainable models of care

Panellists discussed how the health system might need to change in order to be more affordable and accessible.

Mr Rattenbury promised that if the Greens were elected, they would put a far greater emphasis on preventative care to take pressure off acute services. The Greens have also promised additional funding for GPs who provide bulk-billed care for musculoskeletal and mental health issues. The proposal involves a model similar to the ACT Reproductive Health Data Incentive fund, which funds doctors for data collection and upskilling.

Meanwhile, Ms Stephen-Smith said that if elected, Labor would continue to work together with the Federal Government to find better ways to fund doctors for things such as multidisciplinary consultations.

Independent candidate for Murrumbidgee Anne-Louise Dawes painted a grim picture for the future of general practice in the territory, commenting: "Increasingly people are going to have less access to their same doctor if there's continued pressure on people being able to access bulk billed services, which are not always affordable and I would speculate they're not affordable in the ACT… So I think the service offerings will probably need to change." ■

> "There is a place for an honest conversation about low-value care."
>
> **- Rachel Stephen-Smith**

Read more from Politics in the Pub on page 8.

How does the ACT government's pay offer compare?

Proposed ACT Salary is this percentage of the corresponding state/territory pay

Key Classifications	Proposed ACT Pay Points	NSW	NT	QLD	SA	TAS	VIC	WA
Intern	$83,427	110%	95%	95%	102%	96%	100%	100%
Resident Year 2	$106,081	108%	100%	104%	110%	107%	111%	106%
Registrar 1	$119,327	108%	101%	95%	98%	91%	95%	104%
Senior Registrar 1	$166,194	106%	103%	117%	112%	97%	101%	99%
Specialist Year 1	$196,453	105%	95%	96%	86%	94%	77%	102%
Top End Specialist Salary	$264,161	105%	91%	93%	88%	88%	65%	93%

Green cells (>100%) mean that the ACT salary on offer is HIGHER than other jurisdictions.

Red cells (<100%) mean that the ACT salary on offer is LESS than other jurisdictions.

Pilot enables holistic GP-led care of complex patients

The ACT Primary Care Pilot (PCP) is enabling selected disadvantaged patients with complex health problems to receive funded multidisciplinary GP-led healthcare, with the goal of keeping them out of hospital.

Dr Chris Harrison from Ochre Bruce appreciates that the pilot funds him for tasks additional to face-to face with the patient.

Selection criteria

This federally-funded trial through ACT Health is a collaborative intervention involving primary health care and community-based support to participating patients at risk of presentation to the Emergency Department (ED) or hospital, to reduce their preventable risk of deterioration.

This pilot is a collaboration between Capital Health Network (CHN), Canberra Health Services (CHS) and ACT Health and will run for 18 months until mid-2025, with an independent evaluation being conducted by Nous Group.

Benefits for patients

Dr Chris Harrison from Ochre Medical Centre in Bruce, one of the 15 funded practices participating in this trial, suggests that the pilot highly benefits patients who are in a "grey area" where they are experiencing serious illnesses and are not accepted to any of the usual referral services to manage their conditions. In addition, all services delivered through the pilot are free at point-of-care for patients to access.

"The program allows our vulnerable population with severe illness, such as older persons or financially disadvantaged people, to receive funded support, allowing me to spend quality time planning their care without having to worry about financial burdens. When you see them get through the program and back on their feet, it's very satisfying," Dr Harrison said.

Practice manager Maria Haider recalled how beneficial the program was to the very first participating patient. "It was great to have a situation where our doctor could talk directly to the specialist, without needing to go through the process of making referrals," she said.

Benefits for health care providers

For health care providers, the pilot provides an opportunity to spend more time with patients, without the usual financial and administrative burdens. This is particularly beneficial in general practice settings, where economic pressures can limit the amount of time that can be spent with each patient.

"Often in primary health care, the definition of 'consultation' is very restrictive. Thanks to this pilot's funding, the concept of consultation can be broadened beyond the time spent face-to face with the patient, as it supports administrative processes, phone calls with specialists, writing referrals and other processes that are necessary to provide the care that patients require," Dr Harrison said. ■

Find out more at canberrahealthservices.act.gov.au/services-and-clinics/services/act-primary-care-pilot

POLITICS IN THE PUB

"There's a place for an honest conversation about low-value care": Stephen-Smith

The challenge to be a good steward of public money, even when it makes you unpopular, is familiar to both doctors and politicians. As one Canberra GP laconically put it: "If politicians displease their constituents they get voted out; if doctors displease their patients, they get sued."

And yet, not everything a patient or constituent demands represents good use of public money. So, how do both doctors and politicians apply good stewardship?

This question from an audience member at Politics in the Pub provoked a strong response from Health Minister Rachel Stephen-Smith, who called on GPs to be bold in discussing the true cost and value of health care with patients.

"There is a place for us to have an honest conversation about low-value care, not just in the professional part of the health system, but with consumers," Ms Stephen-Smith said.

"Consumer representatives are up for that conversation because they know that we have limited resources to dedicate to the health system and they want resources to go to the things that matter most and are going to deliver the best value for the community, but it's a hard conversation to have in the public sphere. People have an idea of Medicare, that it's going to deliver them free public healthcare."

It's a great point the Health Minister makes. Health care is not free – even when you don't pay for it out of your own pocket. Patients deserve to understand what represents good value for money from their taxes, and how poor spending decisions create inefficiencies that affect everyone in the system.

And yet, the conversation we need to have about low-value care is much bigger than whether GPs should order a colonoscopy here or there. Canberrans deserve an honest conversation about low-value care right across the ACT health care system.

Where would such a conversation begin? AMA ACT has long called for an independent evaluation of the Government's nurse-led Walk-in Centres, which fragment patient care and compete with evidence-based GP-led primary care.

An evidence-based discussion about Walk-in Centres is a hard conversation to have in the public sphere, because as the Health Minister says, people love the idea of free health care. And yet while patients don't pull out their credit cards at Walk-in Centres, these facilities cost taxpayers $22.3 million in 2023. Good stewardship demands an honest evaluation of whether this is money well spent. ■

"We have limited resources to dedicate to the health system," Ms Stephen-Smith said.

Canberra embraces Real-Time Prescription Monitoring

The ACT's Real-Time Prescription Monitoring (RTPM) system 'Canberra Script' has reached a significant milestone, with more than 2,500 prescribers and pharmacists now registered.

Why does the ACT need a prescription monitoring system?

The latest Annual Overdose Report for Australia by Victoria's Penington Institute shows that in 2021 alone, there were 1,675 unintentional drug-induced deaths, of which 765 (46%) were opioid-related. From 2017-2021, opioids were the most common drug involved in polysubstance deaths. Pharmaceutical opioids now caused more deaths than heroin.

So, it's not surprising to learn there have been many coronial inquests, throughout Australia, where coroners have recommended the implementation of RTPM, to help save lives and reduce harms.

What GPs are saying

Canberra GP and experienced medical educator Dr Marisa Magiros sees the benefits of using Canberra Script. The AMA ACT Board Member commented: "The benefit is to ensure medication safety for our patients; to ensure we minimise compounding effects of multiple agents or contraindications that may cause harm and even death; and to enable a coordinated team approach for some patients with safe prescribing limits. There's so much to manage simultaneously as a doctor so I welcome tools that enhance safety."

Canberra Script can be embedded into a prescriber's workflow when prescribing monitored medicines for their patients. Dr Magiros explained: "Canberra Script is an excellent resource to help us ensure medication safety for our patients. I sign on at the start of the day so I'm ready to go. Two factor authentication is pretty standard now for so many apps and programs but reasonably quick. Once logged in in the morning, you then use your 6-digit pin to access again. It's great for GPs that Canberra Script is integrated into our medical software. I've heard it's not integrated for non-GP specialists, so they need to have a different web browser open. Like most tools, the more we get used to using it the quicker and easier it gets."

Notifications and alerts

Canberra Script provides notifications and alerts to help prescribers manage patients on monitored medicines. Notifications are real-time messages that pop-up on screen during the prescribing process within the Practice Management Software. These messages are colour-coded based on the potential risk associated with the patient's monitored medicine history. Prescribers can click on this pop-up notification and be taken directly to the patient's profile within Canberra Script.

Alerts can be viewed within a patient's profile in Canberra Script and are generated to inform prescribers where there may be risk associated with prescribing a monitored medicine for a patient. The purpose of these features is not to determine for the prescriber whether to prescribe. Rather, they provide further information on the patient's monitored medicine history as part of the overall assessment of the patient's needs.

Canberra Script is not intended to disadvantage patients who have a clinical need for a medicine. Rather, its purpose is to support an informed community of prescribers and pharmacists to willingly and confidently identify concerning patterns. ■

canberra script

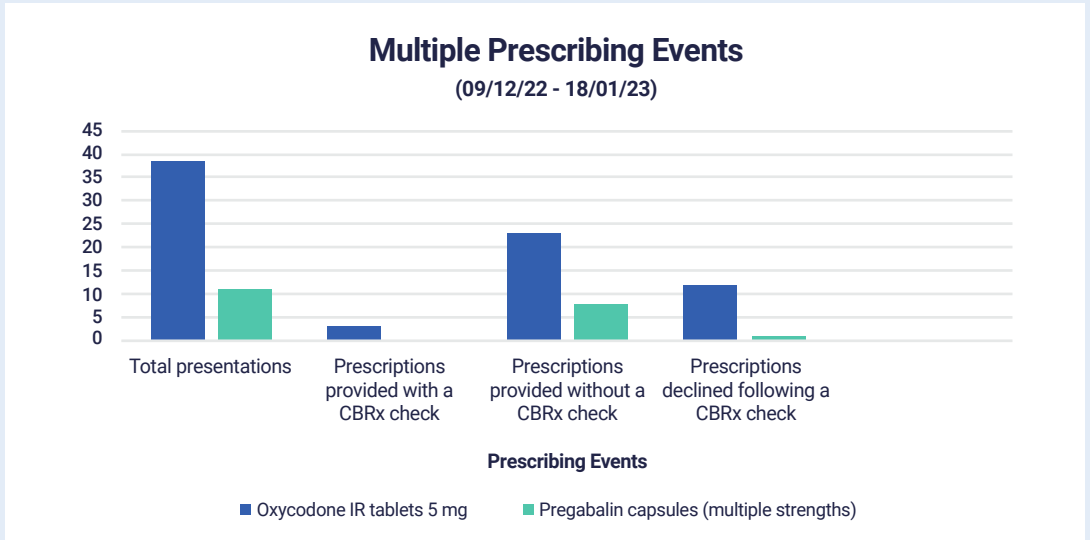
Case study: patient seeing multiple prescribers

Pursuing medical care from multiple prescribers remains a significant public health risk.

The following case study demonstrates some of the complexities involved in identifying a patient who has visited multiple prescribers in a short time and reinforces the need for all practitioners in the care pathway to remain pharmacovigilant. However, it is important to note that multiple prescribers may be clinically appropriate for a patient – perhaps it is a GP in Canberra, a specialist at one of Canberra's hospitals and a referral to a specialist in Sydney. Prescribers are encouraged to consider the data as supporting appropriate clinical decision making.

Between 9 December 2022 and 18 January 2023, one patient obtained 230 tablets of oxycodone and 448 capsules of pregabalin in the ACT, a summary of which is provided below. In all but one instance, Canberra Script produced an alert to indicate the patient had visited multiple prescribers (defined as more than 3 prescribers or clinics in the preceding 60 days). However, there were systemic gaps created by several missed opportunities to check Canberra Script.

A routine check of Canberra Script forms part of best practice for monitored medicines prescribing. This in turn reduces perceptions of stigmatisation and ultimately, aims to reduce the incidence of harms and preventable deaths in the ACT.



Source: Canberra Script

Find out more

In-person training and general enquiries:
canberrascript@act.gov.au | 02 5124 9208

IT support: itsupport.canberrascript@act.gov.au | 1800 776 633

Not yet registered? To join your colleagues and help reverse the trend of growing harms linked to monitored medicines, scan the QR code or visit canberrascript.act.gov.au.

Tackling the root causes of obesity

DR JULIE KIDD
Canberra GP and hypnotherapist

Why do so many diets and eating programs fail long-term? With that question in mind, I combed through my files for data on the emotional and psychological drivers of unhealthy eating behaviour.

Identifying emotional drivers

I extracted all the data from my notes that I could on a random selection of 100 of the patients who came to me for medical hypnosis for weight loss and unhealthy eating habits. The list includes emotional eaters, binge eaters, junk food addicts, night eaters, boredom eaters, and those with simple bad habits, as well as the 'yoyo dieters' who cycle regularly from restriction to blowout.

I took an extensive history related to food and body image over their lifetime, then took them through a gentle process to uncover what actually drives them to overeat. As part of the process, the patients report the memories that came to them during the session.

For so many of my patients who are overweight or obese, there is a clear pattern of their unhealthy habits around food originating in trauma, their family of origin, in being bullied as a child, or in stressful adult relationships and health issues. This indicates to me that, while GLP-1 agonists may temporarily alter the physiology, deep work is still necessary to move and heal the emotional patterns that fuel their addictive or difficult habit patterns around food.

> "Medications only address the physiology temporarily and don't address the mind that wants to eat to placate emotions."
>
> **- Dr Julie Kidd**

Through my patient survey, I found that:

- 21 of the 100 patients had childhood trauma, including 6 patients reporting sexual abuse, 7 physical abuse, 5 neglect, 16 emotional abuse, 6 isolation and 8 reporting a parent who was alcoholic or mentally ill. Some reported multiple traumas.
- 47 reported a history of unhealthy food behaviour and attitudes to body appearance in their family of origin. Of these:
  - 4 had a history of being food restricted as children, by parents (usually mothers)
  - 11 had binge-eating parents or those who lived on junk as the norm
  - 4 were force-fed (for being too thin or because of an authoritarian parenting style)
  - 5 had a mother who was 'always on a diet'
  - 8 had a parent or grandparent who was 'obsessed with appearance'
  - 3 were given sweets specifically to assuage emotions
  - 6 were home alone and ate to fill the loneliness
  - 10 were from an overweight/obese family, as part of their identity
  - 3 reported their mother over-giving food as a demonstration of love
  - 4 were in a double bind with 1 adult encouraging eating and that adult (or another) also telling them they were fat
  - 18 were told they were fat, with particular pejoratives that stuck in their minds, overlapping with 14 who reported that they were teased, or bullied in childhood and/or in their teens
- 18 of my overeating patients started the bad habits after adult trauma or chronic stress. Of those:
  - 15 had deaths, other major losses, DV, stalking, divorces, bullying or sexual assaults
  - 16 had relationship problems, breakups, including family schisms
  - 5 started the bad habits after having children or with menopause
  - several started the habits with changes in their physical condition: 3 with hypothyroidism, 2 with medications and 4 with injuries that caused immobility
  - 1 recommenced binge eating after positive comments on her appearance and one when she was sexually assaulted after losing weight
- Finally, the most common current factors or triggers were relationship stress, family conflict, loneliness, a partner with bad habits or a feeder partner and food as the main basis of family or partner connection.

A role for hypnotherapy

The point for me of uncovering all this is to address the root causes and do my best to neutralise the effect of the emotional drivers. Once that is done to the degree that it can be, then the job of hypnotherapy is to increase the enjoyment of healthy food, delete the desire for unhealthy food and move the patient confidently towards a happy, healthy, active future. There's no calorie counting.

The advent of the GLP-1 agonists has revolutionised our treatment options for overweight and obese people. However, these medications only address the physiology temporarily and don't address the mind that wants to eat to placate emotions, that wants a treat or a reward, that needs to binge to subdue anxious feelings or that needs to punish itself. For this, medical hypnosis can be an effective and safe technique in good hands.

As a GP and as a medical hypnotherapist, I've been working with overweight and obese patients for decades. It's clear to me that the way forward, for our patients who want medication and are suitable for it, is to include both elements in our treatment plans. GLP-1 agonists can be useful to kickstart a positive spiral, but for long-term outcomes in mental and physical health and a healthier weight long-term, it is essential to transform the emotional patterns that underlie a difficult relationship with food. ■

For more information or to refer a patient contact **drjkidd@canberrahypnosis.com.au or 0425300233**

Medical referee opportunities

The Cemeteries and Crematoria Regulator are looking to expand the pool of medical referees in the ACT.

Under the Cemeteries and Crematoria Act 2020 (the Act), there are several procedures in relation to cremation that can only be completed by a medical referee. A medical referee is required to provide a certificate stating there is no medical reason why human remains should not be cremated.

In order to be appointed, a medical referee must be a doctor who is currently in practice and has been for a continuous period of at least five years before the day the Regulator appoints the person as a medical referee. ■

For more information contact **ACTCemeteries Regulator@act.gov.au**

PAGE 14 QUIZ ANSWERS: 1) All written by doctors **2)** The inability to recognise a defect or disorder that is clinically evident **3)** Weary Dunlop **4)** True, he studied medicine, but it was at the University of NSW **5)** Pasteurisation **6)** GP Management Plan and Team Care arrangement **7)** The countries with the world's highest birth rate **8)** Ischaemic heart disease **9)** The Athenian lawmaker was reportedly smothered to death by gifts of cloaks and hats showered upon him by appreciative citizens at a theatre in Aegina, Greece **10)** The liver

BOOK REVIEW

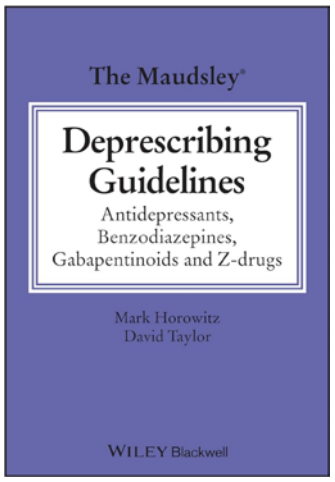
Maudsley deprescribing guidelines: comprehensive and commendable

ALEX GALLO PHD, MPHARM, MPS
Research Officer
School of Medicine and Psychology
The Australian National University

The Maudsley Deprescribing Guidelines: Antidepressants, Benzodiazepines, Gabapentinoids and Z-drugs by Mark Horowitz and David Taylor was released on 12 March 2024. Published by Wiley Blackwell, the book is an add-on to the series The Maudsley Prescribing Guidelines in Psychiatry, which is now in its 14th edition.

The book provides clinicians with the most comprehensive guide to deprescribing in psychiatry to date and comes at a time when deprescribing in psychiatry has been receiving increasing attention, with growing consumer voice around the potential severity for psychiatric drug withdrawal.

While more research is required to support the guidance provided in this book, it is pharmacologically and experientially informed, including valuable guidance on hyperbolic dose reduction methods. The authors should be commended for their work and contribution to this field.



> “Go slowly, at a rate the patient can tolerate, and proceed even more cautiously for the last few milligrams.”
>
> - Horowitz and Taylor

The authors' lived experiences

Dr Mark Horowitz is a Clinical Research Fellow in the NHS and an Honorary Clinical Research Fellow in the Department of Psychiatry at University College London. Professor David Taylor is the Director of Pharmacy and Pathology at Maudsley Hospital and a Professor of Psychopharmacology at King’s College London.

Both authors have lived experience of difficulties coming off various psychiatric drugs, which was part of the motivation for writing the guidelines — to help others safely withdraw. In the preface, the authors note that much of the guidance provided requires confirmation and clarification from further research. Nevertheless, it provides a pharmacologically informed approach to tapering that may be beneficial for patients withdrawing from psychotropic medications. Additionally, it utilises the current evidence in the literature, including patient/consumer perspectives, which have been important in raising awareness for withdrawal effects from psychiatric medications.

Pharmacologically-informed tapering

The premise of the guidelines is to provide a pharmacologically informed method for tapering antidepressants, benzodiazepines, gabapentinoids and z-drugs. This approach draws upon the occupation of receptors at certain doses, whereby receptor occupancy decreases in a hyperbolic manner. That is, dose reductions at higher doses (e.g., 20mg to 15mg) produce smaller reductions in receptor occupancy than reductions at lower doses of the drug (e.g., 5mg to 0mg). Therefore, the recommendation is that dose reductions follow a hyperbolic dose reduction, resulting in larger increment decreases at the start of the tapering process and smaller increments at the end of the tapering process. For example, the fast taper for escitalopram recommends the following dose reduction schedule, reducing every 2–4 weeks: 20mg, 10mg, 7.5mg, 5mg, 3.4mg, 2.3mg, 1.6mg, 1mg, 0.6mg, 0.3mg, 0mg.

Moderate and slow tapering schedules are also provided for drugs, which can be used for patients at higher risk of withdrawal or those experiencing intolerable withdrawal symptoms. This contrasts with the often-recommended linear dose reductions, which can result in large changes in receptor occupancy with each dose reduction (e.g., 20mg, 15mg, 10mg, 5mg, 0mg), which may have a greater propensity to precipitate withdrawal symptoms. Guidance is also provided on how to obtain these smaller doses, which are not found in conventional tablets/capsules. These methods include using liquid formulations (not typically available in Australia), extemporaneous compounding by a pharmacist and counting beads in capsules.

Another key focus of the guidelines is the distinction between withdrawal and relapse. The guidelines emphasise the methodological flaws in many relapse prevention studies, whereby psychotropic medications are stopped abruptly or rapidly tapered, increasing the risk for withdrawal which can be misdiagnosed as relapse of the original condition. This in turn may have inflated the relapse prevention properties of psychotropic medications and is a concept that should be understood by all clinicians prescribing and deprescribing these medications.

As described by the authors, the main takeaway from the book is “go slowly, at a rate the patient can tolerate, and proceed even more cautiously for the last few milligrams, which are often the hardest to stop.”

Limitations

Although it is acknowledged throughout the book, a key limitation of the guidelines is the lack of evidence from high-quality clinical trials to support the superiority of hyperbolic tapering of antidepressants, benzodiazepines, gabapentinoids and z-drugs. The recommendations are based on pharmacological principles and supported by some clinical evidence; however, this is still likely the most evidence-based and scientifically informed guidance that exists until more research is undertaken in this area.

Some have criticised the inclusion of only antidepressants, benzodiazepines, gabapentinoids, and z-drugs; however, Dr Horowitz confirmed in a podcast (Purple Pen Podcast), that there will be two volumes of the guidelines. Given the length of the first volume (553 pages), it makes sense to split the guidelines into two, with the second volume covering antipsychotics, mood stabilisers, stimulants and opioids. When the second volume of the guidelines is released, clinicians will have a clinically useful and complete guide to address concerns around deprescribing in psychiatry. ■

Calling all junior doctors: the medical training survey needs you

Australia’s biggest annual survey of junior doctors, the Medical Board of Australia’s 2024 Medical Training Survey is underway again.

Now in its sixth year, the survey is designed to acquire purposeful data that can be used to drive changes in medical training.

This year’s survey introduces new questions about sexual harassment, medical colleges fees and how well medical education prepares junior doctors for internships.

More than half of Australia’s doctors in training annually do the MTS, making it the most comprehensive national data source about medical training. Stringent privacy controls make it safe and confidential for trainees to take part.

Prevocational and unaccredited trainees, specialist non-GP trainees and specialist GP trainees are invited to do the survey when they renew their medical registration. Interns and IMGs are invited to participate in the survey via an email from the Medical Board of Australia. ■

The survey closes 8 October. For more information and to view past survey results go to MedicalTrainingSurvey.gov.au

More doctors in distress seeking help

The number of doctors seeking help from the Medical Benevolent Association of NSW-ACT has tripled in the past five years, including a surge of calls from the ACT.

The charitable organisation was established almost 128 years ago to provide support for doctors and their families experiencing adversity or hardship. Experienced social workers provide counselling and information, referral and advocacy through the not-for-profit.

Whilst social work services are their main offering, MBA NSW-ACT has added financial counselling, medical career planning services and preventative wellbeing workshops in recent years. Every month they also provide 5 to 8 financial gifts to those doctors who can evidence hardship. These gifts are aimed at covering the basics (rent, groceries, utility and medical bills) to keep them "afloat" whilst the person works a Plan B with the support of social workers.

Many types of hardship

Over the years, MBA NSW-ACT has provided help to medical families impacted by domestic violence, natural disasters, addiction, suicide or loss of a loved one, tragic accidents and terminal illness, professional burnout as well as to the many junior doctors and IMGs from disadvantaged backgrounds, who often face financial challenges.

One doctor who recently reached out for help gave this testimonial: "I don't say this lightly, but if it wasn't for what you and the MBA NSW-ACT Council have done for me, I would not be alive today. I will forever be grateful for your compassion and support."

MBA NSW-ACT is overseen by Executive Officer, Louise Fallon, who ultimately reports to a Council of 14 volunteer doctors including former AMA ACT president, Dr Antonio Di Dio. Ms Fallon told *Canberra Doctor* the MBA has been receiving around 15-20 calls a month in recent years, around a quarter of which have been from the ACT.

"That's about three times the rate of calls we had four years ago and reflects some of the unique stresses faced by doctors and their families in this era, as well as growing awareness and trust in the blend of services we can provide," Ms Fallon said.

MBA NSW-ACT provides financial gifts to doctors who can evidence hardship.

Confidential and independent

Ms Fallon said she understood doctors were sometimes concerned about reaching out for help in case they were reported to the regulator, but said they could be reassured, as MBA NSW-ACT is completely independent of AHPRA and all services are provided in strict confidentiality. A doctor, or family member can remain anonymous, if desired.

"We offer a non-judgmental service, which includes supporting doctors who are facing a regulatory complaint or action," Ms Fallon said. "We also support final year medical students, practising and non-practising doctors including those retired, suspended or deregistered doctors, and also their families who often also need support as well as the doctor." ■

Can you donate?

The MBA NSW-ACT relies on donations to continue to offer these vital support services.

To make a donation please contact 02 9987 0504 or visit mbansw.org.au

Record keeping changes for abuse victims

ACT Health Directorate, together with Canberra Health Services, has guided and overseen implementation of recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse that relate to health services in the ACT.

The Royal Commission made several recommendations about the need to ensure that records and information that may be relevant to allegations of child sexual abuse are retained for at least 45 years, as they may prove vital to victims and survivors of institutional abuse taking civil action.

Information on record keeping practices is available at territoryrecords.act.gov.au. Additional guidance has also been developed by the Council of Australasian Archives and Records Authorities and can be accessed at caara.org.au. ■

Doctors with questions can contact the ACTHD at

ACTHealth.CSARoyalCommission@act.gov.au

Petition calls for fairer rego fees

A campaign is underway to achieve fairer rego fees for healthcare workers on parental leave.

Ahpra and the 15 National Boards don't currently lower fees or provide any proper mechanism or registration fee category to assist healthcare workers who take parental leave. This affects over 877,000 Australian healthcare workers, who are a diverse and predominantly female workforce. ■

Doctors can show their support for the campaign by signing AMA Victoria's petition at

megaphone.org.au/petitions/ahpra-should-act-fairly-and-equitably

OUT AND ABOUT

Safe Space 6: serious fun

Safe Space events are designed by doctors, for doctors, to support the medical community in the Canberra region. At June's Safe Space 6 event, we were grateful to hear from leading local clinicians, Dr Ailene Fitzgerald, Dr Carolyn Droste, Dr Luke Streitberg, Dr Steven Adair and Dr Marisa Magiros on the topics of workplace culture and giving feedback. The event also included an optional fun-run and axe-throwing activity (pictured below). Safe Space is hosted by Drs4Drs ACT and AMA ACT. ■

Time for a profile refresh?

Are you an AMA member? Keeping your AMA profile up to date ensures you never miss out on important news and opportunities. Review your profile details and if you've had any changes to your contact details, employment or other information, now's the perfect time to update your profile! Just log in to your portal at **ama.com.au/sign-in**, click into your profile and make sure we have your most current info so we can stay connected and serve you better.

Visiting the Hospital in the Home team

Dr Kerrie Aust was grateful to visit Dr Karyn Cuthbert and the Hospital in the Home Team (HiTH) at Canberra Health Services (pictured above) to see the excellent work they are doing.

"Hospital in the Home is an excellent example of multi-disciplinary care that has been evolving to meet community needs," Dr Aust says. "Not only is patient satisfaction for HiTH is very high, accessing care in the home reduces the risk of hospital acquired infections and 'PJ paralysis'."

The Care Close to Home project that ended in 2022 saw the introduction of the allied health and medical teams into the service, which has expanded capacity and lays the groundwork for a more linked ambulatory care program in the ACT.

HiTH currently offers assistance to patients with conditions including cellulitis, mastitis, pyelonephritis needing IV antibiotics, dermatitis requiring set dressings, hyperemesis gravidarum, significant oedema such as heart failure and chronic liver disease and eating disorders.

Dr Cuthbert, the medical director, said the team are happy to receive direct referrals from doctors in the community and are available to discuss patient needs. Further information about HiTH referrals is available on Health Pathways. ■

AMA ACT CEO Peter Somerville and AMA President Dr Kerrie Aust, with Minister for Mental Health Emma Davidson at one of their regular meetings in July.

AMA ACT CEO Peter Somerville and Dr Diana Kirk at ACT Health's GP Forum in July.

AMA ACT President Dr Kerrie Aust with Senator David Pocock at a Doctors for the Environment event in August.

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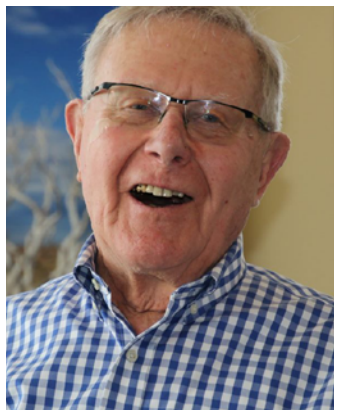
Happy 90th birthday Dr Peter Wilson



AMA life-member Dr Peter Wilson recently celebrated his 90th birthday with family and friends at Red Hill.

Dr Wilson came to Canberra as a GP in 1968, replacing Dr Denis Appel at a general practice in O'Connor. To this day, he still plays bridge with Dr Appel online.

From 1973, Dr Wilson spent 16 years at Scullin Health Centre, a government-established community centre with fee for service medical, dental and ancillary services supported by some clerical staff, alongside friend and colleague Dr Peter Fitt.

By 1987, the health department support services to Scullin had diminished severely and there were problems with renewing the lease. AMA ACT provided assistance but the Health Department announced that the building was to be demolished. A group of local practitioners organised a building in Hawker and by 1989 Birubi Chambers was opened for the Scullin practitioners with psychology, physiotherapy, prosthetic and other services joining later.

Peter and Lyn at Peter's recent 90th birthday celebration.

The Hawker practice had a number of students and trainees over the years including Dr Ta Phensiaroun and Dr Annie Lim. Dr Wilson retired in 2002, succeeded by Dr Wayne Wardman.

In his retirement, Dr Wilson has enjoyed travelling with wife, Lyn, as well as volunteering for new migrants and struggling teenagers, playing tennis, mountain bike riding, bridge and University of the Third Age (U3A). Now at 90, it's a slower lifestyle with gentle social gatherings, but he still plays bridge and participates in U3A online. ■

The Quiz

By Dr Antonio Di Dio

1. What do The Cherry Orchard, The Andromeda Strain, The Kite Runner, and The Hound of The Baskervilles all have in common?
2. What is Anosognosia?
3. Which pioneering gastro-oesophageal surgeon was Australian of the Year in 1976?
4. George Miller, producer of Mad Max, Babe and Happy Feet, studied medicine with his twin brother (True/False) at Sydney Uni (True/False).
5. Used in winemaking in China since 1117 and described by Japanese monks in 1478, what process did Frenchman Louis popularise in the 1860s?
6. What would you be doing with your patient if you billed a 721 and 723?
7. What do Niger, Mali, Uganda, Zambia and Burundi have in common?
8. What is the leading cause of death in Australia?
9. In 620BC, how did Draco of Athena die?
10. Where would you find your caudate and quadrate lobes?

See page 10 for answers.

$150 scrubs prize for student edition

Australian brand Scrub Turkey has many fun scrub designs.

The annual student edition of Canberra Doctor is coming – due out in December. This is a great opportunity for medical students to showcase their talents.

Contributions can include essays, opinion pieces, short-stories, poetry, photographs of original artworks or anything else that will inform or amuse our readers. All entrants will receive an iconic Canberra scrub cab from Drs4Drs ACT. The best entrant, as judged by AMA ACT staff, will also receive a $150 voucher from Australian-designed scrub brand, Scrub Turkey.

Entries must be your own work and cannot previously have been published although they may have been submitted as part of your degree. Written entries should be no longer than 1000 words. Please attach a photo of yourself, provide your postal details and share your medical school name and year. ■

Entries should be emailed to editorial@ama-act.com.au by **November 1.**

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