CANBERRA Doctor

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VMO Bargaining Kicks Off

The bargaining for the next VMO contract will kick off later in June with AMA (ACT), the ACT Visiting Medical Officers Association and Canberra Health Services holding the first bargaining meeting. With the three parties exchanging claims, there will now be a minimum three-month negotiating period prior to an expected arbitration of outstanding matters.

AMA (ACT) and the VMOA are co-operating as we look to improve the current VMO contracts in several areas including in relation to the minimum length of contracts and the pay rates for both fee-for-service and sessional VMOs.

Bernadette McDonald, CEO of Canberra Health Services.

The negotiating period will see each organisation explain their claims and then attempt to agree on proposed changes in a process analagous to enterprise bargaining for salaried public hospital doctors.

Calvary Public Hospital are also represented at the bargaining table with their input being sought as the negotiations take place.

Competing Claims

Pay, of course, remain a central point of difference between the parties with CHS proposing an increase of only 1% in sessional rates and a significant change to FFS rates that, if implemented, would see a reduction of some 11% from the current position.

Both the AMA and VMOA have raised concerns in regard to the FFS proposal as might be expected and are seeking retention of the current arrangements including an increase in annual indexation.

CHS are proposing to introduce a private practice arrangement for VMOs analagous to the current private practice arrangements for staff specialists. In doing so, CHS have stressed that the proposed scheme will 'not impact in any way' on VMOs private patients including in relation to indemnity. Further details will be forthcoming in the near future.

AMA Claims

The major claims AMA has made include a 3% increase in both FFS and sessional pay rates, introduction of a minimum three-year VMO contract, 3-month notice period for new contracts and the introduction of a new 'Digital Recall' clause that would see work undertaken remotely when on-call remunerated as recall.

The AMA and the VMOA are supporting each other's claims and will be working closely together as the negotiations progress.

The AMA and CHS claims are set out in summary on page 10 in this edition of Canberra Doctor.

President's **Notes**

WITH PRESIDENT, DR ANTONIO DI DIO

Our recent AMA (ACT) Annual General Meeting and dinner was an opportunity to spend some time with members, friends and colleagues, recognize our five new 50-year members and present Dr Michael Rosier with the AMA (ACT) President's Award for 2018.

All in all a busy and enjoyable evening.

My first year as President has proven to be not only busy but immensely varied and brought home to me the range of issues the AMA is involved in both locally and at a national level.

Issues

While I've included a few of the range of issues we were involved in during 2018, the full Annual Report can be found at https://ama.com.au/act/ama-act-2018-annual-report

Doctors Health

Changes to Mandatory Reporting laws continued to be pursued at both national and state and territory levels throughout the year. Disappointingly, we weren't successful in convincing the other jurisdictions to adopt the 'WA model' or 'WA-lite model' of reporting. However, this is not the end of the story.

'Caring for colleagues' continued to be a major focus for the AMA over the year. Our combined NSW and ACT DHAS continues to provide a 24-hour telephone line for colleagues to contact and then, as appropriate, be referred on to a local practitioner.

Canberra Health Services Accreditation

A preliminary assessment of CHS in early 2018 identified several serious problems that, if not corrected, would have seen CHS's accreditation under threat. Ultimately, CHS gained its accreditation following the final inspection report but there's not much doubt the issue contributed to the departure of Director General, Nicole Feely, and her replacement by Michael De'Ath.

Hospital Doctors Enterprise Bargaining

After more than two years of tedious bargaining it appeared, by the end of 2018, that the current round of enterprise bargaining was coming to an end. While AMA (ACT) has primarily been focussed on junior doctor issues, we have been co-operating with ASMOF ACT on senior doctor issues and other issues of common concern.

As I write this column agreement is close to being finalised.

Culture Review

AMA(ACT) was the driving force behind Minister Fitzharris's decision to establish the Independent Review of Workplace Culture. Without going over old ground, the Minister's decision was the right one given all of the matters that had emerged over the course of 2018.

In the end, the Review Panel received almost 400 submissions from individuals and organisations and almost 2000 responses to a staff survey. The Panel did a good job identifying the underlying issues, from bullying not being addressed to inefficient processes and complaints management, non-supportive leadership and inappropriate recruitment.

Disengagement by doctors

One of the more disturbing, but unsurprising findings in the Interim and Final Reports was that relatively few medical practitioners engaged with the Review and that this was symptomatic of a general disengagement from the management of the hospitals and health services. Having seen and heard of some of the symptoms of a disengaged medical workforce, including strained relationships with management, this came as little surprise. It also came as little surprise that the disengagement is strongest amongst senior doctors – both VMOs and staff.

Recommendations and Implementation

By and large, we welcomed the recommendations made by the Review Panel.

As ever, the real test will be in implementing the recommendations but I'm heartened by the Minister following through and including AMA (ACT) as part of the implementation group she now chairs.

Abortion Law Reform

Although termination of pregnancy has been legal in the ACT since 2002, last year the Legislative Assembly moved to free up access to medical terminations. The legislation, which the AMA (ACT) supported, did away with the limitation on a location where a medical termination can occur by removing the need for a facility to be approved.

In addition, the legislation now provides that a medical practitioner or nurse who conscientiously objects to participating in a termination must inform the person requesting the termination of their refusal to participate.

AMA (ACT) made a submission to the committee considering the proposed legislation.

AMA (ACT also participated with Legislative Assembly on a range of other matter including a proposal to legalise small amounts of cannabis for personal use and inquiries into the Sustainability of Health Funding and End of Life Issues.

Acknowledgments

Before I move on to some more recent matters, I'd like to thank the AMA (ACT) Board for their support and guidance through my first year in office as well as the many members who have taken the time to get in contact with me and pass on their views.

I'd also like to thank our secretariat staff for the work they do – it's very much appreciated by all.

Finally, it has been an honour to serve you, and an organisation that so wonderfully combines protection and care of its base, with an extraordinary focus on our community. The hallmark of an AMA member for me is someone who fights passionately for the rights and safety of others above themselves; thank you so much.

Dr Andrew Miller AM

Congratulations to Dr Andrew Miller AM, our wonderful Treasurer, past president and staunch advocate for the AMA who was recently awarded a fellowship of the AMA. Congratulations to Andrew from all of us at AMA (ACT).

VALE

The president, Dr Antonio Di Dio, Board members and staff of AMA (ACT) extend their sincere condolences to the family, friends and colleagues of Dr Helen Wiles

Canberra Health Service Ups Offer on JMO Education

With the final few items still on the table for the Hospital Doctors enterprise bargaining, Canberra Health Service has significantly improved their offer for JMO education expenses. AMA (ACT) has been pushing hard to get a significant improvement for JMOs and Canberra Health Service has stepped up and done just that.

With the Hospital Doctors Enterprise Agreement being the last agreement still on the table across the Territory's pubic service, it seems we are getting close to finality.

Focus on JMO Education

The AMA (ACT)'s focus on improving JMOs access to education has largely been driven by the recognition that our JMO members and their families are facing ever escalating costs of education and training, together with the additional inconvenience and costs associated with travelling to relevant training activities outside of Canberra.

Our feedback had been that the current system of applying for leave, attending training activities and then having to claim back expenses was cumbersome, complicated and slow.

In addition, the ACT compared poorly to many other jurisdictions and, in a national market for JMOs and vocational trainees, our local JMOs and Canberra Health Service were likely to be losing out.

Paid Upfront

Earlier on in the negotiations, Canberra Health Service had agreed to the AMA (ACT)'s proposal to pay the education allowance upfront and as part of fortnightly salary. Of itself, this was a significant win for JMOs because it removed the cumbersome process of seeking leave and then claiming reimbursement of expenses.

With the move to a fortnightly allowance, the significant remaining issue was the quantum of the education allowance and AMA (ACT) has been pushing hard to bring ACT JMOs closer to other training centres. With the end of the bargaining process approaching, constructive discussions on the JMO education allowance have taken place with Canberra Health Service that have now led to an improved offer.

Improved Offer on JMO Education

The latest offer is a marked improvement on previous offers and in our view represents a real improvement in the level of support for ACT JMOs. Under the proposal, if accepted, CHS will pay to JMOs the following:

- $4,120 p.a. for SRMO 2, SRMO 3, Registrar 1-4 and Senior Registrars;
- $3,000 p.a. for RMO1, SRMO1 and Junior Registrar; and
- $1,040 p.a. for Interns.

The allowance:

- will be paid fortnightly and pro rata to part-time employees.
- is paid when on paid leave but does not form part of salary for superannuation purposes
- will commence from 1 November 2019 and will be adjusted in line with ACT Treasury annual CPI projections, with the first such adjustment applying from the first full pay period commencing on or after 1 July 2020.

All-in-all the new offer is a significant improvement from CHS and is a major step in improving pay and conditions for ACT JMOs.

Transitional Arrangements

If the improved JMO educational allowance is introduced as part of a new enterprise agreement, AMA (ACT) and CHS have agreed on transitional arrangements to allow JMOs a short window to claim reimbursements under the current enterprise agreement.

In short, JMOs may continue to claim reimbursement for education expenses under the current enterprise agreement incurred prior to 1 November 2019. However, claims for reimbursement must be made by 1 December 2019.

Mental Health, Burnout and Doctors

BY STEVE ROBSON

Why our patients should care about these issues just as we should

It would be too easy to dismiss doctors' "wellness" as a self-indulgent luxury – certainly, I have spoken to colleagues who seem to have such a view. To some of our colleagues in the medical profession, appointment of "wellness officers" and a focus on medical staff "wellbeing" is viewed with scepticism.

I attended the *National Forum on Doctors' Health* in Melbourne in March, and am pleased to report that no sceptics were present. Indeed, the meeting – hosted by the Australasian Doctors' Health Network – was sponsored by Ramsay Health. Ramsay have recognised that unhealthy doctors pose a risk to their patients, and are piloting a Doctor Wellbeing Initiative at a private hospital in Brisbane, so seriously do they take the issue.

There was a large attendance, with the Victoria Ballroom filled with delegates. The participants came from Australia and New Zealand, and ranged from medical students through to senior consultants, as well as representatives from the jurisdictions, Colleges, Medical Defence Organisations, private hospitals, and many other diverse groups.

The meeting began with patient story shared by the chair. She had been seeing a patient with refractory unipolar depression for many years, working through many health crises. Then, on one occasion, the patient arranged an appointment when he was completely well.

"Every time I have seen you for the past few years, I have been miserable and sick," he told her. "I'm actually well now, the best I have been for ages, and I wanted you to see me like this – even if it's just once – so that you I know I am well sometimes!"

It was a great story because it illustrated well the importance of moving away from a paradigm of crisis management, towards a mindset of understanding the importance of what it is to be well. If nothing else, this makes economic sense: recent modelling suggests that one dollar spent on "wellness" in a health care organisation saves up to $6 to the organisation.

Is 'Doctor Wellness' Just a Trendy Idea?

'Wellness' and 'wellbeing' of doctors has come to prominence recently, and it is important to understand that it is a quality and safety issue. Impaired function in doctors leads to:

- Increased rates of medical errors
- Reductions in reported patient satisfaction with care
- Increased sick and stress leave, and compensation claims
- Illicit drug use and other harmful behaviours
- Loss to the workforce

The RPA Hospital in Sydney is so concerned about the measurable clinical effects on patients of medical 'burnout' and poor mental and emotional health, that the role of Chief Medical Wellness Officer, a 0.5 FTE appointment, has been staffed – the forum heard from that doctor. That person's stated role is:

"To facilitate development of healthy and happy, highly skilled workforce with the lowest rates of burnout, highest levels of professional fulfillment, and best patient outcomes.

"To establish a governance structure to effect both cultural and systemic change, with advocacy, design, implementation, and evaluation interventions."

"The real time monitoring of medical staff wellbeing."

Many of these principles are based on the US Stanford University WellMD Program, and RPA is sending three doctors to complete the course. The massive US Health Insurer, Kaiser Permanente, also has recognised the link between poor health in its doctors, and reduced productivity, increased staff turnover, and higher rates of medical errors.

Although the term 'burnout' is commonly spoken about, it is a well-defined syndrome consisting of emotional exhaustion, depersonalization (the tendency to have negative and cynical thoughts towards other people, including patients), and a reduced sense of personal achievement. Burnout is different from depression alone: it refers to work-related exhaustion.

The 2018 Medscape survey revealed that among the disciplines with the highest rates of burnout are general practice, and obstetrics (partly explaining my interest in the area). A study of GPs in the UK found that 53% reported high levels of emotional exhaustion, and one third scored high on depersonalisation. Drilling into the data, the

authors found that GPs at highest risk of burnout were younger, non-principals, and males.

Burnout and depersonalization reduce our quality of medical performance, interfere in our interactions with patients, and reduce our quality of life. For these reasons, burnout syndrome must be an important concern for us as doctors, because it is related to low quality of care for our patients.

The potential Harms of Training

It has become clear that medical vocational training is potentially harmful. Doctors have a large capacity to add to the social capital of society, and have a high level of personal impact on the lives of patients and their families. However, the processes and culture of the training environment have the potential to turn bright young doctors into an institutional liability.

At the moment, places of training – 'siloed' universities, Colleges, and hospitals – tend to act as separate 'ponds' which inhibit the transmission of 'ripples' that can have a positive effect. Times of particular vulnerability for trainees are the points of transition: from medical student to intern; from junior doctor to registrar; and, from registrar to new consultant. From my own lived experience, I found the transition from medical student to junior doctor the most challenging of my life. Some of you may have read my story in other arenas, but suffice to say that I – quite literally – only just survived.

Many other businesses and government organisations have a strong focus on prevention, and workplace health and safety – all of these things aim to keep employees productive. These processes are not so robust in medical training, and there is little literature around them in Australian medical journals.

Preparation for examinations, or dealing with complaints and adverse outcomes, are important stressors for junior doctors and, indeed, consultants. 'Healthy doctors are better healers,' is the phrase. Healthy doctors deliver better patient care, make better lifestyle choices themselves, and are less likely to make errors.

Strategies and Barriers to Doctor 'Wellness.'

Interventions in times of 'crisis' are too late, and a proactive and preventive approach is likely to deliver better outcomes for doctors. The National Forum on Doctors' Health heard details of the approaches being used at various public and private hospitals, and by the College of Emergency Medicine.

One key element of supporting doctors-in-training was agreed upon universally. Many, if not most, doctors fear stigma and potential adverse effects on their assessment, progression through training, and ultimate employment prospects if they are 'labelled' as having a 'mental health problem' or if they are unable to cope. For this reason, they commonly are hesitant to confide in, and seek help from, those involved in their training or hospital HR departments. For this reason, providing an independent, confidential, trusted pathway to seek help that can, if required, provide feedback about workplace conditions, is a key step.

An important finding from research is that administration rarely is able to implement change without leadership from senior clinicians – visible leadership. It is important to make doctor's wellbeing initiatives visible, and to show that they have support from the most senior doctors. Successful doctor wellbeing initiative all have the following characteristics:

- There is visible 'buy-in' and support from senior executives and the medical leadership.
- There is formal 'branding' of the program.
- Adequate resources and funding are available to support the program.

Many of the stressors of doctors are 'cultural,' and occur with the tacit approval of Departmental Heads and Clinical Directors. In Australia and New Zealand, the majority of Heads and Directors are appointed because of, (1) seniority, (2) clinical ability, (3) research or other academic achievement, or (4) a desire to retreat from full-time clinical practice. Very few have any formal training in 'leadership' and fewer have any training in 'doctor wellbeing.'

For improvement in workplace culture to improve, a clear commitment from Heads and Directors to effect change. Unfortunately, many KPIs are aimed at 'waiting lists,' 'sentinal events,' and other easily-measurable metrics. There are few, if any, KPIs for Heads and Directors looking at rates of sick leave, stress leave, and workforce wellness. In many cases, change is only effected in response to a 'crisis,' such as the threat of withdrawing accreditation.

Peer-support groups are a proven and effective way to support the medical workforce. For them to be effective, though, they must meet regularly, be free from stigma, and have senior clinicians present and contributing. In one sense, an important goal of a regular scheduled 'debriefing' or peer-support meeting is to 'normalise vulnerability.'

The wellbeing of doctors is vital if we are to provide the best possible care to our patients. This has been demonstrated repeatedly in the medical literature, and is now being acted upon by a number of health care organisations, large and small. Since all of us aim to provide the best possible care to our patients, we owe it to them to take the issue seriously and act accordingly.

AMA (ACT) Annual General Meeting

This year's Annual General Meeting of the AMA (ACT) was again held at the Hotel Realm and featured an address by Ms Katy Gallagher, ACT ALP candidate for the Senate. Katy reflected on her time as ACT Chief Minister and Health Minister and also, of course, about the Federal election. Given how close the evening was to the time of the Federal election, it was very generous of Katy to commit her time to AMA (ACT) and the members and guests present.

The AGM was preceded by drinks in the foyer of the Hotel Realm with Bill Rowe, from Rolfe BMW in attendance and drawing the winning ticket for weekend away including use of a BMW car.

After dinner, the AGM kicked off, with Senator Katy Gallagher first up and then the President's Report from Dr Di Dio and Treasurer's Report from Dr Miller. Both reports can be found in the AMA (ACT) Annual Report and accessed via the website at ama-act.com.au

The AGM also saw 50-year members, Dr Thomas Walker, Dr Andrew Rososinski, Dr Gary Morris, Dr Graeme Moller and Dr Ian Jeffery, recognized with Dr Walker presented with his certificate.

The AGM finished with AMA (ACT) President, Dr Antonio Di Dio, announcing Dr Michael Rosier as the recipient of the 2018 Presidents Award.

(l to r) Dr Antonio Di Dio, Cath Di Dio, Mary Ann Rosier, Dr Michael Rosier and Dr Rajeev Jyoti.

Dr Elizabeth Gallagher and Dr Michael Gillespie.

Bill Reed from Rolfe BMW presents the BMW prize to Dr Ramila Varendran.

Dr Antonio Di Dio with Sen Katy Gallagher.

50-year Member, Dr Tom Walker with AMA (ACT) President Dr Antonio Di Dio.

Sen Katy Gallagher.

2018 President's Award: Dr Michael Rosier

Canberra paediatrician, Dr Michael Rosier, is the 2018 recipient of the AMA (ACT) President's Award. In presenting the award, AMA (ACT) President, Dr Antonio Di Dio, recognised Dr Rosier's outstanding work as a consultant paediatrician, his dedication to educating generations of medical practitioners and extraordinary commitment to the ACT community.

Dr Michael Rosier.

Award citation

Dr Rosier's citation reads:

'Dr Michael Rosier's longstanding commitment to the health of children and their families marks him apart as a medical practitioner with a singular dedication to his patients and the practice of medicine in the ACT.

Whether it has been through his work as a consultant paediatrician in the ACT community and into the broader regions of southern New South Wales, his service in neo-natal intensive care or through his dedicated efforts in educating medical students, young doctors, nurses and other health workers, Dr Rosier is an outstanding example of what it is to be a medical practitioner.

In his early years in Canberra, Dr Rosier played a key role in providing neo-natal intensive care services to the region – a vital commitment that extended until 1996.

During this same period, as Dr Rosier's private and public practice grew, he set about establishing outreach clinics in southern NSW that saw the service expand to towns such as Bombala, Cooma and Moruya and draw patients from an area extending as far south as the New South Wales and Victoria border.

From the start of his practice in Canberra, Dr Rosier has shown a keen interest in educating young doctors and other health professionals. Following the establishment of the ANU Medical School, he extended his teaching role to medical students, including giving many students the valuable opportunity to observe consultations occurring in both his public and private practice.

He is an outstanding medical professional who has served his community with distinction and excellence.'

Dr Rosier's response

Dr Rosier responded to the award by reflecting on his early days in Canberra and thanked his colleagues from those days. He pointed out that paediatric practice had changed in many ways over the 30 years since he first arrived in Canberra.

While noting a shift away from VMOs providing services to the public system, he believed that private paediatric practice still has a pivotal role in the provision of paediatric services in the ACT.

Dr Rosier thanked Dr Di Dio for the award and referred to the important link he believes the AMA provides between those practitioners who may feel disengaged and those in decision making roles.

Finally, Dr Rosier paid tribute to his family and the encouragement and support they had provided to him at all times.

50 Year Member: Dr Andrzej Rososinski

BY DR JOHN DONOVAN

Dr Andrzej (Andrew) Rososinski has this year become a 50-year member of the AMA.

He was born in London in 1943 to Polish parents who escaped their homeland during World War II, and arrived in Australia aged 10. His mother had been a medical student at the University of Edinburgh, but left her studies to raise a family.

Dr Andrew Rososinski.

Andrew trained in Adelaide and worked there for four years after graduation before coming to Canberra in 1974. He worked at the City Health Centre for most of its lifetime, as he has a strong belief in the bulk billing of patients and affordable healthcare. In 1976, he was awarded Fellowship of the RACGP.

Andrew says enjoys general practice as it allows him to meet many diverse people and help them with a wide range of medical issues.

Andrew worked at the City Health Centre until its closure in 1996 and has since practised at the Erindale Health Centre, where he still works four days per week. He plans to retire at the end of this year, although he says that was a hard decision to make, as he will miss working as a doctor and the many patients he has assisted in the Canberra community.

Throughout his career Andrew, who is bilingual, has had many Polish-speaking patients, some for more than 30 years, and most are now elderly and needing support from other health professionals. His patients include some prominent members of the community and he says some of his older patients still travel across Canberra to see him.

Unsurprisingly, he lists his special interest as the medical and social problems of migrants settling in Canberra.

What Next?

So, what does he plan to do next? Travel of course, to Europe and especially Poland, which he and his wife have visited many times. He has a special attraction to the architecture of the many fine buildings there and says he would have liked to have been an architect if he had not been a doctor. At home, he collects stamps and coins, and enjoys fine wines.

New graduate Dr Andrew Rososinski.

Andrew is married to Elizabeth. He has two children; his son, Anthony, is a GP in Sydney, and his daughter is a lawyer in Canberra.

We look forward to having him as a 50-year member for many years to come.

Practice Notes: Minimum Wage Increases

BY TONY CHASE, MANAGER WORKPLACE RELATIONS AND GENERAL PRACTICE

In its Annual Wage Review Decision of 30 May 2019, the Fair Work Commission (FWC) handed down its decision in the Annual Wage Review for 2018-19. This decision will increase the national minimum wage and Modern Award minimum wage by 3% per cent from the first full pay period on or after 1 July 2019.

The key changes from the Annual Wage Review are:

A 3 % per cent increase in the national minimum wage for award/agreement free employees which will see:

- the current weekly minimum wage increase from $719.20 to $740.78 (an increase of $21.60 per week)
- the current hourly wage increase from $18.93 to $19.49 (an increase of 56 cents per hour)
- the current casual loadings in the modern awards and for award/agreement-free employees will remain at 25%.

This minimum wage increase falls short of last years' increase of 3.5%. The FWC stated their decision to present a lower wage rate increase than last year was due to the current economic environment, especially the recent fall in GDP growth, the drop in inflation and the tax-transfer changes which took effect in the review period which have provided benefits to low paid households. The re-election of the Morrison Government meant that the intervention foreshadowed by Bill Shorten did not occur.

Loadings, Penalties and Allowances

The increased modern award minimum wage will have a flow-on effect to loadings, penalties, allowances and overtime payments under modern awards.

Members are advised to review their current pay arrangements to ensure that:

- any employee not covered by a modern award or enterprise agreement (award/agreement-free employees) will from the full pay period on or after 1 July 2019 be paid in accordance with the new minimum wage rates (including casual loadings in respect of casual employees)
- any employee covered by a modern award are paid in accordance with the new modern award minima rates of pay in respect of employee's classification under the modern award. This also includes casual loading and other loadings, penalties, allowances or overtime which are calculated by reference to the modern award minimum rates of pay.
- If an employee receives an all-inclusive salary, the increase to the minimum rate may affect the lawfulness of that all-inclusive salary. Members will need to ensure that the salary remains adequate so as to compensate employees for the full range of award entitlements.

Members are also advised that due to the rounding factor, care should be taken when determining the correct wage figure to ensure that under or over payments do not occur".

Should members have any questions on this matter you are invited to contact Tony Chase, Manager, Workplace Relations and General Practice on 02 6270 5410 or industrail@ama-act.com.au

VMO Bargaining Kicks Off... *continued*

AMA (ACT) major VMO claims

- Remuneration – Indexation – an increase in indexation of 3% for the Fee for Service component of contracts and a 3% increase in the sessional rate.
- Workload – a VMO contract will include a fixed workload provision for the life of the contract. A VMO's workload may only be varied by agreement
- Cross-Border Indemnity – the Conditions of Liability Cover be varied so as to extend civil liability cover to VMOs in relation to any claim arising from the provision of health care to patients, delivered as a part of their VMO contract obligations to participate in on-call services, including in relation to telephone or other remote advice relating to patients located outside the geographical limits of the ACT.
- Notice Period for New Contracts – a minimum notice period of three months be applicable for any new contract. The 3-month notice period will commence from the date the offer and proposed contract is first provided to the VMO.
- Digital Call-back – describes a circumstance where a VMO, being on-call is called-back to perform duty and is able to perform that duty using appropriate digital resources without the need to leave their residence and/or without the need to return to a health facility.

Digital Call-back includes, but is not limited to, work that requires access, review and/or creation of a record containing a patient's medical information, care or treatments received, test results, diagnoses, and/or medications taken and includes clinical decision documentation.

By way of example, Digital Call-back may arise as result of a VMO participating in an after-hours territory-wide or cross-border service and/or reviewing and providing advice on medical images.

- Handover – when a VMO is required to attend a handover meeting or clinical handover, the VMO is to be paid a minimum of one hour at the sessional rate.
- Consultation – if Canberra Health Services ('CHS') or Calvary Public Hospital ('CPH') propose to replace a VMO appointment with a staff specialist appointment or to create a new staff specialist position, CHS/CPH should:
  - Advise AMA (ACT) and the ACT VMOA of their proposal; and
  - Following a request, provide AMA (ACT) and VMOA access to the business case for the proposed course of action.
- Continuity Bonus – CHS/CPH must include the GST component of a VMO's payments when calculating a continuity bonus
- Car Parking – VMOs will be provided with free, onsite and convenient car parking for the life of the contract.

Canberra Health Services' major VMO claims

FFS payments – reduction in the MBS Base Fee for Service rate from around 130% of the most recent MBS rate to 115%. There would then be no further indexation above any changes to the MBS.

Sessional Rate – to be increased by 1% commencing in July 2020.

Private Practice – CHS is developing a private practice scheme analagous to the scheme for staff specialists proposal to implement a similar scheme involving VMOs. Further details are to be provided shortly.

VMOs' private patients will 'not be impacted in any way' and the intention is that there would be minimal impact on current invoicing processes and no impact on liability coverage.

Introduction of a 'market rate' contract – CHS proposes to implement a 'market rate' contract that would allow for a variation in the contract rate to permit individual VMOs to 'compete' for work that might be out-sourced to non-VMO providers and who provide the service at a lower rate.

CHS will further explain this proposal at the first negotiation meeting.

The Agony and the Ecstasy

BY DR JENNY ROSS

"Would you please write an article about why you love being a GP" my relentlessly cheerful colleague, Dr DiDio flings at me between patients on a frantic Monday morning. "But wait" I whine to his retreating back- "what If I DON'T love it today???" Too late – he has moved on to the next thing, high on life as he embraces his new role as local AMA political advocate and defender of this profession he loves.

25 years I have been sitting in the same little room, in the same little surgery, in the same little suburb, in the same little capital city, with wonderful staff and colleagues providing primary care to our village.

One of my early mentors and colleagues, Dr Dennis Armstrong and I used to compare a day of general practice to "sifting for flecks of gold among all the sand". We would hope to be enriched by that juicy clinical diagnosis or interesting physical sign among all the vague and nonspecific presentations. Perhaps one of the thousands of tired patients would actually have Addison's Disease (Has anyone ever really made this diagnosis??)

Now after all these years as a GP I have come to appreciate that perhaps it is the "sand" itself that enriches me.

I have taken to collecting, for my amusement, "the lists" that patients bring in to their 15 minute consultation. Usually scribbled on the back of an envelope or old phone bill – It might look something like this;

- Script Nexium and new BP tabs – pink ones from the specialist.
- Scabby red lump on hand not healing
- Need a script for something for sleep
- Mouth ulcers
- Pap smear due (no interest in sex ? any suggestions)
- Headaches worse
- Going trekking in Cambodia next week? Need to do anything
- Discuss little Johnny's soiling

In fact none of this is really hard- these things are our bread and butter in general practice –the challenge of course is the sorting, the prioritising, the time management, not missing the brain tumour, the depression, finding time to explore the relationship problem. I struggle with the constant juggle of running late, of feeling guilty for charging for longer visits or asking patients to return for several visits. I struggle with the need to balance their financial stress and valuing my own time and worth.

"Common things occur commonly" we are taught in medical school. One of my daily challenges is living with the constant low grade terror that I will miss the exception to the rule. Which of the many cranky, hot toddlers I've seen will have meningococcal disease? Who among the myriad of irritable, bloated peri-menopausal woman who can't lose weight will have ovarian cancer?

I'm now sitting with patient # 17 for the afternoon. She has been my patient for about 22 years.

I have been with her through her eating disorder, tragic pregnancy losses, IVF, the arrival of her beautiful healthy son. I have done his vaccinations and treated his childhood illnesses. I have enjoyed celebrating with her his first tooth, first steps, first day of school. I have been with her through the postnatal depression, the relationship tensions, the workplace bullying, the juggling of tricky elderly parents.

"I need to write an article about being a G.P" I share with her as I complete her asthma plan.

She pauses and reflects on this statement. "The agony and the ecstasy?" she quips.

I have my title.

Hospital Room with a View: Benefits of Biophilic Design*

BY DR BALAJI BIKSHANDI

Surprising as it may seem, a simple hospital room window with a serene view of a little garden or a water feature could help patients recover better, reduce their length of stay in the hospital, cut down health care costs and improve work culture.

> One impulse from a vernal wood
> May teach you more of man,
> Of moral evil and of good,
> Than all the sages can
>
> (William Wordsworth)

Biophilia, or humans' inherent tendency to like beautiful natural features such as ocean views and greenery, may have a deeper impact on human health than meets the eye. Edward O Wilson introduced and popularised the hypothesis in his book, Biophilia (1984). He defined biophilia as "the urge to affiliate with other forms of life".

Patients recovering from gall bladder surgery were found to have positive outcomes, including that of reduction in requirement for analgesics, if they had a better view from their hospital rooms. Beautiful views from patient rooms also reduced overall health care costs.

While there could be many theories explaining the physiological or psychological basis for the positive health benefits conferred by natural views for patients, it could be safely inferred that there may well be an improvement in staff health and wellbeing also, which has its own knock-on effect to patients.

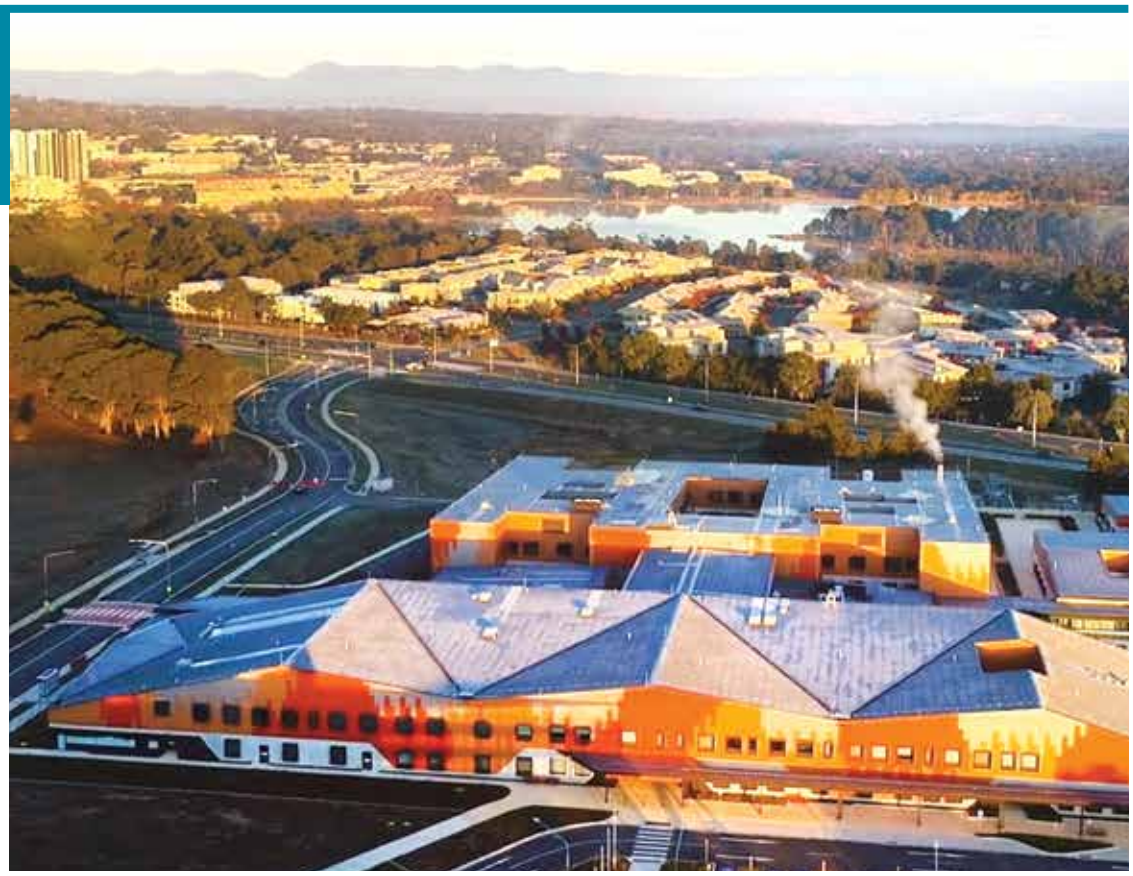
Interestingly, even indoor plants seem to improve pain tolerance. An experimental study found that more subjects were willing to keep a hand submerged in ice water for 5 minutes if they were in a room with plants present than if they were in a room without plants.

Biophilic Quality Index

It is pleasing to see hospitals around the world have now taken this concept seriously. A 500-bed hospital in Singapore won an award for its biophilic design initiative in December last year. The Biophilic Quality Index (BQI) is a new tool being developed to assess the restorative property of a biophilic environment, looking beyond just the aesthetic value. There are now artificially intelligent biological "walls" comprising of living plants specifically designed for health care.

For the evidence-based readers out there, it seems to be true that the positive effect conferred depends on the individual's level of "connectedness" to nature and the "quality" of the environment shown. In other words, there could be subjective variation in the impact that biophilic environments could effect. And this effect could also vary in the same individual over time. It is also true that many studies focusing on these areas are not robust enough or conducted for long enough to be considered concrete evidence.

But, while waiting for such robust studies, we could open our hospital windows to the magnificent views that Australia is blessed with – or design future health care spaces with biophilia in mind. I am sure you will concur with me that there is already evidence out there.



UC Public Hospital: influenced by biophilic design?

Adjunct Associate Professor Balaji Bikshandi is the clinical lead of ICU at North West Regional Hospital, Burnie, Tasmania; Adjunct Associate Professor at the University of Canberra; and Senior Clinical Lecturer at the University of Tasmania. Dr Bikshandi is also an AMA (ACT) Board member.

** This article first appeared in the MJA's InSight+*

New MBS guidelines for diagnostic imaging referrals

Medicare has refreshed its guidelines for doctors on how to request an MBS-eligible diagnostic imaging service for their patient.

As well as detailing mandatory requirements, the guidelines also include advice on the level of clinical detail required, the importance of ensuring clinical relevance, and issues to consider when assessing the benefits and/or risks to patients.

The guidelines refer requesters to the Royal Australian and New Zealand College of Radiologists (RANZCR) *Education Modules for Appropriate Imaging Referrals* which contain decision support tools for selected clinical scenarios, and to consumer-focused information which may be useful for their patients, such as RANZCR's Inside Radiology website.

The guidelines are contained in the Explanatory Notes of the Medicare Benefits Schedule and are available online here:

http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=IN.0.1&qt=noteID&criteria=IN%2E0%2E1

Doctors in the Afternoon

BY JEFFREY A. LINDER*, PROFESSOR OF MEDICINE AT NORTHWESTERN

It's 3 p.m., I've been seeing patients for a few hours and I feel my focus fading. I need to stay sharp for those still to come, so I grab a snack and some coffee.

This has become my afternoon ritual during my 20 years as a primary care doctor. Now, a new study confirms that my feared "3 o'clock fade" is real — and that it could affect patients' health.

According to the study, published in JAMA Network Open, doctors ordered fewer breast and colon cancer screenings for patients later in the day, compared to first thing in the morning. All the patients were due for screening, but ordering rates were highest for patients with appointments around 8 a.m. By the end of the afternoon, the rates were 10 percent to 15 percent lower. The probable reasons? Running late and decision fatigue.

In primary care, doctors run late because the workload is impossible. To do everything we're supposed to for a typical daily patient load,primary care doctors should spend 11 to 18 hours a day providing preventive and chronic care, never mind addressing new problems.

Decision fatigue — another explanation for the new study's findings — is the progressive erosion of self-control as we make more and more choices. Decision fatigue was most famously described in a study of Israeli judges making parole decisions. The probability of a prisoner getting parole was highest first thing in the morning or right after a break. The chance of parole dropped as court sessions went on. The chance of getting parole right before a break or lunch? Basically zero.

Decision fatigue is why car dealerships offer you expensive, unnecessary options at the end of a series of choices and why the supermarket has all that candy right at the checkout counter.

Your doctor is not immune. In a 2014 study, my fellow researchers and I found doctors prescribed fewer unnecessary antibiotic prescriptions for respiratory infections first thing in the morning, but that unnecessary prescriptions gradually increased over the day. We found the exact same doctor, caring for the exact same patient, had a 26 percent higher chance of writing an antibiotic prescription at 4 p.m. compared to 8 a.m.

As doctors got more fatigued, they defaulted to the easy thing: just writing an antibiotic prescription rather than taking the time to explain to patients why it is not necessary. As the day went on, doctors' fears of disappointed, dissatisfied, angry or confrontational patients may have loomed larger and larger. The will to confront those fears may have dwindled and more patients left the clinic with unnecessary antibiotics.

This same pattern of doctors defaulting to the easy thing later in the day has appeared for decreased influenza vaccinations, increased opioid prescribing for back pain and decreased physician hand-washing. We doctors like to think of ourselves — and the public might like to think of us — as rational decision makers, but depending on the time of day, treatments change.

What can be done? Half the battle is knowing this exists, finding a plan to compensate and maybe taking a quick break. But scheduling mandatory breaks doesn't cut down the amount of work. Certainly, improving the efficiency of the current generation of electronic health records would help things go more smoothly in the office.

Most cancer screening and preventive services could be done outside of face-to-face visits by support staff. This would allow doctors to focus on necessary care in the moment. But that requires big changes to most health insurance, which still largely pays only for in-person visits.

Doctors might not be the only ones who are impaired later in the day. In the new study, patients with late-afternoon appointments had lower screening rates even one year later. Late-day fatigue may have made patients less likely to make necessary after-visit cancer screening arrangements.

If doctors were paid based on the quality of care we delivered instead of face-to-face visits, clinics and health systems might make sure that doctors and patients at the end of the day have more effective reminders about follow-ups, more support staff or even longer visits.

So what can you do when you find yourself with a 4 p.m. checkup? After all, not everyone can get the early-morning appointment. Prepare. Learn about screenings you might be eligible for, work with your doctor to figure out which are right for you. Once screening or follow-up tests are ordered, make the necessary follow-up arrangements right away.

And consider having that cup of coffee before your visit.

**Jeffrey A. Linder is a professor and chief of the division of general internal medicine and geriatrics at the Feinberg School of Medicine at Northwestern.*

This article first appeared in the New York Times on 14 May 2019

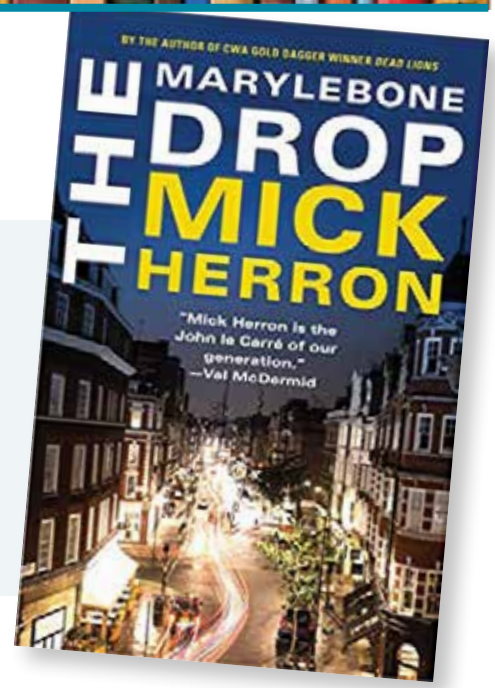
Mini book reviews:

REVIEWED BY ASSOCIATE PROFESSOR JEFFREY LOOI, ANU MEDICAL SCHOOL

Soho Crime 2015 (The List) & 2018 (The Marylebone Drop)

ISBN 978-1616957452; 978-1641290135

These two novellas are framed on the periphery of Herron's "Slough House" espionage series, interlinked via shared characters and context. Both novellas comprise miniatures depicting the vestiges of the Cold War, spies, institutions and methods alike, lingering in modern espionage between nations that may no longer be direct enemies. "The List" focuses on the discovery of a list of agents in the apartment of a former East German spy, while the "The Marylebone Drop" focuses on a retired British spy who witnesses an old-fashioned espionage information exchange. As tasters for the "Slough House" series, they are likely suitable encouragement to delve into Herron's oeuvre.



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The role of the GP is to enhance the clinical services offered at Winnunga Nimmityjah Aboriginal Health & Community Services. The aim of the clinical services team is to optimise the health outcomes for clients through providing best practice, evidence based clinical services and where appropriate to identify where a client requires referral to another team of the service or an external service provider.

Are you a Doctor who is passionate about Aboriginal Health and playing the part to close the gap in health between mainstream and Aboriginal Australia?

If you are, then opportunities exist at Winnunga Nimmityjah Aboriginal Health & Community Services for permanent part time General Practitioners to work 5days/week either between the hours of 9am to 1pm or 1pm to 5pm.

Enquiries for the above positions may be directed to the CEO, Julie Tongs on 6284 6222 or email Julie.Tongs@winnunga.org.au

For more information and/or a copy of the position description please call Roseanne Longford, HR Manager on 6284 6259 or email roseanne.longford@winnunga.org.au

All applications should be addressed and mailed to Julie Tongs, CEO, Winnunga Nimmityjah Aboriginal Health Service 63 Boolimba Crescent, Narrabundah ACT 2604 or by email to roseanne.longford@winnunga.org.au