# CANBERRA Doctor

FAMILY DOCTOR WEEK SPECIAL EDITION

Informing the Canberra medical community since 1988

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## AMA Family Doctor Week 2016

YOUR FAMILY DOCTOR: INVALUABLE TO YOUR HEALTH


*Celebrating our general practitioners in Family Doctor Week*

# Medical Musings

WITH PRESIDENT, **PROFESSOR STEVE ROBSON**

**Now that the longest Federal election campaign in history is resolved at last, it has become clear that health is front and centre as the most important issue for Australian voters. This will not surprise any of Canberra's doctors – all of us recognise just how important the health of our community is. Concerns about the standard of health care, and how affordable good quality health care is for Canberrans, are issues we hear from our patients every day. With the ACT Legislative Assembly elections looming, health issues will again be in the spotlight and your AMA will be making sure the voices of local doctors are heard. After such a close Federal result, our local politicians will be listening very closely to what we have to say.**

I think we all recognise that Australia has a great health system in international terms, and this is acknowledged by organisations such as the OECD. One of the reasons is that General Practitioners play a central role in patient care and 85% of Australians will visit a GP at least once each year. GPs are usually the first point of contact when Australians become ill, and the vast majority of health problems are managed solely by GPs. Because of the amazing work done by Australia's GPs, the AMA celebrates and draws attention to their work with our annual Family Doctor Week.

## Family Doctor Week

When people have a trusted family doctor it is good for their health: those with an ongoing relationship with a family doctor have been shown to experience better health outcomes.

For this reason, our theme for Family Doctor Week in 2016 is Family Doctors: Invaluable to your health. During Family Doctor Week you will hear the AMA highlighting the vital role played by family doctors in preventative health, aged care and end of life care. It is also the perfect opportunity to raise health policy issues that are now hot issues such as the Medicare rebate freeze and general practice training and funding.

## The Vital Role of Primary Care

Just as the AMA recognises the pivotal role that GPs play, so Australians value their family doctors. More than 90% of Australians visit the same practices, and two-thirds actually see the same GP for ongoing care. Our GPs are the most utilised and, indeed, the most trusted source of child health information. For these reasons, by running the Family Doctor Week we put a spotlight on the hard work and dedication of Australia's GPs. It is an opportunity to remind the Canberra community of the vital role played by local family doctors in keeping all Canberrans healthy.

With so much confusion about Government health policy, and some scare campaigns running by political groups, it is worth remembering that the AMA played a major role in the federal election campaign. GPs can be confident that the AMA provides a powerful voice for general practice, and the AMA ACT is your local voice. GPs have a say in the work of the AMA through the AMA Council of General Practice (AMACGP). To provide support for our local GPs, your AMA provides tools and information you will find valuable in both professional and business roles. Your feedback is always welcome and you should feel free to contact the local branch.

## The AMA and Public Health

A great example of how the AMA is acting in the interests of the community is our involvement in development of policy and legislation around responsible alcohol use in the community. We are working with FARE – the Canberra-based Foundation for Alcohol Research and Education – to advocate for protection for the Canberra community with 'last drinks' laws. We will also be involved in the launch and promotion of the Pregnant Pause campaign designed to provide pregnant women with support to stop alcohol use during pregnancy.

In this issue of *Canberra Doctor* you can learn about how your local colleagues work to provide health care for our community. There will be a lot happening during Family Doctor Week, and I hope you can all find time to be a part of this week of celebration. Remember, your AMA is here to assist and support you both professionally and personally. Make sure you contact our local AMA ACT office here in Canberra if there is any way we can help you. So remember to make the most of Family Doctor Week and celebrate the pivotal role played by Canberra's wonderful GPs.

## AMA (ACT) is now on Facebook!

AMA (ACT) has jumped into the wide world of Facebook so please get online and like us. It's a great way to find out what's going on quickly and keep up to date with events. Recent posts have featured the decision by Fair Work Australia to retain one agreement for ACT hospital doctors and the meeting with ACT Health Minister, Simon Corbell. It's easy – just search for AMA ACT.

# Putting the "Family" into Family Doctor

BY **DR ANTONIO DI DIO,** CANBERRA GP AND AMA (ACT) PRESIDENT ELECT

**And here we go again. Another year passes, another election campaign in which the medical profession, like some socially awkward prodigy ignored at home but trotted out to play the piano in front of her parents' guests and safely ushered off before any questions get asked such as, "Gosh, that's the same dress you were wearing last time we were here – you must really love it, dear. It still doesnít fit but hope springs eternal". And another year passes.**

*Dr Antonia Di Dio.*

Anyway – I'm at my desk, waiting for the first punter, and through it all, I'm here because it's important, and because it's a privilege.

## Career Choices

Family doctor week gives us time to pause and reflect, and remember why we do this in the first place. For just a moment our thoughts return to how we got here. Gosh, how did I get here? My mum said I should try to help people, and that basically I wasn't much help at anything else she could think of. Dad was kinder but the message was the same.

My uncle Annunzio said that general practice was a great way to get rich. He worked at the fruit markets and with a side line in selling cigarettes and watches on the freeway and had a fine eye for the cash economy, coupled with a tragic disdain for modern dental practices. Still, some advice was good. Not the bit about purloining real estate from southern Italian land wars, and luckily, not the bit about medicine for money either.

My nonna had a better handle – stories abound about her– it's a fact that she was a matchmaker till her early nineties ( "you don't retire from a calling", she'd say proudly, stirring the perpetually soaking capsicum-and – chilli pasta sauce which she lived on for her last three decades, toothless and full of spit and vinegar. She had an upstairs tenant from about 1918 till the mid-1950s who was the town GP. Some claim that she proudly considered herself his equal, indeed more so as her skills came without the dubious benefits of literacy or numeracy. She could count to 21 well enough, as that was the number of children she had, often with his help.

## Family Practise – Italian Style

Whenever punters came downstairs she'd question intimately their symptoms and what the doctor had prescribed, and memorise for future reference. Eventually she did a lot of the consults before they could go upstairs, especially if they seemed simple enough and she cannily noted that they had both the funds to pay for the GP, and an unmarried 15 year old daughter. My nonna could not abide unmarried 15 year old daughters, and systematically removed them from the village, marrying them off for a fee that rather matched that of the poor GP upstairs, turning them into young matrons quick smart.

Job well done, community need completed. She got invited to a fair few Golden wedding anniversaries, but mostly I think because they feared her wrath.

## The GP Upstairs

Funny about the GP upstairs from nonna. It seems that he never increased his fees very much over those decades. He bravely applied science and compassion to a flock that called him at all hours, complained if he was tired or late, refused to believe half his advice, would give equal credence to and payment to my grandmother's less proven remedies. When a baby was born my other grandmother, or a few of my aunts, would do the necessary, but if anything was really wrong they'd call the doctor. They might pay him, or not. They'd be grateful, and would remember for a polite period.

That old guy lived and died one of the most beloved and respected citizens of that troubled town. And one of the happiest.

## Family Medicine

That old guy. I think of him when our rebates freeze, and the graduate tsunami threatens, the latest wave of pseudoscience blind our patients to common sense , the media sneers and even our colleagues or loved ones wonder about our toil. I think of him when Twinset or Pearls, my partners in GP land, wave benignly as another young woman reaches the desk, tears gone for now and feeling at peace again after some time with them. (How do they do it? The healing power of Liberty prints soaked in White Linen? ).

I think of him when it occurs to me, as if for the first time, what I'm doing today. Yes, this may be my office. It may be that I physically invite them in to sit down and listen to my jokes and haranguing. But the invitation is not from me. It never has been. It's that person sitting in that chair. Thirty or more times a day, that person, new or old, young or once-young, with a cough that's a cold or a cancer or everything in between, that person is inviting me into their life, thinking with such touching confidence that I might be able to help, knowing that whatever happens, I care. That invitation is the privilege, and it brings a smile and sometimes a tear.

Welcome to Family Doctor Week – once Twinset and Pearls are off to Whistler or Colorado or wherever the perfect go mid-Winter, come on over for 26-hour stewed capsicum and tripe. That makes you cry too.

# Capital Health Network: we're here to help

BY **DR MARTIN LIEDVOGEL,** GP, PRACTICE PRINCIPAL AND CHAIR OF THE CAPITAL HEALTH NETWORK

**It's difficult to reconcile the changes that have occurred over the last twelve months since the Capital Health Network was established. Even the concept of 'Primary Health Networks' is barely three years old and to have come so far in such a short time is something we should be proud of.**

A lot has changed in the general practice landscape since the last year's AMA Family Doctor Week. There has been the Federal Government response to the Primary Health Care Advisory Group report with plans to commence medical home trials by July 2017. These trials will see capitated payments for chronic disease management in addition to the fee for service model that has been in place for the last 20 years. We have seen a new statewide GP training provider that has redrawn the training boundaries and the way teaching is delivered. The Federal Government has also given a clear signal that funding for primary health care services will occur through the 31 Primary Health Networks (PHN) throughout Australia, to allow for regional solutions to the health care needs of local communities.

## What PHN's do

As many of you will know, the principal purpose of PHNs is to improve the health of the communities they serve by assessing their health needs. PHNs focus on the health needs of the vulnerable members of society such as the homeless, older people, people with mental health problems, and Aboriginal and Torres Strait Islanders people.

The aim of improving the health of individuals is very close to the heart of the GPs I talk to in Canberra, and connects with the purpose of PHNs. The Capital Health Network ('CHN') is the PHN for the ACT. CHN responds to the health needs of the Canberra community by administering health programs and commissioning services that address the gaps identified in the needs assessment.

Many of the programs and services would not be possible to deliver without the generous and expert contribution of countless GPs in the Canberra and surrounding region. But where does that leave the individual GP, and what support can they expect from CHN? It is that support that I would like to explore further in this article.

## What GPs can expect from the CHN

Education events remain a key means for CHN to support GPs. The format of events has changed from those that were organised by the ACT Division of General Practice. Events are now aimed at a multidisciplinary audience of GPs and allied health professionals which supports the key principle that optimal patient outcomes are achieved by a health care team. Recent popular education events attended by large numbers of GPs included a self-care weekend for GPs, management of musculoskeletal pain, managing chronic disease, and a men's health event. There are also a number of education events that are aimed at upskilling Practice Nurses to support GPs in providing good patient care.

*Dr Martin Liedvogel.*

HealthPathways is a CHN project developed to support GPs to deliver enhanced care during consultations. HealthPathways is a web-based manual for general practice teams to assess, manage and refer their patients to secondary, tertiary and community services. The pathways have been designed for use during consultation, and are jointly developed by consensus and collaboration between hospital clinicians and general practice teams.

The pathways are not intended to tell GPs how to do their job, but rather to allow easy access to information at the point of care. GPs and specialists can apply for access to HealthPathways at actsnsw.healthpathways.org.au.

## Practice support

CHN continues to deliver practice support as a core program delivered by a dedicated team that can help either over the phone or during onsite visits. The team is focussed on supporting practices implement the 10 Building Blocks of enhanced primary care into their work environments. It can help with assisting the practice become more culturally sensitive, practice accreditation, issues of clinical governance, advise about item numbers, and using the skills of Practice Nurses more appropriately.

The team also helps practices enrol and achieve benchmarks for the Practice Incentive Program, as well as the Practice Nurse Incentive program. Practices have the opportunity to participate in our quality improvement program called QI data, which allows practices to improve the health of their practice population through benchmarking. Further support for GPs is available through the CHN website, which contains useful information ranging from Practice Nursing standards, information on advanced care planning, templates for medical software packages, e-referrals to Practice Incentive calculators.

## Pharmacists in General Practice

CHN is undertaking a pilot program to examine the feasibility and viability of establishing a model or models to utilise pharmacists within general practice, at the point-of-prescribing. The program will be used to explore and demonstrate the benefit of incorporating pharmacists into the general practice team to optimise appropriate prescribing in general practice, ensure cost-effective use of medicines and review for specified groups of patients, facilitate and coordinate the quality use of medicines and determine the business case of the Pharmacist role in general practice.

The role of the local GP remains crucial and we are committed to continuing to support you.

# Rigor or relevance? The challenge of undertaking research in the swampy lowlands of general practice

BY **DR LOUISE STONE,** ACADEMIC UNIT OF GENERAL PRACTICE, ANU MEDICAL SCHOOL

**"In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the use of research-based theory and technique. In the swampy lowlands, problems are messy and confusing and incapable of technical solution. The irony of this situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest may be, while in the swamp lie the problems of greatest human concern." Donald Schon "The reflective practitioner"**

## High ground v. the swamp

General practice research is tricky. Being a GP researcher involves a choice: do we stay on the research "high ground" doing top down research that is technically rigorous but relatively irrelevant to our patients? Or do we go "swamp up", starting with the messy and confusing problems we encounter daily and try and build a methodology that will answer questions that matter to people who matter?

I think of this problem every time I get a request to become a recruitment agent. You know, the letter from Professor X from Research Unit Y with NHMRC funding to do a multicentre trial: "we are conducting an RCT of hypertension and would like you to become involved by recruiting patients between 18 and 65 with uncomplicated hypertension." I can't remember the last uncomplicated hypertensive I cared for, and at the end of the day, I wonder whether the outcomes of this trial inform the care of the patients I manage, the ones with complexity, multimorbidity and perhaps a tendency to make choices that are not evidence-informed ("my cousin/ my naturopath/ the internet says that those drugs are toxic, doctor"). But RCTs are relatively straightforward: a protocol, a drug, an outcome. A nice clean answer to the question "what is the best drug for this disease?"

## Treating patients, not diseases

The problem is, in general practice, we need to treat patients, not diseases. Patients who make seemingly irrational decisions, who are under 18 or over 65, who have other illnesses so that clinical guidelines intersect and contradict each other, and who have other issues, like poverty, that impede their ability to follow best practice. And maybe their hypertension is the least of their worries, and I have to prioritise.

But on the other hand, how do I research the problems I am interested in? There is no easy RCT protocol to answer the questions I want to research. How do I encourage patients to lose weight, exercise or take their medication? How do I improve cervical screening rates in my Aboriginal and Torres Strait Islander patients? How do I help the obese parents of obese children to manage their health more effectively? Or teach empathy and compassion? Or provide after-hours services? Or better manage patients with mixed emotional and physical symptoms and no diagnosis?

## A unique opportunity

At the Academic Unit of General Practice, ANU, we think we have a unique context. There are no other areas of Australia where we have one Primary Health Care Network, one health system and one medical school. This gives us a unique opportunity to do health services research, following patients on their illness journey and finding out why they make the choices they do. Including why a person with a rash they've had for seven days chooses to attend accident and emergency at 10pm on a Friday night. We are currently designing a study to take a 72 hour "snapshot" of patients attending community after-hours services and trying to detect why they attend that particular service at that time. We also have our Kindy screening data, decades of information about 4-5 year olds and the issues that have affected their health. No other jurisdiction has that opportunity.

*Dr Louise Stone.*

## Join us at PracNet

But we also have PracNet, a small group of interested GPs who are proposing, designing and conducting research of interest. That's where the after-hours research came from. And we are hoping to follow another research question: does Vicks Vaporub applied topically treat fungal toenails? It's an important question: our current evidence base suggests we should use oral antifungals, but the effects on the liver make it inappropriate for many of our old blokes with dreadful toenails and some form of multisystem disease.

Of course, there is other research occurring in the Unit. Liz Sturgiss is investigating an approach to manage obesity in general practice. Katrina Anderson has done extensive work around medical education. And Kirsty Douglas and I are exploring the impact and recovery of doctors who have been sexually abused by other doctors.

So if you're interested in exploring your particular swamp, you may wish to join us at a PracNet meeting. You might want to do a little (watch and learn, recruit some patients) or a lot (seek funding and lead a project), but all are welcome. Because at the end of the day, if we don't fill the great yawning gaps of evidence in primary care, we will be stuck following guidelines designed for other patients in other disciplines. Which often gives us no guidance at all.

# The nine principles of family medicine

BY **DR KAREN FLEGG,** RACGP ACT CORLIS FELLOW AND A MEMBER OF THE EXECUTIVE OF THE WORLD ORGANISATION OF FAMILY DOCTORS

**AMA Family Doctor Week highlights the role of GPs – also known as family doctors – and their value to the community and the health system as they deliver high-quality holistic health care. The theme this year is *Your family doctor: invaluable to your health.***


*Dr Ayman Shenouda, RACGP rural faculty chair and GP from Wagga, speaks about why he chose general practice.*

This seems an appropriate week to reflect on something which I have often heard Prof Michael Kidd, current president of the World Organisation of Family Doctors (WONCA), reminding colleagues of - that wherever we are and wherever we work in the world, our role and our contribution to the community can be encapsulated by the *nine principles of family medicine* as outlined by Prof Ian McWhinney in his *Textbook of Family Medicine (1981).* Ian McWhinney is as revered by Canadians as John Murtagh is by us - so as you can imagine his textbook is an 'oldie but a goodie'.

*Dr Karen Flegg.*

## The nine principles of family medicine are

- Family physicians are committed to the person rather than to a particular body of knowledge, group of diseases, or special technique
- The family physician seeks to understand the context of the illness
- The family physician sees every contact with his or her patients as an opportunity for prevention of disease or promotion of health
- The family physician views his or her practice as a "population at risk."
- The family physician sees himself or herself as part of a community-wide network of supportive and health care agencies
- Ideally, the family physician should share the same habitat as their patients
- The family physician sees patients in their homes
- The family physician attaches importance to the subjective aspects of medicine
- The family physician is a manager of resources

So do these "nine principles" work for us in Australia? I hope you'll consider looking at a couple of videos in order to reflect on this matter.

This year the AMA has produced some videos for family doctor week and I was interested to listen to this one where real-life GPs speak about what they find rewarding about their work: https://youtu.be/jxX-84Gut9c

Last year for World Family Doctor day (which is a WONCA initiative celebrated on May 19) the Royal Australian College of General Practitioners (RACGP) asked its national council why they chose general practice and the result can be listened to in this video https://youtu.be/wm4pettz-KE

Both videos reflect the nine principles of family medicine and are well and truly worth a few minutes of your time.

## What's happening at the RACGP?

As the RACGP Corlis fellow for the ACT, it is my role to write a little about the activities of our GP College. The RACGP has developed a community awareness campaign aimed at improving the understanding of general practice in the community and enhance the profile of its members. Some of you will have seen their very professional advertisements on television. The campaign aims to highlight the value of general practice and the importance of continuing education for all GPs. I think if you watch the full promotional video you will again recognise the "nine principles" - in just two minutes.

http://yourgp.racgp.org.au/YourGP/awareness-campaign#video

Strong general practice is the cornerstone of any highly functioning health system in the world. In our country general practitioners/family doctors are highly trained and we need to be proud of the fact that we are Medical Specialists. Family Dr week gives us a chance to celebrate the important role we all play in the lives of our patients; to promote ourselves to the community and raise the awareness that our work is encapsulated by the nine principles of family medicine. We need strong collegiality and unity to promote ourselves to both patients and government and ensure that we are adequately remunerated for being the only discipline of medicine that can be proud to say the "nine principles" apply.

# Show that you're an AMA Family Doctor

**As part of Family Doctor Week, show that you're an AMA Family Doctor by downloading and using the AMA Family Doctor logo. The logo is provided as part of the AMA's ongoing efforts to promote the role of general practice. Using the logo will enable AMA GPs to identify and promote themselves as a Family Doctor.**

The logo is only being made available to members of the AMA who are working in general practice. It is intended to be used on their website profiles, and electronic or professional stationery. A template is also available for download to be used as part of an email signature block.

The logo is for individual use only.

The AMA Family Doctor Logo and template can be accessed by logging in to the AMA website https://ama.com.au/article/ama-family-doctor-logo.

When you download the logo you will be asked to agree to its conditions of use.

**If you are unsure of your Member login please contact memberservices@ama.com.au.**

# Who was Canberra's first general practitioner?

BY **DR BILL COOTE**

**Dr Bill Coote* gives us an insight into medical practice and medical practitioners in the early days of Canberra. Just who was the first GP in Canberra?**

In December 1925 the *Medical Journal of Australia* (MJA) observed: "...Hitherto the medical practitioners of Queanbeyan and Yass have provided the medical care to the inhabitants of this fertile and favoured area. The capital city of Canberra has come into existence and the old state of affairs no longer suffices."

Before World War 1 there were about 1000 workers engaged in building Canberra's basic infrastructure such as a water supply and sewers. A rudimentary Canberra Hospital opened in 1913 and closed during World War 1 when building work ceased. Dr Peter Lalor namesake and grandson of the Eureka rebellion leader was attached to the Royal Military College when it opened in 1911.

In the early 1920s construction of permanent housing and the first public buildings commenced. The hospital reopened in 1921 when the population had grown to about 2800. Later in the 1920s public servants began arriving from Melbourne as the Provisional Parliament House neared completion.

The minutes book of the Central and Southern Medical Society (CSMS) for 1919 to 1950 is held by the AMA (ACT). The CSSMS was one of 17 local groups affiliated with the NSW BMA. It had members from Goulburn and smaller towns in the region. The two doctors practicing in Queanbeyan around 1910-1925, Patrick Blackall and David Christie, were active in the CSMS.

The first mention of Canberra the minutes of the CSMS was at a committee meeting in Goulburn in July 1921: "Careful consideration was given to the question of medical practice in the Federal Territory. Dr Christie reported that he had received an invitation to visit Canberra Hospital once a week to attend there free of charge all patients in receipt of not more than £250 per annum. For this service he had been offered £200 per annum. Special visits were to be paid for at a rate of 5 guineas per visit."

The CSMS recommended that both Drs Blackall and Christie be appointed VMOs at salaries of £200 per annum. They were required to visit twice weekly, respond to emergencies and to visit all patients with temperatures that reached 101°F.

## The Feds step in

However, this arrangement was soon under threat. Tony Proust in the *Canberra Historical Journal* of March 1991 provides details.

Dr John Cumpston was appointed Director General of the new Commonwealth Department of Health in 1921. He recommended that "a young, competent, full time salaried medical officer be appointed to the Canberra Government Hospital to avoid transfers to Queanbeyan." The right of private practice was included. As a temporary measure Dr Stocker of Royal Military College was appointed in November 1922 and the services of Drs Blackall and Christie terminated.

*Dr Patrick Blackall.*

Dr Blackall wrote to his friend Austen Chapman, Federal member for Eden Monaro, complaining that Dr Stocker's private practice would ruin his practice and that "it was the first step towards nationalisation of medicine" which was "bad for the doctors and very bad for patients". Dr Blackall travelled to Sydney to complain to the NSW Branch of the BMA.

*Dr Bill Coote.*

Dr Stocker gave up his right of private practice. In the winter of 1923 he managed an epidemic of measles and scarlet fever and had 46 in-patients and scores of out-patients. He believed he was entitled to a bonus in lieu of private practice rights. He resigned after he was granted a bonus of only £50.

## The threat of nationalised medicine

Drs Blackall and Christie returned to their previous positions with the right to transfer serious cases to the Queanbeyan Hospital. Patients with incomes of £250 or more were classified as private patients.

However uncertainty continued. At the general meeting of the CSMS in Goulburn in September 1923 Dr Blackall "drew the attention of the meeting to the fact that he had good reason to believe that steps were to be taken to establish free medical attendance to workmen in the Federal Capital territory or in other words, to nationalize medical practice in the Territory under direct Commonwealth Health Department control."

This appears to refer to the Canberra Medical Benefits Scheme proposed by the Commonwealth. On July 8 1924 the Queanbeyan Age reported that "A mass meeting of federal employees held in Canberra on Sunday afternoon" resolved "that the wishes already expressed by the men, that they pay for medical attention by a per capita deduction from their wages and have the right to choose their own medical officer".

Another paper *Federal Capital Pioneer* outlined the scheme: ".....the scheme would have offered a medical man £1000 per annum up to the (then) 1100 men employed in the Federal Territory and the then BMA rate of 32/- after that number on a per capita basis. The maternity clauses would be strictly a matter between doctor and patient..... (but) the BMA would accept no scheme other than 32/- per member."

## Canberra as well provided for as Queanbeyan

The Queanbeyan Age in September 1924 noted both Drs Blackall and Christie "have assistants residing at Canberra; residents of Canberra are now as well provided for as those who live in Queanbeyan." Charles Daley was secretary to the Federal Capital Commission and in a 1965 *Canberra Times* article wrote, referring to Drs Blackall and Christie: ".....we built consulting rooms for them at Acton. The two young doctors, Drs Dodson and Edwards, lived at the Bachelors Quarters (now Lennox House) and their wing was known as Macquarie St."

## "The Bachelors Quarters"

The Pioneer agitated against this scheme. It believed the proposed scheme gave too much control to the Queanbeyan doctors and in 1925 reported: "A plea was made for resident medical men free from the two doctors at Queanbeyan."

beyan. Had the scheme passed they would have reaped a harvest and all the "benefit" the employee would receive would be conditional medical attendance at the hospital plus mileage if called on by the doctor."

Plans for the scheme were shelved. The main argument for provision of rooms for the Queanbeyan doctors and a Commonwealth managed financing scheme was that it would be years before private practitioners were attracted to Canberra.

## Dr Clyde Finlay buys in Kingston

In May 1925 the *Pioneer* reported: "The private cottages on ground purchased by Mr John Deans the enterprising contractor are adding to the attractions of Eastlake (modern Kingston). The first completed house built since Federal Capital building blocks were sold was one built by Mr Deans and has an attractive appearance. He has already found a buyer in Dr Clyde Finlay, the first medical practitioner to take up residence in Canberra. Dr Finlay though a young man can claim to be the pioneer in private practice. True, we have Dr Dodson and Dr Edwards but they came to practice as assistants to Drs Blackall and Christie of Queanbeyan." Dr Finlay was a 1922 Sydney graduate. This house was in Wentworth Avenue. He later moved to Giles St Kingston where he practiced until 1963.

I have not been able to ascertain the basis on which Dr Blackall and Christie engaged the two young doctors. There is a cryptic entry in the CSMS minutes of 30 April 1925 recommending that "a private agreement between Principal and Assistant be drawn up to prevent any irregular action on the part of the assistant which might mitigate against the interests of the principal." Such agreements probably included clauses similar to those used now by some "corporates" limiting the geographic area in which a contracted doctor can practice outside the contract.

Tony Proust lists other practitioners who came to Canberra in the few years after 1925. Dr Robert Alcorn came to Forrest in 1926 and Dr AJ Mollison to Manuka. Dr Beatrice Sharwood commenced in Braddon in 1928. Dr AJ Cahill established a specialist practice in eye, ear, nose and throat practice in Torrens St Braddon in 1929. Dr J Holt arrived in 1929 as a locum for Dr John James, a surgeon and Canberra Hospital superintendent. Dr Holt married Beatrice Sharwood and practiced in Giles St Kingston until the 1960s.

## Corner houses preferred

Drs Blackall and Christie took other opportunities offered by the growth of Canberra. The MJA in October 1924 advised: "every medical practitioner finds it advisable to live in a house of good

*The Bachelors Quarters.*

appearance. Corner houses are frequently selected, although the central situation is more important. It is usual for the practitioner to set aside a portion of his house for his professional work."

In December 1924, at the first auction of private residential blocks, Drs Blackall and Christie bought prominent corner blocks. Dr Blackall bought Lot 1 Section 26 in Ainslie for £550, Ainslie then covering Braddon, Ainslie and Reid. The block certainly occupied a "central position" being on the corner of Northbourne Avenue and Cooyong St (now the Medina Apartments). Dr Christie bought Lot 3 in Section 5 at Red Hill for £410.

## The Harley Street of Canberra

Dr Moya Blackall, a 1927 Sydney graduate, wrote in the March 1978 *Canberra Historical Journal*: "At the first sale of residential blocks in Canberra two were purchased by my father. The auctioneer of the day claimed that Northbourne Avenue was to be the "Harley Street" of Canberra. The prediction was never fulfilled, but his own plans came to fruition and a fine brick house was erected on the corner of Northbourne Avenue. It was planned with separate entrance, waiting room and suitably equipped consulting room and was home and professional suite to me for many years."

A quest to identify Canberra's first general practitioner provided no clear answer but did lead to a fascinating political story. But when you mix doctors, government, money and add in the BMA (or now the AMA) some politics is the inevitable result.

** Bill Coote graduated from the University of Queensland with an MBBS in 1973 and, for nine years from 1976, ran a rural general medical practice. After making the transition to working for the AMA, in 1992 he was appointed AMA Secretary-General, a position Bill held for six years*

*After stints working as a ministerial staffer and the inaugural CEO of GPET, Bill made the transition to consulting. He is currently Chair of the Professional Services Review.*

# Is AMA NSW's 'Future Practice' the way of General Practice?

**With the Turnbull Government having been returned and apparently committed to extending the Medicare freeze until 2020, there are continuing significant issues for general practice. If the freeze is, in fact, maintained it threatens to cripple thousands of medical practices and force all Australians to pay more for their healthcare.**

For many GPs, the budget announcement extending the freeze to 2020 was a tipping point. With the freeze potentially stretching out for seven years, many have no choice but to pass on the increased costs of running their practices to patients.

As a result, AMA (NSW) has been asking the essential question – what can GPs do to survive? And how can general practitioners provide a quality service that fits the needs of an ageing population, adopts the latest technology and offers patient-centred care, while still being sustainable?

AMA (NSW) says the answer is through innovation and has launched the 'Future Practice' project.

### 'Ideal GP experience' research

As part of the Future Practice project, AMA (NSW) commissioned Essential Media Communications to ask patients to describe a "dream GP experience". Here's what their research came back with:

1. The ability to quickly and easily make an appointment (either online or over the phone) for the same day.
2. Receive a text that confirms the appointment time (and alerts you if the doctor is running late).
3. Arrive five minutes early, and be told the GP is running on time.
4. Wait in a comfortable, bright, clean waiting room that has current, high quality magazines.
5. See a GP at the appointed time for a relaxed, unrushed, thorough, friendly chat – this includes a lot of 'back and forth' about your concerns and issues.
6. Leave the appointment confidently knowing the next steps, your treatment, what your issues are and how to deal with them.
7. Head to reception where the receptionist has all paperwork ready, pay by EFT with an automatic refund from Medicare.

AMA (NSW) says that the good news is most aspects of "the ideal GP experience" are already being offered at many practices across NSW.

### Other research findings

Online bookings and appointment alerts, longer consultations, integration of services and streamlined billing systems are emerging as the backbone of these modern practices.

On the issue of billing, the AMA (NSW) research confirmed the public is open to paying an appropriate fee for those who can afford it, especially for longer consultations, providing those in need retain access to services.

And they are open on whether a practice is a smaller group practice or a larger corporate practice, provided the service fundamentals are in place.

They also reaffirmed the need to have a relationship with a practice, so there is a continuity of care, with many still retaining ties with the practice they used as a child. Looking to the future, most people believe they will continue to rely on a single GP for complex issues, while accessing larger corporate chains for more routine issues.

### 'Future Practice' and website

As a result of these issues and feedback from its GP members, AMA (NSW) has launched 'Future Practice' – a platform for medical practitioners who are interested in providing quality care in the midst of the Medicare freeze. In conjunction with the campaign, AMA (NSW) launched its Future Practice website (www.future-practice.com.au) which covers all aspects of creating a quality, patient-centred, economically viable practice, offering a wealth of resources, including case studies, videos, and a community for GPs to share ideas.

The Future Practice website also offers general practitioners a free health check, a detailed benchmarking exercise and a fee for service pricing guide. AMA (NSW) have held a Future Practice workshop that featured a presentation from Cathy Baynie, NSW/ACT State President of the Australian Association of Practice Management (AAPM). Ms Baynie has joined AMA (NSW) as a consultant to assist with Future Practice.


## CANBERRA Doctor

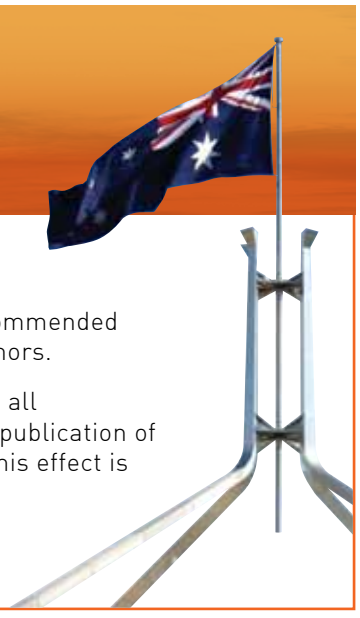
### Interested in making a Contribution to *Canberra Doctor*? Please find information below:

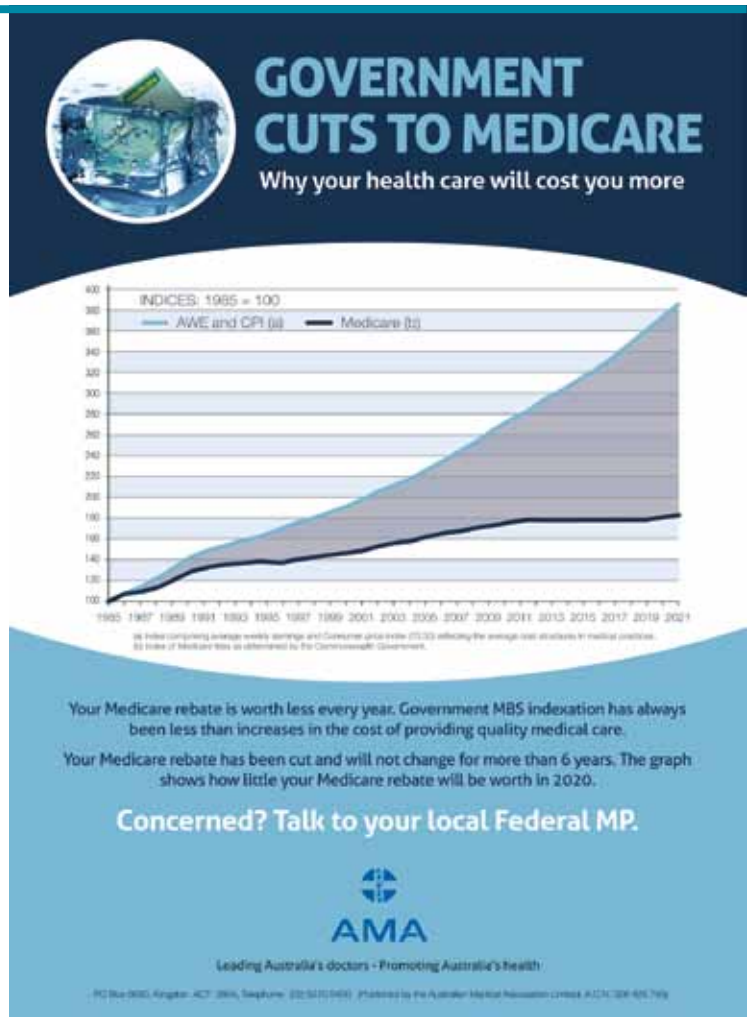
"*Canberra Doctor*" has a general policy of publishing local contributions form medical practitioners and medical students. In general terms articles should be in word (doc). References will not be included, other than to say that they are available on request. Contributions should be between 750-1000 words, but some flexibility on length will be given if the subject matter warrants.

Articles may be submitted to the editorial committee for consideration. If the committee believes that the article is too long, or needs editing, it will be sent back to the author with an invitation to resubmit.

Authors and co-authors need to be identified and an email address and phone number should be supplied. The latter two are not for publication. Photos are recommended including of the author and authors.

When an article is co-authored, all contributors must agree to the publication of the article and a statement to this effect is required.






*Cathy Baynie.*

Ms Baynie's presentation looked at the current financial challenges for general practice, focusing on the Medicare freeze, as well as the Practice Incentive Program, which is not indexed and is now being "streamlined", as well as the pending introduction of Healthcare Home and voluntary registration model.

Cathy Baynie emphasised to GPs that the decision to make any change, whether it be to transition from bulk billing, increase fees, or introduce new services, is challenging. She cautioned attendees that before any such changes can be implemented it is imperative practice systems are in place; this includes management systems, IT systems, human resource systems and appointment and recall systems.

Her presentation also stressed the importance of benchmarking and the development of KPIs and targets. According to Ms Baynie, practices need to focus on quality care and service delivery in order to "sell" any changes. They also need to be transparent in all their dealings with patients surrounding any costs, and lastly, GPs need to educate patients as to what Medicare really is – emphasising that Medicare is their insurance and that patients need to fight for higher rebates. Her advice to all practices looking to make a change is, "what will work for one practice may not work for another, so it is important to assess demographic needs and be innovative."

Subsequent feedback has revealed that some doctors felt that their practice managers were not in a position to implement and manage the practice to a level that was required and were looking for education and resources to assist with these processes.

Other concerns that surfaced were the difficulty of maintaining high quality care standards and delivery, whilst sustaining their businesses. Managing chronic disease on a limited budget was also highlighted at the forum.

Please visit amansw.com.au or futurepractice.com.au for updates.

CLINICAL CASE STUDY

# Carotid-Cavernous Fistula (CCF)

BY **DR MENG CHUNG,** MBBS, FRANZCR

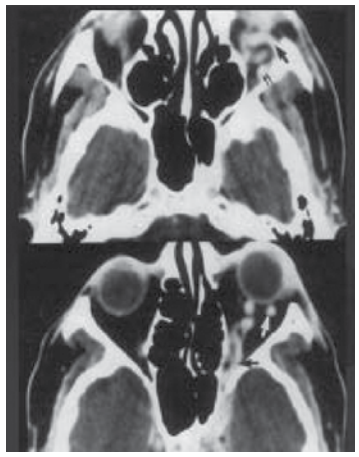
**CCF is an abnormal communication between the carotid arterial system and the cavernous sinus venous system. This may be due to a direct communication between the cavernous portion of the internal carotid artery and the cavernous sinus, or a communication between the cavernous sinus and meningeal branches of the internal/ external carotid artery. Causes may be traumatic or spontaneous.**

## Presentation

Decreased vision (including blindness), conjunctival chemosis (red eye), proptosis, pulsating exophthalmos, diplopia, orbital pain and audible bruits.

## Investigation

CT or MRI (contrast enhanced with angiography) are the most useful non-invasive tests. Findings include an enlarged superior ophthalmic vein (SOV), enlarged ipsilateral extraocular muscles (EOM), proptosis, enlarged cavernous sinus.



*Arrows indicate an ipsilateral enlarged SOV.*

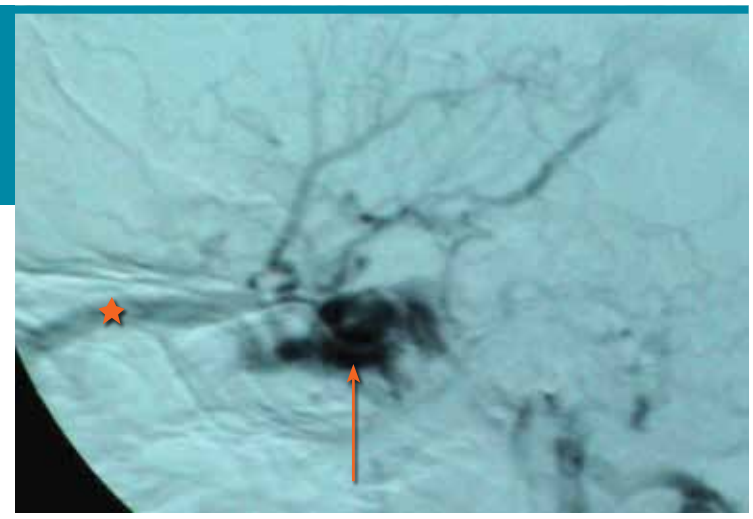
## Treatment

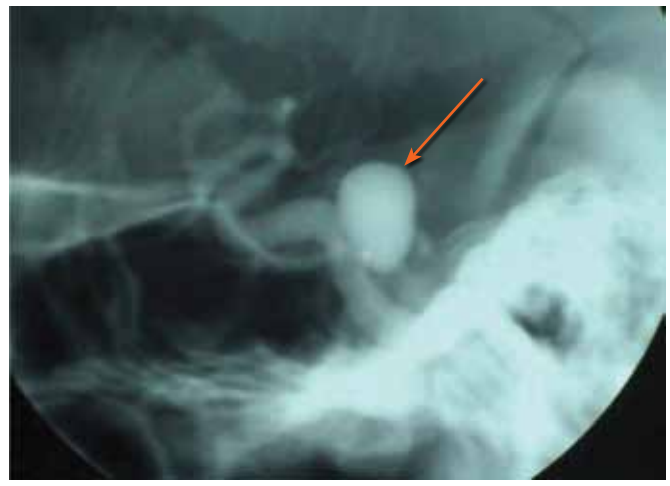
Most CCFs are not life threatening but the involved eye is at risk, including glaucoma, diplopia, intolerable bruit or headache, severe proptosis causing exposure keratopathy, blindness.

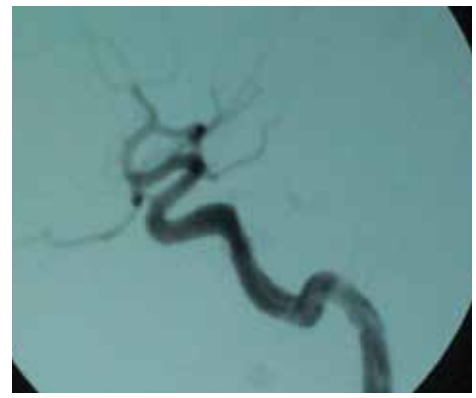
Angiography and endovascular treatments are the gold standards in treatment. Direct fistulas may be treated with a detachable balloon delivered though the internal carotid artery. Stents and coils are other methods employed to close CCFs. The transvenous route may also be used to deliver coils and glue to embolise the fistula.

*RIGHT: Carotid angiogram shows abnormal early filling of cavernous sinus (arrow) and SOV (star).*

*BELOW: Detachable balloon (arrow) inflated within the cavernous sinus placed through the fistula via the internal carotid artery, note non-filling of the cavernous sinus and SOV during the pre-deployment angiogram.*







*Final carotid angiogram after detaching the occlusion balloon demonstrating only normal arterial filling with no evidence of the CCF.*

# Good faith bargaining

**Tony Chase, the AMA (ACT)'s recently appointed Manager of Workplace Relations and General Practice gives us a quick rundown on an important part of the Australian workplace – good faith bargaining.**

Whether you're an employee or an employer, at some time in your medical career, collective agreements and enterprise bargaining are likely to have an impact on you. Maybe it will be when you're working in a public hospital or a large corporate practice or even when you're an employer of staff. Or maybe you've heard about "good faith bargaining from friends or family.

In short, Australia's current Enterprise Bargaining framework is based on the idea of "good faith bargaining" between employers and employees. This approach places additional obligations on both employers and employees.

## What is good faith bargaining?

The *Fair Work Act 2009* ("FW Act") mandates that negotiations be conducted so as to ensure that the principles of *good faith bargaining* are followed. The FW Act sets out obligations to ensure that parties are genuinely trying to make agreements at an enterprise level.

"*Good faith bargaining*" requirements can include:

- Attendance, and participating in meetings at reasonable times;
- Disclosing relevant information;
- Responding to proposals
- Giving genuine consideration to the proposals of others and giving reasons for responses to those proposals; and
- Refraining from capricious or unfair conduct that undermines freedom of association or collective bargaining

If parties fail to bargain in good faith then the Fair Work Commission can make orders compelling bargaining agents to undertake good faith bargaining.

Although the requirements of good faith bargaining compel parties to undertake the bargaining process within a certain framework, it's worth noting that there's no requirement for parties to make concessions, and a tough stance on negotiations can be adopted by either party.

## Enterprise bargaining for DITs

Although the last enterprise agreement for DITs only became operational in January of this year, the delay in settling it means that the next agreement will be negotiated at around this time in 2017.

In preparation for the bargaining, the next few months will see AMA (ACT) out and about at both Canberra and Calvary Hospitals. Firstly, we will be holding some educational activities so you're up to speed on enterprise bargaining. But secondly, we will also be seeking your input into developing the next claim and important issues such as whether we will pursue a separate agreement for DITs.

*Tony Chase.*

Any comments, questions or concerns are vital to our preparation for the next round of negotiations. Contact AMA (ACT) Manager, Workplace Relations and General Practice, Tony Chase, at industrial@ama-act.com.au

## Notes for employers: employment law changes from 1 July 2016

It's a constant challenge for employers to remain up-to-date with changes in the area of employment law. Here are some of the most significant changes from 1 July 2016:

- From 1 July 2106 the minimum hourly and weekly pay rates under Modern Awards have increased by 2.4%
- Make sure that rates of pay under an Enterprise Agreement are never below the Award rate, so some employers will need to review the current levels of remuneration in enterprise agreements.
- Don't forget that for 'Award-free' employees there is also a minimum rate of pay. For employees of 21 years or over this figure has now risen to $17.70 per hour. Junior employees (20 years or younger) are entitled to a percentage of this figure, set on a sliding scale, dependant on age. These changes are effective from the first full pay period after 1 July 2016.
- The rules around whether an employee is entitled to bring an unfair dismissal claim under the Fair Work Act have changed to limit a claim for high income earners up to $138,900.00. The maximum award for damages for unfair dismissal cases is now $69,450.00.
- Under the Fair Work Act employers must provide all new employees a copy of the Fair Work Information Statement as published by the Fair Work Ombudsman BEFORE a new employee starts work, or as soon as practicable after employment commences. This statement provides employees with information on their rights. Failure to give a correct statement can lead to fines being imposed.

# From the archives: on being a doctors' doctor

**Dr Stan Doumani, long-time Canberra GP and for many years convenor of the ACT Doctors Health Advisory Service contributed to the 2009 Family Doctor Week edition of the *Canberra Doctor*.**

"It would be presumptuous of anyone to pretend that they had all the answers when it comes to being a doctor to or for another doctor, but the truth is that it is much the same as being a doctor to anyone with a few significant differences, some subtle and others obvious. This is as much about how to be a patient when a doctor as it is about being a doctor for a colleague.

The cornerstone of any therapeutic association is a trusting doctor/patient relationship. Doctor/doctor just will not work in this setting. That said, you have to be even more mindful than usual of your patient's occupation when they are a colleague. If a colleague approaches you for the first time do exactly as you would for any patient and take a history including past medical and surgical events, medication allergies and family history. Don't expect your patient colleague to have a coherent, fully prepared history ready for you.

The "do exactly as you would for any patient" theme follows through all of the steps that you take when getting to the crux of the matter at hand. It is important never to be intimidated by someone who you feel is at least as knowledgeable as you are. No two doctors, no how matter how equal or unequal they may be, have exactly the same knowledge set. To say that another way, you will always have something to offer. Be confident in that fact.

*Dr Stan Doumani.*

Be full and thorough in your explanations, do not assume that all is fully understood by your colleague patient. This is where doctors miss out as patients, when they are treated as though they know the issues and therefore are not offered explanations. Often, they will not ask because they do not want to appear as though they do not fully understand. How can a doctor possibly relinquish their role as a doctor in relation to their own health if the colleague they attend fails to treat them as a patient? Your colleague patient needs to feel able to let go of the decision-making and hand the responsibility on to you, at least to some degree.

When it comes to treatment you need to be prepared to negotiate as you would with any patient. No one is pleased with the idea of taking medications for blood pressure or any chronic illness and doctors are perhaps more reticent than most. In the end it is always the patient that makes the decision as to whether they will take treatment or not. It matters not what walk of life from which they come. The art of the therapeutic relationship here is the art of engaging your patient in their treatment, pointing out the evidence (sometimes with a colleague this may simply be reminding them of the evidence) and arming them with the knowledge they need to make the decisions you feel they should be making.

Remember to talk about the simple things that you would never fail to do with a lay patient. Their weight, how much exercise they should be doing, the importance of recreation and holidays and all the lifestyle issues. It does get tricky when your patient is a specialist in the field for which you are treating them. But your advantage is that you can detach from their illness and they cannot.

You do not spend years in General Practice and not learn anything – remember – you always have something to offer!"

**Dr Stan Doumani, July 2009**

# Prof Chris Baggoley retires as Chief Medical Officer

**Australia's chief medical officer Professor Chris Baggoley has retried after more than five years in the role. Professor Baggoley will be replaced by Professor Brendan Murphy, who has been chief executive of Victoriaís Austin Health since 2005.**

Health department secretary Martin Bowles said Professor Baggoley had been an "influential figure in the nation's response to numerous challenges and threats to our health".

"In particular, he has been outstanding in progressing the nation's response to antimicrobial resistance, vaccine preventable disease, the risk of new communicable diseases, and improved screening and early diagnosis of non-communicable diseases such as cancer," Mr Bowles said in a statement.

*Professor Chris Baggoley.*

Professor Baggoley led Australia's response to the Ebola outbreak in West Africa and the recent Zika virus.

He also supervised the country's monitoring of the Middle East Respiratory Syndrome Coronavirus (MERS) and led the international effort to minimise the threat from the disease through his involvement with the World Health Organisation, Mr Bowles said.

Professor Brendan Murphy has been named Australia's new chief medical officer. He will start the role in October 2016.

Mr Bowles said Professor Murphy would take up the top job from October.

"Professor Murphy is an experienced clinician but also highly experienced in stakeholder management, strategic direction-setting and policy advice," he said.

Professor Murphy is a director of the Florey Institute of Neuroscience and Mental Health, the Olivia Newton-John Cancer Research Institute and the Victorian Comprehensive Cancer Centre and Independent Chair of Health Services Innovation Tasmania.

Dr Tony Hobbs has been appointed deputy CMO and will be the acting CMO until October.

*Professor Brendan Murphy.*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