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Draft Territory-wide Health Services Framework: content and consultation

ACT Health Minister, Meegan Fitzharris has announced the release of the draft Territory-wide Health Services Framework saying that the Framework "will underpin the ACT's future health system by enabling patients to access care when they need it, delivered by the right team in the right place."

ACT Health says the draft Framework is a "high-level strategic plan that establishes the overarching principles to guide the development and redesign of health care services across the Territory over the next decade."

The draft Framework is focussed on "integrating services across the three areas of health care – preventative health, community-based care and care in hospital – and will guide the establishment of clinical Centres to provide patients with integrated health care."

Clinical Centres

ACT Health says the Territory-wide Centres will "ensure specialty services are integrated across the continuum of care (prevention in the community, care in the hospital and then management of care back in the community) to make it easier for patients to navigate the services they need."

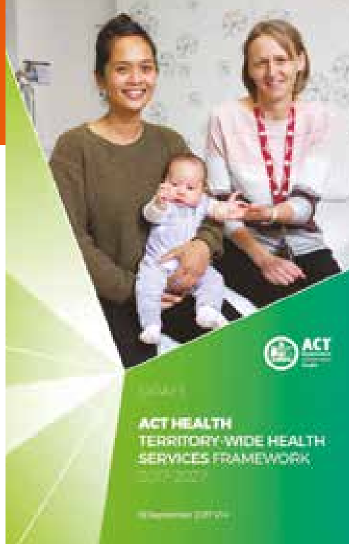
ACT Health Minister, Meegan Fitzharris.

Centres will strategically group specialty services together to "support patient needs" to ensure care can be delivered in a co-ordinated way across health facilities. The means of doing this is by facilitating collaboration between related specialties in the public and private sectors and with community-based services.

Specialty Service Plans

ACT Health says the Centres will be supported by an overall Centre Service Plan, individualised Specialty Service Plans and appropriate Models of Care. The individual Specialty Service Plans "will be developed in consultation with medical, nursing and allied health staff with input from external and internal stakeholders." Specialty Service Plans will describe how the service will be delivered across the Territory and be evidence-based.

Both the Clinical Centres and Specialty Service plans will be developed over the next 12-18 months with some service plans already having been developed and implemented.



Consultation

Following the release of the draft Framework, the consultation process will accelerate and build on the earlier consultation undertaken with NGOs who currently deliver clinical services to or for ACT Health. Expressions of interest have been sought for a 'Territory-wide Health Services Advisory Group' and over the coming months, ACT Health will consult with internal and external stakeholders to refine the draft Framework.

ACT Health says, the Advisory Group will "provide specific advice on engagement activities in the near future. There will be opportunities for specialty areas, representative groups as well as general community forums on the draft Framework and service planning."

ACT Health has undertaken to include "expert advice from clinicians, health personnel and relevant health care consumers, incorporating established best practice and advancements in medical technologies and innovation that are achievable within budget."

The first general community forum will be held in late 2017.

The draft Framework can be accessed at the ACT Health website www.health.act.gov/territory-wide-health-services

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Medical **Musings**

WITH PRESIDENT, **PROFESSOR STEVE ROBSON**

At this time of the year we all begin to think about summer and the festive season. The years seem to become busier all the time, and Canberra's busy doctors are starting to look forward to the usual string of parties, then – hopefully – some well-earned rest with friends and family.

Meeting with the Health Minister...

The latter part of the year certainly has been very busy from the AMA (ACT) perspective. CEO Peter Somerville and I had the opportunity to meet with ACT Health Minister, Ms Meegan Fitzharris, and a number of key topics were discussed. Minister Fitzharris is the COAG Health Council Chair for the next Health Ministers' meeting, and we pressed the AMA case for a national realignment of legislation dealing with mandatory reporting. The model in place in Western Australia is our preferred model, and it will remove the disincentive for doctors who need help to seek and have the same level of confidential access that our patients do.

We also pressed the case for a large-scale Territory-wide approach to Mental Health services in the ACT, with a focus on the specialist psychiatric workforce. Peter and I, along with RANZCP ACT Chair, Professor Jeff Looi, had previously discussed this in detail with Mental Health Minister Rattenbury. We have urged the ACT Government to build a sustainable workforce by taking a view across both the public and private sectors. Let's keep our fingers crossed on this.

The other 'hoary old chestnut' is the nurse-led walk in clinics. These are very expensive, with documents tabled in the Legislative Assembly showing that a single patient visit costs $188 for the existing clinics. Compared to the cost of care provided by our wonderful Canberra General Practitioners, this is breathtakingly expensive. We have proposed a round table of interested parties to try to find complementary solutions that are good for out-of-hours patients and better for the ACT budget. Stay tuned on this one.

... and meeting with the DG!

We also met with Ms Nicole Feely, the Director-General of ACT Health. Many of the same issues were discussed, but we received more detail about the Territory-Wide Services Plan that is being rolled out currently. An issue of special interest to Canberra's doctors is the KPMG-led review into the relationship between ACT Health and the ANU Medical School. We understand that the review has expanded, and there is a great deal of money at stake. We have pressed for a resolution to this as soon as practical, to provide certainty to all parties and especially those Canberra doctors who contribute to training of the next generation of medical students.

The da Vinci Codeine...

The Federal AMA and AMA (ACT), together with all other state and territory AMAs, have reinforced their support for the Therapeutic Goods Administration's decision to make all codeine preparations a 'prescription only' medicine from 1 February 2018.

The issue of prescription-only codeine has emerged again after State and Territory Health Minister's wrote to the Federal Government expressing concern that codeine users will need to access a GP for ongoing prescriptions and the impact this may have on primary care and the users themselves.

The Pharmacy Guild has weighed in to support the State and Territory Health Ministers and many of you will have seen the reaction from the Guild and our AMA response to this.

A battle worthy of a Dan Brown novel broke out over the up-scheduling of codeine, and what a battle it is. All AMAs have expressed their support for the TGA's decision to up-schedule codeine, but this also supports the importance of upholding the independence of the TGA in making decisions about medicines scheduling generally.

Director-General of ACT Health, Ms Nicole Feely with AMA (ACT) President, Prof Steve Robson (right) and Deputy-Director-General, Chris Bone.

The Royal Australasian College of Physicians, the RACGP, Pain Australia, the Rural Doctors Association and the Consumers health Forum have publicly weighed in to support the TGA's decision.

Caring for colleagues...

The Doctors' Health Advisory Service is holding ACT 'Caring for Colleagues' dinner from 6.30pm on Wednesday the 23rd of November. This is a free event for doctors and medical students. Further details are available in this edition of the Canberra Doctor and I encourage all of you to attend this important collegiate event.

Farewell to Anish

Sadly, I have to report that Anish Prasad, our Hospital Organiser has left us for employment with the Australian Federal Police Association. I'd like to thank Anish for the excellent work he has done for AMA (ACT) and its members – particularly junior doctors – and wish him well as he seeks to further his workplace relations career.

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Mandatory reporting and mental health: key AMA issues for Minister Fitzharris

Earlier in October, AMA (ACT) President, Prof Steve Robson and CEO, Peter Somerville, met with ACT Health Minister, Meegan Fitzharris for their regular consultative meeting. These meetings are an opportunity to bring forward issues of mutual concern and to share information that either the Minister or AMA believes is relevant and timely.

This time, the major issues discussed were:

Mandatory reporting

With the next meeting of the COAG Health Council due for November and Minister Fitzharris to chair the meeting, mandatory reporting is front and centre on the agenda. The Health Council meeting will consider the results of the consultation process on mandatory reporting as we move closer to a decision on changes to the provisions for treating practitioners to mandatorily report medical practitioners who are their patients.

AMA (ACT) along with the Federal AMA and all of the state and territory AMAs have been pushing for a 'WA-style' exemption from mandatory reporting for treating practitioners. Minister Fitzharris listened to AMA (ACT)'s presentation and took onboard the need to revise the current mandatory reporting framework in the ACT so as to not discourage medical practitioners from seeking treatment.

AMA (ACT) will continue to follow up on this issue to advocate for a 'WA-style' exemption to apply in the ACT.

Mental health

Following AMA (ACT)'s earlier discussions with Mental Health Minister, Shane Rattenbury, it has come to light that ACT Health has established a Medical Workforce Working Group to deal with psychiatric workforce issues in the ACT public sector. While the establishment of the Working Group is a good start in dealing with the immediate public sector issues, it is only one part of dealing with the overall psychiatric workforce issues in the ACT.

The concern raised with the Minister Fitzharris (who retains an overall responsibility for employment and operations) is that the need to approach the issues of the psychiatric workforce goes beyond the public sector (although the public sector is both the immediate and a longer term focus) and any consideration of workforce should also consider the private sector. AMA (ACT)'s view is that a sustainable workforce needs to include options for working across both the public and private sectors.

Health Minister, Meegan Fitzharris, with AMA (ACT) President, Prof Steve Robson (right) and AMA (ACT) CEO, Peter Somerville.

In addition, AMA (ACT) would like to see incentives to attract and retain particularly younger specialists in the ACT. This should not be limited to the public sector and could include assistance and encouragement with establishing private practices to sustain both the individual and the public and private sector workforces.

This is a matter that AMA (ACT) will continue to pursue with both Minister Fitzharris and Minister Rattenbury.

Nurse-led walk in clinics

For a considerable period of time, AMA (ACT) has been constructively discussing with Minister Fitzharris a broader role that general practice could play in after-hours care in the ACT. On one hand, the ACT Government has implemented nurse-led walk-in clinics at Tuggeranong and Belconnen (with two more planned for Gunghalin and Weston Creek) but on the other hand, these clinics are expensive and there may be options that better integrate after-hours care into general practice.

In regard to the nurse-led clinics, it's recently come to light that the two existing clinics cost $188 per occasion of service that represents a total annual recurrent cost of $3.5m for each of the clinics. Given this cost, AMA (ACT) is of the view that complementary options to the current – and planned – clinics are worth exploring.

To this end, AMA (ACT) has proposed a 'round-table' of interested parties to discuss such options and report back to the Minister.

AMA (ACT) thanks Minister Fitzharris for the opportunity to hold an extended discussion on these important matters.

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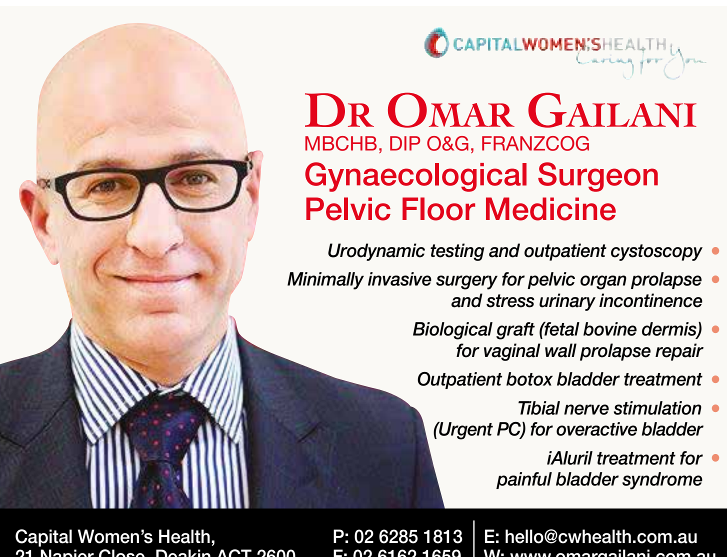


The AMA Indigenous Medical Scholarship

The AMA Indigenous Medical Scholarship supports Aboriginal and Torres Strait Islander students to study medicine, and achieve their dream of becoming doctors.

Each year, the AMA offers one Scholarship to an Aboriginal and/or Torres Strait Islander student studying medicine at an Australian University, but with the help of your tax deductible donation, we can increase the number of Scholarships offered each year and help grow the Indigenous medical workforce.

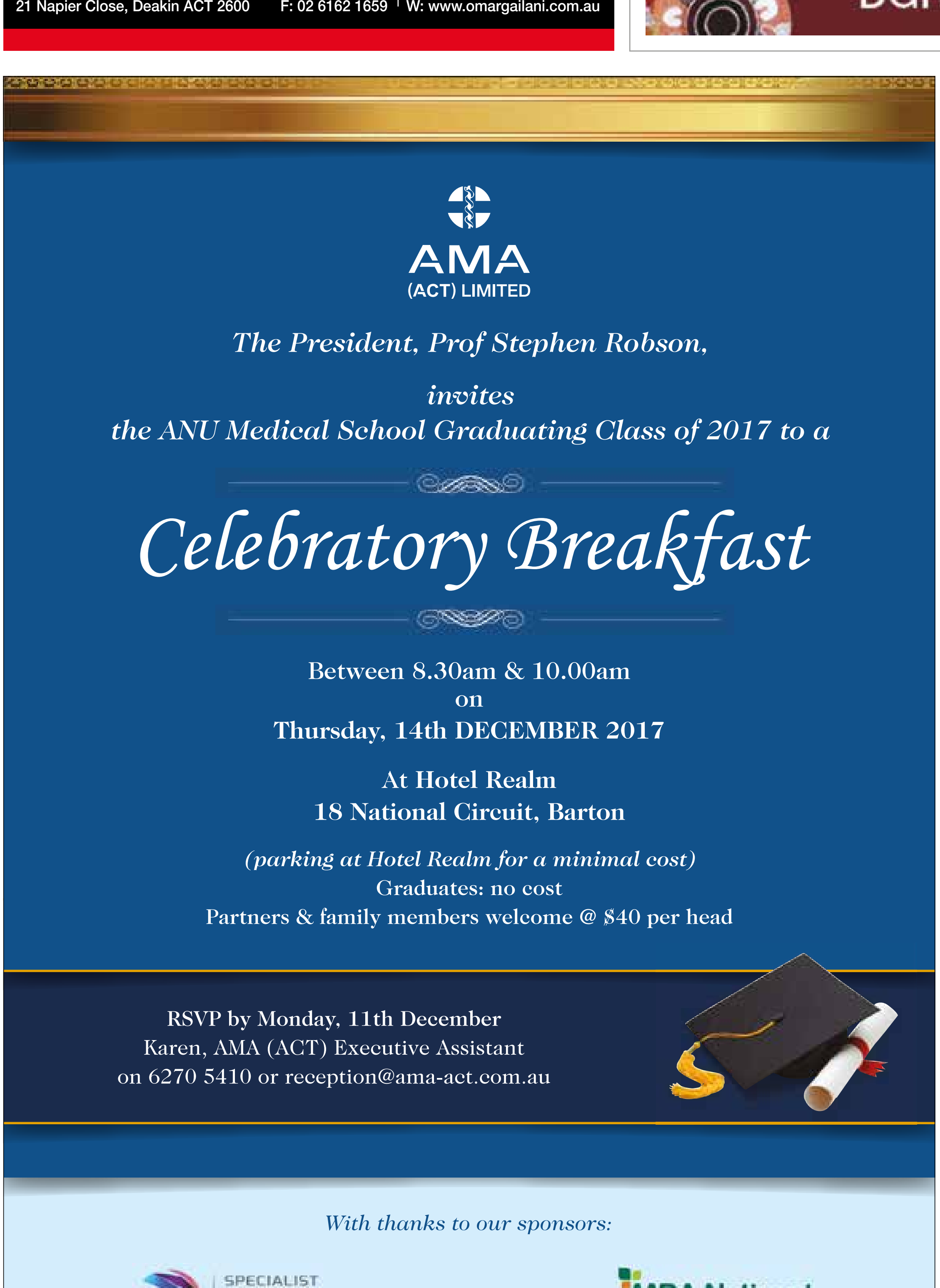
Indigenous doctors have a unique ability to align their clinical and sociocultural skills to improve access to services, and provide culturally appropriate care for Aboriginal and Torres Strait Islander people. Yet, Aboriginal and Torres Strait Islander doctors comprise less than 1 per cent of the entire medical workforce.

Since its inception in 1994, the AMA Indigenous Medical Scholarship has helped more than 20 Indigenous men and women become doctors, many of whom may not have otherwise had the financial resources to study medicine. The AMA hopes to expand on this success and increase the number of Scholarships on offer each year to meet a growing demand for the Scholarship.

By supporting an Indigenous medical student throughout their medical training, you are positively contributing to improving health outcomes for Aboriginal and Torres Strait Islander people.

If you are interested in making a contribution, you can do so by downloading the donation form at: https://ama.com.au/donate-indigenous-medical-scholarship.

Further information about the Scholarship is available on the AMA website. For enquiries please contact the AMA via email at indigenousscholarship@ama.com.au or phone (02) 6270 5400.



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AMA (ACT) urges ACT Govt to maintain upscheduling of codeine

The Federal AMA and AMA (ACT), together with all other state and territory AMAs, have reinforced their support for the Therapeutic Goods Administrationís decision to make all codeine preparations a 'prescription only' medicine from 1 February 2018.

The issue of prescription-only codeine has emerged again after State and Territory Health Minister's wrote to the Federal Government expressing concern that codeine users will need to access a GP for ongoing prescriptions and the impact this may have on primary care. In addition, the Ministers expressed concern that some codeine users, particularly in rural and regional areas will deteriorate as they abandon medication due to out-of-pocket costs of seeing a GP.

The Pharmacy Guild has weighed in to support the State and Territory Health Ministers.

AMAs back TGA

All AMAs have expressed their support for the TGA's decision to upschedule codeine but also the importance of upholding the independence of the TGA in making decisions about medicines scheduling generally.

The TGA has published its reasons for up-scheduling codeine and they are compelling – deaths and illness from codeine use have increased in Australia. This is despite a rescheduling decision in 2010 shifting many over-the-counter codeine medicines to Schedule 3 (pharmacist only) medications. In addition, there is no evidence that low-dose codeine (8mg-15mg/unit) provides any benefit beyond placebo.

To put this change in perspective, all other opioid medicines sold in Australia are available only on prescription (S4 or S8). Codeine is not available over-the-counter in 13 European countries nor in the US.

Effective over the counter medications

Patients who have short term pain will still have access to alternative over-the-counter painkillers which are more effective than low-dose codeine without codeine-associated risks.

AMA (ACT) has pointed out to ACT Health Minister, Meegan Fitzharris, that the TGA's decision was based on facts and the advice of independent experts; it has the sole objective of protecting the public. AMA (ACT) stressed the importance of an independent regulator as the cornerstone of our health system and that it was absolutely essential no decisions be made that undermine its authority.

AMA fees list launches online

Starting on October 16 the AMA Fees List has been launched in its new online format.

The new website at http://feeslist.ama.com.au/ will be replacing the book and CD-ROM formats making it faster and more user friendly than ever before. You will still be able to download PDF and CSV files, plus access a range of new, useful features including:

- Interactive dashboard to find, search and save AMA fees
- Search function that links directly to AMA and MBS item descriptions
- Personalised user dashboard with option to store favourites
- Fee calculator tools including a new Anaesthesia calculator
- Ability to print parts of, or full PDFs of the Fees List
- Online tutorials and help tools
- Mobile and tablet compatible
- Online payment gateway for non-members

Members are encouraged to log on early and familiarise themselves with the new website, before the Fees List is indexed and updated on 1 November.

All financial AMA Members will continue to have free, unlimited access to the new website using their login and password for ama.com.au. For login assistance please contact Member Services on memberservices@ama.com.au or 1800 133 655.

For more information on the new Fees List, contact feeslist@ama.com.au

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AMA welcomes Prof Paul Worley as first Rural Health Commissioner

The AMA has congratulated Prof Paul Worley on his appointment to the new position of National Rural Health Commissioner.

Prof Paul Worley, Rural Health Commissioner.

Welcoming the appointment, AMA President, Dr Michael Gannon, said that Prof Worley is a highly respected member of the profession who has made a substantial contribution to rural health over many years.

"Prof Worley has a big job ahead of him, and he will have the full support of the AMA and other groups with a commitment to improving access to quality health services in rural, regional, and remote Australia," Dr Gannon said.

"The long-awaited appointment of a National Rural Health Commissioner had the potential to boost the profile of rural health issues in Government decision-making and health policy development.

AMA ready to assist

"The Rural Health Commissioner will also lead the establishment of a Rural Generalist Pathway, which could boost the much-needed recruitment and retention of skilled practitioners in rural areas.

"The AMA is uniquely positioned to provide Professor Worley with advice on rural health policy.

"We have an extensive rural membership, including medical students, doctors-in-training, career medical officers, GPs, and other specialists.

"The AMA has also established the AMA Council of Rural Doctors (AMACRD) to ensure our rural members have a strong say in our policy and advocacy.

"We are excited at the prospect of working with Professor Worley, and look forward to meeting with him as soon as he settles into the new role."

Prof Worley is currently Dean of Medicine at Flinders University. He is a past President of the Rural Doctors Association of SA, a previous national Vice President of the Australian College of Rural and Remote Medicine (ACRRM) and is a current Council Member of AMA (SA).

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Dr Yeong Joe Lau is an Australian trained orthopaedic surgeon with an interest in disorders of the lower limb. Joe has completed multiple local and international fellowships in foot, ankle, knee and hip surgery.

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dhas doctors' health advisory service

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https://ama.com.au/act/event/doctors-health-advisory-service-caring-your-colleagues

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AMA NSW Looking for GPs willing to take on doctors as patients

AMA NSW is looking for GPs who have an interest in taking on doctors as patients – particularly junior doctors – in order to develop an online directory. This is part of an effort to both encourage junior doctors to seek care and remove barriers to this happening.

Neither AMA NSW (nor AMA (ACT)) has such a resource and the information reaching AMA NSW from DITs was that they were constantly being told to have a GP but often had rotated away from home or just did not know where to turn.

AMA NSW issues a call

AMA NSW decided to put the call out in a very simple way to members and via PHNs and the Doctors Health Advisory Service. They have also promoted it on social media and will be continuing to do so over coming months with a view to finalising a resource by the end of the year.

If you are interested in taking on doctor patients, please sign up by going to the AMA NSW's website at https://www.amansw.com.au/doctor-in-training-wellbeing/

The directory will be published as a resource for doctors-in-training.

The AMA NSW's Dr Kean-Seng Lim, Dr Brian Morton, Prof Saxon Smith and Dr Robyn Napier.

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OPINION

Preparing the medical profession for assisted dying*

BY DANE LYONS, ANU MEDICAL STUDENT

Euthanasia and Physician Assisted suicide are topics that have been bubbling to the surface of debate for a number years. The Parliament of Victoria will soon finalise a conscience vote on legislation that would legalise voluntary assisted dying and euthanasia. While the bill specifies voluntary assisted dying, in cases where the patient is incapable of administering the drug, the doctor would administer the dose, meaning that the patient is receiving euthanasia.

The Victorian legislation comes off the back of an upper house inquiry regarding end of life choices, which recommended an assisted dying scheme be created and implemented. This legislation has the potential to have a ripple effect right across the country if passed, and has had no trouble in dividing opinions amongst the public and leading medical bodies.

Understanding the terminology

In the medical profession, 'Euthanasia' is defined as the practice of intentionally ending a patient's life to relieve suffering. Euthanasia can be active or passive, with passive referring to omission of treatment which would be expected to keep the patient alive. Passive euthanasia is deemed acceptable practice. Active euthanasia, the more contentious issue, is a deliberate act undertaken to end a patient's life.

Physician Assisted Suicide is defined as a physician aiding a suicide by providing the means for suicide or the necessary information for suicide to occur. For the purposes of this article, the term 'euthanasia' refers to active voluntary euthanasia.

The positions of representative organisations

Earlier this year, the AMA released a position statement which proposed that "doctors should not be involved in interventions that have as their primary intention the ending of a patient's life".

Palliative Care Australia updated their position statement last year, declaring that "palliative care does not include euthanasia or physician assisted suicide". In 2015, the World Medical Association reaffirmed their 1987 statement that "euthanasia... is unethical".

In a recent survey, 50% of Australian doctors believed that they should not be involved in euthanasia.

The arguments against euthanasia can be separated into:

- Disagreement with the concept of intentionally hastening the process of death
- Those who do not believe that such a concept can be implemented in a way that maintains the utmost level of public safety.

Victorian Premier, Daniel Andrews, right, with Deputy Premier, James Merlino: on opposite sides of the voluntary assisted dying issue.

To delve into the ethical side of the debate would require a much longer article, but I believe that there are some important questions that we must ask ourselves – is patient autonomy of greatest importance? Does the relief of suffering via a quick death or prolonging of intolerable life do the 'most good' for the patient? Can we 'maintain the utmost respect for human life' while assisting in its demise?

We need to challenge our own initial emotional reaction to the concept of assisted dying and contextualise these reactions within the framework of our societal and biomedical perceptions towards death.

Public interest considerations

Arguments relating to the implementation of euthanasia, have the interests of the public at their core and therefore need to be appropriately addressed. One such example is the notion that by legalising voluntary euthanasia, we begin on a pathway to engaging in more dangerous and negative practices such as involuntary euthanasia. This slippery slope argument is a consequentialist logical device that can be quashed by the mere fact that physician assisted suicide and or euthanasia has existed in places such as Oregon and the Netherlands since 1997 and 2002 respectively.

Studies have shown that physician assisted suicide has had no disproportionate impact on vulnerable people within those jurisdictions. In Oregon in 2015, physician assisted suicide accounted for merely 0.39% of all deaths. In the Netherlands, rates of euthanasia have risen to 4% annually, however over 85% of these cases can be attributed to cancer, cardiac, pulmonary and neurodegenerative diseases. These numbers do not reflect communities in which a euthanasia or physician assisted suicide bill has led to a downward spiral.

The topic of euthanasia is such an interesting debate as there are wide range of opinions that exist on a spectrum. At one end, we have those who believe that the sanctity of life should be preserved at all costs and 'giving up' on life is admitting defeat. Deputy Victorian premier James Merlino went as far as saying that "this bill endorses suicide, which is a line I don't think our society should cross".

Individual autonomy

While on the other end of the spectrum, some have argued that people should have complete autonomy over their lives and can freely make the choice to die at any time. Pro euthanasia advocate Phillip Nitschke, believes that the Victorian bill does not go far enough to address the needs of the ageing population. Nitschke has stated that, "it is a fundamental human right for every adult of sound mind to be able to plan for the end of their life... at a time of their choosing".

Following this line of thinking leads to asking: are we even having the correct debate? Do the strict guidelines placed on such legislation merely interfere with a person's right to end their life? As this complex, multifaceted issue continues to be debated in the public forum, I urge us all to consider our thoughts, become informed and be prepared for this practice to be integrated into our health care system. As medical professionals, we have a responsibility to actively oversee the design, adoption and implementation of any euthanasia legislation.

**References available on request.*

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Alternative medicine in health management: Is it ethical?*

BY NUNZIO FRANCO, ANU MEDICAL STUDENT

Australia's complementary and alternative medicine (CAM) industry is one of the fastest growing, with companies selling about $4 billion of products per year. CAM refers to a wide range of products and treatments that are not considered to be part of conventional medicine. Few have been able to capture its definition more eloquently than song-writer and comedian Tim Minchin: "By definition, alternative medicine, has either not been proved to work, or been proved not to work… [sic] you know what they call alternative medicine thatís been proved to work…? Medicine".

Attraction of alternative medicine

But what is about CAM that is causing educated people to believe that a vial of very expensive "water" can cure most of today's deadliest conditions? First of all, CAM has been around for a long time, often presented as an alternative to bloodletting or purging offered by 18th century medicine; I must admit it must have seemed the better choice in those days.

Secondly, it is based on our tendency to find causation and association where there is none, as our brains are "hard-wired" to do so. Finally it is accessible, and easy to relate to, certainly not as complicated as randomized controlled trials, double-blinding and statistics that doctors keep mentioning.

Poor health literacy also creates a breeding ground for complementary medicine. I believe many CAM consumers would put the "homeopathic melatonin" back on the shelf if someone had taken the time to explain what homeopathy actually is.

Homeopathy: an example

While I don't want to pick on a specific branch of CAM, let's take Dr. Hahnemann's homeopathic remedies as an example. Sometime during the 18th century, Dr. Hahnemann's decided the first principle of homeopathy: a substance that causes a specific symptom will also cure it. He soon realised that giving too much of something to a patient can be very toxic, therefore the second principle quickly followed: the more diluted the compound, the more potent it is.

At the time it was not a problem that the typical homeopathic dilution of 30C can be compared to having a drop of an ingredient in a spherical pool filled with water, with a diameter from the centre of the earth to the sun. When this became a problem, Dr. Hahnemann decided to reveal the third and last principle: water has memory!

I don't have much to say on this one, except quoting T. Minchin again "Take physics and bin it! Water has memory! And while its memory of a long lost drop of onion juice is infinite, it somehow forgets all the poo it's had in it!"

The point is that it is fundamental that medical practitioners today understand what CAM really is, and are able to explain to any patient why it should not be part of their health management. Having said this, there are many persuasive patients whose neighbour or great aunt was cured of a terrible illness with hypnosis after conventional medicine had given up, and demands an explanation for it.

An evidence base, please

This is where evidence based medicine proudly enters the scene. As you struggle to remember what you were taught in first year of medical school, you might mention the placebo effect and the many studies that show its effectiveness, regression to the mean, the natural history of disease and that sometimes, doctors might have gotten the wrong diagnosis.

Medical ethics and CAM

When faced with the patient who takes "natural" remedies, most medical practitioners today are happy for them to continue to take the treatment as long as the conventional treatment is continued. But is it ethical for doctors to do this?

There have been many reports of CAM being deleterious to patients with serious pathologies. In Australia, there is no independent assessment of the safety or efficacy of CAM remedies before they are allowed on the market and no control over the quality of products people can purchase online. As a result, many independent studies show that some herbal remedies can cause liver and kidney failure due to the presence of naturally occurring toxins and heavy metals.

Moreover there exist known interactions between certain prescription medications and CAM remedies, such as St John's Wort (Hypericum perforatum) and Cyclosporine, which is known to lead to acute transplant rejection.

"Do no harm" is definitely to be considered here by those practitioners who suggest or don't advocate against the use of CAM for serious conditions.

Continued page 12...

Doctors' health resources

Are you looking for a GP?

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

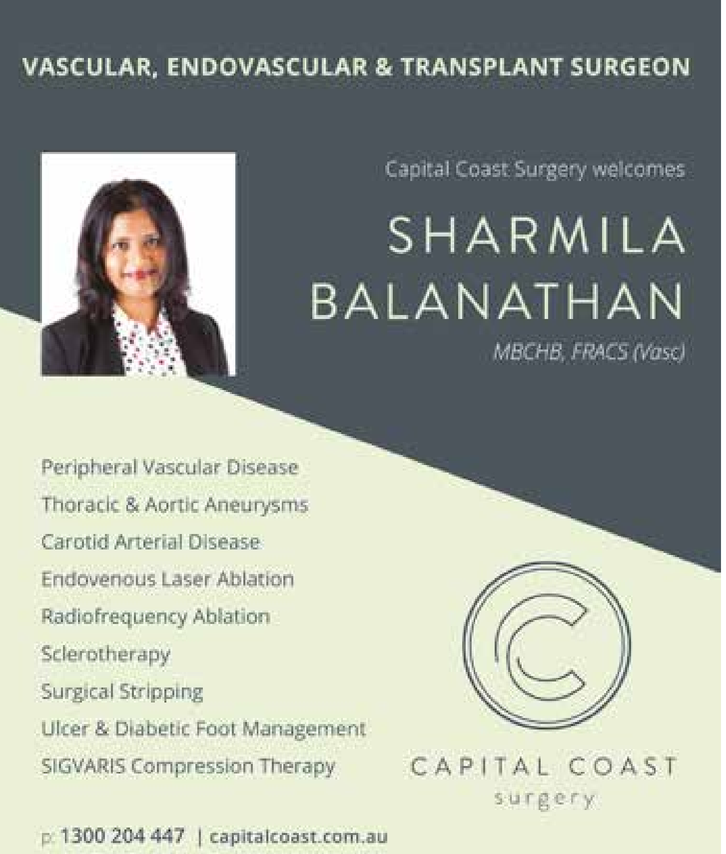
Doctors' Health Resources online

AMA's Doctor Portal:
https://www.doctorportal.com.au/doctorshealth/resources/

JMO Health:
http://www.jmohealth.org.au/
Partly funded by DHAS and a range of other organisations.

Doctors Health Advisory Service
http://dhas.org.au/resources/resources-for-junior-medical-officers.html
On the DHAS website itself.

AMSA students and young doctors:
http://mentalhealth.amsa.org.au/about-the-campaign/
http://mentalhealth.amsa.org.au/keeping-your-grass-greener/



Relocating or closing your practice? Be aware of your obligations in relation to your patients' health records

BY DOMINIQUE EGAN, PARTNER & PATRICIA MARINOVIC, ASSOCIATE AT TRESSCOX LAWYERS

Would you know your legislative obligations in relation to your patients' health records if you relocated or permanently closed your Practice?

Health service providers (*providers*) must be aware of, and compliant with, a number of legislative requirements specific to the Australian Capital Territory ('ACT') when they relocate or permanently close their health service practice (*practice*).

Public notice

Principle 11 of the *Health Records (Privacy and Access)* Act 1997 provides that, at least 30 days before the proposed relocation or closure of a practice, providers must give public notice of the practice's relocation or closure. Further, providers must take other practicable steps to inform each patient who has attended the practice of the matters mentioned in the public notice.

Providers must ensure that the public notice states:

- The patient may request a copy or written summary of their health record be given to them or to their nominated provider (transfer request);
- The transfer request must be made within 14 days of the public notice being published;
- Any fees that apply and, if fees apply, that the patient must pay these fees before their health record will be transferred;
- If the patient does not make a request within the 14 days, a copy of the patient's health record will be given to a stated provider or record keeper; and
- The address and contact details for the stated provider or record keeper.

Providers are also required to notify ACT Health of the public notice as soon as practicable after the public notice is published. An online form is available on the ACT Health's website for providers to complete which, when submitted, is forwarded to the ACT Health Services Commissioner.

Transfer request

Whilst a patient's transfer request can be made verbally, it is recommended providers request a transfer request in writing for certainty. Such requests ought to be dated, include the patient's address and telephone number, stipulate whether the health record will be transferred to the patient or the patient's provider, and include the patient's mailing address and / or the nominated provider's mailing address.

Fees

The fees which may apply in relation to the transfer of a patient's health record are set out in the *Health Records (Privacy and Access) (Fees) Determination 2016* (No 1). Fees include those payable for viewing a health record, provision of a copy of a health record up to 50 pages / more than 50 pages, and provision of a health record summary.

Timeframe for providing records

If a provider receives a transfer request, it must provide the patient or the patient's nominated provider with a copy of the requested health record or written summary within 30 days following the provider's receipt of the transfer request. If however a fee is payable for the health record, the provider must provide a copy of the health record within 7 days after the fee is paid.

In circumstances where a patient is receiving or needs urgent health services, the provider must provide the patient or the patient's nominated provider with a copy of the health records or written summary within 7 days after the date the provider receives the transfer request. A patient is considered to be receiving urgent health services if another provider informs the provider that the patient is receiving or needs urgent health services. This advice does not need to be in writing. Further, the provider may be satisfied that a patient is receiving or needs urgent health services without the receipt of advice from another provider. For example, this may be based on the patient's medical history, the patient's immediate circumstances, or any other information or evidence which may be relevant in the circumstances.

Failure to receive patient request

If a patient does not make a transfer request within 14 days of the public notice being published, the provider must provide a copy of the records to the provider or record keeper stated in the public notice within 44 days of the public notice being published.

How does this impact you?

The relocation or closure of a practice is a matter which medical practitioners do not consider in their everyday practice. The legislative obligations for providers in the ACT in relation to the relocation or closure of a practice are substantial and, as outlined above, a number of strict timeframes must be met. It is prudent providers are mindful of their obligations in this regard and seek legal advice if they require any advice or assistance to comply with their legislative obligations.

FDG PET/CT for recurrent breast cancer

BY DR KHIMLING TEW, MBBS FRACS FRANZCR, CANBERRA IMAGING GROUP ASSOCIATE RADIOLOGIST

A patient with a sternal mass from recurrent breast cancer and a small lung nodule (4mm) was referred for FDG PET/CT scan. The mass showed markedly increased metabolic activity. Metastatic disease in an enlarged internal mammary node was also demonstrated (fig. 1). There was unexpected disease in a posterior paravertebral node (fig. 2). However, the small lung nodule was not visibly FDG-avid.

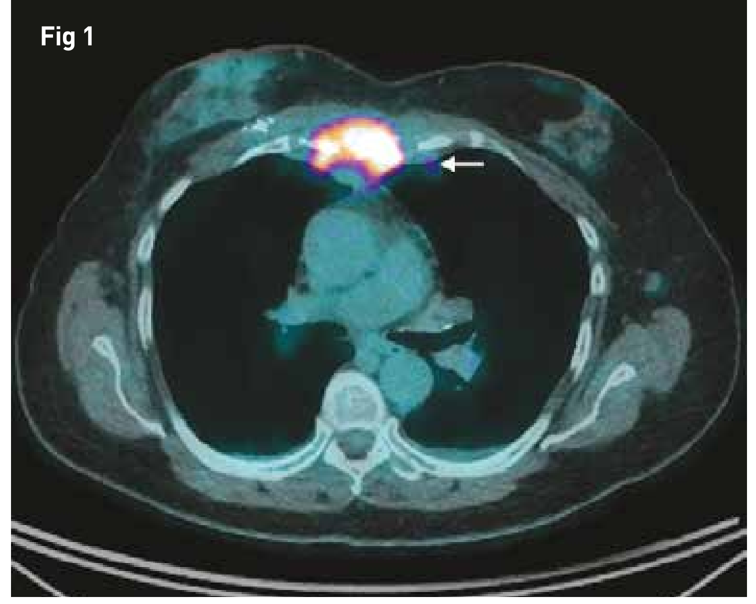


Fig 1

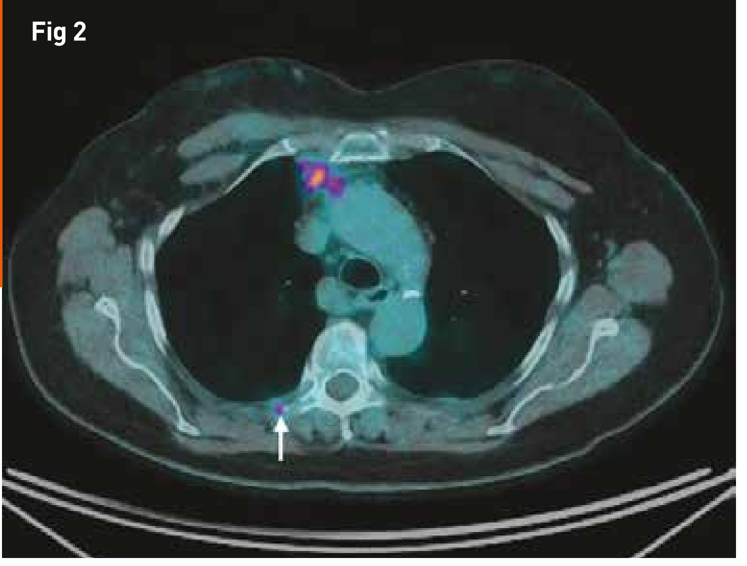


Fig 2

This case illustrates both the strengths and shortcomings of FDG PET/CT for breast cancer. In a study of 56 patients with locoregional recurrence, PET/CT showed more sites of metastatic disease than conventional imaging in 57% and changed management from extensive surgery to palliative treatment in 36%. However, PET/CT is less sensitive for small lesions (←10mm) because of tracer/detector limits and partial-volume effect.

FDG PET/CT is useful in evaluating larger tumours, advanced and metastatic breast cancer. In a study of patient with primary tumours →2cm diameter, 21% were upstaged and 16% downstaged by PET/CT. Progression-free survival was more strongly associated with staging by PET/CT than conventional imaging. Lobular carcinoma shows less FDG uptake than other types, with reduction in sensitivity. High grade, oestrogen receptor negative and triple negative tumours show greater FDG uptake. Cerebral, skin, soft tissue, peritoneal and bowel metastases may be demonstrated. Extranodal metastases are associated with poor prognosis. FDG PET/CT is superior to bone scan for detecting lytic bone metastases and comparable for osteoblastic lesions. It is also useful in evaluating response to treatment after just 1 cycle of chemotherapy, avoiding futile chemotherapy in non-responders.

PET/CT with Fluorine-18 estradiol has been used to study tumour expression of oestrogen receptors in-vivo. The response rate of ER+ tumours (based on immunohistochemistry) to endocrine therapy is 55-60%. There is evidence that metastases are less likely to be ER+/PR+ and more likely HER2+ than the primary tumour.

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BY DOCTORS FOR DOCTORS

www.mbansw.org.au

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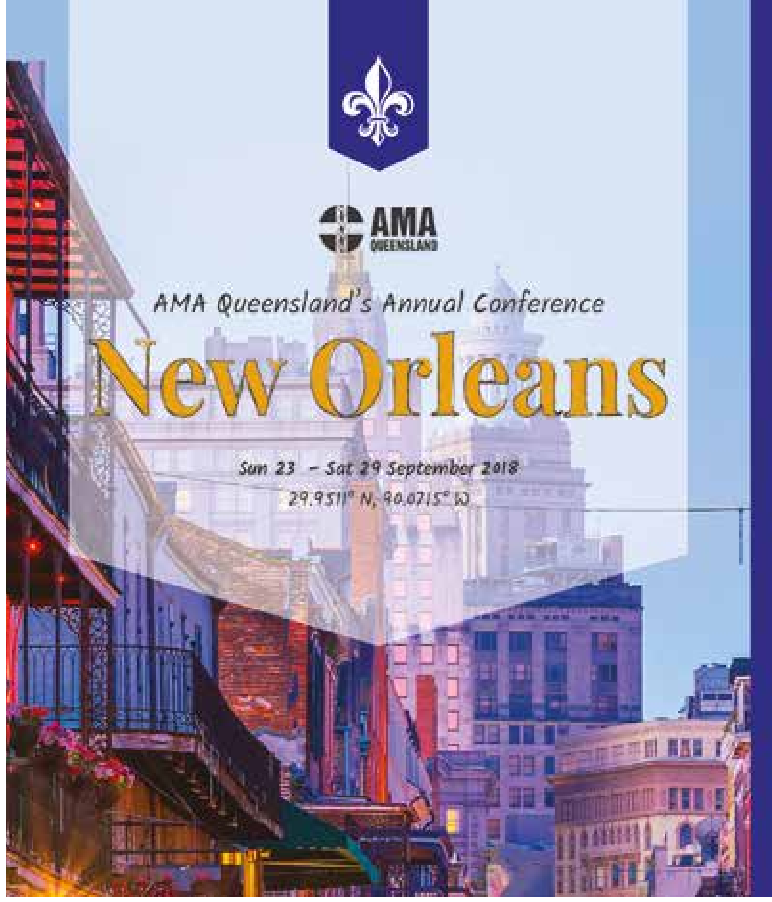
Provides a free and confidential support service to Canberra doctors in need and their family. Financial assistance and counselling support are available to colleagues who have fallen on hard times through illness or untimely death. Support is also available to medical practitioners who may be experiencing difficulties at work or in their personal relationships.

The MBANSW is funded by your donations; please allow us to continue to provide support and assistance to your colleagues in need by making a donation to the Medical Benevolent Association Annual Appeal. Donations can be made visiting our website www.mbansw.org.au

If you are concerned about your own situation or that of a colleague, please contact the MBANSW Social Worker, Meredith McVey on (02) 9987 0504.



Doctors, practice managers, registered nurses and other medical industry professionals from around Australia are invited to attend the ***Annual AMA Queensland Conference* in New Orleans from 23-29 September 2018.**

The program will feature high-profile American and Australian speakers on a range of medical leadership and clinical topics in an exciting, and unique location. RACGP points will be on offer.

To find out more about the conference program or to register, please contact:

Neil Mackintosh,
Conference Organiser
P: (07) 3872 2222 or
E: n.mackintosh@amaq.com.au

Download a conference brochure from the events calendar at www.amaq.com.au

Alternative medicine... *continued*

...From page 9

Patients who are overall well and use CAM to "strengthen their immune system" (watch out for autoimmune diseases) or cure influenza with evening primrose, most of the time face no serious consequences. But imagine a scenario where a healthy patient with sudden weight loss, low grade fever, night sweats and a lump in the neck delays their GP appointment to give natural remedies a chance to help?

What if the patient was finally diagnosed and treated with conventional medicine, alongside CAM remedy and completely recovered, will the credit be given to conventional treatment or to the natural remedy? This is not important just so doctors can receive a pat on the shoulder, but what if the patient decides that CAM remedy was the treatment that actually worked.

The story will be told to many people and many more who might not be as lucky and present to their GP in time.

Advocates against CAM

It is my belief that doctors, as a group, have a moral, ethical, and a professional obligation to advocate against CAM and the increasing role it is playing in the management of patient's health.

The situation becomes more difficult in everyday practice when a patient decides to include CAM in their disease management. In this situation it is up to the single doctor to be able to express their concerns without antagonising the patient. This must be done without compromising the delivery of effective and high quality care, as the health of the patient must always come first.

**References available on request.*

PRIVATE PRACTICE WORKSHOP: SAFETY and WORKERS' COMPENSATION

The AMA (ACT)'s **Tony Chase** (Manager of Workplace Relations and General Practice) and **David Seagrott** (Principal Consultant, Australian Health and Safety Services) will be speaking at this event and addressing concerns of particular interest to medical practices in the ACT.

DAVID SEGROTT MBA, BA (Admin) and Industrial Safety Certificate. David has over 40 years' experience in the health and safety field and holds professional memberships of the Safety Institute of Australia, the Australian Institute of Company Directors, the Risk Management Institution of Australasia and the Australia and New Zealand Institute of Insurance and Finance.

David will provide a comprehensive presentation on the safety issues likely to be encountered in any medical practice including:

- Overview of WHS Laws in the ACT
- Hazards and Risks
- Violence and Aggression in the workplace
- Bullying and Harassment
- Manual Handling
- Working with Sharps and Sterilization
- Hazardous Waste

David will also talk along with Tony Chase about the ACT Workers Compensation Scheme and how it works.

TONY CHASE joined AMA (ACT) in 2016 and is an experienced workplace relations practitioner. He has worked across both the private and public sectors, appearing in most Australian industrial tribunals representing small and medium businesses. Tony has also worked as a workplace mediator and investigator for the Commonwealth Government.

Tony will provide a comprehensive presentation on the following topics:

- An Overview – The ACT Workers Compensation Act – A small business perspective
- Case Studies
- Why are workers compensation premiums so high in the ACT?
- Is your business vulnerable to claims?
- How to protect your business against unreasonable claims.

WHO SHOULD ATTEND: Practice principals, practice managers and other practice staff

WHEN: 4-6pm Wednesday 22nd November, 2017
WHERE: AMA House, Level 3 Conference room, 42 Macquarie Street, Barton
COST: $100 for AMA members and/or their practice staff OR $200 for non-members and/or their practice staff
CONTACT: Karen Fraser reception@ama-act.com.au or call our office on 6270 5410

Using shares to increase the yield on your investments

Unfortunately we are living in a world where it is very difficult to receive yield in the traditional manner. The RBA has driven rates so low that traditional savings account returns are virtually zero, Bond rates are below 2.7% and the property market has been driven higher by significant leverage; this combines with the average combined capital city rental yields being under 3.2% and you still need to pay all the holding costs!!!!

So how do we create yield in such an environment? A strategy that all investors can use is to combine high dividend paying blue chips shares with exchange traded options.

Covered calls

An investor could consider the covered call strategy against virtually any blue chip stock held. This is a great tool as any income generated complements the fully franked dividend yield.

A covered call is a strategy that consists of owning an underlying stock and selling an option against the stock. Since a call option represents 100 shares of the underlying stock, you can sell one call against each 100 shares of stock you own. Because you own the stock, your short call position is "covered" by the stock.

A short option position by itself (without the stock) is more risky, and requires a substantial margin balance. A short call on stock you own, on the other hand, is a very conservative strategy that requires no margin.

Let's dive a bit deeper into this strategy.

As of the Wednesday 1st July, CBA was trading at $83 and as an owner of 1,000 shares, he sold ten calls against his stock position to create some extra yield. For example, he could sell ten September $85 calls for $1.25 each.

If CBA stays below $85 by the September expiration, he will collect $1,250 total ($1.25 x 100 for each contract)—a yield of 1.5% in just three months. If he was able to replicate this four times a year, he'll earn 6%. Add this to the annual 5.5% dividend yield and you are looking at an investment yielding north of 10% alone.

If CBA rises above $85, he will have made $2,000 on his stock, plus he will have banked the call premium, but be taken out of the 1,000 shares by the owner of the call. However, if that were to happen, he could simply buy his stock or Option back, and start selling calls all over again.

Writing Put Options

Writing puts is a more complex strategy, but when broken down and understood, this can be a tremendous investment strategy, and a great way to create yield for all investors.

Let's start with what a put is.

A "Put Option" is a contract between two parties to exchange an underlying stock, at a specific price, on a predetermined date. The buyer of the put has the right to sell the underlying stock at a set price. The seller of the put has the obligation to buy the underlying stock at the set price.

If you write a put, you are the seller of the put. This can be thought of in terms of insurance: you're the insurance agency, and the buyer of the put is the policy owner. If the owner of the Put decides to exercise his right, you will be required to buy the stock at the predetermined price. However, as the seller of the put (the insurance agency), you receive a premium.

Here at Specialist Wealth Group we recently established a sold put on BHP for some of our clients which was trading at $24.00. We felt comfortable that the global reflation trade would continue and in turn support BHP. We were happy to buy the stock at $22.50 so we looked to sell the 30 contracts of the $22.50 puts for $0.50. The options were executed in early July and are due to expire at the end of September (3 months)

If the BHP stock price stays above $22.50 for the expiry of the September option, we will collect the $1,500 we received for selling the "Put" initially. This put is provided an income of 2.2% for three months which is 8.8% annualised.

There is risk associated with this trade: if BHP dropped below $22.50, we would be required to buy BHP shares at $22.50 less the premium we received. But as I said earlier, we are comfortable buying BHP sub $22.50, which is a 6.6% discount to where the stock was trading at the time.

This is a strategy many investors use to enter a stock at a predetermined price. If we feel that BHP is overvalued at its current price of $24.00, but am comfortable buying the stock at $22.50 or less, this is a great way to buy the stock at that level if the price drops. And if it doesn't, we still collect the premium and can always sell another put later on.

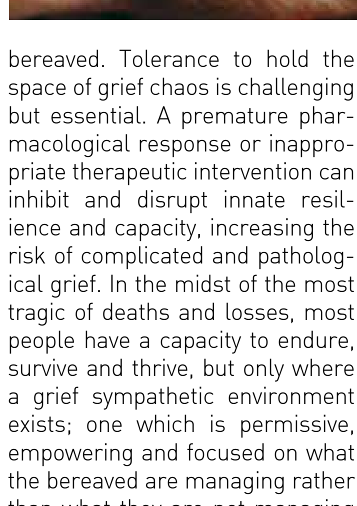
In conclusion, there are countless ways to use options to create yield. Covered calls should be in every investor's playbook. And writing puts is a tremendous strategy to enter a stock at a good price and create additional income.

To find out how to create additional income in your investments or SMSF, call us for more information on these and other strategies

Grief and bereavement: To support or treat?*

BY SONIA FENWICK & MANDY COX, CANBERRA GRIEF CENTRE**

To be human is to experience loss; of home, country, identity, resources, employment, relationship, health, opportunity, future. And in response to this, we grieve. Grief is necessary and appropriate. Grieving is the process of adjusting to 'new' in the wake of what has been taken from us through loss or death.



Bereavement (the experience of loss following a death) is a loss accompanied with finality like no other. In these circumstances, the work of grief requires us to accept the reality and finality of the death, to process the layers of loss that sit around the death, to confront and attend to the multidimensional aspects of the pain (physical, emotional, cognitive, spiritual pains) and embark on the process of change, adaption and re-defining 'self' in the absence of the person.

No magic or timeline

There is no magic nor prescribed timeline for this process. It can't be hurried, nor should it be. Good bereavement outcomes rely on a number of factors but none so important as permission and support to 'grieve' in the midst of re-shaping a new sense of living.

Humans have an innate capacity to grieve well with minimal or no intervention from professional services when permitted to do so. The bereaved instinctively know what it is they need, or at least don't need, in order to attend to this experience. The bereaved are not broken, they are grieving. There is nothing to fix. Instead, in the absence of a key attachment which has been disrupted by death, grief seeks other supportive attachments without judgement or expectation.

All too frequently, grief is misdiagnosed, mislabelled or missed completely. We seek ways to 'treat' it, to move it along, to create a more socially acceptable illusion of 'happiness' to fit with a paradigm of 'wellness'. In many cases we pre-emptively label it depression and support it with a pharmacological response. Grief is not depression. It is sadness.

Treatment may be necessary

However, where major depressive disorder (MDD) presents in bereavement (more commonly presents where there is a history of depression rather than a single episode), evidence suggests, pharmacological treatment in collaboration with grief therapy can reduce the risk of more complex and complicated presentations in grief.

As health practitioners, we must be cautious about imposing our own fears (of client deterioration in health or other factors) on the bereaved. Tolerance to hold the space of grief chaos is challenging but essential. A premature pharmacological response or inappropriate therapeutic intervention can inhibit and disrupt innate resilience and capacity, increasing the risk of complicated and pathological grief. In the midst of the most tragic of deaths and losses, most people have a capacity to endure, survive and thrive, but only where a grief sympathetic environment exists; one which is permissive, empowering and focused on what the bereaved are managing rather than what they are not managing (strengths based).

Client experience insights

There is more to grief than Kubler-Ross. Research, studies and client experiences have provided significant insight and advancements in our understanding of when grief is being derailed. In order to promote good bereavement outcomes, it is imperative that health professionals upskill in understanding the difference between healthy grief and more complex, complicated, pathological presentations. An experienced and trained grief therapist will assist the bereaved to cope and manage the whole grief response, eliminating the need to avoid, deny and medicate that which must be adapted to and lived with.

Our experience with many variants of loss, indicates that for most clients an average of 4-5 visits with a counsellor (where the therapist is specifically trained in and experienced with grief) is sufficient to promote a new and healthy relationship with their grief. Following this time, clients might choose to return in anticipation of certain dates, occasions or where the presenting loss has been aggravated by another life stressor/event.

> Grief is a human, not medical, condition, and while there are pills to help us to forget it – there are no pills to cure it. The things is, nature is so exact, it hurts exactly as much as it is worth, so in a way one relishes the pain, I think.
>
> Julian Barnes, Levels of Life (2013)

**References available on request.*

***Canberra Grief Centre is a private practice managed and owned by Sonia Fenwick and Mandy Cox, professionally registered counsellors supporting death, dying and loss. Clients can self-refer or consent to another person facilitating contact with the Centre.*

Sonia and Mandy are able to consult with GPs about client cases involving general or more complex presentations of grief as a means of designing a healthy bereavement pathway for the client.

Further information about on the services available can be found at www.canberragriefcentre.com.au

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CANBERRA Doctor

A News Magazine for all Doctors in the Canberra Region

ISSN 13118X25

Published by the Australian Medical Association (ACT) Limited
42 Macquarie St Barton
(PO Box 560, Curtin ACT 2605)

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Articles:
Copy is preferred by email to execofficer@ama-act.com.au in "Microsoft Word" or RTF format, (not PDF) with graphics in TIFF, EPS or JPEG format.
Next edition of Canberra Doctor – November 2017.

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Dr Claire Rebentrost
GENERAL PAEDIATRICIAN

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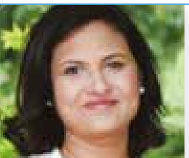
email: reception@yarralumlasurgery.com.au



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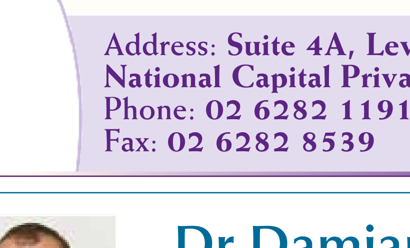

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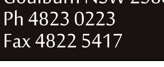

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