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Full bench of Australian Industrial Relations Commission determines ACT VMOs are not employees

Background

On May 2001, the ACT VMOA filed an application with the Australian Industrial Relations Commission for registration as an association of employees under the Workplace Relations Act 1996 which would, if successful, effectively recognise it as a "union".

One effect of such recognition is that VMOs would be able to legally negotiate their VMO contracts as a collective and that under the Act would be able to take some protected industrial action during the negotiation period. This provision to take industrial action is not a blanket right to strike [particularly where it results in the public denied 'essential services'] and comes with opportunities and threats.

The ACT AMA has always supported collective negotiation of VMO contracts and until 1998, VMO contracts were negotiated by the ACT AMA on behalf of ACT VMOs. However, with amendments to the Trade Practices Act which rendered collective negotiation illegal, ACT public hospitals negotiated with individual specialists with great variation in terms of contracts, length of contracts and the amounts paid for services to public patients.

One of the criteria for registration as an association is that the association seeking registration has at least fifty members who are employees.

The Australian Salaried Medical Officers Federation (ASMOF), an association of employees registered under the Act, objected to the application of the ACT VMOA. One ground of objection was that the VMOs who are members of the ACT VMOA were not employees of the public hospitals that engaged them.

With the consent of the parties, Senior Deputy President Williams of the AIRC determined, as a separate question, whether four particular doctors were employees of the public hospitals where they were engaged as VMOs. It was accepted by the parties that those four doctors were representative of the membership of the ACT VMOA and that, if the four doctors were found not to be employees, the ACT VMOs application for registration must fail. In May 2004, Senior Deputy President Williams found that the four doctors were employees of the public hospitals where they were engaged as VMOs.

An appeal to the Full Bench lies only by leave of a Full Bench and requires that a Full Bench must grant leave to appeal if, in its opinion, the matter is of such importance that, in the public interest, leave should be granted.

Subsequently, the ACT and the ACT Health Care Service and ASMOF lodged a notice of appeal and a decision was handed down on 14 June 2005.

There are several indicia to be considered when determining "employee" or "contractor" status and the decision refers to cases relating to many of the indicia applied.

The original decision

In the decision of Senior Deputy President Williams, he referred to the case of Abdalla v Viewdaze Pty Ltd where the Full Bench described the "ultimate question" in determining whether or not a person is an employee or an independent contractor as being "whether the worker is the servant of another in that other's business, or whether the worker carries on a trade or business of his or her own behalf: that is, whether, viewed as a practical matter, the putative worker could be said to be conducting a business of his or her own". It went on to state that this "question is answered by considering the totality of the relationship". SDP Williams continued: "Having considered the totality of the relationship between VMOs and the two hospitals and balancing all the relevant factors, I am of the view that, in the performance of their functions at the Canberra Hospital and the Calvary Hospital, the VMOs do so as representatives of and not independently of those hospitals. As such, they perform those functions as employees f the hospitals and are, therefore, employees within the meaning of the Act."

The decision on appeal

On appeal, it has been found that the VMOs are not employees and reference is made in the decisions to other indicia pointing in favour of this finding. These include:

- The work in question was work involving a profession, trade or distinct calling on the part of the person engaged; the doctors are all highly skilled medical professionals.
- The doctors performed work for others and had a genuine and practical entitlement to do so. Each of the doctors conducted a private practice and had a contractual right to treat their private patients in the public hospitals where they were also engaged under a VMO contract.
- Their work could be delegated. Each of the doctors had a right to arrange for a locum tenens to substitute for him or her in theatre sessions. Although this right was subject to the approval of the nominated locum tenens by the hospitals, on the proper construction of the contracts such approval could not be unreasonably withheld. In practical terms the hospital could not refuse approval where the locum was reasonably competent and was prepared to abide by the requirements of the hospital.
- PAYG tax was not deducted from the payments to the doctors.
- The doctors were not provided with paid holidays or sick leave.

The only significant factor pointing in favour of a characterisation of contractual relationships as one of employment was the question of control. The Full Bench was not satisfied that the hospitals presented the VMOs to the public at large as representatives or emanations of the hospitals in an unequivocal fashion and that their title suggests otherwise. There were significant ways in which the hospitals did not exercise control where there was scope for it and in circumstances where one would expect the hospitals to exercise control if the doctors were employees. This is illustrated by the differences in control evident from a comparison between the position of VMOs with that of employed staff specialists. It was noted that the level of control retained by the hospitals meant that the indicia pointed both ways and considering the totality of the relationship the result was ambiguous. However, the parties removed doubt about the proper characterisation of their relationship by expressly providing in the contracts that the contracts did not give rise to a relationship of employment.

As the four doctors were found not to be employees, then the application by the ACT VMOA for registration as an association under the Workplace Relations Act could not proceed.

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ACT AMA President's report

Dr Charles Howse

Medical Indemnity

Anecdotal evidence is showing interesting trends for Australian medical defence organisations and medical indemnity insurers. This appears to be supported by the Medical Indemnity Industry Association of Australia report of May 2005. The effect of tort law reforms, although not consistent across all States and Territories, appears to be having an effect upon the number of claims. It appears that there is significant and increasing frequency of claims for some high risk speciality groups such as cosmetic surgeons whilst at the same time some other high risk specialities such as neurosurgery have experienced a reduced number of claims.

Amongst the speciality groups, claims against cosmetic surgeons appear to have almost doubled and certainly topped the charts in the number of claims reported. It appears that the number of smaller claims has decreased considerably which could be attributed to the areas of tort law reform in those jurisdictions which have legislated for thresholds.

We understand the number of claims has fallen from 54 claims per 1000 insured doctors to 51 claims - a fall of 7 per cent. Premiums have generally fallen by an average of 4 percent, and the gap between premiums collected and projected claims has virtually disappeared; enabling funds to provide for any unexpected future demand.

The increase in larger claims appears to be affecting premiums in certain speciality groups. The increase in claims on cosmetic surgery is reflected in premium cost - amounting to over 300 per cent in this period or an average of more than 20 percent per annum. Other groups feeling significant increases are obstetricians and general surgeons. Claims in excess of $500,000 represent 55 percent of the total cost of known claims over these nine years and only make up three per cent of all reported claims. Only 1 in 200 claims is greater than $2 million; however, these contribute to 26 per cent of the total cost of known claims. Obstetrics appears to be the speciality most exposed to these large claims, with one in 12 claims greater than $500,000 and representing 90 per cent of the total cost of claims against obstetricians.

The average "negligence" payout has risen by more than $40,000 to about $123,000 since 1999, but with a diminished number of claims. Whilst these figures are encouraging, there are some concerning trends, markedly in the marked increase in claims against cometic surgeons. The move in some States by the legal fraternity to wind back some tort law reforms will again threaten the medical workforce and cause doctors review their practices.

The medical indemnity industry has expressed a commitment to work collaboratively with the medical profession to reduce both risk and increase the safety of a practice. Medical indemnity still remains a vital part of our health system and its security is essential as the population ages, technology advances, and the expectation of patients increase. An ACCC report on the findings into competition in the medical indemnity market appears to show that UMP has had a competitive advantage with funding from the government rescue package.

Electronic medical records

Government attempts through the multi-million dollar HealthConnect project, to set the standard on electronic medical records (EMR) has been one of "one byte forward, two bytes back". The aim of uniform, accessible EMR has changed focus to ensuring the information technology systems used by doctors, hospitals and other relevant parties is communicated through secure systems, such as encrypted emails.

The results of this project have not been forthcoming given initial proposals in 2000. We need a national standard and user-friendly transfer of information that is both practical and valuable for a practicing doctor if we are to use this tool to improve patient care. While the medical profession is slowly embracing IT in medical practice, any unnecessary time wasted on red tape and forms will see the profession throw out any well meaning proposals. GPs are the one major medical group which is embracing I T, and the software companies have recognised this with the development of both accounting and clinical and practice management software. A new software company called "Nxt Health' has launched software which will attempt to attract doctors with a re-branded version of the Plexus software. This is in direct competition to the controversial aspects of "Medical Director at" with its annoying and inappropriate pop-up advertisements and reported mining of de-identified patient data for the sale to third-party marketing companies. Whether this competition is a good thing remains to be seen, however the annoying advertisement which appears in medical director during the process of electronic prescribing, sends the wrong message to both the doctor and patient when the doctor is considering what medication is appropriate to prescribe. This new company hopes to increase its market share of GP desktops and secure a leading role in the potentially lucrative HealthConnect EMR and as mentioned will be dependent on the participation of the willing GPs.

National conference

I recently attended the AMA National Conference held in Darwin, a place where jumpers are an unnecessary item of clothing, given the temperature is a consistent 32 degrees during the day at this time of year. The new face of the AMA executive is a good blend of specialists and GP's with no bias to either group. The vast array of issues presented at conference gives the federal AMA and federal council guidance for the forthcoming year and it is no surprise that public hospital funding and workforce shortages will dominate the immediate future.

Finally the system failures we see in the sad saga in Queensland of Dr Jayant Patel, has seen some OTD's suffer indignation of poor public perception on overseas trained doctors. Another potential fallout is that these doctors will be packing their bags and working in more friendly and welcoming environments in other countries. OTD's provide essential services to our public and rural health care, and should be supported and assessed on standards at the same level of any Australian graduate.

World No Tobacco Day puts health professionals in the spotlight

AMA President, Dr Mukesh Haikerwal, has stated that doctors are in an excellent position to take a prominent role in the tobacco control debate.

Dr Haikerwal said comprehensive tobacco control programs should involve a mix of initiatives including taxation and pricing measures and legislation for smoke-free environments.

Dr Haikerwal said programs should also focus on prevention through education, communication, and campaigns that raise awareness of the serious effects of tobacco on health.

"Doctors have a critical role to play by educating patients and helping them to quit smoking by giving them information about harm caused by tobacco use and advice about how to give up the killer habit," Dr Haikerwal said.

"Counselling by health professionals on the dangers of smoking and the importance of quitting is one of the most cost-effective methods of stopping people smoking or taking it up," Dr Haikerwal said.

"With a long history of advocacy on tobacco control, the AMA has had many wins over the last few decades with changes to taxation, the introduction of health warnings on cigarette packets and the acknowledgement by tobacco companies that their products are addictive and harmful," Dr Haikerwal said.

"The AMA is committed to working with other key stakeholders for a total smoking ban in all Australian workplaces. People have a right to a clean, safe working environment. This is the best way to give all Australian workers healthier workplaces," Dr Haikerwal said.

ACT Government looking to enforcing prohibition on selling cigarettes to the under 18s more effectively

A recently circulated consultation draft by the Health Protection Service of ACT Health invited comments on how sales to minors can be more effectively prevented. The AMA supports initiatives that will reduce the uptake of smoking in the community particularly by children and young adults. Tobacco use is the greatest single cause of preventable death and disease in Australia and more than 18000 Australians die each year from smoking related diseases.

The vast majority of Australians who smoke begin the habit before they are out of their teens. In the ACT the commonest age to begin smoking is 15-16 years of age.

ACT law makes it illegal to sell a smoking product to a person under the age of 18 and the prescribed penalties for breaching the law include prosecution and a fine, and/or suspension or revocation of a tobacco retail licence. A seller can refuse to sell a smoking product to a person if the seller is not satisfied that the potential purchaser is at least 18 years old; has displayed a document that is not genuine or has been tampered with; or is seeking to purchase the product for use by a person under the age of 18.

The problem, according to the discussion document, is that despite the prohibition on selling tobacco products to the under 18s, there is evidence that these sales are occurring.

In 2002, nearly 1 in 5 young smokers aged 12-17 reported having purchased their last cigarette from a shop. Fewer than 1 in 5 ACT secondary school students report that they are "frequently" asked for proof of age when buying cigarettes, and more than 1 in 3 say that they have never been asked to provide proof of age. Without effective enforcement, the objective of preventing the sale of smoking products to minors is unlikely to be achieved. The ability to use the ACT's system of tobacco licensing as an enforcement tool is also limited by the lack of a practicable and cost-effective means of checking compliance.

National and international health authorities support controlled purchase operations (CPO) by as a 'best practice' approach to enforcement. CPO are conducted according to strict protocols and procedures, designed to protect the child and to ensure that the retailer cannot be said to have been 'entrapped' or 'induced' into selling the product . CPO has been used routinely in NSW, WA and other States, in NZ, the UK and the USA as an enforcement tool. CPO has proved effective in identifying retail outlets which illegally sell cigarettes to children and in obtaining clear evidence of these offences. Research has found no evidence of child-purchasers being harmed by their involvement in a CPO and children who participate have less chance of being asked to give evidence in legal proceedings than do children who are apprehended in a surveillance operation.

The use of CPO was upheld in a decision of the Victorian Supreme Court in 2000. In its decision, the Court noted that the conduct of the CPO meant that the retailer was not 'entrapped' or 'induced' to sell the cigarettes to the 15 year old test-purchaser and, "in all probability, would have been prepared to sell them to anyone who asked".

Dr Peter Wilkins, convenor of the ACT AMA's Tobacco Task Force said:

Australians have a natural abhorrence of trickery and subterfuge (hence the unpopularity of speed camera vans), but should support the use of CPO to detect Illegal tobacco sales to children. Prosecuting retailers involved in this "trade of death" should be considered normative and fully acceptable.

AMSA lends a helping hand

Mr. Dror Maor – President, AMSA

Having been at the helm of AMSA for 6 months I still continue to be amazed by how a student organisation – where all its executive, council and members are full time university students – can impact on peoples lives in the way that it does . We have tackled many issues this year, from our policies about Rural Health to addressing workforce issues and training standards. The issues have been many and varied but there has never been such an important time as this to make our presence felt.

Just as important is the impetus on our public health campaign. We all know AMSA has become known for its ability to lobby and fight for the rights of medical students whilst also organising conventions for medical students. However, we also believe that we as privileged students have a duty to help the community – both nationally and internationally. With our involvement in public health initiatives, the International Federation of Medical Students' Association (IFMSA) and running local public health projects, for example, things just seem to get busier and busier.

One such project is the **AMSA/Red Cross Blood Drive**. This is a national blood donor drive to get medical students as well as the greater community involved in donating blood. With blood shortages occurring Australia wide, now more than ever, the success of this project is crucial. The campaign will be run throughout the month of August and will involve all 15 medical schools in Australia, targeting not only the 10 000 student members of AMSA, but also countless more friends and family as well as staff of the faculties and alumni.

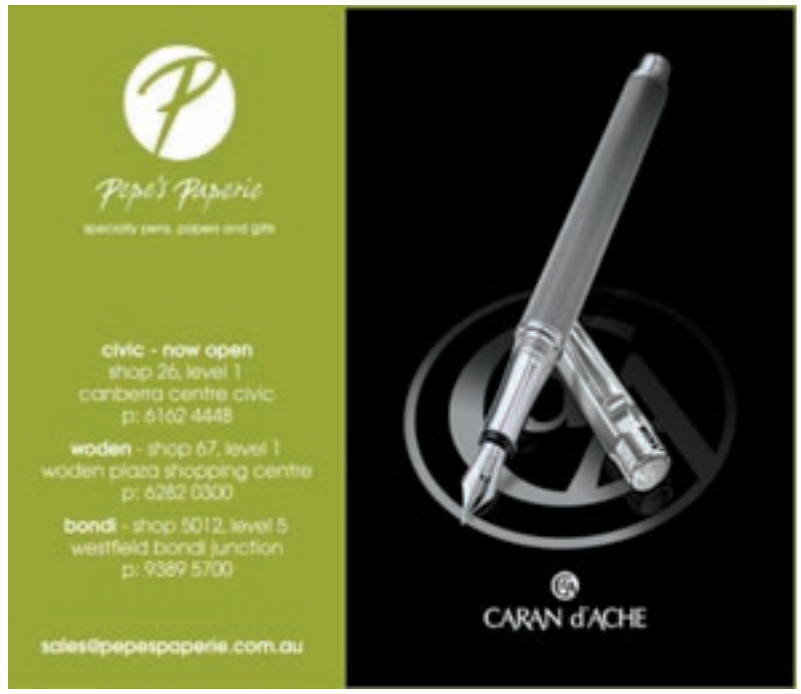
Mr Dror Maor, President, AMSA

This project is appropriately themed, "Let it Flow". Not only do we expect blood donations, but for us to take pride in our culture of generosity and care for one another. As a group who will be needing these blood products to save the lives of our patients we believe strongly in the Blood Drive as it promotes a message to the greater community that donations are vital to sustaining the lives of those who are in need.

It will be launched in Sydney at the AMSA National Convention, a week of academic and social activities, at the beginning of July. This is with the aid of the Red Cross CEO, the AMA Federal President, AMSA President and other dignitaries. There will also be over 700 medical students present.

A second initiative and one that has its birth in 2005 is called the "**AMSA Developing World Conference**". AMSA and all of its members believe in the health of the developing countries. It is no coincidence that this conference has already been booked out with months to go. We are trying to address the significant disparities in health that exist between the "haves" and the "have-nots" in the world, not only from a distance but more importantly with action.

AMSA is proud of what it has been able to achieve thus far but in no way are we willing to rest on our laurels. This year is about taking up the challenge and knowing that we have to secure the future of Australia's medical students. At the same time, AMSA and all medical students have a role to play as future leaders in the community by lending a helping hand in times of great need.



At last – a breakthrough on chronic disease management by GPS

AMA President, Dr Mukesh Haikerwal, said recently that the Government's introduction of chronic disease items to the Medicare Benefits Schedule (MBS) would deliver a double benefit to GPs and their patients.

Dr Haikerwal said the new MBS items will allow GPs to provide more time and specialised care to patients with any chronic disease, rather than a few selected diseases, and it will reduce the red tape associated with the preparation and delivery of care plans to patients with chronic diseases.

"The AMA has been negotiating with the Government for nearly two years for these changes," Dr Haikerwal said.

"There are enormous benefits for patients. Asthma, diabetes, mental health issues, and many other disabling conditions can now be better managed under these MBS items – with less red tape to rob doctors of time with their patients.

"Important clinical decisions on chronic diseases now rest with the doctor where they belong, not with bureaucratically determined areas of care as was previously the case. A GP can now independently prepare a care plan or establish a team care arrangement, or both, depending on the needs of the each patient.

"With Australia's ageing population – and the increased burden of chronic diseases in society and the desire to remain at home while being cared for – these new items will contribute significantly to more effective chronic and complex care, and care of older people.

"Where a GP has contributed to a care plan for a patient in an aged care facility, that patient will now have improved access to Medicare rebates for allied health professionals and dental care."

The new chronic disease management items are for:

- preparation by a GP of a GP Management Plan;
- coordination by a GP of Team Care Arrangements;
- review by a GP of a GP Management Plan;
- coordination by a GP of a review of Team Care Arrangements; and
- contribution to a multidisciplinary care plan being prepared by another health or care provider, including for residents of aged care facilities.

Dr Haikerwal said the new items signify Government recognition that the MBS must not disadvantage patients with chronic disease and complex care needs – but instead allow them an appropriate rebate for more time they spend with their doctors.

"The beauty of these new MBS items is that GPs can spend more time on patient work and less time on paperwork for the Government," Dr Haikerwal said.

Full bench of AIRC continued...

From page 1

Right to appeal to the Federal Court

The ACT VMOA could apply to the Federal Court to appeal the decision of the Full Bench of the Australian Industrial Relations Commission.

The ACT AMA has publicly stated that it supports collective negotiation of VMO contracts and with the ACT VMOA engaged in a process of collective negotiation in 2003. This collective negotiation was authorised by an amendment to the ACT Health Act and resulted in contracts containing terms and conditions superior to most around Australia. It is more likely that not, that with the proposed amendments to the Workplace Relations Act mooted for the spring sitting of Parliament, that the protected industrial action clauses will be reviewed, with the scope perhaps reduced and penalties for breaches perhaps increased. Speculation certainly as we have not yet seen the draft legislation. However the media has reported widely the Prime Minister's intentions for industrial relations reform which are likely to inhibit the rights and activities of trade unions and promote the use of Australian Workplace Agreements or individual common law contracts.

The ACT AMA and the ACT VMOA continue to engage with ACT Health through regular meetings on VMO matters and 2006 will see contracts being renegotiated again. The feedback to the ACT AMA is that VMOs do not want to be classed as employees and lose both their independence and their contract conditions.

Please note that much of the above commentary has been taken directly from the decision handed down on 14 June 2005 which can be downloaded or viewed at www.airc.gov.au for further information.

AMA indigenous health report card focuses on low birth weight babies

One of the last local acts of retiring AMA President, Dr Bill Glasson, was to launch Lifting the Weight, the AMA's fourth report card on Aboriginal and Torres Strait Islander health, from Winnunga Nimmityjah AHS at Narrabundah in the presence of Aboriginal mothers and babies. Winnunga Nimmityjah operates an antenatal service which is run by experienced midwives and is well supported by the local Aboriginal mothers.

Dr Glasson said the AMA has collated important data on low birth weight and premature babies to give our political leaders and the public a snap shot of this huge public health problem – a problem that can be fixed with proper funding, resources, education and political will.

Indigenous babies are more than twice as likely to be born premature or underweight as non Indigenous babies, putting 1,140 children a year at a physical and developmental disadvantage. Low birth weight babies (less than 2.5 kg) are more likely to die in the first year of life and are more susceptible to chronic illness, such as heart disease, kidney disease and diabetes later in life. Major causes of low birth weight babies include smoking, alcohol and substance abuse, sexually transmitted diseases and malnutrition in the mother.

"Women need access to culturally appropriate services early in their pregnancies," Dr Glasson said.

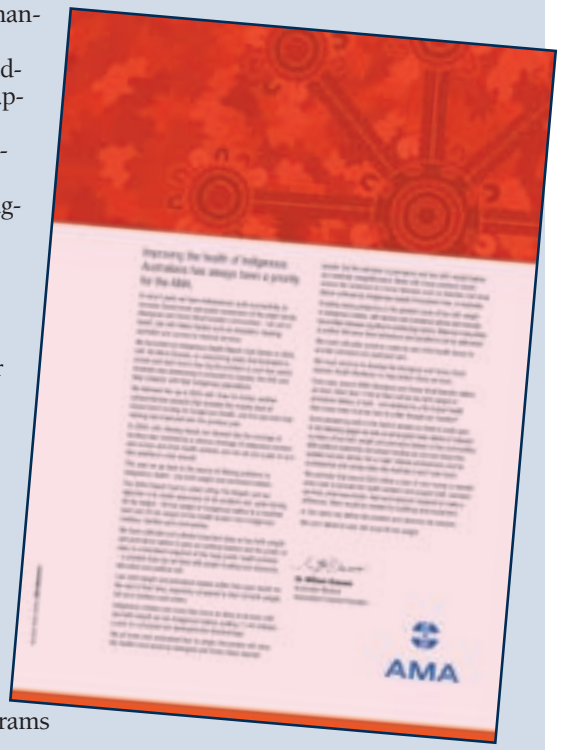
"Resources are needed to encourage and support women in their efforts to give up smoking during pregnancy and to help doctors diagnose and treat sexually transmitted diseases early in pregnancy.

"Pregnant and breast feeding women should be screened for malnutrition and given access to healthy meals where necessary," Dr Glasson said.

The Mums and Babies Program at the Townsville Aboriginal and Islander Health Service in Queensland is one of five successful programs outlined in the "Good News" insert in the AMA's report card. The program is proof that well targeted, well funded measures get positive results.

"The Federal Government committed $62.9 million over three years in new money to Indigenous health measures in the May Budget in its Healthy for Life program. The AMA calls on the Government to use all of this money to provide very specifically targeted services such as the Mums and Babies program in all Aboriginal Health Services in Australia – remote and urban," Dr Glasson said.

"Such a program could be up and running across the country within three years if available funds are focussed on one such program. A well targeted investment will reap very positive returns, but if spread too thinly across a range of initiatives very little will be achieved," Dr Glasson said.



Music for Peace Piano Recital

The Medical Association for Prevention of War (MAPW) is an affiliate of the International Physicians for Prevention of Nuclear War and works for the elimination of all weapons of mass destruction and for the prevention of armed conflict. It aims to reduce the physical and psychological impact and environmental effects of war, and promote the use of human and technological resources for human and environmental well-being rather than the acquisition of armaments. To this end MAPW undertakes research, education and advocacy to engage politicians, the public and our colleagues with medically sound, non-partisan information.

A piano recital by Dr Robert Schmidli

Robert, well known local endocrinologist and respected pianist, performed for MAPW's at their successful fundraising concert last year and they are honoured that he has agreed to perform for them again. If you went last year you'll know how good he was so please come again. If you didn't go last year – don't miss out this year! The refreshments and the company were also pretty good.

When: 30 July 2005 at 7.30pm
Where: Radford College
Cost: Tickets $30 (including refreshments)

Robert's program will be:
Beethoven: Sonata Op 78 in F major
Chopin: Ballade no 1 in G minor
Mussorgsky: Pictures at an Exhibition.

For tickets for the recital or more information about MAPW please contact Dr Rosie Yuille 62475742(w) or email yuille@homemail.com.au.

The great white coat – what happened to it?

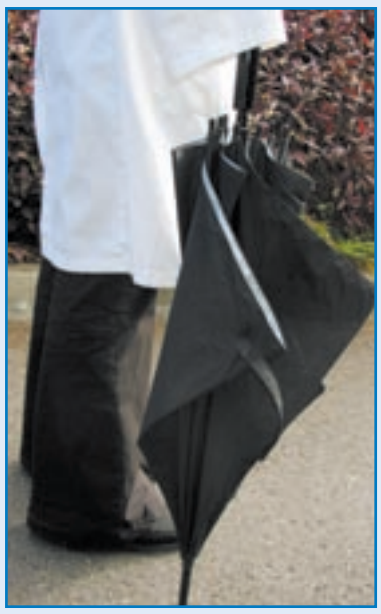
Whatever happened to doctor's white coats?

Certainly in Australia it seems as though this once traditional doctor attire has well and truly gone by the wayside. The question is: why?

The issue of doctor's white coats was investigated in a 2001 edition of the Medical Journal of Australia.

MJA editor Dr Martin Van Der Weyden documented the history of the white coat in his editorial, tracing its roots back to the late 19th Century, a time when science was beginning to make significant inroads into medicine. Physicians adopted the laboratory coat as their own, Van Der Weyden wrote, with its initial purpose to protect the patient and physician from cross-contamination.

Over time, however, and as contamination became less of an issue, the white coat became a symbol of "the authority of science and the art of healing". The coat, pristine and white, projected



connotations of "life, purity, power, and goodness".

According to Van Der Weyden, it was study of the dynamics involved in the doctor-patient relationship in the late 20th Century that became the white coat's undoing. Studies of this nature highlighted the great white coat as a barrier to effective communication.

As a result – in an effort to dispel this perception – doctors began to shed the white coat.

The relevance of the white coat, and arguments for its return, has been discussed at various junctures over the years.

Both doctors and patients have been quizzed on their impressions of the coat – the perception it engenders, and its relevance as a professional symbol for doctors.

A 2001 Australian survey found patients would like doctors to return to wearing white coats in hospitals so they could be easily identified.

The survey, whose respondents were patients attending cancer outpatient clinics in Sydney, asked whether junior and senior doctors should wear white coats.

The results showed 60 per cent of the patients aged between 20 and 90 agreed that junior doctors should wear white coats. Only nine per cent disagreed. For senior doctors the issue was not as clear-cut but many of the patients still preferred these doctors to wear white coats as well.

"Many respondents who supported the wearing of white coats for junior and senior doctors agreed that white coats looked more professional or assisted in identification," researcher Dr Paul Harnett, of Westmead and Nepean hospitals, said of the results.

A UK study on the issue, undertaken in 2004, gathered data on the doctor's viewpoint as well as the patient's. The wearing of white coats by doctors had been declining in the UK since the early 1990s.

The study, which surveyed 400 patients and 86 doctors from a mix of specialties and levels of seniority, found doctors saw their traditional white coats as uncomfortable and a germ reservoir. Patients, however, still preferred them to be worn.

According to the study results, published in the *Postgraduate Medical Journal*, more than twice as many patients as doctors felt that white coats should be worn.

The most common reason given for this preference was that white coats made doctors easy to spot. Only a fraction considered that white coats posed an infection risk.

White coat preference was strongest among patients aged 70 and older and among those whose doctors already wore them. Patients aged between 30 and 39 were least likely to prefer their doctors to wear a white coat. Just 11 patients felt that the wearing of a white coat interfered with the doctor-patient relationship.

What do you think? Let us know by logging on to www.ama-act.com.au – "white coat survey" and voting with a simple yes or no.
We'll report the results.

This article, by Sarah Harding, is reprinted with the kind permission of AMAQ and appeared in the June 2005 edition of "Q Doctor" magazine.

CANBERRA ORTHOPAEDIC GROUP

WE ARE MOVING

Canberra Orthopaedic Group (COG) is made up of seven specialist Orthopaedic Surgeons who have amalgamated their practices into one entity. COG will provide a comprehensive range of surgical skills and expertise, and will be the largest private Orthopaedic Practice in the ACT.

COG is moving to new premises and will be located:

Level 3
Clinical Services Building
Strickland Crescent
DEAKIN ACT 2600
(within the grounds of JJMH)

COG will commence operating out of these premises on Monday 18 July 2005.

The Orthopaedic Surgeons who make up Canberra Orthopaedic Group (COG) are:

Dr Bryan Ashman
Surgery of the Spine

Dr Phil Aubin
Joint Replacement and Revision Surgery
Musculoskeletal Trauma

Dr Rob Creer
Reconstruction and Joint Replacement of Hip, Knee and Shoulder

Dr Brendan Klar
Surgery of the Knee, Foot and Ankle

Dr Chris Roberts
Surgery of the Upper Limb, Knee and Foot

A/Prof Paul Smith
Surgery of the Pelvis, Hip and Knee
Primary and Revision Joint Replacement

Dr Kevin Woods
Surgery of the Shoulder and Knee

To contact any of the above surgeons or to make appointments, please continue using the current phone numbers listed in the white and yellow pages of the 2005 phone directory. All phone calls will be automatically redirected to the new premises.

Further enquiries regarding COG can be directed to The Practice Manager, Margarete Conroy on 0419 125 413

Royal Canberra Hospital – too important to be forgotten!

RCH remembered!

Dr Alan Knyvett in his 1994 foreword to Arthur Ides compilation "Royal Canberra Hospital: An account of its origins and development (the first 40 years – 1914 to 1954)" wrote... "Royal Canberra Hospital is no more! Its doors were closed at the end of November 1991 and its remaining patients transferred elsewhere ... The history of Royal Canberra Hospital is inextricably bound up with the development of the National Capital itself."

Arthur Ide in the introduction to his book said: "the first buildings for Canberra Hospital were erected in 1913-1914 to provide a facility to treat workmen who had come to the district to commence work on construction of the proposed Federal Capital City in its very basic bushland setting. The Hospital was increased in size progressively to meet the demand for its services as the city developed. Its history and heritage value is closely related to and associated with that of the Capital city itself. ... **A hospital is very much more than a conglomerate of buildings. It is a complex unit comprising personnel involved in many areas of the specialised equipment and facilities, in addition to its recognised role in the nursing care of patients.**"

The destruction of RCH

It is now eight years since the long and distinguished history and life of Royal Canberra Hospital ended, with noise and the tragic implosion. The hospital had been providing a wonderful service to the ACT community on the Acton Peninsula site, and many Canberrans were saddened by its destruction, which marked the end of an era.

Preserving the memories

There has been a growing movement among former RCH staff as well as people of the Canberra community to commemorate in some way what had been a very happy work place and a facility which provided an excellent standard of health care.

Wanda Lawler, Jenny James, Peter Pamphilon and David Nott have been mulling over the idea of establishing an appropriate method of remembering RCH.

Keen to keep the memory of RCH in our minds a **BACK TO RCH PARTY** is being planned, similar the most enjoyable evening many shared at the Hellenic Club a few years ago. "It would be great for all friends of RCH get together again, and an ideal opportunity to plan a suitable way to remember the Hospital," said Dr Nott

With this in mind, the committee above, have commenced planning an evening of memories, to be held at the **Hellenic Club, on Friday, July 22**. They will be contacting all former doctors who practiced at the hospital, staff and members of the community in the near future with details, and invitations.

For further information contact Dr David Nott on 6273 3830 or by mail at 67 Darling Street, Barton.

'Caption' COMPETITION

Write a caption for this picture of (left to right) President Elect, Dr Andrew Foote, President, Dr Charles Howse and Immeidate Past President, Dr Ian Pryor...

The winning entry will receive a pleasant surprise!

Caption: _____

_____

Name: _____

Address: _____

_____

Phone (H): _____ (W): _____

Send entries to: AMA ACT Branch, PO Box 560, Curtin ACT 2605 by Friday July 15.

AMA makes submission to Australian Tax Office on taxation of service trusts

The draft tax ruling (TR2005/D5) concerns the deductibility of service fees paid to associated service entities, which are commonly known as Phillips arrangements.

The AMA in its submission to the Australian Tax Office regarding taxation of service trusts, has drawn attention to the fact that the AMA has a significant proportion of members who are involved in private practice, the vast majority of whom fall within the definition of small business and that the draft ruling (TR2005/D5) has the potential to have an adverse impact on members and other small businesses that use Phillips arrangements.

The use of service entities is a common feature amongst the medical profession. With restrictions on the ability of professionals to incorporate, service entities are used as a legitimate means of asset protection. They have also been recognised in the matter of the Federal Commission of Taxation v Phillips (78 ATC 4261) ("Phillips") as a legitimate business arrangement.

In 1978, the ATO issued an income tax ruling in response to the Phillips case. In broad terms this ruling confirmed that service fees paid by a taxpayer to an associated entity were deductible provided the services were connected to the taxpayer's income earning activities and were not grossly excessive. The AMA believes that this accurately reflected the Full Federal Court decision in Phillips and the AMA firmly believes that it reflects a sensible and balanced approach.

The AMA has a number of concerns regarding the draft ruling in its current form. Firstly, it is retrospective in nature and the degree of retrospectivity is unknown. The existence of an earlier ruling, along with the silence of the ATO on this issue over the last 27 years has meant that service arrangements have been put in place on the basis of what was understood to be the ATOs long held position. To overturn these would be, in the AMAs view, grossly unfair.

During an appearance before the Senate Economics Legislation Committee in June 2005, Commissioner for Taxation, Mr Michael Carmody, indicated to the effect that the ATO would provide a 12 month window to allow businesses to examine their affairs and put in place changes to ensure compliance with the draft ruling. The exception to this would be firms that paid service entities more than $1m in annual service fees, and these fees constituted more than 50% of the gross income of the firm. This commitment was also reported in to the "Australian Financial Review" on 9 June 2005.

The draft ruling, whilst not binding, provides strong evidence of any likely final ruling. It affects those who utilise a service entity to provide staff, clerical services, premises and the like, and then redistributes fees derived from the provision of such services, to other entities such as family trusts.

Taxpayers may fall foul of Part IVA if the dominant purpose of entering the scheme was to obtain a tax benefit for a relevant taxpayer. Once again factors such as grossly excessive fees, no apparent added value, use of loss entities or if the arrangement makes no business sense, will be paramount in any ATO decision.

Examples contained in the draft ruling highlight the importance of :

- The taxpayer inquiring into existing service entities and the rates they charge for services
- The creation of a document clearly outlining the nature of the contractual relationship between the taxpayer and the service entity, which describes the types of services to be provided, the resources to be used, how fees are to be calculated and the risks to be assumed by both parties
- A paper trail clearly showing demarcation of the relationship between a service trust and the taxpayer and how that functions in the delivery of services. Control, for example, of staff must be clearly under the service entity, not the taxpayer
- Evidence of actual business activity, such as the holding of business insurance, payment of indemnity cover, payment of rent, owning of premises, owning of assets, records of meetings etc
- How fees are calculated, their commercial appropriateness, flexibility dependent upon workload etc are very important
- How the disbursement of profits to other trust such as family trust is determined is also a factor to be considered
- Evidence of other reasons for entering such an arrangement, such as asset protection is also important.

It is these factors which provide the ATO with an objective explanation for the whole of the expenditure by the taxpayer to the service entity, thus cancelling the need for a broad examination by the ATO. If practitioners have deficiencies in their service arrangements they should take steps to correct and assembly the appropriate administrative foundations to support the ongoing use of a service entity, so they may avoid a broader examination by the ATO and possibly be found to be in pursuit of an independent advantage – tax avoidance.

Further information can be obtained from the ATOs website or from your adviser.

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Next edition of *Canberra Doctor* – July 2005

Bed bugs: still biting

Bed bugs were largely unheard of for a long period of time, but have undergone a recent world-wide resurgence. Increasing numbers of infestations have been reported in Australia, often in accommodation venues such as backpackers' accommodation and motels. The increase in bed bug numbers is thought to be related to factors such as a decrease in the use of household pesticides and an increase in world-wide travel and the second hand furniture trade. So what exactly are they?

Bed Bug Biology

Bed bugs (Cimex lectularius or Cimex hemipterus) are oval, wingless insects that are a rusty brown colour and around 4-5mm long when fully grown. The fact that they are thin and flattened allows them to hide in narrow cracks and crevices. They are blood-feeding insects that prefer to bite humans but will also feed on other warm blooded animals. As their name suggests, bed bugs generally feed at night when people are in bed.

Bed bugs can be transported long distances in the seams of clothing, luggage, bedding and furniture, and are able to survive for long periods of time without a blood meal (adults in excess of a year).

Habitat

Bed bugs will hide (and lay eggs) in a variety of household objects close to where humans sleep (such as mattresses, bed frames and furniture), behind skirting boards, loose wallpaper and floorboards, and in cracks and crevices of walls. Bed bugs emerge at night to feed then return to their hiding spot during the day to digest the blood. They will come out to feed during the day if they are particularly hungry.

Clinical Presentation

Although bed bugs can be irritating, they are not known to be associated with any disease transmission, but in severe cases intense itching of the bites can result in a secondary skin infection. Bed bugs will commonly bite on the arms and shoulders (or any exposed, bare skin surface), which may result in small areas of swelling and itching of the skin. Skin reactions are commonly associated with bed bugs as a result of the saliva injected during feeding. Reactions to the saliva can vary between individuals, with some showing no response, and others showing a delayed response (up to nine days), or an immediate response with great discomfort and loss of sleep. The most common reaction to bed bug bites results in the development of large wheals (often >1cm) and associated itching and inflammation. When present, wheals generally subside to red spots, but may be evident for several days.

Diagnosis

An infestation of bed bugs can be diagnosed through the microscopic identification of collected specimens, including live or dead adults, nymphs, eggs and shed skin. Although there are two bed bug species that will feed on humans, C. hemipterus is generally confined to tropical areas of Australia.

Bed Bug Control

Bed bug presence is generally identified through continuous biting and irritation. Heavy bed bug infestations can be associated with a distinctive sickly sweet smell and blood spotting may be evident on mattresses and/or bedding and nearby furniture.

If a bed bug infestation is suspected, a detailed inspection of the premises is required. Remove mattresses from the bed frames to complete a thorough check of the bedroom. Infested areas can be treated with an appropriate insecticide. There are a variety of products available for bed bug treatment (commonly synthetic pyrethroids). It is advisable to contact a pest control company if the infestation is heavy or if treatment appears complicated.

Bed bugs often prove difficult to eradicate, due to the numerous hiding spots they occupy and limited access to these areas. Repeat application of a treatment product may be necessary depending on the chemical used. Vacuuming the infested area may assist in control, but the contents of the vacuum cleaner bag should be placed in a sealed plastic bag for disposal. Clothes and bedding suspected of being infested should be washed in hot water (>60ºC), followed by heated ironing or drying. Reduce the amount of hiding spots available to bedbugs by repairing/filling cracks and crevices.

When a bed bug infestation is suspected, it is recommended that the Local Council Environmental Health Officer be advised. Further information is available from the Department of Health on 8226 7100.

Author: Renay Cooke,
Scientific Officer
Environmental Health Service
SA Department of Health
This article has been reproduced with permission from the May 2005 issue of medicSA, magazine of the Australian Medical Association (South Australia) Inc (Vol 18, Number 5).

New faces to lead the AMA – election of Federal AMA office bearers 2005-06

Elections were held at the AMA National Conference in Darwin in late May for the positions of Vice President, Chairman of Council, and Treasurer of the Federal AMA.


Dr Mukesh Haikerwal

Victorian GP and former Vice President, Dr Mukesh Haikerwal, was the only nomination for President and took office immediately at the conclusion of the National Conference.

Dr Haikerwal, who runs a busy general practice in Melbourne's western suburbs, has been on the AMA Federal Council since 1999, served as Vice President for the past two years, and is a former President of AMA Victoria.

Dr Haikerwal said that the previous team achieved dramatic gains for health in Australia and more specifically for all Australian doctors. He drew particular attention to the medical indemnity support package, a better deal for Veterans' care, recognition and action on the medical workforce shortage and significant election promises in health.

Dr Haikerwal said his "wish is to continue to serve the doctors of Australia and maintain the momentum we currently have through the next two years. The position of the AMA as the central and indispensable opinion leader with whom all parties must work when considering health will be enhanced. I will lead my team with the same foresign, even-handedness and dedication as I have always displayed when called upon."

"My particular drivers are to retain the balance of the private health care sector and our world class but struggling public sector. Re-engagement of general practice into mainstream care and ironing out the many interfaces and securing its relevance and esteem is priority. I want to propel the AMA and its energies to support those sectors of our system that are under pressure. There are many fronts on which to secure gains including doctors in training, non-procedural specialist sand our interventionists."


Dr Choong-Siew Yong

The new Vice President is Dr Choong-Siew Yong from NSW.

Dr Yong is a psychiatrist who works as a staff specialist in child and adolescent psychiatry at Sydney West Mental Health Service and as a visiting medical officer at the North Coast Area Health Service and South West Sydney Area Health Service.

A former AMA NSW President, Dr Yong has been on the Federal AMA Executive Council since 2002 and has most recently been Chair of the Public Health Committee and the Youth Health Committee.

Queensland's Dr Dana Wainwright has been returned as Chairman of AMA Federal Council, a position she has held since 2003.

Dr Wainwright is in private specialist practice and is Visiting Senior Specialist at the Royal Brisbane Hospital in Internal Medicine. She is a former President of AMA Queensland and is heavily involved in teaching and training medical students.


Dr Rosanna Capolingua

The new Treasurer is Western Australia's Dr Rosanna Capolingua. A GP who runs her own practice in Perth, Dr Capolingua was the first woman President of AMA WA and has been on Federal Council since 1998.

She is Chair of the Ethics and Medico-Legal Committee and Deputy-Chair of the Economics and Workforce Committee.

At the first meeting of the new AMA Federal Council following the Conference, Dr Chris Cain from South Australia and Dr Andrew Pesce from New South Wales were the only two nominations for the vacant Executive Council positions and were duly appointed.

Dr Cain is a spinal surgeon in Adelaide and is the current President of AMA SA. Dr Pesce is a Sydney obstetrician and gynaecologist and is the Chair of the Federal AMA's Medical Professional Indemnity Task Force.

Bioethics from the Journals

with Dr Thomas Faunce

- The US Supreme Court has voted six-three in the Raich-Monson case that medical use of marijuana is illegal, despite contrary laws in 11 states. The court ruling puts the federal government at odds with many in the scientific establishment and with public opinion. (2005) 330 BMJ 1408
- The Supreme Court of Canada in the Chaouilli case has struck down Quebec legislation prohibiting private health insurance. This has created concern that a two tier health care system will arise to replace the whole country's universal publicly funded system. (2005) 330 BMJ1407
- The world's richest countries (in the so-called G8) have cancelled the debt burden of 18 of the world's poorest countries-about $40bn (£22bn; 33bn)-after a final agreement reached in London last weekend by finance ministers. The deal includes all debts owed to the World Bank, the African Development Bank, and the International Monetary Fund by Benin, Burkina Faso, Ethiopia, Ghana, Madagascar, Mali, Mauritania, Mozambique, Niger, Rwanda, Senegal, Tanzania, Uganda, and Zambia, Bolivia, Guyana, Honduras, and Nicaragua. (2005) 330 BMJ1407
- AstraZeneca, Britain's second-biggest drug maker, was recently fined ¤60m (£40m) by the Eurpoean Commission for misleading government agencies with "evergreening" patent applications in an effort to block the sale of generic copies of its ulcer drug Losec (sales $6bn (£3.3bn) a year). According to the commission, the company obtained supplementary patent protection certificates for Losec, by concealing from patent offices the date on which it first received marketing approval. The company was also found to have de-registered Losec capsules in Denmark, Norway and Sweden in order to block or delay market authorization by generic firms. AstraZeneca's newer ulcer treatment, Nexium, is also controversial. The firm is being sued by US healthcare payers who claim that although the drug is marketed as being superior to Losec and is substantially more expensive, it is in fact no better. (Guardian, UK)
- A DRUG-ADDICTED, mentally ill doctor in South Australia who admitted to a 10-cones-a-day cannabis habit has been deregistered, three years after he provided "seriously inadequate" care in falining to diagnose bowel obstruction in a patient who later died 24 hours later. Michelle Bockmann. The Australian June 17, 2005

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Project Director, Globalization and Health
Centre for Governance of Knowledge and Development
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One small step into technology – one giant leap for ACT AMA

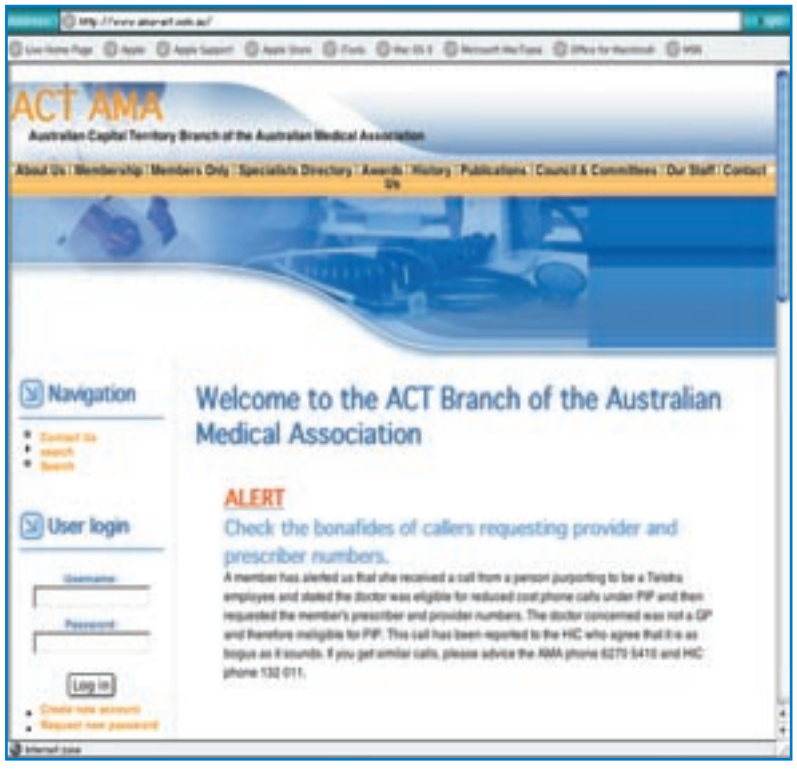
Pay a visit to www.ama-act.com.au

The ACT AMA has joined the 21st century – it now has its own terrific website! The site is still in its infancy, but we have many good things planned. This website is intended to be a resource for the ACT AMA members and to keep them up to date on the latest issues.

The site outlines the professional and commercial benefits of being an ACT AMA member, and with its "members only" page provides access to employment awards and practice advice etc. Members wanting to access the "members only" page will need to register online for their user login.

The website features a "specialists directory" which features ACT AMA members only and is available as a service for specialist members, general practitioners and is publicly accessible. The directory is another valuable benefit for ACT AMA members.

We encourage you to visit our website www.ama-act.com.au and we welcome your feedback to membership@ama-act.com.au or if you have any access problems, please call Leanne Guy, membership manager on 6270 5410.



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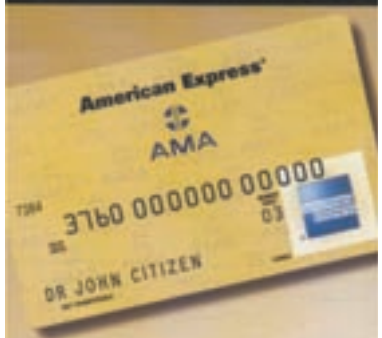

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