Canberra DOCTOR

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August 2005

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FAMILY DOCTOR WEEK

Masked children at Narrabundah Primary.

Charles Howse with stethoscope at O'Connor Co-Op Primary.

LEFT: Tony Sherbon, Peter Sharp and Charles Howse at Narrabundah Primary.

Peter Sharp, Tony Sherbon and Charles Howse at Narrabundah Primary.

Charles Howse at Narrabundah Primary.

Dr Jeremy Price | Dr Iain Stewart | Dr Suet Wan Chen | Dr Malcolm Thomson | Dr Fred Lomas | Dr Paul Sullivan

GP Education Nights:

Update on Spine Imaging, Interventional Radiology & Surgery – 26th October

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ACT AMA President's report

Dr Charles Howse

The next debate on smoking

Recently I found myself in a pub in Sydney lamenting the loss of the Wallabies to the All Blacks. While the game was disappointing the air was clean and I appreciated the ban on smoking in pubs presently enforced in New South Wales. There didn't appear to be any lack of patrons drinking inside, and those who had to smoke did so on the pavement away from the rest of us. There has been much discussion on the 75/25 rule in the ACT and whilst this is soon to be enforceable, the next step in the ACT is to commence discussion on the health and societal aspects of banning smoking in public eating venues and where food is being prepared, and to include all alfresco areas.

Medico legal risk management

The recent edition of the RACGP on standards including criteria on medico legal risk areas including requirements to ensure practices review all test results and act on those received as appropriate to good medical care.

While such standards are intuitively sound, they could cause potential problems as they create a higher "aspirational" standard above that which would be generally accepted as a "reasonable" standard in court. Once the standard is presented in evidence then the burden of proof can be reversed whereby the defending doctor will have to prove that he or she departed from the college standard and was not negligent. No doubt those litigating will draw to the court's attention any published standard as indicative of competence to practice.

The profession's public reputation

One of my interesting duties in the federal area is to serve on the ethics and medico-legal committee, and as such was interested in comments by the Federal health minister in a speech given to rural doctors earlier in the year. He warned that the medical profession's consistently higher public reputation cannot be taken for granted, and the reluctance to accept responsibility for solo practice in country areas or working long and anti-social hours cannot be continued without the loss of community standing. Unfortunately he feels the profession's standing will only be safe if doctors wish to make a difference rather than a "fortune." He advocated the establishment of a central body to oversee the ethics of doctors' decisions such as private billing, and felt medical registration boards were limited in that they can only apply sanctions to those who broke criminal law or were guilty of gross professional negligence. The erudite Professor Komesaroff who also serves on the ethics committee, rightly stated there is no benefit in establishing a central body to oversee the ethics are doctors decisions, and while the current system of ethical debate in decision-making may not be perfect, certainly is better than any centralised new body. The minister's perception that the AMA's Code of Ethics is an inert piece of literature, fails to recognise that these codes are the most commonly cited document in court legal proceedings. Individual medical organisations have their own ethical codes and are therefore best placed to appreciate the issues of the members and the ethical decision-making process. A centralised body would not be able to reflect the full range of views to appreciate the subtleties of individual cases, and is not the function of the government to dictate the substance of ethical judgement. The minister's speech has certainly fostered discussion, and certainly would not argue that case of fostering ethical debate but rather not impose views on the profession.

On-line billing

The slow uptake of the so-called "IT revolution by the Australian health care system" has seen the HIC on-line billing system taken up by only approximately 3000 of Australia's 7000 general practices with only 500 using this process to bill private patients in order to claim the rebate. Unfortunately the immediate benefits to the patient is not transferred the doctor and health institutions who face the additional costs even though incentives are given through various programmes. Given there is some suggestion of making this system compulsory it would be better to engage doctors on demonstrating the improvement to patient outcomes and efficiencies rather than perpetuating the recognised deficiencies of the present system. Ideally patients and GP's should have immediate access to the rebate rather them the current two-day delay, however such a system is illegal and would require legislative change.

Medical competency

The ACT AMA is aware of concerns by some salaried non-clinical medical practitioners regarding some the provisions in the Health Professionals Amendment regulation which particularly relate to the maintenance and demonstration of continued competence, recency of practice and professional development. This is particularly relevant to those practitioners who work in non-clinical practice within government departments and agencies and require full medical registration.. We are reassured that the ACT Medical Board has decided that such medical practitioners will meet the requirements under this clause and as such maintain the the required registration.

Human rights commission

The proposed legislation pertaining to the Human Rights Commission will include the process of handling medical complaints presented to the Health Services Commissioner. While this legislation will stipulate communication between the Health Complaints Commission and Medical Board, the ACT AMA had concerns regarding the decisions made by the Commission without appeal by practitioners - as has been exemplified by recent individual cases. We are reassured by the government that the Ombudsman will be able to investigate the activities of the commission in the exercise of its deliberative functions. We also feel strongly that appropriate amendments to the legislation should include the ability of the commission to determine a complaint that has no merit, is frivolous, unreasonable or vexatious, and to be dismissed without further consultation. There appears to be no limit on the number of fora a complainant may approach to deal with the one complaint, and in order to limit the possibility of forum shopping, a clause should provide that once a complaint has been addressed in a particular forum no further opportunity should be given to hear the same matter within a different commission.

AMA rejects role substitution and task substitution proposals to address medical workforce shortages

AMA Submission to the Productivity Commission Review of Health Workforce

The AMA has lodged its submission to the Productivity Commission Review of Health Workforce with strong recommendations that the Government totally reject any moves to introduce role substitution and task substitution as solutions to Australia's medical workforce shortage.

In its submission, the AMA cites the dramatic advances in medicine over the last twenty years as a compelling argument that it would be dangerous to even contemplate replacing doctors with nurses, allied health workers or hybrids as team leaders in primary care settings.

AMA President, Dr Mukesh Haikerwal, said the AMA recognises and supports the vital roles played by nurses and allied health workers in providing care to patients, but they cannot be used as substitutes for doctors in the health system.

"The skills, experience, education, training and commitment required to become a medical practitioner have to be worked at and developed over many years, usually more than a decade," Dr Haikerwal said.

"Highly skilled medical professionals cannot be found and deployed overnight by Ministerial decree.

"We need to continue to provide a complete medical education for our doctors if we are to do the right thing by patients and communities, and ensure their expert medical care.

"Governments must provide the funding and resources and policies to maintain an environment in which medical teaching, training and research are properly supported and encouraged.

"We need to encourage new technology, new ideas and new enthusiasm for medicine to provide quality care today and predict the most appropriate care for the future."

Dr Haikerwal said medical advances over the last 25 years have been to a large degree the result of a positive medical workforce environment.

"Between 1991 and 1999, the rate of preoperative death from anaesthesia has reduced to one per 79,500 operations from one per 68,000 operations.

"Between 1980 and 2000 in the United States the rate of death from heart attack has declined from around 345 per 100,000 to around 187 per 100,000 population – and Australia will have experienced a similar improvement," Dr Haikerwal said.

"For stroke over the same period in the US, the death rate has declined from around 96 per 100,000 to around 61 per 100,000 population – a decline of 30 per cent, which would be a similar rate of success in Australia.

"But perhaps the most startling figures come from changes in Obstetric and Paediatric practice.

"Between 1980 and 2003, perinatal deaths in Australia have reduced from around 14 deaths per 1000 births to 8 per 1000 – a 42 per cent improvement. Australia has recorded a steady but impressive reduction in maternal mortality rates over the last 35 years. It has fallen from 12.7 deaths per 100,000 confinements in 1973-75 to 8.2 per 100,000 in 1997-99 – a reduction of more than 35 per cent. These are important indicators of the health of the nation.

"A clear warning about warning about role substitution is contained in the influential Cochrane Review of November 2004, which presented evidence comparing perinatal deaths in birth centres and conventional hospital care.

"The review found an 83 per cent higher risk of perinatal death in birth centres in a sample of 8677 women, and warned that caregivers and patients using birth centres should be 'vigilant for signs of complications'.

"The review stated that there is now good quality evidence that the substitution of obstetricians in birthing is associated with higher perinatal deaths."

Dr Haikerwal said that medicine is a team game.

"Doctors, with their full and rounded training, cannot and do not work alone in saving lives," Dr Haikerwal said.

"Doctors work with other highly skilled and motivated people, and each member of the team has different training and a different scope of practice.

"None of them is dispensable, and none of them is substitutable. The work of one group may be helped by a different group, but you cannot and must not substitute one profession with another.

"If we are serious about providing the best quality care for all Australians no matter where they live, we must put an immediate end to any moves towards sudden or forced role substitution or task substitution.

"We must also put an end to the recent dangerous pursuit by some groups and individuals for a new breed of 'hybrid' doctor-nurse medical professionals. This is an insult to both professions and an insult to patients and communities.

"Every patient has the right to a proper medical diagnosis and medical treatment.

"Australia has a world class health system. To keep it world class, we need world's best solutions, not second best.

"The AMA's Submission to the Privacy Commission is full of world class ideas," Dr Haikerwal said.

The AMA Submission to the Productivity Commission Review of the Health Workforce is available on the AMA website at http://www.ama.com.au:

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Winner of the bottle of 'Grange'

We belatedly announce that Dr Patricia Merrifield won the 1992 Grange in the AMA membership draw held earlier this year. We apologise to Dr Merrifield for not advising her sooner.

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'Canberra ASH' delivers its annual report

'Canberra ASH' President, Dr Alan Shroot reporting to members said that the year just past has been quieter in terms of activity.

In his report, Dr Shroot said: "A highlight was the forum for candidates before the ACT election. The meeting was well attended with virtually all parties represented except the Liberals. The vast majority, including a group representing the taverns, supported a complete ban on smoking in enclosed premises. The definition of what constitutes an enclosed space remains a matter of debate. Canberra ASH, like other health promotion bodies, believes that "25% enclosed" is an unsatisfactory definition of an enclosed public space.

"Our other concerns include the backdoor advertising of tobacco through product placement in films, smoking in public housing, the tardiness of any action on the Tobacco Advertising Prohibition Act despite submissions over a year ago, the continuing sale of cigarettes to minors and the pitiful contribution of governments towards assisting those trying to quit.

"At last year's AGM, Senator Lyn Allison, who later became party leader, gave an illuminating account of the Democrats' policy on various tobacco issues.

"I remain on the AMA Tobacco Task Force. The organisation continues to fight the menace caused by tobacco smoking. With less than 20% of the adult population smoking I believe we have made a significant contribution to the public health of Australians over the last 22 years."

In conclusion, Dr Shroot thanked his committee members for their ongoing support and contribution.

For details on Canberra ASH, contact Dr Alan Shroot

ANU Students Making a Difference to the Environment: SHAC

An enthusiastic contingent of ANU Medical Students are using the opportunity of being at medical school to promote environmental sustainability and healthy living. The Sustainability of the environment and Health Action Committee (SHAC) was formed in November 2004, has already achieved a great deal in the 18 months of the ANU Medical school.

What does SHAC want to achieve?

SHAC aims at increasing awareness of how the environment influences and interacts with human health. This is achieved in a variety of ways, for example by running seminars and other information sessions. Another goal of SHAC is to minimise the 'ecological footprint' left by an unsustainable way of living. SHAC seeks to find ways of educating medical students and future doctors on the changes that can be made on a grass roots level to become more eco-friendly citizens – because a sustainable way of living has positive effects on the environment and ultimately human health. But SHAC would also like to initiate changes on a broader scale and aims at providing medical students with the framework needed to actively bring about these changes nationally and globally.

What has happened so far?

SHAC updates and environmentally friendly recommendations are posted regularly on the discussion boards of the ANU Medical School intranet. So far, suggestions have included:

- The use of eco-friendly transport (eg public transport, cycling, carpooling)
- Recycling of paper, cardboard, cartridges, etc
- Re-using water bottles
- Double sided Printing and minimising waste
- Using alternatives to plastic bags

Many of these recommendations are in conjunction with ANU green – the on campus association which seeks to improve the environment. ANU green has participated in and funded some of the SHAC events and also generously printed the posters used on Environment Day.

On March 7th a SHAC BBQ was held in the Medical School and was free for people who arrived in an eco-friendly way (walking, cycling or public transport). All others were encouraged to make a gold-coin donation. This was the first big event for SHAC and made SHAC known especially to the new first year students.

Anika Nihill, Rebecca Coyle and Therese Cox at the SHAC BBQ, March 2005 – which was free to anyone who arrived using environmentally free transport.

May 2nd saw another event for SHAC: the seminar titled 'Sustainability of the environment and human health: How do they interact, and what action should we be taking?' The event included presentations from three high profile environmental speakers Professor Tony McMichael, Professor Bob Douglas and Emeritus Professor Valerie Brown.

The most recent event took place on World Environment Day (June 6th 2005), when SHAC members organised a vegetarian BBQ in the ANU Union Court. At this event information was made available to all ANU staff and students on SHAC and environment issues. ANU green again supported the day by promoting their own stall. Other highlights included T-shirt painting (with an environment theme logo spray painted onto recycled T-shirts) and a relay race which incorporated a recycling theme.

SHAC in the future

SHAC will continue to conduct events that promote sustainability issues. Future projects may include an Op-Shop Drive, with the sale of donated second-hand clothing helping to fund future SHAC promotion and events.

More details about SHAC or ANU Green can be found at http://medicalschool.anu.edu.au/medsoc/shac/index.asp http://www.anu.edu.au/facilities/anugreen/index.html

Stephan Baku, ANU Medical School and SHAC Member
Gemma Dashwood,
ANU Medical School

Vale! Jerzy "Jurek" Gray – Grzeszkiewicz

I first met Jurek and Julienne at Sydney University 1967.

Jerzy "Jurek" Gray

It was a funny year (300 hundred of us). Half of us were of the old 5 year High School course which was being altered to the now well established 6 year Windham Scheme, so there weren't the normal high school graduates entering med 2 that year. One half of the year was made up of people repeating the year…..moi.

The other half of Med 2, class of '67 was made up of graduates and professionals from all walks of life making it a very unusual and interesting year. We had Dentists, Business Managers, Master of a Boat, a Soap Salesman and many others including an interesting young Pole called Jurek with an unspellable and almost unpronounceable surname. Ethnics probably find each other, me being Hungarian born, and sure enough Jurek and I became good friends very quickly.

Jurek, to an 18 year old, was a very mature and sophisticated man. Always immaculately groomed in the continental manner, and reeking of "Neige de France", he was a great role model for me. Very soon after meeting him, I became friends with Julienne, a delightful, good humoured and intelligent French woman who worked for the Professor of Music at Sydney University. Julienne supported Jurek through his undergraduate years at Sydney University so that he could realise his life's dream of becoming a doctor. The three of us used to have lunch together on the grounds, in Jurek's Mini motor car. They always commented on the garlicky aroma of my sandwiches my (Hungarian) mother made me each day. Jurek always ragged me about the large volumes I could eat without putting on weight, also warning me that that would change as I got older, and how right he was!!!

Jurek was barred from doing medicine in his native Poland as his father was out of favour with the communists, so he did the next best thing and became a "vet".

To his last days of practice he would enjoy telling his new patients "don't worry you are in good hands, I used to be a vet". The patients would love it of course, and Jurek was an exceptionally dedicated and good General Practitioner. He had obtained diplomas in both Paediatrics and Obstetrics after graduating from Sydney University. He would also proudly put his veterinary degrees after his name, as well as all the rest. Now there couldn't be too many men like that. His veterinary skills were clearly also exceptional, as his little beloved companion Toy Poodle "Bluey" lived to the ripe old age of 14 years…..108 in human years.

Even though we lived far apart, Hobart – Canberra and more recently London – Canberra, we always maintained close contact by phone, although Jurek was a bit of a stick in the mud as far as travelling went. All the same he came down to Tassie for a long week end one year, and we had a great catch up. On my many flying visits to Melbourne of late, I phoned him and invited him down … knowing full well that he wouldn't come … then suddenly a great idea from Jurek … he will fly me up for the day … OK but I will pay half the fare … what a lovely day we had together. It was sunny and we took Bluey for a walk near a lake on the edge of Canberra, and then had lunch together in his garden and chatted about life and the universe.

I may not have been in London right now, had it not been for Jurek. In fact I may have done a lot of other things differently had it not been for his good advice.

I owe many things in my life to him, not only about telling a wide eyed 18 year old about the greater world and how it "Really" works, giving me my first taste of elegance in giving me my first really good tie, "a Christian Dior" for my 21st, I didn't even know such things existed till then, but many other things too, through the years of a busy surgical practice and family life, raising 4 boys. If ever I needed advice about the important things in life, I would ring Jurek, my very good friend of 39 years … I will miss him terribly.

Miklós J Pohl OAM
MB BS Syd., FRCS Eng, FRACS Gen Surg, FRACS Plastics
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Written Sunday, 17 July 2005, London

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Concerns for Doctor's business
Reducing fraud within your practice

Like many other businesses, doctor surgeries allow for payment of their services by way of credit card. Although it is unlikely that patients would use a fraudulent credit card to pay for their account, it still happens.

Currently in Australia there are about 16 million debit cards and 11 million credit cards on issue. Thousands of transactions occur on a daily basis through the use of credit cards. The retail industry sustained losses in excess of $12 million in 1998, which is estimated to be 20% of the real credit card fraud problem.

The risks to businesses include:
- fraudulent monetary transaction on credit and debit cards;
- used at merchant establishments in payment for goods and/or services; and
- fraudulent manipulation of EFT-POS terminal by offenders.

Below are some tips to reduce the likelihood of credit card fraud occurring in your practice.
- switch off your EFTPOS machine at night;
- check card signatures;
- check that the numbers on the front and back of the card match;
- make sure that holograms are clearly visible;
- check for a valid expiration date and check for ghosting or shading used to cover – up changed numbers.

Another way to reduce undue confusion and angst between patients/customers and the business is to advise them of what will appear on their statement. As the last thing you want is someone who has paid for a legitimate service provided by you, with you contacting their credit card provider to dispute a charge because the name on their statement doesn't clearly indicate that it was a purchase from your business. This can be a trap if your merchant account is in a trading name.

Secondly, fraud can also be perpetrated by employees and staff undertaking any of the following actions:
- theft of cash or stock;
- theft from other employees;
- not charging friends, family or accomplices;
- allowing accomplices to use bad credit;
- supplying receipts for refunds; or
- allowing friends to steal.

The risks of internal fraud include:
- stolen, embezzled or "discounted" stock;
- loss of cash or securities;
- loss of business funds or critical information including patient information; and/or
- loss or damaged business reputation and custom.

You may be at risk of internal fraud by employees who:
- work long hours;
- return to work after hours;
- are unusually or overly inquisitive about the business' payment system;
- resist taking annual or sick leave;
- spend excessive time in toilets, outside etc;
- avoid having others assist or relieve them;
- resign or leave suddenly;
- have a large number of voids; and/or
- have a low number of transactions.

Also, look out for registers that are consistently over or under, undelivered goods, and two or more transactions for single credit card in a row. There are many ways to reduce internal fraud, including a pre-determined "float"; petty cash limits and daily banking – by two people if possible.

The AFP Business Liaison Officer can provide further assistance. The business Liaison Officer (BLO) is part of the Crime Prevention team within ACT Policing. The BLO is there to facilitate communication between Canberra businesses and ACT Policing. The BLO provides advice and information to the business community in order to reduce crime and the fear of crime by educating the businesses about crime prevention strategies and by advising the businesses about crime issues. They can be contacted on (02) 6256 7777. It is important to remember that whatever procedures you put in place to prevent fraud make sure that the appropriate staff are trained in them. It's advisable to have them written down and easily accessible.

For more information please do not hesitate to contact either Joanne Harris or Tal Williams at Snedden Hall & Gallop Lawyers.

Letter to the Editor

Dear Editor,

Over the last fifteen years, I have had the pleasure from time to time of shepherding medical students through their general practice placements as guests of my practice. These were initially from Newcastle then Sydney Universities, and more recently the Canberra Clinical School. The professional benefits of having medical students within the practice are enormous: teaching is one the most fulfilling things a general practitioner can do.

However, such placements come at a price. In my own practice, each session that a medical student is with me costs me $250.00 to $300.00, even after the PIP payment is taken into account, simply because the provision of a quality teaching experience for students demands less patient throughput. Teaching also means increased personal stress: lunch hours evaporate, and paper work tends to accumulate such that it requires either extra attendance at night or in the morning. My staff and I are both usually exhausted by the end of what has traditionally been a two or three week placement.

I have discovered that from February 2006, placements in general practice for ANU students will be for three sessions a week for twelve weeks, and there will be two such rotations a year. This presents unparalleled clinical opportunity for continuity of learning in a general practice setting. There will be more than thirty such students requiring placements for each twelve week term, so clearly more than one third of Canberra's active general practices will need to be involved in teaching.

Yet these placements will require GPs to make a quantum heap of commitment from current expectations. General practitioners considering teaching under the new curriculum should first contemplate whether they have the personal time and resources to devote to the project, discuss it also with their staff and families, and finally discuss it with their accountants. The personal cost to me of twenty four weeks of commitment will be in the order of $20,000 a year. (Even if one routinely bulk billed all patients, the cost of lost patient through-put associated with quality teaching would be in excess of $12,000 a year.) In our professionally depleted workforce, the impact on the community will in effect be the removal of three full time equivalent GPs for the duration of each term.

It will thus be important that the GPs involved in the program carefully balance the enormous professional benefits of the new curriculum with the personal financial and lifestyle realities that will be involved in teaching in Canberra from 2006. Eyes wide open, please, folks!

Ian Brown, Mawson

Remembering the Royal Canberra Hospital

The article in July's Canberra Doctor mentioned a dinner, which was to be held at the Hellenic Club on 22 July 2005. The purpose of that function was to raise funds for the establishment of a commemorative plaque on Acton Peninsula to mark the site of the former Royal Canberra Hospital (RCH). It was decided to postpone the function until negotiations about the type of structure, costs, indicative wording and community consultation were well in hand

A group of former RCH staff, Wanda Lawler, Jenny James, Peter Pamphilon and David Nott are acting as a steering committee for progressing this project. They have made submissions to and had positive discussions with the Chief Minister, the National Museum, National Capital Authority, and ACT Arts, Heritage and Environment. The response has been very enthusiastic and supportive. There has been some commitment of financial or 'in kind' support for the project from these organisations.

The steering committee seeks thoughts, any ideas, and encouragement from anyone with an interest in remembering a great hospital. Particularly it seeks ideas about additional fund raising for the project.

It is envisaged that a dinner to raise funds for the plaque will still be held at a later date. The committee would appreciate everyone who was associated with the RCH to support this endeavour.

Contact David Nott, 6273 3830 or notts@cybermac.com.au, or Wanda Lawler, 6288 7945 or lawl@netspeed.com.au

Watch this space!

Dr Tack-Tsiew Lee

BMBS, BMedSci(Hons), FRACS

Otorhinolaryngologist, Head and Neck Surgeon

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Doctors not responsible for patient gaps

AMA President, Dr Mukesh Haikerwal, said it was mischievous of the Australian Health Industry Association (AHIA) to be blaming doctors for private patients being confronted with high gap payments.

Dr Haikerwal said the AHIA's position was a classic case of the industry ducking its responsibility to patients.

"Doctors charge fees and health funds create gaps," Dr Haikerwal said.

"Doctors are responsible for fees and for delivering good quality care to patients in the private health sector and, where practicable, the doctor should inform the patient of fees payable in advance. This has been AMA policy since 1994.

"The Government and the health funds are responsible for gaps, and they have spent the last 20 years assiduously creating them and watching them grow.

"The Medicare Benefits Schedule (MBS) patient rebates have been so grossly neglected they have not kept up with CPI, let alone the real cost of providing high quality medical services. The Government must address this as a matter of urgency.

"The health funds, meanwhile, enjoy a $2.6 million taxpayer-funded subsidy and automatic annual premium increases without any compulsion to provide better products for patients.

"If the health funds want known gaps, they should all offer known gap products. HCF doesn't. MBF doesn't.

"Health Minister, Tony Abbott, should not approve any premium increase or any gap cover scheme for a health fund that does not make adequate provision for anaesthesia, pathology and radiology services.

"The Minister should not approve a scheme that he knows will force big anaesthesia gaps onto health fund members.

"The health funds and the Government between them have the power to remove gaps. Let them get on with it.

"If they want to discuss sensible gap cover schemes or educational strategies for improving informed financial consent (IFC) with the AMA and the medical profession, we will be pleased to do so.

"We have been asking them to do that for a long time, and it was raised openly at our private health Summit in March – and it will be raised again at the next meeting of medical specialist Colleges and Societies.

"The AMA has repeatedly asked the health funds to help us promote our informed financial consent forms, but they have refused.

"They are not interested in solutions: they are more interested in diverting attention from their own inadequate products and services.

"If the health funds want to raise punitive and draconian schemes to limit gap payments, they must bear and share the responsibility and impact.

"But first they must accept responsibility for gap payments in the first place.

"The health funds want to dictate where a patient service can be provided, when it can be provided, by whom it can be provided, and at what cost – which adds up to US-style managed care. We don't want that in Australia.

"The AMA will fight for a patient's right to excellence in health care. That is a doctor's role.

"The Government has enormous powers over the health funds due to the 30 per cent subsidy it pays on premiums.

"It should use those powers to force the health funds to come up with gap cover schemes that offer proper cover for surgery – all aspects of surgery including anaesthesia, pathology and radiology.

"In exchange for taxpayer support, the health funds should do the right thing by taxpayers and offer them realistic rebates, known gaps, information to patients, and better choice of products," Dr Haikerwal said.

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JB's horse tails

Is there a doctor in the … desert?

– by Dr Jo-Anne Benson

Once again it was time to go for a drive. No ordinary Sunday drive though – it was off to Birdsville for the 2005 Great Australian Outback Cattle Drive.

The inaugural Great Australian Outback Cattle Drive was held in 2002 in honour of the Year of the Outback. It was such a success that another was held this year.

Having ridden last time over the Gibber Plaints of the Sturt Stony Desert, this time I chose to ride the first segment of the trip, through the Simpson Desert from Birdsville to Andrewilla Waterhole. In view of the cold weather experienced last ride, I like all the other "old hands" had come prepared with Driz-A-Bone and thick woollies. This time though, it was T-shirt weather all the way, with scorching +30 oC heat every day.

On Day 1, 67 riders headed out with 534 cattle, 120 horses and a dozen or so stockmen and horse tailers. Actually, it was 66 riders, as one man fell off his horse on first mount, putting him out with a sore back. Late that morning the riders gathered around with three clergymen, a mayor, a Member of Parliament and a crowd of 4WD tourists for the traditional blessing and counting of the cattle.

At this time a pony carrying a 10 year old boy (the only child in the group) spooked and took off. The boy fell onto the sand when the pony suddenly pulled up behind the one and only bush in the vicinity. Both boy and horse were injured, but I reckon the poor bastard who chose the wrong time, place and bush to empty his bladder sure got a shock! By lunchtime we had another casualty – the Cattle Drive Manager, a veteran rider and station owner, fractured his clavicle when he was thrown from his horse. He was attended by the camp doctor; the drive organisers employ a GP to accompany the riders and provide medical care, on-call 24 hours a day, for two weeks at a time. There were plenty of John Wayne impersonations by day's end when riders dismounted. I had trouble trying to convince people that my limp was actually due to a recent injury to my left foot, and with every step, the pain on weight bearing made me question that x-ray that had been reported as "normal".

By the next day the animals and riders had settled down a bit. The drought had left the ground cracked and treacherous as it crumbled under the horses' hooves. For most of the trek we travelled between and parallel to the seemingly never-ending sand dunes, taking the cattle up and over the dunes just a few times a day. The dunes are up to 25 metres high, a kilometre apart and 200 kilometres long. The top of the dunes afforded the best views, as well as a welcome breeze that kept the flies at bay; advantages also enjoyed by the dingoes, who kept a furtive eye on the noisy procession below.

At the end of each day, we left our horses and cattle in the care of the stockmen and were carted back to base camp, where a hot shower, open bar and sumptuous feast awaited us. There was some entertainment provided in the evenings, but the campfire and desert night sky was hard to beat. Early to bed and early to rise was the routine; the cooks were busy from 4.30 am and we were off at 6.00 am. Afternoon excursions of the local area were optional and provided an opportunity to 4WD up Big Red (the tallest dune in the Simpson Desert), visit a station and chat to the locals, and best of all, to go for a swim in the cool, deep waters of Andrewilla Waterhole, a permanent waterhole of the Diamantina River system. A couple of people even managed to catch some good-sized yellow belly on hand lines.

Second to last day, a rider was thrown off and her horse rolled onto her leg. The camp doctor was AWOL. So, blowing my anonymous tourist cover, it was my turn to render care and protect her from the well-intentioned but unhelpful advances of the camp vet. Meanwhile, the drive had continued on its way, and so with patient and fracture secured, this was a good opportunity to canter across the desert until I had caught up with the herd. This was a welcome treat, as anything faster than a walk was usually not permitted, for fear of stampeding the cattle.

Our leg of the drive finished early afternoon on the sixth day. Most of the riders then had to hand over their horses and, still all hot and sore and dusty, board a chartered bus for a two-day drive back to Adelaide via Marree. I was among the half dozen riders who had organised a return flight from Birdsville. We were taken back to base camp and were able to have a shower and change before heading into town. My flight was on a 4-seater Cessna run by the owners of Wilpena Station. This afforded an extra treat, with fantastic views of the desert all the way back to Wilpena Pound. As the plane was needed at Wilpena, the owner drove us back to Adelaide in his 4WD. So rather than a bumpy, crowded two-day trip in a bus, I was back enjoying a long hot bath and hotel room service just 7 hours later – definitely the right option.

In 2002, the cattle drive had been organised and run by the local residents along the Birdsville Track. The South Australian Tourist Commission took over management in 2005, and with more funding, all the saddles were new and there were noticeable improvements in camp facilities and staffing.

Overall, highly recommended. It is advertised as suitable for all ages, but really has no special catering or entertainment for children. Riding experience is not necessary, but inexperienced or older riders may become saddle sore and find the days a bit long and taxing. Accidents can happen, even if experienced. Be aware that the horses are work-horses off local cattle stations – not pleasure riding ponies; they do try to match horse temperament with rider experience though. Return air transfer is preferable to bus and surprisingly adds little in cost.

For more information about the 2005 Cattle Drive or the next one planned for 2007, go on line to http://www.cattledrive.southaustralia.com/home.html

PS – and yes, further imaging on return to Canberra showed I did have a fracture – but hey, you can't ride in a below knee cast!

Bioethics from the Journals

with Dr Thomas Faunce

- In 2003/4, 88 GPs, 45 non-procedural and 43 procedural, were "closely involved" in public sector (country hospitals or non-salaried doctors treating public patients in public hospitals) incidents leading to claims. This represented 1.2% of the 4956 claims reported in the public sector in 2003/04. Obstetrics involved 17% of all claims, accident and emergency 14% and general surgery 11%. 5% of claims were expected to result in payouts of more than $500,000, with more than half (52%) of all current claims expected to result in payouts of less than $30,000 (Australian Institute of Health and Welfare July 2005)
- The new edition of the RACGP standards includes updated criteria on medico-legal risk areas. They require GP practices to review and act on all test results they receive, as appropriate, and create risk management systems. Such standards may become an item of evidence but of themselves will not be conclusive of GP's standard of care in particular areas of practice.
- The Royal Women's Hospital has argued doctor-patient confidentiality, privilege and public interest immunity before the Victorian Court of Appeal against the Supreme Court's recent decision ordering the release a file concerning a 32-week abortion to the Medical Practitioners Board. The patient sought a termination after doctors at the hospital diagnosed that her fetus had skeletal dysplasia, a non-lethal form of dwarfism. The hospital's clinicians said at the time that they "had rarely if ever seen a woman so seriously affected by the prospect of fetal malformation". The woman at the centre of the case is vehemently against its use in a right-to-life political campaign. (The Australian August 05, 2005)
- Henry Miller, a physician, fellow at the PhRMA-funded Hoover Institution and Competitive Enterprise Institute and former director of FDA's Office of Biotechnology has argued in the US that in addressing medications' potentially dangerous side effects,... the FDA should err "on the side of patients' freedom to choose" rather than erring "on the side of safety," which prevents patients with "incurable or poorly treatable diseases" from "exercising their own judgment about risks and benefits," (Miller, Washington Times, 1 August /05).
- The American Journal of Hypertension has severed its ties with the PhRMA influed American Society of Hypertension. Dr. Laragh, a researcher at Cornell University's Weill Medical College, has accused the society's leaders of being improperly influenced by financial ties to the pharmaceutical industry and becoming, in essence, marketers for drug companies, which pay them consulting and speaking fees. In funding continuing-medical-education symposia PhRMA was fostering a new category of 'academic' physician-businessmen. (Wall Street Journal July 29 2005)
- In one of the most ironic presentations ever heard at the national Press Club Medicines Australia (formerly the Pharmaceutical Manufacturers Association) chairman and Merck Sharp & Dohme managing director Will Delaat boldly asserted that it now costs $1 billion to produce every new medicine, that 33 such new substances are produced each year and that with greater subsidisation of them (in addition to patent rights that already produce 20% annual profits for this industry) most of the ills of the current health system and ageing demographic will be fixed. These figures are highly contentious as no public data is released on the pharmaceutical marginal cost of production and most analysts agree there are almost no new molecular entities in the medicines pipeline but only incremental innovation (mostly in patent evergreening). If promise of health benefits form "innovative" medicines is correct, then industry should be prepared to enter into binding outcome agreements which would allow reduction of government reimbursement if claimed gains did not eventuate. Delaat argued that the PBS should essentially be replaced in the long term with Medical Savings Accounts in which citizens put aside a large portion of their regular income (like superannuation) to fund the huge medical bills a privatised health system would offer in their old age. In the meantime co-payments should be increased and means-tested, he argued. He claimed such increased prices would attract more industry investment in Australia though most research shows this is rather driven by high intellectual property protection of which Australia is now amongst the world leaders.

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Assessing Fitness to Drive (2003) Interim Review

An invitation to doctors and other health professionals

The National Transport Commission (NTC) is conducting an Interim Review of the driver medical standards Assessing Fitness to Drive, released in 2003.

The review is being conducted in association with the Australian Medical Association and other stakeholders including all driver licensing authorities throughout Australia. It specifically addresses administrative issues associated with the implementation of the revised standards.

In particular it will aim to determine the impact of changes introduced in the 2003 edition, including the broader application of conditional licences to drivers generally and the requirement for specialist advice on conditional licences for commercial vehicle drivers. The review will seek to gauge impact on the workload of doctors and the capacity of driver licensing authorities to manage any additional work flow arising from these changes.

Health professionals are invited to complete a survey, which explores these issues and also seeks input regarding steps to optimise awareness and access to the standards.

The survey may be completed online via the NTC website www.ntc.gov.au or directly at www.cfh.com.au/AFTDsurvey . Alternatively a pdf file may be downloaded from this site and completed in hard copy.

Submissions will close on 12 September 2005.

A Full Review of the medical standards will be undertaken in 2008. This will involve a review of the medical criteria in light of emerging medical evidence and road safety research.

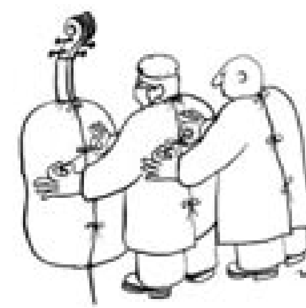
Further information on Assessing Fitness to Drive 2003 is available from www.austroads.com

National medical standards for private and commercial vehicle drivers are contained in the publication Assessing Fitness to Drive 2003. The standards support road safety.

- They form the basis of driver licensing decisions made by Driver Licensing Authorities throughout Australia.
- They provide guidance for doctors and other health professionals in advising patients about medical fitness to drive.

The standards have been distributed widely to doctors and other health professionals and are also available on the internet www.austroads.com.au

Australian Doctors' Orchestra Comes to Canberra!



On September 11 2005, Canberra will have the privilege of hosting the Australian Doctors' Orchestra. This is the first time that Canberra has hosted this prestigious event. The three days of rehearsal will culminate in a concert which will be held at 2.30pm in the Llewellyn Hall at the School of Music.

130 medical musicians are arriving from all over Australia for this wonderful annual event, including 6 players from the ACT: Anne Bicknell (Viola – Clinical Coordinator Breastscreen ACT), George Chan (Percussion- General Practitioner Wanniassa), Gemma Dashwood (Cello – Medical Student ANUMS), Peter Mews (Trombone – Surgical Registrar TCH), Jane Taylor (Flute – General Practitioner Deakin), Veronica Goldrick (Violin – retired General Practitioner now in the Southern Highlands).

The programme includes Brahms' Academic Festival Overture, Rachmaninov's Rhapsody on a Theme by Paganini (with Soloist Clemens Leske), Bizet's L'Arlesienne Suite No. 1, Rimsky-Korsakov's Russian Easter Festival Overture and Souza's Liberty Bell March. There will also be a special arrangement of Collier's 65 Roses, the theme song for this year's charity – the Cystic Fibrosis foundation. Max McBride will conduct the orchestra for this exciting weekend.

All profits will be divided between the national branch of the Cystic Fibrosis Association and the local ACT division. In this way the money can be shared between research and direct help to local families living with cystic fibrosis.

Tickets for the concert are available through Canberra Ticketing (Ph: 6275 2700) or by contacting the Cystic Fibrosis Association (Ph: 6259 7922).

The website for the Australian Doctors Orchestra can be visited at: www.ado.net.au

Dr Anne Bicknell and Ms Gemma Dashwood

Clinical Skills Retreat – Doctors Wanted

Teach Canberra's Future Doctors Whilst Improving Your Own Clinical Skills. By Dr Ashley Watson, Chair, Clinical Skills theme, ANU Medical School

The ANU Medical School is seeking Canberra doctors who would like to combine the clinical with the culinary at a weekend retreat on the first weekend of December 2005. The retreat is aimed at doctors who are interested in clinical teaching and who would like to contribute to the training of Canberra's future doctors. Doctors who are already teaching in the Clinical Skills program are just as welcome as new participants.

The retreat will allow doctors to brush up on their clinical skills and work on their teaching skills. By learning together and sharing clinical techniques we aim to ensure that there will be a reasonable level of consistency among teachers. Participants in the retreat will form small groups and rotate between supervised skills 'stations', each station focussed on a particular clinical skill. The retreat will mainly cover physical examination skills, although participants will also be given the opportunity to experience the history taking methods used in the medical curriculum.

Whilst the medical school is keen to recruit teachers throughout the whole medical curriculum, this retreat is mainly aimed at doctors who would like to teach history taking and physical examination techniques in Years 1 and 2 of the four-year course. Doctors from all fields of clinical medicine are welcome to attend. Preference will be given to doctors with at least five years of post-graduation clinical experience.

The retreat promises to be relaxing and entertaining as well as educational. A delightful venue has been chosen and interested doctors will be notified of the details of the weekend in the near future. The venue is about two hours drive from Canberra. There will be no accommodation or meals costs to participants, however all participants will be expected to make their own travel arrangements. The retreat will begin on the evening of Friday 2 December and conclude in the afternoon of Sunday 4 December.

Interested doctors should contact Ms Suzanne McKenzie, Executive Officer, Canberra Clinical School, on 6244 3361 or suzanne.mckenzie@anu.edu.au.

Specialist directory on ACT AMA website

GPs are invited to visit the ACT AMA website at www.ama-act.com.au and view the "specialist's directory" which includes special interests.

Member specialists who are not yet listed on the directory should contact Leanne Guy in the ACT AMA secretariat on membership@ama-act.com.au or by phone 6270 5410.

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Canberra Medical Society: Christmas in July 2005

145 doctors, their partners and medical students attended the Canberra Medical Society's second function for the year on 23 July. The "Christmas in July" black-tie dinner/dance was held at a prestigious establishment in Yarralumla on July 23, and was so well received that the committee plan to make it an annual event. All were treated to a sumptuous meal in convivial company, followed by after dinner dancing.

Many thanks to the organising committee who made it possible, and to sponsors for the evening.

The next function will be a dinner on 5 November, featuring an auction of art from the Yuendumu community, approximately 400 km from Alice-Springs. Funds raised will assist in flying some of these artists to Canberra for urgently needed eye operations, such as cataract surgery.

Further details on the Society are available from Dr Peter Gibson at p.gibson@act-dgp.asn.au

Dr and Mrs Cam Webber, Dr and Mrs Alistair Taylor.

Drs Charles Howse and Mark Hislop, and Mrs Debra Howse.

Drs Maureen McCluskey and Clinton Foster.

Diabetes Australia-ACT Buddy Support Program

Diabetes Australia-ACT has established a Buddy Support Program (DABS) to assist people in the ACT region who are diagnosed with diabetes. One-to-one peer support is offered by a "buddy" (a person who has lived with diabetes for twelve months or more) to a "friend" (a person with diabetes requesting support).

DABS helps adults aged between 18-75 years who have been diagnosed with Type 1 or Type 2 diabetes;

- gain confidence in the management of their disease;
- access community resources and;
- develop and maintain healthy lifestyles

What is a buddy?

Buddies are members of the local ACT community who have lived with diabetes for twelve months or more; have good communication skills, and demonstrate a positive attitude to the management of their diabetes. Buddies undergo training in order to assist people with the specific issues associated with diabetes and in doing so help their "friend" achieve their self-care goals.

This is not a medical intervention. Buddies can however, provide non-judgmental peer support at a potentially difficult and challenging time in a person's life.

Advantages for GPs

Important self care goals such as diet, exercise and smoking cessation are identified by the buddy and their friend and supported in an informal, social environment.

Buddies can provide the time and the psychosocial support that GPs and other health professionals often find difficult to do in a busy practice environment.

Referral

People wishing to apply for a buddy can approach Diabetes Australia-ACT directly or be referred through a health care provider.

Alternatively, people who have successfully managed their diabetes for over a year and who think they could offer support to someone experiencing difficulties can apply to become a buddy by ringing the number below.

Contact details

To refer people to the program or for more information please ring: Jenny Woodhouse (Co-ordinator), at Diabetes Australia-ACT on 6287 8727. Email jennifer@diabetes-act.com.au or Visit our website on www.diabetes-act.com.au

Speech to the National Press Club –
By AMA President, Dr Mukesh Haikerwal

Dr Mukesh Haikerwal (President of AMA) of his first National address as President.

Below is an edited version of the address given by Dr Haikerwal to the Press Club during Family Doctor Week 2005.

Family Doctor Week is the AMA's annual tribute to Australia's hard-working GPs. Our GPs are highly skilled, motivated and ethical health care experts who are a valuable resource to guide individual Australians and their healthcare. To the nation as a whole, they provide an accessible and cost-effective method of providing top-notch services to the population.

Observations from an overseas trained doctor

Overseas trained doctors

I am an Overseas Trained Doctor – or an OTD. In some quarters, we are known as IMGs, or International Medical Graduates. But at the moment some of our OTDs are being called far worse things – through no fault of their own.

It is because of one infamous OTD known as Doctor Death. I won't comment on the specifics of the case of Dr Patel and the tragic events at Bundaberg Hospital. There is a process in train in Queensland at the moment that is looking into it.

But those events are reverberating around the country. There are good effects and there are bad effects.

Medical racism

Australia is currently experiencing what I call 'medical racism'.

Because of the Patel case, doctors with funny names, accents, coloured skin and different backgrounds are getting a hard time.

Some patients are avoiding them. Some patients are abusing them. This should not be happening.

Australia is in the midst of its worst-ever medical workforce shortage. We cannot afford to lose any of the doctors we have. We cannot afford to discourage others who are considering coming here to work.

The simple facts. More than 20 per cent of our doctors are overseas trained. In country areas, more than 30 per cent are overseas trained. In some places, the only doctors they can get have come from overseas.

As a community, we have to value our OTDs. We shun them at our peril.

Our community and political leaders must get out there with this message as well.

We cannot allow honest, highly skilled doctors to be made pariahs in the communities they are committed to serving.

Because of the negligence of others, they are bearing a burden that isn't theirs. They are under scrutiny for getting a medical degree from overseas. Or for having darker skin. Or a different faith. Or English as a second language.

We have to stamp out medical racism before it takes hold.

Overseas trained doctors do not practise inferior medicine. Nor are they less committed to patient care. They are the pick of the crop – the cream of the education system in the countries from where they hail. The All-India Institute of Medical Sciences, for instance, has a competitive entry exam sat by 60,000 high-ranking students. Those 60,000 students are competing for just 45 places each year.

But we still have to fix the checks and balances so we do not have another Doctor Death situation in Australia.

The debate has to be about:

- skills
- training
- quality
- accreditation
- risk management for all
- assistance with language
- providing guidance about the Australian health system
- cultural awareness training
- recognition of qualifications
- and proper mentoring and supervision and management for those doctors we recruit internationally.

It must not be about race. It is backward-looking and would deprive us of excellent doctors should the wrong line be pursued.

The AMA reflects the reality of multicultural Australia. So does the medical profession.

Whatever our background or history, we are all doctors. We all studied medicine to fix people, not harm them. To do this is our privilege.

Medical Workforce

The biggest issue that will be with us well into the future and certainly for the life of my Presidency is the medical workforce.

There is a dangerous shortage of doctors within our system. But there is also a lack of understanding of their rigorous training and the value of a complete medical education.

The Government got it wrong back in 1996 when it cut back on medical training numbers and restricted provider numbers. They did it at precisely the time we were going into deficit supply. Now we are paying the price.

We have historically relied on OTDs or IMGs to top up our shortages and reduce the pressure on the doctors working in our system. They provided a flexible way to even out the workforce supply. They have now become a permanent structural feature and we have not acknowledged them as such. We need to acknowledge them formally as an integral part of our medical workforce. We need to ensure that new OTDs are properly introduced and supported as they move into our health system. Arranging a happy induction and transition to medical practice for OTDs in Australia will pay dividends. It will make these new recruits more comfortable in their new environment, and it will encourage them to stay as a longer term member of our health system.

Medical Board functions must be clear, fair, timely and decisive. Their views regarding registration and restrictions must be taken as solid expert advice by governments.

The role of the specialist colleges and societies is pivotal in training, standards, continuing education and remediation, as well as recognition of prior learning and other qualifications. Far from being seen as protectionist and aloof, they must be regarded as the arbiter of standards for their particular speciality.

If their standards must be satisfied by Australian doctors, the same standards should be adhered to across the board.

The apprentice model we have is that of the current generation of specialists training the next generation of their own competitors – and this they do gladly. It is the medical way. The trainers need and deserve the time to do this important job properly and to get the recognition that goes with it. Their work in teaching, training, mentoring, credentialing and research is an integral part of the medical curriculum.

Newer activities such as risk management, small group learning and audit go towards many features of re-validation. Touted overseas as the great way to ensure the maintenance of current best practice and safety, re-validation has stalled in the UK. The process developed by the General Medical Council was deemed to be too lax.

This is one of the strictest codes ever developed but was insufficient to quell criticism. The UK Chief Medical Officer is personally reviewing that structure.

How does this relate to Australia? Siple. There are so many layers of compliance and quality assurance in the Australian health system. If these layers are co-ordinated and adopted with the profession's approval, and pursued, the new risk management regime will reap a bonus. And that bonus will be strictly maintained standards and improved public confidence.

The proviso is that vexatious reports would be revealed and outed and refuted as quickly and solidly as genuine misconduct is dealt with. Those processed need to be dealt with in a swift but fair and open manner, ever mindful of the hurt to the reputation and practice any such investigation can have.

The Dr Patel situation has cast a slur on all OTDs in Australia and we are feeling the backlash. Bad news travels fast. Doctors considering moving to Australia to work as OTDs are hearing that the environment here is not hospitable. Given that the medical market is increasingly an international one, these doctors can choose to go elsewhere, and unfortunately they will.

At the same time, we have to start training a lot more local doctors to meet current and future demand. We must become self-sufficient.

Medical Advances

I just wish the good medical and health stories received as much attention and coverage as the bad ones.

The community must be made aware of just how far medicine and surgery have come in the last few decades. People have to know that today we are keeping patients alive who have conditions that could not have been treated twenty or thirty years ago.

This has been brought about by a highly trained and motivated medical workforce operating in an environment in which teaching, training and research is properly supported and encouraged. It is in an environment where new technology, new ideas, and new enthusiasm abound.

Since the times of Hippocrates and before, the goal has been enriching the human condition, sustaining health, preventing and treating illness, and pushing back the boundaries of what cannot be treated.

We have seen great innovations:

- from Jenner and his first vaccinations
- through Lister and his new surgical techniques
- the isolation of penicillin with Fleming and Florey
- radiation for diagnosis and treatment of cancers
- highly potent cytotoxic drugs for leukaemias
- immunosuppressant drugs for multiple conditions and to allow surgical techniques such as kidney transplants.

Things we take for granted now were once only dreamt about, but they were pursued and perfected by driven medicos.

We now have:

- cataract surgery
- joint replacement
- insulin therapy
- IVF
- Pharmacology and drug therapy
- Psychotherapy, etc etc

The point is that these innovations and techniques come from inspired people with commitment and compassion who are striving for the good of humanity. New learning is coupled with the old, established and important to form the bedrock of modern medicine. The complete medical education ensures that the patients of Australia get a full view from their doctors – not an organ-by-organ, disease-by-disease, or symptom-by-symptom approach.

Surgeons today have a knowledge of psychiatry. Psychiatrists know neurology. Physicians can spot the need for surgical intervention. X-ray and pathology specialists can light the way to a diagnosis using their medical training.

To illustrate how far and how fast we have come with medicine, just look at these specific examples.

In relation to heart attacks, the death rate due to heart attacks in the USA has declined from 345 per 100,000 population in 1980 – just before I entered medical school – to 186.9 per 100,000 in 2000.

With strokes, in the US

…continued

death rates have fallen from 96.2 per 100,000 people to 60.8 per 100,000 in 2000.

These rates can be roughly transposed to Australia to reflect similar successes in saving lives. We are getting better. But we must maintain an environment in which scientific excellence can thrive. We must be sure we do not react to individual events in the health system in a way that over regulates, stifles and detracts from the profession.

We need more doctors and we must retain those we have. We need to lift training standards and devote time to maintaining them. We need to keep our public hospitals in a healthy state.

Doctors, with their full and rounded training, cannot and do not work alone in saving lives. They work with other highly skilled and motivated people. Each member of the team has a different scope of practice, different training – but none of them is dispensable. And none is substitutable. The work of one group may be helped by a different group, but you cannot substitute one profession with another.

There is a lot of talk and activity out there at the moment – especially at the State level – about the roles of the various health professionals in the system.

We must never put quality of care in doubt as we search for answers to the medical workforce problems.

Health Funding

Speaking about the recent IVF funding issues – Prime Minister John Howard said 'nothing in life is completely free, nor should it be'. Health Minister Tony Abbott said, 'there needs to be some restraint when it comes to the availability of taxpayer funds for non-essential procedures'. And the man in charge of the Budget, Treasurer Peter Costello, weighed in with, quote, 'taxpayer funding [of health] needs to be based on the likelihood of success of medical treatments'.

Put together, those three statements provide a platform for health reform.

But there are more palpable signs of change, especially on the general practice landscape.

A new standards framework for the Australian Divisions of General Practice, for instance, initially requests doctors – but may well require doctors – to hand over their data through the ADGP network to the Government. The Government wants this data for health budgeting and planning.

The AMA has serious concerns and fears that the Government and some in the profession want this data in order to 'ration' the health budget to the community.

Fundholding

The AMA identified this threat to the Australian health care system some years ago. Last year we reaffirmed a clear policy that strongly opposes this type of financing of the health system. It is a system that takes away the certainty that patients would be able to access the care they need, where they need it, from the practitioner they want, when they need it.

When the doctor cannot access the best care, he or she is damned by the patient. The government then blames the fundholder for shortfalls in service, as they have provided the funds. Although the initial budget may have been insufficient, problems can be easily attributed by government to inefficiency and mismanagement at the local level.

We know that the Government has had a peek at both the UK and New Zealand fundholding models. And we know there are people in Government with a fondness for US-style 'managed care'.

This is all about control. Control of the health budget and control of doctors.

We would see rationing or eligibility criteria for care, especially for long term care of the chronically ill. The philosophical basis of medicine that provision of care is based on need is undermined in such a system, and doctors and the public should be very concerned.

One of the common features of fundholding is patient enrolment – patients would have to enrol with a certain practitioner. However, the practitioner could decide whether they will take certain patients on to their register. Proponents of fundholding in Australia continually point to improved patient health as a reason for going down this extremely difficult track. But there is no evidence that fundholding models provide improved patient care.

The political push for fundholding as a new model for the Australian health care system is largely based on the drivers of cost savings.

Let's put patients first instead, as we do now. Let's build on what is an excellent system, iron out the imperfections of poor communication and inter-governmental bickering, and preserve the freedom of choice, the ease of access to a range of services.

Canberra Doctor 'Caption' COMPETITION WINNER

The winning entry for this caption competition came from **Dr Robert Hain** with his caption:

"Charles pretends to see the funny side of crocodile incontinence".

Congratulations to Dr Hain and he will receive a small gift in the post shortly. Thanks to all those who participated.

We have TWO competitions this month.

Write a caption for this picture of Dr Charles Howse at the O'Connor Co-op Schhol during Family Doctor Week…

Caption: ______________________

Name: ______________________

Address: ______________________

Phone (H): ______________________

W): ______________________

Send entries to: AMA ACT Branch, PO Box 560, Curtin ACT 2605 by Friday September 16.

The second may or may not be more challenging.

The Federal Department of Health and Ageing recently issued its "State of our Public Hospitals, June 2005 Report". On the Fact Sheet for the ACT is the following statement: "In 2003-04, the Australian Capital Territory had three public hospitals, 0.4 percent of all public hospitals in Australia"

What are the three public hospitals?

Please mark them on the map below and the first correct entry received will win. A small gift will follow after next month's Canberra Doctor.

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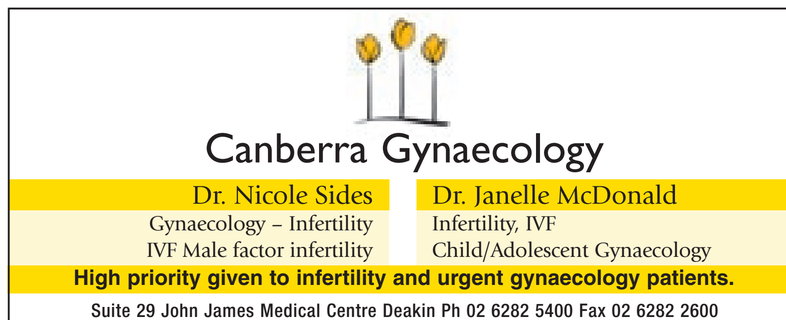

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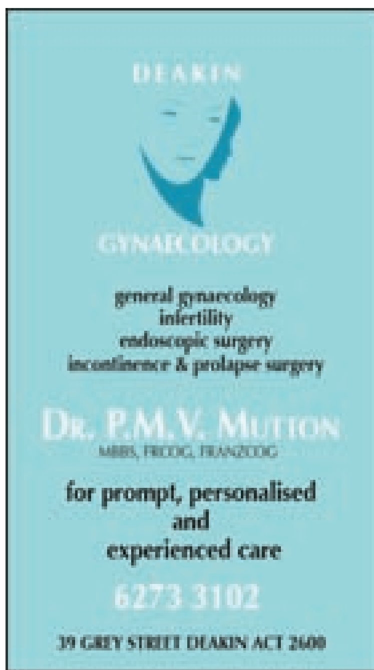

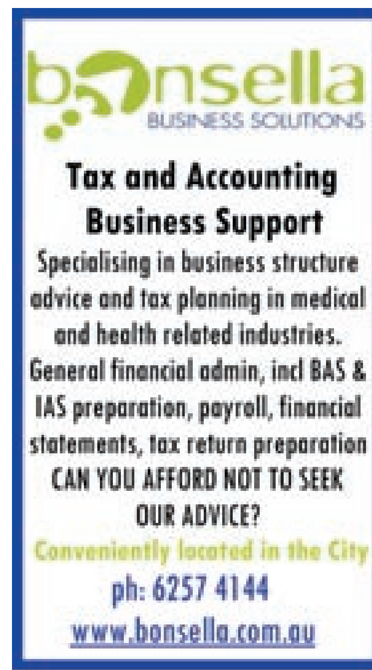

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