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October 2005
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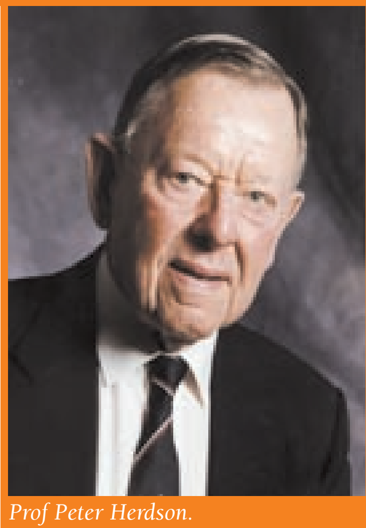
Former ACT AMA President, Professor Peter Herdson has Pathology Museum named in his honour

At a recent ceremony at The Canberra Hospital, Mrs Carol Herdson, widow of the late Professor Peter Herdson unveiled a plaque officially naming the pathology museum at The Canberra Hospital – The Professor Herdson Pathology Museum.


Prof Peter Herdson.

Speaking at the opening, colleague Dr Sanjiv Jain, Director of Anatomical Pathology, said "we remember our Prof, Professor Peter Herdson, with great fondness. Not only we at ACT Pathology but members of the medical community at The Canberra and Calvary hospitals, the ACT Branch of the AMA, the legal community, the judiciary, members of the ACT Police Force and many others remember the very generous, larger than life gregarious personality of Peter Herdson. Peter Herdson was Director of Pathology at ACT Pathology from 1991 to 2005 and his Canberra colleagues were saddened to hear of the passing in late June last year in Auckland.

As Dr Jain remarked, Peter Herdson was a man of many facets and the ACT AMA was among the organisations he made a contribution to – his personality, his love of life, his generosity of spirit, and his fondness for people – are long remembered and now honoured by this museum.

He was also the President of the World Association of Societies of Pathology from 1993 to 1995. The Royal College of Pathologists of Australasia presented him with a distinguished fellow award in 2002 for his outstanding contributions to Pathology.

Peter and Carol Herdson arrived in Canberra in July 1991 when Peter took up the position of Professor and Director of ACT Pathology and from December 1994 he was Professor of Pathology, University of Sydney (Canberra Clinical School). Immediately prior to taking up this position, Peter was Professor and Chairman of the Department of Pathology and Laboratory Medicine, the King Faisal Specialist Hospital and Research Centre in Riyadh, Saudi Arabia. After six years there, he and his wife Carol came to Canberra.

Peter Herdson was born on 29 December 1932 in Auckland New Zealand. Peter graduated with a pharmacy degree from Auckland, and then completed a B.Med Sc and MB ChB in 1959 from Otago. Peter then completed a PhD in Experimental Pathology at Northwestern University Medical School in Chicago and joined the Faculty there as Associate Professor Pathology.

Peter was appointed Foundation Professor of Pathology in the University of Auckland School of Medicine in 1969, a position he held until he took up his appointment in Riyadh.

Peter won many awards including the John Malcolm Memorial Prize in Physiology and Biochemistry, University of Otago, Scott Memorial Prize in Anatomy, University of Otago Medical School, Travelling Scholarship in Medicine, University of Otago Medical School, New Zealand Fellowship Bland-Sutton Institute, Middlesex Hospital Medical School, London, Outstanding Teacher of the Year, Northwestern University Medical School Chicago, USA, Professor Emeritus, University of Auckland School of Medicine, Auckland, Honorary Fellowship in the Royal Australian and New Zealand College of Radiologists and Gold Headed Cane, World Association of Societies of Pathology. His last award as a distinguished fellow, from his own Royal Australasian College of Pathologists, brought him great joy and is a measure of the esteem in which his pathology colleagues held him.

Peter was a prolific writer and authored or co-authored 88 papers, six book chapters, two theses and eleven editorials. He sat on several editorial boards, national (NZ and Australian) advisory committees and was an active member of many professional bodies.

His forensic activities included Coroner's pathologist in Auckland, NZ aviation aircraft investigator, Mt Erebus Disaster pathologist and Coroner's pathologist, Canberra.

Mrs Carol Herdson at the pathology museum at The Canberra Hospital.

Speaking at the official naming, Health Minister, Mr Simon Corbell, said that during the years Professor Herdson was Director of Pathology, his enthusiastic encouragement supported the continuing development of the Pathology museum. Peter Herdson was instrumental in planning the mortuary and the pathology Museum area. He had insisted that there be appropriate space set aside for exhibiting the potted pathology specimens where the medical students would also be taught in their tutorial groups. He was an enthusiastic teacher. It is fitting that this educational facility bears his name and spirit.

"It was quite an honour to invite Mrs Herdson to officially name the museum. She was certainly aware of his work and the appreciation shown by his work colleagues and the many doctors who studied at the Hospital," Mr Corbell said. "Under his leadership ACT Pathology became recognised as the quality pathology provider for the ACT hospitals. Pathology registrar training was markedly expanded in the ACT through his efforts. He mentored the Pathology trainees, who are now well known pathologists around Australia. They warmly remember his untiring support and care. Professor Herdson was a strong supporter of young doctors and was never too busy to provide referees for doctors as they moved through their careers," Mr Corbell said.

Professor Herdson will long be remembered with the museum he established now bearing his name.

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ACT AMA President's report

Dr Charles Howse

Long term care scheme for catastrophically injured

The major last component of professional indemnity is the long-term care scheme for those catastrophically injured in any accident. The excellent review by Price Waterhouse Coopers provides a concise proposal in explaining the natural progress of the long-term care scheme. It is encouraging to see that all jurisdictions appear keen to progress the idea of incorporating a no-fault long-term care scheme for those catastrophically injured initially as a component in a statutory and no-fault motor vehicle and workers' compensation schemes.

Some states have progressed further in this area and will view with interest the success of the New South Wales "Lifetime care and support" motor vehicle accident plan which proposes a no-fault scheme, and also proposes to incorporate a scheme into its no-fault workers' compensation scheme.

In the ACT without statutory motor vehicle accident schemes, this needs to be incorporated before any long-term care schemes can commence. The gradual piecemeal adaptation of schemes within these areas has been referred to as the "layer approach" and specifies that all jurisdictions need to have in place statutory motor vehicle and workers' compensation schemes before any broader long-term care scheme can be implemented. They stated that those catastrophically injured from medical accidents could be easily funded from current funding sources however federal funding would continue to be involved.

The AMA potentially has a vital role within this process as doctors are concerned to have appropriate care in place for their patients injured in a motor vehicle accident or industrial accident, and would also have the same concerns for those injured in medical accidents. It is important for the AMA to take this public interest stance and highlight the fact that most catastrophically injured do not have access to legal avenues and under any no-fault proponent of a long-term scheme would provide the required treatment and intervention at an early rather than later stage. Any contribution to such a scheme by the medical profession would be balanced by the benefit to lowering indemnity costs.

Healthcare complaints

The Community and Health Services Complaints Commissioner's report has just been released outlining a breakdown of complaints received to over the previous 12 months. There were 440 inquiries made to the Commissioner 50 per cent confirmed in writing as complaints and not all related to medical practitioner issues. 76 per cent of claims concerned private providers were related to medical practitioners with dentists 12 per cent and psychologists 4 per cent. This has increased in whole terms from 19 to 45 complaints relating to general practitioners and other medical specialties have generally remained static with 12 cases for surgeons, 11 cases for physicians and 7 for obstetricians.

What next?

It's amazing how the actions of a few can change the availability of a medication. I refer to the Victorian government requesting the TGA withdraw a brand of antihistamine gel capsule because of some drugs abusers injecting the contents into their veins. The decline of heroin on the streets makes those dependent desperate to inject what ever is available, and have turned to diphenhydramine ("Unisom Sleepgels") for this purpose. This follows the removal of Temazepam gel capsules for the same reason some years ago. A warning on the Medical Board website states that GPs should be aware of patients requesting scripts for this medication when it is available as an over the counter preparation. Unless the patient is sneezing, one would be doing them a favour by preventing potential significant vascular damage by irresponsibly injecting the contents of these oral capsules.

Role substitution

The report by the Productivity Commission provide some glimpse into the future general practice which may give GPs much greater freedom and delegation of routine tasks to a wider range of health workers. In the face of workforce shortages and the commissions report allows doctors to delegate more work to "substitute providers" and claim a relevant MBS item. This provides some hope as it allows GPs to focus on the degree of patient care within their practice and still maintain high care standards for their patients. The commission has adopted the idea of a review committee from the Australian Physiotherapy Association to allow a physiotherapist to refer to orthopaedic surgeons, obstetricians and gynaecologists and also directly referring patients for diagnostic imaging would save approximately 9500 hours of unnecessary general practice consultations. While this may have some benefit for investigating more straightforward conditions, there has to be some limitations on the complexity of problems investigated by physiotherapists and the follow-up that must follow when interpreting the investigation results.

MBS GPs rates insulting to highly trained general practitioners

The new increase in the MBS fees for general practitioners has increased by only 2 per cent which represents about half of the 3.55 per cent increase recommended by the AMA for non-procedural G P's. The indexation method does not take into account the cost of running a practice, and for those using the new bulk billing incentives will see this eroded by this ineffective indexation. For GPs it must be like ordering a double decaffeinated, Lo Cal skimmed milk with a touch of soy milk latte – commonly referred to by high end barristas as a "why bother"!

Patients abusing GPs

In a disturbing survey by urban GPs recently published in the MJA shows alarming instances of physical and verbal abuse by patients varying from direct assault on GPs, property damage, slander, sexual harassment and stalking. The groups most vulnerable have been identified as female GPs and those less experienced who work after-hours and are more likely to be facing confrontation with patients. There is still a lack of any systematic response to violence within general practice in Australia and we should take the approach adopted by the UK National Health Service of the zero tolerance. Numerous emergency departments around Australia adopt this policy of zero-tolerance of violence against any member of staff, as they are the ones who have to return to work the next day, and their safety is paramount. Preventative strategies should be put in place in health sector as with other occupations who endeavour test protecting its staff.

Report on the 12th Congress of the International Psychogeriatric Association, 20-24th September, Stockholm

This biennial congress is interdisciplinary in nature, but this year the main focus was on dementia. Whilst there are the promise of advances, it would seem the majority are still some years from translation to clinical practice. I have summarised a couple of talks for this issue, with more to follow in the next.

Evidence-based dementia diagnostic criteria

A particularly relevant session was on evidence-based dementia diagnostic criteria, commissioned under the auspices of the Swedish government Council on Technology Assessment in Health Care. Professors Gunhild Waldemar and Knut Engedal reported on the assessment of routine laboratory screening for the diagnosis of dementia. There was little evidence that thyroid disease caused reversible dementia, but it was noted that treatment of thyroid disease my ameliorate associated cognitive and psychiatric symptoms. Similarly, there was a dearth of evidence on the association between neurosyphilis and cognitive impairment in population studies, but reports of improvements with treatment. There was moderate evidence that elevated homocysteine was associated with cognitive impairment and AD, but so far there was no evidence that treatment with B12 or folate could reverse or prevent dementia. Professor Henrik Zetterberg reported that CSF examination remained largely a research tool. Professor Ole Almkvist reported that comprehensive cognitive assessment batteries were most useful in diagnosing the cognitive changes of dementias; but noted significantly that the MMSE and a clock drawing task were particularly useful single tests of cognitive function. Finally, Professor Lars-Olof Wahlund reported medial temporal lobe atrophy is useful in distinguishing AD patients from controls. The caveat would be that accurate measurements and comparisons need to be made and this can prove difficult in clinical practice.

Lewy Body dementia

An update on Lewy Body dementia was chaired by Professors Ian McKeith and Glen Smith. There has been refinement of diagnosis of this relatively common (up to 10-15% of all causes of dementia), but puzzling disorder. Supplementary supportive clinical features have been added to the cardinal signs of fluctuant cognition, fluctuant Parkinsonism and visual hallucinations. Those clinical features regarded as suggestive of Lewy Body dementia are:

- REM sleep behaviour disorder
- Severe neuroleptic sensitivity
- Low dopamine transporter uptake in the basal ganglia as visualised by SPECT or PET

Clinical features regarded as supportive:

- Severe autonomic dysfunction eg. Orthostatic hypotension, urinary incontinence
- Relative preservation of the medial temporal lobe on CT/MRI
- Reduced perfusion on SPECT/PET in the occipital region
- Abnormal MIBG (Nuclear Medicine) uptake in the autonomic innervation of the heart

Neuropsychological features regarded as supportive were summarised by a meta-analysis by Collerton et al. (2004) Dem Geriatr Cog Dis 16:229-37. Speech is characterised by decreased verbal fluency, whilst visual perception is evident in constructional apraxia. Sleep features of daytime drowsiness, disorganised speech and staring into space (secondary to fluctuation in consciousness) have also been identified.

Jeffrey Looi

Super Duper Super Funds

For most Doctors, super choice may not generate a great deal of interest. That's understandable – after all, super is money we can't generally access until we retire. And that's often a long way down the track. But it's still your money, and these days, thanks to the superannuation guarantee, Australians are accumulating quite substantial nest eggs – around $78,700 on average for men of all ages, and $43,300 for women.

Determining the fund that is best suited to your needs does involve some research, but it's certainly not a process that belongs in the "too hard basket". Sure, our superannuation system is complex, but the key issues surrounding super choice are not, and you don't need to be an expert on the topic to assess what is right for you. It's more a case of familiarising yourself with what your existing fund has to offer, and seeing if you could do better elsewhere.

When you're comparing funds, the main aspects to consider include whether the fund has earned a satisfactory return (relative to the risk involved), the range of investment strategies, the annual fees and the level of insurance cover the fund offers. If, after taking a look at these things, you are happy with your current fund, then there's no reason to change.

Most super funds can be placed into one of the following categories

- retail
- wholesale
- master trust/wrap
- industry
- corporate
- self managed super fund

Retail funds and wholesale funds are self explanatory. If you have upwards of $50,000 in superannuation then you should be able to access wholesale funds, which have lower fees.

Master trusts and wraps give you a far greater variety of investment choice such as access to a range of wholesale funds and listed equities. For lower sums of monies these can be fairly expensive but for larger amounts the fees become competitive.

Industry funds are a solid option that have low fees and for smaller sums are a great place to start.

Corporate funds are those offered by employers who use scale to get good rates for their employees.

Super choice may see more Australians taking a do-it-yourself approach to superannuation. Self-managed super funds (SMSFs) can offer considerable flexibility, but be aware that unless you have a substantial nest egg – usually upwards of $200,000, the annual accounting and audit costs will eat into your money. In addition, every member of a SMSF is also a trustee of the fund – responsible for meeting the extensive legal and tax obligations governing super funds. These obligations cannot be delegated to an accountant or solicitor, and even simple mistakes can land the trustees in serious trouble.

My advice is get advice. Find out what type of fund is best for you given your circumstances and then use that fund effectively. With the removal of the superannuation surcharge and superannuation splitting from the 1/1/06 superannuation is back in vogue.

This article has been contributed by King Financial.

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CARAN d'ACHE

Canberra Doctors and Dentists meet with "Money" Maestro, Paul Clitheroe

Canberra Doctors and Dentists were hosted to drinks at the Boathouse recently by King Financial Services. Guest of honour was "Money" maestro, Paul Clitheroe.

Grant Alleyn of King Financial, Niran Pathmaperuma and Dale Lymn.

Tom Glover, Jill McSpedden, John Sautelle and Mike Empson.

Ken Sunderland, Julie Murphy, Paul Clitheroe, Margherita Nicoletti and Tuan Tran.

National Brain Injury Foundation settles in the new Griffin Centre

The National Brain Injury Foundation has moved to its permanent stall in the centrally located Griffin Centre, Civic after spending the last 12 months operating from a temporary wooden Yurt structure.

"I am pleased to see the Foundation permanently located on the ground floor of the new Griffin Centre premises, Genge Street, Civic. The new Griffin Centre building will house a number of community groups and is an important step toward bringing employment and social activity back to this part of the City," Mr Corbell said.

The ACT Planning and Land Authority covered the costs of the 12 month temporary accommodation, to assist the Brain Injury Foundation provide essential services to sufferers of brain injury and their families while longer term accommodation premises were negotiated

It's time Australian women had access to medical abortion

A senior obstetrician says Australian women should have access to medical abortion using mifepristone (formerly known as RU-486), bringing their choices in line with women in other countries.

In a recent issue of the Medical Journal of Australia (MJA), Professor Caroline de Costa, of the Department of Obstetrics and Gynaecology at James Cook University, says availability of the drug in Australia might largely overcome many of the inequities of access to abortion.

"Availability of the drug is critical for many women in rural areas and women in some ethnic groups whose access to surgical abortion is limited," Professor de Costa says.

"Medical abortion should be an option for all Australian women.

"The overseas experience has shown it to be a safe, effective and acceptable alternative to surgical abortion.

"Medical abortion must be prescribed and administered by a medical practitioner with appropriate experience after discussion with the woman and after informed consent has been obtained."

In the MJA, Professor de Costa tells the story of a young mother with two children under the age of three, both delivered prematurely because of her severe pre-eclampsia, who requested termination of another pregnancy.

She was from a rural community and her only access to a termination meant travelling several hundred kilometres to a private clinic.

The cost of this was beyond her means, and she remained pregnant.

Once again, she developed pre-eclampsia, necessitating an emergency caesarean at 26 weeks.

The infant died within 24 hours, and the woman spent several days in a high-dependency unit, covered this time by the public purse.

"This woman's story could have been very different if Australian women had access to mifepristone, a drug which is safe, effective, cheap to produce, and now widely used overseas for medical abortion," Professor de Costa says.

In 1999, the International Federation of Obstetrics and Gynaecology stated that 'after appropriate counselling, a woman has the right to have access to medical or surgical induced abortion, and … health-care services have an obligation to provide such services as safely as possible'. This view was supported by the World Health Organisation.

While acknowledging the desirability of reducing the high number of abortions carried out in Australia each year, Professor de Costa says, given the complex and compelling nature of human sexuality, unwanted pregnancies will continue, and Australian women will continue to seek safe, legal abortion.

"The safety of abortion has been shown to be directly related to how early in pregnancy it is performed," she says.

"The case for medical abortion in Australia should be judged not on political grounds but solely on evidence-based medical criteria.

"People have to remember that abortion is legal in Australia, which means that this emotive discussion is all about the scientific evidence for medical abortion, not the legality of it," Professor De Costa says.

Professor De Costa's letter to Canberra Doctor is below.

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Dear Editor

Medical abortion for Australian women

I am writing to you about an important matter for the health of Australian women. As you may be well aware, medical abortion – in particular the use of drugs mifepristone (the former RU-486) and misoprostol – is now widely available overseas. Women in the United Kingdom, most of Western Europe, the United States, Canada, Russia, China, Israel, Turkey, New Zealand and many other countries, who make the decision to terminate a pregnancy, can choose between surgical termination of pregnancy or medical abortion, which uses the two drugs to bring about a process similar to natural spontaneous miscarriage.

Medical abortion must take place under the supervision of appropriately trained medical practitioners and only after an individual woman has been counselled and well informed about the procedure. Moreover women must be offered appropriate follow-up and screening services. However the abortion process, once initiated, can be concluded at home although women must have 24 hour access to emergency care as a small proportion – less than 5 % – will require surgical completion of the termination, and a very small proportion will need a blood transfusion. There is now a large amount of evidence from overseas studies and reports, involving millions of women, to show that medical abortion is safe, effective, and very acceptable to women.

Mifepristone as an abortifacient is specifically denied to Australian women under the Therapeutic Goods Amendment Act of 1996. Mifepristone can only be obtained for use as an abortifacient through a cumbersome bureaucratic process requiring a medical practitioner or institution to apply directly to the Federal Minister for Health. To date there has been no such successful application.

The right of women to choose medical abortion has been endorsed strongly by the Royal College of Obstetricians and Gynaecologists, the American College of Obstetricians and Gynecologists, FIGO – the international body embracing all national organisations of specialist obstetricians and gynaecologists – and the World Health Organisation. However medical abortion remains unavailable to Australian women.

As a practising obstetrician and gynaecologist with more than thirty years of experience caring for women, I am concerned that this situation be rectified and that Australian women who have to make a decision to terminate a pregnancy be able to make the choice about method for themselves. I am currently seeking support from women and men throughout Australia, from a wide range of backgrounds, to bring about removal of the restrictive legislation, thereby enabling institutions currently offering surgical abortion services, and private practitioners, the opportunity to offer medical abortion.

As a member of the Australian Medical Association I believe our organisation should be active in seeking legislative change to enable evidence-based medical abortion to be available in Australia. I appreciate that not all our members are pro-choice in the matter of abortion. However abortion is legal in all states although inequities of access continue to exist, particularly for rural women and for women of certain ethnic groups As well, there are many women who would prefer the privacy and less invasive nature of medical abortion.

Recently AMA spokesmen have supported calls for change and improvement in existing state abortion laws. I would now ask that the ACT Executive of the AMA give serious consideration to a discussion of this topic amongst members, with a view to requesting the Federal Government to remove the legislation excluding mifepristone from Australia.

Yours sincerely,

Caroline de Costa

(Professor de Costa is Professor of Obstetrics and Gynaecology, James Cook University, Cairns Qld – Editor)

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Violence in the health workplace

Violence in the workplace is a growing concern for health care workers, prompting the call for better surveillance, prevention and protection measures. A recent issue of the Medical Journal of Australia looks at the statistics, examines the risks and looks at programs for managing aggression and violent behaviour in general practice, tertiary hospitals and emergency departments.

Dr Klee Benveniste, Research Fellow at the Australian Patient Safety Foundation (APSF) in Adelaide, and colleagues examined the data collected using the Australian Incident Monitoring System (AIMS). They found that among 42 338 incidents reported from 1 July 2000 to 30 June 2002, 9 per cent of all incidents involved patients and physical violence or violent verbal exchange. Staff injury was reported in 5 per cent of cases.

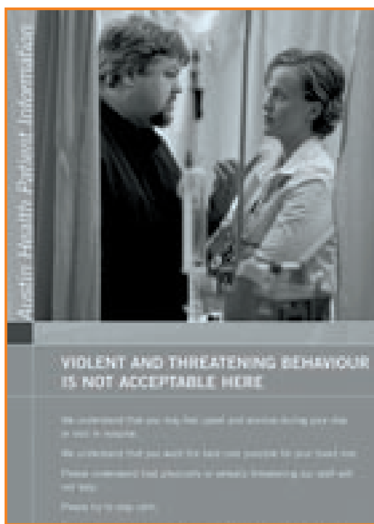
The proportion of incidents involving violence was higher in emergency departments (16 per cent, with frequent involvement of mental health problems or alcohol or drug intoxication), and mental health units (28 per cent).

With the closure of public psychiatric hospitals in the past decade, more patients with mental illness are seeking care in public hospital emergency departments, say the authors.

AIMS analysis highlights the importance of understanding the contributing and precipitating factors in violent incidents, and supports a variety of preventive initiatives, including de-escalation training for staff; violence management plans; improved building design to protect staff and patients; and fast-tracking of patients with mental health problems as well as improved waiting times in public hospital emergency services.

Mr John Forster and colleagues from Austin Health in Victoria say that strategies to prevent and manage violence and aggression in the health care setting have become a primary health and safety issue. Through a series of vignettes, they highlight key elements in developing a program for preventing violent behaviour and aggression in a tertiary hospital.

Key components of the program include staff education and training, risk assessment and management practices, the use of patient contracts and policy development.



Parker Magin and colleagues from the University of Newcastle say that occupational violence is a considerable problem in Australian urban general practice.

Their research showed that about 64 per cent of GPs who responded to a survey had experienced violence in the previous year. The most common forms of violence were "low-level" violence: verbal abuse (42.1 per cent), property damage or theft (28.6 per cent) and threats (23.1 per cent). A smaller proportion of GPs had experienced "high-level" violence: sexual harassment (9.3 per cent) and physical abuse (2.7 per cent).

They found violence was significantly more likely to be directed towards female GPs, less experienced GPs and GPs working in areas of social disadvantage, mental health problems and drug and alcohol problems. Younger GPs and GPs providing after hours care were also at greater risk.

The authors concluded that formal education programs in preventing and managing violence would be appropriate for GPs and doctors-in-training.

Associate Professor Marcus Kennedy, Director of Emergency Services at the Royal Melbourne Hospital, says violence in emergency departments (EDs) has reached a level that requires concerted action and a shift in attitude – to eradicate a socially and professionally unacceptable peril. In some EDs, violence is a daily occurrence, with nursing staff reporting several episodes each week. He says violence in emergency departments is often underreported — in a setting of care victims are likely to excuse the behaviour and lack the time required to complete reports on violent incidents. The key to successful intervention is a strong preventive orientation.

Dr Claire Mayhew and Professor Duncan Chappell, in an editorial in the same issue of the Journal, say that although in Australia the risk of death or serious physical injury from a violent workplace incident is quite remote, each year about one Australian health worker is murdered at work and large numbers are either verbally abused, bullied or assaulted. They say the challenge for health authorities is to implement effective preventive strategies and a zero-tolerance policy.

All workplace violence prevention strategies should be multi-faceted and organisation-wide, and involve widespread consultation with all workers in their development and implementation, say the authors.

Workplace safety has been a long-term concern for the AMA. The policy statement below reflects that concern as a priority issue. The policy is being reviewed by the AMA currently.

Doctors' Personal Safety and Security in the Workplace

The AMA recognises that violence against doctors is a growing concern. This Position Statement is provided in an effort to reduce the vulnerability of medical practitioners, including trainees and registrars, those working in rural or remote settings, and those providing after hours care and home visits.

The statement is framed within a risk management approach, focussing on risk identification, risk assessment, risk control, and evaluation of the effectiveness of risk management strategies. It is intended to guide the violence management efforts of hospitals, practice managers, and individual doctors – these parties should also keep up to date with current literature on the subject. Their efforts are underpinned by Occupational Health and Safety legislation that places on employers a general duty of care to provide and maintain a safe and healthy workplace. The legislation also assigns to each employee a duty to take reasonable care for their own health and safety, as well as for the health and safety of others who may be affected by that employee's acts or omissions at the workplace.

Violence risk management needs to take into consideration the work environment as a whole rather than doctors in isolation. To be successful it requires the commitment of management through sufficient investment of time, money and personnel. This includes commitment to regular audits of the organisation's vulnerability to violence to inform risk management planning.

Consultation with staff is essential for violence risk management planning to be effective. A risk management methodology can be used in conjunction with the detailed knowledge of staff in the local work environment to develop tailored solutions to violence problems. It may be appropriate to assemble a working group of staff to develop a violence risk management plan.

What's happening in Canberra's hospitals?

"Canberra Doctor" will survey our major medical institutions to see what policies they have in place to protect health workers from patient abuse and report in the next edition.

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AMA continues to advocate for Aboriginal and Torres Strait Islander Health

The AMA recently launched its position statement on Aboriginal and Torres Strait Islander Health. AMA President, Dr Mukesh Haikerwal, highlighted the disproportionate burden of illness and social disadvantage compared to the general population, dying up to 20 years earlier than their non-Indigenous brothers and sisters. This is a gap which has not lessened in the last 10 years, Dr Haikerwal said.

The chances of a non-indigenous person reaching 65 years of age are just under 90 per cent. The chances of an Aboriginal and Torres Strait Island woman reaching 65 are 35 percent and 25 percent for a man. This is worse than in Nigeria, Nepal and Bangladesh.

The statement repeats the AMAs call for governments to correct the under funding of health care services provided to aboriginal peoples and Torres Strait Islanders. The AMA believes most Australians are unaware of the way the system currently runs, which – unaltered – is destined to keep failing.

The AMA calls on each level of government to review how they fund these services,the amount that is funded and the need for that funding to reflect the needs and demands that have grown without increases in funding to match.

The position statement is available at www.ama.com.au

Surgically implanted prostheses

- important announcement

Private Health Insurance cover arrangements for surgically implanted prostheses have changed with effect from midnight on 30 October 2005. You need to know what the changes are to fully inform your patients so read on.

- Private health insurance funds are no longer required by legislation to provide 100% benefit cover (no gap) for all surgically implanted prostheses. This means patients may have to pay a gap in some situations and it is vital doctors understand where this will occur so they can tell their patients. This new arrangement commences from midnight on 30 October 2005 and will apply to any prosthesis used in surgery from that time on. Clinical choice remains the paramount consideration.
- The likelihood is your patients will not be much affected by this change. There is a minimum requirement for at least one clinically appropriate prosthesis to be available for each MBS procedure at 100% benefit cover (no gap). In reality, for most MBS items, there will be a full range of no gap prostheses. The prostheses have been classified into clinically meaningful groups by clinicians and clinicians are involved in the relevant decision making bodies.
- The reforms are intended to introduce greater competition into the way prices and benefits are set for the provision of surgically implanted prostheses. This will enable a greater range of prostheses to make their way onto the Prostheses List and in the long run, will improve the quality of care provided to patients and keep premiums down.
- Informed financial consent for patients is the key. If you think a prosthesis that attracts less than 100% benefit cover (gap to patient) is the only one suitable for the job, you need to explain the reasons for this to the patient and, where possible, tell them how much the gap will be. This should be part of the broader informed financial consent you provide about medical services. If there is no gap, tell the patient that too. In an emergency, try to use a no gap prosthesis.
- The Australian Private Hospitals Association and Catholic Health Australia have comprehensive information packages regarding the reforms on their websites. If you want to know what prostheses are on the List, which have full cover and which attract a patient gap, go to apha.org.au or cha.org.au. Where there is a gap, the List specifies the maximum gap which the patient may face.
- To download the AMA Informed Financial Consent form, which includes the information to be given to the patient on prostheses, go to ama.com.au, apha.org.au or cha.org.au
- If you have general questions about the new arrangements, contact your hospital administration or ring John O'Dea AMA on 02 62705400, Paul Mackey, APHA on 02 62739000 or Patrick Tobin, CHA on 02 62605980.

It is very important that these new arrangements come in smoothly and that patients are not exposed to unexpected gaps. Please take some time to become familiar with the new arrangements.

Mental health care in Australia in the 21st century – 'out of sight, out of mind'

AMA Vice President, Dr Choong-Siew Yong, said that the Not For Service report into Australia's mental health care system reveals a sad story of inactivity, poor planning, under-funding and under-resourcing by all Australian governments in the face of one of the biggest health challenges facing the nation in the 21st century – mental health care.

Dr Yong, a psychiatrist, said the report presents a Dickensian picture of 'out of sight, out of mind' when it comes to caring for people with mental illness.

"It is a case of governments shifting blame and responsibility and ultimately failing a very large number of vulnerable Australians and their families and carers at a time when mental illness has one of the highest burdens of any disease," Dr Yong said.

"Mental health policy needs national leadership from the Federal Government and a unity of purpose from the States and Territories.

"At a time when demand for quality mental health services is at its highest, our national commitment to the mental health sector is frighteningly inadequate and fragmented.

"We need to improve access to appropriate care for people suffering mental illness.

"We need to expand community services and provide more psychiatric beds, we need more psychiatrists and nurses and carers, and we need greater funding from all levels of government. Patients need access to aftercare and housing and better access to GPs.

"While the Federal Government has recognised the problem and started to improve funding, services and programs, much more needs to be done, especially for children and young people if we are to slow down the increase of mental health disorders in Australia," Dr Yong said.

Mental health disorders are on the rise in Australia:

- One in five Australians aged over 18 currently meet the criteria of suffering from some form of mental illness
- By 2013, over 100,000 people will be affected by bipolar disorder, an increase of 6 per cent
- By 2011, we'll see a 10 per cent rise to 41,000 in the number of people with schizophrenia
- Dementia and depression are major issues for Australia's ageing population
- By 2050, around 730,000 Australians will be affected by dementia.

The AMA Submission to the Senate Select Committee On Mental Health, April 2005, contains a raft of AMA recommendations to improve mental health care in Australia, and is available on the AMA website at www.ama.com.au

Government must involve GPS in frontline response to possible flu pandemic

AMA President, Dr Mukesh Haikerwal, today called on the Government to do more to involve GPs in the planning for a national response to a possible flu pandemic.

Dr Haikerwal said reports yesterday that the Australian Sentinel Practice Research Network (ASPREN) is underfunded and struggling show that the flu pandemic response is failing before it has even started.

ASPREN is a network of unpaid volunteer GPs mainly in NSW and SA who act as an early warning system for evidence of influenza, including bird flu, and other diseases, but the number of volunteer GPs has dropped to 51 from 110 in 1994.

"Things are going too slow with the pandemic response strategy and it is irresponsible not to include the GP population in response planning from day one," Dr Haikerwal said.

"As the Government's neglect of ASPREN shows, Australia is totally unprepared in the key area of bio-surveillance, if the concerns raised by the AMA are not addressed.

"If we are to repel the flu pandemic threat, Australia needs a national bio surveillance system.

"The first step is to revitalise ASPREN by extending the network of GPs across all States and Territories and provide the specialised training and support to allow early detection of health threats.

"This will require the involvement of the AMA.

"There must also be sophisticated communication networks to facilitate rapid alerts, laboratory support, and centralised data collection systems," Dr Haikerwal said.

Dr Haikerwal said the Government has had plenty of time to establish a system that could activate a flu pandemic response strategy. In 2002 and 2003, the AMA alerted the Government that the national bio surveillance capacity was insufficient to deal with a possible SARS outbreak.

"The Government must heed the lessons learnt from the threats presented by the SARS outbreak. They must act now – and fast," Dr Haikerwal said.

John James Memorial Hospital incorporating Lidia Perin Memorial Hospital 2005 Healthcare Receptionist of the Year Awards

John James Memorial Hospital supported by the Australian Practice Managers Association, invites nominations of Healthcare receptionist employed by general practitioners and specialists in the ACT to enter the 2005 Healthcare Receptionist of the Year Awards. The Awards give public recognition of the dedicated, committed and skilled work performed by Healthcare receptionists throughout the Canberra region.

Entries are invited for:

Healthcare Receptionist of the Year: the entrant judged to be the most outstanding Healthcare receptionist will receive a cash prize of $1,000.00 from John James Memorial Hospital and a $200 Gift Voucher from David Jones.

New Healthcare Receptionist of the Year (New to the role within the last 18 months): the winning entrant will receive a cash prize of $500.00 from John James Memorial Hospital and a $100 Gift Voucher from David Jones.

Conditions of Entry

All nominees must be 18 years or over at the date of nomination lodgment and be employed as a receptionist in a Healthcare practice in the ACT. The attached nomination form should be completed by either a peer, Medical practitioner or patient.

Closing dates for entries is Friday 11 November 2005 at 5pm and forwarded to:

The Secretariat
Healthcare Receptionist
of the Year
C/- John James Memorial
Hospital
PO Box 23
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NO LATE ENTRIES WILL BE ACCEPTED

Awards presentation

The Healthcare reception of the year and New Healthcare receptionist of the year will be announced in at the Secretaries Christmas Party on Thursday 1 December 2005 at the The Lobby, King George Tce, Parkes ACT.

Judging

A panel of two independent judges will assess all nominations and select finalists to be interviewed. Finalists will be interviewed on the following criteria. The judges decision will be final and no correspondence will be entered into.

- The level of contribution the nominee makes to the surgery or practice;
- Effectiveness and efficiency of the nominee;
- The level of understanding of the role of a Healthcare receptionist; and
- Empathy with the position.

HEALTHCARE RECEPTIONIST OF THE YEAR APPLICATION FORM 2005

Before completing and signing this form, please read the information on the other side which contains the terms and conditions.
If space is insufficient, please attach additional pages.

Name ____________________

Name and Address of employer ____________________

____

Telephone (business) ____________________

Relationship to nominee (eg professional) ____________

How long have you known the nominee? ____________

1. What do you regard as the three most outstanding qualities of the nominee?

(a) ____________________

(b) ____________________

(c) ____________________

2. Give a brief description why you feel your nominee should receive the Healthcare Receptionist of the Year Award or New Healthcare Receptionist of the Year Award.

(Please attach additional page if required)

____

____

3. The nominated healthcare receptionist is encouraged to submit a written statement on their own perceptions of their role to assist the judges short list for interview. (statements should be no more than one typed page).

Please include the following:

1. Why you feel you should receive the award.
2. Your interpersonal skills.
3. Customer Service
4. Professionalism
5. Technical Skills.

Please enter my nominee in the: (tick the appropriate category)

- ☐ Healthcare Receptionist of the Year
- ☐ New Healthcare Receptionist of the Year
- ☐ Signature of nominee
- ☐ Name of nominator
- ☐ Signature of nominator

Applicant must be supported by the principal of the practice. (Practice Manager, GP, Specialist)

Name ____________________

Title ____________________

Statement of support.

I support the nomination of ____________________ for the Receptionist of the Year Award.

Signature ____________________ Date __________

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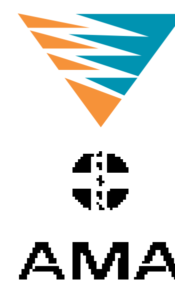

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“Passing the Baton” – The Canberra Hospital’s clinical handover project

Every year at least 15% of patients in hospitals around Australia suffer an adverse outcome, which is unrelated to their reason for admission, Health Minister Simon Corbell stated during the launch of the Canberra Hospital’s Clinical Handover Project.

These outcomes range from infection to delays, and at worst, the unexpected death of a patient. It is estimated that 50% of this patient harm is potentially preventable.

At the launch of the clinical handover project, named Passing the Baton, Mr Simon Corbell, said the project aimed to identify opportunities to improve the safety and quality of care provided to the Canberra community.

“The Clinical Practice Improvement Unit has targeted communication between clinicians as a priority for improvement,” Mr Corbell said.

“In particular, the Unit will concentrate on clinical handover, which is the exchange of information of patients between health care providers at the change of shift or change of patient location.

“Clinical handover has been identified nationally and internationally as a priority area to address for all healthcare institutions. The hospital executive and clinical managers have engaged with consumers, doctors, and nurses to assist in improving the clinical handover and reducing potentially preventable patient harm.”

Each project has a dedicated team consisting of a consumer and a group of clinicians who are passionate about improving clinical handover.

“The Project Teams are making changes in formalising the handover process that occurs between evening and night shifts to ensure all relevant information regarding the patient is passed on to the medical officers, senior nurses, and midwives,” Mr Corbell said.

Changes implemented to date are being trialed and their effectiveness evaluated. The changes that demonstrate improvement in communication will be implemented permanently and used to improve communication in other clinical areas.

“The aim of the Clinical Handover Project is to ensure that handovers will cease to be a primary factor in adverse events at TCH by March 2006,” Mr Corbell said.

Background to the Project

The Clinical Practice Improvement Unit supports the provision of care that meets the highest level of quality and safety at The Canberra Hospital. This is achieved through clinical audit and review, consumer liaison, support of clinical governance committees and facilitation of Clinical Practice Improvement initiatives. Patient safety and quality issues identified through current audit and review processes form the basis of Clinical Practice Improvement initiatives undertaken within the unit.

The Clinical Review Committee identified the lack of communication within the clinical setting as one of the major contributing factors to adverse patient events at The Canberra Hospital in 2004.

The Australian Council for Safety and Quality in Health Care has identified clinical handover as a national priority for healthcare quality improvement. In addition, large body of work has been undertaken internationally on this topic with the United Kingdom National Health Service addressing clinical handover as a patient safety priority.

The Canberra Hospital Clinical Practice Improvement team was tasked with facilitating a project to improve patient outcomes within three domains of handover:

- Resident medical officer handover between shifts;
- Nurse and midwife handover between shifts; and
- Handover between Emergency and the Medical and Nursing team accepting care.

To date the project has engaged with consumers, doctors, nurses and managers throughout the organisation to investigate causes for the breakdown in handover of clinical information. Over 60 consultation meetings have been held. These included meetings with hospital executive, clinical managers, specialist medical officers, nurses, junior medical officers and new graduate nurses.

Each project has a dedicated team consisting of a consumer and a group of clinicians who are enthusiastic about improving clinical handover. From the information gained during stakeholder consultation, the project team addressing resident medical officer handover is making changes in the following areas:

- Improving the availability of information regarding patients admitted after hours; and
- Formalising the handover process that occurs between evening and night rostered resident medical officers to ensure that all relevant information regarding sick patients is passed on to the medical officer responsible for their care after hours.

The project team addressing handover from Emergency to the medical and nursing teams accepting care of the patient are making changes in the following areas:

- Formalising lines of responsibility for patients who have been accepted by a team and who remain in Emergency awaiting a ward bed;
- Formalising the documentation of care and management plans for patients who have been accepted by a team and who remain in Emergency awaiting a ward bed; and
- Standardising nursing handover from Emergency to the nurses accepting care on the ward in line with current evidence based practice standards.

The project team addressing nursing and midwifery handover between shifts are making changes in the following areas:

- Standardising nursing handover between shifts in line with current evidence based practice standards; and
- Formalising the handover process that occurs between day and after hours rostered senior nurses to ensure that all relevant information regarding sick patients is passed on to the senior nurse responsible for their care.

Trials of the changes implemented to date, as outlined above, are being held and their effectiveness evaluated. Changes leading to demonstrated improvement in communication will be implemented permanently and used to improve communication in other clinical settings.

The aim of the Clinical Handover Project is that clinical handover will cease to be the primary contributing factor to adverse events at The Canberra Hospital by March 2006.

The project has been underway since mid 2005.

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Book Review

American Mania – When more is not enough

Peter C. Whybrow, WW Norton & Co: New York, 2005

ISBN 0-393-05994-4, Hardcover, 338pp, US$24.95

Reviewer – Dr Jeffrey Looi

Whilst in Los Angeles, I picked up this book at the UCLA Westwood bookstore and was intrigued that it was written by an eminent psychiatrist and campus neighbour, Professor Peter C. Whybrow, Director of the Jane and Terry Semel Institute for Neurocience and Human Behaviour. This book is best described as popular neuroscience and neuropsychiatry, explicating the biological, psychological and social bases of Americans’ “appetite for life”. This follows in the trend in popularization of life sciences by scientific authorities and communicators such as Matt Ridley, Richard Dawkins, Antonio Damasio, Steven Pinker and Edward O. Wilson. The book skillfully combines journalistic exposition with cutting edge genetics, neuroscience, economics, psychology, psychiatry and anthropology.

Dr Whybrow advances the central thesis that the confluence of American capitalism, centuries of the success-orientated immigrants and the unparalleled prosperity (with of course exceptions, as seen in the South) has overloaded the Americans with a profusion of possibilities. He posits that American’s intense striving for success, observed even by Alexis de Tocqueville in his survey Democracy in America in 1835, has become a recursive obsession with acquisition and consumption. In this last aspect, Dr Whybrow likens the American desire to succeed and consume to the psychiatric diagnosis of mania. “Thus, we Americans, must ask, to what purpose is our manic striving? Why do we live in this way in a land where we are free to choose? Have we fallen victim to the illusion that only more of what we have can be better?” (pg 261)

He contends that it is this consumerism that has driven record levels of debt, obesity; contributing to the development of stress, anxiety and depression secondary to the disjunction between the dream of success and the reality of striving. His writes that Americans are at perhaps a critical juncture, at a point where they should work towards evening the balance between the pursuit of individual success and society. Perhaps it is timely to review these matters, as we, in Australia, face industrial relation reforms that have the potential to shape a similar American-style manic work culture in which we may increasingly work 24/7.

Interestingly, Dr Whybrow, who resides in both rural New Hampshire and Los Angeles (within walking distance to his office in Westwood) may well himself characterize in this pattern of commuting psychologically or physically between the tension described in Jay McInerney’s Bright Lights, Big City – the city like LA or New York, which might consume you whole – and the more sheltered, lower horizons of smaller communities such as the urban enclaves of Santa Monica, LA or Soho, New York.

In summary, this is a fascinating book, written fluently and engagingly. Dr Whybrow has and interwoven a modern neuropsychiatric understanding of and characterised this manic drive of the Americans, captured eloquently in F. Scott Fitzgerald’s quintessential American novel:

“Gatsby believed in the green light, the orgastic future that year by year recedes before us. It eluded us then, but that’s no matter – tomorrow we will run faster, stretch out our arms further… And one fine morning –” (pg 171-172, Penguin Classics edition)

Dr Jeffrey Looi is a Canberra neuropsychiatrist

Health financing examined

General practice, government and consumer representatives met in Melbourne recently to discuss how to best spend the health dollar. The forum, hosted by the Australian Primary Health Care Research Institute, is discussing whether fundholding would be a viable financing system for health care in Australia.

Immediate past President of the AMA Council of General Practice, Dr David Rivett addressed the meeting on behalf of the AMA. He asked why fundholding continues to be on the agenda of some health organisations. He said: “The Minister for Health and Ageing said in a newspaper article in July 2005 that the Federal Government had no intention of introducing fundholding and that such a system had a very limited place in the Australian health system. He also said and I quote “…fee for service is the basis of our health system outside hospitals and it works. I’m not attracted by other models being used overseas. If you asked patients whether they would prefer to be treated in the UK’s National Health Service or in Australia, they will say Australia. It offers great benefits to patients”. So I have to ask. Why are we here yet again debating the issue of fundholding for Australia?”

The AMA has developed a position on fundholding based on consultation with members. The AMA believes that fundholding leads to a situation of rationing of care. Under a fundholding system, GPs face pressures, within capped budgets, to minimise expenditure on services. This creates an ‘ethical hazard’ because the provider is obliged to extend the ‘duty of care’ from the individual to the needs of a population.

Dr Rivett highlighted the overseas experiences that demonstrate best quality patient health outcomes are not supported by fundholding. “A recent Statement on Safe Practice in an Environment of Resource Limitation prepared by the Medical Council of New Zealand opens with the line “The rationing of health services is becoming more explicit.”

“The statement provides some guidance to doctors but consistently highlights the absolute tension between a financing system that is based wholly and solely on cost drivers and the doctor’s objective of providing the best health care to his or her patient. Basically the financial risk for providing a service conflicts with the quality of its provision. The following is a good example of the type of guidance included in the Statement: “Doctors have a responsibility to make clear to any patient to whom care of proven effectiveness is being denied by any funder or provider, that what is being provided is not ideal care, by generally agreed standards of medical practice””.

A recent article published in the journal ‘Australia and New Zealand Health Policy’ said: “The New Zealand scheme is complex, but closely resembles United States insurance-based, risk-rated managed care schemes.” One of the advantages proponents of the New Zealand system often cite is that GPs have autonomy to set their fees and control the governance structures. However this article found “initial evidence suggests that total costs are higher than initially expected, and prices to some patients have risen substantially…. Limited competition and NZPHCS governance requirements mean current institutional arrangements are unlikely to facilitate efficiency improvements. System design changes therefore appear indicated.” It implies that GPs setting their own fees and a fundholding system cannot operate successfully in tandem – it is all or nothing.

“I think it is worth emphasising that what is being discussed is a financial system that has to date nothing behind it that relates to patient outcomes or quality of care. Fundholding, certainly as it is being promoted in some quarters, is not about patients, its not about providing better health care it is not about improving patient outcomes – it is about driving down costs. And without the capacity to demonstrate otherwise there is a very substantial risk that driving down the costs through fundholding will compromise the very reasons we are in general practice – that is delivering best quality care to our patients based on clinical need,” Dr Rivett said.

Reprinted from AMAs GP Network News.

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Bioethics from the Journals

with Dr Thomas Faunce

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- It may seem remarkable, but at a time when global changes in public health are being driven by a rampant corporate ideology based around privatisation and “innovation,” calls are being made to make bioethics (a natural normative opponent of corporate globalisation) more evidence-based. Halpern argues that purportedly authoritative statements of Bioethics often contains unfounded assumptions about human moral behaviour. He describes recent examples in which assumptions made in theoretical writings were later repudiated, or in which empirical work served further to clarify positions taken in theoretical pieces. ((2005) 331 BMJ 901-903).
- Calls have been made to compulsorily licence the patented pharmaceutical Tamiflu as a precaution against avian influenza. Compulsory licensing occurs when a government (for reasonable compensation) allows another manufacturer to produce a patented product (medicine) or process for domestic use without the consent of the patent owner. It is one of the flexibilities on patent protection included in the WTO's agreement on intellectual property – the TRIPS (Trade-Related Aspects of Intellectual Property Rights) Agreement. The 2001 Doha Agreement on TRIPS and Public Health confirms that countries are free to determine the grounds for granting compulsory licences. On 30 August 2003, the TRIPS General Council decided to waive the domestic use requirement, allowing generic copies made under compulsory licences to be exported to countries that lack production capacity, provided certain conditions and procedures are followed. All WTO member countries are eligible to import under this decision, but 23 developed countries are listed as announcing that they will not use the system to import: one of them is Australia.
- From November 2005, the United Kingdom Medicines and Healthcare Products Agency, a body like our TGA entirely funded by user fees, will begin producing Public Assessment Reports of each new medicine its licences. These will include summaries of the clinical trial data that formed the basis of the manufacturer’s application.((2005) 331 BMJ 834-6)
- The Dickey Amendment, passed annually by the US Congress forbids federal funds being spent on experiments that endanger or destroy an embryo. Australia also has restrictive legislation in this area. Earlier in 2005, researchers in South Korea used nuclear transfer to derive human ES cells that genetically matched the patient (Nature 435, 393; 2005). Rudolf Jaenisch and Alexander Meissner of the Massachusetts Institute of Technology have now described in Nature a variant of therapeutic cloning called altered nuclear transfer (ANT), in which a gene permitting uterine implantation in the patient's donated cell is switched off before the nucleus is transferred into a fertilized egg. A team led by Robert Lanza of Advanced Cell Technology in Worcester, Massachusetts, has derived new ES cell lines from blastomeres, while the 8 cell embryos went on to form apparently healthy mice. This research enhances prospects for stem cell research.

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CANBERRA LASER AND MENOPAUSE CENTRE

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