Canberra DOCTOR

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November 2006

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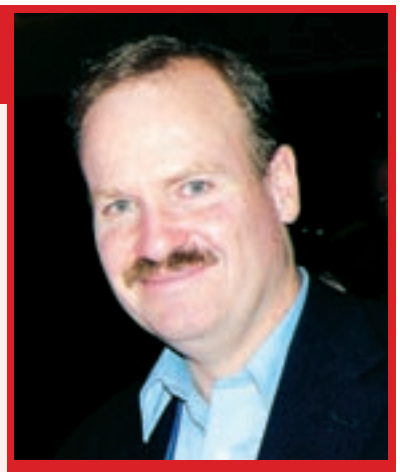
Print Post Approved PP 299436/00041

ACT AMA President's letter



Dr Andrew Foote.

Some Parking Sanity

The other morning I was called to Delivery Suite as one of my patients was ready to deliver her baby. When I entered the room I noticed that her husband was absent and I jokingly asked whether his stomach was a bit weak – only to be told that he had gone to top up the parking meter. Fortunately he did return just in time to see his new family member arrive safely. This is an appalling state of affairs!

I was pleased to hear that some sanity has entered the paid parking story and that ACT Health will now relax the rules so that patients who are delayed because of medical treatments are not subject to parking infringements.

The next step would be to allow free parking after 6pm, when there are ample parking spaces. Have I previously mentioned a multistorey car park at Calvary is urgently needed?

General Practice

We are looking to restructure our GP Forum to include more ACT AMA GP members. The Forum has always addressed the cutting edge and top of mind issues in general practice and I am keen that the re-vamped GP Forum should continue this tradition so that we can better represent our local GPs to support and advocate on their behalf to our local and federal politicians. In particular, it would be nice to be able to address the issues of a diminishing workforce and the inequity of status between city and outer metropolitan practices.

VMO Negotiations

The lawful bargaining period for VMO contacts terminated on 1 November 2006. ACT AMA was able to achieve a rise of 1.1% on the baseline contract rates, as well as a guaranteed minimum 4% rise each year. Both of these will be quarantined from the arbitration process which will take place to determine the outstanding matter as I mention below. There are now no outstanding core-contract issues for sessional VMOs and the individual VMO must make a personal decision regarding renewing their contract. If there is no lapse in contracts the VMOs will also gain a 5% continuity bonus, and have their workload guaranteed and for those affected the transitional allowance will remain – as per the previous contract conditions.

There was no agreement from government to our claim to increase fee for service contracts a further 15% to bring rates in line with the 120% (plus) of CMBS that Veterans Affairs is now paying. There will now be arbitration for this matter only, and ACT AMA will prepare a compelling case for the arbitration and will draw on the expertise resident within the AMA family when preparing the case. This is another example of the benefit of being an AMA member – its expertise is available to you – and contract negotiations such as these are core business for the AMA. We are hopeful that this will be resolved in as short a time frame as possible. However, ACT Health have guaranteed to "back pay" contract holders to 29 November 2006 irrespective of when the decision is finally handed down.

2007 – Why wouldn't you?

A female patient of mine said the other day that she reluctantly came to see me as a male doctor, because the last male doctor had been 'too rough'. Putting on my best bed-side manner I was able to complete the examination with minimal discomfort. I subsequently found no major abnormality and discharged her back to her local GP, whereby she asked if she could return in 2 years for her next Pap smear.

What was the point of that anecdote? I keep on hearing from former members that they resigned in the past because of some terrible policy or deed that Federal or local AMA perpetrated (or didn't perpetrate). Or that the AMA is a specialist organisation, or conversely is a GP organisation or that it doesn't represent x, y or z, and so won't join. I have big shoulders, but I get a little tired of being responsible for the sins of the past – real or imagined, Federal and/or local! I know a lot of you feel passionately about medicine – don't just be an armchair expert, get involved as a member – YES YOU!

From a purely economic perspective the AMA brand discounts would virtually pay for your membership (especially the Commonwealth Bank's merchant EFTPOS terminal discount, and the tax deductibility status of membership). In 2007 we will be offering discounts by a number of local retailers for local AMA members only – watch for upcoming details. The ACT AMA VALUES your membership!

I have also heard various colleagues say that they belong to this GP organisation or that VMO association, and that belonging to AMA is unnecessary. I beg to differ, and would emphasise that the AMA is a membership organisation and is only able to lobby local and federal politicians because of our members. The AMA is a huge family with considerable resources and political clout and remains the only independent representative organisation for the profession. So, don't sit on the sidelines – get involved and make a difference!

I would therefore encourage ALL readers to join the AMA in 2007, by completing the enclosed membership form or going online.

More 2007

The ACT AMA Council has been a hive of activity and is keenly plotting strategies for 2007 which include: an early annual AMA dinner, intern orientation week, welcoming reception for our new cohort of medical students, Family Doctor week, and lobbying the ACT Government to participate in the long term care scheme. This is not an exclusive list – just a sampler!

The Doctor in Training forum will have its first meeting in November and we are in the process of establishing our IMG/OTD forum. I shouldn't need to explain the necessity of these two important fora. If you fill the criteria for membership of either of these two for a please let Christine Brill know if you want to be involved.

Philanthrophic Challenge

For those who read the Kenya article in the last Canberra Doctor you would be aware that former local Canberra GP Dr Joe Radkovic is requesting an ultrasound machine to assist in his difficult and under-resourced work. To that end I am pleased to convey that National Capital Diagnostic Imaging and Canberra SIVF have already made significant contributions to the fund. I challenge other colleagues to contribute by sending a cheque to 'OR34 Korogocho Slum Maternity Clinic – Dr Joe Radkovic' c/o ACT AMA. I would be very happy to mention other significant contributions in the near future.

Federal Issues

The Federal AMA met in Canberra from 3-4 November. Electronic health is lagging behind in Australia, and major areas of concern include electronic communication between hospitals and GPs, and GPs and specialists.

An important resolution was passed supporting long term care for children under age 18 who have permanent disabilities requiring more than 2 hours of personal care/day and for adults who are permanently injured as a result of serious and rare medical complications or accidents. I am a strong believer in the social justice of this initiative, especially for those children with cerebral palsy. The next step will be to get political support. Certainly ACT AMA intends to lobby our local government to support this initiative.

I would like to wish all readers a meaningful Christmas, and look forward to meeting you at an AMA function in 2007.

Medical Benevolent Association to receive $4000 from

Dr Ian Pryor and Mr Nevin Agnew (Minter Ellison) at the cocktail party.

A small group of Canberra doctors recently attended a fundraising cocktail party, organised by the ACT AMA and hosted by President, Dr Andrew Foote and Mrs Foote, to benefit the Medical Benevolent Association. The Association provides a counselling service and financial assistance and is available to every registered practitioner in NSW and the ACT. The evening raised $4000 for this worthwhile aid organisation which supports doctors and their families during times of need.

Dr Liz Rushbrook, an MBA Board member and Canberra-based medical officer with the Navy spoke of the work of the MBA and told the attendees that, "MBA currently assists just under 300 persons in NSW and ACT. About 25% of these are doctors, the remainder are doctors' partners, children or other family. This translates to assisting about 5 doctors (directly or indirectly) in 1000. In recent years support to the total value of $450 000 per annum has been provided. Assistance is provided in the form of direct financial assistance (65%), social worker assessment and support (20%) and essential administration costs (15%)

The beneficiaries of MBA include those that are:

- Mentally and physically ill;
- The bereaved;
- The separated/divorced; and
- Those that have temporarily or permanently lost their right of practice

MBA council does not allow the cause of an individual's needy state to influence the decision of whether or not to help".

Dr Rushbrook pointed out that MBA NSW is overseen by a body of 20 councillors (all registered Medical Practitioners) who give their services on a voluntary basis. A full time social worker is employed to accept calls, provide assessments and practical care and advice (initial and ongoing as required). Since 2005, a part time administrative assistant has ensured timely processing of necessary administrative documents and services. Professional services are outsourced as required.

Dr Rushbrook said that, "the MBA aims to help doctors and their families exist and emerge from times of trouble to self-sufficient status. MBA provides:

- Confidential counselling and support
- Funds for basic life necessities including accommodation, food, clothing, schooling/university basics (texts etc). MBA often pays for mortgages (for limited time) because we have found that if beneficiaries lose their houses, rent will cost even more. We do not restore high-flying lifestyle. We are not too shy to insist that expensive cars be exchanged for more economical models before we accept someone as being truly in need;
- Provision of advice about availability of other assistance programs such as Doctors Health Advisory Service, Commonwealth Social Security and Disability schemes,
- Social Worker: Mrs M Doughty AM.

"MBA derives income from donations from the medical profession – generally through annual and Christmas appeals (direct mails outs to registered doctors). Donations come from doctors via the NSW branch of

Eight months left to take advantage of the tax free regime

In previous articles we looked at 3 opportunities, between now and 1 July 2007 (this is the date most of the federal budget super reforms come into effect) so as to maximise your long term wealth through superannuation.

The 3 opportunities we previously mentioned are:

1. Using the one off opportunity to contribute up to $1 million post tax contributions before 1/7/07 (before a $150,000 cap of these contributions are introduced)
2. Last chance to use super contributions to offset large capital gains on the sale of other assets
3. Final opportunity to maximise the tax efficiency of your super

We have found that many people still understate or don't comprehend the value of these opportunities, particularly number 1 and to a lesser extent number 2. From now until 1/7/07, the word should be spread, particularly to those nearing retirement, to review your overall financial strategy or risk missing out.

The government knows how attractive super will be post 1/7/07 from a tax point of view. Generally, they will receive no tax revenue from either the member, or from the super fund, whilst the fund is paying a pension. A completely tax free entity! Compare this to a 30% tax take through companies and trusts, or as high as 46.5% for assets held in your own name.

Hand in hand with the tax free entity proposal is the contribution limits though. The government must limit how much a taxpayer can contribute to this tax regime after 1 July 2007, otherwise it would be too attractive. The post tax contributions limit of $150,000 per annum was originally announced as effective immediately from Budget night.

During the submission period there was a protest vote however, as some "pre-retirees" had planned to sell large assets and place the proceeds into super just prior to retirement. At the same time, most were also planning to offset any capital gains tax using a deductible super contribution (number 2). The new contribution limits suddenly prohibited this activity. As a result of the backlash, the government conceded and has allowed a $1 million dollar contribution window until July. Beyond July, the $150,000 per annum limit will apply.

The proposed limits from 1/7/07 will also have significant consequences for some medical practitioners. A very popular strategy in the past has been for the self managed super fund to acquire a business premises (usually the building where the practice is run), by way of an in-specie contribution. The fund then leases the building back to the practice. Under the new contribution limits, very few funds will be able to acquire the business premises in this way, unless of course they act before 1/7/07.

The key message is that whether retired or preparing to retire, the decisions you make next eight months are likely be critical to the wealth you will enjoy in your retirement years. Now is the time to review your prospective retirement.

Our advice…get advice.

Canberra doctors

AMA which kindly includes an appeal for donations with its annual membership renewal notice, as does the ACT AMA with additional donations from Local Medical Associations, Divisions of General Practice, Medical Staff Councils, Annual Reunions and other medical bodies.

"Over the past 5 years, individual donors have exceeded 1200, with the average donation being approximately $100-150. A large proportion of current income comes from the MBA investment portfolio. This is where donations and bequests in "excess" of need over past years have been invested for use in the future. Over recent years, it has been this income that has "kept us afloat" in terms of meeting the needs of beneficiaries. (One bequest for $300,000 in 1993 has made an enormous difference).

"MBA exists to help those of our profession who require it. In order to protect yourself and your family, MBA recommends the following:

- Life insurance
- Income protection insurance
- Review your lines of credit – availability, care in over-extending credit limits/exposure
- Social life – Take time for family, spouse, leisure
- Substance abuse. Awareness, limiting risk, accessing assistance
- AVOID Self treatment – GET A GP
- Keep documents "up to date" – wills, financial documents, legal documents (see www.mba.nsw.org.au for "Take Care" advice)
- Referrals – self, colleague, AMA, NSW Medical Board, DHAS, Family members, other social workers; and
- Initial point of contact is our social worker Ms Mary Doughty 02 94197062.

MBA thanks you for your support, now and in the future".

Background to the MBA

The Medical Benevolent Association (MBA) was founded in 1896. Initially it was a group of doctors who themselves assessed and advised needy doctors and their dependants. As the demands upon the service grew more complex, the group appointed an almoner (1941) to provide assessments and dispassionate counseling. Increasing numbers and complexity of cases led to the engagement of a part time social worker (1947). Over time, increasing workload has made this an essentially full time role.

Today, MBA's charter is to assist medical practitioners of NSW and the ACT and their families during times of need. The interpretation of "their families" includes partners, children and other moderately removed degrees of relationship. In fact, the MBA constitution allows help to any person determined by the Council as being "necessitous". This broad definition of whom we can help allows MBA to obtain/retain tax deductible status for donations to us.

In 1859, the original AMA set up a benevolent fund. That AMA became defunct in 1869.

MBA NSW began its life in 1896 as the Medical Benevolent Fund of NSW, made up of a group of thoughtful doctors who wished to provide "money help" for members of the profession and their families as the need arose. It was set up as an independent body which became the Medical Benevolent Association NSW in 1926 and a registered company in 1936. It became a registered charity in 1957. In 1977, it gained tax deductible status for donations made to the Association.

Thank you to all who so willingly gave to support the work of the Medical Benevolent Association. If you were unable to attend and wish to send a donation, please make your cheque payable to the MBA and you can send it to the ACT AMA at PO Box 560 Curtin ACT 2605. Donations are tax deductible.

The event was generously supported by Minter Ellison, Lawyers, Medfin, King Financial and American Express as well as Dawn Drifters, De costi seafoods, Bungendore Wood Works and International Sports Photography.

457 visa requirements must be strengthened for OTDs

AMA President, Dr Mukesh Haikerwal, said today that the requirements of the 457 visa for overseas trained doctors (OTDs) must be strengthened.

The AMA call comes on the back of recent announcements that the health sector is now the biggest user of temporary skilled migrants with 457 visas.

Dr Haikerwal said if the States and Territories can't get their act together and adopt consistent OTD assessment and support standards, then the Commonwealth should strengthen the 457 visa requirements for OTDs to ensure that the Australian health system gains maximum benefit from the contribution being made by OTDs.

The AMA believes that stronger 457 visas would assist moves, led by the AMA, to adopt consistent national standards and processes for assessing OTDs – a development that would ultimately result in OTDs staying and working for the long term.

"It's a two-way street," Dr Haikerwal said.

"We have to ensure that OTDs working in Australia have the necessary qualifications, skills and experience to work in our health system and to maintain patient confidence.

"But we also have to ensure that these doctors are properly educated and mentored in the medical practice, language, and social and cultural facets of being a doctor in Australia.

"Unless we urgently implement consistent national standards, the Federal Government's efforts to implement standardised assessment, training, supervision and support processes for OTDs will fail.

"The States and Territories would continue to do their own thing based on short term political expediency rather than long term benefits for patients and the health system.

"The Federal Government, though, can send a strong message to the States by strengthening the 457 visa requirements for doctors," Dr Haikerwal said.

The AMA is calling on the Government to implement the following new requirements for a 457 visa for OTDs:

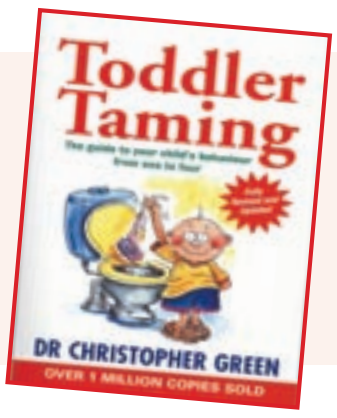
- OTDs' skills and qualifications must be assessed by the relevant Medical College
- employers sponsoring OTDs must provide the OTD with access to a formal orientation program about the Australian health system
- the employer must ensure that the OTD is provided with any supervision and training as determined by the College assessment
- the employer must provide the OTD with a mentor who holds qualifications recognised in Australia and who is established in Australian medical practice

Currently, Temporary Business (Long Stay) visa (subclass 457) are available under arrangement for:

- sponsorship by Australian or overseas businesses: Businesses unable to meet their skills needs from within the Australian labour force can sponsor personnel from overseas on a temporary basis, to work in Australia for up to 4 years.
- Labour agreements: This is a formal agreement negotiated between the Australian Government and employers, including industry or employer associations.
- Invest Australian Supported Skills agreements: For overseas companies that plan to establish their headquarters for the Asia-Pacific region in Australia; and
- Service Sellers. For representatives of overseas suppliers of services negotiating, or entering into, agreements to supply their services in Australia.

Book for review:

A reviewer is wanted for the new revised and updated edition of Dr Christopher Green's *"Toddler Taming – The guide to your child's behaviour from one to four"*. If you are interested in reviewing this for "Canberra Doctor" readers, please contact Linda McHugh in the ACT AMA Secretariat on 6270 5410.



VMO contracts to go to arbitration

The protected "bargaining period" for VMOs terminated on 1 November 2006, following a lengthy process that has engaged both VMOs and their bargaining agents.

Core contract conditions (other than the percentage CMBS increase), are acceptable in the view of the ACT AMA. Modest changes have been applied to the new contracts which have been agreed by all parties to the negotiations. There is no reason, in the view of the ACT AMA, why VMOs should not extend their contracts pending resolution of the remaining matter at arbitration.

ACT Health has guaranteed that any arbitrated increase will be "back paid" to 29 November, 2006 and any contractors who renew or extend will not jeopardise their guaranteed workload, transitional allowance or continuity bonus. At the conclusion of the arbitration, individual VMOs will be able to make the decision to take up a contract or to decline. VMOs will make this decision in the light of the result of the arbitration and their own practice and personal pressures.

The ACT AMA has kept VMOs informed of progress on the negotiations and sought feedback from its members during the process and so VMOs know that it was apparent early in the negotiating process, that ACT Health could not agree to an increase equal to 120 percent of the 2005 CMBS for fee for service contract holders and offered early arbitration of this matter. In any event, any unresolved matter required under the law applying to VMO contracts is subject to arbitration. For further information visit the ACT AMA website www.ama-act.com.au and look for the VMO "Hot Spot".

At a meeting almost literally at the 11th hour, the ACT AMA successfully negotiated for an increase in the floor price to 105 percent of the 2005 CMBS and ACT Health agreed to an equivalent increase of 1.1 percent for sessional contract holders in return for "goodwill". (Fee for service contracts were formerly at 103.9 percent of the 2005 CMBS). Both contracts will attract a 4 percent indexation in July each year. ACT Health has provided guarantees that these will be preserved in the negotiation process and that any rate arbitrated must be either equal to or more than these rates.

The ACT AMA is preparing its case for arbitration and will argue for an increase to 120 percent of the CMBS. VMOs are invited to submit their arguments for this increase to Christine Brill, executive officer, at ACT AMA by email: execofficer@ama-act.com.au or by fax to 6273 0455. The ACT AMA has engaged VMOs throughout the process and intends to remain inclusive.

CORRECTIONS: The 'Canberra Doctor' Specialist Directory

PLEASE CUT OUT & PASTE INTO YOUR DIRECTORY

GENERAL SURGERY

CHONG, Guan	Head and Neck, Endocrine surgeries	6262 1200	Suite 18, John James Medical Centre, 175 Strickland Crescent, DEAKIN ACT 2600

OBSTETRICS AND GYNAECOLOGY

GALLAGHER, Elizabeth	Private obstetrics, private and public general gynaecology. Special interest in pelvic floor prolapse, colposcopy and outpatient LLETZ	6282 2033	Suites 3-5, John James Medical Centre, 175 Strickland Crescent, DEAKIN ACT 2600
HEATON, Roger		6285 1873	Suite 9, John James Medical Centre, 175 Strickland Crescent, DEAKIN ACT 2600

PLEASE REMOVE FROM YOUR DIRECTORY

NEPHROLOGY

FALK, Michael

New palliative care and grieving resources

ACT Minister for Health, Ms. Katy Gallagher MLA and Ms. Julie Tongs, Chief Executive of Winnunga Nimmityjah Aboriginal Medical Service, have recently jointly launched a new range of resources for palliative care and dealing with grief and loss for Aboriginal and Torres Strait Islander peoples.

The new resources included a brochure, poster and workbook developed by ACT Health and aimed at raising awareness of palliative care options, and a series of brochures developed by Winnunga and the community on 'Grieving our Way'.

"While the ACT Health palliative care resources aim to increase awareness in the Aboriginal and Torres Strait Islander communities of the palliative care services available in the ACT, they also aim to increase the cultural appropriateness of palliative care services for Aboriginal people," Ms Gallagher said.

"The resources will provide guidance to mainstream palliative care workers on cultural beliefs and needs when they deliver care to Aboriginal and Torres Strait Islander clients."

"National figures from palliative care services and research within Aboriginal and Torres Strait islander communities indicate that very few people from these communities access palliative care support."

"Hopefully, these resources can open up the valuable and wide-ranging palliative care services we have to Aboriginal and Torres Strait Islanders from the ACT and around the district," Ms Gallagher said.

Funding for the project was made available by the Australian Government Department of Health and Ageing as part of a project to raise awareness of palliative care practice principles in Aboriginal and Torres Strait Islander communities.

Ms Gallagher said the resources had been developed through wide community and government consultation and included Ngunnawal Aboriginal Corporation, Winnunga Nimmityjah Aboriginal Health Service and areas of ACT Health.

The launch was part of a two-day workshop dealing death, dying and grieving in our community – a palliative approach for Aboriginal and Torres Strait Islander peoples.

Bioethics from the Journals

with Dr Thomas Faunce

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Prevocational medical education

The 11th National Forum on Prevocational Medical Education was held in Adelaide at the beginning of November.

One common theme was how to cope with the "tsunami" of medical graduates from Australian medical schools likely over the next few years. Issues of concern include telling full fee paying students that they may not be guaranteed postgraduate training places and whether private hospitals should be able to contract to teach postgraduates and subject to what types of quality assurance programs.

Emergency medicine facilities in Iraq

An article in the BMJ (2006; 333; 847) has highlighted the lack of adequate emergency medicine facilities in Iraq where it is estimated that

terrorist violence has killed 14,338 civilians between January and June 2006.

Federal court injunction

Merck Sharp and Dohme has won a Federal Court injunction delaying market entry of generic forms of its high sales volume osteoporosis drug Fosamax.

It is hoped that proposed amendments to patent laws in Australia (facilitating 'springboarding' or pre-marketing use of brand-name data by generic companies) may limit such 'evergreening' actions (Pharma in Focus 6-12 Nov 2006)

Exclusivity of new pharmaceutical products

In a recent edition of the New England Medical Journal Alastair Wood defends his suggestion that data exclusivity of new pharmaceutical products, now offered for about five years post marketing approval for all allegedly 'innovative' drugs regardless of their community value, be only offered to those that can prove they are more effective than current therapies. He writes "It is eye-opening to review the list of the 10 top-selling drugs and recognize how few of them show any evidence of superiority over generic drugs, even though billions of dollars are spent on them. This is truly an indictment of our prescribing practices." (NEJM 2006; 355 (19) 2046)

US supreme court declines to overturn federal court judgement

Another article in the NEJM discusses the recent LabCorp Case where the US Supreme Court declined to overturn a Federal Court judgement which upheld a patent over a method of diagnosing a vitamin deficiency on the basis of homocysteine levels in blood. The American Medical Association and the American Heart Association had opposed the decision because physicians who are uncertain whether a new treatment has patent protection may not feel free to adopt it, so inhibiting the distribution of medical knowledge.

THE 'USUAL GP" – An AMA WIN

The AMA fought long and hard to remove a significant level of the red tape and complexities related to the old EPC items to deliver the new chronic disease management items. While they are not utopia they do represent a real improvement evidenced by the very significant uptake of the items by general practitioners.

The Government listened to the AMA on this issue and also listened when it raised issues around access to a variety of health checks.

The intent of the health assessment and care planning items is to enable GPs to provide comprehensive and continuing care to patients who have, or are at risk of, chronic illness. To this end the AMA ensured the inclusion in the MBS of a requirement that these services be provided by the patient's "usual GP" or practice.

Anecdotal evidence suggests, however, that the definition around the patient's "usual GP" or practice may be misunderstood or being interpreted loosely by some practices. In the past 12 months, the AMA has received increasing complaints from doctors who are finding that their ability to provide vital care to their patients is being restricted. These GPs are discovering that they are unable to give their regular patients a health assessment or develop a care plan because these services have already been delivered through another practice. Member GPs have questioned the motives behind the enthusiasm with which some GPs, who do not have regular contact with a patient, utilise these items.

There is little doubt that the Government is also questioning some practices in this area as well. While the Government and AMA share a strong view that measures may be needed to tidy up practices which devalue the intent of the items such measures should not compromise access for the genuine "usual GP" or practice to treat their patients and provide access to high quality ongoing care through use of these items.

The AMA urges doctors providing these services to be aware of the requirement that the items be delivered by the patient's "usual GP" or practice and consider whether they will be caring for the patient over the next 12 months before using these items. The first question that should be asked is whether providing this service is "good" for the patient.

The AMA intends to work with the Government in pursuing compliance with the requirement for this service to be delivered by the patient's usual GP in order to ensure this care remains readily available to patients. Contact and consultation with AMA members suggests that appropriate measures aimed at curbing practises that do not comply with the spirit and intent of the items and the "usual GP" requirement in the MBS will be supported and welcomed.

We have been advised that Medicare Australia is planning to conduct an audit of the chronic disease management items next year and this may help highlight the true extent of this problem. Where the service and billing are provided in good faith by the usual GP, in the interests of good patient care, GPs have nothing to fear from this audit.

By Julia Nesbitt, Director of General Practice & e-Health, Federal AMA

AMA SAFE HOURS AUDIT 2006

Hospital Doctors still working long and stressful hours

AMA President, Dr Mukesh Haikerwal, called on State and Territory Governments and public hospital administrators to urgently review rostering and work practices for hospital doctors after an AMA survey revealed that almost two-thirds of public hospital doctors are working unsafe hours.

The AMA Safe Hours Audit 2006 has found that 62 per cent of Australian hospital doctors are working unsafe hours – classified as high risk or significant risk – with one doctor reporting a continuous unbroken shift of 39 hours.

The survey is the first since the groundbreaking AMA Safe Hours Audit of 2001.

Dr Haikerwal said the 2006 survey exposes work practices that contribute to doctor fatigue and stress levels that ultimately impact on the quality of care and patient safety in the public hospital system.

"All Australian governments must take a close look at the results of this survey and urgently put in place measures to dramatically improve the work conditions and work practices for doctors," Dr Haikerwal said.

"Fatigue and stress are taking their toll – we have to stop overworking our medical workforce, which is already becoming a scarce resource.

"Our junior doctors all come up through the hospital system and we cannot risk turning them off medicine or forcing them out of the full-time workforce.

"Things have improved marginally since the last survey, but reform of hospital work practices is too slow and inconsistent across the country.

"The public hospital system is a major and vital pillar of Australian health care, and is the first port of call for many Australians seeking medical care and treatment.

"We must not let our public hospitals and the doctors who work in them fall into neglect.

"Safe hours for doctors equals safe hours for patients," Dr Haikerwal said.

Conducted in May 2006, the audit tabulated responses from more than 550 public hospital doctors of all ages from all States and Territories.

The on-line survey collected data on the hours of work, on-call hours, non-work hours, and sleep time experienced by doctors working in the public hospital system over a full working week.

The most stressed discipline is surgery, where 85 per cent of doctors fall into the significant risk and higher risk categories.

There are minor improvements over the AMA's 2001 survey results, where 78 per cent of respondents fell into the significant risk and higher risk categories.

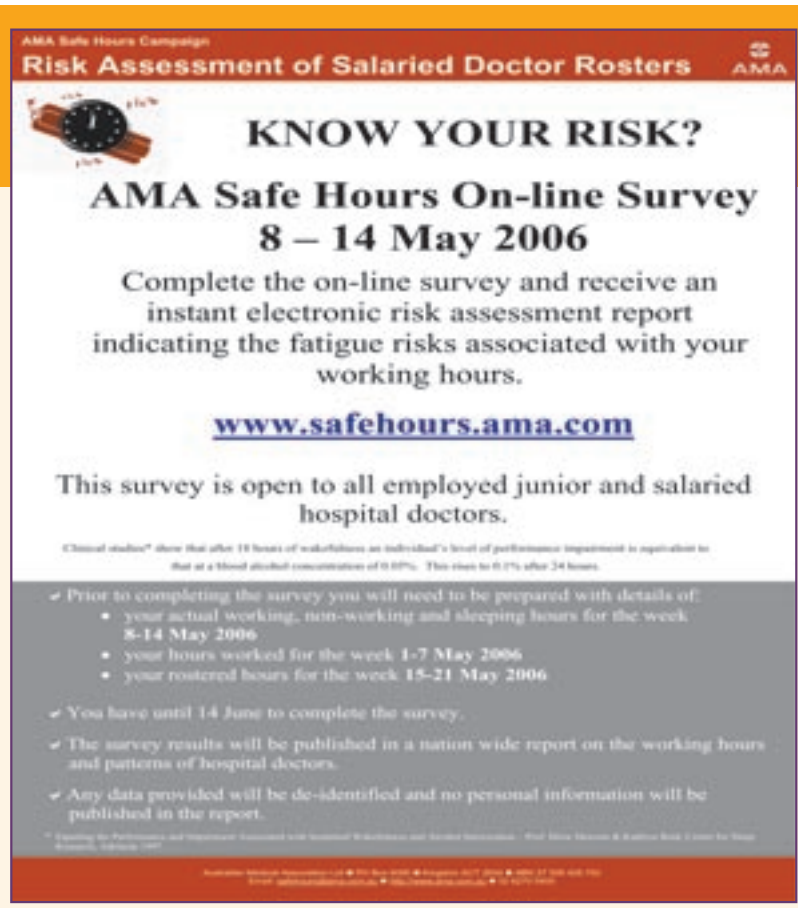
Some other indicators show signs of improvement. For example, for doctors in the higher risk category the longest continuous period of work fell from 63 hours to 39 hours.

Doctors had more full days off work during the audit week and more opportunities for meal breaks when working.

But in the AMA's view, shifts of 39 hours are no more acceptable than 63-hour shifts.

Even doctors in the lower risk category are working shifts of up to 18 hours.

The average of total hours worked in the 2006 audit week was the same as in 2001. However, the longest hours worked by individuals during the audit week actually went up – to 91 (from 86) and 113 (from 106) for the significant risk and higher risk categories respectively. This indicates that the riskiest work patterns are still commonplace.



Dr Haikerwal said that in any other industry or profession, these 'improved' figures would be cause for deep concern and immediate remedial action.

"We now have awareness and recognition that the old culture of onerous hours has to change for the good of doctors and their patients.

"Translating this into practice remains a challenge.

"The AMA's *National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors* should be adopted by all States and Territories as an absolute minimum."

Sensible hours and safe students save lives: Unregulated training hours for medical students

This coming year will see ACT Health welcoming third and fourth year medical students into full time clinical placements. The program involves learning at the patients' side in the context of four rotations, including general practice, surgery, medicine and paediatrics. Compulsory contact hours stand at approximately 20 hours per week with a suggested further 20 hours of self directed learning. However, there are currently no clear and enforceable limits to ensure that students will not work in excess of the hours required, thereby rendering them and their patients susceptible to the consequences of fatigue and burnout.

In Australia, working hours for doctors are largely unregulated. In comparison, mandatory work hour limits were set in the USA by the Accreditation Council for Graduate Medical Education in 2003. This policy states that a trainee should not work in excess of 30 consecutive hours and no more than an 80 hour week, and one day out of seven the trainee should be free of all work duties. In the UK, work days have been limited to 13 hours and a 58 hour working week.

The Australian Medical Association is currently reviewing its policy on the hours young doctors work through the nation wide safe hours survey. The current policy states that working in excess of 14 consecutive hours places doctors at increased risk of fatigue; however the policy does not formally restrict these hours. Unlike the strategies soon to be in place in Australia for practising doctors, universities are yet to consider regulating medical student training hours.

Research has shown that fatigue caused by long working hours can impair the judgement and competence of medical personnel, resulting in negative consequences to both patients and doctors. A study by Arnedt, 2005 looked at the neurobehavioural performance of residents after heavy night call vs after alcohol ingestion. Heavy night call was defined as a month of 90 hour weeks with overnight shifts every 4th or 5th night vs blood alcohol levels of 0.04 percent after one month of 44 hour weeks of daytime shifts. Arnedt and colleagues reported that both sleep deprivation and alcohol consumption impair a person's reaction time, attention, judgement, control and driving ability. Fatigue has been reported to contribute to work place errors, lack of time spent with patients, impaired communication and failure to complete case notes appropriately.

Extended work hours also increase the likelihood of percutaneous injury to physicians by 61 percent compared with non-extended work hours as reported by Czeisler et al 2006. The study also reported that 64 percent percutaneous injuries were due to lapses of concentration and 31 percent were due to fatigue. Although medical students should be considered ancillary staff, they do share responsibilities in patient care. Being plagued by fatigue and sleep deprivation can lead to adverse effects on patient care and student learning and safety.

Both physical and emotional exhaustion lead not only to medical mishaps but also to psychiatric morbidity and the common work place issue of burnout. Historically the intern year has been associated with high levels of depression, anxiety and burnout. Willcock et al. 2004, stated that 26 percent of final year medical students from the University of Sydney suffered from somatic symptoms, anxiety, insomnia, social dysfunction and depression, collectively referred to as psychiatric morbidity. The prevalence increased significantly during internship to 70 percent. Considerable increases in emotional exhaustion and depersonalisation were also reported.

Psychological distress can also result from an inability to achieve often unrealistic ideals by exhausting one's physical, and mental resources. Many medical students enter their degree with altruistic ambitions and heroic fantasies of healing the sick. In order to achieve these ideals, many students develop compulsive type A personalities which further contribute to their propensity to over-extend themselves. In addition to the personal characteristics discussed above, junior doctors face the historically perceived rights of passage dictating arduous duty schedules. Unfortunately this old school of thought is still harboured by some senior medical physicians placing further pressures on students to be available around the clock and emulate their supervisors' work ethic. In light of the literature discussed it is clear that the current culture of the profession leads to dangerous outcomes for both patients and young doctors.

Medical student work hour reforms must be addressed by medical schools, and policies put in place to limit hours spent in the hospital. Strategies that may be developed include: setting time limits for hours on duty, compulsory rest periods, more structured timetabling, and educating students on the importance of self-regulation regarding safe work hours and mental well-being. Student duty hours should be regulated and monitored taking into account the effects of fatigue and sleep deprivation on learning and patient care. In general, medical students should not be required to work longer hours than interns and residents. Although it is ultimately the responsibility of the individual, universities should enforce mandatory regulations to stop those students who can't stop themselves.

- This has been written by 2nd year ANU medical students, Elizabeth Coyle and Giovanna Zuccala. References can be obtained from the authors.

Continued on page 7

Sensible hours …continued

AMA Position Statement Employment of Medical Students in Hospitals (2006)

The AMA understands that in some states, during their undergraduate university course, some final year medical students have been employed inappropriately to fill medical workforce shortages.

The AMA believes that medical students are not substitutes for any type of Medical Officer and they should not be utilised to fill gaps in the medical workforce.

In particular, the AMA is concerned about reports that students employed in hospitals have been left without supervision and are undertaking tasks that require medical practitioner registration.

The AMA believes that the role of medical students in hospitals and other clinical settings should be focussed on learning rather than fulfilment of employment obligations and tasks.

It is inappropriate for medical students, by default or otherwise, to be performing the role of Medical Officer or undertaking tasks which require a registered medical practitioner. Allowing such a situation to arise places students – and potentially patients – at risk and raises medical indemnity and legal issues for the students, their supervisors, the hospital and the university. It may also place at risk the future medical registration of the student. It imposes an unfair and inappropriate burden of responsibility on students, their medical supervisors and other hospital staff.

The AMA does not oppose the employment of medical students by hospitals, as there are circumstances where medical students are employed successfully by hospital departments in appropriate roles (eg pathology assistant or orderly).

The AMA believes that the employment of medical students by hospitals in any capacity should only occur when students:

- are employed in appropriate job classifications (not Medical Officer) and are not undertaking work that would otherwise be part of their clinical training;
- are performing duties commensurate with their level of skill, knowledge and qualifications;
- do not undertake tasks that require medical practitioner registration;
- have clear job descriptions detailing what is expected of them in the workplace and that these are strictly adhered to;
- are appropriately supervised and trained for the work they do;
- are paid appropriately for work performed; and,
- have adequate indemnity insurance with the employer taking full medico-legal responsibility for all their activities.

It should also be ensured that the:

- employment arrangements do not impact on the ability of the student to meet the learning objectives of their medical degree; and
- hours of employment do not encroach on time needed for learning activities.

Proposals for employment of medical students, and any existing employment situations, should be assessed against these criteria.

ACT Health to implement e-rostering using AMA safe hours national code of practice as guide

The AMA and the ACT AMA have written to Health Minister, Katy Gallagher, urging her to act on the findings of the AMA Safe Hours Audit 2006, which is available in full on the AMA website at www.ama. com.au

ACT Health have engaged with the ACT AMA as it progresses its implementation of an electronic rostering system. The first phase of the design of this system is underway with the engagement of CSIRO to conduct research and draft mathematical algorithms that will inform the development of the e-Rostering system. A catalyst for this new initiative is the recognition that rostering is largely fragmented and therefore substantial inefficiencies and irregularities do occur. Examples of these for doctors include excessive overtime, and difficulty in achieving leave alignments with submitted time sheets and approved leave applications.

The AMA's National Code of practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors will help inform the same and responsible shift practice the e-rostering system will establish.

The AMA has available for members copies of the AMAs National Code of Practice, Doctor's Guidelines for Implementing Flexibility and Management Guidelines for Implementing Flexibility and these can be obtained by phoning the Secretariat on 6270 5410.

The report on the recent audit is also available on request or from www.ama.com.au

AMA Position Statement on General Practice and Public Hospital Integration

The AMA is calling on State and Territory Governments and public hospital administrators to urgently introduce processes to better monitor and coordinate patient care as the patient moves from the care of their GP in the community to hospital care and back to their GP's care, ensuring there is continuity of involvement from the GP.

AMA President, Dr Mukesh Haikerwal, said recently that for most Australians their GP is the primary health care provider.

"To ensure the best possible health care for patients through periods of illness or treatment, we must ensure continuity of care from the GP and the spectrum of other health care service providers involved, and eliminate any disruptions.

"One of the most common examples of loss of continuity is when patients are admitted to public hospitals.

"To assist public hospital administrators provide continuity of care, the AMA has adopted a Position Statement on GP-Public Hospital Integration that sets out simple steps to keep a patient's GP involved in the health care process and use their knowledge to help care better for patients, minimising the risk of disruption.

"Efficient integration of general practice and public hospital care can lead to improved patient health outcomes through better clinical management, improved continuity of care, and fewer re-admissions.

"Clear and timely communication is the key.

"GPs and hospitals can both learn to better communicate with one another for the benefit of their patients.

"It is up to the State and Territory Governments and their hospital administrators to develop and implement practical systems that allow hospital doctors, nurses and other carers to keep the patient's GP in the loop.

"This is not a big ask of the hospitals.

"Hospital doctors and GPs are very busy and the system currently works against them communicating with each other as often and for as long as they would wish.

"There must be streamlining of processes and systems to support good communication.

"With a growing trend towards earlier hospital discharge and for more care to be provided in the community, it is vital that a patient's transition through the health system is monitored by their GP.

"Most long-term management of chronic and complex illness is now provided through the primary health care system led by GPs.

"The AMA believes it is vital that hospitals and GPs discuss a patient's pre-admission state and together plan for their discharge at an early stage.

"This can help prevent problems such as doubling up on tests, adverse drug reactions and interactions, or medication errors.

"Proper integration between GPs and public hospitals is an important quality and safety issue," Dr Haikerwal said.

Some of the initiatives set out in the AMA Position Statement on General Practice and Public Hospital Integration include:

- Public hospitals to be compelled to provide discharge summaries to each patient's GP as a condition of that patient's discharge
- Public hospital accreditation to require the provision of timely, detailed and legible discharge summaries to GPs for every patient; and
- GPs to provide comprehensive referral letters to hospitals

Refer to www.ama.com.au for further information.

JBs Horse tales

Thanks to John Donovan's "Canberra Doctor" article printed in the July 2006 edition, and a faint memory of a particular soap advertisement from TV days gone by, the words 'Tahiti sounds nice' sent me recently in the direction of French Polynesia.

Like John and Captain Cook, I also headed for Moorea. Though the thought of bumping into Keith Urban or some other Ozzie notable on Bora Bora was enticing, I did my pre-travel research of travel brochures, Lonely Planet and blog sites and decided that Moorea had the best combination of relaxation and adventure.

And what a good choice it was! Due to heavy bookings I ended up with my third accommodation choice, but that turned out to be a bonus. My over-water bungalow at the Moorea Pearl Resort was spacious, private and had unrestricted views and access to the lagoon. It came complete with Tahitian TV, otherwise known as a glass bottomed floor, through which you could watch the tropical fish (and stray skin diver). It was even more satisfying to watch the storms each evening pass by our perfect weather lagoon on their way to Bora Bora.

The island only had its one road sealed eight years ago, so yes it operates on island time, but when the hardest decision of the day is whether to get in the water or to eat, who needs a watch? One meal at the resort thankfully was enough incentive for me to dust off that high school French and use the local phone book. There are numerous quaint little fine French cuisine restaurants on the island that provide minibus transport door-to-door at no charge.

But what about the horse riding? Yes, this was one reason for picking Moorea. Half day rides set out from the centre of the island near Cook's Bay, but only if there are four or more riders. So if you intend on doing the same, book early and have enough days on your itinerary to find enough people who want to ride. I readily filled in five days swimming with and feeding stingrays, kayaking and scuba diving with big sharks (not just reef sharks; reef sharks are a bit like zebra in Africa – exciting when you see the first one, then they're so numerous it becomes 'ho hum, another one' – but you still take care!).

Well I found that August/September is a good time for

riding in Tahiti – no flies, no mozzies and least chance of rain. The horses were well groomed and responsive. As with most riding, it afforded an opportunity to access the 'back country' and vantage points unavailable to vehicles; plenty of tropical flowers, volcanic cliffs and pineapple groves. The second half of the trail ride provided an opportunity for the experienced riders to canter off and make our own way home while the owner stayed back with the less experienced riders, including the men wearing shorts (another bonus of forward planning – taking jodhpurs to a tropical zone!). No helmets were provided, and this was disconcerting for me as a city slicker who has seen one too many patients with riding injuries. The owner spoke some English, but once again I was thankful that those years reciting French verbs had not been in vain.

All in all a good trail ride and the best holiday I've had yet. You don't have to be a honeymooner to enjoy Moorea, but there really is no catering for children. The horse trail riding on Moorea is a lovely feature yet to find a popular market, and given the number of honeymooners decked out in board shorts, I think it will be a hidden secret for a long time yet.

Jo-anne Benson is Hon Secretary of the ACT AMA and a member of the "Canberra Doctor" Editorial Committee.

Canberra DOCTOR

A News Magazine for all Doctors in the Canberra Region

ISSN 13118X25

Published by the ACT Branch of the AMA Ltd
42 Macquarie St Barton
(PO Box 560, Curtin ACT 2605)

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Next edition of *Canberra Doctor* – February 2007

News from the AMAs GP and e-health department

As a service to our GPs, we will publish this summary of issues reported in the weekly GP Network News produced by the Federal AMA in each issue of Canberra Doctor. Any GP wishing to receive their own weekly copy of GP Network News, should email reception @ama-act.com.au or phone 6270 5410 and give contact details.

Mental health package undervalues the role of GPs

The Federal Government launched a new mental health package recently, which is designed to make it easier for patients to seek help through general practice and other health professionals such as psychologists and allied health workers. While the AMA welcomes the Government's financial commitment to mental health care, it is very concerned that the package undervalues the role general practitioners play in providing mental health care to Australians.

AMA President, Dr Mukesh Haikerwal said the initiative has the potential to improve patient access to psychiatrists and psychologists in team-based care, but the Government has failed to understand that GPs are the main source of expert care for patients with mental illness and that they are the first place turned to for immediate, urgent care, as well as long-term management.

Instead of supporting GPs in this role the package is putting hurdles between patients and the GP care they need, risking its viability. "We have warned that a package that offers so much will be less effective without proper support for the role of GPs, Dr Haikerwal said.

"The Government is undervaluing the role of GPs in mental health, and has failed to recognise the unique skills and experience that GPs have in this area," Dr Haikerwal said. "The Government wants to impose complex requirements on GPs, including compulsory extra training."

"They are also seeking to introduce Medicare rebates for patients who see GPs for mental health care, that are lower than those applicable to services from other health practitioners. Higher Medicare patient rebates would be available for patients who saw a psychologist with no medical training and limited experience, for instance, which highlights the inequity of the package. This demeans highly trained, qualified and experienced GPs. GPs provide ongoing holistic care for patients with a mental illness and this care should be valued accordingly," Dr Haikerwal said.

The AMA will continue to lobby the Government for changes to the package. Importantly the package represents yet again acknowledgement by Government of the shortcomings of the current attendance item structure.

MBS Compliance – Item 10993 – Immunisation by GP Practice Nurse

Medicare Australia has advised the Department of Health and Ageing that they have identified a number of GPs who are claiming item 10993 for any injection provided by a practice nurse. The Department has asked that we draw to the attention of GPs that Medicare Australia intend to seek recoveries where MBS item 10993 is being claimed for injections that do not come within the definition of an immunisation provided in the General Medical Services Table. GPS need to be clear that it is only the administration of vaccines on the Australian Standard Vaccination Schedule and vaccines in the Australian Immunisation Handbook 8th edition 2003 that are covered by item 10993.

Latest MBS Book

On 1 November the new Medicare Benefits Schedule Book came into effect. Under this Schedule the Medicare patient rebate has increased by 2%. The AMA does not believe this is in line with increases in expenses faced by general practice, such as staff wages. The failure of the MBS to keep pace with practice costs will make it increasingly difficult for GPs to bulk bill their patients.

GPs should take time to examine the additions to the MBS Book as there are a significant number of new items contained in this edition.

General Practice Nurse items expansion

The AMA has supported the introduction of items designed to recognise the contribution nurses make to patient care in general practice. Some of the most recent additions to this suite of items were only made available to rural and remote areas of Australia. These were the general practice nurse cervical smear items. The Government was also proposing to make new items for practice nurses taking a cervical smear and preventive checks accessible only by patients in these areas.

The AMA argued that patients around Australia would benefit from the Government making every practice nurse item available to all general practices, regardless of their geographical location.

Therefore, the AMA is very pleased that the Federal Government listened to this plea and has extended these items so they can be used by general practices anywhere in Australia. General practice nurses can now provide cervical smears and preventive checks to patients and those patients will receive a rebate from Medicare no matter where they live.

Primary Health Care Position Statement

The AMA Federal Council has adopted a Position Statement on Primary Health Care, which was developed by the AMA Council of General Practice (AMA CGP) in consultation with grassroots GPs around Australia. AMA President, Dr Mukesh Haikerwal, said the Position Statement sets out practical measures to assist governments to develop sound primary care and general practice policies to ensure patients continue to have access to quality affordable health services.

Dr Haikerwal said primary health care is the foundation of any health care system, and in Australia general practitioners are integral to the successful delivery of all the elements of primary health care. "The AMA believes quality primary health care requires a team approach that allows patients to gain access to care from all the health professionals they will encounter in the health system to address their individual health concerns. But for patients to benefit from primary health care, there must be a leader and co-ordinator of the care team – and that leader has to be the GP.

"The merits of GP-led medical care are widely documented and benefit patients in all parts of Australia every day. We urge all governments to commit to the principles of quality primary health care and acknowledge the key role of GPs in providing and coordinating that care," Dr Haikerwal said.

The position statement can be viewed at www.ama.com.au

ACT Health "management plan" for pandemic influenza released for comment

ACT Minister for Health, Katy Gallagher, recently released the draft ACT Health "Management Plan" for Pandemic Influenza.

Ms Gallagher said the Plan outlined how the health sector was preparing, and drew together what the residents of the ACT may need to know about that planning effort, for a possible future outbreak of pandemic influenza.

"It also explains how people can protect themselves and others from infection, with much local information," she said.

The Plan, which is intended to complement the Australian Health Management Plan for Pandemic Influenza 2006 (AHMPPI), has been developed in consultation with the ACT health sector and the ACT Influenza Pandemic Action Committee (ACTIPAC). Established in 2004, ACTIPAC consists of ACT Health and other key government and non-government agencies, including the ACT AMA.

"ACTIPAC is central to the current agenda of planning and responding to an influenza pandemic, recognising that the consequences of such a pandemic could go beyond the spectrum of health and include social and economic issues," Ms Gallagher said.

"ACT Health is specifically seeking input from community members and groups on the usefulness, accuracy, relevance and comprehensiveness of the Plan."

"The feedback received will be used to review and improve the Plan."

Ms Gallagher urged interested groups and individuals to comment on the draft Plan, which is available on the Internet at www.dhcs.act.gov.au/engagement/ or www.health.act.gov.au/publications. Comments will be received up to 24 December 2006.

Comments can be forwarded to the ACT AMA for inclusion in its feedback or can be forwarded directly to ACT Health.

Australian hospitals must plan for pandemic

In a recent article in the *Medical Journal of Australia*, biosecurity and health specialists have warned that Australian hospitals must plan for the possibility that crucial infrastructure such as power and telephones may fail in the event of an influence pandemic.

In a special influenza pandemic supplement, Mr Ralf Itzwerth, a medical sociologist from the National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases, and Professor Raina MacIntyre, an influenza expert from the University of Sydney, said it is unclear how many hospitals have drawn up detailed and comprehensive plans for pandemic or disaster management.

Mr Itzwerth and colleagues have put together a checklist of factors that hospitals should consider in planning for an influenza pandemic.

"Pandemic planning for hospitals and the health sector needs to consider not only health-related strategies, but also the broader systems upon which hospitals depend – both inside and outside the health system," Mr Itzwerth said.

"Securing critical infrastructure is an overarching requirement for all hospitals, and requires a whole-of-government approach."

While it is obviously important to plan for back-up medical staff in the event of a pandemic, Mr Itzwerth said 'back office' operations and external services are equally critical to maintaining continuity of service.

"Essential infrastructure services outside hospitals may become unavailable or get disrupted," he said.

"These include power, telephones, mobile phones, email and paging services, water, and garbage removal.

"For a hospital, supplies of food, pharmaceutical products, medical gases and other consumables would have to be added to the 'essential' list."

Hospital staff working in pay offices, human resources, IT and building management also keep hospitals running, he said.

"It is hardly conceivable that a complex and sensitive structure like a hospital, at a time when it is overburdened with a surge of critically ill patients, could maintain any of its core functions without some or all of the infrastructure services," he said.

The article and supplement can be accessed in full at www.mja.com.au

General Practitioners vital in event of pandemic

Australia's GP workforce would have to be redistributed to cope with a major influenza pandemic, general practice experts said in the same issue of the *Medical Journal of Australia*.

As part of the special influenza pandemic supplement,

Photo reproduced with permission of Australian medicine.

Sydney GP Dr Nick Collins and colleagues outlined key strategies that GPs need to consider in planning for a pandemic.

"Some areas of Australia are well supplied with GPs, but workforce shortages are recognised in some rural and outer metropolitan regions," Dr Collins said.

"A redistribution of clinical support to bolster local numbers will be required, and is likely to be one of the contentious issues of pandemic planning."

Some of the measures Dr Collins and colleagues suggest GPs consider now include training staff, preparing to collect data to assist in future disease outbreak planning, and implementing infection control measures such as replacing waiting room magazines and toys with masks and gowns.

"Training, protection, remuneration and indemnity are important areas of concern for all groups," Dr Collins said.

"GPs are old hands at dealing with uncertainty in clinical practice. However, when this uncertainty is coupled with anxiety, lack of clear information and limited awareness about strategies to manage the range of possible scenarios, the outcome is more likely to be chaotic.

"The more certain we become of our abilities to act in a pandemic situation and the closer to agreement we are on how the best outcomes can be achieved, the more likely we are to engage in rational decision making and play a clear and key role in maintaining and protecting the health of the Australian public."

The full article, including recommendations for GPs' pandemic planning, can be accessed at www.mja.com.au

The *Medical Journal of Australia* is a publication of the Australian Medical Association.

"Back to Country" – An Inspiring Story about Indigenous Health in Kintore, Northern Territory

Woman receiving dialysis at the Kintore Dialysis Centre.

On October 9 2006, I and four other medical students from the ANU flew to Brisbane for the "Standing Strong Together for Aboriginal and Torres Strait Islander Health" conference, presented by the National Aboriginal Community Controlled Health Organisation (NACCHO), the Australian Indigenous Doctors' Association (AIDA), the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM) and General Practice Registrars Australia Ltd (GPRA).

Our travel and attendance at this conference were kindly funded by the RACGP and provided an opportunity for us to focus on a range of Indigenous health issues. These included preventative health priorities in Indigenous health, Medicare claiming in Aboriginal medical services, counselling skills, management of endemic diseases in Aboriginal communities, teaching and research in Indigenous health, and models of best practice, as well as recruitment and support of GP workforce in Indigenous health.

Throughout the day a number of presentations were made; most painting a depressing picture of the present state of Indigenous health in Australia. However, one truly inspiring story was told of the establishment of a renal dialysis centre in Kintore (also known by its traditional Aboriginal name, Walungurru). This concerned a remote Indigenous community in the Northern Territory located 500km west of Alice Springs near the Western Australia border, which allowed people dependent on dialysis to return home to country.

With the permission of Sarah Brown, Manager of the Western Desert Nganampa Walytja Palyantjaku Tjutaku (which literally translates to "Making Our Families Well"), this is the story of the Yanangu people's success in bringing renal dialysis to Kintore.

Renal disease within Indigenous communities is substantially worse than in non-Indigenous communities. This is primarily the result of type 2 Diabetes Mellitus. In Kintore the rate of end stage renal disease is thirty times the national average.

Previously all patients requiring dialysis had to travel to Alice Springs. This resulted in a large proportion of the community moving away for treatment, causing rifts in families and in the community. This had serious consequences as a number of community elders were no longer present to give guidance in daily affairs. There was a sense of loss to community and family life in Kintore as well as to those on dialysis in Alice Springs, who generally felt dislocated and lonely as a result of being separated from their family and community, and losing their connection to the land. Many viewed a move to Alice Springs as a one-way ticket, with no prospect of cure and many returning to Kintore only to die.

Zimran Tjampitjinpa was one Kintore community member who moved to Alice Springs for dialysis. It was his dream to receive treatment at home and remain there. Mr Tjampitjinpa inspired the idea of selling Aboriginal art to raise money for a dialysis unit in Kintore. As a result large collaborative works were painted by men and women from Kiwirrkurra (in Western Australia) and Kintore. Art dealers and collectors from around Australia also donated paintings. In 2000 Sothebys helped to auction the paintings at the Art Gallery of NSW. According to Tim Klingender, Director of Aboriginal Art, Sothebys Australia, "Our intention was to raise $400,000, and we raised $1.1 million". This money meant the community's goal was achievable, but they still had to decide on how best to do this.

Sadly, Zimran Tjampitjinpa died shortly after the auction and was not able to see the realisation of his dream, however, the development of the dialysis centre was carried forward by determined members of the Kintore community despite minimal support from the Australian Government. The Federal Health Minister at the time, Dr Michael Wooldridge, said kidney dialysis "is something no-one in the world has ever been able to make work in the desert. I understand that the people of Kintore want it, but there are enormous difficulties because it would be a world first if it worked" (Alice Springs News, February 2001). In the words of Sarah Brown, Dr Wooldridge's comments "were like a red rag to a bull" and strengthened the community's resolve to bring dialysis to Kintore.

Between 2000 and 2004, the community of Kintore worked extremely hard to develop a model that would suit the community. Initially they wanted to build a Remote Renal Unit, but they decided the massive expense involved would be prohibitive, a problem exacerbated by lack of resources and infrastructure available to the remote community. Ultimately, they decided that the facility should enable "Self-Care" dialysis – where patients could be trained to manage their own dialysis. A "Reverse-Respite" system was also implemented, allowing people who could not be trained for self-care dialysis to return home with assistance. The Kintore dialysis centre opened in September 2004.

The $1.1 million was used to purchase two dialysis units. One was established in the primary health clinic at Kintore and the second in Alice Springs, in a rented house. The NT government eventually committed to helping Kintore by providing funding for two full-time renal nurses. The Commonwealth government, through a shared responsibility agreement, purchased the rented house in Alice Springs to enable a permanent unit to be set up and also provided a vehicle to transport patients from Alice Springs back to their communities.

Now, community members who are in Alice Springs for dialysis are able to return home for up to three weeks, four times a year. Amy Nampitjinpa was the first Kintore Community member to return home when the dialysis centre opened in 2004. There are currently thirty patients who are able to return to Kintore and receive dialysis.

Already this initiative has proved to have significant financial as well as health, cultural and personal benefits. The Co-operative Research Centre for Aboriginal Health estimated that $113,000 per year of taxpayer money is saved due to reduced hospital care following missed dialysis and through a drop in emergency evacuations by air. Sarah Brown reported that the presence of the dialysis centre in Kintore has increased the opportunities for screening and early intervention, which will eventually decrease or delay the development of end-stage renal disease. There are obviously immeasurable benefits in the wellbeing and stability of this remote community.

This is a rare story of hope and success in Indigenous health. The key to the success in Kintore may lie in the fact that it was a community-driven initiative, developed by the community for the benefit of the community. As Sarah Brown stated in Brisbane, "It gave them the opportunity to develop their own model of care."

Sarah Brown is more than happy to be contacted for further information about the WDNWPT or their activities. They are always in need of donations and support. Ph: (08) 8953 0002, Email: wdnwpt@bigpond.net.au

By Julia Parmeter a second year medical student at the ANU Medical School

"Patients and Doctors – how to misunderstand one another"

This address was given by Emeritus Professor Miles Little, Centre for Values, Ethics & the Law in Medicine, University of Sydney, Sydney, NSW at the 2006 Pink Ribbon Day breakfast held in Canberra on 23 October 2006.

There is a rich narrative literature that has been written or spoken by women with breast cancer and by the people who care for them at home, telling of their experiences, of their encounters with doctors and other therapists. Much of what has been written is frankly critical of the attitudes and communication skills, particularly of doctors. I want to examine the nature of the complaints that people make against doctors and sometimes other members of therapeutic teams, and to plead for an interchange of understanding between consumers and providers of medical services. I propose to use as my main example the narrative of a carer, which, with particular eloquence, distinguishes the heartfelt and legitimate perceptions of those who feel dissatisfied. The case is not even one of cancer. It is one in which a tragic death takes place, but it is the experience of the relationships throughout the illness that concerned the writer. The point to me is that any serious illness – not just cancer, not just one that ends tragically – sensitizes everyone concerned to the words and attitudes of all the others involved.

In November 2005, in the Australian Internal Medicine Journal (the IMJ), Professor Paul Komesaroff of Melbourne published a paper written by the widow of a patient who died after nearly 5 months in intensive care. It was a deeply moving account of a drawn-out terminal illness and its aftermath that indicted the doctors and the hospital because during the terrible last hours of the patient's illness "not one doctor approached me." The hospital offered no formal notification of his death, "no closure of his case, no summation of his medical history." Even his private cardiologist, whom he trusted, made no contact after his death. "Why", asked the anonymous author, "is it so difficult to acknowledge the passing of a valued individual, a valued client?"

This paper was an intensely personal, articulate, engaging and compelling piece that fitted into a familiar pattern, that of a grieving carer with a terrible grievance. It had a clear rhetorical purpose. It was meant to engage us on a moral level, it was meant to make us angry, we were meant to share the frustration, disappointment and even contempt that were so clearly central to the author's experience. The structure and content of this and similar pieces tends to follow a similar pattern. Due deference is usually paid to the technical skill of the medical staff. Often, there's acknowledgement that information is passed on during the illness. The presence of doctors is acknowledged on their daily rounds and during medical crises. What is primarily criticized is the failure of doctors to acknowledge the "person within the patient". And, when it's relevant, writers also deplore the lack of "closure of the case", the failure of doctors and their hospital system to recognize "the passing of a valued individual, a valued client." I might add that patients who survive often deplore the failure of individuals to recognise the presence of a valued individual, a valued client. It doesn't take death to bring out this failing. Illness is quite enough.

This kind of narrative piece dates back a long way. Unfortunately, it seems to have little impact on the way that doctors think and practise. I can think of at least five reasons for this, and most of them make me very sad.

First is the residual paternalism that's the legacy of all the learned professions. If you read about eighteenth, nineteenth and early twentieth century doctors, you'll find that they told people what to do and expected to be obeyed. Regard for autonomy and the consumer's rights are relatively recent. Consumerism has done something to redress the imbalance between the medical profession and the people it cares for. It's expressed in the IMJ article when the author uses the word "client" to describe her late husband.

Second is the lack of any forum for the exchange of views between 'consumers' and 'providers'. The IMJ approach is characteristic of the consumer narrative tradition because it features the consumer's strongly felt argument, but offers no chance for readers to hear the narratives of the providers. Even when doctors write about their bad medical experiences, they don't seem to ask their physicians or surgeons to explain or justify their perceived shortcomings. I'll come back to this, because it's important.

Third, a narrative deals with a singular experience, personally perceived and personally interpreted. That, after all, is what narrative is. Thus, a narrative gives us insight into what this person experiences, rather than providing us with a way to understand the experiences of the many with whom doctors must deal. I've been berated by the wife of a recently dead university professor who was a friend and patient of mine because my condolences were impertinent – how could I have known, she asked, what he was 'really like'? What does that anecdote teach us? Does that mean that we should never offer condolences? Or does it mean that people differ in their needs and wishes at times of great grief and anger?

Fourth, the current privileging of narrative tends to make us conflate individual perceptions with objective truth. There is profound truth in narratives, but it is personal truth. Generalizations and unexpected insights can be drawn from many narratives together – that is how rigorous qualitative research usually works. Reading a moving narrative adds to our store of intuitive insights, makes us aware of issues that mightn't have been obvious. But, as analysis of airline disasters has taught us, each individual episode is unique. It's from patterns and recurrences that we learn how to change policy.

Fifth – and saddest – consumer narrative generally deals with moral issues, and moral issues still rank in importance well below science, policy, economics and practice conditions. Despite all the fuss that has been made about medical ethics since World War II, the medical profession still holds back from translating ethical concerns for relationships and communication into anything that works in practice.

The author of the IMJ article proposed that "the answer lies in better education and communication." I fear that this is simply not true. For many years now, a number of universities have stressed the importance of medical communication, and taught the subject in the medical courses. They have also taught elements of psychology, explaining suffering and grieving to impressionable students, and they have stressed the importance of human relationships. There are usually sessions devoted to 'breaking bad news'. Courses in the medical humanities are increasingly popular. Teaching 'communication skills', however, achieves very little – make eye contact, come down to the physical level of the patient, practise an empathic look, and so on. These were not the performances that the IMJ author was missing. She was looking for something much more basic – a fundamental, innate respect for the worth of her husband and the meaning of his life. I'm afraid that time alone, and the experience of the suffering of many people – including one's own suffering – can teach this, and then only to some people. It's not a wisdom given to all. Formal education can help, but it helps most those who need it least.

Finally, we need to ask whether some kind of education needs to reach carers and friends as well as doctors. Pellegrino and Thomasma –both Catholic theologians as well as doctors – have argued for medical duties to be matched by duties of patients and their carers. This is an unfashionable line of reasoning that will no doubt anger many, but it's an interesting and challenging issue that deserves serious discussion. Public expectations of medicine have become increasingly unrealistic, partly because of media persuasion, partly because of societal change and partly because of the claims made by the profession itself. Doctors have been expected to step into the roles of miracle workers, priests and counselors, to be physicians, psychologists and social workers, to be superhuman in their insights. These are fearsome demands to make of people who, in the long run, are only human.

What might be more helpful than formal education would be the creation of opportunities for bilateral representation of the perceived problems, some way of allowing both consumers and providers to lay out their experiences before one another in a civilized and well moderated way. We now know a lot about consumer perceptions. We know much less about medical perceptions. Medical people aren't intrinsically evil or insensitive, but they're very reserved about offering their narratives to provide insight for others. Outsiders can scarcely appreciate what it means for a physician or surgeon or nurse to know that when one tragic episode is closed by death, there are others waiting to be managed, other cases that involve the still living and their families. This doesn't excuse insensitivity, but the depth and breadth of that responsibility needs to be shared and mutually acknowledged by all the parties involved in delivering and receiving health care. And there is no forum in which this transaction can take place.

What we need, then, I suggest, is an ongoing forum where patients, carers and those who deliver health care might exchange and share their experiences. Isolated narratives are not the answer. We need a dynamic process, the construction of a discourse between all those who are involved. We sometimes forget that the clinic is the setting for distress that's felt by the would-be healers, just as it's felt by carers and patients. Listen to Sue, the Nursing Unit Manager of a Cancer ward, trusted and revered for her empathy and care for patients and their families:

'You are dealing with the public', she says. 'You are going to get some that just love you and some that just hate you. And we do get that mix, which is really frustrating, even when you bend over backwards for some people sometimes it is still not enough, and I find that incredibly upsetting.'

If the medical profession really values its relationships with the community that it serves, it needs to get involved in a dialogue with that community. And it needs to break with tradition, and to speak more freely and openly about the realities of its own distress. This is Jon, a much loved and respected oncologist, speaking about an angry, bereaved relative of a cancer patient who died:

'He had', says Jon, 'a lot of unfocussed anger about everything that had happened, and he was just non-specifically angry, you know, as you would be. And his anger found a focus – me – and a focus was what was needed…That's why people are sued, I believe. Unfocussed anger that finds a focus… and that left a scar.'

Let me close with the words of Max, code name for one of Australia's foremost surgeons, whose words capture the chaos that is cancer treatment, and the vulnerabilities of both patients and doctors. Max begins:

'Further down the track it's a difficult time, because you are meeting people at their most vulnerable. They have been slashed. They have been mutilated. They have been humiliated. They are put in a strange bed in a strange house, in strange pyjamas. Their bodily fluids are around them. They have got nursing staff, you know, who may or may not appear to care for their needs. Doctors who may or may not appear to be concerned about their needs. Food that smells bad, tastes bad, looks bad. Trolleys. People coming in and out, cleaning the machines. Interns who walk in and out, sucking blood out of them, puncturing their veins. Oncologists talking about recurrent cancer; people next door vomiting…; showers that are shared by four different people – it's like a zoo. And in the middle of that, you are trying to establish a rapport … a human rapport in difficult circumstances.

And therein, ladies and gentlemen, lies our problem – 'human rapport in difficult circumstances'. It is certainly a problem we need to discuss, and to keep discussing until we all understand one another better.

This talk was based on a written paper originally published as: Little, M. (2006). "On being both professional and human' – a response." Internal Medicine Journal 36: 319-322.

References available on request to Canberra Doctor.

Calvary VMOs concerned at inequity in the health system which leaves Calvary Public Hospital and its patients disadvantaged

During VMO contract negotiations, Calvary Hospital physicians raised concerns at what they regarded as a glaring inequity in the ACT health system, which sees TCH well resourced and Calvary – having almost as many A&E presentations – being disadvantaged by a maldistribution of staff, resulting in serious staff shortages and reduction in services. This in turn impacts on the physician VMOs who work in the hospital.

Calvary Hospital – indeed any hospital – should strive to be a "centre of excellence" whatever the services provided. These services should be determined by community need and for this to occur adequate funding is fundamental. According to Dr Terry Gavaghan, this means technologically up-to-date facilities, appropriate levels of nursing and medical staff, experienced medical and other allied staff with high levels of supervision for training junior medical staff.

This short article does not address funding and any other agreements which may be in place between ACT Health and Calvary Hospital, but is intended to highlight the issues from a VMO perspective. The political issues are not commented on – only in as much as politicians determine the budgets and to a degree therefore the services which can be funded. No comment is made on disciplines other than general medicine and obstetrics.

Three of the four VMO physicians at Calvary Hospital have contracts expiring in December 2006. And three out of the four celebrated 50th birthdays some time ago and there is general concern among the group at the lack of young physicians looking to work in Canberra; and whilst this remains the burden falls on these committed long-serving doctors.

Dr Gavaghan, a VMO physician at Calvary public hospital, told "Canberra Doctor" that "there were major obstacles to good health care delivery in Canberra and that unless something was done, this would only deterioriate further. This would be tragic, in his view, given the importance of Calvary Hospital to the large catchments of Belconnen and Gungahlin – both of which were expected to expand, rather than contract. There was no doubt that Calvary Hospital was the "hospital of choice" for many patients and certainly the VMOs at Calvary Hospital are equally committed to the hospital. That said, however, unless the hospital was better resourced it was likely that it would be downgraded to a "secondary hospital" for elective surgery only and a VMO hospital, rather than a "tertiary hospital" in its own right. The A&E department had about 48000 presentations each year compared with 53000 at TCH, but it is treated as a back-up hospital by ACT Health and funded only as such. If Calvary is not better resourced, it is likely it will not be able to service the ever-expanding needs of the north

Dr John Hehir.

side of Canberra with "state of the art" facilities and services and staff", Dr Gavaghan commented.

Dr John Hehir, an obstetrician at Calvary hospital said that Calvary obstetricians provide "first on call" cover for three out of seven nights and provide "on call" services seven nights a week. There was a shortage of obstetricians but no shortage of gynaecologists and because of the number of deliveries there would be insufficient to justify accreditation of a training position. This shortage of obstetricians was in part the result of the medical indemnity "crisis" a few years ago. He also reminded that ACT Health committed to fund 24 hour resident cover as part of the 2003 contract negotiations, but this has not been forthcoming. Dr Hehir considered that the senior staffing level was adequate, however, urgent attention was required for junior cover at either the accredited or unaccredited registrar level. Obstetrics and gynaecology is a particularly high-risk specialty and 24 hour registrar cover would provide added patient safety for obstetric calamities such as shoulder dystocia, cord prolapse and massive post-partum haemorrhage. He also said that there was an inappropriate use of medical expertise when residents were tied up for hours in paperwork – a clerical function. Dr Hehir said that they were doing approximately sixty discharge summaries in any given week.

Dr Gavaghan commented that it had not been able to gain a "front door" admission to the hospital for some years – with all his patients being admitted through A&E. He also said that Calvary Hospital doctors performed in excess of 1500 endoscopies annually; these are not doctor driven procedures, but a response to community demand and good diagnostic and preventative health imperatives.

Both Dr Hehir and Dr Gavaghan said that they could earn more money in their private practices, but both had a commitment to Calvary Hospital and to their public patients. In return, they wanted fair compensation and a commitment that Calvary Hospital would be resourced by ACT Government to provide a high level and comprehensive service to the community it served.

Dr Gavaghan said that ICU and CCU were poorly funded and as "backup" for TCH, it was important that they be well resourced and because of this lack of resource funding, staff were under considerable pressure.

Dr Gavaghan said he was looking at the big picture – with too few graduates coming into the profession, too few specialty and sub-specialty trainees, an ageing medical (and nursing) workforce and a reliance on overseas trained doctors, the private vs public patient mix – and regretted that he could not see a bright future for medicine in Canberra unless these issues were addressed. Under the Territory-wide agreement Calvary junior staff were rotated through both TCH and Calvary; however, if TCH was understaffed then Calvary did not receive the promised staff – compromising patient care and placing unreasonable demands on the existing staff. By way of example, Dr Gavaghan pointed out that despite a comparable number of presentations at Calvary A&E, Calvary staffing

Dr Terry Gavaghan.

was considerably less than that of TCH. He believed there were in the order of seven emergency medicine physicians at TCH and only two at Calvary for a not too dissimilar number of presentations. Dr Gavaghan also drew attention to the fact that there was a general roster only, no sub specialty rosters so that the physicians were required to cover all aspects of care, whereas TCH had rostered cover across each of the sub specialties.

In relation to the future medical workforce, Dr Gavaghan lamented the fact that the ANU Medical School Calvary campus had no lecture theatre, no tutorial rooms and limited access to computers for students. This was unacceptable, in his view, for student teaching in this technologically advanced age – making Calvary Hospital not only appear, but in reality be, second rate in this respect. He compared Calvary to TCH with its plethora of tutorial and meeting rooms, as well as lecture theatres and the co-located ANU Medical School. Calvary John James Hospital's new clinical services building at Deakin had a "state of the art" lecture theatre, but none at the main hospital at Bruce. He also commented that there was no common room for doctors to meet with colleagues over coffee and that this exchange at the semi formal level was fundamental to patient care, and learning.

Dr Gavaghan believes that TCH is also under-funded and because of this under-funding "Calvary Hospital has to bear the brunt of the large number of times in any week that Canberra hospital is placed on by-pass. By-pass means that for any period of time, TCHs throughput is compromised, the Hospital refuses to accept any further attendances in the A&E department and all presentations during that time are directed towards Calvary. There is little thought given to the fact that at any one time in an area such as the Division of Medicine, there may be ten or twelve physicians on call at TCH, to suddenly go on bypass to Calvary where only one physician is on call and of course applies across all disciplines and all specialities and sub-specialities. It also applies to a hospital which is funded for 180 beds or so versus a hospital that is funded for six or seven hundred beds. The number of registrars on call in the specialty of medicine is only one compared to ten or twelve in the principal hospital. The issue of by-pass is becoming more and more a problem and puts a very inequitable load on Calvary which tries to back-up services on the south side as well. Recently, Canberra Hospital was on by-pass for nearly three days in the week, but very frequently, at least seven or eight times every week the whole of TCH is on by-pass for any admissions or A&E attendances and all of these people end up being referred to Calvary."

Calvary Hospital is according to both Drs Hehir and Gavaghan, a "great place to work", with VMOs being regarded an important part of the team, embraced for their skills and expertise and treated well by the hospital management.

Calvary Hospital physician and obstetric VMOs remain committed to the hospital and their patients but are concerned that it will cease to be the wonderful place it is – for patients and doctors – unless some of the issues above are addressed. Fundamental will be a demonstrated commitment to fund Calvary Hospital to continue to be the centre of excellence it strives to be across a range of disciplines.

Pathologists mark 50 years of service to Canberra region

Canberra pathologists will meet at Old Parliament House on November 16th to celebrate the 50th anniversary of the establishment of the Royal College of Pathologists of Australasia (RCPA).

"We don't bear much resemblance to TV pathologists in shows like 'Silent Witness'", says Canberra Hospital pathologist Dr. Chris Hemmings, who took over as Honorary Secretary of the RCPA on November 10th. "Most of us are more likely to be busy identifying the cause of a urinary tract infection, monitoring someone's diabetes or diagnosing cancer, than solving a murder."

Something in the region of 2 million.pathology specimens, including cervical smears, tissue biopsies, blood and urine tests (among others) are processed in Canberra each year, and approximately 450 autopsies are performed. In addition to their diagnostic duties, ACT pathologists are involved in a number of local and national committees relating to pathology and public health, as well as participating in research and in undergraduate and postgraduate teaching. As well as the Foundation Dean of the ANU Medical School, immunologist Professor Paul Gatenby, numerous other Canberra pathologists hold teaching appointments at the Medical School, and provide regular education sessions for General Practitioners and other medical specialists and trainees. In addition, pathologists contribute substantially to a number of multidisciplinary groups involved in the care of various diseases, such as the Canberra Sarcoma Group, the Canberra Melanoma Group, Breast Screen ACT/SE NSW, and the SE NSW/ACT Colorectal Cancer Treatment Project.

Several local members take an active role in College affairs, including examination of candidates for admission to fellowhip, and various office-holders within the College are domiciled in Canberra. Dr. Hemmings says "If anything, the ACT is disproportionately well represented in College affairs. Canberra pathologists take an active role in the wider practice of pathology at a number of levels, and I believe the Canberra community is well served by this branch of medicine. There are a lot of dedicated, hard-working doctors here who strive to maintain a high level of service to their patients, even though we never meet most of them, and many don't even know we exist."

History of pathology services in the ACT

Until 1948, pathology testing for the Canberra region was performed in Sydney. With the opening of the Canberra Community Hospital (later known as Canberra Hospital and later the Royal Canberra Hospital), a local pathology service grew out of a public health laboratory that had opened in 1937 in Civic. They serviced the local general practitioners and surrounding regions including Yass and Wagga Wagga, and post mortems were contracted out to general practitioners. In 1959 Dr Ted Macarthur was appointed to do surgical pathology, mycology and autopsies (for both the hospital and the police). By 1964, 60% of all hospital deaths were referred for autopsy. The forensic autopsy caseload increased from 55 in 1960 to 220 in 1980.

By the early 1950's the workload had increased such that the laboratory needed to expand, and was moved to the Institute of Anatomy, in what is now the National Film and Sound Archive. With completion of hospital extension in 1965, the laboratory facilities were moved to the Canberra Hospital. The laboratory was first accredited for FRCPA training in 1968, initially in anatomic pathology and subsequently in other disciplines. With the arrival of Professor Peter Herdson in 1991, the number of registrar training positions doubled. Professor Herdson was instrumental in the establishment of the pathology museum, which now bears his name.

By the late 1960's moves were afoot to combine public health and clinical pathology services in a central laboratory, which was finally opened at the Canberra Hospital (then known as Woden Valley Hospital) in 1976. Dr Jocelyn Farnsworth remained at Canberra Hospital performing frozen sections, whilst the other pathologists moved to Woden. The ensuing 30 years have seen further expansion of the laboratory, particularly in electron microscopy, cytogenetics, molecular pathology and immunology services. Today ACT Pathology, based at the Canberra Hospital, employs more than 200 staff and provides pathology services, including autopsies, to the public and private sectors in Canberra and the surrounding region. Drs Hallam and Jain from ACT Pathology also perform coronial autopsies for the region. In 1991 Drs Bennett and Jain from ACT Pathology established Canberra Aspiration Cytology, a private FNA biopsy service.

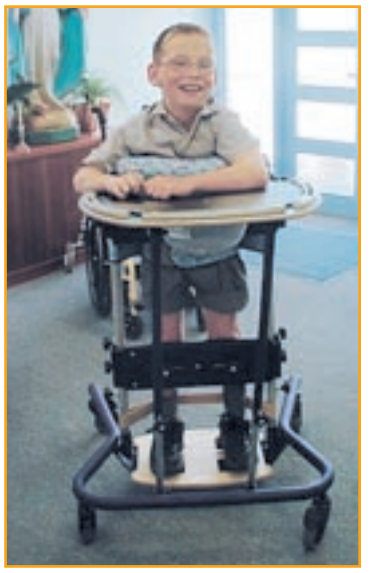
The first private pathology service in Canberra was established by Dr Barry Moran in 1967, servicing general practitioners and the John James Memorial Hospital which opened in 1970. In 1981 Dr Farnsworth established the second private pathology practice in Canberr, which was subsequently sold Drs Barratt and Smith in 1987. This laboratory moved to Queanbeyan and subsequently merged with Dr Barry Moran Pathology to form Capital Pathology in 1996. Capital Pathology provides pathology services to Canberra and the region, including Jindabyne, Cooma, Bega and Merimbula.

Today the ACT contingent of the RCPA represents some 28 currently practicing pathologists, most of whom are employed by ACT Pathology (based at The Canberra Hospital), or Capital Pathology (based in Deakin). In addition, there are currently 12 trainees studying for admission to fellowship, and some private pathology services are provided by Symbion Mayne Laverty Pathology.

With thanks to "Pathology, Professional Practice and Politics: A History of the Royal College of Pathologists of Australasia 1981-2006" which was published by the RCPA this year to mark the Jubilee. (Eds Conyers, MacLeod, Muller & Raik)

Spastic Centre assists children and families

Children aged 0 -18 years of age can access therapy services for advice and recommendations. Referrals can be made directly by families by telephoning the therapy administrator at the Centre – which is located in Spence.



The therapy team consists of a therapy administrator, physiotherapist, speech pathologist and occupational therapist.

The 'Equipment Loan Pool' has been a success story with substantial support from the Canberra community contributing money to purchase specific pieces of expensive equipment to be pooled and used by children and their families who attend the Centre. Many pieces of equipment that are recommended by therapists are beyond monetary reach for families and the establishment of the 'Loan Pool' has been a boon for all.

The Spastic Centre commenced offering therapy services to children with cerebral palsy and associated conditions in 2004. The Spastic Centre, a non-government organisation will receive over $700,000 to assist children and their families in the ACT.

The Centre is located at the Mt Rogers Community Centre, Crofts Crescent, Spence and the therapy administrator, Gilian Coady can be contacted on telephone 6258 8723, or by fax to 6258 5847

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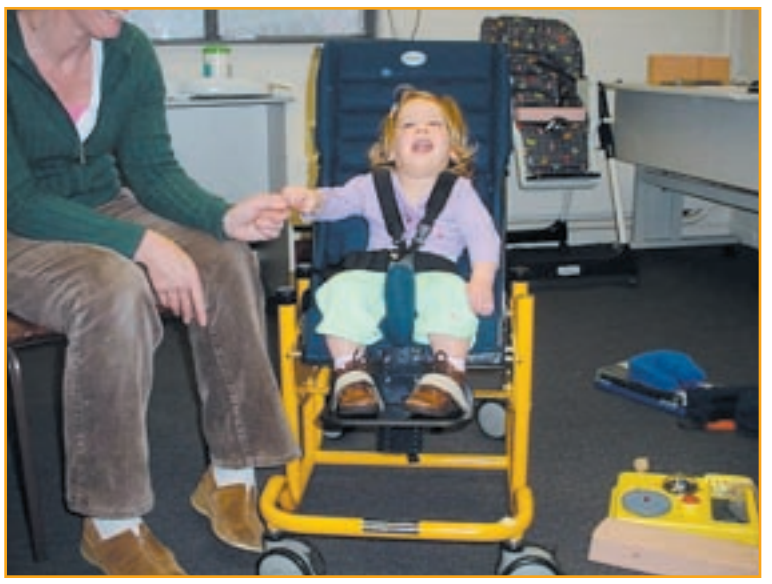

MDA National responds positively to the MDAV/UNITED merger announcement

In response to the announcement by MDAV and UNITED that the organisations have agreed to merge in early 2007, MDA National CEO, Mr Peter Forbes commented that the move is a positive step for the medical indemnity industry.

Mr Forbes has previously commented in the media that consolidation in the medical indemnity industry has been considered desirable by both the Federal Government and the Federal AMA. This merger will reduce the number of doctor owned insurers from 5 to 4, resulting in more streamlined indemnity choices for the Australian medial profession.

"A reduced number of providers will address some of the confusion in the market by presenting Australian doctors with a smaller field of indemnity insurers with clear differentiation in products and benefits", said Mr Forbes.

MDA National will continue to build on its success to date by concentrating on its core business of delivering appropriately priced medical indemnity insurance to Australia's doctors.

Mr Forbes commented that "it is important that the merger of the mutal organisations will require the consent and support of the members of both groups. It will need to be evident that any merger is in their best interests."

"Clearly, to obtain member support, it will need to be demonstrated that the cost of both membership and medical indemnity premiums will be reduced and that there will be an increase in the standard of service-delivery which their members are entitled to".

While confirming that there is certainly no financial driver for MDA National to consider a merger, Mr Forbes stated that "if an opportunity arises we would carefully consider the option on the proviso that it adds to our members' security and benefits. Recent analysis conducted by our professional advisers has indicated no such option existed at that point".

Canberra GP, Dr Ian Pryor, a member of the UMP Medical advisory council said, "This merger creates an efficient opportunity to extend the benefits of scale to members of United and MDAV. It enables United to maximise those advantages of its strong market position to increase its presence in the Victorian sector".

Medical Treatment Act introduced into legislative assembly

The medical treatment direction bill, tabled in the ACT Legislative Assembly, will protect patients' rights in the Territory, ACT Attorney General, Simon Corbell, said when tabling the Bill.

"The direction, known formally as the Director of Public Prosecutions Direction 2006 No. 2, has been issued to ensure that the ACT Medical Treatment Act 1994 remains effective despite the enactment of the Commonwealth Euthanasia Laws Act 1997. The new direction is cast in the same terms as a direction made in 1998, and is intended to replace the 1998 direction."

Mr Corbell said the direction would protect the right of patients to provide instructions in advance regarding the withdrawal or withholding of medical treatment. The direction would also protect the right of patients to appoint a decision-maker to make decisions about medical treatment on their behalf, through the use of a power of attorney.

"The direction requires the Director of Public Prosecutions not to pursue a prosecution against a health professional for the death of a patient in circumstances where the health professional follows, in good faith, the instructions set out in an advance directive, or instructions given by a person exercising a power of attorney, regarding the withdrawal or withholding of medical treatment," he said.

"The Director of Public Prosecutions is also directed not to pursue prosecutions against health professionals who provide pain relief in good faith to a person diagnosed as being in the terminal phase of a terminal illness where an incidental effect of the pain relief appears to have been the hastening of death.

"Recent events prompted inquiries about whether the correct processes were followed in making the 1998 direction. The new direction re-instates the effect of the previous direction, and is made in the same terms as the previous direction."

Under the Director of Public Prosecutions Act 1992, the Attorney General has the ability to issue directions to the Director of Public Prosecutions about the management of particular categories of prosecutions. Given the importance of maintaining the decision-making integrity of the Director of Public Prosecutions, such directions can only be of a general nature, rather than referring to a specific case, and can only be made following proper consultation with the Director. Both of these conditions have been met in relation to the medical treatment direction.

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Qualifying Degrees (Date & Place)

Postgraduate Degrees (Date & Place)

Registration (Date & Place)

Previous Membership of BMA or Other National or Representative Professional Associations

Previous Membership of the AMA (State & Year)

Other Relevant Information (including languages spoken)

Completed form should be returned to the ACT AMA by fax 6273 0455 or by post to PO Box 560, Curtin, ACT 2605.

What's happening with residential property?

The various property markets are behaving exactly as they should and for those who understand the "Property Investment Cycle" this offers excellent opportunities.

Like all commodities, property is subject to strong and predictable cyclical fluctuations. These cycles apply to both capital prices and rental returns. It is important to appreciate though that capital prices and rental returns cycle at different times but profoundly influence each other.

A brief explanation of the property investment cycle should aid in understanding and moreover begin to highlight the opportunities provided to astute investors.

After a period in stagnation of construction activity excess demand starts to emerge. A shortage of rental property leads to rises in rental returns. Higher rental returns attract new "yield seeking" investors into the market. This increased demand causes prices to begin to rise and with it activity in the market. This phase of the cycle is known as "The Upturn".

After the upturn the market enters "The boom". This phase is driven by the entry of speculative investors attracted by the rising prices and hoping to take advantage of the prospect of further price rises. The entry of even more investors into the market fuels further price rises as demand begins to outstrip supply. Developers tap into the increased demand and bring more property to the market. At the peak of the boom prices and activity overshoot realistic levels and property becomes overvalued. Rental yields having fallen to unsustainably low levels as rises in prices have substantially outstripped the growth in rents.

The excess of stock leads to an over-supply and this coupled with poor rental returns due to high prices leads to a withdrawal of investors from the market. Property is now overvalued and new investors do not enter the market. As a result sales volumes fall and building activity drops off accordingly. "The Bust" has arrived and the market activity slows as investors look for other opportunities.

After the bust building activity is subdued below the long term level of new dwellings required. "The Stagnation" phase is characterised by a gradual reduction in excess housing stock created during the boom and sets the stage for the next upturn in activity. Investors are typically hesitant to re-enter the market after the earlier bust and this leads to an undersupply of property resulting in excess demand creating the conditions for the next upturn.

The market today is demonstrating the characteristics of being in the early Upturn Phase with rising interest rates putting additional pressure on supply and increasing the demand for rental as first home buyers are priced out of the market. Rents are rising rapidly and those investors who are able to recognize the next growth opportunities will be well positioned to take maximum advantage of the next boom. At the same time the continued growth in rents will rapidly reduce the holding costs for investors entering the market at this time.

(copy supplied by Geoff Proud, Park Heath – see advert page 10)

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