Canberra DOCTOR
Informing the Canberra medical community since 1988
February 2007
Canberra Doctor is proudly brought to you by the ACT AMA

How many reasons do you need to join the ACT AMA?

How many organisations do you really need to represent your professional interests?

Remember: united we stand, divided we fall!

Read on!

Associations exist to achieve what individuals alone cannot do!

The AMA is truly representative of the whole profession!

The ACT AMA still provides the best value for membership of any local medical association! The return on your AMA invested dollar is huge!

Let's prove it!

Firstly the ACT AMA Council is made up of your elected peers. The current councillors cover a range of disciplines and each brings a level of expertise and diversity of viewpoint to the discussions. This ensures that all the profession is represented and views respected.

It is to the advantage of members, and the profession, that the Council is not overly represented by single issue advocates.

The ACT AMA has a number of standing and ad hoc committees, made up of members of the AMA, who provide advice to the Council on a variety of issues affecting the profession.

A call for nominations for the 2007-2008 Council will be made shortly. Remember, this is your organisation and if you wish to influence its direction, get involved and nominate for a position on the Council.

Visiting Medical Officers

ACT VMOs still have the best contract conditions in Australia. The ACT AMA always intended that this should be the outcome for ACT VMOs.

Anything less was never an option for the ACT AMA.

This achievement is the outcome after months of negotiation and arbitration on the one outstanding matter at the conclusion of the bargaining period – what percentage of the CMBS should be applied?

The ACT AMA represented the views of the profession to ACT Health during the contract process and provided the VMOs with up-to-date relevant and accurate information as well as a feedback loop throughout the negotiations. The ACT AMA took on board ACT Health's commitment to its VMOs and stated intention to offer the best contracts in order to keep its valued medical workforce in the Territory and to attract others to relocate here.

The ACT AMA took its brief to represent very seriously and attended every meeting with ACT Health. The AMA could only represent those VMOs who appointed it as bargaining agent – so if the outcome your group desired wasn't achieved, then you need to ask, did you appoint the AMA as your agent? Your colleagues represented you at these meetings and stayed until the conclusion of each meeting. It did this in order to preserve the negotiating process and to positively influence the outcome. It also did this to protect and preserve the brand-name that is the AMA.

The ACT AMA was able to get the "floor price" lifted prior to commencing arbitration. The quid pro quo was to encourage VMOs to extend their contracts pending the conclusion of the arbitration in order to preserve guaranteed workloads, continuity bonus and transitional allowances.

The ACT AMA submission to the arbitrator was comprehensive, researched and well written and regarded as "professional" by parties to the arbitration. The AMA claims the strength of argument in its submission contributed significantly to the arbitrator's increase in the rate for VMOs.

Importantly, the ACT AMA recognised the industrial and political realities of the renegotiation processes and was mindful of the legislative framework within which these contracts are negotiated. The Health Act provides for collective negotiation of VMO contracts. Collective negotiation by independent contractors is unlawful under the Commonwealth's Trade Practices Act. However, in order to collectively negotiate our contracts, ACT government sought and was granted an authorisation by the ACCC which provides protection from breaches of the Trade Practices Act during a notified bargaining period.

The ACT AMA regards this as core business with no additional cost to its VMO members. The ACT AMA will continue to provide advice to individual VMOs negotiating with the hospitals regarding setting of their workloads. VMOs seeking assistance with this, or other VMO contract matters, should contact the ACT AMA Secretariat on 6270 5410.

Doctors in training

The ACT AMA has waived its membership fee for the 2007 interns. This means that all AMA benefits flow to new intern members at no cost! For example, individual fortnightly copies of the MJA – normally available at a subscription of $368.50 – is a membership benefit so already interns are ahead! If you have not yet completed an application form for your no-cost membership, please contact the ACT AMA secretariat on 6270 5410.

Doctors in training have a dedicated place on the Council of the ACT AMA and have representation at the AMA's Council of Doctors in Training. The ACT AMA's Doctors in Training Forum has also been established to provide a voice to this important group of the profession. Regular information specific to doctors in training is forwarded electronically from the AMA through its periodic "E-dit".

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ACT AMA President, Dr Andrew Foote, writes…

Win for ACT AMA

After many hours of meetings and hard work, the contract dispute between ACT Health and VMOs has been settled by binding arbitration in a decision handed down by the Arbitrator, Dr Iain Ross, on 8 January 2007. The final judgement was a 3.1% initial increase with a 4% per year rise over the 3-year contract, resulting in a final benefit of 15.1%. Whilst this was less than the 120% of the 2005 CMBS we sought at arbitration, at the end of the day AMA was able to help achieve the best contracts in the country.

General Practice

The first meeting of the reconvened GP Workforce working group will occur in the next few weeks and so will the ACT AMAs GP Forum. The Forum's focus over the year, without pre-empting the GPs own views, will undoubtedly include issues such as the attraction and retention of GPs, training places, and residential aged care.

The Aged Care committee will be meeting with ACT Auditor General, Tu Pham and members of her team in the near future to discuss her performance audit of Government's Aged Care services in the ACT.

Interns

ACT AMA recently hosted a pizza lunch for the new interns during their Orientation Week. I was reassured to see that eating large amounts of food in a short time period is still alive and well. I am pleased to welcome our new intern members, and to wish them well in their medical careers - it seems like only the other day that I was starting at St Vincents, Sydney in my intern year…

I look forward to their involvement through our ACT AMA Doctors in Training Forum which will provide them with an opportunity to influence the Council on matters of concern to them particularly.

Staff Specialists

Following ASMOF's decision not to renew provision of industrial services I am very pleased to announce that industrial services will be provided directly to ACT AMA salaried members from the ACT AMA. The ACT AMA has the opportunity under legislative change to represent its salaried members, so we look forward to providing this new service to members. Accordingly, we have recently appointed an experienced industrial officer, Mr Andy Ozolins, who can be directly contacted at ACT AMA by AMA member salaried members – hospital, community or general practice based. Membership of the AMA just got more attractive, I believe, for salaried doctors!

IMG Forum

No, not a bank-meeting, but our new forum for International Medical Graduates, which met recently to discuss issues such as appropriate skills/competencies/training/mentoring, minimising red tape and bureaucracy, ensuring support and advocacy with hospitals and medical colleges, ensuring timely AMC examination, protected pay and working conditions, family access to basic services such as health care and education, and eliminating racial abuse. As many of our internationally qualified colleagues work in salaried positions, I believe AMA just became more attractive to them as well!

COAG

No, not a haematological blood test - but rather a worrying coalition of state and federal leaders who are trying to push for national health professional registration (ie, doctors, nurses, optometrists etc). This could result in role substitution, lowering of medical standards, the take-over of medical education, the end of localised State medical boards, and the end of specialist colleges. Get the message - this has the potential to be a huge issue!

ACT and federal AMA are vigorously lobbying the state and federal health ministers to push for a mutual recognition model of state/territory medical boards (similar to the driving licence model) through the Health Ministers meetings.

Have you got the Card?

The very alluring blue AMA card, with accompanying partner card, has hit the streets. I have given it a spin at Plonk, and had a long wine education conversation (me mainly listening!) from the very helpful owner, Anthony. For those who buy business supplies, Corporate Express (Phillip branch) looks worth pursuing.

Advance Notice

The very first, inaugural, and initial Annual General Meeting and Ball will be held on 16 May. Mark this in your diaries as the must not miss social event of the season! Watch out for the papparazzi! We will also be launching the Doctors in Training Further Education Fund.

Dr Andrew Foote at Plonk.

The West Island

I recently attended a conference in New Zealand with my family, and during an idle conference moment found myself in a New Zealand children's playground with my 3 year old twins. I was struck by how different the playground looked. In particular there was all this equipment that I had not seen since my childhood – things like flying foxes, forts, and very tall slippery dips. Then I realised that New Zealand has a no fault insurance system, and that concerns about public indemnity and getting sued by litigation lawyers is just not an issue. Hmmmm, maybe the Kiwis have got their act together (in this regard!) Good thing they still can't play cricket too well.

Federal AMA Matters

There have been a number of press releases regarding: Smartcard concerns, McDonalds Heart Foundation "Tick" concerns, intellectually disabled new item number, doctor fatigue, safe handover, banning junk food advertising on kids TV, and Gardasil (to mention just a few!)

Bateman's Bay GP, Dr David Rivett honoured for services to rural medicine

Just days after being honoured with the Medal of the Order of Australia (OAM) for outstanding service to rural and remote medicine, the Chair of the AMA Rural Reference Group, Dr David Rivett, is calling on all Australian governments to do more to give country Australians better access to quality health services.

Dr Rivett, a GP in Batemans Bay NSW, said that the gap between city and country health services is getting wider and country people all around Australia are missing out on many of the basic health services that other Australians take for granted.

"There are fewer doctors and other health professionals coming to work and stay in rural Australia, more of our smaller hospitals are closing down, and people are being forced to travel hundreds of kilometres for vital medical procedures and services," Dr Rivett said.

"Country people are no longer getting a fair go on health."

Dr Rivett said many of the solutions to the problems in rural health are neither costly nor complicated.

He said governments should be cooperating to take practical steps, including:

- Increasing funding for the medical specialist outreach program by 25 per cent to give country people better access to specialist care
- Increasing funding for the rural retention program and extend payment eligibility to cover specialists - particularly to address the ageing rural workforce
- Introducing a public interest test to govern the proposed closure of rural public hospitals to help stem the loss of procedural skills in rural areas
- Providing more funding for training and support for overseas trained doctors who are a substantial part of the rural workforce
- Providing more quality training places to encourage doctors to get a taste of rural medicine

Dr Rivett said that he and his rural doctor colleagues are not getting any younger and it's time that something drastic was done to address the ageing and declining rural medical workforce.

The ACT AMA adds its congratulations to those of the Federal AMA President, which have been extended to Dr Rivett.

How many reasons do you need to join the ACT AMA? continued...

From page 1

The ACT AMA has a doctor in training page on its website: www.ama-act.com.au.

The AMA recentl y announced the result of its latest Safe Hours Audit and launched its self-assessment tool for safe hours. The survey, conducted between 8 and 14 May 2006, indicates that almost two-thirds of public hospital doctors are working unsafe hours. The online 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. Survey results are available at www.ama.com.au, or via link from www.ama-act.com.au.

The AMA also launched recently its "Safe Handover: Safe Patients" Guide on clinical handover for clinicians and managers and copies are available on request.

Doctors in training members (interns included) have access to an industrial officer located within the ACT AMA secretariat. Mr Andy Ozolins, industrial officer, is available Monday, Tuesday and Wednesday between the hours of 9.30 am and 2.30 pm, on 6270 5410. Doctors in training should expect the same high level of industrial service from Mr Ozolins as was provided by the ACT AMA on behalf of ASMOF ACT.

Salaried doctors in clinical practice in the ACT

ACT AMA has provided industrial services to ASMOF ACT for a number of years. ASMOF ACT has decided to discontinue this service.

The ACT AMA has decided to make these services directly available to its salaried members as part of normal AMA membership; ie, no additional cost. The ACT AMA will continue to provide the high level of service salaried doctors have previously received from ASMOF ACT via the ACT AMA.

Industrial legislative changes by the Commonwealth make it possible for the ACT AMA to advocate and represent its salaried members in discussions and negotiations with the ACT Department of Health. It is anticipated that the ACT AMA will be a party to 2008 EBA negotiations.

The ACT AMA has provided added incentives for salaried doctors to join the ACT AMA and for further information salaried doctors should contact the secretariat.

Federal AMA provides industrial services, on behalf of CASMOF, to salaried doctors employed by the Commonwealth Government or its agencies and enquiries should be directed to Tania Goodacre in the Federal AMA secretariat on 6270 5400.

General practitioners

General practitioner members who are also employees, may avail themselves of industrial advice from the ACT AMA secretariat on 6270 5410.

General practitioner members who are employers seeking advice should also contact the ACT AMA secretariat for advice.

The ACT AMA with further funding from Department of Workplace Relations, is holding a further series of seminars on the implementation of the new WorkChoices legislation. There are two seminars scheduled for February and details are included on the backpage of this edition of "Canberra Doctor" and via the ACT AMA website: www.ama-act.com.au. Letters of invitation have already been forwarded. If you have not received your invitation, please contact the ACT AMA secretariat on 6270 5410.

The ACT AMA will shortly distribute the AMAs Primary Health Care Position statement to general practitioners in the ACT. This policy is the culmination of months of work within the Federal AMA and provides a vision for general practice and primary care. It 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.

The ACT AMA is represented at the AMAs Council of General Practice and has reviewed the GP Forum's membership and terms of reference and the "new" expanded Forum will meet in March 2007 to consider issues of concern to general practice from a variety of stakeholders and to provide advice to the Council of the ACT AMA.

The ACT AMA President-elect, Dr Paul Jones, will chair the re-convened GP Workforce working group later in February. This last met in 2003 and will consider, among other issues, attracting and retaining GPs and direction and GP workforce strategies in the ACT. This will review the current situation regarding the ACTs GP workforce and investigate ways to increase the availability of general practice in the ACT. The group will be representative of GP groups and other interested stakeholders.

The above is just intended to give you a representative sample of what the AMA is doing, and has done recently, for the profession.

Rewards for Membership

The ACT AMA has developed partnerships with a number of local businesses which have agreed to reward AMA members by providing discounts to members (and their partners) on purchases. These include: Aubergine, Courgette and Sabayon Restaurants, Stephanie's Lingerie, Plonk, Botanics Florist, Simply Wellness Day Spa, The Essential Ingredient, Escala Shoes, Ondina Studio and Corporate Express!

A full list of the businesses is included on pages 4 and 5 in a handy lift-out.

As an added treat: Members who fax (6273 0455) copies of their sales dockets dated to 9 March 2007 will go into a draw for a special treat from one of the ACT AMAs partners! Sales dockets should clearly identify the Rewards partner, with member's name and telephone contact number. No limit on entries. Winner announced next month!

So, do ask yourself whether you can get all your professional needs met by the ACT AMA, and then fill in an application form, pay your subscription and reap the rewards that membership provides!

Congratulations to Dr Richard Pembrey who has won the bottle of 1992 Hermitage 'Grange' for paying his 2007 subscription prior to 31 January 2007.

Community Bushdance to be held by ANU Rural Medical Society

The Australian National University Rural Medical Society (ARMS) is a student run organisation that aims to promote careers in rural health and broaden students' understanding of rural health issues and medical practice and therefore encourage students to pursue careers in rural and remote health. ARMS had 150 members in 2006.

Bushdance 07' will be the biggest event for the year. It will be held at the Yarralumla Woolshed in Canberra on Thursday 22nd March. Medical students, their families and friends, together with the wider Canberra health and medical community are invited to attend.

There will be a live band and dancing, food and soft drinks provided, a mechanical bucking bull and prizes will add to the festivities.

Cost: adults $25 no charge for with children under 12 years of age accompanied by an adult

Dress: Country

For more information email:armsanu@gmail.com

Cowboys and cowgirls welcome!

In 2007 ARMS will be running a number of events for its student members including a ski trip, visits to country shows in the Canberra region, a bushdance, rural high school visits to promote health careers to rural high school students, and Indigenous speaker nights.

ACT AMA Membership Rewards Partners

REWARDING YOUR MEMBERSHIP

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HOLD ON TO YOUR RECEIPTS & WIN

As an added treat: Members who fax (6273 0455) copies of their sales dockets dated to 9 March 2007 will go into a draw for a special treat from one of the ACT AMA Business Partners! Sales dockets should clearly identify the Rewards partner, accompanied by the member's name and telephone contact number. No limit on entries. Winner announced next month!

Plonk

P: 6162 1136

Canberrans now have access to a large range of consistent, quality 'cleanskin' wines, a great range of unique hand crafted beers and also a large number of branded wines that don't generally find space on bottle shops throughout Canberra through a newly opened independent liquor retail outlet at the "M" Centre in Manuka. Great shop with a great name, Plonk.

Plonk sells about 70 cleanskins, great value wines starting from as low as $3.60 to around $15 per bottle, sourced from vineyards committed to producing quality wines. Free local business and residential delivery – just look at our Online Purchasing website – www.plonk.net.au

Botanics Florist

P: 6295 0221
F: 6295 3025
E: botanics@interfloraflorist.com.au
www.botanicsflorist.com.au

Conveniently located in the leafy suburb of Kingston, Botanics Florist is considered Canberra's leading florist with over 60 years combined staff experience and knowledge. With fresh flowers arriving every day, the Staff at Botanics are here to take your orders by phone, fax or email. The website is also available to help you make the perfect choice.

Simply Wellness Day Spa

P: 6257 6020

At Simply Wellness we have created a rejuvenating sanctuary that provides education, evaluation and services to reduce your stress level, improve your life quality and slow the impact of ageing. We proactively create wellness by achieving and maintaining balance for your body, mind and spirit. Our wellness treatments are holistic and are either preventative to maintain your balance or intensive to return you to a healthy balance.

The Essential Ingredient

P: 6295 7148

At The Essential Ingredient, we are not just about good food. Our ongoing search for quality embraces traditional and innovative cooking utensils, classical and elegant tableware, together with inspirational reading from world-renowned chefs.

Throughout our history The Essential Ingredient has continued to source new products and refine its range. Always acknowledging the time honoured ways in which we produce and eat good food, we have sought to encourage producers to remain faithful to simple, artisinal processes, making products suitable for classical and contemporary applications. We are strong supporters of local producers as well as being importers of a vast number of food, kitchenware, and tableware from around the globe.

We look forward to welcoming you to our store.

Escala Shoes

P: 6262 8822

Buying trips to Italy and Spain twice a year by the owner, Gail Lubbock, guarantees footwear with European stylishness, unique designs, classical elegance, comfort with a funky twist, and luscious bags, luxurious wraps and scarves and gloves in soft leather.

Providing beautiful footwear and accessories, with unparallelled client service and care, are the cornerstones of Escala Shoes, a business which has been operating in its present location in the Canberra House Arcade for 8 years.

We are pleased to offer our very busy clients an opportunity to shop after hours, 'a solo' or organise an 'An Friends' evening from 6 - 8pm with champagne and nibbles.

Gail and the team are very happy to be associated with the ACT AMA and look forward to members visiting us at the store soon.

Stephanie's Boutique Lingerie

P: 6295 0469

Stephanie's Boutique Lingerie at 24 Jardine Street, Kingston, has a beautiful range of lingerie by Calvin Klein, Oroton, Morrissey, Simone Perele, Trent Nathan and Elle Macpherson. A personal fitting service is available. Stephanie's also has a great range of men's silk ties, business shirts and men's underwear by Calvin Klein and Oroton. Trading hours are Monday to Friday 9:30am-3:30pm and Sunday 11am-3pm.

ANU Medical School mentorship program

Now in its fourth year

Medical professionals interested in taking part in the ANU Medical School mentorship program should contact the ANUMS Mentorship Program Co-ordinator Stacey Smith on the contact numbers and email address at the end of this short article.

In 2007 *The Australian National University Medical School Mentorship Program* will run for the fourth time. This program exists to provide important collegial guidance and advice to first and second year medical students. Local medical professionals from a variety of clinical backgrounds participate as mentors.

Teams of approximately three mentors meet informally with a small group of first and second year students on a number of occasions throughout the year as organised by themselves.

These social gatherings (many at clinicians' homes) allow the first year students to form a support network of their second year peers and senior colleagues, while enjoying themselves in a relaxed environment that has no formal connection with ANUMS curriculum or governance processes. Mentors facilitate the development of the students in their group by providing personal and professional support in these crucial first two years of study. Hopefully the relationships developed will allow further individual contacts as needs arise in the final two years of study.

The mentorship program is important in welcoming new students to the ACT medical community and maintaining their long-term involvement in it.

The ANU Medical School holds three special evenings at the beginning of each year, as part of fostering a good relationship between the new first year students and their mentors. In 2007, these will be held at Manning Clark House in Forrest at 6-8pm on February 20 and 27 and March 6. Each of these evenings will feature seminars given by guest speakers (many eminent and well known) from a variety of different medical specialties and health-related fields. At the same time mentors and students will also have the opportunity to get to know one another in a relaxed off-campus environment that is still part of the ANU. All existing mentors are encouraged to attend and meet the new first year medical students.

Please send some information about yourself and your area of specialty. We encourage you to get involved and look forward to another excellent year of the program.

Contact Stacey Smith, Mentorship Program Coordinator at stacey.smith@anu.edu.au. (ph: 6244 4966).

AMENDMENTS to the 'Canberra Doctor' Specialist Directory

PLEASE CUT OUT & PASTE INTO YOUR DIRECTORY

GENERAL SURGERY			
CHONG, Guan	General, Head and Neck, Endocrine surgeries	6282 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
PSYCHIATRY			
THOMPSON, Jennifer		6262 7100	Level 8, AMP Building, Hobart Place, CANBERRA CITY, ACT 2601
SPORTS MEDICINE			
STILL, Robert	Sports medicine	6281 5999	Sports Physicians ACT 2 King Street, DEAKIN ACT 2600

Connoisseur Catering

P: 6251 7383

Connoisseur Catering was established in 1989 and now services over 300,000 customers a year. We can supply all your catering needs from morning to night anywhere, anytime, from large to small, formal to informal and cater for special diets. We deliver anywhere in the Canberra/Queanbeyan region.

Please visit our website www.connoisseur.com.au to see our full range of menus, or phone our friendly staff on 02 6251 7383, to discuss all your catering needs.

All services personally guaranteed by Oliver the friendly German.

Aubergine Restaurant

P: 6260 8666

Located in the inner south suburb of Griffith, Aubergine is European trained-chef James Mussillon's first venture and sister restaurant to Courgette. Head chef Jason Rodwell has been at the helm for the past two years and offers a French influenced menu featuring the best of Australian seafood and the highest quality meats. Aubergine offers fine dining in a stylish setting with its high ceilings, plush chairs, white linen tables and feature windows. The decking, which overlooks the park, is perfect for alfresco dining. A la carte and degustation menus are on offer and a good selection of current release and aged Australian wines as well as a sprinkling of international varieties. Aubergine is the ideal venue for a sophisticated corporate lunch.

Courgette Restaurant

P: 6247 4042

When James Mussillon set about creating his second Canberra venture, he envisaged a restaurant that would combine the simplicity and freshness of the basic elements with adventurous sauces and dressings. Backed by a stunning fitout, the result is a superb dining experience that has earned Courgette a Good Food Guide Chef's Hat in every year of its operation. The emphasis is undeniably on seafood, while great effort is made to source high quality meats from all around the country. Courgette stocks a wide selection of current and aged Australian wines, as well as a number of fine international labels.

Courgette is a specialist in corporate functions and offers two private dining rooms ideal for meetings or presentations.

Sabayon Restaurant

P: 6247 8212

Sabayon is the newest creation from James Mussillon offering a smart casual dining approach. Situated in the historic Melbourne Building on West Row, Sabayon delivers the highest standard of food and service in a sleek, modern and relaxed atmosphere.

Sabayon is perfect for business, romance or a pre-theatre dinner. There's also a superb selection of Australian wines at very reasonable prices.

Corporate Express

P: 6285 0000

19 Townshend Street, PHILLIP

Corporate Express are happy to offer in-store discounts on all products with the exception of copy paper, printer toner consumables and already reduced items. These include: office products, IT solutions, business furniture, print management, as well as canteen & catering, promotional marketing and facility supplies and education essentials.

Ondina Studio

P: 6161 4488

Level 1,

35 Kennedy Street, KINGSTON

The studio specialises in honestly advising clients on colour, fabric and the shape of garments, making sure the fit is right. "It doesn't cost anything to have our consultants help update your clothing and there's no obligation to buy," says Ondina.

Ondina Studio offers affordable weekend wear, smart corporate, and high-end fashion perfect for special occasions. New labels include Barbara Lee and Ondina has easy-to-wear basics for all shapes, including Paula Ryan wrap around cardies, skirts and tops.

AMA Student Prize for Leadership awarded to Dr Sarah Koffmann

President-elect, Dr Paul Jones, presented Dr Sarah Koffmann with the AMAs student prize for leadership at the Graduation Dinner held at Parliament House last December.

This is the last presentation to a graduand of the Canberra Clinical School of University of Sydney. The prize will be offered to a graduand of the ANU Medical School in 2007.

Students may be nominated for the AMA prize in one of five categories: student representation and advocacy; research; community service; peer support and individual or personal achievement.

In making the presentation, Dr Jones advised the attendees at the Dinner that Dr Sarah Koffmann was a worthy recipient of this prestigious prize and had been nominated in the "individual or personal achievement" category. Her nominator advised that Sarah was a "valued member of the Canberra student class and has set a formidable example for those of us who intend to balance family and a career. She is a woman of clear thought, sense and compassion, curiosity and humility, wisdom and grace."

Sarah's prize includes membership of the AMA for her intern year, a cash prize and a trophy. The prize is open to all student members of the AMA.

Dr Jones presented certificates to the finalists and commended each for their leadership: Emma Gill, Dan Corkery, Richard Bradbury, Emma Lawrence and Sam O'Connor.

The Nationalisation of Medical Registration

For most doctors, registration is one of those boring administrative tasks that seem to come around all too often. For those registered in more than one state or territory this can be a tiresome and increasingly expensive administrative task. Moving from one jurisdiction to another, and registering anew, is a cumbersome operation. Faded old university parchments and other ancient documents have to be delivered to a central point for administrative perusal.

Imagine then, how much easier life would be for doctors were they to be registered by one national body which permitted them to practise anywhere, anytime in Australia. Guest surgeons and other proceduralists would no longer have costs and delays confronting them with every interstate visit. How much easier would it be for practitioners to perform interstate locum services?

It is a good idea, or at least a good dream. Like many a good dream it has turned into a nightmare through the machinations of bureaucrats. This time they are from COAG: Council of Australian Governments.

Their proposal is for a national board or committee supervising on seven different areas of health and community services. State and territory medical boards are to disappear and be replaced by administrative subcommittees in the various jurisdictions that now exist. All registration, policy and regulation will be subject to the national body.

The proposed national body itself comprises the following membership:

- Government (both State and Commonwealth)
- Educational bodies involved in the provision of health care education
- A cross section of representatives of the health professions
- Representatives of community and health consumers
- Representatives of trainees, and
- A representative of the Board of Governance of the National Registration Authority.

It is obvious that this national body, with supreme authority over all doctors in the country, could legally exist without one member being a registered medical practitioner.

The current Medical Board in the ACT has a majority of medical practitioners as members. The chair, although appointed by the Minister, has traditionally been a medical practitioner. The current chairman, Dr. Stephen Bradshaw, is a Canberra vascular surgeon. The "community" has one representative and one member of the legal profession. As for the doctors, they come from diverse backgrounds and training – two general practitioners, an anaesthetist and experienced administrative clinician, a surgeon and a psychiatrist.

I have been a member of the board for less than a year. That has been sufficient time for me to recognise how the board balances out two major objectives. The first is the protection of the public from shoddy medical practice, or worse, exploitation. The second is to see that all medical practitioners within its jurisdiction are assured natural justice. The board's powers reside in its authority to register medical practitioners, to set conditions upon medical registration and to set in train disciplinary procedures when required. The medical board is therefore the most important organisation in the life of a working practitioner. Without its blessing, no doctor can legally practise medicine.

Despite the cumbersome problems of mutual recognition between six states and two territories, the current system has values that a fully nationalised system cannot. In a geographically small jurisdiction like the ACT, with the population less than half a million, most doctors are known to someone on the board. Even in a much larger jurisdiction, like NSW, the troubled doctors often become well known to the board and their needs can be met by knowledge of who in the medical profession might be best placed to treat the troubled doctor or to supervise the one with restrictions on registration.

The COAG proposals have met with some resistance and criticism. The Council of Australian Medical Boards has adopted its own set of principles and proposals.

There is no need for radical nationalisation of medical registration. There is no need to lump doctors in with naturopaths, osteopaths and spirit healers. A national medical board or council which guarantees no medical representation whatsoever will be a disaster. There is no need for revolutionary change. All that is required is for the Commonwealth and the States to agree on a uniform a set of standards for the registration of doctors throughout Australia and the mutual recognition of medical registration between States and Territories.

Hugh Veness
[Dr Veness is a member of the ACT Medical Board, AMA Council member and Chairman of The ACT AMA Community and Public Health Committee.]

Medical Certificate for Compulsory Third Party Claims

ACT Chief Minister Jon Stanhope issued a press release on December 4 2006, about the upcoming changes to the Compulsory Third Party Scheme in the ACT. In this release, he stated:

"The CTP Scheme has not changed significantly since well before self-government. The legislation dates back to 1948 and while there have been reviews since then, fundamental reform has tended to be put in the too-hard basket."

"The Government is looking closely at all aspects of the scheme – how it is designed, how it runs and how it can better serve motor vehicle owners. It's time we looked at opportunities for streamlining the scheme, whether efficiencies are possible, and whether we can deliver more timely rehabilitation for accident victims."

As part of this streamlining process, the ACT government, NRMA Insurance, the ACT Law Society and the ACT Lawyers Alliance, have been in negotiations for some time about gazetting a claim form. Part of this claim form is a medical certificate. This certificate is different to medical certificates required for other compensable schemes. Medical practitioners should note that it is quite acceptable to write "uncertain" or "not known" in any box on the form where the medical practitioner is unable to complete with certainty. Copies of the Compulsory Third Party medical certificate can be found at the ACT Government website address http://www.treasury.act.gov.au/compulsorytpi/index.shtml

After discussion with the ACT AMA, the NRMA believes a reasonable charge for completion of this form would be (approximately) $18.

The other changes to the scheme that will affect medical practitioners are the consents on the new claim form, which enables the Compulsory Third Party Insurer to request "clinical notes in the possession of a health service provider who treated or assessed me in relation to the personal injury and clinical notes in the possession of a health service provider or hospital which treated or assessed me for the pre existing injury or condition exacerbated by the accident". This will enable the Compulsory Third Party Insurer to fully assess and process the claims in a more timely manner. It is hoped that these changes will benefit patients in their recovery and return to pre-injury status. Medical practitioners should be aware that there may be an increase in the number of requests for reports.

The NRMA has advised that it is not, and never has been, its intention to obtain medical information not related to the accident for which a claim is being made.

Vale!

It is with deep regret that we acknowledge the death of Dr Cyril Evans who, until his retirement, was Medical Director of the Australian Kidney Foundation. Dr Evans had a long and distinguished career in medicine and we hope to report on his life in a future edition of "Canberra Doctor".

It is with sadness too, that we acknowledge the death of Mrs Ann Donovan, late wife of Dr John Donovan and former ACT AMA President and member of the "Canberra Doctor" committee.

The Council, members and staff of the ACT AMA extend deepest sympathies to their families.

AMA

Has the National Heart Foundation tick been 'hamburgled'?

AMA President, Dr Mukesh Haikerwal, said recently he is concerned that the National Heart Foundation Tick may be seen as an indicator of 'less unhealthy' rather than 'more healthy' meals.

Dr Haikerwal was responding to news that the Heart Foundation has bestowed its Tick upon nine of the many meals available from McDonald's restaurants in Australia.

"The question has to be asked: has the credibility of the Heart Foundation Tick been 'hamburgled'?" Dr Haikerwal said.

"We live in a time when obesity is a major widespread health concern and the need for people to take care with food choices is greater than ever before.

"Consumers are also faced with unprecedented labelling confusion as to just what is contained in the food they are eating.

"I fear that the Tick may create a 'halo' effect around a small number of meals on an extensive McDonald's menu that contains many items that are clearly unhealthy.

"These 'less unhealthy' meals could very well be loss leaders to get people through the door and expose them to the toys, chips and burgers that have contributed to the serious obesity and overweight problems in Australia, especially among kids.

"While McDonald's is to be commended for efforts in changing its menu, I think it may be a bit early for the fast food chain to be rewarded with a National Heart Foundation Tick.

"Wouldn't it have been more appropriate when there was clear evidence that the nine new meals were popular with consumers as the first choice foods or the only choice foods ahead of the more unhealthy items available at McDonald's?"

Dr Haikerwal said the reported $330,000 a year that McDonald's is paying for the Tick may also be putting the National Heart Foundation's endorsement out of reach of smaller food outlets that provide genuine healthy food choices across the board.

Access card draft legislation 'full of holes' – AMA

AMA President, Dr Mukesh Haikerwal, said that the Government's draft legislation for the Health and Social Services Access Card is full of holes and does not adequately address concerns about privacy and function creep raised by the AMA and other organisations.

Dr Haikerwal said the AMA was also disturbed by the timing of the release of the Exposure Draft of the legislation to stakeholders and the short deadline for submissions. The draft was circulated the week before Christmas with a 15 January 2007 submission deadline – a period during which many organisations had reduced capacity to respond.

"Nevertheless, the AMA has identified a lot of problems with the draft," Dr Haikerwal said.

"For a start, we are concerned that the legislation does not set out clearly the purpose of the Access Card number," Dr Haikerwal said.

"Nor does the legislation set out the type of information to be held on the Card, explain how the information on the Card is to be verified, or indicate how people are going to be identified.

"It all looks like legislation on the run.

"The purpose of the Access Card number must be specified in the legislation to prevent future use for other purposes, and greater protection is needed to prevent any attempts to extend the use of information or identifiers contained on the Card.

"Our concerns in this area are heightened by Clause 30 of the draft Act which allows for administration of the legislation by Ministerial policy statement independent of the legislation, which appears to be an extraordinary circumvention of usual democratic processes for such a sensitive piece of legislation," Dr Haikerwal said.

Dr Haikerwal said the AMA is opposed to the section of the Government legislation that plans to limit the Access Card to individuals aged 18 years and older, thereby hindering their ability to access services and benefits independently.

"It would restrict young people's privacy by making it harder for them to make life and health decisions free of interference.

"It is difficult to fathom the motivation or rationale for this move when the Medicare Card is available from 16 years of age or even younger in some special circumstances.

Dr Haikerwal said the AMA will raise these and other issues relating to the draft Access Card legislation with the Government at the earliest opportunity.

The AMA's full submission on the Access Card draft legislation is available on the AMA website www.ama.com.au

Letter to the Editor

Katy Gallagher MLA
Deputy Chief Minister
Minister for Health
Minister for Children and Youth
Minister for Disability and Community Services
Minister for Women
Member for Molonglo

Editor

I refer to the article in your November 2006 edition, entitled 'Calvary VMOs, concerned at inequity in the health system'. As ACT Minister for Health, I am always mindful of the vital role played by our VMOs and the importance of ensuring they have access to the best facilities available. However, I did want to comment on a couple of the assertions made in the article.

A common theme of the story was that the ACT Government determines the staffing arrangements at Calvary Public Hospital. This is not the case. Instead, the ACT Government allocates funding to Calvary based on levels of demand and activity, with Calvary's management then responsible for allocating these funds across hospital services to meet the agreed levels of activity.

Calvary and the ACT Government work closely together to plan the delivery of care across the ACT based on the relative strengths of each hospital. Calvary is funded by the ACT Government to provide a range of elective and emergency hospital services and this will continue into the future.

The story's suggestion that the Government had reneged on the provision of an obstetric resident cover at Calvary was also incorrect. The Government provided Calvary with recurrent funding of $0.210m in the 2005-06 budget to allow for Obstetrics and Gynaecology on-site registrar cover.

Finally, the suggestion that during period of by-pass, Calvary has to manage all admissions from TCH was particularly concerning. During periods of load sharing at TCH only some ambulance presentations are re-directed between TCH and Calvary. No urgent patient is ever refused admission from either hospital, regardless of load sharing arrangements. Load sharing only affects less urgent ambulance patients. Patients arriving at TCH by a means other than by ambulance (which are the bulk of presentations) are not covered by load sharing arrangements.

Yours sincerely
Katy Gallagher MLA
Minister for Health

AMA releases its federal budget submission 2007-08

In releasing the Federal AMAs Budget Submission, President, Dr Mukesh Haikerwal called on the Federal government to use the budget to lead an assault on two of the biggest challengies confronting the health of the nation – the poor state of Indigenous health and the tightening grip of obesity on our community, particularly the young.

Dr Haikerwal said the appalling state of Indigenous health remains a sad indictment of our failure to address a major crisis in human health.

"Our international reputation and our national conscience demand a concerted coordinated effort to bring the health of Indigenous Australians into the 21st century – and it must be done with commitment and passion.

"The AMAs third priority is aged care. A missing component of our aged care system is easy access to comprehensive health care from a GP or under the direct supervision of a GP.

"The other elements of our submission are all about planning for a medical workforce in the right numbers and with the right skills to keep Australians healthy, and making better use of the MVS and PBS to ensure every health dollar delivers a benefit to patients.

"We also offer the Government a long term care scheme for people with severe disabilities to ensure money goes to people in need, for proper care, irrespective of how their disability arose, and not just those who can find someone to sue.

"The AMA Budget submission is all about quality health care for all Australians", Dr Haikerwal said.

Other issues in the submission include:

- consultant physician attendance items,
- specialist training in private clinical settings,
- restructure of GP consultation items for quality care,
- GP referral to MRI,
- support for procedural GPs,
- support for training in general practice settings,
- training and support of temporary resident OTDs,
- assistance for bonded medical school students,
- rural retention program,
- medical specialist outreach program, and
- rural hospitals

The submission is available on the AMA website at www.ama.com.au

Enteric diseases, contagion and miasms in the 19th century – Part 1

By Dr Keith Powell

The author is deeply indebted to C-E A Winslow1 for ideas in this paper.

Introduction

This paper deals with a medical tussle, prominent through the 19th century in the UK, Europe and the USA. Until late in the century the mode of spread of cholera and prominent enteric diseases remained obscure. Two opposing theories on the mode prevailed, the contagion (germ) theory, and the miasma theory. This paper outlines this tussle through reference to the enteric diseases, cholera and typhoid fever.

Until clear proof of the cause of these two diseases was shown by the microbiologists, late in the century, confusion and overlap prevailed in the names used when referring to diarrhoeal diseases, cholera excluded. Names included continued fever, relapsing fever and intermittent fever. Names for typhus included ship fever, putrid fever, gaol fever and marsh fever. It became accepted that intermittent fever might develop into typhus in crowded, poorly ventilated, dirty habitations. The astute clinician John Huxham sought to control the spread of infections, and to separate the various types of fevers by careful history taking. Pierre Louis closely studied fever patients in Paris in 1827. From histories of near 900 patients, including 133 autopsies, he concluded that typhoid fever was a disease of the Peyer patches of the small intestine, and probably the same as that labelled typhus by British clinicians in their 1817 epidemic. In the USA, William Gerhard likewise separated typhus patients from typhoid ones. In the UK the distinction between typhus and typhoid fever remained obscure until 1839, and then only for well informed doctors. Such a distinction did not appear in the Registrar-General's returns until 1869. These endemic diseases also occurred in epidemic form.

The terms contagion and miasma are first defined.

In 1719 the Lords of the Regency asked Richard Mead, the leading medical practitioner in London in the early 18th century, to report on the plague sweeping through Marseilles. His 1720 report emphasised the importance of contagion, where 'Contagion is propagated by three causes, the Air, Diseased Persons and Goods transported from infected places.' Mead saw the plague as spreading from person-to-person, and through contagious matter contained in goods of loose texture, such as bedding. As to the air it was capable of spreading the contagious matter, 'but not to any great distance.' Mead did not invoke the idea that the contagious matter was a living organism. Similarly, 19th century supporters of contagion being the mode of spread for plague 'considered that a healthy person developed plague because he had been in contact with a plague stricken individual or with something with which the latter had been in contact', such as bedding. This paper predicates that the mode of spread for cholera and typhoid invoked the same concepts. In the middle of the century two epidemiologists, John Snow and William Budd produced evidence that direct spread included the ingestion of contaminated water or food. Despite this knowledge, any definition of contagion lacked precision until after the isolation of bacteria by microbiologists. Before such isolation, the contagious element was thought of as a chemical or physical agent. Furthermore, part of the puzzle was why were some people stricken and others spared? This problem partly explained the lasting popularity of miasmatic models, holding that sickness typically originated in the environment.

In contrast to the above definition, miasmatists argued that enteric diseases arose 'from poisonous exhalations exuded by putrefying animal remains, rotting vegetation and stagnant water: bad environments generated bad air which turned pestilential.' Dung heaps were part of this foul matter. While the mode of spread from noxious agents was never defined Southwood-Smith, a public health authority, argued in 1830 that the fever was caused by a poison arising from the decomposition of organic matter. A link between organic matter and the patient was not outlined.

Despite the swelling tide of evidence supporting the contagion idea that arose, before and after the scientific publications of Pasteur, miasmatists continued to successfully promote their theory. Their last great advocate, was the distinguished German hygienist, Max von Pettenkofer. Many prominent doctors of the day, including members of the London Royal College of Physicians, then preferred the miasmatic theory.

In 1965 Harvard professor Wade Frost was able to assert that when Snow wrote his 1849 report on cholera, the clinical features, mode of spread and pathology of many of the communicable diseases had been delineated. However, this was not so for the enteric infections where the mode of spread, and 'the indirect evidence of communicability, was by no means so plain as to be incontestable.'

Early ideas on miasma and contagion

In 1546 Girolamo Fracastorius 'suggested that a living contagion was the cause of infection.' He was then the most scientific student of the epidemics typhus, plague and syphilis. He recognised three forms of contagion:

a. simple contact, seen in scabies and leprosy,
b. indirect spread by fomites, inanimate objects such as bedding and clothing,
c. transmission from a distance.

This model was forgotten, until mid 19th century.

The German mystic Athanasius Kircher, aided by the use of a primitive microscope, stated in 1658 that 'invisible animals were present in putrefied tissue and that the contagion of plague was due to similar minute bodies.' He theorised that the spread was by a 'living effluvia' that could be breathed in, or 'transmitted by the fingers or other forms of contact.' Three neglected doctors, R Bradley, B Marten and J-B Goiffon, published work in 1721-22 in which they attributed 'insects', 'animalcules', or minute animals as causing tuberculosis and plague. Forty years later, in his 1762 publication, the Austrian physician. Mark Plenciz maintained that 'contagion was due to a *seminale verminosum*, with a different kind of seed for each disease.

While the first microscopes appeared about 1600 it was the early use of them by Malpighi and the Dutch draper von Leeuwenhoek, that brought benefit to medicine. Malpighi's 1661 book revealed the minutiae of the alveoli, and von Leeuwenhoek 'was the first to describe the spermatozoa and protozoa and to demonstrate micro-organisms on the teeth, giving what constitutes the first illustration of bacteria.'

William Cullen, an influential Edinburgh physician, argued that epidemics were due to 'some matter floating in the atmosphere', which was of two categories. Firstly, the contagion of smallpox gave recipients the same disease. For other diseases the contagion, called miasmata, came from swampy ground and led to diseases such as typhoid, yellow fever and mal-aria (bad air). Unfortunately, Cullen's disease framework, which intermingled contagion and miasma, 'shaped the beliefs and practices of thousands of doctors throughout the English speaking world for the next fifty years.' In Montpellier, Halle and Vienna the teaching was similar to that of Cullen.

An early lone voice was that of William Alison who, in 1817, was practising among the poor in Edinburgh where 'unemployed workmen and their families were virtually destitute.' In these overcrowded living conditions Alison 'became more and more convinced that [continued] fever was spread by contagion [presumably by direct contact], and had nothing to do with dung heaps.' He recommended isolation of the patients and 'the fumigation, whitewashing, and cleaning of the rooms, clothes, and bedding in which they have lain.'

Historians have rightly depicted the medical profession in the early 19th century as anti-contagionists for major epidemics such as plague, yellow fever and cholera. However, those doctors 'practising obstetrics, at immeasurable personal and professional cost, kept alive the issue of contagion during the first half of the 19th century.' They came to accept the grim reality of puerperal fever, namely, that they transmitted the disease to their patients.

continued...

Alexander Gordon of Scotland, Semmelweis in Hungary, and O W Holmes in Boston all argued that the infectious agent was on the obstetrician's hands. The medical establishment rejected their ideas.

The influence of the pioneer sanitarians and the health conditions of the poor

In the first half of the 19th century the diseases of the intestine intrigued sanitarians. Plague had virtually disappeared as a major disease. The challengers for Europe were typhoid fever and cholera. In response to the challenge came the inception of the modern public health movement. As Winslow writes, these were the diseases 'in which environmental sanitation was of vital importance' and diseases in which the concept of the local miasmas fitted the case very well.

Three pioneer sanitarians, two being English, (John Howard and Edwin Chadwick) and the other French, (L-B Guyton de Morveau) initiated early changes of a public health movement. Further reference is confined to Chadwick who, in 1842, produced 'his magnificent visionary plan for an integrated water supply, self cleansing sewerage and drainage system for London.' In the words of his biographer, Chadwick developed what he called 'the sanitary idea', that man could, by getting at first principles, and by arriving at causes which affect health, mould life altogether in its natural cast, and beat what hitherto had been accepted as fate, by getting behind fate itself and suppressing the forces which led up to it at their prime source.

This innovative idea established Chadwick as a trailblazer and diminished the incidence of illness by removing filth from houses, streets and surrounds.

In 1839 Lord John Russell asked the Commissioners of the Poor Law Board to conduct an enquiry into the health conditions affecting the labouring classes of Great Britain. In response, Chadwick's 1842 report on the 'Sanitary Conditions of the Labouring Population of Great Britain', became 'the basis for the wave of sanitary reform which swept over the civilised world in the middle of the 19th century.' At the time of the report filth in towns and cities in all countries, including the USA, was frequently extreme. Houses for the poor and the rich lacked a piped water supply and toilets that could be flushed. It was not uncommon to find, as one surveyor in London did in two houses, that 'the whole area of the cellars of both houses were [sic] full of night-soil, to the depth of three feet, which had been permitted for years to accumulate from the overflow of the cesspools.' When disturbed the stench was powerful and foul. In the poorer parts of the town dung heaps were common. Today we know that direct contact with such excreta, or indirect contact through flies, will transmit disease. By contrast Chadwick, and others, promoted inhalation of atmospheric effluvia as the mode of transmission, where the effluvia contained minute particles of matter.

The report emphasised that if the enteric diseases then prevalent were to be prevented, then it was essential to have an adequate supply of pure water for drinking and washing, to have a vast improvement in disposal of sewage to diminish the foul effluvia, and to reduce the gross overcrowding in the houses of the poor. When the sanitary reformers cleaned up the masses of putrefying filth through which our great grandfathers moved, the epidemics of typhoid and cholera and typhus and dysentery actually ceased. The miasmatic theory was the first generalisation of epidemiology to be actually – and on a worldwide scale – justified by its fruits.

But sanitarians of the 19th century fell prey to a simple fallacy, the 'fallacy of a single cause'. They knew that, with the eradication of filth, the epidemic diseases disappeared. Alas, they rejected ideas on the mode of spread, other than inhalation of the effluvia. Thus ensued 'another long and fruitless controversy between miasmatist and contagionist, with the heavy artillery in the hands of the former.' Miasmatic 'theories of cholera prompted [sanitary] interventions which lessened the severity of future cholera outbreaks. Being right for the wrong reasons can be fine as far as short-term public health outcomes is (sic) concerned, but can be a severe impediment in the long term.'

In 1848 the Metropolitan Sanitary Commission (which included Chadwick) published two reports on health conditions in England that represented the generally accepted beliefs then prevailing in the UK and Europe. A major conclusion in the Commission's first report, that 'decomposing filth and undrained marshy areas were major factors in the causation of epidemic disease', was correct. Its other major conclusion, that 'there is no evidence that cholera spreads by the communication of the infected with the healthy', proved to be wrong. After presenting much evidence the First Report concludes that cholera 'is not, as it was then generally supposed to be, contagious, and that the practical application of that doctrine [eg quarantine] did no good but was fraught with much evil.'

Winslow, in his discussion on these two reports, elaborates on how the reports provide examples of the misleading influence of extreme miasmatic conceptions when carried to their logical conclusions. For Winslow the conclusions of the Sanitary Commission were almost inevitable given that the concept of indirect transmission by water and food was then unknown. Within twelve months John Snow provided evidence of such spread.

Continued next month.

Interest Rates On Hold – Property Gathering Momentum

By, Jeff Proud, Director, Park Heath

The decision by the Reserve Bank in February to leave interest rates on hold is not only good news for home owners. It provides even more reason for smart investors to move back into the property market.

Why is that?

For some time now, vacancy rates have been tightening as a result of reduced building activity and particularly, a lack of interest from investors meaning fewer rental properties being offered to the market. Moreover, first home buyers have been frightened out of the market by the fear of further interest rate rises. This has led to an increase in the number of people looking for rental accommodation at a time when less of it is available. The inevitable outcome of this is higher rents. Good news for landlords!

Now that interest rates appear to be settled for the foreseeable future and indeed may even fall later in the year, buyers are starting to move back to the property market. The higher yields are attracting investors and this is already putting initial upward pressure on prices in those markets where an undersupply of property exists. The Brisbane market in particular is benefiting from this phenomenon as it has a significant stock shortage coupled with ongoing strong population growth.

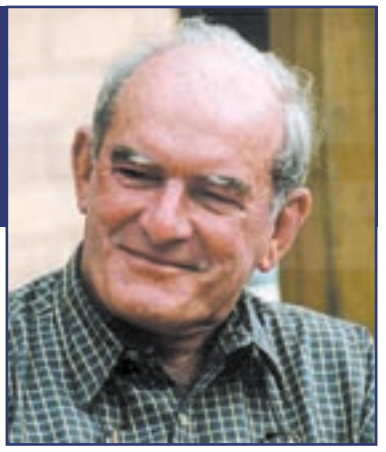
I spent a number of days in Brisbane at the end of January sourcing properties for several clients and the increase in buyer activity was evident right across the market. In fact, of a short list of 10 properties that I had identified, 4 were sold within 3 days of my inspection. One property lasted only 1 day on the market before going under contract!

It will take quite some time for the supply of new property to increase sufficiently to ease the tight vacancy rates and for this reason we can expect rental yields to continue rising. This will continue to draw investors back into the market. At the same time, first home buyer's are likely to be more active given the greater certainty with respect to interest rates and this will put further pressure on the already tight supply of property. For markets such as Brisbane and to a lesser extent Melbourne, the natural consequence of the increased activity will be improved price growth over the balance of 2007 with strong growth likely to occur in 2008 and 2009.

The investors who re-enter the market sooner will be able to take full advantage of the rises in both rents and values and will be in a better position to add to their portfolio when the market really takes off during the next price boom.

A reply to Professor Little's article " Patients and Doctors – how to misunderstand one another" "Canberra Doctor", November 2006

"Human Rapport in difficult circumstances"



by Dr Murray Lloyd, A retired Consultant Geriatrician who has studied the teaching of medical communication since introduced to it by the RACGP in the early 1970's.

In his article in the November issue, Professor Miles Little has suggested that the problem "Human rapport in difficult circumstances" is an appropriate title to further explore the Pandora's Box that he has opened by suggesting that there is "a problem we need to discuss and keep discussing until we all understand one another better".

I hasten to accept this challenge. As with any debate, the kick-off for this round should acknowledge Miles Little's background and reputation as a surgeon of excellence and extensive experience. I suspect his interest in the mystery of poetry has played an important part in his understanding of the psychodynamics of cancer patients.

However, I suggest that his core opinion ***that communication skills cannot be effectively taught*** comes from an information base that is too narrow; one that does not acknowledge the paradigm shift that is taking place in the development of curricula for professional and personal skills in both under and post graduate studies.

My reply 'in opposition' follows the sequence of the five reasons Professor Little nominates as causing the difficulties in teaching communication skills.

Difficulty One ***"Residual paternalism is the legacy of all the learned professions"***

Comment: Some doctors practice and enjoy the autocratic model, justifying it as faster and safer; a protection from getting too close to the emotional reactions of patient and family. It may also be an expression of their innate personality needs to be assertive/aggressive as a protective mechanism in their life story.

The training need for this is a repetitive exposure to the empathic model; the art of practising in the safety of 'identifying with' as distinct from the more draining 'experiencing' what the patient is going through. This sets up an important protective barrier that can be clinically expressed in a variety of ways depending on time, energy, skill and situation.

My work has particularly focussed on the growing numbers of older people being cut off from normal, rational expression by their increasing dementia. The programme of understanding the pursuit of meaning in their muddled world has provided practical approaches that are relevant to all supporters of the disabled elderly.

In the hospital environment apprentices may well see painful and thoughtless episodes at the bedside and thus learn from negative example. On the positive limb, observation of or being taught to use simple phrases such as "If I were in your position, I'd be finding it hard to deal with all this" accompanied by a light touch on the shoulder creates an ambience that is invaluable to the security and healing of the patient and family.

Just after Christmas, rounding a dangerous curve in Malua Bay, I came upon a recent motor cycle accident with the victim lying shocked on the gravelly roadside, surrounded by distressed bystanders.

Because I had recently read a book on how to communicate with shocked accident victims, I was able to use a method developed by Acosta and Prager that was developed at the 9/11 site in New York. It involves touching the person, reassuring them that help is on the way and then directing their attention away from their pain.

My communication training had provided an aide-memoire that stood me in good stead. I drove on with the satisfaction that I had made a difference to the frightened confusion that surrounds any accident.

There are other communication relationships that have to be used in clinical practice. These can be based on a model that witnesses and instructs on the various ways in which we express our leadership skills to both colleagues and patients. The model that supports this approach enables communication theory to be examinable, a key factor in gaining the interest of students!

Difficulties two, three and four.

There is a lack of any forum for the exchange of views between consumers and providers … Singular narratives give us an insight into this person's experiences …rather than a way of understanding the experiences of many. A series of powerful narratives adds to our store of intuitive insights, makes us aware of issues that mightn't have been obvious.

Comment:

Some of my retired time is spent coordinating what has been labelled an Older Person's Advocacy Group. Through this I have learnt what can happen, particularly rurally, when patients and family are dealt with by an overstretched, understaffed system. My over-70 generation isn't used to feeding back what it doesn't like from the system and it has been found difficult to shift this piece of culture.

Currently I'm helping someone with the very frustrating task of defining the best way to proceed with a cancer situation. Through this I have found what I think Miles Little is asking for.

The Gawler Foundation has a two page advice sheet for cancer patients and their relatives. It brings together tactics to deal with the problem that comes from Ian Gawler's 25 years experience as a patient and educator/ supporter of cancer patients.

"It is a sad fact, that with the thousands of people we have worked with over the years , it has been rare to find a patient who has not had at least one major medical complaint that had at its core poor communication.".

Entitled ***Developing good Doctor-Patient relationships***, the advice sheet gives 7 invaluable sections of advice such as ***"practice gentle assertion, take a second person, preferably a partner, ask if you can use a tape recorder."***

This type of material is the bringing together ('conflation' is the word used in the article) of many opinions into a general problem and suggested solution. This reflects the new communication culture; one that doctors need to be prepared for so they don't flinch and react defensively. The phrase my GP taught me ***'two heads are better than one'*** reflects a philosophy that can absorb the increasing tendency of patients to arrive in the surgery with information derived from Google and its outposts.

Another way of promoting this understanding of patient's needs is a method developed at Royal North Shore Hospital in the seventies—the multidisciplinary forum in the hospital at lunchtime where moral and ethical aspects are discussed by all disciplines through role-played recent incidents. Impacted in my memory is the red-headed female student who exploded as we looked at the implications of a barbiturate overdose and the staff rejection attitudes experienced. This was a great way to learn about prejudice and the rejection it can cause.

The Australian Medical Council has an important role in promoting this aspect of medical training; one that comes into all Medical Faculties under the heading of personal and professional development. In its overview of the developing teaching patterns, it is to be hoped that one of the clinical indicators for a quality programme is the presence of this type of session.

Just as Lambie and Armytage's textbook on clinical examination was compulsory reading in my student days – particularly if you, as I did, had to present a case to the 'wee mon', the fiery little Scottish Professor of Medicine – so one would see the two books of Dr.Rachel Remen as compulsory reading for all students of communication, whether students or graduates.

Her chapter-by-chapter descriptions of her life as a patient with multiple operations for Crohn's disease take the reader into what it is like to be on the receiving end. In her 'giving' role as a Palliative Care Physician Dr Remen was able to use her deep empathy because she had had the type of learning experience that Miles Little appears to be envisaging.

Difficulty 5. The saddest. ***I would argue that you cannot legislate either ethics - which then ceases to be ethics and become law - or good communication.***

Comment: What has happened with the problem of bullying in schools presents as a good example of attempting to enforce a morality.

Three of my grandchildren (25%) have been bullied at their schools. Through this I became aware of the move to reduce/ remove from the system this common human behaviour that can have far reaching impact on personality and brain development.

In one school there was the usual mission statement and set of procedures taken direct from the wisdom of Australian manhood expert, Steve Biddulph.

But the newly-arrived, incompletely-trained teacher who represented step two of the awkward process of dobbing in a colleague, 'blew it'. The awkward results required parent intervention but the moral value was upheld, albeit with parental determination required.

Improving communication skills requires a similar set of steps whereby the low performer, in an understanding way, is taught that a better pattern is expected by the system. Sensitive, firm correction replaces legal enforcement.

An active negative feedback system can work towards the goal whereby the average medico can intuitively handle situations; ones that invariably arrive at the wrong moment. Some practitioners may need to be helped to select areas of practice where their inability to achieve communication skills does no harm. Similarly, those like the 'incredibly upset' Sister Sue in the November article should be provided with backup to ensure that burn out does not drive her out of a key position.

Summary

Doctor-patient communication is difficult and needs to be improved. Many changes in the understanding of communication training are available to meet the demands of a new doctor-patient culture and the needs of our increasingly multicultural and ageing society.

Applying the principles of continuing quality improvement by looking at where and from whom most failures take place provides an ongoing task for administrators and teachers.

My arguments support the position that communication can be taught by using a wide spectrum of approaches that have moved on from previous models. The list below summarises some of the steps that arise from this spectrum for change:

1. All medical students have some appropriate form of personality assessment whereby they can become aware of the basic deficiencies they are carrying into medicine from their culture, personalty type and life experience.
2. During and after graduation students are required to learn about how to maintain and develop their resilience. This is already taking place in RACGP training based partly on the excellent workbook circulated in 2006 "Keeping the Doctor Alive". It is a stepping off point from which all practitioners can develop an effective self-awareness approach that will benefit them and their families – and their patients.

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Human Rapport continued...

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3. The ethic of ensuring that every doctor has a GP is promoted actively, particularly when there is heavy exposure to life threatening or violence-related situations.

'The deprived self cannot afford to give itself away" is an old dictum from social work literature. This potent creator of communication difficulties is unfortunately all too common due to the excessive demands of an unsympathetic health system.

4. There is a learning stream through which, particularly males, can learn to talk about their feelings in groups with their peers. This is a fruitful way to learn not only how to communicate with your deeper self but how to share it with others.
5. There is a continuing tutorial programme in the form of clinical sessions devoted to experiencing and solving the complications of team management of people desperately trying to sustain health and quality of life.

This framework requires an ongoing mentoring process that strives for resilience development and nurtures students and young graduates as they slowly learn to engage in the difficulties of the admixture of their family and professional stresses. The anchor of this programme presents as the RACGP programme that was founded in New Zealand, upgraded in Australia and is now available for spreading into the specialist College training programmes as the self awareness training booklet "Keeping the Doctor Alive".

Hopefully this reply and subsequent rounds of the debate catalysed by Miles Little will further reverberate the anguished cry for change from a doctor's wife that was the trigger for his original article in the Internal Medicine Journal.

References for the opinions expressed can be provided on application to "Canberra Doctor"

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Controlling access to flavoured tobacco products and split cigarette packets in the ACT

ACT Health's Health Protection Service is seeking comment on a consultation paper of options for controlling access to flavoured tobacco products and split packets in the ACT.

The sale, supply and advertisement of smoking products are controlled under the Tobacco Act 1927.

Due to concerns that fruit or other flavoured tobacco products could encourage more young people to smoke, the ACT has licence conditions (as an interim measure) in place for all tobacco retailers and wholesalers prohibiting the sale and supply of fruit flavoured tobacco. The current tobacco licence condition is only applicable to the sale of fruit flavoured cigarettes and does not cover any other identifiable flavours such as vanilla, chocolate, and other food related flavourings.

ACT Health is seeking views on split packets, which are two packets of cigarettes sold as one packet with 20 cigarettes. After sale, a person is able to separate the packets.

The consultation paper is available at www.health.act.gov.au under publications and canvasses several proposals to control the sale of smoking products that are targeted at and appealing to young people through attractive flavourings or packaging.

For further information contact the Health Protection Service on 6205 1700.

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