Canberra DOCTOR
Informing the Canberra medical community since 1988
Important information regarding the 2007 specialist directory inside.
Canberra Doctor is proudly brought to you by the ACT AMA

Train your practice staff with the AMA ACT

Exciting new opportunity for medical practices!

The AMA ACT in association with AMA Victoria and Esset Australia are pleased to announce the introduction of a training program to improve the skills of health support staff. They have combined under the training name of "Health Training Solutions" to bring these approved courses to your staff.

The AMA ACT, AMA Victoria and Esset Australia (a Registered Training Organisation) have combined to provide the Certificate II in Health Support Services (Health Administration) and Certificate III in Health Support Services (Health Administration) as well as a Certificate IV in Health Administration and a Diploma of Practice Management. The courses are designed to assist all health support staff work effectively in a modern health workplace.

Units are completed in a range of areas, including

- Patient records
- Infection control
- Senior first aid
- Medical accounts
- Confidentiality and privacy
- Manual handling

Flexible course delivery options to suit the needs of staff and the workplace:

- On the job at your preferred workplace, with course trainers visiting each participant to complete the course requirements and ensure transfer of skills to the workplace
- Optional one day workshops at AMA House in Barton
- Comprehensive health specific print materials and staff support strategies

The Health Support Services stream is anticipated to become the accredited career pathway and industry standard for medical and health support staff.

The courses are available as recognition pathways, offering experienced support staff recognition for skills and knowledge developed over many years of services.

Esset Australia is a nationally registered training organisation (RTO) registered under the Australian Quality Training Framework. As an RTO, Esset Australia has been audited and meets Australian Government educational standards.

A new federal government initiative means that practice staff may have the cost of a Certificate II in Health Support Services (Health Administration) met in full by a Work Skills voucher.

To be eligible staff must be:

- Australian citizens
- Aged over 25 years
- Without Year 12 or a qualification at or above Certificate II

For practice management and support staff the vouchers provide funded support for the opportunity to up-skill in core areas of practice support in areas such as:

- Infection control
- Occupational health and safety
- First aid
- Managing challenging behaviours

We are streamlining the process for obtaining a Work Skills Voucher so practices are aware of staff eligibility for funding before committing to enrolment. Staff will need to provide evidence of eligibility criteria. Esset will notify the Department of Education, Science and Training, which will post eligibile employees the voucher to give to the RTO to pay for their course.

This means that eligible practice staff can enrol in a Certificate II at no cost to themselves or the practice. Some units from a Certificate II can be credited towards a Certificate III. Staff wishing to complete the Certificate III may also b eligible for funding if they have not participated in formally accredited vocational education programs, such as TAFE courses, in the last seven years.

Interested in reducing your risk by up-skilling your staff via our training programs? Contact Elizabeth on 6270 5410 for further information or visit www. ama-act.com.au

Ask about the discount cost to AMA members when you speak to Elizabeth!

This Issue
The year's most exciting social event
– page 11

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ACT AMA President's letter

Dr Andrew Foote.

Has it really been one year?

It is now 12 months since my ACT AMA presidency began and I can reflect with some satisfaction on the achievements that the ACT AMA branch and its councillors have been able to achieve, including:

- promoting a positive image of our great profession via the "Do you want to praise your Doctor" poster, the Family Doctor Week, the Canberra Doctor Award, and the Medical Student Leadership Award
- promoting good community health care via the HEROES school campaign, smoking reduction, pandemic planning, antenatal shared care guidelines, workers compensation arrangements, aged care facility services, cremation certificates, End of Life and Powers of Attorney draft legislation, single expert witnesses and tort law reform
- promoting member benefits via the ACT AMA card with local partner businesses
- ongoing core industrial campaigns such as the very successful VMO pay rise, and our recent expansion into the hospital scene with direct industrial representation for staff specialists. This will become increasingly significant in the forthcoming year with new contract negotiations and the need for a fiercely independent voice that is not afraid to speak out against the hospital bureaucracy. We also successfully intervened on behalf of medical students to win reduced parking fees.
- ongoing government influence via regular meetings with ACT Health, the Health Minister, and Hospital CEOs.
- ongoing promotion of general practice and workforce issues
- support of the Medical Benevolent Association via a Cocktail evening

Canberra Medical Ball

I am very pleased to announce ACT AMA's involvement in the inaugural Canberra Medical Ball to be held on Saturday 30th June, in collaboration with Canberra Medical Society and Medical Women's Society. I would particularly like to acknowledge the willing participation of the respective Presidents Drs Caroline Luke and Jane Twin. The evening looks set to be a great social occasion, so get your tickets early to avoid disappointment.

Employment issues

ACT AMA is excited to announce that it will soon commence courses to train admin practice staff. There is more information on this in this edition. We have also presented information sessions on the impact of WorkChoices legislation and about to run a seminar in partnership with Minter Ellison Lawyers on "contractors or employees" – WorkChoices and the Independent Contractors Act.

Federal issues

Media releases have included smoke free cars, national bowel screening, banning of duty free cigarettes, national anaphylaxis strategy, safe drinking water, genetically modified food safety, government superannuation ethical investing, and alcohol health warning labelling.

The AMA National Conference will be held at the end of May in Melbourne with Dr Haikerwall stepping down after his very productive two-year presidency. We all eagerly await the vote for the new president and executive team, to what has become the premier advocacy lobby group in Australia.

The next year

The Federal election is looming and health is definitely a core issue. I continue to be keen to see a no-fault long term care scheme for the catastrophically injured. I look forward to building on the good work that has already been done, and please don't hesitate to contact me if there are burning issues.

If you are interested in serving on one of our committees, please contact Christine on 6270 5410. Only AMA members need apply, though. Your contribution will be most welcome and you can influence health policy in the Territory through serving on a committee as many of your colleagues do now.

Aged Care
Community and Public Health
"Canberra Doctor" editorial
Medico-Legal and Ethics
Doctor in Training Forum
General Practice Forum
Tobacco Task Force
International Medical Graduates Forum
Salaried Specialists Forum
VMO Forum

A flexible (and now very tax effective) retirement

In February 2006, I wrote an article about how the transition to retirement rules, effective from 1 July 2005, allowed a member to commence a superannuation pension without having to retire. This was a flexible and tax effective way to use you super fund at that point in time. Then came the May 2006 budget and the plan to simplify super. A key part of these changes was to eliminate tax on all benefits, lump sums and pensions, for those over 60.

From 1 July this year, for people still working beyond 55 and particularly for those over 60, the transition to retirement pension combined with salary sacrifice provides a significant opportunity. (From now on we will call these pensions NCAP's or "non-commutable allocated pensions".)

How does it work?

The strategy works as follows:

1) Salary sacrifice your wages (for employed individuals) or make a deductible contribution (for self employed) up to $100,000 for those over 55 from 1/7/07
2) Commence a NCAP (up to 10% p.a.) of the amount of your superannuation account (which will be tax free for those over 60 from 1/7/07)

The benefits are:

1) **Income tax savings:** Income/wages which would otherwise be taxed at your marginal tax rate (possibly as high as 46.5%) are being taxed as superannuation contributions instead at 15%.
2) **Pension income:** As mentioned, the pension income will not be taxed for those over 60 from 1/7/07. For those aged 55-60, the pension income will be taxed but will carry a 15% tax rebate.
3) **Tax within the fund payable by the trustee:** The assets supporting the pension will also not be taxed where previously they were taxed at 15%. This tax saving is passed through to your member account within the fund (for both DIY funds and public offer funds).

Is this too good to be true?

A golden rule that has served financial advice providers well when assessing risks is: "If it sounds too good to be true, is usually is!". In this strategy you are effectively capping your top marginal tax rate at 15%, as well as eliminating tax within your super fund. There is certainly an element of "too good to be true" about this strategy. Let's examine the legislative risk:

ATO – media release NAT – 2005/66: The ATO was asked to provide comment on this strategy in Nov 2005. In this statement, the tax commissioner Michael Carmody, commented

"There has been some media interest recently in the promotion of this strategy. Arrangements entered into in a straight forward way are consistent with the operation of the law, and we do not see grounds for applying anti-avoidance rules.

"For example, an eligible person may take out a pension under the transition to retirement rules. At the same time, that person may engage in an effective salary sacrifice arrangement and contribute to a complying superannuation fund for their own benefit.

"We would only be concerned where accessing the pension or undertaking the salary sacrifice may be artificial or contrived."

It is important to note 2 points:

1) This media release was prior to the "plan to simplify superannuation", and
2) The ATO has mentioned *"artificial or contrived"* arrangements without explicitly detailing what constitutes such an arrangement.

Some comfort

Anyone engaged in the "plain vanilla" variety of this strategy as described in this article and in the media release above, is almost certainly protected by this statement. For absolute certainty a binding private ruling can be obtained.

If the ATO subsequently changes it's view, (perhaps because of the changes in pension taxation from 1 July), NCAP pensions are able be rolled back into the accumulation stage of super at little or no cost.

The "transition to retirement" rules and the "plan to simplify super" reforms have received overwhelming support from ***both*** sides of government. The intent is to address the drastic underfunding of our retirement system as a result of population demographics and inadequate current savings.

On that premise, it's unlikely that strategies which encourage use of superannuation will be penalised.

More information

The "plan to simplify superannuation" and the "transition to retirement rules" are part of a constant stream of changes to superannuation rules over the last few years. Your adviser can help you understand what the changes mean to you and can advise you on the best course of action to suit your personal circumstances.

Copy supplied by Grant Alleyn, King Financial (see advert this page)

Recycled sewage in our water supply; a needless human health

There has been much media interest in this matter since Professor Peter Collignon raised this matter in the public arena. There has also been a weigh-in to the debate by water experts and politicians. The medical profession has a unique opportunity to make its views known and to advocate caution on the basis of public health impacts now and into the future.

It is timely to report that the AMA Federal Council recently resolved:

The AMA recognises the importance of safe drinking water for human health and supports the recycling of water as long as monitoring and rigorous testing of the water is undertaken to ensure its safety for human consumption.

That in light of this, all efforts must be made to reduce demand for water and encourage its more efficient and responsible use; and

That the AMA calls on all governments, councils and industries to maximise their use of recycled water.

The AMA exists to, among other things, promote and advance the public health and it is both appropriate and timely that this resolution be circulated widely in the light of the discussions being held in the ACT and given the contribution to the debate by our own nationally and internationally well-respected authority, Peter Collignon. The health of the community depends on informed, open and robust discussion before any political decisions are taken.

In the light of the ongoing drought conditions being experienced in Australia, this debate is likely to continue for some time and it is important that for the health of us all that we get this right. We would be pleased to consider for publication any contribution you may wish to make to this debate and influence the political agenda, and we encourage you to do so.

Following is a modified copy of the submission that Peter Collignon made to members of the ACT Legislative Assembly.

Peter Collignon, writes:

Please note: These are my personal views and do not necessarily reflect the opinions of the organisations for whom I work or am associated. Many of the necessary facts to have an informed public debate are surprisingly difficult to find (eg, environmental flows per year etc. My sources for information and websites are given in the Postscript at the conclusion of my article.

It is proposed in Canberra we will recycle about 9 GL (9 billion litres) of waste-water and then pump this treated water back into our reservoirs. It will then be used as part of our domestic water supply, which includes drinking water.

Professor Peter Collignon.

Removing sewage from our water was a significant public health improvement

One of our most significant public health improvements was removing sewage from water supplies. Human waste contains numerous viruses, bacteria, protozoans and other microbes that frequently cause disease if ingested. While our sewage will be treated so that it is "safe" to drink, the mechanisms being proposed for this all have potential problems with performance. Thus there is a strong possibility that at times we will contaminate our water supply with disease causing micro-organisms.

Not necessary to recycle sewage in Canberra: unnecessary risk to human health

Worldwide there are localities where there is no alternative but to accept the risks associated with using recycled sewage. However, whenever possible when we can avoid placing treated sewage into drinking water this is hazard obviously desirable to avoid. In Canberra there is no reason to take this risk. The ACT has large volumes of unused water. Indeed it is a very large net exporter of water to NSW (on average about 471 GL per year). We also currently have one of the best water supplies from a safety point of view in Australia (and probably worldwide). Currently no human sewage enters our drinking water in our catchments. We are also very fortunate (and unique) in that minimal domestic animal waste enters the water supply because few farms are in our catchments. Most of our current Canberra water is good enough to bottle!

Can we make sewage "safe"?

A number of methods are purposed to make this recycled sewage "safe" but how many systems work perfectly all the time? If membrane technology is used, how can we be sure that these membranes will be able to accommodate the planned 24 million litres of recycled water that they need to filter each day? How will we know when there are small tears in parts of the membranes? Bacteria are very small and unless the pore size of these membranes is < 0.2 microns it is unlikely that all bacteria will be removed. However if the pore size is so small, I find it difficult to see how these membranes can satisfactorily work without being frequently blocked by larger waste material. Even if such small pore sizes are used, this will still not remove viruses, which are much smaller. Membranes will also not remove drugs passed in urine and faeces that are not broken down (such as oestrogens).

A "reverse osmosis" process is also going to be used. But there is a lack of details available to Canberra residents to see how effective this system (which also has very high energy requirements) may be in removing all viruses (and drugs). Ultraviolet light will also be used as an additional sterilising agent. However this is far from an ideal disinfectant. There are many issues such as time of exposure, susceptibly of different microbes etc, for it to work. How can we be sure that this can handle 24 million litres of waste-water per day?

Safety monitoring is planned, presumably by culturing the water and looking at coliform counts. If coliforms (eg E. coli) are present in the treated water this implies faecal contamination (and thus a failure of the system). However, this type of monitoring has problems. Around the world numerous outbreaks with water contaminated with viruses and Cryptosporidiosis, have occurred despite low or zero coliform counts. In addition these indicator bacteria take 1 or 2 days to grow and identify. There does not appear to be a plan for storing 2 or 3 days of recycled water in a temporary reservoir. Presumably the water will be pumped directly back into our dams after treatment. This will mean that even when we detect a failure with our treatment system, there will be little we can do about it because the contaminated water will already be in our dams. How often will this coliform testing be done? -every half hour, hourly, daily or just weekly? If pressure monitoring is going to be the main method used to assess any system failure, how will we know if only small tears in the reverse osmosis or filtrations membranes have occurred?

Why take this backward step? Other better options

In Canberra we do not need to recycle our waste-water back into our drinking water supply. The current proposal is for initially 9 GL of water per year to be recycled into our dams. On average however about 120 GL per year has been released from our dams into the rivers as environmental flows (46 GL) and as spills (75 GL). Spills are when dams overflow – which has occurred frequently, even in droughts, with the Cotter dam because of is low storage capacity. In 2006 (our worst year on record) we still had 13 Gl that either overflowed or was released from the Cotter dam. This released water is relatively "pristine" from an infection point of view. Why not find ways to withhold 9 GL of this water? Is this not a better option than pumping uphill, 9 GL of very expensively treated waste-water upstream into our reservoirs when we cannot be assured it will always be free of harmful microbes?

Cotter dam.

In February 2006, the Chief Minister announced the start of a transfer scheme commencing in December 2006 of 12 GL per year from the Cotter reservoirs to the Googong Dam. "This Scheme takes water that would otherwise spill over our dam walls, and makes it available for consumption in the Canberra region". This amount is larger than the proposed 9 GL volume of recycled water. Can't more water from the Cotter dams be transferred if we still have a shortage of water in the Googong dam? Given on average 75 GL of water "spills" per year from our dams, surely the amount transferred could be increased to say 20 GL per year and avoid the costs and risks of recycling sewage into our water supply.

This current proposal to recycle sewage also does not seem to make environmental sense. Effectively this will be putting 9 GL less water into our waterways. This is because 9 GL of water will be pumped back into our reservoirs instead of being released into our rivers as occurs currently. We could remedy this by letting an extra 9 GL out of our dams and into the rivers. That however would effectively mean that there is no net increase in the water supply for human use. If we did that we will have spent maybe $150 million or more to process and pump water back into our dams, just to let the same amount of water out again! It makes neither environmental nor economic sense. Reverse osmosis and pumping water uphill also requires very large amounts of energy and thus needless extra greenhouse gas production.

Nearly all of the water that is released from ACT Dams as environmental flows plus natural flows, move into the Murrumbidgee River where it is then captured just over the border in the Burrinjuck Dam (capacity 1,025 GL) near Yass. Nearly all the water in the Burrinjuck Dam is for irrigation purposes, when it is let out for downstream users. One of the major uses of this water is for rice cultivation. In 2001 (Australian Bureau of Statistics), 1,924 GL was used for rice production in NSW/ACT. There is no rice production in the ACT, which means all this water is being used further downstream in the Murrumbidgee river system. If the rice growers down river from Canberra decreased their water usage by just 1%, that would mean that there would be another 19 GL available for the rivers. This is more than double the amount that is proposed to be saved by recycling our wastewater in Canberra. It does not appear to make sense to spend huge amounts of money recycling waste water and putting this water back into our Canberra drinking water, when at the same time we are releasing "pristine" water from these same dams for environmental flows especially when this released water is effectively being used mainly for irrigation purposes downstream to produce water intensive crops such as rice.

Currently with our present water restrictions Canberra residents and businesses extract around 50 GL per year from our dams (and if there are no water restrictions about 65 GL per year). Of this water, about 35 Gl is recycled back into our rivers after it goes through tertiary treatment processes. Thus Canberra residents currently recycle about 70% of the water they use (much higher than any other capital city). We on average

hazard in Canberra

have inflows into our dams of more than 190 GL per year. Since 2001 our inflows have been severely reduced to about a third of normal, however despite this, in every year except 2006, the inflows into our dams has still exceeded 80 Gl per year (i.e. more than enough for our domestic consumption).

In my view this proposal to recycle sewage into our drinking water storage should not proceed in Canberra. Even during prolonged droughts, we have had ample flows of much safer water that could be stored and used for human consumption. If we proceed we will be creating a human health hazard needlessly for our population at great financial cost and without any obvious benefits to our environment.

Professor Peter Collignon
Infectious Diseases Physician and Microbiologist
Director Infectious Diseases Unit and Microbiology Department, The Canberra Hospital.
Professor, School of Clinical Medicine, Australian National University.

Postscript

The current total water available in the ACT per year is 494 GL. Slightly more than half of this is reserved for environmental flows and just under half (222 GL) is available for human usage if needed. In the past the ACT has extracted 65 GL of water per year for human use but of this 35 GL is returned to the river system after processing. This means that there is a net usage of only 30 GL (of the 222 GL that is available for human use). In the last year (2006) our usage has dropped to 50 GL per year, which means that the ACT is only extracting 15 to 20 GL of water (this is the amount of water not returned to the river system).

The ACT is a net exporter of water to NSW. On overage 368 GL/year flows into the ACT from NSW, via the Murrumbidgee River. However, 839 GL flows out of the ACT, via the Murrumbidgee. This means that the ACT exports 471 GL of water per year to NSW.

Large amounts of water are released from our dams each year as Environmental flows. On average this is 46 GL/year plus there is another 75 GL/year that flows into the rivers as spills. Thus currently on average the ACT from its reservoirs is putting 120 GL/year of water into our rivers that could otherwise be stored in our dams (this is in comparison to the net annual human use of water in ACT of about 20 GL/year).

The ACT has storage capacity if all the dams are full of about 200 GL. Currently about 50 GL/year is being taken out of that storage for human use (with 35 GL returned to the rivers after processing). The average annual environmental plus spill flows is 120 GL of which 45 GL is "released". Between 50 to 65 GL of water is extracted for domestic consumption each year. Total about 100 GL. Thus it appears that our dams really only have about 2 years of storage capacity if full re the amounts on average that are currently released or used from the dams.

One of the major users of water in Australia is rice cultivation. In 2001 (Australian Bureau of Statistics), 1,924 GL was used for rice production in NSW/ACT. The net use of water for human use per year in Canberra for our 350,000 people is 20GL. Thus one year's water use for the rice production that occurs downstream from Canberra is equal to 100 years use of current net domestic water use in Canberra.

The ACT is currently suffering a major water inflow problem and an increase in evaporation. However, there have been worse droughts than is currently being experienced in the ACT including the late 1800s, 1914, 1944 and 1981-83.

References and Sources

This source of information is reports from ACTEW 2004 Report, plus "The Need to Increase ACT's Water Storage 2004 http://www.actew.com.au /FutureWaterOptions/Documents/assessmentReport.pdf

ActewAGL Water Facts and "Future Water Options for the ACT Region in the 21st Century, http://www.actew.com.au/futurewateroptions/Reports.aspx

the Australian Bureau of Statistics http://www.abs.gov.au/Ausstats/abs@.nsf/Previousproducts/4EB070C49861DA5DCA256F7200832FAE?opendocument

Burrinjuck Dam; http://www.tourism.net.au/articles/9051371

TRANSFER SCHEME LETS ACT KEEP WATER OPTIONS OPEN. 15 February 2006. Jon Stanhope, Chief Minister, Australian Capital Territory. http://www.chiefminister.act.gov.au/media.asp?id=24&media=1087&section=24&title=Media%20Release

VALE! Dr Hugh Bradbury Pratt

Born 3 November 1926
Died 28 February 2007

Below is an edited version of the eulogy delivered by Hugh's son, Finn at his funeral service recently.

Hugh Pratt passed away suddenly last week. His passing was an enormous shock to all who knew him. He was so youthful, so fit and energetic. He lived an incredibly full and enjoyable life over his 80 years.

Hugh was born on 3 November 1926 in Palmerston North in New Zealand.

At about age seven, Hugh spent an afternoon listening to an international health and food expert. It changed him for life and had a significant impact on his future family. From that young age, Hugh swore off white bread, white flour, white sugar, foods with artificial colourings and preservatives, smoking, and many other things we now know are harmful.

Hugh attended school at St George's Preparatory School and Wanganui Collegiate School. He related to his children that his youth was all study, rugby and freezing showers. In the mid-1940s, Hugh studied arts, law and medicine at the University of Otago.

During World War 2, Hugh attempted to join the New Zealand armed forces. They would not accept him, as he was 16. According to his father, Hugh was not to be denied a chance for adventure and, in his late teens, he up and ran away to sea. He joined the merchant navy and sailed the world.

In the late 1940s, Hugh made his way to Australia where he continued his medical studies at the University of Sydney. He maintained a long relationship with Sydney Uni: he was a clinical lecturer there for many years.

While in Sydney, Hugh married the great love of his life, a beautiful Scottish lass named Helen Docherty. They married in May of 1949 and were together until Helen's death in 1994. They had three children, Keren, Finn and Bente.

Hugh was awarded his Bachelor of Medicine and Bachelor of Surgery from the University of Sydney and University of Otago in 1952 and 1953. Hugh continued his practise of medicine right up until the morning of his passing. His children always knew Hugh would never retire.

He worked as a medical officer at the Greta and Bonegilla Immigration Hospitals and as a medical officer or medical director at a whole range of missions, consulates and embassies for 25 years. These included the Cocos Islands, Austria, Denmark, Sweden, the United Kingdom, Yugoslavia, France, Papua New Guinea and Malaysia.

Hugh semi-settled down in Canberra in the mid-70s and practised here for more than 30 years. He was kind and gentle, and loved helping people. He did have a cold stethoscope, I am told.


Dr Hugh Bradbury Pratt.

This snap shot gives you some idea of who Hugh Pratt was and what he was like. Personally, there were two things about him I will always treasure.

Hugh cared about people and went out of his way to help them whether professionally, as a doctor, or simply as a friend. He was always there for his family.

Looking back over Hugh Pratt's life, it is clear he lived it to the fullest extent possible. He pursued his passions: medicine and travel; he contributed to Australia's development and the health of Canberra's community – he made a difference; he was an endearing character who touched people's lives; and he gave his family marvellous opportunities and supported us constantly.

Finn Pratt

Veterans to get improved access to GP care thanks to AMA

AMA President, Dr Mukesh Haikerwal, said recently that war veterans would have improved access to general practice medical services from 1 May following the introduction of improved funding arrangements for the Local Medical Officer (LMO) scheme for veterans' health care.

From 1 May, the Department of Veterans' Affairs (DVA) will apply a single Repatriation Medical Fee Schedule for procedures and consultations.

In practical terms, this means that patients who see GPs for specialist services such as surgery and anaesthesia will not be disadvantaged.

Up until now, the DVA Schedule has undervalued the role of procedural GPs compared to other specialists when treating veterans for the same care.

Dr Haikerwal said Department has responded to AMA concerns about this anomaly by moving quickly to ensure that veterans treated by GPs are given better financial support.

"The increased funding will help keep GPs in the LMO Scheme and may attract other doctors into the Scheme to provide care for veterans.

"This decision is especially significant for veteran patients in rural areas, where rural GPs are often responsible for delivering surgical care for veterans.

"The change builds on last year's welcome funding boost for veterans' health care, when the major focus was on improving access to specialist care.

"Now there is better access to GP care as well.

"From May, there will also be more financial support for veteran consultations with GPs, further enhancing the value of the Gold Card for the many veterans who have served their country," Dr Haikerwal said.

The Gift of Giving

It is an inherent gift that we all, as human beings possess – the gift of giving. We give clothes, food and money to those less fortunate, and what we receive in return is something much greater, the knowledge that somewhere, in someone's life, we have made a difference. One such difference may have been initiated by a recent decision of mine in the rural town of Goulburn.

As a firm believer in world peace and equality, I have always desired to sponsor a child. As a medical student living for the first time away from home, I now only have a taste of the financial burden life may pose. Another human being in need, helpless in their own community, cannot compare to any seemingly minor stresses I have faced in my lifetime. The gift of money towards easing their afflictions of hunger and disease was and is unfortunately not an option for me. Unaware of the great good that I could do, the donation of money remained a distant wish.

In my eyes, blood donors always seemed so courageous, it was someone I never thought I would be, but always admired. Now, as a future medical professional, I have come to the realisation that the gift of blood is more than just admirable, it is crucial. I learnt of this first hand when I finally decided to donate blood during the second year visit to Goulburn, a decision which would inevitably become routine to me for the rest of my living days.

A selfless act such as donating blood should come natural to a doctor, but does it? Should such a harmless moral act of altruism be compulsory for all medical professionals? After all, the presence of certain infections exist as regulatory drawbacks to prohibit medical students from placing others at risk within a medical facility. Are these limitations not the same as those deferring blood donors? Why has it proven so difficult to recruit blood donors in Australia? Why aren't more of these medical students or indeed medical professionals? A mere 469,000 donors currently exist in Australia, a number which I highly doubt represents those truly eligible. The thought of such a simple procedure having the potential to aid in the treatment of cancer, heart disease, burns and accident victims, to name a few, is phenomenal. Yet to become a qualified medical practitioner, life-saving surgery is currently not feasible, and so it seems the least I could do is donate a small part of myself I can survive without to those who cannot.

Dating back to Hippocrates, ethical principles pertaining to medical practice have shaped the way in which doctors deal with their patients. The modern revision of this oath was inevitable, as many actions forbidden, including abortion and euthanasia, have proved to be somewhat controversial. There is however little, if none at all, controversy associated with blood donation, with its benefits far outweighing any risks. The resources are plentiful, what is lacking remains unknown. Is it an issue of selfishness in giving away a "unique" entity of oneself? Or is it the fear of losing a part of oneself that cannot be regained? For a profession revolving around saving lives, donating blood or blood components should be mandatory.

If a single blood donation can save three lives, imagine what a lifetime of donations can achieve. The power to save lives is not exclusive to the medical profession, but intrinsic to all ethically and morally grounded individuals seeking a more fulfilling existence. Anyone can be successful and aim to uncover the true meaning of life, but to preserve a gift as precious as life, is irreplaceable.

Copy supplied by Alayne Moreira, ANU medical student (year 3)

Feedback and thanks from our medical students

The ANU Rural Medical (Students) Society (ARMS) successfully hosted 'Bushdance07'. The Yarralumla woolshed only needed a little hay to give the venue a classic country setting and atmosphere.

Approximately 160 medical students, doctors, family and friends had a fantastic time bootscooting around, cracking open pinyatas and generally being merry to some country beats.

A spit roast dinner went down well with the crowd and gave them energy to dance late into the night. Some students even had sore legs the next day as well as sore heads!

Thankyou to all that came along and got excited about rural medicine.

eSHACT website launched by Dr Helen Caldicott

eSHACT (Environment, Sustainability and Health ACT) is a group consisting of medical students from the ANU, academic staff in medical research and health professionals in the ACT trying to provide information to the health industry and medical professionals about the ways they might reduce their impact on the environment in the work setting. You can now visit the new website at www.eshact.net

The group was started by the first cohort of medical students to go through the ANU Medical School and is run by medical students. It has two aims:

- To Increase awareness about effects of the environment on our health
- To reduce the effects of the health industry on our environment

The website is the result of hardwork by the students which will provide an easily accessible source of information for health professionals about the environment, sustainability and health and medical student Madelaine Hanson (ANUMS) will be pleased to provide more information.

The launch was held recently with Dr Helen Caldicott doing the honours and featured speakers from the group and from the local indigenous community, as well as a group of indigenous dancers.

Dr Caldicott received her medical degree from the University of Adelaide, she founded the Cystic Fibrosis Clinic at the Adelaide Children's Hospital in 1975, was an instructor in pediatrics at Harvard Medical School before resigning to work full time on the prevention of nuclear war.

Dr Caldicott co-founded the Physicians for Social Responsibility in the USA, an organization of 23,000 doctors committed to educating their colleagues about the dangers of nuclear power, nuclear weapons and nuclear war and has helped start similar medical organizations in many other countries. The international umbrella group (International Physicians for the Prevention of Nuclear War) won the Nobel Peace Prize in 1985. She also founded the Women's Action for Nuclear Disarmament. She is also the Founder and President of the Nuclear Policy Research Institute (NPRI).

Dr Caldicott has received many prizes and awards for her work, 19 honorary doctoral degrees, and has been nominated for the Nobel Peace Prize. The Smithsonian Institute has named Dr Caldicott as one of the most influential women of the 20th Century and she has been the subject of several documentaries. She has written for five books, the most recent one is called Nuclear Power is Not the Answer (September 2006).

Dr Caldicott's presentation outlined the many adverse effects that the health industry has on the environment. She stated that the health sector is the second biggest emitter of greenhouse gases in the built environment after commercial office buildings.

The contentious issue of nuclear power came up as an example of how the environment can severely impact on our health. Dr Caldicott went through the lifecycle of nuclear power from the mining of uranium to the outflow of coolant from reactors. Every stage of the process was shown to produce dangerous radiation. Dr Caldicott explained to the audience made of up primarily of interested public, medical students and medical practitioners exactly how each radioactive isotope damages human tissues and DNA.

This medical science perspective has been missing from the general media debate on nuclear power and is an example of the informed debate that eSHACT is trying to foster. The website is far from one-sided though. On the new website there is already an article written by ANU medical student Hung Tran opposing Dr Caldicott's point of view.

Other speakers included Dr David Carpenter from ANU Green and Mr Duncan Smith from the Wiradjuri Echos.

Dr Carpenter gave many examples of how the ANU is the leading university in Australia if not the world when it comes to sustainability.

The Wiradjuri Echos entertained the audience with indigenous dancing and the uniquely Australia perspective of the effects of the changing environment on indigenous Australia.

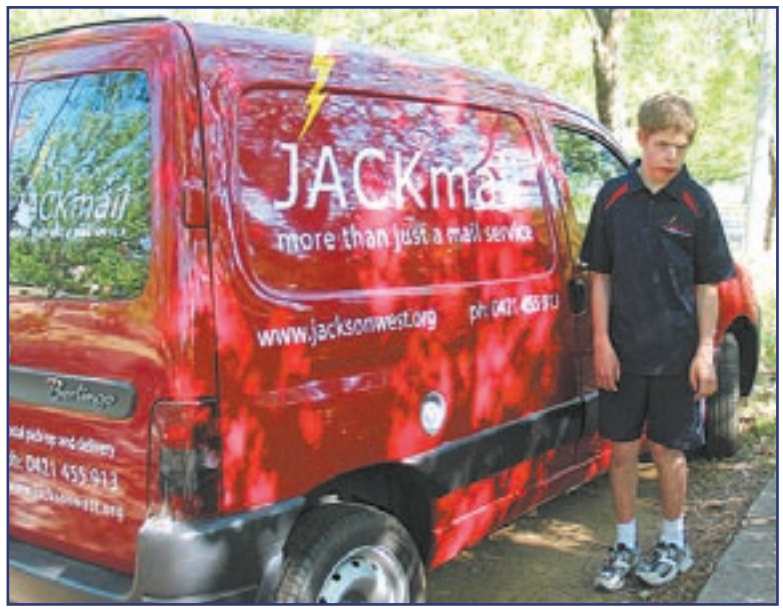
JACKmail delivers for the AMA

JACKmail was officially launched on the 2nd March 2007 by Ms Katy Gallagher, ACT Minister for Disability and Community Services.

The AMA has become the most recent business to enjoy the professional and reliable mail delivery service: JACKmail. Courier, Jackson West, and his driver/support worker, Jamie, collect the AMA's mail from the Curtin post office and deliver it to the AMA office in Barton.

Jackson has a profound intellectual disability and autism due to a unique chromosome abnormality. The business was created by Jackson's parents to employ Jackson part-time and has been designed around his skills and loves. JACKmail delivers tender documents, couriers small items between businesses and collects mail from post office boxes and delivers it to businesses.

AMA ACT office manager, Linda McHugh with Jack.



JACKmail gives Jackson the opportunity to:

- be employed and earn an income
- contribute to his community
- meet many small business owners, operators, employees and customers
- have a busy, active and interesting life
- be an ambassador for people with a disability

His mother, Sally Richards, says, "Jackson graduated from Black Mountain School at the end of 2006 and in this new stage of his life, post-school, he has much to offer. However, we live in a society that often refuses to acknowledge the contribution people with a disability can make. We wanted to ensure that Jackson was a full and contributing member of his community and hence JACKmail was developed."

JACKmail has 13 businesses as clients and is looking for more in the inner south. If you would like to engage JACKmail to pick-up and deliver your mail or courier small items within the Canberra region, phone 02 62810974 (office), 0421 455 913 (mobile) or email sally@jacksonwest.org

To find out more about Jackson visit www.jacksonwest.org

Canberra DOCTOR

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Editorial:
Christine Brill
Ph 6270 5410 – Fax 6273 0455

Typesetting:
DFS Design Graphix
PO Box 580, Mitchell ACT 2911
Ph/Fax 6238 0864

Editorial Committee:
Dr Ian Pryor – Chair/Editor
Dr Jo-Anne Benson
Dr Keith Barnes
Mrs Christine Brill – Production Manager
Dr Ray Cook
Dr John Donovan
Dr Jeffrey Looi
Dr Tracy Soh
Dr Peter Wilkins
Ms Gemma Dashwood
Mr Stefan Baku

Advertising:
Lucy Boom
Ph 6270 5410 – Fax 6273 0455
Email accounts@ama-act.com.au

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Next edition of *Canberra Doctor* – May 2007

NOTICE BOARD "Notice Board" is a new feature of "Canberra Doctor"

You are invited to submit your entry for this free service. Notices will be limited to 200 words and must contain contact details. Notices should be sent to execofficer@ama-act.com.au and headed **"NOTICE BOARD"**. Written reports of the meeting following the event are also encouraged.

Medicare easyclaim seminar series!

In association with Medicare Australia, the AMA ACT is pleased to offer a series of two seminars on the soon-to-be introduced electronic bill claiming.

As reported in the last edition of "Canberra Doctor" the new electronic Medicare claiming will be available in mid 2007 which will enable a totally paperless process for you and your patients. For further information see the article on page 9 of the March edition.

To hear how this will work in your practice you, and your key practice staff, are invited to attend either of the two seminars on offer to be held in the Theatre in the Clinical Services Building, Calvary John James, Strickland Crescent, Deakin.

- Wednesday 6 June
- Thursday 7 June
- 7.00 pm to 8.00 pm with refreshments from 6.30 pm.

RSVP essential to Linda on 6270 5410 or by email to reception@ama-act.com.au with names of those attending by COB Monday 4 June. Preference given to AMA members and their staff.

A seminar for members and their practice managers

Are your staff "employees" or "independent contractors"?

If you thought this was a simple question, you might be surprised to learn that the answer may not be so simple.

With the introduction of the new Federal Independent Contractors Act, it is timely that employing members are briefed on its provisions. Members need to know who is an employee and covered by WorkChoices and who is a contractor and covered by the new Act.

In association with Minter Ellison Lawyers, the AMA ACT invites you to a seminar to be held at Minter Ellison, 25 National Circuit, Forrest on Tuesday 14 May commencing at 7.00 pm with light refreshments.

The seminar will commence at 7.30 pm and conclude at approximately 8.30 pm. As the ultimate responsibility for employment matters rests with the practice principal, they and their practice managers are encouraged to attend.

As a service to members there is no charge for their attendance, and for all others there is a cost of $100 to be paid by credit card at the time of registering. Registrations can be made to Linda at 6270 5410 or by email to reception@ama-act.com.au by COB Thursday 10 May

Another member benefit!
Non-members are welcome to attend. Cost $100 (no refunds).
To check out the benefits of membership visit www.ama-act.com.au or www.ama.com.au

Medical Association for Prevention of War

Presents

Music As Peace Work
Saturday 5th May 2007
at
Canberra Baptist Church
Currie Crescent Kingston

A family friendly festival of music and dance
Bring food to share for a buffet meal
Tea, coffee and cold drinks will be provided
(It is an alcohol free venue)
Live music provided by ACT Doctors, their families and friends

Dinner and music start at 6:00 pm

Donations of up to $50 would be appreciated
Tickets at the door or from Graeme or Rosie

Enquiries:
Graeme Thomson 0419271714
Rosie Yuille 62477090
musicaspeacework@hotmail.com

A new service for salaried members!

The AMA ACTs industrial advice and advocacy service is coming to a workplace near you!
Another exclusive benefit for members!

Mr Andy Ozolins, industrial officer at the AMA ACT, will be visiting The Canberra Hospital on Monday 7 May between 10.00am and 2.00 pm and is available for consultation with salaried members.

The AMA ACT is committed to providing an industrial advice and advocacy service to its salaried members and if you have an issue you would like to discuss with Mr Ozolins, please contact the secretariat on 6270 5410 for an appointment.

Further dates for visits to TCH will be advertised on the AMA website in the near future.

Conversations between members and Andy will be regarded as confidential.

As this is a member service, inquiries regarding membership can be made to Elizabeth on 670 5410 or by emailing membership@ama-act.com.au

A list of the benefits of membership is available at www.ama-act.com.au and www.ama.com.au

Pandemic planning "ready reserve"

AMA ACT co-ordinating a list of doctors willing to assist in an emergency.

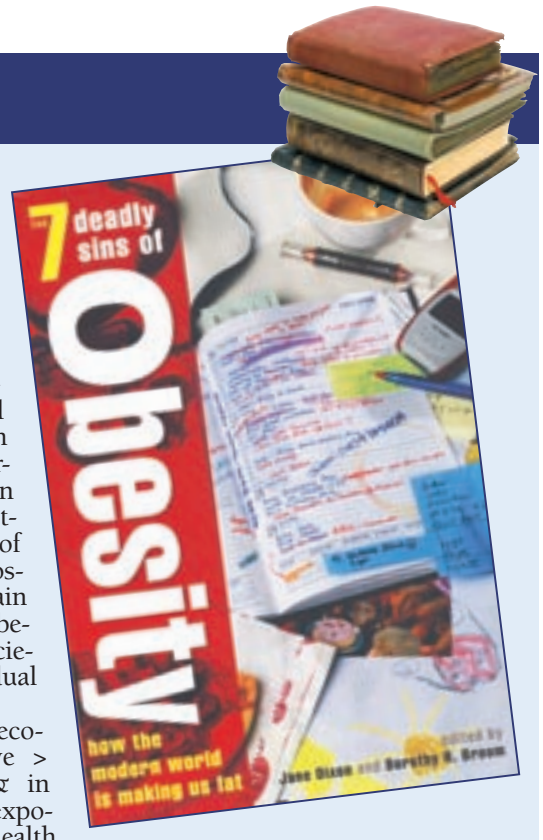
Have you returned your Form yet?

You will have received a letter from AMA ACT President, Dr Andrew Foote, inviting you to indicate your willingness to be considered part of a "ready reserve" medical workforce in the event of an influenza pandemic. The response from the profession has been amazing. Thank you to all of those who have returned their forms.

If you have not indicated that you are willing to be considered as part of this emergency workforce please do so as soon as possible by returning the form to fax 6273 0455 or by post to PO Box 560 Curtin ACT 2605. If you did not receive an "invitation", please contact Christine on 62790 5410 or by email to execofficer@ama-act.com.au

Just to remind: this is an expression of interest only and will not be taken as binding upon you to provide assistance. The AMA ACT will not make the information available to any third party without your consent. It is to gauge whether or not we will have a "ready reserve" of medical practitioners to support our general practitioners so that they and the general public will be cared for.

BOOK REVIEW



Dixon, Jane and Broom, Dorothy H. (Eds): *The 7 Deadly Sins of Obesity (How the modern world is making us fat)*: UNSW Press Sydney 2007. 228 pp (+ xii).

All but four of the eleven contributors to this thought-provoking volume, including both editors, are current or previous staff of the National Centre for Epidemiology and Public Health. Three of the remainder are Canberra-based academics and the final contributor is a strategic advisor to the Australian Greens and former chief of staff to Senator Natasha Stott Despoja. They bring an eclectic range of background research interests to the task of explaining Australia's ballooning collective waistline, and most have published previously in areas of health, economics or nutrition.

The central conceit of this book postulates replacement of Thomas Aquinas's C13 theological list identifying 'the seven deadly sins' (pride, covetousness, lust, anger, gluttony, envy and sloth) with a new C21 psychosocial list centred on selected contemporary factors held responsible for producing the much-discussed modern 'epidemic' of obesity and overweight. After dismissing Aquinas's list as irrelevant to production of an ever tubbier Australian population (even gluttony and sloth are excused), the editors identify the 'top seven explanations for changes in physical activity and food consumption patterns during the past 50 years'.

- increased use of convenience and pre-prepared foods
- increasing 'busyness' and lack of discretionary time
- altered family dynamics
- sedentarisation of leisure activities
- escalating reliance on personal motor vehicles
- aggressive marketing of foodstuffs
- changing knowledge, attitudes and practices concerning physical activity

From this starting point, individual contributors then present their chapter-length disquisitions on a series of less elegantly titled 'modern sins of the environment'*, postulating a causal chain for determinants of obesity, focussing on societal rather than individual responses.

Changes > socioeconomic, > cumulative > individual > BMI & in social gender & age- exposures to dietary & health trends related practices obesogenic physical outcomes environment activity, behaviours.

* The new listing is as follows.

- The codified environment (how the economy feeds obesity)
- The harried environment (is time pressure making us fat?)
- The pressured parenting environment (parents as piggy in the middle)
- The technological environment (digital technologies or space to play [up] and belong
- The car-reliant environment (the vehicle that drives obesity)
- The market environment (formula for fatness)
- The environment of competing authorities (saturated with choice)

Readers familiar with Professor Broom's earlier work in sociology will not be disappointed by her summative final chapters (with collaboration by other contributors) on 'Unequal society, unhealthy weight' and a 'Conclusion' calling for 'multiple synergistic actions by numerous actors' (including governments, employers, unions, marketers and individuals). Overall, this is a well-reasoned and accessible account of multiple (but not all) factors implicated in the national accretion of avoirdupois. Exculpation of individual "Norms" and attribution of most blame to political and social factors may comfort some, but the work lacks balance due to this. Before Aquinas, philosophers and theologians enunciated the doctrine that free will is a necessary pre-condition for sin: 'the devil made me do it' rang as hollow then as claims today that 'I / my kids are only fat due to TV advertising'. However, the book does present a persuasive case for its postulate, and blueprint for remedial action, assisted by copious references and a comprehensive index.

Peter S. Wilkins
(Peter Wilkins is a member of the AMA ACT Council and Canberra Doctor editorial committee.)

Capital Pathology – Looking back on 10 years of growth and development

On 2 June, Capital Pathology will celebrate the ten-year anniversary of the opening of its purpose built laboratory in Deakin. While being the focus of these celebrations, the building is also currently undergoing extensive renovation and refurbishment for the next stage of its role as the hub of Capital Pathology.

View of the Laboratory and staff.

Although most out patients have their pathology specimens collected in collection centres throughout ACT and surrounding NSW, the laboratory is the centre of the extensive courier and electronic network that links doctors and other health professionals from hospitals, nursing homes and surgeries with the pathologists, scientists and other staff of Capital Pathology. The laboratory is also the testing site for blood and other specimens such as tissue specimens and cytology specimens such as Pap smears and Fine Needle Aspirates which are all processed and reported on site.

In some ways there seem to have been massive changes since the laboratory was commissioned in 1997, particularly in regard to information technology and connectivity. For example, it is hard to remember a time when cameras were not a standard feature of mobile phones, but they were developed only in 1997. Also it seems hard to remember how we functioned when less than 5% of businesses had a website and less than 16% of businesses had internet access; however that was the case in Australia in 1997.

Similarly, in diagnostic pathology, 10 years has brought many changes in areas of growth, knowledge and technological advances.

In areas of instrumentation, technology and work flow, a scientist who worked in the lab in 1997 would barely recognise their role and environment today.

Then the laboratory was divided into small esoteric departments of haematology, biochemistry and serology, where much of the testing included manual steps. Now most of the testing is incorporated onto automated testing platforms that have made these separate "departments" largely obsolete. This means that general chemistry, hormones, tumour markers, therapeutic drugs and serology for HIV/ hepatitis testing are done very quickly and accurately on highly automated, integrated machines that eliminate much manual handling and the potential errors associated with manual testing.

Increased automation has also allowed efficiencies that have enabled pathology laboratories to absorb the spiralling cost of labour, instrumentation and reagents during a time when HIC benefits for pathology items have been static for over 20 years.

Changes in technology have allowed a broader range of testing to be done cost effectively and quickly. For example the introduction of polymerase chain reaction (PCR) technology means that modern pathology laboratories routinely provide testing for a wide range of infectious diseases such as Chlamydia, gonococcus, Bordetella pertussis, cat scratch fever, herpes, varicella and CMV. As well as this, advances in the last ten years in PCR technology now allow us to test for haemochromatosis genes, factor V Leiden and prothrombin gene (thrombotic risk assessment) as well as cystic fibrosis. Apart from assisting clinicians with testing that was previously not routinely available; PCR technology has often led to better accuracy and specificity, and faster availability of results. PCR testing has proven performance on a wide range of specimen types, and this has enabled testing on easily collected specimens which can avoid the need for an invasive procedure, for example Chlamydia PCR testing on a first void urine rather than on cervical swab.

Ten years has also seen huge advances in prenatal testing, where first trimester biochemistry combined with imaging of nuchal fold thickness allows early detection of Down's syndrome and neural tube defects. Previous investigations were limited to second trimester screening using biochemistry alone, and offered a risk assessment of lower sensitivity compared with the novel combined first trimeter screening.

In 1997, most laboratories assessed the possibility of myocardial damage through assays of cardiac enzymes (CK, AST, and LDH). Now troponins are the test of choice, as they are a more specific and sensitive marker of myocardial damage.

Staff at Capital Pathology.

The laboratory investigation of Coeliac disease has progressed enormously over ten years, testing initially for gliadin antibodies, then endomysial and now TTG (Tissue Transglutaminase) antibodies which are now the test of choice.

In 1997, surgeries and hospitals filed hard copy pathology reports, and the concept of "paperless" surgeries seemed very futuristic. However, the whole area of information handling, sharing and storage has changed significantly in ten years. As the population grows and ages, and modern medicine becomes more sophisticated, the amount of data generated and handled by pathology laboratories has grown enormously. There have been significant developments in information technology enabling better protection of data from inadvertent or deliberate damage and quicker, more efficient, direct transfer of results to referring doctors using either secure dial-in via Fetch or encrypted email via Argus and secure web based lookup via Webster. The next stage of this exciting phase of development will involve electronic request transmission and this is currently being tested. The changes in information technology have been instrumental in decreasing the incidence of data loss and increasing the speed of result availability.

In histology there have been major advances since 1997 in the area of immunohistochemical staining and flow cytometry for better diagnosis of tumours and other diseases and this has led to quantum changes in the understanding, diagnosis, treatment and prognosis for patients with many types of lymphoma and other tumours. These advances have also influenced patient outcomes by predicting suitability for various treatment options, such as Her 2 receptor chromogenic in situ hybridisation (CISH) testing to assess breast cancer patients for suitability for Herceptin therapy.

In the field of cytology, the cervical Pap smear has undergone further refinement through the acceptance of liquid based testing that was being trialled in Australia at the time of the opening of the Capital Pathology laboratory. An advantage of liquid based testing is that high risk subtypes of HPV can be tested for on the same sample, allowing for better counselling and follow up of at risk women.

So, particularly in areas related to technological developments, 1997 seems a long time ago.

However, possibly as a sign of my own aging, things that happened 10 years ago seem very immediate in human terms. 1997 was the year of the Canberra Hospital implosion and the tragic death of Katie Bender on 13 July. I remember very clearly the Thredbo disaster on 30 July. I find it hard to believe that Princess Di, Mother Teresa and Michael Hutchence have been dead for ten years. In politics, Tony Blair was elected Prime Minister of Great Britain and John Howard was still the prime Minister of Australia.

When Capital Pathology moved into its new Deakin laboratory, the practice employed approximately 120 people. Up until that time we were called Barratt and Smith & Moran after the merge of those 2 long established practices and in 1997 we were still dealing with some of the operational and interpersonal consequences of that merge.

Now we have close to three hundred people working with us and Capital Pathology has the privilege of being the largest community based pathology practice in our region. The number of patients that we help clinicians investigate, treat and monitor has almost tripled since the laboratory was commissioned.

In conclusion, technology has changed a great deal in the last ten years. However, the people of Capital Pathology remain focused on their role of "helping doctors help patients by providing specialist pathology services".

Our pathologists, scientists, technicians, collectors, couriers and support staff take great pride in being part of the largest specialist medical practice in our region.

On behalf of all of the people of Capital Pathology, I would like to thank the members of the Canberra medical community for their support over the last ten years. We very much look forward to working with you to improve the health of our patients and our whole community for many years to come.

Copy supplied by: Dr Gloria Armellin, CEO, Capital Pathology

Australian Medical Association – ACT

A potted history of the AMA and what it stands for!

The AMA was originally the British Medical Association in Australia and in the 1960s the Australian Medical Association was created. Of course, the BMA/AMA transition means that some State AMAs have celebrated very proudly, their Centenaries.

Up until 1981, the AMA ACT was a local association of the AMA NSW (ACT Medical Association) and became an entity in its own right as the Capital Territory Group of the AMA. Under the Constitution of the Federal AMA, Branch status was conferred on those State/Territory organisations with 500 or more members and with Branch status the organisation also received representation at the AMA Federal Council. Following the review of the Association by Sir Robert Cotton in 1988, both the ACT and the NT were granted "Branch" status and received representation on the expanded Federal Council. "Branches" have now evolved as AMA – NSW etc and in due course, we too will change our name to AMA – ACT to reflect the changes to the Federal AMA Constitution and to mirror the State AMA organisations.

The AMA ACT is governed by a Board of twelve directors (Council) elected by their peers. The Council has a dedicated place for a representative of medical students – appointed by AMSA – and for a representative of doctors in training. All other Board positions are elected from within the general membership. Each Council has striven to ensure it represents the whole profession and being such a diverse profession, this is often challenging.

The secretariat is located within AMA House in Barton and is the respository for the old minute books of the previous incarnations of what is now the AMA ACT. They make interesting reading now that the cigarette and pipe tobacco smells have largely disappeared – reflecting the mobile nature of the position of Secretary. I'm told the early archival material lived in one good doctors' garage for a quite a time.

Today the AMA ACT continues to build on the foundations laid down by a succession of Councils and invites membership from all members of the profession in order to keep a strong and united voice to fight for the independence of the profession and to advocate for patients. It's mission is to support doctors serving their communities and everything it does is measured against this objective.

Like all associations it evolves to keep pace with the demands its members place upon it and to ensure it can advocate for the profession on a range of matters which affects it.

Membership application forms can be downloaded from www.ama-act.com.au or can be obtained by phoning 6270 5410.

Canberra Medical Society

The Canberra Medical Society was founded in the late 1950's by a number of eminent doctors in town as an apolitical organization that aimed to foster social contact between the varied arms of medicine in the A.C.T. At that stage there were private practitioners, Commonwealth doctors, military medical officers and medical researchers at the John Curtin School of Medical Research. Among the active members of the Society in its early years were Dr Marcus Faunce, (Honorary Physician to the Governor General and Prime Minister), Professor Frank Fenner (Director of the John Curtin School of Medical Research and winner of the Japan Prize for his work in eradicating smallpox) and Brian Furness (Physician and later ANU Medical Officer). The society would meet every few months for a meal, usually at the ANU College and listen to a guest speaker. This tradition continued into the 1990's when it unfortunately fell into a period of inactivity.

In 2000 it was resuscitated with the main aim of facilitating the social interaction between the diverse groups of medical practitioners and their partners. In recent times an annual benevolent function has increasingly become a focus with successful projects to support the ACT Bushfire Appeal (with AMA ACT), The Tiwi Island mammogram initiative and the Yuendemu eye surgery project. In the last two years we have held a free Welcome BBQ for all new students and doctors to Canberra and this has been a highly successful event to inform the Canberra medical community of our vision and mission:

Vision

To be an organization which unites the entire ACT region medical community via social and benevolent functions.

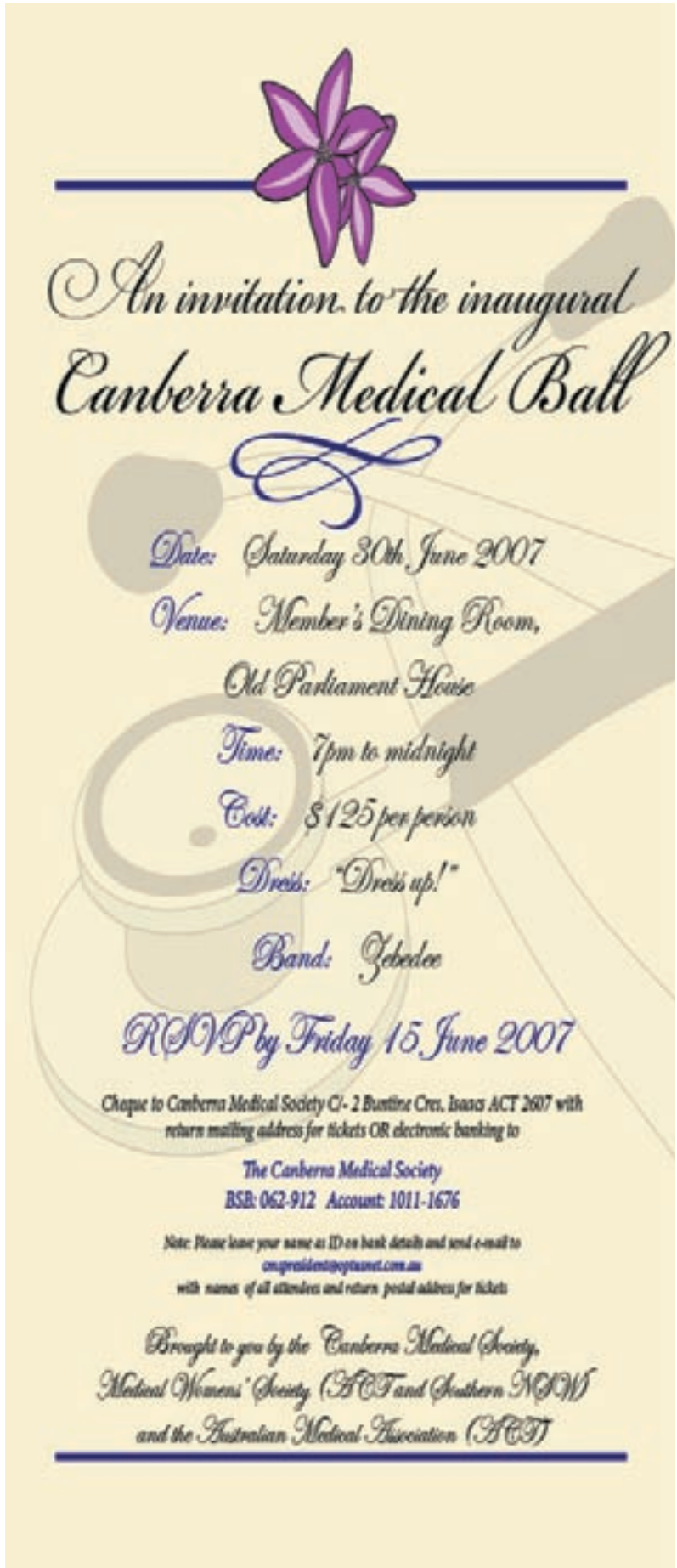
Mission

To identify and welcome all doctors and their partners arriving and living in the ACT region via periodic gatherings for the purposes of support and friendship.

We encourage all doctors to contact us via the website with comments and suggestions for future events www.canberramedicalsociety.com (no .au at end)

The idea of a Medical Ball has flourished this year and we are pleased to be co-hosting the inaugural Canberra Medical Ball with the MWS (ACT and Southern region) and the AMA ACT for what will be one of the best social events of the year!

Dr Caroline Luke, President, CMS



Medical Womens' society

The Medical Women's Society of the ACT and Region is a group with the aim of fostering communication between medical women, both in the ACT and in the surrounding NSW towns. Our members live and work as far away as Crookwell and the Sapphire coast and we cater for all ages. We have a strong link to the ANU Medical School, with student representatives from each year on our committee. The student membership is free, while we ask $60.00 as an annual membership for the qualified members, to pay for costs and for the affiliation fees for the Australian Federation of Medical Women.

The Society has several roles.

Firstly we are a **networking group.** The members have different needs, such as women newly arrived in the region wanting to meet other women with similar interests and make to make friends. There is a Medical Women's Playgroup, which meets at irregular intervals at Black Mountain Peninsula. We are GPs, specialists and registrars working in hospitals, private practice and in administration.

We meet five times a year at various venues, with different themes, but usually associated with dinner or cocktails.

One of our gatherings is a designated **fundraising dinner**, where we specifically aim to raise money for a charity related to women's and children's health.

We have a role in **student support and mentoring**. Through our student committee members we have been made aware of certain problems and have been able to support morally and practically.

In addition, the local Medical Women's Societies are **affiliated with the Australian Federation of Medical Women**, which is in turn affiliated with Medical Women International. Australia, at the present, holds the Secretariat of MWI and as such influences policy with organizations such as the WHO. In Australia, we have members on national women's lobby groups, particularly in relationship to women's health.

We always welcome new members. To join, go to www.amfw.org.au and follow the links to the ACT.

Jane Twin
President
Medical Women's Society of the ACT and Region

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