Canberra DOCTOR
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Medicare Easyclaim – not so easy! says AMA

Dr Rosanna Capolingua, AMA President.

The AMA supports the broad concept of easy payment, easy reimbursement; the premise behind Medicare Easyclaim. While the service developed has promise, it is not ready to market… yet!

Dr Rosanna Capolingua made reference to Medicare Easyclaim in her address to the National Press Club recently.

While supportive of the objectives of Medicare Easyclaim, Dr Capolingua explained that the practical application of implementing Easyclaim into medical practices was "not going to be that easy".

The picture was painted of a mother carrying a sick child on the hip, with a second child running around the waiting room, attempting to find the three cards necessary for the transactions – a credit card for payment of the account, Medicare card for verification and an EFTPOS card to process the Medicare rebate.

Initial trials of the system have recorded best transaction times of four minutes per patient. While Medicare scales back its offices and processing of claims, "we will become the agents of Medicare and we will assume its burden." Dr Capolingua expects the government can do better and reports that the AMA is currently in discussions with Human Services Minister, Senator Chris Ellison, and Health Minister, Tony Abbott, over its concerns.

AMA Secretary General, Mr Kerry Gallagher, also disputed the ease of using Medicare Easyclaim in AMA Queensland's publication, "Doctor Q".

He identified the limitations of Medicare Easyclaim as it currently stands. There are only two banks and one other financial institution offering Medicare Easyclaim and not all Medicare items can be processed by the system. Mr Gallagher also pointed to the cost incurred by practices in the introduction of the system.

"The great sadness of all this is that with more commitment and sincerity, the Australian Government could have introduced a system that would be convenient and EASY for both the doctor and the patient. Of greatest concern to doctors and the AMA is that after all the advertising of its new, easy system to the public, as the Australian Government will do over the next four or five months (did someone mention election), who will be blamed when your practice advises your patient that despite all the Government advertising, Electronic Claiming is not available at your practice? Yes, you're correct! You will be. Easy isn't it?"

While trials of the system continue, the AMA will continue its dialogue with the federal government to address the shortfalls and identify improvements that can be made in order to benefit both patients and doctors.


Mr Kerry Gallagher, AMA Secretary General.

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AMA ACT President's letter

Local Matters

The Family Doctor week was a great opportunity to present the message that general practice is at the hub of our health system. I was able to visit Giralang Primary School and present the children with a simple message that good health starts in childhood and to emphasise healthy eating, regular exercise/sport, and having a family doctor.

The state of our public hospitals report was released which found that ACT Public Hospitals have the longest Emergency Department waiting times, the least number of average available beds, and the longest median waiting time for elective surgery.

We recently met with the Health Minister to discuss future directions of health in the ACT which included: E-Health communication between GPs, Specialists and Hospitals, addressing the shortage of GPs in Canberra and the classifications of area of need, long term management and disease prevention of diabetes, smoking and obesity, support of GP treatment in aged care facilities, and adequate ANU Medical Student placements for PGY1/2.

Federal AMA Matters

Recent press releases have included: the importance of the public hospital system, safe clinical handover in hospitals, reducing hospital infections, streamlining of authority prescriptions, banning junk food advertising to children, folate fortification, indigenous child abuse, hospital ability to cope with major disasters, regional hospital rescue, increase in HIV, obesity in rural Australia, and high risk coronary treatment.

Dr Andrew Foote.

A New Name and New Direction – John James Memorial Foundation Ltd

The Members of the John James Memorial Hospital Ltd approved the company changing its name to the John James Memorial Foundation at a meeting on 12 June 2007. At the same time, the membership overwhelmingly supported the adoption of a new constitution for the company that will allow it to undertake a much broader range of charitable activities in the area of healthcare. The membership of the Foundation, currently consisting of approximately 120 current and retired specialists, remains open to all doctors who are VMOs at the Calvary John James Hospital.

Associate Professor David Hardman, Chairman of the Board, said he was extremely pleased with this outcome and noted the Foundation had now entered a new phase of its activities. 'We have already commenced exploring a range of opportunities for our new operations and are currently focusing on five key areas:

- The provision of specialist services in remote and rural areas, drawing on the skills and time of our specialist member doctors - on a volunteer basis;
- The provision of specialist facilities and equipment that would be considered on a case by case basis. While our focus is currently on the facilities at the Calvary John James Hospital, we are likely to extend this focus in the future and invite applications from a broader range of facilities;
- Providing educational and experiential opportunities for medical students and other health care students and professionals in order to increase or broaden their knowledge base;
- Partnering with the Little Company of Mary, the new owners of the Calvary John James Hospital, providing assistance in ensuring the hospital remains the premier private hospital in Canberra; and
- Careful management, growth and diversification of the assets of the company to provide security and income for future charitable activities. Following the sale of the hospital business last year the Foundation retained ownership of all of the land and buildings on the hospital site in Deakin, now known as the John James Healthcare Campus and has recently acquired the adjoining property on the corner of Denison St and Strickland Crescent. The Board considers the careful management and development of assets as essential to ensuring the asset base continues to grow and generates sufficient income to undertake the Foundation's charitable activities.

'We are currently negotiating with the Commonwealth, Queensland and Northern Territory Health Departments in relation to the delivery of specialist services, on a volunteer basis, into remote and rural areas identified as being most in need, with a particular focus on Indigenous communities. In Queensland we are looking at the Gulf and Cape York regions and in the Territory we are looking at supplementing the existing specialist outreach programs into Gove and Katherine. We are consulting broadly on this issue in an effort to ensure we provide services to areas most in need and to avoid crossing over existing programs and service providers.

'In relation to our educational program, we have commenced by offering final year medical students at the James Cook University in Townsville the opportunity to work with a number of our specialist Members at the Calvary John James Hospital. James Cook was chosen initially due to its high proportion of Indigenous students and those with an interest in going on to provide services in remote areas. The first students will arrive in September 2007 and we will be assisting with some of their costs in travelling and staying in Canberra. Further financial assistance may be available to students able to demonstrate a particular need.

'We also see as a priority the development of a strong working partnership with the Little Company of Mary in order to ensure the Calvary John James Hospital remains the premier private hospital in Canberra. We commenced this partnership with the recent gift of $130,000 of surgical equipment and are underway with preliminary discussions in relation to the construction of a new operating theatre in early 2008, in order to assist with current and future demand for services at the hospital.

The Little Company of Mary has welcomed an ongoing partnership with John James and Paul Robertson, CEO of the Calvary John James Hospital said he looked forward to building on the relationship, which brings together two of the leading not-for-profit healthcare organisations in Canberra and which will ultimately provide significant benefits to the Canberra community. 'Obviously our first priority for the hospital is to make it sustainable in the long term. We are progressively implementing a range of measures to achieve this and the ongoing support and assistance of the Foundation and its membership during this time will be extremely valuable. We are also particularly keen to ensure the hospital offers first rate facilities and the construction of the new theatre is seen as an important element of that'.

John James

Membership Rewards Program Partners ~ 10% discount

Botanics on Jardine Florist (Kingston)
~ *Plonk (Manuka)*

Connoisseur Catering (Canberra)
~ Ondina Studio (Kingston)

Corporate Express* (Phillip)
~ *Aubergine Restaurant* (Griffith)*

Courgette Restaurant (City)*
~ Sabayon Restaurant* (City)

Stephanie's Boutique (Kingston)
~ *Escala Shoes (City)*

Simply Wellness Day Spa (City & Belconnen)
~ The Essential Ingredient (Kingston)

**conditions apply*

George W. Lambert Retrospective – *heroes & icons*

29 June – 16 September, 2007

National Gallery of Australia, Canberra

It is 77 years since the death of George W. Lambert who is arguably Australia's greatest and most versatile artist. Russian born – St. Petersburg in 1873 - he came to Australia aged 14, worked briefly on a cattle station and then studied art under Julian Ashton from 1894-1900 during which time he worked as a black and white illustrator for the *Bulletin*. He won the Wynne Prize in 1899 for his *Across the Black Soil Plains,* leaving for England in 1902 where he specialized in portraiture. Commissioned as an official War Artist during World War I, he returned to Australia in 1921 and was later employed by the Australian Government to portray the major events of the Gallipoli Campaign.

In 1922 he was made an Associate of the Royal Academy (ARA), the only Australian so honoured. His work was wide ranging: including portraiture, including many self portraits, landscapes, flower-pieces and his war paintings, turning very successfully during his last decade to sculpture. In 1927 he won the Archibald Prize for his painting of *Mrs. Annie Murdoch*. His works include a wide range of contemporary notables including Henry Lawson, 'Breaker' Morant and Banjo Patterson as well as a number of well known fellow artists such as Charles Condor, Thea Proctor and Arthur Streeton. He died in 1930.

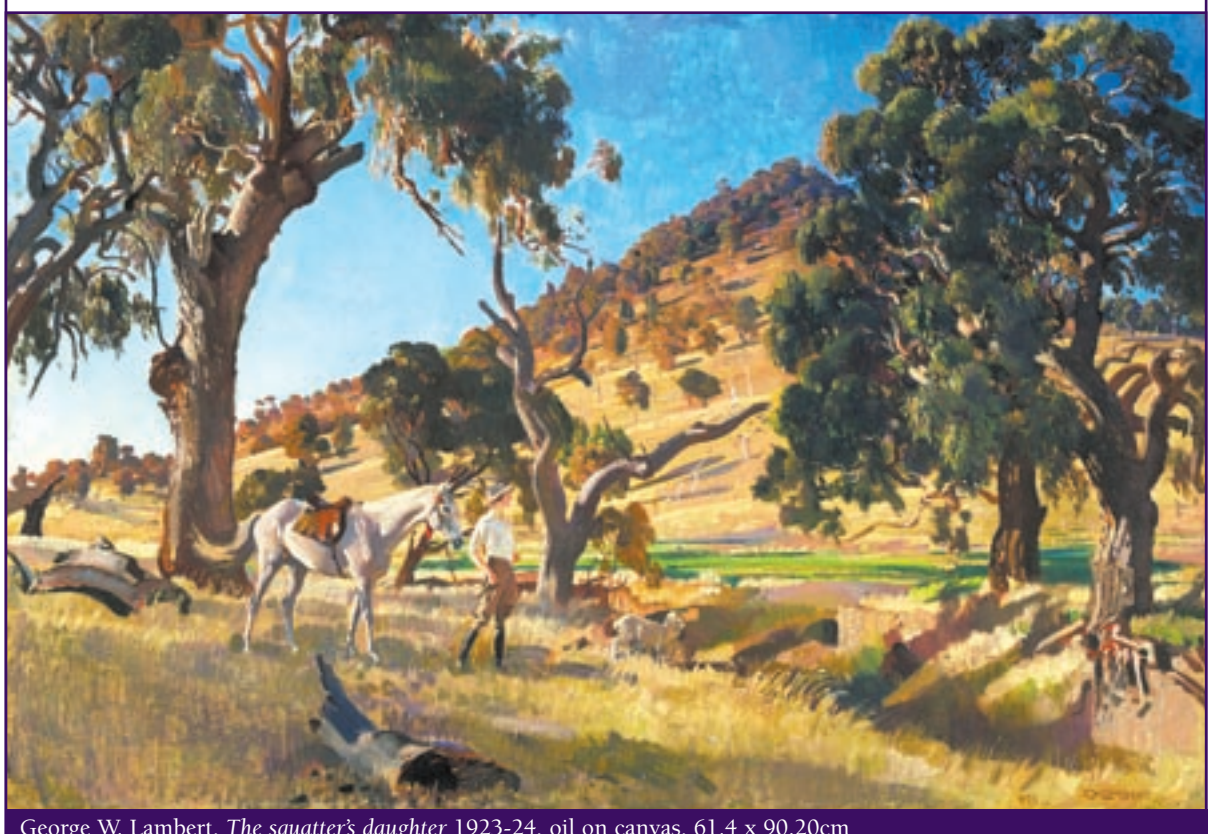
Only a small number of his works can be mentioned. First, his *Michelago landscape* of 1923, one of several landscapes painted of the region, including the very different and better known *The squatter's daughter* 1923-24, depicts the typical undulating Monaro countryside producing an almost map like effect with an emphasis on the rolling hills and valleys. This resembles somewhat a *'locus amoenus'* or 'pleasant place', a Renaissance term, be it on a somewhat smaller scale, designating a beautiful rural retreat. Second, is his *The Garden of St. Luke's Hospital,* c. 1922, located in the hospital grounds at Pott's Point, Sydney, where the Nursing profession is appropriately shown, one of a number of works painted soon after his return to Australia that represented everyday life. This was a scene that Lambert was to experience first hand with continuing bouts of ill health and overwork. Third, his *Chesam Street*, 1910, is one of a series of enigmatic paintings produced between 1910 and 1914. It has been suggested that these paintings, while having meaning, lack any real narrative, perhaps inviting the individual interpretation of the viewer. This particular painting shows an ageing gentleman with an extraordinarily fit torso, perhaps Lambert himself, undergoing a somewhat intimate examination in the context of a consulting room. Perhaps the observer might ponder on the differential diagnosis.

Finally, attention is drawn to his many war paintings: *Anzac, the landing 1915,* of 1920-22, *A sergeant of the Light Horse* of 1920, and the *Australian troop horse, full marching order,* of 1918, are iconic, while his depictions of the desert landscape, *The Road to Jericho,* (of Biblical fame), c.1918 and *The Dead Sea* of 1918 are outstanding compositions.

This superbly presented exhibition that confirms at long last Lambert's premier place in the history of Australian art is perhaps one of the most exciting that we have seen since the opening of the NGA, and its curator, Dr. Anna Gray is to be warmly congratulated for her work. It is an artistic display that is not to be missed, do leave plenty of time as there is much to see and it is just not possible to do a quick rush through and at the same time enjoy such an outstanding exhibition.

Keith Barnes

(Dr Keith Barnes is a member of the Canberra Doctor editorial committee)

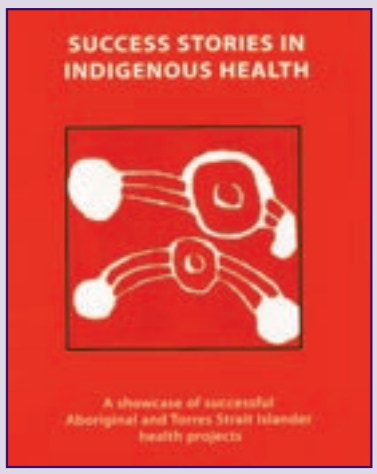


George W. Lambert, *The squatter's daughter* 1923-24, oil on canvas, 61.4 x 90.20cm
National Gallery of Australia, Canberra, purchased with the generous assistance of James Fairfax AO and Philip Bacon AM and the people of Australia in 1991

Success stories in indigenous health

A showcase of successful Aboriginal and Torres Strait Islander health projects.

This little red book was launched recently by Health Minister, Mr Tony Abbott at Winnunga Nimmityjah AHS. Also present was Opposition Health spokesperson, Ms Nicola Roxon and a large gathering of VIPs and interested and interesting people.



There are fifteen "good news" stories in this book that showcase the real success stories in indigenous health.

What is exciting though, is that Winnunga Nimmityjah AHS shares the pages with other success stories. Winnunga, in association with NCEPH, conducted their research project between 2001 and 2004. Over 100 indigenous people shared their personal stories of illegal drug use as part of a project that identified how services could be improved to better address their needs. The research was initiated in response to widespread concern, confirmed by a survey of local Aboriginal Elders about rising levels of substance abuse in the community.

Researchers conducted 95 confidential interviews with people aged between 16 and 50 years, covering topics that ranged from drug use history and treatment services to issues around culture, health, education, employment and housing. Aboriginal and non-Indigenous researchers participated in each interview.

A significant number of the people interviewed said that an important step to recovery was learning about their culture, preferably as part of a residential treatment facility; others pointed to the need for Aboriginal staff in treatment services and easy-to-read information about drug and alcohol services.

These findings form the basis of the 22 recommendations included in the final report – "I want to be heard" – aimed at government agencies and mainstream and Aboriginal service providers.

Other 'success stories' include "Family Well Being", Apunipima Cape York Health Council; "Mums and Babies", Townsville Aboriginal and Islander Health Services; "Nutrition – at the heart of good health", Jalaris Aboriginal Corporation, as well as many others. The booklet is available online at www.antar.org.au/success

(from L to R): Gary Highland, ANTaR National Director; Julie Tongs, Winnunga Nimmityjah CEO; Nicola Roxon, MP, Shadow Minister for Health; Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner

HIV cases increasing in Australia

A concerning rise in the number of Australian HIV cases in the past seven years is likely to be mainly due to risky sexual behaviour in men having sex with men, and some clear geographic differences in trends are starting to emerge, according to research published online for the Medical Journal of Australia.

Professor John Kaldor, Deputy Director and Professor of Epidemiology at the National Centre in HIV Epidemiology and Clinical Research at the University of New South Wales, and his colleagues in State and Territory health departments and the Burnet Institute in Melbourne, studied changes in the number of HIV cases diagnosed from 1993 to 2006.

"HIV exposure through male-to-male sex accounted for 70 percent of all cases, followed by heterosexual contact at 18 percent. The annual number of new HIV diagnoses declined by 32 percent between 1993 and 1999, but then increased by 31 percent between 2000 and 2006", Professor Kaldor said.

"In NSW, long the State with the highest rate of HIV, the trend had been stable over the past five years, but in other parts of the country the trend was upwards with Victoria now roughly equal to NSW in per capita diagnoses."

"In more than half of heterosexually acquired cases, the person was born in, or had a partner from, a country with a high prevalence of HIV."

"Exposure to HIV from injecting drug use was infrequent."

Professor Kaldor says an increase in risky sexual behaviour due to changing perceptions of the seriousness of HIV may have contributed to the high rates of exposure in men having male-to-male sex.

"While Australia remains a low-prevalence country for HIV, evidence that the recent increase in diagnoses in some states is linked to changes in risk behaviour raises questions about the effectiveness of current prevention strategies," said Professor Kaldor.

The publication of the research coincided with the International AIDS Conference held in Sydney recently.

Polio – public health alert!

The Chief Health Officer, Professor John Horvath AO, has issued a public health warning after Victorian health authorities reported a case of polio in a 22-year-old male who recently returned by plane to Australia from Pakistan. The last case of wild type poliovirus infection in Australia occurred in 1986 and the western Pacific region, including Australia, was certified as polio free in 2000, so any case of polio is a significant public health concern.

The risk of disease transmission to the general community is considered to be low. However, polio is a highly infectious disease and the Government is therefore taking appropriate precautionary measures. Australia has available stock of injectable polio vaccine and the 9th edition of the Immunisation Handbook recommends vaccination every ten years for at risk patients.

Vale!

Francis (Frank) Keiller MBE (Mil) OBStJ BA MB ChB FRCS FRCS(Edin) FRACS

20th July 1927 – 9 June 2007

Frank Keiller, general surgeon, died on 9 June 2007 from complications of a chronic illness.

Frank "lived in interesting times," and always somehow got from them an interesting life.

A schoolboy when the Channel Islands underwent German Occupation, he managed to end up a political prisoner in Colditz Castle, where he delighted in baiting the guards.

As a Medical Officer with the RAF, Frank served in Aden (he toured the Forbidden Quarter), once being rewarded with an ancient Greek alabaster bust for treating a grateful sheik's son.

While still with the RAF, he went to Ghana – just after the Russians left. There he first encountered their left-behind, surgical stapling – long before the American devices – "a good idea, but then too cumbersome to be practical." There he truly practised as a general surgeon – hernias walked in, climbed onto the table, were operated on under local, and climbed off and went home. Gram-negative anaerobic (not then discovered) abdominal infections were treated with wound infusions of Gentian Violet. He even tied Patent Ductus – with zero mortality, saying that if he didn't do the procedure no one else would. He did himself an injustice in that rationalisation for he was very competent at paediatric surgery.

While at Traralgon, he experienced the introduction of seat belt laws, when head injuries almost miraculously disappeared overnight.

He was always frustrated when he couldn't get junior colleagues to "handle tissue properly," nor could he accept surgeons who "didn't know their anatomy." From Frank, over the decade we worked together in Traralgon Vic., a young specialist (myself) learnt about compassion and tolerance, and the responsibilities of being a consultant.

With bed closures there, Frank eased into retirement in Canberra doing some assisting and medicolegal work.

One of Nature's gentlemen, a Francophile, intolerant of ignorance and humbug, he had a long association with St John Ambulance (the only organisation allowed to remain in uniform during the Occupation).

Frank was justifiably proud of his children and grandchildren and thought the world of Enid.

A modest, private man, Frank, having touched the lives of many, is remembered with gratitude.

Dr Ray Cook wrote the above obituary.

Inaugural Canberra Medical Ball a huge success!

Over 160 Canberra doctors and their partners attended the Inaugural Canberra Medical Ball that was held at Old Parliament House on 30 June 2007.

Jointly organised by the AMA ACT, the Canberra Medical Society and the Medical Womens' Society, the event's feedback has been so positive that a second Ball is being planned for winter 2008.

Again, in response to the feedback there will be NO speeches at the 2008 event, we'll ensure that the microphone works properly and better manage the fundraising auctions. Thanks again, on behalf of the organisations, to those who donated the wonderful goods for auction and to those who purchased them.

Charles Howse and Michael Gillespie shared the role of MC although Michael was unfortunately late for the commencement of the Ball as his plane was delayed in Sydney. Thanks and well done, Charles and Michael!

The generosity of the medical profession again came to the fore, with approximately $20 000 being raised for distribution to the nominated charities of the three organisations.

From the committee, thank you to all concerned and if you didn't make the event this year, then lock in 28 June 2008 for next year's Bumper Ball!

THE NOTICE BOARD!

Canberra & Region 2nd Annual Pain Day

Saturday 3 November, University House. Focus topics: 'Opioids and its controversies' and 'Pain in Women' RSVP early to Pain Unit, TCH, 6244 3055.

Wine Tasting Night

Sparkling/Pinot Noir selection, Thursday 23 August from 6:30pm @ Plonk, Palmerston Lane, Manuka. All welcome. RSVP Linda on 6270 5410 by 22 August.

DIT Pizza Lunch

Lunch with Alex Markwell, your representative on AMA Federal Council. RMO Lounge, Friday 12 October.

Canberra Specialist Directory

Additional copies of the 2007 Canberra Specialist Directory can be purchased from the AMA ACT for $9.90. Contact Lucy on 6270 5410 or accounts@ama-act.com.au. If you are a GP and did not receive your copy of the Directory in last month's Canberra Doctor, please contact us.

Invitation to members

Members are invited to use The Notice Board to advertise items of interest to the Canberra medical community. Please send items to execofficer@ama-act.com.au

Support staff training program

AMA ACT and Esset Australia are set to begin on-site training for medical practice staff. For more information, contact Elizabeth on 6270 5410 or visit www.healthtraining.com.au

Family Doctor Week celebrations in the capital

The AMA ACT marked the 2007 Family Doctor Week celebrations with some special events. Posters were distributed to general practices courtesy of Capital Pathology and the 2007 Specialist Directory was distributed to all GPs (irrespective of AMA membership) and specialist members of the AMA ACT. If you did not receive your copy please contact Lucy on 6270 5410.

Monday, 23 July:

Dr Paul Jones, president-elect, and Canberra GP was interviewed by ABC 666 presenter, Alex Sloane, where the role of the GP in infant, child and adolescent health was discussed. Paul's concluding comments were in response to a question from Alex when she enquired whether he would make the same decision, in hindsight, to be a GP. The quick response was an unequivocal "yes"!

Tuesday, 24 July:

Dr Andrew Foote, Dr Paul Jones and Dr Sonia Res took the AMA HEROES (Healthy Eating and Regular Opportunities for Exercise and Sport) to Giralang School where children were entertained by the President masquerading as a Harry Potter lookalike (a hero to some of the children present). Sporting heroes from the AIS, Tristan Thomas and Brad Scott (track and field), Emma Cook (rowing), and Jasmine Keene (netball), engaged in physical activities after the celebration and before a healthy morning tea provided by the AMA in association with 'Simply Fresh' greengrocers in the Canberra Centre. Education Minister, Andrew Barr also attended the event.

Wednesday, 25 July:

Dr Rosanna Capolingua, President of the AMA, addressed the National Press Club for the first time. An edited version of her address is included in this edition of "Canberra Doctor".

Wednesday, 25 July: Dr Rosanna Capolingua attended a dinner with some Canberra GPs and academics. Attending were: Nick Glasgow, Marjan Kljakovic, Ian Pryor, Stan Doumani, Ian Brown, Suzanne Davey, Sonia Res, Steven Kennealy and Alex Stevenson. The dinner was sponsored by the Commonwealth Bank and the AMA ACT thanks the CBA for this sponsorship. Brian White and Stewart Creighton of the CBA attended and were provided with some candid feedback on the Medicare Easyclaim system.

Thursday, 26 July:

One of the AMA's Membership Rewards Program Partners – PLONK – hosted a wine tasting for Canberra GPs at the Manuka shop. Anthony (from Plonk) is keen to meet with members and their partners to inform and show you the range of wines. One of PLONK's special treats is to customise the wine labels just for you. See the Canberra Doctor noticeboard for information on the next wine tasting night.

Book Review
Foundations of Clinical Psychiatry – Third Edition

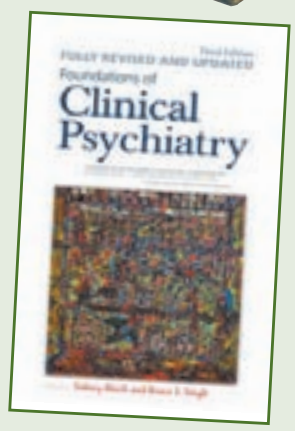
Sidney Bloch & Bruce Singh
Melbourne University Press,
AUD$64.95
ISBN: 052285320X

Reviewing the work of esteemed colleagues is often an unenviable task, especially within a relatively small academic community as in Australia. This short textbook, designed primarily for medical students, is authored by eminent Australian academic psychiatrists from virtually every academic department of psychiatry in Australia. One strength is the pragmatic Australian flavour. Another strength is easy reading style, again probably Australian, straddling the divide between the spare, dry tone of UK texts and the over-inclusive pedantry of American DSM based texts. All the major psychiatric disorders are covered as would be expected in an undergraduate textbook.

The weaknesses of the textbook reflect and interact with the undercurrents of medical education today. One of the challenges, as we move to graduate medical programs consisting of a four-year medical degree following on an undergraduate degree of any complexion, is to develop in students the scientific and critical thinking needed to navigate the uncertainties of clinical medicine. Traditionally, this has been predicated on a shared pre-clinical scientific (and humanities) education which segues into clinical medicine and specialties such as psychiatry. For example, undergraduate psychology, neuroscience, neuropharmacology (amongst other sciences) underpin the understanding of the art and scientific practice of psychiatry. As medical courses have become compressed, we increasingly find that more must be taught in less time. Some material has to be left out in such an abbreviated course. Of late, this has been the pre-clinical (e.g. biochemistry, psychology, physiology) and clinical sciences (e.g. neurosciences, pharmacology, epidemiology). Arguably, this loss has been in order to accommodate teaching communication skills, cultural awareness, medical humanities (including social history of medicine) which could be considered as broadening our future doctors. Is such broadening occurring at the expense of depth, especially in the scientific basis of medicine? Raymond Tallis, in Hippocratic Oaths, has also written of the risk of developing communication skills at the expense of clinical skills in some current models of medical education.

This de-emphasis on medical sciences can be seen in some of the chapters, which lack information on epidemiology, aetiology/pathogenesis (or at least theories thereof) that would underpin a reasoned and critical understanding of the clinical syndromes and treatment. Noticeable exceptions to this observation are the excellent chapters on mood disorders and schizophrenia. The divorcing of the medical scientific bases from the clinical syndromes may potentially reinforce a superficial understanding of the disorders. Thus a checklist mentality of phenomenology may result. Potentially, this would interact with "case" based models of learning in which "checklist monkeys" (R.Looi, pers. comm.) iteratively try to pattern-match patient to diagnosis. The effect of such omissions would be especially noticeable in our current medical education environment. This is even more telling when, as has been described with management consultants in practice, "He just sits there … waiting for me to throw him a case to analyse," students become practitioners. Will some of these innovations in medical education produce MHAs (Masters of Health Administration) rather than doctors?

Of more concern, especially in view of: sub-specialization of the medical workforce, the noted metabolic side effects of atypical antipsychotics, complex medical conditions presenting concurrently in private practice (general and psychiatric) is the omission of a chapter on medical history, examinations and investigations relevant to psychiatry. The psychiatrist, along with the general practitioner and the geriatric/general medicine physician, will be one of the few medical practitioners required to screen for general medical conditions. A psychiatrist may be the only medical specialist seen by a proportion of psychiatric patients. Hence, the assessment and consideration of medical conditions with psychiatric manifestations by psychiatrists is crucial. How even more crucial are such skills for our medical students then, in the context of the avowed mission of a number of new medical schools to produce rural general practitioners, as they may not have specialists to consult? The neuropsychiatry chapter includes such a section, but surely an appropriate physical examination, particularly neurological, is part of modern psychiatric practice?



Returning again to strengths, the narrative style is easy to read and mostly quite interesting. There are aspects of the social context and history of psychiatry that certainly lend colour and make reading rewarding. The major topics are covered clearly and well, with the above caveats. This would be a suitable text for medical students with additional reading around basic and applied clinical sciences relevant to psychiatry (such as Barker's Neuroscience at a Glance) and, potentially for nursing and allied health students. It is insufficiently detailed for psychiatry trainees, but general practitioners may find it useful. The book is currently recommended as a secondary textbook for psychiatry within the ANU Medical School curriculum.

A/Professor Jeffrey Looi
Academic Unit of Psychological Medicine
ANU Medical School
ANU College of Medicine & Health Sciences

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Next edition of *Canberra Doctor* – September 2007

Health policy – up where we belong

The following is an edited version of the recent address given to the National Press Club, by Dr Rosanna Capolingua, President of the AMA.

The AMA always has as its primary driver, PATIENT CARE.

When we talk about hospitals, doctors, private health, public health, from babies to the aged, from birth to the grave ... it is always about the care of the patient, and keeping that focus in the forefront of our minds.

That care incorporates the preservation of the doctor-patient relationship so that clinical choices for patients are made based on what is best for them.

When you come to see me you want to know, and be certain, that the advice I give you is in your best interests.

You want to know that it is not perversely persuaded by Government controls or by other incentives.

You want to have confidence that the doctor you see is well trained and highly skilled.

You want to know that you are seeing a doctor.

You want to know that you are not at risk if you are in a public emergency department, and that your mother or grandmother won't die alone on a trolley in a corridor, or feel like she has been abandoned.

You pay private health insurance, and you want to know that when you need to use it, it's the doctor not the insurer deciding the kind of care you will get, which doctor you will be told to have, which hospital you will have to go to, or the prosthesis you need, or how long you can stay … regardless of your state of health.

If you live in rural Australia, you want to know that the rural hospital has NOT been shut down by the State Government to contain costs.

And you want to be able to see your local doctor when you and your partner and kids need them.

You want your rural doctor to love being in the bush.

You want your rural doctor to have good cover if he has to go away for a while, and you want him to want to come back and stay.

You want your GP to look after you.

Indigenous Health

The doctors that have worked in Indigenous communities in the Northern Territory and elsewhere across the country have been committed to dealing with the problems for years - making a difference with what they had in resources and their own hard work and connection with the people. This must be recognised. Now we have a Federal focus and nationwide energy behind them and alongside them.

Child sex abuse cannot be tolerated, and it has been allowed to fester and harm some indigenous communities. This issue has allowed the doors to be opened and a brave 'once in a lifetime' initiative is taking place.

The AMA is backing and supporting this initiative. Our doctors have put their hands up to be part of this challenge. We are taking the doctors to the Indigenous people and we want the people to want to come to us for their health checks.

We are in for the long haul, and the doctors and the AMA will not support this Indigenous initiative if it is not 'real' and followed through.

The AMA put out a call to the profession and we have some 800 doctors who have responded.

We need a scheme in place that lasts – a scheme that continues to encourage doctors to want to spend time in rural and remote areas as part of their clinical careers.

Aboriginal and Torres Strait Islanders have the poorest health of any group living in this country. Death rates in the age group between 25-54 are 5 to 8 times higher than that seen in non-Indigenous Australians. Indigenous infant mortality rates are three times higher than for non-Indigenous infants. I remind you; there is a 17-year gap in life expectancy between Aboriginal and Torres Strait Islander Australians and the rest of the Australian population. They expect to die in their early 60s, while we can make it to 80.

We have to address the measurable health outcomes.

Fewer low birth weight babies, the eradication of rheumatic heart disease, the management of diabetes, and the prevention of sexually transmitted infections are all goals we can achieve.

We know that medical interventions that can actually produce improved measurable health outcomes are not used by Indigenous people. The gap in life expectancy must be closed within 25 years.

We must ensure there is an ongoing commitment to provide the long-term service needs that will be uncovered in the clinical process currently underway in the remote communities.

So what about the rest of the population?

Dr Rosanna Capolingua, AMA President.

How are they faring with their health care?

Let's talk about the AMA wanting to make sure you get to see a doctor, and a well-trained one at that, into the future.

Doctors

And I am not talking about speaking to a call centre rather than a doctor.

Call centres costs more per call than a Medicare rebate for you to be with the real thing. Call centres have been shown to cause an increase in attendance at Emergency departments …

There has been a sudden realisation for many that Australia has come to rely on overseas trained doctors.

Our international medical graduates have been helping to look after Australians for decades. Many rural communities have had long and strong bonds with their overseas trained doctor GP. These doctors help to hold the Australian health system together.

We must ensure that they know that we respect and appreciate them, and that patients will continue to trust them.

Around 30 per cent of our medical workforce is overseas trained and in rural areas – up to 50 per cent in some cases. Around five-and-a-half-thousand overseas trained doctors arrive each year on temporary visas, including the 457 visa. Another 500 arrive as permanent residents.

Without them, many of our rural, outer metro and even teaching hospitals would be without doctors.

The profession strives to ensure that doctors are people of good standing in the community, and that they have the skills to provide good clinical care to patients.

So how did we end up with this need for so many international medical graduates?

Previous governments had a philosophy to hold down doctor numbers and services, by restraining the medical student intake and using provider number restrictions.

We have an increasing population, and an ageing population with greater health needs, more chronic disease.

We also have a greater ability with advances in medical knowledge to practise preventative medicine, and to manage patients for better outcomes.

Therein lies the gap between the need for doctors and our local graduate ability to fulfil that need.

The overseas trained doctors have been here for us.

In recent years, we have at last an increase in medical student intake from 1200 domestic graduates in 2000 to 3000 in 2012. But I know that you want these young doctors to be highly trained and qualified for the future.

The Governments must fund the places for these young doctors.

The public hospitals are central to this.

Public Hospitals

We are told that Australia is enjoying an unprecedented period of prosperity. So you'd think we'd have a health system that reflects the so-called 'booming' economy.

While State and Federal Governments are in surplus, I want money invested in the public hospitals for today and to establish some foundation for the future.

I want real money going into attracting doctors and nurses and keeping them in the public sector.

I want real investment to train doctors for Australia, in Australia.

I want real money in supporting service delivery so that it makes a difference to patients.

We cannot accept over-run emergency departments, with delays for urgent patients.

We cannot accept wait lists for priority patients when the wait will adversely affect their health outcome.

Doctors and medical staff work hard but their morale is low when they know that patients are compromised.

The negotiation of the next Australian Health Care Agreement will commence in earnest immediately after the Federal election.

The AMA wants a commitment to annual increases in funding that are consistent with health index increases.

If these are the good times, let's invest heavily in our public hospitals so they can survive the bad times.

To its credit, the Federal Government injected much-needed funding and new policies at the 2004 election, which improved the situation significantly at the time.

But three years later, the effect of those initiatives is eroded and the same problems exist, and new ones arise.

Likewise, the aged care sector is in desperate need of new funding and ideas to cope with growing demand.

A major challenge is how to make medical care more accessible for older Australians – either in a Home or in their own home.

Aged Care

Demand for aged care services is growing rapidly.

In the past 30 years—between 1975 and 2005—the number of people aged 65 and over increased from 1.5 million to 2.7 million.

In the next 30 years, the number of people aged 65 and over is projected to increase by 3.5 million to 6.2 million.

Future generations of older people are likely to have more complex needs and demand a higher quality and level of service than is currently available. Older Australians must have access to a range of quality aged care and health services - home care, acute, residential and community care - to meet their changing needs.

There will also be an increasing need to provide quality dementia care in all settings.

The Government provided a 6.4 per cent boost to aged care funding in the 2004-05 budget.

We need a well-crafted aged care policy that delivers:

- More skilled staff, improving nurse to patient ratios
- Incentives for GPs to provide services in both the residential and community aged care settings
- Better access to medical specialists
- And better transport options to take older people to heath care services

There must be a significant investment in capital funding to ensure that sufficient infrastructure is in place to meet future demands for residential aged care and community care.

There must be incentives for GPs, practice nurses, geriatricians and psycho geriatricians to provide services in both the residential and community aged care setting.

There must be improvement in the MBS to underpin this.

The Government needs to fund programs that will put computers in aged care facilities for the use of attending doctors for patient records and prescribing.

The lack of wage parity between the public sector and

the aged care sector must be addressed.

We need private health insurance products and private hospitals to cater for the complex needs of older Australians.

Rural Health

The closure and downgrading of rural hospitals is seriously affecting the future delivery of health care in country electorates.

These decisions are often driven by economic rationalism, without sufficient regard to the significant consequences for local communities or the sustainability of the rural medical workforce.

The state of facilities and equipment in rural hospitals lags significantly behind their metropolitan counterparts.

Health care in rural areas is dependent on a strong primary health care workforce and a viable rural public hospital system.

Without access to decent public hospital facilities, doctors can't maintain their procedural skill levels, specialists may not visit, and the opportunity to train new doctors in rural areas is diminished.

Without the latest technology, rural patients cannot benefit from improved surgical techniques or improved methods of care.

They may face longer recovery periods or may not have the same quality of outcome as they would have if they lived in the city.

We know we need to get doctors to rural communities, and we need to make the opportunity to experience rural and remote medicine in Australia an attractive and valuable part of a doctor's clinical experience.

Remember our increased number of med students?

Five hundred of those are unfunded bonded medical school places each year.

Students taking up the positions are bonded to work for six years in workforce shortage areas.

They get no HECS relief and are so keen to do medicine that they will allow themselves to be conscripted. Unfunded bonding does not address the underlying causes of medical workforce shortages. Unfunded bonding is NOT the answer and may even be unconstitutional.

The AMA has proposed an alternative scholarship based scheme.

We propose that a scholarship should be paid to the student and that there should be an exemption from HECS fees in return for a service period.

This will deliver to communities a willing medical workforce that is treated equitably.

Medicare *Easyclaim*

This is the system that says you don't have to queue at Medicare offices to get your Medicare rebate, or fill out those forms and pop them in the post and wait for a cheque.

It will all happen at the doctor's surgery instead. The fact of the matter is that Easyclaim is not going to be that easy.

The idea is that the patient will be able to get their Medicare rebate at the point of service when they pay the practice account. This will happen through the EFTPOS system.

Patients will have to wait while the doctors' receptionists need to spend more time processing each patient.

Even if it takes only one extra minute per patient, this could be an extra three hours work per day in a busy four-doctor practice. So far, some practices have got it down to four minutes a patient!

The costs, however, to doctors and their practices, are real. We will become the agents of Medicare and we will assume its burden ... in dollars and human burden for patients.

In spite of our concerns, the Federal Government is planning to go ahead with a multi-million dollar advertising blitz to launch Easyclaim in the next few months.

As it stands, though, the system is not attractive for doctors. It will cost money and it will cost valuable patient and practice time.

Meanwhile, we are in deep discussion with Human Services Minister, Senator Chris Ellison, and the Heath Minister, Tony Abbott, over our many concerns.

I am glad to say that the Government is reconsidering the situation.

In Conclusion

Health affects every Australian - we all intersect with health care and it is of key importance and a core responsibility of government.

But their health and the health of their family and loved ones is with them every minute of every day. Now is the time, and we have the wealth, to invest for the future of the health system and to accommodate the health needs of future Australians.

The AMA will keep 'patient care' as its focus, making sure that your needs are appropriately met without compromise. The AMA will be working to ensure that voters know what the health issues are.

We will put doctors and health policy back up where we belong.

Dissecting the new contractor's legislation

The highly skilled nature of the medical industry and the constant need for these skills in a wide range of locations, has resulted in a large number of health professionals working as independent contractors. The *Independent Contactors Act* 2006 which established a new national framework for regulating independent contractor contracts, is likely to ensure that this trend will continue. Understanding the changes therefore, will be essential to all health professionals interested in creating, or increasing the effectiveness of, their independent contractor agreement.

While there is no set definition of an 'independent contractor', generally they can be recognised as a person who performs work under a 'contract for service'. In the majority of cases an independent contractor will be a skilled professional who runs their own business and negotiates their own fees and work arrangements. Importantly, an independent contractor can offer his/her services to a range of clients and is not limited to one source of income.

Unlike an employee who has most of his/her rights protected by law, an independent contractor is protected by the terms and conditions of the contract under which they perform their work. The new legislation which came into force on 1 March 2007 intends to provide further protection for these workers by removing the application of State laws to independent contractor agreements and creating one 'nationally consistent jurisdiction'. To fall within the national jurisdiction one of the parties to the contract must be between either a proprietary limited company or a Commonwealth entity. Amendments to the Workplace Relations Act 1996 have also been made to ensure that employers do not create 'sham arrangements' to avoid paying a legitimate employee their legal entitlements. Importantly, other types of laws relevant to independent contractors, such as taxation, occupational health and safety and superannuation remain unaffected.

Those independent contractors, previously covered by state deeming provisions will retain their employee status for relevant entitlements until 1 March 2010, unless they choose to 'opt out' at an earlier time. Importantly, identifying who is an employee and who is an independent contractor is still set in principles identified by common law. A guide to identifying an independent contractor is set out in the following table .

The exclusion of state and territory laws has also changed the process of challenging the validity of an unfair contract. Under the new laws an independent contractor may bring a claim before a court that their contract is 'unfair' or 'harsh'. For the contract to be found to be invalid a party must show, amongst other things, that it is harsh, unjust, or unconscionable. If this is made out it is then open to the court to replace the contract with provisions that are fair to both parties. However, as with any legal proceedings there are substantial costs and time involved in challenging the fairness of a contract, thus it is important to ensure that the contract is as comprehensive as possible at the time it is signed.

When negotiating an independent contractor contract it is important to remember that entitlements such as sick leave, annual leave or personal leave are not being paid for and consequently the service fee that received for the work must be adequately adjusted to take account of these factors. Further an independent contract is not a replacement for an employment agreement, therefore the terms and conditions of the contract should reflect the commercial nature of the services being provided by the worker.

For further information on how the *Independent Contractors Act* 2006 affects you, contact a legal professional.

Robert Cook is a Partner and Brooke Horne is a Lawyer at Minter Ellison Lawyers, Canberra.

IDENTIFIER	YES	NO
Is the worker free to perform their duties with little or no interference or control?	Independent contractor	Employee
Does the worker perform work for others?	Independent contractor	Employee
Is the worker remunerated by periodic wage or salary and not by reference to completion of tasks?	Employee	Independent Contractor
Is the worker provided with paid holidays or sick leave?	Employee	Independent Contractor
Does the worker have a separate place of work?	Independent contractor	Employee
Does the worker maintain significant tools or equipment?	Independent contractor	Employee
Can the work be delegated or subcontracted?	Independent contractor	Employee