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Canberra DOCTOR

Informing the Canberra medical community since 1988

October 2007

Canberra Doctor is proudly brought to you by the ACT AMA

AMA ACT meets with doctors in training

Pizza Lunch hosts Drs Simon Ussher and Harry Eeman with AMA ACT Industrial Officer Andy Ozolins and Chair of AMA Council of Doctors in Training, Alex Markwell.

The AMA ACT recently met with doctors in training from The Canberra Hospital over lunch to discuss matters of concern. Also attending the lunch, which was hosted by AMA Branch Councillor representing doctors in training, Dr Harry Eeman, was Dr Alex Markwell, a doctor in training from Queensland. Dr Markwell chairs the AMA's Council of Doctors in Training and represents them on the AMA Federal Council. The AMA Federal Council is the peak governance body for the AMA.

Dr Markwell was in Canberra for the meeting of the AMA Council of Doctors in Training (AMA CDT) that was also attended by Dr Eeman.

Included on the agenda as items for discussion were:

- Draft position statement for standards for community placements
- Australian and New Zealand Medical Education and Training
- Core terms for internship
- Training block
- Networked physician training and the psychiatry training program
- DEST medical education study
- Medical Training Review Panel.
- Bonded medical places
- Prevocational general practice placements program
- Infrastructure and resources for clinical teaching
- Medical training in alternative settings
- Surgical education and training (SET) program
- Physician Assistant
- Nurse practitioners
- Role substitution
- NSW Hospitalist proposal – among others.

The recent meeting of the AMA ACTs DiT Forum, chaired by Dr Eeeman, discussed industrial representation of the doctors in training for the next Certified Agreement and more on this will be reported in a forthcoming edition of "Canberra Doctor". Doctors in training should note that through the AMA a number of workplace issues of concern to individual doctors are being progressed internally and externally and doctors in training are reminded that they have access to the AMA's industrial officer, Andy Ozolins and Executive officer, Christine Brill by phoning 02 6270 5410. Membership of the Forum is open to all doctor in training AMA members and interested hospital based doctors should contact Christine Brill for further details. The Forum meets approximately four times a year.

The meeting of the AMACDT joined a meeting of the AMA Coordinating Committee of Salaried Doctors for discussion of matters of concern for hospital based medical practitioners.

Print Post Approved PP 299436/00041

AMA ACT President's letter

Dr Andrew Foote.

Wrongful birth

The word "wrongful" has been applied in the ACT Supreme Court recently to refer to a set of healthy twins born as a result of IVF, where the mother allegedly changed her mind on the day of the procedure to request only one embryo transfer. One healthy twin was OK, but the second was wrongful and required $400K to raise to the age of 18 - thank you very much.

A wrongful healthy birth as a damage that can be sued for is no longer possible in Queensland and NSW. Wrongful democracy could also describe the total lack of community consultation, whereby the ACT government used its numbers to defeat a bill to block such wrongful birth litigation.

Unfettered litigation for a healthy baby has serious implications in the ACT such as prescribing the oral contraceptive pill.

'The doctor did not warn me that vomiting can make the pill ineffective' - $400K please.

'I do not speak English very well and did not understand that my epilepsy medication can make the pill not work' - $400k please.

AMA ACT will be campaigning to urgently request the government to establish a community forum on this issue, and to request new legislation to stop litigation for damages with a healthy baby. Please request your patients sign the petition in he next "Canberra Doctor". We will also be convening a Task Force in the next month, so if you want to get involved please contact myself or Christine Brill.

The other interesting issue that we would like to raise with the ACT government is why was the plaintiffs' family protected from being named but not the doctors'?

Other Matters

The Federal Labor Party has now publicly announced support for the Medicare Safety Net. AMA welcomes this policy change as the Safety Net eases the financial pressure for over one million Australians. The safety net has grown in importance as the MBS has failed to keep pace with the increased costs of providing medical services.

Federal Election

The big day will be on 24 November. Health is a central battle ground, and already we have had announcements about local hospital boards and GP Super clinics. AMA aims to access each issue on its merit and has pointed out that local hospital boards will not necessarily mean more money for hospitals and that bulk billing super clinics in the bush may not offer enough financial incentives to attract GPs from city locations.

Medicare "Easyclaim"

AMA has had a win on "Easyclaim"; from March next year, 18 cents for every Medicare transaction and reimbursement for the set up costs of installing "Easyclaim" software and hardware will be paid.

Emergency in Emergency

The recent death in the waiting room at The Canberra Hospital has put a spotlight on our emergency departments. The press have had a knee jerk reaction to this and reported on patients with alleged horror stories. We need to have a balanced look at areas that need improvement, such as overall waiting times which are worse than the national average, but also to recognize that the overwhelming majority of patients are satisfied with their treatment. We also need to be supportive of the doctors and nursing staff that work in this high pressure environment and to keep the focus on resolving the systemic issues that have resulted in this death and other adverse outcomes.

Fund Raising

The recent Inaugural Combined Medical Ball raised over $20,000 for charity, with the AMA's proceeds going to the Kenya ultrasound project brought to our attention by former local GP, Dr Joe Radkovic and the Medical Benevolent Society in NSW that continues to support many of our colleagues' families during the tough times. Well done all.

Why rent when you can buy your practice premises?

Most small and medium sized practices do not have the funds available to purchase their premises outright. Purchasing your own premises can be a time consuming exercise. Here's a quick list of pros and cons to help you make your decision.

If you do choose to buy, there are several advantages:

- When you own your own premises you are in control and can stay here as long as it suits your needs
- Your costs are relatively fixed, particularly if you have a fixed rate loan, whereas rents are changeable and subject to review.
- You can renovate the premises to suit your patient and staff requirements
- In the long term, if you choose your location wisely, it is likely that the value of the property will rise.
- By investing in your own commercial premises you may be able to convert your rental repayments into an investment for your financial future. Make the comparison – it's possible that monthly loan repayments are similar to your current rental costs.

Against these advantages you need to weigh the disadvantages. Buying property can be an expensive and time consuming process involving significant professional fees and stamp duty. You'll also need to budget for repairs and maintenance costs.

Looking at the finance for your practice premises, there are loan products available that are custom designed for healthcare practitioners.

Tim Bowring of Medfin Finance advises: "Look for a financier that doesn't speak jargon, search for loan advice that is effective and easy to understand. Doctors are not necessarily property experts. That's why Medfin's Relationship Managers are trained to help practitioners to walk step by step, through the loan process".

"Talk to your accountant about the benefits of choosing a practice property loan that does not require a deposit. By not using your own funds, you may benefit by conserving your money for investment in other areas" suggests Tim Bowring. "Always ask about the fees and charges. And I can't stress my next piece of advice strongly enough – please make sure you know that your monthly repayment is calculated on the rate you have discussed with your finance company".

If you'd like further information on Medfin's Practice Property Loan or wish to check that the rate you have been quoted matches the repayment you will be charged, call your local Canberra, Medfin Relationship Manager on 0400 482 301.

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*conditions apply

Top 5 "rules of thumb" for SMSFs in the new superannuation regime:

1. Upgrade your deed

This is a must. At the risk of stating the obvious, if it's not in the deed you can't do it! With the magnitude of these changes, operating under a pre-super reform deed is akin to driving on the right hand side of the road. It's irresponsible not to spend about $500 in order to be on safe ground. Forget doing 2 through 5 if you haven't done 1.

2. If you're over 55 start a pension whether you need the income or not!

Our modelling has shown that in virtually every case, both the individual pensioner and the super fund pay much less tax simply by starting pensions from age 55. This is enhanced even further once the pensioner turns 60 and the pension is not assessed for tax purposes. If the income exceeds your requirements, any surplus funds can simply be re-contributed back into the super fund (see number 4).

3. Develop an effective estate plan

The government will not receive a penny of tax from a superannuation fund paying pensions to those who are over 60. I am sure the government's intention is to recoup a lot of tax when a lump sum is paid to adult children on death. It is no longer possible to pay pensions to adult children (unless they satisfy the financial dependant rules).

There are several strategies to reduce the potential tax bill for the beneficiaries, which obviously need to be implemented whilst you're still alive.

4. Contribute effectively

The abolition of RBLs and lump sum tax for over 60's means the emphasis has now shifted to the "front end". Contributions where a deduction is claimed (either by the individual or their employer) are now called "concessional" contributions (CC) and where a deduction is not claimed are called "non-concessional" contributions (NCC).

There are limits to how much you can contribute per annum with the NCC limit being 3 times the CC cap. The penalty for breaching these is the highest tax rate. There are also enhancements to the small business CGT concessional rules that have their own limit (the CGT cap) and invariably there is an interrelation between some or all of the caps when a strategy is devised.

Once monies are invested, super is now undisputed as the most tax effective structure to hold investment assets. The challenge now is contributing the monies effectively so as not to incur unnecessary up front tax. It takes skill and planning.

5. Get advice

When the "simpler super" reforms were announced on budget night 2006, the treasurer announced that superannuation would be so simple that professional advice would not be required in this area! Our experience in the last 18 months has been very different.

The new super regime has provided great benefits for those who know how to take advantage of it, and we have seen that good advice has created a great deal of value for clients who have had the wisdom to seek it.

Copy supplied by King Financial

Dr Robert Schmidli plays "for peace"

The ACT Branch of the Medical Association for the Prevention of War recently held a fundraising piano recital in the Chapel at Radford College.

The receptive and appreciative audience was treated to a wonderful piano recital by well-known Canberran, Dr Robert Schmidli.

The program included Schubert's: Piano Sonata in A Major Op Posth 120; Poulenc's: Theme Varie and Beethoven's: Sonata in C sharp minor Op 27 no 2 "Moonlight"

Further information on the work of the Association can be obtained by contacting Dr Rosie Yuille: yuille@homemail.com.au

Health of our nation – the AMA's issues for the 2007 federal election

Now that the election date has been announced, once the parties "launch" their platforms, the AMA will consider the promises and commitments of the parties and report back to you.

As the peak body for the medical profession the AMA considers that it is important that the medical practitioners in the ACT are informed of the AMA's stand on a range of issues of importance to individuals and to the patients you treat.

Public hospitals funding and workforce issues are right up at the top of the list.

The following are some of the issues that rate high priority in the AMA's view.

Public hospitals funding

Patients want access to good quality public hospital services in a timely manner.

There should not be significant variations in the level of access, the quality of the service, the outcomes from the service in the various States and Territories, or the services within a State or Territory.

There should be no delays in the most urgent categories for admission or for treatment in emergency departments.

Some public hospitals in Australia are operating at 120 percent occupancy. Patients are treated in corridors. Patients want to be treated in appropriate settings.

Public hospitals should not operate at more than 85 percent bed occupancy.

Patients know our public hospitals are failing because of inadequate bed numbers, including ICU beds, and inadequate resources to back up those beds, leaving patients to suffer long delays in admissions and in emergency departments.

The Commonwealth and State and Territory governments have traditionally, leaving aside year on year variations, shared public hospital expenditure approximately 50/50.

Since the commencement of the most recent Australian Health Care Agreement (ACHA), the State and Territory share of total public hospital expenditure has risen to 48 percent on average, while the Commonwealth contribution has dropped to 44 percent, with the remaining seven percent contributed by individuals.

The policy decision to match indexation has been responsible for changing the cyclical pattern of expenditure. The Commonwealth indexation has been approximately five per cent per annum over the life of the AHCA.

The States and Territories have contributed significantly more than this over the life of the agreement.

A five percent indexation is barely sufficient to cover increases in wages and equipment costs, let alone activity and complexity increases.

The government has announced a $2.5 billion Health and Medical Investment Fund. The Opposition has released New Directions for Australian Health, involving $2 billion over four years for a National Health and Hospitals Reform Plan. Neither offers a comprehensive strategic national solution.

The AMA position

- The AMA supports matching indexation of funding to public hospitals by the Federal government and the States and Territories. Five percent per annum indexation is too low. The Commonwealth needs to provide indexation of 8-9 percent per annum, with a matching contribution from the States and Territories. The Federal Government needs to front-load some funding to bring the funding effort back into balance. This would not need to be matched by the States and Territories.
- There needs to be a greater focus on the expansion of current services and a greater focus on service delivery. Investment needs to be made into infrastructure and clinicians. Too much has been spent on plans and reviews and not enough on the provision of beds and services. The Federal Government needs to use the AHCAs to pressure the States and Territories to provide services. If the Government goes about this intelligently, the doctors will make themselves available to work more in the public hospital system.
- The AMA supports the current system with Commonwealth/State parity of funding, and health reform based on incremental change through cooperative and systematic review. This reform must improve access and quality and reduce bureaucracy and must have strong clinician involvement and support.
- All political parties need to bring the people into their confidence and put an end to blame shifting and cost shifting by making specific commitments in the election campaign to the level of funding they will support for the public hospitals.

Training more doctors

In response to workforce shortages, the Commonwealth government has embarked on the most significant expansion of medical student places that Australia has ever seen.

Between 2006 and 2012, the number of graduates from medical schools will double.

This presents Australia with a unique opportunity to reduce its reliance on overseas trained doctors.

Australia must generate a lot more training places in hospitals and take much grater advantage of opportunities to expand medial training into private and community clinical settings if the quality of our doctors is to be maintained.

By 2013, 3400 intern places per year will be required, compared to the 1622 that are currently available. Similar increases in vocational training places will also be needed.

There is now widespread consensus that the provision of sufficient clinical experience during undergraduate, prevocational and vocational training years will prove to be an enormous future challenge.

Our doctors are renowned for their skills throughout the world. Australians have access to treatment by dedicated doctors who have gone through a rigorous and comprehensive training program.

If doctors are not given enough experience in dealing with a wide range of medical conditions, then the quality of their training will suffer and the high quality of patient care will be compromised.

Training of Australia's key medical workforce – doctors, nurses and allied health professionals – must not be compromised or have its quality threatened.

COAG recognised the need to ensure that more clinical places, intern and vocational training positions are available in the future.

If sufficient high quality training positions are not created, the Commonwealth's significant investment in new medical school places will have been wasted and many future doctors will emerge with significant gaps in their knowledge and skills.

The Commonwealth and State/Territory Governments need to ensure that they put in place the plans and resources required to support the training of our future medical workforce.

Governments will undoubtedly look to general practice and private specialist practice to provide more training opportunities. Both of these areas are ready to answer this call, but need funding support to cover the significant costs of infrastructure and supervision.

AMA position

The AMA believes that a comprehensive strategy must support the training of more doctors. From the day a student enters medical school we must be confident that they will get the best possible training at each stage in their future career. The proposed AMA strategy outlined below will build resources in hospitals, the private sector, community settings and general practice.

- ACHA negotiations must provide more funding to the States and Territories to support medical training in public hospitals. In return for this funding, specific, transparent performance benchmarks targeting the provision of high quality training positions should be built into future AHCAs. This will ensure that additional funding for training is not shifted into general State health department budgets.
- The Commonwealth should provide an additional $100 million over four years to support increased training places in general practice for medical students.
- The Commonwealth should fund 1000 prevocational training places (of up to three months duration) per year in general practice. This would cost around $80 million per year once sufficient numbers of graduates emerge from medical schools from 2011 onwards.
- The Commonwealth must acknowledge and support the role of the Medical Colleges in training.
- The provision by the Commonwealth of $60 million over four years to support a limited roll out of specialist training in expanded clinical settings is a welcome start, but falls well short of what is needed in the longer term, which has previously been estimated at between $125 million and $250 million per year.

Doctor substitution

A highly trained, skilled and motivated workforce is the backbone of a high quality health system. The improvements in treatment options available and health outcomes achieved come from the investment we made in our health workforce. There has been a lot of pressure in recent times to aim for mediocrity in health care in the pursuit of lower costs.

This is an agenda that is being driven by narrow sectional professional interests, not by patient demands. It manifests itself as task substitution, whereby lesser-trained health professionals with limited ability are seeking the authority to act in a particular aspect of health care. This will lead to poorer health outcomes in the long run.

Given the very substantial increases in medial undergraduate training over the last few years, we must ensure that there will be adequate training opportunities for the medical profession itself. It would be negligent of the Government to undermine this principle by creating and training new categories of 'health workers' for economic reasons.

They will compete for training experience, and cannot fulfil the holistic role of the doctor. "Health workers" substituting for doctors or for other specific allied health professions will compromise patient care. A prosperous nation should have a prosperous health system with high quality medical care provided by highly trained doctors.

When patients get sick, they want to see a doctor. The general practitioner is the highest trained general health professional and is the key point of entry into the health system. If the GP needs further expert medial advice, there is specialist referral. These are the basic elements in the health system. GPs and specialists will use support staff where appropriate and safe, and the medical profession will develop training programs for these 'assistants'.

AMA Position

The AMA supports the idea of health care teams with the doctor as the leader of the team. The AMA opposes the substitution of doctors with lesser-trained 'health workers'.

Doctors can and will determine when tasks and responsibilities can be delegated to another on the grounds that

AMA focussed on health issues for the federal election.

there will be no diminution of the quality and safety of patient care.

Governments should commit to higher standards, better training and better health outcomes.

National Registration and Accreditation

There has been mutual recognition of registration of medical practitioners between the jurisdictions for many years. The AMA has supported previous attempts by the jurisdictions to harmonise standards to allow portability of registration across borders with a minimum of red tape.

The last attempt to achieve portability for medical registration in 2003/04 failed because not all the States and Territories could agree on harmonising legislation.

The most recent COAG attempt to achieve portability of medical registration includes proposals to create a ministerial council that, on advice from a non-medical advisory council, would set policy direction, appoint a national medical board, and approve medical registration, practice competency and accreditation standards. COAGs national medical board would have the functions of managing the development of standards of registration for approval by health ministers and approving a list of accredited courses.

Under the COAG model, the safety and quality of medical care in Australia would be threatened.

Accreditation of all medical courses and undergraduate and specialist training would be controlled by Government for political expediency and would not be in the hands of an independent agency, currently the Australian Medical Council (AMC). This is a significant issue because, in some places, lesser-trained health professionals may replace highly trained doctors. This is not in the best interests of patients. When patients are ill they want and deserve a doctor.

If the COAG proposal goes ahead, the international stature of Australian doctors will decline because of the lack of an independent accreditor of standards of medical education. The guidelines of the world Health Organisation (WHO) and the World Federation for Medical Education state that ' … the accreditation system must operate within a legal framework … the legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from Government.' If government adopts the COAG plan, Australian patients may receive lower quality health care through lower standards or inappropriate task substitution.

AMA Position

The AMA supports undergraduate and postgraduate education and training being accredited by a medical council that is independent of government. The guiding principle for a medical council should be to ensure a well trained workforce that can provide the highest standards of practice and medical care. Medical registration needs to be portable, not expensive, non-bureaucratic and accountable

From: *Key Health Issues*; **full copy available at www.ama.com.au**

Canberra DOCTOR

A News Magazine for all Doctors in the Canberra Region
ISSN 13118X25

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

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Next edition of *Canberra Doctor* – November 2007

THE NOTICE BOARD!

2009 Canberra Medical Ball
Saturday 28 June 2009
Venue to be advised
Lock the date in now!

ACE research project
Whiplash update presented by Dr David Hughes
Canberra Business Centre
Thursday 25 October 2007
RSVP 5232 5941

2007 International Doctors Health Conference
Thursday 25 to Saturday 27 October
Sheraton on the Park, Sydney
FYI … www.doctorshealthsydney2007.org

Health Training Solutions Seminar
(AMA and ESSET TRAINING)
Wednesday 24 October 2007
Calvary John James
6:15-7:15pm
RSVP Linda 62370 5410 ASAP

Rural Health Support, Education and Training Program
Enhancing palliation in patients with advanced cancer in rural areas.
Available at no cost to health professionals
Register online: www.moga.org.au

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

Wine Tasting – meet your council
AMA members and partners are invited to meet and mingle with AMA ACT councillors.
Thursday 15 November from 6:30pm
Plonk, Palmerston Lane, Manuka
RSVP Linda on 6270 5410 by 12 November

The ACT Chapter of the Australian Pain Society in association with ACT Health
invites you to a Canberra Regional Pain Day
to be held at University House, ANU on
Saturday 3 November 2007.
For further details contact 6244 3055 or 6244 3011 or email heather.collin@act.gov.au by 24 October 2007.

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Commonwealth Review of the Professional Services Review Scheme – 2006

In May 2007, the report of the Steering Committee's review of the Professional Services Review (PSR) Scheme was published. That review commenced with the establishment in March 2006 of the Steering Committee comprising representatives from the Federal AMA, Medicare Australia and the Department of Health and Aging. The Steering Committee's Terms of Reference were to review the Scheme in light of the legislative changes in 1999 and 2002, to identify the effectiveness of the current Scheme and identify ways in which it could better meet emerging challenges.

The PSR Scheme was introduced in July 1994 to replace the previous Medical Services Committees of Inquiry arrangements. The Scheme's principal objective is to investigate the provision of services by a practitioner to determine whether the practitioner has engaged in inappropriate practice in providing Medicare services, or in prescribing under the Pharmaceutical Benefits Scheme. Inappropriate practice is defined in Section 82 of the Health Insurance Act 1973 (Cth) and is based on the concept of peer review. That is, a practitioner engages in inappropriate practice if the practitioner's conduct in connection with rendering or initiating services is such that a Committee (of peers) could reasonably conclude that the conduct would be unacceptable to the general body of the practitioner's peers.

The Scheme is divided into 4 distinct stages. First, Medicare Australia's investigative phase which was recently amended from a 2 stage to 1 stage review process (Practitioner Review Program). Secondly, referral to the Director of PSR with a request that he conduct a review (including of medical records) of the conduct. He may also dismiss the request, enter into an Agreement with the practitioner, or refer the matter to a Committee. Thirdly, a referral to a hearing before a PSR Committee. Fourthly, the imposition of sanctions by the Determining Authority, which may include a reprimand, counselling, repayment of Medicare benefits and/or partial or full disqualification from Medicare.

Since its inception, the legislation which governs the PSR Scheme (Part VAA of the Health Insurance Act 1973 (Cth)) has undergone major amendments in 1997, 1999 and 2002 following various successful challenges to it in the Federal Court of Australia. The Steering Committee was charged with the responsibility of reviewing the efficacy of those amendments.

Ultimately, the Committee found that the PSR Scheme ought to be retained in its present form – including the existence of its peer review process. It did however recommend changes in respect to the Scheme's processes and administration. Those included:

- the introduction of an Advisory Committee to oversee the Scheme and provide ongoing guidance for its effective operation;
- the Scheme's review processes at both Medicare Australia and PSR be streamlined;
- parameters for identifying possible inappropriate practice by specialists and allied health professionals be developed;
- the current referral of cases to the Medicare Participation Review Committee where a practitioner has 2 findings of inappropriate practice made against them, be instead referred to the Determining Authority which would be afforded the same powers as the Committee;
- the incorporation of the Department of Veterans Affairs (DVA) claims in services reviewed under the PSR Scheme; and
- the provision by PSR of education and support in the context of the appropriate use of items listed in the Medicare Benefits Schedule.

In short, the Committee having consulted widely with stakeholders including medical defence organisations, the AMA, regulatory bodies such as medical boards, PSR and lawyers experienced with the Scheme, ultimately found an ongoing general support for the Scheme and significantly, no one purportedly raised concerns of a fundamental nature such that would require replacement of the Scheme itself.

It is envisaged that the Committee's recommendations will be reviewed and implemented by the Advisory Committee in due course and subject to Ministerial approval, amendments to the legislation made. As with all changes to schemes such as this, only time will tell what impact they have.

One of the most significant proposed changes relates to the incorporation of DVA figures into data reviewed under the current PSR processes. Indeed, many practitioners who already provide a high level of Medicare services may find themselves subject to greater scrutiny should that recommendation ultimately be endorsed and the legislation amended.

Interestingly, the Commonwealth Attorney-General recently submitted to the Full Federal Court of Australia that doctors who were disqualified from providing Medicare services could always establish a practice whereby they consulted solely with DVA patients.

Andrew Davey,
Senior Associate,
TressCox lawyers.

AMA ACT AND LAW SOCIETY ACT NEW MEDICO LEGAL SCHEDULE OUT NOW

Members of the AMA ACT please note that you will receive your updated schedule in the next few weeks.
The schedule takes effect from 1 November 2007.

FEES INCREASED FOR CREMATION CERTIFICATES

Members should note that notification of the fees applicable from 1 November 2007 will be circulated in the next few weeks.

NEW PAY RATES FOR PRACTICE STAFF

Members should note the Fair Pay Commission rates are out now. Please log in to the AMA ACT website for further information: www.ama-act.com.au

Court penalises surgeons $110,000 for moves to prevent competition

The Federal Court has imposed penalties totalling $110,000 on two Adelaide cardiothoracic surgeons over moves to prevent competition from two other cardiothoracic surgeons in the Adelaide metropolitan area.

The Australian Competition and Consumer Commission had instituted proceedings alleging that Dr John Knight and Dr Iain Ross engaged in anticompetitive conduct over the provision of cardiothoracic surgical services to private patients in or near South Australia.

The Federal Court today declared that on or around 6 February 2001 Dr Knight and Dr Ross made an arrangement that they would hinder or prevent a newly qualified surgeon from entering or supplying his services in the market before he had undertaken further surgical training, notwithstanding that he was legally qualified to practise as a cardiothoracic surgeon.

The court also declared that Dr Knight and Dr Ross gave effect to the arrangement on six occasions between 6 February 2001 and 9 March 2001 by advising either hospitals at which the surgeon sought to operate or cardiothoracic surgeons who had been asked to support the surgeon's applications to operate at those hospitals, that the surgeon was insufficiently trained or had not completed his training, and should not be allowed to operate at those hospitals. The ACCC maintains this is not the case.

The court also declared that Dr Ross attempted via a letter in May 2003, to reach a non-compete arrangement with a second surgeon whereby that surgeon would not provide surgical services at Ashford Hospital and that Dr Ross would agree not to provide surgical services at Wakefield Hospital. The court also declared that Dr Knight attempted, via a letter in November 2004, to reach a similar non-compete arrangement with the surgeon.

The court ordered Dr Knight and Dr Ross to each pay a pecuniary penalty of $55,000 and make a contribution of $5,000 each to the ACCC's costs in relation to the proceedings. Dr Knight and Dr Ross are also required to attend trade practices law compliance training.

"This is a reminder to all professions, not just the medical profession, that the Trade Practices Act or the relevant state Competition Code applies to their actions," ACCC Chairman, Mr Graeme Samuel, said.

"With respect to the newly qualified surgeon, the conduct of Dr Knight and Dr Ross went beyond merely expressing a view as to what further training was, in their opinion, desirable for newly qualified surgeons. Their conduct went to the base of effective competition between medical professionals. It concerned the ability of newly qualified practitioners to enter the market unimpeded and the ability of practitioners to apply for accreditation at private hospitals of their choice.

"The effect of the conduct was, in relation to the newly qualified surgeon, to hinder him from gaining access to Ashford Hospital for a period of time. It was also to signal to other newly qualified surgeons that they were required to undertake more training before they could practice as a surgeon.

"Additionally, they attempted to deter a rival surgeon from gaining access to Ashford where they had their practices."

The proceedings were finalised by consent.

Training

Cardiothoracic surgeons are required to be Fellows of the Royal Australasian College of Surgeons to be entitled to perform cardiothoracic surgery in Australia. Advanced surgical training in cardiothoracic surgery is a six year program, requiring a surgeon to have first successfully completed a two year basic surgical training to be eligible to undertake advanced training. Trainees complete their training under the supervision of RACS approved supervisors.

In February 2001, the newly qualified surgeon informed Dr Knight and Dr Ross that he was not going to do an overseas placement as had been proposed by Dr Knight, but was instead going to commence offering cardiothoracic surgical services, specialising in thoracic surgical services, to private patients in Adelaide. The surgeon had trained under the supervision of Dr Knight and Dr Ross during his final year of advanced surgical training. Dr Knight, as his official RACS supervisor, had provided positive assessments of the surgeon to RACS, including that he had impressive operative technique and would make an excellent surgeon in the future.

After the surgeon told Dr Knight and Dr Ross of his intentions, Dr Knight and Dr Ross made an arrangement to hinder or prevent the surgeon from entering or supplying his services in the market prior to him undertaking further cardiothoracic surgical training, notwithstanding that he was legally qualified as a cardiothoracic surgeon.

Accreditation

There are five hospitals in Adelaide which perform cardiac surgery, two public hospitals, the Royal Adelaide Hospital and Flinders Medical Centre, and three private hospitals, Ashford Hospital, Flinders Private Hospital and Wakefield Hospital. To be able to admit and treat patients at a private hospital, a cardiothoracic surgeon must obtain accreditation from that hospital.

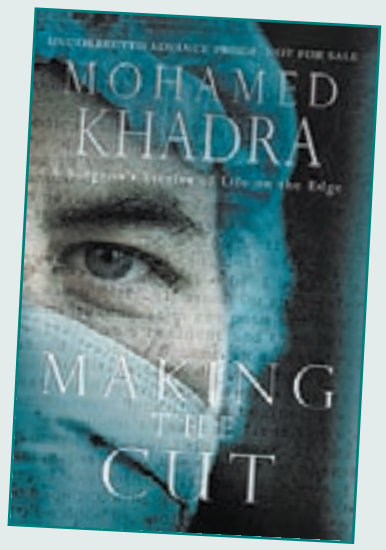
In mid March 2003, a surgeon who had an appointment at the Royal Adelaide applied for accreditation at Ashford. After becoming aware of his application, on 5 May 2003 Dr Ross wrote to the surgeon. In the letter Dr Ross asked the surgeon to reconsider his decision to operate at Ashford, invited him to enter into a non-compete arrangement, and threatened that he and Dr Knight would seek to operate at Wakefield unless the surgeon agreed not to compete with them at Ashford.

The following year, on 23 November 2004, Dr Knight wrote to the same surgeon and advised it was his belief that the surgeon's decision to go to Ashford was disruptive to well established practice patterns in Adelaide and was expressly against the wishes of Messrs Knight and Ross. Dr Knight also invited the surgeon to become a party to a non-compete arrangement.

At the time of the conduct, only cardiothoracic surgeons who held an appointment at the Royal Adelaide provided cardiac surgical services at Wakefield Hospital and only cardiothoracic surgeons who held an appointment at the Flinders Medical Centre provided cardiac surgical services at Ashford. Dr Knight and Dr Ross held appointments at the Flinders Medical Centre

Book Review – *Making the Cut*

***Making the Cut*, Mohamed Khadra**
Random House, Australia, 2007



Mohamed Khadra was until recently, Foundation Professor of Surgery at the ANU Medical School. Prior to that, he had been Pro-Vice Chancellor at the University of Canberra and preceding that, Professor of Surgery and Head of the School of Rural Health, UNSW, at Wagga Wagga. Professor Khadra, a medical graduate of Newcastle, also held degrees in education, computing science, a PhD in Urology, as well as his FRACS. He impresses as a polymath with an intellectual restlessness seen not uncommonly in our most talented colleagues.

His professional autobiography comprises anecdotes of his surgical training, early consultant days and teaching as a clinical academic. At times poignant, at others confronting, his book is no-holds-barred, including a sobering interlude of his struggle with cancer as a young consultant. Professor Khadra's recollections are fictionalised to protect confidentiality, but lose none of their narrative and rhetorical power. Amongst other topics he ranges over: the hard-headed brutality of surgical training; the exigencies of private surgical practice versus best clinical practice; interactions with changes in nursing education and care; as well as struggles with health administration.

Perhaps most poignant is his self-described burgeoning empathy, developed from his experience as a cancer patient and the broader perspective of teaching and public health. He describes this type of empathy, verging on sympathy, as disabling for a surgeon, who in his view needs to maintain a certain empathic distance from patients in order to perform surgery.

In reflecting upon my practice as a psychiatrist, it is ironic that the same empathy needed to support my patients through the travails of their mental illnesses becomes a deepening wound for a brilliant and dedicated surgeon such as Professor Khadra. For psychiatrists, maintaining empathy is a delicate balancing act, assisted by the requirement for formal peer review and support processes. Such processes may need to be further developed in medical practice in general, including surgery.

We should be mindful of the saying inscribed on a sundial referring to the hours: 'All of them wound, the last one kills.' (Quoted from Tallis 2005) Thus it may be with empathy for physicians, and is a counterpoint to the recent simplistic calls for "more empathy" from doctors; for empathy must be balanced against a certain objective distance for clarity of thought and action in medical practice.

Professor Khadra finally depicts his quiet departure from medical practice following this journey, at my estimate around the early age of 45, for a career in provision of distance education in the developing world and more. Making the Cut is a gripping, incisive and poignant autobiography of the meteoric career of a talented surgical professor, now sadly lost to medicine.

Jeffrey Looi
Associate Professor
& Deputy Head
Academic Unit of
Psychological Medicine
ANU Medical School

AMSA Applauds Changes to Bonded Medical Places Scheme

The Australian Medical Students' Association has applauded the Federal Government for making positive changes to the Bonded Medical Places (BMP) Scheme.

AMSA National President Mr. Rob Mitchell said, "AMSA has maintained an open dialogue with the Department for some time, advocating for increased flexibility and support to be built into the program.

The BMP Scheme, introduced in 2004, bonds 25% of all medical students studying in Australia to work in areas of defined workforce need once they have completed the majority of their medical training.

The new changes serve to increase flexibility and pastoral support for students contracted into the scheme. The return of service students must complete is now commensurate with the length of their medical degree, and there is an opportunity to fulfil a component of their return of service as a Junior Doctor. A support program for BMP students, which will provide them with networking and academic opportunities, has also been launched.

AMSA has now written to the Federal Minister for Health and Ageing the Hon. Tony Abbott MP to congratulate his office on the improvements to the Scheme.

"AMSA will continue to communicate with the Department of Health and Ageing and provide a voice for our members, one-quarter of whom are part of the BMP Scheme.

"We are committed to pushing for viable, practical, incentive-driven programs designed to promote the benefits of rural practice. Students must not be exploited in the effort to solve the workforce maldistribution crisis, and AMSA will continue to advocate to this end.

"These changes will make the BMP scheme more palatable for students. This in turn will increase the likelihood of the scheme achieving its goal: to recruit and retain doctors in areas of workforce need."

amsa
AUSTRALIAN MEDICAL STUDENTS ASSOCIATION

Embracing Rural and Remote Health

The ANU Rural Medical Society (ARMS) is now in its 4th year and has grown from a small group of 1st year medical students to a large club with over 160 members from all years of the medical course, as well as a number of staff members. It has a clear vibrant presence within the medical school and enjoys productive relationships with other student bodies and relevant community and medical organisations including the National Rural Health Alliance (NRHA) and South East NSW Division of General Practice.

On Wednesday 19 September 2007 ARMS officially launched it's new website and domain name with a free BBQ and a walkthough tour of the site, which can be found at http://www.arms.asn.au

The website is a major and significant upgrade from the simple information previously available as a subset of the ANU medical school website. As a dynamic content management system ARMS committee members are able to add information as it comes to hand with a minimum of fuss. In line with its aims to promote rural medicine and health, the website contains up-to-date information including news feeds from the Australian Journal of Rural Health and ABC Rural News; latest news from ARMS events; a calendar promoting upcoming rural medical events (both ARMS and external); information on scholarships available to students and conferences to attend; a separate section devoted to Indigenous health; and a community bulletin board and photo gallery. ARMS members can contribute photos to the website and participate in discussions on the bulletin board. There is also a comprehensive link section to other online resources, as well as administrative, historical and membership information.

It is hoped the website will become a well-used resource for students and others interested in rural health. It provides the opportunity for discussion and debate as well as being a tool for sharing information, experiences and images of, and about, rural health.

The ANU Rural Medical Society (ARMS) also aims to broaden students' understanding of rural health issues and medical practice through a number of social and academic events held throughout each year. By encouraging students to get involved in its activities we provide positive experiences to students interested or curious about rural and remote medicine.

It coordinates educational events ranging from presenting guest speakers to providing clinical skills trips around the greater Canberra region. The rural show visits program provides an opportunity for students to travel to towns in rural NSW and provide screening and health advice relating to cardiovascular health alongside local doctors and allied health staff. Students meet with members of the local community, test their clinical skills and experience first-hand the rural lifestyle as well as gain an appreciation of rural health issues. Towns visited so far this year include Bega, Cooma, Yass, Harden and Young. The impressive reception and interest received on these occasions towards visiting medical students has been encouraging and the ANU Rural Medical Society wishes to thank all the communities, doctors and rural clinical staff involved in making our attendance possible. In addition to clinical skills trips, ARMS conducts rural high school visits to educate and inspire students to consider a career in health encompassing medicine and the allied health professions. Academic scholarships have also been provided to conscientious students aiming for tertiary education.

Our student members are able to apply for conferences of national significance through their rural health club and attend formal speaker nights given by prominent members of the medical profession. A number of social events are also held throughout the year including an annual ski trip, bushdance and various barbeques.

The ANU Rural Medical Society hopes to continue growing and maintaining strong relationships with the medical community here in Canberra and greater South-East NSW. It is envisaged the new website as a vital link in keeping members informed about rural health, as an ongoing historical documentation of ARMS activities, and as a way of connecting further with outside communties. For further information or a chance to get involved please contact ARMS through its website. http:// www.arms.asn.au

Shuja Haider
ARMS President, 2007-2008
David Corbet
IT Officer, 2007-2008

ANU rural clinical school

Since its inception, the ANU Medical school has had a strong commitment to the surrounding rural region, and has established an integrated rural training program in south-east New South Wales. The ANU Rural Clinical School was established in 2006 and is funded under the Commonwealth Department of Health and Ageing's Rural Health Strategy.

The School endeavours to enhance the health of this region through the provision of an integrated rural educational program for students from Years 1-4. This program requires all students to spend a minimum of eight weeks in a structured residential rural placement. This includes one week in the first year of study, one week in the second year and a six-week placement in the third year. By 2010 25% of the students admitted to the ANU Medical School each year will enter the rural stream and spend entire Year 3 in a rural town in south eastern New South Wales.

Very early in the course Year 1 students embark on Rural Week 1 and are warmly welcomed by the communities of Bega, Goulburn & Cooma. The aim of this week is to introduce them to the variety of rural medicine and the pleasures of rural life. Surfing with the surgeon at Tathra Beach before Ward Rounds. Waking to sound of bleeting sheep on Pelican Station in Goulburn and being involved in a mock disaster training exercise with the SES in Cooma all contribute to student's enjoyment of this week and awakening interest in rural medicine.

During Year 2 Rural Week activities focus on rural communities. This year ANUMS were joined by physiotherapy and pharmacy students from the University of Canberra. This inter-professional learning experience was well evaluated by the students. The communities of Young, Goulburn, Bega, Bateman's Bay and Moruya are important partners in this program.

The major rural clinical attachments are in Year 3. General practitioners in the region have embraced the program with the majority of practices have students for the six week attachments. The GP supervisors of the long term students have found the experience both challenging and immensely rewarding with some taking both the short and long term students concurrently. The Rural Clinical School is indebted to their commitment and support.

The six-week attachments occur throughout the NSW south east region including, Bombala, Braidwood, Cooma, Eden, Gundagai, Goulburn, Harden, Merimbula, Moruya, Narooma, Pambula, Tura Beach and Yass. A limited number of placements are also available in remote locations of Central Australia for selected students.

During the six-week rural attachment students are attached to a rural medical practice. This experience enables students to observe how general practitioners work in the context of smaller, rural communities. The supervising GP's are encouraged to provide students with as much patient exposure as possible and to allow participation in supervised procedural work. Students attend the local hospitals with their VMO GP supervisors and attend on call, emergency departments and ward round work. During their attachments they also utilise the teaching and patient resources of visiting specialists and community and allied health services.

The focal point of these experiences is in the third year of the course when students spend the entire year attached to a general practice in a rural town. Throughout the year students follow an integrated, patient based, longitudinal study program, combining medicine, surgery and community & child health. While students will be attached to specific general practices, and they will also work under supervision at the local hospitals. Local academic mentors will closely monitor the students to ensure they have had clinical exposure to the important cases/problems identified by the relevant disciplines, and that all coursework requirements are met.

The first long term rural stream placements began in 2006 with the first group of 11 students undertaking their placement in Bega, Cooma, Goulburn, Queanbeyan and Young. This year a total of 14 students are placed throughout the region with Eurobodalla becoming a teaching site. For 2008, 17 students have been selected to undertake the program in the rural stream locations.

The Rural Clinical School has Canberra as the 'hub' and academic teaching nodes are located in Goulburn, Bega, Cooma, Young and Eurobodalla. Teaching facilities have been developed in these centres and consist of tutorial rooms, computers with internet connections and office space. A combined teaching and student accommodation facility in Young has been established with the renovation of an historical building in the town. The Rural Clinical School employs administrative and academic staff in the above towns.

The Rural Clinical School has received wonderful support from the rural communities. They actively participate in the program providing positive opportunities and promoting the rural lifestyle to students undertaking medicine in the region.

The rural communities have embraced the program

Student feedback about the program has been extremely positive. This is also reflected in the high rates of membership and the breadth of activities of the student rural club ARMS (http://www.arms.asn.au/). (see page 9)

Copy supplied by Assoc Prof Amanda Barnard, Associate Dean, Rural Clinical School, ANUMS.

AMA ACT's preferred mail courier service "JACKmail" nominated for Chief Minister's 2007 Inclusion Awards

AMA ACT has nominated Sally Richards, founder of JACKmail and a tireless advocate for people with disabilities and those who care for them, for the ACT Chief Minister's 2007 Inclusion Awards.

The AMA ACT has been using JACKmail for most of this year; in fact, since it discovered the service.

One in five people in the ACT lives with a disability – that's a significant slice of our community - and the Inclusion Awards recognise the contribution of individuals, businesses and organisations that have demonstrated a clear commitment to include people with a disability in their workplace, business or community. AMA ACT nominated JACKmail because it is a highly commendable business that deserves recognition and support.

JACKmail started with a great idea - a vision, a dream – and Sally spent four years planning and developing the courier business which has one employee, Sally's son Jackson West, who has a profound intellectual disability and autism. Jackson has very high support needs and requires one-on-one support at all times, so JACKmail provides a strong model for business structures that put people with severe disabilities firmly at the centre of the business.

JACKmail picks up and delivers mail for Government and Non-Government organisations and businesses as well as offering occasional runs services. Jack is having a whale of a time as he makes his deliveries along with his carer Jamie and, importantly, his work-related and social skills are improving, proving the viability of the business and the 'greatness' of the idea.

So, who's collecting your mail?

Letter to the Editor

Dear Sir/Madam

Is the bonding of medical students a backdoor means of civil conscription of doctors? The Australian Constitution s51 (23A) enables the Parliament to have the power to make laws for the provision of dental and medical services. This section, however, expressly forbids the civil conscription of doctors. However the response of the Federal Government to the crisis of insufficient doctors in the workforce has instituted schemes which appear to mimic civil conscription.

There are two schemes of bonding currently. The Medical Rural Bonded Scheme (MRBS) is offered to a handful of students in each medical school each year. It provides a reasonable tax-free income for the four years of study but requires service, after gaining a Fellowship, in rural areas (RRMA 5-7) for a period of six years. Failure to do so results in loss of provider number and a huge debt to be repaid.

The second scheme, Bonded Medical Places (BMP), has no financial advantages for students and requires students to serve in an "area of medical workplace shortage" for the same length as the medical degree completed. Up to 500 BMP places are offered across Australia each year.

Why do students agree to these conditions? To enable them to get a place in a medical school. Often the BMP places are left to last as no-one wants the obligation. The choice faced by students is accept the conditions or don't go at all. Secondly the money is another incentive. In declaring my interests, I am an MRBS holder. I want to work rurally and I would not qualify for Austudy. The MRBS offered me a way to finance my medical studies. I resent not being able to serve in RRMA 3 areas which have significant workforce shortages but perhaps I should leave that for my BMP colleagues.

All of this is old news. Most recently rumours are circulating about the abolition of all HECS places in medical schools. If this were to eventuate, all medical students would be bonded (either MRBS or BMP) and hence the Federal Government would have some control about where all medical graduates could practice. Where is the independence of the medical community and the protection of the constitution?

There is a great workforce need, including in Canberra itself. Rather than conscripting doctors, there should be sufficient incentives and improvements for doctors to work in areas of need without coercion.

Judith Nall-Bird
Year 2 Medical Student ANU

Federal court makes orders against internet tobacco supplier

Since 1 March 2006, tobacco regulations administered by the Australian Competition and Consumer Commission require that retail packages of tobacco manufactured in, or imported into, Australia must be labelled with prescribed warning, information and explanatory messages and graphic images.

An example of such warning and explanatory messages includes statements such as: SMOKING CAUSES MOUTH AND THROAT CANCER Health Authority Warning" and, "Smoking is the major cause of cancers affecting the mouth and throat." These cancers can result in extensive surgery, problems in eating or swallowing, speech problems and permanent disfigurement. You CAN quit smoking. Call Quitline 131 848, talk to your doctor or pharmacist, or visit http://www.quitnow.info.au.

The information message states:

- Smoking exposes you to more than 40 harmful chemicals
- These chemicals damage blood vessels, body cells and the immune system
- QUIT NOW to reduce your risk of chronic illness or premature death.

The Federal Court in Melbourne has made orders and declarations of consent against Mr Mina Guirguis in relation to his contravention of the Trade Practices Act 1974 for failing to comply with the prescribed consumer product information standard for tobacco products.

The ACCC alleged Mr Guirguis arranged the supply of retail packages of tobacco (eg, cigarettes in packets and cartons) that failed to comply with the Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 2004.

Mr Guirguis arranged for the supply of offending tobacco products on various occasions in 2006 and 2007 via the website www.cheapcigarettes. com.au.

In addition to declaring that Mr Guirguis had contravened the tobacco regulations, the Court granted an injunction restraining Mr Guirguis from supplying or aiding, abetting or being knowingly concerned in the supply of retail packages of tobacco that are not labelled in accordance with the tobacco regulations.

The Federal Court also declared that Mr Guirguis had engaged in misleading and deceptive conduct and made a false and misleading representation in contravention of sections 52 and 53(g) of the Act by representing on the website (www.cheapcigarettes.com.au) that there were no refunds for tobacco products sold on the website. In fact, under certain circumstances customers would be entitled to a refund. An injunction was also granted restraining Mr Guirguis from making such a representation in the future.

ACCC chairman, Mr Graeme Samuel said the warning messages and graphic images on cigarette packets and cartons are an important means by which smokers are informed about the health consequences of their habit.

"Conduct of the kind in the present case undermines important initiatives of health and other relevant authorities to educate and warn consumers about the dangers of smoking and particularly those members of the public making online purchases of tobacco products".

"While the ACCC's current action was a civil proceeding, traders should also be aware that the Act provides for criminal prosecution of certain contraventions of the Act including non-compliance with prescribed consumer product information standards such as the tobacco regulations", Mr Samuel said.

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