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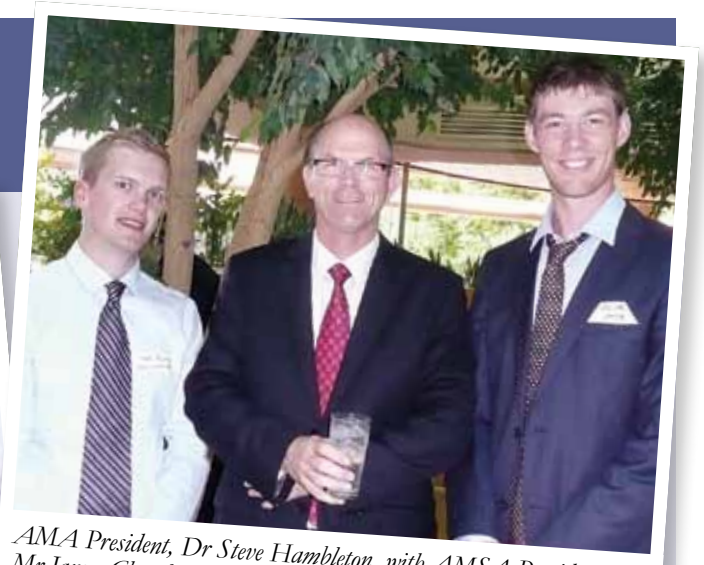
AMA ACT welcomes the ANU Medical School students

The annual AMA ACT welcoming reception for new medical students at the ANU Medical School was held at "Barocca" on Thursday 9 February.



AMA President, Dr Steve Hambleton, with AMSA President, Mr James Churchill and Mr Mark Russell ANU Medical School representative to the AMA ACT Advisory Council

Host AMA ACT President, Dr Iain Dunlop and Chair of the Advisory Council, Dr Andrew Miller with new students. The event was generously sponsored by Investec.

The State of the Territory

Dr Iain Dunlop

Beginnings

Last week 91 new medical students began training at ANU Medical School. I met many of them at our AMA Medical Student Welcome Reception on Thursday 9 February. It is always a good event, an evening that re-invigorates us, the established clinicians, who may lose sight of the wonder and privilege of our profession in the face of the workload and administrative challenges. Here were many who actively chose ANU as a first choice for studying medicine and Canberra as a place to live and work for the next five or more years. The reputation of the ANU Medical School is first class. Many were attracted by the research reputation of the ANU in general. All felt that the teaching ratios and clinical exposure were excellent. There was a palpable excitement, mixed with some trepidation, to be beginning studies. These students had achieved a goal with hard work and application. Barring exceptional circumstances, they will all become doctors, and our colleagues.

CPD concessions granted by AHPRA to new health professions

I was reflecting on these students, and the path they have ahead, during an AMA meeting discussing National Registration matters. You may know that Chinese Medicine has been added to the list of health professions covered by the National Registration scheme. Each health profession has an autonomous Board which must act within the overarching supervision of AHPRA (Australian Health Practitioner Agency). Given AHPRA's strict training and CPD requirements for continuing registration as a medical practitioner, the AMA is objecting to the proposals for just what is required for registration as a Chinese Medicine practitioner. Their Board proposes only 20 hours of CPD annually, 'qualification' in Chinese Medicine as merely evidence of 5 years of practice since 2002 and no requirement to speak English to a standard expected of other health professionals, or to have an interpreter present at consultations. The AMA submits that all health professionals should have a minimum standard of English and formal curriculum, training and CPD requirements.

It is extraordinary that more than half of AHPRA's income comes from medical practitioners yet the standards accepted for other health professionals are so lenient by comparison.

National efficient price of services in public hospitals

Another current AMA concern is the development of the Independent Hospital Pricing Authority (IHPA) which is charged with setting the 'national efficient price' of services delivered in public hospitals. It is the flow-on effects of underfunded hospitals and stifled introduction of new technologies that should concern you as clinicians. How a 'national efficient price' will be set and adjusted is unknown as yet. The Commonwealth will pay 40% of this price and the States and Territories will make up the rest, which may well be more than the apparent 60% remaining. Activity based funding is complex and is frequently a distraction to service delivery. The AMA will argue for weightings of the 'national efficient price' based on local factors. The only current recognised weighting is 'Aboriginality'.

Salaried doctors workplace agreement being finalised

Negotiations for the new Salaried Doctors award are drawing to a close. The AMA ACT is a full party to these negotiations. We thank those junior doctors who have informed our submissions and attended negotiations. You should note that the AMA ACT is the truly independent party at the table. Like most projects, the final 10% takes a disproportionately long time to complete.

VMO contracts for negotiation this year

And just as these negotiations are closing, the next round of the VMO contract negotiations is set to begin. Once again, the AMA will be there.

Health planning

The Health Directorate is planning a new 'ACT Chronic Disease Strategy' based on the 2008-2011 strategy of the same name. There is an opportunity for community and stakeholder input at an individual level and at a forum planned for early March. A draft strategy will be available for public consultation in April-May 2012. A policy consultant has be appointed, Cathie O'Neill. (cathie.oneill@quorus.com.au). The website to register your interest is at quorus.com.au/projects/act-chronic-disease-strategy

In the same vein, consultation has commenced on the ACT Palliative Care Strategy and Services Plan and details are available from joan.scott@act.gov.au

John Buckingham AM

It was wonderful to see that Dr John Buckingham AM was posthumously recognised in the 2012 Australia Day Honours List. Our congratulations go to his family and our thoughts to him. A proposal for an Australian Honour cannot be lodged posthumously, although it may be so granted. The AM recognises John's living contributions to the profession and the community.

Sad note

On another note, it was sad to hear of the passing of Dr Bill Coupland, one of the great contributers to our AMA ACT and to the Canberra community. Amongst his unsung achievements was performing one of the first Australian bone-marrow transplants at the then Royal Canberra Hospital in 1968. Our thoughts are with his family and friends at this time.

A medical life

I began this discussion with our newest medical students. I hope that all have the opportunity to complete as rich and full and rewarding a medical life as did Bill Coupland. That means commitment to one's patients, one's colleagues and one's profession. That is the 'space' that the AMA occupies.

Iain Dunlop
President ACT AMA

Perceived practice change in Australian doctors as a result of medico-legal concerns – By Shrikar Tummala and Yusuf Sediqi

Arguably one of the most trustworthy positions in any given society, a healer of men, women and children, and a wealth of knowledge about what we are.

This is the predetermined image we have when we see a name with the salutation "Dr" suffixed. But are these facets true in the real world? Are all medical practitioners near gods when it comes to practising what they've spent half a lifetime in trying to train up to and refine? It may be quite a surprise to many but the reality of the situation is otherwise. A doctor is not always trustworthy, a doctor sometimes may hurt rather than heal, and a doctor's knowledge is surely not absolute. Thus it is essential to have laws in place for the purpose of protecting the welfare of patients. But are these laws for better or for worse? Nash et al. (2010) conducted an Australia wide cross-sectional survey of medical professionals in a wide range of fields to determine whether medico-legal concerns were affecting their practice at all, and if so, how?

The objective of the study was to explore the perceived impact of medico-legal concerns on how Australian doctors practise medicine and to compare doctors who have experienced a medico-legal matter with those who had not. There were 2999 participants from all major specialty groups, trainees and a sample of general practitioners who were insured with a medical insurance company.

Respondents reported changes in practice behaviour due to medico-legal concerns, with 43% of doctors stating that they referred patients more than usual, 55% stating that they ordered tests more than usual, and 11% stating that they prescribed medications more than usual. Respondents also reported improved communication of risk (66%), increased disclosure of uncertainty (44%), developed better systems for tracking results (48%) and better methods for auditing clinical practice (35%). Concerns about medico-legal issues led to 40% considering retiring early, 33% considering giving up medicine and 32% considering reducing their working hours. These proportions were all significantly greater for doctors who had previously experienced a medico-legal matter compared with those who had not. But what does all this mean with regard to practise in medicine?

There are clear advantages and disadvantages with medico-legal concern in practice, attributable to the whole picture of medical practise, which includes the patient, the doctor, and the healthcare system.

Advantages:

- There was a significantly higher rate reporting an improved communication of risk(s) and disclosure of uncertainty. This is clearly of benefit to the patient. It gives the patient the autonomy that he/she has a right towards. Autonomy is the first of four bioethical principles by Beauchamp and Childress that every medical practitioner is required to uphold in Australia, and is defined as the right or condition of self-government.
- Medical practitioners were employing better systems for tracking results and improved patient data storage. Good document keeping is important on many levels. As well as being important in medico-legal concerns from the doctor's perspective, it's also important in providing optimal patient care. To keep track of the precise events in your practice with each particular patient will save time with subsequent visits and also improve the patient's care by reducing mistakes and having a holistic picture with every encounter.

However, there are also many disadvantages regarding the impact of medico-legal concerns on how Australian doctors practise medicine.

Disadvantages:

- Doctors who have had personal experiences with medico-legal issues appear to excessively order more tests. This may seem beneficial in that doctors are more likely to correctly diagnose the patient, however by ordering more tests than what is required, poses a significant cost burden on the healthcare system. Furthermore, the fear of experiencing a medico-legal issue appears to have a negative effect on doctors in that rather than improving the way doctors take a medical history from a patient (which also increases the chance that the doctor correctly diagnoses the patient), doctors seem to opt for the easier option of ordering more tests.
- Doctors appear to unnecessarily prescribe more medication. Again, this may seem beneficial in that the doctor is trying to treat a condition(s) with a range of medications that are indicated for it, however, it should be noted that excessive prescription of medications dramatically increases the risk of drug interactions, toxicity, adverse effects, allergic reactions and non-compliance, all of which may give rise to further medical problems for the patient. Furthermore, the prescription of a cocktail of medications may make it more difficult for the patient to follow the guidelines for administering each of the medications thus increasing the risk of missing a dose or over dosage. Additionally, excessive prescription of medications poses significant costs for the health care system.
- The fear of litigation causes the doctor's practice to shift from being patient-centered to doctor-centered. Doctors aim to create a safeguard against malpractice liability by ordering more tests, making more referrals, prescribing more medication and avoiding high-risk procedures or situations. This essentially puts the patient's health in the backseat and creates a sense of lack of empathy for the patient, which is in direct violation of the Declaration of Geneva which states that "the health of my patient will be my first consideration." This practice also devalues human life as fear of litigation is placed above improving the health and welfare of a patient which goes against both the beneficence and non-maleficence principles stated by Beauchamp and Childress and the Declaration of Geneva which states that "I will maintain the utmost respect for human life".
- As a result of experiences with medico-legal issues, doctors feel inclined to retire early; give up medicine; reduce working hours; or change specialty. Training each medical practitioner costs the government a significant amount of money and so to do any of the above will add to the cost burden of the health care system. Furthermore, it also means that there will be fewer experienced doctors in various specialties resulting in less guidance and support for junior doctors, who may then be prone to malpractice. A lack of experienced and specialist doctors may also mean that the doctor shortage in rural areas will be exacerbated and more generally, the quality of healthcare will fall and there will be added pressure on existing doctors.
- The fear of litigation is an added stressor to an already stressful life of a doctor.

In conclusion, doctors aren't all they're cracked up to be which means that they are very likely to make mistakes as they practise medicine. The presence of legislation serves as a means of justice for patients who have suffered as a result of a doctor's malpractice. The thought of facing medico-legal issues strikes fear into a doctor's heart and appears to have an impact on how they practise medicine, and while there some advantages of this impact, the disadvantages are greater. As medical students and future doctors, the idea of medico-legal issues and the impact they have on the way we practise medicine is certainly something we need to be aware of and also something we need to avoid. We need to accept that as future doctors, we will encounter a great deal of challenges and that sometimes we will make mistakes, however, this shouldn't deter us from providing a duty and standard of care that we swore an oath to give to patients. We need to focus on learning from our mistakes and improving our knowledge and skills so that we can be worthy of the title 'doctor'.

References available on request from the authors.

Shrikar Tummala and Yusuf Sediqi are at the ANU Medical School

ACCC institutes proceedings against commercial breast imaging providers

The Australian Competition and Consumer Commission has instituted proceedings in the Federal Court against Safe Breast Imaging Pty Ltd and its sole director Joanne Firth, alleging false and misleading conduct in relation to the provision of breast imaging services.

The ACCC has also instituted separate proceedings against Breast Check Pty Ltd and Dr Alexandra Boyd alleging false and misleading conduct in relation to the provision of breast imaging services.

Safe Breast Imaging and for a certain period of time, Breast Check, used a device known as the Multifrequency Electrical Impedance Mammograph to capture images of a customer's breasts. Breast Check also used a digital infrared thermographic camera to capture images.

The ACCC alleges that Safe Breast Imaging and Breast Check represented that the breast imaging services they provided:

- were an effective means of assessing whether a customer was at risk from breast cancer and the level of that risk;
- could assure a customer that they do not have breast cancer; and
- were an effective substitute for mammography services.

The ACCC alleges that these representations were false.

The ACCC also alleges that between May 2009 and August 2011 Safe Breast Imaging falsely represented that its breast imaging service included the provision of a customer report prepared by a medical doctor. The ACCC alleges that in many instances the reports provided to customers by Safe Breast Imaging were not prepared by a medical doctor.

The ACCC is seeking declarations that Safe Breast Imaging and Breast Check

contravened the Trade Practices Act 1974 and the Australian Consumer Law and that Ms Firth and Dr Boyd were knowingly concerned in the conduct. The ACCC is also seeking:

- injunctions
- pecuniary penalties
- an order that corrective letters be sent to affected consumers
- an order for findings of fact pursuant to section 83 of the Competition and Consumer Act 2010
- costs; and
- an order that Ms Firth be disqualified from managing a corporation for a period of five years.

A directions hearing was scheduled for both matters before Justice Barker in the Federal Court in Perth in January.

ACT (nearly) 100 years and growing

The Australian Capital Territory is to celebrate its centenary in 2013. The site of the nation's capital was chosen after months of deliberation, a waste of a good sheep paddock perhaps, but it is now home to 400,000 people with many new suburbs being developed to accommodate the predicted population growth.

The Royal Canberra Hospital was built on what is now the site of the National Museum of Australia. Reflecting its origins in the Cold War, the operating theatres were built underground whilst the wards looked out over the Molonglo River and market gardens that were later flooded to become Lake Burley Griffin. In the 1960s, the Woden Valley Hospital was constructed to service the southern suburbs and in 1979 the Calvary Hospital, run by the nuns of the Little Company of Mary, opened to provide public and private hospital care to the northside. From the early 1970s, there were unaccredited jobs for aspiring primary candidates who, once successful, moved on to training places elsewhere.

Currently the good burghers of the ACT and region are served by a number of hospitals within the ACT. The "region" is south eastern New South Wales and overlaps the catchment areas for Wagga Wagga to the west, Albury to the south, Orange to the north and Bega on the far south coast, the ACT being an "island" surrounded by NSW. The major public hospital is The Canberra Hospital (TCH), the result of amalgamation of The Royal Canberra and Woden Valley hospitals in the early 1990s at the Woden Valley Hospital site and now comprising 400 beds. It is the regional tertiary hospital for trauma, being the only designated trauma hospital west of the divide. This leads to pressures, particularly as the south coast of NSW is a popular retirement destination.

The Canberra Hospital provides all services except for paediatric cardiac surgery, major burns, solid organ transplants and interventional neuroradiology. It is the regional referral hospital for obstetrics with over 2000 deliveries annually. Planning for cardiac surgery began in the late 1990s with the first case done on cardiopulmonary bypass in early 2000.

On the northside, at Calvary Hospital, 200 public beds are co-located with a 160-bed private hospital. General surgery, ear, nose and throat (ENT), ophthalmic, obstetrics and gynaecology (O&G), maxillofacial, and orthopaedics comprise the in-hours workload. Out-of-hours work comprises general surgery and O&G with approximately 1200 deliveries annually. Trainees benefit from exposure to different work practices in this setting.

There are about 160 other private beds spread among three more private hospitals. Across the territory's hospitals and day surgery facilities there are 42 operating theatres. Ten of these have been commissioned in the last three to five years and about 18 are in public hospitals.

There are over 60 anaesthetists in the ACT and there are still shortfalls. The area-of-need process has been ultimately beneficial to the Canberra anaesthetic community, despite the inevitable politics of such a process, with several highly regarded anaesthetists settling in the ACT. Their passage through the international medical graduate specialist (IMGS) process has been interesting for all parties but the hard work of many generous Fellows as well as the individuals concerned has been rewarded. Their hard work continues in key roles such as Dr Imran Ali in the Chronic Pain Unit, Dr Lisa Zuccherelli as Deputy Director of Anaesthesia at TCH and Dr Simon Robertson as the regional education officer.

The climate (change)

As with all hospitals in Australia, there is an inherent conflict in the pursuit of key performance indicators relating to meeting times for categories of elective and non-elective surgery. At TCH, over 60 per cent of the operating theatre caseload is non-elective, less than 50 hours of a potential 120 to 130 hours per week is designated emergency or non-elective operating time.

This inconsistency in resource allocation is a constant source of frustration and perplexity and no doubt familiar to all. The difference in the ACT is that excess workload cannot be dealt with by bypass to another institution: there is nowhere else for timely assessment and management of trauma. "Ramping" of ambulances is not an option as there are seven vehicles on the road as a minimum with two demand crews for busier times.

Certainly there has been recent huge investment in health with acquisition of a positron emission tomography (PET) scanner and on-table magnetic resonance imaging (MRI). Major building works at the TCH site are due for completion soon: a larger mental health facility including secure unit, and a women's and children's hospital (which will utilise the main operating theatres). For the present, Calvary Public Hospital continues to serve the rapidly expanding northside suburbs. In the future, there may be a third public hospital solely for elective surgery. However, the duplication of radiology and other services would appear to make this a more expensive exercise than first mooted.

As to the development of local hospital networks, ACT Health has expressed interest in developing these with Queanbeyan and Yass Hospitals. However, the necessary negotiation between NSW Health and other

involved parties makes this a very 'far in the future' project.

Training

Until the late1990s anaesthetic services in the ACT were almost exclusively delivered by visiting medical officers (VMOs). As a result, the necessary conditions for provision of a training scheme were difficult to achieve. Nevertheless, as a result of the initiative and dedication of enthusiasts such as Dr Paul Christie, Dr Hugh Lawrence and Dr George Jerogin, these difficulties were gradually surmounted.

Accredited registrars from St George and Liverpool hospitals rotated for six months to TCH for their "rural" placement from the eighties on. Locally accredited trainees started with three positions in 1997. Negotiation with hospital administration for allowance for protected teaching time was an achievement which enabled a more structured approach that yielded success in both parts of the exam and led to the expansion in numbers to the current cohort of 26. Many who were local trainees have returned to work as consultants, a gratifying situation.

Rotations of four registrars annually to Albury on six-month placements commenced about 10 years ago. Despite the consolidation of obstetric services to Wodonga, necessitating travel across the Murray, it is a mark of the success of the rotation that several trainees have of recent years returned to Albury as consultants. Rotations to Calvary commenced in 2001, initially with just one registrar, now expanded to six anaesthetic trainees.

All modules can now be completed in the ACT scheme. In the recent past, it has taken some ingenuity to ensure adequate and equivalent exposure for members of occasionally larger than expected part 2 candidate groups. It is a credit to the efforts of the supervisor of training at the time, Dr Frank Lah, that no one was disadvantaged. He has served the trainees of the ACT tirelessly whilst being an exemplar of the art of anaesthesia. His efforts and those of all involved in registrar teaching and exam preparation were rewarded when a local trainee, Dr Louise Ellard, was awarded the Cecil Gray Medal at the Christchurch annual scientific meeting (ASM) last year.

With respect to other support of trainees, a mentor program began a few years ago co-ordinated by Dr Natalie Marshall. More recently, the Group of Australian Society of Anaesthetists Clinical Trainees (GASACT) has organised sporadic social functions that aim to foster trainee collegiality.

The two departments of anaesthesia also provide anaesthetic experience for trainees from intensive care and emergency medicine, and training and refresher experience for general practitioner anaesthetists.

Medical students from the medical school at the Australian National University, and previously from the University of Sydney, are also beneficiaries of the time and knowledge of Canberra anaesthetists whether in lectures, tutorials, in the operating theatres or as examiners. Additionally, through the auspices of the John James Medical Foundation, medical students from James Cook University gain anaesthetic experience as part of a fully funded placement at the Calvary John James Hospital for their elective term.

Continuing medical education

Canberra has gradually expanded in activity and in the number of anaesthetists. As a city-state, Canberra labours under the disadvantage of operating state sectional committees and activities (including training, continuing medical education (CME), other College activities, those of the Australian Society of Anaesthetists, and broader medical representation in bodies such as the Australian Medical Association) with the human resources of a small town.

Personalities such as Dr Ray Cook, Dr Hugh Lawrence and Dr Gerry Flynn took on much more than their fair share to advance the interests of anaesthetists and trainees alike. Dr Linda Weber, Dr Vida Viliunas, Dr David Kinchington and others have carried the baton into this century.

The annual scientific meeting, the "Art of anaesthesia", was the brainchild of Dr Cook and started nearly 20 years ago as a local event to coincide with Floriade, Canberra's spring flower festival. Proving popular and successful, it has evolved over the years under a succession of dedicated convenors such as Dr John Ellingham.

More recently, with Professor Thomas Bruessel as convenor, it has metamorphosed further to include international speakers and a change of season to autumn. This meeting often captures the anaesthetic zeitgeist and continues to attract broad interest.

The national scientific congress (NSC) of the ASA was held in Canberra in 1962, organised at a federal level. The next national meeting hosted in the ACT was in 1992; this was one of the first ASMs of the new Australian and New Zealand College of Anaesthetists, held with the Royal Australasian College of Surgeons (RACS) meeting.

The first locally organised national anaesthetic meeting to be held in Canberra was the ASA NSC in 2001. Despite several challenges including the events of 9/11, the meeting was a great success under the direction of such stalwarts as Dr Cook, Dr Lawrence, Dr Weber, Dr Viliunas, Dr Kinchington, Dr Nicola Meares and Dr Nick Gemmell-Smith.

Canberra will host the ASA national congress again in 2013, a significant centenary celebration! Dr Mark Skacel is the convenor and has already demonstrated great industry in the role. Dr Paul Burt is to be the scientific convenor and preparations are well under way.

Retrieval services

The Capital Region Retrieval Service (previously known as Snowy Hydro Southcare Retrieval service) is the local ACT aeromedical retrieval service that serves the ACT and region.

The service started in 1998 with two ACT Ambulance Service Intensive Care Paramedics rostered to cover helicopter jobs each shift but doing the usual road work unless called out. It was soon appreciated that doctors brought additional and necessary skills and an initially ad hoc roster comprising surgeon, anaesthetists, intensivists and emergency specialists provided on-call services. In 2008, a review over six months, conducted into aeromedical services in the ACT, recommended adoption of the doctor-paramedic model for its standard level of care (as is the model of care elsewhere).

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This has taken several years to accomplish with most doctors now trained for winch and search-and-rescue work.

A new purpose-built base has just been completed which includes facilities for education, video-conferencing, training and accommodation for on-call onsite shifts. The variety, nature and amount of work has resulted in the service recently being awarded accreditation for six months of advanced training for trainees in both the College of Emergency Medicine and our College. These positions have been keenly sought and are already filled for next year.

As part of the trainee's placement, completion of a Pre-Hospital Trauma Course, Helicopter Underwater Escape Training (HUET), a directed fitness test relating to work activities and ground school (where they will be taught to become a member of the helicopter crew and become accredited in winching activities and search-and-rescue missions) is expected.

Overall it provides a very rewarding time that encompasses both the excitement of pre-hospital medical care in the aeromedical field with the specific training of the particular doctor's specialty and exposure to consultants from other specialties.

Volunteer work

Fellows have long provided anaesthesia services as volunteers to a number of organisations in places outside the ACT.

Dr George Jerogin travelled with Interplast teams for many years. A team consisting of neurosurgeon Dr Nadana Chandran, anaesthetist Dr Cliff Peady and two theatre nurses has visited Fiji to provide neurosurgical services for the past 11 years under the Pacific Island Project program.

Patients with requirements for tertiary or more protracted care have been treated at TCH with costs met by fund-raising and ACT government support. Orthopaedic surgery has been the focus of trips to Timor by Dr Don Lu for the last two years under the ATLASS Program of RACS. Twenty procedures were completed on the most recent Timor trip on new patients and those whose treatment began on the previous visit.

Local paediatric surgeon Dr David Croaker and paediatric anaesthetist Dr Nick Gemmell-Smith have been to places as far away as Mongolia and Ethiopia where big cases were performed under a mix of halothane, ketamine and local anaesthesia. These trips have been under the auspices of Kind Cuts for Kids, a Melbourne-based charity.

The Specialist Volunteer Programme is a local initiative established and funded by the John James Medical Foundation. This medical charity emerged from the sale of the operation of the John James Memorial Hospital under the guidance of Dr Peter Yorke, a local anaesthetist who trained in Hobart and has worked in Canberra for over 20 years. Dr Yorke was a significant driver behind the Specialist Volunteer Programme and indeed made the first foray to Katherine with a team of orthopaedic surgeons. In recognition of his work for the Foundation, as an administrator rather than as an anaesthetist, the clinical services building at the John James Hospital was recently named in his honour, a signal achievement.

The objective of this program is to provide medical services in areas where there is a shortfall and its genesis coincided with the intervention in the Northern Territory. The target is 12 trips annually and the specialties involved thus far have been ophthalmology, paediatric dental surgery, ENT, gynaecology, orthopaedics and general surgery.

Support from the foundation has been generous with the purchase of an ultrasound machine for the gynaecologists and a portable slit lamp and tonometer for the ophthalmologists enabling the medical staff to perform point-of-care assessment in remote places. Specialist anaesthetists from the ACT including Dr Prue Martin, Dr Don Lu, Dr Vida Viliunas, Dr Phil Morrissey, Dr Stephen Brazenor, Dr James French and Dr Yorke have enjoyed providing anaesthetic services in places such as Katherine and Gove, and have been made to feel very welcome.

Anaesthetic registrars from Darwin have also formed part of the paediatric dental team and found the experience valuable.

So, in summary, life as an anaesthetist in the ACT provides many diverse opportunities to fulfill the roles of the profession as well as achieving a work-life balance that many in larger cities might envy.

Dr Carmel McInerney,
Chair, ACT Regional Committee

Dr McInerney would like to thank all who collaborated in compiling this article.

Reprinted with the kind permission of the author and Australian and New Zealand College of Anaesthetists. This article was published in the December 2011 edition of "ANZCA Bulletin".

Government must strengthen the 'pillars' of the health system

The AMA is calling on the Federal Government to use the May Budget to strengthen the 'pillars' of the Australian health system at a time when the world is entering a phase of economic uncertainty.

AMA President, Dr Steve Hambleton, said that in hard times it is important for governments to strengthen those parts of the health system that will provide the greatest benefit to patients and the community.

"There is every indication that this will be a frugal Budget across the board, but health funding must not go backwards," Dr Hambleton said.

"The 'pillars' of the health system – the parts that work well and which patients and communities rely on – must be recognised and funded accordingly in the Budget," Dr Hambleton said.

"Economic circumstances around the globe are not strong and the

Government will be keen to shore up the Australian economy for what many predict could be hard times ahead.

"On top of this, the days of 'big bang' health reform are behind us for now.

"Minority Government at the Federal level and the expected further changing of the guard to Coalition governments at the State level mean that big changes in the way that health services are financed and delivered are now almost impossible to achieve. The 'once in a generation' opportunity has passed.

"It is important, though, that there is no slippage in the positive reforms that have been reached, and that we can adjust those reforms and policies that have not quite hit the mark.

"The AMA wanted more from the COAG Agreement but we acknowledge the significant extra funding from the Commonwealth and the move to activity based funding that has been promised.

"The single funding pool is a step in the right direction and there is now greater transparency in the system. The States are now unable to pass the blame for the performance or non-performance of their hospitals.

"It is in the primary care area, however, where we seek more consultation and cooperation from the Government.

"We note that the Medicare Locals are part of the landscape but we do not accept that the governance model has to stay the same. There must be strong GP leadership and management of Medicare Locals.

"The Government must revisit the GP Super Clinics program. We have no problem with the concept where they meet genuine community need, but we have serious concerns in many locations. We cannot support them where they compete with existing GPs delivering exactly the same service.

"The AMA believes the money would be better spent through the oversubscribed infrastructure grants program on existing general practices that are already committed to their communities. We continue to battle for a reversal of cuts to the Better Access program for GP mental health services.

"For the AMA, general practice, public hospitals, and medical training and workforce are at the top of the list.

"The AMA is also urging the Government for action in the key areas of Indigenous Health, Climate Change and Health, Health and Medical Research, and changes to the proposed model for an electronic health record.

"The AMA Budget Submission proposes practical and affordable policies that would deliver tangible benefits to patients and local communities around Australia.

"We urge the Government to give this Submission serious consideration and we look forward to meaningful engagement and consultation with the Government on health funding and health policy development and implementation", Dr Hambleton said

"People need to be encouraged to do more about their own health and wellbeing, particularly in regard to obesity, smoking and alcohol. Preventive health programs must be supported," Dr Hambleton said.

The AMA Federal Budget Submission 2012-13 is available on the AMA website: www.ama.com.au

LETTER TO THE EDITOR

Sir

I noted, in the November/December issue of the Canberra Doctor, yet another article on sleep deprivation in doctors; ie, "safe working hours", this time by Unsworth and Liu. They repeat most of what has been said before and, like their predecessors, avoid any consideration of the consequences of their recommendations.

I acknowledge completely the effect of fatigue on mood and personality (more so as one gets older) together with the consequences and that it leads to "cognitive slowing" (in English this means that you understand and learn more slowly) but it does not abolish it. In my career I saw very few mistakes made from doctor fatigue but many from inexperience up to and including, recently, consultant rank. While I acknowledge the many improvements that have been made in training programs you can't teach experience and you can't get it from a self-learning module. You acquire it (and retain it) only by putting in many hours "at the coalface".

In my own specialty the years of training have been reduced from around nine to six and the hours worked per week by some fifty percent. The effect on the acquisition of experience does not require description. Suffice to say that, both here and abroad, colleagues tell me that they are called in to assist (or take over from) young consultants in situations which they themselves would have been expected (and were competent) to deal with as relatively junior registrars. Soon the last of those relics of the past will be gone and what then? There may be obstetricians coming into consultant practice today who have been deprived of the experience of managing longer labours from beginning to end and who are now expected to do so and teach their juniors how to do so. At present, many obstetric procedures are being progressively abandoned in favour of caesarean section, which sounds fine until you realise that there are occasions on which, in order to save life, either the ability for immediate and skilful manipulation or instant access to theatre (with a team to get the patient there) are required. The former is becoming rare and the chance of the latter negligible.

One might perhaps (uncomfortably) accept that today's specialists will gain the experience of their predecessors while in consultant practice were it not for the fact that many state that they have no intention of working the hours of their predecessors and more and more work part-time, thereby compounding the problem.

The questions for Unsworth and Liu and all others of their persuasion are simply: Are we to accept a general "dumbing down" of the profession and reduce our expectations of care and survival for ourselves and our loved ones when we are in need of the system, are we to substantially increase the years of specialist training or are we to introduce the intelligent compromise of a sensible increase in both working hours and years of training? There is, unfortunately, an alternative which, history shows, mankind tends to adopt – do nothing until there is a disaster, then wring our hands and wish we had done something sooner.

Yours provocatively
Martyn Stafford-Bell (retired gynaecologist)

Getting the right PCEHR

AMA President Dr Steve Hambleton presented to the Senate Community Affairs Committee Inquiry into the PCEHR legislation via teleconference on Monday 6 February to explain the AMA's Submission to the Inquiry.

Here is an edited extract of his opening remarks to the Committee ...

Most AMA members are enthusiastic about using shared electronic health records. They know that with the right system, they can improve the patient healthcare experience.

The right sort of shared record system will help doctors deliver better care. They will have important information about their patients to help them make good clinical decisions.

Some of my elderly patients can tell me the strength and name of their tablets and some the colour and size of their tablets, but many others can't. With new patients, I have to question them about that and it takes a little longer to work out what the medication is.

With a good system, I can at least confirm my assumptions by reading what the last doctor prescribed. This would be an improvement over the current situation.

A good system will save extra costs for repeat tests. It will save time chasing down results. Treatment can happen more quickly.

This is why the AMA supports the long-term goal. The proposed system could be improved to make it much more useful for treating doctors.

The reality of patients having to opt-in means that when doctors look for a patient's record, they will often find there isn't one. Our submission highlights that we don't know what the opt-in rate will be.

If doctors were to find that most of their patients had a PCEHR, they would be more likely to keep using the system. But they will quickly become reluctant users if they look for and can't find a record for their patient.

For better patient care, the AMA advocates for an opt-out system that provides treating doctors with access to the key clinical information to inform their clinical decisions.

We are uncertain about how much of the system will be available on 1 July 2012, and how well the system will be connected to health care providers.

The Parliament may pass the legislation. Some of the technical work might be finished.

But there will be no benefit for patients and medical practitioners until appropriate, interoperable, tested, and affordable practice software is available for providers to connect up to the system.

In terms of the legislation, the AMA is concerned about the administrative impact on medical practices.

Medical practitioners who decide to use the system will have to adapt their clinical workflows and train their staff to work within the requirements of the legislation.

Doctors will have to consider the impact of this additional workload and the changes to clinical workflow on the fees they charge their patients.

The biggest impact will be on general practitioners.

GPs will take on the role of 'nominated healthcare providers' and create and maintain the 'shared health summary'. This is a key feature of the PCEHR.

This is a very specific clinical task. GPs will work with their patients to ensure that a complete and accurate summary is available to be used by other health care providers in their clinical decisions, and this will take time.

It is only reasonable that patients should receive a Medicare rebate for this very important clinical service so that the PCEHR system truly works to improve patient care and reduce waste and risk in health care.

The full AMA submission is available at http://ama.com.au/node/7302

IN MEMORIAM

You will never have heard of Wilton Gainsford Harcourt Evans, and indeed until a family genealogist discovered his existence quite recently, nor had I. He was a first cousin of my maternal grandmother. Born in 1895, he was one of the very many Australians who volunteered for service in World War I. He was killed in action on the Western Front in 1918, and as none of my ancestors talked about wartime experiences, was forgotten.

Like so many of his comrades, Evans GW (as he was known by the Army) has no known grave. His memorial in France is the wall at the cemetery of Villers-Bretonneux, itself a village rebuilt with Australian assistance in the 1920s. After 93 years, he had his first family visit.

John Donovan

Tours of the Western Front operate from Amiens, a town easily reached by train from Paris Gare du Nord. The battlefields in which Australians fought are surprisingly small, and easily covered in one day; extended tours are available. We travelled with True Blue Digger Tours, despite its name owned and operated by Barbara Legrand, a Frenchwoman who previously worked at the Australian Museum on top of classrooms at Victoria School, Villers-Bretonneux. Although it was not necessary to do so, we stayed two nights in Amiens, for half what it would have cost in Paris. We travelled at our own expense.

Photos: Andra Donovan

New AMSA Executive to tackle challenges in medical education and training

The Australian Medical Students' Association (AMSA) has recently welcomed its new National Executive for 2012. The team comprises students from three Victorian medical schools, the University of Melbourne, Monash University and Deakin University, and is led by Mr James Churchill, a final year medical student at the University of Melbourne.

Incoming AMSA President Mr James Churchill said that the organisation had had a number of key advocacy successes in 2011; however, he emphasised that a number of significant challenges still exist for the organisation in 2012.

"Clinical training capacity is being stretched, with twice as many medical students now in the system compared to 2005 and significant underfunding of medical education as highlighted the recent Higher Education Base Funding Review," said Mr Churchill.

"Our key priorities in 2012 will be to advocate for quality clinical placements and adequate numbers of high quality internships for graduates of Australian medical schools. With increasing numbers of medical students, we now face a situation where one in four students are not guaranteed an internship", he said.

AMSA will also be maintaining its focus on medical student well-being and other issues affecting Australian medical students.

"I am proud to lead this Victorian Executive in what will be an exciting year for AMSA. We will continue to represent all medical students as we advocate on important issues in medical education", he said.

AMSA has slammed claims from Curtin University that a new medical school, planned to open in 2014, will help address Australia's medical workforce shortages.

James Churchill has warned recently that further increases in medical student numbers will jeopardise the quality of clinical training and may result in doctors who are unable to find jobs.

"We need to ensure that the quality of medical education and training is maintained at the high levels that we expect in Australia. Clinical training capacity is already stretched, and opening a new medical school will place a greater strain on an already struggling system", said Mr Churchill.

"Medical student numbers have doubled in the last decade and, in 2013, 3045 students will graduate. This increase has not been matched by a requisite increase in funding and support for universities, senior doctors and academics, or the creation of internships.

"Curtin's argument that their medical school will help reduce the rural workforce shortage is misguided. We have already seen over the last few years that simply increasing numbers will not push doctors into rural areas.

"Instead, AMSA calls for funding that may go to new medical schools to be directed to established programs such as rural clinical schools, recruiting students with rural backgrounds and supporting rural doctors in educating students and trainees in rural areas," Mr Churchill said.

AMSA calls for the government to place a cap on medical student numbers and new medical schools to open until all medical students currently in training can be assured high quality clinical placements and that the number of internships is commensurate with the number of medical students graduating.

In calling for more rural medical students from rural backgrounds to be accepted into medical degrees, AMSA vice president, Ms Catherine Pendrey said: "In order to address the rural medical workforce shortage, AMSA believes it is vital that recruiting rural background students is part of a holistic approach, which actively supports all students to engage with rural medicine,"

According to the latest figures from the Department of Health and Ageing, the proportion of medical students from rural backgrounds is lagging below the 25% government target.

The Rural Undergraduate Support and Coordination funding (RUSC) scheme provides medical schools funding to promote the selection of rural applicants. RUSC also funds support systems for medical students interested in rural medicine and rural placements for Australian medical students.

"Rural background is a key determinant of the likelihood a student will go on to practice rural medicine," Catherine Pendrey said.

Of the 18 schools that received RUSC funding in 2010, 10 did not meet the 25% target.

"Medical schools engage in a variety of strategies to promote rural practice amongst medical students. However, AMSA encourages more schools to adopt a proactive approach to increase enrolment of medical students from rural backgrounds", said Ms Pendrey.

The importance of rural background in determining future doctors' decisions to work in rural areas has recently been reaffirmed by researchers from NSW and Victoria.

Medical Board of Australia (MBA) Guidelines on Technology-based Consultations

The MBA has developed and released guidelines on technology-based consultations under s.39 of the Health Practitioner Regulation National Law Act (the National Law) in force in each State and Territory.

The guidelines aim to inform registered medical practitioners and the community about the Board's expectations of medical practitioners who participate in technology-based patient consultations.

The MBA has advised that these guidelines complement "Good Medical Practice: A Code of Conduct for Doctors in Australia" (Good Medical Practice) and provide specific guidance on technology-based patient consultations.

The guidelines are relevant to:

- Medical practitioners required under the National Law;
- Employers of medical practitioners; and
- Patients and the community

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Preferred Name if different: _____

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Practice Address: _____

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Practice Information:
☐ Private Practice ☐ General Practice
☐ Salaried Practice ☐ Doctors In Training
☐ Specialist Practice

Previous Membership of the AMA (State & Year): _____

Other Relevant Information (including languages spoken): _____

_____

The AMA at

Public hospitals

The 2011 AMA Public Hospital Report Card highlighted that there was little improvement in public hospital capacity and performance across Australia in 2009-10, despite extra Commonwealth funding. The AMA is calling for robust, long-term data collection so that it can have proper year on year monitoring and analysis of hospital capacity and performance, including counting elective surgery patients from the time they are referred by a GP to be assessed for surgery.

Professional Services Review

The AMA worked with the PSR to improve the transparency and procedural fairness of the PSR process. As result, the PSR has produced a Guide to the PSR process, into which the AMA had significant input. The Guide assists people who are being reviewed by the PSR to understand the process, and to know what will happen in each step of the review. The Guide allows people to check that their review experience accords with the documented process. In 2012 the AMA will continue to work with the PSR to develop additional guidelines about very specific parts of the review process.

E-health

The AMA was a constant medical voice in the debate on the design and construction of the Personally Controlled Electronic Health Record. Several AMA representatives participated in many workshops on very specific aspects of the PCEHR. The AMA scrutinised draft legislation and was successful in achieving amendments that will provide for greater public scrutiny of the basic access controls to the PCEHR. The AMA also ensured the governance arrangements included the participation of medical practitioners. The AMA is working closely with key Government agencies to accelerate the rollout of e-health initiatives, and ensure that clinicians working in public hospitals have access to high quality IT infrastructure.

Health reform

The AMA argued at every opportunity for greater transparency in public hospital funding and for medical practitioner input into service planning and delivery of health care. As a result medical practitioners have a role in the governance arrangements for Local Hospital Network Governing Councils, and advisory roles in the National Health Performance Authority and the Independent Hospital Pricing Authority.

Aged care

The AMA convened an advisory medical group to provide first hand advice to the Productivity Commission inquiry into caring for older Australians. As a result, medical care to the elderly is featured in the Productivity Commission report, including a recommendation that *The Medicare rebate for medical services provided by general practitioners visiting residential*

work in 2011 – great reasons to be a member in 2012

aged care facilities and people in their homes should be independently reviewed to ensure that it covers the cost of providing the service.

Pharmacy prescribing

The AMA strongly opposed the Pharmacy Guild of Australia's 'continued dispensing' proposal. The AMA wrote to all MPs and Senators urging their support for changes to the *National Health Amendment (Fifth Community Pharmacy Agreement Initiatives) Bill*, which was introduced to Parliament in November. The Bill would permit a significant change in the professional role of pharmacists that the AMA believes is not in the best interests of patients or the professional relationship between doctors and pharmacists. If the Bill is passed, pharmacists will be able to dispense prescription medication without a valid prescription and without consulting a patient's doctor beforehand.

Safer conditions

The AMA leads the way nationally on safe working hours. The AMA has conducted Safe Hours Audits in 2001, 2006 and 2011. Its efforts are helping change the culture of DiTs working dangerous hours to cover system-wide shortages. By highlighting the impact on patients and DiTs through powerful advocacy, the AMA continues to pressure health bureaucracies to ensure safe work hours.

Doctors' health

AMA advocacy, including national surveys, has raised the profile of doctors' health – including the need to establish a positive culture and support structures. This includes continuing to ensure that doctors who need professional medical help can seek it from their colleagues without fearing the consequences of mandatory reporting laws.

Rural workforce initiatives

The AMA has worked tirelessly to ensure that the Government implements strategies to bolster the rural health workforce. The AMA, with other organisations, negotiated a relaxation of conditions associated with the Bonded Medical Places (BMP) program and continues to advocate for incentive-based programs to recruit doctors to work in rural, remote and disadvantaged communities. In 2012, the AMA will work with other GP stakeholders to ensure that any proposal for a national rural generalist pathway increases the number of doctors with the right skills in rural areas.

National registration and fees

The AMA has won a reduction in the registration fees interns pay the Medical Board of Australia (MBA). Doctors are now paying two and three times the previous registration fees to support the new bureaucracy – despite being assured national registration would bring new efficiencies. As a result of AMA lobbying, the MBA will relax its documentation requirements in 2012 for those proceeding from provisional to general registration. This means that the majority of interns will not have to submit the same paperwork twice (at the time of graduation, and at end of PGY1).

Global health

Junior doctors are increasingly interested in practising abroad and engaging in global health advocacy. The AMA is working with governments and colleges to create opportunities for vocational trainees to undertake rotations overseas. The AMA, along with the Australian Medical Students' Association (AMSA), has developed *A Guide to Working Abroad for Australian Medical Students and Junior Doctors*. The guide is a practical toolkit for trainees interested in working and training in overseas settings and has been written to meet a strong demand from medical students and junior doctors for information on studying and training overseas, and global health more generally.

Social Media and the Medical Profession

In November 2010, the AMA launched an online professionalism guide to assist doctors and medical students to maintain professional standards when using online social media. The guide – Social Media and the Medical Profession – was developed by the AMACDT, the NZMA Doctors-in-Training Council, the NZMSA and AMSA. It provides real life examples of the repercussions that doctors can encounter through the misuse of social media and aims to help doctors and students enjoy the online world safely while maintaining professional standards. Hard copy can be obtained from AMA ACT (call 6270 5410)

Education and training

The Government has significantly lifted the numbers of places at medical schools, with the number almost doubling in the past ten years. The AMA is advocating strongly for increases in prevocational and vocational training positions to ensure that medical graduates can access training positions and go on to achieve college fellowships. More recently we have helped secure funding for more prevocational and vocational training places, particularly in general practice. In order to maximise the benefits of the increase in student numbers, the AMA is now working hard to ensure that the quality of clinical training is maintained.

National Training Plan

Building on the success of the Medical Training Summit in 2010, the AMA secured an agreement from Health Workforce Australia to undertake the development of a National Training Plan (NTP). The NTP will provide estimated numbers of professional entry, postgraduate and specialist trainees that will be required between 2012 and 2025 to achieve a goal of self-sufficiency in the supply of doctors, nurses and midwives by 2025.

A national intern allocation system

The AMA is leading the discussion on how to streamline PGY1 job applications via a national intern allocation system. A position statement recently approved by AMA Federal Council recommends a single entry and exit point for all intern applications while continuing the use of local systems to prioritise applications and perform job matching. This will make it easier for prospective interns to apply for, and receive offers from, multiple states. The statement will shortly be published on the AMA web-site.

Specialist trainee survey

The AMA released the Report of Findings for the 2010 AMA Specialist Trainee Survey (STS) on 3 October 2011 providing medical colleges with important trainee feedback about key training issues. The STS advocates for quality training, supervision and feedback for registrars and is an important tool in raising awareness of areas where trainees believe there is room for improvement including access to an effective appeals process, recognition of prior learning, value for money and overall cost of training.

Health reform

The AMA has led the public debate about health reform. Its views have been listened to by Government and many of its positions are reflected in the Government's plans for the National Health and Hospitals Network. The AMA has been particularly active in making sure that clinicians are represented in local governance structures.

General practice

General practice is the key to a strong health system. Working closely with GPs and GP registrars, the AMA called on the Government to preserve and strengthen the role of general practice in primary care. The AMA successfully lobbied the Government for more prevocational and vocational positions in general practice. It also negotiates national minimum terms and conditions for GP registrars.

Preventive health

Our ageing population and the prevalence of chronic and complex health conditions in the community has made preventive health a major element of the health reform agenda. The AMA encourages more Government investment in prevention as well as treatment. Another key AMA policy objective is to ensure that the unique opportunities doctors have to promote good health are properly recognised and supported in the health system.

Indigenous health

Closing the gap in life expectancy between Indigenous and non-Indigenous Australians is an AMA policy priority. AMAs independence allows it to fearlessly report on issues of importance in Indigenous health on an ad hoc basis, as well as in its annual Indigenous Health Report Card. The AMAs influence and partnerships allow it to provide sound advice on practical health measures designed to deliver real benefits on the ground. The health of Indigenous Australians is of deep and abiding concern to AMA members.

Climate change and health

The AMA believes climate change will produce serious and possibly irreversible impacts on health. It believes doctors have a key role in promoting community awareness of the impacts of climate change and encouraging the sustainable reduction of carbon emissions in health care facilities, as well as in their own practices. The AMA highlighted climate change as a key issue before the last two Federal elections and will continue to highlight the potential impacts of extreme weather and longer term changes such as drought on health, food and water supplies, and population shifts.

Youth health

The AMA's youth health policies aim to help young people make good health choices. We advise governments on practical policies to improve the health of young people today and preserve their health in the future. AMA doctors have developed practical, nonjudgmental resources that young people can use to help make the right health and lifestyle choices. AMA resources cover a broad range of subjects from body piercing to drug use.

REDUCING RED TAPE IN GENERAL PRACTICE

The AMA recently met with officials from Centrelink and Medicare to discuss the findings of the AMAs red tape survey conducted last year.

Completing Centrelink forms was the number one area of concern GPs identified in the survey and the AMA was able to provide feedback from the survey to the officials about where the red tape should be cut.

In particular, the AMA advised Centrelink that priority should be given to:

- Improving software compatibility to make sure forms are easily accessible and downloadable in GP offices;
- Software must also enable GPs to have Centrelink forms open and be able to have their patient's medical records open at the same time;
- As much as possible, forms need to pre-populate with known data;
- Repetition in forms needs to be cut; and
- Links should be made to forms that often need to be completed at the same time; eg, Disability Support Pension, Carers' Assistance, Mobility Assistance.

The AMA also stressed that any redesign of Centrelink forms needs to be undertaken with input and feedback from GPs. Centrelink are working towards some improvements and clearly the AMAs red tape survey has been influential in this.

The summary report of the AMAs red tape survey was published in the November/December edition of Canberra Doctor.

2012 SPECIALIST DIRECTORY

... a publication of the AMA ACT

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The **AMA ACT Medical Specialist Directory** will again be published as a service to ACT General Practitioners in 2012 and distributed with the 'GP Week' edition of 'Canberra Doctor'. All existing entries will be automatically included, a confirmation letter will be sent to all doctors to allow for updates where necessary. For new entries the following form must be completed and returned to:

Mail: AMA ACT, PO Box 560, CURTIN ACT 2605
Fax: 6273 0455
Cut-off-date: no later than COB 30 April 2012

In order to be included, it is mandatory that you have recognised and registered specialist qualifications. An AMA membership is not a requirement for entry in the directory.

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Sub-speciality or services offered:
(Please keep brief and use only accepted abbreviations – e.g. MRI, CT, etc.)

Practice Details (1)	Practice Details (2)
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Signed: _____ Date: _____

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A proof of your entry will be sent prior to printing. Please indicate preferred method to receive this:

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IMPORTANT NOTICE FOR AMA (ACT) LIMITED MEMBERS

The Annual General Meeting of the Australian Medical Association (ACT) Limited (ACN 008 615 778)

will be held on
Wednesday 16 May 2012
at AMA House, level 3, 42 Macquarie Street Barton, ACT
Commencing at 7.00pm

Further information will be forwarded in due course.

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The new ANU Medical School students continued...

Book Review: *Satori*

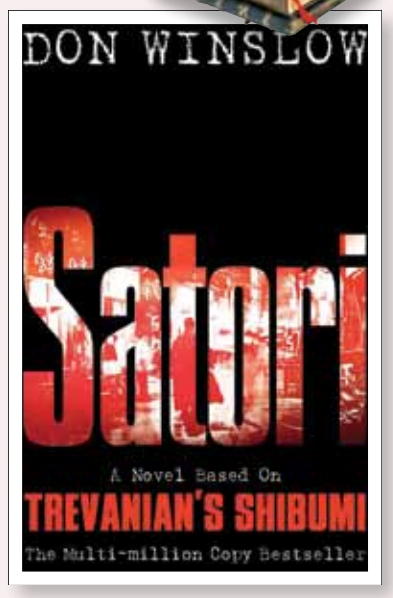
Don Winslow
Headline Book Publishing
ISBN 9780755385966

Satori is an prequel to the novel *Shibumi*, authorised by the family of Trevanian. Trevanian, the pen-name of Dr Rodney William Whitaker, a Fulbright Scholar and university professor, was the author of the bestseller *Shibumi*, which introduced Nicholas Hel, the protagonist of both novels, in 1979.

Satori sinuously intertwines elements from the sequel in the internecine intrigues prefiguring the Vietnam war, depicting Hel's forging as an international assassin and curiously, a mystic. Don Winslow has retained his own Hemingwayesque style, eschewing a pastiche of Trevanian's acerbic, sardonic, and deliberately mannered tone.

Arguably Eurasian in heritage, Hel could be considered an archetype of the semi-mystical martial arts trained assassin depicted by Eric van Lustbader in the Nicholas Linnear novels or, more recently, by Barry Eisler in the John Rain series. An exotic combination of Eastern mysticism and aesthetics viz. *shibumi* underpins Hel's character, which is moulded through a peripatetic childhood as a White Russian emigre in Shanghai, during the Japanese occupation of China. Through the mentorship of his sensei-father-figure, General Kishikawa, Hel becomes an adept of hoda-korosu or "naked/kill" an allegedly potent martial art and hones his "proximity sense", skills advantageous to an assassin. In seeking to protect Kishikawa from the war crimes tribunal after World War 2, Hel is imprisoned in an American prison in occupied Japan.

Hel finds himself in the belly of a byzantine beast of intrigue as he emerges from prison. He is recruited by the CIA and trained by an alluring Frenchwoman for a deep-cover operation; impersonating a Frenchman during the Vietnamese insurgency, under French colonial role. Hel is tasked to infiltrate the insurgency, and is seemingly held in check by labyrinthine layers of deception, intrigue and betrayal. As in Japanese arts, including the martial, his world is replete with omote a public face, or outside, and ura, a hidden face, or inside. However, in Hel's travails, what is omote and ura is opaque.



Trevanian wrote in his original novel: "...*Shibumi* has to do with great refinement underlying commonplace appearances." Whilst the original intention of the publication of this authorised prequel may have been to whet the appetite for a long-awaited release of an unpublished novel by Trevanian, Street of the Four Winds, and *Shibumi*; through Winslow we have a unique contribution to the oeuvre, in itself *shibumi*.

Reviewed by Jeffrey Looi
Associate Professor
ANU Medical School

AMA guidance for GPs regarding nurse practitioners

GPs have been asking what they should do if they receive documents about a patient from a nurse practitioner. Last year, the AMA held a forum with other GP groups, nursing bodies and Medical Defence Organisations. The forum agreed that a GP would be under a professional obligation to review the information; and consider what, if any, action was required.

The same meeting concluded that, where a GP receives documents from a nurse practitioner, the following courses of action would be appropriate, depending on the general practitioner's circumstances:

1. If the GP is in a collaborative arrangement with that nurse practitioner, he or she should comply with the terms of that arrangement.
2. If the GP is not in a collaborative arrangement with that nurse practitioner:

If the results are clinically significant, the GP should satisfy himself or herself that appropriate action is, or has been, taken by the practitioner who initiated the investigation(s).

- If the results are clinically significant, the GP should satisfy himself or herself that appropriate action is, or has been, taken by the practitioner who initiated the investigation(s).
- If the results are not clinically significant, the GP should add the information to the patient's file according to his or her usual practice.
- If the clinical significance of the information is not clear, the GP should satisfy himself or herself that appropriate action is, or has been, taken by the practitioner who initiated the investigation(s).

If you do not consider yourself to be the patient's usual GP because you do not know or you have not seen the patient for an extended period, you should write to the nurse practitioner and the patient advising to this effect and not to be sent any further results in relation to that patient.

The same letter should also state that the results should be given to the patient's usual GP and that the patient should consult the GP as soon as possible.

Alternatively, you can suggest that the patient make an appointment to see you to discuss the results. If the information suggests that the patient needs urgent medical attention, this should be highlighted, with the patient being advised as a matter of urgency.

VALE!

The President, Board, members and staff of AMA ACT extend their sincere sympathies to the family and friends of our late esteemed colleague, William Warwick Coupland.

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We are pleased to announce Dr Michael Ow-Yang has joined Dr Justin Pik at

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We invite you to contact any of our Clinical Directors who will be happy to answer your questions.

Belconnen & Gungahlin

Dr Brendan Cranney
MBBS(Hons), FRANZCR
p: (02) 6203 2020

Calvary Clinic

Dr John Connors
MBBS, FRANZCR
p: (02) 6203 2021

Deakin

Dr Barry Flynn
MBBS(Hons), FRACP, DDU
p: (02) 6203 2033

Dr Niri Ganeshan
MBBS, FRANZCR
p: (02) 6203 2023

Erindale & Queanbeyan

Dr Jenny Bramley
MBBS(Hons), FRANZCR, BSc(Med)
p: (02) 6203 2030

Garran

Dr John Faulder
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