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Busier health services, improved access to care, but still more to do

Dr Peggy Brown, Director-General of the Health Directorate, ACT Government, shares the achievements of the ACT's public heatlh services with readers of the Canberra Doctor, and lists the biggest challenges facing the system into the future.

Dr Peggy Brown.

Four years ago, the ACT Government established its ambitious overhaul of our public health facilities to ensure that our public hospitals and community health centres can meet the needs of our community well into the future.

Some of the first fruits of this program are about to be opened, others are on the way, and the process for designing and building our new tower block on the Canberra Hospital campus has commenced.

The new adult mental health inpatient unit will open soon. It will provide a significantly improved environment for staff, patients and carers. Our new Women and Children's Hospital will take its first patients in the middle of this year, and the Gungahlin Community Health Centre will open its doors in September 2012.

Work has also commenced on building our new enhanced community health centre at Belconnen. This new centre will provide more complex services than have been traditionally available at community centres, with the possibility of expanding to include services such as haemodialysis. The provision of care in the least acute environment appropriate to a condition is one of the objectives on which our infrastructure program is based.

All of this busy building work will have some short term impacts on the way our services are provided. But the end result will provide the ACT with hospital and health services that are more patient friendly, work better for staff and provide the community with a return on their investment.

The underlying principle for the development of our new infrastructure is improvement in patient care. Most of our public health facilities were built in the 1970s and 80s. They were built for the way health services were provided a generation ago. They do not have the flexibility needed to adapt to different ways of providing care.

Our new buildings will not only meet the needs that we can predict for the next decade and beyond, but will also have the capacity to adapt to new ways of providing high quality care.

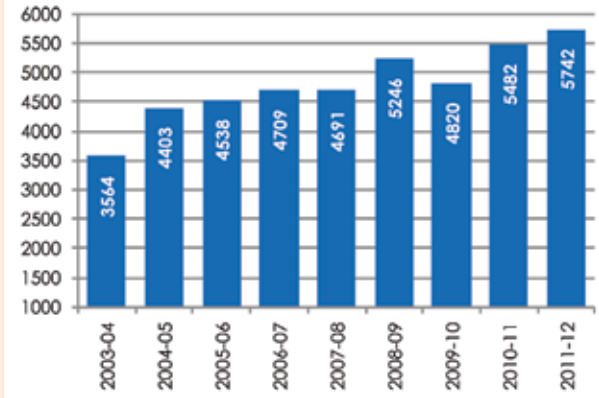
The new facilities are, of course, only part of the delivery of effective and efficient health services. In our public health services we continually review the way we provide services, and make changes to models of care to further improve health outcomes for our community.

Over the past few years, the efforts of those within the ACT public health system have made considerable improvements to the way people access services in the ACT. Waiting times for elective surgery have improved and the numbers waiting for surgery have decreased.

We posted a new record in terms of access to elective surgery in the 2010-11 financial year, with 11,336 patients going through our operating theatres. We expect to match this level in 2011-12, with activity over the first six months of this financial year above the total for the same period in 2010-11 (Fig 1). This additional activity is resulting in improvements in waiting times, with the number of people waiting beyond standard waiting times reduced 36 percent from December 2010 (2,006 long waits) to December 2011 (1,290 long waits).

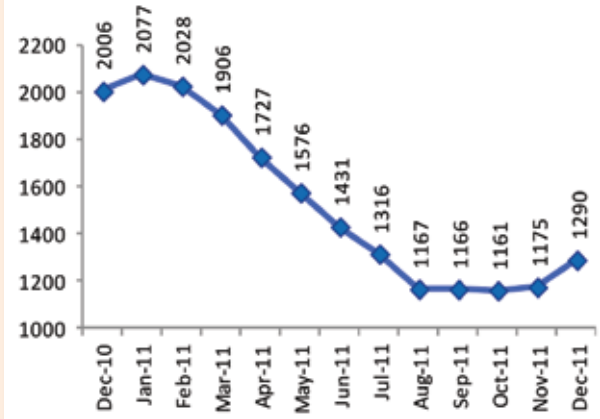
…Continued page 3.

ACT Public Hospitals



Total number of elective surgery operations. Year to December.

Fig 1



Total number of patients waiting longer than clinically recommended time frames.

Fig 2

The State of the Territory

Dr Iain Dunlop

When all is not as it seems

Recently, on one of those Mondays that make you feel that the calm of the just completed weekend is distant memory, I received several phone and text messages to contact a Canberra based ABC film and television journalist. She wanted urgent comment on the status of the intraoperative MRI scanner at the Canberra Hospital for a story to run that day or the next. 'Well', I thought, 'I haven't heard anything lately about the scanner or the high tech neurosurgery theatre….but it is our venerable aunty, the ABC…there must be some meat on these bones. …' So I asked our AMA office if there were any relevant reports in, and rang the journalist. She stated that the intraoperative MRI had been out of service for some months and that potentially, patient care was being compromised. There was little detail but we arranged that a camera and interviewer should visit Tuesday afternoon to contribute to the story planned for the Tuesday night news.

I remained mystified as to the exact nature of the story and its urgency. My enquiries revealed that the specialized bed /theatre table attached to the MRI was unsuitable for many types of neurosurgery, particularly spinal surgery, thus limiting the range of cases that could be treated in the new high tech theatre. Recognising this, the Hospital's biomedical engineers had arranged a work around that enabled the scanner bed/ OT table to be interchanged with a conventional OT table for general neurosurgery. In parallel, the installing company had re-designed the scanner bed for safe and flexible use and that this re-design was under assessment by the TGA prior to use in Australian hospitals. All processes appropriate and timely to solving the impasse and permitting the unit to deal with its full variable case load.

But what of the urgent matter at hand? TCH, the Health Directorate and the Health and Chief Minister were lobbied on grounds of potential patient care compromise. A Canberra man, diagnosed that very week with an intracranial mass for which early surgery was indicated, was advised that the intraoperative MRI would not be available for his surgery in Canberra. The ABC journalist ran with the concept that his care would be potentially sub-optimal without the scanner and hinted that others may have been similarly compromised in the period that the unit was out of service. (It should be noted that there are only three such scanners in Australia and that the vast majority of neurosurgical cases are completed satisfactorily without their use).

What was not revealed is that the patient in question was the brother of another ABC journalist. The initial journalist should have revealed her material interest in presenting this story for comment. The status of the scanner was not an urgent matter and resolution of the practical bed problem was well advanced. Where clinically necessary, the intraoperative scanner could be used. There was no apparent or threatened patient care compromise, past or present.

Confronted with an acute serious illness that is personally close, we all wish to expedite the best possible care. But we should not use our positions to seek unfair advantage. This journalist did not reveal a material interest. It seems that she chose to develop a public story to apply pressure to have the scanner available. This wasn't necessary and it impugned the care and facilities available to Territorians. I had thought that the ABC was above this.

AHPRA and the DHAS

AHPRA has released a discussion document on the future of Doctors Health Advisory Services (DHAS). These services vary in complexity and shape across the states and territories. Generally they were supported by the former State Medical Boards and managed early intervention for doctors under stress or in distress. (The Medical Boards' function in relation to disciplinary and impairment matters are quite separate and will continue under AHPRA's Medical Councils.) The DHASs will be unfunded as of 2012. AHPRA is generally agreeable to taking them on but suggests that this should be at additional cost to our current greatly increased medical registration fees (which provided about $115 million to AHPRA last year). AMA ACT is opposed both to the levy and to the notion that AHPRA be involved.

These services are a jewel in the AMA ACT crown. They are extremely valuable, being confidential, independent, free early intervention activities that aim to keep our doctors (and dentists and vets) from escalating to personal damage. Any association with AHPRA would lose us both independence and confidentiality – in the particular and the general. AMA ACT service is funded leanly from our revenue. Victoria costs approx. $1.5 million annually. We do not wish to report to AHPRA or pay above our registration. Fundamentally it's about independence, confidentiality and effectiveness - a service you can call on with absolute discretion.

We will oppose the proposals in AHPRA's discussion document.

New Medical Career Advisory Service

The AMA, as a whole, has developed a medical career advisory service to assist doctors at all levels in planning and pursuing their careers. This is an initiative of all the States and Territories that will provide on line and telephone advice and information. The need is obvious and expanding. AMA ACT won the tender to house and run the service from inception. The service is expected to be available within the next few months. We'll keep you informed of progress.

ACT Clinical Senate

The President and the Chair of the AMA ACT GP Forum have been invited to sit on the ACT Clinical Senate ex officio. This is a welcome recognition of the importance of GPs in clinical advice fora and of the continuing role of the AMA GP Forum. This group remains the sole GP only representative body. The Medicare Local GP representation is constitutionally in the minority. Not so, the AMA.

Iain Dunlop
President ACT AMA

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Visiting a Crabtree & Evelyn store is a time of discovery: finding products to uplift and inspire, exploring new ideas to add a touch of beauty to one's day and experiencing personalised service in a fragrant and beautiful store. The Crabtree & Evelyn Canberra store is located in the heart of the city in the Canberra Centre, conveniently situated next to the Coffee Club; the same position the store has been in for 10 years.

Customers visiting the store can look forward to a friendly welcome from store manager Angela, Catherine, and other members of the small team. In addition to great advice and assistance regarding our products, one can enjoy a complimentary hand treatment, benefit from complimentary gift-wrapping and leave feeling better for the visit. In addition, AMA (ACT) members get the benefit of 10% discount at our Canberra store only.

New to the store recently is our Avocado, Olive & Basil Hand & Body Care collection which has a unique fresh green herbal fragrance with the scent of avocado & olive blossoms, basil, sage and Mediterranean herbs, making it suitable for both men and women. An exciting new floral range will be launched shortly as well as a number of beautiful new gift packs, all perfect for Mother's Day. So for an ideal gift, a small something to pamper yourself or even just a few minutes escape, visit us at Crabtree & Evelyn Canberra.

Copy supplied by Crabtree and Evelyn.

Crabtree & Evelyn Store, Shop DF35A, Canberra Centre.

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(Canberra) Ph: (02) 6251 7383
– Fine catering servicing Canberra business and private events

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Country Comfort Greenway
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* conditions may apply. These benefits are available for 2012, as at 10 November 2011, and may be subject to change.

Busier health services...continued...

...From page 1.

These results were possible through increased ACT Government investment for elective surgery and contributions by the Commonwealth as part of the National Health Reform (NHR) Program. Under the NHR Program, states and territories have been provided with additional Commonwealth financial support to ensure that all patients are admitted for surgery within standard waiting times by 2016. While this is an ambitious aim, the results to date demonstrate that the target is not beyond our reach.

As part of the National Health Reform Program, all Australian Governments have also agreed to improve access to people who need emergency department care. By 2015, we have agreed to ensure that 90 percent of all emergency department presentations are in and out of the ED within four hours. Our hospitals have interim targets to meet over the next four years on the way to achieving the 90 percent final target.

We are on the way to meeting our interim target for 2012 (64 percent, see Fig 3). However, we are continuing to work on new ways of reducing the time that patients spend in the ED. We have already established a number of initiatives to improve this situation, including the establishment of our medical and surgical assessment units. These units provide for quick transfer of patients to the more appropriate specialist services where required.

The need to achieve these targets is also bringing ED specialists, physicians and surgeons together to work out better ways of ensuring patients get to the most appropriate care in the most appropriate timeframes.

Other initiatives introduced in our emergency departments are also helping to reduce waiting times to care. Streaming of patients on arrival and including specialist input earlier in an ED visit has provided significant improvements in waiting times at Canberra Hospital in particular, with the proportion of patients treated on time increasing from 58 percent in December 2010 to 73 percent in December 2011.

The National Health Reform Program also provides additional opportunitites for community involvement in setting the health care agenda and provides for better communicaton between acute and community-based care providers.

The new ACT Local Hospitals' Network Council includes a representative from the ACT Medicare Local. This body provides advice to the Health Directorate in setting priorities and managing the transformations required under the National Health Reform Program. The work of the Council provides us valuable advice on how our services can work in a more coordinated way, and how we can continue to break down the barriers between acute and community-based care in order to provide our community with services which are focussed on them, and not on who provides the service, or where the service is provided.

Health Directorate also works closely with the Medicare Local in a range of forums aimed at improving the health services on which our community relies. The shortage of GP services in the ACT means that we need that close cooperation and collaboration to maximise outcomes for patients, and reduce pressures on the clinicians who are meeting increasing demands for care.

As part of this approach, we are continually building on our acute care capacity to ensure that people can access hospital-based care when they need it. Over the past decade, increased Government funding has enabled our public hospitals to increase our bed stock by almost 40 percent, from 670 in in 2002 to the 934 now available. This increase in bed capacity has increased the ratio of beds available for our population to match the national rate. While we know that we need to exceed the national average as one-quarter of our hospitals' activity comes from across the border in NSW, the current ratio of beds available in our public hospitals (at 2.5 per 1,000 residents), is well up on the 2.1 per 1,000 Canberrans reported in 2002.

Our new public hospital infrastructure will provide our community with the capacity to meet demand well beyond the next decade. However, we will continue to increase bed numbers in the interim to meet more immediate needs.

Waiting times for radiotherapy services have improved considerably over the past three years, due in part by the provision of a third linear accelerator. However, the Territory has been able to recruit the necessary staff to provide the necessary services, in what is a very competitive area. Over the first six months of 2010-11, over 99 percent of radiotherapy patients received their care within established benchmarks, up from 75 percent three years ago. Over the same period, the number of people starting radiotherapy has increased by 11 percent and the average waiting time to care has fallen from over 18 days to 12.5 days.

Our mental health services continue to provide nation-leading results for a range of indicators which demonstrate a commitment to maximising patient outcomes, providing care in the least invasive environment and providing appropriate follow-up services to meet client needs.

Our seclusion rate is the best in the nation at around two percent of admitted patients, which is well below national benchmarks and considerably lower than previous years. We manage to follow-up three-quarters of all inpatients within seven days of discharge, which is also well above national benchmarks.

Our childhood immunisation rate – at 93.3 percent to the end of December 2011 – remains above the national average of approximately 91 percent, and waiting times for general public dental services are under target and continue to be nation leading at 11.7 months for the first half of the 2011-12 financial year. We continue to manage 100 percent of emergency dental cases on time.

We are also working on the development of a new workforce strategy for ACT public health services to ensure that we have access to the right staff to meet emerging needs and changing demographics. We have been able to more than double the number of doctors who work in our hospitals over the last decade and have increased our nursing numbers by almost 70 percent. However, we are fully aware of changes in our working profile and changes in the population that will provide us with future challenges in meeting our health workforce needs into the future.

ACT Public Hospitals

Proportion of emergency department presentations with a length of stay of less than four hours.

Fig 3

THE NOTICE BOARD!

Pactice Manager's Network Meeting

Thursday 29th March 12.30 to 1.30

Dealing with difficult people

Session will be presented by Tim James from Esset Australia.

Tim will also be available to answer any of your questions regarding training opportunities for yourself and your staff.

Further meeting dates and topics will be available soon.

Not a member of the Network?

Membership is free to nominated staff of AMA ACT members.

For further information contact Sue Massey at AMA ACT on 6270 5410

Doctors' Health Advisory Service (ACT)

Here for you and your needs

The DHAS (ACT) provides peer support for you and your family.

The DHAS (ACT) is a group of experienced Canberra-based general practitioners who are committed to providing support to colleagues and their families experiencing difficult times – which may include:

A stressful incident, violence or trauma in your workplace, workplace issues such as bullying or harassment, workload concerns, feelings of stress or inability to cope, burnout, your professional life, your career plans, personal issues, your well-being.

DOCTORS' HEALTH ADVISORY SERVICE (ACT)

Your colleague of first contact 0407 254 414 – 24 hour

AMA says PHI test money must go to health

As the House of Representatives voted 71-70 to support the Government's private health insurance means test changes, the AMA called for all savings from the changes to be ploughed back into the health system.

AMA President Dr Steve Hambleton said that the extra funding would assist covering existing needs in the system and help compensate the public hospital system for any extra demand that may occur as a result of the changes.

"Australia needs both a strong private sector and a well-funded public sector to deliver effective health care," Dr Hambleton said.

"Private health insurance participation rates must be maintained at current levels to maintain the viability of the private sector.

"There are many disparate views of the possible impact of the means test changes.

"The AMA would be concerned if more people than estimated gave up their cover or if the measure causes people to downgrade their cover to reduce the cost of their premiums.

"It is therefore vital that any savings from the measure stay in the health system.

"The Government must now monitor the impact of this policy and be prepared to make adjustments if there is any significant reduction in private health insurance membership.

"Our public hospitals must be properly resourced and the balance between the public and private sector must be protected," Dr Hambleton said.

Health Minister Tanya Plibersek said the legislation would save taxpayers $2.4 billion over the next three years – or $100 billion over the next 40 years.

"The private health insurance rebate is the fastest growing cost to the health budget," she said.

"The legislation is a win for low and middle income earners, who for too long have been forced to subsidise the private health insurance of higher income earners through their taxes."

Opposition Leader Tony Abbott has pledged that the Coalition will repeal the changes if it wins office.

"Private health insurance is an article of faith for us. We will restore the rebate in Government as soon as we can."

Lord Darzi to address AMA National Conference

One of the leading international figures in health reform in recent years has been confirmed as a keynote speaker at this year's AMA National Conference.

Professor the Lord Darzi of Denham PC KBE led the UK's National Health Service (NHS) Next Stage Review.

Published in 2008, the Review set out a vision for primary and community care under the NHS. The website of the UK Department of Health sets out the Review's vision as follows:

Our vision is for primary and community care to provide high quality, personal care and support, treating people when they're sick and helping them stay healthy, where and when they need it most.

Primary and community care services are regarded with pride at home and admiration abroad. Thanks to the dedication of family doctors, community nurses, health visitors, allied health professionals, social care professionals, pharmacists, dentists and opticians, most patients enjoy good quality care, close to home. There are high levels of satisfaction with services and trust in the staff who provide them.

We need to ensure that high-quality care is a consistent part of everyone's experience of primary and community care.

Services need to evolve to reflect changes in healthcare and society. This document sets out a vision for how services will continue to grow and develop over the next ten years. It is a vision of a continuously improving service, where essential standards are guaranteed and excellence is rewarded.

Lord Darzi is a former Health Minister in the United Kingdom and is the Chair of Surgery at St Mary's Hospital in London.

He will provide the AMA National Conference with a personal reflection on Clinical Leadership in Health Systems and maybe some insights into health reform processes in the UK.

To hear Lord Darzi and to reserve your place at the AMA National Conference in Melbourne contact Theresa Schultz on 02 6270 5474, visit www.ama.com.au/nationalconference or email at natcon@ama.com.au.

The Next Stage Review can be viewed at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937

CALMS granted authorisation to agree and set fee caps for after-hours primary medical care

On 23 September 2011, CALMS Ltd lodged an application for re-authorisation with the ACCC to continue to apply a capped fee schedule for the provision of after-hours primary medical care in the ACT.

The capped fee arrangement has been previously considered by the ACCC and authorised on a number of occasions, most recently in 2008.

The ACCC considers that a capped fee arrangement is likely to continue to provide public benefits resulting from greater certainty to CALMS patients with respect to the maximum fee for out-of-hours medical services. This will promote better-informed decisions by patients in the ACT regarding after-hours medical services offered by CALMS.

The ACCC considers that the arrangements are unlikely to lead to any significant public detriment for a number of reasons including:

- the limited scope of the fee agreement, which only applies to locum GPs in the CALMS service
- the limited extent to which CALMS doctors compete with each other in the provision of after hours primary health care
- the presence of limited competition from other extended-hours clinics
- non-price determinants of demand for out-of-hours care, and
- the agreement is a price cap, not a price floor and doctors retain flexibility in charging up to the capped amount.

The ACCC considers that the public benefits flowing from a capped fee arrangement, will continue to outweigh any public detriments.

The ACCC has assessed the conduct to be of significant public benefit on a number of occasions. As such, the ACCC proposes to grant authorisation for 10 years for CALMS to agree and set a fee cap for the provision of after-hours primary medical care in the ACT.

Under the proposed authorisation CALMS will be able to amend the fee schedule from time to time. Previously the ACCC required CALMS, as a condition of authorisation, to notify the ACCC of any proposed changes to the fee schedule. However, the ACCC does not propose to impose such a condition in this instance. This will provide CALMS with greater flexibility to respond to changes which may require amendments to the amount of the fee cap without requiring CALMS to reapply for authorisation.

The ACCC is satisfied that there are constraints on the ability for CALMS to significantly increase the fee cap and if CALMS seeks to increase the capped fee levels, the ACCC may seek to review the authorisation.

The ACCC is now seeking further submissions on this draft determination before making its final decision. In addition, the applicant or any interested party may request that the ACCC hold a conference to discuss the draft determination, pursuant to section 90A of the *Competition and Consumer Act 2010*.

Pursuant to section 101 of the Competition and Consumer Act 2010, a person dissatisfied with this determination may apply to the Australian Competition Tribunal for its review. An application for review must be made within 2I days of the date of this determination; that is, on or before 19 March 2012. If no application to review is lodged by this date, the ACCC's determination will come into force on 20 March 2012. An application for review of the ACCC's determination should be lodged directly with the Australian Competition Tribunal.

AMA calls for support to General Practice: a fundamental pillar of the health system

The AMA's key message to Government is that the next Federal Budget must recognise and appropriately fund those parts of the health system that work well and that communities rely on.

"I am delighted that the AMA has once again recognised that general practice is a fundamental pillar of the health system, with improved support for GPs being a key focus of the AMA submission," said Dr Brian Morton, Chair of the AMA's Council of General Practice.

"Supporting existing general practices to enhance their capacity to deliver care to the community and to teach and train tomorrow's GPs is, in the AMA's view, a more effective use of funding than the direction of millions of dollars to a few 'super' clinics.

"The AMA has again recommended that the Government redirect funding for unfinalised or not fully supported GP Super Clinics into GP infrastructure grants. We also want 575 more grants (at around $300,000 each) to fund general practice to deliver expanded services, as well as improved subsidy arrangements to encourage more training to take place in general practice.

"With GPs recognised as a core part of the general mental health workforce and the management of chronic and complex disease a key part of general practice, the AMA has called for funding to better support these activities. The Government needs to put back into general practice the funding it 'saved' from last year's cuts to GP mental health items.

"We are already seeing the impact of these cuts with a decrease in the number of GP mental health services. The AMA has also called for existing Medicare arrangements to be enhanced to facilitate streamlined and improved GP-coordinated access to allied health and support services for patiens with chronic and complex care needs.

"Considering that the real value of Medicare rebates for patients has not kept pace with the increasing cost of running medical practices, the AMA has recommended the Government to index all MBS items, including Non VR GP services, in line with the Labour Price Index and the CPI to better reflect the costs involved in providing medical services. The AMA has also recognised the need to increase funding for providing out of rooms consultations to older people living in aged care facilities and in the community.

"Further, Telehealth could enable GPs to efficiently service specific patient groups, such as the house bound residents of aged care facilities and rural and remote patients. For this reason and the enhanced access to care it provides, the AMA has called for MBS telehealth items to be extended to GP consultations for these patient groups.

"In addition, to ensure that e-health initiatives deliver on the potential for improved safety and quality of medical care, the AMA has called for Shared Electronic Health Records to be reliable, relevant, aligned with clinical workflows, integrated with medical practice software, governed by a single entity, fully funded by Government, and supported by appropriate incentives.

"The AMA is looking to Government to ensure that general practice is supported in its pivotal role of caring for the community."

Dr Brian Morton wrote this article originally for Australian Medicine.

Foundation to focus on ground-breaking research

A new ANU Foundation launched recently will focus on advancing human health by funding ground-breaking medical research.

ANU Vice-Chancellor, Professor Ian Young, joined the Director of The John Curtin School of Medical Research Professor Julio Licinio, and the Chair of the Foundation Board, Dr Cameron Webber, to officially launch The John Curtin Medical Research Foundation. Philanthropist, businessman and 2011 Australian of the Year, Simon McKeon, delivered the keynote speech at the launch and highlit the importance of giving to medical research.

"The Foundation will promote the diversity of medical research at ANU and encourage philanthropic support for our researchers in their endeavours," said Professor Licinio.

"The Foundation's mission is to advance human health through scientific discoveries. The path from medical discovery to drug trial to prescribed treatment is time-consuming, resource-intensive and never guaranteed. Researchers rely more and more on philanthropic support of medical research and raising funds to support this crucial journey."

Mr Simon McKeon.

Canberra GP and chair of the Foundation's Board, Dr Cameron Webber said that the Foundation's Board will unite the existing support to medical research at ANU and advocate for the many worthy research projects underway.

"The board has a passion for, and belief in, the transformative power of medical research. We will initially focus on three areas: ensuring that the most promising young minds are able to continue their research at ANU; ensuring that our researchers are provided with the world-class facilities and equipment they need to succeed; and ensuring that discoveries made can be progressed through the drug development and testing phase so that potential cures aren't left to sit on the shelf.

"The Foundation will allow our donors, alumni, staff and the wider community to join our researchers on their journey towards health through discovery," said Dr Webber.


JCSMR Director Professor Julio Licinio, ANU Vice Chancellor Professor Ian Young and Dr Cam Webber.

The Foundation will be established under the ANU Endowment for Excellence and will report annually to the ANU Council. More information and a list of board members is available at: http://jcsmr.anu.edu.au/john-curtin-medical-research-foundation

ECLIPSE making in-hospital services easier to claim

Claims for over 7.6 million in-hospital medical services have been lodged electronically via the Department of Human Services' Electronic Claim Lodgement and Information Processing Service Environment (ECLIPSE) this financial year.

In seven months the number is close to the total services that were lodged via the system in the 2010-11 financial year.

Where individuals with private health insurance choose to be admitted to hospital as a private patient, the attending health professional may be entitled to Medicare benefits and a rebate from the patient's private health fund.

Department of Human Services General Manager Hank Jongen said ECLIPSE allows health professionals to submit and retrieve eligibility checks quickly and carry out patient detail checks instantly.

"ECLIPSE eliminates the long wait time for the patient's Medicare enrolment and health fund eligibility to be verified and processed," Mr Jongen said.

"A claim can then be submitted quickly and easily via ECLIPSE.

"The simplicity and ease of ECLIPSE is making it increasingly popular with health professionals, with almost 60 per cent of In-hospital services now being processed via ECLIPSE.

"ECLIPSE reduces administration and saves health professionals time by allowing them to instantly check the status of the claim, it reduces the chance of rejected claims, and speeds up the processing time, from weeks to days.

"Health professionals can be assured ECLIPSE provides a secure connection between public and private hospitals, billing agents, the Department of Human Services and private health insurers.

"ECLIPSE is part of our commitment to providing health professionals with easier ways to claim."

For more information about ECLIPSE and how to register, phone 1800 700 199 or visit humanservices.gov.au.

2004/2005	2005/2006	2006/2007	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012 (end of Jan)	Total Services
13,335	70,926	157,840	464,439	1,228,236	2,998,404	7,947,732	7,603,019	**20,483,931**

Continued dispensing poses patient risks

The passage of the *National Health Amendment (Fifth Community Pharmacy Agreement Initiatives) Bill* through Parliament recently has the potential to seriously compromise patient care.

The *Bill* allows a practice known as 'continued dispensing', whereby pharmacists are allowed to dispense prescription medication without a valid prescription and without consulting a patient's medical practitioner.

The *Bill* allows for continued dispensing of the contraceptive pill and cholesterol-lowering medications (statins).

AMA President Dr Steve Hambleton said that the AMA strongly opposes continued dispensing because of the risks it creates for patient safety.

"A pharmacist has no way of knowing whether the patient's medical practitioner intended to continue the medication, to adjust it, or to cease that treatment altogether," Dr Hambleton said.

"Who will be responsible if something goes wrong after the pharmacist has given the patient more medication without review by the patient's doctor?

"We now have a situation where a health profession is able to expand its scope of practice outside the national registration arrangements, without any consideration of the patient safety implications.

"Dispensing prescription medication without a prescription also presents a fundamental conflict of interest – the pharmacist is both the prescriber and the dispenser.

"The *Bill* is effectively fixing a problem that does not exist. GPs currently have arrangements in place to see patients who urgently need a consultation to renew prescriptions or get new prescriptions."

Dr Hambleton said it is strange that at a time when US health authorities are requiring additional safety warnings on the labels of statins, Australian patients will be allowed to get statin prescriptions without having to see their doctor.

In 2008-09, PBS arrangements were changed to allow 12 months prescriptions for chronic medications. For statins, PBS data show that, in 97 per cent of cases, medical practitioners prescribed only six months of medication because they prefer to review patients after six months, not leave the review for 12 months.

Investec Medical Finance + AMA ACT = Best finance arrangements for your practice

Considerations when financing your practice equipment

There are a number of options available to medical professionals when looking for finance for the fit-out of your rooms, your equipment requirements and even your car. The most suitable plan varies depending on the desired outcome and your personal circumstances. It is important to understand what you are trying to achieve and then to consider your options.

Some of the more popular financing methods are commercial hire purchase, chattel loan, finance lease or a secured mortgage loan (with property). Each of these financing methods have pros and cons which is why it is so important to take the time and seek advice to carefully consider what works best for you.

Project Finance

One way to fund your practice assets is by leasing them in a single facility with a straight-forward repayment structure. A practice fit-out can be a complex task, which often unveils unforeseen costs such as design, or redesigns as you progress. Using project finance, your financier will look after all progress payments and drawdowns required over the life of your project, rolling the final amount into one easy finance arrangement for you. This provides you with the flexibility to be covered for any unforeseen costs and gives you peace of mind by setting a pre-approved limit to work within.

Cash flow management

An overdraft is an essential cash management tool for your practice and provides a safety net for unexpected expenses. It can be used for working capital needs, advance bill payments and other cash flow requirements. In the set-up process, an overdraft can be used to subsidise costs that are not asset based, such as telephone set-up costs, staffing costs and stationery.

Find the right finance for you

To get the best deal for you, discuss your needs with an experienced specialist in the industry, who understands your profession and your financial circumstances. An experienced financial consultant will be able to help you define what it is that you are trying to achieve and put a plan in place to help you get there. It is very important to consider the journey that you wish to go along in stages as this will affect the way you structure your finances. Speaking with a financial expert will put you in the best position to achieve your financial goals in the most efficient manner.

To discuss your financial options contact Investec finance specialist Michelle Gianferrari on 0414 475 012 or visit the Investec website at www.investec.com.au/medicalfinance

Don't forget to have your AMA member number handy when you talk to Michelle.

Disclaimer

The information contained in this document ("Information") is general in nature and has been provided in good faith, without taking into account your personal circumstances. Whilst all reasonable care has been taken to ensure that the Information is accurate and opinions fair and reasonable, no warranties in this regard are provided. We recommend that you obtain independent financial and tax advice before making any decisions.

All finance is subject to our credit assessment criteria. Terms and conditions, fees and charges apply. You should obtain independent financial and tax advice as appropriate. We reserve the right to cease offering these products at any time without notice.

General practice must be funded to help implement the PCEHR

At a meeting in Canberra held recently, United General Practice Australia (UGPA) leaders unanimously expressed concern about the lack of preparation for the practical implementation at practice level of the Personally Controlled Electronic Health Record (PCEHR), which is due to be introduced on 1 July this year.

UGPA members have been working tirelessly with the Government and agencies for some time to ensure the PCEHR becomes a reality.

The UGPA leaders agree that individual general practices and individual GPs must be properly funded and supported by the Government to assist in the smooth implementation of the PCEHR.

The PCEHR is a great opportunity for patients and the community, but it is in danger of being lost or impaired unless there is coordinated action to meet the deadline for implementation.

A mechanism to encourage GPs and patients to quickly sign up to the PCEHR is needed as a matter of urgency. General practice can assist in this process, but must be properly supported.

The UGPA leaders also raised concerns about two reviews currently being conducted into non-medical prescribing. Both Health Workforce Australia and the National Prescribing Service are looking into issues around prescribing by non-medical health professionals including nurse practitioners, podiatrists, physiotherapists, and optometrists.

To ensure consistent high national standards, a national curriculum and a national assessment framework are required for prescribing.

UGPA is otherwise concerned about patient and community safety with non-medical prescribing and is urging strong linkages with medical practitioners to avoid fragmentation of patient care.

UGPA recommends that an overarching existing national agency should be commissioned to manage and oversee all activities and reviews concerning non-medical prescribing.

UGPA comprises the Royal Australian College of General Practitioners, the Australian Medical Association, the Australian General Practice Network, General Practice Registrars Australia, the Australian College of Rural and Remote Medicine, and the Rural Doctors Association of Australia.

Candidate appeals to salaried doctors in AMA election

Colleagues

I seek your support as AMA Federal Councillor representing Salaried Doctors.

I was first elected to this position in August.

I am a consultant emergency physician, and have been a committed AMA member since graduation in 1992. I am the current AMA Victoria Vice President, Chairman of its Industrial Relations Subcommittee, and a key participant with ASMOF (Victoria and Federal).

My experience for this role includes:

- Substantial industrial relations expertise (I have achieved substantial gains for all Victorian Salaried Doctors);
- Profound knowledge of the AMA: I have already been an effective participant at several Federal Council and National Conference meetings;
- I have lived and worked in regional Victoria, and understand the issues facing doctors outside metropolitan areas;
- I am a fulltime clinician with a comprehensive understanding of issues facing senior salaried doctors as they relate to service provision, teaching and research;
- A record of successful advocacy for the essential role of senior medical staff in hospital based practice.

I would intend to continue pursuing the following issues:

- a closer cooperative relationship between the AMA and ASMOF;
- accountability from AHPRA and the other new federal bodies involved in the funding and administration of the health system;
- steering the right path with regard to the four hour rule, mindful of the potential to improve patient care and our imperative to practice quality medicine;
- ensuring that training standards remain at the forefront of the AMA agenda.

I would welcome your support, and am happy to discuss my candidacy or any issues relating to salaried senior medical staff with AMA members, via my email address stephen@parnis.com.au

Stephen Parnis

2012 AMA AWARD FOR EXCELLENCE IN HEALTH CARE

NOMINATIONS NOW OPEN

This award is for an individual who has made a significant contribution to improving health or health care in Australia. The person may be involved in health awareness, health policy or health delivery. Nominees do not have to be doctors or AMA members.

Criteria for the award can be found at http://ama.com.au/node/7520

The closing date for nominations is Friday 20 April 2012.

The 2012 AMA Award for Excellence in Health Care will be presented at the AMA National Conference on 25-27 May 2012 at the Grand Hyatt in Melbourne. For more information about the AMA National Conference go to http://ama.com.au/nationalconference

For further information regarding the award or nominations, please email awards@ama.com.au

AMA

If you're a doctor in training interested in a research placement, would $25,000 or $50,000 help?

Avant is delighted to announce the launch of the Avant Doctor in Training Research Scholarships Program.

On offer are two full-time scholarships to the value of **$50,000** each and four part-time scholarships of **$25,000** each.

Let us help turn your dream of that elusive research placement into a reality.

> "As a recipient of grants in the past, I would encourage you to put as much detail as possible into the application, it's worth the time and effort to get it right."

Dr Gareth Crouch

Cardiothoracic Registrar (SA)
Member, Avant's Doctor in Training Advisory Council

Applications open at 9am on 13 February 2012 and must be received by 5pm on **31 May 2012**.

For more information or to download the application form, please visit **www.avant.org.au/scholarship**

Avant
Australia's Leading MDO

Announcing "*Assessing Fitness to Drive 2012*"

The National Transport Commission and Austroads are pleased to announce the release of *Assessing Fitness to Drive*, the 2012 revised national medical standards for driver licensing. *Assessing Fitness to Drive* has been extensively revised, drawing on recent research and expert opinion on the impact of various chronic medical conditions on driving. General practitioners have been a key stakeholder group in the conduct of the review, with representation on the project Reference Group by the Royal Australian College of General Practitioners.

New features

The new edition features a simplified structure with ten chapters (reduced from the original 23) which focus on the health conditions likely to affect driving, including:

- Blackouts
- Cardiovascular conditions
- Diabetes
- Hearing
- Musculoskeletal conditions
- Neurological conditions, including dementia, seizures and epilepsy, vestibular disorders and other neurological conditions
- Psychiatric conditions
- Sleep disorders
- Substance misuse
- Vision and eye disorders

Information about the impact of medications is also included in Part A of the publication.

The new edition also features:

- Improved guidance on driver assessment and management including the role of practical driver assessments
- A focus on functionality rather than diagnosis which supports fairness in application
- Improved guidance with respect to multiple medical conditions and age-related change
- Flow charts to facilitate clinical decision making
- Information about medico-legal responsibilities
- Links to supporting consumer information.

It is hoped that these features will aid in the understanding of the impact of medical conditions on driving and will facilitate patient management. As many patients hold a driver licence, general practitioners have an important role in supporting road safety through their management of fitness to drive.

The key changes are summarised on the Austroads website www.austroads.com.au and detailed in a comprehensive report also available on the site.

Supporting resources for health professionals and patients

Links to various supporting information can also be found on the Austroads website www.austroads.com.au, including a fact sheet to assist communication with patients regarding their fitness to drive and their responsibilities to report to the driver licensing authority.

Online training for health professionals is also available via the SafeDrive Medical course – this can be accessed via the Vic Roads website (http://safedrivemedical.vicroads.vic.gov.au/).

Availability and application

The 2012 edition of *Assessing Fitness to Drive* has been signed into force by all state, territory and federal ministers of transport and is effective from 1 March 2012.

The publication is being distributed by Austroads to all GPs, and to relevant medical specialists and allied health professionals. Copies can also be purchased online via the Austroads website www.austroads.com.au which will host an electronic version of the book.

The standards aim to ensure that all health professionals are aware of the road safety implications of medical conditions, and that they understand the licensing authority systems for managing medically at-risk drivers. All health professionals are encouraged to refer to the standards when considering their patients fitness to drive. This will help to ensure that patients are assessed and managed consistently, and will support road safety.

Article provided by National Transport Commission and Austroads.

Fewer deaths and overdoses to result from opioid tracking

Fewer deaths and overdoses from the misuse of prescription opioids are likely to result from the Australian Government's announcement of a national electronic system to track the prescribing and dispensing of controlled drugs, specifically opioid analgesics used in the management of pain.

Real-time electronic tracking of the prescribing and dispensing of opioids was a major recommendation of the Prescription Opioid Policy released in 2009 by The Royal Australasian College of Physicians (RACP), to which the Faculty of Pain Medicine (FPM) of the Australian and New Zealand College of Anaesthetists (ANZCA) was a principal contributor.

That report recommended a web-based, real-time system for monitoring the prescription of drugs of dependence for the treatment of chronic pain.

FPM Dean, Dr David Jones, said the system would enable prescribing doctors and dispensing pharmacists to monitor prescriptions to provide more clinically effective, safer and cost-effective healthcare.

"Given the increasing prescription of opioids to deal with chronic pain over the past decade, the ability for doctors to know when a patient last received a controlled drug will ensure better outcomes for the patient and the community," Dr Jones said.

Professor Paul Haber, President of the Australasian Chapter of Addiction Medicine of the RACP, said a real-time prescription monitoring service was the first step toward solving problems with opioids and improving the management of chronic pain.

"This service is critical within the community and among doctors to ensure these medicines are available to those who need them, while making it even harder for them to be obtained incorrectly or sold on for illegal use," Professor Haber said.

A study published in *Injury Prevention* last year showed deaths reported to the Victorian Coroner involving oxycodone increased 21-fold from four in 2000 to 97 in 2009. At the same time, supply of the drug in Victoria increased from 7.5 milligrams per head of population to 67.5 milligrams nine years later.

Dr Jones said controlled drugs, such as oxycodone, morphine, codeine, methadone and fentanyl, were important in the treatment of some types of chronic pain when prescribed by a doctor with continuity of care.

However, he said there had been some evidence of black market diversion of the drugs and illicit use of pharmaceutical opioids, which had resulted in deaths, overdoses and the transmission of viruses through sharing needles.

"A real-time database will flag to doctors and pharmacists cases where people have been repeatedly seeking controlled drugs, sometimes from multiple sources, and help to manage the illicit use of these opioids," Dr Jones said.

"It will also help doctors better manage the treatment of people who have chronic pain through monitoring their drug usage."

The Australian Government announced $5 million for the Electronic Recording and Reporting of Controlled Drugs system to begin nationally in July. It will monitor drugs listed under Schedule 8 of the Standard for the Uniform Scheduling of Medicines and Poisons, which is administered by the Therapeutic Goods Administration.

Health Minister Tanya Plibersek said the information gathered through the national database would be available to doctors, pharmacists, and State and Territory health authorities.

"While controlled drugs such as oxycodone, morphine and codeine play an important clinical role in managing pain, abuse of these drugs can cause enormous harm and is a growing problem in the community," Ms Plibersek said.

"The new records system will be able to flag patients in real time who have repeatedly sought controlled drugs, helping to prevent people from inappropriately using the drugs or selling them to others."

Ms Plibersek stressed patient privacy would be protected, with only health professionals able to access a centralised database over a secure network.

Diabetes pilot

The implementation phase of the Australian Government-funded Diabetes Care Project (DCP) has recently commenced. The DCP will examine better ways of managing the treatment of diabetes, and is a significant step forward in treating the fastest growing chronic disease in the world.

The Australian Government originally proposed a national diabetes management scheme for primary care in 2010. This scheme is now a pilot to test new ways of funding and coordinating care. GPs and practices will receive different types and levels of support and funding across each of the intervention groups.

Medicare benefits for regular GP visits for people with diabetes are retained, and a more holistic approach than previously proposed is adopted, which offers increased support to both practices and people with diabetes.

The AMA was instrumental in helping to make the modifications to the original model, through its role on the Ministerially-appointed Diabetes Advisory Group.

The pilot will conclude in the first half of 2014, before the findings are released in the second half of that year. The AMA has expressed their interest in reviewing the results of the pilot and supports eligible practices being involved in the pilot. The pilot will involve up to 150 general practices in Queensland, South Australia and Victoria and over 10,000 patients.

This is an edited version of an article written for Australian Medicine written by Dr Tim Fountaine, on behalf of the Diabetes Care Project consortium.

AMA welcomes MBS item interpretation service

The AMA welcomes the decision of the Department of Human Services to introduce a Medicare Benefits Schedule (MBS) item enquiry email service to assist doctors with complex interpretations in the use of MBS item numbers

AMA President, Dr Steve Hambleton, said the service is something that the AMA has been pursuing for some time.

"There are situations when doctors in a busy practice require informed assistance about the interpretation and application of specific item numbers for specific treatments or patient conditions," Dr Hambleton said.

"Doctors can now send queries to a dedicated email address and receive a rapid written response to specific questions about the correct MBS item for a particular medical service.

"The MBS is very complex and there are many grey areas.

"If questions are raised about interpretations of MBS items, doctors can now refer to the written advice they have received from the Department and ask for it to be considered should there be any investigations.

"The AMA congratulates the Department of Human Services for recognising and responding to the need for a mechanism to help doctors navigate the complexities of the MBS so that their patients can access the Medicare rebates they are entitled to.

"We are pleased that enquiries sent to this email address will be handled by a centralised specialist team, who are trained to respond to these often complex MBS interpretation questions.

"This will ensure there is consistency in the advice given to medical practitioners around the country," Dr Hambleton said.

Doctors or practice managers can either:

- email MBS item questions directly to askMBS@humanservices.gov.au;
- or use the online enquiry form available at Contacts for providers.

The Internship Test Match: Australia vs the United Kingdom

The hardest question for any assessment or standards setting agency in medicine is 'when is a doctor safe and competent'. With national standards for internship programs currently being developed, it is useful to discuss the differences between an Australian internship and the UK Foundation Program.

An Australian internship has traditionally been built around core-rotations. In all States and Territories, interns have been required to complete at least one term in each of a medicine, surgery, and emergency care setting.

Historically, if an intern received satisfactory reports in these rotations then they were considered a 'safe' doctor and could gain general registration, as well as proceed to vocational training.

The UK now has a two-year prevocational program, the Foundation Program, to provide all graduates with a range of basic skills deemed necessary prior to starting vocational training.

The trainees, however, gain general registration in their second year of training. This is because the legal requirements for new graduates are seen to be different from the educational requirements for vocational training in the UK.

These educational requirements are based on a set of competencies, soon to be called outcomes, that have been derived from various consultations and undergone refinement over the years.

Holding only provisional registration in the first year after graduation does not impede progression to vocational training from medical school in North America, nor does it affect the curriculum of the UK Foundation Program. In these countries, the presence or absence of a prevocational training period has nothing to do with the requirements for general registration.

One of the major criticisms of the UK Foundation Program, according to the former Dean of Education at the Royal Australasian College of Surgeons Professor John Collins, was the over-assessment of trainees. This process is being reviewed in the UK.

Checklists of procedures led to trainees overly focusing on getting items ticked off rather than learning on the job. From a curriculum perspective, the aim of the Foundation Program was not to have each individual competency ticked off on a checklist, but to provide generic applied training such that the doctors are ready to proceed onto vocational training.

Importantly, no specialty college in the UK has prerequisites for entry as all junior doctors are considered fit for vocational training on completion of the Foundation Program.

In Australia, this would help alleviate the problem of junior doctors doing multiple service years in order to access competitive rotations that are designated by Colleges as pre-requisites.

Whether a two-year program is needed in Australia is still up for debate. However, from both an educational and workforce perspective, the prevocational medical education system in Australia needs reform.

While the UK equivalent certainly has its flaws, it provides a useful template for comparison. We should learn from their mistakes, reviews and experience.

Ross Roberts-Thomson is the newly appointed Deputy Chair of AMA Council of Doctors in Training. He is currently undertaking a Churchill Fellowship looking at international models of prevocational training. This article reflects his personal views, based on examination of postgraduate education systems in the US, UK and Canada.

This article was originally published in Australian Medicine.

2012 SPECIALIST DIRECTORY

... a publication of the AMA ACT

AMA (ACT) LIMITED

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.

Name:	
Speciality:	

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

Practice Details (1)	Practice Details (2)
Phone:	Phone:
Address:	Address:
Fax:	Fax:
Email:	Email:
Website:	Website:

Signed: _____ Date: _____

NOT FOR PUBLICATION

Contact Phone: _____

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

☐ Fax – number: _____ ☐ Email – address: _____

AMSA urges responsibility in a system under pressure

The Australian Medical Students' Association (AMSA) has dismissed Curtin University's recent advertisement for a foundation Head of Medicine as premature, with the University having not yet received Government approval for its plans to open a new medical school in 2014.

AMSA Vice-President External, Ms Catherine Pendrey, said that the supply of medical graduates needs to be assessed from a national perspective. Health Workforce Australia is expected to present its National Training Plan to Ministers later this year.

"Any increase in the number of medical students and graduates must be made responsibly and must consider the availability of sufficient quality clinical placements and further training opportunities on a national scale," said Ms Pendrey.

AMSA calls for a hold on the establishment of any new medical schools in Australia until data are available to assess national medical workforce needs, and until sufficient quality clinical placements and further training opportunities are available for all existing medical students in Australia.

Online tobacco advertising ban

The last bastion of tobacco advertising has been stubbed out, with the Senate passing a Bill to restrict online tobacco advertising in Australia.

Health Minister Tanya Plibersek said the new legislation would bring restrictions on tobacco advertising on the internet into line with restrictions applying to other media, and to physical points of sale, such as shop counters.

"This legislation has extinguished the last remaining opportunity for tobacco companies to freely promote their harmful products to the Australian public," Ms Plibersek said.

"Sales of tobacco on the internet will be subject to the same restrictions as everywhere else, and online retailers won't be able to spruik cigarettes with words such as 'cheap' and 'tax-free'."

Ms Plibersek said that, under the *Tobacco Advertising Prohibition Amendment Bill 2010*, online tobacco retailers would need to carry health warnings and restrict access to sites to persons aged 18 years and over.

She said the new law complements the Government's world-first plain packaging legislation, which removes tobacco companies' ability to advertise on tobacco packaging.

Supermarket chains, specialist tobacco and cigar shops, and other retailers would be consulted as the regulations arising from the amendment are drafted during the next six months.

Ms Plibersek said every year smoking related illnesses kill around 15,000 Australians and are estimated to cost the community more than $30 billion.

Advertising of tobacco products in Australia has been progressively restricted since the 1970s. Bans on cigarette advertising on radio and television have been in place since 1976. Tobacco advertising in newspapers and magazines was banned in 1990.

Meanwhile, there have been unconfirmed news reports that the Federal Government is to axe the duty-free allowance on cigarettes and tobacco for international travellers arriving in Australia.

A Seven Network report said that the Government planned to cut the tax break, worth an estimated $270 million, to help shore up its promised Budget surplus. It said the Coalition was also considering the move.

The 2010 Henry Tax Review recommended the duty-free allowance be abolished.

Neither Treasurer Wayne Swan nor Shadow Treasurer Joe Hockey commented on the report.

Under the current law, inbound travellers aged over 18 are allowed to bring into Australia 250 cigarettes or 250g of tobacco products tax-free.

Return of the ANU Medical Revue

Andrew Duncan,
3rd year ANU medical student writes:

"As a wan summer capitulates to an autumn yet more inclement, the days in Canberra grow shorter, the nights elongate and the capacity of Lake Burley Griffin's waters to cause amoebic dysentery becomes more pronounced.

As Canberra sleepily dims its lights each night, though, one pronounced glow throws back the night. At night, within the ANU Medical School, students are in the process of crafting the new Medical Revue. As other faculties submit to the hour and retreat to their beds, the medical students spurn the stretching shadows for another few hours each night as they hone their performance.

The script is confirmed, the actors are selected and the security guards are under strict orders to keep politicians at bay with unnecessary force. The time of the Sixth Annual ANU Med Revue is at hand. Are you prepared?"

THE FACTS:
The ***ANU Medical Revue*** is an annual play by ANU Medical School students. It departs from the sketch idiom favoured by most medical revues to create a true production, including a plot and songs in a variety of styles, with light-hearted criticism of the world of the medical school and medicine.

As always, all profits will be donated to the *Newborn Intensive Care Foundation* at The Canberra Hospital.

Mark your calendars:
Show dates are **Wednesday 9 to Saturday 12 of May (7pm)**, held at the Canberra Boys Grammar School Theatre in Red Hill.

Tickets: Students ($20); Non-students ($30)

For more information, please contact: anumedrevue@gmail.com

VALE!

Dr. William Warwick Coupland 1935-2012

Dr Bill Coupland, who commenced practice in Canberra in 1964, died peacefully at home on February 7, 2012 of cancer of the prostate. It had been first diagnosed in 1998, when it had already spread to the skeleton, giving rise to his retirement but despite that he was able to lead an active life until about 12 months before his death.

He was born in Manilla in northern New South Wales on June 3, 1935, one of four children of William James Coupland and Vida Amy Coupland, nee Blunt. The first of his Coupland ancestors to come to Australia arrived in 1859 from England and was involved in gold mining east of Tamworth. His father and his uncle operated a farm produce, motor-vehicle agency and carrying business in Manilla.

He attended primary school in Manilla and Tamworth High School. He graduated from Sydney University Medical School in 1959 with an outstanding academic record. He was first in final year, gaining First Class Honours, the University Medal and four separate prizes which were:

Arthur Edward Mills Graduation Prize for Distinction over the whole course R.J. Ritchie Memorial Prize for Clinical Medicine

Clayton Memorial Prize for Medicine and Clinical Medicine

Robert Scott Skirving Memorial Prize for Medicine and Surgery.

He was appointed to the Professorial Unit of the Royal Prince Alfred Hospital and in 1962 became a Member of the Royal Australasian College of Physicians. In 1963-64 he was Senior Fellow in Haematology at Prince Henry Hospital in Sydney, and then he was appointed Junior Physician, Royal Prince Alfred Hospital but he must be almost unique in declining that appointment which would have resulted in his eventually becoming one of the senior specialists in probably Sydney's most prestigious hospital, especially for Medicine. Instead, he decided to come to Canberra.

He commenced work in Canberra in 1964, taking the place of Dr Tony Proust, sharing a suite in the MLC Building with Doctors Jim McCracken and Peter Blaxland. He worked as a General Physician, as we all did at that time, but with his special training in Haematology that part of his practice expanded rapidly and there was a natural progression into the field of Oncology as well. He appreciated the responsibility of the Canberra specialists to service the surrounding areas, visiting Cooma once per week for many years and, in his later years of practice, Moruya on the South Coast every three weeks, consulting and supervising chemotherapy, as part of the outreach initiative of the Department of Oncology.

On a personal basis I remember how welcoming he was to newcomers. We first met at the Annual Meeting of the College of Physicians in Hobart, probably in 1966. I was considering moving to Canberra but was naturally uncertain about the prospects here and the attitude of the other physicians. He was so encouraging that our anxieties evaporated.

Working with him, the most outstanding quality was the breadth of his differential diagnosis; when faced with a problem he could bring to mind a wide range of possibilities which perhaps would not occur to less gifted physicians.

The Woden Valley Hospital, now The Canberra Hospital, had opened in 1973 but there was a natural reluctance on the part of the visiting medical staff to transfer their entire hospital practice from the Royal Canberra Hospital, where we had all been very happy, to Woden. It was Bill who took the initiative and induced three of the Physicians, Colin Andrews, Robert Mitchell, and me to join him in having our inpatients at Woden only. This was an important initiative, both for Woden and for the development of Medicine in Canberra. It is an illustration of what made Bill so persuasive: he liked people and therefore, naturally, they liked him. He was instrumental in the development of the Department of Oncology which has serviced Canberra and the surrounding regions from that hospital.

The tutoring and mentoring of medical students and junior doctors was one of his particular interests and many general practitioners and specialists now practising in Canberra owe a great deal to Bill. Paul Craft, the present Director of the Oncology Department, was one of his registrars, as was his General Practitioner, Stan Doumani. It was those two whose care enabled Bill to live with his illness in relative comfort for so long.

His work on medical committees included President of the Canberra Medical Society 1979-80, Chairman of the following: Royal Australasian College of Physicians ACT Branch 1979-80, the Ethics Committee of the Capital Territory Health Commission 1982-85, the Division of Medicine of the Royal Canberra and Woden Valley Hospitals 1986 and he was a Member of the Court of Clinical Examiners of the Royal Australasian College of Physicians 1984-1986.

The above might appear to leave no time for anything else but in fact he was heavily involved in other Canberra activities. He served on the committees of the Commonwealth Club, the Royal Canberra Golf Club and the Lords Taverners. He had a tennis court at home, being a good player, and there developed the Club Coupland, a group of his men friends, who played regularly and were so proud of their association that they even developed a club tie.

He was a devoted family man and the care given by wife and family allowed him to remain at home despite his illness. He is survived by his wife, Anne, nee Korff, from Coonamble, children Brett, Sarah (Professor of Pathology in Liverpool, UK), Lucy (PhD ANU for medical research) and Frances and grandchildren Holly, Amelie, Zoe, Karl, Timothy, Alice, Emma and Henry.

Bill was a man of great intellectual capacity and accomplishments which did not in any way diminish his gifts of empathy, sympathy and human understanding so important for all doctors and particularly those dealing with cancer and related illnesses. He was always modest and I would think that his accomplishments listed above would only be known to a minority of the Canberra medical population, even those who worked with him for years.

I am indebted to Drs. Angus McIntosh and Farley Thew for their assistance.

Frank Long.

Your complimentary copy of the 2011 Specialist Directory

CANBERRA GPs

A complimentary copy of the 2011 Specialist Directory has been distributed to all Canberra GPs. If you have not received your copy, please contact Sue Massey on 6270 5410 and one will be mailed to you.

HOSPITAL BASED DOCTORS-IN-TRAINING

A complimentary pocket-sized edition of the specialist directory is available for AMA members. If you have not received your copy, please contact Sue Massey on 6270 5410 and one will be mailed to you.

GP REGISTRARS

To receive your complimentary copy of the 2011 Specialist Directory, please call Sue Massey on 6270 5410 and one will be mailed to you.

GPs in SURROUNDING AREAS OF CANBERRA

Please call Sue Massey on 02 6270 5410 with mailing details and the number of copies required.

NOT INCLUDED ABOVE, BUT WOULD LIKE A COPY OF THE DIRECTORY?

A PDF of the 2011 Specialist Directory can be downloaded from the AMA ACT website **www.ama-act.com.au**

Book Review: Perspectives on Complementary and Alternative Medicines

Edited by Ian N Olver (Cancer Council Australia and University of Sydney) and Monica Robotin (Cancer Council NSW and University of Sydney, Australia)

Imperial College Press
488 pages $109.00 (AUD)

The title is misleading it should have been in the singular for more of the book was given to therapies other than medicines. Further it was restricted to those associated with cancer.

The authors trust that "by reading 20 different perspectives on complementary and alternative medicines the readers will then be able to form their own opinions, their perspectives". Unfortunately not all the authors stuck to this ideal, introducing not only their own unavoidable biases but giving mostly their opinions as well.

There was much repetition of attempts at defining complementary and alternative medicine (CAM), and of the statistics on the size of the market – the latter often the only solid evidence presented.

What stood out from the book?

Tom Reeve, now an emeritus surgical professor gave a well balanced view that struck a chord – the reviewer having prescribed plant extracts early in his career; e.g. digitalis extract, belladonna extract.

While Professor Reeve summarises much of the book with "although complementary and alternative medicine is apparently becoming more popular with clinicians there does not appear to have been a parallel level of activity to improve the evidence base for complementary and alternative medicines."

"The reviewer cannot accept the subsequent contention that "choosing from a conventional reservoir of appropriate therapies" differs from "individually tailored treatment". That is unless one forgoes having a full history and examination prior to initiating treatment. Such personalised medicine is being taken further by the use of genetic markers. It is the promotion of the personalisation that differs between practitioners.

Ray Lowenthal, an oncologist, is another that one could repeatedly quote from his review.

Veronica Raszeja suggests a web-based database of evidence of efficacy, side effects and interactions. This would be both a valuable reference for medical practitioners treating patients with or on these therapies, and an aide to patients who decide to self medicate.

This might also help counter the promotion of these therapies that generates the enormous sales frequently referred to. Ken Harvey points out the limited government control of that promotion.

Among the other chapters the reviewer found the chapter on prayer fascinating and that on meditation, while good, suffered from the restriction to cancer, missing its use in obstetrics.

There were two chapters on Chinese medicine that had conflicting views on whether it had any validation.

The chapter on Interactions was good, but again restricted by the cancer topic.

Many chapters did point out that while every decision to prescribe a therapy carries a risk/benefit analysis (*that should be personalised*), the evidence for benefit was not good and the evidence of risk was assumed by self-prescribers to be non existent.

As an introduction to the topic where the quality of the evidence shows a wide variation, the reviewer would have preferred to see a chapter on placebos – there being only brief allusion to it in a few of the chapters.

Some of the data presented were based on small numbers.

The cover blurb describes the book as well referenced, while this may be true for some chapters it is not universal. One chapter repeatedly referred to an unpublished paper, another used a 1992 reference to support a statement on current state of the art practice.

In summary the reviewer found this book a mixed bag, possibly only of interest to oncologists, probably too narrow for GPs and definitely not a reference for medical students.

Reviewer: Dr Raymond Cook, was a foundation member of the AMA's Complementary Medicines Committee and is a member of the "Canberra Doctor" editorial committee

New App to help track medicines

Patients and carers can now keep an up-to-date easily accessible medicines list with a new iPhone application.

The new Medicines List iPhone app – developed by the National Prescribing Service – allows people to be medicine wise by tracking the brand, active ingredient, strength and dosage of their medicines, including prescription, over-the-counter and complementary medicines.

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- saving personal details, health professionals contact details, and questions;
- tracking a schedule of medicines taken and not taken; and
- emailing and printing copies of the medicines list.

The application can be downloaded free from iTunes or from the App Store. For tips and to learn more visit www.nps.org.au/consumers/tools_and_tips/medicines_list

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