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Commitments in the thrifty season

– by James Churchill, AMSA President

With the Federal Government unrelentingly committed to producing a surplus in 2012-13, next month's presentation of the Federal Budget is shaping up to be a significant event for Australians and their future doctors.

The Australian Medical Students Association (AMSA) represents Australia's 17,000 medical students and has been advocating strongly on a number of issues in the lead-up to this budget.

Specifically, AMSA calls on the Federal Government for a commitment in three clear areas.

First, the Federal Government must commit to maintaining quality in the medical education system. The 2011 Higher Education Base Funding Review found that medical education is under-funded compared to international and domestic benchmarks and at universities across the country, medical schools are feeling the pressure of a funding deficit of approximately $23,000 per Commonwealth-supported student per year.

The Federal Government is unlikely to issue a response to the Base Funding Review until later this year. Given the current fiscal environment, medical students are not holding their breath.

Given this substantial underfunding and the uncertainty regarding budgetary allocations, it's a wonder that there are multiple universities putting pressure on Governments to approve new medical schools. In this budget climate, there should be no new medical schools until the funding deficit in medical education is corrected and unless it can be demonstrated that similar outcomes cannot be produced at existing schools.

Before we begin to talk about additional medical schools and more medical students, Governments must commit to further investment in the clinical training system for sufficient numbers of internships and vocational training places for all graduates of Australian medical schools.

Further, it's critical that the Federal Government commit to programs that support Australia's medical workforce needs. Australia continues to suffer from a substantial medical workforce maldistribution, with numbers of doctors in rural areas significantly lower than in metropolitan centres. Now is the time for a re-evaluation of the efficacy of current rural workforce schemes to ensure that funding is being used in the most efficient manner possible.

Schemes which provide positive rural experiences, support and mentoring for students, such as rural clinical school programs and the Rural Australian Medical Undergraduates' Scholarship (RAMUS) scheme, must be prioritised in the upcoming budget. It's disappointing that in recent questioning, the Federal Government has been unable to commit to ongoing funding of the RAMUS scheme.

If more doctors are to live and work in rural areas, more must be done to address the challenges of rural medical career progression. Programs such as RAMUS and rural clinical schools must be prioritised ahead of other flawed and stigmatised rural workforce programs such as the Bonded Medical Places (BMP) scheme and the "10-year moratorium" on Medicare provider numbers, which applies to international students trained in Australia in addition to overseas-trained doctors.

Finally, the Federal Government must commit to pulling our weight internationally on foreign aid. The Federal Government must be held accountable to its repeated promise to lift the AusAID budget to 0.5% of Gross National Product by 2015-16. It's been recently reported that this promise has come under Government scrutiny in the effort to cut expenditure for a balanced budget.

As one of only two countries increasing foreign aid budgets, the other being the UK, Australia has the opportunity to set a shining example of international responsibility in overseas development assistance. Now is a crucial time in the global push to eliminate extreme poverty; the Government must commit to honouring its own promises on foreign aid.

Medical students will be watching with interest when the budget is handed down on the second Tuesday in May.

2012 AMSA executive.

The State of the Territory

Dr Iain Dunlop

Capturing defeat from the jaws of victory

After six years of development and many millions of dollars spent and many thousands of work hours, the Personally Controlled electronic Health Record (PCEHR) is slated for implementation from 1 July 2012. The AMA has strongly supported the concept. From the outset the benefits were obvious. The PCEHR can help overcome fragmentation of health information, improve the quality and availability of that information, reduce adverse medical events and the duplication of treatments, and improve the coordination and quality of healthcare provided. The profession's main concerns involved accuracy of data, privacy and security and broad compatibility with current office systems.

The AMA has developed the *AMA Draft Guide to Using the PCEHR*, available on the AMA website, to assist doctors to become involved with PCEHR for all the benefits that might flow for their patients. It outlines that the PCEHR belongs to the patient, who retains the right to determine who shall add data to the record and who shall have access. The system will be an opt-in rather than opt-out model. There is advice on dealing with a patient's "authorised representative" appointed for minors or those with a limited capacity to make decisions. Importantly the PCEHR does not replace office medical records. Rather it can have data uploaded to it from those records. In each instance, the data entry activity should be recorded in the doctor's own medical record. There is advice on the medico-legal aspects of PCEHR involvement, introducing practice protocols for staff involved in PCEHR access, and on the IT requirements, including security adequacy.

All this has been developed with goodwill and considerable effort. The launch date of 1 July appeared achievable.

Then came the old 1,2, a governmental combination king hit, that will deter any practitioner from ever choosing to register as a healthcare provider for the PCEHR system.

The quick jab was Medicare's refusal to allocate item numbers to the specific extra work involved in managing a PCEHR, either in the presence of the patient or out of session. The AMA has just released time based AMA items (AA340 to AA343) for preparing and managing a Shared Health Summary for the PCEHR. However Medicare rebates will only be available if the Shared Health Summary is prepared as part of a consultation. That is, that the costs of the service will be absorbed by existing consultations.

The knock out king hit is in the just released legal conditions to be agreed by any healthcare provider organisation/practitioner in registering for PCEHR involvement. Note that the IT systems provider for the PCEHR is the Australian Government. Currently the registration proposal places all risk and liability for system failure and breaches on the healthcare provider and none on the PCEHR systems operator. These will likely be matters entirely beyond the control of the healthcare provider. Further, the agreement provides for enter and search powers to access your premises, access your IT systems, inspect and copy any documentation and interview any employees. Even police require a warrant for these powers. The conditions of registration are so draconian as to deter any practitioner from seeking any involvement in assisting with a patient's PCEHR.

The AMA has protested strongly. As it stands, a good healthcare initiative, widely supported and developed, will never see the light of day due to the short sighted pusillanimous obduracy of some middle level legalistic bureaucrat.

An article on the suggested fees for PCEHR and the AMAs draft guide is included in this edition of "Canberra Doctor".

NRAS and our DHASs

The introduction of the National Registration and Accreditation Scheme was a similar though less extreme example of a good concept loaded with additional and secondary features that threatened to sink it. All agreed on the value of a national database of medical practitioners to allow cross border service and transparency of conditional registrations and disciplinary findings. Now, despite greatly increased premiums, our DHASs (Doctors Health Advisory Services) are at risk and there is minimal transparency on how our registration fees are used.

There is an article on pages 8-9 regarding our submission to the MBA on funding these services.

Sustaining our developing Health facilities

Despite the national turmoil and immediacy of hot issues to be addressed, it is salutary to reflect that our Territory has achieved a great deal in the last several years. We will have a new, north Canberra subacute hospital, probably on the University of Canberra site. The Women's and Children's Hospital is nearing completion and work is well advanced on the new cancer centre and adult mental health unit. Given the unique nature of the ACT's single tertiary referral hospital, we must receive a premium on the national efficient price for hospital services that is being developed at present under the NHHR agenda. Otherwise our services risk being significantly underfunded.

Contracts and Agreements

Meanwhile negotiations for the Salaried Medical Practitioners Enterprise Agreement are being finalised and a new round of VMO Contracts negotiations is about to begin. The process and timing will be affected by the ACT local elections in late 2012 as we cannot negotiate with a prorogued government and public service.

AMA(ACT) Board changes

I congratulate Drs James Fergusson and Toby Angstmann on their election to the AMA(ACT) board. I expect that these will become effective at our AGM on 16 May. I encourage all members to attend the AGM, an early evening meeting where you can contribute to or question our AMA (ACT) activities in the past year.

I would like to acknowledge here (and I'll do so formally at the AGM) the contribution of the retiring directors – Drs Katherine Gordiev and Michael Falk. I'd also like to acknowledge the ongoing commitment of Drs Andrew Miller and Jo-Anne Benson.

Can I also draw attention to the vacancies on the Advisory Council and invite you to consider getting involved in the direction of your AMA. Further information is on page 7 of this edition.

As I have related above, the AMA is here to inform you of, and protect doctors from, the excesses of government zeal. And through that, build a better health system for all.

Iain Dunlop
President ACT AMA

Personally Controlled Electronic Health Record (PCEHR)

AMA sets its own items for managing a shared health summary and releases its guide for the profession on use of the pcehr system

The AMA has introduced its own items for preparing and managing a shared health summary for the Personally Controlled Electronic Health Record (PCEHR).

AMA President, Dr Steve Hambleton, said that the Government had not created new items for doctors' time and work with patients on the PCEHR and had not allocated any new funding in the Medicare Benefits Schedule (MBS) to cover this new clinical service to be provided by doctors.

"The public announcements from the Government suggest that patients will only get a Medicare rebate if the shared health summary is prepared as part of an existing MBS consultation," Dr Hambleton said.

"GPs are being asked to do more work in their consultations for no reward. We have sought more information and clarification but no formal public response has been forthcoming.

"So the AMA has taken the initiative to give doctors and their patients some certainty by setting items that realistically reflect the time, the work and the expertise required to ensure that shared health summaries are thorough, up-to-date, and useful across health care settings.

"The items provide guidance to AMA members on medical fees for this important clinical service for their patients. It is not a recommended fee. The AMA encourages its members to set their own fees based on their practice cost experience.

"The AMA items are time-tiered and can be billed in addition to any consultation that is provided to the patient on the same day.

"The AMA is a strong supporter of the PCEHR and the benefits for patients and the healthcare system – but we have to get it right the first time," Dr Hambleton said.

The AMA items for preparing and managing a Shared Health Summary for the PCEHRare as follows:

Background:

While the Government has acknowledged that preparing the Shared Health Summary will require extra work for the medical practitioners who take on this role, it has not said that separate Medicare rebates will be available to assist patients with the costs of this medical service.

At this time, Medicare rebates will only be available if the Shared Health Summary is prepared as part of a consultation. In other words, the costs of this service will have to be absorbed by existing consultations.

The Shared Health Summary is a key feature of the PCEHR. It is also a new clinical service for medical practitioners that will need to be factored into current clinical practice. It is appropriate for medical practitioners to raise separate charges for it.

AMA draft guide to using the PCEHR

The AMA has produced a draft guide for doctors on how to use the personally controlled electronic health record (PCEHR), which is due to commence implementation from 1 July 2012.

In the President's introduction to the draft guide, Dr Hambleton writes:

"The PCEHR system is a new concept of point-to-many information sharing. We may well expect to receive enquiries from our patients about the PCEHR system and the record itself, and can contemplate which of our patients may benefit from using a PCEHR. We are well placed to provide such advice to them. Patients who have additional needs may have complex arrangements for their care, which may merit increased advocacy in their interaction with the healthcare system and with other healthcare providers. The PCEHR system may provide a significant opportunity for the necessary collaborative care of these patients to be improved.

"The Australian Government is the operator of the PCEHR system. A patient's decision to opt in to the PCEHR system, done by registering with a system operator, will establish a relationship between the patient and the system operator. Consequently, it is the Australian Government which has responsibility for educating the community about the PCEHR.

"The PCEHR system is intended to provide Australian health consumers – our patients – with a prompt electronic system of access to a snapshot of their current health information. It is not intended to replace our own patient medical records which we will need to maintain for our own purposes as we do now. Participation in the system is voluntary for patients, medical practitioners and other healthcare providers. The system design, which will be introduced incrementally, provides patients with complete control over both the health information that is held in the PCEHR, and who can access that information. The AMA supports patients taking responsibility for their own health and recognises that "personal control" of their health information could empower and encourage them to achieve this.

"This Guide has been developed taking account of the information "Concept of Operation: Relating to the introduction of a Personally Controlled Electronic Health Record System" document and the Personally Controlled Electronic Health Records Bill 2011, and after consultation with the Medical Defence Organisations. It provides guidance on the use of a new tool in medical practice, particularly focussing on the areas that are not covered by the Concept of Operations document or draft legislation. The Guide does not set new medical standards or set out to explain the policy or the legislation that underpins the operation of the PCEHR.

Continued on page 4...

AMA Number Fee	Fee Description of Medical Service
AA340 $53.00	Professional service initiated by the patient and rendered by a medical practitioner to prepare and/or manage a Shared Health Summary for the patient's Personally Controlled Electronic Health Record – A service of not more than 15 minutes duration.
AA341 $104.00	A service of more than 15 minutes duration but not more than 30 minutes duration.
AA342 $154.00	A service of more than 30 minutes duration but not more than 45 minutes duration.
AA343 $210.00	A service of more than 45 minutes duration.

Personally Controlled Electronic Health Record (PCEHR) ...continued

...Continued from page 3.

"We expect the Government will provide you with information about your legal responsibilities. In any conflict between this Guide and the relevant law, the law takes precedence.

"The use of the PCEHR system by medical practitioners does carry new responsibilities for you, as decisions need to be made about how to use the tool and what information should be shared via the PCEHR system with other medical practitioners and healthcare providers.

"The PCEHR appears likely to have practical clinical limitations for medical practitioners in patient treatment in respect of the content, accuracy and accessibility of the information in the early phase of the introduction. That said, the system will be what it is. As the PCEHR puts the patient in the "driver's seat" for managing their electronically accessible health information, it could also be a tool for making the patient the "senior partner" in the management of their healthcare. It is for the medical profession to make the best of the system and to influence improvements to it over time.

"This Guide has been written by medical practitioners for medical practitioners. I hope that it will assist you to understand the medical professional responsibilities of the use of the PCEHR system and the record itself and to consider how you might implement the use of the PCEHR in your practice".

The guide will assist medical practitioners to make choices about participating in the PCEHR system and explains how they might use the PCEHR in their day-to-day practice.

AMA President, Dr Steve Hambleton, said the AMA supports patients taking responsibility for their own health and recognises that 'personal control' of their health information could empower and encourage them in this role.

"We accept that the intention is for people to be able to register for the PCEHR from 1 July, but we have advised the Government that there will be very few medical practitioners who will have the capability to interact with the system from that date.

"The AMA would have preferred the PCEHR to be an opt-out system, rather than opt-in, to ensure the success of the system in healthcare delivery," Dr Hambleton said.

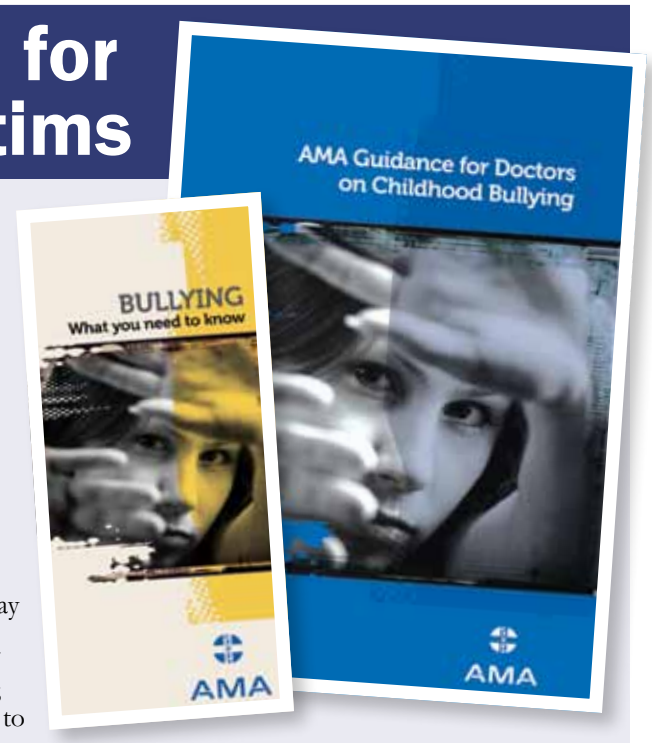
"Nevertheless, the AMA considers the PCEHR will become a valuable addition to quality health in Australia over time and will work with the Government to ensure that the best possible PCEHR is available for patients and health professionals."

The Draft AMA Guide to Using the PCEHR is at http://ama.com.au/node/7648

Public consultation is now open on this site until Friday, 27 April 2012.

The AMA acknowledges the cooperation of the National Electronic Health Transition Authority (NEHTA) in the production of the Draft AMA Guide to Using the PCEHR.

Bullying: guides for doctors and victims



The AMA has released two new practical tools to help raise awareness of child and adolescent bullying and its health effects and to provide sound advice about who people can turn to for help

A brochure for older children and adolescents, Bullying: What you need to know, explains what bullying is, provides specific information on cyberbullying, and gives advice about how to deal with being bullied and how to identify bullying behaviours.

A second brochure, AMA Guidance for Doctors on Childhood Bullying, contains a childhood bullying fact sheet for use by medical professionals who are interested to know more about childhood bullying and its health impacts.

Research from the Murdoch Children's Research Institute found students who were bullied had almost a two-fold increase in the likelihood of depressive symptoms the following year;

- While schools can work towards the prevention of face to facebullying, cyber bullying that happens outside the school setting is an increasing problem;
- Cyber bullying can take a number of forms including sending threatening text messages or emails; circulating untrue, embarrassing or hurtful information by sms, email or social networking sites; emailing or posting altered images; sending a virus or spy ware or taking on someone's identity online and damaging their reputation;
- Cyber bullying can involve a wide audience, the person being bullied may have little or no respite from online bullying, and the person or people doing the bullying may have some element of anonymity;
- According to a January 2012 study by the Ipsos Social Research Institute, of the 24 countries surveyed Australia was the worst place for bullying over social networks, and the fifth for bullying online (this means that Australians were more likely to bully on social network sites like Facebook and Twitter than in chat rooms or on mobile phones);
- A survey conducted by BoysTown found that the most prevalent forms of cyber bullying were name calling (80 per cent), abusive comments (67 per cent), and spreading rumours (66 per cent);
- Recent research suggests that 10 to 15 per cent of students have experienced cyber bullying more than once (experience from the US and the UK suggests that this could increase to 30 to 40 per cent);
- In a survey conducted for the recent Government Inquiry into Cyber Safety, 8.8 per cent of survey participants (15,592) admitted that they had cyber bullied someone else. Of those, 66 per cent reported that they had also been the victim of cyber bullying;
- Research commissioned by Microsoft in 2008 found that 83 per cent of parents did not know what to do if a child was being cyber bullied, and two out of three were unsure of the best ways to help their children; and
- Facebook has introduced tools that aim to reduce cyber bullying (and identify those people who may be at risk of suicide).

Schools and medical practices can obtain hard copies of the brochures by contacting the Federal AMA at mrickard@ama.com.au

Bullying: What you need to know is available electronically at http://ama.com.au/youthhealth/bullying

AMA Guidance for Doctors on Childhood Bullying is available electronically at http://ama.com.au/youthhealth/bullying-guidance-for-doctors

ACT Salaried Medical Practitioners Enterprise Agreement ready for voting

After months of negotiation between the parties (ACT Health Directorate, AMA (ACT), ASMOF ACT and the bargaining agent for the anaesthetists, the draft Enterprise Agreement has been signed off by Cabinet and is available to all medical staff for viewing on both the ACT Health Directorate intranet and website.

This is the first time that AMA (ACT) has been involved in the negotiation process. Previously, the AMA (ACT) was prevented from taking part due to ACT Government policy. The introduction of the Fair Work Act changed this, allowing the AMA (ACT) to represent its salaried members at the negotiating table and provide input into the process. This has resulted in many improvements to the Agreement, some big, some small.

Flowing from the Agreement negotiations, a number of areas were identified which required further discussion. Rather than delay the Agreement further, it has been agreed by the parties that two reviews would be undertaken, and when finalised the outcomes will be implemented.

One review is a review of the JMO structure, to be finalised by 30 June 2012. This review will focus on:

- Catering to the needs of different college training programs
- Contract duration
- Roles of prevocational, basic and advanced trainees
- Outdated technology
- Advancement issues
- Skills and experience requirements

The second review is a review of work organisation, including rostering and on-call arrangements for both JMOs and Staff Specialists. This review has to be finalised within six months of the Agreement approval by Fair Work Australia.

Details of this review will be provided shortly.

A short summary of the more important changes in the new Agreement:

- All employees to whom the proposed Agreement applies will receive a 3.5% pay increase backdated to 18 August 2011 and a further 3.5% pay increase from 1 July 2012 once the Agreement has been voted up by a majority of employees and has been approved by Fair Work Australia.
- Clarified that standard meal breaks are 30 minutes
- Flexible working arrangements for Senior Medical Practitioners extended to allow for approval of 4 day weeks for purposes other than private practice
- Maximum shift length reduced from 16 to 15 hours
- Breaks between shifts now include allowance for reasonable travel time plus 8 hours
- JMOs will be given the opportunity to indicate preferences for the rostering of ADOs, and these will be met unless there are operational reasons for not doing so.
- Mobile phone allowance to be paid to all employees required to be on-call
- Career Medical Officers now entitled to relocation assistance
- The entitlement to paid Maternity and Primary Care Giver Leave has increased from fourteen to eighteen weeks. Clarification has also been added that paid maternity leave is in addition to entitlements under the Federal paid parental leave scheme
- The duration of combined maternity and parental leave has increased to two years per child uncapped, plus additional leave

The AMA (ACT) recommends that salaried doctors vote FOR the Agreement, being comfortable that the outstanding issues as highlighted above, will be addressed by the AMA (ACT) and your colleagues in the next weeks.

Members are encouraged to provide input into the above issues by contacting Andy Ozolins on 6270 5410 or by email: industrial@ama-act.com.au

Boost for rural health with extra specialists trained

Thirty-seven extra anaesthetists and specialists are being trained, with nearly half going to rural and regional areas, thanks to funding secured by the Australian and New Zealand College of Anaesthetists (ANZCA).

The Federal Government funding means 27 more anaesthetists, one pain medicine specialist and nine intensive care specialists are being trained, with more expected over the next three years.

Fifteen of the new training posts are in rural and regional areas.

The training is occuring in an expanded range of settings beyond traditional public teaching hospitals, such as private and rural hospitals.

ANZCA President, Professor Kate Leslie, said the funding was crucial to boosting the numbers of specialists around the country.

"ANZCA has regularly called on governments to increase the number of training positions available and remains ready and willing to provide training for the next generation of anaesthetists and pain medicine specialists," Professor Leslie said.

"We welcome this extra funding which will go some way to increasing the number of specialists, particularly in rural and regional areas."

ANZCA has reached an agreement with the College of Intensive Care Medicine to administer nine intensive care posts on their behalf.

The funding comes from the $390 million commitment announced by the Federal Government to increase the number of specialist doctors in Australia to at least 1010 by 2015 as part of the Specialist Training Program.

The program aims to increase the capacity of the health workforce to train specialists and also to ensure the education reflects the nature of demand and the way health services are delivered.

Part of the ANZCA funding will go to e-learning initiatives, such as podcasts and webinars, teacher training, and international medical graduate specialist support activities.

Book Review: A Dangerous Method

John Kerr, Atlantic Books, London, 607 pages, ISBN 9780857891785, £8.99

This book, upon which the Christopher Hampton play "The Talking Cure" is based, has, via an adaptation of the play, recently been filmed by David Cronenberg as "A Dangerous Method", starring Keira Knightley, Viggo Mortensen and Michael Fassbender. Kerr describes the origins of the psychoanalytic movement through the triangulated relationship between Sigmund Freud, his disciple Carl Jung, and Sabina Spielrein, analysand of Jung. The context is the early twentieth century, as Freud drives to establish psychoanalysis outside of its Viennese Jewish crucible through recruitment of the Zurich-based gentile, Jung.

The machinations of the development of the International Psychoanalytic Association are sketched through the interplay of Freud as the father figure/prophet and Jung as the prodigal son. Within the *weltanschauung* of psychoanalysis intrigue abounds. Through their writing and discussion of psychoanalysis, Freud, Jung and Spielrein intertwine their personal lives, dreams and analyses in a dizzying descent into an inferno of sorts.

First analysed by Jung when she was a medical student, Spielrein qualifies as a physician and trains as a psychoanalyst, becoming Jung's *innamorata*, more realised than Dante's Beatrice, but no less an obsession. Jung, amongst others in the psychoanalytic circle begins to question Freud's insistence that sexuality is the sole basis of psychopathology. As Kerr observes, because Freud's psychoanalysis is not a science, a schism occurs as the Vienna and Zurich groups begin to differentiate. Freud's failure to develop a manual for his therapy and his combativeness towards dissent render psychoanalysis a dark glass broken.

Increasingly estranged from Freud, Jung experiences a psychosis, which thereafter colours development of his psychological theories. It is perhaps not too speculative to comment that Jung's recondite psychological theories of archetypes represent aspects of his outer as well as inner world: Freud (the wise old man); his sense of a doppelganger (the shadow); and Spielrein (his anima). Whilst Jung struggles to recover his persona, Spielrein, who has been fixated on a longed for love-child from Jung, births instead her own psychoanalytic theories with the potential to reconcile the views of Freud and Jung. Ultimately, Jung breaks with Freud, an event from which he incompletely recovers, while Spielrein's work literally becomes a footnote in one of Freud's papers. Kerr shows that Freud's psychoanalytic movement was embedded in the context of his *weltanschauung*, and complicated relationships with his self-analysis, his disciples and their and his analysands.

Kerr quotes William James in the frontispiece to the book: *"I hope that Freud and his pupils will push their ideas to their utmost limits, so that we may learn what they are. They can't fail to throw a light on human nature, but I confess that personally he made on me an impression of a man with fixed ideas. I can make nothing in my own case with his dream theories, and obviously 'symbolism' is a dangerous method."*

Reviewed by Jeffrey Looi, Associate Professor, Academic Unit of Psychological and Addiction Medicine, ANU Medical School

Call for nominations to AMA ACT Advisory Council

Nominations are open for members to nominate for membership of the Advisory Council and close on Wednesday 30 May 2012. Members elected to the Advisory Council will hold office until after the Annual General Meeting in 2014.

The Advisory Council was established to provide a forum for policy development and policy review and to provide advice to the Board on policy matters.

The Advisory Council is advisory in nature only and has no governance or management responsibilities and meets at least four times a year.

The Advisory Council consists of one representative elected by the members of each named craft group as follows.

(i) Anaesthetics;
(ii) Dermatology;
(iii) Emergency medicine;
(iv) General Practice;
(v) Obstetrics & Gynaecology;
(vi) Ophthalmology;
(vii) Orthopaedic surgery;
(viii) Paediatrics;
(ix) Pathology;
(x) Psychiatry;
(xi) Radiology;
(xii) Surgery;
(xiii) Salaried doctors;
(xiv) Medical students (representative appointed by ANU Medical Society)
(xv) Doctors in training; and
(xvi) Physicians.

The current representatives for salaried doctors, pathologists, paediatricians, ophthalmologists, dermatologists, general practitioners, anaesthetists and medical students have indicated a willingness to continue in the role.

Representatives are sought from obstetrics and gynaecology, orthopaedic surgery, psychiatry, radiology, surgery and physicians.

Nomination forms can be obtained from the AMA ACT secretariat (6270 5410) or by emailing: execofficer@ama-act.com.au. For further information on the role of the Advisory Council, contact retiring chair, Dr Andrew Miller.

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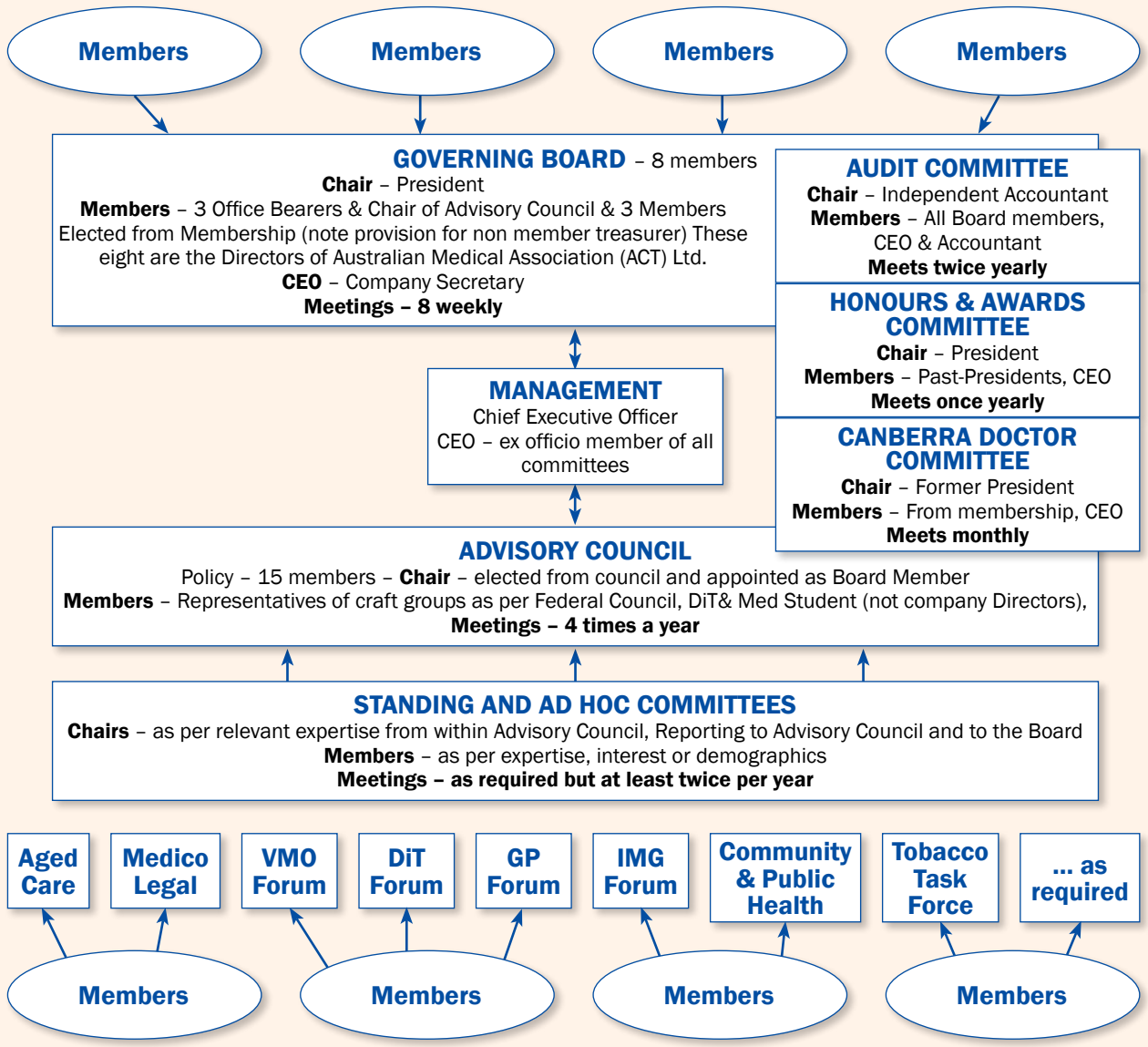
AMA ACT GOVERNANCE STRUCTURE



Medical Board should fund doctors' health services

AMA lodges submission on MBA consultation document

Doctors' Health Advisory Services exist in all Australian States and Territories in various forms and corporate structures. Despite the variety of services, all exist to support colleagues through difficult times before there is impact on patients, family and/or finances. Some models "care manage" the practitioners. Some offer a basic service and receive no funding; others offer comprehensive service and have been funded from the previous State Medical Boards.

The DHAS in the ACT is convened by long-time and respected Canberra GP, Dr Stan Doumani. Stan is supported by a panel of altruistic colleagues who in turn provide support to local members of the medical, dental and veterinary professions and students of those professions. The service provides confidentiality for colleagues using the service.

The AMA has strong links to most existing doctors' health services. State AMAs provide financial and in-kind support for doctors' health advisory services in a number of states and territories and AMA Victoria has a long association with the Victorian Doctors' Health Program (VDHP). In the ACT, the service is supported by, but independent of, the AMA ACT.

In order to provide some certainty for the DHASs, it has been proposed that the Medical Board of Australia fund better access to doctors' health services across the nation.

As a result of discussions with the Medical Board of Australian, the Board released a consultation draft and invited submissions on the issue.

In its submission to the Medical Board of Australia (MBA), the AMA has called on the Board to fund access to DHASs across the country.

AMA President, Dr Steve Hambleton, said the AMA's submission to the MBA highlights the evidence that doctors are at greater risk of mental illness and stress-related problems and are more susceptible to substance abuse than the general population.

"In order to deliver high-quality health care to their patients and the community, and to experience medicine as a rewarding and satisfying career, doctors need to be well," Dr Hambleton said.

"Research has consistently shown that doctors with healthy personal lifestyle habits are more likely to impart healthy behaviours to their patients.

"The experience of existing doctors' health advisory services and the available evidence in the literature supports structured and accessible programs to assist doctors to maintain their health and access appropriate health services.

"This would be good for doctors and patients alike, and it could encourage doctors to engage earlier with high quality care.

"The AMA believes that doctors' health advisory services are in the public interest and, as such, should be funded by the MBA from the existing pool of doctor registration fees," Dr Hambleton said.

The AMA proposes that the MBA provide funding for existing doctors' health advisory services, which have established networks and strong local knowledge. Prior to the introduction of national registration, the MBA funded services in some States.

While the MBA has a role to play in funding external doctors' health advisory services, funding arrangements must be structured so as to guarantee independence from the MBA and the Australian Health Practitioner Regulation Agency. This is essential if doctors are to trust these services and utilise them at an early stage in their illness.

Medical registration fees have increased dramatically since the introduction of national registration arrangements, so the AMA recommends that these services should be funded from the existing registration fees paid by the profession.

Prior to lodging the submission, the AMA surveyed members to get their views on doctors' health services. Nearly 75 per cent of the 2057 survey respondents agreed that doctors' health advisory services are an essential support for medical practitioners, particularly in times of distress.

There are significant barriers that discourage doctors from accessing health services and these can result in doctors using inappropriate practices rather than seeking formal healthcare. Concerns over confidentiality, the impact on career progression and mandatory reporting would appear to be particularly relevant to the consideration of funding for doctors' health advisory services from fees collected by the MBA.

With this in mind, the AMA proposes a framework whereby the funds allocated to doctors' health advisory services are directed to an independent entity (eg trust), which can distribute funding to individual services according to appropriate guidelines

The proposed entity would be required to have in place appropriate governance arrangements as well as provide proper audited accounts to the Board. It would also be required to publish relevant statistics regarding the operation of doctors' health advisory services that were funded through this entity. It would **not** publish information on individual practitioners accessing doctors' health advisory services and nor would this information be made available to the MBA or AHPRA.

This approach would ensure the independence of such services from the MBA and AHPRA and, just as importantly, mean that they were perceived as being independent. These services would be trusted by the profession and this would encourage doctors to utilise these services, particularly at an earlier stage in their illness.

In response to specific questions asked in the MBA consultation paper, the AMA responded as follows:

Is there a need for health programs?

In order to deliver high-quality health care to their patients and the community, and to experience medicine as a rewarding and satisfying career, doctors need to be well. Research has consistently shown that doctors with healthy personal lifestyle habits are more likely to impart healthy behaviours to their patients. Doctors' health programs are important to facilitate doctors' access to health services, along with the education and research roles some of these programs currently undertake.

The results of the AMA doctors' health survey clearly show that the profession believes that external doctors' health advisory services are a vital support for medical practitioners and that many doctors would access these services if they could not utilise an alternative service. In addition, the survey suggests that many doctors would encourage their colleagues to contact a doctors' health advisory service if they were concerned for their health or wellbeing.

The **AMA position statement on the health and wellbeing of doctors and medical students** highlights that most doctors have an above average health status similar to others in advantaged socio-economic groups. They are less likely than the general population to suffer lifestyle-related illnesses, such as heart and smoking-related disease

However, the position statement also highlights evidence that doctors are at greater risk of mental illness and stress-related problems and more susceptible to substance abuse. Further, depression and anxiety are common among doctors and their suicide rate is higher than in the general population. Medical students also experience higher rates of depression and stress.

Some sub-groups of doctors may be at greater risk of poorer health and wellbeing because of their professional circumstances. These include, but are not limited to:

- doctors working in rural and remote areas with inadequate resources and professional support,
- doctors who work excessive hours and/or are unable to access sufficient leave,
- international medical students and graduates and doctors from non-English speaking backgrounds,
- doctors who work shift work
- Aboriginal and Torres Strait Islander doctors,
- those exposed to blood-borne diseases and other specific occupational risks, and
- doctors who are the subject of medico-legal process such as lawsuits, complaints and inquiries.

In 2008 the AMA conducted a confidential survey of doctors in training regarding their health and wellbeing, with the results published in the Medical Journal of Australia in 2009. Based on ProQOL cut-off points,

- 54 per cent of respondents met the criteria for compassion fatigue;
- 69 per cent met the criteria for burnout;

In addition,

- 71 per cent reported being concerned about their own physical or mental health during the previous twelve months;
- 63 per cent had been concerned about the health of a colleague;
- 5 per cent reported using a doctors' health advisory or

similar service in the previous year; and
- 39 per cent reported that they had self-prescribed or self medicated during the previous year.

The survey also found that fewer junior doctors (66%) have their own GP compared with the general population (80%). Bearing in mind the significant barriers to doctors accessing care, such as those referred to earlier in this submission, there is clearly a need for doctors to be able to access confidential, high quality doctors' health services that promote early access to treatment in a respectful and non-judgemental way.

Preferred model for external doctors' health programs

The MBAs consultation acknowledges that there is significant variation in the existing doctors' health advisory service models across the country. These have been developed in response to local needs and circumstances and, for the most part, rely on volunteers along with a well-developed understanding of locally available services that doctors can be referred to.

The AMA does not agree that a new model should be superimposed over the top of existing arrangements. This would potentially lead to a loss of goodwill among doctors who have supported these services and the loss of understanding of local circumstances and services.

There is significant scope to build on existing services through better and more robust funding arrangements and, over time, move towards a more consistent level of service across the country. Rather than prescribe a particular model, the AMA believes that the funding should be made available to services that meet agreed criteria – with the level of funding being commensurate with the scope of services provided.

The AMA understands that existing doctors' health advisory services support this approach and generally agree that funding principles should encompass prevention, contact services, a network of practitioners prepared to treat colleagues and education. The AMA also believes that geography should be taken into account to ensure that funding arrangements recognise the higher costs that may be associated with providing services in states/territories with more dispersed populations.

The role of the Board in funding external health programs?

Subject to opening comments about the independence of services, the AMA agrees that the MBA has a role to play in facilitating funding for external doctors' health advisory services. In this regard, the profession has a responsibility to ensure that programs exist to assist doctors to access quality health care and the MBA is clearly well positioned to collect fees on behalf of the profession for this purpose.

This view is supported by the results of the AMA doctors' health survey, with only 26 per cent of respondents disagreeing or strongly disagreeing with the proposition that the Board had a role to play in this regard.

The experience of existing doctors' health advisory services and the available (albeit limited) evidence in the literature supports structured and accessible programs being in place to assist doctors to maintain their health and access appropriate health services. This would be good for doctors and patients alike and it could encourage doctors to engage earlier with high quality care. This approach is clearly in the public interest and, as such, deserves the support of the MBA.

Range of services to be provided by doctors' health programs

It is important to stress that doctors' health advisory services should not be seen as an alternative to mainstream health services. As far as possible, doctors should be encouraged to have their own GP and to utilise available services in the health system.

However, acknowledging there are barriers that discourage this, the AMA believes that doctors' health advisory services should offer the following core services:
- triage and assessment,
- referral to appropriate services, and
- the development and maintenance of lists of practitioners who are willing to treat colleagues.

Based on the VDHP experience and the excellent programs delivered in that state, we also understand that some existing doctors' health advisory services also wish to offer case management services and want to be more involved in finding services to assist with rehabilitation so as to support doctors to re-enter/remain in the workforce. The AMA agrees that funding should be available to those services that wish to take up these options. It is also important that funding be available to support the ongoing evaluation of doctors' health advisory services as well as money to support more research in this area.

The above is consistent with the results of the AMA doctors' health survey, with the followings levels of support expressed for specific services identified in the MBA's consultation paper.

Funding the services

From discussions with existing doctors' health advisory services, it would appear that an annual funding goal of around $25 per registered medical practitioner would secure the future of the VDHP and put doctors' health advisory services in other states/territories on a more sustainable footing – enabling them to expand the services that they provide. However, it would appear that a transition to this funding goal would be appropriate, particularly as some services would need time to identify local needs and expand in a gradual way.

The MBA is well aware of the profession's concerns at the significant increase in medical registration fees since the advent of national registration arrangements. The most recent annual report of AHPRA sheds very little light on the MBA's finances and how it spends the funds it receives from the profession. Given that the costs of the transition to national registration should now be fully accounted for, it is unclear as to why the Board is unable to keep fees steady while providing reasonable funding to doctors' health advisory services.

For the Board to justify a specific levy on top of the existing registration fees paid by the profession, it needs to provide more transparent information on the state of the MBA's finances as well as details of projected future surpluses.

The AMA doctors' health survey reveals that, if the MBA agreed to facilitate funding for doctors' health advisory services, doctors believe this funding should come from existing registration fees. Only 15.6 per cent of respondents to the survey disagreed or strongly disagreed with this proposition.

On this basis, the AMA believes funding for doctors' health advisory services should come from existing fees. In this regard, we urge the Board to look at a phased approach where funding for doctors' health advisory services was progressively increased over a two year period, such that it could be more easily accommodated from the Board's anticipated revenue streams including any planned CPI increases – avoiding the need for an additional levy or charge.

In addition, funding for doctors' health advisory services should be specifically detailed in the annual report of AHPRA so that the funding provided is accounted for in a totally transparent way.

The AMA believes that the above proposition would be more acceptable to the profession and would provide for a gradual increase in funding to underpin an informed and orderly expansion of existing services across the country. In the event that the MBA was able to demonstrate that it had no alternative but to increase fees to cover the funding required for doctors' health advisory services, the AMA would be prepared to discuss this further with the MBA, including the appropriate quantum.

The health and wellbeing of the medical profession is a very important issue for the AMA. It is in the interests of the profession and quality patient care that we work to ensure that barriers to accessing health care for doctors are properly addressed and doctors are encouraged to better manage their own health. The AMA position statement on the health and well being of doctors and medical students supports the establishment of a profession funded, nationally available, confidential health program to improve the health and wellbeing of medical professionals.

The AMA is keen to work with the MBA to deliver sustainable funding streams for doctors' health advisory services. This would represent a significant step forward from current arrangements, which in most jurisdictions rely on the good will and voluntary contributions from local doctors.

For further information on the submission, or to obtain a copy of the AMA position statement, contact AMA ACT secretariat on 6270 5410 or email: reception@ama-act.com.au

Retired doctor lectures 'for everybody'

Defeated by an acronym you have come across in a journal?

Don't worry, help may be at hand …

For about seven years Professor John Biggs has been presenting short courses of refresher lectures for retired doctors. Recently Dr Gordon Adler has assisted with the arrangements.

Dr Gordon Adler told Canberra Doctor 'We started out thinking of refresher lectures for retired doctors who wanted to retain limited registration for prescribing and referrals only, but they have become lectures for everybody.'

Potential lecturers who have not been approached and feel they can contribute are invited to telephone Dr Gordon Adler on 6257 8483. Please don't wait to be asked!

Lectures will be held at 10.00 am on Mondays in the First Floor Lecture Theatre of the ANU Clinical School at The Canberra Hospital, commencing in mid-June. There will be no charge for attendance.

Dates, lecturers, and their subjects will be announced in future issues of *Canberra Doctor*.

Dr Gordon Adler.

REMINDER: Do not use CSL Fluvax® for children under five years of age

ACT Government Health

Please note that due to the increased adverse events associated with SCL Fluvax®, particularly febrile convulsions, this vaccine is **not registered** by the Therapeutic Goods Administration for children less than five years of age.

Vaxigrip® should be administered to children less than five years and there is a strong preference for Vaxigrip® to be administered to children aged five years to less than 10 years of age.

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Recommended influenza dosage for children

Age	Dose	Number of doses first year of vaccination	Number of doses subsequent years	Formulation
6 - 35 mths	0.25ml (7.5 µg)	2 doses at least 4 weeks apart	1	0.25ml from 0.5ml syringe - Vaxigrip only
3 - <10 yrs	0.5ml (15 µg)	2 doses at least 4 weeks apart	1	0.5ml pre-filled syringe - Vaxigrip only
5 - <5 yrs	0.5ml (15 µg)	2 doses at least 4 weeks apart	1	0.5ml pre-filled syringe - Vaxigrip only
10 years and over	0.5ml (15 µg)	1 dose annually	1	0.5ml pre-filled syringe - any brand

Please discuss any queries or report any adverse events following immunisation to the Health Protection Service on 6205 2300

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The 6th Annual MUSIC AS PEACE WORK festival is on

Saturday 26 May from 6pm to 10pm at the Canberra Baptist Church and Hall

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We will need some announcers, stage managers, kitchen helpers, and a few general helpers for reception, and some gophers.

We also, of course, need MUSICIANS so if you or anyone at your place has songs or instrumental music to offer, now is the time to:

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Please email doctortango@hotmail.com with offers of general help, music, or with any enquiries.

For more information about the MAPW the website: http://www.mapw.org.au/

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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**

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"Being a Doctor is not something I do, it is something I am"

I am not sure if the same is true for other professions or if this is one of the 'privileges' of being a doctor. What I do know is true, is that when a doctor is unable to work, the effect on every aspect of his/her life is immense. The effect of financial stress on ill health can delay recovery by months and possibly years. Many doctors put off asking for help because they are embarrassed. However, the delay can compound problems, banks can foreclose on mortgages and cars can be repossessed. If being a doctor is something you are, don't delay asking for help. Don't put your career and family in jeopardy.

"I have come to understand rather personally the importance of financial stability for health and wellbeing. The MBA carried us through a critical period of time. We are not completely out of the woods but for now we are on much safer ground than we have been for some time".

The Medical Benevolent Association can provide financial assistance and counselling support for doctors and their families. The Association's Annual Appeal letter will be arriving in your mailbox any day now. Please consider a donation to help your colleagues in need and their families regain some stability. You can donate on line at www.mbansw.org.au or by contacting the Finance Officer on (02) 47392409. The Council of the Medical Benevolent Association wisely carries the heavy burden of ensuring that doctors in need receive the support they need.

If work pressure, financial stress or ill health are occupying your mind, or you are concerned about a colleague, please contact the Medical Benevolent Association of NSW, through its Social Worker, Meredith McVey, either at www.mbansw.org.au or by telephoning (02)99870504. All discussions with Meredith are confidential.

Please give generously to the Medical Benevolent Association Annual Appeal and remember that the Medical Benevolent Association is available to doctors in ACT.

MEDICAL BENEVOLENT ASSOCIATION OF NSW

AMA position statements on genetic testing and human cloning revised

The AMA has updated and split the content of its *Position Statement on Human Genetic Issues 1998. Revised 2000. Revised 2002.* to produce the AMA *Position Statement on Genetic Testing 2012* and the AMA *Position Statement on Human Cloning 2012.*

The AMA *Position Statement on Genetic Testing 2012* is more contemporary and reflects current issues relevant to genetic testing.

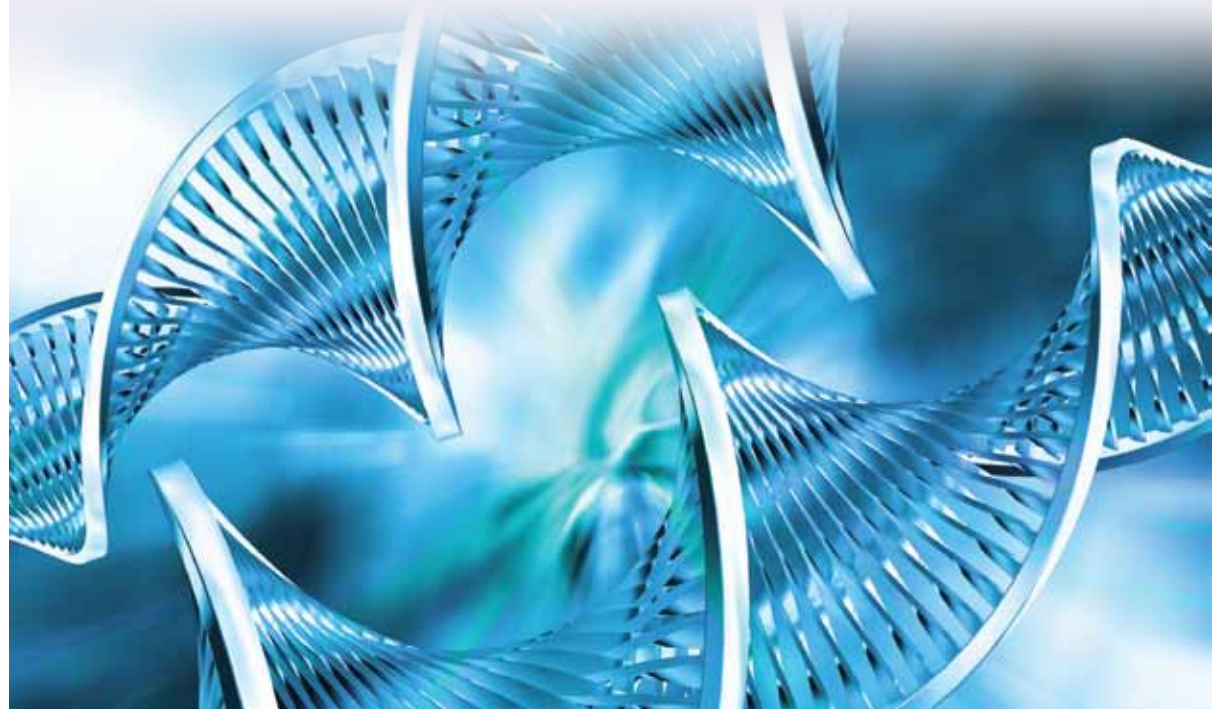
The AMA *Position Statement on Genetic Testing 2012*:

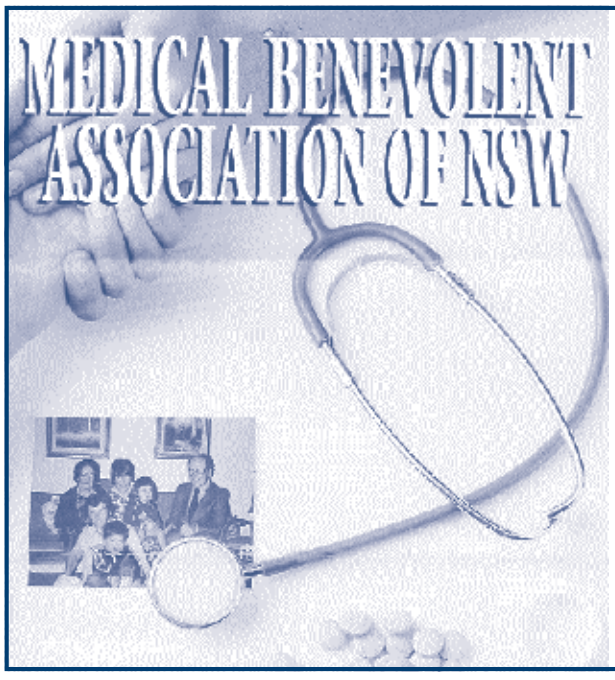
- recognises that genetic testing is now increasingly part of mainstream health care;
- provides greater detail on the types of genetic tests currently available;
- advocates for appropriate education and training of the medical (and other health care) professions on the clinical and social issues related to genetic testing;
- advocates for a sufficient workforce and infrastructure to support the use of genetic testing in mainstream health care;
- recognises the role of genetic support groups and community organisations;
- recognises the uncertainty around incidental findings – including the need for appropriate call back;
- addresses direct-to-consumer genetic tests;
- promotes the need for public education and awareness campaigns;
- maintains the AMA's position on gene patents; and
- maintains the AMA's position on genetic selection ('eugenics').

The AMA Position Statement on Human Cloning 2012 retains the existing AMA policy of opposing cloning for the purposes of creating a human being (reproductive cloning), while permitting cloning for other (non-reproductive) purposes (eg., cloning of human tissue for therapeutic purposes).

The AMA *Position Statement on Genetic Testing 2012* is athttp://ama.com.au/node/7663

The AMA *Position Statement on Human Cloning 2012* is athttp://ama.com.au/node/7664





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The Association provides a counselling service and financial assistance and is available to every registered medical practitioner in NSW and the ACT.

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☐ Specialist Practice

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Other Relevant Information (including languages spoken): _____

_____

AMSA warns of impending internship

AMSA President Mr James Churchill has said that the sharp and sustained increase in numbers of medical graduates is putting significant pressure on the clinical training system.

Mr Churchill said that the just-released 15th report of the Medical Training Review Panel shows that 3,512 medical students will graduate from Australian universities in 2012, which is more than double the number of graduates in 2006.

"This confirms the mismatch between the numbers of graduating doctors and the available internships," Mr Churchill said.

"Urgent action is needed from all governments to avert a genuine medical internship crisis.

"Internship is a critical hurdle to obtain full registration as a medical practitioner and to progress to further training. This year, there is a real risk that medical graduates will miss out on an internship, leaving young doctors out of work and unable to serve the community.

"In addition to a potential shortage of internships, we are now also facing serious threats to the quality of training provided for interns. With graduate numbers surging, it is becoming increasingly difficult to ensure that all trainees receive the high quality teaching and supervision necessary to equip them with the skills Australians expect from their doctors.

"State and Federal Governments must ensure that all graduates of Australian medical schools are able to complete a quality internship and, beyond this, are able to progress through further medical training.

"Ultimately, if medical graduates are not able to complete a high quality internship, the ongoing increases in medical student numbers will have been a fruitless waste of taxpayer dollars," Mr Churchill said.

Despite the internship crisis, the total number of medical students remains unregulated. AMSA continues to call for a coordinated national system of regulation that uses robust data to ensure student numbers are tailored to meet Australia's health needs.

AMA plan to bolster the rural medical workforce

AMA Position Statement on Regional/Rural Workforce Initiatives 2012

The AMA has released its *AMA Position Statement on Regional/Rural Workforce Initiatives 2012*, which sets out a practical achievable plan to attract doctors and medical students to live and work in rural and regional Australia.

AMA President, Dr Steve Hambleton, said that the AMA has for some time identified medical workforce shortage as a major health issue, particularly in regional and rural Australia.

Dr Hambleton said that, while the Government had made additional investments to encourage more locally trained doctors to work in these areas, rural and regional communities are still overly reliant on international medical graduates (IMGs) to fill workforce gaps.

"The *AMA Position Statement on Regional/Rural Workforce Initiatives 2012* builds on earlier AMA work in this area and identifies possible solutions to help attract and retain more doctors to regional and rural areas.

"We outline a range of factors that influence doctors to choose to work in regional and rural areas and offer a range of solutions that would relieve current pressures and entice more doctors to work outside metropolitan areas.

"We also address undergraduate, post-graduate and continuing education.

"Remuneration issues are raised, along with a range of other influences such as hospital and general infrastructure, family support, and rostering and locum services.

"The specific needs of IMGs are also covered."

The Position Statement highlights five key priority areas for Government policy development that would help attract medical practitioners and students to regional and rural areas. The AMA urges the Government to:

- provide a dedicated and quality training pathway with the right skill mix to ensure GPs are adequately trained to work in rural areas;
- provide a realistic and sustainable work environment with flexibility, including locum relief;
- provide family support that includes spousal opportunities/employment, educational opportunities for children's education, subsidy for housing/relocation and/or tax relief;
- provide financial incentives including rural loadings to ensure competitive remuneration; and
- provide a working environment that would allow quality training and supervision.

The Position Statement also highlights the significant ongoing concern at the way in which the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) is being applied to determine the distribution of financial incentives.

Dr Hambleton said that the AMA welcomes the fact that more areas are eligible for incentives, but the current ASGC-RA system is resulting in perverse outcomes in some situations.

"A proper ASGC-RA review is needed to sort out these problems."

Dr Hambleton said that the Position Statement has been sent to the Minister for Health and Ageing, Tanya Plibersek.

"Our Position Statement contains practical solutions that are based on local needs, local thinking, and local realities.

"We urge the Government to give it serious consideration," Dr Hambleton said.

The *AMA Position Statement on Regional/Rural Workforce Initiatives 2012* is at http://ama.com.au/node/7681 [1]

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