Canberra DOCTOR

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AMA Family Doctor Week 2012

For a lifetime of trusted care

Celebrating our GPs

Tterritory topicals – from President, Dr Andrew Miller

Dr Andrew Miller

Casualty Statistics

Mercifully the recent political stoush over the doctoring of Emergency Department statistics at Canberra Hospital appears to be abating. In all of the heat the real casualties of the affair appear to have been overlooked; I refer of course to the staff of A&E. Not a single patient's care was compromised throughout. The Auditor General's report makes interesting reading.It is clear that the EDIS software used in A&E is not subject to adequate governance and security controls. It is also apparent that the staff feels that their working environment is dominated by influences out of their control. Nevertheless the department's performance is being judged by a number of externally determined arbitrary measures. Conformance with these measures is to be rewarded with increased funding. It is easy to understand the despair and disempowerment that some may feel.

The AG's report also listed numerous historical abuses; in the UK the introduction of the 4 hour rule led to "distortion of clinical care, gaming and widespread manipulation of data"; and the Victorian AG has previously reported instances of data manipulation in Emergency Departments, many as it happened using EDIS.

The AG's report shows that presentations to A&E departments in the ACT have bucked the national trends by increasing faster than the national average, and indeed faster than the ACT population. I would like to be able to report that resources available to the departments have increased in parallel.

The NHS introduced the 4 hour rule in the UK in 2004 in an attempt to reduce Emergency Department crowding and waiting times. A review of the data shows that through-put did indeed appear to improve if the proportion of patients departing before the 4 hour cut-off was used as the sole measure. Closer scrutiny of the data revealed that the proportion of patients leaving A&E in the last 20 minutes prior to the 4 hour cut off increased significantly. The time to clinician attendance improved minimally and the adjusted mean stay actually increased (Mason et al; Ann Emerg Med 59(5): 341). The authors drew the conclusion that imposition of time based targets is counterproductive. Whilst the National Emergency Access Target to be adopted in Australia is a somewhat paler (90% in 4 hours) version of the hairy chested NHS target of 98%; this dilution of target doesn't make up for the lack of unequivocal evidence showing a clinical benefit. After prompting from cross-disciplinary organisations including the College of Emergency Medicine and the Royal College of Nursing the NHS has stepped back from the 4 hour rule and introduced a dashboard of quality indicators for assessment of A&E performance. The AG in her report has drawn the same conclusion.

If this approach to funding sounds a familiar note, it's not dejavue, you are recalling the next phase of the national hospitals funding reform which ties Commonwealth funding for our entire hospital system to activity measures compared with an arbitrary national standard.

Family Doctor Week

This issue celebrates Family Doctor Week 2012. Steve Hambleton, AMA Federal President and proud GP writes of the rewards of general practice; and of the pivotal role that GPs play in helping Australia attain its health care goals. Other subjects canvassed in the issue include the future of general practice; and undergraduate, postgraduate and vocational training in general practice.

It is a long time since I practised as a GP, and I have observed over the years how much things have changed. Then a GP was by default the family doctor; small groups or single practitioner practices were the rule; and whilst some doctor and venue shopping undoubtedly occurred, almost every one could identify their "medical home".One of the characteristics of health care is that everyone has a theory; and be assured that theories abound about the way the profession can do their job better. However nothing can mount an effective argument against the importance of having a primary care physician familiar with your health and circumstances. In recent years we have seen a consolidation of practices, largely driven by corporate providers. In this issue Suzanne Davey and Helen Toyne give their views on the impact that this transformation has wrought.

Of course there is another elephant in the room; the super clinic phenomenon. The AMA has contrasted it with the Primary Care Infrastructure Grants Programme showing that whilst the former has proven to be an expensive drain on the public purse, the latter is helping general practices to grow and enhance their services. The AMA has consistently echoed the calls of general practitioners for the resources pushed towards the super clinic program to be made available to all general practitioners. Through years of discounted indexing of the MBS successive governments have made the traditional fee for service model increasingly non-viable. Instead "carrot" programmes (PIP's) have substituted as sources of income for practices to help offset the increasing cost of providing services. And the GPs' ultimate reward for complying with these programmes has been to have them snatched away with no consultation and little warning. Instead more hoops, more paperwork; and all the time the possibility of a super clinic parachuting in down the road, establishment costs all paid up. Brian Morton, Rashmi Sharma and Ian Pryor all discuss the importance of advocating for our profession.

Advocacy?

This advocacy role is all too easily usurped. We see an increasing number of concerned opinions telling us that doctors are overworked; A&E is overworked; GPs are overworked; specialists (even dermatologists) are overworked. The solution we are told is to reduce the time we "waste" seeing routine low priority presentations. These advocates say they will relieve us of tedium and make health care more efficient. What a splendid vision of my future years of practice. Imagine every patient difficult, challenging, complex. Only someone who has no conception of the stresses and strains of a job would ever advocate that it could be improved by taking away those brief mundane moments when we get to draw precious breath. The debate about task substitution is as vigorous as ever. We see it here in Canberra with the continued government funding of the walk-in clinics and their proposed expansion.

I have formed the view, talking to colleagues across the territory, that we all love our job – but that we feel that we have lost the ear of the policy makers. Whilst we may be pricked by a secret pride if our children should decide to follow us in our career, we cannot help a feeling of apprehension for their professional future.

I hope that all of us would take a little time to consider ways we may become involved in advocating for our profession and for quality health care as we join together to celebrate the life giving role of the family doctor.

General practice – the greatest job of all

writes AMA President Dr Steve Hambleton

I love being a GP.
I doubt there are many other jobs that could give you the same amount of job satisfaction or emotional reward.

Every day we have the honour, the privilege, the trusted position to help families with their health and their wellbeing

We help mothers prepare to give birth, we check their new babies, we immunise young kids, we treat the battle injuries that little warriors have endured from weekend sport, we advise teens on drugs and alcohol and sex education, we help people stop smoking or lose weight, we help people control chronic conditions, and we treat and comfort the sick and dying – we are there for people and families throughout their lives.

There is joy, humour, sadness and tragedy – the whole human experience. I would not change it for the world.

General practice is the engine room of primary health care. GPs are an intrinsic part of each and every community in Australia. We are part of the family furniture.

So why do governments take us for granted?

There is overwhelming evidence that when people are sick or injured or want good health advice, they want to see a GP.

We hear kind words from politicians that they see us as the cornerstone of the health system, but their actions tell us other things – bad things.

At a time when general practice should be getting more support, we get more hurdles instead. We get praise, then we get penalised.

It seems that every time the Federal Government needs to trim the health budget it is GPs who

have to offer up the savings. It is happening too often to be a coincidence. Just look at recent decisions.

The 2012 Budget cuts to Practice Incentive Payments (PIP) to GPs – totaling $83.5 million over four years - will have a significant negative impact on the health system and on general practice.

They will penalise GPs for not meeting new higher targets for cervical cancer screening and specialised diabetes care, and they remove incentives for immunisation.

The decision to discontinue the GP Immunisation Incentives Scheme is a public health risk of the highest order.

Australia is a world leader in childhood immunisation rates but this decision could undermine that reputation and undo a lot of hard work by parents, GPs and other health professionals who promote the importance of immunisation in the community and in schools.

Similarly, there was no consultation on the increase in targets for the PIP Cervical Screening Incentive and the PIP Diabetes Incentive, and this will put the brakes on successful prevention and care programs that are helping thousands of people.

These cuts are a big hit to general practice and quality patient care.

They follow cuts in recent Budgets to joint injection rebates and mental health rebates, the loss of Medicare practice nurse rebates, earlier cuts to the GP Immunisation Incentives Scheme, and the imminent loss of the after hours PIP.

These measures, along with changes to the e-health PIP, have the potential to pose serious public health risks and undermine successful preventive health programs that are providing health benefits to many Australians.

These cuts go against the Government's stated objectives of championing preventive health and being a world leader in electronic health.

They also place an even greater burden on the engine room of the Australian health system – hardworking GPs in suburbs and towns across the country – by making their practices less viable.

To make things worse, the Government introduced a requirement that general practices must choose to participate in the Personally Controlled Electronic Health Record (PCEHR) system if they are to continue receiving e-health PIP funding.

This is not a requirement - it is a threat. And it comes on top of the Government's failure to provide any new funding for the new clinical service that GPs are being asked to provide in helping patients prepare a shared health summary as part of the PCEHR.

This double whammy represents a substantial roadblock to the effective implementation of the PCEHR and threatens Australia's efforts to be a world leader in e-health.

GPs are the public face of the health system. GPs are trusted and respected by their patients and their communities. They are the lifeblood of the system.

Sadly, the valuable service provided by GPs is undervalued and under-appreciated by the Government. GPs are being asked to do more – much more – for less.

Australia's general practice workforce is understandably becoming demoralised. Morale is low.

The Government must start supporting our hardworking GPs before it is too late. They are propping up the health system, but for how much longer?

We love our job. We love our patients and we love serving our communities. But we cannot just sit back and continue taking the hits.

Family Doctor Week is a celebration of general practice. It is about looking to the future of our profession with optimism.

The Federal Government must start to appreciate and respect and trust general practice. It must support general practice and make us stronger to meet the future primary care needs of our communities.

If the Government does not act soon, Family Doctor Week in future years will be a sentimental reflection of better times when GPs could do the job they love, free of red tape and bureaucratic hoops and draconian cost cutting measures that make general practice unviable.

Dr Steve Hambleton is a Brisbane GP and President of the AMA

Personally Controlled Electronic Health Record (PCEHR)

President, Dr Steve Hambleton's recent letter to AMA member GPs is published for the benefit of the whole general practice community.

"The Government has (softly) launched the Personally Controlled Electronic Health Record System (PCEHR). Many members will have followed recent media coverage on 'what's ready and what's not' for the PCEHR system.

In the absence of practical information from Government, I have listed below steps that the AMA considers medical practices will have to undertake before they can begin to use the PCEHR:

- Get a Healthcare Provider Identifier - Organisation (HPI-O)
- Purchase and install Individual Healthcare Identifier enabled software and put in place administrative protocols to conform with the Healthcare Identifiers legislation
- Purchase and install a secure messaging system
- Purchase and install PCEHR software
- Decide how to use the PCEHR in the practice and put in place administrative protocols to conform with PCEHR legislation
- Train staff and medical practitioners in the practice
- Check indemnity cover and if necessary acquire practice insurance
- Consider/sign the PCEHR participation agreement
- Review costs of implementation, and cost of handling patient enquiries about the PCEHR
- Implement new fees to cover costs

In this list you will see that signing the PCEHR participation agreement comes towards the end, with many steps to cover first.

Your AMA has been working hard behind the scenes to ensure that the PCEHR participation agreement has a much better balance of obligations between Healthcare Provider Organisations (medical practices) and the PCEHR system operator. Successful implementation of the PCEHR system is absolutely dependent on the cooperation and willingness of medical practices and medical practitioners - it is important that this is recognised through a better sharing of the risks between the system operator and practices.

Members should not feel any pressure to sign up to the PCEHR. You should implement the PCEHR in a way that suits your practice and at a time of your choosing.

On the AMA website the PCEHR landing page provides AMA members with practical and useful information to assist medical practices to understand what they will have to do to become PCEHR ready. It also provides information and links to help you through each of the steps listed above. Over the coming weeks it will be updated as more information becomes available.

Dr Steve Hambleton
Federal AMA President"

The AMACGP: GPs voice

Dr Brian Morton, Chair of the AMA CGP writes for Canberra Doctor.

Over the past 12 months, I earned 890 Qantas status credits which I would have liked to have reflected exotic travel in at least Business Class. The reality is far more sobering as the most frequent flight has been to Canberra on cheap fares worth 10 credits each way; you can do the maths as to the number of flights.

On the morning of the After Hours Technical Working Group, having beaten the Canberra fog by arriving the night before, I woke at 4am to do a live radio (ABC National) interview and call back about antibiotic use. Now most of my friends remain incredulous that I could be awake at that time let alone be lucid to answer callers' questions. AMA spokespersons make themselves available to promote, advocate and safeguard the centrality of the medical profession in health care.

If you the reader are a GP you will know the expertise of a GP is both broad in discipline and knowledgeable in detail. GPs are a trusted voice in health and advocacy in the community and the AMA recognises and supports this paradigm in health with a powerful and authoritative status recognised by the community.

There is no other national organisation in health that represents GPs with an independence and honesty befitting the skill and training of all GPs.

The AMA Council of General Practice (AMACGP) guides AMA policy and direction and does so through representatives from each State bringing a diversity of opinions that reflects the makeup of general practitioners in Australia.

Did you know that the red tape reduction of the streamlined PBS authority prescription process was an AMA initiative? The government's decision to dump its capped arrangements for the care of patients with diabetes was also due to the advocacy of the AMA. Time and again AMA principled argument wins through the views of conflicted opposition.

The AMACGP developed policy which has acknowledged the reach of Medicare Locals and their need to support GPs in managing and coordinating the care for patients in accessing services in the community. The provision by GPs of 120 million services each year must be recognised in the governance structure of Medicare Locals by a preponderance of the highest trained practitioners in the primary health care setting, GPs, being Board members.

Advocacy for GPs and patients is often quietly progressed through AMA submissions to Government and participation in many government working groups and committees. GP ordering of MRIs for under 16 year olds will begin in November 2012. Infrastructure grants for GP practices; expansion of prevocational and vocational GP training places; delaying government changes to afterhours funding arrangements and contributing to the development of the DVA Coordinated Veterans Care Program, all evidence effective wins for General Practice.

As well as advocacy, the AMA provides practical solutions for its members. Most recently, the AMACGP has been instrumental in the development of the GP Desktop Practice Support Toolkit, which members can download from the AMA website and place on their desktop. Links to 300 commonly used practice tools and guidelines are available to support patient management during the consultation.

There are a number of spectres of concern for General Practice for which AMA and the Council of General Practice is applying policy. Our PCEHR position has been consistent and persistently lobbied to government. We support the PCEHR but the work involved must be adequately remunerated. Preparing an accurate and reliable Shared Health Summary requires medical expertise, is a distinct clinical service and will take time with the patient. Budgetary changes to the PIP were made without consultation with the profession and our opposition to this lack of principle by the government have been vociferously voiced.

It's an interesting observation that in the public eye the only organisation recognised as representing the medical profession is the AMA. When the veracity of a Medical Certificate issued by a GP was questioned in Parliament, the AMA was asked and answered unequivocally.

The AMACGP is not just about lip service; it's about representing the interests of general practitioners so they can continue to provide patients with a lifetime of trusted care.

Dr Brian Morton is a Sydney GP and chair of the AMA Council of General Practice

General practice in Canberra in 2012 – Where to from here?

asks Canberra GP, Dr Suzanne Davey

Over the last decade we have seen demographic and social changes in the nature of general practice and the population it serves.

In Canberra, general practice has not changed accordingly. Therefore, there needs to be a better match between the needs of individual general practitioners and the needs of their patients.

There are several factors to be considered. Medicine has seen continuing feminisation of the work force, with up to 60% of medical students being female in some universities.

According to HWA statistics for 2010, 40% of GPs were female. In 2010, employed male medical practitioners worked an average of about 46 hours per week (41.6% worked more than 50 hours per week) and employed female practitioners worked about 38 hours per week (22.3% worked more than 50 hours per week). The average age of male employed medical practitioners in the ACT in 2010 was 48 years and females 42.3 years. Interestingly, the proportion of employed medical practitioners over the age of 55 years was 25.1% in the ACT.

When compared with 2006 HWA figures for the ACT, 2010 figures showed an increase in percentage of female practitioners, a decrease in average age of both male and female practitioners, and yet an increasing percentage of the workforce working beyond the age of 55 years.

When the "baby boomer" generation of doctors eventually retires, many of whom are used to working long hours, the average age of doctors may be expected to decrease more markedly and with it presumably the average weekly working hours of doctors will decrease accordingly.

Here in the ACT, we have seen the growing dissatisfaction of GPs working as principals in small practices because of the arduous responsibilities of running their own practices.

Many doctors have thus preferred to join a corporate structure. With the growth of corporate practices, we have seen much greater access to GPs because these practices are open much longer hours than the average private practice. However, the chance for an individual patient to develop a relationship with one particular GP is greatly reduced. The structure of these large corporate practices is more suited to episodic medical care rather than to preventative holistic care, where training of the new generation of medical students and GPs is also catered for.

At the same time, the needs of patients have also changed. The family unit that includes a stay-at-home mother of school-aged children is a thing of the past. Both male and female patients want to be seen after standard working hours and they want their children to be seen after day care or after after-school care hours.

In my opinion, the best way to marry the needs of the new generation of GPs who want reduced working hours and reduced administrative responsibilities, with the needs of patients who want a GP whom they know, to be available for after-work consultations, is the medium sized general practice open for longer core hours.

If the core hours for a practice were 8am until 8pm, split into 3 sessions per day instead of 2, then more GPs could work shorter working hours. Patients could then develop a relationship with a number of GPs within the practice.

With more GPs available to be practice principals because their needs for shorter working hours were being met, the administrative load could consequently be shared between more people, including the teaching load of students and GP registrars. Practice nurses would continue their very important role in this style of practice.

The state and federally funded government infrastructure grants are helping to make this model of practice more financially viable. Hopefully in Canberra there will be a bigger pool of GPs available as more doctors graduate from the ANU Medical school. Of course the corollary of this plan is that it is our responsibility as the current generation of GPs to take on the training of these graduates as students and registrars to encourage them to become general practitioners in the first place, and then to hopefully stay on in the ACT.

References available on request.

Dr Davey is a general practitioner in Kambah and is the chair of the AMA ACT GP forum and represents ACT GPs on the AMA Council of General Practice

AMA supports general practice – two new GP tools

A general practice landing page on the AMA website

A new landing page is now on the AMA website devoted to GP issues (http://ama.com.au/general practice).

It will updated regularly and brings together in one convenient place all the relevant submissions, resources, articles, press releases etc related to general practice.

It also articulates the current AMA advocacy issues and some of its recent advocacy wins on general practice.

The GP Desktop Support Toolkit

The AMA Council of General Practice (AMACGP) has developed a free GP Desktop Practice Support Toolkit for members (which was launched recently), a one-stop shop for commonly used practice support tools for general practitioners.

The GP Desktop Practice Support Toolkit has links to about 300 commonly used administrative and diagnostic tools. It will help reduce the time GPs spend locating relevant tools for administrative and diagnostic purposes.

It is available free for AMA members and can be easily accessed via a link on the GP landing page and can then be placed on a GP's desktop.

The toolkit is divided into 5 categories/tabs:

1. Online practice tools that are accessible and/or can be completed online;
2. Checklists/questionnaires in PDF that are available in PDF format and can be printed;
3. Commonly used forms that are available in PDF and can be printed;
4. Guidelines (relevant administrative and clinical guidelines); and
5. Information and other resources (relevant reference materials).

State/Territory specific tools such as forms for WorkCover, S8 prescribing etc, have also been included in the State/territory specific tabs.

The AMA will update these links regularly and/or when new information becomes available. New links/tools will be added as they are identified.

Instruction on how to access the toolkit are available in the **member only** area of the AMA Website (www.ama.com.au/node/7733). This will require members to log in to the AMA website on a one off basis, following which he/she can access the Toolkit via his/her desktop. The page also contains instructions on how to find particular information/tools available in the toolkit.

To join the AMA contact Sue Massey at AMA ACT on 6270 5410 or by email: membership@ama-act.com.au

What's driving your car finance?

Conventional wisdom has it that if you want to finance a new car you have three options: roll it into your home loan to ensure you get the lowest rate you can, get a finance deal from the car dealer; or get bank finance. But there is one thing all three traditional options have in common: they are more about the car than the client.

That's where Investec differs from other finance providers, says Andre Karney. "We are more about our client, so we'll look at the client rather than the car."

For example, says Karney, what may at first seem like an attractive option—bundling the car loan up with a cheaper loan, like a mortgage—is probably not a good idea. "Definitely never roll up with all your other loans," he says. "We can do all sorts of loans for individuals, but it's not in your interests to merge a car loan and a mortgage, for example—you want to be able to identify the loan for tax deductibility and you want to match the loan payoff to the life of the asset you are buying."

Effectively, merging the loans suggests the car is a similar asset to the mortgage, where even a bit of scrutiny will confirm for you that's not the case.

"When you're buying a car, you're buying a depreciating asset," says Investec's Barry Lanesman. "A lot of people will borrow or redraw an extra $60,000, and believe they'll get a benefit from only paying their home mortgage interest rate. But that plan only works if you're very disciplined about paying it off every month. Most people aren't, so might not realise the savings they planned".

"A car loan is an instalment loan, and with instalment payments you're reducing the principal and the interest. Unless you put that full amount into your mortgage every month, you end up paying more interest even though you think the rate is lower. Also, a home loan is generally variable interest rate, so if the rates go up it can wipe out any savings you make."

Lanesman says what you should be focussing on is the most effective structure for financing the vehicle, something your accountant can advise you on, and Investec can outline the options for you to consider. "You have to consider arranging a lease, asset purchase or chattel mortgage," he adds. "You don't want to tie up your finance and your purchase through the car dealer because they're two different transactions, each requiring two different sets of expertise – put another way, would you buy a car from your personal banker?"

Car dealers may seem to offer an attractive, and easily available option, but as Karney points out, "the car dealer wants to sell a car. He's about the extras, getting you a more expensive model and so on. He's less interested in the right financial fit for the client".

"Car dealers are happy to do all sorts of different structures so the monthly repayment looks good. So they'll say for an extra $80 a month, you can get the next model up, for example—they're using the finance as a tool to sell more."

Investec's core values—and the values of the people working at Investec—means that's not an issue if you source your finance from them. "We're independent, and we're looking out for our clients' interests," says Karney. "If something's not right, I'd rather not do it because that's not looking after people, which is critical to our core philosophy. As doctors care for patients, we care for our clients."

Karney points out that the process of applying for a car loan with Investec is simple for medical professionals (and even simpler for existing clients): "Doctors and dentists, up to certain levels obviously, only have to provide basic information to us and they can get what amounts to an instant approval. As long as they're qualified and have a good credit record, off they go. There are no forms to fill out. We will go and visit the clients and run through the options with them on a personal basis. And just those things, simplicity, ease, and personalised access, set us apart."

While the point about independence is true of any bank, the downside of sourcing finance from one of the large commercial banks is that they limit your options to fit what suits them.

"When it comes to second hand cars, a lot of other banks won't finance them, or they will put a premium, or have limitations and rules which restrict that," Karney explains. "Their rules are designed for the banks being able to sell the car to pay back a loan.

"But we know the medical and dental professions are a lower risk community. As a result of this, and being specialists in that area we are able to do things which the general financiers are unable to do. We've been doing it for 20-odd years, so we know this market in a deeper way than anyone else."

The information contained in this article ("Information") is general in nature and has been provided in good faith, without taking into account your personal circumstances. While 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. The opinions expressed in this publication are those of the respective authors and do not necessarily reflect the opinions of Investec Bank (Australia) Limited.

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Editorial:
Christine Brill
Ph 6270 5410 Fax 6273 0455
editorial@ama-act.com.au

Typesetting:
Design Graphix Ph 0410 080 619

Editorial Committee:
Dr Ian Pryor – Chair/Editor
Dr Jo-Anne Benson
Mrs Christine Brill – Production Mngr
Dr Ray Cook
Dr John Donovan
A/Prof Jeffrey Looi
Dr Peter Wilkins
Mr Jonathan Sen

Advertising:
Ph 6270 5410, Fax 6273 0455
execofficer@ama-act.com.au
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General Practice or bust!

Writes Canberra GP and former Air Force officer, Dr Mike Seah

I often joked that the only reason I hadn't left the Air Force was because I didn't know what I wanted to be when I grew up. However, after a four-year return-of-service obligation had turned into a 21-year career I felt it was time to move on.

Where was the enthusiastic clinician that I'd started out as? He was buried somewhere under a pile of paperwork and emails that had become my daily lot in life. While the security of receiving a pay cheque every fortnight was reassuring, over the years my role had become less about clinical work and more medical administration. Sorting out problems on an organisational level is far less satisfying than helping an individual patient.

I felt it was time to take action and made the decision to transition back into civilian clinical practice.

My "impulsive" decision took almost a year before actually coming to fruition. Along the way I took some well-earned accrued leave (mainly to stay home and cook), worked as a locum in Queenstown, Tasmania and undertook one final operational deployment to the Middle East. Finally, in November 2011 I was ready to take off the blue uniform, but not for good, transferring to the RAAF Specialist Reserve.

I joined a new practice and rediscovered the joys of dealing with the Medicare system. It was definitely a challenge to re-learn how to bill patients, not having had to think about it in the military health care system. How long did I spend with the patient? What's the item number for a pregnancy test? What do you mean there are 20-odd item numbers for taking out a skin lesion??

I did not anticipate that establishing myself as a General Practitioner in Canberra would be quite so problematic. While reports on the radio about a GP shortage in Canberra were being aired weekly, I was sitting in my brand new consulting room seeing half a dozen patients – on a good day! Luckily I still had some Reserve work to keep me occupied. Less than a week out of full-time service, I was back in uniform to undertake an inquiry into a governance issue that kept me occupied part-time for another four months.

Meanwhile, another opportunity presented itself. A colleague offered me a job to be a fly-in/fly-out (FIFO) doctor for a trial clinic at a mine site in Queensland. With the inability to attract more GPs to rural areas, a mining company decided to pilot a medical clinic at their mine site, to deal with primary care and occupational health issues. Given the paucity of new patients at my practice, the six-month contract seemed like a good option. Practising medicine in a high visibility shirt and steel-capped boots is not unlike working out of a tent in some foreign country, but at least the food and accommodation are better and there's nobody shooting.

So settling into private practice didn't quite go as planned. I now spend a week every fortnight helping to alleviate the strain FIFO workers are putting on rural health services. During my week off I have plenty of time to cook and bake, while working part time the GP practice, and also clock up time as a Reservist – now writing policy in response to the recommendations from the Inquiry I'd previously completed. I still don't know what I want to be when I grow up, but at least it's an interesting journey getting there!

Dr Mike Seah is a general practitioner in Barton and a member of the AMA ACT GP Forum

My GP Journey – a family affair

writes Dr Veronica Kolos

My GP journey began when I was an infant… My mother runs a full-time solo practice in Sydney, which is in the same suburb as our family home, and around the corner from my pre-school, primary school and secondary school.

Registrars taken from a teaching release in Bega last year

I grew up in my mum's surgery. I have very happy memories of staying in my mum's surgery while she saw patients, and very fond memories of her loyal patients.

I'll share a few memories with you now.

At the age of 3, I often remember choosing a book from the collection in the play-room, then walking into the waiting room, scanning across the faces of the patients and feeling happy as they lit up in response to me, then choosing the brightest smile, asking to sit on their lap and for them to read the book to me. I knew all of the stories by heart in the collection and I remember trying to surprise the patients by saying the next sentence before they read it to me.

At the age of 4, I remember sitting on a lady's lap who told me she was 96 years old. I told her that she would die in 4 years and that I would die in 96 years. I don't think she was particularly impressed with my prognostication skills. Over the years, I have watched my nieces similarly grow up in the surgery, being looked after and taken to the park by their adopted grandmothers.

My mum tells me that one particular patient, used to come every morning to feed me morning tea many decades ago, and currently, he still goes to the surgery every morning to feed my youngest niece her morning tea as well!

The memories I have mainly surround the warmth and respect I could feel between my mother and her patients, whom she has looked after for over 30 years. My mother is like an honorary member of the family for many of her patients. I felt a great affinity toward having the sort of relationships with people that my mum demonstrates with her patients, and from early on in my childhood, I had decided that I would grow up, study medicine and become a GP.

Many of my medical school colleagues felt disdain at becoming "just a GP" and thought perhaps they would keep GP as a fall-back plan. But few people felt that it was their primary direction.

During my 3rd year rural placement, I attended Braidwood Medical Centre with secondment to the Braidwood Hospital. I was supervised by Dr Arne Nilsson and I was so impressed with the breadth of his knowledge and skill, and I so thoroughly enjoyed the diversity of presentations, both chronic and acute. There was nothing mundane about general practice, and no two days were similar. Even if the presentation was routine, there were always the underlays of the patient's existing medical conditions to consider, or the presentation was coloured by the impact it had on mental health. I have based a lot of the content of my 'spiels' on what I learnt from Dr Nilsson. Patients seem quite satisfied when I pronounce "we will see you with those results and take it from there", just as Dr Nilsson did.

Throughout my hospital training, I loved all the rotations I participated in and could foresee myself doing the registrar's job. The clincher in steering my career path towards general practice was when I did my PGPPP placement at Isabella Plains Medical Centre. In comparison to banal (mostly secretarial) hospital work, I really thrived in the autonomous working environment, where it was just me - to assess and interpret the clinical findings, determine a management plan and follow the patient through. I really enjoyed the follow-up part in particular, and found myself feeling victorious when the treatment plan I instituted actually worked.

Now, I'm working as a GPT3 registrar at Garema Place Surgery. I still do feel a little bit amazed at how patients' ask your opinion, share such important personal information, and follow your advice. There is such inherent trust and mutual respect for this to occur. I feel privileged that I am capable of forming such therapeutic relationships with my patients. Although I'm only 1 year into my GP journey, I am enjoying the responsibility and challenge of this job. It really is the best job I've ever done. Perhaps I'll be lucky enough to capture 30 years of patient journeys and stories, and live through ups and downs with my patients in the years to come.

Dr Veronica Kolos is a GP registrar

Reflecting on the first year of the ACT Medicare Local

Chair, ADr Rashmi Sharma writes for Canberra Doctor

It is timely during the AMA Family Doctor Week 2012 to reflect on the progress of ACT Medicare Local (ACTML). Readers will be aware that the ACT Division of General Practice (ACTDGP) changed its constitution in August 2011 to become ACTML. ACTML has been constructed on the priorities and values cemented by ACTDGP over the past 19 years.

The objects of the company promote general practice as the foundation of good primary health care. I am confident that our 400 GP members are continuing to enjoy the support that was provided to them from ACTDGP.

In reflecting over the last 11 months on our achievements as ACTML, five key areas come to mind that reflect our commitment to supporting our founding members:

1. Governance structure – GPs substantially represented

GPs have substantial representation within the ACTML governance structure. The ACTML Board has four GP members. The Board is advised by the GP Advisory Committee (including AMA representation) about strategies to strengthen and promote general practice engagement and participation in the primary health care sector. The Board is also advised by the Primary

Health Care Advisory Council, Community Advisory Committee and Clinical Governance Committee all of which enjoy substantial GP membership along with other members with diverse expertise.

ACTML's membership model has ensured general practice is well represented with individual GP membership, general practice membership, general practice nurse membership and peak body representative of general practice membership e.g. AMA ACT, RACGP and the local GP regional training provider Coast City Country GP Training Limited.

2. Advocacy resulting in outcomes

ACTML continues to advocate on behalf of GPs and represent the voice of general practice and wider primary health care in a number of forums.

The AMA ACT and ACTML meet regularly with Katy Gallagher MLA (ACT Chief Minister and Minister for Health) and the Director General of ACT Government's Health Directorate to improve flows of information between ACT Health's multiple service delivery points and GPs, which resulted in:

- Doctor Direct Phone Line
- "Find a health service" – ACT Health Services Directory health.act.gov.au/health-services/
- Outpatient Waiting Times and Outpatient Services online
- Dedicated Clinical Outpatient Registered Nurse – RN provides clinical support by telephone to GPs to assist them with hospital navigation, follow-up missing investigations, discharge information and referral processes.

We will continue to promote this change within the hospital sector to improve its interaction with the primary health care sector.

ACTML is liaising with the ACT Government Health Directorate to reduce the red tape surrounding the prescribing and dispensing of Schedule 8 drugs and to review current legislative requirements that affect the ability of clinicians to deliver best care to their patients.

Like the AMA, ACTML has been approached by many members about the perceived lack of recognition of the GP role during the antenatal and postnatal care of their patients. We are working with the Canberra Hospital obstetrics department to review models of care to ensure that the vital role of general practice in the care of these women is encouraged and recognised.

And for those of you sick of seeing me on the TV and hearing me on the radio, I am sorry! However, ACTML comments on topics related to general practice and primary healthcare to try and move the focus away from hospital centric care to care within the community.

3. Support to general practices increased

Under ACTML our Practice Support team has expanded considerably to include a team leader and three dedicated practice support officers, complemented by the eHealth team of four project officers. As a result, the number of general practices that have been visited and supported by our team has steadily increased. For example, in September 2011 our team visited 26 practices; increasing to 36 practices in May 2012. Many of these practices requested and received more than one visit.

The team has provided support in areas such as data quality, accreditation, eHealth, health assessments, MBS item numbers and practice staff education. For example, supporting the installation of, and training practice staff in, Pen Clinical Audit Tool (PEN CAT). Also assisting some practices to gain accreditation, and providing education to practice staff regarding the launch and implications of the 4th Edition of the RACGP Standards for General Practices.

Many practice owners and principals and practice managers have been attending regular networking events for each group, with interest and attendance increasing, to brainstorm and share ideas to meet the ever increasing challenges that we face in running general practices. ACTML has investigated issues raised at the meetings and has developed solutions to support practices.

4. Education strongly accessed by general practice

Over the past 12 months, ACTML has continued to facilitate quality education events for GPs and general practice staff by offering 87 themed education and peer support meetings (increasing from 60 events the previous year). GPs were strongly represented at education events, with over 1000 attendances by GPs and over 940 attendances by practice managers, practice nurses and allied health professionals.

Education sessions covered a wide variety of topics including Advance Care Directives, CPR, influenza, suturing skills, falls prevention, asthma management and spirometry training.

The RACGP ACT office is located within ACTML which fosters a good relationship with the College and ensures that the education provided by ACTML pertains to the need of general practice.

5. Addressing GP workforce issues

ACTML continues to support GPs in Canberra through a number of workforce initiatives including membership of the AMA ACT Chaired GP Workforce Working Group.

To ensure that GP workforce issues are approached in a sound and sensible way to allow the community to have access to high quality general practice, ACTML is coordinating a GP Workforce scoping study. This will examine the current and immediate past general practice workforce in order to assist in modelling future GP workforce needs accurately.

And so while the first 11 months of the ACTML has been hard but rewarding work, I assure my fellow GPs that you can remain confident that your central role in primary health care continues to be valued and supported. As a GP I know that I do not deliver the best care to my patients by working in a silo model of care - rather my engagement with my practice staff and nurses, community pharmacy and local allied health enhances the care of my patients. So I welcome the new members to the ACTML, as I know that just as I respect their role within the primary health care team, they also respect the integral and valuable role of the GP in the same health care team.

Dr Rashmi Sharma is a general practitioner in Isabella Plains and the Chair of the ACT Medicare Local

AMA urges more people to become organ donors

The AMA has developed a Position Statement on organ and tissue donation and transplantation.

The AMA supports organ and tissue donation and strongly encourages individuals to consider their views and discuss them with their family.

Having been prominent in publicly promoting organ and tissue donation for many years, the AMA felt it necessary and timely to develop a formal policy position on the issue.

AMA Vice President, Professor Geoffrey Dobb, said that the AMA Position Statement adds to the growing body of information publicly available to help people make informed choices about organ donation.

Professor Dobb said that people should also talk openly and ask questions about organ and tissue donation when they visit their family doctor.

"It is important that family members discuss the issues and are aware of each other's organ donation wishes – and are prepared to honour those wishes," Professor Dobb said.

"People can register their consent to become an organ donor on the Australian Organ Donor Register but their families will still be asked to provide the final consent.

"Around 1600 people are on the organ transplant waiting lists at any one time. One organ and tissue donor can save or enhance the lives of 10 or more people.

"Organ donation is a discussion that families need to have," Professor Dobb said.

The AMA Position Statement on Organ and Tissue Donation and Transplantation 2012 addresses a broad range of issues including: determination of death; informed donor choice; donor families; living donors; allocation of organs and tissues; trafficking; workforce and infrastructure; quality and safety; and cultural sensitivities.

The AMA Position Statement on Organ and Tissue Donation and Transplantation 2012 is at http://ama.com.au/node/7859/

AMA organ donation brochures are at http://ama.com.au/node/4018

AMA

General practitioner musings

From Dr Helen Toyne

Given that it is Family Doctor Week, I thought I would share with you an anecdote from my own family which I think helps to remind me why families are important – even when they constantly fight they can make you laugh.

I was driving along between school and swimming and the children were arguing in the back as usual. However, for whatever reason my four year old decided he had an important question and the arguing stopped for a while. He had obviously been considering his question for a while, and he needed an answer. "Doug, can elephants swim?" Doug, who at 9 years of age is the font of all knowledge on matters pertaining to the natural world, being an avid fan of David Attenborough, started to explain: "Yes they can Owen. I've seen it. They paddle all their legs and use their trunks like a snorkel. Really amazing for such a big animal." Owen thought about this for a while, and then asked "But Doug, what about backstroke???"

Sometimes when I am trying to articulate useful and accurate advice, I feel a bit like an elephant trying to do backstroke.

I write with just over a year of being a part time bureaucrat behind me. During this time I have developed a great deal of respect for the professionalism and expertise of the people working within the areas of ACT Health we as GPs need to engage with. I remain baffled at times by the administrative processes required to do the job, but I have to say I my inexperience has been tolerated with great understanding and support. I am constantly reminded of the challenges we face largely due to the Territory-Federal divided system which makes a holistic approach difficult. The advent of the Medicare Local was supposed to address some of these difficulties, but the watering down of the roles (and the funding) of Medicare Locals means there is not likely to be wide-ranging structural change in delivery of primary care services in the short to medium term.

The only way we can deliver the best care for our community is to nurture our providers and ensure they are supported to do their jobs well. This does not mean the focus is solely the GPs bottom line, but it is vital to support complex general practice through systems which reward quality. Currently this can be difficult under the MBS, and it therefore can be left to local governments to support areas where people can tend to fall through the gaps. However we need to recognise that financial support to perceived areas of need can distort what is otherwise a free marketplace, and undermine the viability of practices not supported. Getting this balance right is key to ensuring all in our community can access quality care when they need it. Trust is central to relationships between GPs, Medicare Locals and Government, remembering that ultimately we have similar goals. How we develop a system that rewards quality rather than throughput is the major challenge to primary care funders all over the world.

We know that support for GPs is central to the overall health of the system, and creating a robust, quality primary care sector where GPs have the opportunity to practice across different areas of medicine to the full breadth and depth of their training has benefits for the whole community. The expansion of specialised practitioners (medical and other), services and clinics runs the risk of devaluing the generalist, and it is important for the community that a strong pool of expert generalists is nurtured and grown. I think it is inevitable that new models of care will come - the system is constantly evolving, but I hope that when my grandchildren need healthcare they can still see a GP, preferably the one I see now (or her daughter!), and that like the elephant, we will all be able to swim towards a goal, without having to do backstroke!

Dr Helen Toyne is a Canberra GP and part time GP adviser to ACT Health Directorate

Health and the 2012 ACT Election

A MUST ATTEND EVENT

Members are invited to the 2012 ACT Election Health Forum to be held on Thursday 6 September 2012 in the conference facility, AMA House, 42 Macquarie Street Barton commencing at 7.00 pm.

The Forum discussion will be moderated by **AMA Secretary General, Mr Francis Sullivan** with special guests

- **Chief Minister and Minister for health, Ms Katy Gallagher, MLA**
- **Opposition spokesperson on health, Mr Jeremy Hanson, MLA** and
- **Greens spokesperson on health, Ms Amanda Bresnan, MLA**

Refreshments will following the Forum
RSVP is essential by Monday 3 September to reception@ama-act.com.au or by calling Helen on 6270 5410

Supporting the next generation of GPs

By Dr Tuck Meng Soo

I wasn't having a good Monday morning… One of my patients had turned up without an appointment demanding to be seen urgently for her headaches and from the way that she and her daughter had ensconced themselves in the waiting room chairs, I could tell that she would not shift until I'd seen her.

The new intern had turned up that morning and as my colleague who normally does the orientation was away on holiday, it fell to me to mentor her through the morning too.

So when the phone rang and it was my GPT1 registrar asking me for advice, I felt like it was another interruption I didn't need. She had a woman with her who was alcoholic and on regular benzodiazepines and had been taking 12-15 tablets of Nurofen Plus daily which the registrar didn't think was very good for her. I had to agree with her misgivings and excuse myself to go over to her room as this didn't seem like something that could be sorted out with some brief advice over the phone.

It transpired that this woman had been on a methadone program a few years ago too and she was taking the Nurofen Plus for aching teeth for which she had been waiting for an appointment with the public dentist for a couple of months. The breakthrough happened when I asked the patient whether she now had an opoid dependency and to my and my registrar's surprise, she unhesitatingly admitted that she did. So, taking all the circumstances into consideration, this patient is now on a reducing dose of Oxycontin over a month and has a Team Care Arrangement to see a private dentist. She reports that she is so relieved to have been able to discuss the issue clearly and is feeling so much healthier and more stable now she has been able to stop the Nurofen Plus. She has been back to see my registrar a couple of times since then and they've got a plan they've both working to now.

I think this incident illustrates a lot of the GP supervisor experience and why we supervise registrars. It is an added burden to our busy lives and there will be days and times when we wish we didn't have this extra responsibility. However, I find that moment when I have been able to show my registrar something which makes a difference to their management skills such a rewarding achievement as in this case where articulating the subterranean concerns we have about that patient has enabled the doctor and patient to discuss those concerns and formulate a mutually acceptable consultation plan.

Having registrars bring other benefits too. There is the new knowledge they bring from their recent immersion in the hospital experience and the general emphasis on learning and evidence-based medicine that having a learner in the practice engenders. There are the new bright faces and the new ways of doing things to challenge our preconceptions. There is also the contribution they make to the GP workforce in many practices.

Of course, having a GP registrar is not all a bed of roses either. While I have not had a registrar with whom I have had major personality conflicts, I have heard of some horror stories. I have also had remedial registrars in my practice and I have not always been happy that I have been as effective a teacher with them as I could.

I do worry that there are clouds on the horizon for the GP registrar training program. In Canberra, an increasing number of general practitioners are working in corporate practices and while some of these general practitioners used to supervise registrars, their skills and experience are now no longer available. Most of all it means there are fewer practices to accommodate the increasing numbers of registrars that will be coming through the system. There is also the challenge of the IMGs. IMG supervision is so much less onerous than GP registrar supervision which is counterintuitive given the excellent training our GP registrars have already received through Australian medical schools and hospitals. I worry that there is a real potential for GP registrar placements to be lost to IMGs. On the other hand, the increasingly onerous regulatory and financial demands for employing a GP registrar could mean that many practices would prefer to have an IMG or a GP contractor.

I have enjoyed the challenge of being a GP supervisor and hope that I continue to be involved in this program for many years to come.

Dr Tuck Meng Soo is a Canberra City GP and GP registrar supervisor

Endoscopy facility now open in Deakin

Chief Minister, Katy Gallagher officially opened ACT Endoscopy, Canberra's largest and most modern private endoscopy facility, on 17 May. The opening was timed to coincide with the recent budget announcement supporting prevention of colon cancer, which remains one of the leading causes of cancer death in our community.

The centre is purpose built and is located within the Equinox complex in Kent Street, Deakin. It has already attracted a team of committed and enthusiastic nurses led by Trish Charlton, who has been involved in endoscopy nursing for many years.

One nursing recruit at ACT Endoscopy described her first fortnight by "You feel connected". A smaller and more overtly supportive working environment with well-motivated patients can be a welcome change for staff who have been in large institutions for most of their working careers.

Five gastroenterologists are already working at the centre. There has also been much interest from anaesthetists and GP sedationists.

Endoscopy has now very much embraced the digital age. Not only do patients benefit from use of the latest endoscopic equipment but software will soon enable referring doctors to be emailed encrypted reports with endoscopic photographs included with the text.

Canberra's reputation as a centre of excellence in endoscopy looks certain to grow with the opening of this new facility.

Drs Jonathan Bromley, Mike Corbett, Roger Lee, James Riddell and Andrew Thomson are all associated with the centre. This report was based on information supplied by Dr Thomson.

Interns find General Practice an empowering place to train!

say Drs Katrina Anderson and Sonia Res

The Prevocational General Practice Placement Program (PGPPP) was introduced to Canberra and its surrounding regional areas in mid 2008 initially with two Practices. It is managed by General Practice Education and Training (GPET) on behalf of the Australian Government.

This Program is designed to rotate Junior Medical Officers (JMO) out of the hospital environment and expose them to a wide range of clinical situations within a General Practice. These placements are usually for a ten week term during internship or the first residency year. At the end of this term the JMO returns to their hospital. The key aims are to provide junior doctors with an experience that may encourage them to choose General Practice as a career as well as helping them to attain knowledge and skills around Primary care in the community.

During their rotations the PGPPP JMOs will gain experience in general practice over and above that of undergraduate training. They are exposed to a variety of patients ranging from babies, teen-ages, families and the elderly. They receive ongoing and personal mentoring by respected and dedicated GPs in the field. Our aim is that they will gain a better understanding of the Australian health care system by seeing firsthand what a General Practitioner does on a day to day basis and by doing it themselves. For junior doctors one of the key benefits they describe is that they finally feel like a "real" doctor and get to manage patients from presenting problem to management and ongoing care.

Currently the ACT has five local teaching practices and three regional practices. These practices include the Interchange General Practice, Isabella Plains Medical Centre, Kambah Village Medical Practice, Warramanga Medical Centre and Winnunga Nimmityah Aboriginal Health Service. The regional areas extend to the Bega Valley Medical Practice, the Lighthouse Surgery (Narooma) and The Bombala Street Surgery (Cooma). Currently the urban ACT practices are taking interns (PGY1) while the rural practices and Winnunga Nimmityah Aboriginal Health Service are taking Resident Medical Officers (PGY2). In 2012 40 JMOs will undertake a rotation in General Practice as part of their hospital training.

While the JMO's are gaining work experience within a general practice they are expected to attend weekly lectures and tutorials at the hospital. Here they present interesting cases they have seen and managed in conjunction with their Supervisors. They also receive lectures based on general practice topics and a detailed review of the patients seen through the week.

The following are some quotes from JMOs who have completed their rotations recently…

"Really couldn't have asked for a better teaching experience. I have never felt so at ease to approach my consultants for advice and clarification. I really felt that they treated me like a colleague rather than a student/intern to be told what to do. I really feel privileged to have had this experience."

Dr Katrina Anderson

"The experience of this term is great. I enjoy the GP life and, the term experience assures my career pathway of becoming a GP. All the senior doctors in this practice are very supportive. I enjoyed the teaching sessions as well, especially the case presentation and reflection on the patient log are very useful in terms of raising the common clinical difficulties and sharing resources for better management of cases."

"I could not have asked for anything better than this. Okay, let's talk about the practice now. From day one, I had a great time so far. Admin staff are friendly and polite. The nurses are just awesome. They are really confident in what they do. Vastly experienced. Patiently taught me the practical stuff needed in managing common ailments. Overall I have thoroughly enjoyed every moment during this term."

Due to the popularity among JMO's and the success of this program we are looking to expand and recruit new Practices to this program for 2013.

Dr Sonia Res and daughter.

Dr Katrina Anderson is the Director of Prevocational GP Education and Training and Dr Sonia Res is the GP Hospital Educator supporting the program. If you would be interested in having Junior doctors in your practice or would like to find out more about the program please contact Dr Katrina Anderson on 62444951 or Dr Sonia Res on 62444956 at the Academic Unit of General Practice.

Your complimentary copy of the 2012 Specialist Directory

CANBERRA GPs

A complimentary copy of the 2012 Specialist Directory is included in this edition of *"Canberra Doctor"* for all Canberra GPs.

If your copy is not enclosed, 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 included in this edition for AMA members.

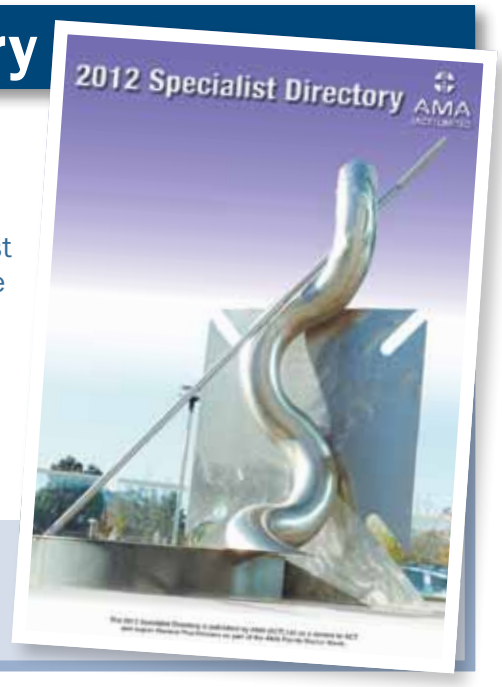
If your copy is not enclosed, please contact Sue Massey on 6270 5410 and one will be mailed to you.

GP REGISTRARS

To receive your complimentary copy of the 2012 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 2012 Specialist Directory will be available for downloading from from 25 July 2012, from the AMA ACT website **www.ama-act.com.au**

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AMA (ACT) LIMITED

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Preferred mailing address: ☐

Practice Address: _____

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_____ Phone: _____

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☐ Specialist Practice

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

Other Relevant Information (including languages spoken): _____

_____

Baby Bear's Porridge

By Dr Ian Pryor

It was not so long ago that Canberra GPs were desperately searching for more doctors to help them in their surgeries. Patient demand meant waiting lists to see one's GP had stretched out to several weeks. GPs were closing their books in order to manage the overwhelming demand for their services and bulk billing rates were dropping fast.

A 2003 study by the then ACTDGP showed that FTE GPs numbers per 100,000 population had dropped dramatically over the preceding three year period from 74 to 65 against a national average of 85.

GPs were stressed, patients were desperate, hospital A&Es were overcrowded with inappropriate attendances and the ACT Government was under pressure from every one, even though theoretically GPs were a Commonwealth responsibility under the Medicare ACT.

The power of the ballot box!!

There was general community uproar and dissatisfaction which was indiscriminately sheeted home to any politician in Government. Coupled with rising costs of running A&E Departments, attributed in significant part to the overflow of patients from general practice, health systems were galvanised into action devising and implementing a comprehensive range of interventions.

Suddenly it was realised that there were just not enough GPs being trained so there were bigger intakes of medical students and new medical schools. ACT got one of its own. Overseas trained doctors were sought with designated geographical areas of need defined to maximise their movement to places of most acute GP shortage - including outer suburbs of the ACT.

CALMS gained unprecedented support to continue and expand its valued after hours services. Efforts were made by the AMA and the Division (of General Practice) to help recruit GPs into local practices and the General Practice Workforce Working Group (GPWWG) was established to examine and recommend effective ways of addressing GP shortages. New GP scholarships were established and substantial funding was made available for practices and doctors to take on students and GP registrars. There was even Medicare funding initially to support practice nurses.

Along with broader aims to reduce barriers to competition throughout Australia's workforce, moves were undertaken to allow various non-medical health practitioners to expand their spheres of practice into areas of medicine which it was thought would improve patients' access to a range of undersupplied services such as optometry, diabetes education, palliative care, vaccination services and more recently nurse run walk in centres and nurse practitioners. Even pharmacists want to provide clinical services.

Which of these interventions have eased the crisis of GP shortages effectively is hard to evaluate or quantify. Many of these changes have had the effect of reducing barriers to medical service delivery by providing increased flexibility and sometimes quality in the provision of some primary care services

So where are we now?

There is strong anecdotal information to suggest that pressures on GP numbers in the ACT have dropped. Fewer practices have closed books. Waiting times to see a GP in a patient's usual practice have shortened and urgent problems are mostly dealt with promptly. Some GPs now have gaps in their appointment books and there appear to be fewer practices wanting to put on extra doctors.

Perhaps the current situation warrants a fresh look?

Will there soon be too many GPs? Will the market become flooded? Are the substantial funds being spent on addressing GP shortages in the ACT no longer necessary and would they be better spent supporting practice improvement?

To this end, the GPWWG which I chair, has sought and received approval and funding from the ACT Government to proceed with a detailed review of our GP workforce. This will take the form of surveying practices, specifically designed research into plans and expectations of current GPs, students and DITs and a review of relevant current literature and research which has been undertaken on the topic. It is hoped by early next year this work will have been completed and recommendations regarding GP workforce can be formulated.

Further to this review, it is appropriate to look at a range of other factors impinging in GPs and general practices.

There are substantial changes in the pattern of general practices. It is well recognised that the numbers of solo or even two doctor GP practices continues to decrease. Larger practices have become the norm with a range of administrative and ownership models. There is no doubt that corporate practices have increased in size and number and have probably been responsible for the majority of the increase in GP numbers in the ACT. It may be that larger practices offer greater flexibility and are more efficient at meeting patient demand.

As mentioned above, there has been a broadening of health services and practitioners who can provide an alternative to seeing a GP. How much this is affecting demand for GP services is unknown. A factor which may be related is changed community attitude and expectations. Without clear evidence, I suspect many patients are using more of the community's non-GP resources to deal with their complaints in the first instance, particularly for less serious problems. This might mean they seek advice from people other than GPs or use modern health information sources.

Finally, the economic climate should not be neglected. General practice is a commercial service which, contrary to the beliefs of many, behaves similarly to retail and other commercial services. We all know how Australians are not spending their hard earned incomes at the rates they used to and ACT retail is desperately trying to encourage customers to spend. This unwillingness to spend affects medical services just as much with quite significant implications for GP workforce. A corollary of this impact on GP demand is that when economic times are better, GPs will get busy again.

Dr Ian Pryor is a former AMA ACT President and current chair of the ACT GP Workforce Working Group

National Boards consult on international criminal history checks

National Boards are consulting on options for refining international criminal history checks used to assess applications for registration as a health practitioner in Australia.

Under the National Registration and Accreditation Scheme, National Boards set registration standards that every registered practitioner must meet. One of these standards relates to criminal history.

The National Boards are working with the Australian Health Practitioner Regulation Agency (AHPRA) to refine the requirements for criminal history checks from jurisdictions outside Australia.

The current approach involves checking Australian criminal history through CrimTrac and requiring applicants to sign a declaration disclosing any criminal history outside Australia. When a criminal history is disclosed, further investigations are made and the criminal history is assessed according to the relevant Board's Criminal History Registration Standard.

The National Boards must decide whether this is adequate or if they should increase the scrutiny of applicants' international criminal history.

In effect, the Boards must balance their responsibility under the National Law to protect the public, with the need to ensure there is no unnecessary red tape in assessing and managing applications for registration as a health practitioner in Australia.

The National Boards are open to feedback and seeking input on this complex issue.

Details of the options under consideration and background information in relation to international criminal history checks are published in a consultation paper . Feedback on the consultation is due by **17 August 2012**.

For more information

Refer to the consultation paper, published on the AHPRA website, under the *News* tab

For registration enquiries:
1300 419 495 (within Australia)
+61 3 8708 9001
(overseas callers)

AMA Fee List Update – 1 July 2012

The AMA List of Medical Services and Fees (AMA List) has been updated to include changes to items for endovenous laser therapy for the treatment of varicose veins.

Summary of Changes/CSV File

The Summary of Changes for 1 July 2012 is available from the Members Only area of the AMA website at http://www.ama.com.au/feeslist.

The comma delimited (CSV) ASCII format (complete AMA List) is also available for free download from the Members Only area of the AMA Website (www.ama.com.au).

To access these parts of the website, simply enter your username and password in the box on the right hand side of the screen and follow these steps:

1) Once you have entered your login details, from the home page go to **Members Benefits** at the top of the page.
2) Under AMA Member Services, select **AMA List of Medical Services and Fees** link.
3) Select first option, **AMA List of Medical Services and Fees - 1 July 2012**.
4) Download either or both the **Summary of Changes** (for viewing) detailing new, amended or deleted items in the AMA List and the **CSV** (for importing into practice software).

AMA Fees List Online

The AMA Fees List Online is available from http://feeslist.ama.com.au. To access this part of the website, simply enter your username and password in the box provided on the screen. Members can view, print or download individual items or groups of items to suit their needs.

If you do not have Internet access, the AMA produces the AMA List on CD. If you wish to order a copy of this CD, please complete the following form and return to:

Sandra Riley
Administrative Officer
AMA
PO Box 6090
KINGSTON ACT 2604

PLEASE PRINT CLEARLY

Name: _____

Address: _____

☐ I wish to order the AMA List of Medical Services and Fees on CD for $51.

AMA

AMA MEMBERSHIP
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AMA (ACT) LIMITED

Dr Bruce Stevens, PhD
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Psychologist at UC

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(level 10 AMP Canberra City)

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Consultant Physician in Geriatric Medicine
Emphasis on Healthy Ageing

Other areas of interest:
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Shoulder2 Hand would like to welcome

Jamie Harradine (nee Errickson)
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- Splinting
- Ergonomic advice on activities of daily living
- Oedema and scar management
- Tissue mobilisation and exercise programme
- Post-operative management and rehabilitation

Both Jamie and Sue are happy to see private and ACT worker's compensation patients.

Appointments can be made by telephoning 6260 4777

Shoulder2Hand
Hand Clinic

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F: 02 6282 2306
www.completewomenshealth.com.au
dradham@completewomenshealth.com.au

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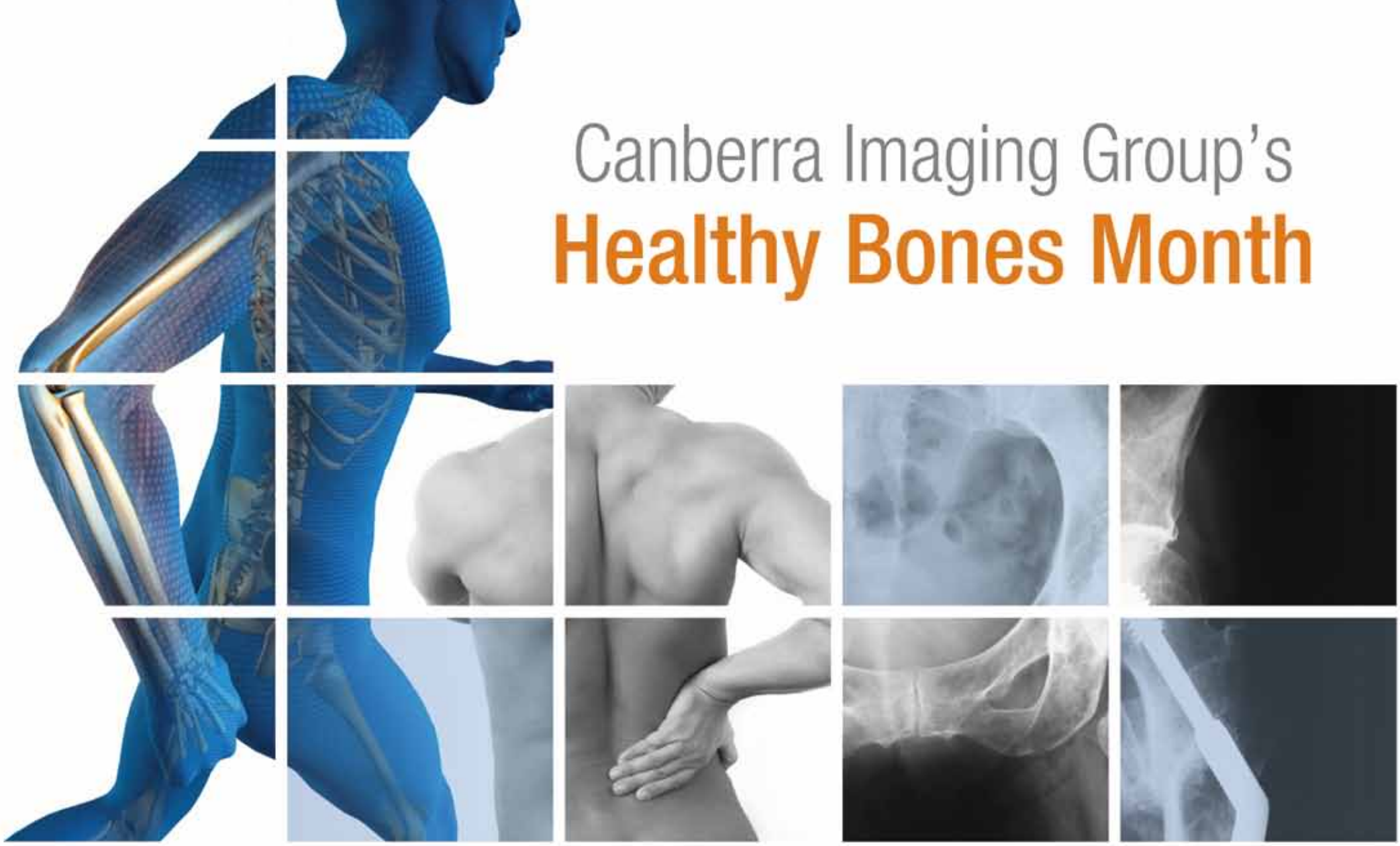

Canberra Imaging Group's
Healthy Bones Month

To promote National Healthy Bones Week, for the entire month of August Canberra Imaging Group are offering bulk billing for any Medicare eligible patients on bone densitometry scans (DEXAs). Patients that do not meet the Medicare criteria will be offered a reduced out of pocket expense of $60.00. Bone densitometry scans are performed at the following locations:

$60

Bone densitometry scans (DEXAs)

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Calvary Clinic
Mary Potter Circuit

Deakin
Calvary John James Hospital
Clinical Services Building
173 Strickland Crescent

Goulburn
Goulburn X-Ray
185 Bourke Street

Please phone our friendly patient booking service for an appointment:

1300 788 508

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Canberra Imaging Group, your locally owned and operated practice with 50 years of history supporting the local community.