Canberra DOCTOR
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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**

Ms Katy Gallagher, MLA

Mr Jeremy Hanson, MLA

Ms Amanda Bresnan, MLA

Refreshments will be available following the Forum

RSVP is essential by **Monday 3 September** to **reception@ama-act.com.au** or by calling Helen on **6270 5410**

TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

Thoughts of friends and colleagues

The Canberra medical community is a small one and many have been touched by the events of the last few weeks. I know that you will all join me in sending our condolences to Damian McMahon's family; Helen (Della), Xavier, Riley, Grange and Dinan. We are also anxiously awaiting news of Marjan Kljakovic who is still in a critical condition in St Vincent's Hospital in Sydney.

Vacancy on AMA ACT board filled

The AMA ACT board has now appointed a treasurer to the board. We have long felt that expanding the financial expertise of the board would strengthen the organisation's governance responsibilities and help to ensure that we can continue to provide the high level of services that our members expect. The Constitution was amended in 2009 to provide for a non-member director in this role and I am happy to welcome Robert Hunt to the board. Robert is a CPA with directorship experience. He has worked in a range of industrial organisations and the not for profit sector; and has a long history of involvement with health care organisations including previous work with the Federal AMA secretariat.

VMO contracts for negotiation early in 2013

The AMA and VMOA have recently met with the Chief Minister to discuss the next round of VMO contract negotiations. It has been agreed to defer these until February next year to avoid the disruption of spreading the negotiation period over the Christmas – New Year break.

Alcohol affected patients and A&E presentatons

Recently released ACT Health statistics have shown the immense burden that alcohol abuse places on our health system. As the Canberra Times reported ("Drinking injuries cost $8m"; M Inman, 5 August), almost a third of the patients presenting to emergency departments have been drinking.

The National Drug Indicators Project has estimated that between 1992 and 2001, 341 lives were lost in the ACT owing to risky and high risk drinking. Alcohol consumption was responsible for 77% of all substance use separations, with acute intoxication forming the largest group (56%). The ACT Health material can be viewed on http//:www.health.act.gov.au/publications/alcohol-and-other-drug/national-and-act-data.

Of great concern is that although alcohol-attributable hospitalisations increased in all jurisdictions, the ACT was the only jurisdiction where alcohol-attributable deaths increased between 1996 and 2005; with the increase being greater than for non-alcohol-attributable deaths.

The price of alcohol excess has been brought into public attention by the recent tragic death of Thomas Kelly after being assaulted in Kings Cross. Much of the attendant controversy has focussed on the Cross as a den of iniquity; however the NSW Police Commissioner Andrew Scipione has drawn attention back to the issue of problem drinking and urged changes to licensing laws. The ACT Liquor Act was passed in 2010 but contained limited and largely procedural changes. Issues such as lock-in / lock-out procedures were left unaddressed. A quick tour through Civic at 1 or 2 am on a Friday or Saturday would I am sure underline the inadequacies of the current legislation.

Michael Short in the Canberra Times on August 2nd discussed the impact of youth suicide. The Canberra community has also been touched by this particular heartbreak in recent weeks. The ACT Health report "The Extent and Nature of Alcohol, Tobacco and Other Drug Use, and Related Harms in the Australian Capital Territory – 4th edition" (D McDonald, 2012) has estimated that 32 deaths due to suicide where alcohol was a related factor occurred in the ACT between 1992 and 2001. The role of psychoactive drugs including alcohol and cannabis is a particular focus of the Young and Well Cooperative Research Centre (www.youngandwellcrc.org.au).

The debate has also extended to include the role of sporting clubs' tacit endorsement of alcohol consumption through their acceptance of sponsorships from the industry. The Federal Minister for Sport, Senator Kate Lundy, has launched the "Be the Influence" campaign in June, whereby $25m of revenue raised from the "alco-pop" excise has been released to sporting organisations in return for dumping alcohol sponsorships. The organisations include Football Federation of Australia, Netball Australia, Swimming Australia, Basketball Australia, Cycling Australia, Hockey Australia, Athletics Australia, Volleyball Australia, Equestrian Australia, Triathlon Australia, Canoeing Australia and Skateboarding Australia. Their courage in accepting the role of trailblazers must be applauded. The initial experience is that the sky has not fallen and these organisations continue to operate successfully. The AMA position statement on alcohol consumption and alcohol-related harms calls for a prohibition of sponsorship of "sporting events, youth music events and junior sports teams, clubs and programs by alcohol companies or brands".

As doctors we have a responsibility to the community to not only individually advise our patients regarding risk behaviours, including risky alcohol consumption; but also to ensure the pressure is brought to bear on our local legislators to ensure that the public health message is heard loud and clear. We should also be active in pressuring local sporting and community organisations to adopt a more responsible role.

Perhaps I am becoming a little PC, but I have even started monitoring my language … I no longer ***need*** a coffee/drink; but would like one. I have not yet conquered my need for chocolate.

Inspiring activity

The Olympics are in full swing as I write this column, sleep deprived as are so many others in our time zone. I did find myself wondering if the whole world should temporarily go onto "Olympic Time' for a couple of weeks. I am sure that our children wouldn't mind going to school in the middle of the night (that almost happened in 2000, didn't it?) to boost national productivity. I am sure that Fair Work Act review didn't consider that one!

I was interested to hear Kate Lundy state that the national curriculum review would include consideration of the role of sport in schools. Baron de Coubertin was most impressed with the compulsory inclusion of sport in the curriculum of British schools as he dreamt of the modern Olympiad. As a dermatologist I find myself seeing large numbers of young Canberrans.; and because I prescribe isotretinoin for acne I must enquire about sporting involvement in case some counselling about activity is required. It is safe to say that I am alarmed at the lack of involvement in organised sport that I see amongst our older teens. My youngest attended a school in England on exchange for a term last year. The school day went from 9 am to 5 pm, with 2 hours of every day being devoted to sporting activities. I asked him if he was tired when he came back into class at 2 pm for the 2 to 5 afternoon periods. He said that there is tired and tired; he thought his brain sparked better after letting off steam in the middle of the day.

There certainly is tired and tired; evidence shows that physical activity is not only good for general health but has mental health benefits. Well-structured sporting activities supervised by appropriately trained teaching or coaching staff would I am sure pay their way as the health benefits become clear over time. I sincerely hope that Senator Lundy carries through with that promise.

At present, however, I am content to relax and tend my jarred back after falling over a wombat (ah the joys of rural life) while I watch other people sweat. Now where did I leave that remote control…

Balancing Economics and Medicine

Dr Bill Coote, Director of the PSR writes for *Canberra Doctor*

In the late 1970s when a rural general practitioner I occupied my time "on call" obtaining an economics degree through the Queensland University's School of External Studies. This introduced me to the work of Kenneth Arrow, a famous economist who won the Nobel Prize in 1972.

That seems a long way from Canberra, November 2011, when I was appointed Director of the Commonwealth's Professional Services Review (PSR) agency.

PSR exists in a complex "borderland" where patient demand and need for medical care meet the clinical, ethical and legal responsibilities of doctors. Outside of public hospitals, this interaction occurs in the economic context of Medicare, Australia's universal, monopoly, publicly funded, fee-for-service medical insurance scheme.

What has PSR got to do with the economist Kenneth Arrow? In 1963 Arrow published a seminal paper "Uncertainty and the Welfare Economics of Medical Care" which examined the market for medical services against standard economic criteria which define an efficient market.

Arrow noted "risk and uncertainty are significant elements in medical care …" and that "the logic and limitations of ideal competitive behaviour under uncertainty force us to recognise the incomplete description of reality supplied by the impersonal price system." Arrow concluded that society had evolved mechanisms to deal with the special features of the medical market including "… the setting up of a relationship of trust and confidence, one which the physician has a social obligation to live up to."

Arrow is alluding to familiar ethical tensions. The Medical Board of Australia's "Good Medical Practice: A Code of Conduct for Doctors in Australia" requires doctors to "contribute to the effectiveness and efficiency of the health care system" and to "use health care resources wisely" while ensuring "the services you provide are necessary and likely to benefit the patient."

The AMA Code of Ethics reminds doctors "to use your special knowledge and skills to minimise wastage of resources, but remember that your primary duty is to provide your patient with the best available care."

Medicare has a sophisticated practitioner review program and refers practitioners to PSR who may be engaging in "inappropriate practice". This is defined in the Health Insurance Act as conduct "in connection with rendering or initiating services" that a committee of peers "could reasonably conclude … would be unacceptable to the general body" of the practitioners peers.

Medicare's concerns when a practitioner is referred to PSR typically include matters such as the overall number of services, an unusual pattern of services, services per patient or the ordering of pathology and diagnostic imaging.

PSR can require a practitioner to provide a sample of clinical records and can establish a committee of peers to assess concerns that a practitioner may be engaging in "inappropriate practice".

PSR committees assess whether services provided were medically necessary and whether there was an appropriate level of clinical input. Committees rely to a significant extent on the requirement in the Act for practitioners to maintain "adequate and contemporaneous" records.

Adverse findings by a PSR committee can lead to repayment of Medicare benefits by the practitioner and partial or full suspension from Medicare.

The complexity surrounding the interaction between clinical and economic reality attracted a famous economist like Arrow. It has also attracted the interest of writers.

Even Jane Austen, in *Emma*, touched on "overservicing". The hypochondriac Mr. Woodhouse, discussing the family general practitioner Mr. Perry, reminds his daughter: "Poor little Emma! You were very bad with the measles; that is, you would have been very bad, but for Perry's great attention. He came four times a day for a week." Perhaps Perry should be referred to PSR.

George Bernard Shaw in *The Doctors Dilemma* provocatively suggested the medical profession was "a conspiracy to exploit popular credulity and human suffering".

Aneurin Bevan, who established the British NHS in the late 1940s, opposed fee-for-service medicine influenced, it is claimed, by AJ Cronin's novel *The Citadel* which depicted some less attractive features of the London market for medical services in the years before World War 2.

Over the last 60 years the structure and organisation of Australian medical practice has been shaped by official support of fee-for-service medicine, initially by conservative governments in the 1950s, in contrast to ALP proposals in the late 1940s to introduce systems similar to British arrangements.

Doctors to provide reality check on hospital performance

Dr Steve Hambleton, AMA President is seeking input from the profession as the AMA prepares its 2012 Public Hospital Report Card

The AMA has published an annual report card on the performance of public hospitals since 2007. The aim of the report is to provide a medical perspective on public hospital performance, by contrast with the many system performance reports released by Federal, State and Territory governments.

The dedicated medical practitioners who work in public hospitals know that the picture on the ground is very different to that painted by sanitised government reports.

The 2012 AMA Public Hospital Report Card will be challenging to compile now that the National Health Reform Agreement has set up myriad reporting measures, through various frameworks and reporting agencies.

The Economics and Workforce Committee is overseeing the selection of new items to report against in the AMA Public Hospital Report Card. The usual capacity measures will continue to be reported as a time series – total beds per 1,000 population; emergency department and elective surgery waiting times; throughput; and administrative staff as a percentage of total public hospital staff.

We know that the many ways in which State and Territory governments are planning to respond to, and implement, the new public hospital pricing framework will have an affect on public hospital services. State governments may well reduce the public hospital service offering in activity-based funding arrangements from July 2012 in order to maximise growth funding after 2014. The AMA will maintain a watch of lost services and list them in future AMA Public Hospital Report cards.

AMA will monitor and report on how the new pricing arrangements affect the Federal Government's share of public hospital funding compared with that from State and Territory governments.

And AMA will keep a very close eye on the funding for teaching, training and research. There is a very real risk that this activity will be underfunded at a time when more money is urgently needed to provide quality training places for the increased numbers of medical graduates coming through the universities.

The AMA maintains that there must be no diminution in the quality of care provided to patients as a result of activity-based funding. Quality of care is difficult to measure and monitor through formal performance indicators.

The voice of the AMA members who are working on the ground is critical to the AMA Public Hospital Report Card. I need your views and stories about how the hospital pricing framework is implemented in your hospital and the impact it has on public hospital capacity, patient access to services and the quality of care.

Please email your contribution to: execofficer@ama-act.com.au

Art In, Butt Out winner announced

President, Dr Andrew Miller, announced the winner of the 2012 Art In, Butt Out competition recently.

Now in its fifth year, the winning artwork was the creation of year 8, Lyneham High school student, Angela Liao who was presented with her prize by Chief Minister and Minister for Health, Ms Katy Gallagher..

Angela's winning design was a standout and the judges were unanimous in their decision and thought that Angela's design was simple, imaginative, creative and very much in keeping with the theme of the competition. It has earned its place alongside previous winning entries. Angela's message clearly states that smoking is anti-social and isolates the smoker from the non-smoking peer group. It delivers an anti-smoking message, to teens particularly, in a very cute and cartoon-like way and links the demise of the dinosaurs a very long time ago, with smoking being a "so last century" habit you don't want to die for.

The winner is a student at Lyneham High school, the school from which the competition was launched with the Deputy Chief Minister, Mr Andrew Barr, then Education Minister and also a former pupil of Lyneham.

Dr Miller acknowledged the entries of other secondary students.

The "Art In, Butt Out" competition is an initiative of the AMA ACTs Tobacco Task Force. The aim of the Task Force is to recommend strategies to reduce the uptake of smoking by young people particularly, and to increase the awareness in the community of the health benefits of "quitting" the smoking habit.

The Task Force has a history of engaging with young people to develop peer-to-peer anti-smoking messages. "Art In, Butt Out" is a competition for young designers in year 8 to design an anti-smoking advertisement for "Canberra Milk" cartons to be distributed across the Territory next month. The artwork will be carried on milk cartons for a period of approximately six weeks on an estimated 60000 + milk cartons. This is the fifth year of the competition and as last year, the artwork submitted was creative and of a high standard.

"Art In, Butt Out" provides an opportunity for media students to exercise their design and art skills in a real-life situation by devising and developing marketing strategies to positively influence their peers and translate these strategies into very visible advertisements. Importantly, the competition encouraged young people to think about their health and well-being in a positive way and specifically bring into focus the harmfulness of smoking and tobacco products.

In making the award, Dr Miller acknowledged the efforts of the Government to reduce the incidence of smoking in the community and to protect the vulnerable in our community from the effects of passive tobacco smoke. Dr Miller said, "such initiatives include smoke free indoor environments, clubs and pubs, smoke free alfresco dining, smoke free when children are in cars, ACT departments and agencies are smoke free as are our hospitals and support for government staff wishing to QUIT. Our competition is just another avenue to promote non-smoking messages in the community.

Dr Miller reminded that, "within the AMA, this competition won the prize for Best Public Health Campaign in 2008. That it is still a viable competition is gratifying", he said.

2012 "Art In, Butt Out" Art Competition

winning entry by Angela Liao

Opening this month – Stage One of New Centenary Hospital for Women and Children

The community was invited to visit the Open Day recently showcasing Stage One of the new Centenary Hospital for Women and Children on the Canberra Hospital campus opens this month with Stage Two to be operational in 2013.

The new facility will bring together services including paediatrics, maternity services, the neonatal intensive care unit, gynaecology and fetal medicine, the birth centre and specialised outpatient services, all under the one roof.

Stage One has involved the construction of a new building around the existing Maternity building. Stage Two will commence shortly after services relocate to the new building and will involve a major refurbishment of the current Maternity building (Building 11).

Stage One will be a fully operational hospital that will be expanded when Stage Two is completed.

Services moving to their final location in Stage One are:

- Postnatal Ward
- Antenatal/Gynaecology Ward
- Neonatal Intensive Care Unit
- Special Care Nursery
- Birth Centre
- Paediatric Day Stay

Services moving temporarily in Stage One are:

- Paediatrics Outpatients
- Birthing Suite (previously Delivery Suite)
- Fetal Medicine Unit
- Postnatal Short Stay
- Maternity Asessment Unit
- Maternity and Gynaecology Outpatients

When StageTwo opens next year, the three-storey hospital will provide more beds, more ambulatory care consult rooms, clinical office space, education and training facilities and family accommodation. It will incorporate the latest information and communication technologies, including technology to automate a broad range of clinical and support functions.

Equipment has been worked into the design where possible, so that rooms look less clinical. The features throughout the hospital have been designed to maximise privacy and support, and improve the environment for medical, nursing and midwifery care.

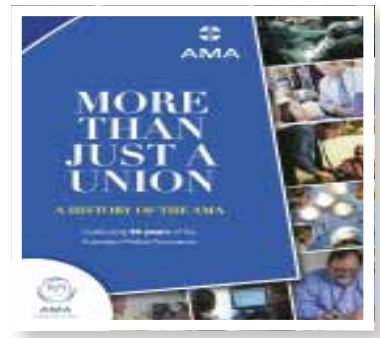
Features in Stage One include: the Ronald McDonald House which will providing accommodation and amenities for families of interstate patients in the new hospital; and Features in Stage Two will include the George Gregan Playground, which will provide children with a safe, innovative and creative place to play and a new café for patients and staff.

Bathing pools for birth and pain relief in the Birth Centre and Birthing Suite create a more relaxing space and the new antenatal/gynaecological ward and postnatal ward include single rooms with ensuites and space where a support person can stay comfortably overnight.

In the last 12 months, Paediatric Outpatients has seen over 12,000 children. Over 2,000 children have been admitted to the day stay unit and the inpatient ward has admitted over 10,000 children.

More than just a union: a history of the AMA

To help mark the 50th anniversary of the Federal AMA, AMA President, Dr Steve Hambleton, released a new publication, *More Than Just A Union:* A History of the AMA.



Speaking at the AMA President's annual address to the National Press Club in Canberra, Dr Hambleton said the publication traces the AMA's growth from fractious beginnings as an offshoot of a British parent to a truly Australian member organisation that was voted Best Lobby Group in the country in a 2006 survey of Federal politicians.

"The AMA has long been a key player in health policy development and the growth of the Australian health system," Dr Hambleton said.

"This publication contains the inside stories of the AMA's role in the great upheavals in the history of Australian health, including Chifley and the Constitution, Medibank, Medicare, the NSW doctors' strike, and the more recent Rudd-Roxon reforms.

"It also looks at some of the larger-than-life characters who have led the AMA throughout 50 turbulent years.

"*More Than Just A Union* is deliberately called a history, not the history, and there is good reason for this.

"The history of medical organisation in Australia actually dates back to the early 1800s with groups of doctors banding together under various names and for various objectives.

"It wasn't until 1880, however, that branches of the British Medical Association (BMA) were formally recognised in New South Wales and South Australia. Others soon followed. But it wasn't until 1962 that the Federal AMA as we know it was born.

"This publication has been pieced together from fragments of the AMA past from many sources to create a seamless narrative. But the source material has been patchy in places – poor or incomplete record keeping, lost files, missing files, and fading memories.

"It is therefore based on the records, recollections, and resources of some of the people who built the AMA. Others will have different memories or different slants on what happened in AMA history, from long ago to more recent events.

"So this particular AMA history does not end here. It is the beginning. It is a living history. It will be posted on the AMA website and we will invite people to provide comment, offer their version of events or add episodes of AMA history that we may have missed. We want to build on this history, round it out, and fill in the gaps."

Dr Hambleton paid tribute to the Federal AMA's Dominic Nagle, who managed the research and put in many months writing *More Than Just A Union.*

***More Than Just A Union:* A History of the AMA is at http://ama.com.au/a-history-of-the-ama**

Introducing the Investec Credit Card

Investec

The credit card market is already flooded, so for any new entrant into the market, its offering would have to be pretty unique. That's why Investec has managed to impress with the newly launched Investec Visa Credit card. Not only can you earn Qantas Frequent Flyer points and the high level of service you've come to expect from Investec – it's a card that also lets you buy assets that you normally can't buy with a credit card.

"Say a client wanted to buy a car," explains Investec's Brent Zurowski. "Normally, a car dealer doesn't like to accept a credit card for such a big value purchase, as he is uncertain there is sufficient credit limit and some of the fees he would incur would be very high. So we take that headache away and process the payment directly to the supplier. So even if the supplier didn't accept credit cards, you could still pay using your Investec card."

Investec's medical and dental clients can, as of this month, choose between an Investec Visa Platinum or a Visa Signature Credit card. Every $1 spent on eligible purchases on your Investec Visa Signature card, and every $2 spent on eligible purchases on your Investec Visa Platinum card, will earn one Qantas Frequent Flyer point. Investec has been developing the card for a while (following success with Investec-branded cards in South Africa and the UK), and according to Zurowski, their goal has been to create a product clients can't get anywhere else. "The Qantas Frequent Flyer points are an important part of the offering," he says. "I think people place value on them. I think the other important part is the relationship with the person at Investec, so if there is ever an issue you can sort it out quickly."

But one of the most powerful points of difference is the client's ability to convert their purchase to a different type of finance with Investec – a lease, asset purchase or chattel mortgage, or whatever best suits their financial situation – and yet still get the frequent flyer points from their purchase. "On top of that," Zurowski continues, "they can make the monthly repayments on the card, and effectively boost the number of Qantas Frequent Flyer points they earn."

Doctors who use the card can also enjoy special promotions from a range of medical suppliers and even have their AMA or ADA membership details printed on the card.

Investec can do this, says Zurowski, "Because as specialists in the medical and dental 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."

Qantas Frequent Flyer points are earned in accordance with the Investec/Qantas Terms and Conditions available at www.investec.com.au/cards. Points are earned on eligible purchases only. You must be a member of the Qantas Frequent Flyer program in order to earn and redeem points. Qantas Frequent Flyer points and membership are subject to the Qantas Frequent Flyer program Terms and Conditions. Full details are available at www.qantas.com/frequentflyer. Investec recommends that you seek independent tax advice in respect of the tax consequences (including fringe benefits tax, and goods and services tax and income tax) arising from the use of this product or from participating in the Qantas Frequent Flyer program or from using any of the rewards or other available program facilities.

GP infrastructure grants a better way to build better primary care in local communities

The AMA has urged the Government to expand its Primary Care Infrastructure Grants (PCIG) program, which is proving far superior to GP Super Clinics in building better primary care in local communities across Australia.

Dr Hambleton said that a recent audit by the Australian National Audit Office (ANAO) provides clear evidence that the PCIG program is delivering important new practical resources faster and cheaper and more efficiently than the GP Super Clinics program.

"The PCIG is building on what works," Dr Hambleton said.

"It is delivering real results for the community with local practices taking realistic steps to improve patient access to services.

"To date, the grants are supporting more than 200 practices to improve IT systems, build more treatment rooms, and ensure they have facilities to train the next generation of family doctors. This number will grow to 475 practices as funding arrangements are finalised.

"The AMA is recommending that the Government build on this momentum by increasing PCIG funding and offering a third round of grants to an additional 575 practices at an average of $300,000 each.

"More than $500 million has been allocated to the GP Super Clinics program, which has been plagued with delays and funding difficulties.

"Only 25 clinics out of a promised 64 are operating to date.

"Any GP Super Clinic funding that is not yet committed should be redirected towards PCIG program.

"It makes more sense to build on established general practices that have been serving towns and suburbs for generations than building expensive new white elephants that cannot attract GPs to work in them," Dr Hambleton said.

New Bat virus could hold key to Hendra virus, says CSIRO

Australian scientists have discovered a new virus in bats that could help shed light on how Hendra and Nipah viruses cause disease and death in animals and humans.

The new virus – named 'Cedar' after the Queensland location where it was discovered – is a close relative of the deadly Hendra and Nipah viruses.

However, CSIRO's initial studies have discovered one surprising key difference – the Cedar virus does not cause illness in several animal species normally susceptible to Hendra and Nipah.

This tantalising difference may help scientists understand how to better manage and control its deadly cousins. The findings have been announced in the journal, *PLoS Pathogens*, published by the Public Library of Science.

Mr Gary Crameri, research scientist with the bat virus team at CSIRO's Australian Animal Health Laboratory in Geelong, Victoria, said the new discovery had significant potential implications for protecting animals and humans from the Hendra and Nipah viruses.

"The significance of discovering a new henipavirus that doesn't cause disease is that it may help us narrow down what it is about the genetic makeup of viruses like Hendra and Nipah that does cause disease and death," Mr Crameri said.

"The more that we can learn about bat-borne viruses, the better chance we have of developing anti-virals and vaccines to help protect human health, Australia's livestock industry and our export trade from the threat of current and emerging animal diseases.

"Over 70 per cent of people and animals infected with Hendra and Nipah viruses die. This ranks henipaviruses amongst the deadliest viruses in existence, yet little is known about just how such viruses actually cause disease or death."

It is still too early to rule out the possibility that Cedar virus may cause illness and death in horses or other animals.

The discovery was a result of a close partnership with Biosecurity Queensland which played an important role by collecting and screening samples from bat colonies across Queensland.

"Field work with bats is an essential part of research into identifying new viruses," Dr Hume Field of Biosecurity Queensland said. "Bats are being implicated as the natural host of a growing number of viruses in Australia and overseas, yet they appear to tolerate infection themselves making bat research increasingly important."

Bats have been identified as playing a role in the spread of viruses including Ebola, Marburg, SARS and Melaka yet they are an essential part of our diverse ecosystem through their role as pollinators, seed dispersers and insect regulators.

The discovery is part of ongoing research by CSIRO to target diseases that threaten our animals, people and the environment and is part of CSIRO's wider biosecurity effort. It follows CSIRO's development towards a horse vaccine against Hendra virus.

Read more about CSIRO's Hendra virus research on their website.

AMA President, Dr Steve Hambleton's address to the

The following is an edited version of Dr Hambleton's address to the Press Club as part of the celebration of GPs during the 2012 Family Doctor Week.

Health reform

"health reform … the pace and extent of health reform in this country has slowed considerably.

To be fair, this does not mean that good and significant changes have not occurred.

The AMA acknowledges that the Labor Government has done many good things in health since coming to office.

The tobacco plain packaging legislation is world leading and a public health milestone in this country.

The AMA strongly endorses the Government's intention to introduce a National Disability Insurance Scheme, which appears to have bipartisan support.

We do not want to see the momentum for this Scheme slowed down.

The Government has invested strongly in Indigenous health.

We now have to work together as a nation to make that investment deliver its full potential.

This will involve capacity building in local Indigenous communities and concerted efforts to address the social determinants of health.

This is a big challenge and a big opportunity for us all. It is not just the job of Government.

After the usual heavy tussle, we now have a COAG Agreement between the Commonwealth and the States…but the blame game is alive and well.

This Agreement will continue to come under immense pressure as new State Governments attempt to flex their muscles. The Federal Government's promise to deliver clinical leadership to Local Hospital Networks has come under threat from the States already.

The Government has provided a significant increase in medical training numbers, including in general practice. This is a great investment in our future medical workforce.

We now need to see all our governments cooperate to ensure we have the right number of intern places to ensure these doctors of the future can finish their training.

And we now have the Australian National Health Prevention Agency dedicated to prevention.

We welcome this.

From our perspective, the dream of health reform that began in 2007 has not been realised.

Let's be clear. Real health reform for doctors, patients, nurses, and allied health professionals means more resources at the hospital bedsides, in the surgeries, and in community health services. The AMA is determined to ensure that the grassroots experience of medical practice is not drowned out in the health reform debate.

Our patients mean too much to us to let that happen.

But we still have many changes. We have to now manage those changes. And hopefully we can do that together. As you know I am a proud GP and this week is AMA Family Doctor Week.

It is our traditional celebration of the hard work and dedication of the nation's family doctors.

These are the GPs who serve local communities in the cities, the suburbs, the rural centres, country towns, and remote areas of Australia.

GPs have always been, and remain, the foundation upon which our health system is built.

To many Australians, GPs are the health system – the first stop every time. Throughout life.

I want to spend the rest of my time here today talking about GPs and primary care and the way ahead.

GPs are the first point of call in the health system when people are sick.

GPs deliver around 120 million consultations each year for patients.

They already deliver high quality, comprehensive care for patients, and they save the health system money. The care that GPs deliver is not only clinically effective, it is cost effective.

Any changes to the health system must add to this record, not subtract from it.

General practices – our family doctors – are key to ensuring that any changes deliver the best possible health care to patients and communities.

It does involve significant investment in challenging economic times – but it is the right investment to make.

I have just returned from a trip to New Zealand, where I visited a number of their primary health organisations (PHOs) – which are their version of Medicare Locals.

It wasn't that long ago that New Zealand was the place to look if you wanted to see what not to do in general practice and primary care. I have to say that things have changed considerably. They have learnt from their mistakes. And that is an important lesson for us.

Patients value the care that they receive, and bulk billing is not seen as a measure of how well the health system is performing.

Co-payments are a fact of life in New Zealand general practice with targeted initiatives in place to ensure affordable access for disadvantaged patients and for young children.

General practice in New Zealand has embraced team-based care – with GPs and nurses working closely together. Most practices have at least one nurse for every GP working in the practice. It's the delegated model of care that that the AMA has recommended. It sees many nurses working to their full potential in a well-supported general practice environment.

General practice is quite rightly relied upon to deliver population health in New Zealand.

I want our Government and the Opposition to make general practice an even stronger priority in the health policies they take to the next election.

At this stage we have seen very little detailed health policy from the Coalition.

There is a pledge to abolish Medicare Locals. But we have not been told what will go in their place.

There is a commitment to cut red tape and bureaucracy, but no detail about where and how much.

The AMA wants to see a competitive policy battle on health at the next election.

There can be no complacency from either side. The current Government has already made primary care a major part of its health reform strategy.

While a lot of its big health reform agenda has been watered down or put on hold because of the nature of minority Government, and the changes in governments at the State level, much of its primary care reform direction remains. However, the AMA has some points of difference about the way some of this policy is being rolled out.

I am concerned that the Government is getting some poor advice on what really happens on the front line of primary care. It seems that a lot of the reform is being brought in around GPs – through Medicare Locals and other health professionals, for instance – rather than being led and coordinated by GPs – as it should be.

The most cost effective health reforms are investments in general practice and reducing red tape, not taking savings from general practice or increasing complexity.

You just have to look at the last few Federal Health Budgets to see that savings have been made at the expense of general practice, rather than increasing funding for GP services.

Let's look at the list …

- Cuts to the Better Access mental health program.
- Cuts to incentive payments for immunisation.
- Cuts to incentive payments for cervical cancer screening and specialised diabetes care.
- Cuts to joint injection rebates.
- The loss of Medicare practice nurse rebates.
- And incentive payments for GP after-hours services are soon to go.

Instead of building and supporting general practice, there are cuts after cuts.

Instead of consulting GPs, there has been too much insulting GPs.

No wonder morale is down in the GP workforce.

But it does not have to be this way. We have shared our concerns with the Health Minister and she has been prepared to have the conversation with us.

We can learn from the New Zealand experience, especially in regard to Medicare Locals.

Medicare Locals will only succeed with GP leadership and majority GP decision-making.

They got it wrong in New Zealand before they got it right. Disenfranchising GPs set them back years.

We still have the chance to get it right first time…but we have almost blown it.

GP Super Clinics are fine if they provide services where they are needed and they do not compete with established GPs.

The shared electronic health summary will only work if GPs are supported for the work they need to do to make it happen. And on it goes. The key to getting primary care right is to work with and for GPs, not around or against us.

The AMA has a plan to turn things around and get health reform back on track.

Improved coordination of primary care services

First we must improve coordination of primary care services.

The AMA Council of General Practice understands the need for primary health care organisations to improve the coordination of primary care services.

They can help to break down the silos, build better links between the hospital sector and primary care, sup-

port improved population health, and address gaps in the delivery of primary care services. The Australian Government has called them Medicare Locals.

The Government has established 61 Medicare Locals across the country.

Although they have been operating since 1 July and been in the planning since 2009, few Australians have heard of them or understand what they do.

The Government is pursuing the wrong model by substituting the role of GP leaders in Medicare Locals and in their decision-making structures. The Government is making the same mistakes that New Zealand made in 2001 when it decided to implement 'skills based boards' that excluded GPs. These boards were initially made up of people who, while experienced in governance, did not understand the complexity of health care delivery.

Clinical leadership was absent in many areas in New Zealand and the models failed to deliver. The leadership role of GPs has now been restored and the PHOs in New Zealand are now playing a more meaningful role in support of improved health outcomes for local communities.

In New Zealand, the PHOs are:

- Supporting GPs to focus on population health;
- Supporting improved quality in general practice by facilitating information sharing among GPs;
- Supporting pro-active management of chronic disease;
- Supporting e-health initiatives;
- Funding specific initiatives to keep people out of hospital; and
- Helping support more sustainable general practice by building improved IT and delivering business support.

These are initiatives that are being built from the ground up and led by GPs, not imposed from the top down.

Our Government must urgently rethink its Medicare Locals model.

They are not local enough.

They will not be responsive to local health needs unless they are fully engaged with GPs. GPs need to be at the helm or it just won't happen.

Complex and Chronic Disease

We know that complex and chronic disease represents a huge challenge to the health system.

Chronic disease now accounts for about 70 per cent of the allocated health expenditure on disease and it is estimated to increase significantly in the immediate future. Current Medicare funded chronic disease management arrangements are limited, can be difficult for patients to access, and involve considerable red tape and bureaucracy.

We need a much better way. We need less red tape and more streamlined arrangements allowing GPs to refer patients to Medicare funded allied health services.

We need a more structured, proactive approach to managing patients with complex and chronic disease. The Department of Veterans Affairs is doing some great work in this area with its Coordinated Veterans Care (CVC) Program. DVA is supporting GPs to provide comprehensive planned and coordinated care to eligible veterans with the support of a practice nurse or community nurse contracted by the Department. The CVC program is a comprehensive approach to the management of chronic and complex diseases.

It supports GPs to spend more time on these patients on a longitudinal basis.

It recognises the non face-to-face work required, including regular follow-up to see how patients are going.

We need to look at how we can roll out this type of pro-active approach more broadly.

We could be investing in a healthier future with better disease management, and prevention of avoidable costly hospital admissions.

Infrastructure

We also need to support better infrastructure in general practice to improve access to multidisciplinary care.

The Government has invested over half-a-billion dollars in 64 GP Super Clinics – with only 25 operating to date. But there are problems across the board – and inequities.

Modbury in South Australia, for example, received $25 million in State and Federal funding, yet has no GPs. There are more than 7000 general practices across the country.

The Government's spend should have focused on supporting many of these practices to expand the services they provide to patients.

Investment in these practices would deliver better IT, new treatment rooms, space for a practice nurses and other health professionals. Access to care would improve and multidisciplinary teams would be encouraged. A recent Australian National Audit Office report showed that the Government's modest investment in its Primary Care Infrastructure Grants Program was delivering good results by investing in existing practices – with many projects being 'shovel ready'.

We need to see this program expanded dramatically, with the AMA wanting 575 more grants on top of those already made available.

Teaching and Training

General practice is a great place to learn.

GPs provide comprehensive care to patients from the cradle to the grave and the work is both challenging and rewarding. Australia has also more than doubled medical student numbers and our public hospital system simply cannot provide enough training places for these students.

There are also training gaps in the years beyond when they have graduated and are looking to complete specialist training. This presents a great opportunity to build the GP workforce.

By investing in a strong GP workforce, the health system saves money. GPs do a great job of treating illness early, recognising and managing chronic diseases, and keeping people out of expensive hospitals. However, many GPs are not engaged in teaching and training.

They may not have the facilities to place students, prevocational doctors and registrars.

They may have no way of recovering the significant opportunity cost to become involved in teaching and training the next generation.

The current subsidies for teaching medical students, for example, have not changed since 2005 -and are estimated to only cover around 30 to 60 per cent of the costs of taking on a student.

Only 14 per cent of general practices are involved in teaching medical students and we know that the GP training program is reaching saturation point.

Around 15 per cent of GPs are accredited to teach GP registrars meaning that there is enormous potential to get more GPs involved in teaching and training.

The fact is the subsidy for teaching medical students should be doubled and indexed annually.

This would be a great start in recognising the costs of teaching and would allow more GPs to get involved. Similarly, an expansion of the GP infrastructure grants that I referred to earlier would support essential upgrades to GP practices. This could allow them to take on a student, a prevocational trainee, or even a GP registrar.

Mental Health

The AMA recently conducted a survey on the impacts of the 2011-12 Budget cuts to funding for GP mental health services.

The results show that patients are missing out on important care as a result of these cuts. GPs are at the front line every day in helping individuals and their families through traumatic events, family crises and ongoing mental and other health conditions.

According to BEACH data, there are around one million GP consultations involving a mental health issue each year. Prior to last year's Budget cuts there was significant trend growth in the use of Better Access mental health services accessed through GPs.

That growth has gone. It must be restored. That is part of our plan.

Team-based care

General practice in New Zealand has embraced team-based care – with GPs and nurses working closely together.

As I said earlier, most practices have at least one nurse for every GP working in the practice.

Through medically-delegated nurse clinics, patients have improved access to care -and patient safety is assured.

We need to reinstate the highly successful and effective 'for and on behalf of' Medicare patient rebates as the foundation of team-based care.

Team-based care is a more effective approach than promoting a fragmented model of care where health professionals, such as nurse practitioners, work independently in isolation of the GP.

A current concern for the AMA is the pressure being placed on the Health Minister to change the collaborative requirement for midwives so that they only need to have arrangements with hospitals, rather than with a medical practitioner.

This approach is not good for patient care. It simply encourages new silos and diminishes a well-supported team based approach.

After-hours

The Government has decided to take the responsibility and the funding for the provision of after-hours services away from individual general practices.

It has given that responsibility to Medicare Locals.

Taking more than $100 million in funding from existing successful general practice after-hours services is not the way to go. It is far too early to give this responsibility and this funding to Medicare Locals. They barely exist. The UK tried this model and it has failed. The upshot of this was that many UK GPs then decided that after-hours was no longer their responsibility. We need a guarantee that the successful Australian after-hours service providers will be supported by the new Medicare Locals. Let's support what works. Let's build on success.

The Personally Controlled Electronic Health Record

The Personally Controlled Electronic Health Record – the PCEHR – is another speech for another time.

The AMA's views are well known.

Health Minister Plibersek knows our concerns and is still considering some of our ideas to help the PCEHR implementation succeed.

We all want it to succeed but it has to be done the right way and it must be more supportive of GPs. Without strong GP support, the PCEHR implementation will stall.

We need urgent clarity over when things will be rolled out. We need to know how doctors will be funded to do the Government's work. Patients need to know what they can realistically expect to receive when they try to sign up at the doctor's surgery. We need a timetable for the rollout.

And we need a comprehensive public education campaign.

Finally

So there is our plan to get primary health care reform back on track.

1 Improve the coordination of primary care services.
2 Introduce better systems to deal with complex and chronic disease.
3 More GP infrastructure grants.
4 Provide more incentives for experienced GPs to provide teaching and training for the next generation of GPs.
5 Restore funding for GP services provided under the Better Access program.
6 Support medically-led team-based care.
7 Preserve existing after-hours services that work successfully based on local knowledge and experience.
8 Get the PCEHR right.

The key elements already exist. They just need recalibration – a new and better direction.

They need a guarantee of GP involvement and leadership.

The health system can only improve if all its essential parts remain connected and become better connected. The glue that holds it together is general practice.

We urge the Government and the Coalition to look seriously at our plan for primary care. It will work. Talk to doctors when developing your health policy.

Talk to the AMA. After all, we are more than just a union.

AMA welcomes new concerted action to address bullying

AMA President, Dr Steve Hambleton, said recently that the AMA welcomes the initiatives and recommendations of the Anti-Bullying Forum, which was convened in Canberra by the Minister for School Education, Early Childhood and Youth, Peter Garrett.

The Forum brought together teachers, parents, young people, and experts in education, child welfare, psychology and marketing to discuss ideas to address bullying in schools.

Dr Hambleton said the Forum had produced a commendable list of ideas for action in schools and within families, and the outcomes were valuable additions to broader strategies to address bullying more widely in the community.

"Schools have an important role to play in the prevention of bullying, and many schools are making concerted efforts to prevent and address the problem," Dr Hambleton said.

"Unfortunately, bullying is not limited to school. Cyber bullying can occur at any place and at any time.

"Young people may be reluctant to disclose that they are being affected by cyber bullying, and may look beyond their parents and teachers for confidants with whom to share and discuss their problems.

"Doctors are a trusted and confidential source of information for young people and their families who are experiencing bullying, including cyber bullying.

"The physical and mental health consequences for those who are bullied are serious.

"Victims of bullying can become traumatised, anxious and seriously depressed, and sometimes these problems can continue through to adulthood.

"Doctors can help reassure children and young people that they are not alone in their experience, and that help is readily available."

Dr Hambleton said that Minister Garrett earlier this year launched AMA brochures to inform and assist young people and medical professionals to deal with issues arising from bullying.

A brochure for older children and adolescents, *Bullying: What you need to know,* explains what bullying is, provides specific information on cyber bullying, 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 medical professionals who are interested to know more about childhood bullying and its health impacts.

"We want young people to know that they can talk about bullying with their family doctor, and we want to make sure that doctors are equipped with easily accessible information and advice to help their young patients," Dr Hambleton said.

Background:

- 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 face bullying, 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).

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

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

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

The National Anti-Bullying Forum Communiqué is at http://www.ministers.deewr.gov.au/garrett/national-anti-bullying-forum-how-schools-and-parents-can-work-together-communique

The inaugural Hippocrates Ball

Hippocrates once said *"Let food be thy medicine and medicine be thy food"*.

This will certainly be the case at the Hippocrates Ball on Saturday 10 November.

Hosted by the Hellenic Club of Canberra to help raise funds for the **Canberra Hospital Foundation** and the **Newborn Intensive Care Foundation**, this ball aims to set new standards for the culinary offerings at such events. Yet, we have been able to set ticket prices at a very low $125 through the very generous support of the Hellenic Club and other supporters. Tickets are available from the Hellenic Club of Canberra.

Your Master of Ceremonies for the night will be the very talented and charismatic musician and musical Director, Ian Mclean. This night will not disappoint.

Cases of wine will be up for auction on the evening so we are looking for wine donations. If you can donate a bottle or two from your cellar then could you call Peter Cursley, Chairman of the Newborn Intensive Care Foundation on 0414 446 662.

Why: to support the Canberra Hospital Foundation and the Newborn Intensive Care Foundation

Where: Hellenic Club of Canberra

When: Saturday 10 November 2012

Cost: $125 and tickets available from the Hellenic Club of Canberra

Donations of wine gratefully received for auction and for further information contact Peter Cursley.

Surgery queues grow as hospitals feel the pinch

Some patients are waiting close to a year for treatment amid a nationwide rise in elective surgery waiting times and persistent emergency department delays that highlight shortfalls in public hospital funding, according to the AMA.

Figures released by the Council of Australian Governments (COAG) show the national average waiting time for public hospital elective surgery grew from 34 to 36 days in the three years to 2010-11, with some patients in New South Wales waiting as long as 333 days for treatment.

AMA President Dr Steve Hambleton said the increases, which came despite a big injection of Commonwealth funds, demonstrated the acute shortage of public hospital beds.

"Doctors on the ground, working in public hospitals every hour of every day, know that there has been little change to relieve the stress on hospitals and health professionals despite an almost 10 per cent increase in recurrent expenditure," Dr Hambleton said.

The AMA President made the comments following a meeting with COAG Reform Council chairman Paul McClintock last week to discuss the outcome of the Council's annual report on the National Healthcare Agreement.

Not only did the report identify an increase in national elective surgery waiting times – driven by a massive blowout in the average waiting time for treatment in NSW from 39 to 47 days between 2007-08 and 2010-11 – but found there had been no improvement in how long it took for emergency department patients to receive treatment.

The report showed that 68 per cent of patients were seen by emergency department medical staff within the time stipulated in national benchmarks in 2010-11, virtually unchanged since 2007-08, when the proportion was 67 per cent.

Mr McClintock said the results called into question the effectiveness of national partnership agreements in achieving improvements in the delivery of health services.

"Nationally, we have not seen a consistent improvement in either elective surgery or emergency waiting times," Mr McClintock told *The Australian Financial Review*. "You are entitled to ask whether the money being spent through the national partnerships [is] really delivering long-term improvements."

A spokesman for Health Minister Tanya Plibersek told *The Australian* the increase in elective surgery waiting times reflected the effects of the Federal Government's blitz on elective surgery waiting lists, which had deliberately targeted patients who had waited the longest for surgery, thereby pushing up the median waiting time.

But Dr Hambleton said the figures showed hospitals were struggling to cope with growing demand for health services.

He said that although there were an extra 872 beds opened in public hospitals in 2010-11, the number of beds per 1000 people had not changed.

"This means the new beds merely kept pace with the population and did nothing to increase the capacity of hospitals," the AMA President said.

Dr Hambleton said the pressure on waiting lists was even worse than that indicated by the COAG figures, because they did not take into account patients who were yet to be assessed for surgery by a public hospital specialist following referral from their GP.

He said patients were only counted towards waiting lists once they had seen a specialist and were booked in for surgery.

Dr Hambleton said official figures should take account of this hidden waiting list, and called on the COAG Reform Council to also adopt the AMA's *Bedwatch* proposal for a nationwide stocktake of the actual numbers of beds needed in each hospital to provide safe care.

"*Bedwatch* would track existing beds, new beds and bed occupancy rates to ensure that public hospitals meet the AMA's preferred level of 85 per cent bed occupancy."

The Reform Council's report showed that the proportion of patients complaining they had to wait an unacceptable time to see a GP fell from almost 18 per cent in 2009 to 15.5 per cent in 2010-11, while the proportion who deferred seeing a GP because of cost climbed from 6.4 per cent to 8.7 per cent over the same period.

But the AMA said the results, based on an Australian Bureau of Statistics survey asking patients about their experience, needed to be treated with caution.

Dr Hambleton said the rise in the proportion who claimed they had not seen a GP because of perceived cost was not consistent with Medicare data showing a record of 81.2 per cent GP services were bulk billed in the first three months of the year.

VALE!

The President, Dr Andrew Miller, Board, Members and Staff of the AMA ACT extend their sincere condolences to the family, friends and colleagues of Dr Damian McMahon.

Our thoughts are with them.

AMA (ACT) LIMITED

TGA ADVERSE EVENTS WEBSITE

This week the TGA launched a 'Database of Adverse Event Notifications' – an online resource that will give the public access to information about adverse events to medicines that have been reported to the TGA since 1971. The database includes adverse event reports about prescription medicines, over-the-counter medicines sold in pharmacies and supermarkets, as well as complementary medicines such as vitamins and herbal remedies, and can be accessed at: **http://www.tga.gov.au/safety/daen.htm**

It is a resource for GPs to use as well as patients. For GPs it's a correlation of the Product information supplied by the manufacturer and local experience.

This means that patients will be able to look up their medications and go to their doctors with the results of their searches. Although there are several disclaimers provided on the TGA's website about the limitations of the information, including that a report of an adverse event does not mean that the medicine caused the event, GPs may experience an increase in patients raising concerns about their medications.

Assisting Canberra Doctors and their families too!

The Medical Benevolent Association is an aid organisation which assists medical practitioners, their spouses and children during times of need.

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

The Association relies on donations to assist in caring for the loved ones of your colleagues.

For further information please phone Meredith McVey on 02 9987 0504

Doctors still working unsafe shifts in public hospitals

Release of AMA Safe Hours Audit 2011

There are still too many doctors working unsafe shifts in Australian public hospitals, according to an audit of hospital working conditions for doctors released recently in Sydney by AMA Vice President, Professor Geoffrey Dobb.

The *AMA Safe Hours Audit 2011* shows that 53 per cent of Australian hospital doctors are working unsafe hours – classified as high risk or significant risk – with reports of continuous unbroken shifts of up to 43 hours.

Professor Dobb said that State and Territory Governments and public hospital administrators must strengthen their efforts to support improved rostering and work practices for hospital doctors.

Professor Dobb, who works and teaches in a public hospital, said the AMA audit exposes work practices that contribute to doctor fatigue and stress levels that ultimately affect the quality of care and patient safety in the public hospital system.

The risks of fatigue have improved since the first AMA Safe Hours Audit in 2001, but reform of hospital work practices is too slow and inconsistent across the country. In the 2006 audit, 62 per cent of respondents fell into the significant risk and higher risk categories, while in 2001 it was 78 per cent.

The AMA is pleased that there is an overall trend of continued improvement, but the 2011 audit clearly shows that extremes still exist and, in some cases, they have become worse.

For example:

- in 2011, 21 per cent of doctors had no days free from work during the audit period;
- the longest recorded shift **increased** from 39 hours in 2006 to 43 hours in 2011; and
- the maximum total number of hours worked during the audit week actually **went up** – from 113 in 2006 to 120 in 2011.

The average of total hours worked in the 2011 audit week for all hospital doctors was 55.1 hours.

Conducted in August 2011, the audit tabulated responses from more than 1486 public hospital doctors of all ages from all States and Territories.

The on-line audit collected data on the hours of work, on-call hours, non-work hours, and sleep time experienced by doctors working in the public hospital system over a full working week, and was independently analysed for the AMA.

The most stressed discipline is surgery, where 77 per cent of doctors fall into the significant risk and higher risk categories.

Even doctors in the lower risk category are working shifts of up to 19 hours, while the average longest periods of work at the significant risk and higher risk levels are similar to the 2006 audit results.

Professor Dobb said that long unbroken shifts can have a significant physical effect on people.

"The performance impairment of a person after 17 hours of sustained wakefulness has been shown to be equivalent to that at a blood alcohol concentration greater than 0.05 per cent," Professor Dobb said.

"If this performance impairment was actually the result of alcohol consumption, prevailing hospital policies would prevent these doctors from working.

"It is not right to have doctors exposed to working conditions that could impair their performance.

"We need urgent action from governments and administrators to create and maintain safer working environments for doctors.

"Doctors don't necessarily need to work fewer total hours in order to reduce the risks of fatigue.

"Often it is simply a case of smarter rostering practices and improved staffing levels so that doctors get a chance to recover from extended periods of work," Professor Dobb said.

The Chair of the AMA Council of Doctors in Training (AMACDT), Dr Will Milford, said that fatigue has a big impact on the lives of junior doctors who are trying to juggle the competing demands of work, study and exams.

"Public hospitals are not just about service delivery," Dr Milford said.

"They play an essential role in teaching and training, yet many doctors can get to a point where they are simply too tired to learn.

"We need to strike a much better balance so that we have a quality training environment that recognises teaching and training and the benefits that environment can bring to quality patient care," Dr Milford said.

The AMA's *National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors* provides effective guidance on how to reduce the risks of fatigue. The AMA believes that it should be adopted by all States and Territories as an absolute minimum.

The *AMA Safe Hours Audit 2011* is at http://ama.com.au/node/8025

The AMA's *National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors* is at http://ama.com.au/node/3756

Renew your medical registration now

The AMA reminds all members to renew their medical registration by 30 September 2012.

AHPRA is encouraging registrants to renew online at www.ahpra.gov.au. To do this you will need to know your User ID and your password. If you have misplaced your User ID and password, contact AHPRA on 1300 419 495. Please note that your User ID is different to your registration number that appears on the National Register.

If you have not yet renewed your registration, you would have received electronic or hardcopy reminders from AHPRA. If you have not received any reminders to renew or are unsure, please check the National Register to make sure your details are up to date or contact AHPRA on **1300 419 495**.

There are four things you can do to prepare for your renewal:

- **CHECK YOUR REGISTRATION EXPIRY DATE:** You can check the online National Register at www.medicalboard.gov.au to confirm when your registration is due to expire and check your details.
- **UPDATE AHPRA WITH YOUR EMAIL ADDRESS AND YOUR CONTACT DETAILS:** Make sure your contact details, including your email address, are correct and current. This will allow AHPRA to send you email renewal reminders and to contact you if necessary. If you have your User ID, go online at www.ahpra.gov.au, click online services and follow the prompts to update your contact details. If you do not have your User ID, complete an online enquiry form, selecting 'User ID' as the category of enquiry or by calling **1300 419 495**.
- **WATCH FOR THE REMINDER TO RENEW:** A reminder to renew registration will be sent to each practitioner up to eight weeks before registration expires. Set your email account to receive communications from AHPRA and the Medical Board to avoid misdirection to an account junk box.
- **RENEW ONLINE, ON TIME:** The quickest and easiest way to renew your registration is online. Make sure you renew on time because under the National Law there is no option for AHPRA or the Medical Board to renew your registration after it has lapsed without a new application.

Leaving renewal to the last minute may have serious consequences for your practice.

- Should you fail to lodge your application to renew by 30 September, there is a late payment period during the month of October.
- If you lodge your application to renew during the late payment period ending 31 October, you will pay a late fee of $170 in addition to the renewal fee of $680.
- If you fail to lodge your application to renew your registration during the late payment period, your registration will automatically lapse from 1 November.
- Once your registration has lapsed, you will have until 30 November to apply to AHPRA for a fast-track application for re-registration at the cost of $340, in addition to the registration fee of $680. If you apply through the fast-track process AHPRA processes most applications within 48 hours of receiving a completed application. Applications that include adverse declarations can take longer.
- If you fail to re-register through the fast-track process by 30 November you will have to apply for new registration and only pay the registration fee of $680. AHPRA will process your application as a new registrant within the usual timeframe of up to 90 days.
- Should your registration lapse, you will not be able to practice until your registration application has been granted.

Your complimentary copy of the 2012 Specialist Directory

CANBERRA GPs

A complimentary copy of the 2012 Specialist Directory has been distributed to all Canberra GPs. If you have not received your copy, please contact Sue Massey on 6270 5410 and one will be mailed to you.

HOSPITAL BASED DOCTORS-IN-TRAINING

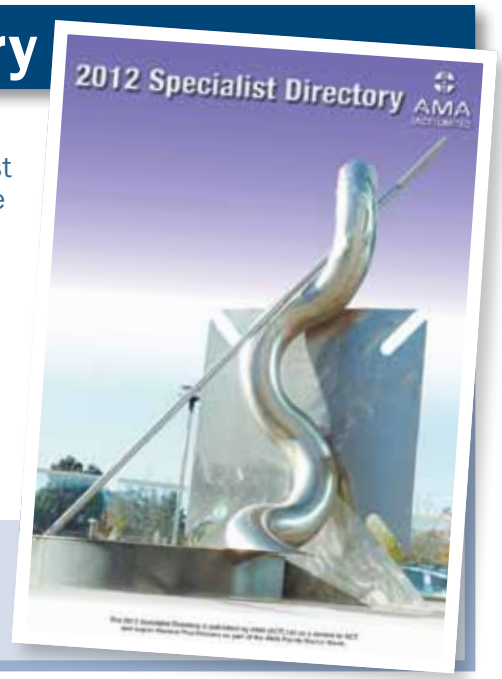
A complimentary pocket-sized edition of the specialist directory is available for AMA members. If you have not received your copy, please contact Sue Massey on 6270 5410 and one will be mailed to you.

GP REGISTRARS

To receive your complimentary copy of the 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 is available for downloading from the AMA ACT website:
www.ama-act.com.au/directory

ACCC CALLS FOR COMMENT ON SONIC HEALTHCARE'S PROPOSED ACQUISITION

The Australian Competition and Consumer Commission recently released a Statement of Issues on the proposed acquisition of the pathology businesses of Healthscope Limited in Queensland, NSW, ACT and WA by Sonic Healthcare Limited.

The Statement of Issues seeks further information on certain competition issues which have arisen from the ACCC's review to date.

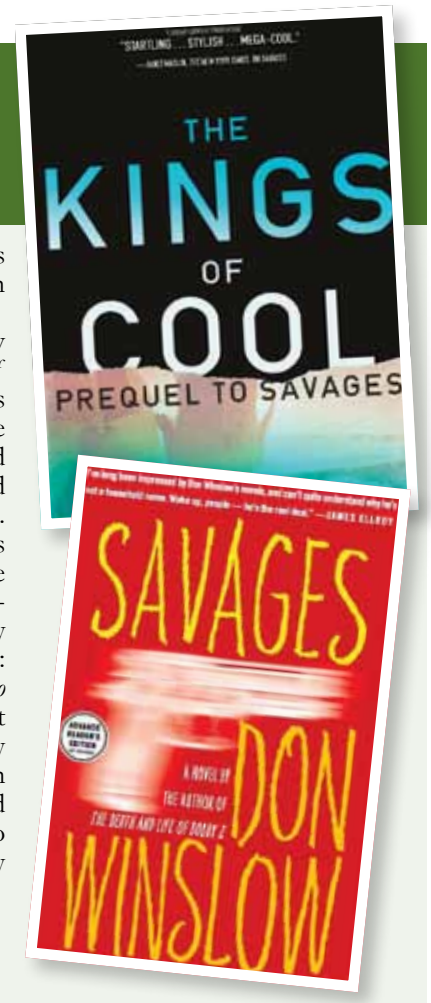
The ACCC invites further submissions from the market in response to the Statement of Issues by 16 August 2012. As a result, the ACCC's final decision will be deferred until 30 August 2012.

The Statement of Issues will be available on the public mergers register on the ACCC's website, www.accc.gov.au/mergersregister.

Submissions can be sent by email to the ACCC at:
mergers@accc.gov.au

Book Review:

Savages – Don Winslow, Simon & Schuster, 2010, ISBN 978-1-4391-8337-3
Kings of Cool – Don Winslow, Simon & Schuster, 2012, ISBN 978-1-4516-6532-1



These two books present a dilemma for the reader. *Kings of Cool* is a prequel to *Savages*, but was published afterwards. My experience was to read *Savages* first and this was quite fitting: for these two books may be likened to an American tragedy, which in a manner analogous to Sophocles' *Theban Plays*, the presentiment of doom sharpens the poignancy of the tragedy. These are fierce human tragedies of misadventure, miscalculation and malfeasance, which have as much universality as specificity to their milieu.

The key characters in the two novels are a trio of intertwined friends and lovers, Ben, Chon and O (for Ophelia), who live in the decaying detritus of the American dream, in SoCal (Southern California). Winslow's sniper shot prose targets the vacuous materialism, *anomie* and *angst* of the world in which this ill-starred trio become the *Kings of Cool*. These books are part morality play and mainly a depiction of the strange bonds of friendship, love and kinship amongst the destructive maelstrom of illicit drugs that rots the SoCal heartland.

Savages depicts of Ben and Chon, lifelong friends and now purveyors of marijuana, and their mutual paramour, O. Ben, who runs a charitable foundation funded by his drug sales is the leader, and Chon is his ex-Navy SEAL enforcer. Living the good life on their profits and their generally non-violent dealing, Ben and Chon are targeted by the Mexican drug cartels who insist they become indentured employees. Intertwined with this is the tale of the savage succession and internecine battles of the cartels on both sides of the border, abetted by corrupt law enforcement.

Kings of Cool comprises flashbacks to the earlier lives of the trio's parents and their travails, in an eerily prescient image of their future lives, intertwined with the history of how Ben and Chon became drug dealers. The seed of the present, through the involvement of Ben and Chon's respective parents in the drug trade from 1960s to the present,have truly been sown in the past. Thus the morality play takes on a darker tone of predestined tragedy, much as Antigone's steadfast intention to bury her brother despite the act being a capital crime or Euripides' tortured Medea plots the death of her own children in revenge.

Savages has been listed as a New York Times Bestseller and *Kings of Cool* is likely to follow. This is remarkable in that both books are sinuous, allusive, unrelenting and rippling with ferocious prose, and thus very unconventional indeed. Yet the harrowing tale of their lives and redeeming love of the trio are arguably universal, as in great tragedy. Winslow's characters,in sly asides, referencetheir heritage to: etymology, Aeschylus and *Farewell to Arms*, showing the generous heart of a great writer, and a playfully sharp sense of humour. We can imagine that Aeschylus and Hemingway would be honoured to appear on this stage, directed by such a great talent.

Reviewed by:
Associate Professor Jeffrey Looi
ANU Medical School

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