

Pro-smoking apps for smartphones the latest tobacco advertising outlet

Pro-smoking content, some featuring explicit cigarette brand images, is being promoted in smartphone apps reaching millions of users worldwide, including teenagers and children.

The easy availability of such apps in violation of Australia's ban on tobacco advertising is the focus of research by the University of Sydney, published recently in the British Medical Journal.

"The regulation of these apps is lagging behind the legislation in Australia and many other countries which ban tobacco advertising including through the internet and virtual stores," said Nasser Dhim, lead author of the study and a PhD candidate from the University's School of Public Health.

"This is despite the fact that the Apple and Android app stores have the technological infrastructure to block the sale of apps in accordance with local laws. As we show in our study Apple has already used this technology to ban access to certain content on its app store, in both China and Saudi Arabia."

The study identified 107 English language pro-smoking apps looking at the two dominant marketplaces – 65 from the Apple app store and 42 from the Android app store.

By February 2012, the pro-smoking apps available in Google Play were downloaded by an average of 11 million users worldwide over the lifetime of the apps. These figures are only for the Android apps as those for Apple apps are unavailable but are likely to be even higher, given the greater popularity of its store.

The research defined 'pro-smoking' content as any app that, for example, explicitly provided information about brands of tobacco, where to buy tobacco products or images of tobacco brands or cigarettes.

Smoking simulation apps, which can show virtual electronic cigarettes that users can inhale and exhale or feature games where users pass a

cigarette among game characters, were also classified as pro-smoking.

"These simulation apps include such examples as HotSmoke, where the virtual cigarette burns faster if you inhale faster and MyAshTray which simulates an ashtray where you can drop your ash and receive messages such as 'Would be even better with a beer in your hand!'" Nasser Dhim said.

"This is because other independent studies have shown that such virtual images of cigarettes are more likely to trigger smoking craving behaviour than to help them quit."

When the developer chooses a retail category to sell the app under in both the Apple and Android stores they are free to nominate multiple retail categories and they can also specify which countries they want their app to be published in.

Pro-smoking apps are available under multiple categories such as 'Health and Fitness', 'Entertainment', 'Games' and 'Lifestyle'.

"The availability of these apps, which feature high quality graphics, in 'Game' and

'Entertainment' categories increases their appeal to teens and children. While the Apple app store shows a warning about content before the app is downloaded the Android store does not. It is also worth noting that app stores are accessible from tablet computers which are increasingly used by school children."

The World Health Organisation Framework Convention on Tobacco Control bans advertising and promotion of tobacco products in all media including the internet. Advertisement and promotion of tobacco products are defined in the convention as 'any form of commercial communication, recommendation or action with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly'.

"So the issue of these apps violating laws on tobacco advertising goes well beyond Australia and applies to all signatories to the convention including the United Kingdom, Sweden and South African which have a complete ban on online ads.

...Continued page 4.

We review below example applications (apps) of each category.

- ▶ Tobacco Shop/Brands apps
 - Cigarettes: Android app that lists famous cigarette brands and products with images, their specifications and their availability in various countries.
 - Cigar smoker: Apple app for iPhone, iPod touch and iPad (figure 4) provides information about various cigar brands, tips, video reviews and allows users to take photos of their favourite brands and share them on social media.
- ▶ Smoking Simulation apps
 - HotSmoke: Smoking simulation app in the Apple App Store that allows the user to pick a cigarette box that resembles a wide range of famous brands in high quality 3D design (online supplementary image 3) and then smoke a cigarette virtually by holding the phone near the mouth and using the microphone. The user will be asked to inhale and exhale, the cigarette will burn faster with inhalation and smoke will show on the screen with exhalation; the user can shake the phone to drop the ash. The cigarettes also resemble the cigarettes of the brand the user selects. This app advertisement started with 'Please enjoy the real smoking anytime in any indoor space including office and home!' It also claims to help users quit smoking.
 - Puff Puff Pass: This app is a cartoon game where the user must click on game characters to order them to smoke and pass the cigarette to the other characters. The user collects points if he or she continues passing the cigarette in the same sequence at a fast pace. Users also can select the type of tobacco (cigarette, cigar and pipe) (figure 5).
 - MyAshtray: Apple app that simulates an ashtray where the user can click on it to open it and click inside it to drop cigarette or cigar ash or a cigarette butt (supplementary figure 8). After each few ashes drop, the app displays messages that encourage smoking behaviour, such as 'Would be even better with a beer in your hand!' This app also has a quit smoking help claim.
- ▶ Wallpaper apps
 - Marlboro Red 3D Live Wallpaper: Android app that explicitly shows the famous Philip Morris brand Marlboro in attractive 3D images that show the pack from various angles so users can have it as a theme background for their phone (online supplementary image 1).
- ▶ Cigarette Battery
 - Cigarette battery widget: Shows burning cigarette on the phone screen with the battery life percentage (supplementary figure 9).
- ▶ Smoking Advocacy
 - CRA—Cigar Rights of America: Available in both Android Market and Apple App Store; its advertisement states that it is for a non-profit public advocacy to protect the freedoms of cigar enthusiasts. The objective is to focus on: opposing restrictive smoking bans, opposing taxation of cigars, government regulation of cigars and policy measures relating to cigars. App contains audio and video streaming for speech-related to the app objectives, news and events, and how to join or support the group (supplementary figure 10).

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TERRITORY TOPICALS – from President, Dr Andrew Miller

Doctors in training ...

The issue of the career paths that our junior doctors will have to follow in the future continues to concern me.

We are faced with the “great wave” of graduations as all the new medical schools begin to send out their products into the medical workforce. Now, we all know that everyone needs an intern year in order to achieve general registration; and that the AMC has decreed that this should include an 8 week emergency term and at least 10 weeks each of medicine and surgery. We also know that our various health authorities are scrambling to be able to accommodate this year’s projected graduation, which will be exceeded nationally in 2014 by another 600 places! At present, as part of a “gentleman’s agreement” most jurisdictions offer a 2 year contract to new graduates, guaranteeing them a PGY1 and 2. If this model continues the effect of the increased graduate numbers will of course be greatly magnified.

Consider then what these health authorities, pressed for cash as they are (and also facing the uncertainty of the new Commonwealth health funding reform which will cut in in 2014), will do to junior doctors who are not engaged in a vocational training programme by the end of their PGY2?

I suspect that we all know. One of the reasons that I arrived in this town was that I was just such a doctor; and I was washed out of my comfortable lodgings in a Sydney teaching hospital by the mini-tsunami caused by Newcastle University graduating its first batch of interns. Not that I regret the move for an instant (which is why I returned

here after doing my specialist training in Sydney).

I can foresee a number of problems here. Firstly, it is debatable as to whether we should be streaming vocational training so early. There is no substitute to patient-miles in a well-supervised environment when it comes to acquiring the general clinical skills that make a doctor competent and safe. Unfortunately, despite the frustrating increase in the tendency to silo medical care, patients do not come pre-packaged for distribution into subspecialty care. It takes the Wisdom of Solomon to decide just how such a division of care should be arranged, and that can only come with experience. All our junior doctors need to see people who are sick, really sick – so that it doesn’t scare them. They need to see people with rare stuff – not so much so they can recognise it next time; but so they understand that when funny little divergences from the expected occur there may be a surprise lurking behind (it’s the Rumsfeld principle: the things I don’t know I don’t know really scare me). They need to work with complex things so they learn to prioritise ... and it all takes time.

The other problem is that some vocational streams rapidly move from general medicine, so limiting the capacity of trainees to continue to acquire those important generalist skills. Of course their patients continue to have those annoying comorbidities. The mix is not conducive to efficient, effective and safe medical care.

The colleges all have their own ways of selecting applicants onto their training programmes. Some years ago my own threw its old system out because we found that our candidates were leaving clinical work and doing research so they could impress with PhDs on their CVs. This was exactly what we did not want – we saw our job as being train-

ers of clinicians (I am aware of only one of these who continued in research). Maybe I am a Luddite – but I can’t help feeling that the others wasted good time that they could have used acquiring clinical skills.

So what will happen to the PGY3 and 4 doctors who are trying to get into vocational training programmes? I am concerned that they may end up parked in jobs with little or no supervision, no real career path ... and in the end that will be a killer on their CVs and they may well miss out altogether.

The AMA is aware of these issues and is trying to advocate for change. I have also raised the issue with my own college and a review of the selection process is under way. We all need to join in advocating for our junior doctors here. The advocacy may be through organisations such as the AMA; certainly the colleges need to be urged to consider their response to the problem. As senior practitioners, those amongst us who are involved in junior doctor supervision and training, we also need to consider ways that these early years can be kept valuable as training opportunities as the patient resource is diluted further and further.

Locally the AMA ACT is engaged in discussion regarding reorganising the classification system for junior doctors. This process will have a very real impact on the outcomes I have mentioned here. We are determined to ensure that there are no dead-end pathways. It may well require innovative thinking; but then this situation is a challenge to most of the conventions of the past.

This debate is about quality care, quality training and the welfare of our protégés.

... and our International Medical Graduates

The issue of supervision of IMG’s employed in

area of need positions has been in the news recently. In particular, the practice of accepting remote supervision by telephone as a reasonable means of support has been criticised by the RDA.

These doctors have medical degrees, but they have not been assessed as being equivalent to our own. They have been assessed as “fit for task” when practising in a supervised capacity. I have no doubt that they are as dedicated and caring as any Australian graduate; and the great majority are as skilled and knowledgeable. There remains, nevertheless, a formal element of doubt; and hence the supervision requirement. This, of course, ignores completely the difficulty of picking up practice in a system as arcane as our own MBS and PBS. Let me make my own opinion quite clear; I cannot conceive any merit other than crass commercial expediency in such an inadequate approach.

There is another concern buzzing in my mind; and that is whether there is a real need for these area of need positions to continue in Canberra. In the past the AMA has agreed with government that there was a 70 position shortfall in the number of GPs in the ACT; and that where local graduates could not be found, an area of need position could be declared. The “newer” suburbs of Canberra have been classified by the Commonwealth as districts of workforce shortage. Yet despite this there are an increasing number of practices in Canberra with spare capacity; which then begs the question as to whether a practice should be allowed to advertise for new area of need practitioners if its neighbours are advertising for



Dr Andrew Miller

patients because of spare capacity. Further, the practice of rolling-over area of need positions should be called into question. It is not sufficient to argue that it suits a practice’s business model to replace one area of need practitioner with another; particularly, once again, when its neighbours have spare capacity.

None of this, of course, considers the long-term viability of the area of need system in the ACT as increased numbers of young Australian graduates move through the system. Indeed one could argue that an apparently saturated market may act as impediment to recruiting local graduates as long term residents.

I agree with the RDA when they say that the area of need system is a “Band-Aid” solution; and I profoundly disagree with the assertion that this is the new face of general practice. I have always told my patients that the most important doctor that they have is the one who knows them best and participates in their long term medical welfare; their GP.

Medicare Local, general practice and pharmacy

Even from afar local events have reached my ears. The inaccurate reporting in the “Canberra Times” of an ACT

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Medicare Local initiative has certainly ruffled feathers.

This new program initiative acknowledges that for years pharmacists have had a de facto triaging role in the community since people will consult a pharmacist for advice before they see a doctor in many cases. We should also remember that many medications have been rescheduled to S3. The program of training proposed by the Medicare Local will ensure that our local pharmacists are not operating in an information vacuum; they will be resourced with local knowledge about local medical practice hours to facilitate on-referral for medical care. Importantly they will also be trained to recognise some of the subtle clinical red flags that come as second nature to us as trained diagnosticians and therapists; so that rather than dispense they will facilitate appropriate medical intervention. I believe this to be a timely and well considered initiative which will involve both the Medicare Local and the ACT branch of the Pharmaceutical Society of Australia. But, of course, we will consider this in detail and make a considered assessment as it moves from a proposed initiative to an implemented program. I have been assured that this is not about diminishing or devaluing the role of general prac-

tice, but rather informing and upskilling pharmacists in order to better assist patients and GPs alike. We would not support any initiative that encouraged allied health practitioners to take over any of the diagnostic responsibilities for which the medical profession is the appropriately trained health professional. We look forward to more detail on this proposal from the Medicare Local in the coming weeks and months.

And a final word ...

I am currently touring the eastern Mediterranean and have been able to observe at first hand the effects financial vandalism can have on an economy. Greece, once a major

cotton producer (and arguably able to more sustainably grow cotton than ourselves) is faced with a drastically reduced cotton crop despite an ideal season, simply because the farmers were unable to obtain the credit they needed to sow.

As a tourist I can't imagine many more beautiful and welcoming destinations; but conversations with the locals revealed a sobering level of hardship. We have, nevertheless, enjoyed ourselves immensely and have done our best to support the local economy, although I suspect I'll need to invest in a gentleman's support after lugging my bag home.

Improving after hours healthcare options through pharmacy

As mentioned by President, Dr Andrew Miller, in his column "Territory Topicals" below are the details, as advised by the Medicare Local of its new initiative.

The Medicare Local media release states the ACT Branch of the Pharmaceutical Society of Australia (PSA) has been granted funding through the ACT Medicare Local (ACTML) to develop a groundbreaking education program which will more fully utilise the skills and extend the knowledge of pharmacists in producing better health outcomes for the capital region.

ACTML Chair Dr Rashmi Sharma said ACTML's After Hours Program is about enhancing access to after hours primary healthcare services and ensuring Canberrans are aware of where they can receive after hours care that is urgent and requires medical attention before the next day.

"ACTML conducted an initial needs assessment which confirmed that pharmacists play a key role in providing assistance to Canberrans during the after-hours health care period. We are pleased to be funding the PSA program to develop and deliver this training package to pharmacists," said Dr Sharma.

The program will raise the awareness of pharmacists in after-hours services and develop their skills for managing and triaging common after-hours presentations.

ACT PSA Branch President Professor Gabrielle Cooper said the project would improve the knowledge and skills of pharmacists and their staff with regard to triage, management and referral of common after-hours presentations.

"This is a very exciting development for the ACT and sets a benchmark in collaborative after-hours care," Professor Cooper said. "The program will result in pharmacists and their staff being more informed, equipped and confident, through improved knowledge and skills, to manage and/or refer common after-hours presentations to the most appropriate service."

"As a result of this program I am confident the community will be more aware of after-hours services available to them, which service is relevant to meet their needs, and when it is appropriate to use the relevant service."

Professor Cooper said for too long the skills of pharmacists had not been used to the best advantage of health consumers.

"One of the aims of the program is to more fully utilise existing pharmacist's skills as health-care professionals. In addition, the pharmacists will be better informed of services that can be accessed after-hours by the community and in so doing reduce the load on the acute care hospitals. The program aims to further address the gaps in after-hours care in collaboration with other primary care providers and the ACT Medicare Local. Working with the ACT Medicare Local, the ACT PSA Branch will develop a program that will set the standard for others to follow," she said.

ACTML is implementing a number of additional strategies to improve access to healthcare after hours.

"ACTML will soon be implementing a consumer awareness campaign to ensure Canberrans know what their healthcare options are after hours. We will be encouraging Canberrans to consider all their after hour options, including going to their pharmacy for after hours help and support," said Dr Sharma.

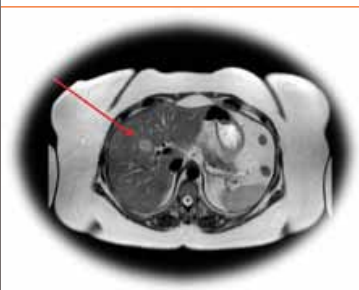


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Pro-smoking apps ...continued

...From page 1.

“These companies already have the infrastructure to comply with this WHO convention on tobacco and many countries’ own national laws restricting tobacco advertising, including to minors,” said Associate Professor Lyndal Trevena, a contributing author to the study together with Dr Becky Freeman, both from the University’s School of Public Health.

“They should immediately move to apply that capability to restricting the sale of these pro-smoking apps.”

A 2011 survey found that smartphones account for 67 percent of all mobile phone handsets in Australia but their use is increasing exponentially and it is expected that in the near future all mobile phones will be smartphones.

Cancer Council Australia, CEO, Professor Ian Olver, said, “the research that identified over 100 apps which encourage smoking is disturbing since such games and simulations of smoking are targeting young people to try to normalise smoking. Health messaging on the harms of tobacco may be circumvented and such apps would be available anywhere in the world and to anyone. The question of whether the tobacco industry is behind any of these should be raised and the legality of these apps some of which display specific brands should be explored since Internet advertising of tobacco in Australia is banned. They are certainly against the spirit of laws such as plain packaging which seeks to reduce attracting young people to take up smoking so that they are not addicted at an early age and suffer the damage to their health that follows”.



Image 3: Android app to collect points for buying Marlboro cigarette

AMA responds to consultation paper on social media policy

The Australian Medical Association (the AMA) has responded to the National Boards’ preliminary consultation paper on social media policy, which deals with an emerging issue that is very relevant to AMA members and the profession more broadly. While young doctors and medical students are seen as being more engaged with social media, its growing popularity and adoption makes an issue for the whole profession.

The AMA in association with the Australian Medical Students Association, the New Zealand Medical Association and the New Zealand Medical Students Association has produced a comprehensive guide entitled ‘Social Media and the Medical Profession: A guide to online professionalism for medical practitioners and medical students’ (the guide). (AMA ACT provides a copy of this resource to all interns).

The AMA is supportive of the development of further guidance for medical practitioners and other health professionals in this area and there are several key areas that the draft policy and the guide have in common. These are:

- Professional boundaries;
- Professional behaviour; and
- Confidentiality.

The AMA recognises that, in preparing the draft document, the

National Boards have done so in the context of their regulatory function and given the attractiveness and widespread adoption of social media there would be merit in providing broader advice on how to participate in social media in a responsible way. In this regard, the AMA would suggest that the draft should provide information on where doctors and other health professionals can access other useful information on issues including:

- Defamation. This is a key risk in social media and a potential looming legal problem which few social media users are aware of, particularly the young.
- The growing propensity for employers to ‘background check’ future employees by checking their social media exposure.
- What to do if a doctor or medical student finds they are being bullied or harassed in a social media setting. This is particularly relevant as it is possible for patients and others to set up ‘hate pages’ and harass doctors on line.
- More information on technical issues such as privacy settings. It is apparent that many social media users are not sufficiently vigilant in their oversight of privacy settings and other technical settings involved in social media, leaving them vulnerable to a range of risks and unwanted communications.
- Warnings around taking part in groups and on-line dialogues which may be offensive, or even illegal.
- A cross reference to other relevant policies prepared by

the National Boards, such as Sexual Boundaries: Guidelines for doctors.

The AMA has agreed to other organisations linking to the guide or using it in preparing their own publications (with appropriate acknowledgement) and would have no objection to the National Boards making reference to it in the final policy document. Further, reference to the AMA Code of Ethics may also be relevant. It provides a comprehensive, broad based ethical structure for doctors. Whilst it does not reference social media specifically, sections of the code resonate in this context, particularly section 2.1 Professional Conduct, which provides:

- Recognise that your personal conduct may affect your reputation and that of your profession.
- Refrain from making comments which may needlessly damage the reputation of a colleague.

The AMA also recommended that future amendments to Good Medical Practice: A Code of Conduct for Doctors in Australia should include specific reference to responsible use of social media, to both educate and protect doctors, as they now face a professional setting characterised by the increasing use of electronic communication with patients and other health professionals.

It is hoped that the guide and the social media policy developed by the National Boards will be effective tools to educate and inform doctors and medical students of their rights and obligations in the social media environment so that they may be more prepared for the challenges of this medium, and use and enjoy it responsibly.

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AMA runs National Summit on Alcohol Marketing to Young People

Last month the AMA conducted a National Summit on Alcohol Marketing to Young People at Parliament House in Canberra, in association with the 70-member National Alliance for Action on Alcohol (NAAA).

The Summit heard from a number of leading researchers and academics in the field, and also heard views from a panel of prominent Federal Parliamentarians with portfolio interests in the area. The AMA also released a major report - *Alcohol Marketing and Young People: Time for a new policy agenda*.

From the deliberations and points of view expressed at the Summit, there was a broad consensus about the following key findings:

- Young people in Australia are regularly exposed to alcohol marketing in the traditional contexts of television, radio, print and billboard media, and also increasingly in new platforms for marketing and promotion through digital technologies and new social media such as Facebook and Twitter.
- Young people routinely encounter alcohol promotion and sponsorship as a feature of music and sporting events where it is presented as a normalised part of being healthy and having fun.
- Alcohol promotion affects young people's attitudes to alcohol and their

consumption behaviour, leading them to take up drinking and to drink more when they do.

- Young people are at particular risk of harm from alcohol use. If left unaddressed, continued irresponsible alcohol marketing to young people will serve to escalate those risks and harms.
- Today's media environment is radically different to when the current policy responses in Australia regarding alcohol advertising were put in place, with increasing take up of Pay TV, more free to air channels, the explosion of social media and the shift to online content.

- The current policy regime is totally inadequate in protecting young people from continued exposure to alcohol marketing. Industry self-regulation is deeply ineffective and has failed. It is time for a robust regulatory response that is independently and impartially applied, and which carries the force of meaningful sanctions.

The AMA and the NAAA believe that the exposure of children, teenagers and young people to alcohol advertising and promotion should be curtailed by government regulation, which is independent of the alcohol and advertising industries.



Major decline in rates of cervical cancer projected Australia's vaccination program a world first

A national vaccination program in Australia to reduce the rates of cervical cancer has been heralded as "outstanding" by sexual health experts presenting at IUSTI 2012, an international sexual health conference which took place in Melbourne recently.

Australia is leagues ahead of other countries in this field, they say.

The success of Australia's National HPV vaccine is a source of international envy," says IUSTI Congress Convenor, Professor Christopher Fairley.

Virtually all cervical cancers are caused by human papillomaviruses (HPVs), sexually transmissible infections that can cause genital warts. In 2007 Australia launched the 'National HPV Vaccination Program' in an effort to reduce the incidence of genital warts and HPV related cancer.

One study presented shows a massive decline in the incidence of genital warts in women under 30 since the introduction of the

vaccination program: in women under 21 years of age, there was a 92.6% decline and in those aged 21-30, a 72.6% decline.

The current vaccine used in Australia provides protection against 4 strains of HPV: HPV6, HPV11, HPV16 and HPV18. HPV6 and HPV11 are responsible for around 90% of genital warts. HPV16 and HPV18 are responsible for 70% of cervical cancer.

In a world first, Australia will next year be launching a publicly funded HPV vaccination program targeting boys.

These developments are leading scientists to project that genital warts may soon be eradicated in Australia's youth, with a related decrease in HPV-related cancer.

About IUSTI 2012

HPV research was presented at the 13th IUSTI World Congress, which took place at the Melbourne Convention and Exhibition Centre, 15-17 October 2012. The Conference incorporated the 2012 Australasian Sexual Health Conference and was held back to back with the 24th Australasian HIV/AIDS Conference.



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Clinical engagement in hospital management

Perceptions about the importance of doctor participation in hospital management have changed over time. Senior Industrial Relations Adviser Rod Felmingham from AMA Victoria examines the importance of having doctors at senior levels of administration in health services.

Improving clinical engagement through mechanisms to formally and informally involve all health professionals in guiding the management and future directions of health reform was the subject of a number of recommendations of the National Health and Hospitals Reform Commission Final Report (2009).

The stated aim was the establishment of better participatory and consultative mechanisms to build 'genuine clinician engagement'.

Why is it generally agreed that clinicians are not 'engaged'? Most academic literature on the subject relates to the UK's NHS, but many observations are readily transferable to Australian public hospitals.

There was a time, probably last seen in the 1960s, when hospitals here and in the UK largely conformed to the model of the classical professional organisation where professional experts (doctors in our case) exercise the power, and managers administer facilities, pay the bills, and support the professionals in their endeavours.

Clearly, hospital management now and for some time has reflected more strongly managerial modes

of operation, seen to be necessary by their funders (the governments) to increase efficiency and control costs.

Corporate managerial structures and business values are superimposed on the professional provision of medical services. Doctor involvement in management has not been welcome.

In Victorian public hospitals, the Department of Health and individual Health Services have clearly been uncomfortable with recognising the potential role of medical administrators in medical leadership. Hence the insistence that medical administrators be employed as 'executives' in accordance with Government Senior Executive contracts, and the strong reluctance to acknowledge that they might be employed as doctors whose speciality is medical administration.

The adverse consequences of not providing opportunities for the professional service providers to be fully involved in hospital decision-making have been pointed to in the Queensland Health System Review, the NSW Camden-Campbeltown Hospital Enquiry, and the WA King Edward Hospital Review. The National Health and Hospitals Reform Commission recognised the issue.

Doctors may not be expert in managing corporate budgets, but there are arguably no greater experts in what should be the core business of a public hospital: treating the sick and injured, and relieving human suffering.

Small changes have flowed from the recognition of the issue. Clinical engagement has application at a number of levels, and at a state-wide level in Victoria, for example, the development of clinical networks, aimed at strengthen-

ing the involvement of clinicians in planning and funding allocation, can be a useful means of bringing a clinical perspective to those high level management functions.

The limitation of that type of clinical engagement, though, needs to be recognised. Its usefulness is to allow administrators to more effectively achieve their goals by accessing good advice from experienced senior clinicians. It does not necessarily play an effective role in helping clinicians, or the medical profession more broadly, to shape the administration and operation of health services to better achieve clinical goals of quality and excellence in patient care.

What exactly is meant by 'clinical engagement'?

Clinical engagement sounds as though it must be a good thing, but what is it? The National Health and Hospitals Reform Commission Report did not offer a definition (or even a helpful discussion). International literature, the vast bulk of which has been generated by management academics in relation to the UK NHS, has produced no consensus definition either.

No operational metric to measure the breadth or depth of clinical engagement has been developed, because there is no consensus on what would be measured.

It is unsurprising that clinical engagement has not seized the imagination of the medical profession, when it is not at all clear what is meant by the term.

The sense of what is sought to be achieved is perhaps captured by an NHS Alliance definition which speaks of 'two-way involvement between health professionals and management at a level that influences decision making'. Involvement should be an integral part of the decision making pro-

cess, rather than an add-on or after thought once decisions have been made – a two-way ongoing and active involvement in influencing decision making.

Some academic definitions have attempted to capture an assumed fundamental purpose of clinical engagement, which relates to informed advocacy for and on behalf of a patient population group or individual patients.

A useful simple definition might be derived from the Welsh NHS, where the stated aim of clinical engagement is to provide opportunities for clinicians to participate in decision making and advise senior management on issues in relation to governance, planning, service delivery, workforce, and safety and quality.

The possible pitfalls of clinical engagement

It is possible for clinical engagement activities to be implemented but with few of the positive results, that doctors might expect, to flow.

The bulk of the literature on clinical engagement is written from the point of view of promoting involvement of senior clinicians in management in order for management to more effectively be able to implement organisational change. If doctors are not involved, they can be an obstacle. There is nothing easily found written from the point of view of promoting involvement of senior clinicians in management decision making in order to better orient health care organisations to achieve quality and excellence in patient care.

Clinical engagement is about getting doctor buy-in for organisational change, because without doctor buy-in, the evidence is that organisational change does not work very well.

A cynical view of the NHS experience might be that clinical engagement is not just about cost cutting. It is about getting doctors on board with cost cutting, and where possible, putting doctors in charge of cost cutting so it will be more effectively implemented.

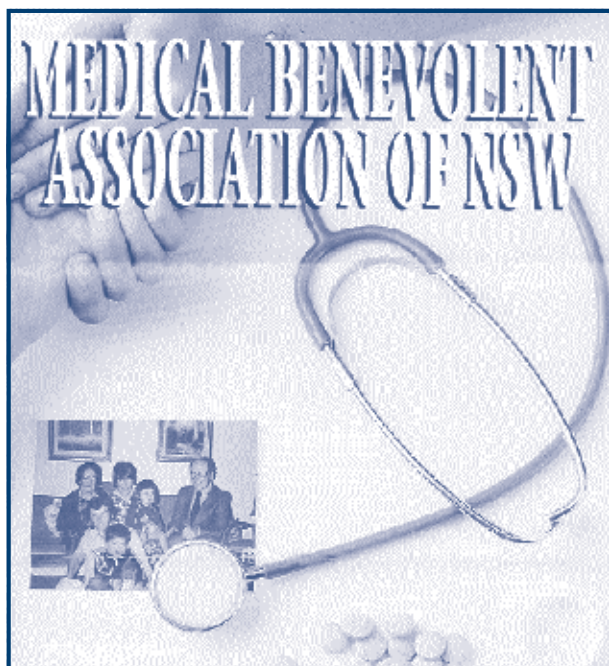
Using clinical engagement to achieve a better health system

The perspective that the medical profession can bring to health system management is its focus on and commitment to quality patient care.

Academic writers have seen it as an issue that doctors tend to have an individualised focus on patients, which is at odds with the more systems-wide view most managers are said to take.

However, an intelligent focus on quality and excellence in patient care, along with the commitment to do the best that can be done for every individual patient, inevitably leads to an appreciation of the importance, for example, of teaching, training and research in the public hospital setting. Possibly not the kind of 'system-wide improvement programs' that are a priority for most managers preoccupied with meeting patient throughput targets within the limitations of an inadequate budget, but fundamental elements of the partnership between the medical profession and the public hospital system.

The maintenance of a capacity to deliver quality and excellence in patient care into the future demands that the 'short-termism' which is required of hospital administrators managing an annual budget in the context of a short-term 'vision' must be moderated by an understanding that there is more



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to providing quality patient care than what is happening this week or even this year.

If the community is to be served by doctors in the future who are hopefully as good as, maybe even better than, the doctors of today, high quality teaching and training of medical students and junior doctors in the clinical setting is essential, and must be an essential part of the work of a public hospital.

If the community is to benefit from this generation of the medical profession continuing to contribute to the development of the art and science of medicine, so that knowledge, treatments, procedures, techniques and technologies are improved, it is equally essential that public hospitals are places where research and development is supported, facilitated and encouraged.

If clinical engagement can be a genuine two-way process, which allows such perspectives to be incorporated into strategic management decision-making, the medical profession will be better able to make the contribution to the community which the community expects from it.

The mechanisms of clinical engagement

In Australian public hospitals doctors are not excluded from management. We have the situation where clinical directors are commonly senior doctors who maintain their clinical roles but also have a management responsibility, sometimes as part of a management team which includes a nurse and possibly a business manager.

Often, however, doctors in senior management roles are seen as occupying a 'no man's land'

between management and clinicians.

It has been commented in the NHS that at worst, medical directors and clinical directors are used largely to respond to and placate senior medical staff in the various budget-balancing exercises that involve closing beds periodically, not filling staff vacancies and cancelling operating lists.

The importance of engaging doctors in leadership on an individual basis is recognised, but it is not a sufficient condition for achieving clinical engagement. Within medicine, as with other professions, a range of leaders exists who might not be official leaders in the eyes of their organisation but will be very influential for other reasons among their peers.

Simply making doctors bosses will not, by itself, deliver clinical engagement.

If two-way clinical engagement is to be achieved, in a way that genuinely enables the medical profession effectively to advocate for quality and excellence in patient care, it is submitted, on the basis of international experience, that it must include a strong collegial element.

The existing structures that would provide the foundation for this in Victorian public hospitals are the senior medical staff associations. If the Department of Health and individual Health Services seriously want to work towards clinical engagement, fostering, encouraging and supporting senior medical staff associations will be an essential element.

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Medicare patient rebates failing to keep pace with the true value of quality medical care

AMA Vice President, Professor Geoffrey Dobb, said recently that the new Medicare Benefits Schedule (MBS) patient rebates, to apply from 1 November 2012, fail dismally to reflect the true value of quality medical care in Australia.

The new MBS patient rebate for a standard GP consultation is \$36.30, an increase of just 70 cents.

The Government's own data shows that, in 2011-12, the average out-of-pocket cost for patient billed services for GP consultations was \$26.97, an increase of \$1.72.

Professor Dobb said that the MBS indexation is totally inadequate.

"It is not keeping pace with the increased costs of providing medical care and it is shifting higher costs to patients.

"It is also undervaluing quality medical care," Professor Dobb said.

The AMA List of Medical Services and Fees, which will be available shortly, better reflects the value of quality medical care and what is occurring at the coalface of health service delivery.

This year, AMA fees have been indexed, on average, by 3 per cent. This compares with the Labour Price Index of 3.65 per cent and CPI of 1.75 per cent. The new AMA recommended fee for a standard GP consultation is \$71, up from \$69 in 2011.

AMA indexation places significant weight on increases in the Labour Price Index in order to reflect increasing practice costs such as staff wages and operating expenses such as rent, electricity, computers and professional insurance. These costs must all be met from the single fee charged by the medical practitioner.

Professor Dobb said that the AMA List of Medical Services and Fees provides guidance to AMA members in setting their fees, based on their own practice cost experience.

"Successive governments have failed to index the MBS fees in line with other key indices such as the Labour Price Index and CPI, let alone the increase in the cost of delivering quality medical care," Professor Dobb said.

"There is now a significant and growing disconnect between MBS fees and the realistic cost of providing the services."

Professor Dobb said that MBS indexation has also created an anomaly whereby patient rebates for seeing a nurse practitioner are higher than the rebates for seeing a fully qualified doctor.

"Consultations with Other Medical Practitioners (non-vocationally recognised doctors) are not indexed, but nurse practitioner consults are," Professor Dobb said.

"A nurse practitioner attendance of 30 minutes has an MBS fee of \$39.75. The same consult with an Other Medical Practitioner for the same amount of time has an MBS fee of \$38.

"It is absurd that a patient will get a lower Medicare rebate for a more highly skilled service."



Background:

Since 2005, MBS fees have been indexed on average by 2.09 per cent per year.

Pathology and diagnostic imaging and some medical practitioner attendance fees, have not been indexed at all.

Since 2005, the average AMA indexation has been 3.11 per year.

While 81 per cent of GP services are bulk billed, there is cross subsidising by patients who incur a gap, and their gap is increasing.

The AMA Fees List is indexed each year based on the AMA MFI, which compromises Labour Price Index, All Group CPI, Private Motoring CPI, and Medical Defence Insurance (MDI) premiums.



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Bosses warned that doctor-patient confidentiality is sacrosanct

The industrial relations watchdog has joined the AMA in objecting to attempts by employers or their representatives to sit in on appointments between workers and their doctors.

The Fair Work Ombudsman said it was “concerned” by reports that bosses were attempting to attend the medical appointments of their staff, and warned that such behaviour would put them in breach of the Fair Work Act.

“The Fair Work Ombudsman does not condone or support this behaviour, and sees no reason why an employer should seek to attend a private and confidential appointment with an employee, unless specifically requested to do so by the employee,” the Ombudsman said.

The Ombudsman’s comments followed a warning from AMA President Dr Steve Hambleton that such behaviour was “unacceptable”.

Dr Hambleton told the Sydney Morning Herald that “companies need to know that intruding on patients’ privacy is not acceptable.”

As reported in the SMH, union officials have raised concerns that some employers have demanded the right to sit in on visits between doctors and their staff, as well as instances where doctors have come under pressure to alter medical reports and certificates.

Dr Hambleton said doctors should also be aware of the phenomenon and act appropriately.

“We’d be very unhappy if medical certificates were not being respected,” he said. “Altering information is a very serious charge ... All doctors should know that the prime responsibility is their patient.”

The Ombudsman said the laws around sick leave were “quite simple”, and while an employer could require evidence of incapacity such as a doctor’s certificate or a statutory declaration, they had no right to intrude in the relationship between a patient and his or her doctor.

“The Fair Work Ombudsman has great respect for the medical profession and there are well established processes within the profession for dealing with practitioners who issue fraudulent or unjustified certificates,” the Ombudsman said. “It is not the role of the employer to attend the appointment in order to determine a certificate’s validity.”

It highlighted the importance of trusting relationships between bosses and their workers in creating a “positive and productive” workplace.

“It is important for employers to respect their employee’s privacy, and to only obtain evidence that is relevant to substantiate [their] absence,” the Ombudsman said. “[Information about] the cause and nature of their absence is not necessary, except in unusual or exceptional circumstances.”

Plan to protect doctors, health workers and hospitals in Syria

The AMA has backed efforts by the Federal Government to protect doctors and medical facilities in war-torn Syria as the death toll among civilians and combatants soars.

Foreign Minister Bob Carr announced late last month that the Australian Government was seeking international support for a plan to ensure all victims of the conflict, which has so far claimed the lives of more than 30,000 people, had unfettered access to treatment.

Senator Carr said the plan called for a commitment from all combatants that they would not target medical personnel, not attack medical facilities and not block access to doctors, hospitals and emergency care.

“This would not be a military or political intervention in Syrian

affairs,” the Minister said. “It would simply be designed to protect the lives of ordinary Syrian caught in conflict zones.”

AMA President Dr Steve Hambleton welcomed what he said was an important initiative to make care for the sick and injured the top priority.

“It is important that people affected by war, conflict and unrest in any part of the world have access to medical care and treatment, and that all medical and health professionals be allowed to carry out their work,” Dr Hambleton said.

“For doctors, the health of patients is the first priority. Individual doctors must have the freedom to exercise their professional judgement in the care and treatment of their patients without undue influence by outside parties or individuals.”

As a member of the World Medical Association, the AMA strongly urges governments, armed forces and others in positions of power to comply with the Geneva Conventions, under which doctors

and other health workers receive the protection they need to provide care to all harmed by conflict, regardless of political affiliation, ethnic origin, nationality or creed.

Under the Australian Government’s plan, a neutral third party such as a non-government organisation, would be appointed to ensure all combatants adhered to their commitments.

Senator Carr said that to make his plan work, he needed support from countries in the Middle East, Europe and Russia.

Regardless of the outcome, the Government has boosted its support for humanitarian relief for those caught up in the Syrian conflict, committing an extra \$4 million to help deliver medical supplies and emergency food aid within Syria, as well as contributing to international efforts to provide food, shelter and health care to the 2.5 million people displaced by the conflict.



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Medical practice – a place for industrial designers

Over the coming months we plan to discuss some of the outstanding medical devices that have helped shape the way in which medicine is practiced today and how industrial design (ID) has helped speed up the process from an idea to production.

For many years surgeons, GPs, nurses and the like have influenced the development of new medical devices and called upon the professional services of industrial designers to formalise their “ideas” to change the world

and improve the experience for both patients and practitioners.

Previously some inventors have left it till late in the development process to call on ID. Perhaps even after having gone through the process of speaking with manufacturers to work out how to make a new device function properly. At this stage designers may then be presented with a functional block of information to start from with the direction of “make it look pretty”.

This is a fantastic direction, and one that most designers are familiar with as it is part of the job description. However it can pose a considerable limitation on the potential success of the new product in the marketplace. In these cases perhaps the most important aspect of the new device has been

overlooked. The factor that may determine whether it is successful in both production and application in the marketplace. In effect the factor that will justify the effort and expense that has gone into its development, marketing, and distribution. This factor is known in design circles as “User Centred Design” which helps determine: how will this device be used? who will be using it? will it be used by people of different levels of comprehension, experience, physical characteristics?

When a device is presented to an industrial designer at the early stages of concept generation all possibilities are still open. The headspace of an industrial designer exists somewhere between that of a psychologist, a sculptor, and engineer.

In addition to understanding manufacturing capabilities, industrial designers offer experienced understanding of consumers and ergonomic form. In the coming months you will learn more about some of the outstanding designs for the medical industry.

If you have a suggestion for a product to discuss that has improved your experience, or you would like to have a confidential discussion about an idea you may have to change the world, we would like to hear from you. Our team is available for your call on 02 6249 8694 or online at www.nflame.com.au/change

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Recall of Infanrix Hexa Vaccine

After consultation with the TGA, GlaxoSmithKline Australia (GSK) has recalled six batches of Infanrix hexa (AUST R 132881) vaccine.

This precautionary recall is being taken because a surface in the area where one of the manufacturing steps for the vaccine takes place was found to have a small amount of contamination with the bacterium *Bacillus cereus*, an organism commonly found in

food and soil. No contamination of the ingredients or in the vaccine itself was found.

The TGA says that GSK has confirmed that the efficacy and safety of the vaccine remain unchanged, and it does not believe this issue poses a health risk to the children who have received it. All of the identified batches passed the quality assurance testing, including sterility testing, required for the vaccine to be released for use in Australia.

For further information and details of which batches have been recalled, please click <http://www.tga.gov.au/safety/alerts-medicine-infanrix-121011.htm>.

Historian or Bibliophile?

You don't have to be fascinated by the history of medicine, but it may help ...

The NSW branch of the Australian and New Zealand Society of the History of Medicine meets outside Sydney from time to time. From 2.00 to 2.30 on Friday 23 November it will be meeting at Berkelouw's Book Barn, Bendooley, Old Hume Highway, Berrima

(about 2km North of Berrima Village). Lunch will be available at the cafe.

The presenters will be:

Mr Leo Berkelouw: A curious life in the rare book trade

Ms Brenda Heagney: Books and people

Prof Charles George: Confessions of a bibliophile

All welcome. For further information phone John Donovan on 6288 7403.

New funding needed to support primary care

AMA Submission on National Primary Health Care Strategic Framework

The AMA has lodged a submission in response to the draft National Primary Health Care Strategic Framework, which has been developed by the Commonwealth and State/Territory Governments under the auspices of the National Health Reform Agreement.

The draft Framework is intended to build on the key priority areas from the Commonwealth's National Primary Health Care Strategy, released in 2010.

AMA Vice President, Professor Geoffrey Dobb, said that the AMA supports many aspects of the draft Framework in principle but is astounded that the whole strategy is currently based on there being no new funding to support primary care over the next three years.

Professor Dobb said it defies logic for governments to shift a greater patient care burden onto the primary care sector without a single dollar of new funding.

"It does not make any sense for the Framework to state that the centre of gravity in health care is going to shift to primary care to take pressure off the hospital sector and expect that this can be done within existing resources in primary health care," Professor Dobb said.

"We support the recognition that general practice is the foundation of good primary health care in Australia and the admission that a strong GP-led primary health care system keeps people well and saves lives.

"The GP-patient relationship is one of the strongest features of

the Australian primary health system, and it must be supported and encouraged, but it cannot survive on goodwill alone.

"The primary care sector, general practice particularly, must be properly funded to meet future demand and to maintain the high quality that makes the Australian health system one of the best in the world," Professor Dobb said.

Key arguments in the AMA submission include:

- E-health - the AMA considers that any National Primary Health Care Strategic Framework must address in detail what needs to happen to ensure that the PCEHR and any other e-health initiatives are supported by GPs and general practices and well-integrated into primary care.
 - Investment in GP consultations - GPs provide all the care needed for 90 per cent of the problems they encounter and, in addition, GPs account for less than one tenth of per capita expenditure on health. In other words, the services provided by GPs provide very good value for money and are an efficient means of using scarce health dollars.
 - Tackling chronic disease - to effectively tackle chronic disease, GP items in the Medicare Benefits Schedule (MBS) need to better encourage longer consultations. This would support GPs to engage in preventive health care and take the time needed to communicate with other parts of the health system.
- Professor Dobb said that the draft Framework also raises a

number of controversial issues that contain little detail or discussion, and upon which there has been no consultation, including:

- blended payments systems;
- pre-payments and payment for performance with salaried arrangements; and
- development of performance indicators, which identify circumstances in which consumers may not be receiving the most appropriate care.

"These issues require extensive discussion and consultation with the AMA and other groups before the Framework is finalised," Professor Dobb said.

AMA ACT has forwarded this feedback to the ACT Health Directorate supporting the views expressed in the AMA submission. The AMA submission is at <http://ama.com.au/ama-response-consultation-draft-national-primary-health-care-strategic-framework>

The AMA has developed the AMA Chronic Disease Plan: *Improving Care for Patients with Chronic and Complex Care Needs - Revised 2012*, which builds on existing MBS items with streamlined access to allied health and other services across levels of care relevant to the complexity of the patients' needs.

The Plan provides for enhanced access to a broader range of services, including the services of a care coordinator for those patients with chronic and complex disease that need greater support and are at risk of a preventable hospital admission.

The Plan is at
<http://ama.com.au/node/5519>

VALE.

The President, Dr Andrew Miller, Board, Members and Staff of AMA ACT extend their sincere condolences to the family, friends and colleagues of their late esteemed colleague, Dr Reginald Kitchin



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Discussions continue on review of ACT doctor in training (JMO) classifications and salary levels

In accordance with Clause 156 of the recently negotiated ACT Public Service Medical Practitioners Enterprise Agreement a revised structure for JMOs must be developed and implemented by June 30 2012. This timeline proved to be impossible to meet, so discussions are still ongoing.

The Health Directorate has provided a draft proposal and input from AMA doctors in training is invited. AMA ACT is a party to the agreement and an active participant in these discussions for doctors in training.

The information below should be regarded "for consultation" and has no status beyond a discussion document. Feedback should be forwarded to AMA ACT Workplace and Industrial Relations Manager, Andy Ozolins via email: industrial@ama-act.com.au and by phone to 6270 5410.

1. Salary Levels and years of service

Postgraduate Year	Interns	Resident Medical Officer	Registrar	Senior Registrar
1	Intern			
2		RMO Year 1		
3		RMO Year 2		
4		RMO Year 3	Registrar Year 1	
5		RMO Year 4	Registrar Year 2	
6			Registrar Year 3	
7+			Registrar Year 4	
				Senior Registrar

Table 1. The current classification of junior medical officers (JMO) in the ACT

Note that, per sub-clause 25.8 of the *ACT Public Service Medical Practitioners Enterprise Agreement 2011-2013* (the Agreement), there are some constraints in salary advancement for part-time medical officers.

2. Background

- This classification structure has been problematic for a number of years because of the overlap of RMO Year 3 and Registrar Year 1 at postgraduate year 4 (PGY4) and a lack of clarity regarding the roles and responsibilities of some JMOs at PGY3 level. The use of local designations in several areas - such as SRMO - has exacerbated this.
- PGY3 is a transitional year for most JMOs and is usually the first formal year of vocational training. (Although many colleges are now allowing vocational trainees to accredit some rotations in their PGY2 year).
- Depending on the setting, a JMO in PGY3 may be performing the duties of a Registrar and, in some cases, have been given permission to

be paid at the level of a Registrar Year 1 i.e. PGY4. This informal arrangement has resulted in a degree of confusion among the JMOs and the lack of transparency in the process has sometimes caused resentment among JMOs who have not been granted this promotion.

- The medical workforce has many examples of people performing the same roles and duties but who receive different levels of pay according to their years of experience. There is no reason that the PGY3 JMO should be treated differently. A

PGY3 who is working in a unit that expects the JMO to perform the duties of a registrar will require more intensive supervision than a PGY4 or PGY5 performing the same duties. This is especially true in the procedural specialties such as surgery, O&G and radiology but is also true for medicine, paediatrics and psychiatry.

3. New Classification

- The essential change is that JMOs will be paid strictly according to years of service.
- The confusion arises because of the historical convention that a JMO is not officially called a Registrar until PGY4. To improve role clarity and to maintain equity among PGY3 JMOs, a new classification - Junior Registrar - has been created. (Table 2).
- In addition, two streams are created - the Vocational and Non-vocational streams. To belong to the vocational stream, a JMO must be enrolled in a training program of a Specialty College. In

some instances this may occur at PGY2 but most will commence at PGY3.

- Junior Registrar refers to any JMO working at PGY3 level **who is enrolled in a vocational training program.** No JMO at PGY3 will be able to be called a Registrar, nor will they receive any additional increment in salary during the PGY3 year.
- It is recognised that some JMOs who are not enrolled in a vocational training program will be performing all of the duties of a registrar e.g. JMOs in surgical specialties may be in unaccredited positions working alongside accredited registrars who are performing exactly the same roles. These JMOs may be informally referred to as Registrars but will not be classified as such for the purposes of the Agreement.
- The title Junior Registrar replaces existing local designations such as Senior Resident Medical Officer (SRMO) and Specialty Trainee.
- A JMO at PGY3 and subsequent years who is not enrolled in a vocational training program will be referred to as a Resident Medical Officer (RMO).
- JMOs in the Vocational stream will progress to the next increment at the end of a calendar year (or at the completion of 12 months at a particular level for JMOs who commenced at a different point through the year). Progression is not dependent on the JMO passing specialty exams but there is no further increment after the JMO completes PGY7.

- JMOs in the Vocational stream do not automatically progress to Senior Registrar without a formal appointment process being undertaken.
- JMOs in the Non-vocational stream will not receive any increment in salary after PGY5.
- JMOs in the non-vocational stream who move to the vocational stream will transfer at current pay level.

4. Classification Definitions

It is recommended that the following classification definitions be included in the Agreement documentation:

Intern means: a provisionally registered medical officer (including overseas trained medical officers) serving in a health facility prior to obtaining general registration as a medical practitioner, and who is employed in a position classified as intern..

Postgraduate Year		
1	Intern	
	Vocational stream	Non-vocational stream
2	RMO 1	RMO 1
3	Junior Registrar	RMO 2
4	Registrar 1	RMO 3
5	Registrar 2	RMO 4
6	Registrar 3	
7+	Registrar 4	
7+	Senior Registrar	

Table 2. Proposed new classification system to commence in Jan 2013

Junior Registrar means a medical officer who:

- Has satisfactorily completed their internship; and
- Has obtained general registration and;
- Who is employed in a position classified as a Junior Registrar.
- Who is enrolled in a vocational training program and who is PGY3

Medical Officer means an employee engaged as a medical officer under the *ACT Public Service Medical Practitioners Enterprise Agreement 2011-2013*

Resident Medical Officer means a medical officer who:

- Has satisfactorily completed their internship; and
- Has obtained general registration and;
- Who is employed in a position classified as Resident Medical Officer.

Registered Medical Practitioner means a person registered, or licensed, as a medical practitioner with Australian Health Practitioner Regulation Agency (AHPRA).

Registrar means a medical officer who:

- Who is enrolled in a vocational training program
- Has completed the equivalent of at least 3 years of relevant full time clinical experience, and

- Has obtained general registration as a medical practitioner, and
- Is employed in a position classified as Registrar.

Senior Registrar means a medical officer who, in addition to meeting the requirements for a Registrar:

- Has completed at least 48 months of (full time equivalent) experience in recognised Registrar training position and substantially completed fellowship training.
- Holds higher medical qualifications and is employed in a position classified as Senior Registrar.

5. Salary Level Proposals

The salary levels in this structure would be the same as at present (as outlined below) and indexed in the usual fashion:

Movement between the classifications - intern, RMO, Junior Registrar, Registrar and Senior Registrar - will remain subject to the merit principle as detailed in Section 65 of the *Public Sector Management Act 1994*.

Reference: The ACT Public Service Medical Practitioners Enterprise Agreement 2011-2013 can be downloaded from the ACT Health Directorate's website.

Postgraduate Year	Classification	Annual Salary (as at 1 July 2012)
1	Intern	\$60,185
	Vocational stream	
2	RMO 1	\$70,783
3	Junior Registrar	\$77,850
4	Registrar 1	\$88,179
5	Registrar 2	\$95,727
6	Registrar 3	\$103,308
7+	Registrar 4	\$110,576
7+	Senior Registrar	\$124,330
	Non-vocational stream	
2	RMO 1	\$70,783
3	RMO 2	\$77,850
4	RMO 3	\$88,179
5	RMO4	\$95,727

Table 3. Current salary rates

Supply and PBS claiming from a Medication Chart in Residential Aged Care Facilities

From 2013, residential aged care services will be able to use a standardised medication chart. This will improve resident safety, and reduce the administrative burden for pharmacists and pharmacy staff, as the new chart will be able to be used as a prescription for most medicines.

Once operational, doctors and other prescribers will no longer need to complete a traditional PBS/RPBS prescription form for most PBS/RPBS items ordered for residents. Pharmacists will be able to use a copy of the order on a standardised medication chart to supply such medicines to residents in the aged care services. However, until these new arrangements are in place in 2013, current medication supply and claiming practices will continue.

The requirements for the new chart will be derived from the design and testing of a paper-based National Residential Medication Chart (NRMC) by the Australian Commission on Safety and Quality in Health Care, in consultation with the aged care sector, prescribers, pharmacists and other stakeholders.

The AMA supports these new initiatives.

The NRMC will be tested in selected residential aged care services to ensure that it functions as it should. There are also state or territory legislations which will need to be changed in order to allow the medication chart to take the place of a prescription. As each state or territory will make these legislation changes at different times, it is not likely that this

process will be completed until at least early 2013. AMA ACT supports Territory legislative change to facilitate these new processes.

The initial version of the NRMC was introduced on 1 August 2012 in selected residential aged care services in NSW, allowing aspects of the chart and supporting documentation to be refined following feedback on chart performance. This testing is expected to take up to six months, including evaluation. Testing will maximise medication safety and administrative efficiency, and may then require further amendments to the PBS legislation and documentation in order to support the safe transition from existing medication charts and PBS supply practices in residential aged care services.

Once all testing and amendments are complete, in early 2013, the NRMC and other commercially available charts will require updating to comply with PBS and state and territory legislation. Compliant charts may then be used by aged care services to authorise supply, and claiming of eligible PBS/RPBS medicines.

The Australian Commission on Safety and Quality in Health Care is contacting individual aged care services and their supplying pharmacists in NSW to participate in the testing of the NRMC and training materials.

Upgrades will be made to the dispensing software, by software vendors, to accommodate the new chart arrangements, however only those pharmacists involved in the testing of the NRMC from selected NSW aged care services, will be able to participate in the new arrangements in 2012. Similarly, only doctors prescribing to the aged care services selected to participate in the testing of the NRMC, will be participating in 2012.



It is important to note that new arrangements will not be available until after your particular state or territory legislation has been modified, which is expected in 2013.

There will be certain medicines excluded from the new arrangements, and these will still require a written prescription from the prescriber, in addition to an order on the medication chart. Such items include:

- all Authority required items requiring preapproval (including PBS/RPBS items with increased quantities and/or repeats)
- all items only available under special arrangements (Section 100)

- Controlled drugs ('Schedule 8' medicines)

Authority required (streamlined) items will not require a separate written prescription, provided the prescriber writes the appropriate streamlined authority code on the medication chart.

Information and resources about this initiative are available from www.5cpa.com.au

Further information about the NRMC Project is available at www.safetyandquality.gov.au

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Watch out for hidden costs when buying a home

One of the biggest hidden costs when you're getting a mortgage is Lender's Mortgage Insurance (LMI). "The banks have to arrange it, and the insurer has to approve it," explains Investec's Trevor Robertson. "The requirements are strict, so many medical professionals starting out would get knocked back on income grounds."

Furthermore, he says, that's a cost that has to be carried by you—and if you're borrowing more than 90 per cent of the loan, it can start getting quite expensive. And LMI isn't a tax-deductible expense, so there are no advantages to paying it. Luckily, Investec knows young medical professionals, their priorities and understands their expected income trajectory. "We understand you're interested in your education or living expenses," he says. "We can offer medical professionals mort-

gages of up to 100 per cent for owner-occupied properties, with discounted, fixed and variable rate options available, as well as offset accounts for all loan types with no LMI requirement. Rather than wait 12 months to save up a 20 per cent deposit, we're here to support you getting into your first home."

Where that gets important, says Robertson, is having a 100 per cent offset account which allows you to preserve the debt while paying it down, which will be an important tax strategy if you move out of that home, but hang on to it as an investment property.

"For a lot of young medical professionals, it's something that's not really on their radar," Robertson explains. "Only 20 per cent of them would buy a property in the first 12 to 18 months out of university. But they don't have a real understanding of how much they can borrow."

Most people, Robertson explains, will buy an apartment as their first home. But frequently, they'll have a plan to hang on to it as an investment property, but will find, when they do so, that it causes them a tax problem. "If you borrow \$400k for your first home, then pay down half of it, then buy another property and hang on to your first one as an investment property, you

can't claim a tax deduction on it," he explains. "So what you should do is leave the loan at \$400k, and accumulate your repayments in a 100 per cent offset account, so the loan is the same but you're only paying the interest. Then they use the money in the offset account to buy the next property."

The various advantages Investec can offer young medical professionals comes from its deep understanding of their situation, says Robertson. "Overall we have over 20 years in understanding this space," he says. "Other banks might have a niche office devoted to it, but if you walk into your local branch and ask for a loan, they're not going to refer it to the niche office immediately."

Adds Investec's Andre Karney "Where we differ is we have the experience and expertise to go by, and there's a real can do attitude here. We know, also, that many medical professionals have no idea about what's available to them and we spend that time and give them the information they need. I think you'll find others don't do that. I think there's a natural passion and that adds value. We know what you should be able to own, so we'll also know if you're paying too much for something. You don't get that insight from the major banks."

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AMA Careers Advisory Service – Update

With the AMA Careers Advisory Service and website now live, Careers Consultant, Kathryn Morgan, reports receiving numerous enquiries regarding general and more specific career pathways in medicine as well as non-medical career alternatives.

The Careers website provides a significant amount of information on these topics, designed to provide advice and support. In addition to direct links to external websites and their specific pages - which address the particulars of these enquiries - it also creates a list of steps to follow along your medical careers pathway.

The Careers Service addresses the needs of all facets of medical professionals, from medical students requiring assistance with their internship applications, particularly resume and cover letter reviews, through to Doctors' in Training requiring interview skills and techniques to enhance their competitive edge for medical college interviews.

Beyond these enquiries, the Service also reports responding to qualified medical professionals who are interested in exploring employment opportunities beyond medical practice, whilst still utilising their skills and expertise. These have included, for example, non-clinical roles in Commonwealth and State public services but which recognise the skills brought.

Over the coming months the Service will continue to update the content on the website including career related events in local areas. Further changes and enhancements will be considered in the light of user feedback.

You are encouraged to visit the website if you haven't already and we welcome and look forward to your feedback; which can be submitted via the online feedback form on the website.

Stay tuned for more information on how this service can assist you along your medical career path.

If you, and your colleagues, would like to convene a skills workshop facilitated by Kathryn, please contact her directly.

Contact details: Kathryn Morgan, Careers Consultant – 6270 5415 or 1300 884 196

Web:
<http://careers.ama.com.au> or
email: careers@ama.com.au



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Contact: Kathryn, Careers Consultant on 1300 884 196 (toll free)

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New AMA position statements

- **Involvement of GPs in Disaster and Emergency Planning 2012**
- **Supporting GPs in the Immediate Aftermath of a Natural Disaster 2012**

The AMA has released two new Position Statements outlining the role of GPs in emergencies and natural disasters and how best to support GPs in these situations.

The *AMA Position Statement on Involvement of GPs in Disaster and Emergency Planning 2012* has been developed to help policymakers at all levels of government and medical practitioners across Australia be more aware of the issues involved in natural disaster planning and emergency management, and the role of GPs in these situations.

The *AMA Position Statement on Supporting GPs in the Immediate Aftermath of a Natural Disaster 2012* is aimed at helping those involved in planning the immediate recovery from a natural disaster or emergency to focus on the needs of general practices in the immediate aftermath of such events.

AMA President, Dr Steve Hambleton, said GPs are at the

forefront of providing care in a crisis.

“When a crisis hits and there are injuries, GPs and other doctors make themselves available to see their patients, patients not able to see their own doctors, backfill positions in hospitals, provide on-the-ground assistance in emergency locations and in emergency accommodation, and they treat the walking wounded – both the rescued and the rescuers.

“We saw this recently in the Queensland floods and the Victorian bushfires.

“Despite this strong record of volunteerism, the role of GPs in emergency response situations is not well understood by governments, and GPs have not had enough input into disaster planning.

“The AMA would like to see a more formal process of involving GPs in planning for emergency or disaster situations.

“We also want to see coordinated planning to ensure that primary health care services remain active in the aftermath of disasters, including when GPs, their families, and their general practices are victims of natural disasters,” Dr Hambleton said.

The AMA Position Statement on Involvement of GPs in Disaster and Emergency Planning 2012 is at <http://ama.com.au/node/8162>

The AMA Position Statement on Supporting GPs in the Immediate Aftermath of a Natural Disaster 2012 is at <http://ama.com.au/node/8167>



AMA Members and members of the AMA ACT Practice Managers' Network are invited to attend an:

E-Health Presentation by Dr Mukesh C Haikerwal AO

General Practitioner
 Chair of the Council of the World Medical Association
 Head of Clinical Leadership and Engagement, National Clinical Lead, National e-Health Transition Authority (NEHTA)
 Professor, School of Medicine, Faculty of Health Science, Flinders University, Adelaide
 Broadband Champion (DBCDE)
 Member NH&MRC Health Care Committee
 19th President, Australian Medical Association

Wednesday 7 November

Venue: Level 3 AMA House, 42 Macquarie Street BARTON ACT

Drinks and light refreshments will be served from 6.30 pm with the presentation to start at 7pm.

RSVP to Helen Longdon on 6270 5410 or reception@ama-act.com.au by COB 26 October 2012.



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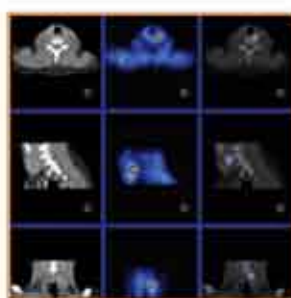
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