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Graduating from medical school – reflections of one's own

The following is an edited version of the address given to the 2012 graduation class of the ANU Medical School by Dr Simon Robertson.

I would firstly like to thank the organising committee for inviting me to speak at the graduation ball. For a long time, I really had no idea what I was going to say. Research shows that there is huge global variability in the nature of grad ball addresses.In the USA, these generally take the form of sermonizing. In the UK, they take the form of cautionary tales whereas in France they appear not to talk to their graduates at all.

I asked my wife for some advice and she had this to say: Simon, you are prone to lecturing, so please don't … You have been lecturing at these poor people for four years. I am sure they would prefer if you gave them a break and just stood up and told a few jokes.

What preparing this speech did allow me, was some time to reflect on my own student years and graduation. As I recall, the over-arching emotion I felt at graduation time was relief. This was because I wasn't a particularly good medical student, and I clung to the knowledge that the person who graduates with 51% in their final medical school exams is still allowed to call himself or herself "doctor".

I am also reminded of a report that a friend of mine once received at the time he was a member of a paratroop regiment. He later went on to be an ED physician. His quarterly report from his commanding officer was one line and it read: "Rob is not very bright, but he can lift very heavy weights". Why he wasn't fast tracked immediately to orthopaedic surgery remains a mystery to this day.

I also cringingly recall one of my oral examinations in anatomical pathology. The examination was held in an old dungeon-like dissection hall in the bowels of the medical school. As I stumbled over answer after answer the professor became more and more exasperated, eventually leaning over one of the specimens and saying to me: "Mr Robertson, this is not meant to be a teaching session, but in your case, I suppose we will have to make an exception".

Another challenge I encountered was that many of the patients I interacted with spoke mainly Zulu and Xhosa and this came as a bit of a shock to a medium size white boy such as myself. The confusion that this caused is best illustrated by an example: As all ANU graduates know, the thyroid gland is best examined by standing behind or to the side of the patient and palpating the thyroid with fingers of both hands on both sides of the neck

and asking the patient to swallow. Now the Zulu word for swallow is Gwinya and the zulu word for crocodile is Ngwenya. Can you imagine yourself as a patient in hospital, have someone walk up behind you, seize you by the throat and shout "crocodile".

One memory which has stuck with me and perhaps drives some of my approach to our profession was related to a group of us as second year medical students. We had the privilege of being taught anatomy by the late Professor Philip Tobias. He inturn had been a student of Raymond Arthur Dart, one of the discoverers of pre-historic man on the African continent. Tobias told a story of visiting an ageing Professor Dart at his home in Cape Town. By this stage in his fifties, Tobias was a full professor of anatomy and a head of department in Johannesburg. Dart was in his eighties but still highly involved in academic life. His current project was a submission to the journal Nature. Tobias was invited into his home and after being served tea asked his mentor: "How is the paper going professor". Dart's reply was: "It is finished dear boy … and so am I". Raymond Arthur Dart died that night, having submitted his paper earlier in the day.

And so, if I was relieved to be allowed to graduate medical school, it was because I had not been discovered for the fraud I knew myself to be. I have to tell you now as medical graduates that this feeling does not go away, but rather stays with you, sometimes masquerading as insight into your own limitations. Narrowing your field of knowledge by specialising doesn't help either, rather you transition from knowing nothing about everything to knowing everything about nothing.

So as you think about these things, I am sure many of you are contemplating your internship and perhaps even have plans for what your future career path is. I remember thinking for a long time that I was going to be a trauma surgeon. I am sure this is because I admired their poise under pressure and above all their decisiveness. In fact, if one had a particularly puzzling patient, you had consulted broadly and were at your wits end and had no idea what was going on with the patient, that you should consult the trauma surgeons … They would have no idea either, but they would certainly do something about it.

So off I went to the trauma unit directly after internship, very proud of myself that I was now firmly on my way to being a real doctor. The trauma unit was a frantic, overworked and frenetic place, with people always running around madly. There was an emergency services radio mounted on the triage desk.

… Continued page 5.

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TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

The new VMO contract negotiations are about to shift into top gear; and I find myself wondering what the make-up of our senior hospital medical staff will be in a decade. Over the last decade we have seen an immense swing towards staff specialist positions across the board. As we moved towards credentialing bargaining agents for this round of negotiations, a process that requires 50 nominations from eligible VMOs (who can nominate one bargaining agent only) it became clear that with the dwindling number of VMOs this task would become increasingly difficult over the next few years. I suppose there are many reasons as to why a specialist may elect to take a staff salaried position, or operate independently as a VMO; and each specialty will generate different motivating factors; but I can't help feeling that part of the reason for these changes is a preference on the part of medical administrators for dealing with employees rather than contractors.

I must say that I don't much feel like it … but I have recently been called a dinosaur by a medical administrator, because I prefer to remain a VMO. His admitted reason was simple - it is easier to control employees. Now I am sure that there are more factors at play, but a recent conversation with a salaried medical officer, when I was seeking background to an issue before speaking to the press, did make me wonder. I was told that it wasn't possible to speak in any detail to me regarding any ACT Health policies, procedures or statistics; but that I would have to speak to the media unit. I exited concerned; and anyway missed the deadline so no public utterances ensued. I know that this may seem a huge non-sequitur; but I was listening to a farmer from Fukushima province on the weekend. She was saying that she had great difficulty believing anything the local authorities told her. At the time I felt comforted that we could count on our tradition of openness of government; but now I remain concerned.

I have also in recent times had a number of VMOs, particularly in medical specialties, reflect to me that they were starting to feel alienated working within our hospitals. I admit to sharing some of those feelings at times. This is, of course, at a time when governments laud the benefits of diversity. I would never suggest that either pathway is the best or most appropriate model for health care delivery to the exclusion of the other, but hope that our policy makers and administrators can see the merits of a diverse medical workforce that includes a complement of both salaried and VMO specialists.

This year will also see the commencement of salaried medical officer enterprise agreements for the ACT Health Directorate. The last round took so long to conclude that it has hardly been put to bed than we must take up the cudgels again. As with previous negotiation rounds, the AMA-ACT is determined to represent its members in this process and to ensure equitable outcomes for all; including both senior specialists and our all-important JRMOs and vocational trainees.

In my last column I raised the issue of the cost of the PBS. I would like to take this further. To contextualise this we must admit that whichever party comes into government after the next federal election, we have been put on notice that heath expenditure will be cut. Demographers are chanting louder and louder that we simply can't afford to keep up the business as usual approach. All sorts of models are being considered … in all sorts of ways that I find disturbing. Most of this discussion is being quarantined from the public arena because both sides of the political divide see this as a lose – lose debate. I suspect that health policy debate will be conspicuous in its absence during the campaign (whenever that begins??).

We pay for our medications many ways; at the doctors in obtaining the prescriptions; material payments for medications including manufacturers charges, wholesale and pharmacy mark-ups, and in dispensing fees. Health economists have suggested that substantial savings to government could be achieved by increasing the dispensed quantity of drugs so that dispensing intervals are increased. Pharmacies have already forgone some indexation benefits for dispensing fees, and mark-ups are regulated; and certainly less than in many other retail sectors.Of course the cost to consumers is a separate issue; and since free market principles broadly apply; people may pay widely varying amounts between pharmacies. It is a matter of habit, rather than scientifically demonstrated benefit, that most medications are dispensed in monthly quantities. It remains to be tested as to whether increasing dispensed quantities reduces the quality of outcomes in health care, so we should be cautious before we encourage government to leap to savings this way.

A further bone of contention is the cost of generic medications. In recent years we have seen a number of "block-buster" medications come off patent. Typical of these is atorvastatin; for which the PBS has outlaid more money than for any other drug in its history (approximately $7 billion). Now that this medication is off patent we should be seeing huge cost savings flowing to the PBS. Instead we have seen that whilst in countries such as the UK and Sweden the manufacturers' prices have dropped by up to 95%, we were only able to exact a discount of 15% here. Even tiny New Zealand has made huge cost savings by comparison. The situation is remarkable, given that the government persists in its public line that the PBS is operating cost effectively.

I will talk more about generic medications next time.

In recent news my eye was caught by a few stories. New Zealand's government has announced in February that it will enact plain packaging legislation for cigarettes, becoming the second country to do so. This would certainly appear to be a good time for the future fund to start divesting itself of equity in tobacco companies; one can only hope that they will eventually be totally snuffed out of existence.

A recent study from Monash University Centre for Health Economics has found that the co-location of GP clinics with Emergency Departments can significantly reduce ER waiting times. One interesting finding in the study was that increasing availability of ER facilities made little difference to waiting times (and in fact increased waiting times for category 2 patients) where as properly staffed GP clinics could reduce waiting times by 19% where

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patients were actively diverted to them. This should be food for thought for all of us, given the recent AIHW data showing continuing problems with ER waiting times in Canberra. Clearly the finding revolves around models of care, and the application into our situation would need to be carefully considered. We already have CALMS clinics operating in our hospitals, but they are operationally constrained. A proper recognition of the value of a fully operational co-located general practice with the more free-wheeling model of care employed in the private setting as an active partner in acute care settings is long overdue.

A partner to this story is an article in the latest MJA; showing that E-Health records may confound attempts to expedite care in ERs. Given the extraordinary proliferation of E-record systems, not all properly inter-operational, in our hospitals; and the specific and not too complimentary attention paid to the IT systems at Canberra Hospital during the investigations into data tampering in ER, I found this article interesting. I have a fully computerised practice, and am steadily recruiting more fingers into my typing; but have noticed that management of IT in a clinical setting requires very active involvement of the clinicians at all stages. This is not something that can just be delegated to a techie. Highly technical data files need to be maintained by the technicians responsible for their contents … i.e US. That's just more time in the day away from patients I guess, but vital to maintaining the integrity records and quality of care.

Oh, by the way, I have just been told that to upgrade my computer systems in my practice to be able to actively contribute to my patients' PCEHRs will cost a minimum of $25,000. So that goes on the back burner too!

Funding overhaul for medical training

Funding for medical teaching and training needs to be overhauled and enhanced to reflect its importance as "core business" for the health system, according to the AMA.

As the Independent Hospital Pricing Authority (IHPA) begins work on a funding model for medical teaching, training and research, the AMA has cautioned that any changes need to encourage and support what is a critical undertaking in sustaining quality health care.

Under the National Health Reform Agreement, the IHPA has until mid-2018 to advise the Standing Council on Health how to shift medical teaching, training and research to an activity-based funding system.

The IHPA has this month established a Working Group to look at the fixed and variable costs to hospitals of providing teaching, training and research services, and advise on how these should be classified.

The Authority expects the Working Group will do most of the conceptual work involved in the change through the next 12 months, with data collection to begin next year, with the possibility the new funding arrangements could be introduced during 2015 or 2016 – well inside the Agreement deadline.

AMA Vice President Professor Geoffrey Dobb said it was crucial that the shift to activity-based funding lead to greater support and resources for teaching and training.

"Current funding arrangements do not adequately reflect the costs of teaching and training," Professor Dobb said. "It is vital that we do more to support this critical activity in our public hospital system."

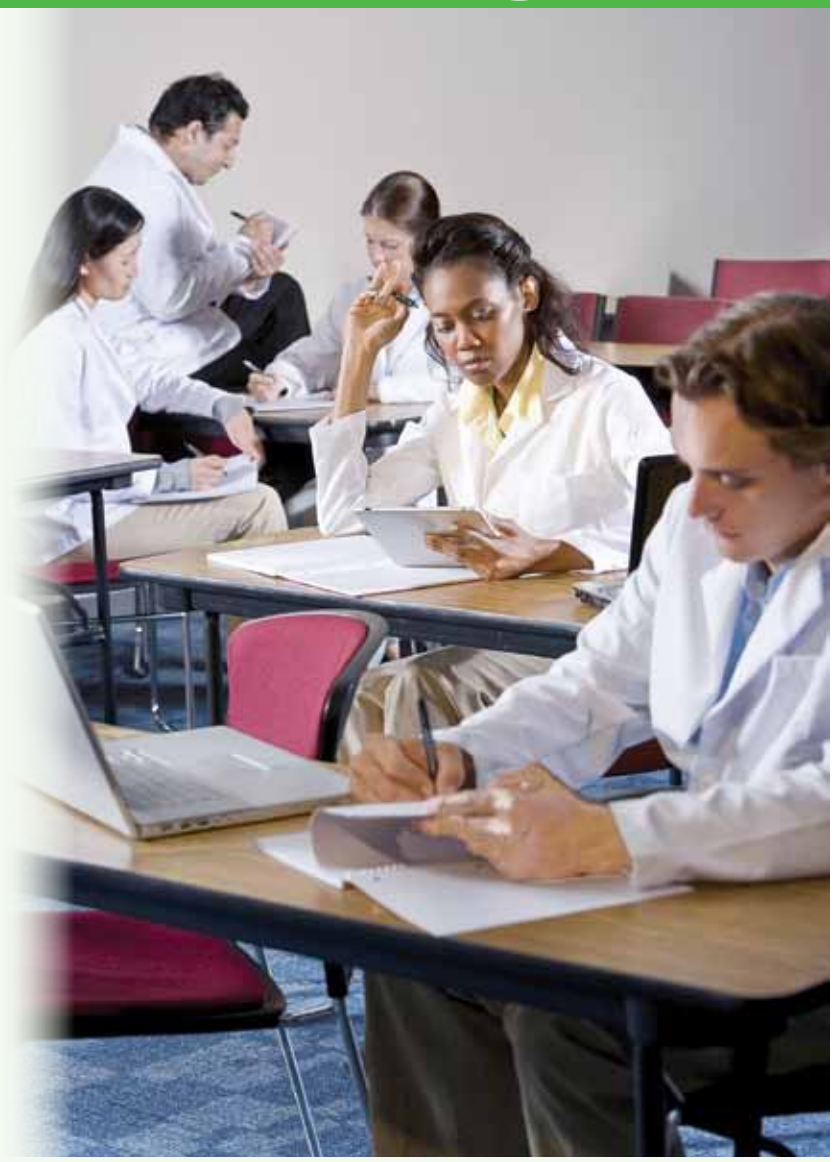
A key concern is that there be sufficient teaching and training capacity to cope with rapid growth in the number of medical graduates.

Professor Dobb said Health Workforce Australia estimates showed the nation was facing a shortfall of 450 first-year specialist training places by 2016 unless there was a significant lift in investment in teaching and training.

"We need to address the significant bottlenecks in the medical training pipeline that Health Workforce Australia is predicting as more and more much-needed medical graduates come through the system," Professor Dobb said. "We also need a funding model that delivers a quality clinical training experience from medical school right through to the completion of vocational training."

The AMA convened a high-level meeting of 13 organisations involved in medical education and training late last year to discuss the shift to activity-based funding.

The meeting agreed on a set of principles to guide the development of the new funding model, including that it should include recognition of the experience and skills of providers, that it be underpinned by publicly reported performance indicators, that it not create disincentives for training in settings other than public hospitals, and that it include consideration of whether funding should be attached to the trainee or allocated to the provider.



The meeting resolved that teaching, training and research should be seen as core business for the health system: "A culture of teaching and learning must be embedded in the public hospital system. Investment in teaching and training must be seen as essential to providing a quality service environment, and a sustainable health workforce."

Acknowledging the looming shortfall in medical training places, the meeting said it was "vital that pricing and funding is linked to health workforce planning and projections, to provide sufficient training capacity for medical graduates and trainees".

A statement of Objectives and Principles from the meeting can be viewed at: http://goo.gl/6xlmR

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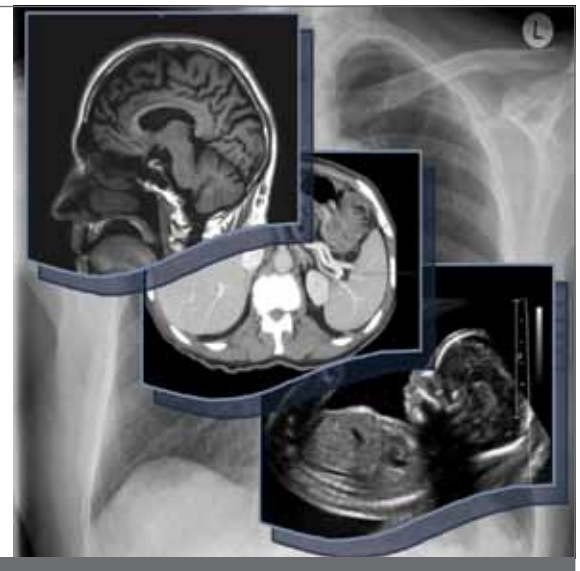

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New position statement from Cancer Council Australia on complementary and alternative therapies

Cancer Council Australia has published a new position statement on complementary and alternative therapies. The statement considers the evidence, risks and benefits associated with these therapies, and makes considered recommendations for cancer patients and health practitioners.

Complementary medicines and alternative therapies have been the subject of debate in the media and among health professionals.

Some of the key recommendations made in the statement include:

1. Supporting the right of individuals to seek information about complementary and alternative therapies and respecting their decision to use them, provided they are not at risk of being harmed.
2. Encouraging people with cancer who are considering using non-conventional therapies to make an informed choice. This includes asking questions about the efficacy, risk, contraindications and the cost of the therapy, as well as the qualifications of the practitioner.
3. Encouraging people with cancer to discuss with their healthcare provider any complementary or alternative therapies they are using or considering using, in order to minimise risk.
4. Encouraging healthcare providers to routinely discuss the use of complementary and alternative therapies with all cancer patients and survivors, in an open and non-judgemental manner.

The statement also recommends the Therapeutic Goods Administration take a more active role in warning consumers about false claims made in relation to the benefits of complementary and alternative medicine and for more scientific studies to examine the safety and efficiency of promising and commonly used complementary and alternative therapies.

Boys get protection against HPV

The roll-out of Gardasil vaccination to boys has begun with more than a quarter of a million due to be inoculated this year.

Health Minister Tanya Plibersek said the vaccine, to be administered free to around 280,000 Year 7 and 9 schoolboys, would help protect them against cancers and genital warts caused by the human papillomavirus (HPV).

The vaccination program for boys, announced in July last year, is a world-first and comes in addition to a vaccination program for girls which began in 2007.

Ms Plibersek said one million girls aged between 12 and 16 years have already been fully vaccinated against HPV and the vaccination of boys would help drive down rates of cervical cancer among women.

"The HPV vaccine is the best protection against the HPV virus, [which] infects four out of five sexually active people at some point in their lives, and is linked to cancer and other disease," the Minister said.

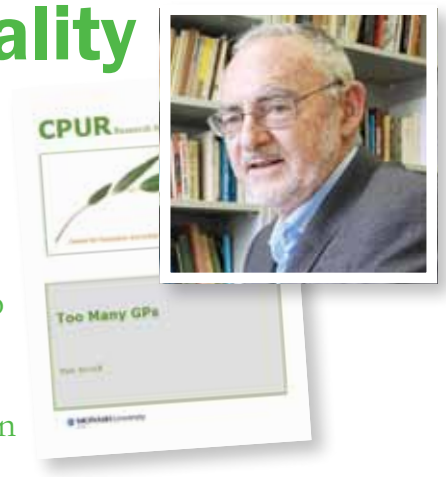
Since the introduction of the Gardasil schools vaccination program, there has been a reduction in HPV-related infections and precancerous lesions in young women, and a reduced incidence of genital warts in both sexes.

"We're confident that extending the program to males will reduce HPV-related cancers and disease in the future," Ms Plibersek said.

More than 400,000 boys and girls received their first dose of Gardasil this month, with follow-up doses to be administered in April and August.

Birrell GP report defies reality

AMA President, Dr Steve Hambleton, said today that the *'Too Many GPs'* report produced by demographer, Dr Bob Birrell, should be catalogued near the 'science fiction' section in libraries.



Dr Hambleton said the view of frontline primary care in Australia depicted by Dr Birrell's report defies the reality of people in suburbs and rural communities struggling to access quality primary care because of the shortage of GPs.

"The report appears to rely on previously discredited analysis of the GP workforce that resulted in previous Governments cutting back on GP training, which led to the shortages we see.

"You cannot use billings data to estimate full time equivalent GP numbers.

"The report's conclusions do not sit well with the recent AIHW report, *Medical Workforce 2011*, which found that, while the supply of specialists-in-training, specialists, hospital non-specialists and other clinicians all increased, the supply of GPs fell from 111.9 to 109.7 full time equivalent per 100,000 population between 2007 and 2011.

"The AMA questions the report's assertion that GPs are expensive to the taxpayer. The current Medicare rebate of $35.60 for a standard consultation is well below the true worth of a GP service as estimated by the AMA.

"Dr Birrell's report fails to recognise the role that GPs play in ensuring that our health system delivers high quality health care in a cost effective way.

"Overall funding for GP services represents a relatively small part of the health budget, yet GPs deal with around 90 per cent of the problems they encounter.

"Health Workforce Australia – whose figures we do support – was established to provide advice to the Government on medical workforce.

"Its most recent report, *Health Workforce 2025*, confirmed that Australia is in the middle of a GP workforce shortage.

"Indeed, if Australia is to reduce its reliance on International Medical Graduate (IMG) GPs, then we must lift our training effort even further.

"We reject the report's suggestion that the Federal Government must restrict access to Medicare provider numbers to better distribute the GP workforce.

"Addressing GP shortages, particularly in rural areas, requires a comprehensive approach that includes appropriate incentives, professional support, and takes into account the needs of a GP's family members with respect to access to education and other family needs," Dr Hambleton said.

The AMA's plan to build a better rural and regional medical workforce is at https://ama.com.au/position-statement/regionalrural-workforce-initiatives-2012

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Graduating from medical school – reflections of one's own ... *continued*

... From page 1.

It was on its own frequency and the ambulance services would use it to alert us to incoming trauma patients. We used to refer to it as the bat-phone. One Saturday night, we got a radio call from the police tactical unit. These calls were highly unusual, and often meant that some form of hell had broken loose in the inner city, so we were all listening intently as the charge nurse took the call, which went something like this:

Tango Mike to Joburg trauma … We continued to listen intently … Joburg trauma, be advised, we are bringing in a criminal suspect with multiple gunshot wounds. The charge nurse replied using perfect radio procedure: Copy that Tango Mike, please advise, where has the patient been shot … there was a rather lengthy pause and then the cop replied … "Oh … I don't know, we haven't shot him yet".

From there, the world opened up to me and I was able to do some anaesthetics, some intensive care and some retrieval medicine – aspects of our profession which remain as exciting to me today as they did, what is now many years ago.

I suppose that this is what is truly wonderful about being the graduates of tonight and the interns of tomorrow. The practice of medicine today is this vast multi-faceted beast. While this presents large system challenges for us all as a profession to solve, it also allows us to find the niche that excites and stimulates. Therefore as I conclude, I cannot help but think how lucky we are as graduates of medicine. Thoreau's most famous quote is that the mass of men lead lives of quiet desperation. I truly believe you and I have been spared this misplacement of values to which Thoreau refers simply by the career we have chosen or been lucky enough to fall into. This career of ours is difficult enough to be stimulating, involves vital human elements and is at times breath-takingly rewarding. And so I will end by borrowing again … this time from William Osler by addressing you as fellow students.

Fellow students … Congratulations … Your colleagues around the room and I look forward to working with you and beside you as your careers grow.

ACCC allows arrangement to increase electronic prescriptions

The Australian Competition and Consumer Commission has granted authorisation to eRx Script Exchange to allow it to enter into a contract with MediSecure to facilitate interoperability between the parties' electronic pharmaceutical prescription exchange systems.

Prescription exchange services enable doctors to lodge an electronic prescription for a patient, which the patient can have downloaded directly by any participating pharmacy.

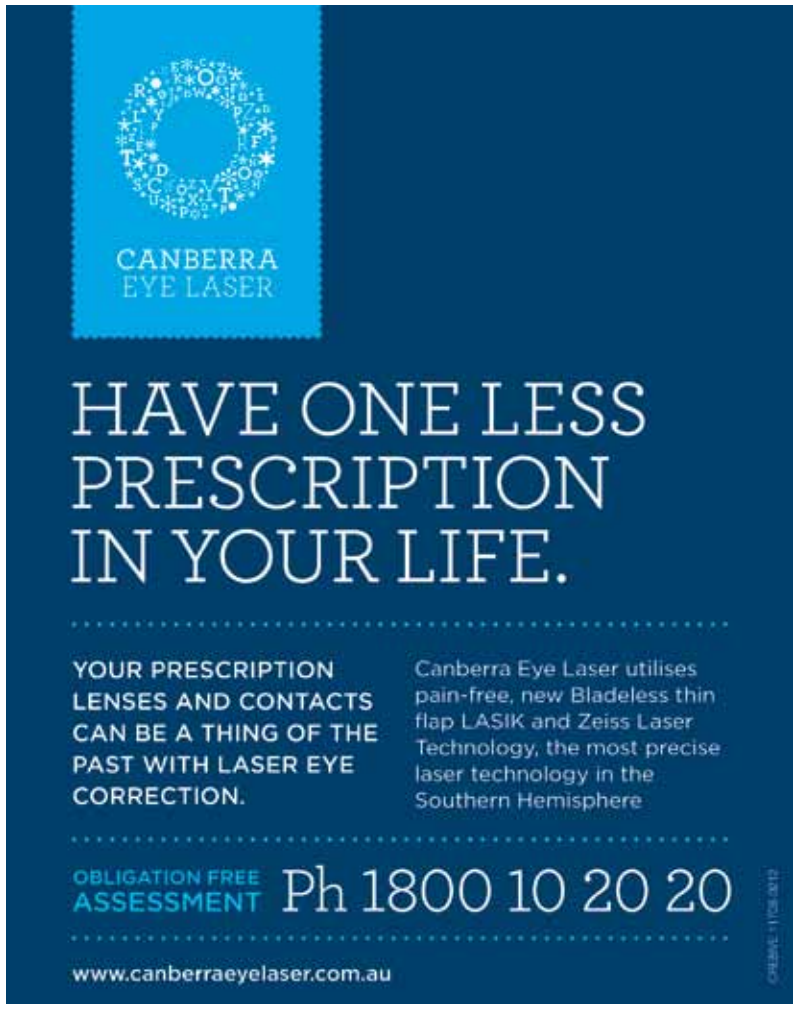
eRx and MediSecure are currently the only two parties operating prescription exchange services in Australia but their two systems currently do not 'talk' to each other.

"Allowing the parties to implement this agreement is likely to lead to greater use of electronic prescriptions, resulting in cost savings and a reduction in prescription transcription errors," ACCC Deputy Chair Dr Michael Schaper said.

The ACCC has granted authorisation until 30 June 2017 by which time an Australian Standard should be in place including technical specifications to ensure interoperability between all prescription exchange systems.

Authorisation provides immunity from court action for conduct that might otherwise raise concerns under the competition provisions of the *Competition and Consumer Act 2010*. Broadly, the ACCC may grant an authorisation when it is satisfied that the public benefit from the conduct outweighs any public detriment.

More information about this application for authorisation and the granting of authorisation, including the reasons for the ACCC's decision, will be available at www.accc.gov.au/AuthorisationsRegister/



Tomorrow's doctors want #socialjustice today

Says Australian Medical Students Association President, Mr Ben Veness.

Social media, especially Facebook, is an important tool used by the AMSA National Executive to communicate with the 17,000 medical students we represent.

Over the past couple of weeks, one of the most popular posts on our page was a copy of a Letter to the Editor of *Australian Doctor*. We sent it in response to a story they published about Dr Lachlan Dunjey, the leader of "Doctors for the Family", who campaigned last year against equal marriage rights for all Australians. Someone had lodged a complaint with the Medical Board about Dr Dunkey's submission to theSenate inquiry into marriage equality, apparently on the grounds that he misrepresentedthe scientific evidence.

Our post was seen by over 1,800 Facebook users. *Australian Doctor* chose to selectively publish quotes from our letter in a follow-up article, so Facebook was very helpful in reaching many more medical students than would otherwise have seen the article, while also granting us complete control over our message.

Our opposition to Dr Dunjey's submission to Federal Parliament was based on the "Marriage Equality and Health" policy AMSA passed last year. Dr Dunjey claimed in an interview with *Australian Doctor* that he was protected by "freedom of speech". We feel this is not an acceptable excuse for misrepresenting evidence to the Parliament and to the public in support of personal prejudices. It concerns us that this group of doctors invoked their status as our colleagues in an effort to confer credibility on their false claims.

AMSA also made a submission to the Inquiry. We made a clear and referenced argument explaining that discrimination is likely to result in "minority stress" and negative mental health sequelae for people who are same-sex attracted. A copy of our policy is available at http://www.amsa.org.au/advocacy/official-policy/

As medical students we look to doctors as role models, and are disappointed when we see our profession brought into disrepute by prejudicial, much less unethical, behaviour.

The NSW Parliament has recently announced a similar inquiry into marriage equality. AMSA will submit our policy and supporting research to them, too. We would welcome AMA involvement in our submission.

In the meantime, James Lawler, AMSA's Global Health Officer and I are travelling to Baltimore in the United States for the International Federation of Medical Students' Association's (IFMSA) General Assembly and will present an adapted form of our policy there. It has been co-seconded by the national medical student associations of both the United States and New Zealand. Since sharing it for review, the emails of support have been pouring in. Recently we have heard from France, the UK, Denmark, Quebec (which is separate to Canada in the IFMSA!), plus Brazil and Lebanon!

The only negative feedback so far has come from an office bearer within the IFMSA, who is nervous about upsetting representatives from some of the seven countries who threaten homosexuals with death, or the over 80 countries who apparently respond with prison sentences.

In countries like Uganda, the extent of the inequitable treatment of people who are lesbian, gay, bisexual, trans or intersex (LGBTI) is astonishing. A particularly powerful spotlight was thrown on the issue in December 2011 when former US Secretary of State Hillary Clinton delivered a compelling speech in Geneva, calling for the protection of this "invisible minority".

Many medical students and junior doctors would agree with Ms Clinton that this is "one of the remaining human rights challenges of our time". Support from senior members of the AMA is welcomed, and helps us to see the relevance and value of membership of a professional association that acts with integrity, compassion and fearlessness.

AMSA would absolutely support prioritising action on these most gross of human rights abuses, however we are hopeful that the IFMSA will still adopt our policy, from which it is easy to extrapolate opposition to death penalties and custodial sentences.

Our argument is based on health grounds, referencing studies such as that by Hatzenbuehler et al. (2010) in the *American Journal of Public Health*, who "studied more than 34 000 lesbian, gay, and bisexual participants and found empirical evidence of the negative health effects of discriminatory policies relative to marriage equality."

They measured psychological health via a survey administered first in 2001 and 2002, and again in 2004 and 2005, "after 14 states approved constitutional amendments limiting marriage to opposite-sex unions."

In the second survey, responses showed significantly increased rates of mood disorders, generalised anxiety disorder, alcohol use disorder and psychiatric comorbidity. Comparable controls from states without such amendments did not show significant increases.

A particularly well-written piece came from Australian drug and alcohol researchers last year. In *Drug and Alcohol Review*, Ritter, Matthew-Simmons and Carragher called out the prominence of discrimination and stigma and its negative effects. They support marriage equality as a "direct, public health approach to managing both community stigma and individually experienced internalised homophobia".

It should be an interesting meeting in Baltimore. What better way to let everyone know how it goes than Facebook?

Late News:
the Policy has been accepted at the IFMSA General Assembly.

Practices get green light for collective bargaining

The competition watchdog will allow GPs in a practice to act collectively setting fees and negotiating charges, in an important decision welcomed by the AMA.

Issuing its final determination on the issue late last week, the Australian Competition and Consumer Commission granted an exemption to allow GPs working in the same practice to agree on the fees charged to patients, and to negotiate collectively with hospitals and Medicare Locals on charges.

The authorisation will come into effect on 15 March.

AMA President Dr Steve Hambleton said the AMA had taken a leadership role on behalf of the profession in applying for the exemption, and was pleased the watchdog had accepted the Association's case.

"We want to ensure that GPs who engage in this type of conduct are not exposed to action under competition laws," Dr Hambleton said. "The decision will remove this uncertainty."

The ACCC has recognised the public benefits that flow from the granting of the application, including cost and administrative efficiencies, improved continuity and consistency of patient care, improved recruitment and retention of GPs, and the streamlining of negotiation processes with Medicare Locals and hospitals.

For further information contact AMA ACT on 6270 5410.

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Weak start for PCEHR

The Federal Government has encountered a poor response so far from doctors and the public to the launch of its controversial electronic health record system.

Figures provided to the Opposition earlier this year show that fewer than 57,000 people have so far registered for a Personally Controlled Electronic Health Record, meaning almost 450,000 will have to sign up between now and the end of June to meet the Government's first year target of 500,000 registrations.

Nonetheless, the number of registrations is up substantially from last October, when just 13,400 people had signed up to the system, and Health Department Secretary Jane Halton said at the time that registrations were not expected to increase significantly until software for GPs became available.

Medical practices have been given until May to make themselves PCEHR-ready, but Government figures show the vast majority are yet to register with the system.

The Opposition's e-health spokesman Dr Andrew Southcott told the Sun Herald that information supplied by the Government in answer to a Question on Notice showed that, of 560,000 practitioners nationwide, just 1325 had registered so far.

According to the Health Department's timetable, most of the major software vendors to medical practices were to have developed desktop products with PCEHR functions by last December, and the Government has threatened to withdraw Practice Incentive Program e-health payments from practices that are not PCEHR-ready by May.

But the AMA declared that practices should not be penalised because of delays in providing them with the software they need to link in with the PCEHR system.

AMA President Dr Steve Hambleton said the Government should provide greater assistance for practices in preparing themselves for the e-health system.

"The AMA supports the PCEHR – it can make a real difference to the continuity of care for patients," Dr Hambleton said. "But the legal framework for the PCEHR has imposed additional red tape on practices. The Government can alleviate this by assisting practices to navigate the complex pathways and requirements necessary for them to participate."

In its Budget Submission, the AMA called on the Government to provide a single set of standardised template policies and protocols detailing what is required to participate in the PCEHR.

"This would save significant administrative time and resources for medical practices, which would otherwise have to prepare these documents from scratch," the Submission said. "Government funding should be provided to an entity that understands the clinical and administrative operations of medical practices to prepare these template documents.

"The Government should provide a standardised step-by-step toolkit to streamline the processes that medical practices will have to put in place to meet the administrative and technological requirements of the PCEHR."

New medical schools could worsen intern crisis

The AMA and the Australian Medical Students' Association have raised concerns about plans by two universities to open medical schools unless there is a significant boost in intern places.

Chair of the AMA Council of Doctors in Training Dr Will Milford has warned up to 250 medical graduates could be left in limbo this year unless federal and state governments committed to boosting the number of internships on offer, casting doubt on the current training system to accommodate even more trainee doctors.

Dr Milford made his warning as Western Australia's Curtin University and Charles Sturt University in rural NSW pushed ahead with their plans to open medical schools, a move that would add significantly to the number of medical graduates coming through the education system.

The WA Government, which was in the throes of a state election campaign, pledged $22 million toward the construction of a medical school at Curtin University – though the Federal Government is yet to make any commitment to the project.

Health Minister Tanya Plibersek last year delivered a blow to the plans of both Curtin and Charles Sturt when she told the AMA it was "difficult to support" any proposed increase in medical school places in the current environment.

"In relation to proposals for new medical schools in Australia, I would like to assure you that the current position of the Commonwealth is that any proposed increase in medical places, whether via establishment of new medical schools or through allocation of new places at established schools, is difficult to support at this time," the Minister wrote in July last year. "It is essential that all governments continue to address their commitment to existing medical trainees, clinical supervisors and patients to increase capacity and maintain high quality training for the existing group of future medical practitioners, prior to making any decisions to increase the intake of medical students."

AMSA President Ben Veness said the number of graduating medical students had more than doubled since 2002, putting the capacity of the internship system under severe strain.

An internship is compulsory for medical graduates who want to go on to practice medicine, and more than a dozen graduates missed out on an internship last year because of the failure of governments to increase funding for places to match the growth in graduate numbers.

Mr Veness said only a last-minute bailout by the Federal Government prevented many more trainee doctors missing out on an internship.

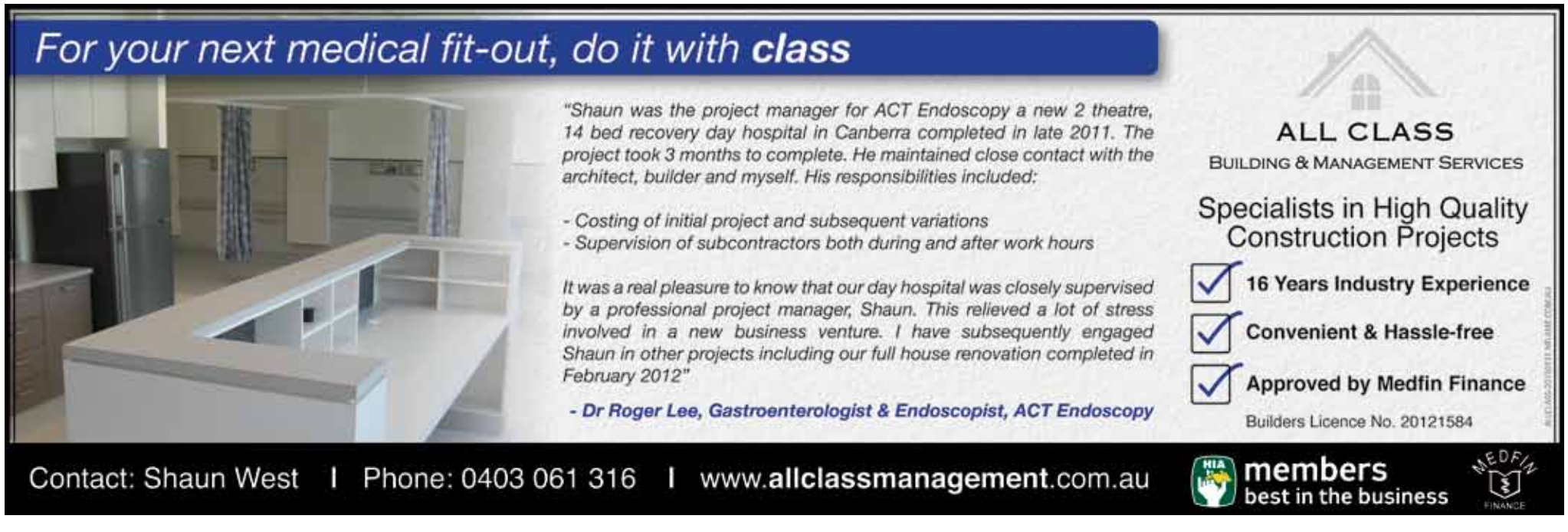
Dr Milford called for much greater coordination among governments regarding medical training.

He told ABC radio in Sydney that the NSW Government had not matched the number of intern places it offered with number of medical graduates coming through the system, and the Commonwealth had yet to indicate whether it would step in again this year to help make up the shortfall in internships.

Dr Milford said that if it did not, up to 250 graduates might miss out on an internship.

Both the AMA and AMSA attended the National Medical Intern Summit, which was intended to bring together health ministers, medical deans and health bureaucrats from around the country, in Sydney on in February.

The summit was called to examine ways to increase the number of internships on offer in both the public and private health sectors.



Tasmania considers 'assisted dying'

Tasmanian doctors will be empowered to administer lethal doses of medication to terminally ill patients under controversial proposals developed by Premier Lara Giddings.

In a discussion paper released earlier this month, Ms Giddings and Tasmanian Greens MP Nick McKim outlined measures to make "voluntary assisted dying" legal in Tasmania.

Under their proposal, mentally competent, terminally ill adults could seek assistance from a consenting doctor to die by taking a lethal dose of medicine, administered either by themselves or their doctor.

"Voluntary assisted dying is a complex issue that evokes strong emotions and generates intense debate," the MPs said. "[But] we believe it is important and necessary to enact legislation that fully demonstrates the compassion we all feel for people who are suffering in extremely difficult circumstances at the end of their lives."

Doctors would play a crucial, but voluntary, role under the arrangements envisaged by Ms Giddings and Mr McKim.

Medical practitioners would be central to a system of safeguards intended to ensure that only patients in the final stages of an incurable illness who are fully aware of what they are asking for, can be assisted in dying.

Both a patient's attending doctor and a consulting practitioner must attest to their mental competence, sign a declaration that the patient has been fully informed of their diagnosis, prognosis, the potential risks and likely outcomes of taking the prescribed medication, and feasible alternatives to assisted dying.

Both doctors must confirm that the patient is terminally ill, defined as being in the advanced stages of an incurable and progressive medical condition that can be reasonably expected to be fatal without significant medical intervention.

Under the plan, the attending doctor can only write a prescription for lethal medication 14 days after the patient has been declared eligible for assisted dying, and the medicine itself must be kept under the supervision of the prescribing doctor.

The medication should not be provided to the patient until they choose to take it, and the doctor must be present at death, to either supervise the patient in taking the medicine themselves, or to administer it where the patient is unable to do so.

Under their plan, Ms Giddings and Mr McKim emphasise that it would be entirely up to individual doctors whether or not they chose to participate.

Anticipating that, if the proposed laws are adopted, Tasmania might be flooded by people from interstate and overseas seeking an assisted death, the politicians specify that only Tasmanian residents – those who own or lease property in the State, have a Tasmanian driver's licence or who are on the electoral roll in Tasmania - would be eligible for assisted dying.

But in practice, this is unlikely to present much of a barrier, because a person can be added to the electoral roll after living at the same address for a month.

If such proposals are enacted, they could provide a much easier alternative for people like Martin Burgess, a 69-year-old retiree from the Northern Territory, who plans to fly to Switzerland to take advantage of that country's right-to-die laws.

Mr Burgess, who has rectal cancer that has spread to his abdomen and has been advised he will be dead within 18 months, told *Northern Territory News* he wanted to go to Switzerland to ensure he had a "painless and peaceful" death.

Voluntary assisted suicide was legalised in the Northern Territory in 1995, but Federal Parliament overturned the law in 1997.

In recent months there has been an upsurge in efforts to reinstate and extend right-to-die laws.

In addition to the Tasmanian Premier's action, the Australian Greens have moved a Bill in the Senate to repeal the Euthanasia Laws Act 1997, which outlawed the practice in the territories.

In South Australia, independent MP Bob Such has moved to ban the withdrawal of feeding tubes and saline drips as a way of hastening death unless other life-sustaining measures such as ventilators are also removed.

Dr Such said his proposed laws were intended to end the "cruel" situation in which people denied the right to decide to end their own lives were instead essentially starved to death.

But there remains considerable resistance to the legalisation of euthanasia, which continues to be a politically-fraught issue.

Among the most frequently voiced concerns are that people with diminished mental or physical capacity may be railroaded into agreeing to assisted dying.

But Ms Giddings and Mr McKim said international experience with euthanasia laws had shown little evidence that this occurred, and the sort of safeguards they envisaged would ensure the vulnerable were protected.

"We have not been able to find any sound evidence that there is a heightened risk for people who may be vulnerable due to their age, disability, mental illness or isolation, as a result of assisted dying legislation," they said. "Consistently expressed fears about voluntary assisted dying law reform have been found, in practice, to be unjustified."

Ms Giddings and Mr McKim have invited public comment on their proposal, which can be viewed at:

http://www.premier.tas.gov.au/__data/assets/pdf_file/0007/185578/Voluntary_Assisted_Dying_-_A_Proposal_for_Tasmania.pdf

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For further information or an application form please contact the ACT AMA secretariat on **6270 5410** or download the application from the Members' Only section of the AMA ACT website: **www.ama-act.com.au**

AMA Staff Assist

– helping you get the right staff for your practice

AMA ACT is pleased to announce its new service "AMA STAFF ASSIST"

This new fee-for-service initiative has been designed to assist AMA members recruit nursing, admin and book keeping staff.

AMA STAFF ASSIST will advertise the vacancy, assess the competencies required for the position, recommend a minimum salary rate, assess candidates and recommend a short-list of candidates for interview. Following the successful selection of a new staff member, AMA STAFF ASSIST will provide the employing member with a template workplace agreement if desired.

For further details on this new service, please contact Christine Brill on 6270 5419 or by email: execofficer@ama-act.com.au

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End of Life Issues and Decision Making – Community Engagement Forum

The Local Hospital Network (LHN), in conjunction with ACT Health Directorate is hosting a forum to identify ways to improve the system for everyone, on Saturday 4 May 2013 between 9.30am and 4.30pm at University House, Australian National University, Acton

The morning session of the forum includes five local and national high profile speakers addressing:

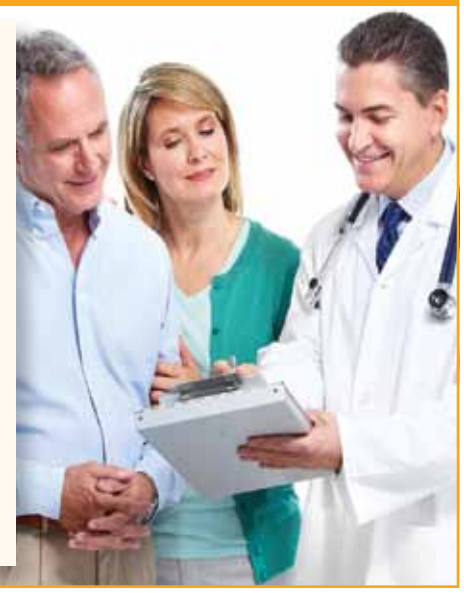
- what happens in intensive care, legal, ethical and consumer issues; and the
- impact on health finances of end of life care.

The highly interactive discussion session in the afternoon is planned to consider and debate a series of questions surrounding end of life health care.

- Would you like to have a say in decisions about your personal future health care?
- Do you know how to make your wishes about future health care known (especially for a time when you may no longer be capable of making your own decisions, as 40% of people are not)?
- Are you living with or caring for a family member with a chronic disease or a life limiting illness?
- Do you work in palliative, aged care, general practice or a hospital?
- How can we design systems that respect and know your wishes?

If you would like to attend, please email lhncouncil@act.gov.au or post your details to LHN Council Secretariat, Executive Coordination Unit, ACT Health Directorate, GPO Box 825, Canberra City ACT 2601. Please include your name, contact details and a brief summary (of only 50 words) stating why you would be interested in attending.

Please respond by 27 March 2013. Numbers limited to 100 participants.



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New Health qualifications and funding released for Health employees

The ACT Department of Education and Training has recently announced the approval of a range of new training programs directly relevant to the ACT Health sector.

New training opportunities

The new qualifications, drawn from the National Health Training Package, enables health administrators, medical receptionists and other health support employees to gain skills essential for the delivery of high quality healthcare including:

- Medical accounts;
- Patient records;
- Confidentiality, security and privacy;
- Infection control;
- Manual handling; and
- First aid certification.

A wide range of topics are available across key qualifications, including:

- Certificate III in Health Administration;
- Certificate IV in Health Administration; and
- Diploma of Practice Management.

Medical practices, allied health providers, private and public hospitals and nursing homes now have the opportunity to provide reception and support employees with vocational training that promotes effective risk management strategies, provides qualifications and leads to the provision of an overall improved healthcare service that benefits the entire community.

Being nationally recognised qualifications, the health training programs provide a new accreditation standard for support employees to achieve in seeking qualifications in their industry, and once achieved, provides a transportable qualification for employees who can be assured that their skills and knowledge will be recognised and valuedin all Australian states and territories.

Support funding available

In announcing the new qualifications as approved traineeship pathways in the ACT, the Department of Education and Training now support these qualifications with course subsidies, ensuring that eligible employees who undertake the courses through a traineeship program have a component of course fees subsidised by the ACT government.

As the qualifications are available as traineeships, employers may also receive Australian Apprenticeships incentives from the Commonwealth government for eligible employees who undertake a qualification, depending on their certificate level of study.

AMA ACT is currently working with MEGT Australian Apprenticeship Centre who can support Practices and other health organisations in determining the eligibility of their employees for this incentives program.

This support is a great opportunity for both new and existing employees, Practices and other Health organisations to undertake refresher training courses and to up-skill in new areas of study, whilst also getting nationally recognised qualifications.

Get your team involved!

These courses are delivered through a competency based process, whereby training and assessment is workplace based, focusing on meeting health industry standards, and participants are deemed competent as they demonstrate they are able to perform in their workplace to this required standard.

Employees completing the qualifications will:

- transfer theoretical understanding to the workplace environment;
- access further flexible professional development opportunities;
- maintain the currency of their workplace skills and knowledge;
- be available to support transitions into new workplace roles/positions;
- recognise and improve their skill levels;
- align study to real workplace issues and needs; and
- complete study aligned to the needs of accreditation processes.

Vocational education and training (VET) courses have risen in significance and prevalence over recent years, leading the charge in responsive and flexible training options for working professionals.

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Painful times as morphine supplies tighten

Health authorities have approved importation and supply of an alternative drug to avert a national shortage of morphine amid serious disruption to supplies of the painkiller.

Pharmaceutical company Wockhardt will begin shipping consignments of its morphine sulphate injection 10 milligrams per millilitre to Australia from the middle of the month to help fill a supply gap caused by a breakdown in the importation of morphine sulfate injections under the DBL brand name, which until now has been Australia's sole registered supplier.

But health workers have been warned to exercise great care in the use of the Wockhardt product because, it contains a preservative, which means it cannot be administered through epidural or intrathecal routes.

The Therapeutic Goods Administration approved the supply of the Wockhardt-made morphine after Hospira, which makes the DBL product, ran into difficulties upgrading its European manufacturer's packaging facility.

The TGA said as a result of the problem, all DBL Morphine Sulfate Injection products, from 5 to 30 milligrams per millilitre, would be in limited supply for at least the first half of the year.

It said it had worked with Hospira to secure an alternative supply of 10 milligrams per millilitre morphine sulphate injections from Wockhardt, though it was not a perfect substitute for the DBL product, and supplies of the 5, 15 and 30 milligrams per millilitre concentrations would remain "tight".

The TGA said the Wockhardt product had "gone through a regulatory approval process" in the United Kingdom, and would be available in Australia from the middle of January.

"[But] there are critical formulation differences between DBL Morphine Sulfate Injection and Wockhardt Morphine Sulphate Injection products which have potential patient safety implications," the Authority warned.

The medicine watchdog said it was aware that on occasion there was a "certain amount of off-label use" of DBL morphine being administered through epidural and intrathecal routes, even though approval was only given for intravenous, intramuscular and subcutaneous modes.

It said that a similar off-label use of the Wockhardt morphine product would be unacceptable because the preservatives it contained made it dangerous to administer it epidurally or intrathecally rather than by the intravenous, intramuscular or subcutaneous routes.

The TGA has warned hospitals, clinics and other places where morphine is used to ensure that the Wockhardt product is not administered by epidural or intrathecal routes. It has also advised those who use morphine by the epidural and intrathecalroute to carefully manage their existing stocks so that they can continue to administer morphine by the epidural and intrathecal route whilst the shortage exists".

Further information is available on the TGA website: http://www.tga.gov.au/hp/information-medicines-morphine-sulfate-products.htm

Aspiring doctors losing ground on pay rates

Starting salaries for medical graduates are growing more slowly than for many of their peers as governments clamp down on health spending.

Figures compiled by Graduate Careers Australia show that the median starting salary for medical graduates rose by just 2.5 per cent last year, compared with an average gain among all graduates of 4 per cent.

While medical graduates remain among the best remunerated in the country – with a median starting salary of $60,000, compared with the national average of $52,000 - data show their advantage over graduates from other fields is slowly being eroded.

Dentistry graduates remain the best rewarded, with a median starting salary of $80,000, rising to almost $97,000 for those in private practice, closely followed by optometry graduates, whose median annual salary jumped almost 13 per cent to reach $79,000 last year.

Graduates in the earth sciences enjoyed a similar surge in earnings to reach a median starting salary of $73,000 – putting them third in the ranking of graduates earnings, well ahead of fourth-placed engineers ($63,000) and fifth-placed medical graduates.

While medical graduates are not the best paid, traditionally they have enjoyed the best employment prospects, and this continued to be the case last year.

The Graduate Careers Australia study showed that more than 98 per cent were in full-time work within four months of completing their undergraduate degrees.

By contrast, just 54 per cent of graduates with visual or performing arts degrees found full-time jobs in the same period.

But the virtual guarantee of work for medical graduates is threatened by the failure of governments to provide enough pre-vocational internships to match the growth in medical school places in recent years.

In November last year a shortfall of 162 internship places was only partially averted by a hastily arranged deal between the Commonwealth and several State and Territory governments to provide an extra 116 positions, leaving 46 graduates in limbo.

With the number of graduates set to swell even further this year, there are fears that without a permanent solution negotiated between the Commonwealth, State and Territory governments, hundreds of aspiring doctors may be denied the opportunity to complete their education, a great cost both to themselves and the community.

Top 10 median graduate starting salaries

Discipline	Median starting salary ($)
Dentistry	80,000
Optometry	79,000
Earth sciences	73,000
Engineering	63,000
Medicine	60,000
Mathematics	57,000
Education	56,000
Physical sciences	55,000
Law	53,000
Computer science	52,500

Source: Graduate Careers Australia

Managing your cashflow

Most of us like to take some kind of break over the holiday period. Unfortunately, your fixed costs don't take a holiday with you. "If you're the principal of a practice, you don't get paid leave," explains Investec's Lynne Kelly"Because everything and everyone in the practice revolves around you, if you're not there to work, nothing happens."

It's a perennial problem for a number of medical practices. While there are many fixed costs that still have to be paid during the first month of the year, there's only one source of income—the principal. And if he or she wants a holiday, the income stops. "The problem is they still need to pay 12 months worth of expenses, but they're doing it with 11 months worth of cash flow,"Lynne continues.

"Your choices to deal with this are either to push your creditors' terms, or use some kind of funding. People that are disciplined could save up one twelfth of their income over the course of the year, and put it away in preparation for this time, but most people just don't get around to doing that. Instead, they find themselves catching up in February, March, and April."

For many people this impact is exacerbated by the fact that the end of January is often the due date of a quarterly BAS cycle—so frequently, you'll come back from holidays to be hit by a tax bill.

For those who don't want the hassle of tracking savings throughout the year or haggling with suppliers, one possible option is an Investec One Account. An Investec One Account with an overdraft facility will provide you with a simple solution to help you manage your day-to-day expenses with the ability to draw up to your approved facility limit. It offers easy access to your savings and overdraft, competitive interest rates on credit balances and full online and mobile banking functionality to view your statements, make transfers, pay anyone or make BPAY payments. It also has no ongoing fees.

The reason that Investec is able to develop these types of solutions is based on their experience in the healthcare sector. "We understand the medical and dental profession well and as specialists in thisarea 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" says Investec's Michelle Gianferrari

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