Canberra DOCTOR

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AMA Family Doctor Week

your family doctor: excellence in health care

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2011 Family D Week iss

AMA launches patient petition to urge major parties to support family doctors

19-25 July 2010

The AMA has launched a petition for patients to sign at their local medical practice to urge the major parties to produce election policies that will support family doctors to continue serving their communities.

Posters and petitions under the heading – Family medicine is running out of time! – are being made available to practices around the country on request.

AMA President, Dr Andrew Pesce, said Australia's family doctors are under enormous pressure.

"Australia has an ageing population, which means that there are more people with chronic and complex health conditions who require more time with their doctor," Dr P sce said.

of delivering health services, and this also affects the amount of time that doctors can spend doing what they do best – caring for patients.

"Now that the election campaign has commenced, the AMA is giving people a voice to call for policies that will support family doctors and ensure that they can continue to provide quality medical services and health advice in their local communities.

"Good health policy will win votes for the major parties, and supporting family doctors is a very good health policy," Dr Pesce said.

The AMA is asking patients to sign the petition to urge the major political parties to produce policies that:

Support your right to choose your family doctor;

Support your right to see your family doctor as often as you need to;

Support the central role of your family doctor in delivering health care and advice to you and your family;

Provide support tl enable you to spend

tape in k and

AMA

Family medicine is running out of time!

00:38

The countdown to the 2010 Federal Election has started. Your family doctor is under enormous pressure. All Australia's family doctors need your help to continue providing the quality health care that you deserve. Please sign the AMA petition to urge the major political parties to release policies that support and preserve the vital role of family doctors in local communities all around Australia.

Remind our politicians that you vote and that you insist on policies that:

- Support your right to choose your family doctor;
- Support your right to see your family doctor as often as you need to;
- Support the central role of your family doctor in delivering health care and advice to you and your family;
- Provide support that will enable you to spend more time with your family doctor when you need it; and
- Cut red tape – minimise the paperwork and processes that reduce the time that family doctors can spend caring for patients.

Please sign the petition in this practice.

Family Doctor Week 2013

YOUR FAMILY DOCTOR: YOUR MEDICAL HOME

TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

This is Family Doctor Week again. I suppose we should have some form of salutation. Happy holidays would be entirely out of place; and merry salt mine sounds a little pejorative – and would probably upset the cardiologists and nephrologists amongst us.

The week represents a celebration of the central role that the family doctor plays in the healthcare of every Australian. I am often asked by people what I think is the most important and effective thing that they can do for their health as they try to age gracefully. Many knit their brows at my standard response "Find a good GP and stick with them". I think they expect some special formula to longevity, some sort of secret doctors business stuff (the real "what we do" when no-one is watching). Before I opted for a simpler life as a specialist I worked here in Canberra as a GP, so I feel that I can attest at first hand to the challenges of life in the primary healthcare lane. I can also recall the patients I saw who undoubtedly benefitted from the fact that I knew them well and could tell intuitively when they had a problem that needed more than the usual attention.

The last published "census" of the Australian medical profession was conducted in 2009. It showed that there were more than 67,000 medical practitioners of whom over 25,000 were "primary care" practitioners. From now on we will be graduating over 3600 new doctors from our universities each year. The figures are daunting. AGPT tells us that the intake for GP training in 2014 will be 1200. This still falls short of the projected demand for training positions, assuming a continuation of the current demographic ratios, but nevertheless suggests that within a few short years we will have between 3600 and 4200 GP registrars (assuming that none are training part time). The teaching load placed on our current GP population will be considerable and as with other vocational training pathways we will need to pay careful attention to ensure that training standards are maintained.

There is of course a further complication to all this. AGPT has minimum eligibility requirements for the training programme regarding prevocational hospital training. Before I went into general practice I had to move to Canberra to obtain the paediatric experience I needed (St Vincent's in Sydney shunned the under 16's). I can see that whilst I had a happy outcome that led me to appreciate the qualities and opportunities offered by the town that would become my home, I can also see that it will be harder and harder for GP aspirants to compete with their peers for this sort of experience in academically sound clinically supervised positions with a caseload diverse and challenging enough to be of benefit to a generalist trainee. The analogy that comes to mind is the forcing yard in the stockyards on our farm. An analogy we need to avoid as a profession, because inherent in it is a loss of personal and professional choice.

AHW tells us that despite these dramatic increases in training numbers, there will still be a shortfall in ultimate medical practitioner numbers after 2025. The calculations are beyond the number pad on my laptop, so I can't comment. What I do find of concern however is the other language coming from the government funders of healthcare in this country. It is undoubted that healthcare costs are escalating, both on a per capita basis and as a proportion of government revenue (and GDP). I do not want to appear churlish, or greedy, but as a profession we need to ensure that any move to contain healthcare costs doesn't involve an externally imposed "demand management" or a drive to reduce doctors incomes (one of the professed aims of the original Medibank attributed to John Deeble). Because of our high profile we are easy targets, of course; but the Australian Institute of Health and Welfare report on Australian health expenditure shows that total national expenditure on health goods and services in 2010-11 was $123.7 billion, with only 18.2% ($22.5 billion) on medical services; and for individual health expenditure over the same period a total of $2.8 billion, only 11.6% of the total spend, was on medical services.

Demand management is a simple tool that ultimately results in some form of restriction of access. In healthcare we have seen it first hand in the complex but nevertheless deliberate calculations that the politicians undertake involving out of pocket expenses that keeps them at an electorally acceptable level but maintains them as a price signal to constrain demand. We have seen also an increasing activism on the part of government towards using the schedule to shape medical decision making, using the schedule as a guide to "best practice".

Of course GPs have been right at the battle front of these changes, with manipulation of a number of chronic disease and mental health items, for little more than cost savings purposes, directly placing the Medicare claims clerk into the consulting room telling you what you can and can't do in a consultation.

As a specialist I find it difficult at times to appreciate the complex interplay of disease and environment that is family practice bread and butter. It is just that complexity that underlines the importance of maintaining medical practitioners at the centre of primary healthcare. It may be fashionable to place other allied health professionals there, however I can see this as either dumbing down (with the greatest of respect) primary care; or siloing it and defeating the whole concept of holistic care.

As evidence I cite a case I have encountered recently where a little mite with a serious cardiac condition was diagnosed by non-medical healthcare givers as having a simple feeding problem. It was the GP that saved the day, and the baby.

So I take my hat off to our family practice colleagues, and thank them for their hard work, perseverance and fortitude. They are our community's secret elixir of life.

Fair decision from Fair Work Commission

The AMA welcomed the decision by the Fair Work Commission (FWC) to reject the Australian Nursing Federation (ANF) claim for a low paid bargaining authorisation for practice nurses working in medical practices.

Chair of the AMA Council of General Practice, Dr Brian Morton, said that the Federal AMA, along with AMA Victoria and AMA Tasmania, opposed this claim before the FWC, arguing that practice nurses are not low paid and that they already bargain extensively with employers at the local level.

Dr Morton said that the AMA argued that the ANF claim had the potential to drive up costs for practices by centralising the negotiation of wages and conditions.

"The AMA presented extensive witness evidence and supporting submissions to the Commission in support of our case," Dr Morton said.

"In rejecting the ANF application, the FWC concluded that most practice nurses were not low paid and that the case for the authorisation was not strong.

"It found several important factors indicated that multi-employer bargaining may be undesirable or less appropriate than genuine enterprise-based bargaining and, on that basis, it was not in the public interest to make the authorisation."

The ANF application covered 682 medical practices, most in Victoria, Tasmania, and New South Wales.

General practice is still the cornerstone of healthcare

By Julie Carr

General Practice remains the corner stone of family practice, comprising 95% of our patient's care. Although it seems every other professional group is trying to grab a bit of it.

The other day I was at the chemist and a man came in asking if he could have something for his child's dry skin. He was handed some Dermaveen by a young woman (she looked about 16 but probably was 20, means I am getting old damn it) and although that was probably ok, in my head I was thinking how old is your child? Is the dry skin new? Is there red patches? Is there any broken skin? Are there any aggravating factors? Is there a family history of eczema? etc. So he left with his $24 Dermaveen wash, no moisturiser.

I then lined up at the counter and a fellow was asking for Voltaren pills and gel, as they "worked better that way".

The pharmacist came to give me my medication; I looked down and the pharmacist asked the assistant what was happening. She found out the patient had back pain and intermittently took Voltaren. No detail about how often, the pain, no red flag discussions, no checking if he also took aspirin or check for dyspepsia etc. And I thought why does everyone think they can replace GPs with other professions? I suppose because most of the time it probably doesn't matter; it doesn't make it good care though.

General Practice is changing: there are government pressures, practice running pressures, hospital structure pressures and community expectations. However I think at the core there is a desire to give holistic care for the patient.

General practice still provides true generalist interests but allows subspecialising. There are broad opportunities in education, research, assisting, anaesthetics, obstetrics and representative roles all in our local area, which allows fabulous diversity for GPs.

I sometimes think that GPs are not utilised effectively when I see expensive hospital programs that can and are already being managed by GPs in the community. Why isn't the GP resource supported and utilised efficiently? Unfortunately, much of the funding for health goes to administration rather than the end care.

Over the last few years I have experienced medicine from the other side, – as a parent.

I used to wonder how parents managed to navigate all the different therapy options, government departments, education and medical care. Now I know it is usually word of mouth rather than specialised review and recommendations. There is no easy centralised source for service options. How can GPs and specialists know what is available? You got it – word of mouth.

As a GP I used to refer to Therapy ACT, but now I know the service has its role but is very limited in providing hands on therapy.

The coordination of complex care needs of children in Canberra is inadequate. Much of the care is referred to Sydney or Melbourne.

We live in the Capital City of Australia yet I have to trek to Sydney to access botox. There is no easy access to public AFOs, paediatric orthopaedics in Canberra is limited, neurology services are limited and multidisciplinary clinics almost non-existent.

Private services are also limited, with specifically skilled therapists having closed books or rare appointments. The number of different funding options are diverse but all involve a deal of administration. I am hoping the NDIS may improve some of these things but when the services don't exist I can't see how a new funding process will change the situation. So if any of you sit on any committees that can change the treatment of chronic disabilities in children, please, please ask for a proper coordinated rehabilitation service in Canberra.

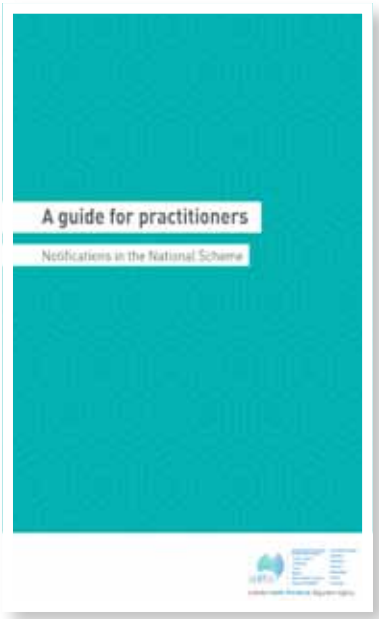
To summarise: let GPs do what they do well. Being a GP is a diverse and valuable occupation and give us the resources we need (by "we", I mean "me").

Last time I wrote something for Canberra Doctor, a surgeon colleague told me I looked dowdy - nice! Unfortunately still the same this time.

Dr Julie Carr is GP Advisor at Calvary Hospital.

News from AHPRA – notifications guides published

This month AHPRA published new guides for health practitioners and the community about how notifications are managed in the National Registration and Accreditation Scheme.



The guide for practitioners and a series of fact sheets aim to explain to practitioners what happens when AHPRA receives a notification on behalf of a National Board. The information complements the direct correspondence that individuals receive if a notification is made about them.

AHPRA collaborated with the professional associations for practitioners registered in the National Scheme to develop the guide for practitioners. The practitioners' guide clearly explains what happens after a concern has been raised about a health practitioner, who decides what happens, how we work with health complaints entities and what practitioners can expect from our processes.

AHPRA has also developed a guide for the community about making a complaint (or notification) about a health practitioner. This guide for notifiers, *Do you have a concern about a health practitioner? A guide for people raising a concern*, will be an early focus for feedback from the newly established Community Reference Group for AHPRA and the National Boards.

Both guides are published online on the AHPRA and National Boards websites in a wholly revised section on complaints and notifications.

Closing the gap

By Marianne Bookallil

The life expectancy gap between Aboriginal and Torres Strait Islander peoples and the rest of the Australian population has been well publicised over the last few years. The causes are complex but relate in part to an increased prevalence of chronic lifestyle related conditions such as diabetes.

Clinical management is influenced by the significant disadvantage still evident in the local community. Aboriginal and Torres Strait Islander people in the ACT require hospitalisation at younger ages than non-Aboriginal Canberrans and have higher rates of hazardous health behaviours such as smoking. Aboriginal people experience multiple personal stressor events and many families have been affected by the forced removal of children (the Stolen Generations). Aboriginal and Torres Strait Islander people are also significantly over-represented in the prison population in the ACT.

As an Aboriginal Community Controlled Health Service, Winnunga Nimmityjah Aboriginal Health Service is in a unique position to identify the needs of the community and implement alternative health delivery mechanisms to improve patient outcomes. One example is the diabetes clinic which has been operating since 2002.

Aboriginal and Torres Strait Islander people face many barriers when trying to access mainstream services. These barriers result in high no-show rates when patients are referred on so Winnunga clinicians try to manage in house wherever possible. Winnunga provides healthcare which removes many of the barriers Aboriginal and Torres Strait Islander people experience in mainstream health services. Transport is provided, medical services are bulk billed, allied health services are free and appointments are not required for many services. Most importantly the service is trusted by clients to be culturally safe and non-judgmental. Comprehensive primary healthcare is provided by GPs, nurses, midwives, Aboriginal health workers and the indispensable Social Health Team. There is a robust mental health team, a drug and alcohol nurse and needle syringe exchange program. Allied health services are available including dental, dietician, audiology and physiotherapy services and a couple of specialists provide a regular service.

Although diabetes is a major concern, clients often have complicated social and medical histories and at times their diabetes is the least of their issues. Someone who is homeless will be forced to accept the diet of the person who has put them up for the night, healthy or not. A client without health insurance will wait a long time for a joint replacement for their osteoarthritis and will usually struggle to exercise during that time, increasing their weight and exacerbating both their arthritis and diabetes. Someone with depression may lack motivation to eat well, exercise and adhere to medication advice. These and other factors are not exclusive to but are more common in the Aboriginal and Torres Strait Islander community. Referring these clients to external endocrinology services will not resolve these issues and so will likely fail to control diabetes.

For many years now, we have been holding a monthly diabetes clinic at Winnunga. It is a chance for diabetic clients to get together, support each other and share information and healthy tucker. There is usually either a presentation from Diabetes Australia or a cooking demonstration by the dietician. Allied health providers from ACT Health attend and provide in-reach podiatry, dietician and diabetes educator services without appointments. Every 3 months an ACT health endocrinologist visits to provide an in-reach service. The ACT Health staff have noticed how much more comfortable and engaged the clients are when seen at Winnunga. Patients enjoy the social interaction and the ability to see the relevant health providers in one place on the one day. This comprehensive joint Winnunga and ACT Health service has reduced access barriers for the diabetes clients who attend and has the additional advantage of upskilling Winnunga's clinical staff on diabetes and ACT Health staff on complex patient focussed social care and culturally appropriate healthcare.

We would like to be able to provide innovative delivery models for other health conditions, but are limited by our physical space, lacking clinical rooms to allow expansion of the service. We are also restrained by our location in Narrabundah, reducing access for Aboriginal people from the north side of Canberra. Like other services, we are constrained by funding and we struggle to get access for our patients to some medical specialties and some allied health services. We are constantly working around these issues and looking at ways to further improve the service and its reach into the Aboriginal and Torres Strait Islander community.

Dr Marianne Bookallil is a GP and public health physician. She works at Winnunga as both a GP and public health physician and is Acting GP advisor at ACT health.

Prisoner health and primary health meet

By Michael Levy

'A Healthier Future for All Australians', the final report of the National Health and Hospitals Reform Commission, published in 2009, identified the case for health reform in Australia.

Tackling major access and equality issues for vulnerable consumers, improving care for consumers with mental illness, and supporting consumers living in rural and remote areas were all identified as important goals of the government. All of these proposed reforms also resonate with a particular vulnerable population: prisoners.

In 2010 the Australian government released Australia's first National Primary Healthcare Strategy, which identified four key priority areas for reform of our health system:

- improving access and reducing inequality
- better management of chronic conditions
- increasing the focus on prevention, and
- improving quality, safety, performance and accountability.

The identification and description of the full spectrum of healthcare needs of vulnerable consumers in the National Primary Healthcare Strategy document, and in epidemiological studies on the health and social welfare of prisoners, is useful in informing future policy on the management of all vulnerable consumers through the primary healthcare system.

Describing the health status of prisoners has enabled the Australian public health community to better identify and understand:

- the needs of other vulnerable consumers and the availability of services they require
- appropriate chronic disease management for vulnerable consumers
- areas where more systematic and integrated approaches to promotion, prevention and early intervention will lead to better outcomes for vulnerable consumers, and
- factors that may enhance or impede the quality and safety of primary healthcare services for vulnerable consumers.

However, the experiences of vulnerable consumers with the primary healthcare system and the experiences of health professionals who treat them have not been given adequate attention. The linkages between general practitioners and allied health professionals who may be involved in the treatment of vulnerable consumers, such as pharmacists, psychologists, etc., are also poorly understood. Analysis of Medicare and Pharmaceutical Benefits Scheme (PBS) data, as well as interviews with consumers and health professionals, will not adequately describe the services provided to prisoners and the gaps in their care, as prisoners are disentitled to Medicare and the PBS for no discernible reason. Important linkages within the healthcare system remain masked; recommended ways of improving coordination of care between different primary healthcare services continue to elude us; and the possibility to optimise outcomes for vulnerable consumers, including prisoners, is not as yet achievable.

Understanding the healthcare needs of vulnerable consumers by examining the experiences and opinions of both healthcare providers and healthcare consumers will provide vital information to inform future policy regarding the management of vulnerable consumers through the primary healthcare system.

So, what do we know, and what don't we know about Australia's prisoners? A lot, and a lot!

In an international sense, the Australian Institute of Health and Welfare is ahead of the game. The routine collection of prisoner health indicators is a tangible commitment to the World Health Organization statement, 'Prisoner Health is Public Health'. No other country in the world has a comparable activity. But New South Wales and Victoria did not participate in the 2010 health census, and this year's commitment of participation by all eight jurisdictions is by no way assured into the future.

The *Medical Journal of Australia* (1 October 2012, p. 382) highlighted the different application of basic harm minimisation strategies for prisoners across the nation. Why is it that Victorian prisoners can now access condoms – 16 years after New South Wales and Australian Capital Territory (ACT) prisoners – and Queensland prisoners still cannot? Why can ACT prisoners access 10 treatment places at any time for hepatitis C treatment, while Victorian prisoners (about 12 times the number of prisoners than in the ACT) only access 10 treatment places in a year?

In the May edition of *Canberra Doctor*, readers may have noted the welcome intervention by Dr Andrew Miller, the President of the AMA ACT, advocating for the ratification of the *Optional Protocol to the Convention Against Torture*. While not immediately apparent from the formal name of this international instrument, the "Protocol" could promote the health of Australian prisoners, through independent scrutiny of our eight prison (health) systems.

In the absence of this scrutiny, Australia's nearly 30,000 prisoners remain poorly served by the Australian public health community, and the public health community has been silent on this issue for far too long – appropriately, the AMA, locally and nationally, is breaching that silence.

Professor Michael Levy is a public health and custodial physician at the Alexander Maconachie Centre, Canberra.

GP Workforce – where to from here?

By Ian Pryor

As a result of increasing complaints by patients about the lack of access to GP services and also heartfelt concerns by general practitioners themselves that they were constantly stressed by patient loads but unable to recruit new doctors for their practices, joint initiative by the ACTAMA, the then ACT Division of General practice and the ACT Health Department was undertaken to form the GP Workforce Working Group chaired by the AMA

The Working Group was established to examine the issues surrounding GP shortages and advise the then Department and the Minister on actions to address the problems . Although GP services are nominally a Commonwealth responsibility, the issues had become particularly pressing locally and decisions to direct support and finances from the ACT budget were to be considered.

In addition to those mentioned above, there have been many other players involved in the Working Group and key among them have been the Academic Unit of General Practice and Community Health, both the ACT and Calvary GP Advisers, Coast City Country Training, ANU Medical School, ACT Chief Nurse, the Winnunga Medical Director and departmental staff.

It is now over ten years since the Working Group started. During this time it was disbanded for a while only to be resurrected in 2009 when GP workforce issues became even more pressing and it has continued regularly since, oversighting and advising on a range of projects and strategies which by and large have had considerable impact on nberra.

Many of these creative initiatives have been devised and developed by the GPWWG in conjunction key stakeholders with the aim of improving recruitment of GPs in the ACT, retaining them actively in the workforce and training and retaining new GPs through ACT's Medical school and through post graduate incentives.

In 2008 the problems of GP workforce here in the ACT seemed to be at least as bad as anywhere in Australia except for remotest areas although there seemed to be little recognition of our plight outside the ACT. In order to mount a campaign informed by facts, the first GP workforce survey was commissioned and undertaken by the ACT DGP in 2008. This survey confirmed the dire predictions about patient to GP ratios, waiting times, closed books by many general practices and the stress on an ageing GP workforce.

A suite of initiatives were introduced over time by the Minister, Katy Gallagher, at significant cost to the ACT Treasury because of the considerable adverse health implications for Canberrans and the unmanageable pressures falling on ACT hospitals' A&E services which could not wait for Federal actions alone.

As a result we now have a GP Marketing and Support Officer for promotion and recruitment including for overseas trained graduates, a GP Development fund, Education Infrastructure Support Grants, a newly updated GP Scholarships program, Prevocational GP Placements Program, ACT GP Aged

Care Day Service and of course the ANU Medical School providing local graduates.

So what have these initiatives achieved? What has changed in general practice in the ACT for GPs and their patients and which actions were those making the greatest difference? What is the state of our GP work force now?

Anecdotally, there seems to be mounting evidence that there are currently significantly more GPs in the ACT, that fewer practices have closed books, waiting times to see GPs are less and recruitment of new GPs is easier. In fact, there has been some suggestion that increasingly practices are looking for extra work and that patients available for GP registrars and for student training are harder to find.

With such reports of increasing GP availability in the ACT, the GPWWG determined to review the state of GP workforce and the programs under its purview. To do this effectively it recognised that a new survey of GPs and their practices was necessary to quantify the current state of affairs and to help make projections of both likely future demand for GP services and of their future supply. It was considered by the GPWWG that a survey of this nature was also needed as a basis to review the current strategies in place to assess their effectiveness and whether they remain relevant.

Happily, requests for support and funding fell on receptive ears and after a comprehensive process the ACT ML has just completed the exercise. The study comprised surveys of GP and practice managers and a review of relevant publications and data to enhance the surveys' findings. The chief researcher was Bruce Weston of the Rural Health Workforce. The majority of Canberra's GPs will know most of this as they were directly involved in the surveys and we thank them for their time and effort and that of their practice managers.

The results are now in the process of a detailed examination by the GPWWG and will be made freely available shortly. However, key findings would appear to be consistent with the intuitive feelings of the profession and indeed patients that Patient to GP ratios in the ACT are reducing from the unacceptably high figure of 1100 of just a few years ago. Because of the known number of GPs reaching retirement age, it is likely that there will continue to be a high attrition of older, mostly male, GPs but we need to determine whether the current initiatives including expected retention of new graduates from the ANU Medical school will do more than address this efflux.

These and many other implications of the workforce survey findings and GP workforce projections require serious examination and interpretation. It is also envisaged that there would be an ongoing process for serial evaluation of ACT's GP work force to facilitate continuing analysis of GP supply and demand. To these ends and armed with the full implications of the Workforce Scoping Study, I look forward to the GPWWG undertaking its planned strategy review process as soon as possible so that it can make appropriate recommendations for the way forward.

Dr Ian Pryor is chair of the GP Workforce Working Group.

Improved contract for GP after hours care – AMA advice to members

You may have received a contract from a Medicare Local in your area for the provision of after-hours services. As you are aware, from 1 July 2013, funding for GP after hours services will no longer be provided via the Practice Incentives Program and will instead be administered via Medicare Locals.

In recent months, an initial round of contracts went out to some members. Many members contacted the AMA expressing concerns at the nature and content of these contracts. The AMA and its legal advisors reviewed many of these agreements and identified a range of issues with the agreements which required some revision.

Following AMA advocacy the Department of Health and Ageing issued revised contracting guidelines to MLs. The Australian Medicare Local Alliance (AMLA) has now issued a revised contract, with input from the AMA's legal advisors.

The AMA now believes the revised contracts are far clearer and fairer to all parties, with many of the more troubling clauses being removed, such as the power for MLs to enter premises and seize documents.

While our advocacy has led to fairer and more sensible arrangements, as with any contract, you still need to exercise caution before signing.

AMLA has issued a template contract for MLs to use and the AMA strongly encourages their adoption by MLs. However the AMA cannot control which MLs will adopt it, so we strongly advise you to ensure that what you are being offered is a revised contract.

We recommend the following steps:

Make sure you have the revised version of the contract. It should come to you in two basic parts:

Standard Terms and Conditions

These are not generally intended to be negotiated, and if it is in the form which has been seen by the AMA, we feel it is on the whole a satisfactory agreement, which should suit most practices. You still need to read it carefully.

After Hours Funding Agreement Details

This second part is the one most likely to raise issues, as MLs can vary it and insert items into it. You need to check this very carefully to make sure that it suits your needs, and you are able to meet the expectations in it. Check carefully for any clauses that may have been inserted or altered, and so differ from the standard revised version. If anything is not satisfactory, you should approach the ML and discuss it with them.

Obtain any specific advice you require, legal, financial or otherwise. You may need to confer with your indemnity insurer or any locum service you use to make sure that you can comply with requirements of the agreement.

… Continued page 12.

Do we dare to be different?

By Karen Flegg

I am writing from Prague where the World Organization of Family Doctors (WONCA) has just held its 20th world conference. It has been a stimulating program. A keynote speaker from Slovenia (Prof Igor Švab) received a standing ovation for asking us to consider "Do we dare to be different?" - meaning do we dare to be different to specialists? Yes we do, but we need to work at it.

Last night, I took a colleague with acute abdominal pain to the 'internist emergency' here in Prague. After a brief history we were told to go across the road to the 'surgical emergency' because this was abdominal pain and they could not deal with surgical problems at 'internist emergency'. At the 'surgical emergency', bloods were taken at presentation, as they often are in Emergency Departments; physical examination preceded history; the doctor spoke just enough English, and of course, my colleague had no Czech! Neither the young Czech GP who had taken us to ED, nor myself had been allowed in while she was seen. The fact that my colleague was diabetic was revealed when the doctor asked what the insulin pump and cannula on her abdomen were. The only history taken related to abdominal scars.

My sick colleague was told she probably had pancreatitis and an abdominal XRay and ultrasound were done at a cost of about AUD80. The trip to imaging gave my colleague and I the time to talk and plan. Left alone, I examined my colleague. Surely the problem was renal, not pancreatic? We decided to insist on a urinalysis (a little difficult given our limited Czech language). This was achieved, but with some angst and proved the suspicion of pyelonephritis – in our minds anyway. My sick colleague was told the tests were all normal but that there were RBC, WBC and protein in her urine.

Luckily many of us travel with a mini pharmacy – maybe not the best practice but at times like this it helps to have some ciprofloxacin, after having been dismissed from the 'surgical emergency' with reassurance and the advice to go home and sleep and have some tea and cake for breakfast. (Hardly usual advice for diabetic and coeliac patients).

The whole process started me contemplating – why we must dare to be different and what teaching lessons were here for my next workshop with our registrars.

Another colleague, who had also been present as a support person, and I sat debriefing afterwards. How could we have avoided this waste of time? What would we as family doctors do in our own countries? What could we have done differently in this situation? I had thought it was best to involve a local colleague, but when thrust into a subspecialised system such as this, the system failed us.

My sick colleague was not told the rationale for the blood tests, nor in fact, which tests were being done. As GPs, we teach a different approach. Yes, the test were cheaper than at home but were they really necessary? We should think about the rationale for each test - which tests are likely to contribute to diagnosis and eventual management. Cost is a concern even when 'Medicare pays' – after all in the end 'Medicare' is funded by the taxpayer! Hopefully we dare to be different and explain the tests we do to our patients.

No medication or allergy history or anything unrelated to surgical problems was taken. Again we must dare to be different. A good history and examination reduces the need for costly investigations.

My sick colleague had no support, nor any help with translation when actually being examined. I started to be glad that in August, we will have a registrar workshop that includes cross cultural communication. My sick colleague would not have had a UTI diagnosed had we not insisted on a urinalysis. Was it possible to treat this medical problem in the 'surgical emergency'? Fragmentation of care brought home the holistic nature of our work as GPs and the need for such an approach to ensure good patient outcomes..

In Family Doctor Week, we should celebrate the benefits of the strong general practice system in our country; and the skills of our GP colleagues who DO dare to be different to our specialist colleagues. The WONCA catch theme at present is "A family doctor for every family". We must promote this concept as despite the strong development of family medicine in Australia, there are still people who do not identify a particular GP as their own.

(Acknowledging Prof Igor Švab's Do we dare to be different.)

Dr Karen Flegg is Director of training of Coast City Country GP Training Program in the ACT and South East NSW region.

The Patient-Centred Healthcare Home

By Rashmi Sharma

There has been increasing interest in recent times around the broad concept of a patient-centred medical or healthcare home (General Practice), with professional bodies such as RACGP, and AMA promoting the importance of the concept in providing comprehensive patient care.

In the development of its recent strategic plan, ACT Medicare Local endorsed this concept as one of its strategies and preferred the term "healthcare home "-not to undermine the role of the GP but to recognise that health is wider than medical interventions and includes addressing the psychosocial needs of our patients over the course of their life. The ACT Medicare Local sees the patient-centred healthcare home as being at the forefront of a strong ACT primary healthcare system and integral to a "whole system, whole person" approach.

At its heart is the evidence-based principle that the development of a long term relationship with a general practice and with a GP-led team at the centre of coordinated, integrated whole-person service delivery, will result in improved health outcomes. This continuity of relationship with the same care team also can lead to much better utilisation of both finite health funding and a skilled but often scarce health workforce. As mentioned the healthcare home is patient-centred because it takes into consideration the patient's broader physical and psychosocial health needs as they change over their life course. This GP-led team of healthcare providers is accountable for addressing these needs along with patients and their carers as well as ensuring that care is organised across the broader health system including with specialists, acute care, aged care, home and community care. This team is also responsible for the delivery of illness prevention and the promotion of well-being to its patients as well as assisting people to manage chronic disease to the level they choose and are capable of.

We all know that this sort of model already occurs with a large proportion of the Australian community identifying with a particular GP or General Practice-this model needs to be encouraged and enhanced by policy makers to prevent silo models of care being promoted/developed. It is heartening to see that this is being visited by policy makers with an initial consultation process taking place through an expert advisory group to explore the way that the principles of this model could be applied in the Australian healthcare context.

While the above may sound like a plethora of bureaucratic motherhood statements I ask my colleagues to reflect on their everyday experiences with those you care for. I am sure this will illustrate the benefits of this concept. Let me share with you one of my many experiences as a GP – one that has been formative in my approach to the care of my patients crossing boundaries between the acute and primary healthcare sector – one where the benefits of the healthcare home were tangible even at times of tragedy.

I still remember clearly the day Helen stood at the front desk as a potential patient of the surgery enquiring about the services offered by the practice. I had just moved to Canberra, my books were empty and so I was recommended as a kind doctor who would be happy to take on the complex care of this family. Complex it was; with one of the children having a severe disability and chronic diseases popping up as the years ensued with the parents - diabetes and hypertension in both parents secondary to obesity, an unwanted pregnancy in a teenage daughter, and the ongoing issues of an immobile growing disabled child with severe developmental delay. Overshadowing all of this was a diagnosis of severe depression in the mother, Helen; so much so that prolonged episodes of hospital admission were commonplace. Despite all of this we made progress – weight was lost with the support of the practice nurses, dietician and diabetic educator. Diabetic medications were ceased and gym memberships became a normal part of life for this family. And when needed, social supports such as respite were put in place and return to work plans developed when mental health inpatient care ceased. We were going as well as we could…

At the end of last year Helen's depression deteriorated. We managed the best we could – requests were made to reinstate the outpatient mental health services and in the meantime psychology support and biweekly GP reviews occurred. Another inpatient episode was deemed necessary when the risk of self-harm became apparent again, and I refused to take "no" for an answer when I contacted the acute services on her behalf.

I was distressed to receive the news on my return from leave that Helen had taken her own life after being discharged – it had all become too much. Of course no health providers or regulatory authorities had let the practice know despite caring for this lady for 15 years – it was down to the grieving family to let us know that the pre-arranged appointments at the practice would no longer be required…

And so for the moment the visits from Helen's family are a time to debrief, a time to grieve, a time to plan as a disabled child is about to become a disabled adult and so on. Flexibility around lifestyle, diet and timing of blood tests was granted at this extraordinary time – I know that when the time is right, focus will once more be applied to these areas but there are different competing priorities now which need to be addressed – priorities that I can understand as I have travelled this long journey with them.

This family has unknowingly adopted the concept of the "medical or healthcare home" – my practice is that home and my colleagues in pharmacy, nursing and allied health have worked with me over the 15 years to try and improve their health outcomes in difficult and catastrophic circumstances.

We all have hundreds of stories like this to tell – they endorse the value of general practice being at the centre of a strong primary healthcare system. And accordingly its importance in regards to meeting the health needs of the ACT Community has been proudly embodied in the strategic plan of the ACT Medicare Local. All Canberrans need a strong supported patient centred healthcare home in the form of their local general practice and GP and their team. This is not a new concept –we just need to keep reminding ourselves and others of it ….

Dr Rashmi Sharma is the President of the ACT Medicare Local and a Canberra GP.

Electronic Health Records Result in Reduced Medical Errors

SYDNEY, Australia; July, 3 2013 – The majority of Australian doctors (77 per cent) say sharing health records electronically had a positive impact on reducing medical errors in 2012, according to a survey by Accenture (NYSE:ACN).

The survey of 3,700 doctors in eight countries – Australia, Canada, England, France, Germany, Singapore, Spain and the United States – also found that 83 per cent of Australian doctors are actively using electronic medical records (EMR) and roughly 70 per cent reported improved quality of diagnostic and treatment decisions as a result of their use of shared electronic health records.

Patient Access to Records

Accenture's survey revealed most Australian doctors (83 per cent) want patients to actively participate in their own healthcare by updating their electronic health records (EHR). However, the majority believe that patients should only have limited access to this record – a view shared across the surveyed countries. There was broad agreement among Australian doctors that patients should be able to update standard information in their health records, including demographics (87 per cent) and family medical history (78 per cent). However, a significant proportion of doctors were opposed to patients providing updates in areas such as medications (29 per cent), medication side effects (28 per cent), allergic episodes (26 per cent) and lab test results (59 per cent). The level of opposition to such patient input was notably higher than most other countries.

"Australian doctors are increasingly embracing electronic medical records to improve the quality of care provided and clinical outcomes," said Leigh Don Accenture's health business in Australia and New Zealand. "This is in line with the most advanced healthcare systems. However, there is clearly more to be done in terms of enabling consumers to play an active role in their own care. This requires a shift in the way clinicians think and interact with patients, harnessing new technologies such as electronic health records and mobile devices. From the survey, this seems to be happening faster in other countries."

Less than a quarter of doctors (18 per cent) believe that a patient should have full access to his or her own record, 65 per cent believe patients should have limited access and 16 per cent say they should have no access. Australia ranked second highest of the eight countries surveyed in the proportion of doctors that say patients should have no access to their record.

"The shift to patient-centered care has long been talked about, but we're now entering a new stage with the rise of the digital citizen and availability of electronic health records. The combination of smartphones, faster broadband, mobile access to the PCEHR system, and a growing array of mobile health applications will trigger fresh demands from consumers for more active participation in managing their own care. To meet changing consumer expectations, Australian doctor's views on patient access will need to evolve."

"It's difficult to predict how quickly this shift will happen or where it will lead, but it looks unlikely to happen in a way that doctors and administrators have fully anticipated or feel comfortable with," Mr Donoghue added.

Doctors Access to Records

Underlining the growing importance of electronic health records, there has been a 62 per cent increase since 2011 in the number of Australian doctors who said they routinely access electronic clinical data about patients previously seen by a different health organisation. The increase in the use of electronic health record systems among Australian doctors was second only to the increased usage by doctors in Germany, who reported a 77 per cent increase. Australian doctors have also increased their routine use of other IT capabilities, including: receiving patients' clinical results electronically (67 per cent), entering patient notes during or after consultations (64 per cent) and receiving electronic alerts/reminders while seeing patients (44 per cent).

Surprisingly, only 5 per cent of doctors in Australia routinely communicate electronically with patients. However Australian doctors expect accessibility to patient clinical records to increase to 76 per cent over the next two years.

I remember When... Musings of a grumpy old GP

By Stan Doumani

For some time I have been reflecting on the changes I have seen in the Australian Medical System in general and in the ACT in particular. I remember when everyone was availed of first timely medical care.

This was when, a person down on their luck and pensioners competed for public hospital beds with each other. They did not have to go on the list behind the middle income earners and the very wealthy. They got their knee replacements before immobility and pain had reduced them to such a state of ill health that a meaningful recovery was extremely difficult if not impossible.

I remember when a GP knew when a patient required admission and did not have to run the gauntlet of the Emergency Department. The idea would seem absolutely laughable to the current generation of doctors a fact that is lamentable in its own right. Private patients would have their choice of surgeon for emergency surgery and so to would the uninsured simply because of the lack of competition as mentioned previously.

I remember when evidence was what informed us. It is what gave us our bank of knowledge. It forms the scientific basis of medicine. The art of medicine was how we took that body of evidence gathered from various studies and trials of large numbers of people and the knowledge it gave us and applied it to the unique individual that sits in our consulting room chair, with their unique blend of personality and social traits and collection of medical problems. Now, it seems to me, that evidence based medicine has become nothing more than protocol driven medicine. Perhaps that's a bit harsh but you get my drift.

I remember when a patient in hospital could identify the person treating them. They could tell from their clothing if they were being seen by a nurse, a doctor, an enrolled nurse, a pathology person or a ward clerk etc. So many times I have my patients complain that whilst they were in hospital, they became very confused about who was who when it came to their treatment. They relate feeling reticent to share their medical history with just anyone. It does not bother all of them but it does bother most.

I remember when Anatomy, Physiology, Embryology, Histology, Biochemistry were actual subjects taught in med school. They were to form the basis for the study of disease processes we would later learn. Oh dear! Now I am really showing my age! Perhaps I don't really fully understand the post-graduate course but it seems that it does not require any graduate course in particular to precede the postgraduate degree. What I do recognise is that the current crop of medical graduates are of a high standard and for that I am thankful.

On the other side of the ledger, I also remember a time when there were no CT scans, MRI had not been invented and PET had not even been thought of. Ultrasound was capable of detecting midline shift and nothing more and real time ultrasound was a pipe dream. As well as that there was no measurement of trophic hormones and the list goes on.

Do I still enjoy my medicine? You bet I do! I find the personal rewards just grow and grow as the little children who have known only me as their family doctor are returning to me with their children in such numbers that 0-5 yrs is once again my largest demographic. That is really very nice. The system in which we work now I would have to say I am enjoying less…

Dr Stan Doumani is a Canberra GP and convenor of the DHAS (ACT).

Revised after hours standards a welcome move

Accreditation standards for general practices regarding the provision of after hours care have been revised following concerns raised by the AMA.

The Royal Australian College of General Practitioners has adjusted its flagged indicators related to the provision of out of hours care after the AMA voiced fears that practices could lose their accreditation and access to Practice Incentive Payments (PIP) without the change.

The AMA wrote to the College early last year warning that the Federal Government's decision to invest Medicare Locals with responsibility for coordinating after hours care and to phase out PIP funding for out of hours care, had created a radically changed setting for practices that made it potentially very difficult for them to comply with accreditation standards.

"This represents a completely new environment – one where the level of financial support for general practices is less certain, and the availability of local out of hours services will be largely dependent on the decisions of Medicare Locals," Chair of the AMA Council of General Practice, Dr Brian Morton, said.

"The extent to which GPs will have genuine input into the design of out of hours services is also unclear."

Dr Morton said the changes had made it imperative for the College to reconsider its standards, which had placed significant demands on practices to ensure patients had access to after hours care.

"The reality is that this obligation now rests with Medicare Locals," Dr Morton said.

"The AMA is pleased to see that the College has responded to these genuine concerns, and that practices will not be unfairly penalised.

"The College has struck the right balance, particularly given the uncertain funding environment and the role now played by Medicare Locals."

Under the revised standards, practices will be required to demonstrate that they are aware of arrangements to enable their patients to get after hours care, and that they have process in place to inform patients of the arrangements.

Celebrating General Practice and the AMA

By Suzanne Davey

No matter what the quality of the relationship between the individual doctor and their patient, there are inherent barriers in our current health system to that patient receiving optimal delivery of healthcare. The general practitioner at the coalface of the patient/health system interaction is easily able to see where the individual patient falls through the gaps.

The GP hears the stories of the many hours that their patients wait in our public hospital Accident and Emergency Departments, followed by the bottleneck for admission to public hospital beds.

We hear of patients being fasted all day for surgical procedures, only to have them cancelled at the last minute. We hear of the prolonged waits for an outpatient specialist appointment, let alone the prolonged elective surgery waiting lists.

The patients themselves witness their doctors wasting time on the phone Authority Drug approval line, where only about 2.8 % of requests are actually refused by the clerks who take our calls. They hear us wasting time ringing the hospital on the doctor's "luke-warm" hotline trying to beg for an appointment or chase up results for their patients. They see their doctors wasting time filling in endless forms to enable patients to access what are their previously determined rights in terms of disability and carer payments. They are also acutely aware that since the inception of Medicare, "gap payments" for patients have gone up 11.7% per annum, as Medicare rebates have failed to keep up with the rising costs of delivery of healthcare in the primary health setting.

There is a great need to look at the big picture of health from both the doctor and the patient perspective to improve service delivery and health outcomes.

Only the Australia Medical Association is able to provide this overview in its role as an advocate for doctors and patients in their interaction with the decision makers in health policy and fund allocation in this country.

The AMA advocates on behalf of its members and the community at the Federal and State and Territory levels by tracking and reporting government performance on health policy, financing, services and programs. It then challenges and works with government to improve public health policy by lobbying politicians both in power and in the opposition, taking part in a broad range of government health committees and if necessary running campaigns to influence government health decisions.

The AMA is the public voice of the medical profession, providing informed and authoritative expert medical commentary on health issues in the media, political debate and public forums. It commissions and conducts research on health issues, as determined by what its members see as health priorities.

The AMA also improves patient care by supporting the medical profession. It protects the academic professional and economic independence of medical practitioners.

- It protects the wellbeing of medical practitioners by advocating safe working conditions and safe working hours.
- It promotes ethical behaviour of the medical profession and protects the integrity and independence of the doctor/patient relationship.
- It preserves and protects the political, legal and industrial interests of medical practitioners.
- It tries to ensure adequate government funding for doctor training and to predict a realistic number of medical student places and craft group training positions to meet the future health needs of our aging community.
- It is constantly working on strategies to improve health delivery in rural, remote and indigenous settings.

So, as a general practitioner in Canberra celebrating Family Doctor Week in July 2013, I regard my membership of the AMA as the only way I can hope to influence the bigger picture of improved and affordable health outcomes for my patients and all Australians.

Dr Suzanne Davey is a Canberra GP and represents the ACT on the AMA's Council of General Practice.

Letters to the Editor

Dear Editor

No Place for Unvaccinated Children in Canberra's Childcare Centres

The other morning as I was doing the rapid fire kiddie drop-off at childcare in order to make handover at eight am in the ED I passed by two nice middle class Canberra mothers having a conversation. "It's just not worth the risk", says one to the other, "the only one we might do is tetanus, because my parents have a farm…" by which stage I was already out the door but already fuming. It came with great surprise that in educated middle class Canberra parents could actually be "conscientious objectors" to vaccination.

In late May this year the NSW coalition approved changes to the 2010 Public Health Act that will require parents or guardians to provide evidence their child is fully vaccinated for age, or is on a recognised catch-up schedule, or has an exemption approved by a GP. From 2014 a child cannot be enrolled unless the documentation is produced and the childcare facility can be fine up to $4,000 if they've enrolled an unvaccinated child without appropriate documentation.

The caveat to the NSW legislation is that a child can still be enrolled in a childcare centre if their parent is a conscientious objector if they provide a certificate from a doctor stating that the doctor has "explained the benefits and risks of immunisation to the parent and has informed the parent of the potential danger of not immunising."

Queensland has a slightly more watered down proposal currently in Parliament that gives childcare centres the right to refuse enrolment to unvaccinated children but they still may enrol those children if they choose to.

Currently the legislation in the ACT only excludes unvaccinated children if there is a case of a vaccine preventable disease at that school.

Education is every child's right. Childcare is not. Childcare puts children from six weeks of age in close contact with other children of various ages and a high proportion of toddlers in childcare have infant siblings at home. Unvaccinated children, not only at risk themselves from their parent's stubborn erroneous beliefs or carelessness, put children too young to be fully vaccinated at risk. Pertussis, measles, invasive pneumococcal and meningococcal disease are some of the real and realistic risks that unvaccinated children face.

Parents that do not vaccinate their children are selfish. If enough parents do not accept the miniscule risk that exists from vaccinations rates will drop below the 90-92% community immunity rates that are needed for the herd immunity effect to protect the unimmunised. They are creating a public health risk.

We must lobby the ACT government to introduce similar legislation here; that children may not be enrolled in childcare or preschool at all if they are not vaccinated for age. If you are a conscientious objector or have a religious objection (no major religion does) you do not need to send your child to childcare or preschool. As doctors we have a responsibility to lead to protect public health, precisely in a time when anti-vaccination movements are becoming just such a threat.

Dr Annie Collins

Dear Editor

I hesitate to write as I think that many of my colleagues would be thinking along similar lines about this issue having read the three summaries provided under this heading.

If 1-2% of doctors are not competent, surely the efforts of the Medical Board of Australia (and all other Medical Boards for that matter) would be better directed in assisting these doctors, as far as possible, to become competent?

Dr Andrew Lark
Weetangera, ACT

("Canberra Doctor, June 2013, page 4, Report of National Conference: reference "Revalidation").

Anti-vaccination group called upon by the Senate to disband

The AMA applauds the Senate's actions this week for passing a motion calling on the anti-vaccination group AVN to disband and cease their harmful and unscientific scare campaign against vaccines.

The motion, presented by Senator Richard Di Natale, Greens health spokesman, noted the low vaccination rates in certain parts of Australia, and the threat this poses to the health of Australian children. The Senator said it was important Parliament take the lead in expressing its disdain for the group's activities.

"Well-meaning parents are being fed dangerous misinformation which undermines their faith in the safety of vaccines. This has to stop," said Senator Di Natale.

"As a doctor, I saw first-hand the tragedy these easily preventable diseases can cause. Today the Senate has joined with the public health community to send a clear and strong message to those who are peddling lies about vaccines – they should pack up and go home," the Senator said.

The NSW Government in May said the Healthcare Complaints Commission had launched an investigation into the AVN.

Boundaries

By Tuck Meng Soo

I've noticed a recent increase in letters to "Australian Doctor" about the issue of conscientious objectors to vaccination.

This has become an issue since new legislation came in on 1 July 2012 obliging parents to get their children vaccinated to receive the Part A supplement of the Family Tax Benefit or to get their GPs to sign a form to say that they have discussed the benefits and risks of vaccination with the parents and that they have weighed up the advice and decided not to vaccinate their children. Most of the letters to the "Australian Doctor" state emphatically that their authors would refuse to sign such a certificate. Certainly, as I understand it, they are under no compulsion to do so. And my experience leads me to agree with quite a lot of the authors of the letters to Australian Doctor that most of these parents have already made their minds up and are not the slightest bit interested in listening to their GP's arguments as to why vaccination is a good thing for their child.

This is where I think an issue of boundaries come in. As doctors, we set boundaries all the time on what we are prepared to do for our patients and how far we let them pull us to the uncomfortable edge. One of my registrars used to get quite upset about mothers who refused to vaccinate their children because they knew their children could rely on herd immunity in Australia without having to run the small risks of vaccinating their children themselves. She thought it was very unfair that her child would face the small risk of vaccination to benefit the children of these selfish mothers. In truth, I haven't worked out for myself where my moral boundaries lie in this case. I share some of the moral outrage of other GPs although not having children myself, it doesn't strike so close to the bone. Nevertheless, I work in a practice that does attract quite a few people with unorthodox beliefs and probably a larger than average share of vaccine refuseniks. I'm not sure that refusing to sign the "conscientious objector" certificate would be very effective in changing their beliefs the way that working patiently with them over many years might. We will have to have this discussion in my surgery soon.

Boundaries are tested all the time in my practice with the large number of drug-dependent patients we see. There are guidelines and legislation about what one can and can't do with methadone and buprenorphine and S8 medications and benzodiazepines. However, all the guidelines and legislation in the world are not very helpful for a young registrar faced with a patient who misunderstands something the registrar has said and fearing the worst, has a temper tantrum in the waiting room and then, having thrown his shopping against the reception desk and shouted out his frustration and fear at the top of his voice in the waiting room, insists on cleaning up his mess and apologising to everyone. Or the man who has vomited his dose of methadone, or the man who has come back from Sydney, having left us while on the methadone program and is now on regular Oxycontin and expecting scripts for the same. And then on other days, the man who had the temper tantrum tells me that I'm the best GP he's ever had and he would gladly give his life for any of the doctors in my practice. And the man who is on Oxycontin admits that Oxycontin isn't really the best option for him and can we put him back on the methadone program.

I often tell my registrars that only half of general practice needs the medical knowledge we have so painstakingly acquired. The rest is about an understanding of human nature and the knowledge of one's own boundaries. I have yet to learn how to really teach that and maybe one day, I will be better at doing it than I am today.

My practice does see many patients with drug dependency. In fact, we have the largest number of patients in the community on the methadone and buprenorphine programs amongst general practices in Canberra as well having the largest number of patients on Benzodiazepine Voluntary Undertakings. Every now and then, we even get patients ringing up to say they'd seen a GP at another practice who'd told them to ring us. Unfortunately, we have reached capacity and currently, we aren't taking on new patients at the Interchange General Practice most of the time. So, maybe, when you have a patient who has disclosed a drug dependency to you, you could stretch your boundaries for that patient who has put his trust in you. And if you would like me to, I'm very happy to have a talk with you over coffee about how I manage my boundaries.

Dr Tuck Meng Soo is a Canberra GP.

Why remain at our post?

By Brian Morton

When the community looks back on the first half of 2013 there may only be a memory of the political turmoil linked to the Prime Ministership and a belief that our democratic system operates better when independents don't hold the balance of power. For General Practice we are more likely to remember the assaults on our viability, our skills and our centrality to the high standards of primary care that our community enjoys.

The new editor of the Medical Journal of Australia, Stephen Leeder posed the question of why "general practitioners remain at their posts" given "the challenges facing general practice including the sheer diversity of clinical responsibility, making sense of new bureaucratic fantasies and upheavals, ..." (MJA198(11) 17th June 2013). Whilst he suggests an answer, GP's goodwill, professionalism, ethics and humanity are being sorely tested.

The AMA is promoting these issues for Family Doctor Week and indeed lobbying for the Federal Election 2013 by recognising these concerns and the imperative for the maintenance of Australia's healthcare outcomes at the top of the OECD countries.

At the top of the list lies the ill-advised decision to cap tax deductions for work-related self education expenses in a profession for which CPD is legislated before we can even earn 1cent. All of us have a part to play in communicating with politicians and our patients the need to maintain our skills and the need for continuous professional development throughout our practising lifetime.

Health access and affordability is a government responsibility which is recognised in the universality of Medicare. The lack of appropriate indexation over more than two decades and the recent deferral of indexation of patient rebates rely cynically on the goodwill and relationships GPs have with our patients. General practice has been able to utilise economies of scale, reducing the costs of running a practice and leveraging off the benefits of practice based e-health. Quality care can only be maintained by the viability of the practice and the attraction to General Practice by this country's high academic achievers who choose to study medicine.

The spectre of overwhelming future national costs for governments in providing for an aging population and the management of chronic illness is a driver for innovations in primary healthcare. Role substitution is not an acceptable answer to this concern when team work and role delegation has the power and evidence base to maintain quality and standards of care. The medical training of General Practitioners ensures the wholistic approach required for patient care and the centrality of the role restricts the fragmentation of that care.

Team care, taking the skills of allied health, nursing and pharmacy and locating that set of knowledge and skills in the physical setting of general practice is a reform worth pursuing but misdirected in the funding of Superclinics positioned not for need but rather political gain. The audit by the ANAO makes for unbiased supportive reading. AMA has called for the redirection of funds to infrastructure grants to existing practices.

The utilisation of Telehealth in modern health practice is gaining pace. The benefits of increased access to medical care especially in rural and remote locations would be matched similarly in metropolitan areas for patients in Residential Aged Care Facilities as well as those with mobility problems. The limitations are the funding restrictions by governments who lack long-term vision. The AMA recommends extending the MBS telehealth items to GP consultations.

The benefits of ehealth in making the best use of existing healthcare services and avoiding errors, duplication and waste are well known. To treating medical practitioners, ehealth means being able to access all of the clinically relevant medical information about a patient at the time of diagnosis or treatment.

The design of the PCEHR means that its use is limited for medical practitioners in terms of their accessibility, content, accuracy, and the comprehensiveness of information.

Healthcare of the patient is best served when the medical practitioner has access to the most basic information that is critical to patient care – pathology and diagnostic imaging results, hospital discharge summaries and information on prescribed medications.

Medical practitioners want to use the PCEHR to enhance clinical care. However, the PCEHR legislation and the participation requirements are complex and introduce new and significant obligations on medical practices. There are substantial penalties for non compliance with the complex legal requirements.

A clinical advisory group, that represents the views of practising clinicians, should be established to oversee and advise the Federal Government on the clinical functionality of the PCEHR and its use overtime. The clinical advisory group would also advise the Systems Operator on the technical adjustments to be made to the system based on experience with its use in clinical practice.

Red-tape is the enemy of efficiency which consequently impacts on access and availability. The time wasted waiting for approval for authority prescriptions can be readily measured by all GPs. AMA is lobbying for removal of the system which has been shown by a Productivity Commission report as an unnecessary administrative burden.

The last word must be from the Declaration of Geneva:

"I will practise my profession with conscience and dignity;

The health of my patient will be my first consideration."

These are the principles by which GPs practise and why we celebrate Family Doctor Week.

Dr Brian Morton is chair of the AMA's Council of General Practice.

Helping patients to change behaviour

By Julie Kidd

In medical practice we've all had patients, who, when presented with the need to change an unhealthy habit, simply make the changes themselves.

They want to live and be well, they believe that it's possible and worth it, they take themselves as the authority in their own lives, make a decision, and have the inner resources to follow through.

However, many people know what they "should" do - stop smoking, lose weight etc - but, either they don't want to because the behaviour is filling an otherwise unfulfilled need, or they don't believe that they can, that they have any agency in the face of the habit.

They mightn't feel that they have the energy, the will, or even the belief that it's possible for them or that it's worth it.

They feel smaller than the problem.

There are negative beliefs; eg, "I can't", "it's impossible", "this is who I am", "I never get it right", "I'll fail again" and strong emotional drivers, such as feelings of hopelessness, anxiety and agitation, a need to sedate the inner turmoil or a need to fulfil an unloved feeling.

Also, there is the sheer force of repetition of a behaviour. Often the requirement to change seems impossible, every "should" is another probable failure.

We all have success, or failure, spirals in different aspects of our lives - self-fulfilling ideas that seem to be true. For example, if you were told as a child that you were good at tennis, you'd have a positive attitude and an expectation to play well, a potential. Then you would be more confident, focussed, alert and so you'd be good at tennis. It then becomes part of your identity "I'm good at tennis, I love tennis". This re-inforces the original belief. This is a success spiral. Belief > potential > action > outcome > BELIEF. Equally this holds true if you were told as a child that you were hopeless at tennis.

Hypnotherapy bypasses the old stories.

It uses the trance state to implant beneficial suggestions in the mind.

Trance or altered state is entered by focussing through one of the senses, most commonly visual, auditory or tactile, and is associated initially with brain alpha wave activity. This provides a doorway to bypass the everyday critical faculty of the mind. A suggestion, or selective thinking, is then readily accepted by the deeper, more open mind without the "I can't" filter. The trance state relaxes the grip of the usual identity- the chain of thoughts, beliefs, reactions, attitudes, opinions and habits- and creates a spaciousness of mind that enables new possibilities of thought and behaviour to be created. It's amazing what becomes possible once the chattering mind is no longer one's dominant platform of reality.

Say, for example, an obese woman, who is an emotional overeater comes to you. She is stuck in a cycle of dieting all day and bingeing at night and each night she embeds the guilt and self-recriminations. It isn't news to her that she needs to lose weight, she probably knows more about dieting and kilojoules than we do. The more she forces herself to diet, be good, be in control, the stronger the backlash. She needs, not to diet, but to sidestep the entire cycle.

With hypnosis she drops below the everyday mental conflict ("you shouldn't" "I want it" "you greedy pig" "I've had a tough day" "I'm ugly", "who cares" etc) into deep, relaxed, spacious awareness where it is possible to eat only when actually hungry, to eat slowly and to stop when the stomach is satisfied.

She is programmed to sleep well and wake happy. Her past experiences of happiness, vitality, and confidence are revivified and "anchored" so that those feelings can be accessed easily every day. The desire for the sweet, fatty and refined foods is deleted.

So, the basic beliefs, desires and inner emotional atmosphere have changed and when she gets home she finds that she no longer needs junk. She feels light, optimistic and purposeful then her weight starts to drop effortlessly. That re-enforces the new belief in herself as light, healthy, active and confident.

In the same way that the desire to eat junk can be neutralised, so too can the desire to smoke, drink alcohol, use marijuana or gamble.

Hypnosis can also be used for stress, anxiety or for those who find that their minds are too busy to be able to meditate or sleep. Deep trance reminds them how to let go, relax physically and mentally, and let the inner agitation subside. People often say afterwards that they feel 'normal' again, the confident, relaxed, happy version of themselves instead of the agitated, tense, irritable one.

Hypnotherapy is an invaluable tool for any GP to have in their skill set. It's easy to help people change for the better the way that they think, feel and live.

Dr Julie Kidd is a GP hypnotherapist. For more information visit www.canberrahypnosis.com.au

Maintaining Vocational Registration

The AMA reminds members who are Vocationally Registered (VR) GPs that they need to continue to practice predominantly in general practice and meet the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs to remain on the Register. Failure to meet these requirements could see them removed from the Vocational Register.

The AMA is concerned that VR GPs who are now recognised by the Medical Board in the speciality of general practice may not be aware that they are still subject to the provisions of the *Health Insurance (Vocational Registration of General Practitioners) Regulations 1989*, at least until the legislative amendment repealing this piece of legislation is proclaimed.

Under Regulation 6 the RACGP must advise the Chief Executive Officer at Medicare Australia if it is satisfied that a practitioner's medical practice is not predominantly in general practice or the practitioner has failed to meet the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

Until such time as the VR regulations are repealed those GPs on the Vocational Register need to be aware of the potential consequences of failing to meet the requirements for remaining on the register.

Improved contract for GP after hours care... continued

... From page 7.

What if I am not offered a revised version?

Write to your ML and ask for the revised version, and ask them to clearly identify any areas that differ from the standard version issued by AMLA. You may have received a template letter from your AMA to assist with this.

What should I do if I have already signed an agreement which is not the revised version?

If you have signed one of the earlier agreements, it is most likely you will be bound by it, however we would anticipate that most MLs would be prepared to release you from that agreement and allow you to execute a new one. You should ask them to do this if they don't offer to do so.

The AMA cannot guarantee that the contract you are offered is right for you, even if it is a revised version. You still need to look over it very carefully and obtain appropriate, specific advice on it.

For further assistance, contact your State or Territory AMA.

Your complimentary copy of the 2013 Specialist Directory

CANBERRA GPs

A complimentary copy of the 2013 Specialist Directory is included in this edition of *"Canberra Doctor"* for all Canberra GPs.

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

HOSPITAL BASED DOCTORS-IN-TRAINING

A complimentary pocket-sized edition of the specialist directory is included in this edition for AMA members.

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

GP REGISTRARS

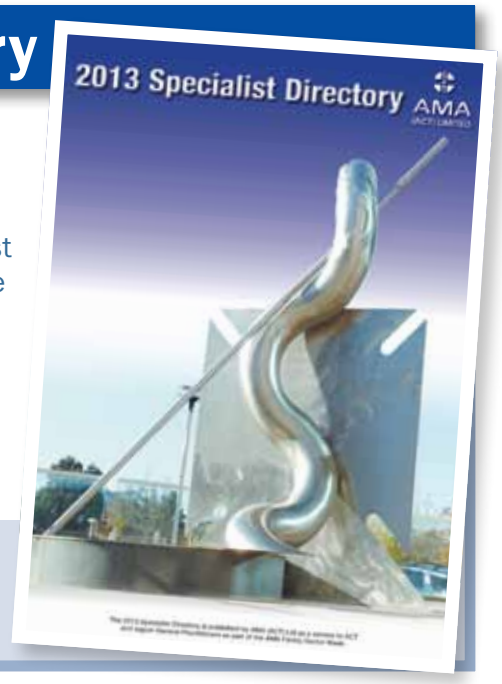
To receive your complimentary copy of the 2013 Specialist Directory, please call Sue Massey on 6270 5410 and one will be mailed to you.

GPs in SURROUNDING AREAS OF CANBERRA

Please call Sue Massey on 02 6270 5410 with mailing details and the number of copies required.

NOT INCLUDED ABOVE, BUT WOULD LIKE A COPY OF THE DIRECTORY?

A PDF of the 2013 Specialist Directory will be available for downloading from from 25 July 2013, from the AMA ACT website **www.ama-act.com.au**



What is a "Family Doctor"?

By Doug Lee

When a poorly constructed house collapsed, we all remember the heroic efforts of the rescue workers who saved the family beneath the rubbles, and rightly so.

Politicians soak up photo opportunities as they present the heroes with medals and announce more funding for the rescue services, again, well deserved.

However, in the midst of the media frenzy, how many viewers will pause to think about the other dwellings, some nearly a hundred years old, which do not collapse?

Those buildings have stood solid and firm because their constructions have been planned and supervised by architects who had constructed the homes according to professional standards.

If you think of your health as your your home, then your "Family Doctor" would be your architect.

He/she collaborates with you to identify the needs and desires of you and your family.

He/she draws up the plan on how to achieve your desired outcome within your available budget.

He/she supervises the construction of your dwelling, coordinating and bringing in specialist services, if and when they are needed, at the right juncture, thus ensuring your dream home will provide you with safety, comfort and security and that it won't collapse under normal usage. Even after you have moved in, your architect will continue to advise you on regular and proper maintenance procedures.

How a professional architect helps you build your dream home is similar to how your "Family Doctor" helps you build your good health. Just as your architect holds the blueprint to your dream home, your family doctor holds the blueprints to your good health.

They are dedicated and committed professionals. However, because they discharge their duties quietly and diligently and create no headlines, many politicians don't understand and don't value what they do.

Anyone can apply for a building permit to build one's own home. There are books and internet sites that tell one how to do it. Some have succeeded and have even done a good job of it. However, for the majority, failing to plan is planning to fail. Those who don't believe in professional help do so at their own risk.

In politics, the squeaky wheel gets the oil. Politicians react to disasters and breath on headline grabs.

Hypothetically, the simple, common-sense solution to prevent further unsound houses from collapsing is to advise DIY builders to "consult a professional architect". However such advice would be too drab and old fashioned. It won't gel with the politicians' ideology of empowering the individual. Politicians need to be seen to be doing something new and innovative. It would be politically more correct and sounds much better to allocate huge sums of tax payers fund to set up "Multi-disciplinary Architectural Consulting Centres" which provide information and advice to assist DIY homebuilders to erect their own castles. Whether these "Architectural Consulting Centres" will lead to saver homes remain to be seen, but at least they provide employment for administrative and clerical staffs, contractors, suppliers and tradesmen. Statistics show that a few home builders actually use the services.

When it comes to building your family's health, would you choose the traditional method of consulting and collaborating with a family doctor or take charge of your own healthcare with the help of politicians? The choice is entirely yours and there is no right or wrong answer.

Not all doctors are family doctors.

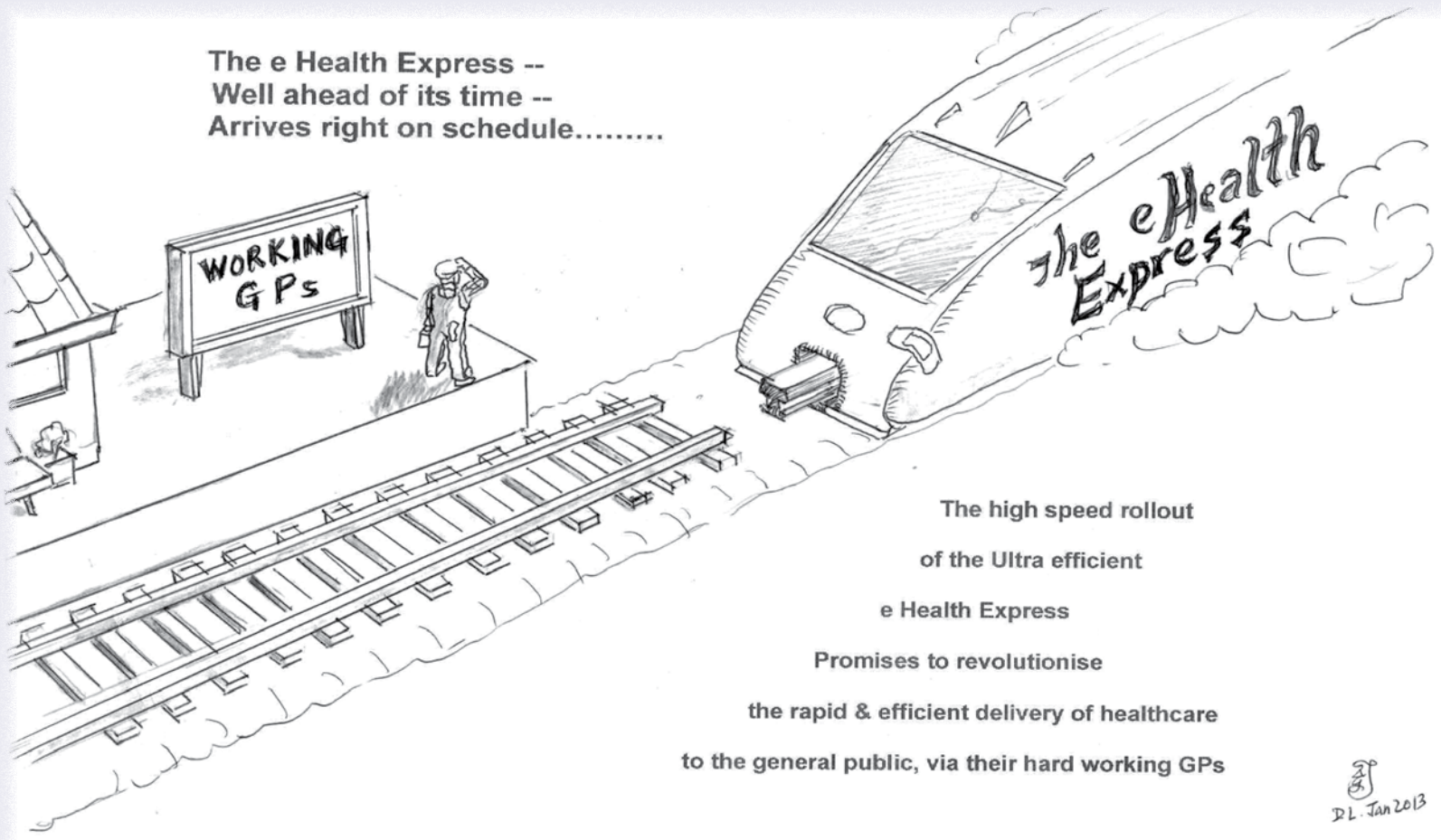
Family doctors are identified by their commitment to, and knowledge of, your family's health needs and specific circumstances.

The simple qualifying test for a "family doctor' is that you know who he/she is and he/she knows who you are if you see each other outside the surgery settings.

However, remember that your family doctor can only help you if your family has an ongoing professional relationship and regular communications with him/her. Accordingly, it is hardly surprising that a significant percentage of the "walk in sick" patients who use the hospital for episodic healthcare cannot identify who their family doctors are.

Next time, when some one asks you what you do, don't say "I'm just a GP", say "I'm a family doctor"!"

Dr Doug Lee is a Canberra GP.



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Buying property

With interest rates reasonably low and rental yields in capital cities quite high, there are a lot of people interested in investing in property right now. Although many medical and dental professionals don't see themselves as property investors, a lot of them end up that way, says Investec's Lynne Kelly. "The profession likes bricks and mortar," she says. "Often they start out buying a small property to live in and then keep this as an investment when they need to purchase something bigger."

The appeal of doing some further investigation into property investment right now is that combination of high yields and low interest rates means you can purchase property with reduced effect on your cashflow.

For example, the rental yield you could expect on a $404,000 property in the ACT is 5.73 per cent, or $23,140. Depending on the type of loan and assuming a five per cent deposit, your interest expense could be significantly less than that, meaning your investment could at least be cashflow neutral.

There's still a huge demand for rental property in the ACT," explains Lynne. However, she urges buyers to be careful when purchasing off plan, as we have seen a few come in short that were purchased 12-18 months ago. "It can be difficult to determine the end value of a completed property when you are purchasing off the plan. There a number of contributing factors such as the layout, property access and the quality of the finished development. "Even though you may be buying into a good development the location is also important as some area's are more sort after compared to others, so it's important to understand what particular pockets are in high demand."

Where this becomes attractive for medical professionals, she adds, is because of the types of financial products available to them through Investec. "As a general rule—keeping in mind that each medical profession is different—we go out of our way to lend 100 per cent for owner occupier with no Lenders Mortgage Insurance," she explains. "If someone is looking to invest in multiple properties, it may be more likely 95 per cent, perhaps dropping to around 90 per cent with a third or fourth property. We're seeing people re-entering the property market because of low interest rates," she says. "There's a lot of demand as a result and agents are putting pressure on people to exchange. That's the case for many people on fixed incomes entering the market."

Where your situation may become complicated, she adds, is in dealing with those groups targeting professionals and encouraging them to gear up to build a property portfolio. "There are a lot of planners out there who advise our clients to gear up to invest, but if they own properties they can't rent out, they could put themselves in a vulnerable financial situation."

Owning an investment property is usually a long-term investment. It's important you can ride through the financial lows so that you are still there to reap the rewards when the market goes through an upward cycle.

"You may do well, but there's always a chance you could lose money, so taking the advice of an accountant, lawyer and financial planner is a good idea before investing in anything" says Lynne Kelly.

Depending on whether you're planning to invest in a property or rent out your existing property, you may want to investigate different sorts of loans, too. Interest only loans can be useful for investment properties if you still have a loan against your principal residence. During an interest-only period, you only pay back the interest that your loan incurs, so any spare cash flow can be used to reduce your home loan debt which, unlike the interest on an investment property loan, is not tax deductible.

If you're investing in your own rooms, that's a different story altogether. For medical and dental clients, Investec offer up to 100 per cent for owner-occupied premises. It's just another example of Investec's extensive experience in working with medical and dental professionals, explains Investec's Andre Karney: "As specialists in that area we are able to do things which the general financiers are unable to do. We've been doing it for 20-odd years, so we know this market in a deeper way than anyone else."

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