Canberra DOCTOR

Informing the Canberra medical community since 1988

Celebrating our 25th Birthday in 2013

October 2013

Canberra Doctor is proudly brought to you by the AMA (ACT) Limited

Circulation: 1,900 in ACT & region

25 YEARS of CANBERRA DOCTOR

Some of the local doctors who have contributed to bringing Canberra Doctor to you over 25 years.

TERRITORY TOPICALS – from President, Dr Andrew Miller

Dr Andrew Miller

The 25th anniversary edition of the Canberra Doctor represents a special milestone. The paper was first published in the year we came of age as the ACT Branch of the AMA. Over the years there have been a number of recurrent themes discussed, and some important landmarks celebrated.

Management standards and the performance of our public hospitals have been consistent themes. I having read the story, and indeed lived, the National Health and Hospitals Reforms Commission report and the subsequent funding and administrative reforms I find a certain cynicism creeping into my thinking as I review the achievements of the last few years. In 1994 the then Labor government deflected concerns about bed shortages by invoking a Yes Minister response and counting "notional beds" (which were staffed by staff currently on leave, so unfortunately unable to be occupied by a sick person). But patients are still waiting for elective surgery and for attention in Emergency Departments, despite a range of measures taken to ameliorate these problems. I note the recent opening of 8 new beds in the TCH Emergency department; and reflect on the way that this may help reduce waiting times over any reasonable period given the flow-through access block that characterises our hospitals operating at unsustainably high occupancy rates.

The role of general practice in the territory has also been a recurrent theme. Primary care is clearly regarded as an easy target for political manipulators, for both budgetary and ideological reasons. Through the issues of the Canberra Doctor we have seen controversies such as the VR debate and provider number legislation unfold. More recently, and more locally, the issues of government funded walk-in clinics and super clinics generate debate. The recent publication of the APHCRI analysis of the performance of the walk-in centre has hardly been glowing. It remains clear, despite any changes of policy or location, that these centres will be incapable of treating patients to the same level of complexity as a general practice at anything approaching the cost efficiency of general practices. Our readership would no doubt also be disturbed to hear that a long established Canberra general practice is being displaced to make way for a new suburban walk-in centre.

We have also seen the gross distortion of federally funded super clinics being parachuted into the territory and surrounds, in areas where there was no manifest need; and serving only to seriously disadvantage the existing local practices. In the ACT this has led to a series of practice closures, and a consolidation of large multi-doctor corporate practices in central Belconnen, depriving the surrounding suburbs of accessible GP cover. I know that this point will be debated, but invite my readers to consider their elderly patients (an increasing proportion of our community), and the difficulties they find in moving around town with the inadequacies of Action and the costs of taxis the only option for many.

I suppose you can see that one of the constant themes in Canberra Doctor, and reflecting community concerns, is access and affordability. Have we come anywhere in the last 25 years? I suppose I may be at a cyclothymic low – but what I see now is increased out of pocket costs; no improvement in surgical and emergency waiting times; and an erosion of the role of medical practitioners in health planning and provision.

In 1999 a front page was devoted to the Y2K bug (the pandemic that wasn't). It is extraordinary just how far the capabilities of IT have come since then. In 2010 Canberra Doctor published a piece by Tom Ward detailing an intern's experience of our public hospitals where he characterised the use of IT systems then as medieval. In 2012 the Auditor General reported on IT security in ACT government systems, and remarked on the increasing number of hand held devices capable of interfacing with fixed computer networks. Predictions later that year had over 3 billion such devices accessing the internet world wide. Of course since then we have seen the PCEHR raise its head; I have not yet applied the pejorative "ugly" although the temptation is growing.

It is also interesting to see how issues have ebbed and flowed around our junior doctors. In 2011 the issue was safe working hours. That was before the "tsumani", now we are faced with the prospect of our junior doctors struggling to access clinical experience and strong supervised positions that provide a mentored learning environment as well as the ever present service component.

Medical education in the ACT took a whole new dimension in 1995 with the graduation of the first cohort of Sydney University Canberra Clinical School students, and then subsequently with the establishment of the dynamic ANU Medical School in 1994. Our medical school now has over 90 students in each year and is already proving to be a great contributor to the long term sustainability of the ACT and surrounding districts' medical workforce.

This continued narrative of our association and local professional community would not have been possible without the generous support given by the dedicated band of editorial committee members who have included over the years Jeremy Price, Keith Barnes, Tom Faunce, Keith Powell, Graeme Moller, Michael Gillespie, Alasdair Robson, Jo-Anne Benson, Bish Mukerjee, Philip Mutton, John Donovan, Peter Wilkins, Ray Cook, Tracy Who, Linda Weber, Jeff Looi, Gemma Dashwood, Stefan Baku, Ian Pryor, Alex Stevenson, Helen Doyle, David Corbet, Konrad Reardon, Jonathan Sen and James Cookman. Of course the anchor person through all these years has been Christine Brill.

Finally I would like to congratulate Liz Gallagher on her appointment as President-elect of AMA-ACT, and Suzanne Davey on her appointment to our board. Eat your heart out, Tony, our cabinet has 4 females!

Canberra Doctor was launched by Dr David McNicol, President and for the next ten years or so, Dr John Eather was the honorary editor. Dr McNicol said in his first President's column: "With the publication of the first edition of "The Canberra Doctor", the Capital Territory Group of the Australian Medical Association is embarking on a bold new and exciting venture.

Canberra Doctor

A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION.

PUBLISHED ON BEHALF OF THE CAPITAL TERRITORY GROUP OF THE A.M.A.

Published by the Capital Territory Group, Australian Medical Association (ACT) Registered by Australia Post NBP 9218 **NO. 1 March 1988**

AMA RESTRUCTURE UNFAIR TO ACT

...t of the Capital ...up of the Aust... ...al Association, ... McNicol, has ...cised the pro... ...cturing of the ...ncil as unfair ...esentative of ...

...d if the plan were ...tors would be re... ...le representative ...h Council and ...epresentative el... ...by the Federal ...membership.

... concerns in a ...ter to all branch ...their support for ...e New South ... be put to the ...il meeting this month — which would give the ACT equal representation with the States.

At a special meeting in December, the AMA Federal Council completed proposals for restructuring it resolved that the Federal Council — to be expanded from 16 to 28 members - would comprise representatives nominated by branches and representatives elected on a geographical basis and by special interest groups.

Branch Status In Act & NT

While it was decided that the ACT and Northern Territory groups will be renamed branches and recognised as full members of the Federal Council, for the purpose of electing the general membership it was resolved that ACT members vote with NSW doctors and NT members with South Australia.

"The CTG-AMA Council considers such a proposal as being most unfair and unrepresentative of ACT doctors and clearly based on inadequate data concerning the medical population in the ACT", Dr McNicol said.

Dr McNicol said the ACT was not in any sense part of NSW and that it would be inappropriate for it to be representated by someone from NSW. The ACT had its own "state" government - which also happened to be the Federal Government — and its own health minister separate from the NSW health administration it operated under its own health legislation had its own health department and Medical Board.

"Political and industrial matters in the ACT that concern the AMA are frequently of a local nature and once again quite exclusive of any consideration of NSW. The same applies in NSW where debate about policy with the NSW Government, for example, has no direct bearing whatsoever on the ACT", Dr McNicol said.

Dr McNicol said it was pertinent to compare the medical population in the ACT with Tasmania which would be entitled to two representatives in the revised structure. There were 1400 registered doctors in Tasmania compared with 1100 in the ACT, 780 practising doctors in Tasmania (ACT 500), and 380 AMA members in Tasmania (250 in the ACT).

TURN TO P. 4

INSIDE

Canberra Doctor

A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION.

PUBLISHED ON BEHALF OF THE CAPITAL TERRITORY GROUP OF THE A.M.A.

Published by the Capital Territory Group, Australian Medical Association (ACT) Registered by Australia Post NBP 9218 **No. 7, October**

HEALTH PROBE CONTROVERSY

After sustained criticism of the ACT Community and Health Service by health unions, professional groups and consumer organizations, the Minister for Territories, Clyde Holding, finally announced that he would arrange for an enquiry headed by Adelaide medical administrator, Brendon Kearney.

In giving very specific terms of reference and indicating that the enquiry should be completed in under three months, the critics have already been saying that the enquiry would end in a whitewash and only cosmetic changes would result.

Senator Reid said that the sort of protection a Parliamentary inquiry could offer was essential, because many people within the Community and Health Service, who had valuable information about problems in the Service, were afraid to make any public statements for fear of damaging their careers.

"An independent Parliamentary inquiry would have the benefit of being able to take evidence in public and in private.

It would be able to protect the identity of those appearing before it and explore the evidence presented".

"A Parliamentary inquiry would have an independent secretariat which could investigate allegations without indentifying those who had given evidence.

"I suspect the Government's inquiry will have its secretariat services provided by the Health Service itself, which would ensure noone is able to speak up anonymously.

"It would be essential to have an outsider ... act as chief adviser and consultant to a Parliamentary inquiry."

She welcomed the appointment of Dr Kearney saying "It would be essential to have an outsider with the expertise of Dr Kearney act as the chief advisor and consultant to a Parliamentary inquiry".

Senator Reid said that the terms of reference for the inquiry needed to examine the efficient delivery of health services by the Community and Health Service within the financial budget presently available to it.

The President of the ACT Branch of the AMA, Dr Brian Richards, said that he was disappointed that the terms of reference did not include an analysis of management structure or financial arrangements, although they did address the major concern of the AMA which was the "de-medicalisation" of health service management.

"Dr Kearney's brief is to look broadly at the administration of health services in the ACT"

Dr Richards said he would be cooperating with the enquiry, whether it be a full Parliamentary Enquiry or only a Ministerial one.

Mr Holding, in announcing the enquiry, said "Dr Kearney's brief is to look broadly at the administration of health services in the ACT and his terms of reference are:

To advise the Minister whether, having regard to population size and comparable services elsewhere in Australia, the present level of health service funding is adequate and without limiting the generality of such advice, to specifically recommend on:

1. *Public Hospital redevelopment needs in the ACT.*
2. *The acquisition of capital equipment, including relevant processes and methods of according priorities.*
3. *The involvement of clinicians and other health professionals in policy formulation and administration relating to hospital and health services.*
4. *Administrative staffing levels.*

in ACT health services".

Senator Margaret Reid

WARD OPEN AFTER YEAR

After a $750,000 renovation, the Isolation Ward at Royal Canberra Hospital remained closed for over 12 months.

It was re-opened on October 7, just 2 days before the hospital's "Open Day" to celebrate limited accreditation.

Unfortunately, the opening of the isolation ward meant a loss of 4 b... to the Canberra community because the 19-bed "H" ward was closed at the time the 15-bed Isolation Ward opened.

The four H-ward patients who were not transferred to Isolation were long-stay geriatric patients awaiting nursing home placement.

They were simply transferred into acute medical beds in the main hospital block, "choking" those beds for the foreseeable future.

The President of the ACT Branch of the AMA, Dr Brian Richards, attacked the loss of beds as being part of a "bureaucratic trick".

He said that, while he welcomed the overdue opening of the Isolation Ward, it should have been in addition to the existing bed numbers, rather than as a ploy to reduce ... availability.

...ICE EQUIPMENT ...PTY LTD ...acMED™ ...ital practice ...olution ...records ...ments ...stem ...dates ...nvitation to our ...seminar, ...BL FITSWICK ...012

INSURER WARNS ON INDEMNITY

The Medical Defence Union has issued a warning to doctors not to desert the union in favour of commercial insurers for their professional indemnity cover.

MDU spokesman Dr John Vallentine said while commercial policies might at first appear attractive, they did not offer the same level of protection to practitioners.

"What worries us is that commercial insurers are coming in with cheap, fly-by-night policies for a year or two. We would very much warn doctors not to join", he said.

Commercial insurance policies covered only those claims made within the year, unlike the MDU policy which covered all incidents which could lead to litigation "even 20 years down the line".

The MDU has sent a letter to all its members outlining the "potentially serious consequences" of leaving the MDU and taking out commercial insurance.

Less Cover With Commercial

The letter warns that a doctor who is commercially insured may have to continue paying premiums for up to 24 years after retirement to be fully protected against late claims, but MDU members who cease practice do not have to keep paying.

More than half of all assistance provided by the MDU has to do with matters other than medical negligence for example, investigating and overservicing committees, disciplinary tribunals, coroners' courts, criminal trials and courts martial.

"If you are commercially insured, you will be on your own," it says.

According to the

TURN TO P. 11

"... We hope to keep doctors abreast of the rapidly changing medico-political issues at a local and federal level.

"In addition, matters of medical interest, particularly achievements of individuals or hospitals or units will receive our attention ..."

Other issues covered during the year included: bulk billing by general practitioners;NH&MRC homebirth issue; a specialist refused VMO status and the case he brought before the AAT; mandatory reporting of child abuse legislation and one principal hospital for Canberra.

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION.
Published by the Australian Capital Territory Branch of the AMA
Registered by Australia Post NBP9218
No 17, September 1989

Planned bed calculations challenged

"DON'T blame doctors if you don't have access to hospital beds after 1990," said Dr Colin Andrews, warning the ACT community.

Dr Andrews, the former chairman of the hospital services board was commenting on the steering committee's report on ACT Public Hospital Redevelopment.

He strongly criticized the basic assumptions used to calculate the number of beds required. (Estimated between 900 – 1100)

Rubbery figures

The first problem is that the calculations are based on an 85% occupancy rate.

"You dont have to sit on a hospital board for long to realize that an 85% occupancy rate requires your hospital to have wide corridors for lots of trolleys for patients," he said.

The second assumption is that average hospital stay will continue to decrease by 1.5% per annum because of the introduction of day surgery and more investigative technology.

"The likelihood of this continuing for another decade is unrealistic he said.

Future developments

The future development of cardio thoracic surgery, especially coronary artery surgery in the ACT is likely to increase patient stay. The committee has also not considered that the principal hospital will enable the difficult long stay cases to be managed in Canberra.

1200 or 1300

"The true bed requirement is much more likely to be 1200 to 1300 beds," he said.

Another factor is the potential development of the undergraduate clinical school, which will require more space for academic staff and tutorial rooms.

Several groups have protested the brief time allowed for discussion of the report. Minister Barry in a press release dated the sixth of September said, "The consultative process to determine the future of Royal Canberra Hospital was alive and well and the ACT Labor Government would continue to accept submissions from the public and interested organisations until 15 September".

The report was only forwarded to the minister on the 18th of August.

A solution

Dr Andrews suggested that the most economic solution was in fact to demolish the old outbuilding around Canberra Hospital, and build a further 300 beds at a accepted figure of $300,000 each, i.e. a total cost of $90 million. The mainblock at Royal Canberra requires refurbishing at an estimated cost of $20 million.

"Thus the 600 bed principal hospital could be achieved for about $110 million," he said.

Natural growth of population will allow the increase of Woden and Calvary up to their designed 400 and 300 beds respectively.

These figures demonstrated the limitations of the report.

"I would like proper debate on the issue, with consideration of all the factors, political, economic, medical, and the potential disruption to providers of health care," he said.

Labour ward fiasco

ONE of Canberra's senior obstetricians was met with more than he expected when called to the labour ward at Royal Canberra Hospital recently.

He was told to "F— off" by the patient and physically removed from the delivery room by her partner.

These events followed transfer to the labour ward of an intended home birth – a primigravid breech apparently undiagnosed.

Despite the time of night and the provocation the obstetrician offered to assist by calling any other obstetrician the patient wished. However this offer was refused.

The baby eventually delivered without [illegible] obstetric help. It [illegible] issue went to press it was still in the intensive care nursery and required tube feeding.

Press Interest

The episode attracted considerable media attention. *The Canberra Times* carried a front page report that the Division of Obstetrics and Gynaecology was to write to the Hospitals Board to establish who had the ultimate authority over births in hospitals. AMA President-elect Grahame Bates' concern over legal responsibility was quoted too.

AMA President John Donovan was interviewed on television about the matter. He told *Canberra Doctor* that he had written [illegible] over both the legal aspects and those of relationships between professions and between doctors and patients.

Dr Donovan said the Minister's staff had told him that the Working Group for Obstetric services would investigate the episode. This is a revival of a group established by an earlier hospital board.

Dr Donovan said he hoped it could resolve the damage to relationships, but the legal questions needed to be answered. He would be taking these up with the Hospitals Board.

Legal [illegible]

The issues of 1989 covered not only these issues, but also the appointment of a new hospital board for the ACT, pathologists and government meeting head-on over pathology rebates; and, VMO sessional contract rates being increased by 6.5 percent and fee for service contracts being increased by somewhere between 5.7 and 6.8 percent. And one of the big topics was vocational registration for general practitioners.

"Canberra Doctor" reported on all of these and more.

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION.
Published by the Australian Capital Territory Branch of the AMA
Registered by Australia Post NBP9218
No 18, October 1989

AMA Moot Backs Principal Hosp.

A well attended meeting at Woden Valley Hospital on Thursday 5 October considered the controversial subject of "one principal hospital for the ACT".

Chaired by ACT AMA President, John Donovan, the meeting was to discuss the report of the ACT Public Hospital Redevelopment Steering Committee (August 1989). This committee was formed to implement the 1988 Kearney Report which strongly recommended that there be one principal hospital.

Dr Tony Clarke first addressed the meeting and summarised the history of the evolution of the Report, and in particular why the Woden Valley Hospital was selected as the principal hospital.

He outlined the number of services which would be required in either hospital to bring it to principal hospital status. Dr Clarke described the costing which led the committee to decide that it would be less expensive to bring Woden Valley Hospital up to a principal status (700 beds) than Royal Canberra Hospital.

As a member of the Steering Committee which reported recently to Health Minister Wayne Berry, Dr Clarke answered criticism of the report by pointing [illegible] restrictions on the Committee imposed by its terms of reference, its composition, and financial and time considerations.

Putting the case for the development of Royal Canberra Hospital, Dr Colin Andrews drew attention to discrepancies in the report concerning the number of beds available.

Dr Andrews agreed that the 1200 beds in the public sector were essential should a teaching hospital evolve in association with an Australian National University Medical School.

Dr Andrews submitted to the meeting that the inclusions of

• Dr Tony Clarke; "I have no doubt that the choice of Woden Valley Hospital is the correct decision in fiscal terms".

geriatric and rehabilitation bed numbers did nothing for the principal hospital except increase bed numbers from 600 to 700. Rehabilitation and Geriatrics could remain at the Woden Valley Community Hospital.

Intensive Care Director Dr Phil Cumpston told the meeting that Canberrans are already paying for a higher level of service than the current system can provide, and that the establishment of a Principal Hospital would give our community better value for money.

He felt that the sitting of the principal hospital was not so important as achieving higher standards of patient care.

• Dr Colin Andrews; "Royal Canberra is ideally placed in terms of geography and popularion distribution to warrant substantial expenditure, and it can be done for much less than the Steering Committee claims".

Branch Councillor Dr Ray Newcombe gave the meeting a historical perspective, portraying Royal Canberra Hospital as the parent of Woden Valley and Calvary Hospitals, and called for

• Dr Ray Newcombe; "Royal Canberra Hospital has successively over 15 years pillage of beds and services."

suitable veneration and respect to be paid to the matriarch of Canberra's health system.

"Royal Canberra Hospital has successively over fifteen years been pillaged of beds and services – all for the benefit of Woden Valley Hospital and later Calvary Hospital", he said.

Dr Noel Tait asked the meeting if it really knew what a principal hospital was. "In a principal hospital all the essential services were on one site", He said that the ACT had too many public hospital beds.

He believed that all doctors would benefit, with the community, in having a non-separated specialist service.

Dr Lindsay Grigg reminded the audience that, as doctors, our prime concern must always be the welfare of our patients. He said that doctors have a duty to provide medical services to meet the needs of the community, and the Principal Hospital fulfils these requirements.

Professor Bob Douglas indicated that we should adopt a long term view, and regard the establishment of a Principal Hospital as a template onto which other functions (such as teaching

Turn to page 7

AMA wary of register

The AMA remains unhappy about the implications of the vocational register documents being distributed to GP's by Medicare and the RACGP.

The Association remains committed to the introduction of content based fees for General Practition Services.

However despite the Senate Select Committee Report, the AMA still strongly believes that the interests of all GP "speciality" groups are in jeopardy.

The narrow definition of General Practice initially put forward by the College, has caused anxiety among the many and varied sub-groups of general practice.

Signing up f[illegible]reg

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS
IN THE CANBERRA REGION.
Published by the Australian Capital Territory Branch of the AMA
Registered by Australia Post NBP9218
No 31 December 1990

New obstetric block starts

OBSTETRIC facilities in Canberra entered a new phase on November 26, 1990, when the Minister for Health Mr Gary Humphries officiated at a tree planting ceremony at Royal Canberra (South) to launch the new obstetric block.

On three levels and built immediately west of the Pathology block, the new unit will replace the twin facilities currently operated at the 'old' hospitals.

The Minister expressed his personal pleasure at the instigation of this first major project in the establishment of the new principal hospital.

The launch, held on the new site, was attended by representatives of medical, nursing and paramedical staff, politicians, together with media representatives.

ACT Community Services health supremo, Mr John Bissett, attended, accompanied by the General Manager of Royal Canberra, Mr Len Withers.

Attending her first official function as member of the new ACT Hospitals Board was Mrs Jenny McNicol.

The new building, designed by the Canberra architect Neville Potts (of Campbell, Di Carli, Potts Pty Ltd) is and has an impressive exterior which will enhance the currently bland exterior of the hospital campus.

On three levels, the building comprises two symmetrical wings, joined at the waist by a spectacular section which features a huge glass wall presented to the northerly sun.

The unit will house 75 beds, and patients will be accommodated in single or twin rooms, each with a north or south view over the surrounding suburbs.

The ground floor will comprise reception and administration areas, together with tutorial rooms and a birth centre of three beds.

The second level will largely be devoted to post natal accommodation, while on the third level will be the obstetric delivery rooms and neonatal intensive care facilities.

The p[illegible]trics unit will be lo[illegible] part [illegible]

easy access to the diagnostic and treatment block, construction of which is to commence in 1991.

While the new obstetric block will initially be isolated from the main theatre suites, necessitating the transfer of patients a considerable distance for Caesar in the event of foetal distress, ultimately the labour wards will be linked to the operating theatres to be housed in the Diagnostic and Therapeutic Block.

Mixed Response

Reception of the plans outlined by the Minister and the Department of Health has been mixed.

While accepting that a single obstetric unit, situated in conjunction with neonatal facilities, is a vast improvement on the previous 'twin campus' idea, local obstetricians have been critical of the plans of the new unit.

Reservations have been expressed that the number of delivery suites (10) and assessment rooms (2) will be insufficient when the building is complete, let alone allowing for extra demand as the years progress.

There has also been negative medical comment about a birthing centre on the ground floor of the new unit.

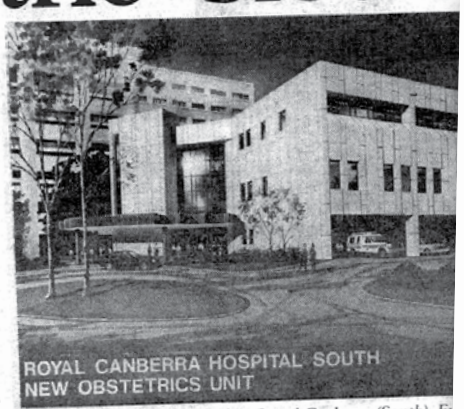
Supervised by mid-wives, without obstetric supervision, the birthing centre is seen by some as a 'time-bomb' within the unit. Fears are that obstetric catastrophes such as foetal distress, ante-partum haemorrhage and malpresentation will be allowed to brew quietly without medical supervision.

Then the midwife will call for instant help from the obstetricians and anaesthetists who will have never seen the patients before and who will have not had a chance to prevent the disaster.

It is anticipated that the new building will be ready for occupation by October 1991.

Obstetricians unhappy

[illegible]bling [illegible]amit-



• *The new obstetric block at Royal Canberra (South). Ev[illegible] great, but inside it's a different story.*

and letters to the hospital chief executive officer indicate that few obstetricians are happy with the plans so far produced.

The first problem is the number and size of the delivery rooms.

Currently the two hospitals have 12 delivery rooms in operation, with a further two spare, with room sizes ranging from 26 to over 36 square metres in size. The new rooms will be up to 7 metres long and as little as 3.5 metres wide. The inclusion of the ensuite within this space further reduces the available floor space to 26 square metres in some.

"In the current 26 square metres space at Royal Canberra, once you get the bed, staff, father and the necessary resuscitation paraphenalia in the room, there is barely room to swing a cat, let alone a drip pole, or a resuscitation team," said Dr Bates.

"For optimum usage of space the rooms need to be approximately square," he said.

The nurses' station is no bigger than the current one at Woden, which will not cope with the extra workload. The nurses' change and locker room is a total of 7.5 square metres, not much space when a shift for 10 delivery suites plus the nursery staff are trying to change for work.

Until the other buildings are completed the floor will be served by only one li[illegible] [illegible]ridor [illegible]lely [illegible]mit t[illegible]

Birthing Centre

The Birthing Centre accor[illegible] dated on the ground floo[illegible] compromise move is unlik[illegible] please anyone.

The ACT for Birth Se[illegible] earlier this year was told th[illegible] only centres that had worke[illegible] cessfully were those locate[illegible] away from the main d[illegible] areas, preferably off the h[illegible] site entirely.

Obstetricians are critica[illegible] space allocated to the b[illegible] centre. The average floor s[illegible] located to the three birthin[illegible] beds, including ancillary [illegible] kitchen, lounge, etc., is 11[illegible] metres, whereas the majo[illegible] cry area on the third floor [illegible] than 70 square metres of [illegible] the floor per bed.

Chairman of the Div[illegible] Obstetrics Dr Grahame E[illegible] it was foolish to use valua[illegible] space on an elitist birth [illegible] dling low numbers of [illegible] for the middle class [illegible] when critical space short[illegible] occur on the third floo[illegible]

"Mothers with com[illegible] who need modern lab[illegible] facilities have just as m[illegible] to balconies, lounge [illegible] kitchenette facilities a[illegible] else," Dr Bates said.

Other stories of 1990 included: who's responsible for the management of patients in the labour ward - midwives, home birthers or obstetricians; demonstration of the new laser technology in gynaecology; methadone in the management of drug dependence; nursing homes and the increasing paperwork imposed on general practitioners; the impaired physician; non-bulk billing doctors in Ballina labelled "greedy" by ABC investigators and a crisis in RMO hospital staffing.

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS
IN THE CANBERRA REGION.
Published by the Australian Capital Territory Branch of the AMA
Registered by Australia Post NBP9218
No 21, February 1990

ROYAL CANBERRA VERDICT: Death by her own hand

AT the end of the latest fracas the ACT Hospitals have inflicted on the ACT public, what has been achieved?

One may well ask, but nobody rushes forward with answers.The realities are that the ACT health budget is down the drain to the tune of $7 - 9 million.

Translated into cold hard cash that means about $25 to $50 dollars per head of population or at least $100 extra per annum per ratepayer.

By any measure the Government hospitals in the ACT perform poorly. The Commonwealth Grants commission has made it clear that ACT hospitals are overfunded when compared with the rest of Australia.

Prior to the change of government in December, the then Opposition Spokesman on Health, Gary Humphries, asked a series of questions on hospital costs. Allowing for waffle in replies and exaggerations in the figures quoted in the questions, it is still not clear that the ACT public have comprehended the hard facts. The figures quoted in this article come from the weekly Hansard of the 5-7th December.

ACT MORE COSTLY

Using a standard formula to compare equivalent hospitals in the ACT and elsewhere, the Australian Institute of Health compared ACT hospitals with other metropolitan hospitals. The costs per bed day were $428 at Royal Canberra, $340 at WVH, and $264 at Calvary.

The staffing figures are far more terrifying. Royal Canberra Hospital labour costs are way above the national averages. While Medical salaries are 6.5% above the Australian average, domestic services 21% above the average, nursing costs are 31% above average, and administration costs 89.5% above average.

The counter claim is that the ACT hospitals should be in fact be compared with teaching hospitals. Even then the figures don't look good. Royal Adelaide hospital, with more beds than Woden and Royal Canberra combined, has 9 level four nurses compared with our 27.

The new nurses career structure has created positions in clinical, management and educational streams so that approximately 15% of nurses have no direct patient care role. This may be of benefit to patient care but the Australian Nurses Federation has not succeeded in convincing any one in the rest of Australia that this is the case.

With no other Australian hospitals using a similar system, other State Premiers are not going to look kindly on extra money going to ACT hospitals.

Cleaning and Food Services are also unimpressive. WVH is cleaned by contract cleaners as is Calvary. The annual cost per square meter at RCH cleaned by hospital staff is $28 as against $18 per square meter at WVH.

Commercial kitchens produce about 100 meals per staff member. Hospital staff at WVH and RCH produce on average 45 meals per staff member. Estimates are that using more efficient techniques in the kitchens could save $1.7 million per annum.

All health workers and health administrators are living in a fools paradise if they think the public will pay for the inefficiencies to continue.

The Federal Government has made crystal clear they are not paying either.

STAFF FORCE CLOSURE

You don't have to be Prince Machevelli to realise Royal Canberra Hospital is being doomed to closure by its own staff. Unless radical changes are introduced soon there will not be the funds in kitty to pay for refurbishment, and the hospital will be closed.

The scenario is that in a few months time an exasperated government, supported by a public tired of the perpetual union wrangling will close Royal Canberra's doors.

The Unions went perilously close this month to allowing the hospital to be closed down and there are sufficient beds at Woden and Calvary to take up the slack at relatively short notice.

Currently Mr Humphries has simply to wait until the public exasperation level rises, or until the next budget forces the cuts. The Unions will strike in support of their jobs, and with a little provocation will paralyse the hospital. C'est fini.

POOR DATA

The only problem with assessing ACT hospitals is the lack of detailed data. Rumours abound, but facts are hard to come by.

Some of the figures quoted above are 3 years old, but are the most recent available. It is time for the ACT public to be fully informed on where their health dollar is spent.

The Annual Reports are couched in vague generalisations with glossy pictures which look pretty but don't necessarily give an insight into the real costs.

Some months ago, a Treasury team went stomping around the hospitals but nothing has been said since. Supporters of Canberra Hospital claim that the figures have been fudged.

That may be so, but who knows?

It is time that ACT health dollar was accounted for!

New director for family medicine

FOLLOWING the departure of Peter Harris, there is a new A.C.T. State Director for the family medicine programme.

Dr Jenny Thomson, who is well known in Canberra, has recently been appointed to the position. She has been associated with F.M.P. since it was started in 1974.

Born and bred in Canberra, Dr Thomson studied medicine at Sydney University before working as a resident medical officer at the Royal North Shore Hospital. After working in several general practices in Sydney, she spent time working in drug and alcohol units.

To seek further experience, she travelled to South Africa where she worked for six months in Soweto practising obstetrics, then worked in paediatrics in Transvaal for nine months. While she was in South Africa she met a school teacher whom she subsequently married in 1976. Nick Thomson, who now works as a computer consultant, will be looking after their four children,aged 10, 8, 6, and 18 months.

Back in Sydney, Dr Thomson worked in child healt[illegible]hen in a Botany community health centre. In 1979 she became a trainee liaison officer for F.M.P. before moving to Canberra.

Jenny Thomson has worked in various general practices in Canberra, as well as spending a year in Christmas Island in 1986. She will continue to work in Scullin Health Centre for two sessions per week.

She plans to build and expand the regional F.M.P. network as a base for training in rural general practice, as well as continuing the commitment to training for part-time general prac[illegible]

This [illegible]she[illegible]

Canberra Doctor

A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION.

Published by the Australian Capital Territory Branch of the AMA Ltd

Registered by Australia Post NBP9218

No 33 March 1991

Empty Nursing Home Beds at Jindalee

With over a hundred patients waiting for nursing home beds in the ACT, it may come as a surprise to find empty beds at the Government nursing home at Jindalee. Several beds (the number is in dispute), have been empty for some months. Why?

The search for an explanation follows a tangled path of inter-departmental and inter-governmental confusion, typical of our health system. If the situation at Jindalee is any example, the ACT Board of Health is going to have its work cut out bring efficiency into the health system.

Jindalee nursing home was the most expensive nursing home to run in Australia in 1989-90, reveals Heidi Ramsay from the Health Authority. It cost nearly $2 million for 127 beds. Needless to say they've been working hard to turn that around in 1991.

Where were the costs? The main thrust of improvement has been the removal of the large number of overlapping job classifications, with administrative costs and wasteful demarcations.

Heidi Ramsay explained that Jindalee would always be an expensive operation because of the type of patient admitted, with government nursing homes taking the more difficult patients that the private nursing homes were unwilling to admit.

What isn't in dispute is that there are over 100 people approved for admission to ACT nursing homes by Geriatric Assessment Teams. These teams work within the state health system but carry out a Commonwealth function, i.e. filling out the NH5 form which is required before you are permitted to enter a nursing home. There are believed to be over 200 people waiting for assessment on top of those already on the list.

The number of nursing home beds in an area is controlled by the Federal Department of Housing and Aged care. Unfortunately in the ACT, the tendency for families moving to the ACT to bring their oldies with them isn't allowed for in the formula.

According to geriatrician Dr Michael Davis, about a quarter on the waiting list come from outside the ACT. "There is no way of knowing how many elderly come to the ACT to stay with family and then deteriorate and require hospitalisation, as they then come from an ACT address. Canberra has the most rapidly growing aged population of any of the capital cities," he said. "The other problem we have is because of the delay, by the time a person gets to a nursing home, they are heavily dependent on care."

"The situation is not going to get any better," Dr Davis said. "A 20 bed extension in an existing nursing home is the only one that is likely to occur in the next 5 years." There are long lead times and no new approvals are in the pipeline.

Thus the Ministry of Housing and Aged Care helps keep its expenditure lower at the expense of the Department of Community Services and Health, who has to pay for the elderly patients trapped in hospital awaiting the rationed nursing home beds. In the ACT, at least 40 acute hospital beds are tied up by nursing home type patients.

This still doesn't help us get grannies into those empty beds. Why can't they be used? Shortage of staff is the reply. Enrolled Nurse Aides are no longer being trained by the TAFE. (Up until 4 years ago they were still being trained by the hospitals, the task was taken over by the TAFE and then scrapped. I didn't dare complicate this tale by asking why?)

An interesting line of enquiry that the Health Board and the Public Accounts Committee might like to take is to ask why the shortages of nusing staff are in government institutions, when Calvary and John James Hospitals have waiting lists, and private nursing homes seem to manage.

No private nursing home has empty beds. Why?

Ironically, the strongest argument for the closure of Government nursing homes comes from the Federal Labor Government, who froze payments to State Government run nursing homes in 1986. Costs of running state nursing homes has to be topped up by the State. In the ACT's case, this top up for Jindalee cost about $2 million last year. Privatising Jindalee would throw this cost back on the Commonwealth.

Further attacks by gay groups

Last month's *Canberra Doctor* contained reports of attacks on President Grahame Bates and two senior doctors who work in the Therapeutic Goods Administration. After that issue had gone to press, our attention was drawn to a pamphlet which had been distributed outside the Sydney office of the Department of Community Services and Health.

This pamphlet repeated the earlier demands of ACT UP (AIDS Coalition to Unleash Power) and of Insidious Acts, which was revealed to be an "affinity group" of ACT UP, for Australia to accept overseas approvals of drugs used in HIV infection.

The pamphlet accused Minister Brian Howe of allowing Australians with HIV to progress to AIDS and die by denying them

BELIEVE IT OR NOT

How to Balance the Budget

Creative accounting has reached new heights in the ACT Department of Health and Community Services. If we just throw the June accounts in a drawer and don't tell anyone about them, we come in under budget don't we?

Treasury is happy and the Health Department gets the same allocation of funds for 1990-1991. The only problem is that this year to make ends meet, May and June's accounts will have to be lost.

You may well all laugh at this comedy, but this is seriously being touted as the reason for the budget blowout in Department circles

Damage control currently suggests that the deficit is $4.7 million. In Mr Berry's day as minister he was silly enough to ask a few questions and found a deficit of $7 million.

Based on our creative accounting model the deficit is likely to be at least $14 million. Canberra Doctor's guestimate is as good a figure as anyone's as the audit for last year is not likely to be completed for some time.

While we are at it why not spend another $1 million or so and set the whole thing to music. "I polished up the books so carefully that now I am the leader of the Queen's Treasury." We may make enough from royalties to pay the interest on lowout.

Medical Ordinance Discovery

Attention has been drawn to the fine print in the front (Definitions) part of the Medical Practitioners Registration Ordinance 1930.

A fascinating little definition of what is encompassed by the term "medical practice" reads as follows'

(4) For the purposes of this Ordinance a person shall be deemed to practise medicine if -

(a) he practices medicine personally on his own account or as a member of a firm

(b) in the course of a business carried on by him, a person or persons employed by him is or are engaged in the practice of medicine; or

(c) he is engaged in the practice of medicine as a person employed in a business carried on by another person (including a company) or by a firm.

This implies that a person (or company cal pract registere themselv who em tioner is medicin

How porate" ACT?

Will prosecu who ar

Non- medica headach ularly proper cal cor

Perh wrote weren't We Medic

INSIDE

Mammnography — The Deb

A Complaint Mechanism Th

Dr Ian Siggins describes how the Victoria

Hospital A

POSITIONS VACANT

"Canberra Doctor" editorial advisory committee is seeking two AMA members to join the committee to provide advice to the production manager on content.

The committee meets approximately 7-8 times per year for an hour or so. Committee members do not carry a workload beyond providing input into the "Canberra Doctor" each month and contributions whilst welcome, are not mandatory.

For further information contact **Christine Brill** **execofficer@ama-act.com.au** or **02 6270 5419**. The next meeting of the committee is scheduled for late January 2014.

AMA (ACT) LIMITED

25 ANNIVERSARY 25 YEARS 25 ANNIVERSARY

Other stories covered in 1991 included: Sydney University's intention to move to a graduate 4 year program in 1996; Measles on the increase in the ACT reported ACT Chief Health Officer, Dr Bob Scott; a lower AMA subscription rate questioned for GPs; Canberra Doctor dinner guest speaker, Prof Peter Herdson, spoke on the Air New Zealand Erebus disaster; MRI unit for Canberra at NCDI Deakin; and prone sleeping and SIDS.

Canberra Doctor

A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION

Published by the Australian Capital Territory Branch of the AMA Ltd

Registered by Australia Post NBP9218

October 1991

GPs Face Uncertain Future

Canberra GPs have been meeting as part of a series of gatherings held around the country over the Government's budget changes to Medicare. The first meeting, was convened by both Royal Australian College of General Practitioners and AMA representatives was held to gauge the feelings of GPs around the country. The College and the AMA have formed a working group to coordinate their responses to Government and develop grass roots networks of GPs.

The next gathering was the much more publicised sky channel meeting where GPs gathered at pubs and clubs around Australia, to hear AMA and College leaders speak.

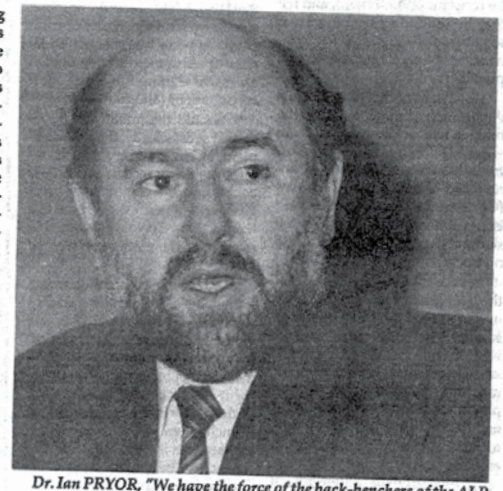
Over the last few days, the ALP backbenchers and the Health Minister have been embroiled in a bitter wrangle over what should be the fate of General Practice.

Dr Ian Pryor Chairman of the ACT AMA GP Subcommittee described the caucus proposals as one of the worst decisions in Australian political history, on a par with taking black children away from their parents, banning communism or interning everyone with a German name.

"The mentality of penalising non-bulkbillers is that of if you don't agree with me politically or philosophically, you need to be punished.

"We have the farce of the backbenchers of the ALP pandering to the entrepreneurs," said Dr Pryor.

"One of the reasons that the Govern strong on the



Dr. Ian PRYOR, "We have the force of the back-benchers of the ALP pandering to the entrepreneurs".

Left holds bulk-billing as the holy Grail, it is prepared to sacrifice good general practice for the Australian public.

"The Government is now insisting that doctors conform to their left wing ideologies, discredited elsewhere in the world. In the long term we are going to have a health service with the standards of the Eastern Bloc," said Dr Pryor.

the reduction in the total pool of finance for General Practice can only drive the quality of care backwards said Dr Bob Allan, ACT AMA President-Elect

"My greatest concern is that the debate is going on without any reference to what is happening at the coal face, with no understanding of the realities of General Practice."

"I am at a loss to explain the hostility that all Government players are showing toward General Practice," said Dr Allan.

Dr Brendan Nelson, AMA National Vice President, said that although he understood the ALP's desire to continue bulk billing for all Australians irrespective of income, the tim

recognise that such a policy was neither relevant nor appropriate to the present and future health needs of the nation.

"The basic problem is ALP policy which demands the wealthy should be able to receive unlimited medical services by simply signing forms. Mr Howe has shown a willingness to accept non-pensioners paying something for their health care, but the AMA and all fair minded Australians believe they are also entitled to an adequate level of health insurance", said Dr Nelson.

"The importance of bulk billing as a marketing tool for medical entrepreneurs was evidenced by the announcement that 24 hour clinics in Melbourne would absorb the proposed $3.50 Medicare rebate reduction rather than charge patients.

Last year, $2 billion was spent on bulk billed medical services. "If bulk billing were restricted to pensioners and unemployed people only, it would not be unreasonable to expect a 10% reduction, with savings of about $200 million per year.

More important than financial savings, we will see in place a system of health care financing favouring committed family General Practitioners rather than the medical supermarkets which have created wealth for individual doctors and businessmen but virtually destroyed the institution of family caring on which the Australian health care system is based," he said.

The AMA proposals to Government are:

* Scrap bulk billing of non-pensioners for all medical services.
* Sustain patient Medicare rebates at their present level.
* Allow optional private insurance of medical services.
* An immediate end to the entry of overseas doctors while Government and the profession developed a quota system similar to that operating in other Western countries.
* A five year moratorium on new medical schools and no increase in student intakes.
* A joint working group comprising business, community, government and medical profession to develop strategies to foster a redistribution of the medical workforce,
* Joint professional and government incentive programmes for technology and capital financing in the context of a healthy fee for service system for General Practice.

1992 saw "Canberra Doctor" also report on: project to develop a division of general practice within the ACT Board of Health; indexation of VMO contracts proposed at 5 to 6 percent; survey indicates support for smoking bans; measles outbreak; future of Calvary Private Hospital at Bruce; public hospitals collapse looms; Medicare reforms and more

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION

Published by the Australian Capital Territory Branch of the AMA Ltd

Registered by Australia Post NBP9218

May 1992

Stop Haemophilus Deaths Now

ACT Branch President Bob Allan has joined a chorus of medical [illegible]s around Australia and the ACT calling for governments to make available free Haemophilus influenzae vaccine to clinics and all medical practitioners on the same basis as the measles mumps rubella vaccine.

"The Haemophilus vaccine should be made available without delay," said Dr Allan.

"The vaccine is recommended by the National Health and Medical Research Council and the Australian College of Paediatrics and has the whole hearted support of the medical profession in the ACT," he said.

"With winter coming on, we have the opportunity to prevent at least half the cases of Haemophilus meningitis and epiglottitis, both potentially fatal diseases. The ACT statistics show that we can expect another 13 to 27 cases this year, with a peak incidence in June."

"Every doctor has seen a tragic case of this disease, either in its acute form, or as chronic brain [illegible]ge in an institutionalized pa[illegible]t.

"We now have the chance to prevent these tragedies," he said.

"All the published data show that we will save the health system money through less hospital utilisation," said Dr Allan.

"The children most at risk are in the lower socio-economic groups and those at childcare, some of whose parents might think twice about spending 15 to 20 dollars on the vaccine with tragic results.

"The ACT has a chance to get moving and lead Australia in a sound public health iniative," said Dr Allan.

Epidemiology

Some 15 childhood deaths occur in Australia each year from Haemophilus influenzae meningitis, a figure comparable with the reported deaths due to measles before immunisation.

ACT studies by McGregor et al and reported in the Medical Journal of Australia, show that the disease is more common in the winter months and the number of cases annually in ACT hospitals varies from 13 to 27. (Epiglottitis 3 to 12, meningitis 7 to 13.) One child died in hospital and another died while being transferred to the ACT by ambulance.

Interestingly, among the meningitis cases, there is a predominance of girls. A similar trend has been noted in Victoria, and in aboriginal children in the Northern Territory.

Most of the trials of the vaccine have been in Finland, where Hib disease has now virtually disappeared.

Technicalities

The Vaccine is based on the capsular polysaccharide polyribitol ribosyl phosphate, (PRP) the bacteria's most important virulence factor. An antigenic response is not produced naturally to PRP in children younger than 18 months, who are unable to respond to polysaccharide antigens. Between 2 and 5 years of age most children naturally acquire PRP antibody, probably due exposure to Hib or cross reaction with other polysaccharide antigens.

To improve immunogenicity in the younger age groups, chemical coupling of the PRP polysaccharide has ben tried and this has produced 4 vaccine types.

PRP has been conjugated with diphtheria toxoid (PRR-D), a mutant diphtheria toxin (PRP-OC), an outer mem[illegible] Neiserria me[illegible] OMP) and teta[illegible] T).

The vaccine[illegible] Australia is PR[illegible] oped. A singl[illegible] months of age[illegible] protection. H[illegible] value prior to[illegible]

Children [illegible] cording to P[illegible] bert from We[illegible] in frequent c[illegible] dren especi[illegible] tres.

It is plan[illegible] newer vacci[illegible] antigen at [illegible] soon as the[illegible] by an injec[illegible]

All auth[illegible] the higher[illegible] compared[illegible] hood imm[illegible] the cost b[illegible] vaccinati[illegible]

The co[illegible] the ACT [illegible] the vacci[illegible] gor et al. [illegible] was 11 d[illegible] and epig[illegible] intensiv[illegible]

consider the institution costs. One [illegible] costs the

New Budget Shortfall

Further financial pressure on the nation's public hospitals has been predicted as the number of privately insured patients continues to drop.

Federal Government reductions in funding to public hospitals mean that hospital bean counters have found the $140 dollars per day from private patients very handy in helping to balance the budget.

However in the past 10 years, the percentage of privately insured patients has dropped from 60% to 40%, and continues to drop by about 2% per year.

For N[illegible]ls, this mea[illegible] [illegible]00 [illegible]

Orthopaedic and Plastic Surgery patients are over 12 months."

"Those waiting in the public system are being discriminated against and squeezed out by the better off who are dropping their insurance," she said.

"I have a problem with that and I expect that any government, especially a Labor Government, would have a problem with that."

"The only thing you get as a private patient in the hospital from a service point of view is bills. What the Minister needs to do is allow public hospitals to introd[illegible]ce some[illegible] [illegible]ive the [illegible]

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION

Published by the Australian Capital Territory Branch of the AMA Ltd

Registered by Australia Post NBP9218

July 1992

Further GP Summit Planned

Health Minister Brian Howe speaking to last month's summit, with AMA Vice President Brendan Nelson

Clinical School Progress

"Canberra has become a clinical school, not will become a clinical school", Professor Charles Bridges-Webb, Professor of Family Medicine at Sydney University told a breakfast meeting of GPs last week.

Professor Bridges-Webb outlined the 3 big changes being undertaken by the Medical Faculty at Sydney University. Firstly there is the devolution of clinical teaching to 4 clinical schools, at Royal Prince Alfred, Royal North Shore, Westmead \Nepean and Canberra. Secondly there is the change to a 4 year post-graduate degree programme and finally the introduction of a 3 week rural placement for students in final year.

"These schools will be semi-autonomous because of distance", he told the meeting. "Westmead is furthest ahead because of the appointment of its associate dean 3 months ago."

"The position of associate dean for Canberra is to be advertised soon", he said.

He also spoke of the change from "teaching hospital" to "clinical school". The clinical school is more broad based, taking account of community medical activities also.

The Australian Medical Council has required that Sydney University increase the General Prac-

Continued on Page 3...

"Canberra Doctor" paid tribute to Dr Fred Hollows who died in February 1993; and reported on palliative care and the new proposed hospice; unemployment - the new epidemic; establishment of and concerns re Pap smear register for the ACT; problems for women doctors; contract anxiety for anaesthetists; the new general surgeon in town (Dr Ian Davis); and the election of Dr Brendan Nelson, the youngest AMA president ever.

Canberra Doctor

A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION

Published by the Australian Capital Territory Branch of the AMA Ltd

Registered by Australia Post NBP9218

March 1993

AMA Backs Health Minister on Smoking

Clean Up the Air

"Health Minister Wayne Berry deserves our unqualified support in his push to banish cigarette smoke from public buildings," said ACT AMA Branch President Dr Bob Allan.

"The weight of medical evidence as to the ill effects of passive smoking continues to grow and I see no reason why the ACT should not be in the forefront of the move to eliminate another health hazard from the community," said Dr Allan.

By the middle of the year legislation should be before the ACT House of Assembly to ban smoking in public buildings.

Last month saw the release in the UK before the Royal Society of further results of Sir Richard Doll's study of smoking and the health of 35,000 doctors followed for 40 years.

And the news is bad. His earlier results showed a risk of 1 in 3 or 4 smokers dying prematurely. Now the results show 1 in 2 will die prematurely. He has extrapolated his results to the general population and has calculated that one Briton in 6 (or 10 million of the current population) will die prematurely as a result of smoking. With a death rate of 1 in 5 in the developed world, smoking is well up with the greatest epidemics in world history.

ACT Health Minister, Wayne Berry.

"There is growing support from the community for clean air in public places," said Health Minister Wayne Berry.

"This is ground-breaking legislation," said Mr Berry, "and because of this the legislation may take a bit longer to draft," he said. He made it clear that he was prepared to take the time necessary to consult with all groups to ensure that the legislation works.

"We need to ensure we don't spoil our clean air by missing people we

either on public health or occupational health grounds.

Employers with staff in smoky environments will eventually have to ban smoking or make decisions to put in all sorts of expensive ventilation equipment.

Dr Allan favours a system of licensing for hotels and clubs where patrons may smoke provided that premises meet satisfactory ventilation standards.

Support for the Minister is also coming from the cross benches from Opposition Spokeswoman on Health Kate Carnell. "The Opposition support this legislation on the proviso that smoking be permitted in public areas with suitable extractor equipment," said

Calvary Hospital To Expand Services

The Board of Management at Calvary Hospital is to undertake a comprehensive review of its future strategic development.

Mr Mark Avery, Chief Executive of the hospital, has called for staff members to join a multidisciplinary service development group.

Chairpersons already appointed to the group include physicians Terry Gavaghan and Chris Ashton and surgeons John Buckingham and Tony Cairns.

Also included are anaesthetist Heather Lopert, gynaecologist Ian Trethewey, general practitioner Phil Barraclough and Imaging specialist Tony Griffin.

It is anticipated that the group will give a strong direction for the expansion of services at the hospital over the oncoming years.

Some issues which have already been raised include the employment of a staff specialist in anaesthetics and the appointment of a Director of the Intensive Care Unit.

Unemployment is Sickening

Unemployment is a significant factor in premature male deaths according to data presented to the AMA unemployment and health forum entitled, ***Unemployment - It's Sickening***, held in Canberra.

For some specific causes of death, unemployed males had much higher death rates.

- Diabetes: 160% higher death rate,
- Mental disorders: 193% higher death rate,
- Diseases of Nervous System: 450% higher,
- Respiratory diseases: 95% higher,
- Digestive diseases: 122% higher

Non-employed males had significantly lower death rates only for neoplasms (14% lower) and injury (8% lower).

These figures apply for unemployed males in the 25-54 age group in 1985-7.

Overall, in 1985-1987, males aged 25 to 54 years w[illegible] were unforce

the AMA at its national conference last May. This stimulated the AMA's interest in the issue.

For more on the Forum, turn to page 6.

Aged Home Care Help

The government has announced a new scheme to assist the aged to live at home. The scheme will be administered in the ACT by the Goodwin Retirement Village.

The Service will provide assistance with:

- Bathing,
- Dressing,
- Meal preparation,
- Mobility,
- Medications,
- Shopping,
- Laundry and
- Cleaning.

Canberra Doctor

A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION

Published by the Australian Capital Territory Branch of the AMA Ltd

Print Post Approved PP 299436/00041

December 1993

VMO Contracts Stalled

Uproar broke out at the emergency AMA Council meeting held at 1.00 pm on Friday 10th December when the terms of the Health Minister's offer of Thursday 9th were revealed.

The AMA has been led up the garden path by Health Minister Wayne Berry who had spoken in conciliatory terms the previous day hinting at a return to the previous contract while mediation\arbitration proceeded.

When the 3 page document finally arrived careful examination shows that the Minister had sent doctors a package of fishhooks. VMOs were offered the old rates of pay but the fine print in the offer covered the clauses the AMA had been arguing against.

"This is against all principles of fair play," said Dr Mark Bassett.

Promises Promises

In his press release the Minister said, "The package will enable the VMOs to work at their old contract rates until 28th February while disagreed matters are resolved."

"A key requirement of the package is the agreement from individual VMOs that they will accept the outcome of any mediation/arbitration of the disagreed matters by 28th February.

"The two parties will consult to find a suitable mediator/arbitrator. If no consensus can be reached within 7 days, the nomination will be decided by a third party.

"A dispute resolution mechanism will be put in place to resolve number of disputed matters," he said.

General Meeting

On Wednesday the 8th December, 140 VMOs packed the AMA national HQ in Barton, to discuss progress, or lack thereof on contract negotiations.

Progress could be summarised at that point in one word - NIL.

Vigorous discussion occurred when the meeting was opened to the floor. Much of the discussion centred around what could be done in the interim to get doctors back to work without prejudicing further negotiations.

Despite a wide disparity of views a consensus was reached to offer to the Minister that doctors return to work under the old contracts with the appointment of a mediator to reopen channels of communication.

"All precedents in industrial relations are that you go back on the old terms and then negotiations are carried out," said Branch President Mark Hurwitz.

The Stress

Several at the meeting spoke of the great heartache about the closedown of public hospital facilities. Many VMOs have worked very hard to build up units such as the paediatric unit and are greatly distressed to see teams crumbling and patients suffering.

One speaker pointed out that many VMOs have spent a lot of their own time building up the first class facilities in the ACT and to watch them lying idle while patients are transferred elsewhere is very painful.

A major worry is that if the dispute drags on, the ACT will only get the scrag ends of the resident and registrar pool. Thus the dispute has the potential to seriously affect health in the ACT for at least a year.

There are a whole series of clauses in the new contracts that have been manipulated in the Department's favour. For example, VMOs are obliged by the agreement to make themselves available for emergencies but the hospital is under no obligation to provide regular work in normal hours.

Powers of administration are given to non-elected unit heads unlike at present and VMOs can be required to conduct outpatient clinics. The lack of consistent employment is also a factor.

The Legal Position

AMA solicitor Justin Stanix described the previous week's proceedings before the Industrial Relations Commission.

The Commissioner made comments on the interim contract which were a propaganda windfall for the Health Minister, but did not make a ruling on the issue of jurisdiction over the AMA.

Justin Stanix discussed the Deed which was negotiated in 1987 after 8 months of dispute which was designed to avoid a protracted dispute in the future. The Deed provides for most of the issues under discussion to be resolved, but the Minister refuses to recognise the Deed.

Thus a writ has been taken out in the Supreme Court to attempt to enforce the Deed.

One stumbling block is that anyone who signs a current contract negates any benefits of the Deed if it is upheld in the court.

The AMA's offer remains: return to work under the old contract and mediation of the remaining matters in dispute.

"Canberra Doctor" published an article by Dr Peter Collignon on "Epidemiology and Politics"; Health Summit discusses changes to private health insurance initiatives by Health Minister, Graham Richardson. AMA President, Dr Nelson reported as identifying "right problems ... wrong answers"; Terry Connolly newly appointed Health Minister meets the Council of AMA to discuss many issues of mutual concern; Comcare reviewing long term compensation cases where payments have been made for years; observations on a visit from a HIC adviser and more.

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION
Published by the Australian Capital Territory Branch of the AMA Ltd
November 1994
Print Post Approved PP 299436/00041

Generic Substitution from December 1st

Canberra GPs gathered at a breakfast to hear from pharmacy industry representatives how generic prescribing is likely to affect general practice.

Substitution can only apply where it is requested by the patient and only for brands under the Minimum Pricing Policy which have been proven to be therapeutically interchangeable. This involves about 170 brands which are clearly flagged in the Schedule of Pharmaceutical Benefits by an "a". Substitution cannot occur if the doctor has endorsed the prescription 'no substitution'.

Pharmacist and ACT Liberal leader Kate Carnell pointed out that the changes were for brand substitution rather than generic substitution.

She then went on to try to explain the complexities of the Australian pharmaceutical system.

NHS lines are substantially lower in price than overseas, with prices approximately 60% of elsewhere.

Companies told the Federal Government that unless the returns were better then they would have to cease research and development in Australia.

Thus the Government came up with what is known as Factor F, direct government funding to pharmaceutical companies in Australia doing research and development.

Brand name manufacturers in Australia can't operate in Australia when getting 40% of the price compared with the USA. As a result, a price premium was encouraged by Government to enable manufacturers to justify staying in the Australian market.

"The Federal Government is attempting to have the best of both worlds, keeping the price down, yet encouraging companies to research a[illegible]velop in Australia," said K[illegible]

Gabrielle Cooper, Chief Pharmacist at John James Hospital

their pensions of $2.60 times 52 and then after 52 prescriptions a safety net mechanism applies. This was to encourage the reduced use of pharmaceuticals.

Pensioners pay more if there is a brand price premium and thus there has been increasing pressure from consumer and pensioner groups.

Thus the Government has come up with the current brand substitution scheme said Kate.

Criticisms

Interestingly, some speakers at the meeting were critical that the legislation was too loose. The chemist is not obliged to recommend or dispense the cheapest generic to a pensioner. The way is also open for the unscrupulous drug company to make deals with the chemist.

While it is currently illegal for companies to offer any bonus deals on prescription medications, there is nothing to stop a company offering deals on proprietary cold remedies in return for using their brand of generic.

sised that good communications between pharmacist and prescriber were essential.

Gabrielle supported keeping the costs down as much as possible for pensioners.

"Patient interest is the primary aim of the pharmacist," said Gabrielle.

She spoke of the problems of needing to use generics in hospitals in an attempt to keep down costs. Gabrielle said there were some generics that she would not use because of doubts about their quality.

Different coloured tablets cause problems for hospital pharmacists as well as GPs.

Gabrielle estimated that counselling a patient on their discharge medication will take about 15 minutes.

She also spoke of the problems of stock control. "The last thing we want is an inventory of different brands pushing stock holdings through the roof," said Gabrielle.

For this reason, neither pharmacist could see[illegible]stock[illegible]

The Company View

Familiarity, confidence and less patient confusion are the main reasons that doctors continue to prescribe brand name drugs according to Peter Miles, the pharmaceutical director of Rhone Poulenc Rorer.

Pharmaceutical co[illegible] search shows that GP[illegible] generic prescribing w[illegible] increased influence o[illegible] macist in prescribing.

Substitution will [illegible] lowed on products ju[illegible] bioequivalent by the [illegible] tical Benefits Adviso[illegible] tee. The permissible r[illegible] 120% bioavailabili[illegible] would be unwise to [illegible] drugs with a low th[illegible] dex such as aminoph[illegible] in or warfarin.

Peter Miles poi[illegible] the potential losses [illegible] lenc Rorer's bran[illegible]

Flagyl Orudis and Quinate is about $4 million per year.

This will have to impact on their pre-clinical trial activity in Australia. Thus their programmes of drug discovery, pain research and orphan drug programmes will be affected.

[illegible]ting legal issues not cov-

and [illegible]

Note: This [illegible] imm[illegible] Col[illegible] Co[illegible] tra[illegible]

Enquiri[illegible]

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION
Published by the Australian Capital Territory Branch of the AMA Ltd
April 1994
Print Post Approved PP 299436/00041

Vanishing Bed Syndrome Strikes WVH

[illegible]umber of beds available in [illegible]en Valley Hospital continues to shrink and attempts to get accurate bed figures are impossible.

The hospital claims that there are 56 fewer beds in use but it is suspected that the figure is at least 67.

The number of cases treated in Woden Hospital continues to shrink, defying population pressures. This financial year there has been a reduction in the number of cases originally allowed for in the budget. The number of hospital cases permitted has been reduced from 50,500 to 48,500 during the course of this financial year.

The decline in beds at Woden Valley Hospital is a major concern for all the people in the ACT says ACT AMA Branch President Dr Mark Hurwitz.

"There comes a time when the ongoing slaughter of beds has to lead to a reduction in services. The reduction in beds has to lead to a blow out in waiting lists, increased waiting times in the emergency department, increasing stress on all staff and finally the stress is transmitted to the public in Canberra," says Dr Hurwitz.

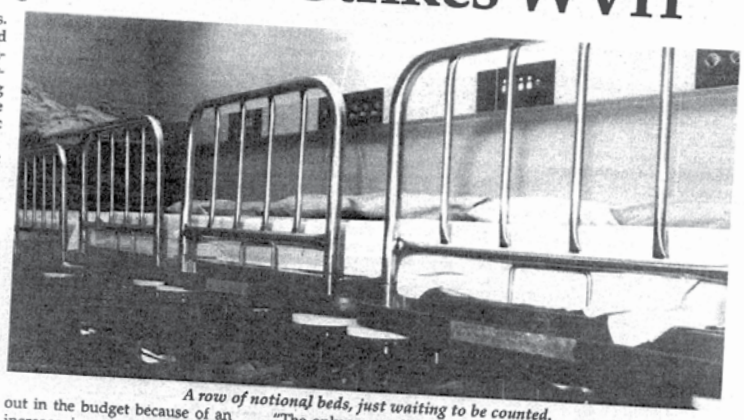
"This has led to a loss of public confidence in the health system," he says.

"As such it is imperative that the issue of bed numbers is addressed as a matter of urgency.

"The recently released inquiry into the health system must be fully evaluated to see if there are savings that can be made, but cherry-picking of numbers from the report is clearly counter productive," says Dr Hurwitz.

"It is amazing that the doctors are still being blamed for both the increase in waiting lists, because of a decrease in services during the dispute, as well as the blow out in the budget because of an increase in service provisions, clearly a 'bob each way' bet," he said.

Closures have affected areas such as geriatrics, where the VMO dispute would have had negligible impact.



A row of notional beds, just waiting to be counted.

Opposition attack

Leader of the ACT Opposition Mrs Kate Carnell, continues to attack the Minister for Health, Wayne Berry, over the Health Budget blow out.

"We have a health system seeing fewer people, with fewer beds and less operating lists," she said.

"Mr Berry continues to blame doctors for the projected $7 million shortfall. The only way the doctors' dispu[illegible]

"The only way a dispute can cost more is if people have to work overtime to catch up," said Mrs Carnell.

The nursing staff at Woden are being squeezed to dangerous levels by not employing casuals and relying on nurses to work double shifts to cover if a colleague is unable to front for work. Overtired, overworked nurses means that morale and patient care will suffer, with the potential for dangerous errors.

Notional Beds

The masterpiece of bureaucratese to come out of this is the concept of a notional bed. A notional bed seems to be one which is in the hospital but has no patient in it. In days of yore and plain English it would have been called an empty bed.

It is in a ward or a corner of a ward, staffed by notional staff, who happen to be all on leave, with or without pay.

The notional bed can be counted as a bed for counting purposes, but cannot be used for patient purposes. These notional beds are not to be confused with casualty trolleys on which patients wait for hours in hospital corridors. Sir Humphrey would have been proud to have thought of this one.

How long will the people of the ACT put up with this farce in our public hospital?

UNE
Practice Manager Program
Residential Course
Correspondence

[illegible]minder

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION
Published by the Australian Capital Territory Branch of the AMA Ltd
Print Post Approved PP 299436/00041
October 1995

Numbers Overrun GP Training Positions

General Practice Training

Government restrictions on the number of placements in general practice training are biting this year, with 575 applicants for only 400 positions.

Thus approximately one third of applicants are going to miss out. Last intake there were 511 applications. This means that over one third of applications will be unsuccessful.

Fingers in the Pie

In the budget papers is a small schedule that behoves wide discussion within the profession and particularly GP trainees.

Basically the Department of Health is now specifying where the money is to be spent and how it is to be spent and is writing the syllabus.

The Syllabus

- **Develop a strategy to provide appropriate training in mental health for all trainees within the broader framework of the training program.**
- **Implement a strategy to provide appropriate training in Aboriginal and Torres Strait Islander health for all trainees within the broader framework of the training program.**

The implication is that the priorities for training are no longer decided by the trainees and the RACGP but by government imperatives and the government response to what ever is the "flavour of the month."

Every year new subjects will be added.

Rationing of Numbers

- **Limit the number of entrants and re-entrants to the training program in 1966 to 400.**

That is it boys and girls! The ladders are being pulled up and the Government is telling the RACGP how far.

Never trust a Government promise. Those with long memories will recall a Minister for Health quelling a RMOs rebellion with the promise that there would be no limits on places.

Any statement from the Government is only as good as the Minister's memory of his or her time in the job.

Part Time Training

- **Establish a process for ensuring that for new entrants to the training program, part time training is only granted to those trainees who cannot reasonably undertake full time training.**

If you want to train for any special interest or take any time off to discover your spouse or children, tough. You are not good enough for GP land.

As for women doctors, who may wish to combine career and family, well they can go away and procreate.

Define Areas

- **Define, nominate or map areas of medical disadvantage including an agreed number in urban areas.**

No other group I know of in our community is required to do national service as part of their training.

To selectively nominate GP trainees to work in specified areas of disadvantage smacks of the old Soviet Lenninist line, and we all know how wonderfully their Health system works.

All in all, this document has 23 paragraphs making it very clear that the lives of trainees will now be determined by bureaucratic fiat.

Within a few years the dead hand of bureaucracy will have encrusted the Training Program.

The picture is further confused by the release of the consultants report into the alternatives to the RACGP training program.

Alternative Training Program

The UK consultants recommend an alternative training program but no consideration has been given as to whether the funding will come from cuts to the existing RACGP training program.

Table

State	Number of Applications	Number of Places
NSW	188	110
Victoria	122	96
South Queensland	66	58
North Queensland	8	20
West Australia	86	42
South Australia	68	30
	14	12
		24

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION
Published by the Australian Capital Territory Branch of the AMA Ltd
Print Post Approved PP 299436/00041
December 1995

New Graduates from ACT School

Back row from left: Rob Morrow, Fadil Earally, Philip Ewart, Nick Adams, Nick Georges, Daniel Priest, David McKeag, Buddhima Lokuge, Daniel Bonner, Mariusz Gajewski. Front row from left: Will Stevenson, Johanna Kuchel, Philip Healey, Executive Officer Leigh Watson, Professor Gatenby, Executive Assistant Suewellyn Gleeson, Michael Reade, Ruth Pryzchodska and Teng Teng Chung. Absent was Jeannie Yoo.

The first group of final year medical students attached to the Canberra Clinical School have completed their studies.

Professor Paul Gatenby, the School's Associate Dean, reports that all seventeen students have passed their examinations, several having received credit or distinction status in either or both Medicine and Surgery, and two students have received University of Sydney prizes - Michael Reade the Hinder Memorial Prize for Surgery and Johanna Kuchel the Sydney B Clipsham Prize for best option term report.

In addition, one of the two external examiners from the University of Sydney who assisted with the clinical examination in Canberra, Associate Professor Michael Field, based at Concord Hospital, has written the following: "I was delighted at the generally very high standard of clinical skills which most of the students displayed.

Indeed a few were as good (especially on the short case segments) as any students at this stage I have ever encountered. This must be a credit to their teachers..."

Six of the seventeen graduating students have applied for internships at Woden Valley Hospital, and a group of about thirty final year students are expected to come to Canberra in 1996. The range of fifth year subjects will be expanded in 1996 as well, with geriatric medicine students spending a four week term here, and paediatric students two weeks as a unit attachment. This is in addition to the small groups of fifth year obstetrics and gynaecology students who will continue to undertake ten week rotations in Canberra next year.

Professor Gatenby said that the success of the School's first academic year was partly due to the efforts of the students themselves, but that the support and goodwill from all quarters of the ACT medical fraternity had been a significant contributing factor.

Access Denied and Inequity Rules

A young woman suffering from a particularly painful attack of genital herpes consulted a locum on a Saturday.

The locum did not have an Authority prescription pad available and attempted to arrange an urgent authority for Zovirax. A phone call to the "hotline" produced the response that without a script number there can be no access to the computer.

Alas, it did not matter to the computer acolyte that the patient was in considerable distress, and the locum's workload was such that he was unlikely to be able to return to get a pad before late that evening, more than 14 hours away.

The response from the computer's acolyte was complete indifference.

Why not allocate a number and then complete the paperwork later? - NOT possible. The computer does not do this.

The unfortunate woman did not have enough money to pay for a private script.

An argument with the supervisor produced the same cold response. No number, no script.

Those who treat patients rather than computers will be aware that a 12 to 14 hour delay in initiating treatment is not a good thing. The Approved Product Information states "The duration of viral shedding is reduced very significantly; the duration of pain and time to heal are also reduced. The promptness of initiation of therapy may influence the degree of benefit of therapy."

The computer flunkey on the end of the phone said that the hotline was available 24 hours a day. Why should a woman spend all day in pain and then drive around after midnight looking for a chemist when she initially presented at 10 am?

Where is the access and equity in a system that is built for its own ends and not the care of the woman in significant distress?

The other question is - where are all the consumer rights groups and activists when this appalling bureaucratic cruelty can be inflicted on a young woman?

But who cares anyway? It was only a woman in pain, not something important like a computer.

New LMO Scheme

In an historic win for GPs, the AMA has negotiated a draft package with the Minister for Veterans' Affairs Mr Con Sciacca, to increase LMO fees.

The proposal awaits ratification by the AMA Council at time of going to print.

The new scheme will come into effect on the First of January 1996, and all those current LMOs will be automatically eligible for the scheme.

The essential elements of the package are an increase in remuneration for a revamped LMO system incorporating improvements for both the LMOs and the Department to advantage of veterans.

The new fees for Surgery consultations are;

- Level A consultation moiety from 60 cents to $1.10
- Level B consultation moiety from 60 cents to $3.00
- Level C consultation moiety from 60 cents to $5.35
- Level D consultation moiety from 60 cents to $7.90

Hospital consultations will be rebated at 100% of the Medicare Benefits Schedule rate.

All other consultations will have a flat moiety of $3.00 for levels B C and D and [illegible] for level A

The draft pac[illegible]

a new fee for an Annual Health Care Plan at $108.20. This firmly positions GPs as the care coordinators for veterans. The plan will be done for Veterans with complex health problems on an annual basis and the format is to be worked out by the Department and the AMA.

LMOs will be required to participate in training courses designed by the DVA in consultation with the LMO registration committee at least once each triennium.

Training courses will cover the special needs of aged veterans, younger veterans repatriation administration issues and development of annual health plans including best practice plans for common chronic conditions. The Department will consider paying an allowance to remote LMOs attending courses.

All current LMOs will be sent notification in December and will have 28 days to reply as to whether they wish to participate in the new scheme. Those who treat Veterans but are not on the Department's register will be eligible for the Medicare rebate plus 60 cents.

The new fees will be effective from 1 January 1996.

Please note all classifieds are on page 15 (inside back page) in this issue.

Want to read more?
Email membership@ama-act.com.au with the name of the story you wish to read and the year we ran it and Sue Massey will email it to you.

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION
Published by the Australian Capital Territory Branch of the AMA Ltd
Print Post Approved PP 299436/00041
September 1996

Contaminated Ice-Cream a Mercurial Mystery

Prompt and thoughtful action by medical staff in the Emer-

gency Department of The Can-

purchased two days previously. The family had the

tub I scooped some of the globules out and confirmed that they were liquid particles which coalesced just like in the "Terminator" movie so we were practically certain it was mercury. There was clearly quite a lot in the ice-cream - much more than you would get from the bulb of a broken thermometer".

"We checked with the Poisons Information Service and established that ingestion of elemental mercury is not usually toxic as it is not absorbed. It would really only become a hazard if the mucosal lining of the gut were breached - if the patient happened to have Crohn's disease for example".

Murray continued "the problem then was we did not know if we were dealing with an isolated incident or looking at a nationwide recall of ice-cream on the scale of the recent peanut butter scare".

The Australian Federal Police were consulted and sent a forensic technician who agreed the findings and the matter was referred to Mr Alec Percival, Manager of the Health Protection Service, from the Department of Health and Community Care for further advice. The police contacted the store manager and by midnight the entire batch of ice-cream tubs had been removed from the shelves. All containers were x-rayed but none revealed any further contamination with mercury particles.

The family, meanwhile were reassured and sent home after taking blood and urine for later analysis and being given aperients. Laboratory results subsequently came back normal and none of the family suffered any ill-effects.

Dr Barrell said: "The entire operation was remarkably smooth. Within 4 hours we had established that the family was not in danger and that this was almost certainly a one-off incident."

Exactly how the single tub of ice-cream became contaminated remains a mystery. A detailed investigation at the ice-cream factory has since ruled out accidental contamination with no mercury-containing equipment used in the production process. Deliberate sabotage is suspected but there is no information as to who may have been responsible for creating this unusual flavour of ice-cream, which hopefully will not be available again.

Canberra Hospital for "Tidy Up"

The prospect of an accreditation inspection has stimulated TCH (The Canberra Hospital) management to remove unsightly signs and general graffiti from its walls.

Visitors and staff alike have commented on the profusion of unauthorised advertising signs which have disfigured public foyers, elevators, ward areas and the public cafeteria.

Bill posters promoting scout drives, church fetes, amateur theatre productions, staff parties, equipment purchase raffles - usually promoted by staff members - have month by month defaced the multi-million dollar hospital.

Cleaners have been instructed to remove all signs which do not have official approval.

Not only do the signs destroy the Quality Management Unit, has appealed to staff to cease the habit on the eve of the hospital's accreditation inspection.

Ms Fisher points out that "Hospital policy states that advertising and other notices are allowed only on official notice boards and will not be permitted on walls, windows, doors or other surfaces. If you have paper signs please remove them. If an official notice is required please arrange with your manager to replace it with an approved sign through Facilities Management".

A face lift for the hospital is one of but many measures to be taken before the inspection commences on 18 November, 1996.

Officers of the Australian Council of Hospital Standards will spend 5 days conducting a survey.

All aspects

Canberra Doctor
A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION
Published by the Australian Capital Territory Branch of the AMA Ltd
Print Post Approved PP 299436/00041
October 1996

Restriction of Provider Numbers Threatens Graduates

The Government's proposed restriction on provider numbers threatens to leave one third of new medical graduates without access to the post-graduate training now required to practise medicine. Health Minister Michael Wooldridge has ignored appeals by young doctors and medical students not to cut off their careers in mid stream.

The Federal Government announced in the August Budget that from November 1996 provider numbers will only be issued to new medical graduates on approved vocational training programs. This move is designed to save $570 million over 4 years, based on the simplistic premise that reducing providers will proportionally reduce the cost of Medicare.

No account is taken of the fact that since Medicare can be accessed without cost to the user demand is infinitely elastic. The problem is thus one of demand not supply. The Minister, however, has opted to target the supply end rather than taking the more responsible (and vertebrate) approach of dealing with the demand end. Doctors, after all, form a very small part of the electorate.

The restriction will only apply to current interns and medical students. It will prevent the charging of Medicare for any service provided by these groups unless they are in an accredited training position. Even then the Medicare number given will only apply to that area of accredited training.

The changes do, however, have ramifications for the profession as a whole. Once the precedent of using provider number restriction to control workforce issues has been established, the government may use provider numbers to determine not only

ultimately affect every doctor in Australia.

Current data on the medical workforce in this country is sketchy at best. Most agree that there is, a maldistribution problem - a chronic shortage of general and, to a lesser extent, specialist practitioners in the rural areas and an oversupply of GPs in the cities. Doctors have been reluctant to pursue careers in the country because of lack of peer support, lack of medical infrastructure, lack of opportunities for spouse and family, lack of financial incentives and poor treatment of GPs by successive budgets; i.e. the systematic squeezing of rebates of the last twelve years. The rural crisis must be addressed by providing incentives to work in the country rather than using coercion.

It is now generally accepted that full registration per se is not sufficient to enter unsupervised practice and that further training

sitions for the number of graduates. There are approximately 1200 graduates from Australian medical schools each year. In addition there are 200 overseas trained doctors (OTDs) and some 50 New Zealand graduates each year.

There are approximately 400 FMP and 550 specialist training positions each year, making a total of 950. There is thus a shortfall of 500 training positions or one third of the total pool of doctors who, 9 or 10 years into their training are told that they have no career options.

Even without provider number restriction the issue of inadequate training places is profoundly inequitable and warrants determined opposition in its own right. Given that further training is now considered compulsory it is essential that access to that training be available. To deny access is to change the goal posts mid-game and cheat young doctors of

Continu... ...ge 3.

We reported on the new academic in general practice (Dr Nick Glasgow); the 25th birthday of CALMS and the election of Dr Heather Munro as chair of John James Hospital Board; medical student Mr Damian Smith's prize winning rural medicine attachment report; and whether people visiting a doctor should be called "patients". These are just a sample of the articles and issues raised during the year.

Canberra Doctor

A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION

Published by the Australian Capital Territory Branch of the AMA Ltd

Print Post Approved PP 299436/00041

September 1997

Responding to Thredbo

First official notification of the horrific landslide disaster in Thredbo came through to The Canberra Hospital Emergency Department from Goulburn Ambulance Service at 0030 hours on the 31st July. An Emergency Medical Team from NSW was being assembled to be sent by air ambulance. The number of injured was unknown, but with preliminary estimates of up to 100 casualties, "The Canberra Hospital" was to be prepared for a major disaster.

At around 0200 hours the Director of Emergency Medicine Dr Sashi Kumar took a call from Dr Trish Saccasan-Whelan, Medical Coordinator for the SE NSW Region, requesting a back-up Emergency Medical Team from the ACT to be despatched to the disaster site.

By this time, a revised estimate of casualties was down to 20-30, but it was still envisaged that more medical manpower could be needed at the scene.

The team was to leave Canberra at 0400 hours to be at Thredbo by daybreak when the search and rescue operation would be able to commence.

A team comprising Dr Sashi Kumar, VMO Anaesthetist on call, Dr Hugh Lawrence, and four Emergency Department nurses were ready to depart by ambulance after being kitted out in the Emergency Department at 0330 hours.

The ambulances stopped first at a ski shop in Cooma which had made its stock of mountain gear

Dr Sashi Kumar with a poster presentation at a recent Emergency Medicine Conference in Israel.

available to the Emergency Services, and there the team were all provided with appropriate clothing for the task ahead. Next, arriving in Jindabyne at around 6am, where the temperature was -9 degrees Celsius, the ACT Medical Team stopped at the Emergency Operations Centre (EOC) which had been set up at the Jindabyne Information Centre. The group was then transferred to the library of the local primary school until Engineers were able to establish how quickly the disaster site could be made safely accessible for the rescue teams.

Dr Lawrence said: "At first we really didn't know what to expect. We were told we would be on standby in Jindabyne. They warned us we might not have much time for food and were each issued with a ration of 3 Mars Bars! In the end, of course, we were holed up in Jindabyne the whole day watching the progress at the scene on television. Obviously there was a strong media presence. I was very impressed with the way the Police spokesman handled all that - he answered every question reasonably and evenly no matter what."

Dr Kumar, outlining how the communications worked, said: "We had regular "sit reps" or situ- ts at the EOC attended Commander at the site and could then relay this information back to the Emergency Department and to Dr Paul Christie (Director of Anaesthesia) and operating theatre staff. Regular communications were also maintained with Dr Doris Zonta and Dr Ken Abraham, the Medical Controllers in the ACT and Sydney respectively."

Meanwhile, back in Canberra, the Canberra Hospital External Disaster Plan had been activated with anaesthetist Dr Kerry Delaney in charge of reorganising the operating theatre lists. Dr Kumar said, "By 0900hrs it was clear that there would be no patients to be transported to Canberra for at least another four hours, so I notified Dr Paul Christie and on this basis the routine morning lists went ahead."

As further updates came through from the EOC at Jindabyne it became apparent that the rescue work was going to continue to be a slow and methodical process, with The Canberra Hospital likely to be receiving patients at reasonable intervals rather than taking a sudden influx of several multi-trauma cases. As a result there was minimal disturbance to elective surgery at The Canberra Hospital with lists proceeding ... out the day.

The A... team ... ved

Canberra Doctor

A NEWS MAGAZINE FOR ALL DOCTORS IN THE CANBERRA REGION

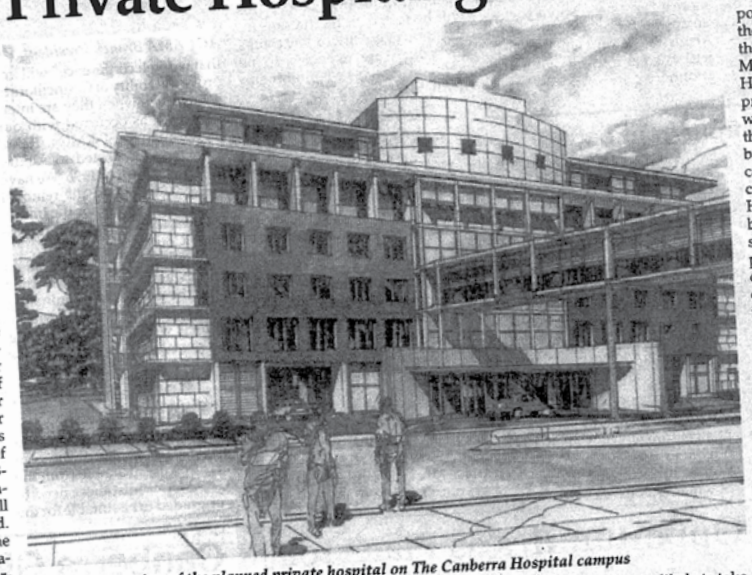
Published by the Australian Capital Territory Branch of the AMA Ltd

Print Post Approved PP 299436/00041

February 1997

Threats and Opportunities as Plans for New Private Hospital go Ahead

The concept of a new private hospital on The Canberra Hospital campus moved closer to reality last month with the announcement that national giant, Health Care of Australia, have been chosen as preferred provider over local developers, The Hindmarsh Group. Work is scheduled to begin in May this year, with completion of the $25m project expected as early as mid-1998.



Artist's impression of the planned private hospital on The Canberra Hospital campus

In tendering for the project, proponents were invited to consider the provision of "a range of private medical services in the more complex medical and surgical fields" according to Mr Maartin van der Kleij in the Chief Minister's office. Following their selection as preferred provider Health Care of Australia now has until April to finalise details of their proposal. "This will be a 3-month period of further negotiation on exactly what services will ... offered" Mr van der Kleij said.

Health Care of Australia is the largest private health care operator in Australia, boasting ownership of some 36 private hospitals throughout Australia. Three of these sites are co-located with public hospitals at St George and the Prince of Wales in Sydney and at the Royal Melbourne Hospital. Two more private facilities on public hospital sites are under construction in Perth and Armidale.

General Manager and Director of Developments, Mr Colin Sinclair said: "The Canberra Hospital private development will include 4 fully-equipped operating theatres, CCU and ICU facilities, an endoscopy suite, on-site radiology and a pathology collection centre. An additional 10-12 specialist consulting suites will also be available within the new hospital complex." A full range of medical and surgical services could be offered, and Mr Sinclair added: "If there is a demand there will be the potential to expand later to include full obstetric facilities".

Mr Sinclair said the hospital would be seeking full accreditation through a strong emphasis on medical education and aimed to establish close ties with Sydney University and the Canberra Clinical School. Mr Sinclair envisaged that responsibility for the various clinical services in the private hospital would fall to "dual-role directors" who would also manage the corresponding public hospital departments. Mr Sinclair appeared to have no concerns about any possible conflict of interests in this regard, saying that this arrangement could only benefit patient management as "common policies" could be developed.

While the new private hospital is certain to have a major impact on medical practice in the ACT there has been little consultation with the medical community or the general public. Opposition health spokesman Mr Wayne Berry has raised strong objections, saying "the plan will involve the withdrawal of public facilities as more patients are pushed into the private system". The concept of a co-located new hospital no doubt appeals to Kate Carnell as a means of cutting waiting lists and improving the ailing ACT health budget. Currently only a small proportion of patients opt for private care within The Canberra Hospital. With top class conditions available in the adjacent private hospital many more are likely to take the benefits of private health cover with consequent savings on the public side.

ACT Health will also contract to provide services to the private hospital such as catering supplies and building maintenance. Hi-tech clinical resources such as nuclear medicine and MRI scans may also be sold to the private hospital, avoiding the need for duplication of such expensive equipment. The new hospital will also offer services not currently available, notably the provision of a cardiac surgery unit, enabling Kate Carnell to fulfil her promise without actually spending the $2.7m earmarked from the public purse in the last budget.

With the inherent advantages of a co-located site backed by the power of a large national group, the new hospital poses a serious threat to both the John James Memorial and Calvary Private Hospitals. As the total number of private beds available in the ACT will surely exceed demand when the new hospital is commissioned, both the existing private facilities can expect a sharp fall in bed occupancy. It is predictable that Health Care of Australia will also be willing to contract for medical services with government and private health care funds, further compromising the two independent private hospitals and bringing managed care to the ACT in the not too distant future.

Dr Kevin Woods, Deputy Chairman of the John James Memorial Hospital Board, told Canberra Doctor that "the location confirms potential advantages on this new hospital. The Management of HCOA have also suggested that Managed Care is desirable.

"If the private hospital market in Canberra were to be dominated by a conglomerate with such a philosophy, there is a real risk that visiting specialists would come to be treated as commodities.

"I believe that it is vital that visiting specialists do not allow John James Memorial Hospital to lose support for the sake of short-term expediency".

An extended hours GP clinic is a further component of the plan, with the ACT Division of General Practice already having accepted an allocation of space in the new building. The GP clinic would be open until 11pm weekdays with limited weekend surgery hours, Mr Sinclair said, emphasising that this would be an emergency serv-

Continued on page 2

Want to read more? Email membership@ama-act.com.au with the name of the story you wish to read and the year we ran it and Sue Massey will email it to you.

Junior doctors in the firing line; proposed new medical records Act and the lack of engagement with health professionals; Government commits $30m to protect children from measles; "Canberra Doctor" wins best branch publication for the first time - a much coveted award around the AMA States and Territories. All reported in "Canberra Doctor".

Canberra Doctor
10 anniversary 1988-1998
A NEWSPAPER FOR ALL DOCTORS IN THE CANBERRA REGION
May 1998
Print Post Approved PP 299436/00041

Competition Law and the Medical Profession

There has been recent discussion, in the media, of the role of the Australian Competition and Consumer Commissioner (the ACCC), formerly the Trade Practices Commission, in major industrial disputes. This culminated in a letter to the Canberra Times, on 23 April 1998 by Professor Allan Fels, Chairman of the Commission. Professor Fels defended the Commission "for trying to do the job which Parliament has told it to do - secure compliance with the Trade Practices Act".

The medical profession has been aware of the potential implications of the Trade Practices Act since the Act's earliest days. When the Trade Practices Act first came into operation in 1974, there were people in many walks of economic life who predicted profound consequences for ordinary commercial and professional behaviour. Many of those predictions have proved unsound, especially in relation to the health sector, which, until relatively recently, has largely been left to its own devices.

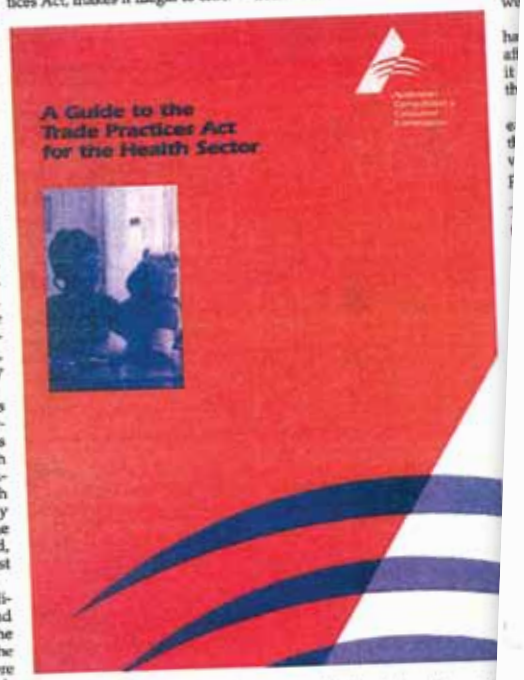
In recent years the ACCC has flagged an interest in various participants in the health sector. This is understandable as the health sector affects virtually every Australian as a consumer of health services. The ACCC has certainly demonstrated an interest in the activities of the health funds and, it seems fairly clear, its interest will not stop there.

In Australia, in 1974, the medical profession was largely beyond the constitutional reach of the Trade Practices Act, except in the Australian Capital Territory where the Act has applied to individuals in the same manner as to corporations. However, many medical practitioners had since brought themselves within the reach of the Trade Practices Act through incorporation of their practices.

Nevertheless, in 1974, when the Act first came into effect the medical profession in the ACT was locked in battle with the Whitlam Government over the appointment of full-time salaried specialists to ACT hospitals and the establishment of Government Medical Centres.

Section 45 of the Trade Practices Act, makes it illegal to enter into contract arrangements or understandings in restraint of Trade or Commerce. That prohibition can, however, be ignored if the ACCC grants an "authorisation" in relation to the offending conduct. An authorisation can be convinced that the anti-competitive effects of the arrangement are outweighed by public benefits.

The AMA sought authorisation, arguing that the existing system of visiting medical specialists was in the public interest. The then Trade Practices Commission declined to be drawn into the somewhat heated politics of the matter. It refused to grant authorisation and a subsequent application to the Trade Practices Tribunal for review was withdrawn by the AMA.



Canberra Doctor
10 anniversary 1988-1998
A NEWSPAPER FOR ALL DOCTORS IN THE CANBERRA REGION
Best AMA Branch Publication 1998
Print Post Approved PP 299436/00041
October 1998

Health's Hidden Infection

Martin Foster - Editor of NSW Doctor

With time rapidly running out medical practitioners have been urged to protect their practices from the Millennium Bug threat. Year 2000 experts say doctors should act swiftly to have all computers and other equipment that contains embedded chips tested for compliance, or face consequences that could be disastrous.

If you think the "Millennium Bug" or Year 2000 issue is a media beat up or purely an avenue for profiteering by unscrupulous computer companies, think again. This threat is very real, and although it is extremely difficult to gauge how profound an impact this problem will have, it is certain to cause major headaches when the clock ticks over to 12 am on 1 January 2000.

The Therapeutic Goods Administration, which is responsible for approving the entry of new medical equipment into Australia, has predicted that foetal monitors, intravenous drug delivery systems and electro-cardiogram machines could fail as a result of the problem. That could mean that ultrasound images could be incorrectly calculated, or the size of a foetus wrongly measured. (UK Millennium Bug expert Professor Mike Smith has forecast that in Britain between 600 and 1500 patients could die if systems fail in its public hospitals on 1 January 2000).

Hospital IT

In Australia each public hospital has an Information Technology Section dedicated to ensuring that scenario doesn't occur and that equipment is Y2K compliant. In NSW the Department has also allocated [illegible] to prepare for health's hidden infection.

The Chairman of the Federal Government's Year 2000 Steering Committee, Mr Maurice Newman, says he has heard "mixed reports" about the progress of Australia's public and private hospitals in safeguarding their equipment against the threat. One of his chief concerns is ensuring the whole compliancy process is completely transparent.

"In New York at the present time they're [considering admitting] only emergency patients to hospitals in the month following the first of January 2000, presumably because they have some concern about the readiness of their equipment," Mr Newman said.

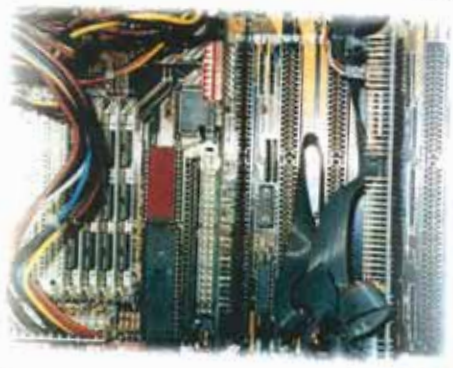
"Now that may change as we get closer to the Year 2000, but that is a contingency which is certainly under consideration there.

"I'd like to see Australian hospitals going on the record [acknowledging potential problems]. There isn't going to be any ability to hide the fact that if our systems aren't ready and start malfunctioning post first of January 2000 we will all know about it."

Origins

To understand the Millennium problem its origins need to be examined. In the mid 1960s [illegible] a bid to express the date rather than four. Thus 1980 became "80" and 1986 "86". So when the dates on many computers strike 2000 they will recognise the year only as "00". If a computer or other piece of equipment is asked to use a Year 2000 date in its calculations it could malfunction with potentially disastrous results; for example patients' ages could be calculated, incorrectly, and overdoses of medicines prescribed. Outside the medical sphere, there are fears that the provision of utilities for water, sewerage and electricity may be adversely affected.

Beyond the rollover from 1999 to 2000 there are other dates approaching that have Year 2000 experts equally concerned. The fact that 2000 is a leap year and the switch over from 28 February to 29 February is not recognised by some equipment is already causing major difficulties, according to Maurice Newman. The date 9 September 1999 could also be the cause [illegible]



The Reality

The reality for the average medical practitioner is that any computer system or piece of equipment that is in their practice and that has an embedded date-dependent chip could be susceptible and could malfunction. Under that umbrella you can specify PCs, airconditioning, fax machines, and security systems. There is a real danger that if equipment is not protected critical data and patient records could be lost forever, and billing mechanisms could fail when the clock strikes 12am on 1 January 2000 and again after 28 February 2000.

Online Help

There are plenty of avenues that doctors can utilise to prepare their practice for the days when the bug strikes. Mr Sandeep Mathur, who is a consultant to Standards Australia and the author of the book "A guide to Year 2000 Compliance", says that in the first instance doctors should contact their suppliers and find out from them if their equipment is compliant. If that fails there is plenty of information available on the Internet at the Standards Australia Year 2000 register, at *www.y2kregister.com.au*. Standards Australia has plans to make compliant products, services and organisations.

A second site that is worth examining is the NSW Government's biomedical database at *www.y2k.gov.au/biomed*. It has a list of equipment that has already been tested and site visitors can examine a particular system by manufacturer, model or description. Each piece of equipment has been put through a series of seven tests relating to its performance on all the dates mentioned above as well as 30 October 2000.

Testing

A number of items have already failed the tests, illustrating just how deep this bug could bite if Governments and the medical profession are underprepared. Among them is the Nihon Kohden TEC-5200B Defibrillator/Monitor, which doesn't recognise 2000 as a leap year. When 28 February 2000 rolls over it will automatically tick over to 1 March 2000.

The other path medical practitioners can take to safeguard their equipment is organise an audit of all the date-dependent equipment in their practice. In recent times dozens of diagnostic service providers have emerged offering their services, and Mr Mathur says that it is certainly worth the expense (anywhere from $500 to $1000) to have equipment tested by an experienced vendor.

"My personal recommendation would be to get someone who is an expert and understands the Year 2000 issue to do an audit of all the equipment in the practice," Mr Mathur said.

"Then that expert can make a recommendation as to what to do. Do you need to apply a patch on your PC? Do you need to upgrade this software and go to

Continued at bottom [illegible] page 2...

Canberra Doctor
A NEWSPAPER FOR ALL DOCTORS IN THE CANBERRA REGION
An AMA award winning publication
1988 to 1999
Print Post Approved PP 299436/00041
April 1999

General Practice at the C

but is "fund holding" the road down which ACT genera

"Fund holding" could become a reality if a proposal developed by the ACT Division of General Practice and ACT Community Care gets support from local general practitioners.

The proposal "Capital Health" - integrating health care in the ACT - is contained in a draft discussion paper, which has been released to Division members.

A Jointly Managed Non-Profit Organisation

The 'integrated care proposal' is based on the establishment of a new jointly managed non-profit organisation. The organisation will manage pooled Commonwealth and ACT health budgets. Ownership of the organisation - "integrated care organisation" - will be vested in the two main community service providers (the ACT DGP and ACT Community Care), and managed by a Board of Directors. The Board of Directors will have four representatives from the ACTDGP and four from ACT Community Care with 2 community and 2 provider representatives with four reporting committees - clinical advisory, community advisory, finance and audit and provider network. It is noted that under the proposal the Board members are "selected" not "elected" on the basis of their skills, knowledge and experience and the numbers appear biased towards non-GPs and potential funding sources are listed as the MBS, PBS, Pathology laboratory, ACT primary care population based (capitated) payment, primary care, disease management funds, and secondary care funding.

Background to the Proposal

The background to the development of the proposal lists five major factors as having an impact on the ACT health system : the ACT's ageing population; change in disease and care patterns with increasing incidence of diseases related to the aged, chronic illness and disabilities; specialisation in health care with a resultant diminishment of the role and capacity in the primary health care sector and increase in costs from referrals for expensive and "unnecessary" interventions and hospitalisation; the increase in the costs of health care and demand for services and "greater efficiency, better integration and coordination is adversely impacted by the multiple funding sources and program boundaries".

The draft states that "the ACTDGP and ACT CC have an excellent working relationship ... and are very well placed to move to a more formal, sophisticated and integrated level of collaboration with the potential to take greater responsibility for and to dramatically improve community health and wellbeing. There is evidence that integrated approaches, particularly those which maximise the capacity and competency of primary health carers, can result in the achievement of improved health outcomes, reduction in hospitalisation and reduced costs".

"The proposal provides Governments with an opportunity to fund health services on a population health outcomes basis ...and thus introducing both incentives and risk sharing for community providers".

Under the proposal, GPs (the providers) would be given the responsibility for ensuring the delivery of services to a defined population, and secondly to monitor their performance in reaching agreed outcomes. A vital ingredient for the success of such an approach is a funding mechanism that incorporates incentives to provide cost-effective care, and ensures that providers share the financial risk of a failure to contain costs or meet targets.

According to the proposal document, there is "strong evidence" that there are major benefits in using incentives. Overseas evidence has shown that better integration of care through a primary care purchasing approach leads to a substantial impact on secondary care arising from improved communication.

What's it all About?

The "principles" list, among other things, structural reform which includes pooling of health finances, a primary care team approach, a quality improvement approach, evidence based best practice information, optimal alignment of financial incentives with population health gains with all participants being rewarded by efficiency gains, new not for profit organisational structure, capacity to reinvest savings in public and community health initiatives and joint management of ACTCC and ACTDGP with capacity to expand "ownership" to other key providers and stakeholders.

Canberra Doctor
A newspaper for all Doctors in the Canberra region
Best AMA Branch Publication 1998
Print Post Approved PP 299436/00041
October 1999

Medibank Private Announces its 'GapCover'

... And the AMA says 'No US-style Managed Care' Wanted Here!

Recently Medibank Private announced details of its first national initiative aimed at eliminating medical gap payments for privately insured hospital patients.

Federal AMA President, Dr David Brand, is highly critical of the proposal saying that the AMA cannot support any scheme which was based on contracting between the fund and the doctors.

"Contracting - in whatever form - is unacceptable because it is the basis of managed care - a US-style health system that rations care and restricts choice", Dr Brand said.

"Let's have gap insurance - but not with contracts.

"Medibank Private's scheme involves contracting - that's the only way the current legislation allows gap insurance to be made available. To suggest the scheme doesn't involve contracting just because the doctor doesn't sign something is simply wrong.

"The AMA has been lobbying the Federal Government to secure legislation to allow gap insurance without contracts".

The Medibank Private initiative will take effect from 1 November 1999 and is expected to cost up to $35m over a full year. Mr Burrowes, Managing Director of Medibank Private, said in a media release announcing details of the scheme, that Medibank Private would be monitoring the impact of GapCover's introduction very carefully, but he anticipated that the cost will be offset by a major increase in their customer base.

* Dr David Brand, Federal AMA President

Mr John O'Dea, Director of the AMAs Medical Practice Department in advising the Branch of the initiative said that the scheme is similar to AXA's Mediplus Ezyclaim scheme.

"There is an opt in or out capacity on a patient by patient basis with a known gap option of $400 to $800 per episode.

"Prior notification to Medibank Private of an intention to charge a known copayment is necessary. It is unclear how the known per episode gap will work as it seems to require some agreement on charges between providers which would have TPA implications.

"The Medibank Private arrangements are based on 'Lawrence' contracts", said Mr O'Dea.

The AMA's strategy is to secure amendments to the National Health Act to allow gap insurance without contracts so that with appropriate adjustments, these schemes can be transformed as approved schemes.

"There is a national Medibank Private Schedule of Fees. The schedule is set so as to capture a fixed proportion of the current doctor charges. Diagnostic medical services will be dealt with separately by either Practitioner Agreements with hospitals or other MPPA arrangements.

The Medibank Private Schedule of Fees generally offers benefits higher than the Medicare Benefits Schedule, which presently forms the basis of Medibank Privates' benefit payments.

According to the briefing document provided by Medibank Private, under the GapCover initiative, doctors will be entirely free to decide whether or not to use GapCover for Medibank Private members, on a patient-by-patient basis. Where doctors use GapCover and charge the Medibank Private Schedule of Fees, the patient can expect to pay no gaps for that medical service, but the billing system is flexible enough to allow for a known gap option to be exercised.

Mr Burrowes said GapCover was "essentially a new billing arrangement. Every recognised doctor in Australia with hospital admitting rights would be invited to provide GapCover to their Medibank Private hospital insured patients.

"Medibank Private cannot guarantee that doctors will use this billing method with our members, because it will be entirely up to each individual doctor to decide whether or not to use GapCover.

"Doctors do not have to sign any form of contract, and can decide whether or not to use GapCover on a patient-by-patient basis. We believe it is this very freedom of choice which, overtime, will help ensure GapCover's widespread acceptance by the medical profession.

Dr David Brand said that health funds should get behind the proposal to secure legislation to allow gap insurance without contracts.

'Health funds should get behind this initiative so we can have gap or know-gap insurance without managed care.

"Contracting is the highway to hell for patient care", said Dr Brand.

Inside This Month...

Canberra Doctor
A newspaper for all Doctors in the Canberra region
Best AMA Branch Publication 1998
Print Post Approved PP 299436/00041
August 2000

Historic Hospital Summit H
Health Minister and

The recent hospital summit jointly hosted by the Health Minister, Michael Moore and ACT AMA President, Bob Allan brought together representatives of the professionals, hospital management, consumers, bureaucrats and government responsible for the administration and delivery of health care to the Canberra population in a one-day forum to identify issues of concern and to consider solutions. The meeting was facilitated by Ms Carla Cranney and her summation of the Summit is included in this report.

ACT AMA President, Dr Bob Allan

President, Dr Bob Allan indicated early in his presidency that he would target hospital funding as priority issue and stated publicly that he regarded oft quoted statement that The Canberra Hospital was "34% overfunded" as a myth. He was convinced, he said, that the hospital had been inappropriately benchmarked and therefore underfunded.

Health Minister, Michael Moore, in opening the summit said that 'the state of the health system has been one of the most important and at times contentious issues facing the Territory ... and while the organisations and individuals gathered here might each hold quite different views about the key issues and problems facing the Territory , we all share a common concern for its welfare.'

'... you know where it works well and you know where there are problems waiting to be solved and you know where our systems can be improved. The hospitals and the health services, are not my workplaces, they are yours ...and as Minister, I want to understand systematic problems in your workplaces and ensure that you have the best opportunity to be able to fix them. Let's look at better coordination between bed management, theatre utilisation and admissions ... cost and service benchmarking ... workforce issues ... purchasing and integrating care across providers'.

The Minister said he was not convinced that the hospital funding levels were inappropriate, but committed to having a comprehensive analysis undertaken of the costs associated with the TCH.

Mr Roger Kilham, economist with Access Economics said that the States and Territories do not have so many degrees of freedom in health policy. The overall health policy framework is set by the Federal Government. Hospital grants are special purpose funds with strings attached. The Australian Health Care Agreements impose many obligations on the States and Territories. There is a struggle for control of the public hospital agenda because the Federal Government puts in about half the money but wants all the say.

Mr Kilham said that there is substantial evidence that the Canberra Hospital is expensive. Any examination of this invites the laying of blame rather than looking for a solution. In summary, he said the ACT system is: overmanaged, lacks scale economies, has been less aggressive in cost-shifting, faces very high community expectations and has to pay ACT wage rates.

Dr Allan said that all Australian public hospitals had been underfunded for many years, and that Canberra's had not been exempt. He said he believed that there was evidence at the TCH in particular that a crisis was emerging. The symptoms were: poor staff morale, unachievable financial targets, and problems with patient access. Underfunding had been exacerbated by under- estimation of the complexity of work (Casemix), inadequate cross border payments, and re duced non-government rev enues. 25% of the hospital's in patients come from interstati and they tend to have more com plex health issues. Private insu ance/DVA income has been lo

Our People in Profile

Canberra Doctor
A newspaper for all Doctors in the Canberra region
Best AMA Branch Publication 1998
Print Post Approved PP 299436/00041
September 2000

Fraud and Theft in Medical Practices

One of the most alarming trends the Association has been noticing in recent years is the increase in the amount of theft and fraud which is occurring by employees and external sources in medical practice.

The vast majority of employees are scrupulously honest and essential to the running of your practice. However, it seems that even the most trusted employee could be ripping you off, sometimes for hundreds of thousands of dollars.

The best way to avoid becoming a victim of theft or fraud is to be aware of what is happening in your Practice.

The following article is designed to improve your understanding of how theft/fraud can occur and some simple strategies to prevent it happening to you.

There are a number of ways in which theft or fraud can occur in your Practice. The following are some of the most common:-

- simple cash theft (e.g. money received by the Practice is not banked; patients are charged an additional fee and given a receipt which does not match the copy retained by the Practice)
- Medicare fraud (e.g. employee provides receipts for services which were not performed by the Practice)
- Fraud by an external party (e.g. Practice being sent an invoice for goods or services they did not order or receive)
- Time and wages fraud (e.g. employee claims to work additional hours to receive overtime)

The Fraud Suspicion Checklist

While fraud comes in all shapes and sizes, there are some common features that we suggest should start increasing your index of suspicion. It is important to note that if your practice has a number if these features it does not mean that theft is occurring. It simply means you need to review the operations of your practice carefully and may indicate that new cash handling protocols are required. Remember - before accusing any employee **CONTACT THE AMA.**

- You feel that you are working harder and harder and earning less and less (this may be caused by continuing to bulk bill patients!)
- You have an employee who rarely takes leave and objects when forced to do so
- You have an employee who refuses to allow other employees to take over financial/cash management tasks
- There is little or no record of transaction reconciliation occurring
- When the employee does take leave (if they do ever do) there seems to be more money banked
- There appear to be a large number of errors in the financial records. This is most prevalent in computer systems if you have a large number of reversal transactions.
- You have no audit mechanisms in place
- You have a large amount of outstanding debt
- Time and wages records are incorrect or not kept

This list is not exhaustive- you may find that all of these things are happening in your practice. Similarly, you may find none of the above occurring and still be on the receiving end of theft. In any case ticking any of the boxes indicates that there are issues in your practice that need to be examined.

Preventing Fraud/ Theft in your Practice

It is not possible to completely safeguard the Practice's assets, however, there are some things which every Practice should do to protect themselves as much as possible. It is important to note that these safeguards do not mean that the practice does not trust the employees. They are as much for the protection of ethical employees as they are for the practice.

- Ensure that all employees, even the most trusted and senior employees, have some level of supervision or accountability;
- Check to ensure that employees are not merely counting money. They must perform an appropriate reconciliation with each banking;
- Bank regularly and start and close the system at the same time. If banking is done every few days and at different times it is difficult to reconcile the banking to the day's transactions. Ideally, the banking should close, for example, at 3.00pm. Therefore, money is balanced from 3.00pm to 3.00pm the next day;
- Most computerised systems have a feature that can be activated to require employees to identify themselves when changes are made. In some cases it is also possible to request that a reason is given. You should have this feature activated on your system. Do not purchase computer systems without this facility.
- Ensure that you have a clear understanding of how your system works and the main features.
- When purchasing a computer system check for identification features and ensure that is it is not possible to change information without it showing up on the system at some stage.
- If possible, consider having staff log in to allow you to identify the user of the computer.
- Implement a system of audit trails in the Practice. A simple audit trail can be to, select a patient at random from the appointment book. Ask the employee to provide you with all of the documentation relating to that consultation, e.g. the receipt issued, or Medicare voucher, the entry into the daily ledger or balance sheet when the money was reconciled and finally, the bank statement showing the money being placed in the bank;

Audit trails should be conducted frequently at random times throughout the year.

Audit trails can help to not only detect or prevent fraud and theft, they can also be a way of examining your system and determining there are better ways of doing things in the Practice.

- Have clear and comprehensive policies for the management of money and the payment of accounts
- Let all employees know, in a policy document or practice manual, that theft or fraud on any level is not tolerated by the Practice and will, if proven, result in instant dismissal.
- Have clear and comprehensive time and wages records. The records should set out the starting and finishing times for staff and the amounts of money they have been paid. It is much easier to see if additional hours are being claimed if starting and finishing times are shown because you will generally recall the time the employee left, even if you may not be sure how many hours they have worked. Check records regularly.
- Minimise the amount of cash in the practice by having credit card and EFTPOS facilities and paying staff by cheque or preferably by electronic funds transfer.
- If you have an employee who prepares cheques for your signature make sure that they provide you with the information about the payment that is being made. This may be the bill, the summary from the wages records or whatever information you require to verify the payment.
- Keep company documents such as Article of Association, Certificates of Business Name Registration, signatures etc in a secure place. We have seen cases of employees setting up additional accounts in the practice name using these items.
- Contact the Association if you have any concerns

Continued on Page 3

Canberra Doctor
A newspaper for all Doctors in the Canberra region
Best AMA Branch Publication 1998
Print Post Approved PP 299436/00041
February 2001

Indemnity Crisis!!!

AMA/ACT Health develops VMO indemnity package

In response to the "call" by UMP, and the possibility of a seriously depleted VMO workforce, Health Minister, Michael Moore, applied the resources of government and his department to develop a package which would cover the public and private practices of VMOs (and salaried specialists).

AMA Branch President, Dr Bob Allan raised the issue of VMO indemnity with the Minister in October 2000, not anticipating the "call" by UMP which has resulted in anger, uncertainty and the reality of considerable financial impost.

The ACT AMA (President Bob Allan, Executive Officer Christine Brill and obstetricians - Bryan Cutter, Andrew Foote and Phil Mutton) had crisis meetings with the Minister for Health, Michael Moore and Departmental CEO, Penny Gregory immediately prior to and following the Christmas holiday period.

Dr Bob Allan

In informing the VMOs of the proposal, the ACT Department of Health advised "in recognition of the continuing difficulties faced by doctors working in Canberra's public hospitals concerning medical indemnity, the ACT Government has developed a proposal to use the combined buying power of the Government and these doctors to negotiate a better solution - which provides premium security and coverage certainty for doctors; which shifts some of the future risk of escalating costs for public patient treatment onto the Government and which will involve doctors in a tender selection process to get the best private practice insurance product to meet doctors' needs.

Background to Medical Indemnity Arrangements**

Traditionally medical indemnity in Australia was provided by medical defence organisations (MDOs), some of whom were based in London. In the early 1990s, there were 10 MDOs in Australia. They are generally "mutual organisations", that is, they are owned by their members.

They are not insurance companies, because they do not offer a doctor contractually defined cover. Coverage of a doctor's professional indemnity liability is at the discretion of the MDO. While in theory this provides little security for doctors, there have been few examples where cover has been refused retrospectively. Exceptions to that have been where doctors have died - in some cases, MDOs have refused to accept any claims made after the estate of a doctor is finalised. This has had a bad outcome for the injured patient, but no effect on the deceased doctor or his or her surviving family.

The MDOs have generally provided "claims incurred" or "occurrence based" cover. This means that a doctor is covered for any claim arising out of care provided in the year the premium is paid, whenever that claim is lodged. Theoretically, this provides maximum security to both doctors and patients. However, it is difficult for MDOs to estimate premiums accurately, when a claim may come in many years after. Those claims which are made later and where potential for the claim is not known about at the time the care is provided are called "incurred but not reported" or IBNR claims. Sometimes, the aggregate of all the IBNRs is called "the tail".

In medical negligence litigation, it is recognised that claims often take some time to be lodged. ACT public sector and overseas data shows an average of 3-4 years between an incident occurring and a claim being lodged.

ACT Branch President, Dr Bob Allan said that he believes that the "government is acting in good faith, and that it is genuinely concerned to maintain VMOs as an integral part of the public hospital system in the ACT".

There is also a significantly long period of time between the claim being lodged and paid. The "down side" for MDOs with these delays is that they aren't sure for a long time whether they have collected enough premium for the liabilities incurred in any one year. The "up side" is that the delays in payment often gave them many years between knowing of the claim and having to pay it, and this allowed them time to collect enough new premiums to cover ... shortfalls in

Mr Michael Moore

the premium they had collected.

A Brief History of the Australian Industry

Up until the 1960s the frequency of litigation against doctors [illegible] only [illegible] throu[illegible] other[illegible] queen[illegible] sider[illegible] claim[illegible] time[illegible] sign[illegible] were[illegible] they[illegible] den[illegible] sur[illegible] Co[illegible] in [illegible] co[illegible] cie[illegible] ha[illegible] st[illegible] th[illegible] w[illegible]

to pay out claims they had to pay that year with an amount for their administration and costs. Crunch point came at the end of the 1980s, when two organisations had to make calls on their members to meet claims costs.

MDO premiums began to rise, and the cross-subsidisation across all doctors started to reduce, with individual speciality rating coming in the early 1990s. However, competition for members between the MDOs meant that the underfunding question was not fully addressed. The Commonwealth is Professional Indemnity Review took a close look at the MDO industry and in 1994, its actuaries estimated that the industry had unfunded liabilities of about $250M.

Addressing Industry Underfunding

[illegible] the in[illegible]

Canberra Doctor
A newspaper for all Doctors in the Canberra region
Best AMA Branch Publication 1998
Print Post Approved PP 299436/00041
June 2001

PAPA WHISKY'S RESORT REPORT

Monday 4 June 2001. Day 4 in-country. There was a little rain this evening, returning relative humidity to 85%+ on a temp of 32 deg C. Gotta love this place - The Nat Cap in late Autumn it is not!

Yesterday the RAAF's current Aeromedical Evacuation Operations Officer in east Timor, Wing Commander Mike O'Donoghue, and I spent part of our weekly day off driving into the mountains behind Dili. We visited the Australian Soldiers' WW II memorial and then went up to about 2,000 ft altitude for a photo opportunity, looking back towards Dili. Not likely to show much as there is generally a persistent tropical haze throughout the day.

After that, Mike got involved in arranging two Aeromedical evacuation missions for injured UN civilian staff, so we went back to the UN Military Hospital for several hours to sort all that out.

One of the casualties was a young man who believed he could operate a motor bike and survive in local traffic. That is quite a feat, as there is no local tradition of driver/ rider education, nor requirement for licensure here - if one can afford wheels - GO FOR IT!

Anyway, having obtained my own UN licence, last night I drove the 7 km or so back to our lines in "Crocodile Alley" from the UN Military Hospital around 2200 hrs, just for the experience. My only close call was with a small pig which tried his/her best to kamikaze by running out in front of me ... narrowly avoided.

So far as locals go, there is likewise no tradition for drivers necessarily to use headlights at night nor for pedestrians to walk facing oncoming traffic. The people sitting on side of road - (not verges, which basically do not exist) side of ROAD also cause some excitement for the tyro driver, particularly when dealing with a sulky, Indian-built, underpowered manual 4 cyl diesel turbo 4X4! And I will say nothing at all about the state of the roads.

Interesting disease vector problems in our camp at present - mice, cats and dogs all over. Once we can catch at least some of them, I guess we will probably have to feed them to the crocodile's.

My other excitement yesterday came from permethrin re-dipping of my camouflage uniforms, repairing my shower curtain and toilet cistern with string, and fitting a borrowed mozzie dome to my bed. I now have to crawl in over the foot bar, involving a gymnastic skill level of about 3.5, then turn and zip it closed. But it gives me more room than the net I used previously... just wish I had one with a side rather than an end opening!

Our rooms/cabins at HQ Peacekeeping Force are not too bad, though sparsely equipped. One shock to the system is the complete absence of piped hot water. It surprises me that no one so far has set up a bank of solar panels to heat the water - I guess other things have higher priority, as there is surely no shortage of sunlight.

While I was at the UN Military Hospital yesterday I checked out the accommodation there, where I had expected to stay. Their cabins are about one third the size of mine, and do not have ensuites. Their only real improvement is swivelling reading lamps by the bed over fold-out desks. On balance, I know that I am fortunate to be where I am. The trick is to turn off air conditioner about a half to one hour before rising for morning shower - that way the shock of the cold water is much less.

PSW in front of HQ PKF compound, burnt out building to rear. Photo by Wing Commander WB (Ratz) Wood Environmental Health Officer HQ PKF, Dili.

Re the ensuite ... before you run away with visions of ADF officers living in luxury, I will point out that the cabins we occupy are all designed and made in Japan. Ergo, designed for the Japanese physique: ie, bloody small. To conceptualise it best, think of the ablutions accommodation on the Indian Pacific, then halve it. To get through the door, I have to turn sidewise if I am wearing my pistol belt. When I use the toilet, my options are to adopt an unlikely yoga pose, hold my knees up under my chin, or sit with my feet in the open doorframe. There is a tiny wash basin and a short, narrow but deepish bath with removable sprayhead on flexible hose. I should photograph the set-up as a better means of portraying its challenges.

Because of concerns over local water quality (which suffers from heavy metal contamination in addition to an unacceptable bacterial count), we drink only bottled water, which is also used for cleaning teeth, and each get through at least 4 - 5 l per day.

Our food is good and also plentiful: there are ample salads and fruit as well as meat dishes etc. Brekky features availability of German sourced tomato juice, which contains additives 0.8%lemon juice and sea salt. Other condiments are either very strange - I am discovering some exotic REALLY HOT chili sauces - or quite banal: Black and Gold tomato sauce and UHT milk feature prominently. I guess the UN lets relevant supply contracts all over.

The assessed level of threat to Australians in Dili is such that we go armed at all times. The ADF takes this seriously and we have regular weapons handling drills and live firing practices. That said, and despite the grenading in Western Sector last week (3 people killed, more than 20 injured) which arose from a dispute between 2 of local bad guys, things in Dili are militarily quiet at present.

I am looking for an opportunity to get out on visits to deployed units in next few days. More UN military people have been lost here as a result of motor vehicle collisions, illnesses, aircraft accidents and other mishaps than as a result of actions by the militias. However, seems to me to be a good idea to stay alert at all times as there are some particularly nasty illnesses about, without worrying over hostile elements' activity.

As many have remarked before, the East Timorese people are most appealing. They are courageous, friendly and industrious. The choir for Sunday's Mass at Sao Jose in Comoro would give the better-known Pacific Islanders a run, while the bongo accompaniment lent just that little air of difference, reinforcing the knowledge that one is NOT at home. One hopes their forthcoming national elections in August result in some political stability for the people of this severely traumatized land. At least, with the UN PKF here to ensure a smooth transition, they seem to have a chance at last.

Peter S. Wilkins

Editions in 2002 also ran the following stories - and much more besides. Honours for two local doctors in Australia Day Awards; GP bulk billing rates in free fall - patients paying more for health; www - not easy to look on the bright side with Australian internet sites; Canberra GP Dr Glynn Kelly nominates for President of the RACGP; and "private" nurse practitioners for the ACT.

Canberra Doctor
A newspaper for all Doctors in the Canberra region
Best AMA Branch Publication 1998
Print Post Approved PP 299436/00041
April 2002

Medical Indemnity – The Local Issues!

Notwithstanding AHMAC's attention to issues surrounding indemnity for the medical profession, and indemnity summits to consider the issues on a national basis, there remain unresolved issues for the profession locally.

These difficulties remain despite the most welcomed initiative of ACT government to indemnify VMOs for their public work.

This government and the previous goverment was sufficiently perspicacious to recognise the crisis for obstetricians and neurosurgeons particularly and the potential for losing the highly skilled and committed VMO workforce.

To recreate the climate, it is important to recap a little of what went before this commitment by the new Government.

In late November 2000, United Medical Defence made a "call" on its members. As a result of this action, some VMOs – principally obstetricians - considered resigning their MDU membership and taking out 'private only' cover.

In December, following representations from the AMA and individual obstetricians and gynaecologists, the then ACT Health Minister, Michael Moore offered the following solution to the immediate problem :

"The scheme would cover public or private patient liability costs, that arise from incidents occurring on or after the 1 January 2001 ...in relation to complaints, disciplinary processes and coronial matters, it would cover advice and legal costs where the doctor becomes aware of the matter after the joining date.

"... the Government would seek private sector insurance or MDO cover, which would also include the additional services which MDOs have traditionally provided to doctors. This cover will be sought on a claims made basis, but with additional incurred but not reported claims (IBNR) and tail cover to address the special needs of doctors, in the post 1 January 2001 environment, as discussed below.

"... the scheme will use the combined buying power of all the doctors who work in the Territory public hospital system and that of the government to negotiate a better premium price deal in the marketplace than is currently possible for individual doctors.

"Current VMO contracts require that VMOs hold adequate insurance cover for professional indemnity. The options to satisfy this need are for VMOs to provide for their own cover for liability arising from public and private patients using the public hospital system or VMOs may satisfy this requirement by participating in this scheme.

"... doctors contributions to the scheme would not exceed the MDO premium which they paid in 2000 for the next 3 years. If we are able to negotiate a price for a product which results in overall savings, ... we would seek to pass that on ...

"... the setting of the premium for three years will be subject to individual claims experience adjustment.

"... ACT government taking on considerable risk. ... the offer is likely to provide direct financial benefit to doctors by maintaining premiums at the same levels as at 2000.

The then President, Dr Bob Allan responded to the Health Minister on 22 December in the following terms :

"The package that you offer seems to represent a small improvement over the current arrangements in financial terms but with several strings and a few risks attached. I will not elaborate on the barrage of concerns that have been raised, but could do so later.

Our initial request was for the public to carry the burden of indemnifying the obstetricians for their work in public hospitals. This is where a crisis has emerged.

Your argument against this is that they are contractors, not employees, and therefore responsible for this expense.

It is clear to all that medical indemnity insurance has become a de facto welfare fund for victims of medical misadventure, and in the case of obstetrics, every child born with less than a perfect outcome has been encouraged to sue the doctor involved. Of course, negligence need play no part in the equation for the court to feel sympathy for the plaintiff. With a little commonsense and fairness this system may have been able to continue. However, the courts have made a welter of what they must consider to be a bottomless pit of money. Awards of $7m have been made, and amounts of $20m are anticipated. The cost of funding this extravagance has fallen on the medical profession, and it is becoming unaffordable. In obstetrics, only a small portion of deliveries occur in the private sector, and the majority of litigation arises from the public sector. Contract VMO fees have not increased to cover indemnity costs, and there is little option to increase private fees as MBS rates have not increased. The corollary with be a withdrawal of private contractors from the public system. You have stated that this is not what you would like to achieve.

The courts, the law, and the outrageous outcomes are the responsibility of the whole community. It should not fall on one profession to fund a system in need of urgent repair. In simple terms, they are your hospitals and your courts. It should not fall to private individuals, merely by virtue of their employment status, to prop up an unsustainable system.

Finally, your offer alludes moving towards contractual rangements applying in NS NSW... indemnifies its V obstetricians for their public w

If you feel you are unabl indemnify VMOs because they are contractors then consideration should be given to making them part time employees.

I urge you to reconsider this option.

The feedback that I am receiving is that no-one is likely to accept your offer".

A meeting of interested VMOs was held in January 2001 w addressed by Chief E

- *The Territory will manage the claims for the public portion*
- *There will be no tail from the public practice component ...Territory offering occurrence based coverage for the public component only*
- *Legal representation*

The scheme, according to the government "...achieves a transition from private to public funding of the risks associated

Canberra Doctor
A newspaper for all Doctors in the Canberra region
Best AMA Branch Publication 1998
Print Post Approved PP 299436/00041
March 2002

Branch Proposes Collective Bargaining Option for Government Consideration

The ACT Branch of the AMA has raised new possibilities for collective bargaining on behalf of VMOs with Mr Mick Reid, consultant to the Chief Minister.

As VMOs will be aware the Branch has undertaken a survey to determine their preferences for "employee" or "independent contractor" status. Unsurprisingly the results show the great majority of VMOs prefer to be independent contractors.

This unequivocal response provides impetus to find a model for collective bargaining under the AMA umbrella.

It is not news that a major issue for VMOs over recent years has been the inability to negotiate as a group on the terms and conditions of their VMO contracts.

The spectre of breaching the Trade Practices Act has been a very real deterrent to engaging in such action, which would almost certainly bring the VMOs to the attention of the Australian Consumer and Competition Commission (ACCC) as has occurred in Western Australia.

If one needs to be reminded of the impact the ACCC and the Trade Practices Act can have on the profession and the AMA, then one needs to look no further than the AMA's WA branch.

That Branch has been fined for breaches in relation to price-fixing and primary boycott conduct. The penalties and costs were $265000.

The Executive Director and a former President have been likewise fined under the Act an amount of $10000 each.

The Chief Minister has engaged former NSW Director General of Health, Mr Mick Reid, to review the administrative arrangements within the health portfolio.

As part of this review, the Branch is hopeful that serious consideration will be given to the ACT AMA being empowered to act on behalf of the VMOs in a process similar to that existing in NSW. This gives the NSW VMOs the opportunity and right to have their claims arbitrated by a senior member of the NSW Industrial Commission, but generally precludes industrial action.

Some VMOs in their desire to gain industrial representation have proposed the creation of two new organisations – one, the Society of Australian Surgeons (SAS) seeks national cover and the second, the ACT Visiting Medical Officers' Association seeks to represent local VMOs only.

The profession does not need to further fragment. So it is hard to argue a case for setting up these new organisations. Unity is what is needed!

It can be argued that the VMOA has grown out of the inability of the Branch to negotiate for its VMOs. It would appear that the VMOA thought that it could achieve what the Branch was unable to if it could obtain registration under the Workplace Relations Act as an association of employees. An application for such registration is currently is before the Australian Industrial Relations Commission. The matter is relisted for hearing in October 2002.

The Federal AMA, along with other organisations, has lodged an objection to the registration.

If VMOs are employees (and there is no clear evidence that all VMOs are), then ASMOF exists to act on their behalf. If they are not employees, then the VMOA will not be able to achieve any more than the Branch can under the severe constraints of the present legislation.

Given our understanding that VMOs generally want to remain independent contractors, for them to be encompassed within an umbrella which demands they accept employee status could well raise the ire of many VMOs.

However, if government is willing to legislate to permit collective representation under the auspices of the ACT AMA, then VMOs will gain a satisfactory outcome. It will be a huge win for the VMOs in that they will get their industrial representation, without the necessity of funding another organisation to do this, and the AMA with its infrastructure, resources and expertise will be well placed to act on their behalf.

Let's hope a commonsense approach prevails and VMOs are granted the ability to have industrial representation under the auspices of the AMA.

Canberra DOCTOR
Informing the Canberra medical community since 1988
October 2003
Canberra Doctor is proudly brought to you by the ACT AMA

That IBNR Tax- the Latest!

The Government and the AMA have agreed to work together and a committee has been established and the terms of reference agreed. Dr Glasson said, "it's very important that we now move forward to an outcome to really focus on the real issue, and that is preserving the medical workforce in this country. And I'm very hopeful, as I say, with the team we have, with the expertise we have both within that committee and also the group that surrounds that committee, that we can actually deliver for the Australian public.

"As a result of establishing this co-operative committee, the profession has signalling they are going to hold off tendering those negotiations and wait for the outcome of this".

Dr Glasson said "I can reassure them that the discussions we had with Mr Abbott, which extended over a couple of hours, really tried to address the root of the problem. And I'm sure Mr Abbott is better informed as a consequence of those discussions and, as I say, I'm happy that we can actually come up with an outcome in early December.

The New Medical Indemnity Policy Review Panel

Health Minister, Mr Tony Abbott has announced the membership and terms of reference for the Medical Indemnity Policy Review Panel, which will make recommendations to ensure a fair,

Continued Page 7

VMO Contract Negotiat Down to Tin Tacks

Without sabre rattling the AMA has been right in the thick of VMO contract negotiations with the ACT Department of Health and to date the process has been firm but very constructive.

We have been listening to our members' concerns to direct our bargaining and we encourage you to attend the VMO meetings.

It is expected that as a result of our collective discussions, the Government will be able to offer "core" contracts to Doctors that will retain the current VMO workforce and in addition be attractive on the Australian medical market to encourage quality specialists to more seriously consider Canberra a career destination. But, we are not there yet!

Government has committe extra money to the future funding Doctors' contracts although the fir increase will of course depend the completed contract agreemen VMOs will have a choice "sessional" or "fee for servic contracts. Doctors taking up n contracts without a gap in servi

Canberra DOCTOR
Informing the Canberra medical community since 1988
February 2004
Canberra Doctor is proudly brought to you by the ACT AMA

Welcome to the ANU Medical School Inaugural Year

Susanna Harris and Dr. Cathy Owen

There has been much interest in the arrival of the Australian National University Medical Schools' first cohort of medical students. While Canberra already has a substantial history in the teaching of medical students, 2004 represents a major new development: the establishment of our own new medical school. Students who met the Graduate Medical School Admissions Test (GAMSAT) requirements and academic performance standards were selected for entry in September 2003. The admission procedure involved a 2-part process: a group activity, which engaged students in teamwork and was very popular, followed by an individual interview with a 4-member panel. The medical school is grateful to all the people who contributed their time, including community, rural, recent graduate and faculty panel members.

Of the cohort of 82, 67 are 25 or younger and 15 are over 25 and approximately 60% are women. The class is geographically diverse and includes 2 Canadian students. Interestingly 17 students are locals from the Australian Capital Territory. It is not surprising that over 50% of students have a Biomedical Science background but this first year's cohort draws from a multitude of backgrounds and experience ranging from the Arts, Commerce, Economics, to Engineering, Mathematics and Psychology. Some students also come from careers in Health fields such as Nursing and Physiotherapy.

Orientation week has just ended and classes have begun in earnest. Orientation consisted of a number of days on campus spent familiarising students with ANU services, student organisations, with Medical School staff and the layout of the campus. During this time, students were introduced to strategies for staying healthy while studying and to the problem-based learning approach they will be using throughout the ANU medical program. Students and faculty enjoyed an overnight retreat to Jindabyne, which gave everyone a chance to get to know each other better. Students understandably are concerned about coping with the workload and balancing their family and life commitments against study, but the program is designed to offer frequent opportunities for feedback and support. An enormous thanks goes to all the people that have contributed so far to curriculum and teaching development. We look forward to reporting further on the progress of this inaugural class.

The program is a four-year graduate medical degree, and will use problem based learning (PBL) as the principal method of instruction during the first two years, supported by an entire clinical day each week (with patient contact), five or six lectures and two theme sessions. Four themes, Medical Science, Clinical Skills, Population Health, and Personal and Professional Development weave through the entire program. Every student will have at least 8 weeks experience in a rural setting and 14 will spend the entire third year in a rural location. By the completion of third year, rural stream students will have covered the same topics of basic medicine, surgery, paediatrics and community medicine/general practice. All students, rural and urban will complete the same assessment at the end of the year. The fourth year will be spent again in Canberra.

A large proportion of the tutors and lecturers are members of our local medical community, and many of them are GPs. All of the PBL tutors have attended a full-day training session to prepare them for this important role in the ANU program. Tutors will meet regularly to debrief, and will have support available on an ongoing basis, through activities such as debriefing meetings, and contact with more experienced tutors as mentors. Local practitioners are also participating in the Medical School program as mentors to students and as Clinical Skills tutors. The ANU Medical School is delighted to have such enthusiastic participation from the medical community and again extends many thanks.

This Issue

Just a sample of what "Canberra Doctor" also reported on in 2006: VMO contracts go to arbitration; safe hours audit of hospital doctors indicates they are still working long and stressful hours; pandemic influenza management plan released for comment; Medical Treatment Act introduced to Legislative Assembly which is designed to protect patients' rights; detention, uncertainty takes toll on the mental health of refugees and AMAs concerns over the new pregnancy counselling Medicare item.

Canberra DOCTOR
Informing the Canberra medical community since 1988
October 2005
Canberra Doctor is proudly brought to you by the ACT AMA

Former ACT AMA President, Professor Peter Herdson has Pathology Museum named in his honour

At a recent ceremony at The Canberra Hospital, Mrs Carol Herdson, widow of the late Professor Peter Herdson unveiled a plaque officially naming the pathology museum at The Canberra Hospital – The Professor Herdson Pathology Museum.

Prof Peter Herdson.

Speaking at the opening, colleague Dr Sanjiv Jain, Director of Anatomical Pathology, said "we remember our Prof, Professor Peter Herdson, with great fondness. Not only we at ACT Pathology but members of the medical community at The Canberra and Calvary hospitals, the ACT Branch of the AMA, the legal community, the judiciary, members of the ACT Police Force and many others remember the very generous, larger than life gregarious personality of Peter Herdson. Peter Herdson was Director of Pathology at ACT Pathology from 1991 to 2005 and his Canberra colleagues were saddened to hear of the passing in late June last year in Auckland.

As Dr Jain remarked, Peter

The Royal College of Pathologists of Australasia presented him with a distinguished fellow award in 2002 for his outstanding contributions to Pathology.

Peter and Carol Herdson arrived in Canberra in July 1991 when Peter took up the position of Professor and Director of ACT Pathology and from December 1994 he was Professor of Pathology, University of Sydney (Canberra Clinical School). Immediately prior to taking up this position, Peter was Professor and Chairman of the Department of Pathology and Laboratory Medicine, the King Faisal Specialist Hospital and Research Centre in Riyadh, Saudi Arabia. After six years there, he and his

Faculty there as Associate Professor Pathology.

Peter was appointed Foundation Professor of Pathology in the University of Auckland School of Medicine in 1969, a position he held until he took up his appointment in Riyadh.

Peter won many awards including the John Malcolm Memorial Prize in Physiology and Biochemistry, University of Otago, Scott Memorial Prize in Anatomy, University of Otago Medical School, Travelling Scholarship in Medicine, University of Otago Medical School, New Zealand Fellowship Bland-Sutton Institute, Middlesex Hospital Medical School, London, Outstanding Teacher of the Year, Northwestern University Medical School Chicago, USA, Professor Emeritus, University of Auckland School of Medicine, Auckland, Honorary Fellowship in the Royal Australian and New Zealand College of Radiologists and Gold Headed Cane, World Association of Societies of Pathology. His last award as a distinguished fellow, from his own Royal Australasian College of Pathologists, brought him great joy and is a measure of the esteem in which his pathology colleagues held him.

Peter was a prolific writer and authored or co-authored 88 papers, six book chapters, two theses and eleven editorials. He sat on several editorial boards, national (NZ and Australian)

Canberra DOCTOR
Informing the Canberra medical community since 1988
March 2006
Canberra Doctor is proudly brought to you by the ACT AMA

GUEST EDITORIAL

This month Professor Paul Gatenby, Dean, College of Medicine and Health Sciences at the The Australian National University writes for Canberra Doctor

Reflections on the Development of the ANU Medical School

Now that the Medical School has just started its first full clini-

Queanbeyan and Young. They are attached to a practice but also spend time in the local hospital, community centres and clinics on offer in each of the towns. On Wednesdays they come together in a number of key sites and join in the tutorials and lectures delivered to the Canberra students. Our information technology linkages appeared to be working reasonably well and the whole program will gradually be expanded as we formally develop a Rural Clinical School. We have recently received funding for this from the Commonwealth Department of Health. Thanks are due to the many staff, both in Canberra and in surrounding south east NSW, who have worked very hard to get this up and running. At any one time these long-term students are joined by those from Canberra on a six week rural rotation. We appear in that way to be using almost every small town in the Canberra region.

Readers may have also noticed considerable building activity at both The Canberra and Calvary Hospital. Both sites have Medical School buildings underway – that at The Canberra Hospital is nearing completion. Funding has been provided by the ACT Government and represents a farsighted investment in the medical workforce of Canberra and the region.

At the end of 2007 our first group of students will graduate. A number will stay in Canberra for their hospital-based training; some will leave and will return to us later for their vocational training. Ultimately, over a period of some years, I believe that the output of the School will come to make up a significant part of the medical workfo

Fundholding not supported by profession

The AMA is concerned at the Australian Division of General Practice's continued assertion that it represents the profession's wishes when it lobbies for the introduction of fundholding in Australia. In a public address and in the medical media, ADGP chief executive, Kate Carnell said the Australian health system requires fundamental change and the solution is not "just about more doctors and more dollars".

The ADGP CEO spoke about expanding fundholding in the primary health care sector both through Divisions and general practices "... every single one of these approaches rely on the Division holding funds and purchasing services .... Divisions have capacity and experience to independently hold funds on behalf of all levels of government...."

AMA President, Dr Mukesh Haikerwal said: "ADGP, funded by the Government, continues to tell Government what it wants to hear and claims to speak on behalf of the profession. There is no evidence that fundholding will improve health care or that it is supported by GPs. Overseas experience clearly demonstrates that fundholding actually has very real weaknesses. A recent document from the Medical Council of New Zealand opens with the line "The rationing of health services is becoming more explicit." The British Medical Journal said of that country's fundholding experience it "has had little effect on clinical outcomes, the shape of secondary care or overall costs". All GPs understand the fact that fee-for-service is the best way to ensure quality health care and should expect their public advocates to strenuously promote and defend their demands."

"The fundholding push from ADGP is about their survival. But with loss of interest and participation by the GPs themselves, it heralds another dismal attempt at self-promotion and detracts from the support desperately needed and usually provided at the local Division level. GPs must continue to watch with wonder at what is being promoted in their name! What are the objectives being pursued and for whom? "

Canberra DOCTOR
Informing the Canberra medical community since 1988
July 2006
Canberra Doctor is proudly brought to you by the ACT AMA

Pharmaceutical brand substitution – AMA surveys GPs

Policies allowing pharmacists to substitute brand name medicines for bioequivalent generic medicines – unless a prescriber actively indicates otherwise – have been in place for more than a decade.

Of concern to the AMA are anecdotal reports that a doctor's prescription directive "Brand Substitution Not Permitted" is being ignored, as well as recent speculation that the Commonwealth is considering policies that would compel doctors to prescribe generic medicines. At the same time, a policy statement on brand substitution, including professional roles and responsibilities, is under development by the Australian Pharmaceutical Advisory Committee.

The results of an AMA fax survey of 386 Australian GPs on brand substitution issues in April 2006 revealed:

- Most GPs do not indiscriminately prevent brand substitution of all their prescriptions, with 80% of doctors surveyed only designating "Brand Substitution Not Permitted" in a minority (one-quarter or less) of patient prescriptions.
- Most GPs decide to disallow substitution on prudent and reasonable grounds, with more than 60% of doctors saying patient safety, patient compliance, and clinical issues were the key factors influencing their decision. Another common consideration was patient requests to stay on a brand name medicine.
- Despite these clinical considerations and advice on scripts, 75% of GPs estimate there have been instances where their prescription has been changed against their advice. Forty per cent of GPs believe this to be happening to up to 1 in 4 scripts marked "Brand Substitution Not Permitted".
- 15% of GPs reported that they had only found out about the medicines change because their patient had an adverse reaction as a result.
- The most common way a GP discovered their script had been changed was through their patients -at their next consultation or when seeking another prescription (68%), or when patients contacted them for advice on the substitution (43%). About 16% of GPs reported that a pharmacist had contacted them about the substitution.
- Discovery of "double-dosing" by patients was another common issue raised by GPs, as well as increased patient confusion due to multiple generic substitutions.
- A majority of GPs (77%) were either somewhat or very concerned about the effect of their scripts being substituted, without consultation or advice, on their patients' health care management.

Background

Commonwealth policies that allow pharmacists to substitute brand name medicines for bioequivalent generic medicines -unless a prescriber actively indicates otherwise -have been in place since 1 December 1994. Since the 1980s the AMA has had formal policies opposing the substitution of medicines without the prescribing doctor' s permission, as well as any compulsion on doctors to prescribe generically (policies 44/84 and 45/84).

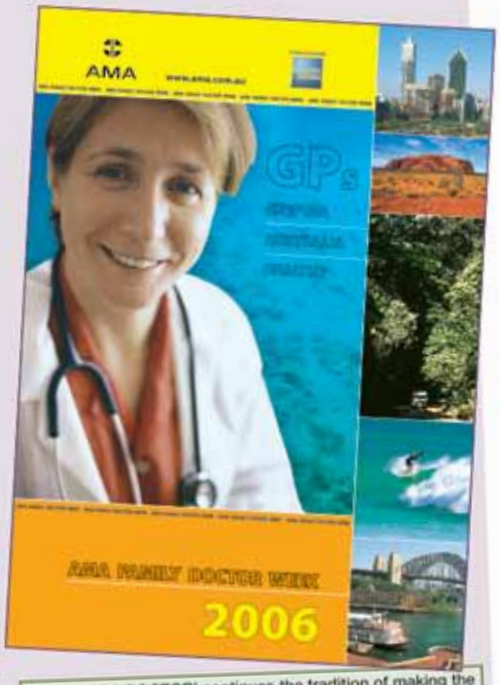
The AMA recently received anecdotal reports that substitution is occurring even when the "Brand Substitution Not Permitted" box has been ticked by GPs on PBS prescriptions. At the same time, it was reported in March 2006 that the Commonwealth was considering PBS cost-saving proposals that would give subsidy preference to one medicine in a class, probably a generic medicine. The AMA warned that such a move effectively amounted to compulsion on doctors to prescribe a generic medicine based on a patient' s financial -rather than medical -circumstances.

More recently, some media reports suggested that doctors are denying patients access to generic medicines because of the influence of pharmaceutical marketing, following the Australian Competition and Consumer Commission's announcement that it proposes to re-authorise the code governing the pharmaceutical industry' s dealings with doctors.

To gauge the extent of brand substitution, its impact and doctors' views, the AMA sent a fax survey to 1,508 privately practising GPs in April, to which 386 doctors replied (a response rate of 25.6%).

In the context of the results throughout the survey, the higher levels of GP concern appear to be strongly linked to the need for consultation rather than a blanket rejection of the notion of generic substitution.

A full copy of the survey report is available on request.



'CANBERRA DOCTOR' continues the tradition of making the July edition a special one to celebrate Family Doctor Week and our GPs.

As usual we have sought contributions from a number of GPs and you will notice again the diversity of views and talents which make up our general practice workforce.

'CANBERRA DOCTOR' committee hopes you enjoy this special edition and in particular the Directory of Specialists contained within it. This is provided by the ACT AMA to our local GPs as a service to the medical community.


Canberra DOCTOR
Informing the Canberra medical community since 1988
May 2007
Canberra Doctor is proudly brought to you by the ACT AMA

Electronic Medicare claiming:

- Further to our earlier reports and ahead of the seminar series for GPs and specialists, the following short Q&As of the new Medicare Easyclaim are provided.
- Don't forget the seminars are being held on Wednesday 6 June and Thursday 7 June commencing at 7.00 pm and concluding by 8.00 pm at the Theatre in the Calvary John James Clinical Services Building on Strickland Crescent, Deakin. You are invited to attend along with your key practice staff.
- As light refreshments will be available from 6.30 pm. RSVP is essential for catering purposes. Please phone Linda on 670 5410 or email her on reception@ama-act.com.au if you would like to attend.

Just in case you missed the earlier information:

Medicare Easyclaim is fast, easy and convenient:

Bulk bill claims lodged using electronic Medicare claiming will require much less paperwork – no more batching or storing claims. The assigned patient rebate will be paid into your nominated bank account, usually on the next working day. Medicare Easyclaim will also provide instant confirmation of a patients concessional entitlement status.

Your **paying patients** can pay their account as they do now – by cash, EFTPOS, cheque or credit card. After they have paid their account, their Medicare claim can be lodged over the EFTPOS network and their rebate will be paid into their bank account, almost immediately.

If you have **patients who take an account**, you can swipe their Medicare card and lodge their claim to speed up the process of getting your "pay doctor via claimant" cheque.

Current legislation prohibiting gap payments remains in force and the new system does not alter compliance with this legislation.

Medicare Easyclaim—your questions answered (information supplied by Medicare)

Independent research conducted for Medicare Australia shows that 84% of patients surveyed (who normally pay their doctor) said they'd use the new Medicare Easyclaim system when it rolls out in the second half of this year.

Over the past few months our Business Development Officers have been speaking to hundreds of ACT practices about this new system, called Medicare Easyclaim. Here are answers to some of the common questions:

Does my practice need to install new equipment?

No – Medicare Easyclaim uses the current EFTPOS terminal already in many ACT practices. As a result, practice staff will only need minimal training in how to use this new claiming channel. Ask your bank if they will be offering Medicare Easyclaim through their terminals. We are aware that the Commonwealth and National Australia Banks are offering Medicare Easyclaim and Tyro Payments, a new provider of EFTPOS services, will be delivering a fully integrated practice management software Medicare Easyclaim solution. Some practices, through Medicare information sessions, have asked if they will need a second EFTPOS terminal. This is a matter for the practice, and depends on how the practice runs and which claiming solutions are in place.

What's the difference between Medicare Easyclaim and the online claiming channel (previously known as HIC Online)?

Medicare Easyclaim is simply another claiming channel for practices to choose from. If you currently use online claiming, you might decide to keep using it for lodging some types of claims, and choose Medicare Easyclaim for other types. It depends which works best for your patients and your practice. Nationally, over 6,000 practices use online claiming and around 1,800 of those use it for patient claims. You can choose to use online claiming for patient claiming instead of Medicare Easyclaim, if this suits you better.

What happens if a claim is rejected?

Claims lodged through Medicare Easyclaim are assessed instantly, so if a claim is rejected the EFTPOS terminal prints a receipt with a code that explains why. Patients can then contact Medicare Australia and, if necessary, lodge a paper-based claim themselves.

Will traditional patient claiming methods stay?

Yes – patients will still be able to claim by sending forms to Medicare or through one of the 238 Medicare offices around Australia, which will all remain open. Medicare Easyclaim gives


Canberra DOCTOR
Informing the Canberra medical community since 1988
Best State AMA Publication 2007
October 2007
Canberra Doctor is proudly brought to you by the ACT AMA

AMA ACT meets with doctors in training

Pizza Lunch hosts Drs Simon Cooke and Barry Zeman with AMA ACT Industrial Officer Andy Ozolins and Chair of AMA Council of Doctors in Training, Alex Markwell.

The AMA ACT recently met with doctors in training from The Canberra Hospital over lunch to discuss matters of concern. Also attending the lunch, which was hosted by AMA Branch Councillor representing doctors in training, Dr Harry Eeman, was Dr Alex Markwell, a doctor in training from Queensland. Dr Markwell chairs the AMA's Council of Doctors in Training and represents them on the AMA Federal Council. The AMA Federal Council is the peak governance body for the AMA.

Dr Markwell was in Canberra for the meeting of the AMA Council of Doctors in Training (AMA CDT) that was also attended by Dr Eeman.

Included on the agenda as items for discussion were:

- Draft position statement for standards for community placements
- Australian and New Zealand Medical Education and Training
- Core terms for internship
- Training block
- Networked physician training and the psychiatry training program
- DEST medical education study
- Medical Training Review Panel.
- Bonded medical places
- Prevocational general practice placements program
- Infrastructure and resources for clinical teaching
- Medical training in alternative settings
- Surgical education and training (SET) program
- Physician Assistant
- Nurse practitioners
- Role substitution
- NSW Hospitalist proposal – among others.

The recent meeting of the AMA ACTs DiT Forum, chaired by Dr Eeeman, discussed industrial representation of the doctors in training for the next Certified Agreement and more on this will be reported in a forthcoming edition of "Canberra Doctor". Doctors in training should note that through the AMA a number of workplace issues of concern to individual doctors are being progressed internally and externally and doctors in training are reminded that they have access to the AMA's industrial officer, Andy Ozolins and Executive officer, Christine Brill by phoning 02 6270 5410. Membership of the Forum is open to all doctor in training AMA members and interested hospital based doctors should contact Christine Brill for further details. The Forum meets approximately four times a year.

The meeting of the AMACDT joined a meeting of the AMA Coordinating Committee of Salaried Doctors for discussion of matters of concern for hospital based medical practitioners.

"In 2007, "Canberra Doctor" also reported on: electronic Medicare claiming; Royal Canberra Hospital commemorative site unveiled; national medical registration mooted; AMA offers training courses for medical practice staff to add value to membership; level of informed financial consent by doctors survey by Health Minister Abbott; AMA warns of "healthy" food labels danger

Canberra DOCTOR

A News Magazine for all Doctors in the Canberra Region

ISSN 13118X25

Published by the Australian Medical Association (ACT) Limited
42 Macquarie St Barton
(PO Box 560, Curtin ACT 2605)

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

Typesetting:
Design Graphix
Ph 0410 080 619

Advertising:
Ph 6270 5410, Fax 6273 0455
execofficer@ama-act.com.au

Copy is preferred by Email to editorial@ama-act.com.au or on disk in IBM "Microsoft Word" or RTF format, with graphics in TIFF, EPS or JPEG format. Next edition of *Canberra Doctor* – September 2013.


Canberra DOCTOR
Informing the Canberra medical community since 1988
Best State AMA Publication 2007
March 2008
Canberra Doctor is proudly brought to you by the AMA ACT

ACT Health welcomes AMA ACT submission of salaried members' workplace concerns

In a recent submission to ACT Health, the AMA ACT has informed ACT Health of the concerns of its members in relation to workplace conditions. This has been forwarded for consideration as part of the current Certified Agreement discussions being held between the union and the Department.

AMA ACT members have expressed concern at conditions being behind those of other States and the AMA has listened to these concerns and, in order for ACT Health to be able to both recruit and retain JMOs particularly, the AMA ACT has unashamedly "cherry picked" from other State industrial instruments and has put these to government as its recommended "gold standard" of conditions to be adopted.

Acceptance of these issues will contribute positively to junior medical officer recruitment and retention, the AMA and its JMO members believe. Both parties seek a JMO friendly workplace, and the current agreement does not provide that. Some of the other matters relate very much to safety for both patients and doctors whilst others address equity and equality matters.

The AMA is of the view that unless these issues are addressed, it will be increasingly difficult in the current environment of international and national workforce shortages for the ACT to be considered as the "destination of choice" for highly skilled medical practitioners. Equally, it is argued that unless these matters are addressed, it will be difficult for ACT Health to be regarded as "employer of choice" in the same tight labour market.

The AMA has detailed these and other issues in its submission and members have been provided with a copy of the submission and its covering letter. Any affected member who has not yet been provided with a copy should contact AMA industrial officer, Mr Andy Ozolins. An invitation is extended to members who wish to raise further issues, or have any queries regarding the submission, to contact Mr Ozolins on 6270 5410 or by email to: industrial@ama-act.com.au.

The following is a summary of some of the issues provided to ACT Health in the submission:

- The new Certified Agreement should be a comprehensive agreement combining conditions and entitlements currently in the Award, Certified Agreement, Public Sector Management Act and Public Sector Management Standards with removal of reference to any and all New South Wales Industrial Instruments.
- Secondment conditions for Junior Medical Officers must be included in the agreement.
- Interns should not be rostered for night/relief duty.
- Remove the provision for the employer to subsume payment of On-Call Allowance if a Junior Medical Officer is recalled to duty whilst On-Call. On-call rosters should be no more than one in three.
- A Junior Medical Officer should be entitled to a paid thirty minute rest break within each rostered period of duty. If a period of duty exceeds ten hours, the Junior Medical Officer to be entitled to a second paid rest break of thirty minutes.
- Leave entitlements to be guaranteed for Junior Medical Officers. Although Junior Medical Officers apply annually for training positions they should be treated as permanent employees for all leave purposes, including long service leave and maternity leave.
- Independent Private Medical Indemnity Insurance for all Medical Officers to be paid for by ACT Health.
- Increase Junior Medical Officer paid maternity leave entitlement from 9 weeks full pay or 18 weeks half pay to 14 weeks full pay or 28 weeks half pay and increase Junior Medical Officer annual leave entitlements from 4 weeks to 5 weeks to reflect the entitlements for their more senior colleagues.
- Medical Officer annual leave should be approved if three or more months notice is given. The onus must be on management to provide replacements. Management should advise the medical officer of the outcome of an annual leave application within two weeks of the application being submitted.
- Applications to take a single day of ADO leave should be approved. Applications for more than one day of accumulated ADO leave should be treated in the same manner as applications for annual leave.
- Junior Medical Officer shift penalty entitlements
- Allowance per annum.

It will be some time yet before the so-called tsunami of

In 2008 "Canberra Doctor" reported that new graduate, Christopher Gilbert won the AMA student prize for leadership; workplace bullying of junior doctors from a report in the NZ Medical Journal; our first winner of the "Art In Butt Out" competition was announced; new registration requirements for practitioners visiting NSW. For more information on the 2008 "Canberra Doctor" editions, email Sue Massey at membership@ama-act.com.au


Canberra DOCTOR
Informing the Canberra medical community since 1988
November/ December 2009
Canberra Doctor is proudly brought to you by the AMA (ACT) Limited
Serving the medical community for 21 years

Calvary public hospital and Clare Holland House sale?

Although somewhat dwarfed by ACT Government's capital development plans for the TCH campus, its current proposals to acquire Calvary Public Hospital and sell Clare Holland House have raised a disproportionately greater public outcry, writes Ian Pryor, chair of the Canberra Doctor editorial committee.

Because of the importance of the issue to doctors, Canberra Doctor has canvassed and published a considerable range of views from key players which include the ACT Health Minister Katie Gallagher, The Opposition Shadow Minister Jeremy Hanson, The Greens Health Spokesperson Amanda Bresnan, the ANF Secretary Jenny Munguya, Archbishop of Canberra and Goulburn the Most Reverend Mark Coleridge and the Palliative Care Society President David Lawrence and Walter Kmiet, Director of public hospitals within Little Company of Mary Health Care.

In many respects these well-expressed statements do not need further commentary. However a number of the matters raise further issues so I will take the liberty of offering Editorial comment.

Firstly, I do not have a predetermined view on the matter, although I admit that I find it to be a fascinating exercise from so many viewpoints. It is a credit to the Canberra community that it is able to have open dialogue without avoiding important social, political and religious aspects of the debate.

It is clear that, for the Government's health agenda, there are potentially many synergies which can be anticipated by bringing Calvary Public under the same umbrella as the rest of the ACT public hospital services. The Government has made statements to the effect that it is committed to keeping the essence of Calvary the same as it is currently, however, one can only assume that in making promises to spend an extra $200 million on the site, there are real changes envisaged for its further development so that it will augment the TCH conglomerate. A clarification of the plans for this future expenditure would in all probability ease the concern of many and make it more apparent how the community will gain benefit.

It has to be said that the community holds Calvary and its services in high esteem and the assumption that unifying it within the ACT health portfolio will de facto lead to the best health outcomes needs greater examination and argument particularly when comparing with the option of a new agreement of service and funding with the Little Company of Mary. Of course these considerations will have been examined but it is hard for the community to get behind the Government's proposal without some fleshing out of this scenario.

Like most doctors, my financial and accounting skills are not well honed, however I do have concerns about the dollars. Whilst $77 million seems little enough compared with say the cost of building National Capital Private Hospital some years ago, when one considers the $1,400 million ticket for upgrading and modernising TCH one might wish to ask whether a completely new hospital would be a better venture than purchasing and refurbishing the now ageing Calvary public hospital complex. No doubt this also has been modelled in detail and should be part of the open discussion.

Clearly there are differing opinions amongst prominent economic experts which have been expressed regarding the economic implications of purchasing Calvary compared with the alternatives. Such widely differing estimates of financial impact are so often with us when considering major capital outlays but they also add to the uncertainty of opting for change versus the status quo and somehow need to be addressed.

One of the more intriguing aspects of the whole matter is the complementary and apparently deal-breaking sale of Clare Holland House to the Little Company of Mary. This part of the deal has animated discussion at least as much as the Calvary proposal itself. In essence, it would appear that Canberrans consider the Hospice to be a great community asset which meets their needs so compassionately and well in its current form, that there is no compelling argument for transferring its ownership and long term management. The valuation of the site and facility and future possible development of the site probably warrants further public discussion also.

There are many other issues relating to the sales, many of which are conjecture or unresolvable and ultimately come down to personal weighting of the pros and cons. With the Catholic Church itself having to deal with assessing both the relevant economic and commercial factors and the Church's own mission, it is not surprising that Canberrans generally find the debate stimulating and emotive, particularly as it is likely to effect their own and their families' health care and as taxpayers, their pockets.

Governments and Ministers should not have free reign on such major decisions as these and the public consultation processes should be allowed to be comprehensive, honest and transparent. At the end of the day, however, as a community we have to trust our elected representatives to conscientiously look after our interests after having heard us out.

More stories inside...

Read what they say about the sale!

In 2009, stories covered included: health doctors = better medicine writes President Dr Andrew Pesce; National Health and Hospital Reform Commission Final Report released; Dr Peter Sharp, Medical Director at Winnunga Nimmityjah wins AMA award of excellence in health care; and the inventiveness of the Comma GP Dr Hamish Steiner and his emergency alarm system.

Your complimentary copy of the 2013 Specialist Directory

CANBERRA GPs

A complimentary copy of the 2013 Specialist Directory has been distributed to all Canberra GPs. If you have not received your copy, please contact Sue Massey on 6270 5410 and one will be mailed to you.

HOSPITAL BASED DOCTORS-IN-TRAINING

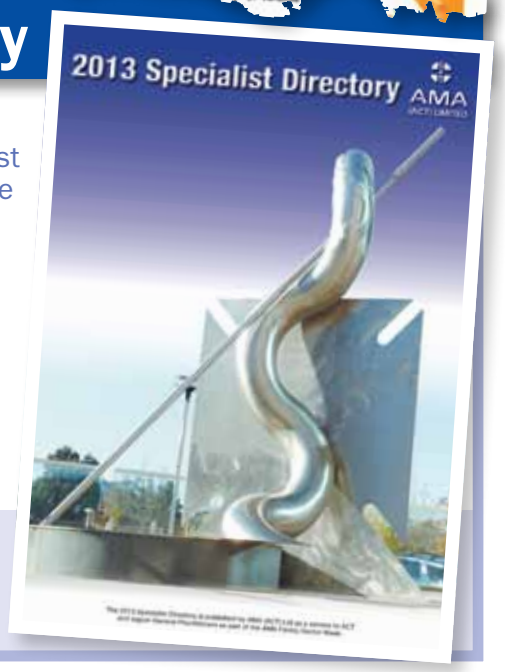
A complimentary pocket-sized edition of the specialist directory is available for AMA members. If you have not received your copy, please contact Sue Massey on 6270 5410 and one will be mailed to you.

GP REGISTRARS

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


Canberra DOCTOR
Informing the Canberra medical community since 1988
June 2010
Canberra Doctor is proudly brought to you by the AMA (ACT) Limited

Guest editorial: "Our hospital system viewed from the bottom: an intern's experience" by Dr Tom Ward

A very wise professor named Nick Treferhan, FRS, once offered some frank commentary on the rather idiosyncratic workings of Oxford University, soon after moving there from MIT. To paraphrase, he said that there was a small window of opportunity to see an organisation for what it is before forgetting what life was like before. In this spirit, I would like to share a number of insights during my transition from management consultant to medical student and now junior doctor working in a public hospital. These are best categorised as lessons that we should learn from the corporate world and lessons that medicine is under pressure to adopt, but ones that would be to the detriment of our patients and our profession.

First, let me clarify what my former role as a management consultant entailed. Often without vast experience of a particular industry, management consultants offer new perspectives about problems faced by businesses and governments. This can be genuinely valuable, often when a dysfunctional organisation is unable to clearly articulate a strategy or make difficult but necessary decisions. However, sometimes this approach simply repackages already well known solutions, or worse, may suggest things that are impractical and naive. Nevertheless, as a management consultant, one is exposed to the inner workings of many organisations and is in a good position to compare them.

If I were to compare the running of our health system with the average corporate entity, the most striking operational deficiency is our medieval use of information technology. There have been recent improvements with electronic imaging, but as an intern an enormous amount of time is spent filling in paper forms, scribbling semi-legible notes in paper folders, looking for these paper folders when they are lost, and trying to decipher the barely legible instructions of registrars or the totally illegible scratching of consultants. Furthermore, every time we see a patient in the emergency department, they are asked the same questions numerous times, by numerous people. The redundancy, wasted time and the potential for error are simply unacceptable in an age when people can often type faster than they write, and when electronic information is far more robust and accessible than information on paper. Medicine needs to become completely paperless. If noodle restaurants can have computers at the end of each table, hospitals can have computers at the end of each bed.

There are some aspects of the corporate world which medicine should continue to resist. The dedication and professional ethic in medicine are very strong, and a shift towards a more 'business-like' approach risks undermining this culture. Every day, I see doctors making decisions which are genuinely in the best interests of their patients, albeit within the resource constraints of the public health system. While many companies try to adhere to ethical standards, it is harder to achieve in the corporate world. As per their mandate, corporate decisions are generally made to maximise profitability within the limits imposed by the legal system. Given this, I feel that moves towards rebranding patients as 'customers', 'clients' or 'consumers' in the hope of engendering a more 'efficient' or 'responsive' approach, reflects a misguided trend. Viewing medicine as a business cheapens our profession and risks compromising the [illegible] between doctors and [illegible]. As doctors our challenge is twofold: to embrace complexities. As doctors our challenge is twofold: to embrace

GPs call for health iden

General practice representative groups joined forces recently to push for the Healthcare Identifiers Bill 2010 to be passed.

Members of United General Practice Australia (UGPA) – the Rural Doctors Association of Australia, the Australian General Practice Network, The Australian Medical Association, the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine a[illegible]

"Canberra Doctor" also reported on: health reform agreement and LHNs; more beds, more surgeries, more security said Chief Minister, Jon Stanhope on signing up to Health reforms by COAG; priority access to treatment for heart attack victims; anaphylaxis e-training courses for scholls and children launched; sale of Calvary Hospital not to proceed and smoking to be banned in outdoor eating and drinking areas.


Canberra DOCTOR
Informing the Canberra medical community since 1988
November 2010
Canberra Doctor is proudly brought to you by the AMA (ACT) Limited

New graduate wins AMA leadership prize

At the recent Graduation Ball, Dr Iain Dunlop, President of the AMA ACT awarded the 2010 Prize for Leadership to final year student, Mr Steve Peterson.

In nominating Steve, his student colleagues reported on his ability to organise events particularly the "Big Issues" and "Life after Graduation" fora for the medical students – events that had not been offered previously. He was also instrumental in the production of the first ever ANUMS "Year Book".

His colleagues remarked on his ability to manage his academic studies, his social life, and his community and volunteering activities. He was able to motivate his student colleagues to participate in the community and volunteering activities as well as provide personal support when needed.

Steve's enthusiasm and drive were also remarked on and his engagement in many committees attested to this. Steve has also been involved with AMSA (Australian Medical Students Association) as a delegate to the National Leadership and Development Seminar in 2008 and the Global Health Conference in 2009.

Dr Dunlop remarked that all the finalists were worthy of recognition for their leadership qualities and presented certificates to: David Corbet, Nadia Guerin, Alicia Paul and Sarah Golding.

At an afternoon tea held recently to celebrate their graduation, Dr Dunlop wished the graduates well as they embark on their intern year and their future careers in medicine. The afternoon tea was sponsored by the AMA ACT, MDA National, Doctors Health Fund and Medic Onecall.

More pictures - page 3

Canberra DOCTOR
Winner of the Best AMA State Publication - 2011
Informing the Canberra medical community since 1988
October 2011
Canberra Doctor is proudly brought to you by the AMA (ACT) Limited
Circulation: 1,900 in ACT & region

The ACT Workplace Privacy Act 2011 – what you need to know about surveillance in the workplace

On 16 February 2011, the ACT Legislative Assembly passed the Workplace Privacy Act 2011.

The object of the Act is to regulate the collection and use of workplace surveillance information.

Parts 3 and 4 of the Act, dealing with notified and covert surveillance, commenced on 24 August 2011.

Some of the new requirements that are in force deal with prohibited surveillance. These include banning surveillance in prohibited non-work areas or surveillance of workers if they are not in a workplace.

What is prohibited surveillance?

The Act prohibits an employer from conducting surveillance of a worker in a prohibited non-work area. These areas are:

(a) a toilet facility;
(b) a change room;
(c) a shower or other bathing facility;
(d) a parent or nursing room;
(e) a prayer room;
(f) a sick bay;
(g) a first-aid room;
(h) any other area in a workplace prescribed by regulation

Can employers conduct surveillance of workers while they are not at work?

The Act provides that it is an offence for an employer to conduct surveillance of a worker if the worker is not in a workplace. The maximum penalty for this offence is 50 penalty points.

This offence does not apply where the employer is conducting surveillance of:

- The worker's use of equipment or resources provided by the employer (and this is undertaken using a data surveillance device)
- The worker using a tracking device that cannot be deactivated
- A worker where the employer is a law enforcement agency

Offences regarding failure to protect surveillance records

Section 44 provides that an employer commits an offence if the employer fails to take reasonable steps to protect surveillance records from misuse, loss or unauthorised access or disclosure.

Employers also commit an offence if they fail to destroy or permanently de-identify a record after the Act provides that it is no longer needed.

Primary requirements for notified surveillance

Section 13 of the Act states that an employer may only conduct surveillance of a worker in a workplace if the employer gives written notice to the worker and the surveillance is conducted in accordance with the notice. This notice must be given to the worker at least 14 days before the surveillance starts or a shorter period if agreed by the worker. For new workers, the notice must be given before the worker commences work.

Notice of surveillance must include

The notice must include the following:

- The kind of surveillance device to be used for the surveillance
- How the surveillance will be conducted
- Who will generally be the subject of the surveillance
- When the surveillance will start
- Whether the surveillance will be continuous or intermittent
- Whether the surveillance will be for a stated period or ongoing
- The purpose for which the employer may use or disclose the records of the surveillance

- That the worker may consult with the employer about the conduct of the surveillance.

This notice may be in the form of a policy of the employer or otherwise.

There may be additional requirements discussed below for specific types of surveillance.

Circumstances when an employer need not give the notice of surveillance

Section 13 of the Act provides that an employer doesn't need to give the written notice for surveillance using an optical surveillance device in a workplace if the workplace is not a usual workplace of the worker.

Need to consult with workers about the conduct of surveillance

Section 14 requires the employer to consult with the worker in good faith about the conduct of the surveillance. This means that the worker must be given a genuine opportunity to influence the conduct of the surveillance.

Additional requirements for optical surveillance

An optical surveillance device, such as a camera, can only be used for surveillance of a worker if the device is clearly visible where the surveillance is conducted and a sign is visible at each entrance to the workplace advising people that they may be under surveillance.

Additional requirements for data surveillance

An employer may only conduct surveillance using a data surveillance device if this is in accordance with the policy and the worker has been notified prior to conducting the surveillance of the policy and that the worker can understand the policy. The policy must state:

(a) how the employer's computer resources may or cannot be used; and
(b) what information about the use of the employer's computer is logged and who may access the logged information; and
(c) how the employer may monitor and audit a worker's compliance with the policy.

Additional requirements for tracking devices

An employer may only track a vehicle or other thing if there is a notice on the vehicle or other thing stating that it is being tracked.

Offences for employers in regard to surveillance

The Act provides that an employer commits an offence if they are required to notify a worker or surveillance under Section 13 of the Act and they fail to comply with the requirements in Section 13. The maximum penalty for this offence is 20 penalty units.

surveillance without complying with the specific requirements for these types of surveillance.

What can an employer use the surveillance records for?

Section 22 of the Act provides that an employer commits an offence if they conduct surveillance of a worker and then use a record of this surveillance to take action against the worker. This offence does not apply if the worker has been given notice under Section 13 that the surveillance may be used to take action against the worker.

Access to surveillance records by workers

An employer must give workers access to surveillance records that relate to them, if they have received a written request. An employer who fails to allow access cannot generally use the records in a legal proceed against the worker or to take adverse action against a worker. (there are some exemptions to the rule set out in the Act, such as frivolous applications by a worker).

Covert surveillance

The Act provides that an employer may apply to the Magistrates Court for the authority to conduct covert surveillance of a worker in the workplace for the purpose of finding out if the worker is carrying out unlawful activity in the workplace.

The Act sets out the things the Magistrates Court must consider before permitting covert surveillance and sets out strict requirements for permitted covert surveillance.

Disclaimer: The above is intended as a basic guide to the Act and it is not legal advice. Members are advised to seek independent legal advice. The material above has been taken from ACT Government

"Canberra Doctor" also reported on: health reform agreement and LHNs; more beds, more surgeries, more security said Chief Minister, Jon Stanhope on signing up to Health reforms by COAG; priority access to treatment for heart attack victims; anaphylaxis e-training courses for scholls and children launched; sale of Calvary Hospital not to proceed and smoking to be banned in outdoor eating and drinking areas.

Want to read more?
Email membership@ama-act.com.au with the name of the story you wish to read and the year we ran it and Sue Massey will email it to you.

Canberra DOCTOR
Winner of the Best AMA State Publication - 2011
Informing the Canberra medical community since 1988
March 2012
Canberra Doctor is proudly brought to you by the AMA (ACT) Limited
Circulation: 1,900 in ACT & region

Busier health services, improved access to care, but still more to do

Dr Peggy Brown, Director-General of the Health Directorate, ACT Government, shares the achievements of the ACT's public health services with readers of the Canberra Doctor, and lists the biggest challenges facing the system into the future.

Dr Peggy Brown.

Four years ago, the ACT Government established its ambitious overhaul of our public health facilities to ensure that our public hospitals and community health centres can meet the needs of our community well into the future.

Some of the first fruits of this program are about to be opened, others are on the way, and the process for designing and building our new tower block on the Canberra Hospital campus has commenced.

The new adult mental health inpatient unit will open soon. It will provide a significantly improved environment for staff, patients and carers. Our new Women and Children's Hospital will take its first patients in the middle of this year, and the Gungahlin Community Health Centre will open its doors in September 2012.

Work has also commenced on building our new enhanced community health centre at Belconnen. This new centre will provide more complex services than have been traditionally available at community centres, with the possibility of expanding to include services such as haemodialysis. The provision of care in the least acute environment appropriate to a condition is one of the objectives on which our infrastructure program is based.

All of this busy building work will have some short term impacts on the way our services are provided. But the end result will provide the ACT with hospital and health services that are more patient friendly, work better for staff and provide the community with a return on their investment.

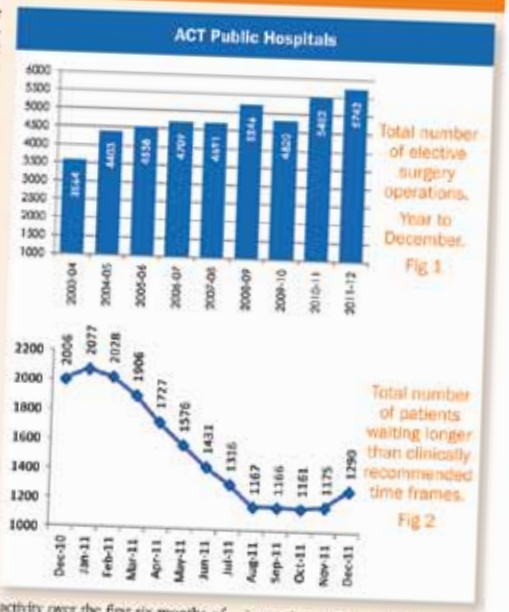
The underlying principle for the development of our new infrastructure is improvement in patient care. Most of our public health facilities were built in the 1970s and 80s. They were built for the way health services were provided a generation ago. They do not have the flexibility needed to adapt to different ways of providing care.

Our new buildings will not only meet the needs that we can predict for the next decade and beyond, but will also have the capacity to adapt to new ways of providing high quality care.

The new facilities are, of course, only part of the delivery of effective and efficient health services. In our public health services we continually review the way we provide services, and make changes to models of care to further improve health outcomes for our community.

Over the past few years, the efforts of those within the ACT public health system have made considerable improvements to the way people access services in the ACT. Waiting times for elective surgery have improved and the numbers waiting for surgery have decreased.

We posted a new record in terms of access to elective surgery in the 2010-11 financial year, with 11,336 patients going through our operating theatres. We expect to match this level in 2011-12, with



activity over the first six months of this financial year above the total for the same period in 2010-11 (Fig 1). This additional activity is resulting in improvements in waiting times, with the number of people waiting beyond standard waiting times reduced 36 percent from December 2010 (2,006 long waits) to December 2011 (1,290 long waits).

...Continued page 3.

OFFICE SPACE
TO LET

37 Geils Court, Deakin West
222 metres,
first floor office suite.
Fitted out as one or two units.
$330/metre ex GST
Phone Maria: 6282 1783

VRGP

full time/part time needed for very busy computerised modern practice. Flexible hours and full time nurse on site. No A/Hrs and good conditions to right candidate.

Phone Jamison Medical & Skin Cancer Clinic – 6251 2300
www.jamisonmedicalclinic.com.au

To Advertise in Canberra Doctor
email
execofficer@
ama-act.com.au

Dr Julie Kidd
GP Hypnotherapist

Smoking, alcohol, binge-eating, stress, anxiety etc.

Canberra Complementary Health Practice
Suite 4, Playoust Bldg, Hawker Pl, Hawker
0425 300 233 | www.canberrahypnosis.com.au

AGEING WELL CLINIC

Dr Sue Richardson
Consultant Physician in Geriatric Medicine

Emphasis on Healthy Ageing

Other areas of interest:
- Cognitive Impairment/Dementia
- Medication Management
- Falls

Geriatric Medicine Comprehensive Assessment & Management Reports as well as Consultant Physician Patient Treatment & Management Plans provided which can be incorporated into GP & Team Care Management Plans

Residential Aged Care Facility & Private Hospital Consultations provided.

Veterans Welcome

Unit 10,
Brindabella Specialist Centre
Dann Close, Garran ACT

APPOINTMENTS 02 6285 1409

Capital Respiratory & Sleep Service

Dr Peter Jones
M.B.B.S.(Hons), F.R.A.C.P.
Respiratory & Sleep Physician

Specialist consultation service
Home based sleep studies (bulk billed)
In-lab sleep studies (bulk billed)
Complex lung function testing
Bronchial provocation testing
Bronchoscopy

3/18 Bentham Street,
Yarralumla ACT 2600
P: 6260 3663 F: 6260 3662
www.canberrasleep.com

COMPLETE WOMEN'S HEALTH

Dr Omar Adham
~ Obstetrician ~ Gynaecologist
~ Gynaecology Endoscopic Surgeon

Complete women's health is guided at all times by the values of compassion and respect for the dignity of every patient. Our mission is to care for the mind, the body and spirit of each client.

~ Obstetric Care
~ Pelvic Pain & Endometriosis
~ Prolapse & Incontinence

Correspondence:
Suite 3-7, John James Medical Centre
175 Strickland Crescent
Deakin ACT 2600
T: 02 6282 2033
F: 02 6282 2306
www.completewomenshealth.com.au
dradham@completewomenshealth.com.au

GCA GYNAECOLOGY CENTRES AUSTRALIA

Canberra Gosford Wollongong Newcastle Sydney

Pregnancy Termination
Medical & Surgical

- Private & individual treatment
- Consultation, ultrasound & counselling prior to the termination
- Approx 2 hour visit for surgical termination
- Medical termination available for early pregnancy only
- 24 hours on call advice
- IUD insertion with sedation or under local anaesthetic 4-8 weeks post TOP
- D&C for incomplete miscarriage, foetal demise

All Hours: 6299 5559
www.gcaus.com.au

WOMEN'S HEALTH on STRICKLAND

Dr Elizabeth Gallagher
and
Dr Omar Adham

offer a comprehensive obstetric and gynaecology practice, including high risk obstetrics, advanced laparoscopy, endometriosis, pelvic floor reconstruction, incontinence, urodynamics and colposcopy

from **Suites 3-7 John James Medical Centre**
175 Strickland Crescent, DEAKIN ACT 2600
Phone 02 6282 2033 Fax 02 282 2306

Additional services include: physiotherapy (**Marita O'Shea**) who specialises in pelvic floor and incontinence treatment, antenatal and post natal musculoskeletal problems, post natal pelvic floor assessments and nutrition (Dietitian (**Lyndall Hayes**) who has special interests in pre-pregnancy and pregnancy focused nutrition, healthy eating for weight loss or to improve general health, PCOs and management of gestational diabetes

---

Dr Colin Andrews, Neurologist

is pleased to offer same week assessment for first seizure.

This will involve an EEG followed by a consultation.

The advantages of this service are as follows:

1. Higher yield of abnormality on the EEG soon after a seizure.
2. Reduction of risk of subsequent seizure.
3. Reduced anxiety and better compliance with the management plan.

Suite A8
Canberra Specialist Centre
161 Strickland Crescent
DEAKIN ACT 2600
Telephone: (02) 6282 4807
Facsimile: (02) 6285 3609

Eyelid Surgery • Thyroid Eye Disease
Periocular and Orbital Tumours
Endonasal Lacrimal Surgery

Committed to timely and effective care for your patients

Consulting and operating weekly

Dr Angelo Tsirbas

Over 30 years of combined Specialist experience

Dr Benjamin Burt

Canberra Oculoplastics

Capital Specialist Centre
Suite 9, 3 Sydney Ave
Barton ACT 2600
Phone: 1300 37 87 47
Fax: 02 8362 9441

Dr. A-J Collins MB BS FRACS
Breast and Thyroid Surgeon

Oncoplastic Breast Surgery – including:
- Immediate breast reconstruction and breast reduction techniques
- Breast Cancer surgery
- Sentinel node biopsy

Thyroid and Parathyroid surgery

Address: **Suite 3,**
National Capital Private Hospital
Phone: **02 6222 6607**
Fax: **02 6222 6663**

CANBERRA LASER AND GYNAECOLOGY CENTRE

colposcopy & laser endoscopic surgery specialist gynaecology treatment of prolapse and incontinence

Dr. P.M.V. Mutton
MBBS, FRCOG, FRANZCOG

for prompt, personalised and experienced care

6273 3102

39 GREY STREET DEAKIN ACT 2600
FAX 6273 3002

CAPITAL WOMEN'S HEALTH
Caring for You

Dr Tween Low
Gynaecologist Infertility Specialist

Dr Omar Gailani
Obstetrician and Gynaecologist
Urodynamics and pelvic surgery

Canberra Fetal Assessment Centre
Gynaecological Imaging

Capital Women's Health in Deakin provides a complete and unique specialist service to women in Canberra and the surrounding region. Dr Tween Low provides expert gynaecology and infertility treatment; Canberra Fetal Assessment Centre provides complex obstetrics and gynaecology ultrasound with Dr Ken Tan specialising in high risk obstetrics; and Dr Omar Gailani provides specialist private obstetrics care, urogynaecology service and affordable urodynamic study.

21 Napier Close DEAKIN ACT 2600
P: 02 6162 1649 F: 02 6162 1659
hello@cwhealth.com.au

We fix feet

the foot CLINIC

- We can provide the latest in foot and shoe analysis using F-SCAN.
- Video gait analysis
- Prescription orthosis
- Foot, leg and knee pain
- Paediatric foot problems
- Footwear advice
- Overuse injuries

Canberra's Family and Sports Podiatry Centre
Service provider to the ACT Academy of Sport

Suite 18, Corinna Chambers, 36-38 Corinna Street Woden ACT 2606

6282 5466

Podiatrists: Paul Fleet | Krystle Mann | Joanna Milgate | Matthew Richardson

www.thefootclinic.com.au