Canberra DOCTOR
Informing the Canberra medical community since 1988
March 2015
Canberra Doctor is proudly brought to you by the AMA (ACT) Limited
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In the first of a series of Canberra's hospitals, this month we feature: National Capital Private Hospital

Construction on the Canberra Hospital campus is not new for the people of the ACT; however one of the largest programmes underway is not for the public hospital amenities.


Concept bedroom.


Concept suite.

Healthscope have invested $50million in the expansion of the National Capital Private Hospital. The hospital opened in 1998 and the activity has grown beyond the current site. "The planning and expansion of the site has been three years in the making" stated Elizabeth Porritt, the hospitals General Manager. "We are all very excited about the new wing and the opportunities that it will bring for our doctors to be able to provide the best care for the people of the ACT and surrounding region".

The new expanded hospital will have 130 beds, in this there is a 22 bed new Critical Care Unit, 8 of which are state of the art ICU rooms. There is a further 35 bed ward with predominantly single rooms and an expanded Rehabilitation Unit. An additional three operating theatres will bring the total to 7 theatres within the site. Of the three theatres one is designed for cardiothoracic surgery, a second is a general theatre with design features that will be suitable for neurosurgical, orthopaedics and general surgery and intra operative CT is planned. The third theatre is a "hybrid" theatre; it will work as a vascular, neurovascular and cardiac laboratory as well as more general operating room.

The new theatres are fully integrated and will have additional technology that will allow the surgeon the best image quality. The procedures can be live streamed to Education facilities for the training of other doctors and staff. The hybrid theatre will also allow the expansion of the numbers and types cardiology procedures.

The current Cardiac Catheterisation lab is very busy, explained Elizabeth, "So we have chosen this type of theatre to meet the demands of our Interventional Cardiologists as well as our Vascular and Neurosurgeons. With the support of our ICU Specialists the surgeons can continue to do the complex surgery that we have seen happen in recent years, safe in the knowledge that the ICU support is readily available."

The expansion doesn't stop there, there is also a new purpose built Day Oncology & Infusion Unit, a private on site radiology practice as well as other new private consulting suites which will be available for lease from December.

"The additional ward beds will assist our Physicians bringing their patients in for treatment; currently we do occasionally experience bed shortages at peak times. The design has also allowed us to have an outdoor area for our patients and visitors to sit and relax and have a drink from the new coffee shop!"

The new wing will open in the spring with the project completion in February 2016.

Capital Conversations with President, Dr Elizabeth Gallagher

Welcome everyone to the March edition of *Canberra Doctor*. March is a funny sort of month, the summer holidays are far enough behind to be a diminishing memory, the leaves are just starting to turn and yet the year is still young and Christmas seems so far away.

So far things have been reasonably quiet locally. I have yet to catch up with our new Health Minister but look forward to hearing what his priorities are going to be for health in the ACT in the next year or two. Tenders for the new Primary Health Network have closed, but the successful applicants are yet to be announced. Submissions on the proposed Cannabis legislation have closed but again need to be considered and reported. We are still engaged in negotiations around the salaried medical practitioner's agreement which has been delayed because of a technical breach by ACT Health. With all these pending, and new adventures on the horizon it is not going to stay quiet for long.

I attended the first Federal Council meeting of the year. The Federal AMA's success so far in challenging and changing the Abbott government's health policy, especially related to primary care, has been well covered so I will not repeat that. What I will say though, is that the next round- challenging the freeze on MBS rebates will affect all doctors who privately bill, specialists and GPs, and also the hospitals who sometimes use Medicare billing in public hospital outpatients and pathology services. This as well as the federal government cuts to public hospital funding are going to impact there too. Dr Suzanne Davey has written a very comprehensive report on the Meeting of the Council of General Practice later in this edition.

The Federal AMA announced its planned Public Health Campaigns for 2015 and AMA ACT looks forward to working with them to implement some of the campaigns. The one I found a little confusing is "to increase public awareness of the benefits of reduced physical inactivity". Apparently this is subtly different to "increasing physical activity". Other public health issues they are planning to work on this year relate to the dangers of excessive alcohol and harm minimisation, concussion in sport, and road safety.

I sit on the Federal Workforce Committee. One of the biggest issues facing the medical profession in the future is related to workforce planning. We are training many more medical students than even half a generation ago. We have a responsibility to these young doctors, and also to the Australian public to make sure that they continue to get the high quality post graduate training that will allow them to work as skilled medical practitioners throughout their careers. While intern places have been in the spotlight and a lot of work has gone into dealing with them, training for PGY2 and beyond still needs a lot of work. Workforce issues do not just affect these junior doctors though, as it is becoming obvious that even at specialist level there is a potential problem, with exit block already becoming a problem in a number of specialties.

The plan at Federal Council is to try and have 2-3 craft groups make a report at each of the council meetings so we can get an update at least once per year. The Anaesthetic report was very concerning especially in relation to workforce planning. This is one of the first specialties NMTAN (National Medical Training Advisory Network) is going to look at. ANZCA released a new fellows survey which highlights the dangers of oversupply are already starting to impact on this craft group. Already, 11% of new fellows had not entered the workforce after 12 months, 35% thought they were under employed in the first 5 years and even more concerning 28% of young anaesthetists thought their current workload mix was inadequate for maintaining their skills. This is not the only specialty on the brink, and medical student numbers are not due to peak until next year!

Also in this edition there are 2 articles looking at how technology and social media are starting to impact on every aspect of our clinical practice. It has been an eye opener to me to realise just how important it is to be careful of what I photograph, put into emails, texts, and put into all other forms of communication. We need to consider patient confidentiality but also be careful about using anything that may be used to identify clinical information even if we set out to keep it anonymous. The privacy act now controls how we store and share clinical information. I draw your attention to the article on data storage using cloud services. It also sounds a warning bell to those who use overseas dictation services. Last year, the AMA also developed a brochure to disseminate and educate, especially junior doctors, about how to manage clinical images on personal mobile devices. I would encourage everyone that has ever used a mobile device at work to refer to the link ama.com.au/article/clinical-images-and-use-personal-mobile-devices. I was shocked to hear that fines for breaching the privacy act, including having clinical images obtained and or stored without consent can attract fines upwards of $300,000! Later in this edition is also the other warning from Avant that doctors may be exposing ourselves to medico-legal risk if we sign up to, but do not respond to the GoodSAM App. So if you are using technology- make sure you are very aware of all ramifications and consequences.

Please remember our AGM ON Wednesday 13th May starting at 7pm. This year it will be held at AMA House in the Conference Centre on Level 3. The sooner we get a quorum the sooner we can start and complete our business. Look forward to seeing you, and Happy Easter!

GP co-payment: "dumped, dead, buried and cremated"

In welcoming the statement of the Prime Minister, AMA President, Dr Brian Owler said that "the news is most welcome and the end to that uncertainty, and the fact it is "off the table"."

Dr Owler, when interviewed by ABC Radio National Drive host, Patricia Karvelas, said:

On hospital inefficiencies

"I don't think it's a novel concept that the medical profession are working to actually improve the efficiency of the health care system. Doctors do that every single day in their practices and in their hospitals. Look at things like the relative length of stay – the number of days or nights patients spend in hospitals for procedures has fallen dramatically over the years. So we're always looking to get the best value for the health dollar, and certainly the medical profession sees itself as playing an active role there.

Price signal

Dr Owler said that he did not agree that the price signal flagged by the Government as something for further discussion, has a place in general practice or primary care. "People need to be encouraged to see a doctor. The idea of a mandatory price signal is not something that the AMA can support."

"But, where there could be some flexibility that makes it easier for people who can afford to contribute to make a modest contribution, that, to the AMA, is not unreasonable and we have argued all along that most of our objections have been around the protection for vulnerable patients. So if we can have those projections, we can make sure patients are not forced to make a contribution, and that discretion is there for the doctor, who is in the best positon to make some sort of judgement, then that's the sort of policy that the AMAs happy to work with."

Freeze on Medicare indexation

"(GPS) have overheads – staff, equipment, practice nurse, for instance – and if the rebate is staying the same over the four-year period it means that they either have to compromise on their consultations, see more patients within a shorter time, or they just can't afford to hire people like practice nurses. And so the alternative is to start privately billing, and for some areas, and for some disadvantaged areas in particular, that's just not viable. It is harmful to patients and threatens the viability of those practices."

Specialists and private health insurance

"But for specialist practice there are more issues with private health insurance and the schedules for private health insurance. That is going to put strain on out-of-pocket expenses and the participation rates in private health insurance, and that in turns puts stress on the public hospital system. These are the sort of consequences when policy is introduced without speaking to the medical professionals at the coal face".

Dr Owler concluded, "The AMA works in the best interest of patients. We are doctors at the end of the day, and that's the reason why we're actually here. So, we're interested in getting better health policy, not only for our members – obviously we work to look after their interests – but our major interest is in looking after our patients and getting better health policy. I'm very keen to work with the Government and the Prime Minister to come up with those policies that will benefit, not just the Government, but of course our patients. And so we're happy to play that role".

Expressions of interest sought

AMA (ACT) is seeking expressions of interest from general practitioners who are interested in representing the AMA (ACT) on the Department of Veterans' Affairs, Local Medical Officer Advisory Committee (LMOAC).

The committee has been tasked with facilitating communication and liaison between the Department of Veterans' Affairs (DVA), who is representing the Repatriation Commission and the Military Rehabilitation and Compensation Commission, and relevant key representative bodies for general medical practitioners for the purposes of:

- Promoting effective dissemination of information from DVA to Local Medical Officers (LMOs);
- Facilitating feedback of LMOs views on Departmental initiatives and processes;
- Advising DVA on the conduct of educational activities for LMOs, which relate to veteran-specific health issues;
- Facilitating DVA liaison with key representative general practitioner bodies;
- Promoting aged care issues at both undergraduate and postgraduate levels;
- Assisting in the formulation of Veterans' Affairs policy pertaining to primary health care; and
- Increasing DVAs understanding of the issues that affect general practice.
- The LMOAC is not an industrial committee; it is an advisory committee to DVA on LMO matters.

For further information, please contact AMA (ACT) CEO, Christine Brill on 6270 5419 during business hours.

AMA ACT announces new business to its Member Rewards Partners

AMA (ACT) is pleased to announce that Onyabike has joined our member rewards program.

Onyabike offers a range of family, kids, commuter, electric, road and mountain bicycles priced to offer exceptional value.

10% off the full price of all cycling parts, accessories and clothing in 2015 (excludes all bicycles, and Garmin and Stages products).

They offer a price match guarantee (some conditions apply), lay-by and interest-free finance.

Membership card must be produced to receive the benefits.

This is a great offer for AMA (ACT) members to save on all their cycling needs and Onyabike looks forward to seeing you soon in one of their three convenient locations at Belconnen, Civic and Woden.

Is our current health system sustainable?

"Is our current health system sustainable" asks Professor Elizabeth Geelhoed

By international standards, Australia has a strong and efficient health system. However the pressure on expenditure is relentless and without comprehensive strategic reform, our collective health will be compromised, impacting most on those already disadvantaged such as low socio-economic groups, individuals suffering chronic diseases (particularly mental health) and other marginalised sectors of the community.

Maximising population health is not only fundamental for individual wellbeing, but is also important for national prosperity, through productivity contribution and workforce participation. As consumers tend to spend a higher proportion of their disposable income on health as GDP per capita rises, health expenditure is rising faster than GDP.

Expenditure on hospitals is one of the fastest growing components of health spending, due primarily to increasing cost per case. This is related to increasing technology and complexity of treatment, often leading to small incremental improvements at significant cost. Consequently, opportunities for all available health treatments now exceed our capacity to pay for them. So a considered and transparent roadmap is required in order to achieve a fair and efficient budget distribution.

Necessary overriding themes are equity and efficiency. Since there is frequently a trade-off here, transparency, consultation and a clear evidence base are required to balance competing interests. Average outcomes do not take account of distribution, so we need to recognise 'how' we spend our health dollars in addition to 'how much' we spend – for example, Indigenous health requires specific address to ensure equal outcomes. The evidence base is an important contributor not only to identify optimal priorities, but also to recognise low return interventions, where funds being used inefficiently could be better employed elsewhere, thereby increasing health overall within the same budget.

The originally proposed GP co-payment appeared to be an example of policy on-the-run. While legitimately aimed at increasing revenue and introducing price signals, it threatened to impact most on disadvantaged groups. The evidence is clear that low socio-economic groups already under-use primary care and have higher rates of hospital attendance. Consequently, this policy had the potential to compromise health and increase long-term costs. There is a need to change consumer behaviour in terms of recognising the value of medical care and raising individual responsibility for health management, but let's ensure that this does not come at the cost of health overall.

International data shows us that increased use of primary care improves health overall and leads to decreases in hospital attendance rates. Countries that have a strong focus on primary care demonstrate better health outcomes at lower cost. Primary care is the gateway to development of strategies that address overall wellbeing, empower individuals to manage their own health and decrease preventable illness. Chronic diseases loom largest in terms of future burden of the system and we know that a large proportion of this burden can be mitigated through lifestyle initiatives such as reduction in tobacco use and alcohol abuse, better dietary habits and reduction of physical inactivity. These are issues being addressed globally and there is a wealth of evidence to identify best strategies for outcomes and best health investment opportunities.

Ideally, the proposed Primary Health Networks will provide an organised means of delivering evidence-based healthcare which incorporates prevention opportunities such as regular health checks, medication plans, risk factor education and regular vaccinations which will reduce preventable hospital admissions and improve population health. The increased focus on prevention is widely accepted as a strategic imperative for a sustainable health system.

Maintaining optimal community health also depends on universal access to care, particularly for population sectors at highest risk, but could also incorporate incentives to encourage individual responsibility. Patient history through e- cards or systems that link patient records can also assist in ensuring comprehensive and efficient healthcare by reducing duplication.

Further though, the primary care-secondary/tertiary care interface requires improvement. Problems in developing incentives for better cooperation are commonly slated back to the funding divide whereby economic investment in one sector reaps financial benefits across the divide. For example, investment in primary healthcare by the Commonwealth will potentially benefit hospital costs, borne mainly by the state. Unless policy can promote continuity of care, the consequent risk is that individuals with chronic disease will rely almost entirely on hospital resources – often without maintaining a regular GP. This is already evident in some areas.

Expenditure then becomes very inefficient when the disease could be largely managed within the community as long as the links to specialists and hospitals remain with easy access.

Australia currently ranks well across developed countries in terms of efficiency, reflecting our better than average outcomes relative to our spending. However the current pressures and trends will threaten its sustainability without comprehensive reform. Transparent and fair prioritisation will necessarily include efficiency measures.

Primary care provides the portal to address the impending burden of chronic diseases and to improve health generally. Using evidence-based practice and ongoing evaluation, ensuring a fair distribution and developing strategies to 'enhance' the interface between primary care and hospital care will ensure that we continue to achieve an internationally competitive health system.

Professor
Elizabeth Geelhoed
Health Economics, School of Population Health
The University of Western Australia
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Important information for AMA members

The Annual General Meeting of the Australian Medical Association (ACT) Limited will be held on Wednesday 13 May 2015 commencing at 7.00 pm.

The meeting will be held in the Conference Centre on Level 3 of AMA House, 42 Macquarie Street Barton.

Further details of the meeting will be mailed to members in the near future.

AMA (ACT) LIMITED

Privacy Act and data storage using cloud services

Johanna Churchill explains the recent amendments to the Privacy Act and your obligations as a health service provider to keep personal information secure.

The Privacy Act applies to all organisations and businesses that provide a health service, including general practitioners and other specialists. It regulates the collection, use and storage of personal information and allows individuals to access and correct personal information relevant to them. For the purpose of the Act, 'personal information' includes patient records which contain names, contact details, photographs, or any other information which may identify a patient or other individual.

Furthermore, all personal information collected by a health service is 'health information' and therefore 'sensitive information', and subject to higher privacy standards.

Amendments to Privacy Act

It has always been a requirement that businesses caught by the Privacy Act must take reasonable steps to protect the personal information they hold from unauthorised access and disclosure and other misuse. However, new Australian Privacy Principles that came into operation in 2014 now require such businesses to include in their privacy policies and collection statements information about other entities the business is likely to disclose personal information to.

In addition, businesses disclosing personal information to overseas recipients must now also include in their privacy policies and collections statements a warning that they disclose personal information to overseas recipients and in doing so, specify the countries in which such recipients are likely to be located. Furthermore, before making disclosures of personal information to an overseas recipient, they must take reasonable steps to ensure that the overseas recipient does not breach the Australian Privacy Principles in relation to that information. In some circumstances, a business disclosing personal information to an overseas recipient will be responsible for the actions of the overseas recipient in dealing with that information.

These new Privacy Act requirements have implications for all businesses using or proposing to use cloud services to store data, including health service providers. Also, recent events relating to the unauthorised distribution of photographs of Hollywood celebrities have shone a light on some of the perils of using cloud services to store data.

What is a cloud storage service?

Cloud storage is the storage of digital data on multiple servers (often in multiple locations which are mostly overseas) where typically, the server is owned and managed by a third party (host service provider). These service providers are responsible for protecting and keeping the servers running and ensuring the data remains available and accessible to users of the service.

Although most reputable cloud service providers invest heavily in cyber security and safety, as recent events demonstrate, security in respect of data stored using these services is never guaranteed.

To use or not to use (a cloud storage service)?

All businesses must think carefully about whether to use a cloud storage service at all, and if they do decide to do so, what kinds of data will be stored using such services. This is even more important for heath service providers in dealing with health information. Although the Privacy Act does not prohibit the storage of health information or other sensitive information using cloud storage services, given the treatment of such information as sensitive information, there is no doubt that storage of health information using cloud storage services will be closely scrutinised by the Privacy Commissioner in the event of any security breach or privacy complaint.

In light of the above, although it may be convenient to store all data in the same manner, from a privacy and general risk management point of view, it may be prudent to avoid storing health information on a cloud storage service, or at least only to store such information once the information has been 'de-personalised' so that it no longer identifies the relevant patient. This could involve coding such information before it is stored.

Heath service providers and researchers should also be cautious about using a cloud storage service to store commercially sensitive information including information comprising or relating to valuable know how or other intellectual property.

Health service providers who make the decision to use cloud storage services to store some or all of their data also need to think about which service to use.

Is use of cloud storage service disclosure?

In addition to grappling with the general security requirements under the Privacy Act, health service providers looking to use cloud storage services need to consider whether using the service constitutes disclosure of information. In many situations, the mere storage of personal information using a cloud storage service will constitute disclosure of personal information to the service provider triggering the requirements for above statements and warnings to be included in privacy policies and collection statements. Whether or not that is the case in any instance will largely depend on the contract between the user and the service provider and the level of effective control the user retains over the data stored.

Tips for using a cloud storage service

Health service providers seeking to use a cloud storage service should only deal with reputable service providers operating within Australia or in jurisdictions which have stringent privacy standards and laws (such as countries in the European Union, Singapore, South Korea and Argentina, and to a lesser extent, the USA).

In addition, they should interrogate the proposed service provider about what security settings should be used and ensure that there is a binding contract for the provision of the services by the service provider. This contract should include adequate privacy and security obligations on the part of the service provider and allow the user fairly granular control over access to and retrieval of their data, and the modification and deletion of such data. The contract should also restrict the ability of the service provider to subcontract the services to a subcontractor, and require any subcontractor to comply with the privacy and security obligations imposed on the service provider.

Consequences of ignoring these issues

Not only is a health service provider failing to take the above steps taking significant risks in terms of the general protection of its data, it is likely to breach its obligation under the Privacy Act to keep the personal information it holds secure.

Also, it is likely that the use of the cloud storage service by the health service provider constitutes disclosure of personal information requiring the above statements and warnings to be included in the privacy policy and collection statements for the health service provider, and making the health service provider responsible for the actions (and inactions) of the cloud service provider.

For more specific information on any of the material contained in this article please contact Johanna Churchill at Norman Waterhouse on 08 8210 1236 or jchurchill@normans.com.au.

This article was first published in "medicSA", the journal of AMA (SA) and reprinted with permission.

ACCC targets alleged false and misleading Nurofen claims

The Australian Competition and Consumer Commission has instituted proceedings in the Federal Court of Australia against Reckitt Benckiser (Australia) Pty Ltd (Reckitt Benckiser), alleging that it made false or misleading claims that its Nurofen Specific Pain Products were each formulated to treat a specific kind of pain, when the products are identical.

The Nurofen Specific Pain Product range consists of *Nurofen Back Pain, Nurofen Period Pain, Nurofen Migraine Pain,* and *Nurofen Tension Headache*.

The ACCC alleges that Reckitt Benckiser made representations on the packaging of each Nurofen Specific Pain Product, and on its website www.nurofen.com.au, that each product:

- was designed and formulated to treat a particular type of pain;
- had specific efficacy in treating a particular type of pain; and
- solely treated a particular type of pain.

The ACCC alleges that these representations were false or misleading because the caplets in all four Nurofen Specific Pain Products are identical and each contain the same active ingredient, ibuprofen lysine 342mg. All four products are also approved on the Australian Register of Therapeutic Goods as being suitable for treating a wide variety of pain types.

"The ACCC takes false or misleading claims about the efficacy of health and medical products very seriously," ACCC Chairman Rod Sims said.

"Indeed, truth in advertising and consumer issues in the health and medical sectors are ACCC enforcement priorities in 2015."

"In this case, we allege that consumers have been misled into purchasing Nurofen Specific Pain Products under the belief that each product is specifically designed for and effective in treating a particular type of pain, when this is not the case," Mr Sims said.

"The retail price of the Nurofen Specific Pain Products is significantly above that of other comparable analgesic products that also act as general pain relievers. Recent price sampling conducted by the ACCC revealed that these products are being sold at retail prices around double that of Nurofen's standard ibuprofen products and standard products of its competitors."

In Australia, Reckitt Benckiser markets and supplies a range of consumer health and household brands, including Nurofen, Mortein, Clearasil, Finish, Airwick and Gaviscon.

The ACCC is seeking declarations, injunctions, an order for the publication of corrective notices, penalties and costs.

This matter is listed for a case management conference on 31 March 2015 in the Federal Court of Australia in Sydney.

The ACCC recently released its *Compliance and Enforcement Policy* which identified truth in advertising and consumer issues in the health and medical sectors as key areas of priority for 2015.

McDonald's slammed for offering cash rebates to schools when students buy fast food

Health groups have condemned McDonald's for seeking to promote its unhealthy products to children in schools, kindergartens and early childhood centres.

Members of the Mildura community were dismayed to find that McDonald's had written to schools in the community encouraging them to have McDonald's products, including burgers, fries, nuggets and desserts, delivered to their students, with incentives for participation such as cash rebates and free drinks.

The letter, which was passed on to The Parents' Jury and the Obesity Policy Coalition (OPC) by a concerned Mildura parent, outlines the 'McDonald's School Support Program' where food can be ordered for lunch days, fundraisers, end of term treats and for school excursions and functions.

Campaign Manager for The Parents' Jury, Dimity Gannon, says "Allowing McDonald's to be promoted in schools normalizes the consumption of fast food, undermining both parents' and schools' efforts to teach children about nutrition and instill healthy eating habits.

"Some schools might fall into the trap of taking up this offer because they see it as an opportunity to fundraise. However, the financial benefit for schools is minimal while McDonald's benefit greatly by marketing to a captive audience of hundreds of children."

Jane Martin, Executive Manager of the OPC, says attempts by McDonald's to promote its unhealthy food to entire schools of children are insidious.

"This deliberate targeting of children in these settings shows that McDonald's is putting profit ahead of children's health. This is from a company that claims to be committed to 'responsible' advertising to children," she says.

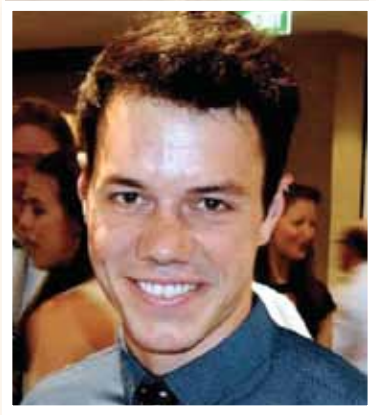
"The Australian Health Survey 2011-2012 shows that children are eating way too many energy dense, nutrient poor 'discretionary foods' that are not necessary in the diet, with very few consuming recommended quantities of fruit and vegetables.

"The Victorian State Government's Healthy Together Victoria initiative in Mildura is doing a great job of supporting schools to create healthy canteen menus and implement healthy fundraising activities. Making McDonald's available in schools would undermine this positive work."

The Parents' Jury and the Obesity Policy Coalition have each written to McDonald's urging them to immediately stop the McDonald's 'School Support Program' in Mildura and cease all promotion of McDonald's branding and products in schools across Australia.

Meet the 2015 ANU Medical Students' Society

In 2014 the ANU Medical School celebrated its tenth birthday. This was a truly tremendous milestone, a wonderful celebration of the successful establishment of medical education at the ANU.



With a medical school comes a students' society, enter the ANU Medical Students' Society (ANUMSS). The ANUMSS is now the amalgamation of 10 years of student leadership. In 2015 we are proud to be bigger and wider reaching than ever before. We are a team of committed individuals working collectively for the benefit of our peers.

This year will encompass a renewed focus on the three core goals of ANUMSS. To *support, represent,* and *entertain* the student body.

We will *support* our students with the continued growth of a teaching culture within the student body. Senior students teaching junior students and inter-year integration is not new to ANU but it will be bigger in 2015. *Entertainment* is something we do very, very well. Our social events are much needed respite for our students. The production of the ANU Med Revue leaves many wondering why our students chose the stethoscope over the stage. Lastly, we will *represent*. A large element of the representation of our student body is to AMA ACT. We aim to build a more fluid relationship with the AMA ACT through publications such as this, The Canberra Doctor. We are also working on a new initiative aimed at educating our student body on topical issues in the medical sphere – *The Informant*.

With the increasing engagement of the student body, we have begun to look at new ways to harness the energy and enthusiasm of students. The ANU Medical School is in a unique position being the only medical school in the ACT. We are looking at ways to grow our relationship with the AMA ACT and the ACT community.

We hope you get to know the fresh faces of the ANUMSS throughout the year to come. We welcome your input and guidance as we work to implement new ideas and increase representation of medical students.

Chris Wilder
President of the ANUMSS and in his third year at the ANU Medical School. He joined the ANUMSS in 2014 as the Academic and Advocacy Officer. Contact: president@anumss.org

Lauren O'Rourke
AMA Representative on the ANUMSS and in her fourth year at the ANU Medical School. She has been involved with the ANUMSS since her first year, serving previously as Academic Rep (2012), Sponsorship Officer (2013), and President (2014). Contact: Lauren.Elissa.ORourke@gmail.com

CLINICAL CASE STUDY: CT Colonography

CT colonography is now a tried and trusted colonic examination. It is more sensitive and specific than barium enema, and rivals or outperforms formal colonoscopy as a cost-effective screening tool for asymptomatic patients.

The bowel preparation is a more limited "dry" prep than that used for formal colonoscopy, although in the near future that is expected to change and require essentially no bowel preparation other than drinking a small amount of contrast for a day or two before the examination.

The difference lies in the way the examination is performed, the cost of the examination, and the results.

After (currently) 2 days of bowel preparation, the patient lies on the CT scanner bed. A small soft catheter is inserted in the rectum and the balloon may be inflated in the lower rectum against the anal verge. Carbon dioxide is then gently insufflated into the colon with an automated device, mildly distending it, whilst Buscopan may be administered to prevent colonic spasm.

The patient is scanned with a low-dose technique in the supine position and then again in the prone position. This takes up to 15 seconds for each scan. The patient is then free to leave.

The images can then be displayed in any plane as 2D images, or as a 3-D "fly-through" as a conventional colonoscopy might see the colon. They can also be displayed as a conventional barium enema.

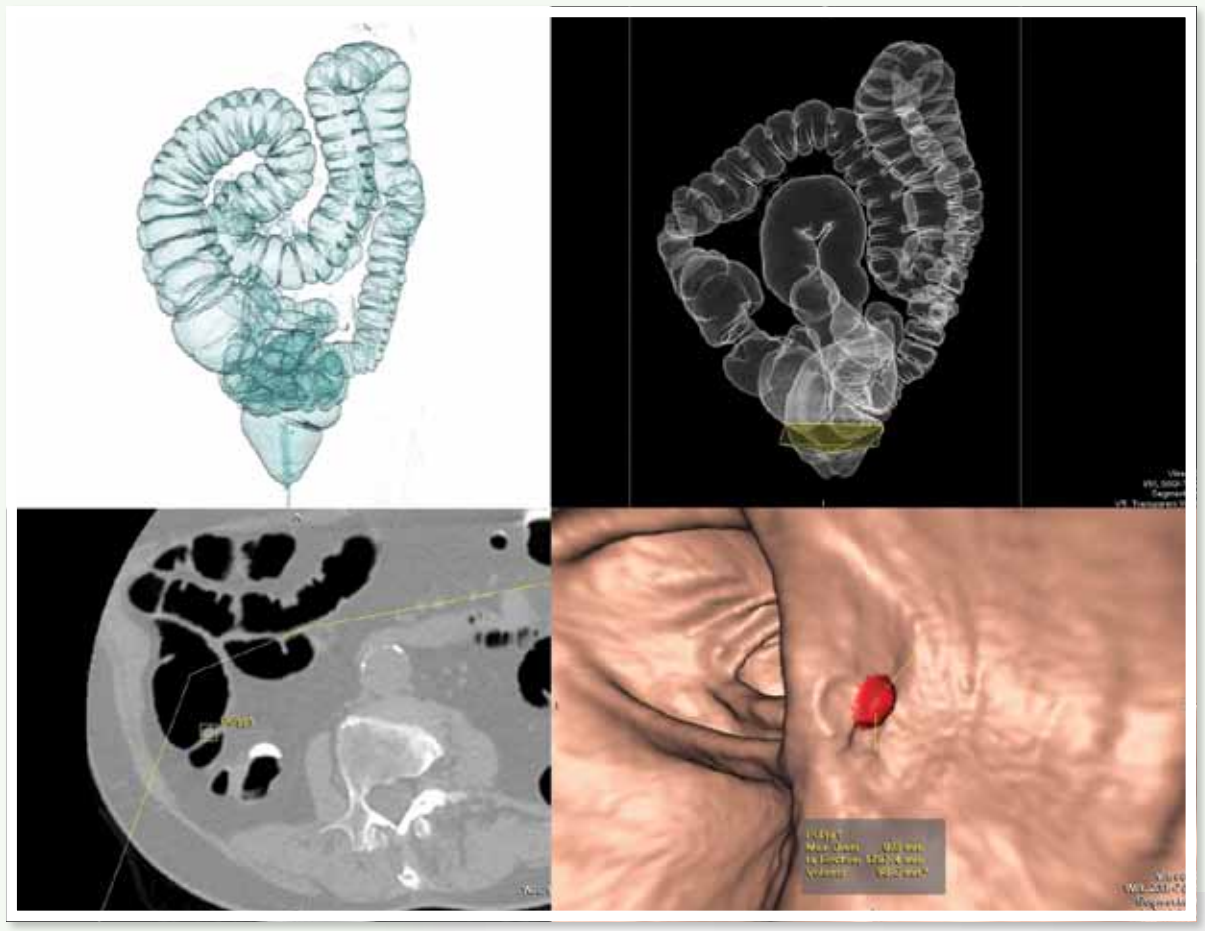
Additionally (and importantly), other abdominal organs as well as the lung bases are able to be interrogated as part of the examination. Unexpected findings such as renal tumours, pancreatic tumours, lung base lesions, aortic aneurysms, etc, are not uncommon.

Advantages over formal colonoscopy:

1. Essentially no risk of colonic perforation.
2. No anaesthetic required.
3. Warfarin etc not an issue.
4. Almost 100% reliability in reaching the caecum (vs 90% with formal colonoscopy).
5. Able to look back at the leading edge of semilunar folds.
6. Able to perform screening examinations of non-colonic organs as a 'freebie'.
7. Less costly than formal colonoscopy.
8. Quicker and better tolerated.

Disadvantages:

1. Major disadvantage is the inability to perform biopsy of any identified lesion. Fortunately, the vast majority (over 95%) of screening colonographies performed have no lesion identified requiring biopsy. By definition, a lesion only requires biopsy/review if it is 5mm or larger in diameter.
2. Radiation is employed in the process. The effect of the radiation from this procedure is currently believed to be of no significant health risk in the screening population age. And bowel cancer is very common in our society.
3. Contraindicated in currently active inflammatory bowel diseases (as is formal colonoscopy) to a relative extent.



In short, CT colonography is believed by most to be the current *screening* technique of choice, where available. If there is a higher likelihood of a biopsiable lesion, my recommendation is of course to do a formal colonoscopy.

Current ACA recommendations for colonic screening is for the procedure to occur every 5 years after the age of 50, or every 3 years if there is a significant family history.

Dr Malcolm Thomson
M.B., Ch.B., FRANZCR
Accredited CT Colonography Radiologist
Canberra Imaging Group

Flu vax program delayed

The Department of Health advises that the National Seasonal Influenza Immunisation Program for 2015 will not commence on the usual start date of 15 March.

The main reason for the delay is that the 2015 southern hemisphere seasonal influenza vaccine will contain three seasonal influenza strains, with two strain changes from the 2014 vaccine.

This double-strain change, which is an unusual occurrence, has caused manufacturing delays. A decision has been made to delay the program until sufficient supplies of influenza vaccine are available from at least two suppliers in order to mitigate the risk of administration of bioCSL's Fluvax to children under five years of age. The delay will not affect vaccine supply volumes, and no vaccine shortages are anticipated.

The trivalent influenza vaccine components for the Australian 2015 influenza season will contain the following:

- A (H1N1): an A/California/7/2009 (H1N1) – like virus, 15 µg HA per dose.
- A (H3N2): an A/Switzerland/9715293/2013 (H3N2) – like virus 15 µg HA per dose.
- B: a B/Phuket/3073/2013 – like virus, 15 µg HA per dose.

When available, further information on the commencement date will be placed on the Immunise Australia website.

AMA reminds GPs and patients that this provides an opportunity for a health check

AMA (ACT) President, Dr Elizabeth Gallagher and Dr Suzanne Davey, Chair of AMA (ACT) GP Forum believe that it is important that vaccinations are done by qualified medical practitioners despite pharmacists being able to provide vaccinations legally.

"This is not necessarily in the best interests of the patient", Dr Gallagher said.

"While it is recognised that vaccinations by pharmacists is a state and territory issue – the drugs and poisons legislation giving pharmacists the authority to prescribe and administer vaccines for influenza, measles and whooping cough in the jurisdictions, this is occurring without any solid evidence about the safety and efficacy and it is the AMA view that vaccinations should be performed by adequately trained and accredited health professionals".

"Dr Gallagher said, "vaccinations save lives and improves quality of life for millions of Australians, but we need to ensure that patients who would not otherwise present, are provided with an annual opportunity for a comprehensive general health check.

Dr Davey commented "the safest way for people to receive vaccinations is through their usual general practitioner where it is performed by either a medical practitioner or by a nurse practitioner who has undertaken accredited training. We know all medicines carry benefits and risks. While anaphylaxis and adverse reactions to vaccinations are rare, health practitioners must have specific training that includes how to make an assessment of the safety of the vaccine for a particular patient and how to recognise and respond to adverse reactions.

"Vaccinations are not urgent. They can be planned for and appointments made with general practitioners at a time that is most convenient for patients", said Dr Davey.

The AMA encourages everyone to have their vaccinations with their family doctor.

Giving back can be more powerful than you think

By Michelle Gianferrrari, Perpetual Private

As a medical practitioner you pour your heart and soul into your profession, making a difference to your patients and communities. We find that many of our clients like to give outside of their profession, especially on discovery of their life goals and aspirations. What many don't realise, however is that there are more efficient and structured ways to give, with more benefits.

Structured giving means planning when, how and where to give for maximum community impact. It's different to just writing a cheque, and is a great way to leave a gift that keeps on giving. Setting up a charitable structure is an achievable goal, and is a tax-effective way to provide a sustainable income stream for charities or causes. A charitable structure bearing your family name can also become a lasting legacy with a demonstrated reflection of personal values for individuals and families.

Structured forms of philanthropy, such as an endowment or private foundation, play a vital role in the areas of advancement of health, medical research and science. Australia's excellence in these fields is renowned worldwide, yet the research base remains highly vulnerable to inconsistent funding and its distance to collaborative partners abroad. Capital intensive and long-term focused, research programs can only thrive with sustained funding, be it from multiple sources, including private and public grants. Philanthropy, vital to the progression of health and medical research in Australia, can provide this much-needed stable funding base.

As a manager and distributor of philanthropic funds for over 128 years, Perpetual has seen philanthropy evolve through structured giving, moving from ad hoc, relief-focused giving, often in response to disasters or tragedies, to a more structured format that reflects greater consideration of the longer term benefits that can be achieved with funding certainty. This is not to suggest that one form is better than the other, certainly unexpected lump sum donations can help organisations accelerate development and achieve critical milestones sooner, but increased structured giving affirms the role of philanthropy as addressing the root causes of societal issues rather than merely supporting band-aid solutions.

If you're considering a planned and long-term approach to giving, there are a couple of things to keep in mind:

- **It's simpler and more achievable than you might think.** A structured giving program can be established with as little as $20,000, meaning you don't have to be Bill or Melinda Gates to leave a meaningful legacy.
- **There are many ways to give.** You can create a structured program that works for you. Once you've determined the right structure, you can also choose from a range of ways to give, such as scholarships or awards, through your estate or during your lifetime, individually or involving family.

Philanthropy is also a wonderful way to bring your family together. Many of our clients utilise their family endowment or private foundation to engage their children and grandchildren with community and social values. Making annual decisions around who and where to direct funds can also be an ideal way of sharing and passing on family values and social responsibility to the next generation.

We look forward to sharing examples of how our clients have made an impact in their communities through charitable structures, in the upcoming issues of Canberra Doctor.

Report of March meeting of AMA Council of General Practice (AMACGP)

The AMACGP is representative of general practitioners across the country. It brings together GPs across multi-faceted general practice profiles including GPs in training.

Sydney GP Dr Brian Morton is the chair of the AMACGP. Professor Bernard Pearn-Rowe from Western Australia convenes the meetings of the AMACGP. The meetings are always held in Canberra.

ACT representative, Dr Suzanne Davey reports below:

GP co-payment and related matters top of agenda

AMA President Brian Owler addressed our meeting and stated that most of his work since assuming the presidency had involved advocacy regarding issues affective general practice.

In December 2014, 3 major new Budget initiatives were announced.

1. There was a change in descriptors for level A and B time based consultations such that B consultations had to be for a minimum of 10 minutes.
2. The Medicare rebate on all items was fixed not to rise until 2018.
3. The $5.00 Medicare cut was changed so that it did not apply to concession care holders, reversing the Budget decision.

Dr Owler informed us that the former Health Minister (Peter Dutton) had not consulted with the AMA at all prior to this announcement.

Then there was a Cabinet reshuffle and Sussan Ley was appointed as Health Minister. She proved to be very approachable and the AMA started a big campaign to lobby parliamentarians, sending more than 7000 emails.

This campaign was successful and the Item A/B time tier changes were reversed.

In early February 2015 the AMA organised GP rallies in every state, for all doctors whether or not they were AMA members. The turnout in every state involved about 5% non-AMA members. (In Canberra we had about 50 doctors come to our rally, of whom 50% were non AMA members.)

After the leadership spill vote, the Prime Minister decided to review his health policies and

finally reversed the $5.00 rebate cut for everybody. He announced that he supported Medicare and stated that where doctors were opposed to a particular political view then "the doctors usually wins because they have their patients' best interests at heart."

The Health Minister has said that she won't take any new initiatives to parliament unless they are supported by the AMA.

Our Chairman Brian Morton then updated us on a number of issues affecting GP's

1. **PIP payments:** The PIP IT payment will be based on the number of PCeHR records uploaded. The After Hours PIP payment will revert to those who actually do the on call work.
2. **GP Training:** The national boundaries for the Regional training programs have not yet been announced. The AMA thinks that a health model is required for GP training rather than a business model.
3. **Scope of practice of pharmacist:** An MoU between doctors and pharmacists is required to delineate roles, but pharmacists are already advertising that they do flu vaccines.
4. **PSR review:** AMA continues to be proactive in advocating fairness to GPs
5. **Primary care accreditation:** There are only 2 accreditation providers and the issue as to whether the RACGP are applicable to all practices was discussed.

General Practice Funding

The RACGP draft paper "Working towards a sustainable primary health care system" was discussed. Their 6 level time tiered consultation system was thought to be unworkable. Number of problems treated and outcome should be involved in the equation for payment, as some doctors are slower than others for exactly the same outcome, and this should not be rewarded.

Role of Private health Insurers in the GP space

A model similar to the CVC model for Veterans was discussed, involving private insurers wanting to keep their patients out of hospital. The AMA gives this concept guarded approval, but does not want PHIs setting up their own practices in competition with existing GP's.

Barriers to Teaching

As well as the usual barriers of time and money, the suitability of the training environment was discussed. Practices in a geographic cluster could perhaps join together for group registrar training. Although training of GP supervisors is required, the meeting felt that the requirements of supervisors should not involve too much red tape which might discourage otherwise willing GP teachers. The vertical model of teaching was discussed, as happens in the hospital system. It was noted that there are 2 aims of training-one to be a good doctor and the other was to be able to pass the required exams. Several GP trainers complained that there was a lack of work ethic amongst trainees. This involved the taking of sick leave and staying on after the required hours to finish seeing patients and doing paperwork. This was regarded as the responsibility of the RTP, but it was accepted that the old model of the GP who worked long hours and did not take any sick leave, was over.

The demise of the PGPPP program was discussed. The model of training was too expensive for the Federal government to continue. The WA government have funded an alternative PGPPP style program called the Community Residency program, but other state governments are unwilling to fund similar models.

Primary Health Networks

We were addressed by Mr Mark Booth, First Assistant Secretary, Department of Health, who is responsible for policy and implementation of the PHN's.

- He told us that the tender process was almost completed. The tender criteria, in particular, addressed improved efficiency and effectiveness of medical services for patients at high risk of poor health outcomes. They also addressed improved coordination of care so that the patient would be able to receive the right care in the right place at the right time.
- There was at least one applicant for each area.
- The contract negotiations would be completed by the end of March. For the last quarter of 2014/2015 the existing Medicare Locals would work with the new PHN's to ensure a smooth transition.
- Comparative performance benchmarks would be set up and reported on publically.
- Key performance indicators for PHN's will be set up on a National, Local and Organisational level.
- National indicators would be such measurements as preventable hospitalisations, childhood immunisation rates and cancer screening rates
- Local KPI's would reflect local issues such as hospitalisation rates for COPD patients, and smoking rates for Aborignal and Torres Strait Islanders
- Organisational KPIs would reflect compliance with contractual arrangements in key areas of established operations and activity.
- The PHN's would use existing GP data available to them initially, but there was a lot of relevant GP data not yet being collected, but which might be collected in the future.
- If the new PHN does not enjoy the confidence of local GP's a mechanism would be put in place for GP's, the community and the AMA to feed back their concerns to DOH.
- Clinical councils will be GP led, and the skill based board should include GP's
- Mr Booth indicated that he was fully aware of the conflict of interest should a Private Health Insurer tender to be the PHN for an area.

Delayed GP training motion

The AMACGP recommends that the Federal Council of the AMA condemns the management and implementation of GP training reforms by the government, including the lack of detail about the governance, structure and delivery of GP training beyond 2015, and requests an urgent meeting with the health Minister to discuss these concerns.

Family Doctor Week

The use of the Medical Home logo for AMA doctors during Family Doctor Week was discussed.

The AMACGP will meet again in June 2015.

Dr Suzanne Davey
Canberra GP and Chair of the AMA (ACT) GP Forum and a member of the AMACGP representing the ACT

For further information of any of the matters above, please contact Dr Suzanne Davey directly. Her contact details are available from the AMA ACT Office.

Membership of the GP Forum is open to all AMA member GPs and if interested please contact either Suzanne Davey or Christine Brill for further details of how you can get involved.

Census conducted once a decade? A major setback for health in Australia

A proposal from the Australian Bureau of Statistics (ABS) to conduct the Census every ten years instead of five would come at an unacceptable cost to healthcare planning, according to a number of national health peak bodies.

Australian Healthcare and Hospitals Association (AHHA) Chief Executive Alison Verhoeven said that, while the proposal might help the ABS fund its planned IT systems upgrade, significant flow-on effects would negatively impact the Australian healthcare system.

"At a practical level, information from the Census is used in decisions about where hospitals and health services should be located, what services they should provide, and how health funding is distributed," Ms Verhoeven said. "It is imperative that consideration is given to developing alternative mechanisms to support health systems planning, before introducing wholesale changes to a key national data set such as the Census."

Public Health Association of Australia (PHAA) Chief Executive Officer Michael Moore said that the social, economic, regional and cultural dimensions of Census data provided essential guidance that could be muddied through the ABS proposal.

"We know that health is determined often by factors outside of the health portfolio by such things as housing, where you live, your remoteness, whether you have a job," Mr Moore said. "If the Census is conducted less frequently, it will be very difficult for the government to focus their policy on the most effective ways to keep people healthy and keep them productive. It's the baseline on which we can understand the health of Australians."

Consumer Health Forum of Australia (CHF) Chief Executive Officer Adam Stankevicius said that, given the pace of change in the health area, it is vital that Australia has a regular snapshot of the population's health as offered by the five-year Census.

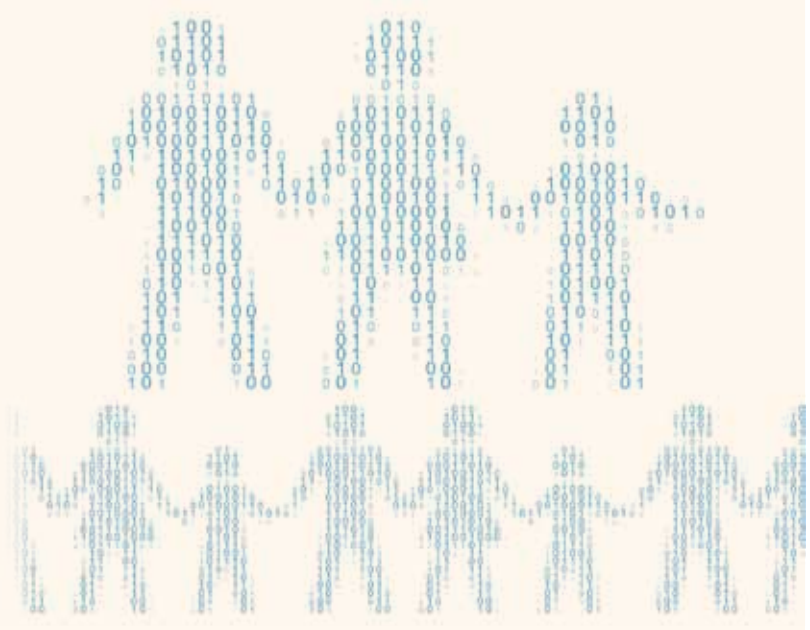
"You can't manage what you don't measure," Mr Stankevicius said. "The rapid growth in the incidence of obesity and chronic disease are examples where timely statistics can help us combat these serious population health problems faster. A great strength of Australia's governance is its strong statistical system. We should not weaken it to meet short term bean-counting edicts."

Ms Verhoeven said that, in particular, the ABS proposal would limit the country's understanding of the population health needs of Indigenous people and those living in rural and remote areas.

"Less frequent Census data and a reliance on sample-based surveys is of particular concern for these groups that already experience significant health inequity compared with other Australians," Ms Verhoeven said.

As the Census provides the benchmark for population weighting other ABS sample surveys, the health peak bodies are concerned that the robustness of these processes will be lost. This includes concerns around the Australian Census Longitudinal Dataset, a valuable initiative for health research that commenced in 2006, which could be compromised by the ABS proposal.

The health peak bodies also fear that frequent smaller sample size surveys to supplement a ten-yearly Census, as proposed by the ABS, could be vulnerable to funding cutbacks, further undermining the credibility of population data.



While ABS-acknowledged concerns over the length of time it takes to release Census results are important to address, the health peak bodies warn there is no guarantee that the results of a ten-yearly Census would be available in a more timely manner.

"The proposed move to ten-yearly Censuses has been flagged less than three months prior to the Budget announcements by the Australian Statistician, who has publicly commented that the ABS is 'consulting widely with government'," Ms Verhoeven said.

"The Census is such an important asset for the health sector that any changes should be the subject of wide consultation, and should be aimed at improving the data available to inform policy for a strong, productive and health Australia.

2014 AMA Specialist Trainee Survey

The AMA has released the *2014 AMA Specialist Trainee Survey* – a national snapshot of medical training that provides valuable feedback to medical colleges on how Australia's future doctors value their medical training experience.

AMA President, A/Prof Brian Owler, said after release of the survey that the it has recorded a high level of satisfaction among Australia's 16,800 specialist trainees with both their work and training experiences.

A/Prof Owler said that, overall, the survey respondents reported a more positive view of their training experience than respondents to the first AMA survey four years ago.

"The survey shows that medical colleges are performing well in most areas of vocational training," A/Prof Owler said.

"Career choice, level of supervision, standard of training, clinical experience, and access to safe working hours are areas where trainees continue to have a high level of confidence.

"There are however, significant areas where colleges have fallen short of their trainees' expectations, many of which have remained unchanged since 2010.

"There has been underperformance in responsiveness to cases of bullying and harassment, training feedback, and appeals and remediation processes.

"The cost of training remains an issue for trainees.

"Trainees are also uncertain about how to access academic streams and accredited overseas rotations as part of their training program."

A/Prof Owler said the survey not only highlights strengths and areas for improvement in training programs, and identifies emerging issues and trends in vocational training, it can now provide longitudinal data on core issues over the period covered by the two surveys since 2010.

"These results will help medical colleges and health departments shape and improve the quality of vocational training, and will inform AMA advocacy for vocational training.

"Australia must maintain the quality of vocational training in the face of escalating trainee numbers, and a changing work and policy environment.

"To ensure that quality is maintained and improved, the AMA is calling for funding for a National Training Survey to monitor and inform the quality of training nationally.

"A National Training Survey – similar to the successful United Kingdom model – would dramatically improve workforce planning, including important downstream planning to guarantee employment for doctors when they have finished their specialist training."

A/Prof Owler said the AMA strongly supports the Australian model of specialist training, which does a great job in preparing doctors for independent practice.

"Our medical colleges do their best to heed the views of their trainees," A/Prof Owler said.

"The AMA surveys provide the colleges with valuable complementary information to help them further support their trainees.

"The challenge is to manage career expectations, promote a safe and healthy workplace, and better integrate high-quality prevocational and vocational training pathways to ensure Australia continues to produce highly qualified doctors."

The 2014 AMA Specialist Trainee Survey is available at https://ama.com.au/article/2014-ama-specialist-trainee-survey-report-findings-february-2015

Legal consequences for GoodSAM App 'responders' who don't respond

Doctors registered as first-aid 'responders' on the GoodSAM (Smartphone Activated Medics) App in NSW and the Northern Territory should turn off the App when they are unable or unwilling to respond to an alert, to avoid exposing themselves to medico-legal risks, according to MDO, Avant.

While Avant's medical legal experts acknowledged the potential role of the GoodSAM App which uses GPRS technology to alert registered first-aid 'responders' to emergency medical situations in the area, they believed doctors could be potentially exposing themselves to medico-legal risk.

"If doctors practising in NSW and NT have chosen to be alerted to an emergency in a local area, but choose to ignore that emergency without good reason, in our view they may be criticised for failing to provide assistance," Kate Gillman, Special Counsel, Medico Legal Advisory and Health Law, Avant Mutual Group, said.

Ms Gillman confirmed that Avant's Practitioner Indemnity Insurance Policy provides worldwide cover for registered GoodSAM responders who act as a Good Samaritan, subject to the terms, conditions and exclusions of the policy.

However, she said that while doctors do not have a common law duty to provide assistance in an emergency in the absence of an existing doctor/patient relationship as held in the recent *Dekker* case, there were different legal requirements for doctors practising in NSW and the NT.

"In the Northern Territory it is a criminal offence if a doctor "callously" fails to provide medical assistance in an emergency where a life may be endangered," she said.

In certain circumstances, doctors practising in NSW could also be liable for unsatisfactory professional conduct for refusing or failing to provide medical assistance without reasonable cause under the Health Practitioner Regulation National Law (NSW), Ms Gillman said.

"In our view, doctors in NSW and/or NT may need to respond to a request for assistance when alerted on the GoodSAM app, unless they have a reasonable excuse, to avoid the ramifications of the state and territory legislation," she warned.

Dr Penny Browne, Senior Medical Officer, Avant Mutual Group, advised doctors that The App could create an expectation that the doctor is available to attend an emergency when they are unable to do so.

"One option for doctors to limit that expectation and their potential exposure is to turn off the App when they are unable or unwilling to respond to an alert," she said.

Under the App's terms and conditions, responders are advised not to respond to an alert in the following circumstances:

- If formal certification is out of date then acting as a responder must not occur
- A responder should only respond if fully alert and prepared (do not respond if alcohol has been consumed)
- A responder must not go outside of his/her skill set. Basic life support and AED use are all that should be provided when appropriate.

Guardianship Act under review

The ACT Law Reform Advisory Council has been asked by the Attorney-General to review the *Guardianship and Management of Property Act* in light of the United Nations Convention on the Rights of People with Disabilities.

The full terms of reference are at http://www.justice.act.gov.au/review/view/31/title/review-of-guardianship-and-management.

A most significant provision in that Convention is Article 12 which says that people with disabilities have the right to 'enjoy legal capacity on an equal basis with others in all aspects of life', and requires the provision of support to allow them to exercise legal capacity.

This particularly effects decision-making, where currently a substitute decision-maker is often appointed by a Tribunal or court for an adult who is said to 'lack capacity'. This relates to many areas of life, such as health care, ownership and inheritance of property, and financial management including taking out loans.

People who are currently found to 'lack capacity' include people with intellectual disabilities, people with some mental illnesses and older people. Under the United Nations Convention, people have the right to make their own decisions, but if they require support to do this then support must be provided. Current guardianship arrangements, which are based on substitute decision-making rather than supported decision making, are the exception rather than the rule.

While the ACT Council's inquiry is recent, the move to what is called "supported decision-making" has been in the policy pipeline for some years. It has already been tackled in pilots for the National Disability Insurance Scheme and under reform proposals in other states and overseas .

In November 2014, the Australian Law Reform Commission released its Final Report called *Equality, Capacity and Disability in Commonwealth Law.* This is available on the web: https://www.alrc.gov.au/publications/equality-capacity-disability-report-124 . This very detailed report proposes a supported decision-making model to conform with the United Nations Convention, based on National Decision-making Principles and Guidelines, which ensure that:

- supported decision-making is encouraged
- representative (substitute) decision-makers are appointed only as a last resort, and
- the will, preferences and rights of persons determine decisions that affect their lives (Recommendation 3-1).
- The Principles say that:
- all adults have an equal right to make decisions that affect their lives and to have these respected
- people who require support in decision-making must be provided with support necessary for them to make, communicate and participate in decisions that affect their lives
- the will, preferences and rights of people who require decision-making support must direct the decisions that affect their lives, and
- there must be effective legal safeguards when people require decision-making support, including to prevent abuse and undue influence.

The Australian Law Reform Commission recommends that these principles and guidelines be used to guide law reform in all States and Territories.

Given the comprehensiveness of the Australian Law Reform Commission's work and the need for compliance with the United Nations Convention, the ACT Law Reform Advisory Council is using the proposed National Decision-making Principles and Guidelines as a starting point for its review of the Guardianship and Management of Property Act. Through a consultation process, it is also seeking information about the experience of people subject to guardianship orders, the experiences of their families, carers and guardians, and of those who rely on these arrangements, including doctors, lawyers, financial institutions and other service providers.

The Council is consulting, and looking at lessons from experiences with supported decision-making both in Australia and overseas, to help shape the law in the ACT. A Public Response Booklet will be made available soon to provide an accessible way for people to participate in the consultations.

Doctors have extensive experience working with vulnerable people and related decision-making. The Law Reform Advisory Council hopes that the medical profession will participate actively in this important reference. Doctors can help to shape sound, rights-based laws that can help patients and families in their care to have a more respectful and just engagement in the decisions that affect their lives. If you would like to be on the email list for the reference, please email your details to the Council at lrac@anu.edu.au.

ACT Government
Justice and Community Safety

2015 Directory of Medical Specialists, Directory of Allied Health Professionals and Directory of GPs with Special Interests

… a publication of the AMA ACT

AMA (ACT) LIMITED

The second edition of the directory of **Allied Health Professionals** and **GPs with Special Interests** will be published as a service to ACT general practitioners and distributed with the 10th edition of the **Directory of Medical Specialists** during Family Doctor Week in July 2015.

Entries must be on the form below and returned to the address below no later than 30 April 2015.

Mail: AMA ACT, PO Box 560, CURTIN ACT 2605
Fax: 6273 0455 Email: reception@ama-act.com.au

☐ **Directory of Medical Specialists** ☐ **Directory of Allied Health Professionals** ☐ **Directory of GPs with Special Interests**
(Select which Directory/s you would like to go in)

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Speciality:

Services offered:
(Please keep this brief and use only accepted abbreviations – eg: DCH, Diploma in Child Health)

Practice Details (1)	**Practice Details (2)**
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Fax:	Fax:
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A proof of your entry will be sent prior to printing. Please indicate preferred method to receive this:

☐ Fax number:_____ ☐ Email address:_____

Medical students Trans-Pacific Partnership Agreement (TPPA) may reduce access to medications

The Australian Medical Students' Association [AMSA] has welcomed the report released by the Public Health Association of Australia [PHAA] detailing the negative impacts of the Trans-Pacific Partnership Agreement [TPPA] on the health of Australians.

"The TPPA poses a significant risk to the affordability of medications and has the potential for major follow-on effects for the Australian, and global, population." said AMSA President, James Lawler.

"The provisions in the TPPA may mean longer and broader monopolies on medicines and other health technologies, ultimately increasing out-of-pocket expenses for already vulnerable populations.

"Increased cost of medicines will intensify medical non-adherence, with an Australian Bureau of Statistics survey finding 1 in 11 people delayed or did not fill a prescription due to the cost. The TPPA is a dangerous move in the wrong direction.

"The Government should be prioritising community public health needs, since equitable access to medications can have far-reaching benefits.

"AMSA is calling upon the Government to ensure that broader transparency is afforded to the Australian people, and for strong provisions to be included in the Agreement to protect public health and keep medicines affordable.

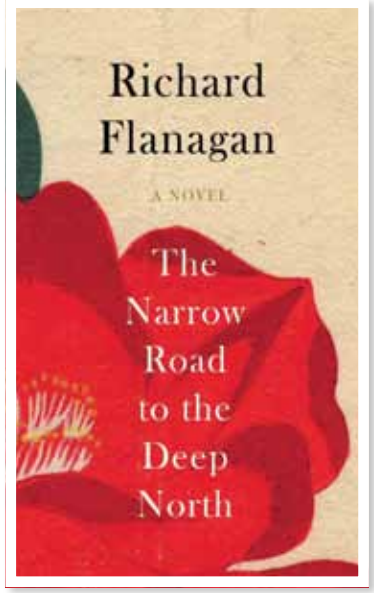
"This Health Impact Assessment has been put together by a large team of academics and non-government health organisations – AMSA urges the Government to listen to experts on public health policy."

Mr Lawler also pointed out that medical students had taken particular interest in the negotiations and their potential impact on public and global health, to the point where Australian medical students had attended negotiations overseas.

AMSA calls on the Department of Foreign Affairs and Trade to apply the report's recommendations in the final days of TPPA negotiations.

BOOK REVIEW: The Narrow Road to the Deep North

Richard Flanagan
ISBN 978087980366
Published by Vintage as paperback October 2014
RRP $19.99



The Narrow Road to the Deep North is the title of a 17th century Japanese text by the celebrated poet Bash.

The elderly Bash describes, in haiku and prose, meditative walking journeys through Japan after selling his possessions. Flanagan borrows the name for his Man Booker Prize winning story of the Thai-Burma railway. Flanagan's father, a prisoner of war on the railway, died the night Flanagan announced to him that the book was complete.

The book makes for difficult reading. The protagonist, a surgeon, is inadvertently promoted to leadership within his labour camp. Descriptions of cholera, beatings, beheadings, crude debridement of tropical ulcers, amputation and malnutrition are rendered with skin-crawling medical accuracy. Flanagan has never shied away from the diseased body, we can recall the descriptions of the syphilitic Commandant in *Gould's Book of Fish*. In *The Narrow Road to the Deep North*, the surgeon must negotiate the quota of men fit to work on the line. This is leadership, as he decides between releasing men to work who are too ill, and losing what little negotiating power he retains through obstructionism.

Because he provides adequate witness to the horrors, Flanagan is permitted an almost sympathetic exploration of the Japanese military psyche. Post-war, we follow several guards previously introduced to us only as two dimensional brutes. The guards' fates are mixed, and the reader is left with an incomplete sense of justice. Furthermore, our Australian protagonist is not without fault himself in marriage, fatherhood, or even as a lover, as affairs devolve from hot blooded raisons d'être to mechanical routine.

Readers will lose themselves in this evocative tale, and Flanagan writes in a contemporary style that feels timeless. We are not given the answers, but encouraged to muse further with the suggestion that Bash's poetry might help guide us.

Dr Philip Keightley
Psychiatry Advanced Trainee
ANU Medical School

Canberra DOCTOR

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WOMEN'S HEALTH ON STRICKLAND

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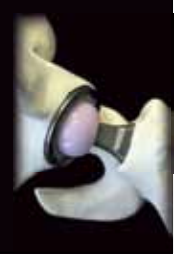

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