CANBERRA Doctor

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A Message from the AMA ACT President

BY PROF WALTER ABHAYARATNA

Colleagues,

Late in August, following the re-emergence of community transmission of COVID-19 in the ACT, I sent a message to our AMA ACT members. Given the persistence of the current outbreak, I thought it worthwhile to update that message and address the broader Canberra and region medical community.

(Photo courtesy Canberra Times).

While the first and most important message is to look after your own health and wellbeing, I wanted to touch on some other important issues too:

- Small business support
- Information for public hospital doctors and medical students
- Clear documentation needed for over-60s and Pfizer
- Retired doctors volunteering to assist with the COVID-19 response

Health and Wellbeing

But firstly, I wanted to emphasise the need to take care of your own health and wellbeing, and that of your family, colleagues, and practice staff, as you provide care to your patients. It's essential that our healthcare workers stay healthy and are able to deliver the care that our community needs.

Locally, the **Doctors Health Advisory Service** (DHAS) operates a 24/7 phone help line that offers personal advice to medical practitioners and students facing difficulties. Medical practitioners concerned about their own health, the health of a colleague or family member who is a doctor or medical student, can call the DHAS for advice.

DHAS is a confidential service that provides doctors and medical students with the opportunity to talk about the challenges they face. Callers often seek advice in relation to stress, mental health issues, drug and alcohol problems, career crises and personal and relationship difficulties.

The DHAS help line is 02 9437 6552.

Another very good resource is the website at **drs4drs.com.au** where you'll find information on available services including telemedicine options, undertaken confidentially. Alternatively, you can call 1300 Dr4Drs (1300 374 377).

Drs4Drs.com.au also offer learning modules and a resource hub to further assist.

Small Business Support

With the current lockdown planned to extend to at least 17 September, the ACT Government has announced small business support grants for businesses operating in the ACT. The main features of the ACT assistance program are:

- Grants of up to $20,000 over the current lock-down period to 17 September
- To be eligible, a business must have experienced at least a 30 per cent reduction in revenue due to restricted trading conditions, to be assessed by comparing a consecutive seven-day period in the declared lockdown (between Friday 13 August and Friday 17 September), with a consecutive 7-day period in April 2021 to August 2021 for which comparable business activity would have occurred.

More information can be found at https://www.act.gov.au/business/business-support

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Assistance for Practice Employees

Employees who are unable to derive income due to the ACT-wide lock-down may be eligible to access to the Commonwealth COVID Disaster payment through the Services Australia website. Payments vary under this scheme but more information can be found at https://www.covid19.act.gov.au/community/access-help

Vaccination of Practice Staff

As most practice owners will be aware, mandatory vaccination of practice staff is a complex issue. While the AMA has called for public health orders to mandate vaccinations for health care workers, the ACT has not yet moved down this path.

In the interim, here are some very good resources for practice principals, and doctors who are engaged as contractors or employees, on the Avant website:

https://www.avant.org.au/covid-19/vaccination-faqs/

Public Hospital Doctors

While the obvious focus is on preparation for and dealing COVID-19 positive patients while continuing to undertake care of other patients, enterprise agreement negotiations continued until recently. Last week, Canberra Health Services notified us that they needed to postpone the meeting scheduled for 2 September, to which we ultimately agreed.

The most recent negotiating meeting held earlier in August dealt with a variety of our Doctors in Training claims loosely grouped into the concept of 'working hours'. Several of our claims have now moved into the 'agreed in principle' column, including:

- guaranteed consecutive days off
- penalty rate eligibility for using technology when on call instead of physical recall and
- improved management (and cashing out) of ADOs.

While this represents progress, don't forget that it's subject to 'the detail' being agreed and the adequacy of the final total package offer from CHS and Calvary Public Hospital.

Our claims with respect to rosters and managing excessive hours of work have seen us provide a number of materials about AMA Safe Hours National Code of Practice. Our claims about fair roster posting rules remain on the table and were also discussed on 12 August.

The full AMA ACT Enterprise Agreement claims can be viewed at https://act.ama.com.au/node/932

ANU Medical Students Assisting with COVID-19

I've been pleased to work with the Director of the ANU Medical School, Professor Zsusoka Kescakes, to ensure that our student doctors are included in the call-out for assistance with COVID-19 efforts, including vaccine provision, contact tracing, and COVID-19 testing. Of the 400-plus ANU medical students, 98% are COVID-19 vaccinated, and the students are eager to join the health workforce during these challenging times to ensure that they play their part during the pandemic.

At this point, a new role of Medical Student – COVID Worker, has been developed to facilitate the involvement of 3rd and 4th students in the ACT COVID response.

Clear documentation needed for over-60s and Pfizer

I have been approached by GP colleagues to reach out to our members and remind them of the ATAGI guidelines regarding the criteria for patients who are 60 years or over who would be eligible for the Pfizer vaccine because of conditions that render them unsuitable for the AstraZeneca COVID-19 vaccination. If a specialist tells a patient 60 or older that they should be able to get have Pfizer vaccine rather than AstraZeneca, then the specialist needs to clearly document, preferably in the correspondence to the patient's GP, which one of the known exclusion criteria the patient has, including the following conditions as per the ATAGI guidance update from the 30 July 2021:

- A past history of cerebral venous sinus thrombosis (CVST)
- A past history of heparin-induced thrombocytopenia (HIT)
- A past history of idiopathic splanchnic (mesenteric, portal and splenic) venous thrombosis
- Anti-phospholipid syndrome with thrombosis

Presidents past and present, back row from left back row, Dr Iain Dunlop, Dr Andrew Miller, Dr David Brand, D John Donovan, Dr Antonio Di Dio, Dr Walter Abhayaratna. Front row from left, Dr Colin Andrews, Dr Ian Pryor, Dr Suzanne Davey and Dr Grahame Bates.

- People with contraindications to COVID-19 Vaccine AstraZeneca, i.e.
  - Anaphylaxis to a previous dose of COVID-19 Vaccine AstraZeneca, or to an ingredient of the vaccine
  - Capillary Leak Syndrome
  - Thrombosis with thrombocytopenia occurring after the first dose of COVID-19 Vaccine AstraZeneca
  - Other serious adverse events attributed to the first dose of COVID-19 Vaccine AstraZeneca

Dr Suzanne Davey

Congratulations to Dr Suzanne Davey for her richly deserved AMA Fellowship, awarded at the AMA National Conference. Suzanne has been an outstanding advocate for general practice both locally and at the national level. I could hardly think of a worthier recipient.

AMA Award to CHOs

This year's AMA President's Award has recognised the outstanding service and medical leadership shown by the state Chief Health Officers and Commonwealth Chief Medical Officers during the COVID-19 pandemic. In making the Award, AMA President Dr Omar Khorshid, said the CMOs and CHOs had provided expert health guidance to Australians during and unprecedented health emergency, which had challenged us all in ways that we could not have envisaged before the pandemic.

Of course, the Award includes our own ACT CHO, DR Kerryn Cleman. Congratulations Kerryn!

Farewell 42 Macquarie Street

Finally, I wanted to let you know that AMA ACT has vacated our old offices on Level one of AMA House at 42 Macquarie Street Barton. While the move to new premises at 39 Brisbane Avenue won't happen until later in the year, we will be sharing premises on Level 4 of AMA House until then.

To mark the last Board meeting in our home of more than 20 years, we invited our former presidents to join the current Board for drinks. I'm pleased to say that the AMA Secretary General, Dr Martin Laverty, was also able to attend along with Dr Suzanne Davey.

VALE

The President, Professor Walter Abhayaratna, Board members and staff of AMA (ACT) extend their sincere condolences to the family, friends and colleagues of
Dr Alan Normington Cowan

Dr Suzanne Davey, AMA Fellow

Longstanding general practice advocate and AMA ACT Board member, Dr Suzanne Davey, has been awarded an AMA Fellowship. The award was announced at the recent AMA National Conference.

Dr Suzanne Davey with AMA ACT President, Prof Walter Abhayaratna and AMA Secretary-General, Dr Martin Laverty.

AMA Fellows are required to have made a real contribution at the State and Federal level to improve working conditions for doctors, to improve safety for patients, to train the next generations of medical practitioners, and to make the Australian health system work more effectively for patients and communities.

In her career, Dr Davey has excelled not only as a general practitioner but also in her role as an advocate for the profession.

> “...greatly admired for her advocacy and integrity and very worthy AMA Fellow

Citation

In recommending, Dr Davey for the award, the AMA ACT Board cited her leadership and involvement with AMA and AMA ACT with particular reference to general practice. She has been an outstanding leader for AMA members and for seven years provided key representation for the AMA ACT on the AMA Council of General Practice. Not only did she provide long-term and highly valued input to the AMA CGP, but during this same time she led general practice advocacy in the ACT.

Dr Davey's involvement with the AMA Council of General Practice included key contributions on the design and implementation of Primary Health Networks, the redesign of the Practice Incentives Program, and advocacy on mental health, chronic disease, and telehealth.

Of course, Suzanne Davey has held AMA ACT office bearer and other board positions and chaired the AMA ACT GP Forum. She has played an important role with the Doctors Health Advisory Service in the ACT and supported medical students and medical practitioners in a variety of roles as varied as teacher, colleague and treating practitioner.

Presentation

With this year's AMA National Conference being held online, the AMA President, Dr Omar Khoshid, was not able to make the presentation to Dr Davey. However, the farewell event the final Board meeting at 42 Macquarie Street Barton saw AMA Secretary-General, Martin Laverty join AMA ACT President, Professor Walter Abhayaratna and past AMA presidents jointly recognise Dr Davey's achievement.

Dr Suzanne Davey has been a tireless advocate for patients and colleagues alike. She is a stalwart leader, greatly admired for her advocacy and integrity and very worthy AMA Fellow.

Enterprise Bargaining Kicks Off Again

While it's only a matter of months since the Fair Work Commission approved the 'new' Enterprise Agreement ('EA'), the delays that occurred means that we're already back into bargaining for the next one. In fact, the first negotiating meeting was held on Thursday, 29 July and it also marked the start of AMA ACT's campaign to achieve a better deal for our Members working in Canberra Health Services and Calvary Public Hospital.

The 2021 AMA ACT EA claims have come about from listening to our DIT Members' concerns arising in their workplaces, and converting that feedback into responsible and comprehensive solutions for presentation to CHS and CPH.

Our Claims

Our claims focus on inserting new, legally enforceable conditions into your employment contract. In 'snapshot', this is what we're striving for:

- Respect: make your payslips clearer, make rosters reflect your work contribution and pay you for it, reduce the workplace encroachment into your study/personal/family time and allow you to plan with greater certainty.
- Training & Education: rostered and paid time free from clinical work for on-site training, paid exam and conference preparation and attendance and increases in quantum of Training Allowances.
- Reducing Burn Out: guarantees for the taking of annual leave, introduction of fatigue.

Our full list of claims can be read here: https://act.ama.com.au/node/932

At the first negotiating meeting held on Thursday 29 July, we spent most of the time explaining to CHS and CPH the detailed meaning of each claim item, and the merit underlying each.

What Happened at the Latest Negotiations?

Prior to the 12 August meeting, AMA ACT provided our analysis of other states arrangements for *Free From Service* Training Time and Education Allowances, showing that the ACT is behind several major states in providing rights for accredited Registrars.

We also provided our model clauses for DITs and specialists regarding protections from bullying and sexual harassment, and rules designed to facilitate fair treatment where a practitioner is the subject of performance management or disciplinary investigation.

The negotiating meeting saw an in-depth discussion of a variety of our claims that were loosely grouped into the concept of 'working hours'. As a result, several claims have now moved into the 'agreed in principle' column, including:

- guaranteed consecutive days off;
- penalty rate eligibility for using technology when on call instead of physical recall; and
- improved management (and cashing out) of ADOs.

While there's no doubt this represents progress, it's important to remember that 'the detail' is still to be agreed and, in the final count, whether the overall package on offer meets our members' requirements.

Our claims regarding rosters being mandatorily designed to properly reflect the true size of each DIT's job and to properly manage excessive hours of work, saw us provide materials relevant to the *AMA Safe Hours National Code of Practice*. In essence, this claim is about making unrostered overtime a small aspect of your working week, because it is genuinely unpredictable.

Next Meeting

Given the re-emergence of COVID-19 in the ACT, CHS advised us last week that they cannot meet the proposed negotiating timetable. The next meeting is now not likely until late September.

AMA ACT Claim in Focus: Payslips

While you can read the full list of our claims at https://act.ama.com.au/node/932, the issues around clear information on payslips continues. AMA ACT's claim about payslips states:

"[P]ay and payslips must relate to the immediately preceding pay period" AND "Payslips must provide specific, detailed information directly aligned to agreement entitlements and be capable of lay understanding as to what has been paid, and for what work, as related to overtime, penalties and allowances et al." [AMA ACT Claim Item 2.6]

We are asking for plain English pay slips designed with direct nexus to your EA entitlements, that show information about your work in the immediately past fortnight. If we are successful, this should prevent your payslip suddenly including penalties that related to shifts worked months earlier and other anomalies.

Keeping DITs Informed

After each bargaining meeting we will publish a member update. The two updates published so far can be accessed at https://act.ama.com.au/ under 'Latest News & Media'.

Please make sure you and your colleagues know about the 2021 AMA ACT EA claims. By itself, AMA ACT just talking to CHS and CPH won't solve your workplace concerns; what we need is continued engagement and support to succeed. If you're an AMA member and would like to join the EA Reference Group, or you have other feedback, please contact us at industrial@ama-act.com.au

If you're not a member, *please join* because every additional member gives us added strength at the bargaining table. You can join at https://act.ama.com.au/join

2021 MBA Medical Training Survey Open Now

This year's Medical Bard of Australia Medical Training Survey (MTS) is running through August and September and now's the time for junior doctors to have your voice heard.

Many of our doctors in training would be familiar with the MTS, an annual national survey of all doctors in training. The MTS is an important way to obtain national, comparative, profession-wide data to improve medical training in Australia and is a quality improvement tool to help strengthen medical training.

Past year's MTS have had high participation levels in the ACT and this helps all organisations – AMA, Colleges, employers and the MBA – to get a good idea of DITs' views on what's done well in current training and workplaces and what needs to be improved.

Already, stakeholders are already using MTS results to identify issues and improve training. The MTS findings are supplemented by the training section of AMA's Hospital Health Check, which is to be conducted in September as well as surveys run by the Canberra Health Services. Together, these surveys' findings help form a strong evidence base to identify issues and for the AMA to advocate for junior doctors' training.

Look for the link

2020 saw a record number of responses and we are looking to repeat that again this year. Interns and IMGs will receive a survey link in an email from the Medical Board of Australia. Prevocational and unaccredited trainees, Specialist non-GP trainees and Specialist GP trainees will see a survey link appear when renewing their medical registration.

The survey will ask questions about your training program and training post. It also includes questions about your supervision, access to teaching, workplace environment and culture and your wellbeing. This year, it is also asking about the impact of COVID-19. The survey tool has been revamped to make it shorter and easier to navigate.

So who runs the MTS? The Medical Board of Australia design and oversees the MTS and an independent, third party, EY Sweeny, conducts the survey. APHRA will send you your survey link and EY Sweeney will collect de-identified data. Many steps have been taken to ensure it is safe, confidential and anonymous to complete the survey. Answers will be de-identified and aggregated in reporting of results.

This de-identified and aggregated data will be published and shared with jurisdictions, employers, specialist college and postgraduate medical councils to shape future training improvements.

Past survey results

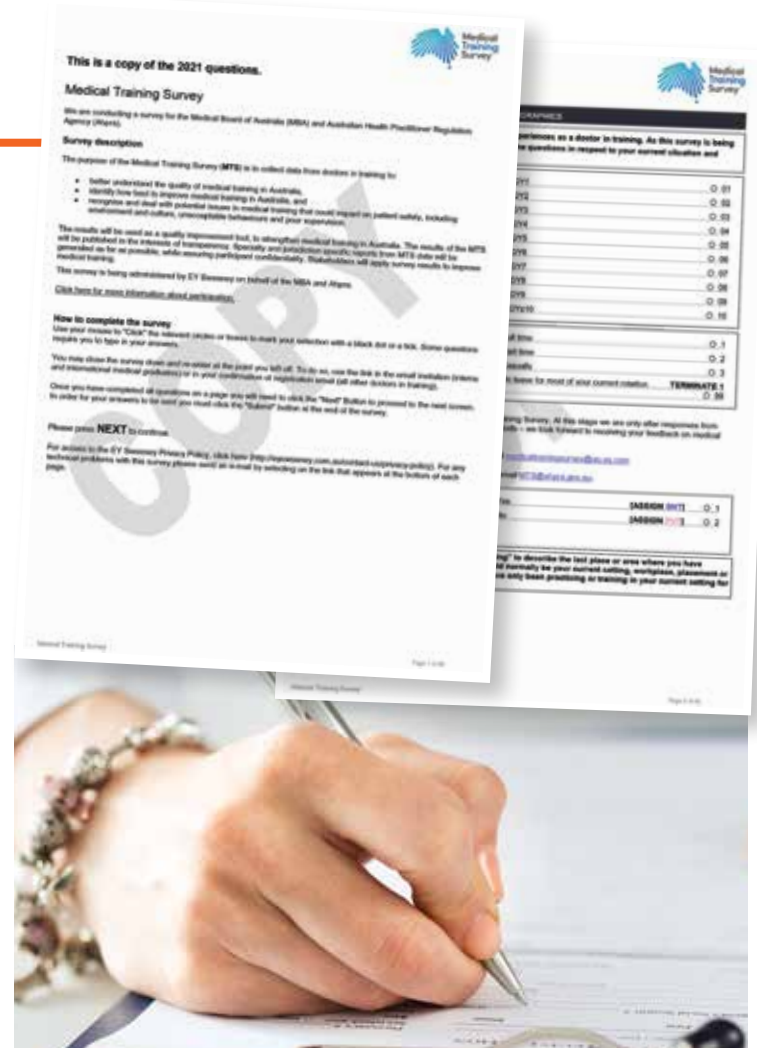
You can also access the de-identified and aggregated data yourself from the past surveys online at https://medicaltrainingsurvey.gov.au/Results/Reports-and-results website.

Please have a look at the Past survey data could help you in planning and investigating future training locations. You can create your own tailored reports with our online data dashboard. Use it to compare specialities and training sites – use the results to inform your training choices.

The MTS will run through to the end of September so look out for your email link or the link when renewing your registration and help improve training both in your jurisdiction and across Australia.

Top 3 reasons to do the MTS

1. Contribute to the data identifying issues and helping improve medical training nation-wide
2. Create your own custom reports from previous years' data to help plan and inform your future training choices
3. Contribute to the evidence base used by AMA to advocate for your training



Farewell to AMA House

AMA Past Presidents with Christine Brill (back row, third from left), AMA ACT CEO Peter Somerville (far right) and Dr Suzanne Davey.

With the AMA ACT Board meeting on 11 August marking the last occasion the Board would get together at AMA House, it seemed like an opportune time to get together and remember the 20-plus years we'd been there. Importantly, it was also an occasion to recognise and congratulate Dr Suzanne Davey on her award of an AMA Fellowship.

While Dr Davey was the special guest for the evening, she was joined by ten of our former AMA ACT Presidents in addition to former AMA President, Dr David Brand, AMA Secretary-General Dr Martin Laverty, former AMA Secretary-General, Dr Bill Coote and long-time AMA ACT CEO, Christine Brill.

AMA ACT President, Prof Walter Abhayaratna welcomed former Presidents Dr Peter Hughes (1984-86), Dr John Donovan (1989-90), Dr Grahame Bates (1990-92 and 1994-96), Dr Colin Andrews (1997-99), Dr Ian Pryor (2001-04), Dr Charles Howse (2004-06), Dr Iain Dunlop (2010-12), Dr Andrew Miller (2012-14), Prof Steve Robson (2016-18) and Dr Antonio Di Dio (2018-21).

AMA ACT will be moving to 39 Brisbane Avenue Barton later in the year and co-locating with the Federal AMA.

BELOW: AMA House, 42 Macquarie Street Barton.

Tony Chase, Manager Workplace Relations and General Practice (far left), AMA ACT Board, back row from left, Dr Iain Dunlop, A/Prof Jeff Looi, Dr Miriam Russo, Dr Kerrie Aust. Front row, Prof Walter Abhayaratna, Dr Suzanne Davey, DR Andrew Miller and CEO, Peter Somerville (far right).

AMA Gold Medal to Prof Nick Talley

The Australian Medical Association's (AMA) highest award, the Gold Medal, has this year been awarded to Laureate Professor Nick Talley in recognition of his outstanding services to medicine, including publishing the *Medical Journal of Australia.*

AMA Gold Medallist, Prof Nick Talley.

AMA President Dr Omar Khorshid said the Gold Award was presented for exceptional service, which was recognised by the winner's medical peers in recognition of his or her advancement of the practice of medicine.

Professor Talley is the Pro Vice-Chancellor, Global Research, at the University of Newcastle. He is considered to be one of the world's leading gastroenterologists and an outstanding clinician and educator.

Dr Khorshid said Professor Talley's outstanding contribution to medicine included oversight of the AMA's *Medical Journal of Australia* (MJA), as Editor-in-Chief, which had adapted to the urgency of the COVID-19 pandemic by reorienting the peer review process and adopting pre-press publication to ensure emerging evidence of COVID-19 was presented in a timely way.

Under Professor Talley's leadership, the MJA had achieved a very high impact factor with the number of citations of articles published to make it one of the top 17 medical journals globally.

Dr Khorshid said: "As a result of Professor Talley's leadership and drive, the latest vital information about the novel and emerging COVID-19 pandemic was presented in a scientifically rigorous way to inform clinicians so we could take up the fight on the frontline armed with the latest insights."

AMA President's Award Recognises CHOs

The Australian Medical Association (AMA) has recognised the outstanding service and medical leadership shown by the state Chief Health Officers and Commonwealth Chief Medical Officers during the COVID-19 pandemic.

The AMA President's Award has been granted to ten Commonwealth, State and Territory Chief Medical and Health Officers (CMOs and CHOs) for their exemplary roles during the pandemic in providing leadership to Australian governments and members of the community.

AMA President Dr Omar Khorshid said the CMOs and CHOs had provided expert health guidance to Australians during and unprecedented health emergency, which had challenged us all in ways that we could not have envisaged before the pandemic.

Dr Khorshid said that the CMOs and CHOs had served with great distinction during a very difficult time and they were a credit to the nation and their medical profession.

"They have not only guided the community with their medical expertise and knowledge, but also with compassion, accessibility and resilience to be able stand up every day to, sometimes, deliver bad news while underlining to the community that we are all in this together and the way out is working together," he said.

"I believe these awards are well deserved and recognize the recipients' extraordinary contributions and I'm sure that Australians will join me in giving the Chief Medical and Health Officers our sincere gratitude for their work."

Dr Kerryn Coleman, CHO ACT Health (photo courtesy ABC).

Dr Paul Kelly, CMO Department of Health.

CLINICAL CORNER

Perceval Sutureless Aortic Valve Replacement

BY DR GLENN MCKAY*

Many GPs and Cardiologists in the Canberra region will increasingly have patients who have undergone aortic valve replacement using a newer type of valve. These are the Perceval suture less valves supplied by Liva Nova. These valves have been increasingly implanted at both National Capital Private Hospital and The Canberra Hospital, particularly in the commonest age group affected by aortic stenosis, the over 70yr old patient. Over 150 patients have now had this type of valve implanted between the two hospitals.

The advantages of these valves over the more traditional sutured tissue valve are decreased cardiopulmonary bypass times, outstandingly good effective orifice area, greater ease of implantation for small or heavily calcified aortic annulus, and increased ease of implantation for redo aortic valve surgery.

Perceval also facilitates minimally invasive cardiac surgery often done through a right anterior chest incision. Its design also allows even circumferential expansion to accommodate possible future transcatheter valves, which may be of great importance when implanted into younger patients who wish to avoid long term anticoagulation with Warfarin, necessary for more traditional mechanical valves.

Compared with transcatheter aortic valve implantation (also known as TAVI), pooled analysis demonstrated a statistically significant reduction with Perceval in paravalvular leakage (1.26% vs 14.31%) and early mortality (2.3% vs 6.9%). Favourable hemodynamics, acceptable valve durability, and ease of implantation in minimally invasive cases were reported as benefits.

Whilst percutaneous valve replacement is becoming increasingly common, standard traditional surgical replacement of the aortic valve still has a very large role to play in the management of aortic valve disease and has never been safer/easier than with these new innovative type of bioprosthetic valves.

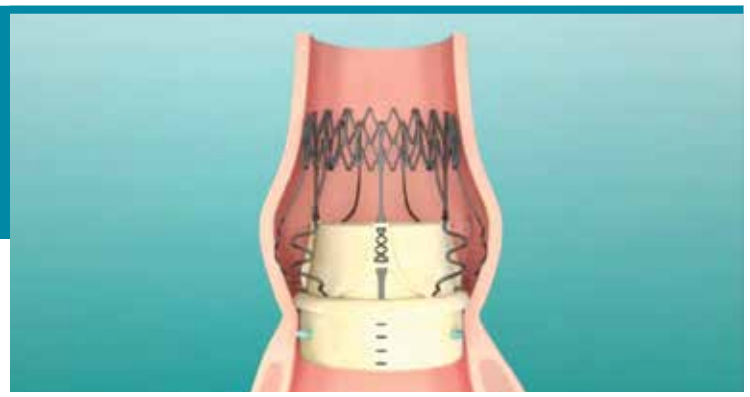
PleurX drainage system

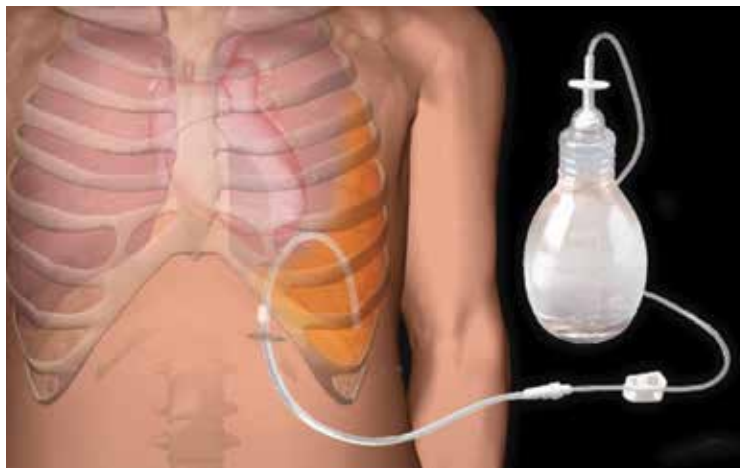
A common advanced malignancy presentation is with a pleural effusion with the classic triad of dyspnoea, chest dullness to percussion and decreased or muffled breath sounds on auscultation. Common underlying cancers are breast, lung and mesothelioma, although any advanced malignancy in any age group can unfortunately present in this way.

Ideally early referral for a thoracic surgery thorascopic pleurodesis provides not only a pleural biopsy based diagnosis to guide oncological treatment in terms of chemotherapy or immunotherapy, but also the best avenue to avoid recurrent effusions. However, not all of these effusions are effectively managed with talc pleurodesis due to associated lung entrapment. Recurrent dyspnoea and a sensation of fullness in the chest can be palliated in these cases with a longer term indwelling catheter such as the illustrated PLEURX system.

The PleurX drainage system can most often be managed by the patient themselves or community nursing teams, but it is also important for their GP to have a basic understanding in case the system needs troubleshooting including blockage, failed vacuum suction drain bottle and the importance of maintaining sterility during intermittent attachment/detachment of the sterile self-vacuum bottles.

Cardiothoracic surgeons and interventional radiologists both insert these catheters which can usually be done under light sedation and local anaesthesia or at the time of both diagnostic and therapeutic Video assisted thoracoscopy under general anaesthesia. Should the patient have a good response to oncological therapy, the pleural space can sometimes pleurodes itself and in these cases the catheter is easily removed.





Management of any suspected malignant pleural effusion is best managed by early referral for Vats and talc pleurodesis, if not possible a PleurX catheter system can avoid a patient's dependence on recurrent and often distressing pleural aspiration with the small but attendant risk of a pneumothorax on each occasion.

**Dr Glenn McKay is a Canberra-based Cardiothoracic Surgeon. His undergraduate training included posts at the Royal Melbourne Hospital and Greenlane Cardiac Hospital in Auckland, New Zealand. He is a Fellow of RACS in both General and Cardiothoracic Surgery (2008) and has extensive training in the management of both simple and complex chest surgery.*

Quicker, more comprehensive CVD risk assessment for Canberra GPs

BY NATALIE RAFFOUL, HEART FOUNDATION RISK REDUCTION MANAGER

ACT general practices will have access to a more comprehensive cardiovascular disease (CVD) risk assessment to identify patients who may otherwise be slipping through the gaps.

Close to 5,000 general practices across the country now have access at point of care to absolute CVD risk assessment and management templates that link to patient records through the MyGPMPtool (MGT), a software application available on Topbar.

The templates and new functionality within MGT allow for a more comprehensive absolute CVD risk assessment compared with the existing Australian online calculator.

The templates from the Heart Foundation's Heart Health Check Toolkit*, which are embedded in MGT and Topbar software, allow risk factor information from patient records to be automatically drawn and pre-filled during an absolute CVD risk assessment. This means that patient records can be used to identify people who may be at clinically determined at high risk of CVD, including patients with diabetes or microalbuminuria.

Integration advantage

This is an advantage over the existing online Australian absolute CVD risk calculator and addresses previous concerns that these patients may be slipping through the gaps.

The embedded 'Heart Health Check Risk Assessment' and 'My Healthy Heart Plan' templates are available on the MGT app, with free access to all general practices using the Topbar clinical support platform or the browser-based version of MGT.

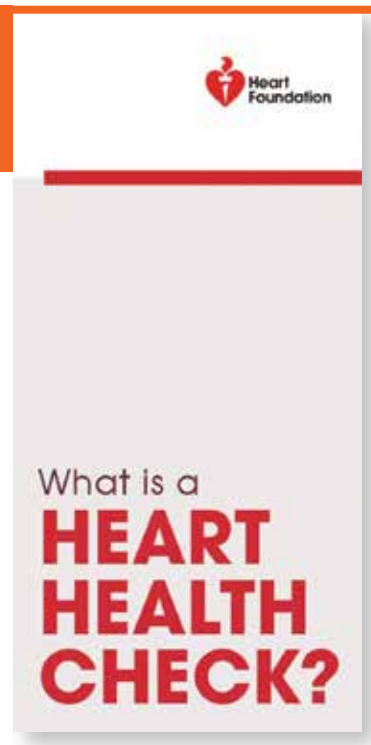
Having the templates from the Heart Health Check Toolkit built into GP software is a big advantage, as it frees up time for GPs and practice nurses by making it easier to treat patients who are most at risk of CVD.

Using the templates within MGT streamlines the delivery of absolute CVD risk assessments by removing duplication as patient data is drawn from the patient record to create comprehensive documents.

All outputs align with requirements of the 699 and 177 Heart Health Check MBS items and current clinical guidelines.

Importance of HHC

The Heart Health Check is the first preventative health assessment MBS item to incorporate absolute cardiovascular disease risk calculation and facilitate yearly assessment. Heart Health Checks were introduced as temporary MBS items in 2019 and are available to Australians aged 45 and over, or from 30 if for Aboriginal or Torres Strait Islander patients. In May this year, the Federal Government extended the temporary MBS items until 2023.



Heart Health Checks are vitally important. Heart Foundation modelling shows that an estimated 1.8 million Australian adults are not being prescribed the recommended lipid-lowering and blood pressure-lowering therapy to manage their risk of heart attack and stroke.

Meanwhile, about 22% of Canberra adults have high blood pressure (↗ 140/90 mmHg). Only the Northern Territory has a lower rate (18%). The national average is just under 23%.

Our modelling also shows that treating high-risk patients with guideline-recommended blood pressure and cholesterol-lowering medicines could prevent more than 103,000 heart attacks, strokes and heart related deaths and save almost $1.8 billion in health care costs over the next five years.

Further, treating all patients at high risk of heart attack and stroke over the next five years would allow Australians to gain an extra 45,580 years lived in good health.

Validated calculation of a person's CVD risk during a Heart Health Check allows therapy to be targeted to people who would most benefit from it. We can learn from international preventative screening programs such as those rolled out across the UK and New Zealand to drive better assessment and management of CVD risk in Australia.

Medications to lower blood pressure and cholesterol are currently recommended in adults at high risk of cardiovascular disease and can significantly reduce an individual's chances of having a heart attack or stroke in the future.

Pharmacological lowering of blood pressure, even in people without existing CVD, reduces the incidence of coronary heart disease events by up to a quarter and a 1 mmol/L reduction of LDL cholesterol is associated with a 20 to 30 per cent reduction in coronary heart disease events.

The Heart Foundation developed its Heart Health Check Toolkit to support clinicians in the delivery of Heart Health Checks. Since the Toolkit's launch at the end of February 2021, over 20,000 people have accessed the resources.

The Toolkit offers pre-populated assessment and management templates for GPs and practice nurses to collect CVD risk factor information and support patients to manage their risk. It also includes a range of resources that can be used by general practices to help engage patients in their heart health.

*https://www.heartfoundation.org.au/bundles/heart-health-check-toolkit

New Ahpra Framework for Vexatious Notifications

BY DR CHRIS MOY, CHAIR AMA MEDICAL PRACTICE COMMITTEE

The AMA understands how intensely distressing receiving a notification from the Australian Health Practitioner Regulation Agency (AHPRA) is to every medical professional. It is one of our key areas of advocacy and something we focus on each and every year.

In response to the AMAs calls, Ahpra released a framework to support the identification and management of vexatious notifications* in December 2020, hopefully taking another step forward to improve their processes.

This framework has been a long time in development and stems from two Senate reports into the Medical complaints process in Australia and the Complaints mechanism administered under the Health Practitioner Regulation National Law.

One of the key issues identified in evidence to these inquiries was that of vexatious complaints. Many health practitioners argued that complaints are too often made for vexatious reasons, using the complaints process as a tool of bullying and harassment, including by other health practitioners.

In its submission to the second inquiry the AMA called for the Ahpra complaints handling mechanisms to be improved by developing a system to triage and remove complaints that are clearly vexatious.

This evidence led to the Senate recommending that Ahpra and the national boards develop and publish a framework for identifying and dealing with vexatious complaints.

Having commissioned research on this issue, Ahpra published a research report in 2018 Reducing, identifying and managing vexatious complaints: Summary report of a literature review prepared for the Australian Health Practitioner Regulation Agency.

This research was the first international literature review of vexatious complaints in health practitioner regulation. The report found that the number of vexatious complaints dealt with in Australia and internationally is small, representing less than one per cent but concluded that these complaints have a significant impact on practitioners' lives.

The AMA continued to raise this issue with Ahpra and the Medical Board, urging further action be taken to enable vexatious complaints to be identified and managed earlier in the notification process thereby reducing harm to the practitioner.

Following detailed consultation with the AMA in the second half of 2020, Ahpra released its new framework to support the identification and management of vexatious notifications. This framework outlines:

- principles and features of vexatious notifications
- the significant impacts of vexatious notifications
- potential indicators of vexatious notifications
- how to identify vexatious notifications, and
- what to do where there is a concern that a notification is vexatious.

At the urging of the AMA, the framework also reinforces that health practitioners should not make vexatious complaints about other health practitioners. Vexatious notifications made by a registered health practitioner with the intent of harming another practitioner are taken seriously. A Board can take action against a practitioner who makes a vexatious notification about another health practitioner. This includes investigating the practitioner and, where vexatiousness is apparent, taking action that could affect the practitioner's registration. Vexatious notifications do not have good faith protections under the National Law.

It is hoped that this framework will provide Ahpra staff with a better understanding of what a vexatious complaint might look like and how to manage one when they have identified it.

Ahpra CEO Martin Fletcher said the publication of the Framework was "an important milestone in more rapidly responding to concerns about the potential vexatiousness of a complaint."

In 2021 the AMA will be asking Ahpra for an assessment of the implementation of this framework and looking for a demonstrable decrease in practitioner burden in their metrics.

*https://www.ahpra.gov.au/Notifications/How-we-manage-concerns/Vexatious-notifications.aspx

GPs Supporting Veterans Post-Afghanistan Evacuation

DVA have provided the following key information for General Practitioners supporting veterans amid recent events in Afghanistan.

In light of the media coverage of the recent events in Afghanistan, showing your veteran patients understanding and responding appropriately to their needs will be vital to supporting their mental health and wellbeing.

Combined with the stressors of the COVID-19 pandemic your veteran patient may need increased mental health or medical support.

Support for your veteran patient

Here are the key things you can do to provide optimum support to your veteran patient during this challenging time:

- Demonstrate an understanding of the military experience*. This can strengthen the therapeutic alliance and the delivery of effective treatment. Veterans are more likely to engage with health care practitioners they feel understand, or seek to understand, their mental health problems within the context of their military service.
- Visit our GP information page** — which provides a one stop webpage that links to the key information you need to know when treating clients, including:
  - Veteran Cards and what they cover
  - Veteran Health Check
  - Coordinated Veterans' Care program — where GPs and a nurse coordinator work together to proactively manage Veteran Gold Card holders with chronic conditions and Veteran White Card holders with accepted mental health conditions
  - Non-Liability Health Care for mental health treatment.
- Keep abreast of DVA updates with our DVA Provider News articles
- Visit our Provider COVID-19 webpage for what you need to know when treating veteran patients during the pandemic, including information on telehealth and shopping assistance.
- Get support to help you support your veteran patients via the Veteran Mental Health GP Assistance Support Service and Advice Line which provides access to free consultations with veteran mental health subject matter experts, supporting Psychiatry and Clinical Psychology consultations. The Hotline can be accessed by calling 1800 VET777 (1800 838 777) or through the **https://www.phoenixaustralia.org/for-practitioners/working-with-veterans/** which provides links to best practice and professional development resources.

Tell your patient about:

- **Open Arms** — Veterans & Families Counselling. This national mental health service provides 24-hour free and confidential counselling available to current and ex service ADF personnel and their families. The Open Arms website also provides a range of self-help resources and wellbeing tools. Visit openarms.gov.au/ or phone 1800 011 046.
- **Safe Zone Support** — an anonymous counselling service that supports serving members, veterans and their families impacted by the unrest in Afghanistan and the Inspector-General of the Australian Defence Force (IGADF) Afghanistan Inquiry. This service is available at any time, day or night. The specialist counsellors have an understanding of military culture and experience and can be accessed online or by calling 1800 142 072. Calls to Safe Zone Support are not recorded.
- For all current ADF members and their families, the Defence all-hours Support Line is a confidential phone and online service and is available on 1800 628 036. Families of serving personnel can also contact the Defence Family Helpline on 1800 624 608.
- Ex-service and non-government organisations who play a vital and complementary role to DVA by providing mateship, advocacy and welfare report. Veterans can visit **https://www.dva.gov.au/civilian-life/find-ex-service-organisation**
- Lifeline — patients can call 13 11 14 for 24/7 crisis support or visit **lifeline.org.au/**

If you are unsure about the support available, please contact DVA on 1800 VETERAN (1800 838 372). Information about support services can also be found on the IGADF website page.

If you know someone in need, please pass on this important message — DVA is here to help.

*https://www.dva.gov.au/providers/notes-fee-schedules-and-guidelines/training-and-research/training-providers

** https://www.dva.gov.au/providers/general-practitioner-information

Medical Certificate under Ahpra's Scrutiny

21 MAY 2021 CLAIRE BASSINGTHWAIGHTE, B.COM, LLB, PRACTICE MANAGER LEGAL – PROFESSIONAL CONDUCT, QLD, AVANT LAW

Writing a medical certificate may be an everyday occurrence for doctors, but it isnít always a simple matter. There has been an increased willingness by employers of patients to make complaints against doctors in relation to the provision of medical certificates, as a GP member recently found.

A patient presented to his treating doctor requesting a medical certificate for time off work in relation to workplace stress and anxiety. The patient's work-related anxiety had increased over time following an interaction with his manager some eight months earlier.

The doctor assessed the patient and wrote a medical certificate, providing personal leave from work. Since the patient was already on annual leave, and was not due back for another fortnight, the doctor dated the certificate two weeks in advance so it would commence when the patient was due to return to work.

When the patient later decided to make a WorkCover claim in relation to his work-related anxiety, the doctor was asked to fill in a standard WorkCover certificate which required further details, including a specific date on which the patient first suffered the 'injury'. As the patient's mental health had deteriorated over time, the doctor considered the original 'injury' to be the incident between the patient and his manager some eight months earlier.

Date discrepancy

Both certificates were completed with due diligence, but one required a date the patient was unfit for work, and the other required the specific date of the 'injury'. The patient's employer noted the discrepancy in the dates and made a complaint to the regulator.

Ahpra contacted the doctor wanting to know why the medical certificate was post-dated and why it had a different date to the WorkCover certificate.

Board notes doctor's self-reflection

In responding to the complaint, the doctor highlighted the difference in the specific questions posed by the two certificates and noted the information he provided when completing all forms was accurate and honest. He further explained that in completing both certificates he had given as much information as he could, he had not withheld information, nor had he provided deliberately false or misleading information.

The doctor acknowledged that upon reflection, the date on the medical certificate should have been the date he examined the patient and considered him unfit for work, not the date he considered the patient required additional leave from work. He apologised and reassured the Medical Board he would not repeat this.

The Medical Board took into account the doctor's honesty and self-reflection and decided to take no further action.

Key lessons

It is important that doctors give proper consideration to what they are certifying when providing a medical certificate, and as always, ensure that it is supported by good record keeping.

- The Medical Board of Australia's **Good medical practice: a code of conduct for doctors in Australia** states a practitioner should only sign a document they know or reasonably believe to be true. In practice, this means you need to verify information presented by the patient and in some cases, it might be prudent to refuse to write a medical certificate.
- A consultation should occur if you are writing a medical certificate or medical report for a patient as a clinical examination should take place to inform what is provided in the certificate or report. Ensure you are thorough in your notetaking and can show clinical justification for your conclusions. It's important that you include all relevant information and be as accurate as possible.

Medical certificate guidelines

- The **AMA Guidelines on Medical Certificates** specify that a diagnosis does not need to be included in a medical certificate. The only details required are confirmation you have examined the patient and the dates you consider the patient unfit. Be mindful of your privacy obligations, especially if asked for confirmation from a third party. Any other details should be kept in the patient's medical record.
- Medical certificates should be written on the day of examination, not back-dated or post-dated. When considering how long to provide the certificate for, consider clinical guidelines and document the clinical justification in the patient's medical notes.
- A lack of supporting information and a lack of objectivity may leave you vulnerable to an accusation of unprofessional conduct. If a certificate is not warranted, then document in the clinical notes the explanation given to the patient as to why.
- Clearly record the diagnosis or clinical findings that formed the basis of the medical certificate in your clinical notes. You may be asked to give evidence to a court, tribunal, board or other authority, about the medical certificate and your assessment of the patient.
- If you are issuing a medical certificate for a legal purpose, such as in support of a patient's application for benefits, ensure you are familiar with your legal obligations under the relevant rules and legislation.

Useful resources

Guidance about completing medical certificates can be found in Section 8.8 of the Medical Board of Australia's **Good medical practice: a code of conduct for doctors in Australia** and in our factsheet, **Medical certificates and your responsibilities**.

If you have concerns about completing a medical certificate, email us on **nca@avant.org.au** or call **1800 128 268**, available 24/7 in emergencies.

This article was originally published on 21 May 2021 by Avant Mutual: **https://www.avant.org.au/news/medical-certificate-under-ahpra-s-scrutiny/**

Digital Image Prescriptions: Avoiding double dispensing

The Pharmacy Guild of Australia – ACT Branch and Capital Health Network, ACT's PHN provide important tips to avoid double dispensing when using Digital Image Prescriptions.

GPs are reminded when using Digital Image Prescriptions (DIPs) to not give the paper copy of the script to the pharmacy or patient. Unfortunately, this has occurred resulting in double dispensing of the same medication through the one prescription which has adversely impacted both patients and pharmacies. Following a telehealth appointment, digital scripts should only be sent directly to the pharmacy and not to the patient.

Reminder for GPs

- Retain the script paper copy (that was faxed or emailed to the pharmacy) for at least two years.
- Do not give the paper copy of the script to the pharmacy or patient.
- Obtain and record patient's consent to send the prescriptions electronically.

Electronic Prescriptions are widely available nationwide and is the preferred prescribing method to support telehealth arrangements in the long term. Therefore, Digital Image Prescriptions will cease on 30 September 2021.

If you have any questions about this or any other Digital Health tools or initiatives, please contact Capital Health Network's Digital Health Team: **digitalhealth@chn-act.org.au**

AMA Policy on Advertising and Public Endorsement

Doctors have a legitimate interest in advertising their medical services; however, inappropriate advertising practices have the very real potential to harm both individuals and the wider community.

In recently updating its policy on advertising and public endorsement by doctors, now referred to as the *Position Statement on Advertising and Public Endorsement 2020*, the AMA's Ethics and Medico-Legal Committee (EMLC) concluded that the line between appropriate and inappropriate advertising is increasingly blurred. This can lead to confusion for doctors in how to meet their ethical, legal and professional obligations and potentially result in harm to patients.

The AMA's updated policy will support members by referring to a range of legal obligations and professional standards set by entities such as the Australian Health Practitioner Regulation Agency (Ahpra), the Medical Board and the Therapeutic Goods Administration while providing additional ethical guidance to support doctors to advertise in the interests of patients and the wider community.

Guided by Ethical Values

Advertising by doctors should be guided by ethical values including respect, honesty, integrity, transparency and accountability. They should facilitate – , not undermine – informed patient choice, relevant medical referral and the community's trust and confidence in the medical profession.

Inappropriate advertising practices can be coercive and exploitative in nature (possibly unintentionally), leading some individuals to use products or services indiscriminately or unnecessarily, potentially resulting in physical, psychological and/or financial harm. Further, inappropriate advertising feeds the perception that doctors are greedy and self-interested, caring more about their own personal and financial interests than patients' interests, damaging community trust and confidence in the integrity of the medical profession.

While doctors should clearly not be involved in inappropriate advertising practices, there are less obvious forms of advertising that can nonetheless prove ethically (and sometimes professionally and legally) problematic if not managed effectively.

Social Media

For example, social media increasingly lends itself to innovative and unique ways to advertise medical services to potential patients, colleagues and other third parties. The 'real time' nature of social media allows doctors to post up-to-date information such as changes to practice arrangements which can benefit patients by enabling them to make informed decisions about the appropriateness of the services.

The interactive nature of social media can also enable doctors to engage directly and publicly with patients and others on doctors' own social media platforms. For example, by allowing individuals to post comments or questions on a doctor's Facebook page, comments that appear (deliberately or inadvertently) to entice or persuade others to use the doctor's service can be considered a form of advertising even if the doctor did not solicit the comments.

Not only is this ethically problematic but Ahpra may consider such comments to be testimonials which are distinctly banned under section 133 of the National Law. Some confusion in this area has arisen in relation to enforcement, due to the obvious proliferation of advertising on some social media platforms that seems to infringe this regularly, but goes uncorrected.

Position Statement Available

As the opportunities to advertise in new, innovative and dynamic ways continue to grow, the AMA's *Position Statement on Advertising and Public Endorsement 2020* will assist members to not only meet their legal and professional obligations but to maintain a strong ethical focus to advertise in the interests of patients and the wider community.

The position statement outlines the ethical principles to guide doctors' advertising practices, refers to relevant legal obligations and professional standards, and addresses advertising in a range of contexts including advertising of medical services; social media advertising; publicly endorsing products and services; participating in media reports, magazine articles and advertorials; and pathologising human conditions and experiences.

The *Position Statement on Advertising and Public Endorsement 2020* can be found on the AMA website at https://ama.com.au/articles/position-statement-advertising-and-public-endorsement-2020

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