Canberra DOCTOR
Informing the Canberra medical community since 1988
August 2015
Canberra Doctor is proudly brought to you by the AMA (ACT) Limited
Circulation: 1,900 in ACT & region

In the fifth in a series on Canberra's hospitals, we go just across the border to Queanbeyan District Hospital, which works in partnership with the ACT

A major $51 million dollar upgrade in 2009 transformed Queanbeyan District Hospital, just over the border, into a modern acute care public hospital which shares in a cross-border relationship with the ACT.

The Queanbeyan District Hospital and Health Service works closely in partnership with ACT Health and the Canberra community. It is only a 15 minute drive from The Canberra Hospital (TCH) and 25 minutes from Civic.

Run by the Southern NSW Local Health District, it is assisting with ACT's waiting lists by treating its patients from NSW in a new reverse-flow agreement signed this year. More than 100 NSW patients have been accepted from ACT lists already, and they will now have their general surgery, minor orthopaedics, and maternity and gynaecology procedures at Queanbeyan.

Queanbeyan District Hospital's Medical/Surgical ward has 38 beds. There are 18 medical/surgical beds, a four-bed Close Observation Unit, two mental health rooms and two isolation rooms

Two operating rooms and facilities cater for day surgery and inpatient surgery. There is a theatre with laminar flow, and an endoscopy room. Specialties provided are general surgery, gynaecology, endoscopy and dental. Minor orthopaedic procedures have commenced recently.

The ED has recently been upgraded to provide even better specialist care. A new FACEM Director has been appointed and the unit has also gained a full-time GP ED Registrar, with two more to join next year. As well as a major step up in care for the 17,500 patients using ED each year, Queanbeyan's ED has become a training and mentoring facility.

The 24-hour ED has seven acute and two resus beds and two paediatric beds (four hours only). The ED has an isolation room, three procedure rooms – eye, plaster and treatment – two consultation rooms and a mental health bed with mental health service.

The eight-chair Renal Unit is operational Monday to Saturday, in partnership with ACT Health Renal Services through TCH.

Queanbeyan District Hospital is a mixture of VMO GPs and Specialist Medical Officers. It is classified as a regional hospital with an on call anaesthetic and obstetric service. There are Junior Medical Officers on the ward seven days a week. The introduction of Diploma Obstetric trainees commenced in February this year.

The Medical Imaging Department has been boosted through the addition of a CT scanner that will go into service later this year. The department performs ultrasounds, mammography, plain X-rays utilising the RIS/PACS. The service operates from 8.00am to 9.00pm, with an on-call service available out of hours. A NSW Breastscreen service also operates from the Imaging Department.

The Pathology Department caters for inpatient and outpatient appointments from 8.00am to 6.00pm, with an on-call service available out of hours.

Queanbeyan's maternity service links with TCH through the specialist obstetricians and a recently installed telehealth service in the nursery. Queanbeyan has three labour rooms, seven post-natal rooms, and a midcall service (post discharge visit). The Maternity Unit has been awarded its fourth consecutive Baby Friendly Health Initiative accreditation certificate, an award developed by the World Health Organisation and UNICEF.

Community and Allied Health Services include oral health and an extensive range of support services including physio and occupational therapy, and a pharmacy service.

For staff, patients and visitors there is ample parking, and the hospital's patient directed visitation policy, meaning open visiting hours, has improved patient and family satisfaction—and that of course benefits staff.

The hospital and health service listens to patients, giving the local community a voice through its Community Consultative Committee. Through the committee, the Health Service hears the patients' thoughts and concerns to improve the service and more thoroughly meet expectations.

While not a Canberra hospital, it's a modern hospital on Canberra's doorstep, and a proactive partner with ACT Health.

Capital Conversations with President, Dr Elizabeth Gallagher

It is with great sadness that I write my first column without our long standing CEO Christine Brill by my side. True to form though, she did prepare this edition to be published after she retired at the end of July. Many of the past presidents that have served alongside Christine, as well of some of our longest serving members said our farewells last week at her retirement dinner at the Boathouse. I enjoyed hearing the tributes, and stories from our older members who have seen her progress through her career.

Christine started with the ACT branch of the AMA in 1983, her first job as she returned to work having started to raise a family. Her first role was as the executive officer, which was a part time position, and the offices were a small space on the ground floor of the residences of the then Woden Valley Hospital. As the AMA grew, so did Christine. She completed graduate qualifications in management and employment relations, and a Masters of Human Resource Management. She has seen us get independence from the Federal AMA, grow our membership and influence, grow out of our premises, and grow the work required to keep our organisation growing, and running. Those who have known her for all those years tell me that at first she presented as a quiet, mild mannered lady, whose confidence grew over the years. She never shied from confrontation and yet when things got tough, or murky, somehow "got the job done and kept her nose clean". One thing I can say even though I have only been on the AMA scene for a mere fragment of her career, is that Christine has stood behind our presidents and boards, often working very hard, and then standing back while we took the credit for things that she did. I have great respect for her, and will miss her support and encouragement.

On the other hand- there are also exciting times ahead as we welcome Peter Somerville as our new CEO. Peter has a law background, and is moving from Sydney to take on this new role. He will need to get to know the Canberra medical community as it is the local knowledge that he is new to. Saying that, he has spent many years working closely with the Federal AMA as part of the ASMOF team, so has an excellent knowledge of what the AMA is about, and industrial relations. I am hoping at some stage in the future, Peter will write a paragraph or two in the Canberra Doctor about his visions for AMA-ACT over the next few years. Welcome Peter.

On another note, there are a few local issues I would like to bring to your attention.

The consultation period for GP training boundaries recently closed, and tenders were issued mid- July. Unfortunately, despite intense and commendable lobbying by the ANU Medical School and ACT Health, some of our local politicians, and with the support of AMA-ACT, the Department of Health has fixed the boundaries. ACT is no longer associated with rural areas where we have built strong ties and relationships, and with no regard to patient flow. Queanbeyan, Bungendore, Braidwood and coastal towns to the Victorian border will now get their rural GP trainees from Southern Sydney. This may well impact on our local GP training scheme, as trainees who want to work in those areas, and who may have already spent time in those regional centres as medical students and junior doctors, may not be able to remain Canberra based.

At the time of writing, negotiations between Medibank and Calvary Health Care have broken down and even despite mediation through the Private Health Insurance Ombudsman an agreement was unable to be reached. While Medibank's argument is that Calvary could not agree to measures to "reduce unfortunate mistakes that can occur in hospitals" they are using The Classification of Hospital-acquired Diagnoses (CHADx) which was intended for use within hospitals to track unintentional patient harm. It was not intended as a means for external monitoring of hospital performance and to hold them to account. What Medibank is proposing is that it will not cover the extra care required to treat patients who suffer a "Highly Preventable Adverse Event" (HPAE) of which it has listed 165 conditions, some of which are the most common surgical complications. They are not going to cover sentinel events, such as maternal death, readmission as a result of a HPAE, readmission for any related condition within 28 days, or a HPAE while in hospital. As an obstetrician, the thought that this sort of control will make me even more likely to work with my team to prevent a maternal death is laughable! What they are assuming is that anything more than a 0% complication rate is a reflection of poor practice.

There is evidence that only 44% of the events being proposed are preventable. The implications for patient care in private hospitals is obvious. Private hospitals will have to monitor the procedures it provides. Patients at high risk of falls, those patients that require more difficult or complicated procedures that are associated with a higher complication rates could be shifted to the public hospitals. Patients who suffer the worst and most expensive complications, may also need to move to the public hospitals.

Calvary is not arguing that quality and safety is not important, just that the tool Medibank is using is flawed. The AMA is also busy lobbying to get a satisfactory resolution to this. Unfortunately in Canberra, two of our largest private hospitals are affected. It was suggested by the staff at Medibank to one of my pregnant patients that she ask if she could go to another hospital, showing how little insight into the impact on private healthcare in Canberra.

AMA-ACT has been approached about staging a rally to protest about the Border Force Act. It is proposed we walk from AMA House to Parliament House. We are very interested to gauge interest and support for this, as we do not want to arrange it unless we can get enough support to show solidarity, strength and determination. This is a very important issue as it is effectively trying to stifle the rights of health care workers to speak out about the treatment and health of asylum seekers and turn them into criminals. I urge you to read the article on page 12 of this edition and register your support with the AMA-ACT if you would like to be involved.

And just a final note for all our VMO members. The next round of contract negotiations with ACT Health have started this month, will continue through to November, with arbitration of unresolved issues is due to start in February. Please feel free to call me if there are any issues you would like raised.

Our next edition will be the first for our new CEO. Till then…

OPINION: Pre-conception genetic screening – let the mutants beware!

By Steve Robson

All of us are mutants, whether we like it or not. The human genome differs in every individual, so there is no 'normal human genome.'

Areas of our genome where differences between people are commonly found are referred to as 'variations,' and in locations where the frequency of alleles is greater than 1% these variations are called 'polymorphisms.' The term 'mutation' is generally reserved for a DNA change that is known (or thought) to be associated with a disease. The commonest mutations known to lead to disease are those in the cystic fibrosis transmembrane conductance regulator (CFTR), with about one person in 26 carrying a mutation in this region of the genome. Mutations for spinal muscular atrophy are also relatively common.

When these polymorphisms or mutations are present in the germ cells – sperm and eggs – a disease tendency can be transmitted to an offspring and will generally be present in every somatic cell of the body. When new mutations arise in somatic cells, tumours may develop but these will obviously not be transmitted to an offspring.

As we are all aware, the pace of genetic research is extraordinary. Large-scale research projects have identified single-nucleotide polymorphisms (SNPs) throughout the genome (the 'Genome-wide Association Study') that now allow identification of the genetic associations for many complex conditions. The genome-wide association studies have mapped SNPs and the presence of many common conditions: many hundreds of disease-SNP associations have now been identified and more are being discovered all the time.

This new and expanding bank of genetic knowledge has developed in concert with remarkable changes in molecular diagnostic technology. Previous mutation testing based on polymerase chain reaction (PCR) for single-gene mutations has been overtaken by highly multiplexed tests that can detect thousands of variants at the same time. These are based on a combination of microfluoresence detection methods and computer chip manufacture processes, allowing 'gene chips' to be mass-produced to exacting standards – a single chip can detect hundreds of thousands of base-pair variations in just hours, and cheaply. The chips are a matrix of small, sequence-specific oligonucleotides fixed on a microarray.

A person's DNA is cut into small fragments, labelled with fluorescent marker, and merely incubated with the microarray chip. Computerized analysis is performed on the fluorescence pattern and the sequences present in the DNA sample are interpreted with high sensitivity and specificity. The pace that this technology is moving is truly breathtaking.

The fruits of this change has been evident for about two years now, with easy commercial availability of cell-free DNA testing for Down syndrome from maternal blood in the first trimester, commonly referred to as 'non-invasive prenatal screening' or NIPS. The introduction of NIPS, based on massively-parallel sequencing, has seen the number of amniocentesis and CVS tests tumble to the point where it is going to be difficult to train future specialists in these invasive techniques.

The next area where microarray technology is going to have a massive potential impact is 'screening' for polymorphisms and mutations in couples before they try for a pregnancy. But whereas NIPS is commonly used either to triage women who have a higher-risk combined screen, are older, or have some other risk factor, 'pre-pregnancy genetic screening' – PGS – of the potential mother and father before a pregnancy is conceived has extraordinary potential ramifications that are only just being recognized.

Because providing PGS is so potentially profitable (since there is a strong economy of scale), commercialisation and direct marketing to prospective parents will put doctors under great pressure. But as Feero and colleagues pithily remind us in the New England Journal of Medicine, "don't order a test unless you know what to do with the result."

Polymorphisms are so common that it is highly likely 'screening' will detect disease predispositions in couples that are completely healthy. More importantly, with the rapid pace of medical advance, improvements in management of disease are likely to change the course of many heritable illnesses before any child conceived comes of age. This effect has dogged screening for adult disease in other areas: over-diagnosis and false-positive tests can be extremely stressful for people who have screening tests.

The assumption made by those offering PGS is that, since newborn genetic screens identify children who benefit from

treatment, parents planning a pregnancy can have potential health problems in their offspring identified early and allow them to make 'better reproductive choices.' Is this really the likely outcome? As new tests offer more and more comprehensive identification of disease susceptibilities, decision-making in light of the results becomes more and more challenging. Genetic screening programs are already beset by unanticipated incidental findings, ambiguous results, false-positives, and over-diagnosis.

All of us perform genetic screening for our patients, a process we know as taking a family history. The ability to assess for multiple heritable risks simultaneously, and at a level of detail almost beyond comprehension to all except experienced genetic counsellors, can present tremendous difficulties for couples. This screening approach is not designed to allow any treatment – the usual goal of screening – but to give prospective parents the opportunity to avoid the birth of an 'affected' child.

Unfortunately, doctors' desire to avoid litigation and the commercial interests of companies marketing these tests (often directly to patients) is likely to drive uptake. While a clear case can be made for pre-pregnancy screening of mutations for cystic fibrosis and spinal muscular atrophy, which are relatively common, it is completely unclear as to whether there is any value (other than commercial) for wider screening tests.

The information provided by genome-scale screening tests has the potential to be very confusing and to present difficulty in interpretation. The conditions detected may be untreatable, or indeed very mild in effect. Treatments may become available over the lifespan of the child conceived.

Doctors who wish to engage with commercially-available pre-pregnancy genome-scale testing – the type heavily marketed by biotechnology companies – will need to be very conversant with the technology, the results, and the diseases and predispositions tested for. If you find this confusing and daunting, imagine how difficult it is for your patients. Let all of us mutants beware.

A/Prof Stephen Robson is a Canberra O&G specialist and President Elect of AMA (ACT).

Recommended Reading:

Feero WG, Guttmacher AE, Collins FS. Genomic medicine – an updated primer. N Engl J Med 2010; 362: 2001-11.

Burke W, Tarini B, Press NA, Evans JP. Genetic screening. Epidemiol Rev 2011; 33: 148-64.

AMA warns against radical changes to medical intern training

The AMA has lodged a submission in response to an options paper released by the Council of Australian Governments (COAG) Health Council National Review of Medical Intern Training.

AMA President, A/Prof Brian Owler, said that there is no need to radically change the Australian model of medical intern training.

"The AMA urges caution on any proposed major changes to internship training for medical graduates," A/Prof Owler said.

"There is no evidence to show that the current model of internship in Australia is 'broken', or that radical changes to its structure are required.

"Our submission highlights that the current model of intern training in Australia has served the community well.

"It gives new medical graduates a well-rounded, generalist, supervised, and protected introduction to medicine, which enables junior doctors to develop their medical skills and professionalism.

"Instead of sweeping changes, we need to build on what works.

"We support improvements to supervision and assessment processes, and expanding prevocational experience in non-traditional settings, such as the community and private settings, where there is evidence that these changes produce results."

A/Prof Owler said the COAG Review is considering a range of options to reform intern training, from incremental change to more radical proposals such as a two-year prevocational training program or transferring the intern year into the last year of medical school.

"The Review shows there is a lack of data surrounding the quality and effectiveness of the intern year in preparing junior doctors for independent practice," A/Prof Owler said.

"The AMA believes the Review must propose new systems to provide better information on the quality of medical intern training, the transition from medical school to intern training, and in the remaining prevocational and vocational training years.

"To support this approach, the AMA has recommended a national survey of medical training, similar to the survey that the General Medical Council undertakes in the United Kingdom."

The AMA submission is at https://ama.com.au/submission/medical-intern-review

OPINION: Caught in the middle – the controversies of intersex intervention

By Ben Loel

In 1965, during what was to be a routine circumcision, the penis of a Canadian boy was accidentally destroyed beyond repair. The boy's name was David Reimer. David was born into an era now commonly remembered as the 'sexual revolution', a time characterized by rapidly changing ideologies regarding gender and sexuality.

At the center of the sexual revolution was sexologist and psychologist John Money, who was receiving media attention for his controversial theories around gender. Money postulated that humans are born gender-neutral and that gender is an embodiment of physical appearance and environmental exposure, meaning that it could be altered accordingly.

Soon after this tragic surgical complication, driven by what was undoubtedly honest and well-intended parental concern, David's family sought Money's professional advice. Money seized this opportunity to implement an experimental form of 'therapy', which would subsequently alter the course of David and his family's life, though not in the way he had envisioned.

Acting on the concept that the appearance of one's genitals largely influences their gender, Money deemed David's penis no longer compatible with being male. He proposed that surgically crafting David female genitals would therefore ensure him a better life as a female.

David was raised as a girl, but by 13 years old had assumed a male identity. He committed suicide at the age of 16. Despite his own appraisal of the success of this intervention, it is now a unanimous consensus that Money was sadly mistaken.

Fast forward to now – has the situation changed? The answer is simply and obviously yes. But do surgeons still undergo non-therapeutic surgery on the genitals of children – arguably representing a fundamental disregard to the essential human right of self-determination? Unfortunately and to the surprise of many, the answer is also, but not so simply, yes.

David was not intersex, but he represents a lesson learnt on the potentially devastating consequences of taking another's gender in your own hands. One in 2000 babies are born intersex, many of whom possess ambiguous genitalia. There are two reasons these infants undergo surgery: to treat a physical malfunction or disease, or to make them appear more male or female. The latter still occurs due the failure of many to properly distinguish it from the former.

The dichotomisation of gender and pathologisation of non-conforming gender identities means that medical intervention on intersex babies is

driven largely by social ideology despite unequivocal scientific evidence to dispute its therapeutic outcomes. A recent study that followed up intersex babies who underwent gender allocation contradicted the dominant view by concluding that early gender allocation or 'sex assignment' was not the best predictor of gender identity development. Subsequently, they called for a reassessment of medical approaches to intersex people, and a conceptual divorce between gender identity and gender role.

Numerous other studies have raised uncertainty about the outcomes of surgical sex allocation of intersex babies, yet the practice remains largely unquestioned.

Aside from the uncertainty regarding the actual benefit of surgical intervention in many cases, why else might it be morally wrong? If you wish to take an unbiased approach to this issue, with a goal to ensure the best outcomes for the people at the center of the debate, listening to them is a start. Intersex organisations across the world take a pretty unambiguous stance towards intersex surgery – they don't like it.

Alternatively you could explore the human rights of intersex babies that have arguably been disregarded. Consent, for example. In Australia when a person is too young to demonstrate competence, responsibility to consent to a medical procedure is assumed by the parent or legal guardian. In a medical emergency, consent is not required to perform surgery that is life saving or to prevent serious harm. The question arises however, should parents be able to consent to intersex surgery when it is not a medical emergency? The courts have never directly addressed this issue. However, in 1992 the High Court of Australia deliberated on whether a parent was able to consent to a hysterectomy and oophorectomy to be performed on a 14 year-old girl with an intellectual disability.

The case is now well known as Marion's case. The court ruled that court authorisation is required for a medical intervention that is invasive, irreversible and not for the purpose of curing malfunction or disease. The courts decision was to ensure the child's best interest, given the serious consequences potentially resulting from a poorly informed decision. How then, is non-therapeutic surgery on an intersex infant any different? Yet cosmetic alteration of the clitoris is just one of several non-therapeutic genital altering surgeries that occurs on intersex babies today, despite being shown to result in higher rates of non-sensuality and inability to achieve orgasm.

There is no current standard of care for intersex infants in the ACT. For one to exist, one that is embraced by the intersex community and supported by unbiased outcome measures, a transcendence of binary sex and its inextricable link to gender is required. Today, only the stubborn remnants of archaic gender stereotyping prevent doctors from considering a person's individual experience of gender in their medical management.

It is for no one to argue that there is a simple solution to what is undoubtedly a complex ethical issue. However, when such a dispute between opposing moral imperatives continues to impact newborns across the world, it is a conversation that needs more airtime.

To some extent, we are all victims of the discriminatory and marginalising ideologies held by the society in which we are raised. But the more access we have to information and technology, the greater ability we have to ask questions ourselves, and at a lesser expense. Ignorance is no longer a forgivable excuse. If a blatant defiance of social and human rights will not insight you to ask these questions, than perhaps the idea of medical mutilation in the absence of sufficient supporting scientific evidence will.

Ben Loel is a Year 3 student at the ANU Medical School

References are available on request from the author

AMA responds to RACS issues paper on bullying and sexual harassment

Following a Four Corners report on bullying and harassment amongst the medical professions earlier this year, the Royal Australasian College of Surgeons established an Expert Advisory Group to examine the issue within the surgical workforce (http://www.surgeons.org/about/expert-advisory-group/). An issues paper was developed by the EAG aimed at "triggering debate and finding solutions to address discrimination, bullying and sexual harassment in the practice of surgery".

The issues paper covered four areas – organisational culture, the culture of surgery, 'bystanders are silent' and complaints. Comment on each area was sought from stakeholders including the AMA.

The AMA's submission to the issues paper covered several areas:

- Although discrimination, bullying and sexual harassment are not limited to the medical profession, the AMA believes doctors should take a leading role in addressing them.
- While policies are generally in place to deter or deal with these matters, the awareness of those policies is low.
- More co-ordination between colleges and employers is needed
- Education of all practitioners, both in the workplace and as part of the training curriculum, is required. Trainees, fellows and managers should be trained and aware of the different components and requirements of relevant policies in accordance with roles, obligations and rights.
- There is a need to ensure that female trainees have strong, supportive female role models.
- Work stressors, leadership styles, systems of work, work relationships and workforce characteristics all add to the likelihood of discrimination, bullying and sexual harassment occurring.
- Research shows that 'intentional inclusion' strategies are needed to breakdown the male norm of the culture. AMA supports the principle of such strategies.
- Cultural change needs to be led by the senior male members of the profession. Explicit statements to the effect that sexual harassment is unacceptable are one means of doing this.
- Bystanders are often silent because they do not recognise discrimination, bullying and sexual harassment or they do not have faith in the systems meant to deal with these issues.
- Colleges must have systems in place that provide for a fair and safe appeals and remediation process and must ensure that trainees are aware of how to access grievance and remediation processes if required.
- The AMA supports a centralised, accessible database about discrimination and related complaints for effective, on-going management.
- The AMA believes that the implementation of a national training survey is essential to provide data on which training programs and locations are managing bullying and harassment well and where there is room for improvement.
- The AMA believes that health departments and hospitals should maintain reporting statistics (de–identified) to develop an ongoing database to accurately target problem areas on an ongoing basis.

A copy of the AMA submission in full can be obtained from AMA (ACT).

51% more likely to die: older patients in the firing line

Older patients are suffering most of all from overcrowded hospitals, according to new research undertaken at the Canberra Hospital, ACT.

The three-year study looked at the experiences of over 13,000 patients aged over 50.

It found that patients who waited more than four hours to be transferred to a bed in the main body of the hospital after receiving their emergency care were 51% more likely to die than people who waited less than four hours.

The finding calls into question the rationale used by hospitals to decide which patients are moved into a bed first.

"In emergency departments (EDs), we take in the most vulnerable patients first," said Associate Professor Drew Richardson, who conducted the study, "But this hospital is using different criteria to decide who should be moved from the ED to the main body of the hospital."

"The sicker patients with the more complex problems – who are almost always over 50 – are not being admitted into the hospital as soon as they should be to receive the care they need."

Ideally, a person admitted to an ED is given the acute care they need and then either sent home or moved into the main body of the hospital to receive further care. But with Australia's growing, ageing population there are fewer hospital beds available, leading to overcrowded EDs and ambulance ramping.

"This important research adds to the already significant body of evidence demonstrating the very real negative health impacts caused by access block," said Dr Anthony Cross, ACEM President.

"The likelihood of these findings being replicated in hospitals across Australia is high, which paints a concerning picture about the level of care over-50s can expect from our health system."

"Older patients shouldn't be put at risk simply because their more complex conditions require more resources."

Associate Professor Richardson is Chair of Road Trauma and Emergency Medicine at the Australian National University Medical School. He presented his findings at the ACEM Winter Symposium in Alice Springs at 11.00 am Monday 27 July 2015.

Educational partnership launched: NPS Medicinewise and Primary Health Care

In a new initiative Primary Health Care, NPS MedicineWise and the Primary Health Care Institute are pleased to announce a partnership in which NPS MedicineWise will support the continuing professional development of Primary Health Care health professionals.

The partnership enables educational visits with NPS MedicineWise clinical services specialists – independent, evidence-based learning that focuses on quality use of medicines and medical tests.

Primary Health Care operates a total of 71 medical centres across Australia, with approximately 1300 general practitioners, specialists and allied health professionals within its network. Primary Health Care facilitates 7.5 million consultations with GPs every year which is around 7% of national GP care, and also operates imaging clinics and pathology labs.

Primary Health Care Institute CEO and Managing Director, Peter Gregg, says providing learning opportunities is a key focus for the network and Primary has a strong commitment to education and continuing professional development.

'Primary continues to focus on training opportunities for our doctors and practitioners and we are delighted to be partnering with NPS MedicineWise to ensure our professionals have access to the best and most recent thinking on medicines and medical tests," says Mr Gregg.

"This educational partnership will bolster existing learning initiatives at Primary, including regular clinical training accredited through the Royal Australian College of General Practitioners and available via the Primary Health Care Institute."

NPS MedicineWise CEO Dr Lynn Weekes said she is delighted that NPS MedicineWise programs will be available to Primary Health Care staff through this new partnership with the Primary Health Care Institute.

"Keeping up-to-date is a constant challenge for busy health professionals. The educational partnership enables us to deliver our educational programs face-to-face throughout the Primary network and will support practitioners to make better decisions in line with the latest evidence and best practice," says Dr Weekes.

"This partnership with Primary Health Care Institute will enhance and build on Primary's commitment to fostering continuous learning across its network."

New "Women Want to Know" campaign targets Canberra doctors

Did you know that 97% of Australian women wanted to be asked about alcohol use in pregnancy?

A new campaign launching this August in the Australian Capital Territory (ACT) encourages Canberra's health professionals to speak to women who are pregnant, or planning a pregnancy, about alcohol.

Each year 5,316 babies are born in the ACT region, and beginning these important conversations will reduce the risk of children being exposed to alcohol before birth.

Alcohol is a teratogen and its consumption during pregnancy is associated with a range of adverse consequences including miscarriage, still birth, low birth weights and Fetal Alcohol Spectrum Disorders (FASD). There is no known safe level of alcohol consumption where damage to the fetus will not occur.

For these reasons, Australian health guidelines recommend that for women who are pregnant or planning pregnancy, not drinking alcohol is the safest option.

Unfortunately, research shows that awareness of this advice remains low. The National Drug Strategy Household Survey (2010) undertaken by the Australian Institute of Health and Welfare, found that one in five Australian women continue to drink alcohol after becoming aware of their pregnancy.

Research also shows that health professionals encounter a range of barriers in initiating conversations with women about alcohol consumption. Some say they are reluctant to discuss alcohol consumption – as they are concerned that women may feel uncomfortable with the conversation, or are unsure of what advice to provide and where to refer women if necessary.

This new campaign, *Women Want to Know*, aims to overcome these barriers and support Canberra's health professionals to broach the subject.

Women Want to Know provides online Continuing Professional Development (CPD) accredited training and resources which are relevant to health professionals and women.

These resources was presented at the ACT event, where *Women Want to Know* was officially launched by Deputy Chief Minister, Simon Corbell MLA at the ACT Legislative Assembly 12:30pm on Wednesday 12 August.

The ACT launch of *Women Want to Know* also presented new research from the University of Canberra on women's understanding and perceptions of health messages around alcohol consumption in the ACT. This research highlights how women interpret health messages and the important role which health professionals, as a trusted source, can play in influencing their health decisions.

More information about *Women Want to Know* and resources, including free print materials and online training for medical professionals, is available at *www.alcohol.gov.au*.

Women Want to Know was developed by the Foundation for Alcohol Research and Education (FARE) in collaboration with leading health professional bodies including the Australian Medical Association and the Royal Australian College of General Practitioners. It is funded by the Australian Government Department of Health and supported by the ACT Government under the ACT Health Promotion Grants Program.

AMA President, A/Prof Brian Owler expressed his views on private health insurers and more at the National Press Club

The following is an edited version of the AMA Federal President, Associate Professor Brian Owler's address to the National Press Club on 22 July 2015.

"Twelve months ago, at my first National Press Club address, I outlined the strengths of our health care system – the foundations that make the Australian healthcare system one of the best in the world.

I talked about universality, equity of access, the sanctity of the doctor–patient relationship, a balance between private and public medicine, and the high level of training of those within the system, especially our doctors.

I reminded our politicians, our doctors and healthcare workers, and our community that these foundations must be preserved and they cannot be taken for granted.

Since the 2014 budget, the AMA has fought to preserve those foundations and seen off the worst elements of the 2014 budget – the $7 GP co-payment, changes to the Level A and Level B consults and the $5 cut to Medicare rebates.

However, the freeze on indexation of patients' Medicare rebates is still in place.

This year I want to talk about what we should be doing to strengthen our healthcare system and the first of these relates to the Government's **review of the Medicare Benefits Schedule (MBS)**.

The AMA welcomes the opportunity to ensure the MBS meets the needs of a modern healthcare system. However, our support is predicated on the review not being aimed at cutting the funding to health. While it's early days, we already have concerns about the direction of the review and the need to engage with experts, especially our Colleges and Specialist Societies.

We agree with not paying for procedures that don't work for certain indications, but we also need to ensure that we don't deprive people of important services.

Indexation freeze

The freeze on indexation of patients' Medicare rebates is still Government policy.

It is important that people understand that the Medicare rebate is the rebate to the patient and it is only in the case of bulk billing that the rebate goes directly to the doctor.

The freeze is, once again, a proposal based purely on reducing health expenditure, rather than investing in the health of patients. The Government failed to consider the consequences.

For a long time, the Medicare rebate has been indexed in such a way that it has failed to keep pace with the value of the services provided, let alone the cost of providing those services. As wage costs increase and other practice costs increase – and we expect more from general practice – the costs of providing services will be passed directly on to patients.

While the Government portrays doctors as being only concerned about indexation in terms of their incomes, this argument is false. This is about the viability of practices in socially disadvantaged areas. It is about whether they can employ the practice nurse or invest in the equipment for their practice that helps them provide the patient with better health care.

The freeze to indexation is a direct attack on general practice. This is not AMA rhetoric. It is what GPs all over the country are saying to the AMA and to their patients.

Private health insurers

I am proud of many of the features of private health insurance in this country. Patients with pre-existing conditions have been able to join a health fund and receive treatment, even for their pre-existing condition, after a waiting period of usually one year. Patients cannot be denied coverage. Community rating ensures that patients with significant medical conditions continue to be covered.

Without these measures, both our private and public systems would be in jeopardy.

The private health insurance landscape changed last year with the float of Medibank Private. For the first time, we have a major insurer in the market – with 29.1 per cent market share and coverage of 3.8 million people – where the primary responsibility of directors is to shareholders. We know shareholders care about growing market share and increasing returns.

Periodically, each private hospital group negotiates an agreement with each private health insurer. The details are normally not disclosed, but the negotiations between insurers and funds appear to have become more aggressive. There have been recent reports of a dispute between Medibank Private and the Calvary Health group. As things stand, Medibank Private patients will no longer be fully covered for treatment in a Calvary Hospital.

This is very concerning for patients in the ACT, Tasmania, and South Australia, in particular, where Calvary Hospitals are most prominent.

The dispute is wrapped in the cloak of concerns for quality. Medibank Private has proposed that they will not pay for treatment in the instances of a number of 'preventable complications'. While the AMA does not have any problem for refusing to cover rare mistakes such as surgery on the wrong site, there are many other areas where complications will occur despite full preventative measures.

The Medibank Private list includes 165 different 'preventable' clinical conditions or events. One of those is maternal death associated with childbirth. Unfortunately, maternal death can and still does occur in a very small number of cases – as tragic as that is.

Personally, however, I find it offensive that a private insurer would refuse to cover the costs of that patient and hospital in such a tragic event. If someone thinks that a financial incentive will motivate doctors, nurses or anyone else in a hospital to prevent maternal death any more than they desire to do so now, then they have no understanding of medicine or the people in it.

The Future for Our Healthcare System

I want to now talk more generally about where we should be going with our healthcare system, and I want to make five key points.

First and foremost, it is time to **value health**.

We need to recognise what our healthcare system means to us and our families, value those working within it and recognise the contributions that all healthcare workers make to the health care of all Australians.

Health is an essential ingredient to any economy; it's essential to learning and to going to school. Health is essential for training and employment, and to supporting a family.

We need to see healthcare expenditure not as a waste, but as an investment.

Second, we need an **overarching plan for health care**.

What is the national strategy for our healthcare system? A long-term, bipartisan National Health Strategy may be difficult to achieve, but allowing our healthcare system to meander risks its future, and allows its foundations to be undermined piece by piece.

A National Health Strategy should guide our health policy, our decisions, and any future reform of the healthcare system. It requires a commitment to engage with those who work in the system, and political resolve from Federal and State leaders.

The third point is **efficiency**.

Healthcare expenditure is not out of control and doctors have been working to make the healthcare system more efficient for decades, and have had remarkable success in doing so.

However, there are ways to reduce healthcare expenditure without punitive measures, and without restricting access for those people who need it.

We need to be smarter at achieving efficiencies. Integration of our healthcare system, underpinned by information technology, is an obvious solution. Linking general practices with each other, as well as with hospitals and other healthcare workers, not only improves quality and safety, it reduces waste and provides efficiencies.

Fourth, everyone knows that the biggest challenge for our healthcare system is the growing burden of **chronic disease**.

Investment in general practice is essential if we are going to keep people well and in the community and our family doctors are the cornerstone of chronic disease management. They need to be supported to do this work with investment, funding, and resources.

The AMA is working with private health insurers on ways that private health insurers can support our family doctors in the management of chronic disease. Policies in health must be re-orientated – they must pivot to general practice.

The fifth and final point is the **importance of our public hospitals**.

People will always need hospitals. Our public hospitals are far from meeting demand. We must continue to invest in our public hospital system.

Treasury estimates that $57 billion will be taken out of our public hospitals between 2017 and 2025. This is a real cut from the funding commitments agreed to by the previous Federal Government with the States.

The scale of the cuts is significant and for the smaller jurisdictions, the cuts will be even more profound as they struggle to manage the long-term healthcare needs of their community without a sufficient taxation base.

The funding of our public hospital system is not an argument for the abstract. It is about those in our society who are suffering, about those who are getting left behind.

While I welcome the Prime Minister and Premiers' discussions about future funding of health, this is the message that I want to send to our leaders: Sort this mess out. Fund our public hospital system properly, and don't keep leaving the sick and the suffering behind."

AMA community residency program – a plan to train the next generation of family doctors

The AMA is promoting its Community Residency Program, a plan to train the next generation of family doctors.

The Program, which is currently being examined by the Government, was developed following the scrapping of the Prevocational General Practice Placements Program (PGPPP) scheme in the 2014 Federal Budget.

AMA President, Professor Brian Owler, said today that the AMA Community Residency Program would provide Junior Medical Officers (JMOs) with opportunities to undertake important general practice prevocational training in an effort to encourage more young doctors to choose a career in general practice.

"With the loss of the PGPPP, general practice is now the only major medical specialty that does not offer JMOs the opportunity of a prevocational training experience," Professor Owler said.

"You have to remember that GPs must train for 10 to 15 years to become providers of quality comprehensive care.

"The AMA had serious concerns that the loss of the PGPPP would see a decline in the general practice workforce, especially in rural and remote areas, at a time when community need for GPs was growing.

"So we developed an alternative GP training plan to ensure Australia could keep producing the GP workforce necessary to meet future community demand.

"Our plan sets out the design and funding principles that would support opportunities for JMOs to undertake rotations of up to 13 weeks into general practice, which would help them to experience life as a GP and enhance their clinical experience.

"A recent major study (Comparing general practice and hospital rotations, *http://onlinelibrary.wiley.com/doi/10.1111/tct.12224/pdf*) shows clearly the educational value of a general practice placement in comparison with hospital placements.

"The study recommends that the expansion of prevocational general practice placements should be considered to provide all junior doctors with the benefits of exposure to generalist skills in the community.

"The AMA's Community Residency Program is affordable, and would be a very worthy investment in our future medical workforce," Professor Owler said.

Details of the AMA Community Residency Program for JMOs are available at *https://ama.com.au/submission/community-residency-program*

Background:

- At the time of its conclusion, the PGPPP funded 900 prevocational placements in general practice annually for JMOs.
- The PGPPP was a valuable program for many reasons. It supported efforts to deliver more training and care in the community, supplementing the traditional hospital-based approach to medical training. Through careful targeting, it also boosted access to GP services in rural and remote communities.
- The PGPPP gave JMOs a valuable insight into life as a GP, and informed their career choice.
- The PGPPP also helped build an understanding of how general practice works, informing future practice in other specialty areas. With a deeper appreciation of the role of GPs, other specialists can make better decisions about patient care, and work more closely with their GP colleagues.

OPINION:
Perioperative Medicine – Everything old is new again

By Dr Bill Burke

When my father returned to Sydney in the early 1950's as a freshly minted neurologist from a heady few years at Queen's Square in London he was advised in no uncertain terms that he would not make a living practising solely in neurology and he must do as all others before him had done. He was left in no doubt that almost by definition a physician was a "generalist with an interest". Apart from family and horse racing, neurology was his great passion so he disregarded the proffered advice and over time built for himself a large practice and a reputation to go with it.

The 1980's, the decade in which I started and finished my physician training, is remembered for many things. Big hair, Alan Bond and mostly bad music spring to mind but medically it was a decade that saw the shift from general to subspecialty medicine at both a micro and macro level. With only a few notable and farsighted exceptions hospitals all over the country wound down their general medical units and physician training was very much sub-specialty based. Locally the closure of RCH in 1991 was the catalyst for the new principal hospital to move to a subspecialty roster although Calvary remains to this day a general medical hospital although its subspecialty input has grown by necessity with the rapid growth of North Canberra.

When I returned to Canberra and put up my shingle in 1994 it was with an empty bank balance and a growing list of expenses that needed feeding and clothing. Despite the fears most of us have when starting out eventually the work does come, at times too much so, but one of my early lifelines was work coming my way from my surgical colleagues who didn't necessarily want to or feel competent to deal with the inevitable post-op fluctuations in renal function, blood pressure, blood sugar and electrolytes, chest and urine infections, DVT's and PE's, arrhythmias etc. There were lots of calls for help from colleagues at odd hours and all were welcomed.

I wasn't the only one doing this of course. There were generations of excellent physicians like Frank Long, Bill Coupland and Brian Goldrick doing this well before I came on the scene and I was very grateful that they didn't just tolerate but actively encouraged a newcomer like myself. As they retired the work expanded and others have come to replace them and with the passage of time as patients get older, their operations more complex and their list of co-morbidities and pharmaceutical interventions lengthening, we are eventually seeing the rise of a new branch of general medicine generally now referred to as Perioperative Medicine (POM).

This has happened at least partly as a consequence of the "re-discovering" of general medicine as a discipline and the belated recognition of the value of the generalist. Credit must go to a number of individuals who, over the past decade and a half, have recognised this and championed the revival of general medicine as a discipline in its own right which has seen the re-opening of a number of general medical units and the formation of a collegiate representative in the form of IMSANZ (The Internal Medicine Society of Australia and New Zealand). The RACP is now also firmly on board with accredited training programmes in general medicine now running in many centres.

Till relatively recently the perioperative part of general medicine has been unstructured and ad hoc. While creeping over-regulation and overzealous accreditation requirement are not always a good thing and the top down imposition of "targets" and "KPIs" can be more of a hindrance than a help – are our ED doctors really sitting around sipping lattes for 3 hours and 59 minutes before rushing out to clear the waiting room so they don't get spanked. POM is in the process of becoming formalised and if anything that should be taken as an overdue recognition of its importance.

The essence of the change centres on the identification of which surgeries and patients are associated with most risk so appropriate measure can be taken before surgery as opposed to picking up the pieces afterwards along with of course, prompt recognition and management of problems if they do arise post-op. The REASON study into postoperative complications published in Perioperative Medicine in 2013 is one of a number shedding on light on where we should be paying more attention. It demonstrated that in a cohort of 4000 patients across Australia and New Zealand over 70 having non-cardiac surgery 5% died within 30 days, 10% were admitted to Critical Care, 30% experienced complications, many more than one, and patients who experienced one or more complications stayed a week longer in hospital. No doubt some factors integral to post-op recovery are not easily remediable such as age, frailty and nutritional parameters such as albumin levels but there will be many patients with often multiple co-existing chronic medical conditions which are

open to optimisation to reduce post-op risk.

One thing we do not want to see is a turf war developing between those who have the greatest stake in the area; i.e surgeons, physician, anaesthetists and intensivists and by no means do we want to be another barrier between patients and their necessary surgery, but elective surgery, which is where most of this effort will be directed, is just that. Almost always elective operations can be delayed while medical status is assessed and optimised and this must involve a co-operative approach between the disciplines involved. Even many semi-urgent procedures such as neck of femur fractures will allow a small window to attend to any acute medical issues.

Knowledge and interest in this area is building. POM now has its own dedicated journal, a summit on the subject is planned for February next year in the USA, and within Australia Monash Hospital has rebadged it's Anaesthetic unit as the Department of Anaesthesia and Perioperative Medicine and fellowships in POM are offered at Monash, The Alfred and Sir Charles Gardiner Hospitals and a Perioperative MSc degree is available in the UK.

This area is as yet in its infancy in Canberra. There is as far as I'm aware no dedicated hospital based POM service in the ACT although I am in the process of convening a working group of interested parties at Calvary Hospital where it will be a good fit with the hospital's strong general medical support base and designated elective surgery role. I have started a regular pre-operative consulting service with a group of local Orthopaedic colleagues. I'm hoping this article will stimulate some interest and discussion and give the process a bit of a kick along and I would love to hear from anyone who wants to be part of the process. If we get it right our patients will be better off and we will have less of those late night "hey doc I need" some help calls.

Dr Bill Burke, Respiratory and General Physician with an interest in Perioperative Medicine

Patients at risk of losing subsidy for dry eye syndrome

Nearly half a million Australians who suffer dry eye syndrome that makes eyes feel 'gritty' or 'sandy' are at risk of losing a subsidy for ocular lubricants, often referred to as artificial tears.

There are serious concerns that the Commonwealth government may remove ocular lubricants from the Pharmaceutical Benefits Scheme which subsidises their cost.

The dry eye condition can seriously reduce quality of life and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) believes treatments should remain subsidised. The condition, known as Sjogren's syndrome, is an autoimmune disease with no current cure. The disorder attacks the body's moisture-producing glands and affects around 1 in 200 Australians, 90% of them women.

Early diagnosis is important for preventing the more serious complications of the disease and RANZCO recommends people with dry eyes see an ophthalmologist regularly to check for damage.

Dr Elsie Chan from RANZCO says diagnosis is determined by an eye examination and performance of a Schirmer Test which measures production of tears using a special paper strip placed under the lower eyelid. "If Sjogren's syndrome is suspected as a cause," she explains, "exploratory blood tests will also be performed."

Dr Chan noted that some patients with Sjogren's syndrome are prescribed hourly lubricant drops. "Diagnosed patients have lifelong symptoms that require effective management to prevent further eye complications and loss of vision. Universal access to affordable ocular lubricants that are the mainstay treatment to relieve dry eye syndrome for patients with this condition is critical."

The exact cause of Sjogren's syndrome is unknown but scientists think it has to do with a combination of genetics and infection with a virus or bacteria. The most frequent complaint is a sensation of a foreign body in the eye, often described as a gritty or sandy feeling.

Other symptoms include decreased tears, redness, a burning sensation, light sensitivity, eye fatigue, itching and a "filmy" effect that interferes with vision. Sjogren's syndrome is often undiagnosed or misdiagnosed because symptoms may mimic those of menopause, drug side effects or inflammatory conditions such as rheumatoid arthritis. While most patients are diagnosed in their late 40s, age is no barrier and children can also suffer from it. The disease can affect nearly all ethnic groups.

New Border Force Act designed to intimidate doctors

The AMA has repeatedly called on the Federal Government to amend the Border Force Act 2015 (the Act) to explicitly protect health workers and allow them to advocate on behalf of their patients. The AMA has also called for the establishment of an independent medical panel to oversee the health of asylum seekers in Australia's care.

Pictures: Hamed Shahnam, Common Rounds

The Act contains new laws under which doctors could face two years' imprisonment for speaking out about shortcomings in the healthcare of asylum seekers. Since the announcement of the provisions of the Act, doctors and medical students across Australia have gone public to show they will remain outspoken advocates for all of their patients – asylum seekers or otherwise.

Assertions by Immigration Minister, Peter Dutton that the Act would "not restrict anyone's ability to raise genuine concerns about conditions in detention, should they wish to do through appropriate channels" have provided doctors no comfort.

Anyone deemed an 'entrusted person' under the Act can be jailed for two years for publicly commenting on what they see inside detention centres. There is a belief amongst health professionals working within detention centres that the law would serve to silence them from speaking out about the human rights abuses they see within immigration detention. Psychiatrist, Dr Louise Newman, an ardent advocate for improving the mental healthcare of asylum seekers, considers this to be "unprecedented interference in medical and clinical practice, with a political agenda".

AMA President, Associate Professor Brian Owler, views the laws as being designed to intimidate doctors against speaking out and they will pose a serious ethical dilemma for doctors working in immigration. He has strongly made the case that doctors should never be stopped from speaking out about concerns they have for their patients and this law erodes the heart of this ethical responsibility.

It appears that Section 48 of the Act permits past or present detention centre employees to speak out about a serious threat to life. This requires doctors to make judgments as to whether or not a threat to life or health is "serious" enough to warrant disclosure. They are then required to defend their actions in court. Does the unwillingness to do so, through fear of the consequences, make a doctor complicit through his or her silence? How does the Act define "serious"? Many practical, ethical and clinical questions arise from the Act.

The AMA, together with other medical organisations, had called for an amendment to the law which would explicitly protect health workers and allow them to advocate on behalf of their patients. There is little government transparency in respect to the provision of healthcare in Australian-run detention centres. This affords little reassurance that we are fulfilling our obligations of providing good healthcare to people in detention. The law will restrict doctors in a way that is entirely at odds with Australian codes of medical practice and clinical standards.

The Federal Government has responded to doctors' concerns by asserting that the Australian Border Force would investigate leaks of "operationally sensitive" information, and that "the public can be assured that it will not prevent people from speaking out about conditions in immigration detention facilities".

More than 100 doctors in Victoria recently gathered to speak out against the Act and to challenge the ethical constraints it will impose on them. The ethical considerations which are so integrally a part of medical practice may be alien to politicians, but they are mandatory for doctors – under the provisions of the Australian specialty medical colleges and AHPRA. The AMA has a clear position in respect to the medical professions' ethical requirements in relation to the care of children and adults in detention.

Medical students have also rallied against the law, marching from the ANU to Parliament House calling for an amendment to the Act. The Australian Medical Students' Association issued a release stating:

The Australian Medical Students' Association (AMSA) is vehemently opposed to the Federal Government's Border Force Act 2015, which will see doctors face imprisonment for speaking out about the reprehensible conditions in Australia's detention centres.

Medical students recently marched from the Australian National University to Parliament House, before heading to their university tutorials and hospital rotations. They called on the Federal Government to amend this Act, which effectively gags doctors and other health professionals working in detention centres."

President of the Australian National University Medical Society, Chris Wilder, said that med-

WANTED Canberra doctors to rally against the Border Force Act!

If you are interested in taking part in this Rally which will begin at AMA House in Barton and walk to Parliament House, could you please email Karen Fraser, Secretariat Manager on reception@ama-act.com.au

The date for the Rally will depend on the number of doctors willing to protest the legislation and their availability.

ical students across the country feel strongly about the impact of the Act, with many walking to Federal Parliament today to protest the draconian legislation.

"Medical students know that today's detainees will be tomorrow's patients. As Australia's future health practitioners, we have a duty to speak out on their behalf," Chris said.

Medical students Australiawide will also be calling Members of Parliament to convey their outrage regarding the Border Force Act 2015 and its implications.

AMSA President, James Lawler, said that to silence those committed to the preservation and protection of human life is abhorrent, and contradicts the very nature of the medical profession.

"AMSA encourages all concerned Australians, whether a medical professional or not, to contact their Member of Parliament and tell them that this Bill is unacceptable, James said."

"Australia's treatment of refugees and asylum seekers is an utter disgrace, and stands in direct opposition to both the Universal Declaration of Human Rights and basic human decency.

"The Border Force Act 2015 goes a step further, pushing doctors to compromise their ethics and contravene the Declaration of Geneva.

"Our Government is institutionalising cruelty against an already vulnerable population, and censoring those who would criticise them for it. It is both cruel and unfair to ask doctors to choose between imprisonment and the safety of their patients.

"It is disgraceful how far the Government has gone in its quest to treat asylum seekers inhumanely, and unfortunately the Opposition is cowardly complying.

"The Federal Government is attempting to blackmail doctors into silence by leveraging their personal freedom against their desire to ensure the wellbeing of their patients.

"AMSA calls upon the Federal Government to amend the offensive regulations from the Border Force Act 2015 immediately."

Doctors should be able to speak out and subsequently inform the public – together putting pressure on politicians to act against the illness and suffering of the vulnerable people within Australia's detention centres.

This is an edited version of an article which was published in Medicus – the publication of the AMA WA – in July 2015. Reprinted with permission

Medical Women's Society members run for charity

The ACT medical women and friends braved the elements to run or walk for charity at the recent Mother's Day Fun Run.

Dr Catherine Drummond and Dr Sue Packer.

It was probably the worst possible May weather with a howling gale threatening to blow runners off the bridge. The women have been joining the Fun Run for some years but this year won a very handsome trophy for largest community team – with a team of 31 – all proudly displaying the new MWS T-shirts. The team raised for $3303 for Breast Cancer research.

The next MWS function is annual fund raiser for chosen smaller charities of particular interest for women and children. This year the plan is to circle the globe in 80 minutes.

Games, prizes and food from around the world. Come and join us and compete next month on Friday 21st August at the Ainslie Football Club for fun and laughter.

Members and non- members all welcome.

2015 directory of medical specialists, allied health professionals and GPs with special interests

CANBERRA GPs

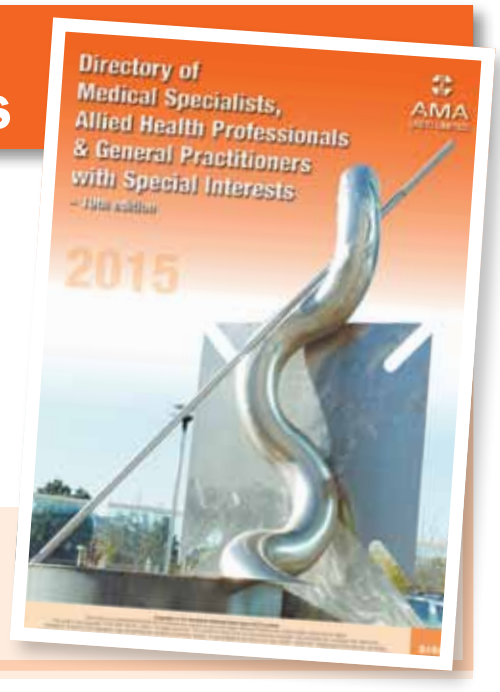
If you are a Canberra GP (or an AMA member who is not a GP) and have not yet received your complimentary copy of the 2015 directory, please contact the AMA (ACT) secretariat manager, Karen Fraser on 6270 5410.

GP REGISTRARS

If you are a GP registrar, please contact Karen and a copy will be mailed to you.

GPs in SURROUNDING AREAS OF CANBERRA

GPs in the surrounding areas of NSW and who refer into Canberra, please call and sufficient copies for your practice will be mailed.



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

The directory is available for sale (**$199**) from the AMA (ACT) secretariat.

Please call **6270 5410** to purchase your copy.

OPINION: Announcement of a smoke-free ANU campus – it's more than smoke and mirrors

By Anna Habeck-Fardy

When Australian National University (ANU) Vice-Chancellor Professor Ian Young announced on "World No Tobacco Day" (May 31) that the campus would be smoke-free from July 20, 2015, it was not merely a public relations exercise.

Much of this pertains to the fact that the announcement was coupled with an offer to finance staff and PhD students to attend QUIT courses that will be run on campus by certified educators from the ACT Cancer Council. Recognising that smoking is a part of our society, and that it is not easy for smokers to quit, the offer reflects that this employer is exercising a level of duty of care to its workers.

Tobacco smoke is the single largest modifiable risk factor for a multitude of health conditions including, but not limited to, cancer of the lung, oral cavity, pharynx, oesophagus, stomach, bowel, liver, pancreas, nasal cavity, paranasal sinuses, larynx, uterine cervix, ovary, urinary bladder, kidney, ureter and bone marrow.

As a future health practitioner currently attending the ANU medical school to learn about the pathology, prognosis, management and prevention of these (and many other) conditions, as well as the ethical, legal and human rights principles that will underpin every conversation that I will have with my future patients about these (and many other) conditions, I am able to appreciate the implications of the announcement. Sir Richard Doll and Bradford Hill writing in the British Medical Journal first reported the link between smoking and lung cancer some 65 years ago, yet smoking was still the major cause of cancer in 2014. Despite the widespread knowledge about the detrimental effects of tobacco smoking, the addictive quality of nicotine is mostly underestimated. Thus, quitting tobacco smoking is a complex task: physically, physiologically, mentally, emotionally and socially.

Given that tobacco smoke is such a conspicuous and modifiable risk factor, it is appropriate to look at this through a lens of medical ethics.

The decision to go smoke-free may be deemed a utilitarian approach, in that the autonomy of a minority group is essentially being challenged for the beneficence and non-maleficence of the campus majority. (Although, ultimately for the beneficence of the smoking minority, too.) However, this arguably depends on the timescale being considered. Longer-term, the smokers on campus who quit, or cut down their smoking subsequent to their workplace becoming smoke-free, are perhaps exercising their autonomy to do so … possibly with some prompting. Indeed, this announcement provides a classic example of public health promotion and prevention, in that switching to a smoke-free campus:

(i) will enable people to increase control over, and improve, their health;

(ii) serves as a primordial prevention strategy by limiting exposure to tobacco, thereby potentially discouraging non-smokers to start; and

(iii) is also primary prevention by supporting smokers to stop. There are also positive longer-term environmental ramifications, because cigarette filters ("butts") are not readily biodegradable, and are the single most common item collected each *Clean Up Australia Day*.

As a non-smoker, it is admittedly easy to write such comments, and it would be incredibly naïve and remiss of me to expect all of the smokers of the ANU to use the switch to a smoke-free environment to quit smoking. Yet, if even just one or two staff or PhD students accept the ANU-financed QUIT course offer, and succeed, in my opinion, the announcement has also been a success (this is of course foregoing the obvious benefits for the non-smokers on campus). The literature suggests more than one or two ANU workers would quit smoking, however. A systematic review of 26 studies on the effects of smoke-free workplaces found that they are associated with a ~4% reduction in smoking prevalence, as well as a reduction in the cigarettes smoked per day per continuing smoker. This indicates that smoke-free environments do encourage smokers to reduce consumption, or quit, in addition to protecting non-smokers from passive smoking. And compared to voluntary smoke-free workplace restrictions, legislation is more effective in doing so.

Professor Young and the university should be applauded for the announcement made on "World No Tobacco Day". I thank you for my own health; I thank you on behalf of my future colleagues for potentially reducing the number of difficult conversations they have with a patient about a tobacco-related health condition; and I thank you on behalf of the members of the community who now perhaps will never have to present with a tobacco-related health problem.

Anna Habeck-Fardy is a Year 2 student at the ANU Medical School

References are available on request from the author

Beware of tax time scams

The ATO is reminding taxpayers to be wary of scams this tax time as scammer's ramp up their efforts to defraud the public of their personal information and money.

During the 2014 calendar year the ATO received in excess of 42 000 reports from the public of email and phishing scams.

John Becker, Chief Information Security Officer at the Australian Taxation Office (ATO) highlights that scammers can be very convincing and trick people into handing over money, their Tax File Number (TFN) or personal information.

"Their tricks include impersonating ATO representatives on the phone or sending fraudulent emails," said Mr Becker.

Key tips to protect yourself

- Never share personal information, such as your TFN, myGov or bank account details on social media.
- Change any passwords you may have shared with family or friends.
- If you receive an email or phone call out of the blue from 'the ATO' claiming that you are entitled to a refund or asking you to confirm, update or disclose confidential details like your tax file number, press 'delete' or just hang up.
- Don't open any attachments or click on any links or reply to these emails. They may take you to a bogus website or contain a harmful virus.
- If you're not sure whether a call or email is a scam, verify who they are by using their official contact details to call them directly. Never use contact details provided by the caller – find them through an independent source such as a phone book or online search.
- Always keep your computer security up to date with anti-virus and anti-spyware software and a good firewall. Only buy computer and anti-virus software from a reputable source.
- Never send money or give your financial details to someone you don't trust – it's rare to recover money from a scammer.
- If you think you have provided your account details to a scammer, contact your bank or financial institution immediately.
- If you use a tax agent, make sure they are registered by checking at www.tpb.gov.au/onlineregister (link is external).
- Never put your tax file number (TFN) on your resume. Only give it to your employer after you have started your job.

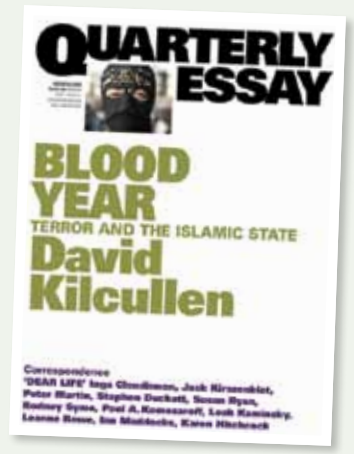
John recommends that if you receive a call from the ATO and are concerned about providing your personal information over the phone, ask for the caller's name and phone them back through the ATO's switchboard on 13 28 69.

People can also forward suspect scams to ReportEmailFraud@ato.gov.au or call the ATO during business hours on 1800 060 062 to discuss a suspected scam.

More information: Read more tips on how to protect your identity or how to protect your information online.

BOOK REVIEW – Quarterly Essay 58, 2015: Blood Year by David Kilcullen

ISBN 9781863957328
AUD$ 22.99



Dr David Kilcullen's essay guides the general reader through the shifting sands of the last year and antecedents in the amorphous "War on Terror".

A senior military advisor in counter-insurgency and counter-terrorism, Kilcullen contends that major strategic errors were made in Iraq, during the post-Gulf War stabilisation phase resulting in a viciously sectarian failed state. Whilst there was success in "disaggregating" the original terrorist movements such as Al Qaeda into regional splinters, this led to expansion of these regional groupings into the Arabian peninsula and Africa. In parallel, there was the phenomenon of self-radicalisation, via exposure of the disaffected to new terrorist media. The rebellion in Syria during the Arab Spring served as a launching point for the establishment of terrorist forces which expanded into Iraq, exploiting the sectarian divisions.

The so-called Islamic State of Iraq and Syria represents, according to Kilcullen, a state-building structure which engages as a conventional military force rather than as a terrorist grouping. Kilcullen argues that at least elements of conventional warfare will be needed to defeat such a conventional force, such as an air campaign and ground troop engagement. The concept that the normative state role can be assumed by the insurgent follows on from the arguments about the new nature of conflict in his previous book "*Out of the Mountains* (2013)." In this context, Kilcullen observes that we are living in an era of persistent conflict that requires a comprehensive strategy not delimited to global terrorism. He concludes that solutions will require great coordinated political will at the level of nations: "*Preserving and strengthening the political will of our societies, the will to continue the struggle, without giving in to a horrific adversary, but also without surrendering our civil liberties or betraying our ethics, is not an adjunct to the strategy – it is the strategy.*" (p.87)

Reviewed by Associate Professor Jeffrey Looi, Academic Unit of Psychiatry and Addiction Medicine, ANU Medical School

Canberra DOCTOR

A News Magazine for all Doctors in the Canberra Region

ISSN 13118X25

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

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

Typesetting:
Design Graphix
Ph 0410 080 619

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

Articles:
Copy is preferred by email to execofficer@ama-act.com.au in "Microsoft Word" or RTF format, (not PDF) with graphics in TIFF, EPS or JPEG format. Next edition of *Canberra Doctor* – September 2015.

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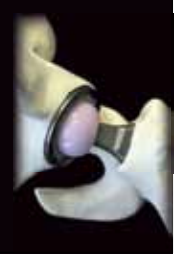

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