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AMA Public Hospital Report Card: crisis deepens

The 2017 AMA Public Hospital Card, released recently, shows that against a series of key measures, the performance of our public hospitals is virtually stagnant, or even declining. In releasing the report, AMA President, Dr Michael Gannon, said that inadequate funding has consigned Australia's public hospitals – and all the dedicated health professionals who work in them – to a constant state of emergency.

AMA President, Dr Michael Gannon.

ACT fails to report

"To put it bluntly, public hospital performance against these measures across all States and Territories is woeful," Dr Gannon said.

"But this is not the fault of the highly-skilled and hard-working doctors, nurses, and other health professionals and hospital workers who work around the clock caring for patients, and who are being asked to do more with less year after year.

"Our over-stretched and over-stressed public hospitals are suffering because of inadequate and uncertain Commonwealth funding, which is choking public hospitals and their capacity to provide essential services."

Report Card results

The AMA Report Card shows that, across 48 key measures, there were 40 'fails' and only three positives, with the ACT returning 'no scores' because the data was not provided.

"Bed number ratios have remained static," Dr Gannon said.

"Emergency department (ED) waiting times for Urgent patients (patients who should receive care within 30 minutes) have worsened and, in most cases, remain well below the target set by governments to be achieved by 2012-13.

"NSW alone achieved the target for ED patients as a single group across all triage categories, while still falling short of the target for patients in the Urgent category.

"The percentage of ED patients treated in four hours has not changed over the past three years (since 2013-14), and is well below target.

"Elective surgery waiting times have worsened, and treatment times have only improved marginally.

"Public hospital performance has not improved overall against the performance benchmarks set by all Governments.

More funding needed

"Without sufficient funding to increase capacity, public hospitals will never meet the targets set by governments, and patients will wait longer for treatment," Dr Gannon said.

Dr Gannon said the additional Commonwealth funding announced at the Council of Australian Governments (COAG) meeting in in April 2016 of $2.9 billion over three years was welcome, but inadequate.

Value public hospitals

"Public hospitals are at the core of our healthcare system, and much loved and respected by the Australian people," Dr Gannon said.

"Our public hospitals are the training ground for the future medical workforce.

"They are the first port of call for emergency care.

"Public hospitals require sufficient and certain funding to deliver these essential services. The Commonwealth must work with the States and Territories to reach an agreed long-term strategy to fund public hospitals appropriately," Dr Gannon said.

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Medical **Musings**

WITH PRESIDENT, PROFESSOR STEVE ROBSON

The dog ate my report card...

Each year, the Federal AMA uses data contributed by the states and territories to compile a Public Hospital Report Card. This year's report card was released in mid-February, and it made for depressing reading. Public hospital performance across the country was disappointing – of the 48 key measures, there were only three positive results. Forty 'fails' were recorded and, most embarrassing of all, the ACT failed to submit data for analysis. All in all, the performance of our public hospitals is stagnant, or even declining.

Much of this is the result of inadequate and uncertain Commonwealth funding, a situation that is holding back our public hospitals and their capacity to provide essential services. Unfortunately, these results are not simply performance measures but tell the story of a direct impact on our patients. Patients are waiting longer for treatments including elective surgery.

Public hospitals provide essential healthcare services across our community, and the dedicated and hardworking doctors, nurses, and other health care practitioners who work in them continue to provide Australians with world class health care. Our hospitals are also the training ground for the future medical workforce, and the safety net for the people who can't afford private health insurance. They are also the places where innovation and new treatments are developed that continue to enhance the extraordinary gains in medical science and for patient outcomes.

None of this makes for good reading, but the ACT came in for special mention as we didn't even make it to first base: ACT Health failed to submit their data in time to be included. One might think this is bad enough, but things are actually worse. The issue of reliable data for Canberra's public hospitals has widened into a much bigger issue with consultants brought in to try and clear up what seems like a significant mess. The accuracy of data from our public hospitals has been subject to question before, so it is disappointing to see further problems in what is a small jurisdiction.

While I commend Health Minister Meegan Fitzharris for ordering an urgent review into ACT Health's data collection, the fact remains that the situation is an almighty stuff up made worse by the fact that we don't know whether the issue is a recent one or has existed for a longer period. The findings of this latest investigation will make interesting reading.

Junior doctor survey

Canberra's hard-working junior doctors are the backbone of our public hospital system. With enterprise bargaining now underway, the AMA (ACT) has surveyed our junior doctor members to find out what the problems are with the current agreement and what conditions can be improved. There was clearly a great deal of interest, with more than 180 responses to the survey. It is wonderful to see engagement from Canberra's young doctors, and several consistent themes emerged:

- An inability to take leave with access to ADOs being limited, or even non-existent, and a significant build-up of untaken annual leave.
- Unpaid overtime remains a hot-button issue for doctors-in-training. In broad terms, the AMA (ACT) recognises that junior doctors work as professionals and, naturally, there is a balance to be struck between working professionally and being paid for all the hours doctors are required to work.
- Many respondents told us about repeatedly facing short-notice roster changes, with the continual over use by hospital management of the 'emergent circumstances' provision in the current agreement.
- Insufficient resources provided to assist with training funds, including support for conference leave
- Lack of access to leave either before or after rotation to regional health facilities, and the clear need for improved 'parent hospital' supervision of these rotation arrangements.
- Spending a large amount of junior doctors' time and resources meeting various mandatory training requirements.

The AMA (ACT) has run information sessions on enterprise bargaining at both Canberra and Calvary Hospitals, during which these survey results were discussed with the participants and further feedback obtained. We will use this feedback, and the survey results, to allow AMA (ACT) staff and the Council of Doctors-in-Training to develop our claim ready for presentation to ACT Health.

Head kicking...

The ACT Government is planning to introduce new legislation governing so-called 'combat sports' this year, following a period of consultation and policy development. There are some very positive aspects to this, with a broadening of the definition of sports to include emerging 'sports' such as mixed martial arts. The aim is to provide a safer environment for participants, hopefully to protect them from serious neurological injuries, blood-borne virus infections, and the crime that sometimes seems to accompany such 'sports.'

We are all doctors, and our core business is protecting people from harm. It makes no sense to support sports where the primary goal is to bash an opponent senseless in order to win. For this reason, the AMA remains opposed to combat sports and supports prohibition for potential participants younger than 18 years. Harm minimisation is critical, and authority must be given to doctors to stop events if there is evidence of serious injury to one or more of the fighters. There is also plenty of scope for changing equipment such as gloves and mouthguards, and ideally changing the emphasis in scoring away from blows to the head.

'Driving change'

Alcohol-fuelled violence remains an important issue in the ACT, as it is around the country. FARE – the Foundation for Alcohol Research and Education – in partnership with the AMA (ACT), Deakin University, and the Australian Federal Police Association, are jointly sponsoring the 'Driving Change' forum. This important forum will take an unflinching front-line perspective on alcohol-related harms. Professor Jonathan Shepherd, who is visiting Australia to assist with the 'Driving Change' research study at Calvary Hospital, will be a key participant in the Forum.

I urge you to join us for an open and frank discussion about what really happens on Canberra's streets on the weekends. The Forum will be held at the ACT Legislative Assembly on Tuesday 7 March from 10.30am – 12.30pm. It promises to be an important event, and further information is available in this edition of Canberra Doctor.

Dr Iain Dunlop AM

Finally, on behalf of the AMA (ACT) Board and members, it gives me great pleasure to congratulate Dr Iain Dunlop, current chair of the AMA Board and Past-President of AMA (ACT), on his richly-deserved award as a Member (AM) in the General Division of the Order of Australia. Dr Dunlop has received his award for significant service to ophthalmology, particularly through executive roles with professional medical organisations, and as a practitioner.

Iain has an outstanding record as a clinician, as an office bearer with the RANZCO, of many years' service to the AMA and AMA (ACT), and volunteer activities with opthalmic and other charities. He is a most worthy recipient of this honour and richly deserves the recognition as a Member of the Order of Australia. It is a pleasure to know and work with this great Canberran.

AMA (ACT) is now on Facebook!

If you want to be up-to-date on all things AMA, medico-politics, medical research and doctors well-being then search 'AMA (ACT)' on Facebook and like our page. We are also posting upcoming AMA events on the page and so it is a great way to stay in touch. Recent posts have featured the Dean of the ANU Medical School (Professor Imogen Mitchell) sharing her personal experience of being harassed early in her career and hope that by sharing this story with ANU students they too will feel safe to speak up.

Young doctors 'speak up' on enterprise bargaining

BY ANISH PRASAD, AMA (ACT) HOSPITAL ORGANISER

In the lead up to enterprise bargaining with ACT Health, the AMA (ACT) has surveyed its junior doctor members on the issues they see as affecting doctors covered by the current enterprise agreement. The survey focused on access to Leave (Annual, Exam Professional Development), Overtime, Accrued Days Off (ADOs), Rosters and Parent-Hospital arrangements.

Dr Anish Prasad.

Following the closing of the survey, AMA (ACT) has met with our local Council of Doctors in Training and held two Information Sessions to consult with all other affected doctors. If you would like access to the presentations made at the Information Sessions, please contact Anish Prasad at organiser@ama-act.com.au

In general terms, Doctors in Training are looking for practical changes to the enterprise agreement that will help them meet the needs of patients and one way to achieve this is to ensure that work arrangements/practices facilitate this goal.

In brief, the responses to the survey are as follows:

Annual leave

The approval of annual leave in 2016 highlighted a variety of practices across the departments. 32% of respondents said that they had access to 2-3 weeks of annual leave, 26% reportedly had access to 1-2 week of leave, 13% had access to less than 1 week of leave, and 12% had access to more than 4 weeks of leave. When asked whether they are encouraged to use all of their annual leave entitlements, 81% of respondents said NO with the remaining 19% saying YES.

Unpaid overtime

In contrast, working unpaid overtime continues to be an implied expectation for many. 51% of respondents said that they are expected to work unpaid overtime and 49% said they were not. Over a fortnight, 21% worked less than 5 hours, 33% said they worked between 5-10 hours of unpaid overtime, and 13% said they worked 10-20 hours of unpaid overtime.

Rosters

The timely release of rosters was yet another question that highlighted the variety of practices across departments. In light of the enterprise agreement requirements that rosters be released at least 14 days in advance, 43% of respondents reported that on average they were released between 14-21days and 20% reported that they received their rosters more than 21 days in advance. However, 26% reported that on average they received their rosters less than 14 days in advance, and 11% received their rosters less than 7 days in advance.

ADOs

Despite 94% of respondents being entitled to 13 ADOs per year, ADOs are largely an entitlement in 'name only'. When we asked about how many ADOs respondents were given in 2016, 45% reported to have given less than 6 ADOs, 22% had access to 6-12 ADOs, 16% and access to all of their ADOs.

Parent-Hospital rotation arrangements

In regard to rotation arrangements, a number of respondents highlighted the lack of rest between rotation arrangements. Whilst 56% of respondents said they had access to annual leave during or after rotation 31% said they didn't, and 13% said N/A. In the comments section, a number of respondents raised the issue of breaks between rotations. It was noted that some have worked "7 consecutive night shifts and finished [their] last shift on a Monday at 8am. Yet, [they] were expected to start at a hospital in NSW at 8am Wednesday and move at the same time."

Paid maternity leave

Whilst the survey did not have a specific question dealing with maternity leave, a number of respondents raised concerns about the current arrangement in light of proposed changes. Under the current enterprise agreement, 18 weeks of maternity leave (at full pay) is available to full-time workers and this scheme is complimented by the additional 18 weeks at minimum wage by the Federal Government. The AMA (ACT) will continue monitoring this situation and will act appropriately to if the proposed changes are legislated. Moreover, under the current enterprise agreement 'Bonding Leave' of up to a maximum 3 weeks is available. Again, we will consult with the local council of DiTs and others to understand whether the current arrangements are appropriate.

What's next?

All in all the survey has given us good feedback on important issues for the upcoming round of enterprise bargaining. Following the Information Sessions, we will develop a 'log of claims' and refine the log through consultation with the AMA (ACT)'s Council of DiTs. Ultimately, our claims will be presented to ACT Health and the bargaining will commence in earnest.

The practical step DiTs can do to assist us – and you – is to join AMA (ACT) if you're not already a member. To join please either go to ama.com.au/join-renew or contact Anish Prasad, AMA (ACT)'s Hospital Organiser at organiser@ama-act.com.au

AMA Public Hospital Report Card...*continued*

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ACT fails to provide data

ACT Health Minister, Meegan Fitzharris

From a local perspective, ACT Health's failure to report their data to the Australian Institute of Health and Welfare was disappointing to say the least. AMA (ACT) became aware of the situation in mid-January and wrote to the Director-General urging her to follow up on the matter and ensure the problem was not repeated. AMA (ACT) has not received a reply to the correspondence.

The reasons for the lack of reply emerged almost a month later with ACT Health Minister, Meegan Fitzharris ordering an urgent review into ACT Health's data collection. The Minister stated that ACT Health was unable to meet reporting deadlines because of concerns around the accuracy of the data.

It's most unfortunate that problems with data collection have again surfaced as an issue following the 2012 Canberra Hospital Emergency Department data tampering scandal. On this occasion, however, Minister Fitzharris maintained the issues were "administrative in nature" and would not affect frontline health services.

PricewaterhouseCoopers (PwC) was called in to review the accuracy of the data. The minister did not detail its findings.

"As minister for health I know how important it is that the community, our patients and our health sector stakeholders have confidence in health reporting.

The minister said the ACT Auditor-General would be kept informed of the review.

AMA (ACT)'s response

AMA (ACT) President Prof Steve Robson said he had written to ACT Health's director-general about the missing data weeks ago but failed to receive a response.

He said it "wasn't quite right" to say the inaccurate data would not affect frontline services.

"I think it's critical to know the care that's being provided is measurably appropriate and the only way you can do that is the careful analysis of data," Prof Robson said.

Dr Robson said problems with data accuracy "goes to the heart of the delivery of care and the confidence the community has in its health services".

"The public have a right to reassurance that their healthcare systems, particularly in this case public hospitals, are appropriately benchmarked, that they're appropriately compared to services elsewhere in the country." Prof Robson said.

Table shows a summary of the Report Card findings

This section includes performance information for each State and Territory using available data sources.

A summary of State and Territory performance is shown in Table 1.

Table 1: State and Territory Performance – Summary

State/Territory	Improvement in Emergency Department waiting time – urgent (category 3) 2015-16	Met National Emergency Access Target (NEAT) 2015+	Improvement in Elective Surgery waiting time 2015-16	Met National Elective Surgery Target (NEST) +* 2015+	Improvement in Elective Surgery Category 2 admission in 90 days	MYEFO 2016-17 increased Commonwealth funding for 2016-17 over Budget 2016-17
NSW	✗	✗	✗	✗	✗	✗
VIC	✗	✗	✗	✗	✓	✗
QLD	✗	✗	✗	✗	✓	✗
WA	✗	✗	✗	✗	✗	✗
SA	✗	✗	✗	✗	✗	✗
TAS	✗	✗	✗	✗	✗	✗
ACT	n/a	n/a	n/a	n/a	n/a	✗
NT	✗	✗	✓	✗	✗	✗

+ Targets are set on a calendar year basis, performance as reported by AIHW. AIHW reported elective surgery Category 2 performance for financial year 2013-14 but data for the period 2010-11 to 2011-12, and January to June 2013 has not been published. Elective surgery Category 2 year on year performance is graphed for each State and Territory below, excluding these periods.

** Treating patients within clinically recommended time – Category 2 (within 90 days).*

AMA Board Chair, Dr Iain Dunlop AM honoured

The recent Australia Day Honours announcement included the awarding of a Member (AM) in the General Division of the Order of Australia to Dr Iain Dunlop, current chair of the AMA Board and past-president of AMA (ACT).

Dr Dunlop addressing medical students as AMA (ACT) President.

Dr Dunlop's citation for the award states *"for significant service to ophthalmology, particularly through executive roles with professional medical organisations, and as a practitioner."*

Dr Iain Dunlop AM

Dr Dunlop's award recognised his service to ophthalmology, both as a clinician and through RANZCO, his service to the Australian Medical Association and the AMA (ACT) and his other volunteer and charitable work.

Dr Iain Dunlop graduated with honours in Medicine from the University of Sydney in 1980 before training in and around Sydney. Iain became a Fellow of the Royal Australasian College of Surgeons (RACS) and the Royal Australian College of Ophthalmologists (RACO) in 1987; a Member of the American Academy of Ophthalmology in 1994, and the American Society of Cataract and Refractive surgery in 1995.

RANZCO contribution

Dr Dunlop has been active in the affairs of RANZCO for many years, holding positions of President, Honorary Secretary, Honorary Treasurer and Chair of the Audit Committee.

He was elected President of the Australian Society of Ophthalmologists (ASO) in 2004 and was actively involved in representing ophthalmology to government and at the Australian Medical Association (AMA).

In 2005 Iain was elected to the Board of Vision 2020 Australia from 2005 to 2008, a position that directly linked the College to the wider vision care sector in Australia.

Dr Iain Dunlop and the AMA

Dr Dunlop has been an AMA member since 1980 and has been an outstanding contributor in a wide variety of roles. He was AMA (ACT) President from 2010-2012, having held the position of President-Elect for the previous two years and currently continues to serve on the AMA (ACT) Board.

During his term as AMA (ACT) President, Dr Dunlop was appointed to Federal Council as nominee director for AMA (ACT). In 2013-14, he served the AMA as Chair of Federal Council (and National Conference) having been elected to this role by his peers.

When the new Board of the AMA came into existence, Dr Dunlop was nominated by the AMA (ACT) as its director to the Board and continues to hold that position. In 2016 he was appointed as Board chair and continues in that role.

At all times, Ian has carried out these duties with his trademark courtesy, professionalism and consideration.

Why Ophthalmology?

On an earlier occasion, when asked about his choice of specialty, Iain replied "Because it has everything. You have the ability to have an ongoing association with patients and their families in the longer term when you are dealing with problems such as diabetes and glaucoma; there are some magical moments following highly effective surgery [in which sight is restored]; there are the technical challenges of working with evolving technology such as the lasers, and we also have the benefit of almost immediate results."

On Canberra life

Dr Dunlop has lived in Canberra ever since beginning his professional career in 1989.

"I moved here because my former wife had a position at the Australian National University," he said. "I quickly realised I wouldn't want to live anywhere else. In Canberra my set point for getting anywhere is 10 minutes, not the 40 minutes minimum it would be in Sydney.

"There is a real sense of civic pride and you get to experience the four seasons. And, of course, Canberra is a wonderful place to bring up and educate children."

Our sincere congratulations to Dr Ian Dunlop AM on his award and recognition for the exceptional contributions he has made as a clinician, with the RANZCO, AMA (ACT) and AMA and his volunteer activities with ophthalmic and other charities.

Prof Stephen Bradshaw AM

Prof Stephen Bradshaw AM

The Australia Day honours list also saw the announcement that Prof Stephen Bradshaw had been recognised as a Member in the General Division of the Order of Australia. The award recognised Prof Bradshaw's 'significant service to medicine as a vascular surgeon, to health practitioner regulation, and to medical education.'

AMA (ACT) congratulates Prof Bradshaw and particularly recognises his service as, firstly, a member of the ACT Medical Board and then, from 1998 as President and subsequently Chair, until his recent retirement from the Board in 2016. At same time, Prof Bradshaw served as the ACT practitioner representative on the Medical Board of Australia.

Finally, his work as a clinician and medical educator is well and highly valued by both the Board and members of AMA (ACT).

Tale of the depressed billionaire and the brain chemicals*

It might bring a wry smile to faces of parents or teachers tormented by their children's obsession with all things Minecraft, that the billionaire 36-year-old creator of the video game, Markus Persson, is in a deep funk now he's "got everything" he wanted in life.

In a series of despondent tweets sent on a Saturday night, the Swedish programmer, who sold his video game company to Microsoft last year for $US2.5 billion, said he's never felt more lonely in his life.

Even though he pocketed $US1.3 billion out of the deal.

The problem with getting everything is you run out of reasons to keep trying, and human interaction becomes impossible due to imbalance.

Markus Persson, the problem with having everything.

Persson, who famously outbid Beyoncé and Jay-Z for a Beverly Hills megamansion - paying $US70 million - is on the Mediterranean island of Ibiza.

He's rocking out with the rich and fabulous but says he's "never felt more isolated".

It's apparently not much better for Persson when he's in his homeland, either.

Persson's tweets are a very public reminder of an oft-ignored fact - a person's brain chemistry is the defining factor in their happiness.

You can be rich, famous, beautiful, talented, intelligent, revered, adored, in love and accomplished but if you're not getting enough serotonin, dopamine and oxytocin zapping around your head, life can seem pretty ... blah.

Israeli professor Yuval Noah Harari, in his fantastic book Sapiens: A Brief History of Humankind, says as much when he writes: "Nobody is ever made happy by winning the lottery, buying a house, getting a promotion or even finding true love. People are made happy by one thing and one thing only - pleasant sensations in their bodies.

"A person who just won the lottery or found new love and jumps for joy is not really reacting to the money or the lover. She is reacting to various hormones coursing through her bloodstream, and to the storm of electric signals flashing between different parts of her brain," writes Harari.

This is one of the most confronting, yet liberating, revelations visited upon people who suffer from major depression - that the human experience of the world is a construction of our emotional system and psychophysiology.

It can be a pretty scary door to walk through because even when you get "better", you're left with the knowledge that whatever happiness you're experiencing in your life is determined by the interactions of chemicals and a vastly complex system of nerves, neurons and synapses.

Yes, you can do things to improve what's going on up there - by exercising, eating well, avoiding alcohol and drugs, as well as destructive or dysfunctional people - but whatever your brain chemistry is, is what it is (hello, antidepressants!)

Thomas Ligotti (inspiration for much of the ethos of HBO's True Detective) puts it thus: "This is the great lesson the depressive learns: Nothing in the world is inherently compelling. Whatever may be really 'out there' cannot project itself as an affective experience. It is all a vacuous affair with only a chemical prestige.

"Nothing is either good or bad, desirable or undesirable, or anything else except that it is made so by laboratories inside us producing the emotions on which we live," writes Ligotti.

This is one of the benefits of living alone: your mood is how happy you are. When you live with someone else, however, you're only as happy as the least happy person in the household.

"Not knowing this ground-level truth of human existence is the equivalent of knowing nothing at all," writes Ligotti.

And, just think, Persson had to earn $US1.3 billion to learn this.

That should cheer anyone up.

** This article first appeared in the Sydney Morning Herald on 31 August 2015.*

AMA (ACT) welcomes first year medical students

In early February AMA (ACT) was pleased to welcome the latest batch of ANU first year medical students at drinks held in the UniPub. With Dr Liz Gallagher doing the honours, supported by Dr Kieran Barr, Co-chair of the AMA (ACT) Council of Doctors in Training and Christine Brill from the AMA's Career Advice Service, it was a quick update on the role the AMA will play in the years ahead for the budding doctors.

In addition, there were some immediate benefit for two students in joining the AMA with two stethoscopes being raffle prizes for the evening.

In addition to Dr Gallagher and Dr Barr in attendance, AMA (ACT) was represented by Dr Suzanne Davey, AMA (ACT) Secretary, Dr Andrew Miller, AMA (ACT) Treasurer and A/Prof Jeff Looi, AMA (ACT) Board member. They were all in high demand from a room full of keen students wanting to ask a range of questions.

Our thanks to the ANU Medical Students Society for their assistance and also to Drs Gallagher, Davey, Miller and Barr and A/Prof Looi for being part a key part of the evening.

ABOVE: Dr Liz Gallagher, AMA (ACT) Immediate Past-president.

ABOVE LEFT: Dr Kieran Barr lets the students know something of what they face over the next four years.

LEFT: Dr Gallagher addresses ANUMS First Year Students.

Nominations open for 2017 AMA Public Health Awards

The AMA Public Health Awards provide well-deserved recognition of the extraordinary contribution doctors and associated health groups make to health care and public health.

The 2016 AMA Excellence in Healthcare Award was presented to Associate Professor John Boffa and Ms Donna Ah Chee for their contribution to reducing harms of alcohol and improving early childhood outcomes for Aboriginal children.

The 2016 AMA Woman in Medicine Award was presented to Associate Professor Diana Egerton-Warburton in recognition of her exceptional contribution to the development of emergency medicine, and her passion for public health.

In 2017, nominations are sought for awards in the following categories:

- AMA Excellence in Healthcare Award
- Woman in Medicine Award
- Women's Health Award
- Men's Health Award
- Youth Health Award

The presentation of each award is dependent upon a sufficient number of nominations being received.

A full description of the criteria for nominations, and information on how to nominate, is available at ama.com.au

Please read the criteria for each award thoroughly, and ensure that your nomination clearly states which category you are putting the nominee forward for.

Nominations, including all required documentation, should be submitted electronically to awards@ama.com.au. The closing date for receipt of nominations for each award is COB Wednesday 19 April 2017.

Diana Egerton-Warburton

John Boffa and Donna Ah Chee

SURVEY: Dental Problems in General Practice

Researchers in the School of Dentistry at the University of Western Australia are conducting a study examining *'Dental problems in general medical practice – how common are they and how are they managed?'*

As indicated by its title, the project aims to investigate the frequency of dental problems presenting to general practices and the typical management of dental problems provided by general practitioners.

Participation is simple and involves completion of an online questionnaire. The questionnaire is accessible from the following link:

http://www.dentistry.uwa.edu.au/new_pages/dentistry-survey-diagnostic-procedures2

The questionnaire will take approximately 5-10 minutes to complete. Respondents will not be identifiable and responses will be entirely anonymous.

If you have any questions about the survey or related matters please contact the Supervisor of the research project, Winthrop Professor Paul V. Abbott via phone +61 8 9346 7665 or email paul.v.abbott@uwa.edu.au.

Why the Rebate Freeze needs to go

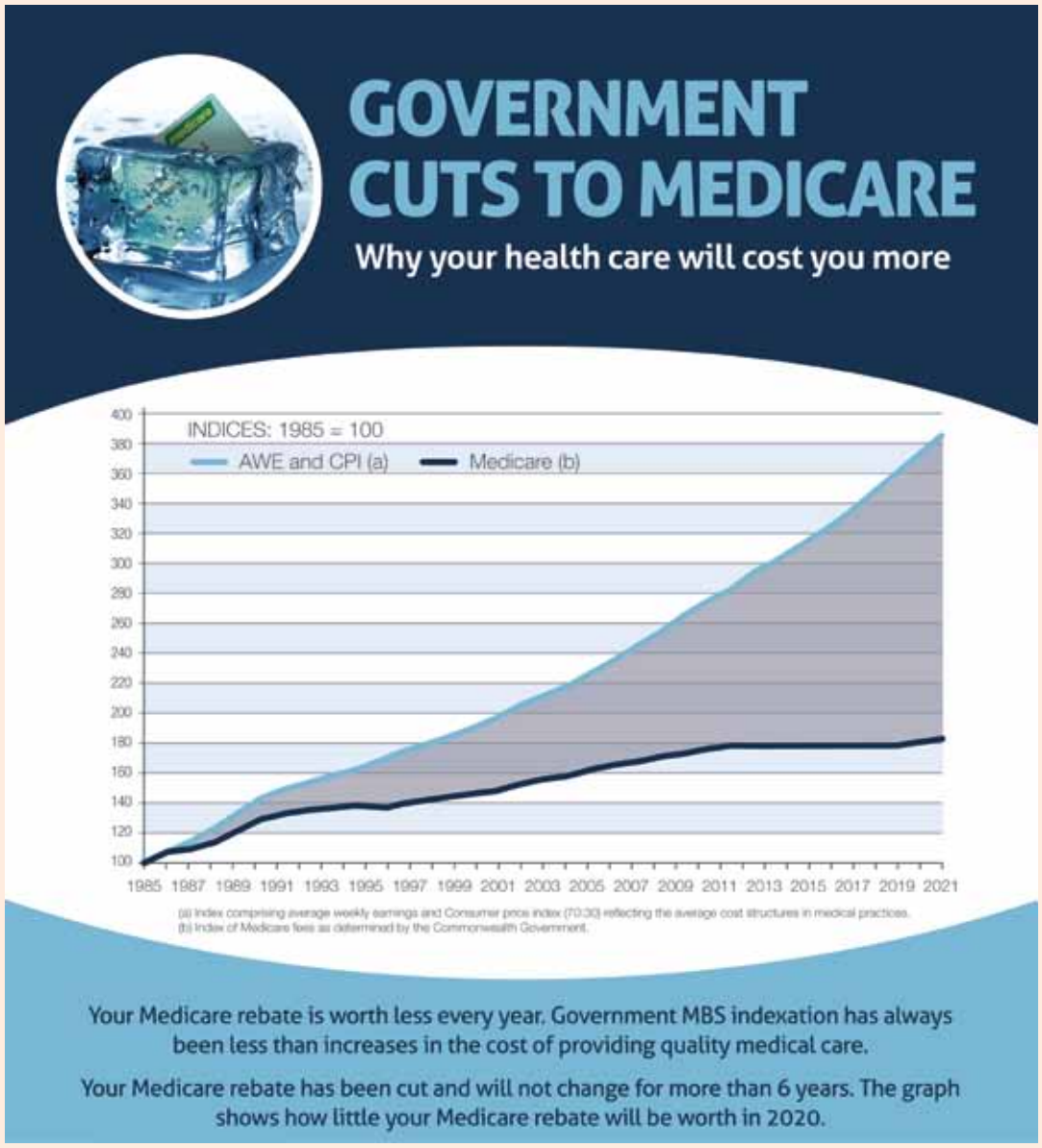
While recent media talk and hints from politicians suggest that the Medicare Rebate Freeze is about to be lifted, the time for its lifting is well overdue. Not only has the freeze kept rebate levels as they were in 2013 but some specialties – notably pathology and medical imaging – have had longer freezes or other 'productivity cuts' imposed.

For example, in regard to pathology, the AMA (ACT)'s information is that rebates have not been indexed for 18 years and that repeated cuts to fees have exacerbated the lack of indexation.

When the freeze was introduced by the Gillard Government in 2013, it was said to be a "temporary" measure. However, the "temporary" measure was then extended to 2020 in the first Abbott budget in 2014.

In the meantime, practice costs continue to rise with wage inflation and the CPI increasing regularly and steadily. The AMA has prepared a chart (right) showing the increase in Average Weekly Earnings and the Consumer Price Index (weighted 70:30) against increases in the Medicare Rebate, with a starting point of 1985. If the freeze did continue until 2020 it's estimated the difference between the two indices would be more than 200 percentage points.

It's well past time to lift the freeze.



How might the latest superannuation changes affect you?

BY RUSSELL PRICE, DIRECTOR AT SPECIALIST WEALTH GROUP

With several major changes to Australia's superannuation system due to take effect from 1 July 2017, here's a summary of the main ones. These changes involve a lot of fine detail, so if you think you may be affected make sure you seek qualified advice sooner rather than later.

New $1.6 million cap on retirement balances

This move limits the sum that retirees can invest in tax-free pensions. It will also apply to current pensions, so if you have more than $1.6 million in retirement stream products on 1 July 2017, you will need to roll the excess back to an accumulation phase account where earnings will be taxed at 15%.

This cap will be indexed in line with inflation, in $100,000 increments. The Federal Government estimates this figure will grow to $1.7m by 2020-21. Also, once the income stream is established within the applicable limits, subse quent earnings will not be subject to the cap.

If you intend to set up a pension account before 1 July 2017, take this cap into account to avoid creating additional headaches.

New non-concessional contributions cap

The current limit on non-concessional (i.e. after tax) contributions is $180,000 p.a. or $540,000 over three years. From 1 July 2017 the limit is reduced to $100,000 p.a. or $300,000 within any three-year period. In addition, people who have reached their retirement balance cap (initially $1.6 million) at the start of each financial year will be unable to make non-concessional contributions.

If you plan on making large non-concessional contributions, perhaps from the sale of property for example, be aware that the current caps apply until 1 July 2017.

Concessional contributions cap reduced

Current annual caps on pre-tax contributions are $30,000, or $35,000 for over-49s. From 1 July 2017 these reduce to $25,000 p.a., irrespective of age.

This measure is softened in that, from 1 July 2018, if you have a super balance of less than $500,000, you will be able to carry forward any unused cap for up to five years.

As for this financial year, if you currently contribute less than your current cap you may want to increase your salary sacrifice or self-employed contributions prior to July 2017 if appropriate.

Reduced income threshold for additional contributions tax

The annual income threshold above which superannuation contributions are taxed at 30% (rather than the usual 15%) will be reduced from $300,000 to $250,000.

Tax-deductions on super contributions extended to all

From 1 July 2017 all residents under 65, or between 65 and 74 if they meet the work test, will be able to claim a tax deduction for superannuation contributions they personally make. This is a win for workers whose employers don't allow salary sacrifice contributions, and some individuals who are both self-employed and employees. Don't forget that the concessional contribution cap will still apply.

Tax on earnings to be applied to Transition to Retirement (TTR) pensions

The current tax-free status of TTR pensions will be removed, so earnings within the fund will be taxed at 15%. The tax treatment on pension payments to individuals will remain unchanged.

Linked to this, individuals will no longer be able to treat certain superannuation income stream payments as lump sums for tax purposes. Currently such lump sum payments are tax-free up to the lifetime threshold low rate cap ($195,000).

Extended spouse tax offset

Currently, an individual who makes a superannuation contribution for a spouse earning less than $10,800 per year can claim a tax offset of up to $540. The threshold will rise from $10,800 to $40,000, increasing the number of people able to claim the offset.

Removal of anti-detriment rule

Super funds will no longer be able to claim a tax deduction for a portion of a death benefit paid to a dependent. An anti-detriment payment represents a refund of the 15% paid on contributions made by the deceased member over their lifetime. The government claims the current provision is inconsistent with parts of tax law.

Tax exemptions extended to additional retirement phase products

Deferred lifetime annuity products will receive a tax exemption on earnings in the retirement phase, bringing them into line with other retirement income streams.

The importance of advice

These changes will affect us all in different ways, and as they do little to simplify the superannuation system, it's critical to seek expert advice to ensure that you continue to make the most of your retirement savings.

To learn more about how these latest changes may affect you contact an adviser at Specialist Wealth Group on 1300 008 002 or visit www.specialistwealth.com.au.

When adults report past child sexual abuse: clarifying your obligations

BY RUANNE BRELL, MEDICO-LEGAL ADVISOR, AVANT LAW

Julie, a 38 year-old mother of two children and a long standing patient, presents to you for a follow-up appointment. Julie seems more anxious than usual and at the end of the appointment she discloses for the first time that she was sexually abused by Mr P from the ages of 12 to 14, but was too frightened at the time to tell anyone. She felt that she should say something now as she has heard that Mr P has returned to the area and is working as a gardener at the local school. She is very worried that he may do the same thing to other young girls.*

As a doctor you are aware of your obligation to report concerns about children at risk of harm. However you wonder what you should do as Julie suffered the abuse as a child and many years have passed. Should you report Mr P to the police?

Doctors uncertain on how to deal with past child abuse reports

Doctors' obligations around mandatory reporting of child sexual abuse can be unclear and often confusing given that there are differences in the requirements across states and territories. It was also recently found, as part of the Royal Commission into Institutional Responses to Child Sexual Abuse 'Report of Case Study 27', that doctors are particularly uncertain about how to deal with reports by adults of abuse they suffered as children. The Royal Commission deemed that doctors need further education and training about their mandatory reporting obligations, particularly when considering historical child sexual abuse.

Mandatory reporting obligations in your state

While each state and territory has slightly different legislation, they all require doctors to report suspected child sexual abuse. This generally applies to anyone up to the age of 18, except in NSW where reports for 16 and 17 year old patients are voluntary and in Victoria where it is mandatory only up to the age of 17. In the Northern Territory a child can include someone who appears to be under 18 years old and in Western Australia can include someone whose age cannot be proven.

When should you report past child sexual abuse?

In situations like the case example above where an adult patient has informed their doctor of past sexual abuse, doctors' mandatory reporting obligations vary depending on the state or territory.

In NSW, doctors must make a mandatory report if there is an identifiable class of children at risk of significant harm, such as when an adult patient reports that they know an alleged offender continues to have contact with children, for example through their occupation. This means that the doctor must report the suspected or reported abuse, even if there appear to be barriers such as the length of time between the adult patient's own reported abuse (meaning they are no longer a child under the legislation) and the time of the report.

The legislation in the other states and territories differs in that they do not contain equivalent provisions to those in NSW regarding reporting classes of children at risk. However, evidence given by witnesses in the Royal Commission highlighted a common theme. One of the first questions asked by survivor victims when reporting their own abuse was whether the people that abused them were still practising in healthcare or otherwise had contact with children. This can often be the tipping point prompting a victim to talk about their historical sexual abuse, as they are concerned about protecting other children.

Therefore, the obligation to report child sexual abuse may arise from a reasonable belief or suspicion that sexual abuse may continue to be perpetrated against other children in close contact with the alleged offender. If these legal obligations are not triggered in particular circumstances, information may still be disclosed to police if the exceptions to disclosure without patient consent are met under the privacy legislation. Read our article on disclosure of information to the police.

Key lessons

In view of the Royal Commission's recommendations, the Australian Institute of Family Studies published resources clarifying doctors' mandatory reporting obligations in each state and territory and outlining how to make a report. Of course, each situation will be different, inherently complex and sometimes uncertain. Essentially, doctors' obligations are as follows:

- Suspected child sexual abuse must be reported in all states and territories to the Child Protection Unit at the State or Territory Department of Health.
- A report of historical sexual abuse by an adult patient may still warrant reporting to the Child Protection Unit, where the offender continues to have contact with children, particularly if through their occupation and there is a risk of harm to the children.
- If the law does not mandate reporting of historical sexual abuse, information may be able to be disclosed to police under the privacy provisions. However, it is necessary to ensure these provisions apply to a particular situation.

**This case has been created based on our experience. All names have been created and any relation to actual people is purely coincidental.*

Need advice?

If you need advice on your mandatory reporting obligations around suspected child sexual abuse or historical accounts of abuse, call Avant's Medico-legal Advisory Service on 1800 128 268.

Visit the Avant Learning Centre for resources including case studies, articles, eLearning courses, fact sheets, checklists and webinars.

Adult means an individual who is at least 18 years old.

young person means a person who is 12 years old or older, but not yet an adult.

Child means a person who is under 12 years old.

Sponsor an indigenous medical student

The significant gap in life expectancy between Aboriginal and Torres Strait Islander people and other Australians is of great concern to the AMA. Closing this gap and achieving health equality should be a national priority. The AMA believes that Australian governments, the private and corporate sectors and Aboriginal and Torres Strait Islander people all have a part to play in ending the cycle of disadvantage. You can contribute to the solution.

What is the solution?

The AMA recognises that there are no easy fixes. Aboriginal and Torres Strait Islander people do not access health and medical services at a level appropriate to their needs. However, Aboriginal and Torres Strait Islander people are far more likely to attend health and medical services that reflect their own values and perspectives.

The health of Aboriginal and Torres Strait Islander people fares better when they are involved in the planning and delivery of their own health and medical care. Having an Aboriginal or Torres Strait Islander doctor at a clinic can often make the difference between a community member turning up to the clinic for their scheduled appointment and never visiting the clinic at all.

AMA Indigenous Peoples' Medical Scholarship Scheme

Each year since 1994, the AMA has offered at least one Scholarship to eligible Aboriginal and Torres Strait Islander students who have entered an Australian university to study medicine. A range of skills and qualities contribute to someone becoming successful as a doctor. Academic ability is one of them.

However, as the AMA realises from working with Aboriginal and Torres Strait Islander communities, cultural understanding and commitment to one's community are also very significant factors in providing best practice health and medical care to Aboriginal and Torres Strait Islander people. Who is eligible? The AMA Indigenous Peoples' Medical Scholarship targets Aboriginal and Torres Strait Islander medical students who demonstrate a commitment to their community and to medicine, and who may not have the financial means to realise their dream.

The Scholarship is advertised in November each year, and applications close in January the following year. The winner is chosen and the Scholarship is usually presented at the AMA's National Conference in May. It costs between $10,440 and $15,000 to attend one year of university studying medicine and students typically undertake four to six years of study to complete their degree and become a registered medical practitioner. Support for the training of an Aboriginal or Torres Strait Islander medical practitioner to provide culturally appropriate care is invaluable.

Scholarship Donations

The AMA seeks your support of the Scholarship. Please contact the AMA should you wish to discuss a package tailored to your organisation's needs or to simply make a donation to the scheme. For sponsorship enquiries and payment details please contact the AMA via email at indigenousscholarship@ama.com.au or phone (02) 6270 5400. Information regarding the Indigenous Peoples' Medical Scholarship can be found at https://ama.com.au/advocacy/indigenous-peoples-medicalscholarship

Winnunga's Prof Ngiare Brown reappointed to PM's Indigenous Advisory Council

Prof Ngiare Brown is a familiar face around Winnunga and the ACT region. The well-respected Winnunga doctor and Professor of Indigenous Health at the University of Wollongong, was re-appointed earlier this month to the Prime Minister's Indigenous Advisory Council.

Prof Ngiare's re-appointment was welcomed by Winnunga CEO Julie Tongs. "Professor Brown's re-appointment comes as no surprise to me as she is a strong advocate for our mob and understands the challenges of working in an Aboriginal Community Controlled Health Service. Professor Brown is a valued member of the Winnunga team and I know that her on-the-ground experience will assist in her decision making on the Prime Minister's Indigenous Advisory Council" Julie said.

Dr Ngiare joins fellow members Andrea Mason, Susan Murphy, Roy Ah See, Chris Sarra and Djambawa Marawill in their important role in engaging and providing the Australian Government with a range of advice to help deliver better outcomes in partnership with our mob, stakeholders and communities.

This article first appeared in Winnunga News, February 2017

Why the NHS junior doctor strikes matter in Australia

With enterprise bargaining about to begin for ACT Doctors in Training it's relevant to look back to 2015 and the early days of the UK junior doctors' contract dispute and to reflect on the issues and underlying causes as described by Dr Matt Bray.

The following is an edited version of an article that first appeared in the *Medical Observer* in November 2015.

Junior doctors in the UK have voted to strike over changes to conditions. This is why it matters in Australia.

EARLIER this week, and for the fourth time this year, I encountered a registrar admitted to my hospital after an attempted suicide.

I recounted the story (an antidepressant overdose) to the shaking heads and downcast eyes of my fellow junior doctors as we huddled in the resident quarters on night shift. Each then launched into their own anecdotes of trauma and friends' near misses.

We were sobered, not surprised, by the thought of blooming careers and bright young colleagues overburdened to the point of such hopelessness.

Stories such as these are all too familiar and the result, no doubt, of the interplay of emotionally and physically taxing work, isolating work hours, intense training programs, and personality types.

Medicine demands much from its devotees, particularly in the earlier years in the trade. To summon the personal reserves to cope in an increasingly complex, demanding and client-oriented environment, doctors in training must feel valued.

Our ongoing education and development must be supported and protected through safe, fair rostering conditions and allowances for study.

Standing with our colleagues

This is why I stand with our colleagues in the UK, who have just voted in favour of striking to demand guarantees of safe hours and adequate pay for their work.

The Tory government's moves to slash penalty rates and extend hours of work is symptomatic of a misunderstanding — or, at worst, a calculated manipulation — of the ethics and culture of the junior medical workforce.

The millions of hours of unpaid overtime written off each week is perhaps the best evidence of the sacrifice — of time, money, energy and relationships — that junior doctors make.

We are at the forefront of hospital care in all its beauty, rarely voicing a complaint, in the hope that one day we will reflect back on our hard work with a satisfaction that will be somewhat commensurate with our personal investment.

But we also do it out of respect for our patients and colleagues, and with humble deference to the noble nature of our ancient craft, cognisant of — or perhaps embarrassed by — the fact that previous generations of doctors worked longer hours in a less automated age. This, of course, flies in the face of the evidence illustrating the relationship between resident fatigue and medical errors.

Mantle of martyrdom

Usually when talk arises of the state of industrial relations for Australian doctors, the prospect of striking is seen as unconscionable. Despite our treatment by health care systems as just another cog in the wheel, we take the attitude that the system is too big to fail and that we must bear the burden to keep the ship afloat.

We invoke a kind of medical exceptionalism, adopting a mantle of martyrdom and sacrifice for our patients, rather than the elitism and entitlement some might expect. Gallant as this may sound, taking responsibility for the wellbeing of others to this self-sacrificial extent often comes at the expense of our own wellbeing.

I suspect this has a big impact on the collective self-esteem of our profession. When our patients, our superiors, or our employers fail to respect our needs as public servants and trainees, this leaves junior doctors feeling alienated and deflated.

Inevitably, questions of self-worth and the merit of one's work can foment to aggravate pre-existing psychiatric vulnerabilities.

An important lesson in advocacy

This is why I am proud of our UK colleagues for standing up for themselves in such a concrete way. Their movement is consequential globally.

For our part, this is an important lesson in advocacy as our elected representatives butt heads with the AMA on GP fees, MBS reviews, climate change and health, shrinking funding for public hospitals and unnecessary new medical schools.

Be prepared

The NHS debate is also critical in Australia because untenable working conditions and unjust reforms in the UK will see thousands of UK doctors flocking to Australia seeking better conditions and flooding an ill-structured system already unable to employ all Australian graduates.

We are fortunate in Australia to have an enviable level of pay and safer work hour conditions than many of our colleagues overseas.

Should the need arise one day, Australian doctors have to be prepared to emulate the same level of self-defence as our British colleagues, even if it means strike action: a poignant, heartbreaking act for doctors who have "consecrated our lives to the service of humanity".

However, a public healthcare system that respects the work and wellbeing of its medical workforce should affirm their role, protect their working conditions and seek to partner with doctors in the pursuit of health for all.

Book review:

REVIEW BY A.J. (TONY) CHASE

John Le Carré – The Biography
Adam Sisman
ISBN: 9781408827932

Fiction? What Fiction?

The political theorist Francis Fukuyama famously proclaimed that the end of the Cold War marked "the end of history"; a triumph of capitalist liberal Western democracy over competing ideologies.

Based on this thesis it was believed that 21st century humanity would be a globalized post-conflict society moving in deterministic concert toward collective peace and prosperity. Of course Fukuyama's declaration was made before the September 11, 2001 attacks and the subsequent open warfare between nation-states. Nonetheless, this type of 'traditional' state v state conflict has become rare where nowadays, the bulk of non-state, intrastate, and interstate conflict and violence is played out in special operations warfare where nations use techniques to harass and destabilise opponents through non-traditional means.

Smiley: the archetypal spy

The master of fiction would surely allow the idea that his famous spy hero George Smiley (*Tinker Tailor Soldier Spy* and *Smiley's People*) would have flourished in our supposed post-conflict society. At least this avowed le Carrè fan is sure that Smiley would have raised a critical eyebrow as George didn't go in for declarations. Smiley's instincts and impeccable judgement would have quietly set such a grandiose declaration aside.

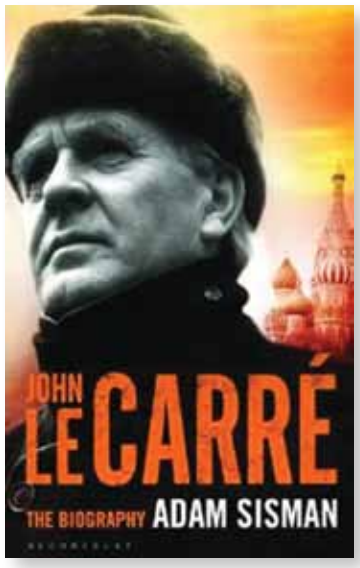
It is easy to forget as le Carrè fans often do, that Smiley is and always will be a fictional character. So as readers and fans we have licence to speculate on Smiley's response and treatment of our contemporary mores. In his lifetime career as a spy Smiley would have characteristically marked his successes as few and no more than incremental but always and certainly, no victories.

In his rare moments of triumph during the cold war years of grinding attritional conflict, he would have allowed himself only a quiet moment of self-congratulation shared with a small group of MI-5 insiders or fellow operatives. Even in his crowning career achievement having induced the defection of his arch rival (Karla) the head of the KGB, (*Smiley's People*) Smiley recognised that he and Karla have shared a common fate as well as a life-long obsession and mortal struggle.

In his personal letter to Karla (delivered under the cover of diplomatic immunity) Smiley welcomes Karla to the 'West' and ends his letter with the exquisite salutation;

> "greetings and welcome to no-man's land

This famous personal letter in le Carrès hands, was written from one fallible human to another, not as one would expect as a veteran foot soldier in the midst of the life and death struggle of the cold war. Smiley's victory in le Carrès hands, becomes shot through with ambiguities and an overriding absence of moral certitude. Our friend Smiley knew that your old self did not fully survive the battle itself, recognising the ultimate futility of war; and more especially, the cold war where winners and losers were hard to find.



The art of biography

The great English biographer Francis Spalding delivered the Seymour Biography Lecture in Canberra in 2010, where she spelt out a great truth about the business of writing biographies.

"It is a hybrid and fluid genre, always spilling out in neat packages and persistently reshaping its enquiry as the questions that interest each generation change. This is one reason why there can be no such thing as a definitive biography."

Adam Sisman takes a good shot at the definitive biography; there's a long and compelling look at the life of John Cornwell (alias John le Carrè) from his early years where the master of fiction spent his boyhood as a fugitive escaping his monstrous father. At 5 years old he was abandoned by his mother who left home for another man.

It is notable that Sisman devotes much space and effort to Cornwell's father (Ronnie); after all, he was an extraordinary "mythic figure" in Cornwell's life, and does represent an amazing back story to Cornwell's life. Ronnie was a notable business, social and sporting identity, rubbing shoulders with the upper classes and royalty. In 1948, he threw a successful house party for Bradman's legendary Australian Cricket Team.

Notably however, Sisman has little to say about Cornwell's mother, no doubt Cornwell was probably less than forthcoming on this subject. We may hear more on this subject in Cornwell's own memoir, *Stories from My Life, The Pigeon Tunnel,* published late in 2016.

Sisman also gives us a compelling account of Cornwell's early life where he and his brother benefited from an expensive public school education after which he read modern languages at Oxford where he undertook covert work for MI 5, spying on his left wing friends and associates. Sisman has an interesting account of Cornwell's first encounter with the intelligence world. He joined MI 5 as a professional spook in 1958 when in 1961 due to his mastery of the German language, he took up a diplomatic posting in the British Embassy in Bonn as cover.

The successful author

Sisman fills in the gaps about Cornwell's life in espionage and around this time he started writing novels. Within a year of the publication of Cornwell's breakthrough novel, *The Spy Who Came in From The Cold* (1963) he had become a millionaire. This seminal spy novel spent 35 weeks on the *New York Times* best seller list and sold hundreds of thousands of copies in Europe and the United States.

Sisman provides great insight into Cornwell the business man, and he chronicles his dealings with publishing houses, making money by optimising the rights and sale of his work in the European and American markets. We see how he often changed publishers and agents and we are given access to his development as a highly successful professional writer.

Sisman also provides some enjoyable stories around movie-making with encounters with movie stars such as Richard Burton, and more successfully with Alec Guinness who became so closely identified as the archetypal spy of the acclaimed BBC TV series. No sooner had devotees of le Carrè and the spy genre been picking our way through Adam Sisman's expertly crafted account of the man behind the le Carrè pseudonym, we are now presented with John Cornwell's *Stories from My Life, The Pigeon Tunnel*. This is described by Robert McCrum writing in *The Guardian (September 2016)* as a "patchwork memoir" of a "natural storyteller" where Cornwell concedes that being untruthful became the modus operandi of both the spy working as he did for MI5, and as a realistic novelist; two potent kinds of invention indeed.

John Cornwell with Alec Guinness on Hampstead Heath during the shooting of Smiley's People.

In his excellent review of Sisman's work novelist William Boyd (*New Statesman*) commends Sisman's work and is confident that it will stand as the definitive biography of a man described as the Dickens of the Cold War; not a bad epitaph for a genre writer.

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