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Independent Review: findings and implementation

With the release of the Final Report of the Independent Review due imminently, it's likely any changes from the Interim Report will be limited in scope and effect. The Interim Report contains detailed findings in regard to the current problems and makes broad-ranging recommendations for change.

The Review Panel received close to 400 submissions from individuals and organisations, together with 1800 responses from a staff survey they undertook. By any count, this is an overwhelming response from the Canberra community, health staff and stakeholders and represents a sound basis for the Review Panel to work from.

The findings set out in the Interim Report are troubling and point to a range of problems that will undoubtedly take an extended period of time to fix. The Review Panel have likewise indicated they believe cultural change will take a similarly extended period and require sustained attention.

Submissions and staff survey

The submissions received overwhelmingly highlighted:

- inappropriate behaviours and bullying and harassment in the workplace,
- inefficient procedures and processes including complaints handling
- inadequate training in dealing with inappropriate workplace practices
- inability to make timely decisions
- poor leadership and management at many levels throughout the ACT Public Health System, and
- inefficient and inappropriate Human Resource practices, including recruitment.

This was backed up by the staff survey results that indicated high levels of both observed bullying and of respondents being bullied themselves. Of significant concern was that 12% of staff indicated they had been subjected to physical harm, sexual harassment or abuse at work.

The survey results were similar across Canberra Health Service, Calvary Public Hospital and the Health Directorate and were worse than comparable data for NSW Health.

The Reviewers stated that "a point regularly raised in submissions was that whilst the contribution of poor leadership over the past few years has led to this unhealthy workplace culture, it was also generally acknowledged that this poor culture had been present for many years."

A start on change

The Reviewers have proposed a series of steps towards change that includes adoption of a program based on a similar undertaking at the Vanderbilt University Medical Centre aimed at building a culture of safety and quality in the workplace. The emphasis is on training and through that, empowering staff to better support each other and raise concerns early.

Emphasis is also been given to developing, valuing and sustaining strong partnerships and , both internally and externally. The Reviewers point to the need for strengthened relationships between Clinical Divisions in Canberra Health Services, between the acute and community health sectors, and between Canberra Health Services and Calvary Public Hospital.

Externally, improved relationships with Non-Government Organisations, universities, and other health sectors, such as NSW Health, are needed. The Reviewers believe that such improved relationships will not only contribute to improved co-ordinated care and enable a better research and learning system but, importantly, will also help strengthen culture by breaking down the relative isolation of the ACT Public Health System.

Clinical engagement

The Review Panel observed that a number of very dedicated clinicians, including medical practitioners, had 'fully engaged' with this Review even though some expressed reservations regarding the Review's impact. However, "it was apparent that, unlike nurses and allied health workers, the significant majority of the medical workforce did not engage."

Based on this observation, submissions and interviews with staff, the Review Panel members concluded that such disengagement

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President's **Notes**

WITH PRESIDENT, DR ANTONIO DI DIO

The release of the Interim Report of the Independent Review that occurred at the end of January, was a welcome insight into some of the cultural problems of the ACT public healthcare system. My earnest hope is that we can all learn from it and, when it is released, the final Report too.

The Interim Report makes it clear that the Review Panel received a wide range of information from submitters, from staff surveys and from meetings held with interest groups and individuals. It's apparent that much of the information received by the Panel was similar to that which had been provided to the AMA (ACT).

The Review Panel's recommendations are significant because they point the way forward and propose structures, practices and processes designed to bring about cultural change in the workplaces of the ACT public healthcare services. Implementation of the Review Panel's recommendations is the next challenge and we will be doing our best to ensure the recommendations are implemented in both the letter and spirit they were intended.

While implementation is now the major challenge, in my view, the missing element in the 'independent review' process is how we ensure that some level of individual accountability for the cultural and workplace problems set out in the Interim Report is attributed.

Individual accountability

One advantage a Board of Inquiry into workplace culture would have had was its ability to investigate both the current and past problems and hold appropriate people to account. There's no doubt in my mind that a Board of Inquiry would have come up with broadly similar recommendations to the Independent Review – given that the available information was always going to be similar – but important differences meant that a Board of Inquiry would have taken the next step and identified some of the perpetrators responsible for the workplace problems.

Even though the Independent Review was not able to take this next step, it's clear from both the contents of the Interim Report and the public statements made when the Interim Report was launched that significant action against some individuals who have shown poor behavior for years, will need to be taken.

Addressing the issue

While implementation of the recommendations is the single most important issue facing us now, it's also clear that individual accountability remains a significant challenge to be dealt with. It's apparent from the findings in the Interim Report, the recommendations made and the referrals that have occurred, that follow up work needs to be done to address individual accountability for past inappropriate conduct.

This is where I'd ask Minister Fitzharris to take the lead and work with AMA (ACT) and other stakeholders in addressing these issues. It really now falls to the Minister, given her decision that we didn't need a Board of Inquiry, to identify a way forward on this important issue.

Referrals by review panel

The Interim Report states that some matters raised by submitters have been referred to an appropriate authority for action or investigation (with the consent of the submitter). In addition, where 'clusters of information' about inappropriate behaviour were received, the senior executive of the 'relevant arm of the ACT Public Health System' was advised.

Given these matters we have proposed that the Review Panel identify how many referrals have been made, the general nature of the referrals, to which organisation or in the case of relevant health service executive, the title of the office, that referrals have been made to and how those referrals will be followed up to track both progress and outcome.

I'd imagine the Review Panel could provide this information in a sufficiently general form to avoid identifying submitters.

While the Independent Review can't deal with individual accountability, a better understanding of the referrals that have been made would be helpful in balancing the future focus of the Interim Report against the failings of the past.

JMOs and education expenses

It's hard to believe but for many years, ACT Health have maintained that college fees are not education expenses for JMOs. This has meant a generation of our Canberra JMOs have missed out on being reimbursed for this part of their education expenses. While times are finally changing, with ACT Health agreeing to pay a small amount of expenses 'upfront' as part of salary, they now propose to only pay the total pool of what was previously paid to JMOs and then split this amongst all JMOs.

The net result is no increase in the total funding for JMOs' education expenses and a message that ACT Health doesn't really care about the increasing costs JMOs are facing or the fact that many educational activities require travel and accommodation costs away from Canberra. AMA (ACT) had a proposed a small additional increase in the overall JMO education budget but ACT Health have rejected our proposal.

In my view, it's past time for ACT Health to get serious about our hard-working JMOs and support them as they strive to improve themselves and the services they provide to Canberra's patients. For more on this see Tony Chase's article on page 5 of this edition of *Canberra Doctor*.

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Independent Review...*continued*

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was symptomatic of medical practitioners general disengagement from the management of ACT public hospitals.

The Review Panel found that, while hospitals in the ACT still achieve good clinical outcomes, the real cost of disengagement manifested itself when the knowledge and input of individual clinicians was not used to improve the quality of care across the system.

"A critical success factor to improving the ACT Public Health System workplace culture is to enhance clinical, in particular medical, engagement within the health system. The onus to engage should be equally recognised by both individual clinicians and the system in which they work."

The Review Panel also proposed enhancing clinical engagement by progressively adopting 'Clinical Divisional Directors' with business manager support and moving away from the current structures.

Implementation is crucial

The Reviewers acknowledged the "challenges in resetting the culture of a complex, multifaceted system like the ACT" and emphasised the need for a clear focus on developing a sustained, transparent and measurable approach for monitoring implementation.

Consequently a key recommendation in the Interim Report involves the establishment of an Implementation committee, chaired by the Minister for Health and Wellbeing, that includes the Minister for Mental Health, senior health service executives, the Health Care Consumers Association, AMA (ACT), relevant unions and key colleges.

The Review Panel have also recommended an independent annual external review, with similar methodology to the current review, which measures the extent of success of the implementation of the recommendations and the consequent impact on cultural change within the ACT Public Health System.

AMA Pre-Budget Submission: GPs the key

The AMA has lodged its Pre-Budget Submission with Treasury, calling on the Federal Government to provide a detailed and funded vision for the Australian health system.

With this year's Budget day being brought forward to April 2, ahead of an expected Federal election in May, AMA President Dr Tony Bartone said the date offered an ideal opportunity for a health vision to be articulated.

But he said that vision must be based on the reality that all parts of the health system are linked, and depend on each other to meet patient and community demand effectively.

"You cannot concentrate on one or two parts of the system and neglect the others – they must all be properly resourced and funded to ensure a quality patient journey," Dr Bartone said.

"The key to successful long-term health reform is to properly fund and invest in primary care, especially general practice.

"General practice is the beating heart of the health system, and it must be supported."

Dr Bartone said there was plenty of time for the Government to roll out a series of fully-funded policies designed to meet the increasing health care demands of a growing and ageing population.

Health reform needed

"The conditions are ripe for a new round of significant and meaningful health reforms, underpinned by secure, stable, and adequate long-term funding, to ensure the best possible health outcomes for the Australian population," Dr Bartone said.

The 2019 Budget and the election come as the Government finalises significant reviews, most notably the Medicare Benefits Schedule (MBS) Review and the implementation of the review of the private health insurance (PHI) sector.

The AMA and the medical profession will watch closely to see which MBS Review recommendations become Government policy.

"It has been our view from the start that the MBS Review must not be a cost saving exercise – it needs to be a credible clinical process to produce a strong contemporary MBS," Dr Bartone said.

"The private health insurance reforms – the Gold, Silver, Bronze, and Basic policies – are already being introduced. But we are yet to see how they will be accepted by the public and the health professions.

"At the same time, the Government will be navigating the implementation of vital public hospital funding negotiations with the States and Territories via the Council of Australian Governments (COAG) processes.

Dr Tony Bartone: MPs need to value general practice.

"The AMA is adamant that more funding is needed to ensure hospital capacity to meet rapidly growing patient demand.

"The Government, led by Health Minister Greg Hunt, has shown strong commitment to the Pharmaceutical Benefits Scheme (PBS), and we expect this ongoing commitment to be reflected in the Budget.

GPs the key

"The key to successful health reform is keeping all the important and disparate sections of the health system linked – and the key to keeping everything working to a common goal is general practice and the local GP."

The AMA stresses that this Budget and the imminent election policies from all parties must contain a significant, long-term funding commitment to primary health care, led by general practice.

"This will be one of the key factors by which we will judge the Budget and the election policies," Dr Bartone said.

"The Government acknowledged the importance of general practice in the Mid-Year Economic and Fiscal Outlook (MYEFO) statement in December, but the funding commitment was inadequate. More is needed.

"This AMA Pre-Budget Submission sets out a range of policies and recommendations that are practical, achievable, and affordable. They will make a difference. We urge the Government to adopt them in the Budget process.

"We have stuck mainly to the major pillars of the health system – public hospitals, the private health sector, the PBS, and primary care – in this submission.

"The AMA will release a broader policy agenda – encompassing Indigenous health, public health, prevention, and other issues – ahead of the election.

"Health should never be considered an expensive line item in the Budget. It is an investment in the welfare, wellbeing, and productivity of the Australian people.

ACT Health challenged to step up on Junior Doctor Education

Tony Chase, AMA (ACT) Manager of Workplace Relations and General Practice.

AMA (ACT)'s 2018 Hospital Health Check survey asked DITs to rate the opportunities for professional development activities at Canberra Hospital and the results were less than flattering. Over 50% of respondents rated Canberra Hospital as either *poor* or *very poor* with 32% rating it as *fair* and 16% as *good*. Not one respondent considered the training culture as *excellent*.

These results were backed up in the Interim Report of the Independent Review of Workplace Culture where the Review Panel members left us in no doubt about what they thought:

"The Reviewers found evidence that to date developing a learning culture within the ACT Public Health System was not valued, and that striving for academic excellence and greater academic output was often not encouraged. The situation needs to be rectified".

Junior staff shortages

The problems associated with junior doctor training are , of course, not confined to the ACT public

Health Minister Meegan Fitzharris: invest in staff.

healthcare space and need to be approached at both State Territory and national levels. At the local level, it's difficult to reconcile how the ACT public healthcare sector continues to sustain medical staff shortages without recognizing that it is becoming increasingly difficult to recruit to the Territory.

Whatever the underlying reasons may be, the shortages are directly impacting on the quality of training and educational opportunities for local JMOs. This is set against a background where we are witnessing a record number of medical graduates seeking training places. Despite the growing numbers of prevocational and vocational trainees and the increasing number of medical students, ACT Health still presides over staff shortages.

We all know that training the next generation of doctors is and will continue to be a huge challenge for the medical profession in general, and more especially for the learned colleges and public hospitals. While the ACT is not immune from the structural problems, it must look to its own corner when addressing the training and workforce planning issues.

Teaching time

The challenge thrown up by the Independent Review is clear and, make no mistake, 'cutting corners' on junior doctor training is happening in parts of our local public healthcare system.

Teaching time needs to be protected from the competing pressures

DR OMAR GAILANI

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of immediate clinical service delivery to ensure that the quality and effectiveness of teaching is maintained.

Our junior doctors need appropriate supervision and oversight including;

- Protected teaching time for tutorial attendance, workshops and conferences
- Examination preparation time
- In-training assessments, including feed-back with supervisors
- Teaching activities including, lectures and case presentations, and grand rounds
- Attendance or presentation at departmental or regional continuing education sessions
- Attendance or presentation at local and international conferences and workshops
- Peer Review and self -directed continuous learning including reading and review

Enterprise bargaining – conference leave and educational expenses

Canberra Doctor readers will know that enterprise bargaining negotiations have dragged on for over 18 months and during this period ACT Health were given every opportunity to properly consider AMA (ACT)'s proposals to improve the level of support for the training and education of our JMO cohort.

After months of attritional discussions and negotiations ACT Health have not budged on their negotiating position.

Put simply, no extra funding will be available for the JMOs and the opportunity for ACT Health to demonstrate a greater commitment to education and training for JMOs has again been missed. The growing JMO training deficit across the ACT public sector persists.

In the context of the overall budget bottom line for ACT Health, AMA (ACT)'s proposal to improve the support package for the JMOs would have a negligible impact of about 0.0625%. Our detailed proposal has fallen on deaf ears and ACT Health has offered no real improvement over the last four EBAs; a period in excess of 16 years.

This approach has been taken in the face of the ever-growing costs of college and examination fees sustained by the JMOs and their families.

ACT Health: college fees are not education

ACT Health continues to maintain that such expenses are not considered part of the cost of JMO training and education. This argument is hardly credible and is not supported across other jurisdictions in Australia. The AMA (ACT) has reminded ACTH that ACT-based JMOs additionally incur additional travelling and accommodation when compared with other metropolitan teaching centres. In the current environment where staff shortages are considered the norm, JMOs are also facing serious difficulties where access to leave to attend necessary training and conferences is minimal.

In a press release on 4 June 2018 Minister Fitzharris said that the Territory public hospitals represents a;

"Healthcare hub for a region of over 1 million people, and that calls for a sustainable step in our investment in frontline staff and health services"

Maybe the Minister should tell this to ACT Health and ask – what about the JMOs?

New pay rates and back pay

The implementation of the new pay rates comes in two parts:

- The first is to get the new rates into the pay system and commencing paying in accordance. Given there have been a number of increases this is whatever rate is current at that time.
- The second is back pay, which will be effective to October 2017 and involves recalculating pays already made including taking into account the previous increases.

CMD advises that there will be a delay between paying the new rates and paying back-pay – likely to be one or two pay periods. This is because the payroll system has to calculate the back-pay, and some of it gets very complicated where shifts, overtime, PT etc. all interact.

CMD also advises that back pay to employees who have left the Service will be available on request. A simple email to Payroll is sufficient.

Pay increases

The increases are:

- 2.25% from the first full pay period in October 2017;
- 0.5% from the first full pay period in June 2018; and
- 1.35% every six months from the first full pay period in December 2018 to the first full pay period in June 2021

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AMA (ACT) welcome drinks for new medical students

AMA (ACT) President, Dr Antonio Di Dio and CEO, Peter Somerville have welcomed ANU's new medical students at drinks held in the Llewelleyn Hall on the ANU campus.

With Dr Di Dio doing the honours, supported by Dr Zaheer Jayhoon, and Adrian Armitage, the new Executive Officer for AMSA, 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.

Our thanks to the ANU Medical Students Society for their assistance in organising the welcome.

*Discount offer is valid for Australian car rentals booked via the AMA booking tool. This discount applies to the base rate (time & kilometre charge) only. Standard age, credit card and driver requirements apply. Rentals are subject to the terms and conditions of the Avis and Budget Rental Agreement at the time of rental. Offer valid until 14 September 2021.

ICON Cancer Centre opens in Bruce

Earlier in February, Health Minister, Greg Hunt officially opened the new Icon Cancer Centre located in the Bruce health precinct. The centre will deliver Canberra's first private radiation oncology service, in addition to providing chemotherapy and treatment for blood disorders under the one roof. Also present were Prof Deep Saini, University of Canberra Voice-Chancellor and Dr Antonio Di Dio, AMA (ACT) President.

Stuart Giles, Chairman of the Icon Group said that the centre would form part of a wider integrated service based at the new Canberra Specialist Medical Centre,

"We are extremely proud to deliver on this commitment for the people of Canberra, with local patients now having greater choice to receive integrated and holistic cancer care on their doorstep at Canberra Specialist Medical Centre," Mr Giles added.

"Icon Group was founded on a vision to provide the best care possible, to as many people as possible, as close to home as possible." Mr Giles said.

Icon says the new Cancer Centre offers:

- Radiation therapy – The latest radiation therapy technology delivering pinpoint precision radiation with speed and accuracy, including plans for advanced stereotactic radiation therapy.
- Chemotherapy and haematology – 15-chair private day oncology hospital providing chemotherapy, targeted therapy and treatment for blood disorders (from early 2019)
- Radiology – Onsite radiology services (PET-CT) provided by Qscan (from March 2019)

An integrated approach to cancer care

The official opening took place alongside the opening of Qscan Canberra. Qscan Canberra is a new facility providing specialist oncology services supported by PET-CT, Digital X-ray and Ultrasound imaging.

Both Icon and Qscan are co-located in the purpose-built Canberra Specialist Medical Centre (CSMC), alongside the University of Canberra's allied health service. The aim is to bring together leading educators, researchers and healthcare providers to offer greater choice for patients as to where they receive their cancer treatment.

The co-location with UC is designed to foster the next generation health workforce with work-integrated learning opportunities. Students from the Faculty of Health will work closely with Icon Cancer Centre to develop their skills and play a part in delivering services for patients during their oncology treatment.

Health Minister Greg Hunt (second from right) with, left to right, ICON Chair, Stuart Giles, patient John Barrett and Prof Deep Saini.

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How to reduce early preterm birth for 10c a day

BY PROFESSOR JULIE QUINLIVAN, OBSTETRICIAN AND GYNAECOLOGIST, AUSTRALIAN NATIONAL UNIVERSITY AND UNIVERSITY OF NOTRE DAME AUSTRALIA

Preterm birth, especially early preterm birth (EPTB) at less than 34 weeks gestation, is the leading global cause of death and disability in children. There are immediate direct costs in terms of pregnancy and neonatal intensive care unit expenditure, as well as lifelong costs of educational intervention and disability support. There are secondary economic and social costs for primary caregivers of children with disability.

A low-cost public health solution to EPTB is one of the Holy Grails of modern medicine. In 2011, the Bill and Melinda Gates Foundation called the need for an intervention to prevent EPTB as a leading global challenge in healthcare.

Approximately half of all EPTB are spontaneous. Most occur in low risk women. The remaining 50% are due to underlying disorders affecting mother or baby such as pre-eclampsia, antepartum haemorrhage or diabetes.

In 2005 a multidisciplinary group of Australian researchers secured NHMRC funding to test the hypothesis that a low cost, dietary intervention in pregnancy could improve pregnancy outcomes. One of the pre-planned analyses was to explore whether dietary consumption of omega 3 long chain polyunsaturated fatty acids like Docosahexaenoic acid (DHA), would shift the balance of prostaglandins in the cervix of pregnant women to prolong pregnancy in women with an underlying risk of EPTB. In alphabetical order, the team was Robert Gibson – biochemist, Maria Makrides – nutritionist, Andrew McPhee – neonatologist, Julie Quinlivan – obstetrician and gynaecologist and Lisa Yelland – biostatistician.

Background science

The background science to the hypothesis came from an understanding of the hormonal cascade that lead to the initiation of labour and observational and epidemiological studies that reported an association between dietary consumption of fish high in omega-3 long chain polyunsaturated fatty acids and pregnancy duration.

Omega-3 are a competitive antagonist for arachidonic acid incorporation into cells, and levels within the materno-feto-placental unit can alter the production of prostaglandins from pro-inflammatory 2-series that drive cervical ripening, towards other end products that stabilise the cervix. There was good evidence from dietary studies that pregnant women had poor consumption of omega-3 and considerably less than the quantity recommended by the World Health Organisation.

This lead to the hypothesis that a dietary supplement could help switch natural prostaglandin production in the cervix away from 2-series prostaglandins that predisposed to shorter pregnancy duration and instead towards prostaglandins associated with stabilisation of the cervix.

DOMInO

Omega-3 comes in many forms but the most promising was DHA and the research team based their DOMInO trial around a supplement containing 900mg of a DHA loaded omega-3 versus a placebo. In 2010 the results of the DOMInO trial of 2399 Australian women was published in JAMA. It was reported that supplementation halved the incidence of early preterm birth (1.09% intervention, 2.25% placebo, adjusted RR 0.49 CI 0.25-0.94, p=0.03). The intervention also halved the number of babies that required admission to neonatal intensive care (RR 0.57, 95% CI 0.34-0.97, p=0.04).

After DOMInO was published, international researchers were asked to validate the findings. A Cochrane review in 2010 stated that further research was required to validate the findings, which at that time consisted only of DOM-

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InO and a few small trials that were not adequately powered. The global health community took up this challenge and late last year international validation occurred with the publication of a revised Cochrane review of 70 randomised trials involving 19,787 women from Australia, USA, England, USA, The Netherlands and Denmark. The Cochrane summary confirmed that supplementation with Docosahexaenoic acid reduces EPTB by 42%. The evidence is strongest for singleton pregnancy.

Robust evidence

There is now robust scientific evidence that EVERY pregnant woman with a singleton baby should take 500mg to 1000mg per day of an omega 3 fish oil, of which at least 500mg should be Docosahexaenoic acid. Supplementation should start from week 12 of pregnancy. The supplement can be produced for less than 10c a day. It is not a pharmaceutical drug – it is a nutritional supplement – but it does need to be a pure supplement of the right fish oil (Docosahexaenoic acid).

The Australian team have another NHMRC funded trial (ORIP) of over 5000 Australian women that will soon be published to explore the impact in twin pregnancy and the timing of supplement administration.

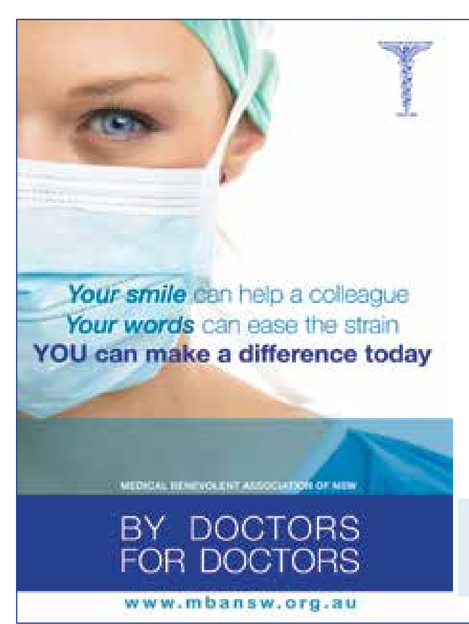
We are now fortunate to have a number of strategies to help reduce early preterm birth including tertiary hospital clinics, ultrasound screening of cervical length and vaginal progesterone therapy and cervical suturing. However, at a population level, we can achieve far greater impact using a public health approach that reduces levels of 2-series pro-inflammatory prostaglandins in the cervix by advising all pregnant women to cease smoking and take an omega-3 supplement from week 12 of pregnancy.

Future research

We still need to understand whether the omega-3 intervention is effective in multiple pregnancy as the mechanism of early preterm birth is different. We also need to refine the timing of supplements. Should they continue until birth or can they be ceased earlier, from 34 weeks?

We also need to tackle other causes of preterm birth. I am involved with a second research team that includes microbiologists, meta-genomic biostatisticians and clinicians in Peru, USA and Australia evaluating whether we can enhance our understanding of the microbiome of pregnancy using new culture independent tests to help identify women at risk of early preterm birth and miscarriage. We are performing pilot work on whether miscarriage may be linked to Niacin consumption in the diet. These additional areas of research will hopefully add to our understanding of the science behind miscarriage and early preterm birth and help clinicians address the remaining 52% of early births in the future.

In the meantime, all clinicians interacting with pregnant women should adopt the Cochrane review findings and recommend pregnant women take an omega-3 supplement from 12 weeks of pregnancy. You can now help prevent preterm birth and the need for our precious babies to enter neonatal intensive care.



The Medical Benevolent Association of NSW (MBANSW)

Provides a free and confidential support service to Canberra doctors in need and their family. Financial assistance and counselling support are available to colleagues who have fallen on hard times through illness or untimely death. Support is also available to medical practitioners who may be experiencing difficulties at work or in their personal relationships.

The MBANSW is funded by your donations; please allow us to continue to provide support and assistance to your colleagues in need by making a donation to the Medical Benevolent Association Annual Appeal. Donations can be made visiting our website www.mbansw.org.au

If you are concerned about your own situation or that of a colleague, please contact the MBANSW Social Worker, Meredith McVey on (02) 9987 0504.

Changes to fees under the Health Records (Privacy and Access) Act 1997

The ACT Health Directorate has increased a range of fess within the fee schedule under the Health Records (Privacy and Access) Act 1997. The Determination took effect on 1 January 2019.

Fees for consumer access to health records	
(a) To view a health record under the Act, section 13C(2)(a).	A fee of $15.60
(b) Provision of a copy of a health record up to 50 pages inclusive of any search fee under the Act, section 13C(2)(b)(i).	A fee of $42.70 plus an additional 40 cents per page charged for each page copied over 50 pages
(c) Provision of a copy of a health record for health records containing more than 50 pages inclusive of any search fee under the Act, section 13C(2)(b)(i).	A fee of $42.70 plus an additional 40 cents per page charged for each page copied over 50 pages
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Fees for access to health records by solicitor and insurer	
(f) For fees for access to health records by a consumer's solicitor or insurer - see fees determined under section 192 of the Health Act 1993.	
Fees for transfer of health records under Principle 11 of the Act–Relocation and closure of health service practice	
(g) When a health service provider notifies of a practice closure or relocation and transfers the health records or copy of the health records to another health service provider or record keeper.	No Fee
(h) When a health service provider notifies of a practice closure or relocation and transfers a copy of a health record at the request of the consumer to the consumer or another health service provider nominated by the consumer.	A fee of $42.70 plus an additional 40 cents per page charged for each page copied over 50 pages
(i) When a health service provider notifies of a practice closure or relocation and transfers a written summary of a health record at the request of the consumer to the consumer or another health service provider nominated by the consumer.	A fee of $89.10 plus the cost of actual postage
(j) When a health service provider notifies of a practice closure or relocation and chooses to transfer an original health record at the request of the consumer to the consumer or another health service provider nominated by the consumer.	The cost of actual postage
Fees for transfer of health records under Principle 12 of the Act–consumer transfers to another health service provider or health service provider transfers to another practice	
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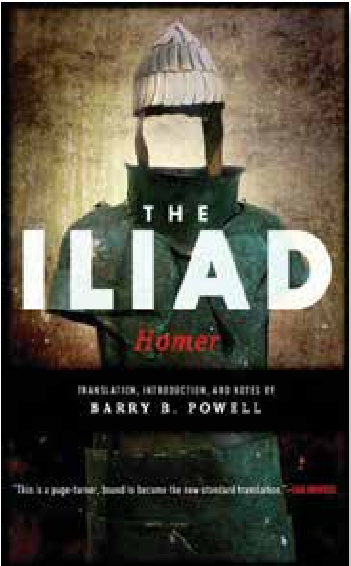
Book reviews:

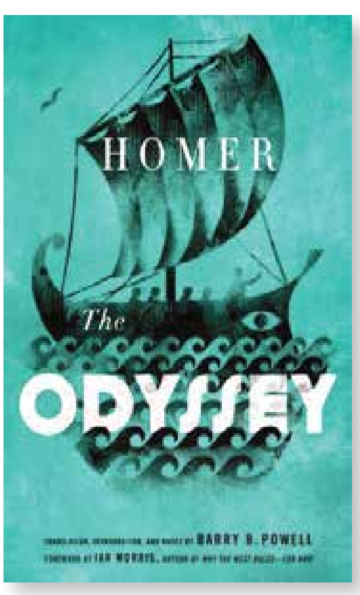
REVIEW BY A/PROF JEFFREY LOOI, ACADEMIC UNIT OF PSYCHIATRY AND ADDICTION MEDICINE, ANU MEDICAL SCHOOL

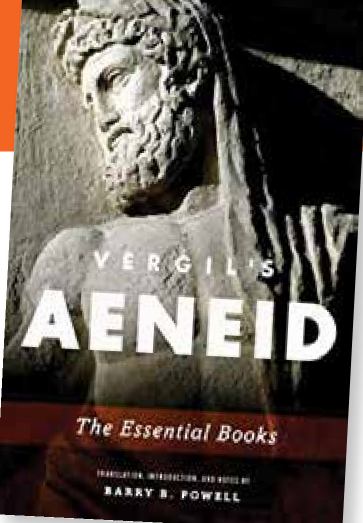
The Iliad, The Odyssey and The Aeneid

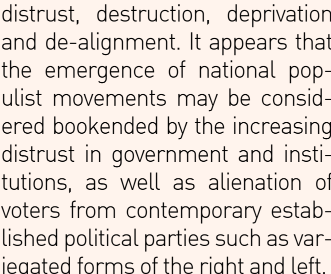
Translated by Barry B. Powell, Oxford University Press, Oxford

The Iliad – ISBN-13: 978-0199925865
The Odyssey – ISBN-13: 978-0199925889
The Aeneid – ISBN-13: 978-0190204952









Seldom has this trilogy been translated by the same scholar. The advantages brought by a uniformity of style highlight the differences in tone and composition of each epic poem, and are complemented by the introduction and excellent footnotes by the translator, Barry Powell, Bascom-Halls Professor of Classics Emeritus, University of Wisconsin Madison.

In addition, there are marvellous illustrations of scenes from the poems, from ancient through to pre-modern times, carefully curated and annotated by Professor Powell to match the text. From the fraught fields of fury around Troy; with the wily Odysseus wending his way home from Troy; and the invention of the origin of Rome in Aeneas's tale; all is writ resoundingly clear. The origin of the Iliad and Odyssey as oral epic poetry contrasts with, and is used to derive Vergil's Aeneid.

For the average reader, these translations seem the most accessible in terms of clarity of expression and style. Other excellent lyrical translations of these three epic poems, such as those of the late Professor Robert Fagles, may benefit from complementary reading of Professor Powell's work and vice versa.

National Populism

Roger Eatwell and Matthew Goodwin

Pelican, 2018

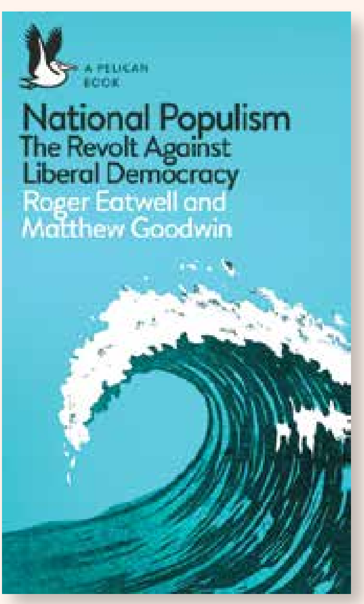
ISBN-13: 9780241312001

This book yet another of the reborn, very well-written Pelican Introduction Series, such as: Mike Savage's, Social Class in the 21st Century; Walter Sinnott-Armstrong's, Think Again-How to Reason and Argue; and Robin Dunbar's, Human Evolution, amongst others.

This is an excellent primer for the average person on the political science of national populist movements, of which the authors describe being reactions against Western liberal democracy and the elites that promulgate it.

Their central thesis is that such movements are founded upon the four Ds affecting the polity: distrust, destruction, deprivation and de-alignment. It appears that the emergence of national populist movements may be considered bookended by the increasing distrust in government and institutions, as well as alienation of voters from contemporary established political parties such as variegated forms of the right and left.

The role of sentiment looms large, if not monolithic, as Professors Eatwell and Goodwin demonstrate that the perception of threat to or destruction of social and cultural identity, as well as feelings of relative deprivation in contrast to others in society as the intervening D's. This introduction makes for chilling, as well as bracing, food for thought.



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ISSN 13118X25

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Dr Singhal's special interest includes Neurodevelopmental Psychiatry and working with children with complex mental health presentation including ADHD, ASD, Intellectual disability, Tourette Syndrome and similar presentations. Family therapy is her other special interest area.

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Dr Anandhi Rangaswamy

MBBS, MD, FANZCA, FFPMANZCA

Dr. Anandhi Rangaswamy is a Pain Specialist and Anaesthetist. She completed her Pain Fellowship and Anaesthetic Fellowship from Nepean Hospital Sydney and then went on to do Paediatric Pain Fellowship from Westmead Children's Hospital Sydney.

Dr. Rangaswamy believes in a whole person's approach to pain management. She works with a multidisciplinary team to get the best outcome for her patients. Her area of interest includes Back pain, Neuropathic pain, CRPS, Pelvic pain, Paediatric and Adolescent pain management. She also offers evidence based interventional pain management to her patients where appropriate.

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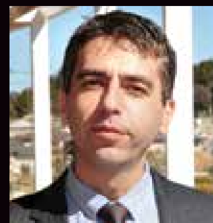

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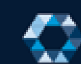

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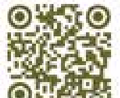

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The updated **2019 Directory of Medical Specialists, Allied Health Professionals and General Practioners with Special interests** will be published in July in time for **'Family Doctor Week'**.

Specialists wishing to be included in the directory need to complete the below form and return to ACT AMA by no later than 30 April 2019. Alternatively, you can fax the below form to the ACT AMA on 6273 0455 or email reception@ama-act.com.au

2019 Directory of Medical Specialists, Directory of Allied Health Professionals and Directory of GPs with Special Interests

… a publication of the AMA ACT

AMA (ACT) LIMITED

The Sixth edition of the directory of **Allied Health Professionals** and **GPs with Special Interests** will be published as a service to ACT general practitioners and distributed with the 14th edition of the **Directory of Medical Specialists** during Family Doctor Week in July 2019.

Entries must be on the form below and returned to the address below no later than 30 April 2019.

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

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

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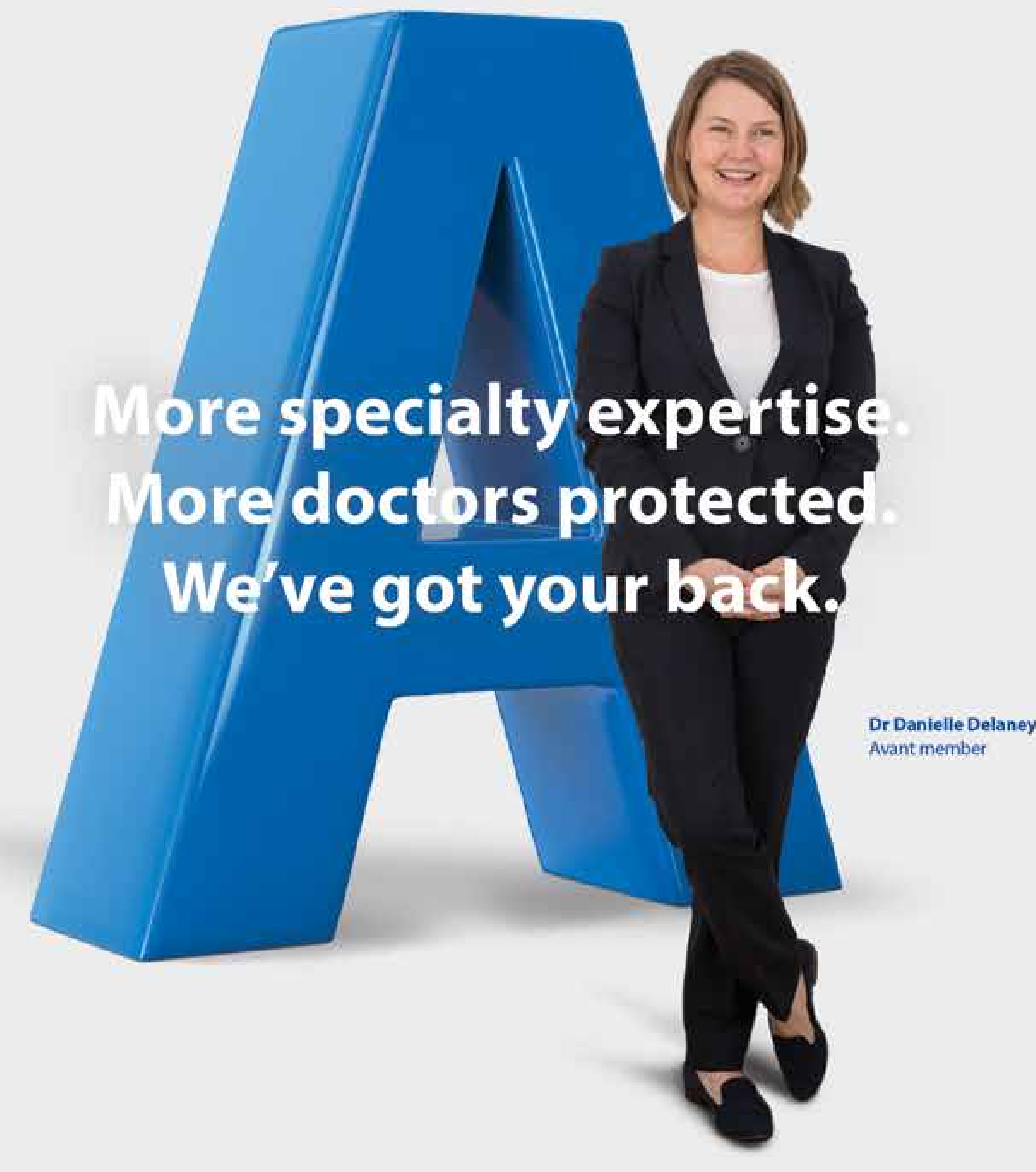

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