Canberra DOCTOR

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AMA Family Doctor Week 2015

YOU AND YOUR FAMILY DOCTOR:
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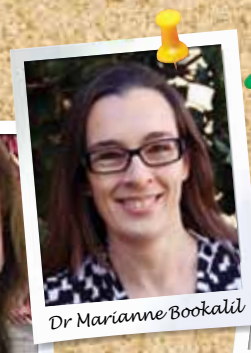
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Celebrating our general practitioners in Family Doctor Week

Capital Conversations with President, Dr Elizabeth Gallagher

Welcome to our July Edition that celebrates "Family Doctor Week" which is the annual celebration and recognition of our dedicated Family Doctors and General Practitioners.

As a specialist, I understand so well the importance of good and dedicated GPs who make managing patients so much easier, and are able to co-ordinate care among the whole of health system – including allied health, specialist and hospital care and the management of chronic health conditions. They are the hub that prevent the silos of health care delivery that we all risk developing. As usual, we have a wonderful range of contributions from our general practice members, and I will let their contributions speak for themselves.

Over the past 12 to 18 months, primary health care and general practice have been in the sights of Federal Government cost saving measures, more so than any other area of our profession. The Federal AMA under the leadership of our President Brian Owler and colleagues, have been lobbying and negotiating tirelessly since the 2014 budget with some good wins, and a lot more yet to be settled. A few of the outstanding challenges include the Medicare rebate freeze (which I remind you actually affects all of us who bill Medicare including the hospital outpatients), the move of allied health such as pharmacists into roles that create a silo of health delivery that has traditionally been overseen by family doctors, and the momentous change in the training of our GPs. This has now been taken over by the Department of Health, with the cancellation of programs such as the General Practice Prevocational Placements Program (GPPPP), and changes to the rural training boundaries which undermine patient flow and current relationships the ANU and ACT health have developed with rural general practices and rural hospitals in our surrounding areas. Just a little plug for those non AMA member GPs, we are out to bat for all of you, not just our members. As with any organisation, strength lies with the membership though, and certainly this year, the question of "what can the AMA do for me?" has been answered most obviously in general practice.

And last but not least, at the end of this month we finally say farewell to our well loved and respected CEO Ms Christine Brill, who heads into retirement.

Breast cancer screening rates drop, despite new data on life saving benefits

Cancer Council is encouraging all eligible Australian women aged 50 to 74 to consider participating in the free BreastScreen program following the release of data showing a downward trend in participation.

New figures from the Australian Institute of Health and Welfare show that BreastScreen participation rates for women aged 50 to 69 have fallen from a high of 57.6 per cent in 2001-02 to 53.7 in 2013-14.

The new data follows recent major international analysis from the International Agency for Research on Cancer (IARC) which confirmed the life-saving benefits of screening mammography.

Chair of Cancer Council Australia's Screening and Immunisation Committee, Associate Professor Karen Canfell, said the IARC analysis showed that women aged 50 – 69 invited for mammogram screening had an average 23 per cent reduction in the risk of breast cancer death.

"That translates to thousands of premature breast cancer deaths prevented over the past 20 years – a number that would be increased if more women participated in the screening program," A/Professor Canfell said.

"Breast cancer is the most common cancer in Australian women and the second most common cause of cancer death in women, however most breast cancers can be successfully treated if found early.

"Screening saves lives, so we need to encourage more eligible women to consider the benefits of participating in the BreastScreen program."

A/Professor Canfell said screening also carried the risk of harms such as over-diagnosis and over-treatment, so it was important that women were advised of the risks and the benefits before participating.

Newly released data also showed that Australian women's participation in cervical cancer screening has remained steady at 57.8 per cent.

"Australia's cervical screening program is the main reason we have among the world's lowest cervical cancer death rates," A/Professor Canfell said. "Participation rates are good, but we could prevent more cervical cancer deaths if more women aged 18 to 69 had their Pap test every two years."

BreastScreen invites women 50 to 74 to participate in breast cancer screening using mammograms every two years. Women aged 40 to 49 or aged 75 and over can also attend the service free of charge.

Women aged 18 to 69 years, including those who have had the HPV vaccine, are encouraged to participate in cervical cancer screening every two years.

Family doctors: partnerships are at the heart of a GPs work

By Lisa Cutfield

I am a proud family doctor and partnerships with patients are at the heart of my work. They develop through clinical encounters that might be frequent, regular, continue over the long term and involve contact at significant points in my patients' lives. These partnerships can be arduous and glorious by turns. They engender the full range of emotions from frustration and despondency to delight and deep satisfaction.

There is tedium in negotiating a lengthy workers compensation process, disappointment when an alcoholic relapses, unbearable sadness after the suicide of patient who had struggled for years with an intractable eating disorder, pleasure in a chortling bouncing baby whose mum had suffered recurrent pregnancy loss, relief when a "helpless and hopeless" patient takes charge of their situation and a sense of profound privilege in attending a patient dying at home among family. My contribution as a family doctor to the health of individuals and the community turns on these partnerships in which I am an interpreter, an advocate and a constant for my patients.

A family doctor has both specialist medical training and an intimate knowledge of their patient's priorities and circumstances. My task is to translate clinical findings, the evidence, specialist opinion, latest guidelines and "internet research" to their particular situation. Patients often return from hospital or the specialist rooms seeking help to make sense of their experience there or the advice they received. I can put it in terms that the patient better understands and we can weigh up the recommendations together. The likelihood of a patient taking up and sustaining health interventions is increased if I can appeal to the things that matter to that person, if I can make those interventions relevant and practicable in that patient's unique context. This may mean not doing things completely by the book.

A family doctor goes into bat for their patients. The best health outcomes proceed from "knowing the system" as much as knowing what the patient needs. When it comes to making referrals I want to be able to pick the right match for my patient. I want to send them to clinicians who will recognise their individuality, consider their circumstances and respond thoughtfully and sensibly to their problem. I need to be roughly aware of fees and costs and scout for services that will be within a patient's means. Together we navigate the tortuous passages of the outpatient labyrinth and win over the guardians of the clinic appointments. I have to communicate convincingly and with the right people so as to sell the patient's case. I must be prepared to press firmly for a second look or a second opinion or a more timely appointment or an expeditious procedure. My leg work, often in the form of multiple phone calls, can reduce the chance of the patient exhausting themselves on a wild goose chase. I am hoping that HealthPathways will smooth the path to the right services for patients but I suspect that advocacy will remain in the family doctor's job description.

There are often many players in a patient's health care experience especially if they have complex medical needs. The family doctor connects the parts for the patient, provides a reliable contact point through it all and keeps the longitudinal perspective. Sometimes the constancy of the partnership is the therapy. This is especially the case when there isn't a "fix" for the patient's problem, where all the experts have said that there is nothing they can offer or when the patient's condition falls outside the purview of any particular specialist. Patients value the assurance that their doctor will hang in there with them and continue to monitor and support them even when there aren't easy answers. Peter Sharp, one of my medical heroes, was an exponent of the long view. We might not be able to make an immediate difference to the patient's situation but a relationship of trust and respect can lead to positive outcomes down the track. Dr Pete was strong on the futility of being judgemental and the importance of staying with the patient – even if they don't always adhere to medical advice or they fall off the wagon or lose momentum in their efforts towards better health.

I would like to see the value of that partnership between family doctors and their patients better understood. The time spent interpreting, advocating and being there for patients is poorly remunerated especially if you consider how cost-effective this activity can be for the Australian health system as a whole. How can health funding be remodelled to promote and reward comprehensive and consistent primary care? I don't know but there are many good brains at work on this question.

I want hospital staff and administrators and our specialist colleagues to be alive to the relationship that many patients have with their family doctor. Not all patients and not all doctors enjoy these relationships but where they exist they can be utilised to good effect. Time and expense and hardship for the patient can be minimised with some enquiries about what was happening for the patient prior to admission. We can avoid reinventing the wheel or undoing a carefully engineered treatment regimen. Patients don't come to the hospital from the void. There is care going on out here!

A patient's local doctor is officially part of the hospital treating team and it is wonderful when this is acknowledged. Once a medical oncologist phoned just to let me know how my patient was faring part way through a prolonged hospital stay. Given the privacy concerns, staff can be rightfully reluctant to give information about patient progress over the phone so hearing from the treating team is very helpful. This is particularly so when it comes to discharge. With good communication we can smooth the transition between hospital and the community and make sure the follow-up arrangements are realistic and carried through. I am especially grateful to be advised when my patient dies in hospital as there is often an intense period of clinical contact that precedes an admission near the end of life.

Being a family doctor working in partnership with patients is demanding and rewarding in equal measure. I deal with every body system and see patients in all stages of life and know them for years. I share their funny stories, their success stories and their tragedies. I like to think that my work as interpreter, advocate and constant contributes substantially to their good health and is good value for the health system overall.

Lisa Cutfield
is a Canberra GP

Family doctors and some plain talking about partnerships

By Antonio DiDio

Evening all and wonderful to be here, in Family Doctor Week.

It means a lot to us in GP land to know that our efforts are recognised, as occasionally we all need a reminder that we are doing OK. It's worth noting that people should have a family doctor, and that those who do seem to have far better health outcomes than those who don't. I could look up some stats but will wait till tomorrow, when Captain America turns up (tall, thin and square jawed medical student, who has a device that looks up anything in seconds like Bones McCoy – it's probably just his Gen-Zed phone but looks for all money like an Avengers communicator or a really small TV. It amuses me that last week he was surreptitiously watching Breaking Bad on the screen while I was talking to a genuine drug villain in the office). Rather than focus on normal people needing a GP – let's think about doctors having a family doctor. Let me count the ways.

I'm writing this because the wonderful Dr Doumani rang me last week to announce that he was hanging up the boots after about 179 years running the ACT version of the DHAS, or Doctor's Health Advisory Service, a group I served with in NSW before deciding I wasn't the butt of enough jokes and moving to Canberra myself. I knew that Stan dealt with doctors who needed urgent and serious help, so imagine my surprise when he rang out of the blue. I had just had my usual 9am internal existential tantrum as the waiting room filled with heartsinks, whilst Captain America asked about the pay rates of all the specialities he was considering, and I stared vacantly into the foreground silently mouthing "Help". At that very moment Stan's smooth voice comes through the speaker. "Mate", he says, sounding like a cross between Sinatra and Dracula, "mate, how ARE you?" That guy can read minds. Anyway, he's off into the sunset and I'm the new Stan you call if distressed by this life we all choose, without his wisdom but with all the love and enthusiasm I can muster. It's been good so far – there's some lovely young people out there who've called already.

So why do doctors need family doctors? The research just in is compelling. Well, when I say "research" … let's talk about "research" … My dear mate Stent the cardiologist announced at the weekend café 'exercise' session that the number of articles published in the Heavyweight Journals which have subsequently disproved findings can possibly be 50% (wouldn't be so bad, I reckon, if he'd stop writing to the Lancet every time one of his registrars has a bowel motion that vaguely resembled the Shroud of Turin. Call me back when it resembles the NHMRC building, they say). With this in in mind, I did some of my own research at GP central (stick my head out the door and shout questions down the corridor. Wait 30 seconds. Repeat.) and found some staggering conclusions that need sharing before our editor attacks them with a red texta. My partners, Dr Twinsette and Dr Purls, are world authorities on the practice of looking after families over generations with an unflappability not seen since Bertie Wooster met Jeeves. They answer my questions easily.

Well, they purr over their decafs, never trust a vegetarian butcher. Cars should be serviced. Equipment should be maintained. Pianos should be tuned. (But never piano accordions, she says to me pointedly. A gentleman, she says, is a man who can play the piano accordion, but chooses not to). Anyway, doctors should see a family doctor. We at The Practice come in all shapes and ages (but so few genders. Of 26 staff and doctors, all are female except for myself and a fine young doctor who is so emotionally intelligent, thoughtful and well-groomed that he hardly counts as a bloke), yet Purls tells me that the 24 ladies all get a pap and lady-screening often enough to see a proper GP and they are all thriving. I see a GP every time I go through a pubertal growth spurt (and the next one is taking, like – forever!) and feel lousy. We talk about screening and management and family care and holistic care and we love it, so we should get it too. This week my appointment book features about 25 doctors or their family members and it's no different to anyone else – rewarding and generally wonderful and, well, kind of essential. It also tells me that I perhaps should have those bloods done that the nice lady I saw weeks … er … months ago said I should do, just before she said my bum was bigger than Beyonce's and unless I planned to release an album including the word Booty in the title I should maybe eat less. I said I exercised for 2 hours every Sunday morning, the first 90 minutes of which was intensely sitting in a café with some really outstanding preventive care physicians. She looked down her glasses and sighed.

In my world, I look down my glasses and do the sighing. Especially at Captain America, who is now wanting to know if plastics makes more money in New York or Los Angeles. I tell him neither could possibly be as lucrative as an hour with a diabetic elderly patient in a nursing home whom you haven't sent a bill to in 15 years, but who make regular deposits into your Karma bank. Gosh, now he's rolling his eyes!

The message is clear. Family doctors are good eggs. They do a lot of good work and they do it in a structure and context that allows the best of the work to happen. My favourite is the bit where, having checked the tiny tympanic membrane of the 4th generation of the family that sees you, first generation great grandma has a bloody great calf that you tease her about before hastily ordering the duplex scan, and as you write the referral you notice that generation 3, the young mum, is looking a little post-natal. That's the kind of medicine that Checkov and Maugham and Lev and Crichton and all those smug buggers who left the medical party a little early to Write The Great Works miss out on. Our masterpieces are written on all the faces I see at soccer or the shops or everywhere else someone can look at us and say, "That's my doctor".

Get a family doctor and turn up regularly and stick to them. How regular is regular? Do you know your psa? Your lipids and blood pressure? Your cervical screening? Did you last have them tested before your kids at Uni were born? Well that doesn't count! And be a kind and caring doctor yourself. And if it's all a bit grim sometimes, that's ok too, but see someone. If you've got a family doctor see them, and if not, call the Doctor's Health Advisory Service on this number (0407 265 414). It's a tough job and no one short of Kildare does it as well as Twinsette and Purls, but there are many more in Canberra as well – and all the ones I've met in this town are excellent … I'd recommend the lot of them!

Dr Antonio DiDio is a Canberra GP and one of the DHAS supportive GPs

General Practice – what's the future?

By Suzanne Davey

Currently only 7% of the total Australian healthcare budget is spent on general practice, and yet the social determinants of health interacting with the local community are largely responsible for the health of the individual living in Australia today. Of course this interaction largely takes place within the confines of general practices.

General practice itself is very much exposed to the winds of change.

Patients themselves have very different expectations of their health provider, who is expected to be available on demand at short notice and over an extended working day.

The doctor is expected to be able to compete with Dr Google, the local pharmacist dispensing "free advice" attached to commercial gain, Telstra's new Ready Care 24/7 telehealth service (only $69.00 plus GST with no Medicare rebate!), and the local nurse practitioner creaming off the easy consultations at no cost to the user. (The Nurse-led walk-in clinics operating in the ACT currently cost the taxpayer about $200.00 per consultation). At the same time the doctor is expected to run on time, and yet spend extra time with the individual patient as necessary, and, of course, charge far less than the local hairdresser, vet or plumber. The doctor must also make time for preventative care and life style advice to the patient.

The general practitioner's expectation of life work balance has also changed dramatically. The model of the GP working long hours with a non-working spouse on hand to provide family backup no longer exists. Today's average general practitioner is part of a working couple who wants to work sociable hours with time for family life, without the administrative demands of running a practice on top of their clinical load. However, GP's still experience that pressure to provide the level of service that old style general practice was able to provide. They have to cope with a changing demographic of ageing patients, who are living longer and so have far more complex care needs. There are also so many more investigations and treatments available for the doctor to keep up to date with and apply appropriately, and yet with an eye to not wasting the health dollar. There is also the decision whether to over-investigate in the interests of practicing defensive medicine, in an increasingly litigious society, at great cost to the health system.

It would seem that in order to provide quality health care and yet satisfy the conflicting expectations of both doctors and their patients, a model such as the American concept of the Medical Home is a feasible one, with Family General Practice as the heart of this Medical Home. This would consist of doctors and other health care providers co-existing under the one roof so that patients would expect to see their own doctor some of the time but not all of the time, and yet detailed medical records would provide the desired continuity of care. This model would hopefully allow enough flexibility to prove acute care and yet provide the lifestyle advice necessary to prevent so many of today's diseases such as obesity, diabetes and back pain.

In 2012-2013, 84.7% of Australians visited a general practitioner, and on average they visited a GP on 5.6 occasions. 93% of patients returned to the same practice, and 66% of patients returned to the same GP. This is a huge number of health consultations to be managed with as high a standard of care, and yet as cost-effectively as possible. This is the challenge of General Practice in the 21st century.

Dr Suzanne Davey, Chair ACT AMA General Practice Forum, member of the AMA Council of General Practice and Canberra GP

General practice – how things have changed

By Julie Hewitt

I started working part-time for the "boys" in Macquarie in 1989. Firstly two sessions a week when my girls were very little, then five sessions as Dr David Jarvis eased back a bit. In 1994 I bought his practice and very proudly teamed up with Robert (Bob) Smethills who was the first doctor to practise in the Belconnen region in the 1960s; he probably delivered half my patients.

Privileged to care for four generations – Belinda Turner, Penny Beattie, Sylvia Moyse and Jade Turner on Penny's lap (1997).

I paid $20,000 in good will and became the owner of a 56 sq m suite connected to Bob's. We shared 4 part-time receptionists who each stayed with the practice for 20-25 years! They had watched our patients grow up, then age, and knew instinctively who would need longer appointments or when to fit a patient in urgently – like the 60 year old with a five hour history of "gastro" who survived his MI thanks to a canny receptionist. How we relied on them and trusted them.

I too have seen the babies grow to teenagers, when you no longer recognise them, and then to parents themselves; following their life's struggles and achievements, as well as their health, and occasionally getting to care for four generations all at once. World War 2 veterans abounded and there were many more heart attacks and strokes; not everyone headed straight to the ED; they called us and we went. We didn't have statins, loose blood pressure guidelines allowed 100 plus your age as an acceptable systolic reading and AF was not generally recognized as a major cause of CVA (although I do remember stemming a patient's string of TIAs by putting her on Warfarin in the days when it was only used for DVT or PE). A smaller proportion of people died of cancer then (with the exception of lung cancer) – they didn't live long enough. And the day I first had a patient turn 80 we really made a big thing of it – she's still going 18 1/2 years later.

I think my training in New Zealand was pretty all right. Great emphasis was put on medicine as an art as well as a science. Being in a small private practice, the former held great sway with the patient. Much like in rural practice, you became part of their community. Everyone knew which car I drove, they asked after my mother's health, they played with my daughters in the waiting room. I borrowed a pair of shoes off one the morning I wore my slippers to work!

Unfortunately, running a business, along with monthly tax installments, three monthly BAS returns, EOFY tax returns, being a mother and working full-time all got the better of me after 16 years. I caved in to the offer to join a corporate practice and was teamed up with some very respected colleagues from the north side of Canberra. The set-up looked great with promises of autonomy and delivery of top quality medicine with the best facilities, staff and equipment.

The manager's intention was sincere but soon he was enticed elsewhere, the business was taken over by a greater giant and the promises melted away. Many of us were left disillusioned and unhappy, stuck in our windowless offices, often not even knowing what the weather was like outside. Our receptionists who had followed us gradually left, one by one, until there were no longer any familiar faces at the front desk for my faithful patients (nearly all of whom stuck by us, despite the extra travel) to turn to – nobody asking after their families.

No longer the short waiting room times, either. Our "girls" used to know who would need more time, what procedures took me longer, and would book accordingly. My waiting time blew out from less than 10 minutes to, sometimes, an hour – I was ashamed! Inappropriate booking was part of the problem but oft-times it was because I was so tied up doing all the things my "girls" used to do for me – things the new girls were not tasked nor equipped to do. It was not their fault. They had no formal training but learnt "on the job". They were young and often just working part-time while they studied. There was no commitment to the patient and they did not stay long enough to learn how each doctor operated.

Do I sound a bit begrudging? Well, the five years began to drag and my patients noticed I didn't smile as much. Some of us talked of hatching plans when our time was up. A few others somehow managed to abscond earlier but not always without drama.

And then along came John … and Mel!

Phase 3 of my GP practice life. Working in a privately-run practice again, but where I don't have to run the business. The owners also work in the practice, so have a vested interest in making sure it works and is "tops" in terms of patients care. After all, wasn't that why we all went into medicine?

The GPs have been handpicked to ensure we work well together and our goals are the same. The nursing and reception staff are also carefully chosen – they are more mature; they go the extra mile. The practice is not small but that means the facilities are of the quality we could never have afforded "back in the old days". I'm happily working alongside the colleagues I have known for over two decades; we each have our fortes and share our knowledge.

Equally, it is wonderful having some "new blood" to work with – well-trained and very competent colleagues whose brains I can pick when stuck – and it keeps me on my toes. I thought my clinical notes were good but their's are every indemnity-provider's dream! In recent times I have been concerned regarding proposals about the direction the training of GPs may take. I only pray that the quality of training my younger colleagues have received will continue in future generations.

My hope is that more GP practices will follow the model of the practice I now work in; providing care and continuity; somewhere the patient feels secure and trusts they will be well looked after; where the faces and names are familiar and where the kids grow up knowing "their family doctor". I laughed this week when one young lad whispered to his mother before the consult: "Do you think she'll say I've grown?"

I now have a room with a view! I laugh and smile again!

Dr Julie Hewitt is at Canberra GP and practices at YourGP@Crace

The Physicians' Lament

By Bill Coote

An important, thought-provoking article on the "scourge of managelialism" by four Australian physicians, published in June in the *Medical Journal of Australia*, raises interesting issues.

Managerialism, the authors tell us, began in the private corporate world and was then joined in the 1970s with neo-liberalism. Mrs Thatcher added another evil to the brew, "the market". This concoction has diffused into our hospitals and universities. The authors see "an increasingly hierarchical approach to every aspect of institutional and social organisation"; the "autonomous discretion of the professional is undermined, and cuts in staff and increases in caseload occur without democratic consultation of staff"; staff must focus on "financial targets, efficiency and effectiveness".

The article raise important issues regarding the interaction of doctors with "payers", "regulators", "administrators" and "managers".

The Royal Australasian College of Physicians

The immediate concern of the authors is with the Royal Australasian College of Physicians (RACP). They describe "the transition of the RACP from a cooperative association to a commercial enterprise run by professional managers", away from the original purpose of the RACP to "bring together physicians for their common benefit and scientific discussions." The college has become "increasingly centralised"; "democratic involvement of physicians" has been replaced by "administrative functions carried out by paid managers" with "all Board and administrative activities now characterised by extreme secrecy", leading to an "intensified authoritarian structure."

Public information on the RACP website shows the four authors were among a group of members who requisitioned an Extraordinary General Meeting (EGM) of the college which was held in early July. Maybe in the interest of gathering votes the authors engaged in a little hyperbole in describing such a frightful state of affairs within the RACP.

The advocates of the EGM want "a democratic and transparent setting" so that "physicians can come together for

common benefit". Members must have "full and adequate information about policies, procedures, financial transactions and commitments, administrative decisions and records and minutes relating to all aspects of college business … available on request". Office holders could be removed from office on a simple majority vote of members; members would have the power to "direct and authorise the Board to implement certain policies or undertake certain actions". The Board must hold a plebiscite if requested "by at least 100 members".

The 2014 Annual Report of the Royal Australasian College of Physicians (RACP) indicates the college has 14,000 fellows across Australia and New Zealand, is responsible for over 6000 specialist trainees and manages many complex programmes. The college has assets of $110m and an annual cash flow of over $50m. Can such a large organisation be run like a suburban Men's Shed?

Michael Foot was no match for Mrs Thatcher when leader of the British Labour Opposition. However he was a wonderful writer. The RACP EGM proponents might read his biography of Aneurin Bevan, the founder of the British National Health Service (NHS). Foot describes how in negotiations over the introduction of the NHS during the 1940s the British Medical Association was often paralysed by a constitution which provided avenues for second guessing by disgruntled minorities. Foot describes "the right of either the leaders or the led to demand plebiscites and questionnaires addressed to the whole membership. The leaders might be outbid or rebuked by the Council; the Council in turn might suffer the same experience at the hands of the Representative Body; on some occasions the Representative Body found itself hamstrung by the results of a referendum". It was "a democratic machine seemingly constructed by Dr Strabismus."

That a non-member of the college can access detailed information about the RACP on the college website is illustrative of a major change in the organisation of the Australian medical profession over the last 25 years. The medical colleges have evolved from mysterious guild-like bodies into professionally managed, accountable organisations. Did the colleges have any option? Since 2002 college education programs have been subject to external review and accreditation by the Australian Medical Council. The colleges also had to change in response to external pressures made explicit by such challenges as the 2005 review of the specialist medical colleges by the Australian Competition and Consumer Commission and the 2006 examination of the Australian medical workforce by the Productivity Commission.

The profession is indebted to those who led the Colleges through those difficult times and consolidated their place as providers of postgraduate education with retention of the power to bestow legally recognised specialist credentials.

Modern Medical Discontents

This physicians' jeremiad raises more basic issues. I recently drove past the Royal Brisbane Hospital where I was a medical student in the early 1970s. It seemed a dauntingly large complex in 1970 but has now expanded almost into a separate city. How could such a place be run without management of some sort? Everyone from the youngest cleaner to the most distinguished clinician must be part of the organisation and subject to some sort of orderly arrangements. Within such a complex (despite Mrs Thatcher) there must be some sort of "society". The inter-relationships among the various disciplines within the medical profession are more complex now than in the 1970s and much modern health care can only be provided in large complex institutions and often involves many professionals.

Foot suggested "much the strongest bent in the medical mind was a non-political conservatism, a revulsion against all change, a habit … which enabled them to magnify any proposals for reform into a totalitarian nightmare. Nothing good could ever come from the meddling of outsiders."

In *Our Present Complain: American Medicine, Then and Now* the American medical historian, Charles Rosenberg, writes on issues which go to the sentiments agitating the authors of the MJA article: "These are difficult times in which to practice medicine. These are the best of times, and these are the worst of times … never have physicians been able to intervene more effectively in the body … yet never have practitioners felt themselves more constrained-if not besieged-by bureaucratic guidelines and intrusive administrative oversight."

He suggests "therapeutic decisions are never made in a disembodied intellectual space" and physicians and patients are "embedded in an ever-more-elaborate institutional and intellectual, government and corporate complex upon which we have come to depend … for medical deliverance from pain and premature death."

Rosenberg argues "the efficacy claimed for the market's discipline fits uneasily with more traditional ideas about healing the sick and defining humane ends." He suggests "structured conflicts" will persist in health care, "a consequence of the very complexity and scale of the system and of the cumulative ad hoc decisions that have helped constitute it." This is, he admits, a "set of attitudes and expectations postmodern as well as quintessentially modern".

Rosenberg suggests the challenge to the profession is to maintain balance "among a variety of not-always-consistent identities", medicine "as humane caring, as applied science, as marketplace actor, and as an object of public policy". He warns "petulance and hand-wringing are not the same as policy."

Conclusion

The writers of the MJA article want the RACP to "return to its original mission of providing a forum for physicians to communicate with each other". In 1750 Dr Johnson wrote on "hereditary imputations, of which no man sees the justice, till it becomes his interest to see it". One "imputation" to which Dr Johnson advised "very little regard is to be shown" is that of the older man who "recounts the decency and regularity of former times, and celebrates the discipline and sobriety of the age in which his youth was passed, a happy age which is now no more to be expected, since confusion has broken in upon the world and thrown down all the boundaries of civility and reverence."

This MJA article raises important issues. However, it is not clear that nostalgia is the best guide for the medical profession or its organisations in responding to an environment in which public hospitals struggle to match limited resources with limitless professional and public demands, government seeks to be involved in decisions once the prerogative of the profession, medical workforce policy is apparently set by university accountants desperate to raise cash, more and more GPs work on "contracts" in "corporate" practices while "corporates" circle around the edges of traditional private specialist practice, pathology and radiology are already largely under corporate control, the Federal Government is desperate to constrain Medicare expenditure and the General Manager of Medibank Private says the fund will now "flex its muscles" to exploit its purchasing power.

** References available on request*

Bill Coote is the Director of the Professional Services Review Agency

General practitioners add value to patient wellbeing

By Marianne Bookalil

As GP Advisor I have discovered that there is widespread misunderstanding of the role of the GP and where we add value. This misunderstanding leads to inappropriate policy and stops specialists sending patients back to GPs for ongoing care, in turn lengthening outpatient waiting times. The GP's value is in relationships, which leads to personalised care by knowing the person over time in the context of their family and community. GPs manage complex clinical scenarios, identify priorities and manage the patient based on what is best for the individual.

Population level evidence tells us that where there is a robust primary health care system, better health outcomes are provided at a lower cost.* This is in part because the attributes of primary care are not limited to clinical content knowledge and skills. The RACGP curriculum for GP registrars has five domains with *Applied Knowledge and Skills* (ie, clinical skills) as only one of the five, but it is often seen as the only important aspect for those who don't understand general practice.* Starfield defines the features of primary care as *first contact access* for each new health need; *long-term person-focused care; comprehensive care* for most health needs, and *coordinated care* when it must be sought elsewhere.* I will discuss long-term person-focused care and comprehensive care in more detail.

As an example of comprehensive care, think about the patient with depression and diabetes – a common enough combination. There is interaction between the two conditions. Both the symptoms (amotivation and change of eating patterns) and medical treatments for depression can lead to weight gain and increase the risk of diabetes. Fatigue can be a symptom of both poorly controlled diabetes and depression. Which condition is most important and should they be managed in series or in parallel? Of course the answer is 'it depends'. It depends on the severity of each disease, it depends on the patient's preferences and it depends on what else is going on in the patient's life. A patient with severe depression will rarely be able to comply with lifestyle advice given for diabetes so with well controlled diabetes, it may be worth postponing management until the depression has improved. For more poorly controlled diabetes, it may be worth prescribing medication earlier than would be advised by guidelines, because it is unlikely that the patient will adhere to the recommended lifestyle modifications. For someone whose depression is now controlled, but has been diagnosed with diabetes, ceasing the antidepressant or changing to an alternative may help weight stabilisation. The GP will weigh the pros and cons of various options and treat both conditions. Specialists are not comfortable treating conditions outside their expertise, so are unable to treat both conditions leading to fragmentation of care.

Now consider the patient struggling with domestic violence and depression as an example of long-term person-focused care. The patient may have clear symptoms of depression but antidepressant medication is not going to resolve the underlying issue of abuse. But to be able to help the patient manage the abuse, the patient will have to be comfortable enough to disclose the violence to the clinician. Patients will be more likely to admit to stigmatising situations when they trust the clinician. A longstanding relationship with a GP built on previous simple consultations will help. Starfield has found a relationship of two to five years is needed to provide optimal person-focused care. Fragmenting care by using different health professionals for services that can be provided by a GP (such as pharmacists for chronic conditions screening) reduces the interaction between the GP and patient and will increase length of time to build the relationship. However, GPs need to examine their own practise as well. In some practices, patients are attached to the practice rather than the individual GP, with an understanding that the patient's medical history can be obtained from the clinical software. Yes it can, but trust is not built simply by providing the medical care, rather mostly via the non-medical interactions such as asking about family. These non-medical interactions cannot be replaced by software. Commonwealth policy has ensured that funding for general practice has not kept up with inflation. Practices have needed to become more efficient to survive and this is done in part through increasing the numbers of GPs per practice. We need to ensure there is a way to maintain continuity of care as well as an efficient business model.

So now to link Starfield's features to policy and my job as GP Advisor to ACT Health. Remember, that most policy relating to primary care is a Commonwealth rather than State or Territory responsibility, so ACT Health officials can advocate for but not initiate or deliver change.

Access

The two main aspects to access are the availability of practitioners and cost of services. The cost is related to Medicare and unfortunately the current policy of freezing the Medicare benefit for six years may force practices that bulk bill all or some of their clients to review their policy. ACT government cannot change the policy, but can join the multiple voices advocating for change. ACT still has the fewest GPs per head of population, but the total numbers are increasing and are likely to continue to do so given the increasing numbers of GP registrars. Anecdotally, most GP surgeries have their books open again.

Long-term person-focused care

The Australian government lacks policies that encourage patients to develop and maintain a relationship with one practitioner and for that practitioner to remain in a practice long-term. The UK supports it through patient registration, though that is at a practice, not practitioner level. In Australia, it is left to practices to manage through practice policies and to patients, who incidentally do seem to value continuity of care as most have a regular GP.

Comprehensive Care and Coordinated Care when care is sought elsewhere

Comprehensive care is taught through the GP training program, but is not encouraged by government policies. If anything the fee-for-service model encourages short consultations, so discourages comprehensive care. Interestingly, the policy doesn't deliver short consultations, so policies don't always deliver either the intended or unintended consequences.

There is a policy aimed at coordinated care delivered through Medicare items. While it is a start, it is simplistic and doesn't address communication between clinicians in an easy

to implement manner. I look forward to a genuine shared electronic health record, though am not holding my breath!

When looking at these two areas it is worth thinking about how GPs can best use specialists to add value. Patients should see specialists for procedures, for rare diseases or diseases requiring complex treatment regimes and reviews (one-off where possible) for advice to help manage the more complex patients with more common diseases. Patients with multiple chronic conditions should be managed as much possible by the GP who coordinates the care and seeks advice when needed. However, when a specialist takes over the management of one of the conditions, it can lead to fragmentation of care and when patients see multiple specialists regularly, patients can receive conflicting advice.

GPs and specialist services need to work together. GPs need to set up their practices to support comprehensive and coordinated care and specialists need to let go of patients, sending them back to GPs with advice rather than providing regular reviews. This should lead to better care, free up outpatient appointments and shorten waiting lists.

** references available on request*

Dr Marianne Bookalil is the GP Advisor to ACT Health and a Canberra GP

Reflections of a GP

By Katrina Anderson

We think that we learn our medicine at medical school but that is only the start of a life long journey of learning. The internet has made my life as a GP so much easier in some ways. As a Generalist it is hard to keep up with every therapeutic change or with the latest guidelines but these days it is so easy to look up the latest. Or sometimes not so easy when the guidelines and evidence disagree with each other.

However when I reflect on twenty or more years of general practice it is my patients who have really taught me to be a doctor and who continue to teach me. The medical knowledge and information is the easy bit. The translating this to a real human being who is anxious, scared, sad, angry, prejudiced, reluctant, difficult, compliant, non-compliant, confused and overwhelmed is the real skill. We talk about patient centred-ness as if it is simple, but being patient centred is the most difficult skill to learn and the only place to learn it is from listening to your own patients. There is no one size fits all.

Luckily as a GP if I am a slow learner my patients get many opportunities to keep trying to teach me the things I haven't yet been able to understand. I get to look after them over many years and see them through the good and bad times and so I get plenty of opportunities to understand where they are coming from when I don't get it initially. On this journey that can go on for years we both get to discover many things. There are lots of surprises for us both in terms of illness and recovery. So often I have to say to people yet again, "I am sorry but you are just not fitting the statistics or the textbook – we will have to think a bit more laterally." Then there are so many different paths and life events from weddings and births to funerals. I know it is a cliché – but as a GP I get a front row seat on life.

One of the special parts of being a GP is watching rather wild children grow into beautiful young adults. Recently I ran into a patient who I hadn't seen for a number of years. She said to me, "I have been wanting to run into you because I wanted to tell you I have finally realised you were right but it has taken me ten years to believe it." "Oh no", I replied, "what did I say ten years ago!" "When I was having trouble with my wild little four year old daughter, you said to me that she had spunk and independence, great qualities for the future and that I was the right mother for my difficult child. I didn't believe you at the time but a few weeks ago my daughter, now 15 said to me, "You know what Mum, you are exactly the right mother for me!" My own journey as a parent has been one of many mistakes and constant learning and it has been a pleasure to share this journey with so many of my patients. They are reassured to know that I struggle just as much as they do.

As GPs we often talk about those patients who made our "hearts sink"- the ones with terrible luck, with ongoing chronic pain, with chaotic families, with broken lives. For me they are the patients who have taught me the most and have challenged me to be a better doctor; to be compassionate and non-judgemental. To continue to look after them despite their inability to follow my advice, or their decision to take risks, or their avoidance behaviour. These patients challenge me to innovate, to be brave, to find new ways to help them and to not give up. It is in responding to them in a patient centred way that makes my job so intellectually engaging and interesting. There is always something new to learn, to understand and some new problem to grapple with.

Katrina Anderson is Associate Professor Academic Unit of General Practice , Australian National University Medical School and a Canberra GP

General Practice ownership – does it matter?

By Mel Deery

The last decade has seen a decline in practice ownership by GPs. Many practices around Australia are now owned by companies or businessmen, not by the doctors who work in them. Does this really matter? What difference does it make?

A number of more experienced colleagues have recently told me that they have never seen so many concerning changes influencing General Practice. For example:

- The training of GP registrars has been removed from the RACGP and is now to be run by the government and who knows who? No other college has relinquished the training of their registrars to such an uncertain future. What will this mean for quality training?

- There is a freeze on Medicare and a review of Medicare funding with anticipated 'savings'.

- There is an oversupply of medical graduates, with pressure on training places and uncertainty about future employment. This year Canberra has been allocated more GP registrars than the practices can accommodate. This has left many GP registrars stuck at hospital and unable to start GP training.

However, another real concern, which is the area of most concern to me, is the low rate of uptake of practice ownership by younger GPs.

Local research in Canberra and South Eastern NSW, published in the AFP*, found that 'less than 1% of recently Fellowed general practice registrars have gone on to become owner-operators within 10 years.' This is at odds with their other finding that 32% of local registrars would like to own their own practice in the future, with 43% being undecided.

So why are so few GPs following through with becoming practice owners? Some of the concerns cited were the anticipated workload, bureaucracy and cost. The greatest reason cited, however, was the barrier of insufficient knowledge.

I would like to share our story of becoming practice managers to encourage others to consider practice ownership.

When my husband John first started talking about opening our own practice, I was extremely reluctant and hoped the idea would just pass. I was concerned that it would ruin our work/life balance. It was outside my comfort zone as I come from a family of salaried professionals without business experience. I also thought that if it turned out to be a big mistake, it would be hard to back out. However as the years passed, John's desire to open a practice did not pass. He described it as a desire God had planted in him. So I decided that I had better get on board, despite my fears. Once I said yes to the idea, my heart changed and I became excited about the prospect. I soon found myself brainstorming and daydreaming about what we could do if we ran our own practice.

We opened our first practice, YourGP@Lyneham, in 2012 in a previously closed down general practice. At the same time we were designing a new facility, YourGP@Crace, which we opened in May 2014.

We both recognised that there was so much we didn't know about running a business or a practice. But we had a vision of a place of excellence and figured that we could learn the rest as we went along.

We started off with just the two of us and one FTE receptionist. We had no practice manager so John and I learned everything about running the business. We divided responsibilities into our 'portfolios' based on our strengths and interests.

Opening a practice was a little like being an intern again. There was so much to learn and we sometimes felt out of our depth, but you learn so much by just doing it.

We are now three years in and have promoted ourselves to being 'SRMO' practice owners, but there is still so much to learn. The practice has grown far beyond our expectations with twelve GPs across our two sites.

I have loved the journey and I am so glad that we made the decision to open our own practice. I have greatly increased job satisfaction, enjoyment of my clinical work and engagement with my patients. I have a passion for medicine which I previously never had.

It has been a satisfying creative venture on many levels, which was unexpected. First, it has been a creative process to partner with architects and builders to design our practice, YourGP@Crace. We have spent countless hours in meetings and studying drawings. We thought carefully through the functionality, flow and aesthetics of the building. We wanted a practice that was calming and uplifting with attractive views from all consulting rooms. The building has exceeded our expectations and it is a pleasure to work in. We are very pleased that the building just won the ACT MBA Project of the Year for 2015 for the under $5M category.

More important than a beautiful environment is how the practice functions. This is built on the foundation of practice values and culture. We have carefully considered and crafted our practice values. Our practice motto is 'clinical excellence, genuine care'. We carefully select our GPs, receptionists and allied health staff and seek to establish our values at the first interview. We want our patients to feel cared for by the whole practice team.

Another area of creativity is in crafting our practice systems and processes. It is so satisfying when the practice is running smoothly. When areas are not functioning well, we brainstorm solutions along with our practice managers. When we find a functional solution, it is an Eureka moment.

We have a wonderful team of GPs whom we greatly respect and feel honoured to work with. Our GPs have a range of experience from our first registrar through to those whose patients have been seeing them for decades. Several of our GPs have been previous practice owners which initially scared me. If we were not running the practice well, they would know! But they have been very supportive and are a great resource of knowledge.

We chose the name 'YourGP' as it incorporates a sense of belonging and evokes a long-term relationship -- patients can feel their doctor is 'my GP'. We are developing relationships with our patients many of which will span decades to come.

If you think practice ownership may be for you, I would encourage you to carefully consider your purpose. For us, good patient care is our first goal and profits come second. I believe that, if you swap those around, you will compromise your job satisfaction as well as the health and growth of your practice.

As practice owners, our umbrella of leadership, care and responsibility extends over the whole practice. This does take extra time and it is a labour of love. For us it has been well worth the extra effort.

* 'Who will be running your practices in 10 years?' by Martin Liedvogel, Emily Haesler and Katrina Anderson (May 2013).

Dr Mel Deery is a practice principal, with her husband John, at YourGP@Crace

What is 'best partnership' in health?

By Amanda Barnard

"Partnership" is a word that comes up daily in my work – it's one of those words that has somehow become necessary in most activities. We are urged to form organizational partnerships, institutional partnerships, research grants ask for industry partnerships, partnerships within our practices, partnerships with other primary care providers.

In this currently rapidly changing landscape of General Practice and primary care we have recently seen long standing partnerships disrupted.

In particular, from my Rural Clinical School perspective, the abolition of the SE NSW Medicare Local and the changes to GP training borders and providers, have been challenging. I'm told by the politicians and bureaucrats I've lobbed over the changes to the RTP borders, which cut SENSW off from the ACT, that the changes won't adversely affects our GP registrars or students who are planning to work in the region, band to form new partnerships with the new providers. Of course we will work collaboratively and look forward to the opportunities that change can bring.

But it gave me cause to reflect on that word partnership, that has become a much bandied about word, and one that has I think, lost much of its impact and meaning. So musing on what partnership is, I went back to my trusty and now tattered shorter Oxford English Dictionary, a 21st birthday gift form a much loved and somewhat bemused grandmother ("Are you are that's what you really want dear?") So partnership, first recorded use 1576: "The fact or condition of being a partner; association or participation; companionship." So let's try partner. The first recorded use is in the early 14th century. "A person with a joint share in or use of something; a person who is party to something. In early use: a share or partaker (in or of something) So the key seems to be sharing – a mutual working together for something.

And that key is to be found in the doctor and patient partnership. It is telling how the discourse has changed from the doctor-patient relationship to the doctor-patient partnership. The 2014 Medical Board's Good Medical Practice: A code of conduct for Doctors in Australia has in this guide to working with patients, a substantive section on the doctor-patient partnership. But what, as a GP, is the core of this partnership? Some of the key elements are trust, respect, a common goal, a willingness to give and take (on both sides), responsibility for action on both sides, and the preparedness and capacity for an ongoing relationship. A partnership builds on relationship to involve both parties working towards a shared goal.

This partnership is not only the best partnership in health for individuals, but its elements are the key to other successful partnerships in the wider health arena. I started with a pyramid of partnerships, from large organisational down to the individual doctor-patient relationship, but it should be the other way around. When we hear that word partnership we should think about the fundamental of that core doctor and patient partnership.

Reflecting on the factors that have led to the success of training medical students rurally and seeing them return to the region, it is those key elements of partnership that are critical. There are now many ANU graduates working as GP registrars and Fellowed GPs and procedural GPs in our region, as well as further afield in rural NSW and other states. Talking with these young doctors, what has been key to their decision to work and locate rurally has been the relationship and partnership that they have developed with rural doctors during their training. This has been more than relationship – a partnership in that that there has been joint working together at something, a common goal – successful training, mentoring and career advice about working rurally. Students and registrars have felt valued and that there is a partnership in their learning and development to be a rural doctor.

As GPs, our work is founded on relationship and partnership. The privilege of the consultation where we share some part of our patients and their families lives and journeys and work with them for health, is the cornerstone of our work. Those key elements of that partnership in turn and the basis of work practice partnerships and teams, our work with our other medical colleagues. Evidence tells us that partnership is good for patients' health. Basing other partnerships on those key elements of relationship and working together actively for a shred goal, will be good for the health system.

Professor Amanda Barnard is Associate Dean and Head, Rural Medical School, ANU Medical School, ANU College of Medicine, Biology and the Environment

Menopause – Mind over Matter

AMS Congress, 25-27 September 2015, Canberra

Local doctors and other interested health professionals have a rare opportunity to be updated and stimulated by some fantastic speakers on a range of topics related to menopause, writes Dr Linda Welberry.

The unique flavour of an AMS menopause conference (held annually somewhere in Australia/New Zealand) is that topics covered include all aspects of women's health from the perimenopause to old age. Many of these topics are controversial, and there promises to be a lot of new information.

As the title suggests, the focus this year is on cognitive function, related to both the normal aging process and to how this may be affected by menopause and by hormone treatment. We are fortunate to have Dr Michelle Mielke from the Mayo Clinic, who is doing some exciting research into finding early markers for dementia, and the sex differences relating to dementia.

In addition, there will be segments on genetic testing for gynaecological cancers, menopausal management after cancer treatment, case studies on other difficult management problems, and lots more.

The pre-congress update and workshop, which can be attended as a stand-alone module, will be held on the morning of Friday, Sept 25. The topic is perimenopause, which will also include a section on prescribing HRT.

Please register your interest on the website:-

http://www.menopause.org.au/register2015

Looking forward to seeing you there!

Linda Welberry is Chair of local committee

PS. The Jean Hailles Foundation will be hosting a Public Forum on the Sunday afternoon at the same location.

PHNs – an opportunity to provide GP-led support for quality primary care service delivery

From 1 July, 31 new Primary Health Networks (PHNs) started work across the country, replacing the former Government's Medicare Locals.

AMA President, Professor Brian Owler, commented that the AMA has always acknowledged the importance of a network of primary health organisations to facilitate improved patient access to primary care services, but Medicare Locals had been patchy at best in delivering the results promised by the former Government.

"The PHNs provide an opportunity for a fresh start to support consistent high-quality primary care services across the country," Professor Owler said.

"We cannot afford another Medicare Local-style failure, so it is critical that PHNs better target services and recognise the central role of general practice in the delivery of primary care services.

"With many PHNs in the early stages of their development, they have a great opportunity to get their structure, processes, and services right."

The AMA believes that PHNs should focus on the following areas:

Population Health

Identifying community health needs and gaps in service delivery; identifying at-risk groups; supporting existing services to address preventive health needs; and coordinating end of life care.

Building General Practice Capacity

Supporting general practice infrastructure to deliver quality primary care through IT support; education and training of practices and staff; supporting quality prescribing; training and supporting the use of e-Health technology and systems; and facilitating the provision of evidence-based multidisciplinary team care.

Engaging with Local Hospital Networks/ Districts

Identifying high risk groups and developing appropriate models of care to address their specific health issues (e.g. those at high risk of readmissions, including noninsulin-dependent diabetes mellitus, congestive cardiac failure, chronic obstructive pulmonary disease, and other chronic diseases); and improving system integration in conjunction with local health networks.

Professor Owler said the evidence from countries such as New Zealand shows that GP leadership and input is vital for PHNs to be effective.

"GPs are generally the first point of call in the health system," Professor Owler said.

"They can provide high quality clinical input as well as first-hand knowledge of where improvements in the health system need to be made.

"Not only should GPs be included in Clinical Councils, they should also participate at all levels of governance, including on the PHN Boards.

"There is a great deal of goodwill in the profession to make PHNs work well for patients and local communities.

"The AMA stands ready to work with the Government to ensure that PHNs are an effective and integral component of the health system," Professor Owler said.

What we GPs really do

By Denise Kraus

As we celebrate family doctor week it is timely to reflect what we do in our GP work.

General Practice is a privileged but difficult job, which allows us into the lives of multiple generations in a family. It can be intensely satisfying yet frustrating as we act as advocates for our patients' health needs, in a complex multilayered health system, dealing with more demands for efficiency and cost shifting.

Our patients return to us because they trust us, and forgive us, when we run late, have a bad hair day, and don't have the black and white answer to everything, and admit when we make mistakes.

They even offer us useful advice, clippings from magazines about exotic herbs and vitamins, remedies concocted from ground up stone fruit kernels when we are also showing signs of a viral URTI, because they want us to get better, all of which is appreciated.

Some of them are suffering from that relatively new syndrome called "Googleitis", which wasn't around when I was in Med School, and takes a bit of time to resolve, via magic talking therapy.

I feel immensely privileged to work at the Interchange General Practice with respected colleagues who share a similar philosophy, and with whom I can share problems and case loads. There is such a variety of work streams available to us, and it is never dull. I am enriched by the time spent at the practice by medical students during their undergraduate years, and the GP's doing their vocational training at the practice.

One of our GP registrars, Dr Kate Reid recently started up a knitting circle in the waiting room, where waiting patients can knit squares, which will be made into blankets, to be donated to Companion House and Clare Holland House. This has been embraced by the patients, who talk to each other, some of whom continue to knit them at home, and makes the waiting time pass quickly.

I lament the demise, due to federal funding cuts, of the PGPPP program which was a fantastic program which introduced interns to a 10 week term of General Practice where they could manage patients autonomously under a GP supervisor. The program ran for 5 years and was highly successful and popular. It proved to be very much a two way learning process for those of

us who were a few years distant from hospital work, and similarly for the interns who had not anticipated the variety and complexity of some of the patients they saw.

I congratulate my colleague, Dr Tuck Meng Soo, a recipient of an Order of Australia this year, for services to General Practise as well as the other ACT recipients, and I thank Dr Brian Owler, and Dr Suzanne Davey for their hard work behind the scenes, lobbying for the General Practitioner at the Federal Health level.

Let us never lose sight of the freedom we have to practise in our democracy without interference in General Practice, and the freedom to lobby for our patients. I am troubled by the fact that our medical colleagues who work in off shore detention centres, and speak out against any abuse or maltreatment of refugees, may potentially be subjected to prosecution under new Commonwealth laws which came in on July 1. As a post war baby boomer, a child of refugees who arrived here by boat, I reflect that bad things happened in their time, because good people, would not, or could not speak.

Dr Denise Kraus is a Canberra GP practising at the Interchange General Practice

Partnerships are crucial to chronic disease management

By Martin Liedvogel

My motivation to become a doctor started early in life, and never really wavered. I still remember lighting a candle in a church as a 10 year old boy, and making a solemn wish to become a doctor one day. God only knows, no pun intended, how I arrived at medical school as my teachers described me as a late "bloomer".

My journey to becoming a GP was not quite as clear from the outset. Although I had some exposure to General Practice in my undergraduate degree, the culture of public hospitals during my junior and formative years was not encouraging of General Practice. A fresh start after a self-imposed year "in exile" away from medicine saw me enter general practice training, starting my career path into general practice. Now that I am here I love being a GP, a sentiment that grows stronger with every year in the speciality. One of the many reasons why I like being a GP is the relationships and partnerships that are forged between practitioner, patient, and other health care providers to achieve the best outcome for the patient. The opportunities to improve the health of the nation abound with 90 % of Australians having a usual GP, and over 80% of Australians seeing their GP at least once a year, and

with the majority of health encounters occurring in general practice and the wider primary care community. It is this partnership or continuity of care that consistently delivers superior health outcomes in developed countries that choose to build a strong General Practice/ Primary Health Care sector.

General practice is the most responsive and cost efficient part of the Australian health care system. But the profession increasingly finds itself at the coalface of the snowballing burden of multi-morbidity and chronic disease management, which will define the next 20 years of general practice. What makes general practice the most appropriate part of the health care system to address the burden of multi-morbidity and chronic disease management is the continuity of care underwritten by the ongoing relationship GPs have with patients, enabling them to coordinate and integrate the care that is required to produce the best outcome for the individual patient. However, we need to recognise that the patient-GP relationship is not always enough to provide the best health outcomes for our communities.

A methodical and consistent approach that runs in the background of the GP-patient relationship and supports ongoing chronic disease management will enhance the ability of practices, and the GPs working there, to deliver effective chronic disease management. Positioning the culture of an organisation that wants to focus on chronic disease management is an important change on the path to enhancing this process. A shift towards prioritising patient safety and quality of care, providing culturally appropriate care, creating policies that enhance chronic disease management, and access to a multidisciplinary team whether onsite or part of an external network will make chronic disease care easier and more effective. Defining and knowing the population with a chronic disease will identify the patients who will benefit from chronic disease management. Suitable clinical software packages allow easy access and management of key data regarding individual patients, practice populations, and communities. Providing health care providers with evidence based clinical decision making tools at the point of care during a consultation has the potential to improve medical management and the integration of services required for the patient with a chronic disease. Empowering patients with self-management needs has the potential to complement the coordinated care that health care providers wrap around the patient with a chronic disease.

The areas described above provide an opportunity to enhance the excellent care that is already being provided by general practices in Canberra, and will lead to a stronger doctor-patient alliance. The practice I work in has been participating in the Coordinated Veterans Care (CVC) program over the last 18 months, and I believe that this program is a good example of integrated care coordination for patients with a chronic disease. Patients have found the program very useful to reach their health goals, and in the process they have formed stronger partnerships with the health care team at the practice.

Chronic disease management provides a good opportunity for practices, GP's and allied health providers to engage with their local primary health care organisation to actively shape a system that works better for everyone. Capital Health Network will continue on from the ACT Medicare Local, and is looking for opportunities to have input and guidance from health professionals to improve the health of the Canberra population and to avoid hospital admissions, which in the end will mean a better outcome for the patient.

Although I am not certain about what and how general practice will be asked to deliver patient care in the future and the inevitable changes that will occur over time, I remain confident about the ongoing essential role that the profession of general practice will play in the health of our community.

Dr Martin Liedvogel is a GP, Practice Principal and Chair of the Capital Health Network

Ongoing medicare rebate freeze sends a shiver through patients and medical practices

AMA President, Professor Brian Owler, has said that the ongoing indexation freeze of Medicare patient rebates is placing further pressure on the viability of many medical practices, especially general practices, and forcing patients to pay higher out-of-pocket costs for their health care.

Today is the third anniversary of the Medicare rebate freeze. There has been no increase to Medicare patient rebates for consultations and operations since 2012. GP services were last indexed on 1 July 2014.

While the Medicare rebate indexation remains at zero, the latest Consumer Price Index (CPI) is at 1.3 per cent, the Wage Price Index (WPI) is at 2.3 per cent, and the ABS reports an increase in Hospital and Medical Costs of 6.5 per cent.

"The rebate indexation freeze is a co-payment by stealth, and it is currently planned to continue until 1 July 2018," Professor Owler said.

"The freeze is delivering savings of $1.3 billion over four years to the Government.

"This funding shortfall has to be met by patients and practices.

"While the rebates have remained unchanged, the costs of providing quality medical services continue to rise.

"Practice costs such as wages for practice staff, rent, electricity, technology, and insurance are increasing every year.

"Medical practices cannot absorb these increasing costs for four years in a row and remain viable."

Professor Owler said the freeze is also having a significant effect on private health insurance.

"Some private health insurers have indexed their schedules of medical benefits, which means they are covering the Government's shortfall.

"Other insurers will not index their medical benefits until the Government lifts the freeze.

"This will put upward pressure on the costs of medical services and private health insurance premiums," Professor Owler said.

The AMA will continue lobbying the Government to lift the Medicare rebate freeze as early as possible.

New nuclear imaging technology now available in Canberra!

Dr Iain Duncan, Dr Kevin Osborn and Nick Ingold with the new Intevo xSPECT nuclear imaging system.

The GMI team in front of the MRI machine.

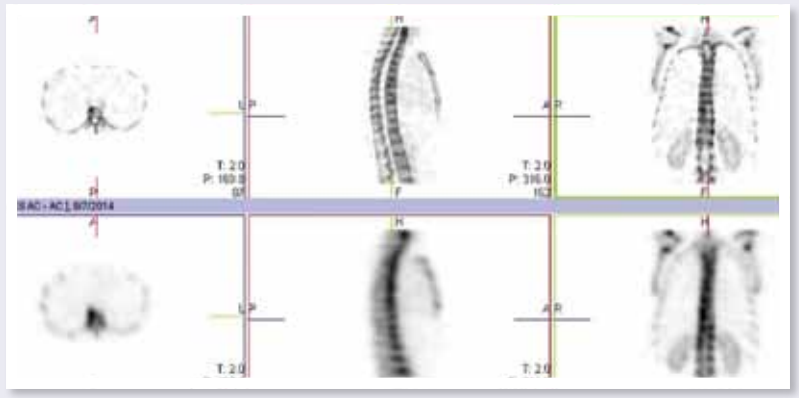
The most advanced gamma-camera in private practice in Australia is now available at Garran Medical Imaging (GMI). The new Intevo xSPECT delivers improved diagnostic information at the same or lower doses of radio-isotopes.

There are only a handful of high-end Intevo xSPECT machines currently operating in the country so it's not surprising that GMI is keen to let Canberra doctors know about it.

"Our new xSPECT delivers nearly double the bone image resolution that most existing equipment provides. So there is a huge step up in the image detail" explains Dr Iain Duncan, Director of GMI. "It can identify the smallest of lesions which enables more subtle diagnoses and allow more confident monitoring of metastatic disease.

There is improved resolution around prostheses (hips, spine, knees) and in small bones and joints. These technical improvements should lead to much better clinical interpretation, enabling better patient treatment and management.

The image below demonstrates the difference in bone resolution achieved with the Intevo xSPECT. The top scan uses a new Intevo xSPECT, while the bottom line is a scan using current Symbia SPECT-CT technology.



"We are currently the only private practice capable of producing such images in in Australia. When SPECT-CT [nuclear medicine-CT fusion] was introduced in 2009 Barry Flynn and I undertook a study which showed an amazing improvement in diagnostic accuracy and specificity with fusion imaging. This latest technology is about bringing nuclear medicine-CT fusion to maturity so we can make another leap forward."

"I am passionate about finding how to make technological improvements translate to real benefits for patients" says Iain. "To help achieve this we've established valuable partnerships with both Samsung [ultrasound] and Siemens [nuclear medicine] to introduce several new technologies and define and assess the clinical benefits of each. These partnerships will enable us to continually improve patient care locally and allow others internationally to benefit from our experience."

"As an example later this year we will be among a few sites worldwide to enhance this technology even further as part of our collaboration with Siemens." Iain concluded.

Iain and Kevin established GMI because they are passionate about imaging excellence and customer service – for both referring practitioners and the patients themselves.

"We are determined to deliver excellence at every interaction and from all angles. We particularly want to partner with a range of specialists to provide better solutions and de-stress the patients' healthcare journey" Iain explains.

GMI provides the entire spectrum of nuclear medicine, including both pharmacologic and exercise stress myocardial imaging.

Just minutes from the Canberra Hospital, GMI is located at the newly completed Medical Centre, at 2 Garran Place, Garran.

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e-Safety commissioner to improve online safety for children

AMA President, Professor Brian Owler, said the establishment of the Office of the Children's e-Safety Commissioner is an important step to increase the online safety of Australian children.

The new Commissioner, Mr Alastair McGibbon – a former Australian Federal Police Officer and a recognised expert in online safety – will oversee a complaints system that will issue formal notices to quickly remove harmful cyberbullying material that targets Australian children on large social networking sites.

Professor Owler said that cyberbullying is a serious health threat for young people.

"Cyberbullying can result in a range of health and development problems, including an increased risk of suicidal thoughts and suicide," Professor Owler said.

"The substantial growth in the use mobile internet devices, such as smart phones and tablets, means that children and young people spend an increasing amount of time online, with little or no supervision, which creates the right conditions for cyber bullying.

"The Government's appointment of the Children's e-Safety Commissioner recognises this reliance on online social networking, and represents a serious approach to reduce the impacts of cyber bullying on Australian children.

"The Commissioner will raise awareness of cyberbullying, and issue 'notices' to remove cyber bullying content from large social networking sites.

"These notices can also be issued to individuals who upload cyberbullying material aimed at Australian children.

"The AMA encourages young people to explore and embrace this new avenue to report cyber bullying," Professor Owler said

Background

- one in five children aged eight to seventeen reported being exposed to cyberbullying over a 12 month period;
- this gives a rough estimate of the number of children involved in cyberbullying as somewhere between 460,000 and 560,000 children in a 12 month period; and
- according to the Raising Children Network, 12 per cent of children and young people who use mobile phones have reported receiving a threatening or abusive text, and seven per cent reported sending one.

Details of the Children's e-Safety Commissioner are at www.esafety.gov.au

Cradle to grave care – in the city?

By Thinus Van Rensburg

As nicely demonstrated in the recent RACGP promotional campaign GPs are closely associated with the concept of "cradle to grave" care. As an ex-country GP obstetrician I can closely relate to this concept but here in the city it is often very hard to recognise that this is still appropriate and applicable to what we do.

When one works in a busy suburban environment, especially in a large clinic where you are a cog in a large multidisciplinary machine, it can easily become a system in which the patient is just a number in an appointment book. This is especially easy when one considers that city GPs are no longer doing hospital related work such as delivering babies or dealing with patients who are in a palliative stage of their lives as an inpatient.

Nonetheless it is still very possible and in fact very enjoyable and one might even say mandatory that we as GPs should maintain our involvement in a cradle to grave care. Not only is this beneficial to our patients but it is hugely satisfactory to us in terms of work satisfaction and personal pride in what we do. There are a few more satisfying moments than seeing a patient whom we delivered decades ago showing off their own children on social media or still sending you a Christmas card decades later.

So how does one achieve this in a suburban practice? For my wife and I it is relatively easy as we are a small and quite family friendly clinic but I can easily understand that it would be very hard to achieve the same outcome in a very large clinic.

The most important component of this type of care is to allow the patient, as far as possible, access to a regular GP. Secondly it is critical that the various GPs at a clinic should be talking to the doctor that a patient would normally see. Patients very quickly volunteer that they do not normally see Dr A but was seeing him/her on this specific occasion because their regular doctor (Dr B) was not available. It is a simple matter of informing Dr B, once available, that the patient had been seen. This might seem onerous and time-consuming but a simple corridor consult/handover can make enormous differences in how we deal with patients especially if it involves mental health issues.

Whilst the tendency is to develop multidisciplinary teams with allied health workers of various sorts I do believe that the buck stops with the GP. This might be considered old-fashioned, paternalistic and not suitably patient centric but a large number of our patients would still crave the personal interaction that such a professional relationship would create. The effort spent in building up these long-term relationships within a GP clinic pays off in many measurable and immeasurable ways. Specific examples would be the teenage patients who are much more likely to confide in a GP that they have known since they were small children than some stranger that they are only seeing for the first time. This also applies to palliative care which does not always involve in-patient care. While it is hard work helping the patient through this final stage of their life, at home and surrounded by family, it is a most satisfying part of a busy GP life.

Cradle to grave care is not easy. In fact it is easier to just see the patients as a number, treat them, get them out of the door, and go home to our own family. That is not why we are GPs as it is not a career, it is a lifestyle. It means being there for a patient when they need you even if this is not at a time that suits you. It means fighting your way through the maze that is the public hospital system and making sure that your patients are looked after it even if does mean getting home after dark yourself.

One of the greatest losses that we has profession will have is if we teach the new generation GPs to not act in this fashion. This will in fact not just be a loss for us as professionals but it will be a massive loss to patients as they still consider GPs one of the most trusted health professions that they can access.

Even more critical is to make sure that our hospital-based colleagues are aware of this crucial role that we as GPs play. Too often hospital-based doctors, consultants and trainees, are dismissive of the skills and roles that GPs play in the care of patients. The concept of "just a GP" is still prevalent and sadly patients frequently report to us terribly negative attitudes and comments about GP care when they are attending specialist care or hospital care. This manifests itself in an increasing delegating of outpatient care to service providers other than the patient's usual GP as our role is simply not understood or our skills are not trusted.

This is partly due to the total misunderstanding of the hospital-based doctors/specialist of the role/skills of a competent GP but it is also part of a turf-war between various professionals and sadly is also a reflection of some GPs who are no longer willing to take part in a comprehensive cradle to grave management of patients.

We as GPs therefore need to make sure that our professional organisations including the AMA and the various Colleges continue to fight for our role and our right as Specialist General Practitioners to provide a cradle to grave care to our patients whether rural or in the city. We also need to ensure that the new generation of General Practitioners understand that this is who we are and this is who we should be and that they should be proud of this even if it does mean we earn a bit less and we work a bit harder.

Dr Thinus Van Rensburg is a Canberra GP

Partnerships between family doctors and patients – looking at it the other way around

By Kirsty Douglas

Functional partnerships are, by definition, mutually beneficial to both parties. Often as doctors we focus on what we can do for our patient's through partnership rather than what they do for us. In the last couple of weeks I have been looking at it from the other perspective – I have been reflecting on what my patients have done for me.

I am moving general practices for only the second time in the last 21 years - so not something I do lightly and, on this occasion, not instigated by me. As I left my previous practice for the last time on Tuesday I felt sad for several reasons but chief among them was the simple fact I am going to miss some of the many partnerships with patients I have established over the last nine years that have been of value to me.

I will miss the bloke who, though one of my most challenging patients, has repeatedly taught me about resilience and the value of listening. This is a fellow who has multiple chronic illnesses complicated by his unfavourable socioeconomic circumstances and by the residual personal effects of a chaotic and abusive upbringing. I suspect the most valuable thing I have ever given him was time – time to get things of his chest and time to articulate his frustration and challenges. What he has modelled for me is just how strong the will to live can be despite everything being flung at you. His coping strategies may be far from optimal but they are coping strategies that he has had to employ time and time again. I know that had I been dealt his hand in life I would have folded many years ago. I value that after nine years our mutual respect was such that I could challenge him and he would accept and almost welcome it. I will never forget the time I read out loud to him a brutally honest letter I had written to the court which acknowledged his illnesses, misdemeanours and also his engagement with those who were trying to help. I had warned a colleague that my next consult could "go pear shaped so please keep an eye out for raised voices and be prepared to interrupt." As I finished the letter I looked up to find silent tears rolling down his cheek. He said very choked up … "you got me right Doc … its true but you still seem to think I'm worth working with" "Thank you – the letter is great". He walked out having very formally and uncharacteristically shaken my hand. Wow was that ever a lesson that respectful honesty can be more valuable than superficial support no matter how difficult it is.

I will miss the teenager who having endured a very stormy road the last 7 years seems to have re-engaged with study and life. His "I'm loving TAFE" was a wonderful spontaneous claim from a adolescent who was previously crippled by social phobia. I would have loved to be involved over the next 7 years because he is a young man who will be a success and I, selfishly, wanted to witness it and feel a little bit of a part of it.

I will miss the young mother who five years ago was struggling to develop any sort of rapport with her first born and who was concerning in her quick temper, but who last week came in with all three of her kids and managed their illness, tantrums, enthusiasm and distractions with firm, competent warmth and guidance. She has given me a strong lesson in how you can shift several peoples life trajectory with a timely support and education.

Most partnerships have been beneficial because of the positive lessons but a few because of their negative aspects. On a challenging day it was easier to be sanguine about my own kids' issues when I compared them to some that I had seen in clinic. Perspective is a wonderful thing. Women coping with loneliness remind me of the richness of my shared life. Patients facing death have taught me afresh to appreciate my life and live it to the fullest.

I love that my working life combines research, education, some policy and clinical work. On a bad day I fear it is all too much to juggle and fantasise about simplifying it and one day I will. But when I do simplify things I suspect the last element to go will be my clinical work because it is through partnerships with patients that I personally feel most enriched.

Professor Prof Kirsty Douglas, is Professor of General Practice, Australian National University Medical School; Director Academic Unit of General Practice, ACT Health Directorate and a Canberra GP

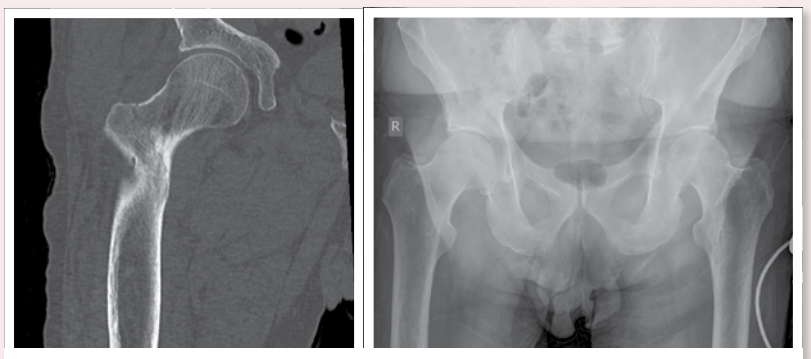
Clinical case study: the occult fracture

The definition of an occult fracture is a fracture that cannot be detected by standard radiography until several weeks after the injury. They can be from high energy trauma, fatigue fractures or insufficiency fractures. Early detection offers more effective treatment and shortens treatment time. Missing these fractures results in prolonged pain, loss of function, disability and may result in non-union, malunion, premature osteoarthritis and avascular necrosis.

Conventional radiography should always be the first investigation of a possible fracture, but, by definition conventional radiography does not demonstrate occult fractures initially. We are all aware of the need to repeat radiography after 10 to 14 days for suspected scaphoid fractures as up to 18% of scaphoid fractures are not detectable on initial radiography. However, there are several other fractures that have a high incidence of not being detectable initially, some of which are other carpal bone fractures, particularly the hamate and triquetrals elbow fractures, especially of the radial head in adults and supracondylar fractures in children, sacral fractures, hip fractures, rib fractures, facial bone fractures, calcaneal and talar fractures.

Traditionally repeat radiography after 10 to 14 days has been used to diagnose occult fractures, This may result in a splint or plaster being applied for 10 days and the associated morbidity and loss of income.

Today if there is a strong clinical suspicion of an occult fracture then either a multidetector CT scan, magnetic resonance scan or an isotope bone scan should be the next line of investigation. These all have a higher sensitivity than plain radiography for detecting fractures.



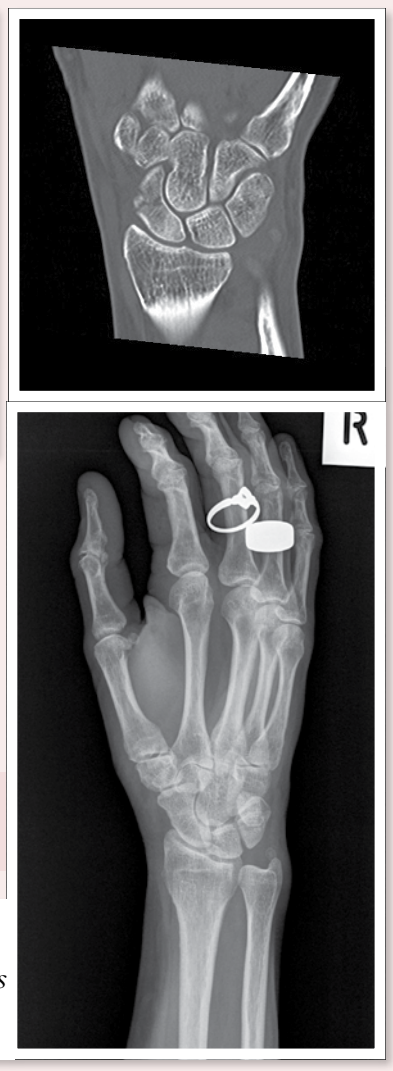
Images 1 & 2:
Plain image of hips shows no fracture, Multidetector CT shows a fracture of the femoral neck.

Multidetector CT is quick, only a few seconds of scan time is necessary and modern machines use a low dosage of radiation. Magnetic resonance scanning has been shown to be comparable or better than multidetector CT in diagnosing occult fractures. Magnetic resonance scanning has a Medicare rebate for approved machines for children with normal radiography of the elbow or scaphoid where the clinician thinks there is a strong possibility of a fracture.

Isotope bone scans are highly sensitive for the detection of an occult fracture, however, its lack of specificity limits its diagnostic usefulness.

The investigation of choice should therefore be either a multidetector CT or magnetic resonance imaging in a patient who has normal radiography when a fracture is suspected clinically. These can be performed in the acute situation without a 10 to 14 day delay.

Dr David Morewood
Canberra Imaging Group



Images 3 & 4:
Plain image of wrist shows no fracture, Multidetector CT shows a fracture of the waist of the scaphoid.

The myriad aspects of general practice that satisfy

By Felicity Donaghy

I was honoured to be asked to write this article for Canberra Doctor and wanted to thank Christine Brill very much for giving me this opportunity. I would also like to thank Christine Brill for her many years of service to the Canberra medical community and to wish her well for her retirement.

In this article I thought might reflect the nature of a day General Practice itself. It starts out well with a plan and a sense of order then rapidly descends into a flurry of chaotic activity before ending with mental exhaustion but a sense of satisfaction that all that could have been done in the day has been done.

I have been a GP now for twenty four years which is quite a while yet general practice remains a job I still view as exciting and rewarding.

There have definitely been some challenges along the way but essentially the nature of what we do is unchanged.

We are so often bombarded with bad news about General Practice. From frozen rebates, patient co-payments, ungrateful litigious patients to doctors behaving badly. We ourselves are prone to having a good complain when we get together, however I feel there is much to be positive about.

The theme of this year's Family Doctor week is "You and Your Family Doctor the best partnership in health" and as those who work in General Practice know we do work in partnership with our patients to strive to attain good health.

I believe as GPs we are extremely fortunate to do the work that we do. I believe we also benefit from this partnership in many ways. I do believe that a strong relationship with your GP is the best way to achieve optimal health.

There have been and will continue to be challenges to our role from others who believe they can do what we do better or for less money but in almost quarter of a century none have really succeeded.

General Practice continues to be where people go to when they are unwell.

That hasn't changed and despite the continuing interference from various Governments

in the background and it is not likely to.

I still recall my first patient in general practice all those years ago. It was 6pm on a Friday evening and I had not seen a patient since 8.30 am "being the new doctor" in the practice.

He was a 3 year old boy who had been in day care all day with an acute exacerbation of asthma who was wheezing and had moderate respiratory distress. I was shocked that he had been unwell all day yet had presented late but his Mother worked full time and was not able to bring him any earlier. I was then shocked that the practice didn't have much in the way of emergency equipment, but we managed to treat him with what was available and he recovered. The family became one of the first to nominate me as their GP. Something I was really proud of at the time and still find it a compliment when you are given the honour of being someone's GP.

I have been extremely fortunate to work in some great practices and have very fond memories of the first practice in Sydney where I trained and then worked for twelve years.

One of the great aspects of General Practice is seeing your patients from infancy to adulthood. It is a privilege to see families as their babies grow into children, then teenagers and young adults with all of the challenges that brings.

One aspect of General Practice that stood out when I started and is still a remarkable feature is the teamwork required to have a functioning practice. We are certainly more fortunate now that our teams have expanded to include Practice Nurses and Managers and allied health professionals. It is great to know that all of that expertise contributes to comprehensive patient care and we as clinicians have the support of our colleagues who become friends.

One of the other great aspects of your work is the flexibility we have.

After working full time for ten years and obtaining my fellowship through the Family Medicine Program I took time off to have a family.

I returned part time to the same practice to very grateful patients who were genuinely pleased that I had returned and were very interested in me and my family.

There are not many other jobs where you can take up where you left off and have your clientele wait patiently for your return.

I was reminded of this partnership where respect and genuine concern are mutual when I received a card from a patient following the recent death of my Dad. She expressed her sympathy and was genuinely concerned for my wellbeing. In the card she wrote to thank me for the care I had provided for her twelve months ago when her husband suddenly passed away and she was left on her own in Canberra with family far away. She remarked on how she thought of me as a friend as well as her doctor. I reflected on what a privileged position we hold.

Another great thing about a career in general practice is its portability. It is relatively easy to move from state to state or indeed country to country as a GP. Whilst I have not really taken much advantage of this with only a move from Sydney to Canberra, it is possible to move from work in urban centres to remote areas where the experience of general practice varies greatly.

I have practised in Canberra now for twelve years. General practice in the ACT has changed greatly in this time. When I arrived there was a definite shortage of GPS with most practices having closed books. Now the situation is very different with the majority of practices taking on new patients and a host of new practices opening in Canberra.

The constant here though is the strength of general practice and, I believe the high quality of GPs we are lucky to have in Canberra. We have some very dedicated and passionate people working in General Practice in Canberra. Real champions for our cause. There are many to mention but one in particular stands out at present and I would like to join with the rest of my colleagues in congratulating Dr Tuck Meng Soo on his recent Queens Birthday honour for services to the ACT community.

We are also fortunate to have a Territory Government that has supported and valued general practice. The same cannot be said for some of our colleagues in other states and Territories.

Another aspect of practise in the ACT that is beneficial is to have only two hospitals to work with both of which recognise the importance of general practice and do try to cooperate with us, well at least some of the time.

Another aspect of general practice that I think is fantastic is the variety, not only of the patients that we see but also our roles within general practice.

Five years ago I was given the opportunity to become a practice owner. This was not something I had ever really been interested in, however I decided to give it a try thinking that the worst that could happen was that it failed and I could then give someone else the opportunity to be a practice owner!

Fortunately that hasn't happened and the practice has experienced growth requiring two expansions and now has all consulting rooms occupied daily.

This experience has allowed me to become a small business owner and an employer. Something I would not have imagined when I signed up for my MB BS degree.

The skills I have learnt have been many and varied and there have definitely been some challenges but it has been an extremely rewarding experience. I have been helped along the way by some very experienced practice owners who have very generously shared information with me. A unique situation I think to general practice where your competitor is only too happy to help.

I recall at the time when I purchased the practice there were many who predicted doom and gloom as Canberra was experiencing some practice closures and the rise of the corporates: however offering consistent and reliable service has proved them wrong.

I have also been fortunate to have been given the opportunity to develop skills as a board member having served on the board of ACT Medicare Local for three years. Again many new skills learnt including diplomacy when dealing with bureaucrats who thought they understood how health works. There was an opportunity to work with some outstanding clinicians both from general practice and the allied health sector in addition to some very clever and wise senior executives from non-health backgrounds.

One of my most favourite and challenging roles has been that of GP supervisor which I also took on five years ago. It is extremely rewarding to be able to guide a doctor through their first experience of general practice and to see how they master the skills required to be a safe and competent GP. There is a great sense of satisfaction in knowing that you have successfully passed on some of your own knowledge and skills.

There are not many other jobs where you can be a clinician, small business owner, teacher and board member all with the one qualification from almost quarter of a century ago!

So yes, you and your family doctor are the best partnership in health and as general practitioners seeing patients we know that only too well but I also like to think the partnership works both ways.

I have learnt a great deal from my patients and from the many and varied roles I have been given the privilege of playing in my career as a GP.

I very much look forward to my next twenty five years in general practice!

Dr Felicity Donaghy is a Canberra GP and practice principal at the Garema Place practice in the City

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Making the most of the small business tax breaks

Small business was a clear winner in the recent Federal Budget. BOQ Specialist's Lynne Kelly takes a closer look at the much publicised $20,000 tax break means for medical practitioners.

The big ticket item announced in this year's Federal Budget was a surprise tax write-off to enable small business to accelerate the depreciation on the purchase of assets up to $20,000. The former small business tax threshold was just $1000.

With the proposal now officially passed into legislation, BOQ Specialist answers five questions to help medical practitioners take advantage of this generous tax deduction:

Q1. What is the $20,000 accelerated depreciation tax break?

Small businesses will now get access to a $20,000 tax write-off to purchase items relating to their business. The asset will be fully depreciated in the first tax year rather than spread over several years.

Q2. What businesses will be eligible?

Any small business or sole trader with an Australian Business Number is eligible for the tax deduction as long as their business has an annual turnover of less than $2 million.

Q3. What assets are eligible?

Depreciating asset under $20,000 that the business acquires and uses or installs ready for use for a taxable purpose from 12 May 2015 until 30 June 2017. This includes equipment, such as a new computers, medical equipment, a car or any item that relates to your business. Items don't have to be brand new so can also be second hand. Items to be claimed must be physical assets so things like marketing costs are not permitted. There is no limit on the number of items a business can claim.

Q4. What assets are not eligible?

There are a few depreciating assets that are not deductible under this tax initiative, including horticultural plants and any software developed in-house by a business. Medical practitioners should seek their own advice from their tax advisor as to what is eligible.

Q5. What finance arrangement can be provided to the eligible asset?

Small businesses have to purchase and own the asset in order to be entitled to the immediate depreciation treatment. The client may finance their purchase via an asset purchase or chattel mortgage, credit card or overdraft/line of credit.

When it comes to leasing, since your financial institution will own the asset under a lease/rental agreement, you will not able to depreciate the purchase price of the asset in your tax return and therefore cannot get the tax benefit. You will only be able to claim a deduction for the lease instalments as usual.

In addition to the tax deductions, a tax cut of 1.5% was passed for companies with annual turnover of less than $2 million.

BOQ Specialist has over 20 years' experience providing distinctive personal and commercial banking solutions to medical professionals. Helping professionals best structure their finance is what we do, but as always you should always seek your own advice from a tax advisor.

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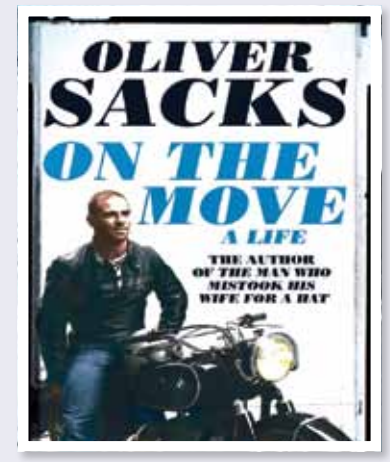
Book review

Oliver Sacks played a big role in my career choices; over time I have grown to appreciate that reading his books had been a guide for me. So it was with a sense of wary but excited unavoidability that I brought home his autobiography *On the Move*; as enticing as gossip, but slightly sacrilegious, to find out his secrets.



By his own admission Sacks is '... a man of vehement disposition, with violent enthusiasms, and extreme immoderation in all my passions'. (*My Own Life*, in The New York Times 19/2/2015) This year, at the age of 81, he was diagnosed with metastatic melanoma, unexpected liver metastases years after treatment for ocular melanoma. Readers of *On the Move* may find themselves surprised that he survived his early risk-taking and made it to middle age, let alone 81. Born into a brilliant, Jewish, London medical family a few years before the Second World War, Sacks was separated from his parents and evacuated to a harrowing boarding school at the age of six. As he has written before in *Uncle Tungsten*, intellectual excitement and curiosity kept him afloat in childhood and seem to have formed the raft that carried him through the storms that followed.

There is a sense, in reading his confessions, of an urgent need to get down on paper first, who he is, and second, what he has achieved. Perhaps, given his past books, we should have been expecting that *On the Move* would read more like a series of case studies of events in his life rather than a continuous narrative; it is only fair that he be exposed using the same methodology he used to describe his patients. As a far from disinterested reader I found *On the Move* to be fascinating.

Dr Philip Keightley
Psychiatry Advanced Trainee
ANU Medical School

VALE

The President, Dr Elizabeth Gallagher, Board members and staff extend their sympathies to the family and friends of colleague *Dr David Craigie* who died recently.

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