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Accreditation risk for ACT Health

Health Minister Meegan Fitzharris has announced that ACT Health has received a preliminary accreditation report from the Australian Council on Healthcare Standards that identifies several operational and policy areas that need urgent improvement. In particular, the report identifies a small number of areas where patients were placed at extreme risk including parts of the ACT's mental health service.

In total, ACT Health failed to meet 33 of the required 209 standards – a disappointing result by any account. ACT Health now has 90 days to rectify the problems or risk failing final accreditation or receiving a shorter accreditation.

Minister Fitzharris, in releasing the preliminary report, said "Of note to me are the findings of the ACHS that there is a lack of clarity and a policy gap between corporate and clinical governance, and its recommendation to review the governance system. These are precisely the issues that the ACT Health transition team is currently addressing as part of the ACT Health restructure that will be subject to consultation over the coming months.

"This will enable ACT Health to focus on improving operational performance, governance and accountability frameworks to better provide patient-centred health-care to our growing population."



Health Minister Meegan Fitzharris.

Mental Health Minister Shane Rattenbury said the adult mental health facility remained the safest place in Canberra for anyone at risk of suicide.

"Notwithstanding that we've got some risks to deal with, it's still the best place for them to be in terms of that supervision," he said.

The report recommended an urgent independent external review of all mental health inpatient units, drug and alcohol and

justice health facilities to assess safety and risk to consumers.

AMA ACT's Response

Prof Steve Robson, AMA (ACT) President responded to the preliminary report by expressing AMA (ACT)'s disappointment at the result but reassuring the patients and residents of the ACT that he "remains confident that the standard of care at Canberra Hospital is very high."

Prof Robson also recognised that "an incredible amount of work goes into getting a major hospital like TCH ready for accreditation and regardless of the current situation, I'd like to acknowledge the many doctors, nurse and other staff who have contributed. We all want a good outcome, but it hasn't been achieved at this time."

Prof Robson said hospital staff were frustrated that good clinical



Prof Steve Robson, AMA (ACT) President.

care was under threat by governance and management issues. "When the governance is wonky it sends ripples through the entire organisation," Prof Robson said.

"There's been huge upheaval at ACT Health recently and a lot of balls in the air."

"The real issue is the tools they have at their disposal and the rules and processes they have to follow."

The recent decision to split ACT Health into two parts – policy and operations – had come as a surprise to the AMA (ACT) and "with Director General, Nicole Feeley's sudden departure, it engenders concern with everyone."

Fixing the problems

ACT Health now has 90 days to rectify the issues and maintain its accreditation. Interim Director-General, Michael De'ath, said he had convened an "extremely high level" group of senior executives to ensure the criteria are met by the end of July."

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Medical Musings

WITH PRESIDENT, PROFESSOR STEVE ROBSON

ACT Health Accreditation

It was with considerable concern that I learnt about the significant failings identified in the preliminary accreditation report for ACT Health. The real question, however, is what we can do as representatives of the medical profession in the ACT to work towards achieving accreditation within the ninety-day period now allocated.

Almost inevitably, system errors will lie at the heart of the issues. However, I can't help but believe there is a bigger story to emerge given that only three years ago, ACT Health achieved an unconditional accreditation.

The current situation requires all of us to continue to do our best to ensure that the goal of accreditation is achieved. I've made an offer of assistance to Minister Fitzharris should that be required.

Private Health Insurance

Many of you will have been following the media stories about private health insurance (PHI) and its affordability and value. I would like to discuss this in some detail,

as the uptake and use of PHI has major effect on medical practice in this country – whether patients have PHI affects the referral patterns of general practitioners, and it directly affects specialists' ability to offer inpatient care to their patients. The Federal Government has undertaken some important reforms to PHI to help people understand the different conditions that each policy category. These have been categorised as gold, silver, bronze, and basic.

Private Insurance and, indeed, the entire private health system is likely to be a flashpoint during the next Federal election. More importantly, it represents a major investment for many families and it is critical that people with PHI understand what the cover involves and will reimburse them for care. The issues are so important that a number of Ministerial Advisory Committees are busy providing advice to Government. I should declare that I am a member of the MBS Review and the Ministerial Advisory Committee on out-of-pocket costs.

We all realise that there is a bewildering array of PHI products on offer, yet many leave patients without cover when they need it most. As a way of helping doctors and their patients deal with this uncertainty, the AMA Private Health Insurance Report Card is produced each year. It aims to provide clear and simple information about how PHI really works. This year's report was released earlier on, at the height of a media storm involving sensational reporting of the 'gaps' charged by a very small number of procedural specialists.

The Report Card shows that there are many policies on offer: these provide greatly varying levels of benefits, cover, and gaps. Importantly, the 2018 Report Card also highlights the increase in profits for PHI funds. With profits rising for insurance companies has come a rise in exclusions, and a rise in complaints. The Report Card also highlights something that we all recognise – the need for PHI to be simplified, with greater transparency,

and the need for policies to cover the real costs of treatment. In view of the changes made by Australia's largest insurer, the British-based company BUPA, it is important that private health insurance does not impact a patient's ability to choose the doctor that is right for them, and to have their treatment at a facility that suits them. The Report Card suggests that recent changes made by BUPA have the potential to be severely detrimental to patients and doctors alike.

This year's report card clarifies the significant variation in a fund will pay towards a medical procedure on behalf of the patient. Some insurers perform well overall, some only perform well for certain conditions. As procedural specialists know, the same doctor performing the same procedure can be paid significantly different rates by each fund. This is an important and often overlooked story behind patient out-of-pocket costs, hidden by high levels of no- and known-gap billing statistics. The latest

APRA statistics show an overall 'no-gap' rate of 88.1% and a known-gap of 7.3%: our profession is working hard to ensure patients receive value for money.

The Report Card emphasises the need for PHI to be simplified, more transparent, but also to cover the real costs of medical treatment – including the theatre fees, equipment, consumables, hospital costs and staff time – rather than simply pointing the finger at the doctor or pushing increased out of pockets onto patients. If people are looking to save money, I would suggest that they are not deceived into downgrading to a junk policy. From the AMA's perspective, these junk policies should not exist at all.

The AMA will continue to fight for our patients' right to choose the doctor that is appropriate for them, and to have their treatment at a facility that suits them. We will fight to ensure that doctors can refer patients to the right specialist – not just the one that an insurer deems appropriate.



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VALE

The president, Prof Stephen Robson, Board members and staff of AMA (ACT) extend their sincere condolences to the family, friends and colleagues of Dr John Bernard BAGGOTT



Salaried Doctors bargaining: pay increases and JMO education expenses

BY TONY CHASE, DIRECTOR OF WORKPLACE RELATIONS AND GENERAL PRACTICE

In these days of social media and the 24-hour news cycle, *Canberra Doctor* readers could be forgiven if they are seen to nod off when asked to read another progress report on the Salaried Doctors enterprise bargaining round. While the bargaining has been spluttering along for at least 18 months, there is some reason to be optimistic.

On 10 April with no fanfare, preamble or warning, the ACT Government announced that it had undertaken a review of its November 2017 offer and improved the pay component to be:

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

With the Agreement to expire on 31 October 2021.

Wage stagnation

This ACT Government offer must be seen in context. ACT Public sector workers are being asked to accept a minimal CPI based wage offer for a 4-year agreement. At the same time, the ACTU is making submissions to support its highly ambitious claim to the Fair Work Commission's Annual Wage Review for a uniform 7.2% increase to the minimum wage. Employer groups are calling for a modest increase of 1.8% for those on the minimum wage and \$14.60 for the lowest award rates.

The ACTU and others have pointed out that wage movements have continued to stagnate. The ACT Government's wage offer over a four year period seems to suppose that this period of wage stagnation will continue for the whole period of the proposed agreement.

AMA claim for JMO medical education expenses and leave

Given the prospect of limited opportunities for wage increases, the AMA (ACT) has continued to focus on assisting its JMO/DiT members in other tangible ways and particularly as regards training costs.

The AMA (ACT) claim for Medical Education Expenses is that the allowance be:

- Calculated as 12% of each practitioner's fixed wage
- Payable pro rata fortnightly from the first pay period on or after an agreed date
- Payable during periods of paid leave but is not counted as salary for any other purpose of this Agreement.
- The allowance would be adjusted in line with general percentage increases in



wage movements over the life of the Agreement.

Leave

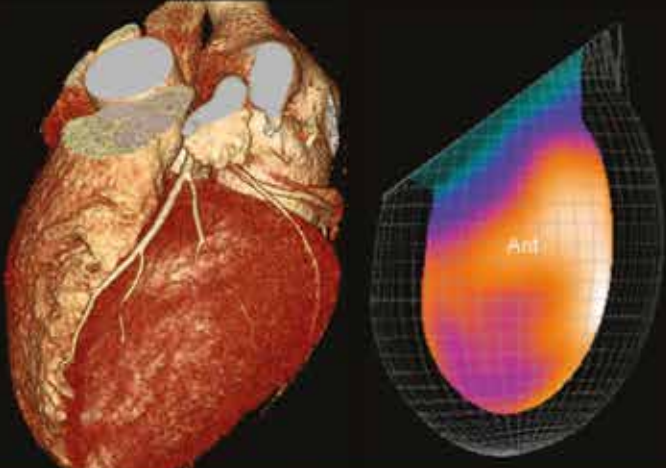
The AMA is also proposing 3 clear days study leave = (2 days preparation + 1 day for attendance at each exam). This leave may be utilised for study purposes outside the study requirements of Colleges.


This is to accommodate the circumstances where training is required for further study associated with their training as a Doctor.

In addition to these changes, the AMA proposes together with ACTH, that we confer directly with each of the Colleges to determine the appropriate level of study leave to meet the Territory's stated

training objectives. The current arrangements provides ACTH with a pre-emptive right to decline study leave. The AMA proposes this clause be deleted or revised.

Finally, in support of this proposal the AMA proposes that there be a clear difference between what is considered 'exam leave' and 'study leave'.





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PBS listing of HIV prevention drug an important milestone

With PrEP having been listed on the Pharmaceutical Benefits Scheme since 1 April 2018, HIV and LGBTI organisations have welcomed the listing.



"This listing of PrEP on the PBS is very important as it finally gives affordable access to the highly effective HIV prevention drug to people across Australia," ACON President Dr Justin Koonin said.

"We are thrilled this milestone has been achieved. Widespread access to PrEP is critical if we are to meet our goal of ending HIV transmissions in NSW so we commend the Australian Government on this decision.

"Combining PrEP with high HIV testing rates among gay men, strong treatment uptake among people with HIV and the continuing high rates of condom use gives us the tools to deliver the biggest reductions in HIV transmission rates in NSW in three decades."

PrEP

PrEP (pre-exposure prophylaxis) is an antiretroviral medication taken by HIV negative people at high risk of acquiring HIV to prevent infection. Studies have shown that PrEP is extremely effective, and recent demonstration projects in Australia, such as

the Expanded PrEP Implementation in Communities in NSW (EPIC-NSW) study, have shown PrEP is both a desirable prevention option and extremely effective for people at risk of acquiring HIV.

PrEP was approved by the Therapeutics Goods Administration in May 2016, but without federal subsidy, the proven technology has been too expensive for most people.

"We know that PrEP works and today's announcement will ensure those who would benefit most from PrEP will now be able to access it in an affordable way," Dr Koonin said.

"Our community has demonstrated that it is ready to incorporate PrEP into their lives as part of the range of HIV prevention options that we now have available."

"Gay men in NSW have consistently shown that they're committed to ending HIV and have adopted the use of new technologies such as PrEP as soon as they have become accessible."

"ACON salutes gay men, both HIV positive and HIV negative, for their commitment and action to end HIV transmission. We remain steadfast in our commitment to further driving down infection rates."

ASMR New Investigator Forum

The Australian Society for Medical Research (ASMR) in the ACT will be hosting the *New Investigator Forum (NIF)* on Thursday 7 June 2018 (9am – 5pm) at The John Curtin School of Medical Research (ANU) Finkel Theatre as part of the ASMR Medical Research Week.

The forum will include oral presentations and posters from early career researchers, including post-graduate students, research assistants and post-doctoral fellows (<5 years of submitting PhD). The forum will commence with a keynote speaker session where distinguished researchers with diverse experiences in medical research will talk about their careers in academia, industry and the public sector.

This year, the keynote speakers are:

- Dr Julie Glover, Acting Executive Director of the Research Programs Branch at the National Health and Medical Research Council (NHMRC)
- Dr Si Ming Man, Australian National University
- Dr Damien Belobrajdic, CSIRO Health & Biosecurity

ASMR is inviting all post-graduate students (Honours, Masters, Medical and PhD) and early

career researchers (<5 years post-PhD) who are based in medical research to submit an abstract for the NIF. Abstract submission closes on Friday 12 May, and submission is open to both ASMR members and non-members. New abstracts and abstracts presented at other conferences within the last 12 months are welcome.

Staff and students who are not presenting an abstract are invited to register for the NIF, and are encouraged to network with their colleagues and support the early career researchers. There is no cost for the NIF but numbers are required for catering purposes, so please submit your registration and abstracts at the following link: <https://asmr.org.au/asmr-mrw/canberra/>

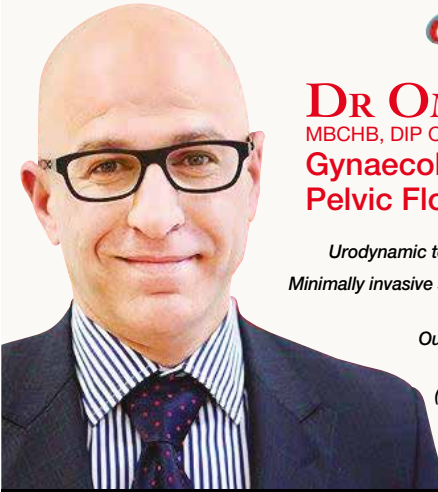
This year, there will also be a Sundowner Event (Thursday 7 June 2018, 5.15 – 7pm) to follow the NIF at the foyer of The John Curtin School of Medical Research. The function will comprise a plenary speaker, a poster of merit session and will conclude with an awards presentation. Food and beverages will be provided. Tickets are \$15 for students and ASMR members, and \$20 for non-members, which will be available for purchase from April.

Please do not hesitate to contact asmr at asmract@gmail.com if you have any questions.



The President, Prof Stephen Robson

Invites you to dinner
To celebrate the inauguration of incoming President Dr Antonio Di Dio to be held prior to the AGM on
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DG Departs as ACT Health is split into Operations and Policy

On Friday 23 March Health Minister Meegan Fitzharris announced that ACT Health will separate operational health services from policy and planning function to “improve access, timeliness and quality of health services for Canberrans and those in the region.”

From 1 October 2018, ACT Health will be separated into two organisations, focussed on:

- the delivery of quality health services, and
- the strategic policy and planning stewardship of the health system.

The Minister said that “the restructure is will bring the ACT into line with every other Australian jurisdiction.”

DG Nicole Feely to leave

As part of these changes, the ACT Health Director General, Nicole Feely will leave, and has advised the Minister that “she will pursue new opportunities.”

The Minister thanked Ms Feely for her “commitment and focus. She has been instrumental in beginning this reform process within ACT Health, transforming strategy and positioning ACT Health for a sustainable financial future.”

“Her strategic insight and operational expertise has skilfully repositioned the Directorate for the transition to a truly person-centred, integrated health service.

“On a personal level, we thank Nicole and wish her every success,” said Minister Fitzharris.

Restructure

“This is all about making sure Canberrans get the best possible care and continue to be the healthiest people in the country. With our health system expanding and increasing demand on our health services, now is the perfect time to move towards a more contemporary health system. This separation will enable a clearer focus on operational effectiveness and efficiency, and improve accountability for health service delivery.”

“The ACT Government will continue to invest in preventive, community and hospital-based services to build and improve health facilities in the ACT, for a Territory wide system that is adaptable to the community’s changing needs.” Minister Fitzharris added.

“Both organisations will continue ACT Health’s commitment to the health of our community, specifically an approach to health that is all about people, as well as a commitment to quality, innovation, engagement and accountability.

“The clinical and service planning underway through the Territory-wide Health Services Framework will remain a key priority for government and we will continue



Former Director-General Nicole Feely.

to establish clinical Centres, which will group clinical services through Centre Service Plans and Specialty Service Plans.

Mental Health

“The separation will facilitate im-

proved mental health services delivery, while also allowing mental health policy to improve its focus – within Health and across Government. The establishment of the Office for Mental Health will ensure that these efforts are well

coordinated,” said Minister for Mental Health, Shane Rattenbury.

Staff, employee representatives and health stakeholders and the broader community will be consulted.

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Post-operative treatments and services for DVA clients

Hospital discharge planners and physicians can refer eligible Department of Veterans' Affairs (DVA) clients to a range of DVA-funded medical and allied health services for post-operative care and rehabilitation.

Hospital discharge planners have an important role in coordinating the transition from hospital back into the community, and in consultation with the surgeon and the client's GP, will usually arrange treatment referrals prior to the patient being discharged from hospital.

Where a medical practitioner assesses that additional services are clinically required, or where these have not already been arranged by the discharging hospital, they can arrange the referrals for the necessary medical or allied health services.

If the services are not available on the Medicare Benefits Schedule (MBS) or the Repatriation Pharmaceutical Scheme (RPBS), the clinician should contact DVA for prior financial approval before progressing with or arranging the treatment.

Key post-operative clinical treatments funded by DVA can include:

Occupational therapy (Factsheet HSV23 – Occupational Therapy Services via dva.gov.au)

Physiotherapy (Factsheet HSV19 – Physiotherapy Services via dva.gov.au)

Exercise physiology (Factsheet HSV30 – Exercise Physiology Services via dva.gov.au)

Podiatry (Factsheet HSV20 – Podiatry Services via dva.gov.au)

Dietetics (Factsheet HSV21 – Dietetic Services via dva.gov.au)

See also: full list of clinical health services (Factsheet HSV01 – Health Services Available to the Veteran Community) available to eligible DVA clients

DVA also funds community-based services that can be accessed through a referral from a clinician, including:



- Community Nursing
- Rehabilitation Appliances Program (RAP) – including clinically required home modifications and household appliances
- Veterans' Home Care program – including carer support and Safety Related Home and Garden
- Maintenance services
- Convalescent Care (Factsheet HSV77 – Convalescent Care).



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Dr Gordiev specialises in Arthroscopy, Reconstruction, Replacement and Trauma of the Shoulder and Upper Limb. This includes arthroscopic and open shoulder stabilisation, shoulder replacement, rotator cuff repair, elbow, wrist and hand surgery. She has practiced in Canberra since 2005.

Dr Gordiev undertook Orthopaedic training in Sydney and Canberra and further specialised for 18 months at the Cleveland Clinic in the USA. She regularly attends local and overseas conferences concerned with developments in the surgical treatment of shoulder, elbow, wrist and hand disorders. Dr Gordiev participates in the teaching of Orthopaedic registrars through the AOA training program.

Dr Gordiev seeks to ensure that her patients are well informed about all treatment options available to them and to offer a high standard of operative treatment and aftercare. Please visit her website or call her practice for advice or more information.



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AMA's Doctor Portal:

<https://www.doctorportal.com.au/doctorshealth/resources/>

JMO Health:

<http://www.jmohealth.org.au/>
Partly funded by DHAS and a range of other organisations.

Doctors Health Advisory Service

<http://dhas.org.au/resources/resources-for-junior-medical-officers.html>

On the DHAS website itself.

AMSA students and young doctors:

<http://mentalhealth.amsa.org.au/about-the-campaign/>

<http://mentalhealth.amsa.org.au/keeping-your-grass-greener/>

Patient focussed trauma care in the ACT*

BY DR AILENE FITZGERALD

The Australian Capital Territory is undergoing a decade long redesign of its health services. It is a bit sad that we have to designate 'patient- focused care' as a major priority of the redesign. As clinicians, I am sure we like to think that our work is ultimately patient-focused – be it through the provision of direct patient care, teaching, revising protocols, reviewing literature or attending quality assurance activities.

Surely our consistent aim is patient-focused care. So why the need to 'guide its establishment'? Could it be that our ability to holistically care for patients is impeded by administrative or other processes? Do clinicians, administrators and politicians share the same perception of what patient-focused care looks like? What about the perception and expectation of patients?

Clinicians and administrators must collaborate thoughtfully and respectfully to understand each other's views and determine the best way forward.

Clinicians must attempt to understand the political pressures, competing priorities and complex issues that administrators face.

Administrators must truly listen to clinicians and understand the daily challenges they face, where often the quality of patient care able to be provided is heavily influenced by limitations within the system. Often senior clinicians are uniquely placed to provide complex, well considered, reasonable solutions to challenging issues. Both clinicians and administrators must listen to patients and their families as they often have unique insights of the system's strengths and fail-

ings from which we can learn.

The cost of patient care

Health economics plays a significant role in determining service delivery. Asking clinicians to put forward a business case for improved patient care highlights the tension between sustainability of expenditure and best practice. Often the true economic value of service improvement gets lost in the narrow process of costing a specific resource and comparing it to a proposed potential saving within the restraints of that service's budget.

Yet good fiscal management and best patient outcomes need not be mutually exclusive. Perhaps if we were to focus more on overall quality of care throughout the patient journey, from injury prevention to acute care to rehabilitation and reintegration back into the community and return to work, the true economic burden to society would lessen.

Changes in trauma care

Trauma care is an excellent example. Once perceived to be the domain of general surgeons, present day trauma care is largely comprised of critical care and

non-operative management of blunt multi-trauma patients. Surgical intervention when required is predominantly handled by orthopaedic surgeons and other subspecialties.

That is not to say that general surgeons shouldn't maintain an interest in trauma management, but clearly the model in the ACT where all general surgeons working at a Major Trauma Centre are required to be trauma consultants is outdated and does not deliver best patient outcomes.

Trauma care should be left to those that wish to pursue a sub-specialty interest in this area, and to clinicians who feel comfortable with time critical decision-making in the acute management of multiply-injured patients. Trauma resuscitation in Australian Major Trauma Centres is often led by Critical Care Consultants as team leaders, with surgical decision making the domain of the relevant proceduralist in collaboration with the team leader.

In many of Australia's Major Trauma Centres, a multidisciplinary trauma consultant roster involving critical care specialists and surgeons has been successfully



Dr Ailene Fitzgerald, RACS ACT Chair

implemented. Probably the most important factor in the success of these teams is collaboration among different sub-specialties to ensure appropriate and timely management of all injuries.

This model recognises that no one specialist has all the necessary knowledge and skills to provide holistic care to the multiply injured. Implementing such a model requires a great deal of dedication by the clinicians involved and a willingness by administrators to put their faith in the expertise, dedication and knowledge of their

senior clinicians. In the ACT, it has been a long journey to persuade general surgeons and administrators of the need to implement a best practice model.

Systems of care which truly support patients and modern day best practice are only possible through careful, considered collaboration between administrators and clinicians. As clinicians we must also be prepared to continually evaluate and adapt to ensure we are truly providing the best care possible.

*This article first appeared in RACS 'Surgical News' April 2018.

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World Doctors Orchestra

BY DR ANNE BICKNELL

Barcelona Wednesday October 5th

The conductor stepped onto the platform. "Good morning everyone. We will start with the Brahms: 2, 3, 1 ..." and off we went, straight into the Brahms 2nd symphony. So began my introduction and first experience of playing with the World Doctors Orchestra. Despite the no-nonsense beginning to the first rehearsal, this turned out to be an unforgettable experience and a major highlight of my musical and medical life.'

I began learning viola at school when the orchestra was in need of another player. I took to this beautiful mellow instrument with relish and for some years had my heart set on becoming a professional viola player.

In my last year of high school my direction changed to thoughts on a career in medicine. I was accepted into the Sydney University Medical School. and now, 40 years later, I'm preparing for retirement after a long career as a GP in Canberra.

Throughout my medical career I have been able to relax and enjoy playing music, without the accompanying stressors that a professional musician may often experience. As well as involvement with local community orchestras, I have had the good fortune to be a long-term member of both the Australian and NSW Doctors Orchestras which each meet once a year to perform concerts raising money for medical charities.

Last year I applied for a position in the World Doctors Orchestra (WDO) and was delighted to receive an invitation to play with them for the Barcelona/Girona concerts in Spain, October 2017.

WDO

The WDO was founded in 2007 by Stefan Willich, artistic director

and conductor. Stefan trained as a cardiologist and combines a busy medical career as Professor and Director of the Institute for Social Medicine, Epidemiology and Health Economics at Charite University Hospital in Berlin with multiple commitments as musician and conductor.

The orchestra meets and performs concerts 2-3 times a year in different cities throughout the world, with profits from the concerts donated to medical charities in the host country. The members of WDO are all doctors who give up their time from their medical practices, fund their own travel and expenses to share the enjoyment of coming together to play and perform music with like-minded colleagues for a good cause. The committed local organising committees of the host city work hard to ensure each concert is a success.

Members receive their parts for the concert program 2-3 months prior to the concert week so there is enough time for individual practice before the orchestra meets. Three long and intensive days are allocated for rehearsal in the week prior to the concerts. Further rehearsals occur before the weekend performances.

Sharing a glass of champagne, sangria, and tapas together in

the evenings after rehearsals and a formal dinner following the Barcelona concert provided more opportunities to relax and enjoy meeting other members of the orchestra and their families. For the Barcelona/Girona concerts 94 medical musicians participated, with most fields of medicine represented.

My colleagues had come from all over the world including Germany, Spain, Italy, France, Netherlands, Sweden, Norway, Switzerland, England, Ireland, Scotland, Canada, USA, South Africa, Japan, Hong Kong, Taiwan and Australia. Of the 5 Australians in the orchestra, 4 of us were fellow viola players.

WDO in Spain

My husband and I travelled to Spain 10 days before the orchestra was due to meet. This gave me time to adjust to the demands of overseas travel and also gave us an opportunity to take a tour of the Andalusian region of Southern Spain. Our rehearsals took place in the Seminari Conciliar – a beautiful old building adjacent to the university, not far from La Rambla. We had a large and very welcoming viola section of 16.

The performances were held at L'Auditori Palau de Congressors de Girona (about an hour's drive north of Barcelona) and in L'Au-



Concert performance in Girona.

ditori de Barcelona. Both concert halls are modern with excellent acoustics. The proceeds from the Girona concert were donated to The Oncological Foundation, the AECC-Catalunya Against Cancer and the Biomedical Research Institute of Girona. The Laboratory of Molecular and Translational Oncology and Agatha Group (supporting women with breast cancer) were the recipients of the proceeds from the Barcelona concert.

The program was the same for both venues:

- Vocci della Natura (Voices of Nature) specially arranged for our Orchestra by the Spanish composer Jordi Cervallo who also attended a rehearsal and concert
- Schumann Cello Concerto – soloist Louis Claret (Pablo Casals was Louis' godfather and he was taught by his brother Enric Casals)
- Brahms Symphony No. 2

It was a huge thrill to be a part of this orchestra and wonderful group of colleagues. I looked

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around the stage in Barcelona and thought "Wow! We have come from all over the world to play together, we're all doctors and have so much in common.

What an extraordinary experience this is!"

Some of the members return to play regularly, others every few years – it's easy to see how addic-



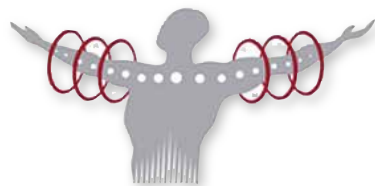
The five Australians in the Orchestra – Drs Damian Thomson, Anne Bicknell, Brian Hughes, Patricia Samson and James Smith.

tive it can become to travel to the other side of the world to meet up each year. I'm hoping to have the opportunity to attend again for the Jerusalem/Tel Aviv concerts in 2019. Meanwhile I look forward to receiving a recording of the concert when I will enjoy sitting back to re-live the excitement of this adventure all over again.

A special joy

Being part of a medical orchestra brings a special joy and excitement for the doctors involved. If others in the Canberra medical community are interested further information including registration details and forthcoming concerts can be found on

the websites for the New South Wales Doctors Orchestra, Australian Doctors Orchestra and World Doctors Orchestra. I highly recommend it as a wonderful way to relax away from the daily stressors of medical life while extending and enjoying your musical experience with like-minded friends and colleagues.



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Dr Edward Fleming – WWII Lancaster pilot

The following story was compiled by Louise Maher, ABC Radio Canberra and first appeared on 8 March 2018.

Dr Edward Fleming served with Bomber Command in WWII.

‘Before he had a licence to drive a car, Melbourne-born Edward Fleming was learning to fly Tiger Moths with the Royal Australian Air Force (RAAF).

By 1944 the then 19-year-old flying officer was piloting Lancasters with Bomber Command in England during World War II.

Next month he will return to where he served, joining 14 other Australian veterans at the official opening of the International Bomber Command Centre and Memorial Spire in Lincoln.

It honours the million aircrew and support staff from 60 countries who played a key role in the Allied victory.

Now 93, the retired Canberra surgeon looks back on his RAAF service as one of the most significant times of his life.

“Flying anything is an enjoyable experience... the Lancaster in particular because it was such an iconic aircraft.”

More than 55,000 Bomber Command members were killed during the war in raids over enemy-controlled Europe, training exercises and accidents on the ground.

Dr Fleming joined 550 Squadron (RAF) two weeks before the end



of the war after several months in operational training units.

Though initially “extremely disappointed” to have missed out on taking part in bombing missions, he later realised his good fortune.

“I think you have an indestructible complex at that time of your life,” Dr Fleming said.

“In retrospect, I have absolutely no doubt we would not have survived.”

On one occasion he and his crew lost their way at night during bad weather over the English Channel.

The flight almost ended in tragedy.

“I had an instructor on board at the time and he broke the rules and gave a mayday call,” Dr Fleming said.



Inside the cockpit of a Lancaster bomber (courtesy of Australian War Memorial).

“A little airfield... put on lights for us and we landed virtually out of fuel at about four o’clock in the morning and got away with it.

“We’d been circling around... totally lost in the dark... a terrible feeling.”

Commemoration trip a moving experience

Dr Fleming was one of 10,000 Australians who served with Bomber Command; more than 3,400 never returned.

Last year, with his son and daughter, he attended a commemoration for his squadron at its former base in Lincolnshire.

“There were about five or six... fellow people from the squadron of a similar age group and that was a very moving experience,” Dr Fleming said.

A Lancaster bomber flew in tribute at one of the ceremonies they attended.

“It was very exciting for me to hear it again,” Dr Fleming said.

“But in particular, for me to think my children were hearing the same thing and seeing the same thing that had been so familiar to us.”

The trip to the memorial opening for veterans and their carers is being organised by the Bomber Command Association in Australia, supported by a \$200,000 Commonwealth grant and community fundraising.

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Book review:

AUTHOR: THOMAS MORRIS: PUBLISHED BY BODLEY HEAD 2017

THE MATTER OF THE HEART – A History of the Heart in 11 Operations

Today it is widely accepted, by both the medical profession and the public, that surgical treatment, for a wide variety of disorders of the cardiovascular system, is generally safe, with low rates of morbidity and mortality.

However, as Thomas Morris tells us in his book, *'The Matter of the Heart'*, this was not always so. Indeed, as he points out, until the late 1940s, cardiac surgery, except for simple suturing of wounds, was virtually impossible, with most attempts at anything more complex ending in the death of the patient. Spectacularly unsuccessful were other unusual treatments of cardiac injuries, such as cocktails of strychnine and whiskey, or enemas of hot coffee and whiskey. Not surprisingly, these treatments have faded from use today!

George Bernard Shaw said that *"the reasonable man adapts himself to the world; the unreasonable man persists in trying to adapt the world to himself; therefore all progress depends upon the unreasonable man."* So it was with heart surgery, with many eminent and reasonable specialists worldwide agreeing that the surgical treatment of cardiac conditions was virtually impossible. However, in the mid-20th century, unreasonable men and women, clinicians, scientists, technicians, and even desperate relatives of terminally ill patients, sought to slowly change that perception, unfortunately often through painful trial and error, resulting in high mortality rates but with occasional outstanding results. Any success frequently came at a high price even after years of painstaking research and it often encountered much opposition, from an uninformed and at times suspicious, even hostile public and profession alike.

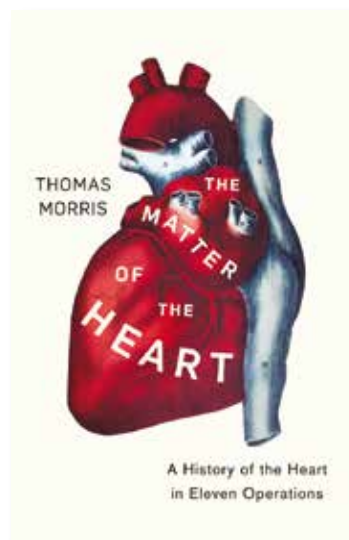
Modern heart surgery

Modern heart surgery really began in the mid-1940s, in the Cotswolds in England, and was born of the tragic necessity of dealing with the horrific chest and cardiac injuries to allied servicemen and women. The unlikely hero was a young American surgeon, Dwight Harken who would subsequently become the 'father' of modern cardiac surgery. Harken perfected an operation to remove shrapnel and bullets, from the beating hearts of wounded soldiers, without the benefit of the yet-to-be developed heart-lung machine. He operated successfully on 134 patients without a single death. In those days there were no randomised controlled trials, protocols or guidelines to aid the

surgeon, just the necessity of trying to relieve the suffering of patients, young and old, dying from cardiac problems, not of their own making.

Morris documents the trials and tribulations, the failures, the outright disasters and occasional triumphs as the cardiac pioneers attempted to revolutionise the way medicine dealt with heart disease and in doing so, developing new techniques that gave hope and life to many. He also covers the development of pacemakers and defibrillators, including the short but spectacular period of nuclear powered pacemakers of the 1970s.

He covers the accidental development of coronary angiography by Mason Sones and the various surgical attempts to deal with ischaemic heart disease, including the work of the tragic Rene Favaloro, whose suggestion of using conduits of saphenous veins, to bypass atherosclerotic lesions, was really just following on from a suggestion of Alexis Carrel in 1910. Sometimes there appears to be more to the story than we appreciate.



Transplantation

Many people know the name Christian Barnard, the South African surgeon who carried out the first cardiac transplant in 1967, but how many know the 'story behind the story' of this operation that was in fact long in the making. Who were the real heroes, the surgeons, the patients or those who worked out how to deal with the difficult and

ever-present problem of rejection? Transplantation was in fact not a new idea, so why was Barnard first?

Today for desperately ill patients, mechanical support devices, such as the ventricular assist device (VAD) may be employed as a 'bridge to transplant' but what did the aviator Charles Lindbergh have to do with all of this? Was he really the inventor of the first artificial heart in 1932 and how did the use of an artificial heart lead to a bitter feud between Michael DeBakey and Denton Cooley that would last 40 years and at one stage ended up in the courts?

What next?

So, now after a frantic 60 years of tragedy and triumphs, research and innovation, we live in an era when intervention for all manner of cardiac problems is possible. These advances now include diverse treatments such as intrauterine surgery on the foetus, trans-aortic valve replacement (TAVI) for desperately ill, virtually inoperable and often very elderly patients dying of severe aortic stenosis, robotic surgery and percutaneous valve repair, developments that would have been considered science-fiction a century ago. So where to from here? Morris also speculates on what the future holds.

This is an interesting, well written and informative book that all in the profession should enjoy, and quite rightly it has received many excellent reviews. Personally I would highly recommend it, especially to those unreasonable ones out there, who are still looking for solutions to the problems the profession encounters on a daily basis.

Despite the spectacular successes of the last 60 years, there is still much to be done. To quote Winston Churchill *"the longer you can look back, the further you can look forwards."* Thomas Morris reminds us that we all should remember how we got here today, so that we can move forward tomorrow.

Further reading

For those who enjoy reading about the weird and the wonderful, the tall tales and true from the legendary medical past, Thomas Morris publishes a regular and entertaining weekly blog on medical history, to which you can subscribe for free. He details the problems and the attempted solutions to a wide variety of medical problems which are both entertaining and occasionally chilling. To find out more, go to his website, the URL is thomas-morris.uk

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Rostering and JMOs

Avid readers of *Canberra Doctor* will recall back in January 2017 where AMA (ACT) cautiously welcomed the introduction of a centrally co-ordinated rostering scheme for the Junior Doctor cohort around the Territory public health service. Industrial problems associated with rostering and associated payroll issues across the Territory health sector have perennially been the cause of industrial friction and wasteful disputation.

The AMA (ACT) Workplace Relations Team are pleased to offer a tick of approval to ACT Health's report card. The establishment of the Centralised Medical Rostering Team (MOSCETU) (*the One-Stop-Shop*) is beginning to deliver some tangible improvements. AMA (ACT) members have continue to benefit from the improved communication and response time.

The centralised coordinated approach to JMO/DiT rostering and associated problems has given AMA (ACT) Workplace Relations staff an opportunity to have members' problems and issues addressed in a timely fashion with a minimum of fuss. If MOSCETU continues to improve its operational efficiency the benefits to AMA (ACT) members will deliver a less stressful working environment for our JMOs/DiT members.

We would appreciate any feedback on issues you may have with rostering or related industrial issues, particularly as we move towards and new enterprise agreement for the ACT's salaried doctors.



Recent MOSCETU clients.

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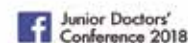


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