

ACT Government rejects lockdown laws, looks for new solutions

With laws to combat alcohol-related violence, including lockdowns, reaching their third year in parts of Sydney and being prepared for roll out in Queensland, the same can not be said for Canberra. ACT Chief Minister Andrew Barr recently announced that his government would not be following the examples of NSW and Queensland and introduce lockdown laws as part of the ACT Government's response to alcohol fuelled violence.



ACT Chief Minister, Andrew Barr

Following Mr Barr's announcement, Prof Steve Robson, AMA (ACT) President-elect expressed his surprise and disappointment that the Chief Minister had rejected lockdown laws that appeared to be working elsewhere to reduce alcohol fuelled violence.

"I'm a little bit surprised by the misinterpretation of the clear ev-

idence that when lockdowns came in, particularly in Newcastle, there was a marked reduction in alcohol-related violence and violent injuries presenting in the emergency department," he said.

Professor Robson called on the Labor leader to visit an emergency department in the early morning to understand the benefits Canberra could enjoy with extra controls on bars and clubs.

"There are big pressures on emergency waiting times in the ACT and it's so difficult having drunk people and victims of violence there."

Professor Robson said lockdown laws would be popular among the community, reflecting a significant decline in alcohol-related

assaults in Sydney's CBD since their passing and a significant reduction in weekend emergency room presentations.



AMA (ACT) President Elect, Prof. Steve Robson

NSW and Queensland

The NSW lockdown laws, as they apply in certain parts of the Sydney CBD, Kings Cross and Darling-

hurst, ban takeaway alcohol sales after 10pm with a venue lockdown in place from 1.30am and last drinks at 3am. Alcohol-related violence has reduced significantly since the new laws were introduced and NSW Premier, Mike Baird, has cited a 42% reduction in assaults over the period in the area where the laws apply.

An independent review of the effectiveness of the NSW laws is currently being undertaken by former High Court justice, Ian Callinan. The review, which will report in August, will also consider the impact of the new laws on "business viability and vibrancy".

Meanwhile, in Queensland the Palascuk Government has been successful in getting new lockdown laws through their parliament. The new laws, which are to take effect from 1 July this year, will see a number of changes but primarily will introduce a new requirement that sale and service of alcohol will cease at 2am.

The exception to this will be venues trading in a "safe night" precinct that will be allowed to continue serving alcohol until 3am on the condition that they have a 1am lockdown.

ACT Govt White Paper

To their credit, the ACT Government has been going through a lengthy white paper process to review local liquor laws including extensive consultation with stakeholders. This has resulted in the release, earlier this month, of the Government's Building on Liquor Reform white paper.

In relation to late night alcohol-related violence, the Government proposed three options:

- Restrict last sale of alcohol on premises to 3am and retain current licensing fees
- Restrict last sale of alcohol on premises to 4am with a 300% increase in licensing fees

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Capital Conversations

WITH PRESIDENT, DR ELIZABETH GALLAGHER

Well, as we move through April, the Christmas/January lull fades into a distant memory and the pace of the year accelerates. This is my penultimate *Canberra Doctor* column as I prepare to step down after two years and hand over the reins to Dr Steve Robson.

There has also been some movement in the board membership with Dr Guy Buchanan resigning and being replaced by Dr Jeff Looi. My thanks to Guy for his work and best wishes for the next step in his career.

While Guy will be a loss, we are fortunate that Jeff has stepped up considering both his background in psychiatry and extensive experience on the AMA Federal Council as the Psychiatry Craft Group Representative.

Dr Jo Benson

Recent months have also seen the AMA (ACT) Board lose one of its true stalwarts – Dr Jo Benson. After many years of loyal service, Jo has had to resign both as Secretary of the Board and as Chair of the *Canberra Doctor* Editorial Committee.

We are all very sad to see her leave and will miss her dearly, and hope that she may be able to join us again in the future!

With Board elections now underway, I urge you to consider nominating for a position. All the Board positions are up for election with the exception of President and the Board position reserved for the Chair of the Advisory Council, Dr Rashmi Sharma.

AMA (ACT) AGM and Dinner

I'd like to encourage you to come along to the AMA (ACT) AGM to be

held on Wednesday 11 May at the Hotel Realm. We have decided to try something different this year and have arranged a dinner from 6.30pm to meet and talk with members prior to the AGM. Dinner and drinks is a very reasonable \$35 per head and places for the dinner are limited. Please RSVP by 2 May to 6270 5410 or reception@ama-act.com.au

Our guest speaker will be Ms Nicole Feeley, Director General of ACT Health.

The AGM will then commence at 8pm. Even if you can't make the dinner I look forward to welcoming you a little later in the evening for the AGM and reaching a quorum as early as possible.

Lockout Laws

The recent decision by the Act Government not to introduce "lockout laws" has had a very mixed reaction with President-elect, Dr Steve Robson, expressing his concern on behalf of the AMA (ACT). The Government's decision to re-vamp licensing fees as a means of combatting alcohol-fuelled violence is a different approach and one that we only hope will work.

VMO Contracts

Along with Dr Andrew Miller and our CEO, Peter Somerville, I've just spent two days at the VMO arbitration hearing attempting to thrash out a new VMO contract. Due to

the truncated negotiating period a very large number of matters were on the list to be arbitrated. To my mind this doesn't help anyone and, indeed the arbitrator adjourned the hearing after two days by urging the parties to get together and try and settle some of their differences.

While there is always some argy-bargy in these types of matters, two claims that ACT Health has made have deeply concerned me – and I know they are of great concern to the VMOA too. Firstly, the claim to be able to terminate a VMO on three months' notice for any reason or, in fact, no reason and, secondly, the claim to reduce the Fee For Service contracts from 122% to 100% of the MBS and freeze the indexation to zero for the duration of the contract for both FFS and sessional contracts.

While parties can make whatever claims they like, I would have preferred that ACT Health had not gone down this path because, in my view, it can only have a negative effect on their relationship with the VMO workforce. Cool heads need to prevail and I believe there is still room to move on several aspects of the contract to get closer to an agreed outcome.

AHPRA and access to health records

Recently, I've become aware of a legal loophole that allows a health consumer in the ACT to obtain a copy of a practitioner's response made to AHPRA following a complaint about that practitioner made by the consumer. I became personally involved in such a case and was, to say the least, surprised to find

that what I thought was confidential correspondence between myself and AHPRA to help in a full and honest investigation, satisfied the meaning of "health record" under the access to health records legislation, and was subsequently released to the complainant. This situation is unique to the ACT. In other States and Territories the response to AHPRA remains with AHPRA.

While in this instance, I had no concerns about the release of the response to the complainant, I can imagine that in other circumstances practitioners – and their representatives – might be less fulsome in their responses to AHPRA knowing that it may be accessed by complainants. I don't think this is a helpful situation for the practitioner, AHPRA or the complainant.

A little plug for DVA gold card holders

Having grown up with grandfathers that both saw active service in WW2 in Papua New Guinea, watching the psychological and physical impacts their service had on a whole generation, and then seeing them through old age and the health problems that in itself creates, I saw first-hand the advantages and importance to them of a DVA Gold Card. This is a little reward providing health care to veterans that have seen active service overseas, and often lived through things those most of us now practicing could never imagine.

Therefore I was very distressed when a friend rang me about his very elderly father with a Gold Card and who required some minor surgery. He was referred privately,

but then sent back to go through the public system. While our public system is good, the waits are long and the services overcrowded.

While it is quite within every practitioner's rights to choose who they see and what they charge, I felt a little uncomfortable that this had occurred when the veteran was entitled to care in a private hospital and there are doctors more than willing to look after them.

Perhaps a referral to a colleague who does see Gold Card patients may have been more appropriate? Perhaps also, it may be relevant for GPs referring these patients to try and find out the best referral channels for them?

Sadly, there are not many veterans like my friend's father left and we owe them a lot. Just my thoughts.

Prof Brian Owler

Finally, my thanks to the AMA President, Brian Owler, making himself available for an open forum at the Canberra Hospital on 30 March. Brian address and grasp of the issues – highlighted by the Q&A – demonstrated yet again why he's been such a success as president. Thankyou Brian!

Member Engagement

One of the most important thing for any membership organisation is engagement of members. Peter Somerville and the Board are working on strategies to reach out to members and other local doctors to find out what you want from us, and what we can do for you. I urge members to try and get involved and feedback to us so that we can best direct our efforts.



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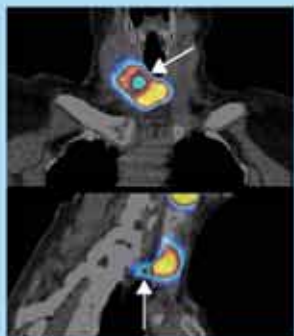
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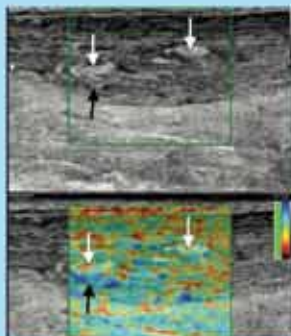
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VMO Arbitration: ACT Health proposes 20% rate cut for FFS and termination at will

The arbitration hearing for a new VMO contract was held over an initial two day period on 5 and 6 April before Arbitrator, Greg Smith AM. The hearing was adjourned by Mr Smith at the conclusion of the second day with the arbitrator urging the parties to seek agreement on several of the outstanding matters.

By the time the arbitration hearing commenced, between AMA (ACT), the VMOA and ACT Health some 120 claims had been made with 80 or so remaining to be arbitrated. This is an extraordinary number and reflects the truncated negotiating meetings that were held in the last few months of 2015.

While many of these claims, both agreed and not agreed, relate to relatively minor matters there are some fundamental issues that remain between the parties. In particular, ACT Health has sought fundamental and far-reaching changes to the contract that would, if accepted by the arbitrator, significantly change the relationship between VMOs and ACT Health. These include:

- The right for ACT Health to terminate a VMO's contract for any reason, or no reason, on the payment of three months' notice
- Extended rights for ACT Health to terminate without notice or payment
- Removal of the VMO's right to utilise the contractual Dispute Resolution Process when termination occurs. This means that the VMO could only report to the civil courts
- A VMO can be directed to work at any ACT Health facility (although some notice of the change would be given)
- Workload may be varied on one months' notice including for reasons of "operational needs and service delivery needs"



- No or minimal increase in the sessional rates
- Removal of the indexation factor in FFS contracts resulting in the indexation factor to be applied to the MBS from 122.61% to 100%

While many of these claims may be seen as "ambit" they have, at this stage, been put forward for the arbitrator to decide.

Meanwhile, the AMA (ACT) and VMOA have proposed a series of changes that we would like to see made to the new contract with the major claims being:

- Increase in sessional and FFS rates
- Further limitations to the variation of workload
- Minimum term contract – either 3 or 5 years

- Consultation on changing workplace policies
- Enhanced parking facilities

There's no doubt that ACT Health's claims, if adopted, would represent the most serious changes to the VMO contract since the introduction of the arbitration process. Importantly, they would also mark a very significant change in the relationship between VMOs and ACT Health going to the very heart of that relationship.

With a short timeframe until the arbitration resumes, we urge ACT Health to consider the implications of the position they've taken and for all parties to aim to reduce the number of outstanding matters. While AMA (ACT) and the VMOA have identified areas where further discussions can be fruitful, the real test will be how ACT Health approaches the major issues to ensure this doesn't turn in to a lose-lose situation.

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- Restrict last sale of alcohol on premises to 5am with a 300-500% increase in licensing fees

The white paper proposes that additional revenue from licensing fees would be used to fund safety measures such as additional police or infrastructure.

At the same time, small venues,

that seat 80 or fewer guests, will have their licensing fees reduced by 75%.

Exemptions from the NSW lock-out laws apply to smaller venues as they do for some tourist locations and restaurants.

While there is a balance to be struck between lockout laws and citizens' rights generally, doctors working in any major hospital know only too well the sorts of

cases they are likely to see on a Friday or Saturday night. The dilemma faced by the ACT Government is that they propose to go down a different path to NSW and Queensland in circumstances where the NSW evidence seems compelling.

At least by August we will have the outcome of the Callinan review of the NSW laws and will be better informed all round.

AMA President on asylum seeker health

The following is an edited version of a speech given earlier this year by the AMA President, A/Prof Brian Owler, at the AMA Forum on the Health of Asylum Seekers.

There are times, in any nation, where the medical profession must act in the interests not only of our patients as individuals, or for patients in a health system, but it must act in the national interest.

Doctors, along with nurses, lawyers and others, must lead a debate on an issue of national importance.

I believe that is the case when it comes to the issue of children in detention and Australia's provision of health care to asylum seekers.

Doctors at the Royal Children's Hospital in Melbourne and, of course, more recently at the Lady Cilento Hospital in Brisbane have refused to release children from hospital because they would be returned to detention.

Some commentators have seen this as a form of political protest. But as a doctor working in a paediatric hospital, who deals with the consequences of physical abuse, I know that there is no reasonable other option for these doctors and nurses to take.

There is an absolute ethical, not to mention moral, obligation to that patient who is in their care. The obligation is to not release a child back into a situation where they have reason to believe that there is a risk of harm, whether that be physical or psychological.

Let me say that it is not an issue of denying someone else a bed for

elective procedure. The obligation of that hospital, of those doctors, and nurses, is to the patient that is under their care.

To those doctors and nurses, and indeed, the State Governments and hospital administrators who have supported them, let me say you have our support.

The *2014 Report of the Human Rights Commission: The Forgotten Children* clearly documents the harms that children experience as a result of mandatory detention.

The Report documents that the rates of mental health disorders were significantly higher compared with children in the Australian community. These findings included cases of self-harm by young children.

Children being detained on Nauru are suffering from extreme levels of physical, emotional, psychological, and developmental distress.

The results of this national inquiry could not be more clear.

Immigration has enriched our society. That includes those who have come by boat, those who have fled wars and persecution.

I know of one young boy who fled his country by boat - stuffed on an overloaded boat, he became unwell and almost died.

The boat was seized and he was returned to his homeland, where he



and his family were jailed. They fled again by boat, reaching Australia, where he and his family this time were sponsored by a local family.

This is a story that is similar to any of those children who are in detention now. The difference here is that he was Vietnamese and it was the 1970s. He and his family were embraced by Australia.

He grew up to become an anaesthetist. I am proud to have had him as my anaesthetist for 10 years.

There are many other examples of the contribution that asylum seekers have made to Australian society.

In the theatre next to mine at Northwest Hospital is a man who started his journey as a young Iraqi doctor working in Iraq during the Saddam Hussein regime.

He fled Iraq when his senior doctor was shot dead in the car park by soldiers for refusing to cut the ears off deserting soldiers.

He fled to Malaysia and then Indonesia, and came here by boat. He spent months in Curtin detention Centre, where he was treated appallingly.

When he was finally released, he completed his orthopaedic training and joined our defence force.

He is an expert in osseous integration, and has given many British soldiers, who are double amputees as a result of military injuries, the ability to walk again.

In fact, when Prince Harry was here recently, he made a special visit to him and to see his work. I am proud to call him a colleague and friend.

I am aware of many others who are among the brightest and the best of our profession who did not start

life with privilege, but fled in fear of their lives seeking asylum in Australia, where they found safety and made a home.

They have enriched our country, and we should be proud to have them as Australian citizens.

Detention is not just harmful to children.

The same psychological consequences occur for adults, particularly when detention is prolonged and seemingly indefinite.

When people are detained for whatever reason, they have a right to the provision of an appropriate level of health care.

The AMA's policy is clear.

It is the AMA position that all asylum seekers and refugees under Australian care should have access to the same level of health care as Australian citizens.

In addition, it should be ensured that their special needs, including their cultural, linguistic, and health-related needs, are addressed.

As President of the AMA, I have been approached by concerned doctors and advocates about particular cases.

The case of an otherwise healthy 24-year old Iranian asylum seeker who died of a treatable condition stands out.

This man presented with early sepsis while in detention on Manus Island. He had a temperature of over 40C, he was tachycardic, and hypotensive.

He was started on antibiotics. He developed cellulitis and, over the next 24 hours, another antibiotic was instituted - but his symptoms did not settle.

It was decided that the patient should be transferred for inpatient care at Port Moresby the following day on a commercial flight. He was to be escorted by a doctor who was travelling on the same flight.

The following morning, at 10.30am, the request was made for approval for the transfer, and he was booked on the flight. At 3.30pm, there was still no approval and the transfer was therefore cancelled.

That night, the patient deteriorated and developed septic shock with adult respiratory distress syndrome. He was saturating at only 77 per cent.

An emergency evacuation was arranged through International SOS. He was transferred from Manus Island to PNG Pacific Private via air ambulance.

He was not intubated for reasons that are unclear.

The patient was saturating at 60 per cent, and was unconscious on arrival at the ED at Pacific Private in Port Moresby.

There was apparently no warning to the hospital that the patient was arriving, and a further hour and half passed before the patient was intubated and resuscitated.

By this time, the patient was brain dead. He was transferred to the Mater Hospital in Brisbane where this was confirmed, and treatment was later withdrawn.

The death was referred to the Queensland Coroner. A report was also prepared by the Department of Immigration and Border Protection. This latter report has not been released to the public.

The fact is that this young man should never have died. He should have been treated. If he had had access to appropriate treatment in a timely manner, he would still be alive today.

When you have people in isolated tropical locations under these conditions, people will have significant health problems.

It is not possible to provide the level of care that Australian citizens would expect when you are on an island as isolated and remote as Manus Island or Nauru.

Keeping people in such locations when they are sick places these people at risk of death.

More recently, I was asked to look into three different cases about which doctors and advocates had raised concerns.

A 70-year old who had been an inpatient in PNG Pacific Private in Port Moresby for 7 months was returned to Manus Island detention facility where he then waited 20 days for a doctor's appointment.

His diagnosis was described as being a heart condition with high blood pressure.

His legs, of which I was provided pictures by an advocate, were grossly swollen and oedematous.

He was only able to stand or walk



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for a few minutes. It turns out that he has TB pericarditis, and he was obviously in gross cardiac failure.

A young man who complained of headaches was investigated and found to have a small pituitary tumour on an MRI performed in Port Moresby.

He has not had a full panel of blood tests as anyone in Australia would normally have. His eyesight reportedly deteriorated, and he complained of more severe headaches.

He was transferred back to Manus Island where he was seen by an endocrinologist by teleconference, who prescribed a two-year course of medication. An eye review by an optometrist was to be conducted within six months.

We were last told that he had not received any medication, because the doctors were unsure if he wanted to take it. Therefore, it had not been ordered for the island.

Finally, another man appears to have deteriorating mental health with PTSD and depression. He was witness to a brutal murder, for which two former detention facility workers have been charged.

He remains in the same environment where the event occurred that started his PTSD. Is not removing him from such an environment the most logical and basic step that could be taken to assist this man?

It is not appropriate to keep these patients on Manus Island or Nauru. They need proper investigation and treatment. They need health care.

I have written to Minister Dutton in relation to these cases, and I have met with Dr John Brayley, who is the Chief Medical Officer and Surgeon General of the Australian Border Force.

Dr Brayley was unaware of most of the cases we raised with him.

And, consistent with the culture of secrecy that I have described, at every step of the process there were barriers and obstacles imposed that made transparent health care almost impossible.

First, these asylum seekers needed to provide me with a signed and scanned consent form, but the Department couldn't tell me if they have access to scanners on Manus Island.

Their own health records were eventually provided to the detainees after some delays, but they were on computer discs. The Department couldn't tell me if they had access to the appropriate IT to read them.

When I was eventually provided with these health records, they were also on a disc. Only it was password protected - and the Department didn't supply the password.

As a result of this process and our intervention, I am pleased to say that Dr Brayley recommend urgent transfer of the man with TB pericarditis to the mainland.

I want to say that I believe Dr Brayley is a good man. He has done great work in his previous roles, but he is clearly in an impossible situation.

It took a week of emails and calls, but this sick man was eventually transferred. I don't know where to, or what the outcomes are, but I am told that he has been removed from Manus Island.

The concerns about the other patients remain, but this process also highlighted two other major concerns.

First, it took the President of the AMA to write to the Minister for Immigration, arrange an appointment with the Chief Medical Officer, and provide health records and photographic evidence, before action was taken. That is not open, transparent, and appropriate health care.

It is also absolutely wrong that the decision on transferring this asylum seeker for urgent treatment was not made by medical practitioners, but by IHMS.

It was not the ABF's Chief Medical Officer who made the decision. He could only make the recommendation.

So, when the Government and the Minister say asylum seekers enjoy the same level of health care as ordinary Australians, that is simply not true.

In Australia, when a doctor makes a clinical recommendation, including medical transfers involving significant distances, a request does not need to be made to the Department of Health for clearance.

Recently, the Department of Immigration told the Senate Estimates hearing that they decide who is

transferred, not the Chief Medical Officer, or the treating physician.

Doctors should not only exercise their professional judgment in the care and treatment of their patients, but they must be able to speak out about unjust, unethical maltreatment of asylum seekers without persecution or prosecution.

Rather than a culture of clinical independence and transparency, we have the Border Force Act - a piece of legislation that was passed with the support of both the Coalition and Labor, but opposed by the Greens.

The AMA is rightly concerned about the restrictions contained in the Border Force Act.

Despite the Government's claims that the intent of the Border Force Act is not to prevent doctors from reporting publicly on conditions in detention and regional processing facilities, the AMA has received legal advice that does not reassure us.

There are provisions in the Border Force Act that are unnecessary and shouldn't apply to healthcare workers.

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The legislation must be amended to make it absolutely clear that it does not apply to doctors or nurses working in detention facilities.

It is imperative that medical practitioners working with asylum seekers and refugees put their patients' health needs first. And, to do this, we must have professional autonomy and clinical independence without undue outside pressure.

The AMA has continued to call for the establishment of an independent panel of doctors and other health professionals who can provide independent advice to Parliament, and who can report in a transparent manner on health-related issues.

At the end of the day, if Minister Dutton and the Department of Immigration and Border Protection believe that the care and treatment of asylum seekers is at a level that is appropriate, then why should they oppose this level of transparency?

Refugee and asylum seeker policy is complex. It is also highly political. Both the Coalition and the ALP know that elections have been won and lost on this issue.

The dehumanisation of the asylum seekers by Minister Dutton and others referring to these people as 'illegals', combined with cloaking them in secrecy in offshore processing, has made it more difficult for the Australian public to identify with these people.

The predominance of mental health conditions among the problems of detainees, including among children, does not seem to convey the same sense of seriousness as it might if the problems were physical.

A question has to be asked about the apparent pervasive indifference to mental health conditions despite the promotion, discussion and apparent progress that has been made in this area.

Somehow, these asylum seekers seem less worthy. The Syrian asylum seekers that we can see arriving in Europe or waiting in Turkish refugee camps seem more human and in need of help.

I was pleased at the announcement that Australia was accepting 12,000 more Syrian refugees, but disappointed that the same indifference to the asylum seekers in offshore processing centres remains.

The issue of a boycott in terms of providing services to detention facilities by Australian doctors has been raised a number of times.

I don't agree that is the way forward, not just because IHMS will recruit from overseas, as it is already doing, but for simple reasons.

Provision of medical treatment to asylum seekers is not condoning the system or being complicit. Far from it. Rather, it is what doctors and nurses always do. They put the patient first.

As I said at the National Press Club last year, it would not matter

what we said on this issue. Doctors would go and care for these people because that is what doctors do.

If we want to change the Government's approach, it must be through the weight of public opinion.

Australians need to understand that this is not an argument based on political ideology.

Rather, it is an argument based on our Australian identity, not just in terms of how the rest of the world sees us, but how we see ourselves.

It is based on the prevention of harm, the welfare of our patients as people but, most importantly, it is based on compassion. It is the right thing to do.

There will be some who might wonder why the AMA has spoken out so strongly on this issue.

As doctors, we care for all people, without regard to race or creed, without regard to where they come from. That is a basic moral tenet of our profession.

My message to the Government and to the Labor Party is this: You need to listen to doctors, nurses, and other health practitioners - particularly the experts in the fields of psychiatry and children's health.

The AMA is calling for the following:

One - a moratorium on asylum seeker children being sent back to detention centres.

Two - the immediate release of all children from both offshore and onshore detention centres into

the community where they can be properly cared for.

Three - the establishment of a transparent, national statutory body of clinical experts, independent of government, with the power to investigate and report to the Parliament on the health and welfare of asylum seekers and refugees.

And, four - if the Government or Opposition cannot provide satisfactory health care to people seeking asylum, then their policies should be revisited.

Australia, to me, represents democracy, freedom, openness, and accountability. A fair go and honesty are sources of national pride.

The reality is that children, and adults, are being subjected to physical and emotional harm.

People are being moved in the middle of the night without notice; under a cloak of secrecy and intimidation.

Denying people access to their legal representatives.

Our colleagues are being intimidated.

It is being done by the Australian Government, and it is being done in our name.

This is happening now. It is occurring during our time.

It's time for all of us to listen to our conscience. To give a voice to our better angels.



It's time to say that this is not what Australia is, it is not what Australia stands for, and we want it to stop.

Colleagues and friends, it is a simple truth that asylum seekers are people like me, like you.

They are no different. Just as our friends and colleagues came here seeking asylum for themselves and their families, to escape persecution and death, so are these people.

But, just like all of the other wrongs, Australia's detention of children and our treatment of asylum seekers is indefensible because it fails the one true test.

That test is how we love and care for our fellow man and woman, and particularly how we love, care, and nurture the children of this world.



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It's likely that a patient can access your response to an AHPRA Complaint

A recent decision by the ACT Human Rights Commission has highlighted a conflict between Health Records (Privacy and Access) Act (HR Act) and the Australian Health Practitioners Regulatory Authority Act (AHPRA Act) in the ACT.

In normal circumstances, a compulsory response made to AHPRA by a practitioner under the provisions of the local AHPRA Act is confidential and "protected information". Release of the information is an offence unless such a release is authorised under another law.

In the ACT, the HR Act applies to health service consumers and allows them to access their "health record".

Legal Loophole

However, the ACT Health Services Commissioner takes the view that "health record" includes a compulsory response made by a practitioner to AHPRA. Our advice is that the Health Services Commissioner is most likely correct.

The effect of the interplay between the two pieces of legislation is to circumvent what is supposed to be a confidential process under the AHPRA legislation. This is so despite the practitioner being compelled to provide their response to

AHPRA under threat of sanction.

Practitioners now find themselves in a very vulnerable position where they are forced to reply to complaints, no matter how vexatious or unjustified, only to have those responses released to the complainant at a later time. This is even where AHPRA assesses those complaints as being without merit.

Raised with AHPRA

AMA (ACT) has raised this issue with the responsible AHPRA officer in the A.C.T. expressing our concern that practitioners may not be fulsome in their responses knowing that responses may be subsequently released to complainants. AHPRA have responded positively and have commenced an internal process to review the matter.

While practitioners should consult their medical defence organisation as each case is different, If AHPRA confirms our advice then it seems legislative change is a real option.



REMINDER

2016 SUBSCRIPTION PAYMENTS ARE NOW OVERDUE

To renew your membership please go to website: <https://ama.com.au>

Or contact membership officer: membership@ama-act.com.au

Important information for AMA ACT members

The Annual General Meeting of the Australian Medical Association (ACT) Ltd will be held on Wednesday 11th May 2016

High Courtyard North at the Hotel Realm
18 National Circuit, Barton ACT

Please join us for dinner beforehand commencing at 6.30pm.
Limited places are available at \$35 per head. For those members not attending dinner, the AGM will commence at 8pm.

RSVP by Friday 2nd May to reception@ama-act.com.au
or Phone: 02-6270 5410

Further details of the meeting will be mailed to members in the near future.



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Dr Yeong Joe Lau is an Australian trained orthopaedic surgeon with an interest in disorders of the lower limb. He has now returned to Canberra to start practice after completing local and international fellowships in foot, ankle, knee and hip surgery.

Joe operates at The Canberra Hospital, Canberra Private Hospital and National Capital Private Hospital. He consults from The Specialist Consulting Suites at Canberra Private Hospital.

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AMA Vision Statement for GP Training 2016

The AMA has recently launched its Vision for General Practice in Training 2016 at the annual AMA Trainee Forum held earlier in March. The Forum, which hosts doctors in training and trainee representatives from across the country, was addressed by the AMA President, Professor Brian Owler who said that general practice was the cornerstone of health care in Australia.

"GPs are the first port of call when Australians feel unwell or want health advice, and GPs directly manage 90 per cent of the medical problems they are presented with."

"According to surveys, around 93 per cent of patients return to the same practice, and 66 per cent of patients return to the same GP." Prof Owler said.

"General practice is also an efficient and cost-effective part of the Australian health system, with spending on general practice just seven per cent of total health spending.

"GPs are increasingly caring for patients with multiple illnesses and complex care needs. It is a challenging career, but one that affords great personal rewards."

Professor Owler said the AMA Vision Statement for General Practice Training 2016 puts the spotlight on the professional and

personal rewards of a general practice career, with the aim of attracting more medical students into the specialty.

"Our GP Vision Statement sets out key principles for the development of an appropriately trained and sustainable general practice workforce that meets individual and community needs, serves the most disadvantaged, and achieves health equity."

"We need to produce GPs whose patients want to share their journey, who people see as the first and ongoing primary source of help and expertise, who have the wisdom to help guide patients with their personal health needs, who are enthusiastic about helping people navigate the system when they need other specialist care, and who can coordinate the complex health care needs of a growing number of people in the community.

"The Vision Statement sets out what the AMA believes are the core values and priorities for GP training, and it will guide the AMA's advocacy in this area for 2016 and beyond."

Professor Owler said there are currently around 4500 GP registrars undertaking general practice training in Australia, and more than 2100 actively engaged GP supervisors, and the AMA wants to ensure that all trainees and supervisors are strongly supported throughout the GP training journey.

"The AMA has always been a strong advocate for more resources to be invested in support of GP training – registrars, supervisors, more training places, incentives, and infrastructure – to maintain a sustainable GP workforce," Professor Owler said.

"The AMA is passionate about building a sustainable general



practice workforce, which is equipped to respond to the changing health care needs of individuals and local communities."

The Vision Statement can be accessed at <https://ama.com.au/ama-vision-statement-general-practice-training-2016>

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Doctors in Training News

Doctors in Training issues remain a key focus for AMA (ACT) with the new enterprise agreement being bedded down, issues around bullying and harassment being dealt with and a new publication – CanDIT – being launched.

Don't forget - all AMA (ACT) DiT members are invited to attend the regular ACT Council of Doctors in Training meetings (ACT CDT), the most recent of which was held on 5 April at AMA House. Dr Nushin Ahmed is the chair of the Council and shares the delegate role to the national Council with Dr Lauren O'Rourke.



Dr Nushin Ahmed, chair of the ACT Council of Doctors in Training

Nationally, the AMA CDT is the key representative body for DiTs and draws representatives from each of the state and territory AMAs. Local DiT concerns can be passed on to the national body and information can make its way from the AMA CDT out to local DiTs.

Typically, the AMA CDT deals with the implications for Doctors in Training of legislation and government policies affecting medical education and training, registration, entry into and progress through vocational training programs, restrictions on the nature or location of medical practice and part-time and flexible post-graduate training.

Locally, while training and policy issues are important, there tends to be more of a focus on workplace relations issues.

ACT Council of DiTs

The 5 April ACT CDT meeting covered a range of issues with Lauren reporting on the recent national CDT meeting and

trainee forum held in Melbourne. The AMA CDT have also identified several opportunities to work with other ACT-based groups, such as the Junior Medical Officer Association on shared events.

The key focus for our ACT meeting was workplace relations with the new enterprise agreement top of the list with "old favourites" like unpaid overtime still high on the list.

A new matter that's come up is reimbursement of conference leave expenses under clause 108 of the new enterprise agreement. Several members have complained that the Canberra Hospital is refusing to reimburse expenses incurred on conference leave unless the TCH mandatory training has been completed.

While we agree that mandatory training is important, the two issues shouldn't be confused and should be dealt with separately. Andy Ozolins, the AMA (ACT) Manager of Workplace Relations is working on resolving these issues. Andy can be contacted on 6270 5410 or industrial@ama-act.com.au in regard to this or other workplace issues.



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0401 973 820

Private practice? Beware of fair work audits

The Fair Work Ombudsman (FWO) has recently started a new education and compliance campaign in the health care and social assistance industries. The campaign has been developed in consultation with key stakeholders including AMA, and focuses on raising industry awareness of Australian workplace laws, providing education on these obligations where needed and improving compliance within the industry.



According to the FWO, inspectors will check up to 600 employers over the coming months to ensure their businesses are paying the correct minimum hourly rates, penalty rates, allowances and loadings and providing appropriate meal breaks. Compliance with record-keeping and pay-slip obligations will also be monitored.

For medical practices, the FWO will focus on employees covered by the Health Professionals and Support Services Award such as medical receptionists.

In the last three financial years, the FWO has taken the following actions against employers in the health care and social assistance industries:

- 43 formal letters of caution regarding workplace practices were issued to employers;
- Seven matters were taken to court for prosecution; and
- Eight employers received on-the-spot fines for infringements.

The FWO has indicated that the focus of the campaign is to ensure employers of reception and administrative staff in general practice and specialist practices are meeting their wage rate and record keeping obligations. It is estimated that around 200 medical practices will be assessed by FWO inspectors.

Practices that are selected by the FWO to participate in the campaign will be directed to provide

employee time and wages records for a recent pay period. Where an employer has more than 25 employees, they will be requested to provide a representative sample of no fewer than 10 employees. This sample should include (where applicable to the practice) a range of different employee classifications and employment types (full-time, part-time and casual) and must include all 457 visa employees.

The time and wages records for the selected recent pay period will need to specifically include the following information:

- Payroll advice records or pay slips which clearly state

amounts paid to employees, including base hourly rates of pay (or salary), loadings, penalties and allowances;

- A sample payslip, which the FWO will assess against the payslip requirements prescribed in the Fair Work Regulations 2009. Compliance with payslip requirements will be one of the main areas of focus during the campaign, and FWO inspectors will have the discretion to issue on-the-spot fines for breaches;
- Attendance records (i.e. time sheets and rosters) showing

hours worked by employees, including any overtime;

- Records of any hours where employees attended training sessions or staff meetings (note: inspectors will be looking to see that employees are being paid for these meetings if they are held outside an employee's ordinary working hours);
- Copies of any Individual Flexibility Arrangements (IFAs) made with employees; and
- Copies of any apprenticeship or traineeship agreements.

For further information please contact AMA (ACT) on 6270 5410.

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Anterolateral thigh pain

BY DR MALCOLM THOMSON, M.B., CH.B., FRANZCR

The other day a 65 year old lady came to see me.

"How can I help you Mrs ..."

"Hi Dr Thomson. It's my sciatica. It gets me here (rubbing her hand across her lower back/upper buttocks). And I have burning pain down my leg (rubbing her thigh). It's my sciatic."

I asked her: Does the pain go below your knee? "No. Just to the knee"

I asked her: What is your hip like to sleep on at night? "I can't. It hurts too much."

How are you when climbing stairs or getting up from a chair? "I don't climb stairs. It hurts. And getting up from a chair hurts."

I locate her greater trochanter and push solidly on the antero-superior facet and the postero-superior facet. Both times she

exclaims her displeasure.

I also prod her ipsilateral SI joint, again incurring displeasure.

The commonest cause for anterolateral thigh pain in my practice is trochanteric pain syndrome. And half of those with it also have ipsilateral SIJ dysfunction. I see on average 4-6 patients with this each day.

The treatment is simple:

1. Ultrasound-guided injection of steroid and lignocaine around

the gluteal insertions and relevant bursae.

2. CT-guided injection of the SIJ AND posterior sacroiliac ligaments (if applicable).
3. Physiotherapy by a therapist SKILLED in hip physio, to rehabilitate the muscles and tendons and posture etc.



4. Attention to weight.

Sometimes anterolateral thigh pain is from the hip joint, but the trochanter is not usually tender.

Occasionally anterolateral thigh

pain can be from the Lateral Cutaneous Nerve of the Thigh, but the Trochanter is not tender.

Rarely anterolateral thigh pain can be from the L2 nerve root. *Rarely.*

The Medical Benevolent Association of NSW (MBANSW)

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

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

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

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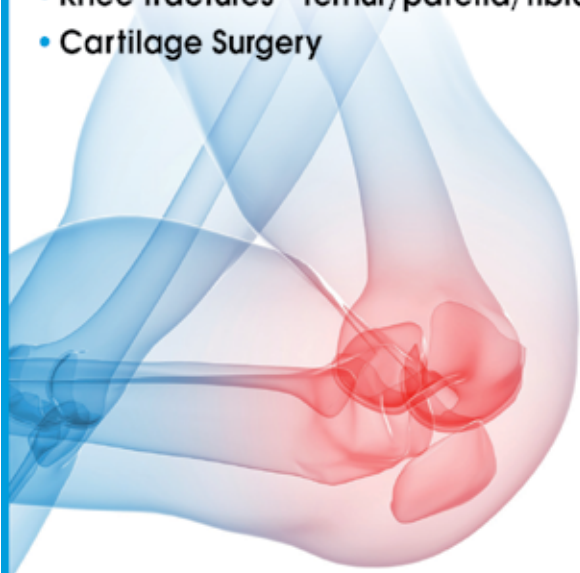
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When the Coroner calls

BY JANET HARRY, MEDICO-LEGAL ADVISER, MDA NATIONAL

Our Medico-legal Advisory Services team regularly receives phone calls from Members who have been contacted by the Coroner's office in relation to an investigation involving the death of a patient. This article addresses some of the most frequent questions and concerns raised by Members.

Q. I have been asked to send the medical records to the Coroner – should I comply, or do I need authority from the family or executor of the deceased patient's estate?

A. You should comply with this request and send the records to the Coroner's office. Doctors have a professional obligation under the Code of Conduct to assist the Coroner when an inquest or inquiry is held into a patient's death, by responding to their enquiries and offering all relevant information.¹

Q. I have been asked to provide a report or statement to the Coroner – what should I do?

A. We recommend that you always contact MDA National for advice before providing a report to the Coroner.

If you are a hospital employed doctor, you may be asked by your hospital administration to prepare a report or to be interviewed for a statement. If you are in private practice, you may receive a request for a report directly from the Coroner's office or from the police assisting the Coroner. In either case, MDA National can assist you. Hospital employed doctors may also be able to seek assistance from their hospital's legal representative.

A well prepared report or statement can greatly assist the Coroner in understanding your role in the care of the patient.

Q. Do I need to see the medical records before I prepare my report or statement?

A. Yes, it is important to refresh your memory from the records when preparing a report or statement. If you are hospital employed, you will generally be provided with access to the medical records by the hospital.

Q. Will the matter proceed to a hearing or inquest?

A. The Coroner's office will review all the relevant information obtained from the police, the forensic pathologist, the medical records, and statements provided by treating doctors and other interested parties, including the family, before deciding whether the matter should proceed to an inquest. Generally, less than 5% of deaths reported to the Coroner proceed to an inquest.

Q. I have received a summons to give evidence at an inquest – what should I do?

A. We recommend that you contact MDA National as soon as possible to discuss the matter and determine what assistance you may require.

Q. What is a letter of adverse outcome and what does it mean?

A. During the lead-up to an inquest, the Coroner may raise concerns about the care provided by an individual doctor and issue a letter advising the doctor that there may be an adverse finding made which could lead to a referral to the Medical Board. It is essential that you obtain legal advice and assistance in this situation.

It is important to contact MDA National as soon as possible when you become aware of a request for medical records, a report or statement to the Coroner or an inquest into the death of one of your patients. The sooner we know about the matter, the more effective our assistance will be. We can provide you with personal support and help you with:

- understanding the Coronial process
- preparing reports and statements
- preparing for an inquest.

1. Medical Board of Australia. Good Medical Practice: A Code of Conduct for Doctors in Australia. Section 8.10.3. Available at: medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

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The Australian and New Zealand Audit of Surgical Mortality (ANZASM)

The Australian and New Zealand Audit of Surgical Mortality (ANZASM) program has been operating for over 10 years. Beginning in Western Australia in 2001, the Royal Australasian College of Surgeons (RACS) took over responsibility in 2005, and by 2012 it had expanded to incorporate all Australian states and territories.

Dr John Tharion is the Clinical Director of the ACT Audit of Surgical Mortality (ACTASM). Funding is currently provided by the ACT Health Directorate, with oversight by representatives from surgical specialties within the ACT. Gynaecologists and anaesthetists have also begun participating in the audit.

The principal aims of the audit are to inform, educate, facilitate change and improve quality of practice within surgery, gynaecology and anaesthesia. This is done through peer review of all deaths associated with surgical care, with confidential feedback provided to the treating clinician. De-identified reports are sent to surgeons of the same surgical specialty usually from a different hospital, or in small specialties interstate, for first-line assessment. In cases where a more detailed assessment is required a second-line review is performed. Due to the small number of surgeons in the ACT, all second-line assessment reviews are carried out interstate, to ensure anonymity.

The audit process is designed to highlight system and process errors, identify trends in surgical mortality, and act as an educational rather than a punitive process.

Since ACTASM began in 2010, over 600 cases have been reported. Key findings:

- 90% of all surgical mortalities have been emergency admissions;
- Over 90% of patients had at least one comorbidity, with the most common being cardiovascular disease;
- Average age of the patients referred to the audit was 76 years;
- Average length of stay in hospital was 5 days, with a range of less than one to 165 days.

The ANZASM and ACTASM receive protection under the Commonwealth Qualified Privilege Scheme, *Health Insurance Act 1973*. This means that any information provided within the audit process cannot be accessed for legal action, making improved clinical practice the focus.

Consistency in audit processes and governance structure across all jurisdictions is essential, so that nationwide trends and issues in surgical care can be identified. Individual regional audits also work with health departments to provide outcomes and statistical data on identified system issues.

Participation by surgeons is mandated as part of the RACS's Continuing Professional Development program, with all public and private hospitals in the ACT participating. Reviewing surgeons report on the perceived impact of clinical incidents, whether they may have contributed to death, if the death was preventable, and information about whether care could have been improved is conveyed to the treating clinician, providing a better understanding of optimal care.

By paying special attention to the details of deaths, the audit is able to ascertain whether it was a direct result of the disease process alone, or if aspects of patient management might have contributed to that outcome.

The national audit has reviewed and provided feedback on over 24,000 patients during the last 10 years. A recent analysis using data from the Australian Institute of Health and Welfare (AIHW) has shown that since ANZASM was introduced there has been a one-third reduction in national surgical mortality. While this may not be solely a result of the audit process, having oversight of clinical activity may be a factor in this reduction.

More information is available in the ACTASM Annual Report available at www.surgeons.org



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Joanne Flowers

“ Dear Editor,

I refer to the article in the February edition of the Canberra Doctor, “Substance use and addiction in primary care”.

The 2014 RACGP prevalence figures for PTSD are 4.4% per annum and 7.2% over a lifetime in the Australian population. This means in primary care, at least one in every twenty GP patients are likely to have PTSD in their history.

As General Practice is where PTSD would initially present, you would expect the prevalence to be higher than for the general community. You would also expect it to be even higher in practices that provide primary care for substance use and addiction, as substance abuse is a common consequence of PTSD.

The article in the February edition of Canberra Doctor by Melissa Kent makes no mention

of PTSD while advising General Practitioners on how to manage addiction. In my view, this is a major oversight.

My experience with patients, as well as comments from therapists who deal with addicted individuals, is that there is often a precipitating traumatic event and substances are initially sought to self medicate.

My impression is that there is a lot of underlying, untreated PTSD in this group.

I would like to participate in a prospective trial of identification and management of PTSD in ACT general practice, with the intention to publish the results.

If any practice is interested, I would be happy to discuss a possible protocol.

Dr Henry Berenson

Updated resources on contracts and corporatisation

The AMA has recently updated two resource kits for members – *Corporatisation of General Practice Decision Support Kit for Doctors* and the *Guidelines on Service Contracts between Doctors and Medical Practice Principals*.

The Decision Support Kit provides assistance to doctors on issue including:

- Contract documentation
- Sale of an existing practice
- Practising under the focus umbrella
- Life and practice after the corporate

Since the Decision Support Kit was first published the process of corporatisation has developed and the current guide includes the experiences of AMA advisers and members on the benefits and pitfalls of corporatisation.

This invaluable tool for doctors considering corporatisation can be obtained by contacting the AMA (ACT) on 6270 5410.



The Guidelines on Service Contracts provides guidance to doctors on issues such as:

- Whether a person is an employee or an independent contractor
- Amount and basis of payment
- Access to non-fee for service income

- Share band mix of patient load
- Obligations and payment for oncall and after hours service
- Arrangements for holidays and other time off

The Guidelines on Service Contracts can also be obtained from AMA (ACT) on 6270 5410.

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implement effective plans of multidisciplinary management towards effective defined outcomes.

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The clinic is recognised by ACT and Interstate Workers Compensation and Private Insurances after 40 years of litigation case assessments and management should this part of the clinic's practice be of interest.

There is additional growth capacity to this practice depending on the physicians expertise and interests. A larger suite adjoining the clinic is also available to lease if a full complement of in house allied health team service is preferred.

Negotiable terms of sale.

CONTACT: The Director on 0412 043 245

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