CANBERRA Doctor

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Dr Antonio Di Dio takes over as AMA (ACT) President

The recent AMA (ACT) Annual General Meeting saw Dr Antonio Di Dio take over as AMA (ACT) President from Prof Steve Robson. Dr Di Dio, a Yarralumla GP, will hold the office for two years. In taking office Dr Di Dio paid tribute to Prof Robson and the outstanding work heíd undertaken over the last two years, a period that started early on with the ACT election and ended amongst a flurry of changes at ACT Health.

Once again, the AGM and dinner was held at the Hotel Realm and provided an opportunity for AMA (ACT) members to get together, renew some old friendships and acknowledge the work of office bearers, board members and staff during 2017. This year, with the changeover to Dr Di Dio, it also represented an opportunity to recognise Prof Robson's work and, in turn, welcome Dr Di Dio to the presidency.

Mrs Vicki Dunne

As guest speaker this year, we were fortunate to have Mrs Vicki Dunne, the Canberra Liberals Health Spokesperson. Mrs Dunne gave the meeting her views on how the ACT Government might better provide health services to Canberrans. Chief amongst her views was the need to make the hospital system more efficient and better co-ordinate the interface with primary care.

Mrs Dunne also criticised the proposed "split" of ACT Health as risky, wasteful and of questionable value in such a small jurisdiction. Vicki finished her address by congratulating Dr Di Dio on his election as AMA (ACT) President and looked forward to continuing to work with AMA (ACT).

AGM

After Mrs Dunne's address, the formal part of the meeting proceeded with Prof Robson making his final report as AMA (ACT) President. He reported that 2017 had again been a busy year for AMA (ACT) and one where we faced a number of challenges.

From ACT Health's data difficulties early in the year, through to the mental health crises centred around the shortages in the psychiatric workforce and on to the very real issue of doctors' health, AMA (ACT) had been working hard on behalf of patients and the profession.

Mandatory reporting was a key issue with Federal, state and territory AMAs co-operating to urge all Australian governments to adopt a uniform system that removes the barriers for doctors seeking help with their health and wellbeing.

AMA (ACT) had also been working hard to advocate on behalf of general practice and urged the ACT Government to come to the party on after hours care.

Prof Steve Robson, left, congratulates Dr Antonio Di Dio, on becoming AMA (ACT) President.

An expanded capability in workplace relations has been a key part of the service AMA (ACT) now provides to its members. With Tony Chase on board, members now get better access to representation in both individual issues and collective bargaining. Tony's presence has also expanded our ability to give first-class advice to members who are practice owners and contractors.

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Dr Antonio Di Dio... *continued*

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Prof Robson finished his report by thanking the AMA (ACT) Board for their support, advice and assistance over the course of 2017 and by recognising the secretariat staff and the key role they play in all that AMA (ACT) does.

The Annual Report can be accessed at https://ama.com.au/act/annual-report-2017

President's Award to Dr Ailene Fitzgerald

Prof Robson announced that the 2017 President's Award was to be made to Dr Ailene Fitzgerald, a General/Trauma Surgeon and Director of Trauma Services at Canberra Hospital. Prof Robson cited the short reasons for the award being made to Dr Fitzgerald including her:

"Outstanding service to the ACT community and medical profession in the areas of trauma care and leadership. Whether as a General/Trauma Surgeon, Director of ACT Trauma Services, as a surgical educator, caring for the welfare of junior medical staff or as regards her military service, Dr Ailene Fitzgerald has shown an extraordinary commitment to her colleagues, the profession and the community."

Presidential inauguration

Prof Robson then moved on to inaugurate Dr Antonio Di Dio as President of AMA (ACT) and present him with his chain of office. Dr Di Dio addressed the meeting and thanked the members of AMA (ACT) for the faith they had shown in him and looked forward to the next two years and the opportunities and challenges that lay ahead. He also thanked his family and friends, including a number who were present on the evening.

Finally, Dr Di Dio paid tribute to Prof Robson and the work, time and effort he had contributed to AMA (ACT) over the last two years. A presentation was made to Prof Robson and the meeting concluded.

Dr Antonio Di Dio

Dr Di Dio is a well-known Canberra GP and practice principal at the Yarralumla Surgery. Born in rural Sicily, Antonio moved as a child with his family to country NSW. He went on to graduate from the University of Sydney in 1990 and then achieved a Dip. Obs. and awarded his RACGP fellowship in 1996.

Having practised for the past ten years in Canberra, first in outer metro Erindale and since then at the Yarralumla Surgery, Antonio says his passion is in quality care and looking after his medical colleagues.

Dr Di Dio is similarly passionate about participating in medical life as a whole – from teaching and examining medical students, postgrads with RACGP and assisting overseas trained doctors.

Another key interest area for Antonio has been pastoral care for colleagues through the Doctors Health Advisory Service in NSW and the ACT and he's also been prominent with the Medical Benevolent Society.

Sponsors

Finally, our thanks to the sponsors for the evening, Rolfe BMW and Specialists Wealth Group. Rolfe BMW provided two display cars for the evening and a prize of the use of a BMW vehicle for the weekend and accommodation at the Hotel Realm. AMA (ACT) member, Dr Rajiv Jyoti was the winner.

Dr Rajiv Jyoti, right, with Bill Reid from Rolfe BMW .

Of course, AMA (ACT) members have access to the BMW and Mini Corporate programs and more information is available in this edition of Canberra Doctor.

We were also joined by Alex Stephen from Specialist Wealth Group and we thank Alex for being part of the evening. SWG has now expanded its offer to AMA (ACT) members to including banking and finance broking in addition to financial planning advice.

Election results

The AGM saw the new AMA (ACT) Board take office with Dr Balaji Bikshandi, a Canberra-based intensive care physician, joining the Board and Prof Steve Robson taking up the position of Secretary, after finishing his term as president.

The AGM also saw Dr Elizabeth Gallagher step down as a Board member after several years of outstanding service including AMA (ACT) President from 2014 to 2016. Dr Gallagher will continue on the Advisory Council and the VMO Committee.

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2017 President's Award: Dr Ailene Fitzgerald

Dr Ailene Fitzgerald is the recipient of the 2017 President's Award. The full citation for the award reads:

'For outstanding service to the ACT community and medical profession in the areas of trauma care and leadership.

Dr Ailene Fitzgerald is a General/Trauma Surgeon and has been the Director of Trauma Services and full-time Staff Specialist at Canberra Hospital since 2012. She is chair of RACS ACT, chairs the ACT Trauma Committee and is the regional representative for the ACT on the RACS Trauma Committee.

Ailene also has a keen interest in surgical education and welfare of junior medical officers and is the supervisor of non-accredited surgical registrars at Canberra Hospital.

Dr Fitzgerald is also active as a Commander in the Navy Health Reserves having joined the Royal Australian Navy in 1991 as an undergraduate medical student. She served in a number of establishments and ships and completed a number of deployments prior to transferring to the Reserves in 2000 to pursue surgical training. She remains active in the Navy Health Reserves.

Ailene has been a tireless advocate for a better Model of Care for the ACT's Trauma Service to improve outcomes and care for the most seriously injured patients. In 2016 she played an integral part in the ACT Government's decision to allocate an additional $1.1m in funding to better resource the service. Dr Fitzgerald has played a key role in implementing the service improvements with a new dedicated trauma roster to commence in July 2018.

Dr Ailene Fitzgerald is an outstanding example to the medical profession of commitment to and advocacy for, quality patient care.'

Prof Steve Robson with Dr Ailene Fitzgerald.

Mackenzie's Mission: Carrier screening for all prospective parents in Australia

Racheal and Jonny Casella are a young couple living in Sydney. They were married just over two years ago, and had planned to start their family very soon after the wedding.

"We spent the six months before the wedding preparing to get pregnant," said Racheal. "We ended up getting pregnant [soon after the wedding] and could not have been happier. During the pregnancy we did everything we could to ensure we had a healthy baby including taking vitamins, doing the required scans and even had the expensive NIPT test."

The author (left) with Mackenzie's incredible parents, Rachael and Jonny Casella at Parliament House on Budget Day.

However, at the age of only ten weeks, their cherished daughter Mackenzie was diagnosed with Spinal Muscular Atrophy (SMA) type one.

"We were told it was terminal disease, there is no cure. In Mackenzie's case, we were advised that we had a matter of months to create memories with her," explained Rachael. "It felt like a living nightmare and we couldn't wake up. We haven't really woken up from it since that day."

"On Sunday, 22 October, 2017, we took off her oxygen mask... Mackenzie passed away... Our hearts are forever broken, missing a piece."

Spinal Muscular Atrophy (SMA)

SMA is an inherited disorder, an autosomal recessive mutation in the SMN1 gene: the damaged gene reduces production of a protein known as SMN. The protein is vital for survival of motor neuron cells in the anterior horn of the spinal cord. Low levels of SMN result in widespread atrophy of skeletal muscle.

The disease has varying degrees of severity, but results in dysfunction of respiratory and proximal limb muscles. As happened in Mackenzie's case, SMA is the commonest genetic cause of death in children.

It transpired that both Rachael and Jonny Casella were carriers of SMA, but were completely unaware of the disease or its consequences. It is possible to undergo genetic testing for SMA, and had this occurred with Mackenzie's parents, the tragedy might have been avoidable.

Mackenzie's Mission

I have had the honour of meeting Mackenzie's parents – they are truly an extraordinary couple. I felt absolutely humbled in their presence.

Many couples, perhaps most, would be devastated after the loss of their first infant and retreat in pain. Racheal and Jonny used the emotional upheaval to do something incredible – to speak out as publicly and passionately as they could about preventable inherited diseases.

"When you are touched by tragedy, you seem to gain a new perspective," explains Rachael. "So I wrote a letter, a letter which described Mackenzie's life, her condition and what could have been different. My family sent that letter to every member of the Australian Parliament ... all 275 members."

The passionate letter achieved something remarkable. It touched many members of Parliament – especially Health Minister Greg Hunt. And, in this year's Federal Budget, the first step in realizing Mackenzie's Mission was realized. A staggering $20 million was granted to a group aiming eventually to make pre-pregnancy carrier screening available to every Australian couple wanting it.

Carrier screening

Like cystic fibrosis, SMA is a recessive genetic condition that is relatively common in our community.

Estimates suggest that over one million people in Australia are affected – directly or indirectly – by genetic disorders. In addition to the profound personal tragedy, these conditions have an enormous economic impact.

The costs of hospital care, specialised treatments, disability services, special education, and income support for carers are enormous. While there has been rapid progress in the development of treatments, they usually are not curative. Indeed, such treatments are costly and may convert a fatal condition into a chronically disabling condition.

The project is more formally known as *The Australian Reproductive Carrier Screening Project* (ARCSP) and the clinical co-leaders are geneticists Professor Edwin Kirk, Professor Martin Delatycki, and Professor Nicholas Pachter. I am humbled to be the obstetrician for the project.

Trials and errors

The funding is for a very large pilot study involving about 10 000 couples from around Australia. Over the course of the project, it is planned to develop and implement processes for delivering screening, to build capacity towards scaling up to a population-wide level for the whole of Australia.

An important part of this is to evaluate the psychosocial impacts, ethical issues, possible barriers to successful uptake, and health economic implications of the proposed program.

Screening will be conducted for couples. Both partners will be tested for almost 500 genes associated with severe disorders that affect children. Fortunately, the vast majority of couples tested will be at low risk of conceiving a child with one of the conditions.

Some other very important aims of the project are to study the views of Australians regarding which genetic conditions should be included in carrier screening, and indeed their views on the program overall.

Perhaps most importantly, the project aims to undertake a comprehensive assessment of ethical issues and considerations at the heart of the screening program. The technology underpinning genomics is advancing at a dizzying pace, far beyond society's capacity to keep up.

To assist in the field of ethical endeavour it is planned to develop interactive decision-aids for couples and their families, and educational resources for those caring for couples – doctors, midwives, nurses.

Couples who find they screen positive for conditions will need access to skilled and sensitive counselling.

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Disposing of Patient Files

BY CHRISTINE NEOU, AMA (ACT) WORKPLACE RELATIONS ADVISOR

Itís now 2018, and everything is digital. I haven't been back to Greece since 2013, but I've "seen" my auntie almost 50 times since then. I bank online, I sent my Mum a Mother's Day card online, I pay my bills online, the app store emailed me my receipt on online, and I catch up on missed lectures through the University's online lecture recordings.

But, things weren't always electronic – there's some stuff I still need do the "old way." I hand write my university notes, I file them receipts in my inappropriately expensive Kikki-K folders and I love the feeling of ticking things off my to-do list. And for doctors with "old school" paper filing, there's something you might need to know about disposing of these files under the *Health Records (Privacy and Access) Act 1997* (ACT).

When to destroy?

As a medical practitioner, you are a 'record keeper' – that is, an entity that has possession or control over a health record.[1] Generally, you are unable to destroy these records;[2] however, you can under three conditions:[3]

- If the destruction is required or allowed by ACT law; or
- If the allotted amount of time has passed – for **adult patients** at the time the information was collected, it may be destroyed 7 years after the last day of service provided to that patient. For patients **under the age of 18** at the time the information was collected, it may be destroyed the day the consumer turns 25 years old; or
- If an electronic copy[4] of the record has been generated. Scanning of records should be of sufficient quality to allow a complete and legible hard copy to be reproduced from the electronic copy. It is also recommended that you create a back-up for your digitised record, as technology can be just as much a foe as it is a friend.

How to destroy?

You must dispose of the medical records in a manner the preserves the confidentiality of your patients. It is your duty to take reasonable steps to destroy health information, making it permanently deidentified.

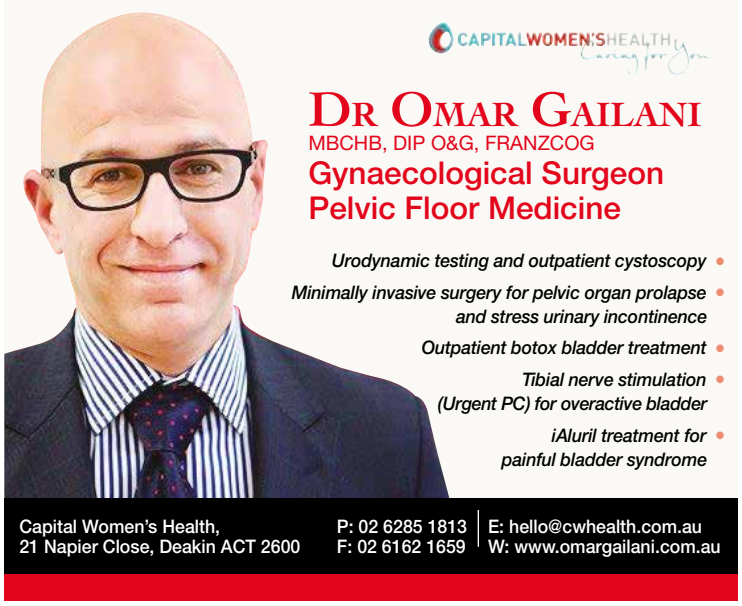
What happens next?

But, your recording requirements don't stop there – once you have destroyed any medical records, you must keep a register of what was recorded for a further 7 years. The register must identify:

- The consumer to who the record relates; and
- The period of time the record covers; and
- The date the record was destroyed.

For further information or assistance please contact AMA (ACT) on 02 6270 5410 or wradvisor@ama-act.com.au

1. *Health Records (Privacy and Access) Act 1997 (ACT) s 4.*
2. *Ibid sch 1 4.1(1).*
3. *Ibid sch 1 4.1(2).*
4. *Electronic Transactions Act 2001 (ACT) s 8(2).*



Mackenzie's Mission... *continued*

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The testing is very easy – the decisions are hard. Likewise, to avoid a genetic apartheid, it is absolutely critical that equity of access is at the heart of the Mackenzie's Mission. Access to testing and the resources demanded to support it must be available to every Australian, no matter their circumstances.

Life matters

As the sole obstetrician on the formal leadership group for the Project, I feel both excited and overwhelmed. Seldom in our professional lives are we placed in a position that carries such responsibility and expectation. Yet also it is invigorating to work with such an incredible team.

Any emotions I might have are embarrassingly feeble in comparison to those of Rachael and Jonny Casella, though. Any impact I might have is puny compared to theirs.

"Life is important," says Rachael. "Things that I used to be 'overly passionate' about are now in perspective. This doesn't mean I don't have passion for life, I just feel now that my passion is different. It is focused where it should be."

Quotes in this article are taken from an interview with Rachael Casella published in *The Delivery* on Sunday, 18th March this year. The entire extraordinary interview is accessible at: https://thedeliverymag.com/mackenzies-mission/

Federal AMA on budget: safe and steady, bigger reforms to come

The Federal AMA has characterized the 2019 Commonwealth Health Budget as "safe and steady" that outlines a broad range of initiatives across the health portfolio with some of the bigger reforms and the biggest challenges yet to come.

AMA President, Dr Michael Gannon, said "the Government has provided some necessary funding to aged care, mental health, rural health, the PBS, and medical research, with many decisions directly responding to AMA policy."

Dr Gannon said that, due to a number of ongoing major reviews, this Budget is notable as much for what is not in it as for what is in it.

"There are many significant and worthy announcements, but the bigger structural health reform announcements are yet to come," Dr Gannon said.

Major announcements

"The major reviews of the Medicare Benefits Schedule (MBS) and private health are not yet finalised, and the ensuing policies will be significant.

"We are pleased that indexation has been restored to general practice and other specialty consultations, but new and considerable investment in general practice is missing.

"Also, the signature primary care reform – Health Care Homes – did not rate a mention.

"The Stronger Rural Health Strategy is a very positive package and will go some way to improving access to doctors for rural and regional Australians.

Dr Michael Gannon.

"Public hospital funding is consistent with the COAG National Health Agreement. However, as pointed out in the AMA Public Hospital Report Card, more funding will be needed over the long term.

"This will involve the States and Territories doing their bit to work with the Commonwealth to increase the funding to appropriate levels.

"The Government is to be congratulated on its ongoing commitment to medical research, and for its positive contribution to improving Indigenous health, especially eye health, ear health, and remote dialysis.

Greg Hunt, Federal Health Minister.

"The investments in aged care and mental health must be seen as down-payments with more attention needed in coming years and decades as community demand drastically increases.

"We need to see a more concerted approach from the Government in prevention. We need to keep people fitter and healthier and away from expensive hospital care."

GP Workforce incentive

Dr Gannon said that the AMA also supports the establishment of the Workforce Incentive Program, which will incorporate and expand on the existing Practice Nurse Incentive Program and the GP Rural Incentive Program.

"This new funding program will increase the support available for general practices to employ other health professionals, including non-dispensing pharmacists, as part of a GP-led team-based approach to care."

Summary

Dr Gannon said the Government has correctly identified many of the areas of greatest need in this Health Budget, but the reality is that even greater funding will be needed to ensure long-term sustainability of the pillars of the health system.

"Good health policy is an investment, not a cost," Dr Gannon said.

"We look forward to the finalisation of the private health and MBS reviews, and the reforms that will flow from those processes.

"We expect to see any savings from the MBS Review reinvested into the MBS in the form of new and improved items in a transparent way.

"We anticipate more significant health policy funding announcements ahead of the next election," Dr Gannon said.

Guidelines spell out how much exercise older Australians need to support ageing brains

A new set of guidelines aimed at Australians aged 60 and over, who have noticed changes in their memory and cognitive abilities, recommends how much and what type of physical activity these seniors should undertake for improved brain health.

Research led by University of Melbourne Professor of Psychiatry of Old Age Nicola Lautenschlager shows older people should, in consultation with their doctor, engage in:

- 150 minutes of moderate aerobic activity or 90 minutes of vigorous activity every week
- Progressive resistance training twice a week
- Activities that help improve and maintain balance

Professor Lautenschlager said older people who regularly participate in physical activity experience health benefits such as improved cognitive outcomes, physical health and physical function.

"Many older people with cognitive impairment or decline lack confidence to start or increase their physical activity," Professor Lautenschlager said.

GP is the first stop

"Starting with a very small amount of activity then increase it gradually is recommended. Also, doing physical activity with someone else and choosing something fun can help to stay active and makes getting started less daunting."

Professor Lautenschlager said research into how physical activity affects brain health was relatively young and many details about the underlying mechanisms remain unknown.

"Current evidence suggests that physical activity can protect the brain through indirect effects, such as by lowering the blood pressure and increasing heart health or through direct effects, such as stimulating activities of nerve cells via release of specific chemicals directly in the brain.

"So many countries already had guidelines for healthy people of all ages, but these Australian guidelines are the first of their kind as they are specifically for people who have noticed changes to their memory and cognition with aging and are therefore at increased risk to develop cognitive decline or dementia in the future," Professor Lautenschlager said.

The guidelines, funded by Dementia Collaborative Research Centres, are available at: https://medicine.unimelb.edu.au/__data/assets/pdf_file/0005/2712884/PA-Guidelines-layversion.pdf

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Dr Katherine Gordiev
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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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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/

And the list goes on – finding the clinical gold

BY DR ANTONIO DI DIO, AMA (ACT) PRESIDENT

First things first. Crazy Guido did it again this morning. Leaning forward, head still like a Rodin genius thinking up a rebuttal of chaos theory, he finally spoke. Looking at the bowing from damp in the roof at our house he said ominously "It'll cost ya. Roof's old, house is old…worried about the saggy bits – you know. Lotta probs we could meet along the way". He went out to his ute, which was neither old nor saggy but had a satellite dish and what looked like a 24-carat roo bar, and wrote me a quote for the job.

Peter Finch in Network.

An hour later, while Guido was still writing page 9 of the quote, I was at work chatting to a busy young man about his cervical mass (problem 5 for this particular visit). This was interesting enough, but I was still writing notes about the difficult rash around his malar area with recent onset of arthropathy (problem3) as he was describing his neck. Just as I was typing something like "small eruption non-vesicular" – bashing keys with four fat fingers fast as I could so I could get to problem 4 (small inner lower conjunctival lesion, ectropion maybe? – will have a look when I jump up and do the examination bit) he said "yeah, and dad got the lymphoma a few years back".

Jack

Polite young man that Jack is, he wants to take up as little of my time as possible. Consequently, he describes 10 minutes of a wide variety of symptoms, a trait clearly inherited from his grandmother, who will die one day, at least 80 years later than she is constantly predicting. In his haste not to waste my time, Jack just keeps jumping from one symptom to the next, like a recording from Hell's waiting room. Unfortunately, this means that I'm racing like a loon to write it all down, examine him, make a diagnosis, formulate a plan – the little things. Jack thinks he's helping me by being quick.

He takes up a minimum of my time, he thinks, by talking – the rest of it is my indulgence. One day, when the Peter Finch Network nervous breakdown happens to me at last, I will attack Jack with the box of patient "lists" my colleague Dr Purls has secreted under her desk next to the bottle of Pymms Extra Fruity For The Lady Seeking Discreet Befuddlement. Until then, clinical radar goes up – neck lump? Dad lymphoma? Sorted. And off we go. Referral, admission. Fix it.

GPs are good value

When did this happen to us? When did general practice become a race through lists? Did you know that in 2018, a female GP at the 75th centile of incomes, earns after costs the grand total of $67 per hour? For a male it's about $74? And that a single patient encounter at a walk in centre is … ahem … a well documented number many multiples greater than $37.05? I think the numbers are connected. I think there's a very good reason why my GP colleagues are the lowest paid faux geriatricians since Methuselah's doc started bulk billing people over 300. I look at our appointments and see the simple stuff disappearing. No more coughs and colds, sprains and pains, tums and bums. The things we saw briefly enough to "catch up". Everyone has a complex list. You mourn the loss of the general physician? Look in the mirror, my GP friend – it's you!

With a national increase in GP numbers, home doctor visits, walk in centres, and a variety of important workforce issues, the traditional family GP remains under siege. To continue to survive we spend as much time with our patients as we can and provide the best possible service, we don't charge anybody with a story, and we keep paying higher practice costs and staff wages. And that $37.05 has stayed the same since 2014. I love Jack, he's a great kid – he goes elsewhere for coughs and colds because he will get bulk billed, and comes to me with a long list of ailments when he is worried. It is a massive compliment and I treasure it while, at the same time, it demonstrates the stupidity of my business model. I'm not here to get rich. I'm here for Jack. But to stop going completely gaga, I'm in the AMA, fighting for all doctors who want to practice good medicine and actually make a living.

Help wanted

Jack returned two weeks later with a bottle of something stronger than battery acid and a thank you card. He looked great and the chemo had started already. He knew he would be ok. As he left he was so grateful he wondered if I could see his other grandma as new patient. She was old, her bones were old, she had a hundred things wrong that the people at her clinic didn't have time to see her, and she was sagging everywhere. And Jack said she had no money so … you know, would that be ok with me? I smiled as he left, put the bottle under Purls' desk (she was actually down there quietly rocking back and forth, gave me a nice wave), and went to an AMA meeting to work advocating for my buddies in the profession.

I left Guido to close the surgery – he was measuring up to fix a leak (did you know Rolex made Tape measures? Go figure), muttering "looks like a lot of work – it'll cost ya…"

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ACT Health rural internship opportunities

ACT Health and Southern NSW Local Health District (SNSWLHD) have developed a unique opportunity for Junior Medical Officers (JMOs) to complete all, or part of their Internship, in a rural location.

SNSWLHD and ACT Health say that rural hospitals provide an excellent environment for JMOs to learn quickly, develop a varied skill set, be exposed to a broad array of medical conditions, and get hands-on experience during the first year as a junior doctor. They say, it is a great asset to a resume to demonstrate flexibility, responsibility and a broad range of procedural experience. Additionally, the opportunity widens supervisory networking relationships for employability in the future.

ACT Health and SNSWLHD

The Rural Internship Program will provide:

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For further information, please contact:

Medical Officer Support, Credentialing, Employment and Training Unit ACT Health

P: 02 6244 2779W: health.act.gov.au/employment/medical-officer-training-and-recruitment/interns

ANUMS RCS SENSW Rural Training Hub

P: 0477 932 327E: rcs.hub@anu.edu.au W: www.facebook.com/ANUMSRCSHUB

AMA Hospital Health Check

If youíre a junior doctor working in the ACT, keep an eye out the AMA (ACT)ís upcoming Hospital Health Check survey. The data gathered from the survey will be used to provide hospitals in the ACT with grades and overall ratings in five different domains. These are:

1. Overtime and Rostering
2. Access to Leave
3. Wellbeing
4. Education and Training
5. Morale and Culture

This is an opportunity for ACT DiTs to voice their concerns, opinions and experiences within the ACT public hospital system. We encourage as many of you to complete this survey in order for us to be able to express your concerns and to address ways in which we can assist you in improving them. The higher the participation rate, the higher the accuracy.

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Federal Budget makes changes to Bonded Medical Places

The Bonded Medical Places (BMP) Scheme is an initiative implemented by the Australian Government to provide more doctors to locations that need qualified medical practitioners.

Of the first-year Commonwealth Supported Places (CSP) in Australian medical schools, 28.5 per cent of students were expected to be bonded through the BMP Scheme each year, beginning in 2016. These programs are now being overhauled as part of the 2018-19 Federal Budget announcement, affecting all new participants from January 2020.

2018 Budget changes

The changes are said to offer more certainty and flexibility in how Return of Service (ROS) obligations can be satisfied and standardise conditions for bonded medical graduates by:

- The introduction of a standard three-year return or service;
- ROS eligible locations to include Modified Monash Classification areas 2-7 and outer metropolitan Districts of Workforce Shortage;
- Up to 50 per cent of prevocational and vocational training in ROS eligible locations can count towards ROS obligations, with the remaining 50 per cent required post Fellowship;
- Where Fellowship is not achieved within 10 years of internship, the remaining balance can be completed in a non-specialist role;
- ROS can be served in three-month blocks, including in the post Fellowship years;
- Scaling in ROS according to rurality will continue;
- Compliance with ROS requirements will be managed through a web-based portal, avoiding some of the administrative problems currently encountered;
- Bonded graduates will have more options to work in 'ineligible' areas during their ROS period.

The Government also agreed to establish a more transparent process for assessing requests for special consideration due to a medical condition.

AMA's role

The AMA, in conjunction with the AMA Council of Doctors in Training (AMACDT), extensively lobbied for these changes through the formation of a Bonded Medical Graduate Working Group. The AMA will continue to draw on the advice of this Working Group to inform the ongoing negotiations with the Department of Health (DoH).

Existing Bonded Graduates

Existing BMP and Medical Rural Bonded Scholarships (MRBS) participants are able to opt in to these new arrangements, even if they are part way through their ROS requirements. Existing graduates may even find they have already completed their obligations under the new reduced length of ROS and will be eligible to exit the program. MRBS recipients' current twelve year 'Medicare ban' will be cut back to 6 years, though this could be avoided given the additional flexibility announced in the Budget.

Where to from here?

Telephone lines will be re-instated shortly for bonded medical graduates to provide better assistance and more timely advice to participants. The AMA has pushed for an earlier commencement date for these reforms; however, DoH is unable to do so due to a range of considerations. In the interim period, bonded graduates will continue to comply with their current contract arrangements.

AMA (ACT) appoints a new Workplace Relations Advisor

AMA (ACT) has appointed Christine Neou as a Workplace Relations Advisor.

Christine writes:

My name is Christine Neou and I am the new Workplace Relations Advisor at AMA ACT. In conjunction with Tony Chase (Manager, Workplace Relations and General Practice), my role has a focus on junior doctors including:

- Supporting the ACT (AMA)'s Council of Doctors in Training;
- Providing individual advice and representation to AMA (ACT) members;
- Assisting in the negotiation of industrial agreements;
- Producing regular communications to junior doctors including social media;
- Providing support for DiT events in the ACT;

I have a bachelor's Degree in Human Resource Management, a Graduate Diploma in Secondary Education and am one semester away from completing a Bachelor of Laws (Honours). I have a keen interest in Workplace Relations issues, having tailored all my Law electives to suit an Employment Law major.

I have worked for the last four years as a Business and Legal Studies teacher in various Canberra schools and was part of the Staff Wellbeing team at Canberra Girls Grammar School. As a team, we were able to implement workplace benefits that looked at reducing early career teacher burnout and addressing the turbulent nature of the teaching profession.

My interests include dance classes, remedial massages, binge watching TV series, cooking with my grandmothers, spending time with my family and attending live sports games.

I look forward to meeting many of you and giving you the information and support you need as you progress through your medical careers. My contact details are:

Phone: (02) 6270 4515
Email: wradvisor@ama-act.com.au

Psychiatrist's $64,000 discharge error

BY DR PETER WALKER, MBBS, BSC, GENERAL PRACTITIONER AND SENIOR RISK MANAGER, NSW AND PAUL TSAOUSIDIS, BA LLB, HEAD OF PRACTICE ñ LEGAL, AVANT LAW, NSW, AVANT

A court has found a psychiatrist breached their duty of care to a patient for the injuries she sustained in a car accident while driving home following discharge from the hospital.

The patient alleged that at the time of her discharge, she was excessively tired and/or sedated and should not have been permitted to drive home. She claimed the psychiatrist and admitting hospital's negligent conduct had caused her to lose control of the car and sustain personal injuries.

In reaching its decision, the court considered a range of evidence from the psychiatrist, hospital, witnesses, experts, as well as medical notes and letters.

Ultimately, the court found the psychiatrist and the hospital each liable for negligence, and apportioned responsibility between them. The hospital and the psychiatrist were ordered to pay the patient $32,167 and $64,333, respectively, plus costs.

The case highlights the risks when discharging patients potentially under the influence of sedating and psychoactive agents, and the importance of conducting and documenting a careful assessment before allowing any unattended patient to drive home.

Car accident following discharge

The patient was a woman with a background as a registered nurse, who had been terminated from her job due to absences because of back pain following a work accident. She visited her GP complaining of depression and feeling suicidal and was admitted to an acute hospital's mental health unit for about a month. She was then admitted as a voluntary inpatient, to a private hospital under the psychiatrist.

During her admission, which lasted another month, she suffered both insomnia and daytime tiredness. She was taking multiple psychoactive drugs including antidepressants, opiates and other strong analgesics as well as Stilnox at night.

During a consultation the day prior to the patient's discharge, the psychiatrist assessed her readiness for discharge in relation to her mental state. The patient was able to assure the psychiatrist she was no longer suicidal and the psychiatrist authorised discharge for the next day.

On the morning of discharge, the patient took her regularly prescribed OxyContin. Prior to discharging her in the afternoon, a nurse completed a driving risk assessment and then returned the patient's car keys so she could drive the 50 kilometre journey home. Unfortunately, the patient drove off the road and into a wall, quite close to home.

She was taken by ambulance and treated at an acute hospital for her injuries, including pain in her neck, head, shoulder, lower back and leg. She was then re-admitted to the private hospital under the original psychiatrist, where she remained for another month.

Court's findings

The court heard in the days prior to discharge, the patient was often excessively drowsy and would fall asleep even while sitting eating meals. On the day of discharge, the patient had again fallen asleep over breakfast. Nursing staff had tried to wake her on several occasions, but she kept falling back asleep.

The court noted medical records from the hospital in which staff had reported the patient appeared

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over-sedated and drowsy. The nurse's risk assessment completed at the time of discharge, also stated, "reports tiredness lately – Psych aware".

Given the "overwhelming evidence", the court found the patient was tired, drowsy and sedated upon discharge.

The court concluded the car accident occurred as a result of the patient falling asleep due to tiredness, fatigue or excessive sedation.

Psychiatrist's grounds for negligence

While the psychiatrist conceded the scope of their duty of care extended to reasonable care of treatment, they sought to deflect liability on the basis of s50 of the Civil Liability Act (CLA), claiming they had acted in a manner which at the time was widely accepted in Australia by peer professional opinion as competent professional practise.

In determining the psychiatrist had breached their duty of care to the patient, the court noted they had granted the patient permission to drive her car and was the sole person with control over whether the patient drove. Based on hospital protocol, staff could only give the keys to the patient with the psychiatrist's permission.

The court accepted the patient's evidence she had expressed concern to the psychiatrist about driving due to drowsiness, to which the psychiatrist had responded, "you should be fine to drive."

The court found that at no stage during the consultation before her discharge, did the psychiatrist discuss how she would travel home. Furthermore, the psychiatrist admitted they left the decision up to the patient as to whether she was fit to drive.

The psychiatrist was also found negligent by failing to review the patient or enquire about her condition on the actual day of discharge, despite her observations of the patient the day before discharge and personal knowledge of the patient's sedation, as evident in the records and other correspondence.

Hospital breaches duty of care

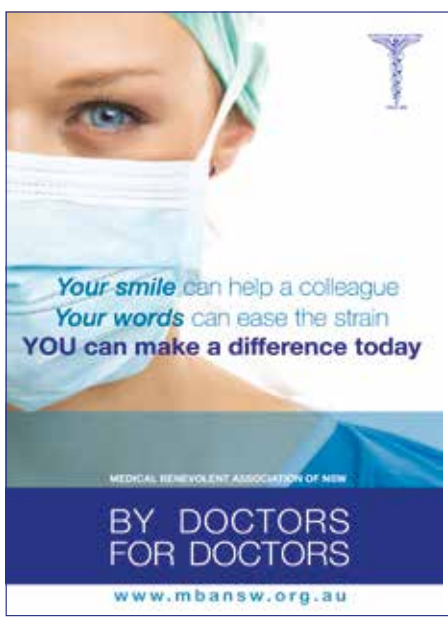
The hospital argued they had relied upon the fact the psychiatrist had authorised the patient to drive, as well as the patient's own assessment of her capacity to drive and knowledge of the effects of the medication, given she was a registered nurse. The court rejected these defences.

The hospital was found to have breached its duty of care to the patient for permitting her to drive following discharge in circumstances where she was unfit to drive.

Key lessons

- Doctors and hospitals have a responsibility to carefully assess the safety of their patients being discharged from their care. This includes identifying suitable arrangements for transport home and may require prolonging admission if no arrangements can be organised.
- Doctors should remain aware of the risk of excessive sedation of patients taking psychoactive agents, especially in combination, and carefully assess their risk for harms. In preparing patients for discharge it is good practice to carefully review their use of sedating medications and other risky agents warranting special advice. This of course extends to showing caution when prescribing sedating medication in the community including sleeping tablets, strong analgesics and psychoactive agents, and adequately warning of the risks.
- Doctors should always carefully document their assessments of patients, especially in higher-risk contexts such as transitioning from care. It is important to record the relevant positive and negative findings which would justify discharge and to outline the discussed options and agreed plan.

If you need further guidance, call the Avant Medico-legal Advisory Service on 1800 128 268.



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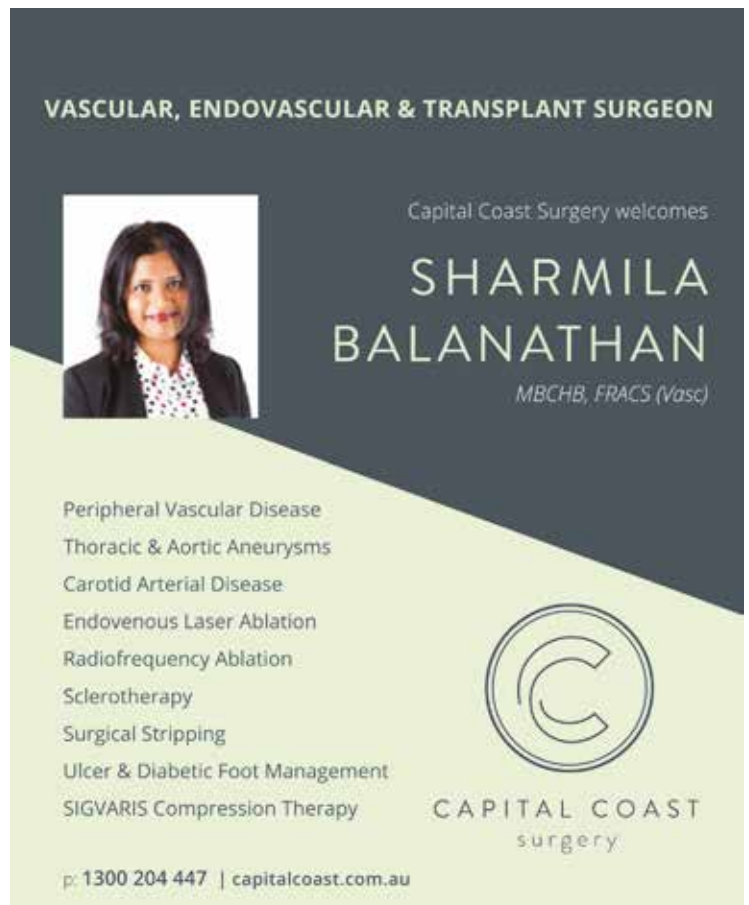
Provides a free and confidential support service to Canberra doctors in need and their family. Financial assistance and counselling support are available to colleagues who have fallen on hard times through illness or untimely death. Support is also available to medical practitioners who may be experiencing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



Insurance premiums on the rise

BY RUSSELL PRICE, DIRECTOR AT SPECIALIST WEALTH GROUP

Have you had an increase of life insurance premiums over the past year or two? If so, youíre not alone. Life Insurers across Australia have imposed premium rate increases at an alarming rate over the past few years, to the detriment of their policy holders.

Some Insurers have increased their premium rates as high as 30% (plus increases for age & inflation), leaving their clients with little alternative other than to absorb the increases, cancel or reduce their cover. Others have increased their rates twice in the short period of 2 years. With more insurers announcing in the past few months of upcoming rate hikes.

The cause for the significant increases cannot be put down to any one reason however the fact is that most Insurers are seeing an increase in claims. As a result, they need to remain profitable with significant losses in the industry.

What can you do?

While you it's difficult to avoid insurers increasing their rates, you can look to limit the increases on your own policy. This means setting up the right policy early on by means such as Level premiums.

A Level premium starts off more expensive but does not increase with age – remaining 'more level' over time. For younger policy holders, who have the intention of keeping their policies long term, the savings can be significant.

A good Financial Adviser will make sure they take the time every year to review your policy and ensure your cover is adequate – as an example, if it has been a few years since your cover has been reviewed, you may find your mortgage or debts could be lower than what they once were. Therefore, considering less insurance may be appropriate to your circumstances and a good way to reduce costs over time.

There's also ways to hold some insurances within superannuation to further reduce your out of pocket costs.

Many insurers are now also encouraging their customers to live a healthy and active life by rewarding them with discounts on all their insurance for doing so.

Review regularly

If you have a life insurance policy which has seen recent increases, you should have your policy reviewed by a professional. You may be able to save a significant amount of money by doing so and at the same time, improve on the policy definitions and features.

Specialist Wealth Group specialises in providing financial advice and personal insurances for medical professionals. Most of our clients who are doctors are very time poor and haven't given much thought to their old policies, often set up many years ago, potentially outdated and rising in costs unnecessarily.

In addition, the life insurance industry continues to change with new competitors in the marketplace and existing insurers merging; there really is no better time to check the cover that you have is right for you.

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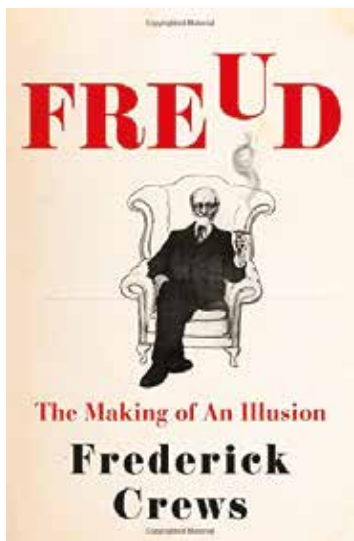
Mini book reviews:

REVIEWED BY ASSOCIATE PROFESSOR JEFFREY LOOI, ANU MEDICAL SCHOOL

FREUD: THE MAKING OF AN ILLUSION – Frederick B. Crews

Metropolitan Books, 2017.
ISBN-13: 978-1627797177

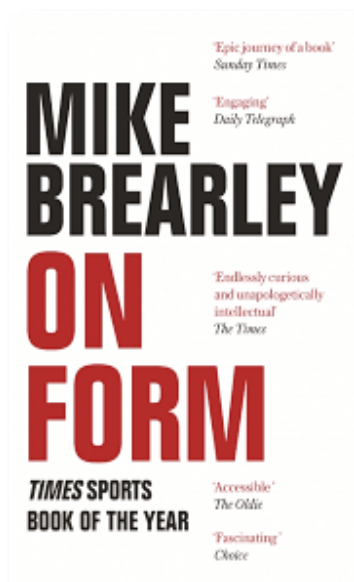
This self-admittedly trenchant critique of Freud's life, career and development of psychoanalysis is founded on previously unavailable personal correspondence between Freud, his fiancé/wife and other intimates in his circle. Crews describes Freud's earlier life, university studies, extended medical school studies and research into histopathology. Freud's immense drive to be successful socially, intellectually and materially despite numerous setbacks, is depicted vividly. Through Freud's own words and those in his circle, the serpentine course of development of psychoanalysis, which forms the basis of the much more variegated psychodynamic psychotherapies, is documented. This is harrowing view behind the curtain of conventional Freudian psychoanalytic history.



ON FORM – Mike Brearley

Little Brown, 2017.
ISBN-13: 978-1408707357

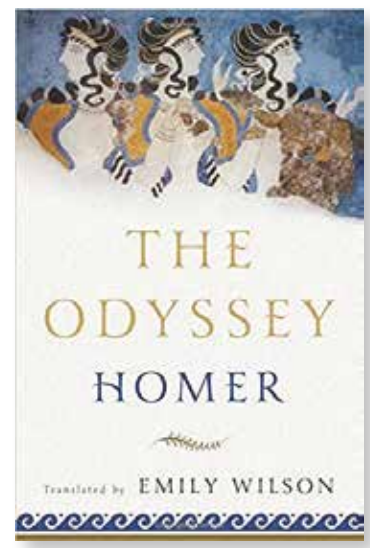
Mike Brearley, distinguished former English Cricket Captain, and now practicing as a psychoanalyst, goes in to bat, so to speak, in discussing the concept of "form" in sport and professional practice. Drawing chiefly on his experience in cricket, as well as a smattering of other sports, he appears to attempt to relatively unconvincingly draw down on psychoanalysis to understand the mechanisms of form, while seeming to be unaware of, or discount, some research into expertise and expert performance in sport (pioneered by K. Anders Ericsson). The latter part of the book appears to drift off-form, into espousing the universality of psychoanalysis in understanding life in general, and away from sport and professional practice.



THE ODYSSEY – Translated by Emily Wilson.

W.W. Norton and Company, 2017.
ISBN 978-0-393-08905-9

Emily Wilson, Professor of Classical Studies at the University of Pennsylvania, has authored a lyrical iambic pentameter translation of the Odyssey in modern English. The oral traditions of the epic are evident in the repetitions of phrase describing key characters and rituals, whilst the action and reminiscence of Odysseus's travails are vibrantly staged. Whether referring to the flashing eyes of Athena, the hideous six-headed Scylla, the youthful forlorn Telemachus and the simmering anger of Odysseus against Penelope's suitors; the gods, monsters, heroes and villains are alive in this beautifully crafted and presented epic poem.



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Dr Deepa Singhal
FRANZCP, FRANZCP (child certf), FRACP, DCH
Paediatric Neurodevelopmental Psychiatrist
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Canberra Child Psychiatry Centre

Dr. Deepa Singhal is also working as 'Consultant Child and Adolescent Psychiatrist' in The Canberra Hospital.
Dr Singhal's special interest includes Neurodevelopmental Psychiatry and working with children with complex mental health presentation including ADHD, ASD, Intellectual disability, Tourette Syndrome and similar presentations. Family therapy is her other special interest area.

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