Canberra DOCTOR
Informing the Canberra medical community since 1988
March/April 2005
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When the doctor becomes the patient!

On Monday 31 January 2005, Canberra anaesthetist, Dr Ray Cook (and member of the "CANBERRA DOCTOR" editorial committee), suffered a stroke! Ray's usual role was as provider of care to patients and as a result of the stroke Ray found himself on the receiving end of his colleagues' care. The experience of being the patient was not one with which Ray was familiar. Ray's stroke/hospital experience diary follows.

SUNDAY 30 JANUARY

"Sunday. I had a TIA. Onset in bed – one hour after awakening. As always in retrospect, easy to diagnose, but when taken to Calvary by ambulance with my anxious diagnosis of an allergic reactions, my symptoms were poorly described, my signs were poor.

"Improving by the afternoon – I went home.

MONDAY 31 JANUARY

"But awakening the next morning I had a recognisable vertical nystagmus, an unstable gait and more significantly parasthesis left hand and foot – face was OK. In addition, on opening both eyes, a gyrating nystagmus. So off in the ambulance to Calvary again.

"The ambulance crew on both occasions was excellent. I received a swift and painless cannulation. Met my old foe – the plasticiser – in the oxygen mask. If you've never met it, attach a new oxygen mask and turn the oxygen on and smell. All my registrars have had to. On this occasion it induced vomiting in me.

"Then I met the Frontline Innovations vomit bag.

"Vomit bowls in hospitals and ice cream containers in cars should have become redundant. I kept mine as a security blanket for the next two days until my nystagmus settled.

"So Monday, I had another stay in Casualty at Calvary. I live just five minutes away. The attention and care I got was tremendous and I hope that all patients receive the same level of attention of care and that I was not getting "special" treatment because they were looking after one of their own. In any event, it was good to know that we care for our own.

"I got a very thorough neurological exam – then a wait in the new clinical decision unit (CDU) just off casualty where it was quieter. It was explained that I was too late for thrombolysis but I would be transferred to the new Stroke Unit where I had access to rehabilitation – another ambulance ride that I have little recall of. This was the result of the combination of stemetil and closed eyes to avoid the nauseating effects of nystagmus and weariness from previous events on top of a stressful week.

TUESDAY 1 FEBRUARY

"I remember little of Monday afternoon and Tuesday in the assessment unit as I slept most of the time between observations. I recall adequate explanations of a foreign world, frequent observations, the difficulty of voiding – even using a commode.

"The Unit seems to combine the functions of an assessment unit and a high dependency unit. There is amazing heavy lifting gear there. I still have concerns for the nurses' backs, however, when they are forced to support unstable but independent patients. The nurses worked very hard when I was there. Like all nurses, they run well on chocolate. My thanks to those who kept me well supplied.

"By Tuesday morning I could manage slight movement in my left little finger with nothing else below elbow or hip; the nystagmus was still there for a little longer. One gets deep and dark thoughts.

WEDNESDAY 2 FEBRUARY (my birthday!)

"Dramatic improvements on Wednesday – a transfer to a private room, a visit to the gym – sitting opposite a less successful craniotomy I'd recently anaesthetised.

THURSDAY 3 FEBRUARY

"By Thursday morning, return of all movements – though some were weak.

"The CT scan done early on at Calvary was a minor event. Slight claustrophobia made the MRI a major event. I am slightly built carrying perhaps an extra five kilos.

Dr Raymond Cook.

Arms across the chest with the "escape warning" bulb in one hand. My head was put in a cradle, jammed in with foam, then a mask – like a welder's helmet but with clear glass – pulled across the face scant inches beyond that – the tunnel into which one is fed! Not unlike the shell and cordite being loaded from a cradle into the breech of a naval gun, I think.

"My pulse, I am certain, reached 200 and I forced images of our view from the verandah behind my closed eyes. A total of two hours in that tunnel and my BP went up again.

■ *continued page 2*

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ACT AMA President's report

What's in a title

Recently a member wrote in complaining of a referral he received from a paramedical which was all quite normal except for the printed caption at the end which said "referring doctor". I wonder if this is an honest mistake on a pre-written template, or a very unsubtle misleading statement by the paramedic. As I complained previously in a report, we are now constantly seeing various paramedical groups attempting to compartmentalise medicine and consider they can be "doctors" in their own area. For example we see suggestions of pharmacists in rural areas treating depression, which not only trivialises the condition, and they are not trained to deal with this sensitive issue. Pharmacists should receive training to recognise the signs of depression, and suggest a visit to a GP. Everyone wants to be a doctor but not take the responsibility incumbent on decisions. The workforce shortage of GPs is not helping by making it more difficult for patients to see a doctor in a reasonable time, but is not solved by circumventing the process, by adopting a piecemeal approach to medical care. The roles must be complementary – not competitive.

The Royal College of Surgeons has responded to the call and by the federal government for more qualified surgeons in Australia by increasing the number of training positions. This comes at a cost to the public health care system where trainees must receive the stipulated exposure and teaching to maintain the standards of their training. This increases the pressures on an already strained system, and the possibility of the private system providing some patient exposure has been raised. In fact the Medical Specialist Training Taskforce has expressed the firm belief that the support of state health jurisdictions was essential to the success of this proposal to expand medical specialist education into private clinical settings. Locally it's important to maintain the required standard of the increased accredited positions, otherwise the loss of such positions will be much harder to regain.

Private patients in public hospitals

In the ACT are only 3-4 % of patients who are privately insured elect to go private when presenting to the public hospital, and well below the average, when compared to approximately 15 per cent uptake in other regional areas. While the public hospitals would like to see this proportion increase, patients in Canberra are pragmatic and in most cases realise there is no significant benefit to go private as opposed to remaining a public patient. As one of the mature doctors in Canberra, we remember the private floor at the old Royal Canberra Hospital which worked well in conjunction with the public hospital. There has to be some tangible benefit such as a separate ward and access to operating theatres in an acceptable time from presentation. Obviously this should not impede the normal triage of emergencies for operating theatres, and would have to involve increased staffing to cope with the demand.

Indemnity & tort law reform

A recent report by the ACCC shows some falls in the average medical indemnity premiums. These are signs that the Government's medical indemnity reform package of 2003 and state tort law reform are having the desired effect. These reductions apparently are coming more from the higher premiums which still remain well over $100,000 for some speciality groups. While it is encouraging to see some reduction in the increasing costs of indemnity premiums, we would look forward to a downward trend in premiums across all medical specialties.

Pharmacy Guild & AMA

The recent criticism of the Pharmacy Guild by Federal AMA President Bill Glasson produced some interesting responses. The main point being the anti-competitive rules allowing only pharmacists to own pharmacies. The Guild's reply was confusing, saying "if doctors could buy pharmacies they might prescribe needless drugs to their patients to boost their own profits", and "some doctors owned or had shares in diagnostic imaging businesses – creating the potential for a test being ordered not because patients needed them, but because the doctor was making a business decision." Needless to say, we need not be reminded by such ludicrous statements of our ethical responsibility in treating our patients, and HIC regulations preventing such behaviour.

Dr Charles Howse

New AMA fellow

On behalf of the ACT AMA I wish to congratulate Ian Pryor on his award on being accepted into the AMA Roll of Fellows. This is recognition for his long service to the AMA at a local and federal level and thoroughly deserves this important accolade. This award will be presented to the other approved nominations at the forthcoming AMA National Conference in Darwin at the end of May.

When the doctor becomes a patient... continued

■ from page 1

"Another day at the gym. Physios look after the leg and balance walking. Occupational therapy: the arm and cognition. All of this in one room in one session. A little crowded but it does allow one to see patients with varying degrees of inability progressing. A most useful, friendly and supportive environment with excellent staff. Physios also make the assessment and control patients' freedom of mobility around the ward and hospital. A useful and necessary safety precaution. That day a patient who had had major back surgery declared to the room: "that's my anaesthetist, he had a stroke!"

FRIDAY 4 FEBRUARY

"By late Friday – almost ready for discharge. But the emotions couldn't cope and the BP was still poorly controlled.

SATURDAY 5 FEBRUARY

"How quiet the hospital is at the weekend. I had forgotten! Theatre is always busy when one comes in then – after all that is why one has been called.

MONDAY 7 FEBRUARY

"Home! First thing – well midday – again the differences between theatre and physicians' work practices are apparent.

REFLECTIONS

- I was lucky!
- I was lucky to have such a wake up event
- I am lucky to have such caring colleagues
- I was lucky to be treated in the stroke unit

COMPLAINTS AND CRITICISMS?

Do I have any complaints or criticisms? None. The staff, ambulance, casualty, stroke unit, gym, X-ray and porters were all professional and caring. The food I ate was good and I've paid a fortune for food nowhere near as good at conferences. It was great to have a room with a view.

DID I LEARN FROM THE EXPERIENCE?

- Always order the fresh fruit and not the desserts which are akin to those on the airlines (soft, smooth, sweet and sticky)
- Nurses are at the busiest, giving patient care, in the first four to five hours in the morning, commencing around 6 am. The afternoons are less hectic. The admitting of all patients at 7 am is hardly efficient.
- Ceiling-mounted lifting devices should be available over every bed. They are a cable winch-mounted on ceiling rails – rather like the devices used for years in garages and factories. As nurses are ageing and patients getting bigger, the need for them becomes an imperative.

CANBERRA NEUROLOGIST COMMENTS ON RAY'S EXPERIENCE

Former ACT AMA President, of Dr Colin Andrews, who has written – "I must admit I enjoyed Ray's account of his illness. I do recall seeing Ray in his rapid recovery phase in the Rehab unit we have on the 9th floor at The Canberra Hospital. His spirits were certainly very good for someone who has just gone through a small stroke.

The new stroke unit is certainly making a difference to stroke outcome.

Stroke units – there have been many controlled trials – are cost effective and also shorten the length of stay and there is a small improvement in mortality and improvement in disability after stroke.

Ray mentioned the possibility of thrombolysis. I thought I would make the medical population more aware of the importance of this and I have enclosed our "Ischaemic Stroke Thrombolysis Protocol", the inclusions criteria and exclusion criteria are highlighted. (Copies available from the TCH Departments of Neurology, Imaging, Pharmacy and emergency Medicine)

I note that Ray's TIA occurred on Sunday 30 January. It may not have been recognised as TIA but in principle we like all TIAs to be seen by a neurologist the same day or the next as often TIAs can be the presentation of an impending stroke.

Coincidentially, we have been informed that the University of Newcastle is offering new web-based postgraduate studies in stroke management. The new course is being offered across eight disciplines to graduates of medicine, social work, speech pathology, nursing, occupational therapy, physiotherapy, dietetics and psychology. The studies are solely web based. They are offering three areas of study and full details are available from the university by phoning Lorna Davin, Manager, medical professional development, school of medical practice and population health on 02 4921 4852 or 0437 370 951.

As a result of the stroke, Ray has retired from anaesthetic practice and his colleagues, Linda Weber and Vida Viliunas are coordinating a testimonial dinner to celebrate the career of Dr Ray Cook.

In the company of guests of honour, Dr Ray Cook and Mrs Diane Cook

You are invited to a dinner…

To celebrate the career of Dr Ray Cook and to mark the occasion of his retirement

at

The Lobby Restaurant From 7 p.m. On Saturday 30th April, 2005

Please include $100 per person with RSVP, and advise of seating preferences.

Please write cheques to "The Lobby Restaurant" and mail to PO Box 9533, DEAKIN 2600 by Friday 22nd April.

Contacts:
Vida Viliunas 0413 057 113
Linda Weber 0417 487 677

POST SCRIPT! from Dr John Donovan, member of the "*Canberra Doctor*" editorial committee:

Ray Cook's account of his stroke reminds me of something I have intended to do for 30 years, but never done. So can I expect you to accept my argument that when we discover something we should set it down for others to read? Perhaps I am not a good exemplar.

Thirty years ago I had thyroid surgery. The operation went well and I returned to full consciousness in the ward. The time came to sit me up for the first drink. A nurse grabbed each arm and pulled me up. Nobody, myself included, remembered that the strap muscles had been cut, so my head fell back onto the pillow. Most disconcerting, to say the least.

So I think nursing texts should show how to move the thyroidectomy patient. Donovan's method is to roll the patient onto his side, IV apparatus uppermost. Flex the hips so that the knees and lower legs hang over the edge of the bed. Then roll the patient upright using the lateral side of the thigh as a fulcrum. The patient can help with his free arm.

Easy, isn't it.

Canberra Doctor seeks your suggestions for improvement of medical practice. Nothing is too unimportant. Please send your suggestions to the Editorial Team, c/- ACT AMA. The editorial committee will select the best and announce the prize winner in the December edition of "*Canberra Doctor*".

ACT AMA immediate past president admitted to the Roll of Fellows of the Australian Medical Association

Dr Ian Pryor.

Dr Ian Pryor, immediate past president, has been admitted to the Roll of Fellows of the AMA. The AMA Federal Council, at its recent meeting, admitted nine members of the Association who have contributed to the organisation and their profession.

Dr Ian Pryor was born in Werribee, Victoria in 1947 and studied medicine at the University of Melbourne from where he graduated in 1970.

Dr Pryor was in the first intake of students at the Austin Hospital clinical school and in the first group of newly graduated doctors to undertake residency at the Austin. Following his residency in Melbourne, which included the first rotating residency program for aspiring general practitioners. Ian spent the next 13 years in general practice in Echuca. During his time in Euchuca he served three terms as mayor of the municipality.

In 1985, Dr Pryor came to Canberra to work on health policy in the Commonwealth Department of Health and Community Care but in 1988 decided general practice was what he really wanted to do and following a period in a shared practice, Dr Pryor opened his large Tuggeranong Square Medical Practice in 1992.

Dr Ian Pryor first joined the ACT AMA Branch Council in 1990, retired in 1992, was re-elected in 1996 as Treasurer, a position he held until 2000. In 2000 Dr Pryor was elected as President Elect and assumed the Presidency in 2001, a position he held until May 2004. It was during Dr Pryor's Presidency, that the UMP precipitated "medical indemnity crisis" threatened the delivery of medical services to children and young people in the ACT. Dr Pryor's leadership, political nous and determination delivered tort law reform in the ACT. The key features of the new legislation included a reduced statute of limitations and a modified-Bolam principle test.

Dr Pryor headed the ACT AMA team through renegotiation of VMO contracts in 2002 following enabling legislation in the ACT Assembly to provide for collective bargaining by notified "bargaining agents". The VMO contracts currently in place have provided excellent terms and conditions for ACT private specialists contracted to the public hospital system.

Dr Pryor has been a contributor to the ACT AMA since 1990 through many and varied roles including Treasurer, President and currently as Convenor of the "*Canberra Doctor*" committee. In addition to being an active member of Branch Council, Dr Pryor is a member of the Aged Care; Membership and Finance; and, Medico-Legal Committees of Council as well as the ACT AMA GP Forum.

During his term as President – and Federal Councillor – Dr Pryor was a member of, and contributed to the several following Federal Council committees. These include the Finance Committee over a period of three years; Economics and Workforce Committee over two years; and, Constitution and Policy Review Committee. Dr Pryor was a strong protagonist for the development and instigation of an incorporated arm for commercial activity by the AMA and continues to serve the Federal AMA as a member of AMACom – having been appointed in October 2003.

Dr Pryor has represented the views of the ACT AMA and Canberra general practitioners on the AMA Council of General Practice on many occasions over the years since1996 and prior to the advent of the AMACGP was ACT representative to to the National Association of General Practitioners of Australia (NAGPA) during 1990-91.

Dr Pryor was awarded the Inaugural ACT AMA President's Prize in 2000 by retiring President, former Federal Councillor and Fellow of the AMA, Dr Robert Allan. This Award recognises individuals who have made a significant contribution to the profession in the ACT as well as to the Association.

Dr Pryor represents many of our local doctors who quietly and tirelessly work to improve the well-being of patients and, at the same time contribute to their professional association and the wider community.

Government providing funding for injectable polio and chickenpox on Australian standard vaccination schedule

The replacement of oral with injectable polio vaccine will enable the use of a new six-in-one combination vaccine – Infanrix Hexa – that provides protection against diphtheria, tetanus, pertussis, hepatitis B, Haemophilus influenzae type b and polio. This new combination vaccine means that many infants will receive one less injection at 2, 4 and 6 months of age, potentially making the whole immunisation experience simpler and less stressful for infants, parents and doctors.

These two new vaccinations will be funded under the National Immunisation Program and will commence on 1 November 2005. Chickenpox vaccine will be offered free to all children turning 18 months of age. In addition, children aged between 10-13 years who have not received chickenpox vaccine or who have not had the disease will be eligible for free vaccine as part of a long-term catch up program.

The move to these new combination vaccines was endorsed last year by the Federal Government's expert medical advisors – the National Health and Medical Research Council – and the vaccines are already being used in other countries.

‘Gammon’s law’

London, England, 2005

The following is an edited version of an article by Dr Max Gammon printed in the February edition of the Australian Doctors’ Fund newsletter in February. “Canberra Doctor” thanks the ADF for permission to reprint it here.

For the past fifty years a disorder has been slowly but surely destroying our medical services in Britain. I say destroying our medical services rather than destroying the National Health Service, because it is the National Health Service itself which is the destroyer, involving the progressive

displacement of productive activity by non-productive and often counterproductive bureaucratic activity.

Bureaucracy is not synonymous with administration. By bureaucracy I mean a rigid system of human organisation governed by fixed rules and excluding individual initiative. By administration I mean the guidance and facilitation of an enterprise. And this should be the very opposite of bureaucratic. The tragedy of the NHS is that it is inherently bureaucratic and imposes the bureaucratic mode of operation on all who work in it.

When the NHS was established in 1948 we had 480,000 hospital beds. By the year 2000 the number had fallen to 186,000. This represents a fall from 10 beds for every thousand of the population in 1948 to 3.7 in the year 2000. It means that we often now have insufficient hospital capacity for prompt investigation and treatment even of emergencies. According to official statistics we have just under one million patients waiting for hospital admission. There is no margin for handling epidemics and admissions for elective surgery are frequently cancelled owing to lack of beds. In an attempt to deal with this state of constant crisis patients are now being sent to France and Germany for their operations. And still the number of NHS beds is falling

As for staff, the number employed by the NHS has more than doubled from 350,000 in 1948 to 882,000 in 2002. The greatest increase has been among designated administrative staff. Between 1997 and 2002 Senior Managers and Managers increased by 47.6% compared with an overall increase in the workforce of 16% (nurses increased by 1.8%) But these figures reveal only the tip of the bureaucratic iceberg. For example large numbers of nurses are now wholly engaged in management but are still counted as nurses.

We come to the heart of the matter.

Nearly thirty years ago I discovered a close correlation between the increase in the numbers of NHS administrative staff and the fall in numbers of NHS hospital beds over the preceding nine years. For statisticians: linear regression analysis showed a correlation coefficient of -0.99. For non-statisticians I should explain that this figure represents an almost perfect correlation between the growth in numbers of administrators and the fall in numbers of beds.

A statistical correlation, no matter how close, is not necessarily significant. However I suggested that this correlation could have an important explanatory value if the number of designated NHS administrators was proportional to the bureaucratic activity of the NHS workforce as a whole. The correlation of the growth in numbers of administrators with the fall in the number of beds would then follow from a progressive displacement of productive activity of all NHS staff by the proliferation of useless and often counterproductive bureaucratic activities throughout the whole organisation. In this way, an expanding workforce and increased spending would be matched by a fall in production; the more that was put into the system the less would come out of it, a process I likened to the implosion of a black hole.

Owing to a combination of circumstances that existed 30 years ago, I believe that I was given a glimpse of a deep mechanism that is usually concealed by ‘contaminants’ Those circumstances were:

- The very large size of the organisation which damped out the effects of local variables;
- A rigidly centralised structure;
- Absence of the distorting pressures of commercial viability; and
- Ignorance within the Department of Health of the significance of the statistics it was publishing.

The NHS had provided a huge ‘culture medium’ for the uncontaminated growth of bureaucracy, and the Department of Health had provided uncontaminated statistics to prove it.

Since that time, there have been two major underlying causes for the failure of various attempts to reduce bureaucracy and improve the performance of the NHS.

The first cause stems from failure to recognise that bureaucratic displacement is a disorder which is not confined to designated administrative staff; it involves all members of the organisation. Bureaucracy’s most destructive effects are due to its permeation and impairment of the activities of non-administrative staff.

An example is the progressive transformation of nurses from patient-centred carers to administroids whose requirement to produce detailed patient care plans and participate in workshops and seminars leaves them little time to attend to patients’ basic dietary needs or prevent them developing pressure ulcers.

The second major cause derives from the mechanical nature of bureaucracy. Its proliferation is not simply the product of individual empire building. Although a

bureaucratic organisation encourages, and is nourished by, individual self-interest, proliferation is inherent in the system itself.

No organisation is 100 per cent bureaucratic, but bureaucracy, relentlessly increasing, directly or indirectly, permeates, vitiates and displaces the productive activity of all members of the organisation. Stealthily lethal, bureaucracy slowly but surely kills.

Bureaucratic monsters arising among organisations whose survival depends upon their persuading customers to buy their products are sooner or later destroyed or dismembered by their competitors. However, in a protected environment, shielded from competition, a bureaucracy will grow indefinitely and approach ever more closely the black hole state, in which externally supplied resources are entirely consumed by its furious internal activity. And this is what is happening in the NHS.

By contrast, within non-bureaucratic organisations, continuous ad hoc procedural adjustments are made on personal initiative rather than imposed by remote directive. If successful, these local adjustments are likely to be more generally adopted. If unsuccessful, they are usually eliminated without widespread damage. The efficient non-bureaucratic organisation has a Darwinian internal economy involving a process of natural selection and survival of the fittest procedures. Such organisations may be described as ‘sensitive’ or spontaneously responsive to internal and external stimuli. An essential component – the motor – of such systems is the dependence of their survival on their performance. Sensitivity to external stimuli transmitted throughout the system, rather than centrally prescribed rules and directives, is what ultimately drives and governs individual performance in the non-bureaucratic organisation.

By contrast labyrinthine systems of ‘monitoring’ and the setting of targets – with penalties and rewards – is characteristic of bureaucratic organisations attempting to improve performance. As was notoriously demonstrated in the Soviet Union and as we are now finding in the NHS, centrally imposed targets cause systemic distortions and rigidities that further impair performance and also, inevitably, lead to falsified statistics and the coercion of those tempted to reveal the truth.

The British National Health Service is an experiment which has failed. The cost of this failure to patients, to the medical profession, to the nursing profession and the to profession of Hospital Administration is beyond calculation. But the experiment will not have been in vain if others learn from its example not to repeat it.

Notice for ACT AMA members

The annual general meeting of the ACT Branch of the AMA will be held on Wednesday 11 May 2005 commencing at 7pm.

The meeting will be held in the conference rooms on the third floor of AMA House, 42 Macquarie Street Barton.

Futher information will be distributed to members in the near future.

Any questions can be directed to the executive officer/company secretary – Christine Brill on 6270 5410.

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Next edition of *Canberra Doctor* – May 2005

VALE! Matthew Davey

It is particularly sad when one of our youngest and brightest die unexpectedly. "Canberra Doctor" extends its sympathies to Dr Davey's family and friends at this sad time.

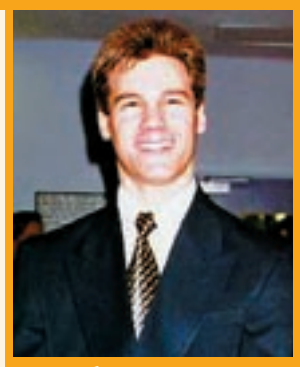
Matthew Davey as born in 1973, graduated with a Bachelor of Science with First Class Honours from the ANU; his majors being mathematics and neuroscience. He won the University Medal and the Tillyard Prize from ANU and during the time of his studies was an exchange student at the University of California at Berkeley.

He was a talented young man. Before studying medicine, Matthew Davey was senior resident/tutor in physics, mathematics and psychology at John XXIII College ANU, leader of the Australian delegation to the International Biology Olympiad in Utrecht, The Netherlands, tutor in mathematics and engineering physics within the Faculty of Information Sciences and Engineering at the ANU, tutor in Mathematics in the Department of Mathematics and Statistics at Flinders University and visiting fellow at both the Centre for Visual Sciences, ANU and Department of Neurology and Neuroscience, Cornell University Medical College, New York.

He graduated BM BS from Flinders University, South Australia in 2000.

He spent his intern and RMO years at The Canberra Hospital and was, up until his death, an intensive care registrar.

Health Minister, Mr Simon Corbell, in paying tribute to Dr Davey said he was an exceptional young man of amazing talent who would be sadly missed by those who knew him.



Dr Matthew Davey.

"His dedication to both his role as a Navy reservist and his core role with ACT Health is inspirational," he said.

Mr Corbell said it was obvious to all who met him that Dr Davey was an exceptional medical officer. "I am told that, not only was he very bright, but also good fun to work with," he said.

"He was a hard worker, dependable and always happy to help out. His appraisal reports and personal testimonials from those with whom he worked indicate that he was an outstanding young doctor.

He had a commitment to his country, as well as to his profession and variously held the rank of Lieutenant in the Royal Australian Navy, having completed medical related courses – underwater medicine, rotary-wing aeromedical evaluation course and the medical officers' nuclear, biological and chemical defence course.

He had a commitment to community which he realised through St John Ambulance. He was active in a number of organisations on a voluntary basis. He also had a passion for paragliding and ballroom dancing.

Matthew Davey passed away as a result of a tragic accident whilst on military service in Indonesia assisting earthquake victims. Matthew Davey lived a short but eventful and fulfilling life and he will be missed by colleagues, family and friends.

Children's vision – early intervention

Research has shown that:

- Convergence insufficiency (poor near eye coordination) affects 5% of children
- Convergence insufficient is evident in up to 15-22% of children with ADD/ADHD
- Stabismus affects 3.5% of the school-aged population
- Amblyopia affects 6% of school-aged population
- Up to 20% of the school aged population have a refractive error (short or long sighted or astigmatism)

(information supplied by Orthopic Association of Australia Inc)

Canberra Melanoma Unit

In November 2003 a group of doctors intent on improving the management of melanoma in the ACT and surrounding region formed the Canberra Melanoma Unit (CMU).

The CMU was incorporated as a non-profit association within the ACT. The foundation membership was made up of general practitioners, dermatologists, surgical oncologists, a plastic & reconstructive surgeon as well as pathologists, radiologists, radiation and medical oncologists.

During my first year in Canberra as a Surgical Oncologist it became apparent to me that patients diagnosed with melanoma were being managed in a disparate fashion by individual practitioners both local and interstate without a coordinated approach to overall patient care. Local general practitioners, dermatologists as well as practitioners at the Sydney Melanoma Unit or other practitioners in Victoria were involved. This is not in any way a reflection of the quality of care locally and is more to do with the nature of the disease itself. Melanoma, like many other entities in medicine, is by its nature a disease requiring inter-disciplinary care. Follow-up for some patients may consist of long-term surveillance of cutaneous naevi whereas in other cases management of metastatic disease and palliation may be required.

An analogy may be drawn with breast cancer which is optimally managed by early detection and diagnosis in the first instance. This is practiced in the most expert fashion by radiologists with mammography being the main screening tool. In the case of melanoma early detection offers the opportunity of reducing the mortality due to this disease. Since melanoma initially presents as a cutaneous lesion it is the expertise of the dermatologist and general practitioner which makes early detection and diagnosis a possibility in the first instance. While tools such as dermoscopy (epi-luminescence surface microscopy of the skin) as well as digital monitoring systems which incorporate both macroscopic and dermoscopic images are useful adjuncts to increase the accuracy of diagnosis, good clinical acumen is still the mainstay of early diagnosis. It is particularly important if early detection is to be optimised that patient awareness and public education is also utilised. While patients are only too aware of the need to examine all their naevi on a regular basis once they have already had a primary melanoma, increased public awareness will be required for those patients potentially at risk to perform "mole self-examination" and be encouraged to report early changes.

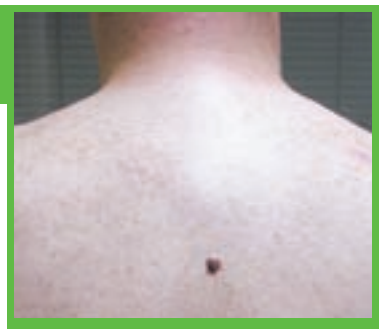
Once a diagnosis of melanoma has been made expedient access to definitive treatment (within 6 weeks) is essential. In most instances a wide excision, (with a local reconstruction, if required), is all that is necessary. In some cases where lymph node metastases are clinically present at the time of diagnosis regional node dissection is performed. Lymphatic mapping and sentinel node biopsy to detect microscopic nodal metastases at the time of diagnosis is currently best regarded as a prognostic and staging tool rather than a therapeutic one. It's role in the management of melanoma is still being defined and currently is the subject of large multi-centre trials.

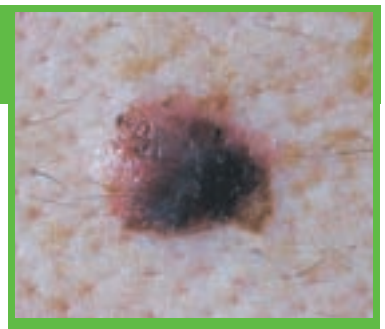
Unlike breast or colonic carcinoma, there is as yet no proven adjuvant treatment to minimise the risk of relapse in high risk patients with melanoma. For this reason several clinical trails are in progress. Because melanoma is a highly immunogenic tumour biological response modifiers and vaccines as well as novel targeted therapies and standard cytotoxic treatment are under investigation.

All eligible patients in the Canberra region are provided access to available trails via our links with the Sydney Melanoma Unit and the Peter MacCallum Institute. The Sydney Unit also offers an adjuvant radiotherapy trial. Highly specialised procedures such as isolated liver infusion is also under investigation.

Perhaps the most important element in the surgical management of patients with a diagnosis of melanoma is on-going support and follow-up. While there are several prognostic factors which may assist the practitioner and the patient in predicting the likelihood of systemic recurrence occurring in the future melanoma is still to be regarded as having a largely unpredictable long-term course. Follow-up, whether it be for high risk skin surveillance or for the patient at risk of developing metastatic disease will in many cases need to be life-long.

At a particular point during the course of a patient's illness any one of the following practitioner's expertise may be required: Plastic & Reconstructive Surgeon, Neurosurgeon, Thoracic Surgeon, Radiation & Medical Oncologist, Palliative Care Physician, Vascular Surgeon. Expertise in pathology and medical imaging is also essential. Specialised nursing care and allied health, eg in the management of lymphoedema, is also very important. No fully functioning melanoma unit would be complete without a clinical psychologist and liaison psychiatrist as well as other member of a supportive care team.





What does the CMU hope to achieve?

The main objectives of the CMU are to optimise patient care using a coordinated, centralised and cohesive approach so that all facets of care delivery can be managed seamlessly to minimise patient effort and inconvenience. There is no doubt that individually all the expertise required exists in Canberra and it is a coordinating body which is of tantamount importance. The CMU holds regular Clinico-pathological Meetings where all individual patients diagnosed with melanoma are discussed, their pathology reviewed and a management plan agreed upon. These meetings are currently held on a monthly basis. The CMU has also developed a patient database which prospectively accrues all aspects of the patient's management related to their melanoma. This will provide a basis on which future examination of the demographics of patients with melanoma and patterns of management can be examined. I believe that this will also benefit patients by optimising and standardising best practices as well as providing their care within the region to minimise displacement of patients interstate.

Further aims of the Unit are education of primary care physicians, medical students and the public in general. An Inaugural Forum for General Practitioners was held in November 2003 and further educational meetings for general practitioners are planned for later this year. There are also plans for an educational program within secondary schools prior to summer 2005/2006 to target school children at an impressionable age when modification of at risk behaviour (ie sun-bathing) is more readily achievable.

Research is also an integral part of the Unit and several projects are underway. In addition, clinical trials which are currently available through the Sydney Melanoma Unit and the Peter McCallum Cancer Centre in Victoria will be made available within the ACT region.

Private donations are currently the principal source of funding for the Unit and fund raising events such as free-mole checks have been very encouraging.

The CMU is currently working with the Calvary Hospital to provide a melanoma clinic which will initially focus on the detection and diagnosis of new melanomas and provide on-going surveillance with those patients at high risk of developing melanoma.

Membership of the CMU is intended to be inclusive rather than exclusive and any interested medical, nursing or allied health professionals are encouraged to join and share their expertise and experience. For further enquiries please call: 1300 789 268. Dr Peter Barry is the curre

GP support program

The GP Support program is an initiative of the Belconnen Community Service. This information service provides Medical Practitioners in the Belconnen region with pathways to connect their patients to support services in the community.

The Family Doctor continues to have a critical role in our community and can sometimes be the only person with whom people have contact outside their home.

However the demographics of our community have changed greatly over the past 10 years and many doctors have expressed a desire to have more appropriate and up to date information available to assist them with their patients' holistic care.

Doctors receive an information package of support and referral services including:

- Language interpretation
- Advocacy
- Home help
- Personal care
- Respite options
- Skills based rehabilitation courses
- Pathways for connecting patients to their local community.

The GP Support program is preventative medicine in action. It demonstrates the fine qualities of a community caring for its members.

Belconnen Community Service is pleased to be working in partnership with 60% of doctors practicing in the Belconnen region as a result of the GP Support Program.

Home and Community Care within the ACT Health Department and the Department of Immigration and Multicultural and Indigenous Affairs are associated with the ongoing development of this program.

For further information contact the Belconnen Community Service on 6264 0200.

Do you need a professional interpreter for your patients who need to speak languages other than English?

The Doctors Priority Line 1300 131 450 can help you

The Doctors Priority Line 1300 131 450 is a **fee free** telephone interpreting service to help doctors to communicate with non-English speaking patients. The service is available for eligible medical practitioners in private practice and can be accessed 24 hours a day, 7 days a week anywhere in Australia. Doctors in regional and remote areas are able to access the service as easily as those in metropolitan areas – all that is needed is a hands-free telephone. For the cost of a local call, doctors who phone the **1300 131 450** receive **priority access** to an interpreter within 3 minutes (for major community languages).

The free service can only be provided to a non-English speaking permanent resident or Australian citizen who is entitled to a Medicare rebate.

Doctors can use the line to access telephone interpreters immediately, or conveniently book a telephone interpreter for an appointed time.

1300 131 450 is dedicated solely to doctors.

Why use the Doctors Priority Line for interpreting?

The 1300 131 450 provides doctors with access to reliable interpreters who are bound by a professional code of ethics which requires them to:

- interpret information accurately and honestly without adding or omitting anything being said;
- maintain absolute confidentiality;
- be impartial and objective; and
- act in a professional manner at all times.

Patients too benefit from the interpreting service, as it gives them better access to health care and provides them with greater privacy when consulting with their doctor.

Risks that may be encountered from working with informal language aides or family members include:

- misrepresentation of the information communicated;
- distortion of family relationships, where family members are used as interpreters;
- lack of a confidentiality guarantee for the patient;
- significant legal implications, such as claims of negligence or inadequate service.

The Doctors Priority Line 1300 131 450 is an initiative of the Department of Immigration and Multicultural and Indigenous Affairs provided through its Translating and Interpreting Service (TIS).

Australian Government
Department of Immigration and Multicultural and Indigenous Affairs

Medical students reflect on a successful first year and gear up for the second

As the new cohort of first-year medical students arrive wide-eyed and enthusiastic, it is time to reflect on the year that has passed for the now second-year ANU medical students. It was a year of embarking on new adventures for both staff and students as the inaugural ANU medical school began its journey. The curriculum had a mixture of basic medical science combined with population health, ethics and the social foundations of medicine. The structure of the course reflected the changing nature of society and practice of medicine. The students relied on mini-formative exams held throughout the year to gain some understanding of the format of the summative exams that are held at the end of each semester. Feedback by students and staff, as well as open discussion, has formed the key to successful reinforcement and change.

The introduction to clinical medicine remains a popular aspect of our initiation into the field. As Dr Watson, Professor Bowden and the team began each Thursday morning with a snippet of a relevant and entertaining video, students found themselves learning the basics of clinical practice through innovative and contemporary ways. Venepuncture (initially practised on mannequins which bleed), setting up ECGs, cardiac and respiratory examinations all engaged the students, as we all aimed towards passing our first set of OSCEs. The essential tool of history-taking become second nature by the end of many hours of practice.

The academics were of course well balanced by a busy social schedule. The trivia night was a great mix of ANU and Sydney Uni students and some staff and as the night wore on, it was obvious that the advantage of life experience facilitated answering some of the questions (all non-medical). Social events such as the cocktail party and pub crawls were well supported, but the most successful event was the end-of-year Medical Ball. As students and staff danced the night away, the success of the night was a glorious end to a year of hard work.

So as each second-year ANU medical student embarks on a new year of challenges and hopefully rewards, our hands are extended in friendship to support the new cohort of students through formal mentorship programs as well as through the many social events and everyday mingling. We hope that our support will provide assist the new students reach the goal of entering their second year as medical students.

Devini Ameratunga
Gemma Dashwood

Liam Turner, Jessica Stuart-Harris, Deveni Armeratunga, Beth LaBrooy and Sarah Catford at the Ball.

Associate Professor Wayne Ramsey and Ben Piper at the Ball.

Bioethics from the Journals

with Dr Thomas Faunce

- The New Zealand National Ethics Committee on Assisted Human Reproduction (NECAHR) Guidelines on Preimplantation Genetic Diagnosis (PGD) have been approved by the Minister of Health. Fertility clinics will need to gain approval from NECAHR to offer PGD to patients. They will then be able to use PGD to test, according to guidelines, for disorders such as Haemophilia and Cystic Fibrosis.
- The TRIPS Council of the WTO, at its meeting this week, was unable to reach agreement on the "permanent solution" to the issue of Paragraph 6 of the Doha Declaration on TRIPS and Public Health relating to countries having no or inadequate drug manufacturing capacity.
  Article 31(f) of the TRIPS agreement specifies that the use of the subject matter of a patent without authorisation of the right holder (for example, compulsory license to produce) shall be authorised "predominantly for the supply of the domestic market." The Doha Declaration in its para 6 recognised that countries with insufficient or no manufacturing capacities that wanted to import generic drugs might have difficulties in finding supplies since the producing countries face limitations in exporting, as if they get a compulsory licence they have to supply "predominantly" for their own domestic market (Ip-Health March 2005).
- Of the many patient deaths caused by Dr Harold Shipman reviewed by Dame Janet Smith in her report to the UK GMC, that of Mrs. Renate Overton, a 46-year-old patient with asthma, became "emblematic of the failure of physicians to identify colleagues who were unfit to practise." At a home visit for an acute asthma attack, Shipman gave Mrs. Overton 20 mg of morphine either IV or IM in a single injection. The resulting cardiopulmonary arrest from which she was resuscitated and admitted to ICU left her in an irreversible coma; she died a year later. That Shipman had administered a contraindicated drug in a lethal dose was known by the senior physicians in charge of the ICU; it was never reported, nor was Shipman questioned (Canadian Med Assoc J, March 2005)
- Christchurch School of Medicine in New Zealand has included a dress code in its medical student handbook after complaints from Elder Care Canterbury. "They were concerned about seeing far too many tummy buttons and the hipster trousers with the G-string out the back," said former Elder Care Canterbury facilitator Gill Coe. Especially the registrars – they all seem about 16 or 18 anyway. If you want to be taken seriously by older people, you would be wise to dress in a professional manner," she said. The updated handbook advised medical students that patients could be uncomfortable with piercings, casual clothes such as shorts and sandals, midriff-exposing tops and long hair on men (The Press 16 March 2005).

Dr Thomas Alured Faunce
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Lecturer ANU Law Faculty
(Health Law, Ethics and Human Rights)
Senior Lecturer ANU Medical School
(Chair: Personal and Professional Development)
Ph: 61253563

Conscription not the solution for Rural Doctor crisis

The nation's rural doctor crisis was a major agenda item on the Australian Medical Students' Association (AMSA) National Council Meeting, which was held recently, in Western Australia.

AMSA President Mr Dror Maor said; "As medical students, we are very concerned about shortages of doctors in rural areas and the impact it has on rural communities. The AMSA Council has discussed the problem at length and has now released its Rural Clinical School Policy – a blueprint for the future of medicine in rural areas."

This meeting involved the Executive of AMSA, Deans of medical schools, Medical School Presidents from across Australia and numerous other stakeholders in the medical profession.

According to Mr. Maor, "rural-bonded places or involuntary conscription of medical students to RCSs are not the way to create more rural doctors. Conscription reinforces a view that medical education in the rural setting is not an attractive option and the sooner universities and the governments realise this, more medical students and junior doctors will want to attend rural areas."

It was found through a Rural Clinical School Survey conducted by AMSA that the Rural Clinical Schools were a very useful initiative and allowed for an opportunity of quality medical education in a rural setting at the sites which students were not forced into going."

"However, it must be said that medical students from certain medical schools are simply not happy with the standards that have been offered to them by their medical schools when allotted rural placements for a length of time."

"Our survey indicated that those students forced to go where less likely to ever come and practice in a rural area as doctors" Mr. Maor said.

Mr. Maor stated that governments must realise "that an investment in medical education is an investment in Australia's future."

Some highlights of the policy include:

- Removing automatic conscription of medical students if certain quotas are not met
- Improving accommodation and computing access to medical students
- Incentive to be provided such as job opportunities for partners to enable a smooth transition
- Educational forums, information evenings and seminars to better inform medical students about rural life.

These issues along with others were voted upon and passed at the Council Meeting. A copy of the entire rural clinical school policy is available from Mr John Ding, the Public relations Officer of AMSA.

ACT workcover – OH&S and dangerous substances ACT compliance

The ACT AMA has received a letter from the Office of the Occupational Health and Safety Commissioner advising that Workcover Inspectors will commence issuing infringement notices in relation to breaches of the Occupational Health and Safety Act1989 and Regulation (OHS Act) and the Dangerous Substances Act and Regulation (DS Act)

This has been perceived as a warning to comply with the regulations, given that St John Ambulance has just recently had a surge of clients from Industry across Canberra, hastening to comply.

In this brief article the emphasis is on aspects of OH&S compliance and doctors and practice managers should refer to the ACT Workcover site for further information on compliance under the two pieces of legislation referred to above:

http://workcover.act.gov.au and http://www.legislation.act.gov.au

Type of workplace

The ACT First Aid in the Workplace Code of Practice defines workplaces under three categories: Group A, Group B and Group C. It is apparent from the code that medical practices generally would fit into the Group A or Group B categories.

First Aid kits

Irrespective of the categorisation of the workplace, there is a requirement to have a basic First Aid kit and there needs to be employee awareness of procedures to be followed when First Aid is needed..

The contents of the kit are specific according to the Group with additional modules for specific hazards; eg needlestick injuries and body fluid spills.

Arrangements must be made for access to appropriate emergency or medical treatment. The kit must be clearly accessible, signposted and looked after by a designated person, and reasonably restocked.

Hazardous substances used e.g. Na hypochlorite solution in the practice should have copies of their Material Safety Data sheets located near the First Aid kit with sufficient recommended material for treatment of mishaps

First Aid personnel

First Aid personnel should be responsible for rendering First Aid and in small workplaces where there is a specific hazard a First Aid service may be needed.

Employers should ensure that in any workplace First Aid personnel are immediately available and/or on call at all times when employees are at work, subject to specific requirements of the Code.

In workplaces where the principle activities do not present a significant risk of injuries or diseases through normal workplace practices" there does not appear to be a necessity to provide a First Aid person; however, the minimum numbers of First Aid personnel may need to be increased, depending on "the nature and specific hazards of the work"

Thus while there are no specific requirements for a trained First Aider, it would not be inappropriate to have one, in that although the code of practice refers only to 20+ employees requiring at least one First Aid person it is assumed that to fulfil a duty of care, one First Aider should be provided in any workplace with under 20 employees.

The recommended levels of First Aid training as provided by St John Ambulance or the Australian Red Cross Society are a senior First Aid certificate if rendering First Aid, or occupational First Aid certificate for employees responsible for a First Aid room. Recognition of Prior Learning e.g. doctor or nurse or previous certificate from any RTO may mean that only a Refresher Course is needed. It is probably preferable to repeat the Senior First Aid, as they can both be done in a day face to face (certainly with St John after studying the new CD-ROM for Senior First Aid)

Complying with the Dangerous Substances Act has been referred to above in relation to Material Safety Data sheets located near the First Aid kit, one would also for example need a Spills Kit to cope with potentially infected body fluids, a review of any hazardous substances stored and used on the premises is necessary together with enough substances to treat mishaps.

A number of organisations can provide help with these requirements. St. John Ambulance uses its commercial activities to support its charitable work among the less privileged of the community e.g. street kids, remote aboriginal work – as well as the familiar First Aiders at sports and events, most support stays in Australia with a small amount going to help an eye hospital in Jerusalem.

It is the responsibility of an employer to provide a safe workplace for employees and visitors to the workplace (i.e. patients plus escorts).

It is suggested that you refer to ACT First Aid in the Workplace Code of Practice and the relevant acts, but be aware that the former at least is poorly worded.

To the Training Manager St. John our thanks

Letter to the Editor

Editor

I read with interest your article on TCH accreditation on page 11 of the February issue of *Canberra Doctor*.

John James Memorial Hospital (JJMH) was re-accredited shortly after TCH and obtained a full four-year accreditation having met all of the nineteen mandatory criteria at a Moderate Achievement level or higher. The new process is very rigorous in regard to safety and governance issues but ACHS is generous in assessments where an institution may have recognised deficiencies but has in place action plans and remedies within a realistic timeframe.

While some 66% of health services have only achieved a two-year accreditation it is disappointing that TCH, Calvary Public and ACT Community health all only achieved a two-year accreditation. This is particularly so given the size of the ACT investment in specialised quality units with annual salary costs collectively exceeding $1m per annum. The private sector has relatively few specialised quality units but involves most of its staff and doctors in the EquiP programme to achieve better overall outcomes than the public sector. Furthermore, it does so with the cooperation and support of its visiting medical officers who are not even employees.

The medical community probably should be seeking reassurance that the ACT is addressing its public institution deficiencies and seek the action plans of public institutions in critical areas.

I enclose a copy of the recent Clinicians Guide to Improving Safety and Quality of Care with EquiP including at page 10 the consolidated 19 pass/fail criteria.

Phil Lowen – CEO, John James Memorial Hospital

Securing GPs for the ACT

An article in the "Canberra Times" recently reported that a contract between the ANU and City Coast Training was critical to training and retaining doctors in the ACT and region. The two-year agreement provides for training GP registrars in south-eastern Australia and the ACT.

The ACT has one of the lowest number of GPs per capita and had vacancies for about 40 full-time doctors, the article continued.

The rural and Community Clinical School of the ANU Medical School will be involved in supporting and training the medical students, hospital medical officers and GPs in training. ANU Medical School Professor of General Practice, Marjan Kljakovic said "this meant the doctors might stay in the community after completing training."

City Coast Country Training (CCCT) has called for Expressions of Interest from medical practices interested in continuing as or becoming involved in the provision of GP Registrar education.

CCCT is the provider of The Australian General Practice Training program for Southern NSW and the ACT, covering the area of six Divisions of General Practice: Illawarra, Shoalhaven, Murrumbidgee, Riverina, SE NSW and ACT. CCCT has been training GP Registrars in the region since January 2003 utilising practices previously accredited by the RACGP.

To meet future training needs and ensure that interested practices have the opportunity to participate in the program, Expressions of Interest inviting practices participation for the period 2006 to 2008 have been sought.

For further information, contact Fran Trench at City Coast Country Training on 02 69335205 or by email at ftrench@ccctraining.org

Federal AMA President quacks for health care!

The AMA judges the success or failure of health policy by five tests, AMA President, Dr Bill Glasson said recently: Independence, Quality, access, Affordability and Choice – IQAAC or I quack. And, he said, I tend to quack a lot.

Dr Glasson was speaking at the federal Parliamentary breakfast and said that health is still a major political battleground. And health issues now also reflect the mainstream issues of the day: infrastructure, skilled worker shortages, access to services and affordability of services.

The AMA has been talking about these issues for years in relation to the health system. But now they are being talked about as the fraying edges of the fabric of Australian society.

The AMA's budget submission this year applied those five tests to a few key areas of health in urgent need of assistance.