Canberra DOCTOR
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In the second of a series on Canberra's hospitals, this month we feature Calvary Hospital Bruce campus

A number of projects occurring at the Calvary Bruce campus will expand Calvary's role in both ACT public health and hospital services and high quality private hospital care.

Calvary Health Care ACT Chief Executive Officer, Karen Edwards, is excited to see that almost 40 years after Calvary opened its doors the Bruce campus will realise the dreams of those who planned the facility in the mid 1960s.

"Work is well advanced on a 700 space car park that will open at the end of this year. With parking and access issues resolved, work can continue on projects to expand the capacity and activity within Calvary public and private Hospitals.

"The car park enables Calvary to progress the construction of a stand-alone private hospital at Bruce. This new private hospital will feature world class clinical and hospitality services and provide contemporary models of care, whilst retaining the compassionate and patient focussed service for which Calvary is so well known and respected in our community.

Karen Edwards.

"The opening of the new private hospital will allow the existing private beds in the Calvary Xavier Building to be repatriated into the public health system.

"Some of our sub-acute services will also relocate to the hospital at the University of Canberra when it opens, thereby increasing capacity for new and existing acute care public health services at Calvary.

Calvary Public Hospital provides public health and hospital services for the ACT Government. This arrangement is governed by the Calvary Network Agreement (CNA), which formalises, through annual performance plans, the funding to Calvary and the level of activity to be performed.

The CNA commenced in 2012 and replaced a number of older contracts and agreements that originated in the 1960s and preceded self-government in the ACT.

According to Karen "the Agreement provides an excellent governance framework for the management of health services by the ACT Government and Calvary for the people of the ACT. However, the greatest strength of the partnership between the Territory and Calvary is a shared philosophy and commitment to providing people in need with timely access to safe and high quality healthcare services.

"In achieving this, I am very keen to integrate an episode of 'hospital care' with a patient's primary care, generally managed by their General Practitioner or Specialist and often involving other agencies and community based service providers. We need to make significant progress in this regard, through better communications with primary care providers and mutually developed and agreed care plans.

…Continued page 3.

Capital Conversations with President, Dr Elizabeth Gallagher

Welcome all to the mid Autumn, April edition of Canberra Doctor.

I am writing this column from Yulara near Uluru in the Northern Territory at the beginning of a short break touring my favourite places in Australia. Its 38 degrees outside and I am reminded how quickly the temperatures are dropping, and how quickly the leaves are changing back in Canberra.

Departures

There have been a number of breaking stories in the past few days. Firstly, and sadly, after 32 years of service (nearly half her life she tells me) our illustrious CEO Christine Brill has announced her retirement. No words can describe the role that she has played or the experiences she has had over the many, many years of service to AMA in the ACT. The amount of corporate knowledge she has accumulated and the contacts she has made, are irreplaceable and she will be sadly missed. But of course – at some stage after all those years, we did have to let her go into retirement! So now starts the daunting task of finding a new CEO to start in August as Christine winds back to spend time for herself and her family. Much thanks to her, and I am sure we can spend some time reminiscing over her long career in a later edition of Canberra Doctor, before she finally dances off into yonder.

Congratulations to the medicare local

The Federal Government has finally announced that the ACT Medicare Local has won its tender to become the ACT Primary Health Network. I look forward to working with their Chair – Dr Martin Liedvogel and maintaining the strong relationship we have had over the years with the Medicare Local, and the Division of General Practice before that. We hope together we can develop and support a stronger primary health care system in the ACT.

AMA Hospital Report Card released

The AMA Hospital Report Card has been released this week. This reports on 6 key areas of health delivery in our public hospitals, particularly relating to Emergency Department waiting times and elective surgery waiting times. It is not great news for our Public Hospitals Australia-wide although some states are doing better than others. No state was able to meet the National Emergency Access Target where 90% of Cat 3 (urgent) patients are seen within 30 minutes. Although the ACT had a minor improvement, it is still well behind even the national average of 70% with only 50% of local patients being seen on time. Again although the ACT had a slight improvement overall in elective surgery waiting times, we are still behind where we need to be to meet the 2016 target, and our patients are still waiting more than 10 days longer than the national average for all categories of surgery. More disappointing is that there has been a fall in the number of Category 2 patients being treated on time and this was the category that ACT Health was concentrating on trying to improve in 2014. Back to the drawing board I think! This report card is concerning as federal funding of public hospitals is not going to keep pace with what is needed to help the states improve services and provide quality care to our aging population in the years to come.

VMO contract negotiations to commence soon

Contract negotiations for VMOs are due to start in August of this year. One of the bug bears over the years has been the requirement to get nominations from 50 VMOs to get a guernsey at the negotiating table. There is often a last minute scramble and confusion with a number of VMOs doubling up and others not realising they need to formally put in a nomination for their preferred bargaining agent. This takes time away from the important job of negotiating! We have had legal advice late last year that as we have been appointed in the past, our nomination stands until it is revoked. This is more satisfactory and we are happy to stand with our legal opinion. Our understanding is that the Health Directorate has had similar advice.

Medicinal cannabis

I recently appeared on behalf of AMA (ACT) before the ACT Legislative Assembly's Standing Committee on Health, Aging, (Cannabis Use for Medical Purposes) Amendment Bill 2014- Exposure Draft and Related Discussion Paper. (What a mouthful!) They were hearing submissions from a number of interested community groups and government representatives regarding the legislation proposed last year by Greens member Shane Rattenbury. I reiterated our stance that while we support the possibility of legalising the use of medical marijuana in the context of a nationally regulated approach to a consistent and controlled product, we cannot support the legislation as proposed locally. The findings and recommendations will not be released for a number of weeks yet.

President elect needed for AMA (ACT)

Finally, I have a request. I am now nearly half way through my term as President. As yet, the position of President Elect is still vacant on the board. I cannot tell you what an honour it is to serve in this position, and would love to have one of our financial members put up their hand and help me through the next year! The year prior to taking on the big role was very important in setting the scene, learning the ropes, and making the contacts so that the transition to President was smooth. We are looking for expressions of interest, and would highly recommend the role as a change from clinical medicine.

On that note, I am heading out to watch the sun set over Uluru…

PS: An updated fees gap poster is enclosed with your Canberra Doctor this month.

Canberra's hospitals...*continued*

...From page 1.

"Calvary's Specialist Community Palliative Care Services delivered from Clare Holland House provides a model of how this can be achieved. Since the new Palliative Care model commenced last year, our palliative care patients and their primary care providers have reported improved and more convenient and effective services, and far fewer occasions of delays and disruptions to their treatment and care regimes.

"Calvary will continue to expand and enhance our treatment of patients in the 'non-acute or non-hospital' setting. We have increased our Hospital In The Home (HITH) program, we continue to extend our Outpatient Clinic services, and are working closely with Calvary's Community Services to treat patients in their residential location when that is a safe and effective way of managing their treatment and recovery.

"With so much recent population expansion occurring in North Canberra and Molonglo, in the immediate and longer term future Calvary will be the most accessible health and hospital service for a significant proportion of the community.

"In partnership with ACT Health we are continuously reviewing and refining the services that should be offered at Calvary to ensure we are able to meet this growing need. Quite obviously Emergency Services, Maternity and General Medical and Surgical services can be efficiently offered at both major public hospitals.

"Many highly specialised services are only available at Canberra Hospital, and it would be impracticable to think that these can or should be replicated at Calvary. The capital costs of doing so would be prohibitive, and it would be difficult to spread the existing and required clinical expertise across two services, this is where and when networking services across the Territory becomes necessary.

"At Calvary we are doing some really good things – we are seeing more patients through our emergency department and undertaking more elective surgical cases, our waiting times to treatment for both emergency and elective admissions has improved significantly – I believe Calvary's strength is our capacity to provide consistently safe and high quality care delivered by good people. I invite all primary care providers, General Practitioners and Specialists, to contact me and take a brief tour through Calvary.

"You may be interested to see our clinical teams model working in the ED; meet our stroke service and medical assessment and planning unit teams; visit the Calvary birth centre; catch up with the multidisciplinary group from our mental health service; tour a medical or surgical ward; or inspect our coronary care and intensive care unit.

"I welcome the opportunity for Calvary to work with you so we provide better services for our patients."

Students meet surgeons and trauma victims in canberra hospital

The Royal Australasian College of Surgeons (RACS) supports a new pilot program underway with ACT schools to educate young people about the dangers of alcohol and the life-altering consequences it can have for trauma victims.

Six schools have been selected to participate in the pilot, which takes students through a range of activities and talks at Canberra Hospital with ambulance and emergency department nurses, surgeons, physiotherapists and trauma survivors.

The Prevention of Alcohol and Risk-related Trauma in Youth (P.A.R.T.Y.) pilot began last month and received just over $100K from the NRMA-ACT Road Safety Trust.

ACT Chair of RACS Trauma Committee, and Director of Canberra Hospital's Shock Trauma Service, Dr Ailene Fitzgerald said, "the pilot aimed to reduce the incidence of alcohol and risk-related trauma in youth.

"Each week, on average, more than 100 Australians die and more than 3,000 are hospitalised as a result of excessive alcohol consumption", Dr Fitzgerald said.

"In the ACT, people aged 16-24 years have the highest rates of injury. They are more likely to drink at risky levels or engage in activities like texting while driving, and this means they are more likely to end up in hospital.

"One of the worst things I will ever have to do in my job is to tell a young person's parents that their child has been killed in a car accident, or fallen off a balcony because they've had too much alcohol. It's tragic, and it's preventable.

"The P.A.R.T.Y. program originated in North America and has been running in Australia since 2006. There are more than 100 sites worldwide.

RACS Trauma Chairman, Dr John Crozier said highly effective P.A.R.T.Y. programs were being run in WA, SA, Victoria, NSW and Queensland.

"The Perth program is estimated to cost $1000 per week to run, while the health costs of a quadriplegic are estimated at roughly $8 million for the rest of their shortened life," Dr Crozier said.

"Program participation was associated with a reduced subsequent risk of committing violence – or traffic related offences, injuries, and death among juvenile justice offenders.

"There is huge community support for these programs, so we hope to see the ACT program funded after the pilot concludes in June, Dr Crozier said.

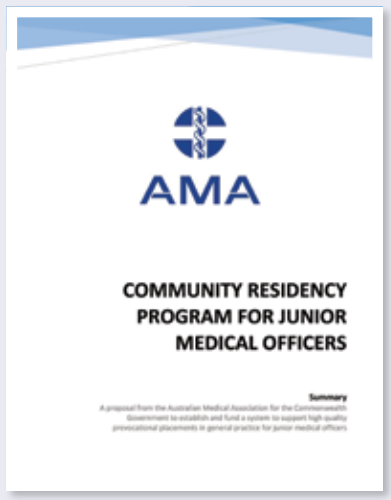
Photo courtesy Melbourne P.A.R.T.Y. program.

AMA plan to bolster GP workforce

Community Residency Program for Junior Medical Officers (JMOs)

The AMA has developed a plan to provide Junior Medical Officers (JMOs) with important general practice prevocational training in an effort to encourage more young doctors to choose a career in general practice.

AMA President, A/Prof Brian Owler, said today that, following the 2014 Federal Budget decision to scrap the Prevocational General Practice Placements Program (PGPPP), general practice is now the only major medical specialty that does not offer JMOs a prevocational training experience.



A/Prof Owler said the AMA feared that the loss of the PGPPP would see a decline in the general practice workforce, especially in rural and remote areas, at a time when community need for GPs was growing.

"To fill the PGPPP gap, the AMA has developed an alternative GP training plan – the Community Residency Program for Junior Medical Officers – and we have already raised it in discussions with the Health Minister," A/Prof Owler said.

"The AMA plan sets out the design and funding principles that would support opportunities for JMOs to undertake rotations of up to 13 weeks into general practice, which would help them to experience life as a GP and to enhance their clinical experience.

"A recent major study (*Comparing general practice and hospital rotations, http://onlinelibrary.wiley.com/doi/10.1111/tct.12224/pdf*) shows clearly the educational value of a general practice placement in comparison with hospital placements.

"The study recommends that the expansion of prevocational general practice placements should be considered to provide all junior doctors with the benefits of exposure to generalist skills in the community.

"The AMA's Community Residency Program is affordable, and would be a very worthy investment in our future medical workforce," A/Prof Owler said.

Details of the AMA Community Residency Program for JMOs are available at *https://ama.com.au/submission/community-residency-program*

At the time of its conclusion, the PGPPP funded 900 prevocational placements in general practice annually for JMOs.

The PGPPP was a valuable program for many reasons. It supported efforts to deliver more training and care in the community, supplementing the traditional hospital-based approach to medical training. Through careful targeting, it also boosted access to GP services in rural and remote communities.

The PGPPP gave JMOs a valuable insight into life as a GP, and informed their career choice.

The PGPPP also helped build an understanding of how general practice works, informing future practice in other specialty areas. With a deeper appreciation of the role of GPs, other specialists can make better decisions about patient care, and work more closely with their GP colleagues.

New campaign to boost early breast cancer detection

All Australian women aged 50 to 74 will receive an invitation that could save their life as part of a $55.7 million Australian Government initiative to boost breast screening rates in at risk age groups.

Minister for Health Sussan Ley launched the 'An invitation that could save your life' campaign to make sure all Australian women aged 50 to 74 were aware they qualified for a free breast screen every two years.

Ms Ley said this also marked the first time Australian women aged 70 to 74 have been specifically targeted for breast screening awareness, with an additional 220,000 breast screens expected to be delivered over four years as a direct result.

"Breast screening saves lives. It is the second most common cause of cancer-related deaths among women in Australia, however if detected early and managed nine-out-of-10 cases can be successfully treated."

Ms Ley said breast screening could identify cancer before symptoms appear or a change is noticed in the breast meaning a better range of treatment options are available and a more successful outcome.

"BreastScreen Australia has been extremely successful since it was introduced more than 20 years ago having reduced the number of breast cancer deaths by over a third.

Ms Ley said the additional screening delivered as a result of the campaign could potentially lead to the detection of an extra 600 breast cancers a year.

More than 1.8 million women are screened every two years and more than 75 per cent of breast cancers occur in women over 50. Most women who get breast cancer also have no family history.

The 'An invitation that could save your life' campaign will run across print, radio and online media to make sure women who receive a breast screen invitation in the mail are aware of its importance.

AMA warns of public hospital 'perfect storm' as commonwealth funding decreases and benchmarks are not met

AMA Public Hospital Report Card 2015

The AMA is warning of a possible 'perfect storm' in Australia's public hospital system as Commonwealth funding shrinks, performance benchmarks are not being met, and prices for hospital services under activity-based funding decline.

Releasing the *AMA Public Hospital Report Card 2015* in Sydney AMA President, A/Prof Brian Owler, said that, despite some small improvements, the public hospital system is not meeting the clinical demands being placed on it, and the situation will only get worse as real Commonwealth funding reduces dramatically in coming years.

A/Prof Owler said the Federal Government should be looking at restoring public hospital funding in the May Budget.

"The States and Territories are facing a huge 'black hole' in public hospital funding after a succession of Commonwealth cuts," A/Prof Owler said.

"The Federal Government cut $1.8 billion in May in the 2014-15 Budget by ceasing funding guarantees under the *National Health Reform Agreement*.

"There was a further $941 million funding reduction to the States in the Mid-Year Economic and Fiscal Outlook (MYEFO) in December.

"On top of this, the Government scrapped the National Partnership Agreement funding to the States, which rewarded performance in meeting waiting time targets for emergency departments and elective surgery.

"The enormity of the ongoing cuts was starkly highlighted when the Treasury advised the Senate Economics Committee that Commonwealth funding for public hospitals from 2017-18 to 2024-25 would be reduced by $57 billion.

"Public hospital funding will be the biggest single challenge facing State and Territory finances for the foreseeable future.

"The hospital funding blame game is back, and bigger than ever. Public hospitals and their staff will be placed under enormous stress and pressure, and patients will be forced to wait longer for their treatment and care," A/Prof Owler said.

The AMA Report Card shows only marginal improvement in public hospital performance against the performance benchmarks set by all Governments, with no State or Territory meeting the target of 80 per cent of emergency department Category 3 urgent patients being seen within clinically recommended triage times.

A/Prof Owler said that public hospitals must have the capacity to provide treatment efficiently and effectively to people needing acute care.

"Unfortunately, instead of putting the public hospital sector on a sustainable footing for the future, the Federal Government has retreated from its responsibilities in regards to public hospital funding arrangements with the States," A/Prof Owler said.

"Rather than funding the necessary hospital capacity, the Commonwealth has withdrawn from its commitment to sustainable public hospital funding and its responsibility to meet an equal share of growth in public hospital costs.

"Funding is clearly inadequate to achieve the capacity needed to meet the demands being placed on public hospitals.

"To make matters worse, the price for hospital services under activity-based funding will be lower in 2015-16, at $4,971 than the price in 2014-15, at $5007.

"A perfect storm is building ahead of new Commonwealth public hospital funding arrangements based on indexation and population growth, which will take effect from 2017-18.

"These new arrangements will be imposed on a system already struggling with insufficient capacity, a system that is under-performing against key benchmarks, a system with inadequate and reducing Commonwealth funding, and a system with a reduced price for hospital activity.

"This will lock in a totally inadequate base from which to index future funding for public hospitals.

"State and Territory Governments, many of which are already under enormous economic pressures, will be left with much greater responsibility for funding public hospital services.

"Performance against benchmarks will worsen and patients will suffer. Waiting lists will blow out.

"It is vital that all governments come together to produce an agreed plan to fund public hospitals to sufficient capacity to meet growing demand.

"The Federal Government should also be using the Federation White Paper to address the public hospital funding crisis."

A/Prof Owler said the Government cannot justify reducing public hospital funding on claims that Australia's health spending is unsustainable.

"Australia's health financing arrangements are not in crisis," A/Prof Owler said.

"Compared with OECD countries, Australia's expenditure on health is sustainable. In 2012-13, Australia had the lowest growth (1.5 per cent) in total health expenditure since the Government began reporting it in the mid-1980s.

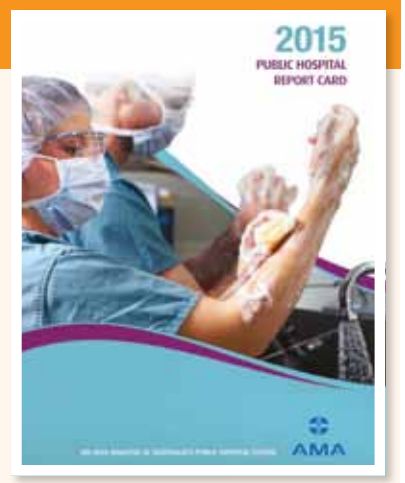
"Without any specific Government measures, there was negative growth (minus 2.2 per cent) in Commonwealth funding of public hospitals in 2012-13, and only 1.9 per cent growth in 2011-12.

"Australia's expenditure on health has been stable as a share of GDP, growing only one per cent over the last 10 years."

Key findings of the AMA Public Hospital Report Card 2015 include:

- bed numbers per 1000 of the 65 and over population (at 17.5), and as a ratio per 1000 of the general population (at 2.57), have declined since 2011-12 (from 18.6 and 2.6 respectively). We have maintained roughly the same bed to population numbers over recent years, while there has been increasing demand for hospital services;
- most States and Territories performed well below the target of 80 per cent for emergency department patients seen within clinically recommended times;
- nationally, only 70 per cent of emergency department patients classified as urgent were seen within the recommended 30 minutes. This is a small improvement over 2012-13. If this rate of improvement were to continue, we could be on track to achieve the 80 per cent target in 2018, six years later than intended;
- in 2013-14, only 73 per cent of all emergency department visits were completed in four hours or less (the 2015 target is 90 per cent);
- for calendar year 2013, no State or Territory met the interim National Emergency Access Target. Performance in Victoria, Tasmania, South Australia, the Northern Territory, and the ACT was below their 2012 targets, with the Northern Territory performance in 2013 failing to meet their baseline for this target;
- nationally, median waiting times for elective surgery have increased over the last 10 years. In 2013-14, the national median waiting time remained unchanged at 36 days, meaning no improvement since 2010-11;
- the number of admissions from waiting lists for public hospital elective surgeries in 2013-14 across Australia was 699,023. This was an increase of around 4.2 per cent over the number of elective surgery admissions in 2012-13 (671,033);
- 2.4 per cent or 16,777 of the patients admitted for elective surgery in 2013-14 waited for more than a year;
- data for 2013-14 indicates 79 per cent of elective surgery category 2 patients (those who should be admitted within 90 days) were admitted on time. This is well below the National Emergency Surgery Target (NEST) performance benchmark of 100 per cent set by COAG. There has been no sustained improvement in waiting times for Category 2 patients since 2002-03;
- Commonwealth funding for public hospitals for the years 2013-14 to 2016-17 was reduced by $1.8 billion in the Budget 2014-15 (May 2014). The effects of this reduction will be compounded by the further reduction of $941 million announced in MYEFO 2014-15.

The AMA Public Hospital Report Card presents core information simply and clearly, to show the trend in performance over time.



The AMA Public Hospital Report Card 2015 has been compiled using information from:

- Australian Institute of Health and Welfare, *Australian Hospital Statistics 2012-13; Admitted Patient Care 2013-14: Australian Hospital Statistics; Australian Hospital Statistics 2013-14: emergency department care; Australian Hospital Statistics 2013-14: elective surgery waiting times; Health Expenditure Australia 2011-12 and 2012-13.*
- Commonwealth Budget documents, *Budget Paper No. 3 2013-14 and 2014-15; and Mid-Year Economic and Fiscal Outlook (MYEFO) 2012-13, 2013-14, and 2014-15.*
- Council of Australian Governments (COAG) Reform Council, *National Partnership Agreement on Improving Public Hospital Services: Performance Report for 2013 (NEAT and NEST targets).*

The report is available on the AMA website: www.ama.com.au

Review Essay: The alienists and the alienated

Dear Life: on caring for the elderly by Karen Hitchcock.

March 2015, Quarterly Essay 57, Black Inc., ISBN 9781863957168, AUD$22.99

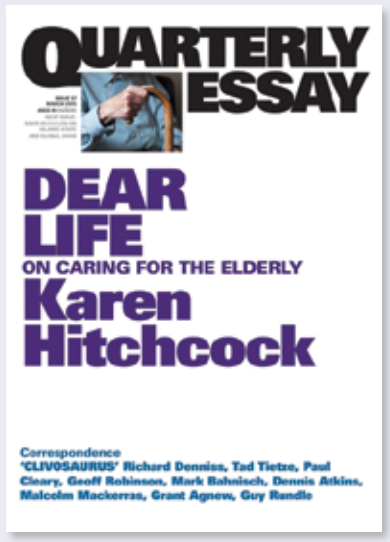
In the not so distant past, persons suffering from mental illness were transported to vast asylums where they were physically and psychologically exiled from society, to be tended by "alienists", asylum physicians and custodians in one. It is not much of stretch to discern commonalities in the health care of the elderly and those former inhumane times.

In modern life, the elderly have been exiled to a liminal shore of our public consciousness, alienated souls tended by a new class of alienists on the periphery of medicine and society. From these distant shores, with the grim but steady hand of *Charon*, Dr Karen Hitchcock steers us through the failures of humanity in care of the elderly.

An accomplished writer and specialist general physician, Hitchcock brings to a broader audience the manifold travails that ageism in healthcare entails. She argues, justly for the respect of the essential humanity of older people, and against viewing them as a stereotyped homogeneity. Through vivid vignettes, she sparks empathy with the elderly, emphasising the individual narrative continuity of a person through the temporal span of life.

In challenging ageism, Hitchcock highlights the intellectually impoverished discourse that passes for arguments from economic rationalism, utilitarianism and a narrow view of human rights that dominates in medicine, politics and Australian society. She argues the elderly are depicted as homogenous aliens outside of society.

The consequences of such alienation are dire. There is the insidious, seductive temptation of weighing lives by their projected remaining extent in some form of perverse moral calculation dressed in the Emperor's new clothes of rationality. Cogently, Hitchcock observes that the pressures on the elderly provide advanced care directives can have unwanted consequences, given the significant complexity of advanced care planning (such



as confronting mortality, knowing what your future self would want, knowing the nature of the medical procedures you are forgoing or not). Indeed, there is a field of cognitive neuroscience known has affective forecasting, popularised by the leading researcher Dr Daniel Gilbert, which has coined the term "miswanting" as a description in part of how human predictions on what people think they want differ when they get closer to what they thought they wanted.

Similarly, Hitchcock correctly observes that the older person's view of what constitutes a good life may well differ from that of their younger selves, family members, physicians and public intellectuals. The unique adaptability of humans is such that even those most frail can find joy and fulfilment in what others might view the quotidian and despite considerable constraints.

There seem very few wrong notes, which it may seem churlish to mention in the context of such well essayed points. As a psychiatrist specialising in care of the elderly, I would agree with Hitchcock that there is much that needs improvement in the provision of humane medical care in the person's home, in residential aged care facilities, health services and hospital. Hitchcock references an extraordinary residential aged care facility in the Netherlands, built at immense expense, staffed by community volunteers and with the goodwill and resources of an entire region: *De Hogenwyk*, which is known as a beacon on the hill of the most humane, person-centred care. However, Hitchcock observes incorrectly and irrelevantly that: "… there is something creepy about the notion that we need to construct alternate universes – *Truman Show* theme parks – to contain the elderly." (p56) Research into the design of aged care facilities that has shown that settings reminiscent of the youth of residents and higher levels of skilled staffing, together with smaller, more homely or village environments reduce the incidence of behavioural and psychological symptoms of dementia as well as improving anxiety and depression levels. Facilities such as *De Hogenwyk* are designed for the well-being of residents, not for the sensibilities of external observers.

Eschewing nostrums and simplistic algorithmic care pathways, Hitchcock justly calls upon society to fully engage with the humanity of being old. In this, she rightly exhorts us to comprehensively reconsider our health care for the elderly. The ultimate inhumanity of much of the deracinated system for health care for the elderly is a damning indictment of our collective societal failure of engagement in enacting life-long health care. It is time for the alienation of the elderly to end. As Hitchcock wryly observes, we owe action to our future selves, our children and their children who will likely live longer.

Reviewed by:
Associate Professor Jeffrey Looi
Academic Unit of Psychiatry and Addiction Medicine,
ANU Medical School.

Opinion: Open disclosure, the future of legal apologies in Australia

Sara Hamdani

There are many moments in a doctor's career where they may make a mistake that could adversely impact a patient's life and wellbeing. Most doctors would admit the most difficult part about making a mistake is admitting it to the patient and saying you're sorry.

However, previously doctors were often warned by their legal counsellors and lawyers to avoid apologising to patients to prevent medical litigation and law suits from occurring. These lawyers suggested that accepting responsibility for the fault would prompt the patients to use this as primary evidence against the doctors in a court. Despite this, apologising for a mistake you commit is the most ethical and compassionate thing to do to let the patient know that you're genuinely sorry. This notion has now found its stronghold in medico-legal frameworks around the world that are now incorporating open disclosure policies to allow doctors to apologise for their errors in a legally 'safe' environment.

The term open disclosure itself has a broad meaning and is defined by the Australian Commission for Safety and Quality in Health Care as the "open discussion of incidents that result in harm to a patient while receiving health care." Open disclosure laws and policies have also found their place in the legal contexts of other countries such as the United Kingdom and Canada. Hence the common issues which arise in the definitions used by Australia and other countries include the need to honestly and openly communicate to the patient and their family after an adverse event has occurred. The open disclosure standard was devised and released in 2003 by Australian health ministers. This resulted in Australian states and territories integrating the standard into their respective local health policies and laws. In 2008, the Australian health ministers subsequently endeavoured to implement the standard in all health care institutions around the country. The standard has been incorporated into the Australian Medical Council's Good Practice Guide and is recognised by each state's Health Practitioner Regulation National Law Act.

There are apology laws implemented in each state and territory which are not made exclusively for open disclosure. In other words, the laws vary in the manner in which they examine the definition of open disclosure and expressing sorrow and regret. Thus, open disclosure is not a statutory law and was devised through common law, Wighton v Arnot. This case involved a surgeon having suspicions about the patient's nerve injury in surgery. The court concluded that open disclosure may have enhanced the prognosis and would have helped the doctor avoid litigation due to negligence. It has been reported that the apology laws are not uniform across the states and territories, for example apology laws in states such as New South Wales refer to explicit statements of regret where fault is not disclosed or inferred whereas South Australian law implicitly avoids admission of fault. The current apology laws allow doctors to admit they are sorry but not why they are sorry. Thus the ambiguity and uncertainty of how to express liability means doctors need more legal protection and reforms that assure them they are safe from litigation when admitting fault.

The AMC Good Medical Guide (s3.10) explicitly states that doctors have a duty and responsibility to report their findings, including adverse events to the patient through open and truthful communication. The practice of open disclosure involves a number of steps including: understanding that an error has been made and recognising the patient's emotions which can involve anger and distress. The doctor may be required to report the case to the appropriate authority and should review and identify possible strategies to prevent the mistake from occurring in the future. Thus, open disclosure is an essential part of being a doctor, primarily because doctors need to exercise professional conscience. Open disclosure should not be implemented just to avoid litigation but rather there are underpinning ethical aspects as well. According to Fallowfield and Jenkins (2004), open disclosure has the effect of improving the rapport between doctor and patients, resulting in the cultivation of increased trust for the doctor. Furthermore, the patient has a right to understand the event so that they can make an informed decision about how to continue their treatment, i.e. patient autonomy and this goes hand in hand with the patient's right to self-determination as well. In addition, open disclosure is beneficial for the doctors themselves, as it provides a form of cathartic medium where they can remove some of their guilt and be given support if required. In this manner, the doctor can evaluate their actions and make changes if necessary to improve the standard of their care to future patients.

The views and perspectives of patients and families involved in open disclosure following adverse events were examined in a study conducted by Iedema and colleagues. 23 participants were interviewed and their responses indicated that the participants were satisfied that a member of staff spoke to them about the adverse event. However, they had concerns regarding the nature of the open disclosure. For example, participants complained that the disclosure was not formal and was often delayed in some cases. In addition, participants felt they were not provided with avenues for support following the disclosure consultation. Some participants were not provided the chance to consult the doctor involved in the actual adverse event itself. Hence, these results indicate that doctors need to modify their apology in an appropriate manner and provide follow up support.

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Opinion: Is a closer look appropriate at e-cigarettes as a quitting strategy in pregnancy?

Dr Stephen Robson, Australian National University Medical School, and Robert Bryce, Flinders University, Sturt Road, Bedford Park 5042, South Australia, ask.

Cigarette smoking rates

Estimates from Australia suggest that about one woman in seven smokes during pregnancy. This rate is similar to overseas experience, and while the prevalence of smoking varies between countries there is no evidence that smoking rates in young women are decreasing globally. Because studies that rely on self-reporting underestimate the number of pregnant smokers, real levels of smoking in pregnancy may be higher. This is a major concern since cigarette smoking is perhaps the single most important avoidable cause of adverse pregnancy outcomes. Unfortunately, smoking in pregnancy is more common in women at social disadvantage, including Indigenous Australians. As well, exposure to 'second-hand smoke' may affect other children in a family by contributing to otitis media and chronic middle-ear effusion, childhood asthma, and lower respiratory tract illnesses.

Quitting strategies

Despite universal acknowledgement of the importance of smoking cessation during or ideally before pregnancy, data regarding the success of 'quit' programs in pregnancy have been disappointing. Pregnancy motivates some women to cease smoking, and as many as 40% of pregnant smokers quit in the first trimester before attending for antenatal care. Women who quit in early pregnancy are likely to be a subset of smokers with the best prognosis, leaving the more "dedicated" smokers as the subjects of quit programs. It is difficult to stop smoking and the majority of smokers who attempt to quit, whether on their own or with assistance such as nicotine replacement therapy (NRT), will not be successful.

Nicotine eplacement therapy

Finding better ways of helping pregnant smokers to quit is obviously a public health priority. Unfortunately, trials of NRT in pregnancy yield disappointing results and the majority of pregnant women who commence NRT therapy in clinical trials stop using the treatment before completion of the trial. Secondary analyses of such trials show that those pregnant women who actually use the NRT reduce their cigarette use. Systematic review suggests that those smokers who switch to NRT in pregnancy have decreased risks of preterm birth and low birth weight compared to those who continue to smoke. Other data about neonatal outcomes following NRT are a little more difficult to interpret, since many studies have not adjusted for confounding factors associated with malformations.

E-cigarettes

E-cigarettes, sometimes referred to as 'electronic nicotine delivery systems' (ENDS), have become popular over the last decade. The e-cigarette delivers nicotine and flavourings as a vapour that is inhaled by the user: inhaling from an e-cigarette is colloquially referred to as 'vaping.' Designed to replicate smoking behaviour, e-cigarettes are battery-powered devices consisting of: a cartridge that is filled with liquid nicotine, a heating element, and some supplemental electronics. E-cigarettes differ from other forms of NRT because they simulate the hand-mouth repetitive motions of cigarette smoking, and provide the visual cue of steam vapour that is similar to smoke. A recent randomised trial has reported that e-cigarettes are at least as effective as other forms of NRT in non-pregnant smokers, but seem to have higher rates of compliance presumably due to their similarity to the act of smoking.

E-cigarette cartridges typically contain nicotine, glycerine, propylene glycol, and tobacco flavouring. The greatest volume of cartridge solution is usually propylene glycol. In some cases other contaminants such as diethylene glycol (a recognised carcinogen) have been identified in a small number of e-cigarette cartridges but such contaminants probably arise from use of impure propylene glycol.

In contrast, smoke from tobacco cigarettes contains many hundreds of potentially carcinogenic chemicals, including volatile organic compounds (VOCs), polycyclic aromatic hydrocarbons (PAHs), and tobacco-specific N-nitrosamines (TSNAs). On balance, studies of the vapour from e-cigarettes are reassuring when compared to traditional cigarettes. The amount of total TSNAs isolated from an e-cigarette is approximately the same as that in other nicotine products. A review of the relevant literature found that e-cigarettes have either low or undetectable levels of particulate matter, trace metals, VOCs, PAHs, and TSNAs when compared to cigarette smoke.

E-cigarettes appear to have a nicotine pharmacokinetic profile roughly equivalent to nicotine inhalers. Although early versions of e-cigarettes were found to deliver nicotine unpredictably, more recent studies reported that refill solutions were labelled accurately and contained consistent nicotine concentrations. The amount of nicotine delivered to the circulation is less than occurs with smoking a conventional cigarette. Serum concentrations typically peak at 1.3 ng/mL after vaping an e-cigarette for about 20 minutes, compared to 2.1 ng/mL 30 minutes after using a nicotine inhaler, and up to 13.4 ng/mL after 15 minutes of smoking a tobacco cigarette.

In summary, e-cigarettes appear to be a safer alternative to conventional smoking and they deliver a similar quantity of nicotine and have comparable toxicity to nicotine patches. While there appears to be a small potential for harm from nicotine exposure in pregnancy, the potential is less than continued smoking. For all of these reasons, D L Palozollo writing on "electronic cigarettes and vaping: a new challenge in clinical medicine and public health" in a literature review in Front Public Health 2013 has concluded that:

"Compared to the harmful effects of smoking, these studies suggest that vaping could be used as a possible harm reduction tool. There is evidence supporting e-cigarettes as an aide for smoking cessation, at least as successful as currently-available FDA-approved NRTs."

In Australia and New Zealand, e-cigarettes are regulated as pharmaceuticals if they are promoted for human therapeutic use – that is, smoking cessation. Nicotine itself, when used

for non-therapeutic purposes, is captured under Schedule 7 of the SUSMP as a 'dangerous poison' and state- and territory-based legislation require a permit to possess, purchase, or otherwise deal with it. Some states and territories also have tobacco control legislation that prohibits the sale of products that 'resemble tobacco products,' and increasingly e-cigarettes that resemble pens or lip gloss are being marketed to avoid being captured by tobacco control regulations.

Pregnancy is a special situation where there is a limited window to reduce the risk of harm to the fetus. The available data suggest that e-cigarettes have a risk profile very similar to that of currently available forms of NRT, but that trial participants are more likely to use them because of the similarities to conventional smoking. The best evidence we have is that NRT is safer than continued smoking, certainly for women who smoke more than five cigarettes a day in pregnancy. At the moment, searches of the major Australian and international clinical trial registries reveal no trials of e-cigarettes in pregnancy: indeed, pregnancy is usually high on the list of exclusion criteria for such clinical trials.

A number of health bodies, such as the British Medical Association (BMA), stand against the free availability of e-cigarettes, and the Australian Medical Association (AMA) has expressed concerns that e-cigarettes might be an "entry into smoking, not necessarily … an exit from smoking." Arguments put forward are that e-cigarette usage might increase rates of cigarette smoking by attracting new recruits and reducing the success of quit attempts, a situation referred to as 'renormalising smoking.' Other objections have even been based on the fact that explosions of the heating mechanisms in e-cigarettes have been reported and that fire might be a theoretical risk. However, in Australia alone, an average of 14 people die from fires associated with smoking every year, and smoking is associated with more than 4500 fires each year, including perhaps 7% of all bushfires.

Ethics committees are likely to be hesitant to approve trials of e-cigarettes in pregnancy, but an important first step might well be observational studies. There are few published clinical trials of e-cigarettes at present, and at this time e-cigarettes do not appear to have gained licensing approval as a therapeutic good, a situation that might present a barrier to trials. However, in light of this gathering information perhaps it is time to take look to e-cigarettes in clinical trials during pregnancy. Should they prove to be an acceptable and safe harm-reducing alternative to tobacco cigarette smoking for the duration of pregnancy, the benefits to babies and the health system will be worth it.

References are available from Dr Robson on request. This article has been edited with permission, from the original article to be published in the near future in ANZJCOG and

Open disclosure…*continued*

…From page 7.

The perspectives of health professionals were also encapsulated in a national cross sectional survey performed by Studdert, Piper and Iedema. The study surveyed 51 doctors who have had experience with open disclosure. The vast majority of doctors agreed that open disclosure is the correct thing to do. However, many were concerned with potential medico-legal risks whilst others felt they did not have sufficient education and training to deal with open disclosure.

The barriers to disclosure can be classified on a number of levels, for example on a personal level, Fallowfield and Jenkins (2004) classify the primary barrier as the doctor's fear of being embroiled in medical litigation and the effect this may have on their reputation/character and financial status. Allan and Munro (2008) used other levels such as intrapersonal, organisational cultural, meta and professional levels to classify other barriers. For instance, on an intrapersonal level, doctors may lack confidence in their ability to perform open disclosure competently. Furthermore, on a professional level, Allan and Munro (2008) explain how doctors do not really understand the reasons behind open disclosure and how important it is for their patients. This follows on to an argument which has already been encountered in the Studdert, Piper and Iedema study, that doctors believe they have not acquired the necessary skills and training to perform open disclosure. They are often unsure and confused about how to approach open disclosure.

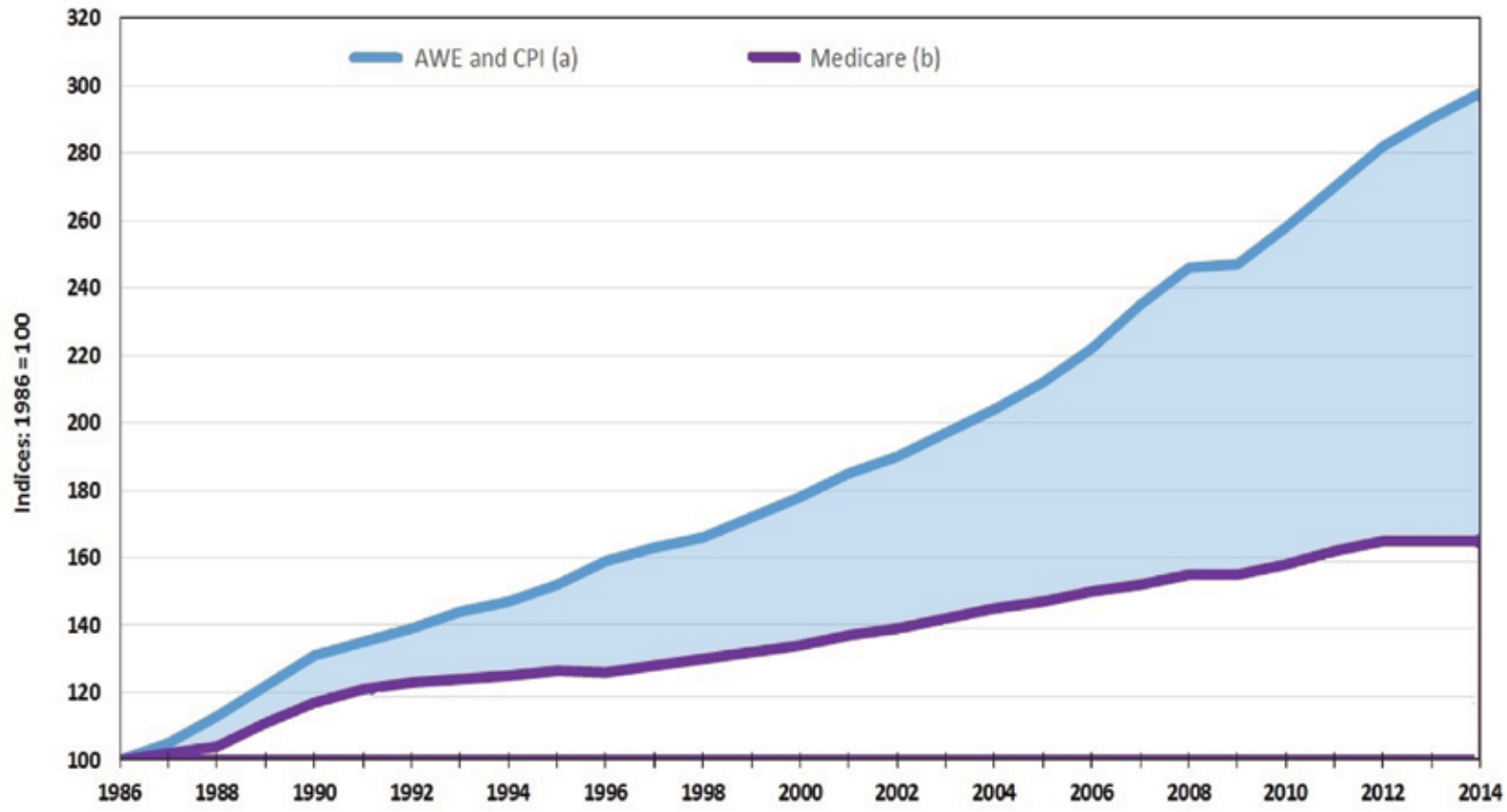
Hence, there are many barriers to disclosure, particularly from the health professional point of view. This means there needs to be reforms and improvements in the open disclosure standard to encourage more doctors to participate in open disclosure with confidence and capability. From the patient's perspective, follow up support was often not provided, which means this needs to be incorporated as a key component of the standard. From the doctor's point of view, education and training regarding how to approach open disclosure could be implemented in healthcare institutions. Furthermore, there is a strong need for evidence based practice in the future of open disclosure. This involves using surveys and interviews based on scenarios to understand the patient's needs and preferences and determine the best method of delivery. In addition, legal reforms to the standard could be introduced to increase legal protection is sufficient for doctors who fear what they say will be used against them. This means there should be consistency in apology laws across all states and territories regarding statements admitting fault and regret. Moreover, open disclosure should be integrated in the federal health care system and contracts which would greatly increase doctor's complying with the practice.

In conclusion, Australia is one of the leading countries in open disclosure policies through its implementation of the open disclosure standard. The standard has greatly improved the view and practice of open disclosure between health professionals such as doctors and patients. Despite this, many barriers to disclosure exist and need to be targeted through a number of improvements and reforms. These reforms aim at allowing doctors to understand the legal and ethical undertones in open disclosure and improve their compliance with the standard. This ultimately ensures continuity of care and ensures the patient receives the best healthcare possible.

Sara Hamdani is a year 3 student at the ANU Medical School.
References are available on request from the author.

GAPS

Why is there a gap?



(a) Index comprising average weekly earnings and Consumer price index (70:30) reflecting the average cost structures in medical practices.
(b) Index of Medicare fees as determined by the Commonwealth Government.

Government's indexation of Medicare rebates has never kept pace with the rising cost of medical practice. On average AWE and CPI increase by 3% per year. Practice costs rise by the same amount. Medicare rebates only increased by 1.7% per year.

This is why your Medicare rebate is worth less every year.

Concerned? Talk to your local Federal MP.

AMA

Leading Australia's doctors - Promoting Australia's health

Opinion: Legalising cannabis – look before you leap

By Dilini Hemachandra

The debate of whether cannabis should be legalised for medical use in Australia has been a long drawn out one.

Currently it is illegal to possess or trade cannabis in Australia as it is labelled an illicit substance. However, there is mounting support in Australia to see this changed. It can be assumed that this support will only increase as many other countries worldwide change their laws to legalise medical cannabis.

But, with much of the research on cannabis focusing on its association with serious health risks and with very little understanding of how cannabis may cause these changes, is it too much of a risk to jump on this bandwagon?

Cannabis is the most widely used recreational drug worldwide; its use second only to alcohol use in the Western world. Even in Australia, despite being illegal, the Australian National Drug Strategy Household Survey found that recent and lifetime cannabis use in people in Australia aged 14 and over was the highest among illicit drug use, at 10.2% and 35%, respectively.

The alteration in mood or the feeling of 'high' is attributed to the main active cannabinoid in cannabis, delta-9-tetrahydrocannabinol (THC). However, cannabis contains over 400 chemical substances, of only about 60 of which fall into the cannabinoid category responsible for its effects on movement, emotion and impairment of memory and cognitive function. Due to this vast variety, while cannabis has been widely studied, we still do not have a clear understanding of how it affects the body and what it's short or long-term effects are. Though this may not be of primary importance to those suffering from a terminal condition, those that may use it for non-terminal illnesses may be put at harm by prescribing cannabis as a treatment.

Cannabis use has long been associated with psychotic disorders such as schizophrenia. Studies have suggested that cannabis use increases the risk of developing psychosis and those with a predisposition to psychotic disorders are especially sensitive to its effects. A study by Solowij et al. has also shown that heavy cannabis use can reduce cerebellar white matter volume to that seen in schizophrenia. Changes like this, especially in the central nervous system, raise special concern for cannabis use in children and adolescents, who are undergoing constant brain development and differentiation of higher cortical centres. Recently, cannabis has also been linked to cardiovascular changes and stroke. Cannabis consumption has been suggested to trigger adverse cardiovascular events such as angina, myocardial infarction and tachyarrythmias, while the risk of stroke is thought to be associated with its effects that alter cerebral autoregulation and lead to postural hypotension, vasospasm, cerebral vasoconstriction syndrome, vasculitis, and atrial fibrillation.

Despite being illegal, cannabis is already used by people for medical purposes. For example, it is used by 10-15% of patients with multiple sclerosis to reduce spasticity and non-cancer type chronic pain. Various studies have supported that cannabis can relieve peripheral, post-traumatic and Human Immunodeficiency Virus (HIV) induced neuropathic pain. Furthermore, studies have also suggested a synergistic interaction with opioids and cannabinoid systems which can enhance the analgesic effects. However, these results should not be looked at in isolation from the rest of the knowledge we have about cannabis when changing or making new legislation to legalise cannabis for medical purposes.

According to the current laws in Australia, it is illegal to use cannabis as a medicine. In the Australian Capital Territory (ACT) it is illegal to sell, supply, cultivate or possess any quantity of it. Minor offences regarding cannabis is already decriminalised in the ACT and can be dealt with by a civil penalty such as a fine. The recent *Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014* by Greens' member, Mr Shane Rattenbury seeks to further permit the use of cannabis for medical purposes to mitigate symptoms not only in terminally ill patients, but also in those suffering from several listed conditions such as cancer, multiple sclerosis and epilepsy, as well as, any other medical condition or treatment. Under this amendment, an approved person can also apply for a licence to cultivate cannabis for medical purposes. This bill ignores the facts that there are no established dose-response data by which to guide therapy and that different cannabis preparations and parts of the cannabis plant carry widely varying cannabinoid concentrations that can lead to variations in its effects. Furthermore, it ignores the effect this could have on eligible patients with existing psychological disorders.

As an already widely available illicit drug, legalising cannabis will complicate controlling its access only to those who need it medically.

Ethically, doctors will also have to face the probability that prescribing a poorly understood medication with known adverse health risks may breach the Hippocratic oath of 'above all do no harm' to the patient. Therefore, to minimise the potential risks to the society and to get a better grasp of its effects, cannabis should undergo the same rigorous testing as other medical products where its efficacy, dosage and side effects are compared to current medications, before it is legalised for medical purposes. Furthermore, since cannabis plant preparations significantly vary in cannabinoid concentrations, channels should be established to provide people with cannabis that is quality controlled to allow for unequivocal dosing and effect.

Like any other drug, cannabis carries both positive and negative effects. Despite the many studies supporting the negative impact of cannabis on health, it may not be ethical or even humane to deny the positive impact of cannabis to those who most need it. However, at this point in time, we do not possess enough information about the effects of cannabis on our health to make an informed decision, especially with regards to non-terminally ill patients. This lack of knowledge can only be combatted with further research into understanding the effects of cannabis, so that we can make a decision that carriers the least adverse consequences to society.

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References available on request from the author by emailing: u5381494@anu.edu.au

Immunisation and family payments – "No jab, no pay" policy announced by the Federal Government

In responding to the Government's new announcement to encourage parents to routinely ensure their infants and children are immunized, the AMA reiterated to the community that routine infant and child immunisation is a proven, cost effective public health measure that reduces the spread of communicable disease.

Dr Brian Owler is responding to the Government's initiative reminded that routine immunisation protects the broader community, particularly infants who are too young to be immunised, and those who are immuno-compromised.

"Vaccination is probably the most effective public health measure that we have. That's why childhood immunisation is well funded by Governments, Dr Owler said.

"The fact that we heard about vaccine preventable deaths illustrates the important public health issues.

"Data from the Australian Childhood Immunisation Register shows that there has been a significant increase in the number of children who haven't been vaccinated.

"The Government, and the Opposition, understand that we must have high immunisation rates for the good of the community.

"The "No jab, no pay" policy is another mechanism, or another lever to use, to try and get the vaccination rates up.

"It's not going to reach all families, but it's a step in the right direction to ensure that our children are protected from preventable disease.

"It's important that parents understand the benefits of immunisation.

"It's also important for parents to be across the potential risks, which is why it's best to discuss this with their family doctor who can properly assess the child and determine whether immunisation is unsuitable.

"Immunisation is something families can plan for, and book an appointment with their family doctor at a time that is convenient for them. This means that the doctor can make a plan for catch up where kids haven't had their vaccinations according to the schedule," said Dr Owler.

Background

- Currently, Family Tax Benefit Part A Supplement, Child Care Benefits and Child Care Rebates are only paid to the families of children who are fully immunised, or have an approved exemption – being medical grounds or as a conscientious objection.
- Documentation confirming an exemption must be completed by an 'immunisation provider' or doctor. This requirement provides an opportunity for health professionals to engage with parents who may not fully understand the benefits of immunisation.
- The Government has announced that it will now restrict the exemption to medical conditions and for religious beliefs. A religious objection will only be available where the person is affiliated with a religious group where the governing body has a formally registered objection approved by the Government (noting that no mainstream religions had registered vaccination objections with the government).
- AMA immediate past president, Dr Steve Hambleton was quoted in 2013 as saying "rather than an outright ban (on enrolment to childcare or preschool), the AMA is more supportive of measures that oblige parents to supply full documentation of their child's immunisation status before they are allowed to attend school".
- Data does indicate that the number of children with a formally recorded conscientious objection has increased from 4,271 in 1999 to 30,880 in 2012. This increase may be partly explained by the introduction of the ACIR (which routinely records a child's immunisation status), as well as the stricter requirements for immunisation in relation to eligibility for some social welfare payments.
- The National Health Performance Authority *Healthy Communities: Immunisation rates for children in 2012–13* report found that while conscientious objection was growing, there were also growth in the number of children falling behind the immunisation schedule.

  However, the increase in children with a formally recorded conscientious objection does not fully explain the number of children with incomplete immunisation records. It seems likely that many children have simply fallen behind the immunisation schedule. Checking a child's immunisation status as part of the school enrolment process provides an opportunity for children to be referred on for appropriate catch up.
- Following on from the 'no jab no play' campaign in 2013, NSW Government introduced legislation allowing children to be excluded from preschool and childcare if their immunisation status was not up to date. It is not clear how many facilities have taken up this approach. There have been some concerns that excluding children from preschool punishes them for a decision made by their parents/carers. Financial disincentives (ie. withholding Family Tax Benefit payments) could be seen in a similar light.

Opinion: No Jab, no pay: a step in the right direction

By Georgia Clare

Vaccination is not about the individual choice to protect yourself or your family, it is about a society collectively protecting its most vulnerable members. It simply does not work if those who are healthy enough to be vaccinated fail to do so on anything other than serious medical grounds. This is because there are people who are genuinely unable to receive vaccinations. Newborns, people undergoing chemotherapy and other at-risk members of society should be able to rely on the herd immunity provided by the rest of the (duly vaccinated) population. This is increasingly not the case, and you're probably wondering why.

Vaccination is a classic collective action problem as outlined by Mancur Olson Jr in "The Logic of Collective Action" (1965). Olsen argues that individuals in a society working towards a common goal; i.e. herd immunity, will be incentivised to "free ride" if the society is working to provide public goods. It is thus rational for an individual to conscientiously object to vaccination if they are confident they will be protected by the rest of society. They will still be able to obtain the public good without absorbing any of the perceived risks.

The perceived risks in question are a gargantuan repercussion of competing drug companies preying on the fear surrounding a medical unknown, the unprecedented rise in rates of autism since the 1990s, to stamp out competition and increase profits.

A fraudulent study commissioned by one such drug company, published in reputable British Medical Journal "The Lancet" in 1998 linking the MMR vaccine to autism essentially spawned the powerful anti-vaccination movement.

The article was later retracted for being "utterly false" and the author, Andrew Wakefield, was found to have been paid more than £400 000 for its production, in the hope of spurring a wave of lawsuits based on the MMR vaccine being unsafe. While Wakefield was stripped of his medical licence and publicly denounced by the country's General Medical Council chair, Dr. Surendra Kumar for "bringing the medical profession into disrepute", a combination of celebrity endorsements, bad science and general fear of the unknown ensured the damage was done.

While it may be rational for an individual to choose not to vaccinate if they are confident all others in the group will offer protection, gaping holes in this logic appear when 39000 other people are thinking the same thing. This is the number of under 7 year olds who are not fully vaccinated on the grounds of their parents being 'conscientious objectors'. This is the cause of over one hundred people contracting measles at Disneyland in a country where measles was officially declared dead in 2002. This is the cause of a Western Australian newborn succumbing to whooping cough in March this year. This is exactly the collective action problem.

For those of us being put at risk by these conscientious objectors, there is a light at the end of the tunnel. Olsen also posited that individuals will not "free ride" in groups in which benefits are only provided to active participants. This is why the policy dubbed 'No Jab, No Pay' announced with bi-partisan support is so important. In a world first, parents of unvaccinated children will be denied up to $15000 in child care and family tax benefits per year.

Starting 1 January 2016, the conscientious objector exemption category will be removed from child care and family tax forms. While medical and religious exemptions will remain available, the religious exemption has been significantly tightened up. People seeking to rely on this exemption will need to prove not only that they are affiliated with a religious group but that the governing body of that group has a formally registered objection approved by the Government.

While conscientious objectors have spoken out against the "harsh" policy, is simply the latest in a long serious of attempts to manage "free riders" in our society. Compulsory third party insurance exists to deter drivers from "free riding" on our roads. Why should the protection of society's most vulnerable members from preventable diseases be any different?

It is interesting to note that there is far less opposition by conscientious objectors to the tetanus vaccination than other vaccinations. Tetanus is transferred through bacteria in soil directly to individuals and thus herd immunity does not offer any protection. This seems to solidify the fact that these "free riders" are in many cases knowingly taking a half-hearted approach to the condemnation of vaccinations. They are against vaccinations when they presume they have the protection of herd immunity. The argument raised by some that the 'No Jab, No Pay' policy is an encroachment on civil rights undeniably loses traction in light of this evidence.

The introduction of the 'No jab, no pay' policy, is certainly not the complete solution to the problem. Many of the conscientious objectors are affluent, educated people who would not receive the benefits in question anyway. What it is, however, is a step in the right direction. The first attempt by government to send a general message of disapproval to those putting the rest of our community at risk. This, combined with widespread community backlash culminating in prominent US anti-vaccination campaigner having her Sydney and Melbourne shows cancelled is cause for hope. Hope that the tide is turning against anti-vaxxers. Hope that deaths from preventable diseases become a thing of the past once again.

Georgia Clare is a penultimate year Law (Hons)/Science student studying at the ANU with a particular interest in public health.

Clinical case study: DEXA
(Dual Energy X-Ray Absorptiometry)

4.74 million Australians over 50 (66% of people over 50) have osteoporosis or osteopenia.*
22% have osteoporosis and 78% have osteopenia.

By 2022 an estimated 6.2 million Australians over 50 will have osteoporosis or osteopenia.

In 2012 there were 140,822 fractures that occurred as a result of osteoporosis

The total direct cost of fractures over the next 10 years is estimated at $22.7 billion.

Age, previous fracture and BMD are the strongest predictors of fracture risk. 30 -50% of women and 15-30% of men over 50 will experience an osteoporotic fracture.

Osteoporosis can be diagnosed and managed to reduce fracture rates, and in many cases could be prevented. However osteoporosis remains under-diagnosed, even when a fracture has occurred.^

DEXA

DEXA measures the relative attenuation of x-rays at 2 different energies and corrects for soft tissue attenuation. The study provides an area density for calcium content in g/cm2 and has a precision of 0.5-1.5%.

The study takes approximately 15 minutes with two regions assessed, usually the hip and lumbar spine. The radiation dose is extremely low.

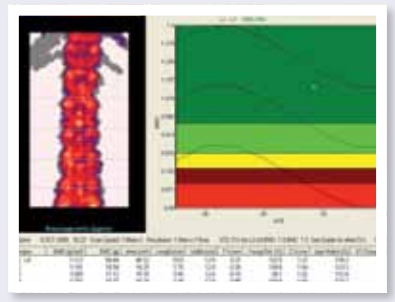
The derive BMD is referenced against normal data (from the Geelong OP study and Hong Kong for Asian patients) giving a T score (SD above or below the young reference) and a Z score (SD above or below an aged matched standard).

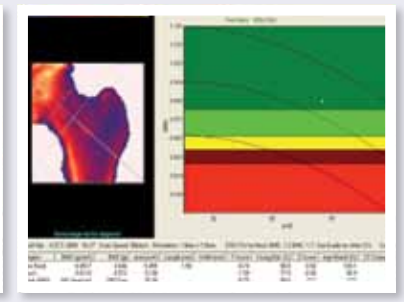
WHO classifies Osteoporosis as a T score <-2.5, osteopenia as a T score -1.0 to -2.5 and normal as >-1.0.

The highest risk category is osteoporosis. However the absolute numbers are greater for the osteopenic group and fracture risk determination should include BMD and clinical risk factors.

FRAX, the fracture risk assessment tool introduced by the WHO in 2008 estimates the 10 year probability of fragility fracture in untreated patients 40-90 years of age based on hip BMD and a range of clinical risk factors. US data suggests that treatment is cost effective from 2.5-4.7% in women and from 2.4-4.9% in men, mostly based on 5 years of bisphosphonates. The absolute risk is lower for which first line treatments are cost effective.

Dr John Connors
MBBS, FRANZCR
Canberra Imaging Group





Opinion: Navigating male breast cancer in a sea of Pink

By Allirra Selkirk

In Australia, 100 men and 13,000 women are diagnosed with Breast cancer annually.

Men are disproportionally diagnosed at a later stage than women, an imbalance hypothesised to be due to patient and doctor delays in recognising and diagnosing the disease. An estimated 80% of men are unaware that they are at risk of breast cancer, compounding delays in diagnosis and contributing to social stereotype as a female disease.

An estimated 40% of women diagnosed with breast cancer utilise internet resources for information regarding their diagnosis and cancer is one of the top two diseases researched on the internet in America. A trend towards obtaining health information from the internet reflects many perceived benefits including the ability to access information in private, compare multiple sources, seek out support groups or online communities and find a range of plain and technical language information.

Due to the perception of breast cancer as a female disease, male patients risk losing their sense of masculinity and ultimately feeling isolated in their experiences and risk becoming disengaged with their treatments and health care. In 2006, Brain et al. reported that 25% of men diagnosed with breast cancer suffer significant psychological distress associated with their diagnosis and recommended improvements be made to the information and support offered to male patients.

Male patients who use the popular Google search engine to search for the term “Breast Cancer”, without specifying gender, will find seven well recognised cancer-related organisations on the front page. Of these, three are predominantly pink webpages with dominant female imagery. Another website is predominantly purple but again features images of females and only offers a women-only support group. Men who persevere with the female-targeted National Breast Cancer Foundation (NBCF) will find a link to a documentary called “Shades of Pink Doco” which includes a single story of a man with breast cancer and an appeal for men to join a research register to contribute to male breast cancer research.

Only two of the seven websites addressed male breast cancer in more than one line. The Breast Cancer Network of Australia (BCNA), represented by the feminine “pink woman” silhouette, offers a section on male breast cancer with information regarding management and coping with the diagnosis before providing links to four American, two UK and two Australian based organisations. BCNA also offers a private online support network for men with breast cancer; however these links are not well-highlighted and appear lost amongst photos of women and links to female networks.

The design of the Australian Government’s Cancer Australia website is significantly more male-friendly in terms of its content, language, gender-neutral colour scheme and imagery and has the added benefit of being Australian based with links to local information and support. The male breast cancer section provides extensive information addressing male concerns including libido, body image, mental health and treatment options. This male-specific information aims to assist men dealing with anxiety and fear of their disease through its acknowledgement of these gender-specific issues.

Men who search Google for the gender specific “Male breast cancer” will find only one pink website (BCNA) in the top 10 search results. The remaining front-page search results are a mixture of Australian and American sources and offer a wide range of basic and in-depth information regarding signs, symptoms, diagnosis, treatments and outcomes on neutral-coloured backdrops with specific acknowledgement of male patients. Despite many websites suggesting male patients seek support networks, BCNA and CA are the only sites in Google’s top 10 results to provide links to Australian resources and counselling. The same search also returns a Sydney Morning Herald article detailing Former New South Wales Premier Nick Greiner’s experience with breast cancer and makes for an enlightening read, going some way toward raising awareness and reducing a male individual’s sense of isolation in their diagnosis.

There is a well-recognised gender bias in the understanding of treatment for male breast cancer. The current basis for surgical and medical treatment is derived from female breast cancer, including the use of tamoxifen in oestrogen receptor positive cancers with little research specifically evaluating its use in male patients. The limited nature of this evidence and delays in diagnosis may contribute to the reduced 5 and 10 year survival rates of males (85% and 76%) relative to females with breast cancer (89% and 83%)1 and is evidence of the need for further research into male breast cancer.

Australian men diagnosed with breast cancer face a significant psychological battle with a diagnosis that is typically reserved for women.

Health care workers and medical services for breast cancer are skewed towards female patients. Navigating online information and support services is a confronting experience for male patients due to the large proportion of pink-themed webpages with female imagery, pronouns and testimonials. With only around 100 diagnoses annually in Australia, many medical staff will never treat a male breast cancer patient, but it is important for the psychological well-being of male patients that they are treated with compassion while navigating a potentially emasculating diagnosis. For this reason it is important that health care workers are better educated in the challenges male patients face while engaging them in their own care.

The near-ubiquitous availability of modern internet access makes the internet a convenient tool for Australians to access the health information and support they need in a private, timely manner. As described here, there is limited online information and support available for men with breast cancer in sharp contrast to the readily available female-oriented pages. There is a recognised need for more male-targeted online information and for more research into male breast cancer to begin to close the survival gap between the genders.

Allirra Selkirk is a year 4 student at the ANU Medical School.
References available on request from the author.

ACT Primary Health Network secured

By Dr Martin Liedvogel

The Australian Government has announced the ACT Medicare Local (ACTML) will form the ACT Primary Health Network (PHN) from 1 July 2015. It will be a strong primary health care organisation as it was designed with substantial member and stakeholder input during an extensive co-design process.

ACT PHN is well placed to build on current ACTML work in the six priority areas identified for PHNs by the Australian Government, namely mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.

The ACT PHN Blueprint, which sets out the approach to new ways of working in the future, has been endorsed by ACT Government, AMA ACT, NSW/ACT Faculty of the RACGP, the Health Care Consumers Association of the ACT and ACT Council of Social Services.

ACT PHN will be informed by both community and health professionals through a Community Advisory Council and Clinical Council.

ACT PHN will have four areas of focus:

- Better health – continuing to analyse the health needs of Canberrans, particularly of our most vulnerable populations, and continuing to identify and address service gaps.
- Better care – developing new or improved models of care, improving coordination across the primary care sector and with hospitals, and developing health pathways and inter-professional collaboration tailored to the needs of individual patients.
- Better supported workforce – supporting health professionals to improve productivity, providing access to tailored educational opportunities, promoting the value of general practice and developing leadership capability.
- Better value – reducing unnecessary duplication, leveraging investment and brokering public-private partnerships in service delivery, and stimulating market responsiveness to fill service gaps.

Special General Meeting

A Special General Meeting (SGM) of ACTML members will be convened in the evening of 4 June 2015 in order to consider a proposed new Constitution for the company. This new Constitution will be based on a simplified and amended version of the current ACTML Constitution. While this is not essential in order for us to enter into contractual arrangements with the Department of Health to become the ACT PHN, it will enable us to:

- align the company more closely to the Government's PHN requirements e.g. enshrining a new Clinical Council and a new Community Advisory Council as the Board's pre-eminent advisory structures
- introduce a new company name
- streamline and remove some of the redundant clauses in the current Constitution.

Members will be advised shortly on the details of information sessions to be held in early May to provide a full explanation on the new Constitution and key differences from the ACTML Constitution, as well as provide more detail about the operations of the ACT PHN and what this means to you.

The ACTML Board hopes that as many members as possible will be able to attend these sessions and the SGM to consider the new Constitution and take an active interest in the transition to the ACT PHN.

Dr Martin Liedvogel is the ACT Medicare Local Chair and a Canberra GP.

Proposed Murray-Darling medical school will cause more problems than it solves

The Australian Medical Students' Association (AMSA) continues to oppose the proposed development of a new medical school in the Murray-Darling region.

AMSA believes that regulating the total number of medical students is essential to maintain quality clinical teaching and excellence of medical graduates, and to avoid overwhelming Australia's capacity to train doctors.

"This is ultimately an issue of patient safety – increasing the number of junior doctors, while compromising the quality of their education and training, poses a significant risk to public health," AMSA President, James Lawler said recently.

"Australian medical schools must provide students with suitable exposure to an extensive range of medical specialties and clinical settings including public hospitals, rural clinics, community health care facilities, and general practice," Mr Lawler said.

"There are already ten medical schools between New South Wales and Victoria; opening another one when there isn't sufficient capacity for hospitals to provide junior doctors a high-quality clinical education would be irresponsible.

"Before this proposal can be legitimately entertained, there must be substantial evidence provided showing there is capacity to appropriately train these students.

"Increasing the number of medical schools without increasing the available training positions for internships and beyond would cause massive problems.

"AMSA recognises the rural workforce shortage in medicine, but an additional medical school will, paradoxically, compound the problem.

Mr Lawler said it is important to remember that medical training does not begin and end with medical school.

"Medical graduates fresh out of university still have years – in some cases, more than a decade – of training in hospitals ahead of them before they are fully-qualified doctors," Mr Lawler said.

"Increasing the number of students entering medical school will not currently translate to an increase in the number of fully qualified doctors in the Australian health workforce.

'We are now well aware that the issue is beyond medical school admission, and into the post-graduate training pipeline. But this is a short-sighted approach.

"It would be far more productive for the Government to invest in rural vocational training positions to increase the number of doctors working in our rural communities."

AMSA encourages Charles Sturt University and La Trobe University to reconsider their proposal for a new medical school.

Medicare: midlife crisis?

29-31st May, 2015, Brisbane

Given the ongoing debate in Canberra over the Government's proposed Medicare changes – including the infamous GP co-payment model – the theme is timely and appropriate. Policy sessions at Conference this year will explore the core areas and ideals that underpin the medical profession and the health system.

- Funding Quality General Practice – Is It Time for Change?
- Quality public hospital services: funding capacity for performance
- Waste not, Want not: Ethics, Stewardship and Patient Care
- General practice training – the future is in our hands
- Key AMA Public Health advocacy – local and global

The AMA is honoured to have former Prime Minister, the Hon Julia Gillard, as Guest Speaker for the Leadership Development Dinner.

Find out more at ama.com.au/nationalconference or contact us via email natcon@ama.com.au

2015 AMA National Conference

Medicare: midlife crisis?
29–31 MAY 2015 | BRISBANE

AMA

Live your legacy: Bring your philanthropic plans forward and involve your family

By Michelle Gianferrari, Partnership Executive – Perpetual Private

Involvement in philanthropy can come about for many reasons, often a combination of personal and financial motivations. However, there are particular factors which predispose medical professionals to becoming impactful philanthropists.

Your daily work as a medical practitioner is underpinned by the drive to make a positive change in the lives of your patients and the broader community. You're also undoubtedly aware of the great need for research and enhanced health services.

Through your experience in the industry, you'd also understand the profound impact that ongoing, well-targeted funding can have. You may have even benefited from philanthropic donations in your own practice or royal college.

For higher income earners, philanthropy is not only achievable, it also makes financial sense. Structured giving is a tax-effective means of redirecting part of your income to make a significant difference over the short and longer term.

But how can you structure your giving to make an impact during your lifetime, and, should you wish, how can you be actively involved with the organisations you support?

The Private Ancillary Fund (PAF) has emerged as an increasingly popular structure through which medical practitioners can give back to the community. The same way a self-managed super fund is established for control of investment decisions and flexibility, so too is a PAF – allowing you to create your own charitable foundation and determine your level of involvement.

As well as allowing you to share your wealth throughout your lifetime, a PAF is also an effective bridge to a lasting family legacy, as several generations can be involved in the charitable activities of the trust.

The amount of funding available from a PAF relies on contributions and investment returns. This is where a charitable foundation has an advantage over direct donations to a charity. A PAF generates revenue for distribution while attempting to grow capital. Rather than providing a finite amount which may cease at any time, setting up a PAF means you can put your funds to work and provide much-needed ongoing income to the charities and sectors you're passionate about.

Once established, a PAF can be 'topped up' through bequests from your estate, which are not subject to capital gains tax, and incorporated into your will to ensure it serves your intentions in perpetuity.

For medical practitioners wishing to set up a PAF, Perpetual recommends an initial investment of $500,000, but can advise on other appropriate options for smaller amounts. Expert assistance is also recommended to set up a trust deed, secure tax office approval, develop an investment strategy and distribute the funds.

While philanthropists such as Vera Ramaciotti set up a philanthropic structure to provide grants for biomedical research, other philanthropists provide broader mandates that meet with the diverse passions they or their family might have. Ultimately, the most compelling feature of a PAF is that it makes philanthropy 'do-able', tailored and flexible, empowering medical professionals and their families to make a lasting community impact, beyond their work and lifetime.

Long-term legacies in action

The notion of perpetuity is a powerful one. For example, the Ramaciotti Foundations were established by Vera Ramaciotti in 1970 with an original investment of $6.7 million. Under Perpetual's management, this investment has grown to over $52 million (as at March 2015), and has distributed close to $55 million to medical research over that period. Last year alone, it distributed over $1 million in research grants and awards.

More recently, the Samuel Nissen Charitable Foundation was established as a PAF by Mrs Rowena Nissen, to honour the legacy of her late husband, Samuel. Mrs Nissen was particularly keen to establish a PAF structure, while still alive and healthy in 2002, to ensure that the capital from her estate could also be invested to make a difference.

Earnings from the Foundation have since been distributed to a range of worthy causes each year, supporting disadvantaged children, as well as the advancement of medical treatment and research. In the area of medical research the Foundation has been flexible in its approach to funding, supporting everything from a post-doctoral position, advancing prenatal research to solar simulation equipment for the study of sun-related diseases. Since Mrs Nissen's death in 2006, the Foundation has distributed approximately $4 million, demonstrating the legacy she created in her husband's name has already had an impact.

If interested in exploring a PAF, please contact Christine Brill (email:execofficer@ama-act.com.au)

Important information for AMA members

The Annual General Meeting of the ustralian Medical Association (ACT) Limited will be held on Wednesday 13 May 2015 commencing at 7.00 pm.

The meeting will be held in the Conference Centre on Level 3 of AMA House, 42 Macquarie Street Barton.

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

AMA (ACT) LIMITED

Government and Prison Officers' Union agree on development of needle and syringe program for the Alexander Maconachie Centre

Minister for Justice, Shane Rattenbury, announced recently that the ACT Government has signed a Deed of Agreement with the Community and Public Sector Union (CPSU) regarding a proposed Needle and Syringe Program (NSP) for the Alexander Maconochie Centre (AMC), which will allow the Enterprise Bargaining Agreement (EBA) to be finalised.

"I am pleased to announce that after a period of solid negotiation, we have found common ground which will allow us to move forward with the EBA," Mr Rattenbury said.

"The EBA negotiations have been delayed due to concerns in relation to the clause in the current EBA relating to the NSP".

"While maintaining the Government's commitment to implementing an NSP in the AMC, I also understand the need for this to be developed with input from ACT Corrective Services (ACTCS) staff, and the Deed of Agreement will ensure that we recognise the genuine concerns of staff as we consider any proposed models.

"The Deed sets out very clearly the process for engaging staff in the development of an NSP model, including a joint working group to develop a model, a staff ballot process to determine support for any proposed model and a commitment not to implement a model that is unable to gain majority support from voting staff.

"The intent of the proposed NSP is to reduce the spread of blood-borne viruses through the sharing of injecting equipment. We know that there are, unfortunately, confirmed cases of detainee-to-detainee transmission in prisons.

"ACTCS is committed to a Harm Minimisation Strategy to manage drug use in the prison, and remains focused on all aspects – supply reduction, demand reduction and harm reduction.

"ACTCS has a range of measures in place to reduce the amount of contraband entering the AMC and offers a suite of therapeutic and rehabilitative programs. However, an NSP, if endorsed by the ACTCS staff, will fully complete our harm reduction policies and deliver the same level of health service that is available to the rest of the community.

"I would like to acknowledge the hard work of the ACT Government officials and the CPSU over the past few months to get us to this point, and I look forward to seeing the progress of the working group as they take a fresh look at this complex but vital health issue," said Mr Rattenbury.

"The finalisation of the EBA has been a priority of the ACT Government for some time. I am pleased that this step will move staff closer to finalising the EBA and receiving their full entitlements."

AMA (ACT) hopeful of an NSP agreed model

AMA (ACT) is supportive of removal of this issue from the EGA negotiations and is keen to see an "agreed" model in place as soon as possible.

AMA (ACT) President, Dr Elizabeth Gallagher, welcomed the move and stated that it was AMA (ACT) policy to do whatever it could to facilitate a NSP at the AMC in the interests of prisoners, custodial and medical staff at the AMC, and the wider community.

"This is a real opportunity to show leadership and to work with us and other stakeholders to reduce the spread of blood borne diseases in the AMC. We have made an offer to assist in developing and arguing for a model, and we now wait on the Union to take us up on this offer. We acknowledge that other strategies must also be developed and implemented and we're on stand-by to assist with those as well."

"If we can develop a model acceptable to all stakeholders, we have an opportunity to show case this in the hope that other Australian prisons will do likewise", Dr Gallagher said.

One step forward, one step back: Mixed feelings about ACT Government's latest attempt to implement needle exchange policy

Hepatitis ACT cautiously welcomed the announcement by Corrections Minister Shane Rattenbury that the ACT Government remains committed to the implementation of its prison needle exchange policy. The policy has stalled since former Chief Minister Katy Gallagher's departure, and stakeholders are uncertain whether the latest developments represent progress or capitulation.

Executive Officer of Hepatitis ACT, John Didlick said "We remain optimistic, though it is surprising that this new Deed of Agreement between Government and some prison staff seems to allow ACT public servants an effective veto over whether to implement existing Government policy."

Evidence from community and prison-based needle and syringe programs demonstrates that blood borne viruses can be prevented and reduced when people who inject drugs are able to access regulated sterile injecting equipment. Prisoners at the ACT prison have high rates of hepatitis C, access to illicit drugs and contaminated injecting equipment, and experience in-prison transmission of viruses that could be prevented through evidence-based health policy.

"The ACT Government's *Strategic Framework for the Management of Blood-Borne Viruses in the Alexander Maconochie Centre* (AMC) is an excellent policy document," said Mr Didlick. "It ticks every box of what could be a comprehensive and effective response, if only it were implemented in full.

Prison needle exchange is one important component of an ACT Government policy yet to be fully adopted."

Hepatitis ACT understands that the new Deed of Agreement requires custodial officers to consider possible models for a needle exchange. However, such consideration may be hampered as the prison workforce as a whole has not yet been provided with the "comprehensive, mandatory and regular training and education" about relevant issues that the strategic framework requires.

Mr Didlick said "When people have limited access to current and reliable information, it is only natural that doubts and myths will prevail."

Hepatitis ACT is funded by the ACT Government to deliver ongoing and regular awareness training and education with prison staff, but has not yet been able to provide these services to all custodial staff, due to competing operational requirements.

"The provision of current and relevant information and training to all custodial officers could help inform their consideration of possible models. It is important that the expertise of

custodial staff is harnessed in the development of a model and related operational protocols. However, no one group should be able to veto the implementation of measures designed to prevent the spread of blood borne viruses, which effects everyone in the Canberra community," said Mr Didlick.

PHAA welcomes step forward in prison NSP process; however plan should not depend solely on custodial officers' support

The Public Health Association of Australia (PHAA) welcomed the ACT Government's latest efforts to progress the implementation of a Needle and Syringe Program (NSP) in the ACT prison, including finalisation of a new Enterprise Bargaining Agreement for custodial officers. However, PHAA is concerned that ultimate implementation of the program is still limited to the endorsement of custodial officers via a ballot rather than all stakeholders.

"We believe the input of custodial officers is integral to the development of a workable model for the implementation of a NSP in the Alexander Machonochie Centre (AMC). Most importantly, it is also clear that the deed is signed in 'good faith' recognising "it is Territory policy to introduce a Needle and Syringe Program".

"It is not appropriate that custodial officers should ultimately have the power to veto the implementation of a workable model," explained Michael Moore, "especially when their members have been integrally involved in the development of the proposal".

"It is important and appropriate that custodial officers are involved in the development of a model for the implementation of a NSP in the prison, including the establishment of operational protocols that address health and safety concerns. However, as only one group of stakeholders set to be effected by the NSP in the AMC, they should not be allowed to actually block the implementation of an important public health measure designed to prevent the spread of blood-borne viruses (BBVs) among detainees and the broader community".

"The implementation of key public health measures should be based on evidence, not popular opinion. The evidence from such programs run overseas indicates that they can operate safely and effectively in prison contexts. Likewise, community-based NSPs – while not always popular with everyone – have been shown to dramatically reduce the incidence of BBVs among at-risk populations, thereby reducing the risk to the broader community.

"We call on the ACT Government to ensure that the best interests of all stakeholders are served in the development of evidence-based policies and programs to promote better public health outcomes for the ACT community," said Mr Moore.

2015 Directory of Medical Specialists, Directory of Allied Health Professionals and Directory of GPs with Special Interests

… a publication of the AMA ACT

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The second edition of the directory of **Allied Health Professionals** and **GPs with Special Interests** will be published as a service to ACT general practitioners and distributed with the 10th edition of the **Directory of Medical Specialists** during Family Doctor Week in July 2015.

Entries must be on the form below and returned to the address below no later than 30 April 2015.

Mail: AMA ACT, PO Box 560, CURTIN ACT 2605
Fax: 6273 0455 Email: reception@ama-act.com.au

☐ **Directory of Medical Specialists** ☐ **Directory of Allied Health Professionals** ☐ **Directory of GPs with Special Interests**
(Select which Directory/s you would like to go in)

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Speciality:

Services offered:
(Please keep this brief and use only accepted abbreviations – eg: DCH, Diploma in Child Health)

Practice Details (1)	**Practice Details (2)**
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I am/am not interested in taking a display advert to accompany my listing in the directory.

Signed: _____ Date: _____

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Note: In order to be included in this directory,it is mandatory that you are a medical practitioner currently registered with the Australian Health Practitioner Regulation Authority (AHPRA)

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Contact Phone: _____

A proof of your entry will be sent prior to printing. Please indicate preferred method to receive this:

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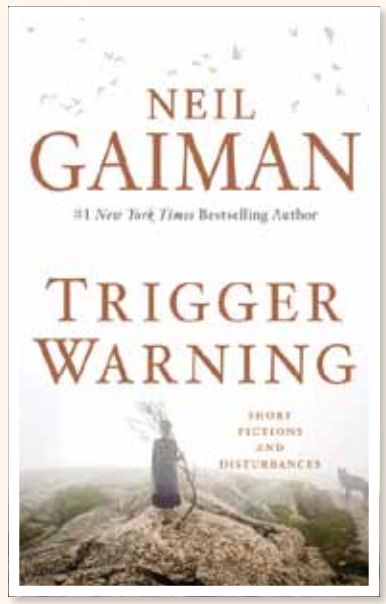
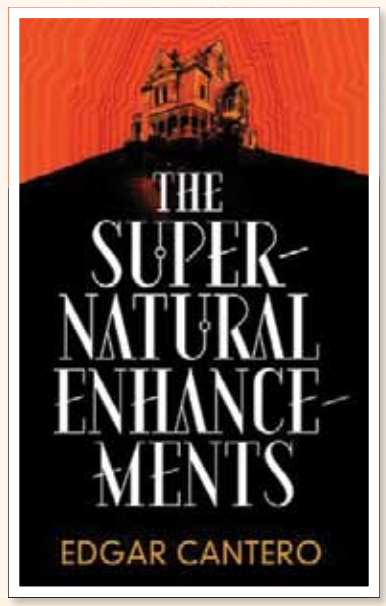
BOOK REVIEWS: Trigger Warning *and* The Supernatural Enhancements

Trigger Warning, Neil Gaiman, Headline, ISBN 978-1-4722-1769-1, GBP 14.99

The Supernatural Enhancements, Edgar Cantero, Del Rey, ISBN 978-0-091956-46-2, GBP 12.99

These two books are written by skilled fabulists, Gaiman, a luminary, and Cantero, a sparkling new talent. The authors share a sense of whimsical macabre, but the book formats differ.





'Trigger Warning' is a collection of short stories and a little poetry from Gaiman. Having read a somewhat uncharitable review of this book recently, I would demur that the chatty introductions to the contexts of the stories are actually quite atmospheric. Gaiman is known as an author of quite unique fantastic novels often anchored in wistful melancholy, such as 'American Gods', 'Coraline' and 'The Ocean at the End of the Lane'. Two standout stories in a cave of treasures are: 'Black Dog' which charts the travels of Baldur 'Shadow' Moon, the protagonist of sorts of 'American Gods', in a strange version of Derbyshire; and 'The Truth Is a Cave in the Black Mountains' builds a twist on the tradition of Aesop's morality play fables with a haunting denouement. There are also stories on 'Doctor Who', Sherlock Homes, and of course, some re-imagined fairy tales.

'The Supernatural Enhancements', as the author Cantero acknowledges, has a title borrowed from Edith Wharton. This is an epistolary novel, built upon the diaries of 'A.', a young man who inherits Axton House from a mysterious relative Ambrose Wells; but also fleshed out with notes, audio transcripts, receipts, excerpts from ancient books and even transcripts of video recordings. As 'A.' and his companion Niamh explore the mansion, communicating back and forth with the sphinx-like 'Aunt Liza', they seek to descry the intaglio of intrigue imbued in the manse and its inhabitants. Cantero has crafted a beautiful independent masterpiece in the oeuvre of cosmic horror championed by legendary epistolarian Howard Phillips Lovecraft, author of the 'Cthulhu mythos' stories.

There are many thrills and delights to be savoured from these tales of whimsical macabre by two masters of their art – though you may be advised to leave on the lights after reading at night….

Reviewed by:
Associate Professor Jeffrey Looi
Academic Unit of Psychiatry and Addiction Medicine,
ANU Medical School

New training regions for GP specialist training

The Minister for Health, Sussan Ley, has announced new training regions and governance arrangements for the future delivery of GP specialist training.

Ms Ley said the new geographic boundaries for 11 training regions to deliver the Australian General Practice Training (AGPT) programme had been developed in consultation with GP stakeholders and would commence from 2016.

"The Abbott Government is committed to continuing our high quality vocational training programme for general practice and ensuring there are more GPs in training to deliver primary health care to Australians for generations to come," Ms Ley said.

"Through streamlining administration and corporate requirements, these new geographic boundaries will assist to support more GP registrars including 1500 fully funded GP registrar training places in 2016."

Ms Ley also announced the establishment of a new profession-led General Practice Training Advisory Committee to provide advice to government on GP training policy and delivery.

This advisory committee will undertake evaluation of the Australian General Practice Training programme and be jointly managed by the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine. The advisory committee will include representatives of General Practice Registrars Australia, General Practice Supervisors Australia, an independent Aboriginal or Torres Strait Islander GP, two independent clinicians, the Department of Health and an independent chair.

The Australian Government will shortly conduct a tender to deliver the AGPT programme from 2016 onwards. This will ensure new regional training organisations and arrangements are in place for the 2016 intake of GP registrars.

The AGPT programme is a postgraduate vocational education and training programme designed to prepare GP registrars for fellowship. There are currently more than 4,700 GP registrars on the AGPT programme nationally.

The change is part of implementing the 2014-15 Budget initiative, Rebuilding general practice education and training to deliver more GPs.

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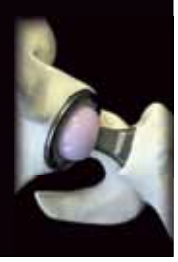

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