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CANBERRA Doctor

Informing the Canberra medical community since 1988

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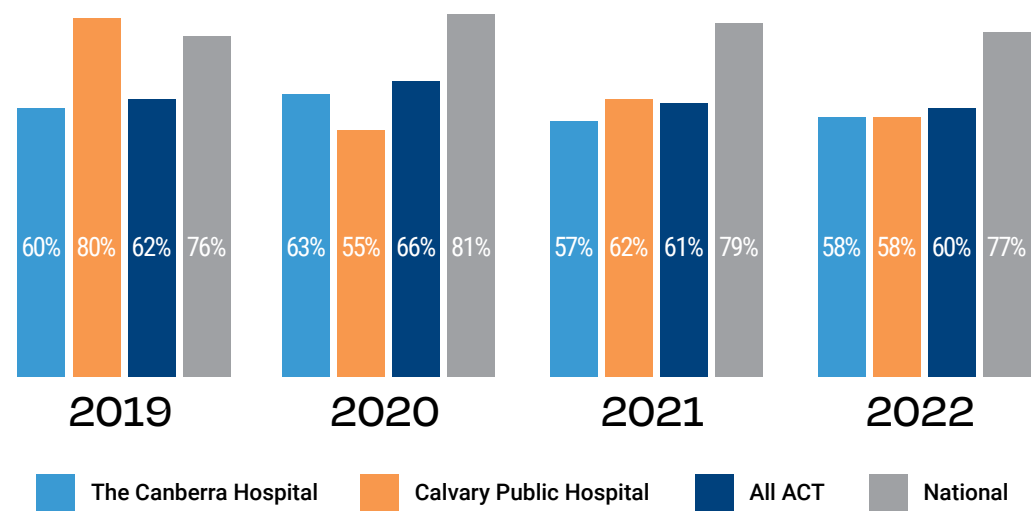
Canberra trainees least satisfied: national survey

Overall satisfaction
"I would recommend my current workplace as a place to train."

Agree/Strongly agree:



Canberra's reputation as a training location for junior doctors continues to lag the rest of the country, new survey data reveals.

Only 60% of junior doctors in Canberra would recommend their current workplace as a place to train – well below the national rate of 77%, according to the 2022 (fourth) edition of the Medical Board of Australia's Medical Training Survey. The finding is consistent with previous year results for the ACT and is based on responses from 446 Doctors in Training (DiTs) in the ACT. Nationally, the survey attracted 23,083 respondents.

Of the ACT respondents, 290 came from Canberra Hospital, 41 from Calvary Public Hospital and 70 were not located in a hospital. Some 11% of the sample were GP trainees.

Only 58% of DiTs at Canberra Hospital would recommend their workplace as a place to train, consistent with the previous year's low rate. Likewise, only 58% of trainees at Calvary Public Hospital would recommend their workplace, however this was down from a high of 80% in 2019.

Across the jurisdictions, 79% of trainees in Victoria would recommend their current workplace as a place to train, along with 78% in Queensland, 78% in Western Australia, 77% in New South Wales, 77% in South Australia and 71% in Northern Territory. Nationally, the overall workplace satisfaction rate (77%) declined from a high of 81% in 2020.

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President's Notes

WITH PRESIDENT,
PROFESSOR WALTER ABHAYARATNA

Prof Walter Abhayaratna, ANU medical student Jeanette Ryan, Dr Tanya Robertson, Dr Kerrie Aust and Dr Antonio Di Dio at the Student Welcome Drinks in February.

If you feel like 2023 is shaping up to be a big year, you're not alone. The DHR is bedding down, voluntary assisted dying is set to be made legal in the ACT and this year's Federal budget has a 'make or break' feel about it for our overstretched healthcare system.

How do you feel about what lies ahead?

The doctors I meet through the AMA give me great confidence. Our own Kerrie Aust has done a wonderful job in recent weeks of communicating the value of general practice on radio and television. There's also Dr Tanya Robertson on the AMA board, who is actively working to improve the lives of disadvantaged Canberrans through her work at Directions and her role at Deepend (see p6). Dr Betty Ge, our ACT representative on the AMA's Federal Council of DiTs is well-known and loved by many younger doctors in the region, for whom she tirelessly advocates. All this is just to name a few.

We have many wonderful members, but we need more. In such an important year, I urge all doctors in the ACT who are not already a member to consider joining AMA ACT. Doctors need a strong, clear and consistent voice to government if we are to overcome the many barriers to providing quality care to our patients and make a life in medicine sustainable and rewarding. As a member, you also have the backing of experienced industry experts, including industrial relations support and access to our fees list. AMA ACT also provides valuable networking opportunities to our members throughout the year.

Voluntary assisted dying

Over recent weeks I have met with a handful of our members to talk about the heavy issue of assisted dying, including some who were firmly against it and others who were strong supporters. The compassion, integrity and intelligence of these senior doctors underlines the importance of this issue. The community has decided in favour of VAD, and every doctor in the ACT is going to be affected by this issue once it becomes law. It is important that we get the best model we can for the ACT, considering all the evidence. Please get in touch to share your views as we work together with the ACT Government.

Welcoming all interns

I've recently had the pleasure of mixing with some of our inspiring new interns, including at the Orientation Breakfast. In particular, I would like to recognise Dr Nese Gezer, who won the 2022 AMA Student Prize for Leadership. Dr Gezer has been a thoughtful, measured and courageous advocate as secretary and president of the ANU Medical Student's Society. Her tireless efforts to support her peers have included creating an anonymous bullying and harassment reporting portal, which will continue to serve the students who come after her. Dr Geze was a standout nomination for the leadership prize and I have no doubt we will continue to hear from her.

I would also like to acknowledge the valuable contribution of Dr Emily Sisson, our outgoing inaugural Junior Doctor Advisor who did a fantastic job coordinating the Council of Doctors in Training (CDT) and ensuring trainees' voices are heard. We wish Dr Sisson all the best with her internship and welcome this year's advisors, Ellie Gundry and Abigail de Waard.

I want to encourage all junior doctors to be a part of shaping the culture they are working in. The results of the Medical Training Survey are not uplifting for doctors starting out in Canberra, but all of us can be a part of improving the situation, no matter what stage of our career we are at. The CDT is a regular forum where DiTs are invited to share their experiences and work together with AMA ACT to improve our advocacy and support for the profession. All interns are welcome to get involved.

GP Regs single employer model

I want to finish by flagging a very important development in Tasmania, which could be replicated here in the ACT. I'm talking about the news that GP trainees will now be covered by a single employer agreement as they move across their placements, under a Tasmanian pilot. This agreement will enable GP trainees to take their leave entitlements with them and avoid the significant cut in wages they typically experience when they leave the hospital system. It is fairer to young doctors and redresses a perverse disincentive to considering a career in general practice.

This agreement between the State and Federal government is a rare example of successful collaboration across the jurisdictions to take shared responsibility for primary care. It shows what's possible when we stop blaming one another and start working together to solve entrenched problems in our healthcare system.

AMA ACT will be ramping up its efforts to facilitate a similar agreement here in the ACT. Watch this space. ■

VALE

The President, Professor Walter Abhayaratna, Board members and staff of AMA (ACT) extend their sincere condolences to the family, friends and colleagues of

Dr Peter Giffard

Blood transfusions safer at Canberra with DHR

Amid the ongoing disruption caused by the rollout of the new digital health record (DHR), a good news story has emerged from the field of transfusion medicine.

Dr Philip Crispin, haematologist at Canberra Hospital, said the ACT now has what is "probably the safest approach to blood transfusion in the country" thanks to changes enabled by the Epic DHR.

"Every patient who comes through the door gets a barcode, and we have the capacity to match their identity with previous blood group information we have for them," he said. "The whole way through their hospital journey, their identity is checked electronically."

Previously, two health professionals were required to independently confirm a patient's identity and the product being issued immediately prior to a transfusion. However, under the new system, only one health professional is required to do the check.

Dr Crispin explained: "At every hospital in Australia, the double independent check has been a critical feature of blood transfusion safety, because if the patient gets the wrong blood, they could die.

"However, at Canberra Hospital, we have now been able to safely withdraw that second person because a computer does the second part of the check for us."

Dr Crispin led a committee of the Australian and New Zealand Society of Blood Transfusion which in 2021 produced guidelines on the use of electronic medical records in transfusion medicine. He said he believed Canberra Hospital was now the first in Australia to implement these.

Laboratory savings

At the laboratory end too, Canberra Hospital has found efficiencies through the DHR, which integrates inventory management and ordering systems so that data no longer needs to be entered twice.

Kelly Sliwinski, a senior transfusion scientist from ACT Pathology said this was a "dream come true" for her staff, noting the Hospital uses up to 800 units of blood each month.

"The new system has removed double-handling, which is saving us a lot of time," Ms Sliwinski said. "When a unit is used, our system sends a message to Bloodnet [the National Blood Authority's interface between laboratories and Red Cross], and that will drop our stock down so we know exactly what we need to order." The system will also automatically alert Bloodnet if stocks become critically low.

ACT Minister for Health Rachel Stephen-Smith, Kelly Sliwinski, Simon Newton (Acting Director of Laboratory Operations) and Jessica Driscoll (DHR and Evolution Analyst) (L-R).

All information associated with each individual donor comes into the hospital's laboratory system so the team can do a functional search to look at a specific phenotype in a donor unit, Ms Sliwinski said. "Prior to now, we had to have fridge doors open and individually go through about 170 units to look at the phenotype on each donor unit, so it is so much quicker now," Ms Sliwinski said.

Ongoing disruption

Unfortunately, these time savings are currently offset by disruption caused by the DHR, including the work of migrating patient data across to the new system and poor integration with some GP software. Dr Crispin acknowledged aspects of the DHR have been "really difficult" in daily practice.

"We still find things that appear difficult and frustrating to us with the system" he said. "But at some point, we need to put those trials and tribulations behind us and start building on the base to make this fantastic."

"We need to aim high and make sure along the way that we look after each other; our patients really need us to stick together and build it and the opportunities here are enormous." ■

Acute care doctors: share your views

Healthcare staff working in acute care hospitals are invited to participate in a nationwide online survey about the Comprehensive Care Standard in acute care hospitals.

The anonymous and confidential 15-minute survey is being undertaken by Beibei Xiong, a PhD candidate working with Dr Melinda Martin-Khan and Professor Christine Stirling at the University of Queensland and the University of Tasmania.

Respondents will have the opportunity to reflect on their own knowledge, views, and experiences with the Comprehensive Care Standard. They will also be offered the opportunity to take part in a subsequent interview and receive a $50 gift card to share their story.

To take part in the survey visit survey.app.uq.edu.au/comprehensive-care

The deadline for participation is EOD 31st March 2023. ■

COVER STORY

Canberra trainees least satisfied: national survey

2022 Medical Training Survey ACT snapshot

Continued from page 1

Longer hours

Dr Betty Ge, an AMA ACT board member and ACT representative on the AMA's Council of Doctors in Training said the findings signalled ongoing deficiencies with the culture and working conditions at Canberra's hospitals.

"In the ACT, our trainee doctors work longer hours than their interstate peers and that may help explain why they have more concerns about patient safety," she said. "These things are all interconnected."

On average, trainees at Canberra Hospital worked 50 hours a week – slightly down on previous years, but above the national average of 46 hours. Calvary respondents worked an average of 45.5 hours per week.

Regarding patient safety, 75% of junior doctors at Canberra Hospital agreed there was a culture of proactively dealing with such concerns in their workplace – a 10 percentage point improvement compared with 2019, but below the national rate of 82%. Calvary Public Hospital experienced a decline on this measure, from 80% in 2019 to 72% in 2022.

While satisfaction with the quality of clinical supervision has risen at Canberra Hospital over the last four years (now 84%, compared with a national rate of 86%) there has been a consistent decline on this measure at Calvary. Only 68% of Calvary respondents rated the quality of their supervision as good or excellent, down from 79% in 2019.

Wellbeing

Only 49% of respondents from Calvary Public Hospital agreed with the statement 'My workplace supports staff wellbeing' in 2022, a major decline from 76% in 2019. This compared to a rate of 62% at Canberra Hospital, a slight improvement on last year, but still well below the national rate of 77%.

Dr Ge said AMA ACT had repeatedly raised concerns with Canberra Health Services about doctor wellbeing, but the problems persisted. "These figures reflect hospital-wide problems, affecting nurses as well as doctors," she said.

Bullying

The latest survey drilled down on some of the specifics of workplace bullying, harassment and discrimination. While there were improvements at Canberra Hospital on this measure over the survey period, disturbing trends have emerged at Calvary Public Hospital.

Canberra Hospital trainees experienced their lowest rate of bullying, harassment and discrimination in four years (27%, compared to the national rate of 22%).

However, Calvary trainees experienced the highest rate of bullying, harassment and discrimination over the period, at 43% (up from 32% the previous year). National figures show that most often the perpetrator was in the trainee's team, although hospital-specific data was not available on this measure.

Differences between Canberra's training hospitals also emerged when it came to the culture of reporting abuse and bullying. At Canberra Hospital, 46% of respondents who experienced mistreatment made a report—a significant improvement on previous years and above the national rate of 30%.

However only 23% of Calvary trainees made a report about their experience of bullying, harassment or discrimination, down from 45% in 2019.

The main reasons for not reporting an experience of workplace mistreatment in Canberra and nationally were concerns about repercussions, a belief that nothing would be done about it and a feeling that it was not the accepted practice.

Among those Canberra DiTs who did report an incident of mistreatment, 75% were satisfied with how it was followed up (sample size, 21). This compared with a satisfaction rate of only 59% nationally. Results for individual hospitals were not available on this measure.

Pay and conditions

The survey showed there has been some improvement on the issue of unpaid unrostered overtime in the ACT over the past four years, although there remains a long way to go. Some 64% of Canberra Hospital respondents reported getting paid for unrostered overtime 'always or most of the time' in 2022, a steady increase from 46/47% in 2019/20. At Calvary, the rate was 68%. This compared with the national rate of 61%.

The survey also demonstrated gains for trainees at Canberra Hospital on a number of issues AMA ACT has agitated for in enterprise agreements. These include:

- 60% of trainees at Canberra Hospital reported having access to protected study/time leave, a return to the pre-Covid rate
- 66% reported that they can attend conferences, courses and/or external education events, getting closer to the pre-Covid rate of 73%
- 73% said their employer supports them to attend formal and informal teaching sessions, the highest rate in four years
- 60% said they were able to participate in research activities, the highest rate in four years
- 79% said they can access the training opportunities available to them, the highest rate in four years

Unfortunately, Calvary Public Hospital showed declines on several measures, including:

- Only 58% said they could attend conferences, courses and or external education events, down from 76% in 2019
- Only 53% said their employer supported them to attend formal and informal teaching sessions, down from 81% in 2019
- Only 35% said they were able to participate in research activities, down from 52% in 2019

Covid impact

The latest survey showed the Covid-19 pandemic continued to impact on training nationally, but in a slightly different way from the previous year. More ACT respondents said the pandemic negatively impacted their workload in 2022 than in 2021 (63% vs 45%). However fewer said the pandemic was negatively impacting their exam preparations (49% vs 57%). These findings were broadly consistent nationally.

Overall

While only 60% of ACT respondents would recommend their workplace as a place to train, 70% would recommend their current training position.

Dr Ge said this showed trainees were reasonably happy with the support their college was providing them, including with exams, goal-setting and support. Although satisfaction rates were slightly lower for DiTs in GP specialist training than those in non-GP specialist training, Dr Ge said this was to be expected given the sector is in a transition phase.

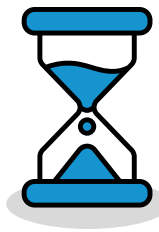
Dr Anne Tonkin, chair of the Medical Board of Australia said that overall, the national results suggest that things are not quite as good in medical training in 2022 as they have been in previous years.

"Qualitative research and analysis would be needed to definitively understand the reasons for this, but it is possible that broader, pandemic-related health system pressures are adversely affecting medical training," she said. "Through the MTS, the health sector has been given early warning about issues to address. We all owe it to trainees to act." ■

View and compare the survey results at medicaltrainingsurvey.gov.au

Average weekly hours

The Canberra Hospital	Calvary Public Hospital	National Sample
50 HOURS	**45.5** HOURS	**46** HOURS
2019: 51.2	2019: 48.5	2019: 46.9
2020: 51.4	2020: 51.8	2020: 45.6
2021: 50.5	2021: 51.4	2021: 45.5



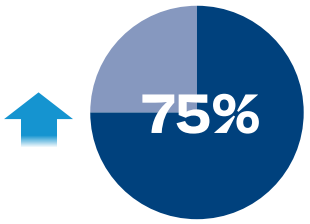
"My workplace supports staff wellbeing."

Agree/Strongly agree

The Canberra Hospital	Calvary Public Hospital	National Sample
62%	**49%**	**77%**
2019: 61%	2019: 76%	2019: 75%
2020: 64%	2020: 60%	2020: 81%
2021: 59%	2021: 73%	2021: 78%

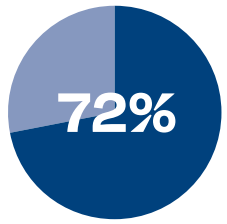
"There is a culture of proactively dealing with concerns about patient care and safety in my setting."

Agree/Strongly agree



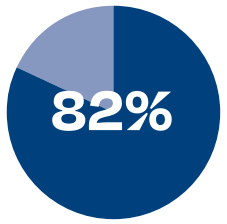
The Canberra Hospital
2019: 65%
2020: 72%
2021: 67%

NO CHANGE



Calvary Public Hospital
2019: 80%
2020: 63%
2021: 72%

NO CHANGE



National Sample
2019: 79%
2020: 82%
2021: 82%

"I get paid for unrostered overtime."

% Always/Most of the time

64%
The Canberra Hospital
2019: 47%
2020: 46%
2021: 53%

68%
Calvary Public Hospital
2019: 28%
2020: 39%
2021: 57%

61%
National Sample
2019: 47%
2020: 50%
2021: 55%

"I have access to protected study time/leave."

Agree/Strongly agree

60%
The Canberra Hospital
2019: 60%
2020: 56%
2021: 45%

60%
Calvary Public Hospital
2019: 57%
2020: 49%
2021: 53%

NO CHANGE

64%
National Sample
2019: 63%
2020: 64%
2021: 65%

At your workplace in the last 12 months have you experienced bullying, harassment and/or discrimination?

% Yes

27%
The Canberra Hospital
2019: 30%
2020: 33%
2021: 33%

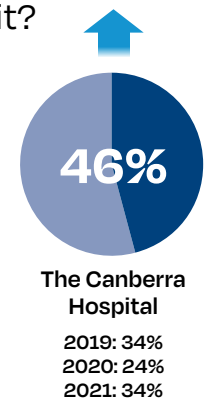
43%
Calvary Public Hospital
2019: 33%
2020: 28%
2021: 32%

NO CHANGE

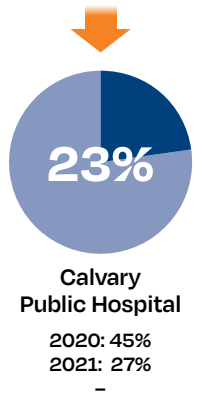
22%
National Sample
2019: 22%
2020: 21%
2021: 22%

Have you reported it?

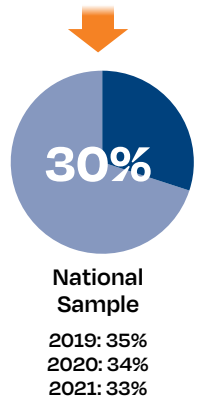
% Yes



The Canberra Hospital
2019: 34%
2020: 24%
2021: 34%



Calvary Public Hospital
2020: 45%
2021: 27%
–



National Sample
2019: 35%
2020: 34%
2021: 33%

Comment

It's time to let the MTS set the benchmark for wellbeing

PROFESSOR WALTER ABHAYARATNA
AMA ACT PRESIDENT

The headline result for the ACT from the Medical Board of Australia's Medical Training Survey (MTS) makes for hard reading: ACT trainees have the lowest satisfaction rate of any DiTs in the country. Only 58% of trainees at Canberra Hospital and at Calvary would recommend their workplace as a place to train. While that's a majority, it's well below the national average (77%) and calls into question the ACT's ability to attract and retain great doctors.

This discouraging figure is not a blip in the data. The MTS is a repeated survey rigorously undertaken annually by the Medical Board of Australia and involves more than 23,000 junior doctors across the country. It enables valuable year-on-year and state/territory comparisons and can be broken down to results by hospital and by specialty.

The Medical Training Survey shows trends over time, and the picture could not be clearer – many of our young doctors are not happy. I recently had the pleasure of meeting many of Canberra's new interns at their orientation breakfast. How hard it must be for them, having climbed the mountain that is medical school, to know that they are entering a workplace where they can expect longer hours of work than their interstate peers, unpaid overtime still running at high levels, and for many, bullying and harassment from other staff members.

We have some wonderfully dedicated heads of department and supervisors among our doctors here in Canberra, who hope their trainees will catch their vision for excellence and stay on. How frustrating it must be for them to see such a low satisfaction rate among the trainees, and to lose good people to more attractive interstate workplaces.

What does this say about the organisations that are supposed to be looking after our young trainee doctors at work: Canberra Health Services, Calvary Public Hospital Bruce, AMA ACT, the Australian Salaried Medical Officers Federation (ASMOF) and the colleges?

To AMA ACT, the results of the Medical Training Survey are very grave. If despite our ongoing work to improve doctor wellbeing, the benefits and support in the enterprise agreement and policy, and best intentions, our junior doctors are reporting worsening experiences at work, we are failing them.

In my view, all of the responsible organisations must face up to the data and take the decision to be accountable for improving the workplace and training experience of our young doctors. In fact, it's time we all agreed to use the Medical Training Survey as a benchmark for how well we are supporting our junior doctors.

For the sad truth is that unless everyone at the table can agree on an objective measure of success or failure – and there is arguably no better measure than the MTS – easy public relations wins will trump measurable wellbeing gains for doctors.

However, the good news is, if we can agree on a measure to hold employers and policy-shapers accountable, the next step becomes a collaborative implementation plan to bring about the outcomes we all want.

Finally, the latest survey results provide some evidence of improvement on issues AMA ACT has been advocating for – at Canberra Hospital, more trainees are being properly paid for the overtime they work, more are accessing training and research opportunities, and trainees who experience workplace bullying are increasingly coming forward to make a report. These gains may signal a brighter future ahead. ■

Spotlight on...

Deepend Canberra

Dr Peter Tait is a founding member of Canberra's 'Deepend' group, an independent network of doctors and nurses working with disadvantaged patients in the ACT. Through their regular meetings and mailing list they support one another in what can be an otherwise isolating aspect of primary care. The group also provides educational opportunities, engages in advocacy work and facilitates research to improve care for marginalised populations. Dr Tait spoke with *Canberra Doctor*.

You were a GP in remote areas of Australia for over 30 years before moving to Canberra and now do regular work at Directions Health Service. What nugget of wisdom can you offer about caring for disadvantaged patients?

It comes back to the core of general practice, which is making robust, long-term relationships with people who are disadvantaged and often traumatised. The disadvantaged patient needs that really long-term stable relationship in their life to get to the point where they know you well enough that they're confident that you might be able to help them. And then you can make change.

What is the 'Deepend' concept?

The first Deepend groups were set up in Scotland some decades ago. It was given the name because healthcare staff who spend a lot of their time working in disadvantage communities often feel out of their depth. There are now Deepend groups around the world. The groups offer important support for doctors, who can otherwise feel very isolated working in this space.

Who are the disadvantaged in Canberra?

Most disadvantaged people aren't housed securely; that includes those living on the streets, those who are couch surfing, and those living in ACT housing accommodation but in fear of their neighbours.

There are people with overlapping mental health and substance abuse issues, many of whom have had traumatic adverse childhood experiences. There are also people living in domestic violence and coercive control situations.

Concession cards are a very crude indicator of disadvantage. If you're really impoverished and living on the streets and not in Centrelink's 'good books', you might not have a healthcare card.

Disadvantage also includes those people who can't afford to pay for their kids' excursion fees or buy them new shoes when they need them, who are missing meals so they can feed the kids. A lot of these people won't necessarily admit to disadvantage, but if they can't be bulk-billed they will choose not to seek medical care.

Are disadvantaged patients able to access GPs in Canberra?

The situation was bad and it's got much worse. In the last few months, as many practices in Canberra have tightened up their billing, we're noticing more people coming to Directions. They're saying, 'I can no longer go and see my long-standing GP because they no longer direct bill me and so I'm coming to see you.'

One of the problems is that even if the patient gets $39.75 back from Medicare, they still have to front up the $80 to 100 they are charged. If they don't have the $80 in their bank account that's going to be a problem, and all the more so if they've got a few kids.

Dr Peter Tait

> "Health care is not like other business enterprises; it is something governments should make available, affordable and accessible to people as part of the social contract."

How do we fix this?

The problem is that our model of care and funding model reliant on fee-for-service is outdated. Doctors are trying to run a small business. It's become more costly to run a practice. So as costs go up, practice income has to go up. That means greater throughput and or higher fees.

Health care is not like other business enterprises; it is something governments should make available, affordable and accessible to people as part of the social contract. It needs to be thought about and funded in this way.

What the general public and politicians don't understand is that when the patient gets charged $80, only around half of that goes to a doctor because the rest goes to practice costs. While that might look like $160 an hour of face-to-face work, there is no payment for time-consuming paperwork like writing referrals and applications for disability support pensions or for making phone-calls to other members of a patient's care team. These things can take the GP hours each day and part of the fee the patient pays is for that time.

If the GP is working in the disadvantaged population it takes even more time, so they will see fewer people in the day and need quite an extensive support team – social workers, psychologists, case coordinators. Practices should be funded for this.

What projects has Deepend Canberra been involved in?

One of our earlier projects was getting ANU medical students to come up with a survey tool for general practices to look at their patient population and work out who is disadvantaged; the aim being then to advocate for greater support for those practices who were seeing a lot of disadvantaged people. That support could come in the form of extra practice incentive payments or social workers being embedded in the practice.

Another project was working with Canberra Hospital to rejig its emergency department triage system so that it could positively discriminate in favour of people who were disadvantaged.

We are also working with agencies in the ACT who are looking at the homelessness situation.

How can doctors get involved with Deepend?

The group welcomes new members. To find out more contact deependcanberra@gmail.com ■

To find out more contact deependcanberra@gmail.com

Immediate action needed to save general practice

Frustration is mounting over the Albanese Government's slow response to the Medicare crisis, with leading voices calling for immediate action to save general practice.

AMA President, Professor Steve Robson expressed disappointment that the federal government made no major announcements to revive the sector after a highly anticipated National Cabinet meeting on February 3.

"We were hearing talk from all of the premiers, chief ministers, and the Health Minister that health is the highest priority for the government at the moment and Australians can see the crisis the health system is in," he said. "We were surprised to see nothing more come out of [the National Cabinet meeting]. We had the most powerful political leaders in the country, all in one room. Doesn't seem they could agree on anything."

The government used the meeting to release its glossy 12-page Strengthening Medicare Taskforce Report, a high-level document emphasising integrated multidisciplinary teams and blended payments.

"There is absolutely nothing in the report, as released today, that will allow Australians who are struggling to see a GP or struggling to afford to see a GP, see that GP any more quickly, any more affordably, and Australians who are waiting for operations and surgery to relieve pain to have these procedures any more quickly," Professor Robson said.

"So, while the report is very welcome and certainly has changes that will strengthen the system that we know, there is absolutely nothing in the report at the moment that will provide anything immediate, and that is what we need."

No more waffle words

At a National Press Club event the following week, AMA-ACT President Elect Dr Kerrie Aust, RACGP President, Dr Nicole Higgins, and renowned health economist Dr Stephen Duckett called on the government to act now to address the growing crisis in primary care.

"Primary care is in pain," Dr Duckett said. "There must be an immediate down-payment in the May budget, and very clear signals, not just waffle words of what will come in the near future."

"More money needs to be invested in primary care; significantly more than the $250 million per annum that the government put on the table at the last election."

Dr Duckett said the government needed to get specific about how money would be spent. He outlined several possible actions for the government, including:

- Commit to fair indexation of general practice rebates through an independent tribunal. "This would give the profession some surety for the future and would be a sign of good faith," he said.
- Introduce a Level E long consultation item
- Reduce rebate spending for in-hospital medical specialists and shift it to primary care to better incentivise general practice as a career choice
- Redesign and increase bulk-billing incentives so that practices are rewarded if all patients in a certain group are bulk-billed. Dr Duckett hinted at how this might work, saying "the rise of corporates may make this easier through direct negotiations with those chains and possibly the [PHNs] primary health networks."

Dr Duckett said the health system was in desperate need of structural reform as a result of major changes over the last 40 years, including a wider variety of skilled health professionals, more profit-seeking corporates and more patients with chronic conditions.

Dr Duckett described autonomous pharmacy prescribing and telehealth disruptors as "unfortunate developments". "They both fill a niche being vacated by general medical practice [as a result of the falling bulk-billing rate] and they will grow," he said. "How these changes play out really depends on how government responds and how traditional general practice repositions itself."

GP perspectives

Dr Kerrie Aust, AMA ACT President-Elect highlighted the ways GPs save lives and save the health system money through early intervention.

[L-R] RACGP President Dr Nicole Higgins, health economist Dr Stephen Duckett and AMA ACT President-Elect Dr Kerrie Aust at the National Press Club.

"We know general practice can help prevent disease; we know general practice manages patients with chronic disease well; and we know it can avoid the higher cost and late intervention of hospital treatment required for untreated disease," she said.

Dr Aust described the chronic underfunding of general practice as "illogical" and warned about the dangers of pharmacy-led prescribing, which is now in effect in Queensland and NSW.

"[Making a diagnosis] looks simple but it's decades of training," she said, noting urinary tract infections had to be distinguished from other conditions such interstitial cystitis and sexually transmitted infections. "Really the only way to make sure we don't miss those things is taking a sensitive clinical history, which is best done in the privacy of a consulting room."

Dr Aust also raised concern about GPs who work in corporate practices being stereotyped as providing high-throughput, low-value care.

"My practice owner isn't pushing me to practice medicine in a particular way," she said, noting he also owns other practices. "I do home visits, palliative care and residential aged care to look after some of our most vulnerable patients… but it's very poorly recognised and remunerated."

Dr Aust said more GPs would consider owning practices if new funding models made it viable.

Dr Higgins warned that while Australia's healthcare system is 'one of the best in the world', that position is at risk following years of primary care being 'sadly neglected'.

"We are being asked to do more for less," she said. "GPs can no longer afford to subsidise patient care. The Medicare rebate hasn't kept up with the cost of providing that care.

"We reward procedural medicine over cognitive medicine, we spend a fortune on hospitals, and we starve general practice." ■

DRS4DRS ACT
Australian Capital Territory

The 24/7 Drs4Drs ACT Helpline is 1300 374 377

Welcoming all interns!

On behalf of Drs4Drs ACT, the staff of AMA ACT were delighted to organise an afternoon tea for interns during their orientation at The Canberra Hospital last month.

The gathering of more than 100 new doctors included many graduates of ANU Medical School as well as several internationally trained doctors. While most will undertake their internship in Canberra, a handful will head to regional centres such as Bega and Goulburn to commence their first term.

AMA ACT's President-Elect Dr Kerrie Aust gave a brief presentation at the event, urging interns to take steps to care for themselves, including having their own GP and maintaining hobbies and interests outside of medicine.

"Putting your entire identity into being a doctor is a very dangerous thing, because… if that [part of your life] starts to unravel, your sense of self can unravel as well," she said.

She urged interns to be aware of signs that they or colleagues were not coping, such as irritability, sleeplessness, relationship fracture, unsociability, a drop in work performance, feelings of depression and anxiety, and suicidal thoughts.

All doctors experiencing distress or those with concerns for a colleague can contact the 24/7 doctors' telephone support service Drs4Drs ACT on 1300 374 377.

Dr Aust urged interns to put the phone number for Drs4Drs in their contacts list.

"No problem is too small or stupid to call the service about," she said.

AMA ACT wishes all new interns the very best in a year that will be full of "firsts" and challenges. We encourage interns to consider becoming an AMA ACT member if they are not already. Members have direct access to workplace relations advice and support, whether the issue be payslip discrepancies, leave entitlements, workplace harassment or discrimination or something else.

Members also gain access to valuable career support and coaching, and receive 22 editions of the highly respected *Medical Journal of Australia* every year. The AMA is Australia's leading medical voice; with more members, we can more effectively advocate for the issues that matter most to you. ■

AMA ACT President Elect Dr Kerrie Aust (second from left) with interns.

Interns at the Orientation Breakfast, including outgoing AMA ACT Junior Medical Advisor, Dr Emily Sisson (left).

Have your say: voluntary assisted dying

The ACT Government has opened the consultation to inform the development of a Voluntary Assisted Dying (VAD) model for the ACT. Members of the public are invited to make submissions online in response to the government's discussion paper. The AMA has also been invited to a health professionals' roundtable on 16 March to discuss how VAD should work in the ACT.

There are a variety of views within the medical profession, including within the AMA about the issue. AMA ACT is asking doctors who make a submission to also consider sending a copy to our office to better inform our advocacy. Our priority is to ensure the safest possible model is adopted in the ACT, with consideration to the wellbeing of patients and their families, participating doctors and conscientious objectors, and the wider community.

There are several concerning elements in the government's discussion paper, including a question about whether nurse practitioners should be able to assess eligibility for VAD and administer the substance, as is the case in Canada. It notes: "in a small jurisdiction like the ACT, with limited health resources and a relatively small workforce, imposing narrow or inflexible health professional qualification requirements is likely to restrict the pool of health professionals who are eligible to participate in voluntary assisted dying, which in turn may restrict a person's access to voluntary assisted dying."

Another issue to be considered is whether health professionals should be free to initiate a discussion about VAD with a patient, as is the case under laws in WA, Tasmania, Queensland and NSW. In Victoria and South Australia the patient must raise the topic first. The paper says these measures in Victoria "have been identified as an unnecessarily strict safeguard and a barrier".

The paper also asks whether VAD should be restricted to people above a certain age. It states: "If a registered medical practitioner considers that a young person has the maturity and capacity to make their own decisions about VAD, denying them this choice may result in increased suffering and unfair outcomes."

Other questions in the discussion paper include:

- What kind of suffering should a person be experiencing or anticipating in order to be eligible to access VAD?
- Should a person be expected to have a specified amount of time left to live in order to be eligible to access VAD, and what should the timeframe be?
- How should a person's decision-making capacity be defined or determined in relation to VAD?
- If a coordinating health professional or consulting health professional declines to be involved in a person's request for VAD, should they be required to take any particular action?
- Should a person have a choice between self-administration and administration by an administering health professional of a VAD substance?
- Should a health service be permitted to not facilitate VAD at its facilities?

Minister for Human Rights, Tara Cheyne, said the government was looking to learn and draw from other jurisdictions' experiences while developing a model which reflects the Canberra community's values.

"With strong community support for voluntary assisted dying in the ACT, this consultation is about understanding the community's views about how a scheme in the ACT could work, including eligibility criteria and appropriate safeguards," she said.

"While we have the benefit of existing legislation and experiences in the Australian states, they are at different stages of implementation and each jurisdiction has its own unique characteristics."

The consultation will close on Thursday, 6 April 2023. Following community consultation, the ACT Government will prepare a listening report that summarises and reflects the feedback it has received. The government intends to introduce legislation into parliament in the second half of 2023. It is anticipated that a parliamentary committee would review the legislation before the law is debated. ■

If the issue of a voluntary assisted dying law raises issues for you or your family, please contact Lifeline on 13 11 14 or Griefline on 1300 845 745.

Find out more or have your say at: YourSay.act.gov.au/vad

Tassie paves the way with single employer model for GPs

Tasmania has become the first state to announce a single employer model pilot for GP trainees. The announcement follows strong AMA advocacy, and other states and territories are under pressure to follow suit.

Under the pilot, up to 20 medical trainees hoping to specialise in general practice will have the choice of being employed by the Tasmanian Health Service for their training period, ensuring comparable employment conditions to trainees working in other specialty areas.

AMA President Professor Steve Robson said: "The AMA, at both state and federal levels, had been negotiating with both governments to make the initiative a reality, with the single employer model having been developed by the AMA over several years and a key ask of the AMA's Modernise Medicare campaign.

"General practice is the backbone of our health system and an extremely meaningful and good career. However, the reality is doctors considering entering the GP training program need to grapple with the prospect of a significant cut in wages once they leave the public hospital system, estimated to be around $25k per year, as well as inferior access to personal leave, annual leave, long service leave, and parental leave."

"This is one of the key reasons the Australian General Practice Training Program fails to fill many of its training places each year," Professor Robson said.

"The single employer model overcomes this problem, with the state government continuing to employ GP trainees while they undertake their general practice training — ensuring they get equitable pay and conditions.

Parliament House, Tasmania. The state government will employ GP trainees under a pilot.

"Given the pressure on general practice around the country, we encourage all states and territories to work with the Commonwealth to implement a single employer model for GP trainees."

There are many possible ways to implement a single employer model. A simple arrangement is to include a classification for GP registrars in the Enterprise Bargaining Agreement. The trainee doctor then signs a separate agreement with the private practice where they are seconded, covering things like work arrangements and privacy. Through a mechanism of government, a proportion of the trainees' billings then go to the public hospital to fund their wage, ensuring that general practice costs and revenue are adequately covered. ■

A life in medical politics

Part 1: The way things were

Canberra local, Dr Bill Coote, was Secretary General of the AMA from 1992-98 and remains interested in the evolution of the Australian medical profession. He also worked as a rural GP, an economics tutor and Director of the Professional Services Review. In this first instalment of a two-part memoir, Bill reflects on what it was like to practice medicine in the era before Medicare; a time when older doctors shuddered at the memory of capitation, when GPs were literally generalists and when doctor knew best.

DR BILL COOTE

I graduated MBBS from the University of Queensland in 1973. I became interested in the politics, financing, and regulation of the medical profession. I worked at the Federal AMA from 1987 until 1999.

The profession has complex relationships with governments, regulatory bodies, employers, public and private insurers, 'big pharma', consumer groups and others. State health systems have hierarchical administrative structures. By contrast, my experience was with Commonwealth health programs, especially Medicare. These are overseen by a large Commonwealth bureaucracy and implemented by independent practitioners working within a maze of financial incentives and regulations. Many special interests seek to influence Commonwealth decisions using policy and economic arguments supported by diverse political and public relations initiatives.

The last lodge doctor

In 1972 I undertook a student placement in Queenstown Tasmania, then a busy mining town with a full-time surgeon and several GPs. A GP engaged by the Zeehan Medical Union told me he was "the last lodge doctor in Australia". I have since read extensively on the political battles in early 20th century between the then British Medical Association (BMA) and the "friendly societies" and "lodges", cooperatives to which subscribers paid weekly fees and in return received sickness benefits. GPs were paid an annual "capitation" fee. In 1930 about 45% of Australians were members of friendly societies. There were bitter disputes with the BMA over the level of capitation fees and onerous contract conditions. Doctors resented wealthier people joining lodges to avoid private medical fees. GPs developed countervailing strategies: a Melbourne surgeon told me he remembered as a child in the 1930s asking his mother the meaning of a large sign in their GP's waiting room: Lodge Patients Last.

The ultimate rural generalist

Another student placement was at Charleville in western Queensland with the remarkable Dr Lou Ariotti, the ultimate "rural generalist". He conducted a mixed specialist/general practice. Patients were referred from all over southwest Queensland. He practiced surgery, orthopaedics and obstetrics. His GP partners were his anaesthetists. In his autobiography Lou discussed his two year "sabbatical" in the UK in the mid-1950s. Rather than pursuing fellowship in London he undertook the Edinburgh FRCS because it "prepared one for all surgical disciplines, general, orthopaedic, urological, paediatric, vascular, neurosurgical and gynaecological". At a farewell in 1990 a senior Brisbane colleague said "Lou is the last of his breed".

AMA Federal Council meeting 1994: Dr Brendan Nelson, President; Professor Priscilla Kincaid-Smith, Chair; Dr Bill Coote, Secretary General.

Indigenous medicine – how not to do it

My first two postgraduate years were at the Princess Alexandra Hospital in Brisbane. In my second year, I volunteered for a rotation on a Queensland Aboriginal ear program which aimed to counter educational disadvantage resulting from hearing impairment. I was based in Cairns and did fly-in-fly-out visits to remote Aboriginal communities on Cape York Peninsula. These were the dying days of strict, regimented state government control of these communities. School teachers were rostered to march their class up to the health centre where our team – nurse, audiologist and I – would examine each child. The

The official opening of the Kippax Health Centre in 1975, where Dr Coote did locums.

Dr Bill Coote with Prime Minister John Howard and AMA President Keith Woollard in 1997.

many children with ear infections and perforations were prescribed antibiotics and drops according to Brisbane middle class protocols. There was no engagement with parents. The health centre nurses were expected to oversee and administer these treatments.

In the early 1990s, when Brendan Nelson was AMA President, he lobbied for initiatives to improve the health of Indigenous Australians. I was AMA Secretary General. I assured Brendan I was an expert in the provision of medical services in remote Indigenous communities – an expert in how not to do it.

Salaried vs private practice

In 1976 I was an RMO at the Canberra Community Hospital at Acton where my wife did her internship. The government was fostering a salaried specialist service in Canberra. Relationships among specialists were tense, requiring, for example, separate change facilities in the theatre suite for the established private VMOs and for the salaried surgeons.

Extremes of GP organisation

In 1977 I did GP locums in Canberra. Earlier in the 20th century a common Australian GP arrangement was a solo practice attached to the home, comprising a waiting room and a consulting room with the doctor's wife (sic) as receptionist. I did locums in two such practices, at Ainslie and Chapman.

In a contentious 1970s Canberra initiative, "community health centres" were established, staffed by salaried GPs, nurses and allied health practitioners. Each centre served a group of suburbs. The aim (espoused in language similar to that of the Rudd government's "GP Superclinics" and the recent "Health Care Homes") was to foster "integrated, multidisciplinary care". One advertisement sought applications from "non-dominant doctors". These centres were opposed by the ACT AMA. In a letter to *The Canberra Times* a (male, specialist) doctor argued that small home-based practices scattered around a suburb were preferable so that mothers pushing prams could access their GPs. I did locums at the Kippax and Melba centres.

24/7 on call

We returned to Queensland and purchased a general practice at beautiful Tamborine Mountain in the Gold Coast hinterland. It was a small, diverse community. These were the closing years of the era when GPs routinely undertook many house calls, especially to elderly residents. We received the then common invitation from surgeons, in our case on the Gold Coast, to assist when a patient was to undergo surgery.

Had the community been surveyed, the most highly valued feature of our practice would have been "24/7" availability for management of acute medical conditions and minor injuries. Close cooperation with local ambulance officers was vital for more dramatic events.

How politics and money works

Being on call much of the time had a positive outcome. I completed an economics degree through the UQ Department of External Studies. Keynes suggested "economics is a method rather than a doctrine, an apparatus of the mind, a technique of thinking which helps its possessor to draw correct conclusions." More relevant for my subsequent career was the advice of Joan Robinson, another famous Cambridge economist: "The purpose of studying economics is not to acquire a set of ready-made answers to economic questions, but to learn how to avoid being deceived by economists".

> "I told an older GP I felt guilty abandoning my loyal, regular patients. I wasn't sure whether to feel comforted or deflated when he suggested that in three months the patients most dependent on me would be those most dependent on my successor."

I was elected to the local Shire Council and learnt how the mix of politics and money works. I was on the Queensland AMA General Practice committee as the Fraser Government (1975-83) gradually dismantled Whitlam's universal health care insurance scheme, Medibank. Before the Hawke Government established Medicare in 1984, the Coalition implemented a sequence of confusing, unpopular changes to Australia's medical insurance arrangements.

Time for a change

We sold our practice in 1984, concerned about our children's secondary education and tired of "on-call". I told an older GP I felt guilty abandoning my loyal, regular patients. I wasn't sure whether to feel comforted or deflated when he suggested that in three months the patients most dependent on me would be those most dependent on my successor.

I did GP locums, some tutoring in economics and preliminary work on a PhD in economics. In 1987 I acquired the grand title of Assistant Secretary General (Medical Economics) at the Federal AMA.

Medicare tensions

In 1987 open opposition to Medicare remained within the AMA. There was an innate fear of 'nationalisation' of the profession, influenced perhaps by UK doctors who decamped to Australia from the NHS, and maybe by echoes of onerous contract conditions imposed on Australian doctors in earlier decades by the friendly societies. In 1987 specific fears were that as "medical Medicare" evolved Governments would impose "geographic provider numbers" to control the distribution of doctors and a "participating doctor scheme", limiting fees to MBS fee levels.

In May 1991 the Hawke ALP Government proposed a compulsory GP co-payment. AMA leaders publicly supported the initiative but retreated given opposition from "grass roots" general practice. The political potency of the issue was highlighted later in 1991 during Paul Keating's second, successful challenge when he deposed Bob Hawke to become Prime Minister. Newspaper photographs showed Keating leaving the meeting after the vote with Senator Rosemary Crowley, a former GP, at his side. The media's line was that she had "delivered the Left" on the promise Keating would abandon the co-payment proposal.

In 1991 the AMA commissioned a former Treasury economist to develop a more "market-orientated" health financing system. Medicover was launched with considerable fanfare. It included some reversion of medical insurance from government to private insurers. The AMA vigorously supported the "Fightback" proposals Liberal leader John Hewson took to the 1993 "unlosable" Federal election, which included policies similar to Medicover. Hewson's unexpected loss impelled John Howard to promise in his successful 1996 election campaign that "A Coalition government will maintain Medicare in its entirety". ■

New project to tackle orthopaedic waiting list

A new study will explore the best ways to actively manage Canberra's public orthopaedic waiting list as the system groans under overwhelming demand.

Professor Jennie Scarvell, Associate Dean of Research and Innovation at the University of Canberra's Faculty of Health, has received a $206,000 grant from the HCF Research Foundation to develop an Advanced Musculoskeletal Clinic at the Canberra Hospital. Her collaborative team includes Executive Director of Allied Health Dr Jo Morris, academic GP Professor Kirsty Douglas and surgeons Dr Tom Ward and Professor Paul Smith.

Canberra Hospital already employs advanced musculoskeletal physiotherapists to manage its orthopaedic waiting list, including screening and triaging patients. However, Professor Scarvell said the existing system was struggling to cope with increasing numbers of referrals.

"We just have far too many referrals coming through," Professor Scarvell told *Canberra Doctor*. "GPs are aiming to do the best for their patients by putting them on the waiting list for knee replacements years before they will need them, because they know there's a 3-4 year wait, but it means we have all these people on the list who have not exhausted all the non-surgical options."

> "We know what best practice is because it has been rolled out in other places in Australia and in Scandinavia – patients need screening at regular intervals, to make sure people are getting knee replacements when they need them."

Professor Scarvell said only 10% of people with hip or knee osteoarthritis have a joint replacement – most manage successfully with diet and physiotherapy exercise. However, she stressed that for those who require a replacement, it should be done at the optimal time, when they still have movement in the joint. "The amount of movement a patient has going into surgery is a key determinant of how successful the surgery will be," she said.

Under the existing screening process, physiotherapists refer many patients to the GLA:D physiotherapy programs run at Belconnen and Phillip. However, Professor Scarvell said many patients have barriers to accessing the programs or do not believe they will succeed. Furthermore, there is not capacity to review patients regularly enough to ensure that if a knee replacement is required it is given at the optimal time.

"We know what best practice is because it has been rolled out in other places in Australia and in Scandinavia – patients need screening at regular intervals, to make sure people are getting knee replacements when they need them," Professor Scarvell said.

Professor Scarvell and a team of medical and allied health providers are working with consumers to develop the new clinic, which is expected to be established in early 2023. The clinic will be the first point of contact for patients who have been referred to Canberra Hospital Orthopaedics for a knee replacement or with osteoarthritis of the knee.

While the specifics are yet to be worked out, Professor Scarvell said one option was to establish regular screening for all patients on the waiting list. Another model was to establish a drop-in musculoskeletal clinic in the community.

HCF data shows there's been a 64% increase in members admitted for total knee replacement surgery in the ACT over the past five years. While patients can wait 3-4 years on the official surgical waiting list, there is also a "hidden waiting list" of patients still awaiting an initial consult with a surgeon. AMA has been calling for this data to be routinely reported. ■

CPD Home accredited

AMA (WA)'s, national CPD Home service (formerly Doctorportal Learning) is now accredited by the Australian Medical Council (AMC).

Medical Board of Australia Chair, Dr Anne Tonkin, said the Board was pleased to take the AMC's advice that after a rigorous accreditation assessment, the new CPD home provided by the AMA (WA) would provide quality CPD to doctors, relevant to their scope of practice.

Australian doctors will no longer be able to self-manage their CPD from 2024. Instead, they will need an AMC-accredited CPD home. CPD Home joins all AMC-accredited specialist medical colleges as a CPD home. It is available for all doctors.

During 2023, doctors who do not have a CPD home can keep doing the same type of CPD that they are currently doing, while keeping an eye out for new, accredited CPD homes to emerge that offer CPD programs relevant to their scope of practice.

The AMC expects other new aspiring CPD homes will apply for accreditation in 2023, along with some of the organisations not successful in the 2022 round of CPD home accreditation.

Find out more at: cpdhome.org.au

Feedback wanted on GP training

As we transition to GP college-led training in February 2023, the AMA wants to hear from GP trainees, GP supervisors, and practices about how the transition is going, and any issues or concerns you may have, so we can continue our work in advocating for GP training.

You can reach us at workforce@ama.com.au. Rest assured all communications will remain completely confidential, and while we cannot provide individual advice, your experiences will help shape our feedback to RACGP and ACRRM to ensure all GP trainees enjoy a fulfilling and safe training experience.

New cancer research centre

A new research centre is coming to the Canberra Region Cancer Centre as part of an integrated site to deliver treatment, research, supportive therapies and emotional support all in the one place.

Minister for Health Rachel Stephen-Smith said the research centre, a 2020 election commitment, will bring together the knowledge and expertise of academics, clinicians, industry and health professionals in a collaborative, purpose-built facility.

The facility will integrate a research laboratory into a clinic space where patients are assessed for clinical trials, alongside the ability for sample collection to be seamlessly coordinated with lab technicians to process samples or store them in appropriate cooling facilities until ready.

Construction of the cancer research centre is scheduled to start in late 2023 and be completed in late 2024.

Medicinal Cannabis: GP changes

The Department of Veterans Affairs says under its Medicinal Cannabis Framework GPs can now seek approval of funding for medicinal cannabis without the need for a non-GP specialist's assessment in many circumstances.

Applications may be made over the phone by calling the Veterans' Affairs Pharmaceutical Advisory Centre on 1800 552 580.

dva.gov.au/providers/provider-news/simplified-process-dva-funding-medicinal-cannabis

What's On

Speed Networking Your Future

You're invited to an evening with the AMA ACT Board and a range of local specialists to get the inside running on the next step in your career. Dinner and drinks included.

When Tuesday, 28 March, 2023
6:30pm - 8:30pm

Where ANU School of Medicine
Building 4, TCH

Who Interns and RMOs

Cost Free

Register Email reception@ama-act.com.au

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JMOA Member Lunches

Join us for lunch on the last Friday of the month to catch up with your fellow JMOs. Different cuisine each month, including vegetarian and gluten-free options. If you're not yet a member you can join on the day.

When 12 - 1pm Friday, 31 March, 2023
12 - 1pm Friday, 28 April, 2023

Where JMOA Lounge,
Lvl 8, Building 1, TCH

Cost Free for JMOA Members

Register Register on arrival

Sponsored by AMA ACT and Drs4Drs ACT

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Editorial:
Sarah Colyer
sarah-colyer@ama-act.com.au

Design:
Juliette Dudley
jdudley@ama-act.com.au

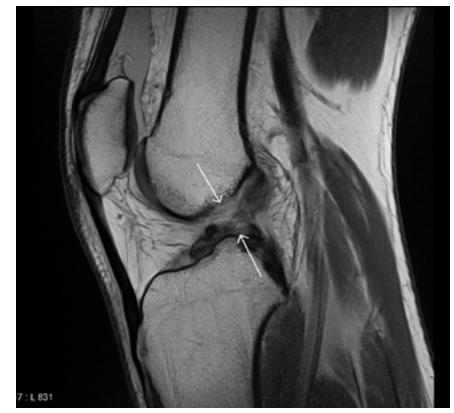
Advertising:
Ph 6270 5410,
Fax 6273 0455
reception@ama-act.com.au

Contributions:
Copy is preferred by email to execofficer@ama-act.com.au in "Microsoft Word" or RTF format, (not PDF) with graphics in TIFF, EPS or JPEG format.

ADVERTORIAL

Southside gets new MRI machine

Canberra's southside now has its own Magnetic Resonance Imaging service thanks to a new machine at I-MED Radiology Tuggeranong.



MRI's superior soft tissue detail often makes it the preferred modality for imaging the brain, spine, and musculoskeletal system. Its applications include the following:

Brain

- MRI is more sensitive for tumours than other modalities and is better at characterising and siting tumours.
- MRI is the test of choice for demyelination, inflammation, and white matter diseases in general.
- Epilepsy and dementia should be evaluated by MRI.

Spine

- MRI better demonstrates the relationship of disc and most bone disease to the adjacent thecal sac, spinal cord, and nerve roots than other modalities.
- MRI is the test of choice in spinal cord disease (eg. demyelination, transverse myelitis, tumour) and the initial choice for spinal cord or cauda equina compression.
- Infection is best demonstrated on MRI (eg. discitis, epidural abscess, osteomyelitis).

Musculoskeletal

- Internal and para-articular joint derangement (ligament or tendon tears, meniscal and labral tears) are well visualised on MRI, which is particularly useful for the knee and shoulder, but also extensively used for the hip, elbow, wrist, ankle, hand, and foot.
- In avascular necrosis (Perthe's disease, adult avascular necrosis of the hip or other bones) MRI allows early diagnosis of ischaemia before bone collapse or remodelling has occurred.
- MRI has a role in the assessment of undisplaced fractures in and around joints that are not visible on initial x-rays, especially in children (because of radiation concerns and lack of ossifications). However, such assessment should not occur hyperacutely because the fracture may not be visible on MRI for the first 48hrs.
- In articular hyaline cartilage disease, MRI can demonstrate chondral disease in detail, showing both early and late chondromalacia and frank chondral loss. Note that plain x-ray is still the best test for degenerative joint disease/osteoarthritis.

This information is provided as a guide. For more information please contact your local I-MED clinic and ask to speak to a radiologist. **To watch the latest webinar recording – MRI for GP's – considerations & common cases, please scan the QR or visit i-med.com.au**

Scan the QR to watch the latest webinar for GPs.

New facility, job opportunities at Medical Visa Services

Dr Cate Ealing (left) with team members at Medical Visa Services.

Medical Visa Services has moved to a new dedicated facility at the University of Canberra campus in Bruce. Run by BUPA on behalf of the Department of Home Affairs, the centre provides immigration health examinations to Australian visa applicants.

Dr Cate Ealing, Lead Physician at Bupa Medical Visa Services said the organisation is currently looking to recruit doctors to be Panel Physicians.

"The joys of the role are in meeting people of all ages, from all walks of life and parts of the world, performing high-quality customer-focussed work where you use your clinical skills, working in a lovely community workplace, and having a structured workload with regular hours, working either part-time or full-time, and no after-hours work," Dr Ealing said. "There are defined career paths and opportunities for those seeking career progression."

Panel Physicians come from a wide variety of clinical backgrounds. They require 3 years postgraduate experience and current unrestricted AHPRA registration.

The facility is located on the top floor of the Canberra Specialist Medical Centre.

For more information contact Dr Cate Ealing on 0427 511 061 or Centre Manager Jenny Hardaker on 0403 721 430. ■

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