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CANBERRA Doctor

Informing the Canberra medical community since 1988

ACT presses ahead with VAD
PAGE 3

Hospitals respond to trainee dissatisfaction
PAGE 4

Dr Bill Coote reflects on the Medicare era
PAGE 10

GPs call for lead role in ADHD amid specialist gridlock

Canberra GPs say they have their hands tied trying to help an increasing number of patients with suspected ADHD who cannot get a timely appointment with a specialist authorised to prescribe psychostimulant medications.

Charnwood GP, Dr Henry Berenson recently described the situation in a letter to Health Minister Rachel Stephen-Smith, saying it was time to loosen restrictions that prevent GPs from initiating psychostimulant therapy for ADHD.

"Last week I had a single mother tell me that she had been left to deal with her child acting out for 2 years after my referral (for ADHD) to a paediatrician in the public system before he was seen and treatment prescribed," he wrote. "Treatment resulted in a dramatic improvement in the child's behaviour at home and function at school."

"We would be appalled if patients with diabetes or cardiovascular disease had to wait for a specialist to approve management, yet we do that with diagnosed ADHD.

"GPs are trained to recognise and manage common conditions. CPD keeps us up with the latest thinking. We have the advantage over specialists in that we can closely follow up our patients yet we are blocked from managing ADHD, which is at least as prevalent as diabetes or cardiovascular disease."

GP confidence

AMA ACT President Elect Dr Kerrie Aust, a GP with a special interest in ADHD, agreed that delays accessing a paediatrician or psychiatrist to perform an initial ADHD assessment were a major problem in the ACT.

"Some patients are spending thousands on psychology assessments to have the work done before they see the non-GP specialist," she said.

"Many patients struggle to access ADHD assessment – they can't afford private fees and the public system has lengthy delays."

While many GPs were confident in this space, she noted that others felt insufficiently trained and could benefit from mentoring.

"I personally support ADHD assessment and management being GP-led, with involvement of non-GP specialists for those that are not straight-forward, such as when there is a concern that inattention is secondary to anxiety rather than ADHD," she said.

"I am not in favour of advanced

Continued page 9

A child waited 2 years to be prescribed psychostimulant medication for ADHD.

President's Notes

WITH PRESIDENT, **PROFESSOR WALTER ABHAYARATNA**

On the morning I sat down to write this column, the Federal Government released its Independent Review of Medicare Integrity and Compliance. The report confirms that doctors have not been rorting Medicare to the tune of $8 billion, despite sensationalist claims in the Australian media last October.


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Medicare fraud claims unsubstantiated

7.30

AMA President Professor Steve Robilliard told ABC's 7.30 only a small number of doctors misuse Medicare.

Recent news reports, jointly published by *ABC News*, *The Sydney Morning Herald* and *The Age*, blamed medical practitioners for a staggering $8 billion worth of Medicare fraud and waste, representing 30% of the Medicare Benefits Schedule (MBS) budget. One article began: "Doctors are abusing the $28 billion Medicare system, at times putting patients at risk, billing dead people and falsifying patient records, all to boost profits."

The investigation was based on a published PhD thesis, 'Claiming and Compliance under the Medicare Benefits Schedule: A Critical Examination of Medical Practitioner Experiences, Perceptions, Attitudes and Knowledge'. This thesis comprises a literature review on medical billing fraud and non-compliance, a policy analysis, a quantitative survey of 66 identified stakeholders that were considered to provide Medicare billing education, and a qualitative survey involving in-depth interviews of 27 specialist

Importantly, the thesis abstract concluded in the penultimate paragraph: *"The research found that a principal cause of non-compliant Medicare billing in Australia is system issues, rather than deliberate abuse*

and comply with a complex system they cannot shape, do not understand, and feel powerless to change. Without reform, the government can expect no improvement in leakage, increased litigation and out-of-pocket costs for patients and continued decreases in private health insurance uptake. Regulatory, educational, and digital reform are required urgently."

Fraud unquantified

There are only nine instances of the search term "Medicare fraud" in the thesis, of which six refer to specific case law pertaining to individual cases. The remaining three are general statements that are unquantified.

A key acknowledgement by the thesis author (p77) is that "... *quantifying the precise monetary value attributable to inappropriate claiming has proven an impossible task*". The author thus frequently (and appropriately) uses the word "estimate". The only estimate of Medicare non-compliance, not a definitive number, is on p290 of the thesis: *"In the 2018-2019 fiscal year, total Medicare expenditure was*

[medical practitioners] in Australia (Agency 2018/9). Given the quantum of non-compliant Medicare billing is 5–15% of the scheme's total cost, non-compliance in that year was in the range of $1.2–$3.6 billion."

Systemic issues

The results of the qualitative survey of 27 specialist and general medical practitioners that formed part of the PhD highlighted poor training in the mechanisms of billing, a lack of reliable support and the fear of being audited (p210). The doctors felt that they had little control over the billing process even though they were ultimately legally responsible. Participants always contacted Medicare if there was an over-billing mistake but rarely when there was under-billing (p220). This is reflected in the RACGP's Health of the Nation report where 47% of doctors either avoided claiming rebates or providing certain services, again, through fear of a Medicare billing audit.

Therefore, the thesis findings describe non-compliant, not fraudulent, Medicare billing. As

A review has confirmed that Medicare fraud claims were unsubstantiated, as reported in Canberra Doctor in November 2022.

The Pradeep Philip review sets the record straight and confirms the integrity of doctors. Most leakage from Medicare (an estimated 1.5b to $3b) is due to error and non-compliance – not fraud – and is the result of an exceedingly complex system, the report concludes. The report acknowledges the existence of under-claiming for MBS services provided, also related to the complexity of the Medicare system.

While the report's focus is on how to reduce MBS leakage, Dr Philip is clear that nothing short of far-reaching reform of the whole unwieldy system is required. "There is no longer the same connection that there used to be between patient, the practitioner, and the payment," he writes. He describes how Medicare has failed to keep up with a changing landscape including the changing burden of disease, corporatisation and new technologies, with the system blowing out to now include over 6000 items.

Medicare should be simpler and clearer to understand, the report says – something with which we can all agree. Dr Philip also raises concerns about doctors spending "more time on administration, not care".

No doubt, the release of this review will unleash a fresh round of 'doctor-blaming' media coverage, but the report itself is clear that the medical profession is not to blame. AMA is committed to working with government to improve compliance arrangements, keep red tape to a minimum and restore confidence in Medicare.

Federal budget

With the Federal budget around the corner, the Albanese government has the opportunity to offer more than words to address the worsening Medicare crisis. Many of the problems articulated in the Philip report dovetail with the objectives of AMA's Modernise Medicare campaign, which clearly outlines a set of actions to make Medicare fit for purpose. At the heart of the plan is voluntary patient enrolment at general practices to facilitate better coordinated, integrated care. MBS-funded chronic disease care plans, health assessments and medication reviews could be restricted to enrolled patients (with some flexibility for vulnerable and hard-to-reach populations), protecting the MBS from potential misuse and saving an estimated $225 million over four years. The Government has endorsed the Primary Health Care 10-Year Plan. Will the 2023 Federal budget be the one where the Government finally puts its money where its mouth is?

AMA ACT AGM

Please mark down Wednesday 17 May for the AMA ACT AGM. The meeting will be held at the Federal AMA office, Level 1, 39 Brisbane Avenue Barton and a light dinner and drinks will be available. The meeting notice and annual report will be distributed in the lead up to the meeting.

Peer support

I recently had the opportunity to meet with Dr Kerrie Aust and Dr Antonio Di Dio regarding Drs4Drs ACT. Dr Aust is the new Lead for Drs4Drs ACT, taking the reins from Dr Di Dio, who has been a driving force for doctors' health in the ACT for over a decade.

One issue that came up at our meeting was the problem of loneliness and isolation in medicine. We are very concerned that doctors should have support among their peers here in Canberra and to that end are planning a regular schedule of Drs4Drs events, aimed at building relationships. In addition, we are also working to co-create a mentorship program for our junior medical colleagues.

I encourage all doctors to consider getting involved in the events Drs4Drs will be running throughout the year.

Your own GP

A recent meeting with some very distressed hospital doctors reminded me again of the many doctors in our region whose health is suffering because of their work. I would like to take this opportunity to restate the importance of all doctors having their own GP. AMA ACT maintains a list of doctors who will see doctors as patients. If you don't currently have your own GP, please reach out.

For those in distress, the **Drs4Drs ACT hotline 1300 374 377** is staffed 24/7 by doctors experienced at treating doctors. I would encourage all doctors to put the number in your phone ready for a time when you or a colleague might need it. ■

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 Mary Hoyle

‘Right to die’ divides doctors as ACT presses ahead

AMA ACT was recently invited to participate in a health roundtable about how voluntary assisted dying should work in the ACT.

Legislation to establish a scheme for the ACT is expected to be introduced into parliament in the second half of this year. As part of its consultation process, the ACT Government has said it will consider whether nurse practitioners should be involved in eligibility assessments and also whether patients aged under 18 should be eligible.

Nevertheless, AMA ACT President Professor Walter Abhayaratna said he was satisfied from the roundtable that the government is at this stage working toward a conservative scheme, along the lines of Victoria’s, which has existed since 2019.

“We don’t at present see any red flags,” he told ***Canberra Doctor***. “The intent appears to be for a scheme that would be restricted to people over the age of 18, whose eligibility is determined by doctors.”

Victoria’s example

In the first three years of Victoria’s VAD program, 1,035 permits have been issued and 604 people have died from taking the prescribed substance. As of June 2022, 618 doctors across Victoria had registered to complete the voluntary assisted dying training.

Victoria’ system is the first VAD program in Australia and when debated in parliament, was described as “the most conservative law of its kind in the world”.

It is limited to adult patients with a terminal illness and a prognosis of fewer than six months who have decision-making capacity. Doctors are not able to raise the topic of VAD; it must be introduced by a patient. A person seeking VAD must make three requests – one written and witnessed – separated by a mandatory minimum 9-day period between the first and final requests. Doctors who make the assessment have received training to identify signs a patient may be being coerced to end their life. At the last step, the patient is assessed for mental competency and is reminded they don’t have to take the medication.

Advocacy group Go Gentle Australia has produced a detailed report of the first three years of the Victorian program, which it says demonstrates the legislation is operating “safely and as intended”.

“There have been no ‘wrongful’ deaths referred to police, no rogue doctors abusing the system and no evidence of coercion of the vulnerable,” the report states.

The report features interviews with patients and families who have accessed the scheme, as well as their treating doctors and Justice Betty King, inaugural chair of the VAD Review Board.

“I have not seen – and I have been looking, believe me – any type of coercion,” Justice King says in the report. “It’s not an easy process. But neither should it be. This is the ending of a life. And it ought to be treated in a serious manner. Because it’s a serious thing to do.”

Several doctors quoted in the report speak about VAD providing relief to

patients by enabling them to regain some control over their lives.

Overseas experience

While Australian supporters of voluntary assisted dying often cite the Victorian model, opponents often describe the international experience.

Dr Paul Jenkins, an ACT paediatrician who opposes euthanasia and voluntary assisted dying said even if the first few years of data from Victoria suggest the system is working well, the evidence from Belgium and the Netherlands provides a concerning picture of the long-term trajectory of such schemes.

“If ACT uses the Victorian legislation as a template, it probably would be a pretty secure system but the problem is not what the initial legislation says but what happens down the track when people without terminal illnesses pressure medicos for ‘the right to die’,” he said.

“More than 20 years of data from Europe shows that once legalised, there is a slippery slope,” he added.

Although the original intention of euthanasia laws in Belgium and the Netherlands was to relieve the unbearable suffering of the dying, it has gradually expanded to embrace minors, the psychiatrically ill and patients with dementia on the basis of advance directives.

Itinerant doctors now offer end-of-life services in some cities, undermining previous assurances that a close relationship between doctor and patient was an essential prerequisite.

An article in *The Guardian* showed how easily safeguards can be circumvented in Belgium. In one case, a GP refused to euthanise a patient after witnessing the coercive behaviours of his wife, who called him a ‘coward’. However, when the GP went on holidays, her colleague in the practice euthanised the patient.

Dr Jenkins said stories such as these showed how VAD could undermine trust in the medical profession. “Voluntary assisted dying and euthanasia take us away from where the ethics of medicine always was,” he said. “Ending patients’ lives is not our job; we should be putting our efforts into palliative care.”

Dr Jenkins said he had spoken to some doctors in Canberra who shared his concerns about VAD, and who were unlikely to participate in an ACT scheme. However, he said some of these doctors were gagged from speaking about their concerns as employees of ACT Health.

“If the ACT Government pushes ahead with its plans to legalise VAD, there will be a division down the middle of medicine between those who will support it and those who will never support it,” he said.

The AMA’s position

The AMA’s official position, expressed in its 2016 position statement on Euthanasia and Physician Assisted Suicide (2016) is that doctors should not be involved in interventions that have as their primary intention the ending of a person’s life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.

However, it says that if governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect all doctors acting within the law; vulnerable patients; patients and doctors who do not want to participate; and the functioning of the health system as a whole. ■

Read more on pages 8 and 9

- **‘VAD learnings from Victoria’: Cam McLaren**
- **A personal reflection by an ACT doctor opposed to VAD**

INTERVIEW

Meet Calvary Public's new top doc

Dr Elaine Pretorius shares her initial impressions of the Canberra bubble, Calvary Public and the challenges ahead.

Dr Elaine Pretorius is the new Executive Director of Medical Services at Calvary Public Hospital in Bruce. A general physician and endocrinologist, Dr Pretorius was Executive Director of Medical Services at Limestone Coast Local Health Network on South Australia's Victorian border for the last three years – a "nightmare job" during Covid, she says, when border closures created staffing chaos.

Dr Pretorius will face a fresh set of challenges at Calvary Public, arriving in the wake of last year's major leadership shake-up and amid troubling new survey evidence that many of the hospital's trainees are unsatisfied (see box). The hospital is also still rebuilding after a fire destroyed several of its surgical theatres in December. *Canberra Doctor* was delighted to speak with the new top doc in her second month in the job.

How is Canberra different to other places you've worked?

It's an interesting place. I'm starting to understand this 'Canberra bubble' thing. Everybody knows everybody, which is similar to regional areas and allows for influence in ways other than the standard governance structure. The structure of ACT Health and Canberra Health service is quite unique and takes a bit of getting used to. As the health service as a whole is much smaller, the relationships between the hospitals and ACT Health are much closer. I am hoping that in the long run this allows one to be able to improve services and influence new initiatives more readily.

How are you adjusting to your new workplace?

One always enjoys a challenge, and there's always an opportunity to learn and for some personal growth and development opportunities and so it's always interesting to come to a different jurisdiction and find the things that they do well, and the things one thinks they can do better.

I've enjoyed meeting the people here at Calvary. They've been enormously welcoming and are very excited and happy to share their stories and experiences. I have found many things that I need to address and things that I hope we can improve but have also found a group of people in our staff who are enormously committed to Calvary and to the community, especially to the north of Canberra. I think Calvary has a wonderful culture of pride in being part of the wider Calvary national group and a real commitment towards patients.

What are the challenges for Calvary Public?

The organisation has been challenged in the last three years. We've had Covid, which buckled most organisations. Calvary Public also had a turnover in leadership, and then the fires happened in December.

Even still, I'm very excited about the potential within Calvary Public Bruce and about being part of a new team with a new vision we can deliver. We'd like to start thinking of ourselves as an organisation that can stand shoulder-to-shoulder with CHS, with each of us contributing in our own individual way at what we are good at.

What are Calvary's strengths that can complement CHS?

CHS is a Quaternity Centre and that means they have a particular pressure in being able to deliver all those specialist services. Having a good general hospital that provides the day-to-day care in a thoughtful and excellent way would reduce that pressure. We could take some of the routine work and straight-forward presentations off CHS, such as people presenting with pneumonia or an appendix or a fall. The way I would see it is that they would do a lot of the high-end stuff and we would do a lot of the bread-and-butter stuff.

We are also very good at high-volume, high-turnover surgery and at palliative care – Clare Holland house, and the outreach palliative care and aged care services that we provide.

Canberra trainees least satisfied: national survey

Canberra Doctor's **February/March issue revealed troubling results from the latest (2022) edition of the Medical Board of Australia's annual Medical Training Survey.**

Only 60% of junior doctors in Canberra would recommend their current workplace as a place to train – well below the national rate of 77%.

Canberra trainees in general practice had the highest satisfaction rating out of the disciplines (76% would recommend their workplace as a place to train), followed by trainees in anaesthesia (71%). By contrast, only 65% in emergency medicine, 64% in surgery and 41% in adult physician medicine would recommend their workplace for training. The satisfaction rates were even lower in obstetrics and gynaecology and psychiatry, however there were fewer than 30 responses in each of these categories.

The survey showed some troubling declines in trainee experiences at Calvary Public Hospital, and some improvements at Canberra Health Services.

"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%

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

% Yes

The Canberra Hospital	Calvary Public Hospital	National Sample
27%	**43%**	**22%**
2019: 30%	2019: 33%	2019: 22%
2020: 33%	2020: 28%	2020: 21%
2021: 33%	2021: 32%	2021: 22%

NO CHANGE

Medical Training Survey 2022.

The Medical Board's 2022 Medical Training Survey had some troubling results from trainees at Calvary Public Hospital Bruce. There was a decline in trainees who felt their workplace supported staff wellbeing and an increase in those who experienced bullying. Do you trust the numbers?

I think it's a point-in-time survey. It is one more of the measures that tell us that our trainees are having a troubled time. Absolutely, I think that these are all measures that we should be giving attention to.

The worry is that the survey was done during a very difficult time for Calvary. But regardless, it does tell us that there is work to be done in how our junior doctors experience their time with us.

There's been a substantial deterioration in those survey results. I don't want to point my finger at Covid alone, because everybody has been through Covid, but you know, a smaller organisation like ours doesn't have that critical mass, or the fat in the system, so when we start losing staff it is far more impactful on a smaller organisation. The pressures on the remaining workforce are far more evident than in a bigger organisation. On top of that, there has been the fire and the changes in leadership.

When there is leadership uncertainty, that spills down to affect staff at all levels of an organisation. There might be delays in decision-making, for instance.

Is there a culture of bullying at the hospital?

I was surprised by the results on bullying. I've only been here 9 weeks but so far I have encountered a positive culture. That was probably the finding that struck me most from the survey results. However, I can understand that people might have been unsettled by an environment of uncertainty and tempers might have been frayed.

Regardless, it is something that we need to take note of. The whole of ACT Health has committed to a program called 'Speaking up for Safety' which has a component designed to help people escalate their concerns about behaviours. It makes people reflect a little bit on how they're being experienced. There is substantial evidence from international literature that it improves unprofessional behaviour and impacts on safety and quality outcomes. We're hopeful that program will impact on the psychological safety of all our staff, but especially the junior medical staff who often feel afraid to speak up because they think it might impact on their future careers.

What are your priorities to improve the experiences of trainees?

Our biggest challenge is attracting and retaining junior staff. Some of the things they've mentioned in the survey about not being released to attend education sessions and not having the opportunity to do research are things we'd really like to concentrate on.

One component would be really investing in the education program; thinking about how we deliver education in different ways. I think Covid has shown us we can use different platforms and people find them palatable and comfortable now, so we're looking at our education program and how we deliver that.

Does online learning replace protected teaching time during work hours?

Having dedicated teaching time during hours is a very important function of a public

Calvary Public Hospital in Bruce

hospital. It's an important optic for the junior staff to emphasise to them that part of their job is to learn and to participate in their training program. And it's also an important signal to people around them that this is dedicated time that is the trainees' time. Using digital platforms allows us to deliver education to someone who might have missed out on a lecture or wants to revisit it. But it doesn't replace that powerful optic that 'This is part of your job, and we want you to be able to attend it and ensure this is protected time'.

What else do you have in mind to improve the trainee experience?

Another aspect would be sprucing up the facilities we have for junior staff, like the RMO lounge and looking at the general wellbeing program; enabling them to spend a bit of time in a more relaxed atmosphere and build relationships. We also need to consider career pathways; thinking about how juniors can envision themselves spending quite a significant portion of their time with us, perhaps staying on with us long-term. And we need to be making some investment in our supervisors, in their skills and capabilities.

We wish you all the best with the challenges ahead. How will you refresh yourself along the way?

I am looking forward to the challenges and I'm enjoying being in Canberra. My husband and I have some very close friends from our time in South Africa and Adelaide who have also moved to Canberra and it's lovely being together again. There's also a certain excitement about being in Canberra – the pollie spotting and driving past Parliament House. Canberra is a fantastic place. ■

"We're not where we need to be, yet"

DAVE PEFFER

Dave Peffer, Chief Executive Officer of Canberra Health Services writes in response to the 2022 Medical Training Survey results.

Facilitating a high-quality junior medical officer (JMO) education program is a priority for Canberra Health Services (CHS) and key to ensuring our junior doctors are well supported as they transition into the medical profession.

While we saw increases in some areas, the results from the 2022 edition of the Medical Board of Australia's Medical Training Survey for Canberra Hospital remain less than the national average, which shows we're not where we need to be, yet.

At CHS we're working hard to ensure our education and training is improving, and when this doesn't meet expectations, we take it seriously. We're making changes and taking feedback on board to deliver for our JMOs.

CHS has been making improvements. We've shown this in the quality of and access to teaching sessions and orientations, which is promising. We've also seen an increase in the quality of training to raise patient safety concerns, a testament to our focus on the Speaking Up for Safety program, rolled out to all CHS team members.

Canberra Hospital trainees experienced their lowest rate of bullying, harassment and discrimination in four years; however, it still remains a serious concern for us that 27% of respondents to the survey reported having experienced and/or witnessed bullying, harassment or discrimination. This is something we continue to work on.

Improving workplace culture is a focus for us as an organisation. We continue to engage with our junior doctors around these experiences. It was positive to see that 46% of respondents who experienced mistreatment made a report – a significant improvement on previous years and well above the national rate of only 30%. What this shows us is that more team members feel comfortable to come forward with their complaints, which is the direction we want to be heading.

Recently, we employed a dedicated clinical psychologist for our junior doctors to improve their wellbeing and mental health. The psychologist will provide education and training around self-care and wellbeing and will be on hand to provide support to individuals and teams.

We receive a lot of direct feedback from our JMO's regarding the teaching program. We're on the right track but there's still more to do.

Recently we've implemented a new method to evaluate the quality of teaching we offer. Consultation has just closed on our CHS Learning and Teaching Strategy, which outlines our commitment to strengthen learning and teaching. It includes building dedicated learning and teaching infrastructure and resourcing, as well as working on our processes to better enable learning and teaching to happen.

This will see support for learning and teaching being provided by all leaders, at every level, with oversight and accountability by senior leaders.

I'd like to acknowledge and thank our junior doctors for the terrific work they do every day as part of team CHS. Our junior doctors provide exceptional health care to our patients and are an integral part of our clinical teams across a range of disciplines in the service.

We know that entering the medical profession can be a challenging transition, and we are committed to ensuring our junior doctors are equipped, prepared and supported with the necessary clinical skills to flourish at this crucial time in their careers. ■

Cardiologists remain concerned after meeting with Health Minister

Five cardiologists recently wrote to ACT Health Minister Rachel Stephen-Smith detailing their grave concerns about the deterioration of Canberra's public cardiology services.

In their letter to Ms Stephen-Smith, dated March 6, private cardiologists Dr Libby Anderson, Dr Darryl McGill, Dr Chris Hii, Dr Ben Jacobsen and Dr Siang Soh warned there had been "an unacceptable and dangerous deterioration in the last twelve months in cardiac services provided by the Cardiology Department of The Canberra Hospital, superimposed upon a longstanding decline in the provision of such services."

The group is concerned that the deficiencies in the availability of cardiac services at The Canberra Hospital are particularly impacting "those in our community most dependent on an effective public health service." They wrote of growing inequity in the ability to access cardiac services in the ACT, determined by health insurance and socioeconomic status.

The cardiologists met with Ms Stephen-Smith in person on March 15. Dr Anderson said they left the meeting with mixed feelings of hope and dissatisfaction. "Although the Minister acknowledged it's been a challenging time, she wasn't able to answer our basic question of how long patients have to wait at present to have an angiogram in the public system," Dr Anderson said.

Canberra Health Services CEO Dave Peffer, who was also at the meeting, told the group he expects the new electronic health record will eventually streamline cardiology referrals. Dr Anderson commented: "We were encouraged to hear referrals will be efficiently logged and triaged through the DHR system, which has been in use for a few months now, but we have yet to receive any information about how we should submit our referrals to this system."

In an *ABC News* article, Canberra Hospital's general medicine clinical director Dr Ashwin Swaminathan said CHS was holding an international recruitment to fill permanent positions in cardiology. Dr Swaminathan rejected the suggestion that wait times had blown out as a result of 2022's controversial suspensions.

Here are some extracts from the cardiologists' letter:

Referrals disappear

"The Cardiology Department does not have a functional central waiting list system. Complaints of inaction relating to specific referrals are met with the response that it should be taken up with the specific doctor to whom the referral was made."

"The reality of the last twelve months is that our referrals 'disappear' into the Cardiology Department. No "receipt-of-referral" communication is sent to the referring doctor, nor any estimate of waiting time. Thus, neither we nor our patients have any idea when, or indeed if, the referral will be acted upon, regardless of how often the patient calls, and regardless even of whether a referral is marked URGENT and includes a comprehensive history detailing why the requested procedure needs to be done expediently."

Procedures delayed

"Even prior to the suspensions of 2022, the waiting time for electrophysiological (EP) procedures was very long, and there was ongoing interstate referral of many uninsured patients for procedures that should have been performed locally. However, in the last twelve months, the EP situation has become critical, because of insufficient qualified medical staff, and dismal retention of nurses/cardiac scientists with specific EP training."

"At present, it is almost futile to send outpatient referrals to The Canberra Hospital for EP, as procedural spots are taken by patients already in hospital (e.g. post-cardiac arrest) or by patients self-referred after seeing the single EP-trained staff specialist in his rooms. The result has been an increase in interstate EP referrals, although these necessitate patient expenditure that is minimally reimbursed by ACT government funding, particularly as EP is ostensibly available here. Furthermore, some patients are too frail, or have insufficient family resources, to permit interstate travel, so are obliged to accept decidedly second-line therapy in Canberra."

Investigations outsourced

"Outpatient cardiac investigations (stress testing, echocardiography and Holter monitoring) have had very long waiting lists for years at The Canberra Hospital. This situation has become markedly worse in the last twelve months."

"As GPs have long understood that for an expedient stress test or echocardiogram, it is pointless to refer to The Canberra Hospital, the increased waiting time now is perhaps not a critical issue (except regarding patient expense), although it is certainly a highly unsatisfactory situation for a teaching hospital."

"However, it has become routine practice for Accident and Emergency (A & E) staff at The Canberra Hospital to refer patients requiring specific cardiac tests (who presented with chest pain/breathlessness/palpitations but were not admitted) either back to the GP (for the GP to organise the required investigation), or to a cardiologist in the private sector. Thus, instead of an internal referral (with expedient outpatient testing and hospital follow up if needed), the responsibility for organising (and paying) for the test is transferred away from the hospital altogether. This is particularly problematic in a city where bulk billing in general practice is uncommon, and GP waiting times are frequently well over a week."

"The delay in the required test being performed may be critical, with regard to the patient's health. There have also been cases where patients have assumed their symptoms were not important, as the A & E team neither admitted the patient nor arranged follow up testing, and as a result, the patient ignored recurrent symptoms, to the detriment of their health."

"The provision of these services is now such that even inpatient requests for such services are being ignored. Patients admitted with myocardial infarction who develop secondary heart failure may be discharged without an echocardiogram (to evaluate the extent of the damage). Patients may be diagnosed and treated for heart failure without echocardiographic proof of diagnosis. Patients admitted overnight at high risk of an acute coronary event are often discharged without a screening stress test. Non-cardiac inpatients needing an echocardiogram for optimal management (e.g. patients with severe respiratory issues, or severe peripheral oedema) are now invariably referred to one of us post-discharge, after their requested test was not performed during their admission."

Cardiac beds scrapped

"It is accepted world-wide that patients with cardiac conditions do better (morbidity and mortality) when managed by cardiologists, in specific cardiology units staffed by allied health personnel with specific cardiac expertise."

"Some years ago, The Canberra Hospital appropriately established a Chest Pain Evaluation Unit (4 beds within Sub-acute Coronary Care) to permit overnight assessment of patients at high risk of an acute coronary event. It is our understanding that as of fairly recently, this unit no longer exists."

"Ward 6A has always had beds specifically allocated to cardiac patients who did not require Acute Coronary Care (primarily patients with resolving cardiac failure - a relatively chronic condition albeit still with significant morbidity and mortality risk). It is our understanding that these beds have now been re-allocated to the Acute Care Medical Unit. Cardiac patients who would previously have occupied those beds are now cared for wherever a bed is available. This is likely to be in a ward where there are no nursing staff skilled in the challenging management of cardiac failure."

Trainees under-supervised

"In the last twelve months, concerns have been raised by Advanced Trainee Supervisors about the quality of training provided to ATs in the ACT…The concern was initially in the context of the acute shortage of consultants (particularly those with sub-specialty skills) in the Cardiology Department."

"Unfortunately, several other recent administrative decisions are adversely impacting upon the training and education opportunities ATs currently receive. For example, the ATs are now forced to cover night shift in Coronary Care, a position previously filled by a basic physician trainee (BPT), who has been redeployed to cover the Acute Medical Unit. After working a night shift (where there is no teaching, nor consultant involvement unless something goes badly wrong), the AT loses a day of training in the Angiography suite (or elsewhere) in order to comply with OH &S regulations… The possibility of loss of accreditation for AT positions needs to be considered very seriously." ■

New service stops sick kids falling through gaps

A new service is helping ensure Canberra children with complex healthcare needs don't fall through the gaps when care is being provided across several teams.

PLaNS team members: Jess, Chrystal and Kara

The Paediatric Liaison and Navigation Service (PLaNS) has been running for six months and provides a dedicated care coordinator – a nurse or allied health professional – to eligible families. The PLaNS team member works with the family and the patient's treating teams to create an individualised care plan and streamline clinical handover across the healthcare system.

Kirsty Cummin, Program Director of Integrated Care at The Canberra Hospital said the service provides a single point of contact for eligible families whose child requires care across multiple disciplines, such as oncology, orthopaedics, cardiology and endocrinology.

"We allocate eligible families with a care coordinator/navigator who becomes their advocate, working with the paediatric team, with speciality groups, with social services and community organisations to make sure communication is clear," she said. "We are empowering the clinicians, the family and child to have the patient's needs at the forefront of their journey."

The service currently has 45 children and families and has already developed a close relationship with the Sydney Children's Hospital's specialities and navigation liaison service, for cases where patients receive some of their medical care in NSW.

"When an oncology patient is admitted to The Canberra Hospital, one of our navigators will work with the Sydney Children's Hospital and the family and paediatric team on the ward to ensure all the care needs and requirements are catered for," Ms Cummin said.

The service has also been working closely with the Emergency Department at The Canberra Hospital on emergency management planning for eligible patients.

"We are streamlining the journey, so that if a patient comes into emergency, staff can look up their care plan, which shows agreed steps to take and how to connect with their usual treating team."

The service currently has three dedicated registered nurses and is planning to recruit two allied health professionals. Families can self-refer to the service through CHS Central Health Intake, and their eligibility will be assessed by the team.

Once a care plan has been developed for a child it is available in the child's DHR record, which parents can access through the MyDHR link.

The new service has been co-designed with the Health Care Consumers Association in response to research into the difficulties experienced by families of children with complex healthcare needs. The research highlighted the challenges for families trying to integrate back into Canberra's health system after their child received care interstate.

Ms Cummin said Canberra Health Services was now looking to expand the concept to adult populations with complex or chronic diseases who are requiring access to multiple services across the Canberra health care system. ■

To refer to the Paediatric Liaison and Navigation Service call 02 5124 2415 or email plans@act.gov.au

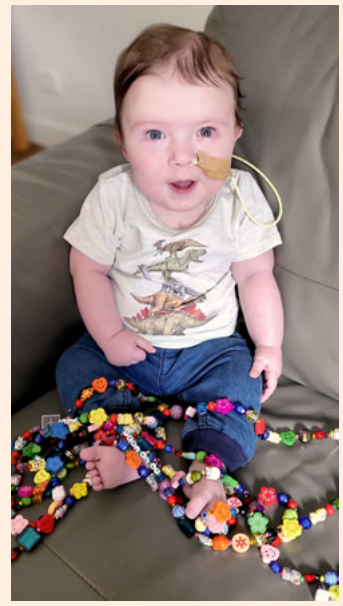
PLaNS gives peace of mind to Eugene's parents

One-year-old Eugene spent the first nine months of his life at the Children's Hospital at Westmead, Sydney, where he has undergone three heart surgery operations. Last Christmas he was able to return to his home in the Canberra region, with assurances from Canberra Hospital that in the event of an emergency, they would contact his team in Sydney who have expertise in his extremely rare condition; pulmonary atresia with ventricular septal defect and major aortopulmonary collateral arteries.

Eugene was set up with a "pink card" in Canberra's new DHR, designating him as a PLaNS patient. Eugene's mother Michelle said the system is working well, and she now has confidence Canberra Hospital will know what to do if he needs urgent care. "Eugene can deteriorate so quickly, so it's really good that when we go to ED now, they make him a priority and get in touch with his treating cardiologists in Sydney," she said. "It's given me peace of mind and enables us to live at home rather than stay up in Sydney."

Michelle said their paediatric liaison worker Jess has been excellent: "If we're having any difficulties, she's the one that takes the pressure off us and follows things up."

The system had a bumpy start. In January, Eugene pulled his feeding tube out and had to be brought to emergency, where he waited three hours. By the time the doctors saw him he hadn't eaten for eight hours. However, after that episode, the PLaNs team worked with the family and the hospital to improve the situation for next time. When Eugene was brought to ED in February for a fever he received urgent care. "We only had to wait about 15 minutes and they called our team at Westmead straight away," Michelle said . ■



When Eugene was brought to ED he received urgent care as a PLaNS patient.

Spotlight on...

Voluntary Assisted Dying

What can we learn from Victoria about Voluntary Assisted Dying?

Melbourne oncologist Dr Cam McLaren has been involved in 250 cases of application for Voluntary Assisted Dying (VAD) under Victoria's scheme, which began in 2019. Of those cases, 120 have progressed to taking their medications and 107 have died without taking their medications, either by choice, or more commonly by not surviving the application process. *Canberra Doctor* asked Dr McLaren how Victoria's experiences might inform the ACT Government's work toward a model of VAD for the territory.

DR CAM McLAREN

What safeguards do you believe are essential in a VAD regime?

This is a tough question, as a lot of the safeguards are determined by where the society that is introducing VAD sees the boundaries for acceptable access to VAD. We've seen overseas jurisdictions allow competent minors, and we've seen just recently Canada approve access to their equivalent MAiD (Medical Aid in Dying) for people with a mental illness as their "qualifying diagnosis". Australia as a society needs to continue to have open discussions about where the lines are to be drawn. In my opinion, having two doctors assess the patient independently against the eligibility criteria (whatever they may be) is vital to ensure greater safety. Many other safeguards, such as the 6 vs 12 month prognosis topic, whether doctors can initiate conversations, etc, are important considerations for each jurisdiction, but we've seen these be employed variably across the different states' legislations, and so I wouldn't regard them as "essential".

Are there any safeguards which ACT should consider not adopting?

In Victoria, only Australian citizens or people holding permanent residency visas are eligible. We've had several cases where applicants who have lived in Victoria for sometimes longer than I've been alive, have been denied access due to the fact they moved here and never took out citizenship or formal permanent residency. We have fed this back to other states and we've seen legislation such as that introduced in Queensland that allows for exceptions.

The need in Victoria for one of the two assessing doctors to be a specialist in the area of disease from which the patient is suffering would cripple the VAD process in the ACT. The last Victorian VAD Review Board Report showed that 47 of the 303 Medical Oncologists in the state (16%) where eligible to provide VAD assessments. In the last Australian Medical Board Report of Registrant data, there were 15 Medical Oncologists in the ACT. If the same uptake of VAD training occurs in the ACT, there will likely be only 2-3 Oncologists available for assessing patients.

In which situations have you seen the greatest value of VAD?

The value of VAD to the individual is variable. For the minority, it functions as many want it to; to relieve truly untreatable suffering. We need to be mindful that Palliative Care do amazing work and the frequency of patients having these truly untreatable symptoms is exceedingly rare. Where we've seen the greatest benefit of VAD has been in providing comfort to patients who don't fear death, but fear how they will die. For many, the availability of VAD as a "trump card" if their worst fears about how they will die start to materialise, has provided immense palliation in its own right.

Can you share any situations when VAD did not go well, and what was learned?

There are rarely major complications to the VAD act itself – I've had some patients vomit as they fell asleep, and several patients who fell asleep quickly after ingesting the medication, but their family had to then experience a prolonged time to death (sometimes 4+ hours). No patient has ever woken from the full dose of the medication that is used orally. There have been even fewer complications from Practitioner Administration (IV).

In Victoria you cannot initiate a conversation about VAD. How then do the conversations typically come about, and how do they progress?

Patients are often referred to me through either the statewide VAD navigators or the public hospital VAD coordinator for assessment, so they have often already initiated that conversation with another doctor. When I see patients, I review their history, recent investigations, reach out to their usual treating specialist GP and oncologist, and then have an hour assessment with them to determine if I feel they meet the eligibility criteria. If they do, I refer them to another doctor for a second assessment. The most common reason patients are ineligible is that their prognosis is not clearly less than six months, in which case I review them every month or two. For all patients, with their consent, I explain to them how I would expect them to die (liver failure, kidney failure, etc), and discuss with them how that may look and how the symptoms would be able to be controlled. If I feel there is more active treatment that is appropriate, I urge them to discuss that with their usual oncologist. I have been able to introduce many patients to palliative care teams who were previously against the idea.

How have you seen doctors being impacted by the introduction of VAD?

Those of us who do work in VAD have certainly been impacted by the low uptake of VAD by most doctors; we are having to see many patients who would be better-assessed by their usual teams, but who can't due to their team's reluctance to engage in and provide VAD. Many doctors (including myself) are learning to adapt to patients making decisions to embark upon VAD rather than continue with the treatment plan recommended to them – it's not uncommon for this to be conflicting.

What extra support do you think the profession requires to make sure the introduction of VAD does not add additional stress to doctors?

The introduction of VAD will add additional stress to doctors, there's no escaping that. We need to remember that if we are going to provide patient-centred and patient-directed care, that we need to walk the walk, and support the patient no matter the decisions they make. Patient-centred care is easy when the patient does what you want, but it is no less important when they do not. The other point on this is that many hands make light work. If VAD is left to the few, that additional stress will be concentrated amongst those few. Uptake should be encouraged amongst doctors early.

How has your own attitude to VAD evolved since experiencing it in action?

I still feel that the patient's opinion is the only one that matters, and if they want to pursue VAD, they should be supported. But I have become more committed to ensuring that the decision they make is a fully-informed one. It has been eye-opening to have a no-holds-barred discussion about death and dying with patients; sometimes they walk away so relieved when I tell them that their expected death from renal or hepatic failure is generally painless, and symptoms can be well-managed. Sometimes this frank discussion has been enough for patients to say, "maybe I won't need VAD after all". There is a lot of fear about death and dying in our community and much of it is unwarranted through the magnificent work that our palliative care colleagues provide.

Do you have any further recommendations for the ACT as the government here prepares to introduce VAD legislation?

I would recommend a centralised model with perhaps a Clinical Lead doctor for VAD for the ACT who oversees all cases of application. VAD has proven itself to be a rare event in Australia so far; it is important to concentrate the experience of a rare event amongst a few doctors in order to ensure the expertise develops amongst them. This is the same principle for which we have trauma centres or cancer centres – the safety of systems comes from the experience of those who work within them. ■

Dr McLaren is one of the Clinical Moderators of the Victorian VAD Community of Practice, the Founder of Voluntary Assisted Dying Australia and New Zealand (VADANZ) and is on the Board of Dying with Dignity Victoria.

in the ACT

"Life should not be taken from a person, but yielded by the person in their own time"

A personal reflection by an ACT doctor opposed to VAD

Having witnessed the deaths of many patients, it is my deep conviction that we should refrain from hastening this process. No one can really know what goes on in the mind of a dying person – psychological factors relevant to their entire life may, in some unknown way, be under consideration, regardless of their pre-existing views or present condition. Respect for them as a unique individual implies that this process – their life's final 'work' – should not be presumed complete, or prematurely terminated.

Furthermore, no one can definitively say what fate awaits them beyond death. Neither religious conviction, nor believing that no form of existence is possible after death determines with certainty what will actually befall the dying person once they die. Given such existential ignorance, I believe alternative forms of care to VAD/euthanasia should be practiced with every person experiencing degenerative or terminal illness, supporting them in ways that do not specifically aim at ending their lives.

The psychological and physical suffering associated with dying may be amenable to alleviation in varying degrees, but perhaps not entirely, and perhaps not always. Fear of what may lie ahead of them (this side or the far side of death), or doubts regarding their beliefs thus far about death may concern the dying person.

Such apprehensions may be alleviated through empathetic interpersonal interactions, but again perhaps not entirely. Apprehensions about the nature of existence beyond death may only develop, or appear in some novel form, as death approaches. From a more hopeful standpoint, however, what the poet William Wordsworth termed 'intimations of immortality', perhaps as memories from an earlier time in life, may also come to mind (or arise afresh) near life's end, causing the dying person to wonder about the possibility of encountering a perfect peace beyond death.

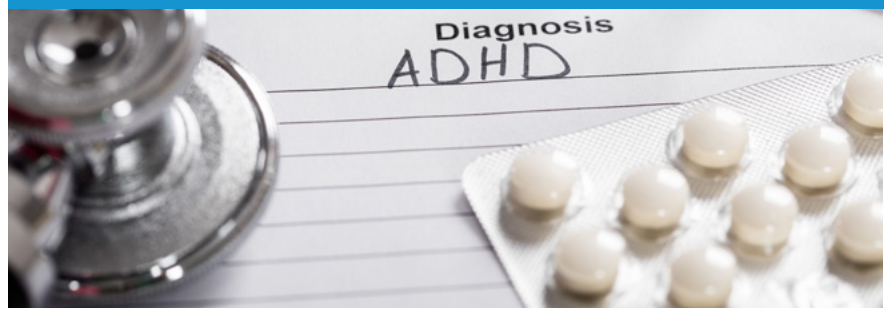
At the same time, as death approaches, a sense of regret at life's passing may afflict the dying person – they may regret fractured relationships, actions they took that were ill-considered, and opportunities for good they may have foregone, and such regrets may induce in them a desire for reconciliation with those whom they may have injured or been in discord.

Thus, certain forms of suffering near life's end may be unavoidable, and some may even be of benefit to the dying person. We know from other stressful experiences in life that suffering may be of value. May this not also be true as life draws to a close?

Although some doctors may believe they are showing compassion by helping a dying patient end their life, others may see this as an abrupt and concerning interference in another's personal journey. Dying is not something that can be done by a surrogate – it is an activity or process that, while onlookers can observe and be involved with in some ways, can only be undertaken and directly experienced by the person themselves. Life should not be taken from a person by others who believe they know best when and how to intervene, but yielded by the person themselves in their own time. A holistic approach to the dying person would seem to be best demonstrated by allowing them all the time they need, providing all relief available, but not hastening the process of dying. ■

Dr Paul Burt FANZCA FCICM

COVER STORY



GPs call for ADHD prescribing rights amid specialist gridlock

Continued from page 1

training being onerous," she added. "More and more GPs are being asked to do special diplomas for the things that we already manage, without evidence that it improves outcomes."

Paediatrician shortage

Canberra paediatrician Dr Michael Rosier agreed the shortage of paediatricians in Canberra was causing "immense frustration" to patients and their GPs. "A number of local paediatricians have closed their books or are no longer seeing patients with certain issues such as ADHD," he said. "In fact, our own practice has been forced to stop seeing new patients as our waiting lists are over one-year to see patients with conditions such as ADHD and this is obviously not workable."

"This is an issue crying out for a solution, not only in Canberra but around the country," he said. "I think we really need to consider something like a national taskforce to look at this."

Dr Rosier said he was not convinced that enabling GPs to initiate the prescribing of psychostimulants would be the long-term solution. "As it stands, I just can't see that GPs have the time and skill set to do the work up required to prescribe psychostimulant medication to children," he said. "The initial assessments are very detailed and often include liaising with the student's school and seeking feedback from various sources. When prescribing medicine to children, they often need to be adjusted regularly in response to the benefit and side-effect profile."

Dr Rosier urged the ACT Government to look at possible strategies to encourage more paediatricians to come and practice in Canberra.

However Dr Berenson argued ADHD was far too common to leave diagnosis and management in the hands of non-GP specialists alone, saying interested GPs are "more than competent" in this area. "GPs have the advantage of being able to prescribe a medication for a week and see how it goes, whereas a patient might only see their psychiatrist or paediatrician ever few months," he said.

Street amphetamines

The issue has come to a head as the ACT Government prepares to decriminalise possession of small quantities of illegal drugs, including amphetamines, from October this year.

Dr Berenson commented: "Under the heading of harm minimisation, unsupervised possession of 1,500 mg of ice and 1,500 mg street amphetamine will be decriminalised in the ACT, while GPs remain unable to prescribe and monitor the effects of 5mg dexamphetamine tablets."

Noting that ADHD guidelines associate substance abuse with unmanaged ADHD, he added: "Accessible GP ADHD management has the potential to reduce the use of untested, possibly contaminated street drugs for many drug takers."

"If we really want harm minimisation, the regulations on controlled prescribing for ADHD by GPs need to be reassessed," he said.

Australian ADHD Clinical Guidelines published in July 2022 note that community ADHD prevalence is 6-10% in Australia, with higher rates among Aboriginal Australians and prisoners.

An ACT Government spokesperson said there was "no proposal for a change to existing requirements around ADHD prescribing".

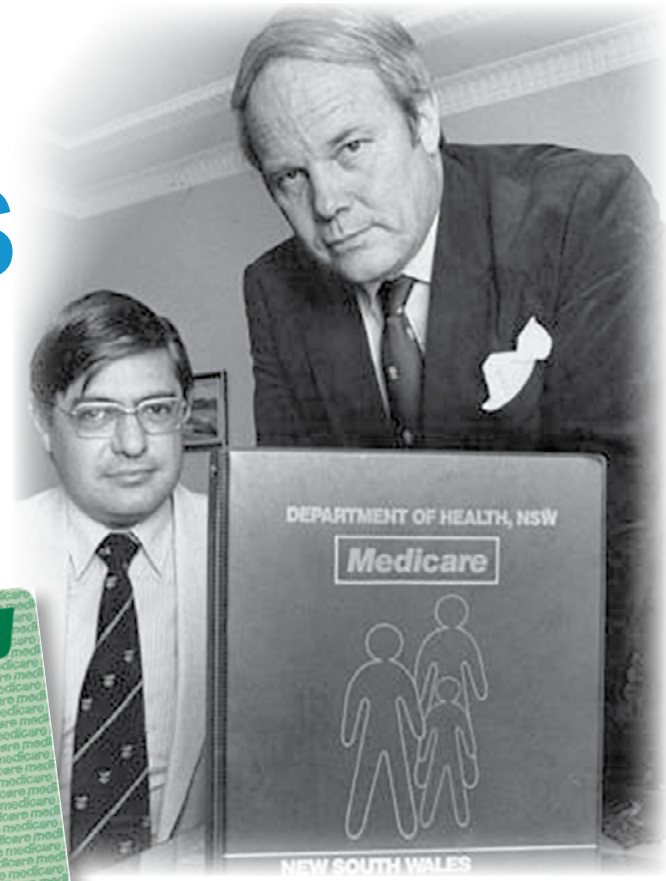
They noted that once psychostimulant medication is initiated by a paediatrician, psychiatrist or neurologist, a GP can continue to prescribe it with their documented support.

According to the government, the current wait time for an initial diagnostic ADHD psychiatric consultation at Access Mental Health is approximately nine months – calculated from the time that the psychiatrist receives all the required supporting information from the patient and pathology from their GP. The current wait time for initial paediatric consultation in the public system is 18 months, they said. ■

A life in medical politics

Part 2: The Medicare era

Canberra local, Dr Bill Coote, was Secretary General of the AMA from 1992-98 and has maintained a strong interest in the evolution of the Australian medical profession. He worked as a rural GP, an economics tutor and was Director of the Professional Services Review from 2011-16. This is the second instalment of a two-part memoir he has written for Canberra Doctor. His memories of flashpoints in medical politics help make sense of how the health system got to where it is today.



Around 1990 the AMA adopted a more confrontational approach to government under the leadership of Dr Bruce Shepherd (right).

DR BILL COOTE

Government relations

Today's $30 billion per annum Medical Benefits Schedule (MBS) has its roots in the 1970 Gorton Government's medical insurance scheme. Until the early 1990s the AMA, under formal agreements with government, coordinated the profession's negotiations over amendments to the MBS. This included arbitrating in professional "turf disputes", seeking to ensure balance across fee levels and ensuring MBS regulations were not overly prescriptive. The AMA lobbied for occasional inquiries that adjusted MBS fees to reflect inflation. An AMA Fees Bureau provided accounting and economic support. I was employed to manage this Federal AMA activity.

It was an interesting era. Technical advances such as endoscopy, arthroscopy, laparoscopic surgery and IVF meant many sub-specialties, with distinct economic structures and political priorities, evolved out of the general medicine and general surgery groupings of earlier decades. Large corporate entities evolved as practices consolidated in pathology, diagnostic imaging and general practice. Modern IT provided extensive information on MBS utilisation patterns; government no longer courteously accepted the professional advice of doctors. New MBS items needed "evidence of their safety, clinical effectiveness and cost-effectiveness".

Formal AMA policies blended clinical and financial autonomy: doctors set fees independently and insurers decided what rebates to pay. These doctrines co-existed with political pragmatism. For example in early 1987 the government introduced Item 119 for all third and subsequent attendances by a consultant physician, with a substantially reduced rebate. Physicians were outraged. A major public campaign engaged chronic disease consumer groups. A compromise allowed the Minister to save face by announcing a "minor" change: Item 119 would be optional. The Item was seldom used. One physician told me he would only use Item 119 for an inpatient if he did not stop walking as he passed the patient's bed.

Around 1990 the AMA adopted a more confrontational approach to government under the leadership of Dr Bruce Shepherd. He had led the 1984 NSW hospital doctors' dispute. Federal AMA "intervention" in that dispute left simmering animosity between NSW AMA and senior Federal AMA doctors. Dr Shepherd's contribution to a booklet prepared in 2011 for the 50th anniversary of the AMA's establishment evokes the tensions of that period: "The AMA had been captured by a group for whom negotiation was little more than appeasement... AMA office was a reward for years on committees rather than fighting on behalf of the profession." Dr Shepherd marched out of the National Press Club in front of the TV cameras half-way through Prime Minister Keating's televised address in the week before the 1993 federal election.

GP politics explodes

In the early 1990s the medical press regularly reported on tensions between the many GP political groups. There was the Federal AMA but also The National Association of GPs (NAGPA), a federation of AMA state GP committees. Some feisty GPs formed the independent Australian Association of GPs (AAGP). The RACGP involved itself in political issues. The Rural Doctors Association emerged. The left-wing Doctors Reform Society maintained its strong defence of Medicare. On the libertarian right was the GP Society in Australia (GPSA), which, as it faded, became the Private Doctors of Australia (PDA).

GP politics had exploded in late 1988. In secret negotiations, the RACGP convinced the health minister to introduce the GP vocational register (VR), linking the payment of higher GP MBS rebates to attainment of the FRACGP. Some AMA Council members supported formal GP postgraduate training but bitterly opposed implementation through Medicare. GPs were outraged by the RACGP's proposed "random practice audits" to assess a GP's use of proposed new MBS attendance Items. Some older AMA GP councillors had been GPSA leaders in the late 1960s when the GPSA claimed 40% of GPs as members. The GPSA dismissed the very concept of a GP college as "hollow, meaningless and self-contradictory".

My literary skills were tested drafting the AMA submission to the Senate Inquiry into GP "vocational registration". My position was delicate. I would have benefited from professional guidance and mentorship when entering general practice in 1977. In 1980 I had sat the FRACGP exams. Fortunately no one recalled a paper I presented to the Queensland AMA in 1982 proposing mandatory GP postgraduate training.

In 1991, after the heat died down, AMA GPs, working with the RACGP and government, analysed MBS financing issues and other forces shaping general practice including workforce issues. A document General Practice: A Strategy for the Nineties and Beyond, sent to all GPs, incorporated the recommendations of two large "GP Summits" organised by the AMA.

Subsequently, billions of Commonwealth dollars have been spent seeking to influence how GPs are educated, where they practice and how their practices are organised. A national network of Divisions of General Practice was funded. GP practice accreditation was introduced. Attempts to link GP remuneration

to evidence of quality practice were introduced. The outcome of all this activity is another story.

Workforce: a manageable problem

The lament of a former Secretary of the Commonwealth Health Department that he had many levers but none were attached to anything is pertinent to medical workforce policy. Decisions of universities, state health authorities, medical colleges and individual practitioners influence the number, training, and distribution of doctors, with the Commonwealth often left to pick up the tab. Every decade sees another national medical workforce collaborative. In the 1990s I was a member of the Australian Medical Workforce Advisory Committee (AMWAC), which assessed the relationship between Australia's postgraduate training capacity and future needs. I was influenced by a 1992 Canadian medical workforce report by two health economists. They argued that some medical workforce problems are "manageable rather than solvable" and that there is no optimum number of doctors "in an absolute technical sense... because ultimately this is not a technical but a social matter".

Making headlines

AMA relations with private insurers were strained in the mid-1990s by the "Lawrence reforms", proposed contracts between health funds and hospital specialists. The AMA ran a major political campaign opposing these changes, seeking to ensure that Australia did not adopt "US-style managed care" with clinical decisions influenced by third party financial considerations. The senior Canberra lobbyist for the health insurance industry enjoyed referring in the media to "the AMA's managed scare campaign".

Every few years in the 1980s the ABC's Four Corners produced a sensationalist report on "overservicing" which tarnished the whole profession. Government officials challenged the AMA with extreme examples, such as a patient they labelled Jumbo who had 747 medical attendances in one year. In 1994-95 the AMA opposed a Medicare plan to deal with "overservicing" by bureaucratic fiat, with an aggrieved doctor's only redress an appeal to the Administrative Appeals Tribunal. The Minister, against the advice of senior officials, accepted the AMA's proposed peer-review based scheme and the Professional Services Review (PSR) was established in the Health Insurance Act.

A Federal Council Meeting, 1988: Dr Bill Coote, Assistant Secretary General middle; Far table, centre: Dr Bryce Phillips, President; Dr Bruce Shepherd, Vice-President on Dr Phillips' right; ACT President Dr Brian Richards to left of Dr Coote.

In the 1990s the chair of the Australian Competition and Consumer Commission sought to crack down on alleged anticompetitive behaviour in the profession. The ACCC may have been influenced by a famous 1975 US Federal Trade Commission finding that US AMA ethical rules had "deprived the public of any meaningful competition among physicians". As late as 1989 the AMA Code of Ethics advised doctors contemplating setting up a "competitive practice" to seek AMA Branch advice to ensure the proposal "is free from ethical objection" and advised that telephone book listings "should appear in small print only". Compliance with such restraints on competition had largely died. The ACCC did pursue allegations of "anti-competitive" behaviour against some obstetricians in regional Queensland and against the WA AMA.

In conclusion

I moved on from the AMA in 1998. Working with the organised medical profession was challenging and rewarding if sometimes frustrating. It was a great privilege to work with many leading Australian doctors. Perhaps the last word can be left with then NSW BMA President, Dr Crago, writing in the Australasian Medical Gazette of January 15, 1895: "There has been a curious fallacy of regarding the medical profession as an inanimate, soulless, unresponsive thing, a being from which it was hopeless to expect any intelligent cooperation… our profession is, on the contrary, a body sensible and intelligent, capable of generous feelings and possessed of a soul capable, when properly appealed to, of nobly responding." ■

Is it time to rethink how we use psychiatric labels?

NESH NIKOLIC,
STRATEGIC PSYCHOLOGY

We need to talk about psychiatric labels. Around one in five Australians have a mental illness and Australians are increasingly feeling at ease talking about their psychiatric diagnoses. Clients walk into my clinic telling me what they 'have' and what they 'are'. ADHD, depression, anxiety, PTSD – these labels, once given, become embedded in many peoples' sense of self, especially impressionable young people. I hardly ever hear anyone say they're sad anymore, but many say they're depressed.

While the cultural mood is to view this openness as a sign that mental health is being 'destigmatised' I worry we're seeing the opposite effect at play: psychiatric labels run the risk of foreshortening a person's sense of the future and disempowering them. Labels can affect the way families, teachers and employers think about a person and the goals a person has for themselves.

In a podcast interview I did recently, eminent psychologist Dr Steven Hayes described psychiatric labels as "ill-fitting suits that barely describe a tiny portion of what a person's life is about". I think he's right.

What a label means – and what it doesn't

Sometimes the ill-fitting suit is better than none. Labels have value in providing a common language for clinicians and allied health workers to describe symptomatology and to do so efficiently. Under time-pressure, it's easier to write 'PTSD' in a referral letter than describe in detail the nightmares and flashbacks a client with a complex history of trauma is experiencing.

And yet the use of a label can make psychiatric illnesses sound more absolute than they are in science. For the truth is that unlike physical illnesses, there are no sensitive and specific biomarkers for psychiatric illnesses, despite popular belief in the community that some mental illnesses are primarily caused by a simple chemical imbalance.

The result is that different clinicians will often arrive at different diagnoses for the same psychiatric patient – is it major depression, an adjustment disorder, a bereavement disorder or PTSD? In the end, the label is less useful than a description of the client's experience and how their feelings, thoughts and behaviours affect their lives. The label is just a short-cut.

If we're going to use labels, we should be ready to review whether the client still meets the diagnostic criteria over time. I would like to see more clinicians consulting regularly with their clients about whether their symptoms are still within the clinical range for a diagnosis.

Mind your language

While I'll use a diagnostic label for the sake of efficiency when speaking with a health professional colleague, I'm careful how I do it. I've designed a template that all our psychologists use when writing to GPs, where we say that a person 'presents with symptoms of' a particular condition, rather than saying they 'have' it. We also describe the other life circumstances the client is facing, recognising that symptoms are just part of the client's wider life story and the context is just as important as their experience. The wording might seem like a small thing, but it can make a difference to how the client sees themselves if the paperwork falls into their hands.

When talking with clients, I personally try to not use labels. Instead of using words like 'anxiety' or 'panic attack' or 'generalised anxiety disorder' I would say the client has 'significant apprehension about going into particular environments' and that they 'avoid settings because they're fearful of those unwanted sensations returning'.

My aim is to normalise the client's unwanted feelings as part of the human experience. Sometimes therapy will enable the client to control those feelings, but sometimes they will need support to learn to function well despite their symptoms.

Empowerment and stigmatisation

As health professionals, we must be careful not to participate in a culture that wants to 'sort' people into categories. It bears remembering that some contributors to psychology were deeply invested in eugenics – people like Francis Galton, who worked on applying the bell-curve and standard deviations to categorising human differences in the belief that genetic differences made some humans superior to others.

The truth is that there's lots of neurodiversity among people, and that the average isn't 'right' – it's just the average. We need to be very careful how we use labels lest we give the impression that those on the outer edges of the bell curve have a brain disorder or are 'broken' or 'wrong'.

Take the example of the highly active child who is very interested in sport, who doesn't tolerate boredom well. They're likely to grow up and work with their hands or juggle lots of professional roles. I wouldn't want that child to grow up thinking there was a dysfunction in them. That's just not a fair appraisal.

I recognise that some clients and families find reassurance in having a diagnostic label. Recent media stories have highlighted the 'aha moment' for women diagnosed with ADHD in adulthood, who feel like the diagnosis makes sense of their life experiences up to that point.

Although many will disagree with me, I think we can still achieve acknowledgment of someone's temperament and life experiences without giving them a label. The goal is for people to walk away from their psychologist or doctor feeling understood and able to explain features of themselves. We try to equip them to utilise some of those features as great strengths and moderate other features that are not functionally useful.

In the end, I would like to see greater focus across the spectrum of neurodiversity on what all people can do to foster better mental health, social wellness and endurance and capacity to rise to life's challenges, label or no label. ■

AMA calls for two months' supply per dispensing

The AMA has urged all members of the Federal Parliament to support its campaign to increase the maximum dispensed quantities of selected PBS items from one month's supply to two months' supply per dispensing.

The recommendation was first made by the Pharmaceutical Benefits Advisory Committee (PBAC) in 2018 and would save patients up to $180 a year on selected PBS medicines. It would also allow up to 12 months' supply in total from a single script, saving patients an extra trip to their doctor.

AMA President Professor Steve Robson has written to all MPs and Senators, calling on their support for the Federal Government to immediately implement the recommendation.

"It would free-up GP consultations ... This is time GPs could spend with other patients who, we know, can benefit from the preventative health care GPs provide," Professor Robson said. ■

Foetal Medicine loses accreditation

Training has been suspended in the Foetal Medicine Unit at The Canberra Hospital due to workforce shortage in subspecialist maternal medicine, a Canberra Health Services (CHS) spokesperson confirmed.

There is a significant skills shortage in tertiary foetal medicine nationally, leading to challenges attracting staff to the organisation. CHS said it is working hard to recruit additional subspecialists and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists have committed to reinstate CHS training accreditation once the staffing situation improves. ■

Hobart Place General Practice closing

Hobart Place General Practice will be closing on 30 April 2023. The practice, formerly called Interchange General Practice, recently informed patients that it had become financially unviable to continue.

In a letter to patients it cited the "erosion in the value of the Medicare rebate" and said it had been "increasingly difficult to practise the mixed billing model in general practice".

"Government policy about GP registrar placements has also meant that very few of the GP registrars who have trained with us have ended up staying with us," the practice stated.

"The focus of Interchange General Practice on disadvantaged populations has also meant that many GPs think that working at Hobart Place General Practice will also mean working with a lot of complex and challenging patients and so have avoided applying to work with us."

Dr Clara Tuck Meng Soo, Dr Yew Choy Cheong, Dr Liz Fraser, Dr Shelly Gill, Dr Mary Jane Micua, Dr Kate Molinari and Dr Lindsay Rodgers will be moving to the sister practice, East Canberra General Practice. Dr Peter Tait and Dr Denise Kraus will retire when Hobart Place General Practice closes. ■

Mental health workforce meeting

The ACT Government's Office for Mental Health and Wellbeing is running a workshop that will contribute to the development of the Mental Health Workforce Strategy – Action Plan.

The workshop aims to bring people together to identify and develop a set of actions that:

- address workforce challenges across the mental health sector including workforce shortages
- support the building of a strong resilient and effective mental health workforce
- support the ongoing development of a highly skilled, diverse, well-distributed and sustainable workforce

The event will be held on Wednesday 26 April from 11am - 1pm at Nara Centre, 2 Constitution Ave, City and online via Webex. For more information contact officeformhw@act.gov.au ■

What's On

Scan the QR code or go to **ama.com.au/act/events**

AMA ACT Events 2023

28 April 12 - 1pm Friday	**JMOA Member Lunch** JMOA Lounge, Lvl 8, Building 1, TCH Free for JMOA Members, *Sponsored by AMA ACT and Drs4Drs ACT*
17 May 6:30pm Wednesday	**2023 Annual General Meeting** AMA ACT Office, Level 1/39 Brisbane Ave, Barton ACT Light dinner provided. **RSVP** by 10 May reception@ama-act.com.au
31 May 6:30pm Wednesday	**Council of Doctors in Training Meeting** AMA ACT Office, Level 1/39 Brisbane Ave, Barton ACT Light dinner provided. **RSVP** by 25 May reception@ama-act.com.au
6 June 6pm Tuesday	**Speed Networking Your Future** 6pm dinner followed by speed networking 6.30-8.30pm. Light dinner provided, ANU Clinical Skills Centre, TCH Free for Interns and JMOs. **RSVP essential** by 31 May **Register here**
14 June 6:30pm Wednesday	**Careers Night** AMA ACT Office, Level 1/39 Brisbane Ave, Barton ACT RSVP by 7 June reception@ama-act.com.au

Conferences

For a full list of conferences visit mja.com.au/conference-calendar

Please check with individual conference organisers about cancellations or postponements.

01 May - 04 May	National Suicide Prevention Conference 2023 Canberra, ACT
01 May - 05 May	Spineweek 2023, Melbourne, VIC
06 May - 09 May	Australian Rheumatology Association ASM 2023, Hobart, TAS
19 May - 21 May	GPCE Sydney 2023, Sydney, NSW
25 May - 26 May	Finish the Fight Against Malaria Global Congress 2023, Melbourne, VIC
26 May - 28 May	ANZSNM 2023 Annual Scientific Meeting, Adelaide, SA
27 May - 30 May	2023 Australasian College of Dermatologists Annual Scientific Meeting, Sydney, NSW
29 May - 31 May	Renal Society of Australasia 2023 Conference, Sydney, NSW

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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.

Canberra radiologist invents time-saving tool

Canberra radiologist Dr Chaturica Athukorala is the creator of Aurabox, a new cloud-based medical imaging storage platform that is gaining popularity among local doctors. The tool enables specialists to view all their patient's images in one place.

Dr Athukorala told *Canberra Doctor* the idea first came to her as an intern in 2008 when she was given the job of chasing up patients' images. "I often wondered why I was wasting my time hunting down images and sending and receiving faxes when these jobs could be streamlined with technology," she said. "Being a doctor is already a stressful job and inefficiency is a huge contributor to doctor burnout."

The catalyst to build a solution came in 2021, when a close friend was diagnosed with breast cancer. "In those first two weeks she went to three different imaging practices so she could get all the images she needed before she saw her surgeon," she said. "Although in principle patients should get all their images done at one place, the fact is you can't get appointments at the same place when it's urgent, and so my friend had to carry around a USB stick and passwords and wasn't sure her doctors would be able to access the information they needed."

Aurabox went public five months ago and is already being used by around 40 doctors (mostly in Canberra) and more than 200 patients. Dr Athukorala said the platform has been well-received by specialists providing team-based care to patients with complex conditions such as cancer and chronic diseases, where images need comparison over time.

A pilot study at the Canberra Region Cancer Centre compared patient experiences before and after using the platform. In one example, a Canberra brain cancer patient who underwent chemotherapy in Sweden was able to share his complete imaging history with his Swedish oncologist within minutes.

Dr Chaturica Athukorala

Images from different radiology providers can be viewed on one platform.

Another patient with metastatic melanoma described how useful it was to provide her different doctors in Canberra and Sydney with access to her full medical imaging history.

Aurabox now has 5 staff, who provide on-boarding assistance to doctors and administrative staff. Staff or patients can use Aurabox's high speed DICOM uploader to efficiently upload images from a CD or USB onto the platform. "You simply drag the icon onto the platform and it automatically extracts the images along with metadata like patient name, date of birth, and the practice where images were taken," Dr Athukorala said.

The platform has a rigorous consent process and is working towards strict US data security standards. ■

To find out more or to sign up visit aurabox.cloud

Art In Butt Out winner comes full circle

On the eve of this year's call for entries to AMA ACT's Art In Butt Out competition, *Canberra Doctor* was delighted to discover that a former winner now works in the policy team at the Federal AMA.

Sally Witchalls won the 2013 Art in Butt out competition as a 14-year-old and now works on preventive health policies at the AMA. The competition, now in its 16th year, invites year 8 students to design a poster to discourage their peers from taking up smoking or vaping.

Sally told *Canberra Doctor* that winning the competition as a year 8 student kickstarted her interest in public health messaging. "Winning the prize really encouraged me along a path of wanting to work towards a healthier future for all Australians," she said.

Sally used the generous prize money she received to buy an Ipad, which became essential to developing her own photography business. She is continuing her passion for photography, while studying towards a Master of Public Health through the Australian National University.

Entries are now open for AMA ACT's Art In Butt Out competition. This year's judges will be looking for well-designed posters that send a strong message to teenagers about the dangers of vaping as well as smoking.

Sally commented: "Vaping is now a major threat to young peoples' health. These products are given names and flavours that make them sound like lollies, when in fact they often contain chemicals that can cause serious damage to the lungs.

"Art In Butt Out is a chance for teenagers to craft a message that appeals to their generation so they won't be duped to take up smoking or vaping." ■

Entries close Friday 30 June. For more information visit ama.com.au/act/artinbuttout

Sally Witchalls (right), now and in 2013 (inset), with her prize-winning artwork.

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