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VMOs get pay rise, but still no parking spots

Visiting medical officers will get a pay rise from 1 July after the Arbitrator granted a number of the claims brought by AMA ACT and the VMOA in the current VMO Contract round.

From 1 July 2024 the base Fee For Service rate for VMOs will increase from 133.73% to 136.96% per cent of the MBS fee, while sessional rates will be increased by 4.1%. Both pay rises will come into effect from 1 July but neither will be retrospectively applied.

Fee for service

In the case of Fee for Service rates, the increase in indexation will be for 12 months before falling back to 133.73% for the remainder of the contract period. The increase reflects the recent period of high inflation but only on a temporary basis.

In his decision, the Arbitrator warned about the problem of "unsustainable increases" in pay rates and said that in view of predicted falls in inflation and interest rates in 2024 and 2025, the base fee should return to 133.73% per cent of the MBS in coming years, without further indexation.

The Territory will be required to carry out six-monthly reviews of MBS items (each January and July) and ensure that the updated rates are included in the payments schedule, including new or revised item numbers.

Sessional rates

Regarding sessional rates, the Arbitrator acknowledged the Territory's claim that sessional indexation had "tended to run ahead of inflation over the past decade" but noted that rapid and unexpected increases in inflation and interest rates over the past two years had "significantly eroded the value of VMOs' remuneration". He thus accepted the AMA's proposed 4.1 per cent increase for the 12 months commencing 1 July 2024 but reduced the increase in subsequent years to 2 per cent.

Daily rates for locums

An ongoing issue for VMOs over the course of the current contract has been a series of disputes regarding daily rates for locums. The issue has been resolved by the Arbitrator in ruling that the hourly rate of pay reflected in a locum's daily rate will not be less than the relevant sessional hourly rate.

Other matters

The Arbitrator accepted the Territory's claim that VMOs have an obligation to comply with the Digital Health Record (DHR). However, he also said contracts should be amended to make clear that VMOs will be provided with the necessary support in order for

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President's Notes

WITH PRESIDENT, **PROFESSOR WALTER ABHAYARATNA**

This is my last column for *Canberra Doctor* in my role as President of AMA ACT. When I took on the role back in May 2021, at the height of the pandemic, one of the things I spoke about was Canberra's potential to be a pillar of excellence in healthcare. It's still something I very much believe in, and I know many colleagues do too, despite the challenges of the last few years.

There is ample potential to provide an excellent and reliable healthcare service in Canberra; to strengthen the connections between our hospital and primary care providers and our education and research institutions, to attract the best and brightest to come and work in our beautiful bush capital.

How do we get there? Here are a few themes I've found myself regularly returning to over the last few years.

Integration

First, we need better integration across our health system. We are far too siloed. We need to keep working to ensure GPs are in the loop of what is happening in the hospitals and that the GP's voice is respected. This issue is particularly acute in the mental health space, where patients easily fall through the cracks if they don't have a regular doctor who is aware of what is going on for them. I worry that a small group of professionals bear the tremendous load of caring for an ever-increasing volume of complex patients. We must be in this together, bearing the load together. Conversely, policymakers should be wary of practises that further fragment care.

Excellence

Second, a hospital is so much more than a service-provider. The "service provision mentality" leads to under-resourcing of our healthcare staff and is a major contributor to their burnout and a lack of professional fulfilment. It leads to locally-trained medical school graduates seeking training positions over the borders, because they want to work where teaching is valued. I picture a day when Canberra's training programs are so well regarded that we become the first preference for junior doctors. I am encouraged that some of our hospital leaders have caught this vision, but there needs to be much broader cultural change, so that all of our healthcare leaders value excellency in clinical care, training and research. All this of course feeds into how hospitals remunerate, roster, recruit and facilitate staff enrichment, which is part of AMA's bread-and-butter industrial relations work.

General practice

Third, general practice remains the cornerstone of effective and efficient primary care, which underpins a well-functioning health system. The relationship of trust between a patient and their GP is essential to good preventive healthcare and chronic disease management. I have no doubt that the increase in Category 4 and 5 patients in our Emergency Departments and on our waiting lists relates to patients not being able to access chronic disease management through general practice. Our Federal and State/Territory Governments neglect general practice at their peril.

One of the unpleasant surprises over my period as President has been the ACT Government's imposition of a fresh payroll tax on GPs' earnings. General practices that made it through the challenging COVID years and survived the long rebate freeze now face a fresh existential threat at the hands of the ACT Revenue Office.

Prof Walter Abhayaratna, Dr Kerrie Aust, Dr Antonio Di Dio and Dr Marjorie Cross at Safe Space 4.

New AMA ACT President and board

One of the leading voices against the new tax has been our President-Elect, Dr Kerrie Aust, who takes up the reins as AMA ACT President in May. Dr Aust is well known to many of you, as a passionate GP and vocal advocate for sensible, evidence-based reforms in healthcare. Dr Aust grew up in Canberra and trained in Canberra, and is as ambitious for this city and its healthcare sector as I am. I thank Dr Aust for her tireless efforts over the last few years and wish her all the best in her new role.

I would also like to thank and congratulate those who have been elected to serve on the AMA ACT board. The new board, which will commence from the conclusion of the AGM on Wednesday 22 May, comprises Dr Clair Bannerman, Professor Kirsty Douglas, Dr Iain Dunlop, Dr Betty Ge, Dr Marisa Magiros, Dr Andrew McMahon, Dr James Miller, Dr Jason Gluch as Treasurer, myself as Secretary and Dr Aust as President.

Thank you

While I know that many colleagues are finding these times challenging, my experience at the AMA is a constant reminder there is excellent work going on in the region to make things better. I am especially thankful to the AMA ACT board and staff, and to our many active members, who together form a wonderful network. I am also glad to be able to recommend the Drs4Drs ACT helpline (1300 374 377) to all doctors and their families who might be doing it tough. Support is always available for our colleagues in need.

To all of Canberra's doctors, thank you for the incredible privilege of representing you and the joy of meeting so many of you. ■

COVER STORY

Continued from page 1

them to deal with the DHR.

The Arbitrator accepted a claim for VMOs to be paid penalty loadings for all ACT designated holidays, whether gazetted or not. The claim relates to the day following Boxing Day. The claim was resisted by the Territory, but the Arbitrator said it would be "somewhat irksome" for VMOs working with salaried medical officers to be denied the benefit of a public holiday when salaried medical officers enjoyed it. Furthermore, the impact of adding a further public holiday for VMOs would be "very slight".

The new contract will contain a definition of Digital Call-back so that defined work performed remotely can be paid on the same basis as a physical Call-back.

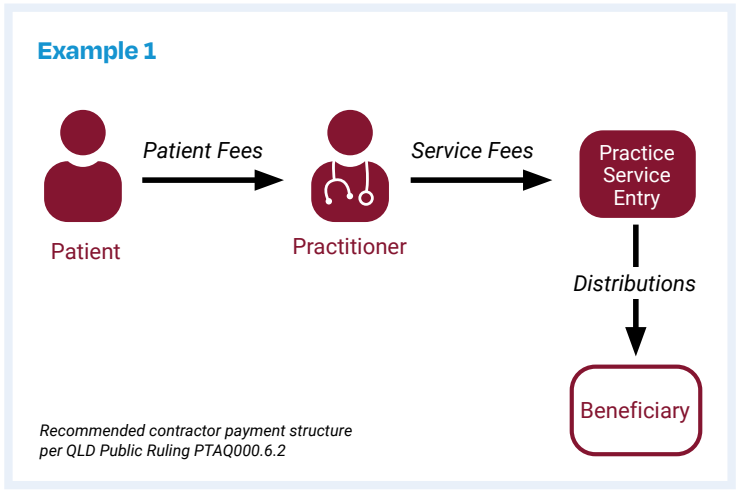
The contract will also clarify and strengthen provisions setting out Liability Cover, including indemnity cover for cross-border issues.

Unfortunately, there is no resolution to the continuing parking problems VMOs encounter at the Canberra Hospital. The VMOA had sought the installation of a boom gate to secure up to 30 car parking spaces in the car park nearest to the Hospital helipad. However, the Arbitrator said it was inappropriate to dictate to the Territory how it manages a specific car park at a particular facility. Instead, he said the contract should be re-worded to create a clearer obligation on the Territory to provide car parking for the VMOs.

An updated version of the VMO Core Conditions contract is currently being drafted to incorporate the negotiated and arbitrated changes. ■

Restructuring to avoid payroll tax? Think again

JARROD BRAMBLE
Managing Partner, Specialist Medical Services



Payroll tax will apply in the ACT with either of the payment arrangements above.

GPs and practice owners who thought they might escape the ACT Government's looming payroll tax by restructuring their business should think again.

The ACT Revenue Office has provided advice that unlike in other jurisdictions, models where a GP receives patient fees directly and then pays an administration fee to the practice are not exempt from paying payroll tax on the GP's earnings.

As a result, a large number of general practices in the ACT are likely to have a payroll tax problem. Meanwhile, questions remain over the implications for non-GP specialists.

Despite this, it's also important to remember that the ACT Government has waived any payroll tax liability for general practices prior to 1 July 2023, unless the practice was already in the payroll tax system.

Payroll tax exemptions

In the ACT, the most relevant exemption requires a practice to assess whether a practitioner provides the same kind of services to other principals, such as other medical centres. If they do, this satisfies the criteria for an exemption from payroll tax liability.

However, it's the practice's responsibility to apply to the ACT Revenue Commissioner for an exemption determination. The Commission will then "*review aspects of the contractor's business and exercise discretion accordingly*". This is in contrast to Commonwealth tax law, which relies on self-assessment. There is no formal pathway for obtaining a Commissioner's exemption, which is likely to add pressure and costs onto practices.

The bad news

In the landmark case *Thomas and Naaz Pty Ltd v Chief Commissioner of State Revenue NSW (2023)*, three practitioners were found to be exempt from Payroll Tax liability assessment because they received patient fees directly. The court observed that: "*As is clear from the position of the three practitioners who processed their own claims for Medicare benefits, there is a ready mechanism….*" to overcome a payroll tax liability.

On this basis, tax accountants in NSW and Queensland have been recommending practices restructure their businesses accordingly. In the ACT, many accountants assumed the same rule would apply. However, the ACT Revenue Office recently advised that there will be no exemption for such arrangements. In other words, there may be no way for practices to escape the tax.

The ACT Revenue Office has advised that it will typically assess up to five years of records to determine if payroll tax should be paid. If a medical centre is found to engage practitioners under a relevant contract, has total deemed wage payments of over $2 million per year and is not eligible for an exemption, then those payments over $2 million will be subject to payroll tax of 6.85%.

The ACT Revenue Office has provided a temporary payroll tax amnesty to 30 June 2025 (registration closed 29 February). However, given the requirement that at least 65% of patient attendances are bulk billed, only a handful of medical centres in ACT will be eligible. The conditions of the amnesty are highly unusual, given sole traders are typically free to determine their own billing.

Impact on non-GP specialists

Non-GP specialists generally undertake work under multiple contracts and provider numbers in the same year. Medical centres should not automatically assume however that their arrangements with non-GP specialists are exempt. They should consider all arrangements to help determine whether an exclusion applies, including:

- patient referrals
- your website information
- direct bankings to practitioners (not via a medical centre clearing account)
- current agreements in place

Cutcher and Neale's payroll tax checklist (see the QR code) will help practices understand the arrangements they have in place with non-GP specialists and whether they are high or low risk. ■

Stay up to date and get help

The payroll tax situation in the ACT is evolving. Stay up to date with information on the AMA ACT website.

For expert advice on reviewing or updating your service agreements and payment structure, contact Cutcher & Neale. **You can organise a complimentary consult on 1800 988 522 or medical@cutcher.com.au.**

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"I won't be going out quietly": Professor Kirsty Douglas on her retirement

Well-loved GP academic Professor Kirsty Douglas recently retired from her combined roles as Professor of General Practice at the ANU and Director of the Academic Unit of General Practice at ACT Health. Douglas spoke with *Canberra Doctor* about the insights she gained from working in the sometimes opposing worlds of academia and policy, and the controversial reforms she thinks are critical to Australia's healthcare future.

Finding general practice

Over the years, Douglas has influenced many medical students to pursue a career in general practice.

"Kirsty's one of the reasons I'm a GP," says Dr Kerrie Aust, AMA ACT President-Elect.

However, Douglas's own path into general practice was not straightforward. "I was very hesitant about going into medicine," she says. "Even after I finished my degree, I couldn't make up my mind what to specialise in because I liked everything."

Douglas studied medicine at the University of Adelaide and did a research doctorate on eclampsia at the University of Oxford, with a view to possibly becoming an obstetrician. While in the UK she met her now husband, who hailed from Tasmania, and they decided to settle in Canberra.

Douglas began GP training, largely because it satisfied her wide interests as a generalist specialty. It was also more family-friendly than other specialisation options at the time. While training, she worked part-time at a general practice in Yarralumla, which is also when the couple's four children were born.

"I loved working in general practice at Yarralumla," Douglas says. "It was a really high-quality surgery and Yarralumla was one of the most diverse populations in the ACT because it had the highest proportion of public housing but was also becoming very gentrified."

However, as the demographics of the area changed over 12 years, Douglas became frustrated that most of her work had become caring for the worried well.

The family took 12 months off to travel around Australia while Douglas worked at Broome Regional Aboriginal Medical Service.

> "You can lay out quite compelling evidence and it's still not enough to get something across the line in the policy world."
>
> **Professor Kirsty Douglas**

"That's where I fell in love with Indigenous Health," she says. While away, Douglas wrote to Dr Peter Sharp, medical director of Winnunga Nimmityjah Aboriginal Health Service in Canberra, to ask if he would have her on board.

Douglas worked part-time at Winnunga for the next nine years, which included the very sad time when Sharp got sick and died, and Douglas became acting clinical director together with Dr Marianne Bookallil.

In more recent years, Douglas has been working at Interchange General Practice and Health Cooperative because of its strong social justice agenda.

Douglas believes strongly in the relationship that underpins care between a GP and their patient.

"The gold of general practice is that patients get to know their healthcare provider in the long term and trust them and then are willing to disclose all other factors that are impacting on their health," she says.

She contrasts this to what she calls "transactional healthcare" where patients are at risk of becoming lost in the system and the nuance of a presentation is lost on a new doctor who doesn't know the patient well.

"In a transactional system, different practitioners might try to treat a patient's smoking, overweight and cardiac issues by the book, but the patient is easily overwhelmed. In contrast, a GP who knows the patient well can work with them on the underlying issues –their mental health and their unstable accommodation, while over time addressing the other issues too."

Academic life

Douglas has been part of the academic staff at the ANU medical school since its inception in 2003, having worked as a senior lecturer at its predecessor, Canberra Clinical School (part of the University of Sydney).

Douglas's primary research interest has always been how to get health services in the primary care space to be most effective and efficient. It's an area of research that has strengthened her convictions that strong general practice is critical to a safe, equitable and efficient healthcare system.

"The general medical training GPs have, and the continuity of care we provide over a long period of time, means we know our patients really well and are comfortable with 'uncertainty', so that we don't need to investigate every symptom every time, and over time builds particular savings," she says.

Over the years, Douglas has held many senior positions at the ANU medical school and at the Australian Primary Health Care Research Institute, culminating in her appointment to Head of the Department of General Practice in 2014. Historically, the role was funded by ACT Health, with an expectation that the Head would also provide policy advice to the department.

Professor Douglas was the ACT Government's main advisor on general practice and primary care, in addition to her academic role.

However, the demands for policy advice increased over the years, becoming extremely time-consuming. "I became the ACT Government's main advisor on general practice and primary care as well as my academic role," Douglas says. "It was really fascinating, but I was effectively doing two roles as one, and it has been tiring."

Upon her retirement, two roles have been created to fill Douglas's position; a Chief of General Practice, funded by ACT Health, and a full-time academic role at the ANU as Head of General Practice Teaching and Research, which will be advertised shortly.

Working with government

Douglas says working with the ACT Government has been "challenging at times".

"It's given me a far greater appreciation of the challenges and the time lines and the difficulties in the policy world, but there's also been real frustration because I'm committed to evidence-based practice and sometimes you can lay out quite compelling evidence and it's still not enough to get something across the line in the policy world," she says.

"For people sitting in ACT Health Directorate, if they get strong ministerial guidance that they need to 'do this' and 'make it work' that's what they need to do, regardless of what the evidence shows."

Douglas points to the ACT Government's increasing reliance on nurse-led primary care. "The evidence internationally shows that centres such as our nurse-led Walk-in Centres are safe and effective in that limited scope of practice that they provide, but they are very expensive and more expensive than GPs would be – not in terms of salary but in terms of investigation and management that is not followed through," she says.

Nevertheless, she says the GP shortages in Canberra and nationally leave state and territory governments with fewer options, and attracting and retaining

> “I spent time with Kirsty as a medical student at Winnunga. I sat in with her in clinic, taking the history and examining patients. She let me practice my clinical skills every time. As I watched her teach the registrars it was clear her clinical knowledge was exceptional. She spoke of the GP's skill at sitting with uncertainty. She fostered respect from peers and patients alike with her adaptable bedside manner. She was a strong influence on my desire to be a GP.”
>
> **Dr Kerrie Aust, AMA ACT President-elect**

Professor Kirsty Douglas (far right), with (L-R) Dr Liz Sturgiss, Dr Melanie Dorrington, Dr Jessica Tideman and Dr Kerrie Aust.

doctors into general practice is a critical need for the next 10 years.

“It’s an unfortunate reality, but it's fundamentally a problem caused by systemic undervaluing of general practice at the Federal level,” she says.

Douglas suspects the ACT Government may move back to the 1970s model of having some Community Health Services with salaried GPs in the near future.

“We need to be able to ensure there’s high quality primary care for that small but very significantly disadvantaged population in the ACT, and one of the ways of doing that is providing community health services funded by the ACT,” she says. “If they’re going to do that, they have to make them only available to those people with real disadvantage – and they need to continue to support and advocate for mainstream general practice.”

The future of general practice

Douglas says there needs to be a fundamental shift in the way health services are funded in Australia, towards greater recognition of general practice.

“We’ve got to make sure that as we move forward building our primary healthcare systems we don’t undermine that relationship base that is so critical to general practice and so critical to strong primary care,” she says. “That’s my real regret about some of the current federal initiatives such as the frequent flyer program or the Urgent Care Clinics; they’re building more and more transactional models.”

While the current Labor Government has signalled a move toward blended payments and voluntary patient enrolment to help address the inadequacies of fee-for-service, Douglas says she is “not terribly hopeful” that they have the model right yet.

“We need a more wholesale challenge to the way medicine is funded in this country; it really needs to be turned upside down, with truly blended funding models and a level of capitation so the practitioners who are providing more complex care to more complex patients are compensated,” she says.

Controversially, Douglas says it’s unrealistic to expect GPs to be paid more without some non-GP specialists being paid less. “Some of the really overpaid and overvalued specialists will need to come back to the pack for a little bit to allow general practice to move up,” she says.

“The reality is, we have a limited spend in terms of the health dollar; there are other things worth spending money on as well, like housing and education. We need to start having some really good discussions and debates about where do we want to spend our health dollar and what’s important.”

They’re debates Douglas will continue to be involved in, despite stepping back from her official roles. Over the coming months she plans to spend time with family, including a new grandchild, while thinking through what to do next. Rural and remote locum work is on the cards, as are health research projects at the ANU.

“I won’t be going out quietly,” she says. “I hope I can still be a really strong advocate for general practice, because it’s an incredibly rewarding career, and incredibly important for the sustainability of the healthcare system.” ■

New board to decide if children get treated

Dr Michael Rosier and Dr Jacky Hewitt have been named as the two medical representatives on the ACT Government's 13-person board charged with assessing applications for restricted medical treatments under new Variation in Sex Characteristics (VSC) laws.

Dr Rosier is a well-known local paediatrician, having practised in Canberra for more than 30 years. Dr Hewitt is a paediatric endocrinologist from Victoria and is on the Differences of Sex Development (DSD) subcommittee of the Australia and New Zealand Society for Paediatric Endocrinology and Diabetes.

The rest of the board members (see box) come from the fields of ethics, human rights and psychosocial support, including several who have lived experience of VSC. President, Megan Mitchell is a former National Children's Commissioner.

A spokesperson for the ACT Health Directorate said the positions were publicly advertised, with appointments made after a rigorous assessment process.

The new rules

From 24 December 2024, restricted medical treatments will only be able to proceed on a person with VSC who does not have decision-making capacity if an application for an individual or general treatment plan has been approved by the Board. Doctors and parents could face jail time for breaking the law, which includes taking a prescribed person interstate to receive restricted treatment.

Restricted medical treatments include surgical and medical procedures or treatments that change a person's sex characteristics, including the prescription or administration of a drug. Treatment plans are not required if the treatment meets the Act's definition of 'urgent'.

ACT Health said templates will be available online shortly for individual treatment plans for a child or for an adult under guardianship, as will a template for a general treatment plan. Once an application is made, it will be reviewed by a committee of five of the Board's members, including either Dr Rosier or Dr Hewitt.

An assessment committee can only approve an application if there is sufficient evidence that significant physical or psychological harm would result if the proposed treatment or an alternative treatment option were not undertaken. The committee must also be satisfied that alternative treatment options have been sufficiently considered, and that the proposed treatment will not be more restrictive of the patient's ability to make a decision about their sex characteristics in the future compared with alternative treatments.

The committee must disregard any evidence that the treatment needs to be undertaken to reduce discrimination or stigmatisation or a perceived risk of discrimination or stigmatisation.

Doctors frustrated

Several ACT doctors have expressed frustration about the new scheme to AMA ACT, but were unwilling to comment on the record for fear it could affect their ongoing employment with Canberra Health Services. Among their concerns are the Act's broad and inconsistent definition of VSC (it includes Turner syndrome and Klinefelter syndrome but not circumcision); the increased administrative burden on doctors, which could further blow-out waiting lists for paediatric services in the ACT; and the disregard for existing multidisciplinary evidence-based patient-centred medical care.

It remains to be seen how the new Board's decisions will compare to the evidence-based advice of existing multidisciplinary meetings such as the Sydney Children's Hospital Network's VSC/DSD meeting, which regularly involves doctors from Canberra and their patients with VSC.

Professor Sonia Grover, head of the Department of Gynaecology at the Royal Children's Hospital in Melbourne acknowledged the past hurts experienced by people with VSC in relation to their medical care, but said practises were now thoroughly patient-centred. She warned ACT's new laws created barriers to some children receiving care that was potentially in their best interests and even consistent with the aims of the legislation.

"If I had two daughters, one of whom had Turner syndrome and one who had cancer in childhood and was given chemotherapy such that her ovaries are now non-functioning, the child with the cancer would be allowed to start HRT to take her through puberty once she turned 11, but I would not be allowed to take my daughter with Turner syndrome through puberty until she was old enough to give consent," Professor Grover said. "So I would be allowed to make a decision in the best interests of one child, but not in the best interests of my other child."

"It is not even clear to me that I would be allowed to give permission for my daughter with Turner syndrome to have growth hormone, as this too has an impact on puberty and growth."

Professor Grover said the new laws reflect a very narrow understanding of human rights, and warned of potential psychosocial harms to children as a result of not being able to access treatments.

"This legislation has been driven by the word 'human rights' but in fact there are many things about human rights that are ignored in this legislation," she said. "Everything we are doing as doctors in this space is trying to optimise people's sexual function and fertility function and there are important psychosocial considerations as well."

Professor Grover is concerned that many individuals with conditions affected by the legislation have been completely unaware of the process occurring, including people with Turner syndrome, MRKH, AXYS, and "people with VSCs who do not feel that their diagnosis defines them, and hence have no links to any support groups".

"Many of the issues facing people and families of children with VSC do not relate to their genitals or sex characteristics, but the current legislation focuses only

> "Many things about human rights ... are ignored in this legislation."
>
> **Professor Sonia Grover**

What conditions are affected by the Act

The new laws widely define VSC as any condition that involves atypical sex characteristics. This is with respect to a person's chromosomal, gonadal or anatomical sex; and includes—

(i) the person's hormones that are related to sex; and

(ii) the sexual and reproductive parts of the person's anatomy; and

(iii) the person's secondary physical features emerging as a result of puberty.

Conditions specifically excluded in accompanying regulations include:

(a) bladder exstrophy;

(b) epispadias;

(c) hypospadias, other than proximal hypospadias with cryptorchidism;

(d) polycystic ovary syndrome;

(e) undescended testis

on this, ignoring a wide range of other health needs," she said.

Patient stories

The new ACT laws have been welcomed by advocates from the intersex advocacy community. Dr Agli Zavros-Orr, a board member of Intersex Human Rights Australia told a recent episode* of ABC's Radio National program the laws strike the balance right in "putting power back to the people whose bodies' it's about" (see QR and link below).

Dr Zavros-Orr shared her personal ordeal of discovering she had an intersex condition at age 17 and feeling she had little choice over what was done to her body, which included surgery and taking HRT.

However, another patient, Jenny Smith, told the same program she supported her family's decision to start her on HRT when she was 11-years-old, having been diagnosed with partial androgen insensitivity syndrome at age 7. Smith lamented what would have happened to her had she been growing up in the ACT today.

"What about the right to be free from the psychosocial harm that might come from an 11-year-old girl who has lived her entire life as a little girl, who is friends with lots of other little girls who are about to go through puberty, and all of the sudden she starts developing secondary sex characteristics of a male?" she said.

ACT is the only jurisdiction in Australia to have introduced these types of reforms thus far. ■

Listen

abc.net.au/listen/programs/bigideas/intersex-sex-development-variation-genetics-law-rights-science/102960694

SCAN ME

Who's on the new Restricted Medical Treatment Assessment Board?

Dr Jacky Hewitt

Dr Michael Rosier

- President – Megan Mitchell AM: ethics and human rights
- Dr Michael Rosier: medicine
- Dr Jacky Hewitt: medicine
- Dr Leith Henry: psychosocial support
- Simone-lisa Anderson: psychosocial support, ethics, lived experience and human rights
- Anna Brown OAM: human rights
- Dr Michaela Okninski: ethics and human rights
- Amanda Turnill: ethics, human rights and psychosocial support
- Chloe Hanna: psychosocial support
- Dr Susan Cochrane: ethics and human rights
- Dr Morgan Carpenter: ethics and human rights
- Ghassan Kassisieh: human rights
- Kristiina Siiankoski: lived experience

More students seeking doctors' help with exam provisions

The Office of the Board of Senior Secondary Studies (OBSSS) recently met with AMA ACT to raise awareness about its approach to special provisions and to clarify the type of information needed from doctors.

There has been a significant increase in the number of students seeking special provisions for the ACT Scaling Test (AST), which is used to rank students so they can obtain an Australian Tertiary Admission Rank (ATAR). *Canberra Doctor* understands that around 10% of students sitting the AST last September requested special provisions.

The AST is the one common examination between all of the schools offering the ACT Senior Secondary Certificate. The OBSSS therefore stressed that it is crucial for there to be confidence that special provisions are being applied fairly, including that students with similar conditions are provided with equivalent provisions, and that where provisions are granted, this does not undermine fundamental aspects of the test.

The OBSSS made the point that special provisions are about making sure that access is "neither biased for nor against any particular student". This is why the decisions about which provisions to apply are made centrally.

The OBSSS thanked doctors for their continued commitment to young patients and the process, and the thoroughness of their approach in completing the special provision application process. They asked doctors to focus on describing the child's diagnosis and its impact on them sitting a pen-and-paper examination, rather than detailing how their needs might be educationally accommodated, such as additional examination time or individualised supervision.

"Medical practitioners provide information on the student's condition, its impact on the student, and medical interventions that are necessary, and then based on this information the educational interventions that are appropriate will be established," the OBSSS said in a written statement.

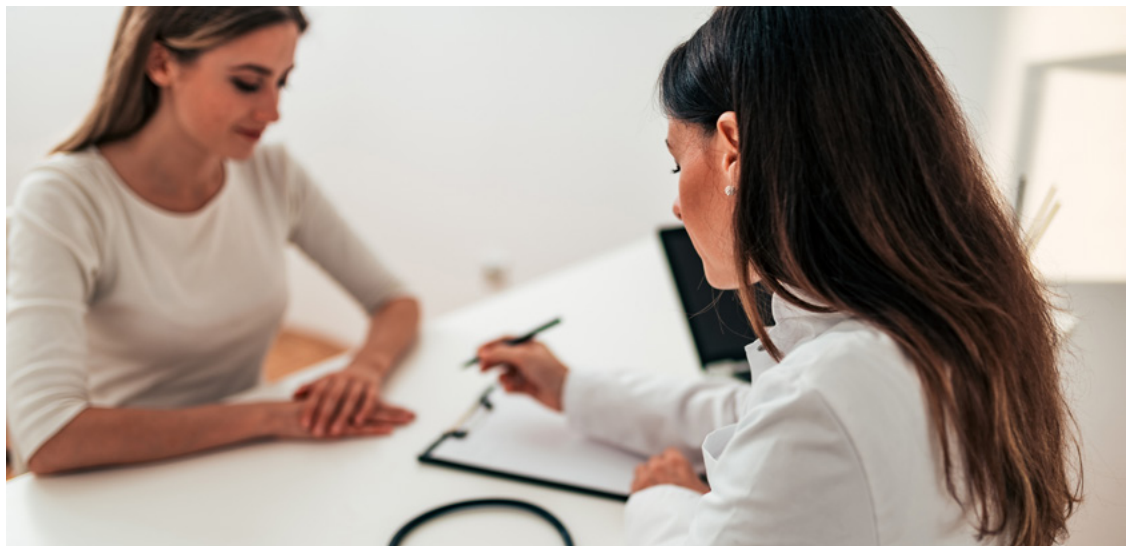
The OBSSS noted that curriculum authorities in all Australian jurisdictions communicate regularly so that there is consistency in how special provisions are organised across the country. Dependent on the individual student's functional impairment, special provisions may include stop the clock/rest and movement breaks, extra working time, small group supervision, individual supervision, use of a computer, use of a support person or use of noise-cancelling headphones.

The OBSSS said that applications were rarely rejected outright , and that although on occasion students may not receive all the provisions applied for, due diligence is always maintained through the process to establish appropriate provisions. Reasons may include that there was no formal diagnosis of the condition, there was an absence of evidence, the provisions requested were not reasonable, or they were not educationally sound.

The OBSSS said it warmly welcomes inquiries from medical professionals regarding questions or clarifications of the special provisions available for students in the context of the AST. ■

Govt incentivises GPs to provide abortion care

The ACT Government's pledge to make abortions free through general practices is taking shape, with a new fund reimbursing GPs for providing data related to abortion care.



The Government announced in April last year that it was making abortions free to ACT residents, however making it happen has proved a logistical challenge, given GPs cannot receive gap payments if they bulk bill for services.

Together with Women's Health Matters, the Government has developed a practice incentive model, based on existing precedents including the PIP QI program.

Under the ACT Reproductive Health Data Incentive Fund pilot, general practices and health services work with Women's Health Matters on quality improvement activities related to abortion care. Payments are provided for activities including data collection and participation in evaluation.

The model is compliant with the Health Insurance Act 1973 because GPs and health service providers are not being remunerated for the provision of clinical services, a spokesperson for Women's Health Matters said.

Medical abortions can be provided up to 9 weeks gestation at a GP. Beyond 9 weeks, only surgical abortions are available. These can be done electively at MSI Reproductive Choices and also at the Canberra Hospital in selected cases.

One GP who is involved told *Canberra Doctor* they currently perform four or five abortions a week, with a wait time of under one week.

"MSI is struggling with demand, so it makes sense to provide abortion care through general practice," they said. "A fair few of the patients I've seen have remained as a patient of the practice, which means they're getting continuity of care."

The GP explained that they bulk bill the patient using time-based item numbers. "While that nowhere near covers my costs, the ACT Government pays me to provide data on those services once a month, and that enables me to afford to provide the care," they said.

The patient takes their script to one of the participating pharmacies, who provides the medication and IUDs for free to the patient.

As of March 2024, the following services are enrolled in the program pilot:

- MSI Australia
- Watson General Practice
- Canberra Family Planning
- Capital Pathology
- Capital Chemist Charnwood
- Capital Chemist Dickson
- Capital Chemist Wanniassa
- I-Med Radiology Network

To be eligible for the Fund, practices must agree to provide abortion and LARC-related care at no cost to all patients living in the ACT; agree to be placed on a public register of medical abortion and related service providers in the ACT; and agree to refer to other providers participating in the program. ■

‘This is not real life’: why a Canberra cardiologist returns to Pakistan regularly

Dr Ahmed Khan leads an unusual life. An interventional cardiologist, you might have seen him here in Canberra, where he works as a VMO at the Canberra Hospital and consults privately at Heart of Canberra and National Capital Private Hospital. However, every couple of months, he’s working in very different conditions, providing life-saving cardiac care for free to patients in his birth country, Pakistan.

Dr Khan (third from left) visiting a cardiac institute in Quetta.

Dr Khan (far right) with cardiology fellows in Islamabad.

Dr Khan did his MBBS in Pakistan and came to Australia in 2003, where he did his fellowship in Interventional Cardiology at the Canberra Hospital. “It would have been very easy to settle into the kind of comfortable lifestyle that a professional medical career in Australia affords,” Dr Khan says. However, just before he attained his fellowship, Dr Khan had an encounter with a patient that changed him forever.

“It was the 18th of December 2012,” Dr Khan recounts. “The patient was 52-years-old. He was talking about his dream to spend a white Christmas in the US with his family. He was telling us how he had just booked flights from Sydney to New York to Washington. Then a few seconds later he had a cardiac arrest and died.”

“That moment changed the dreams I was chasing,” Dr Khan says. “I could see my senior colleagues doing well professionally and financially, driving big cars, going on exotic holidays, and then all of the sudden it hit me: ‘This is not real life. Real life is that you can make all your plans and die the next second’.”

Soon after receiving his fellowship, Dr Khan set up and registered his charity, Healthy Heart International in 2015. With support from Australian donors as well as several pharmaceutical and device manufacturers he is able to provide medical and surgical care free of charge through ‘camps’ run out of clinics at Islamabad and Quetta.

Dr Khan and his Pakistan-based teams see hundreds of patients at each three-day medical camp; and perform up to 10-15 procedures at each three-day coronary intervention camp. “I spend a lot of time teaching the junior doctors, sharing knowledge,” Dr Khan says.

At a recent visit, Dr Khan was invited to lecture medical students and doctors in training, where he spoke about cultivating character traits such as professionalism, kindness and gentleness. “I really want doctors everywhere to have a greater sense that medicine is a noble profession, not a business, and that we should have a heart not just for our own small circle of family and friends, but for every human being,” he says.

The contrast between Pakistan and Canberra has left Dr Khan with a discomforting sense of how much Australians take for granted.

“Recently we had a patient in Pakistan waiting for three months with angina,” Dr Khan says. “He was a religious scholar but he couldn’t teach or preach; couldn’t work outside of the house because of the ongoing crushing pain.

“All three of this man’s arteries were blocked and he needed multiple stents, but we had 38 patients waiting and we only had 35 stents available, so what were we to do?

“We had a very heartbreaking choice to make with that patient on the table. We just fixed the most important artery, the LAD, to save his life and decided the rest could be treated with medication.

“Another patient in our medical camp was only 38-years-old but looked very old. He’d had a stroke, and his blood pressure was 190mmhg, but he wasn’t taking any medication because he couldn’t afford it. We gave medication and then organised ongoing supply.”

The cost of that man’s medication for six months was only around AU$25. “In Australia we go out and buy lunch for $25 and don’t think about it,” he says.

Dr Khan is now in the process of setting up a Hospital On Wheels to bring cardiac care to people throughout Pakistan, with more than $110,000 raised from the Canberra community.

He continues to advocate for accessible healthcare, believing that no person should lose access due to cost or lack of resources. “We should open our hearts for those less privileged,” he says. ■

DRS4DRS ACT
Australian Capital Territory

The 24/7 Drs4Drs ACT Helpline is 1300 374 377

Why finding your own GP is worth the effort

DR DANA PHANG

Having your own GP is one of the best investments you can make in your own self-care as a doctor.

I've always made an effort to have my own GP, and have found that relationship to be a vital source of support. I can talk with my GP about health concerns that I wouldn't share with anyone else, and in doing so, stop those issues from becoming growing problems.

However, I acknowledge seeing a GP is not an easy task, particularly for doctors in their prevocational years or in specialty training as they work long hours and don't commonly have a rostered day off on a weekday.

The business hours most GP practices keep can be a challenge to the busy doctor. Nonetheless, finding a GP is not impossible. Telehealth has opened up opportunities to improve access to care for doctors. AMA ACT also keeps a list of doctors willing to see doctors as patients, who are often willing to consult after-hours. It can be challenging to have the same GP if you're being uprooted every 6 to 12 months to different towns for work. So how does one go about finding a GP in that situation? Personally, during my junior years, I would ask my colleagues for a recommendation. And when I was about to move on to another town, I would ask my current GP at the time if they had any GP recommendations for the next town I was being seconded to. If that method was unsuccessful, I would turn to resources such as my local Drs4Drs service.

Unfortunately, I have often heard that doctors are concerned to receive medical attention for mental health disorders, out of fear they will be reported to AHPRA. This is a tragic myth that persists despite many years of assurances from both AHPRA and the medical indemnity firms.

The truth is that in order for a doctor to meet the threshold for mandatory reporting, they would need to lack insight into their condition or be observed putting a patient at risk of harm due to their impairment. Taking an antidepressant or seeing a psychologist for therapy for a mental health condition do not constitute impairment. They show a doctor is caring for their own health, which is not only in their own interests, but in the interests of their patients.

In conclusion, finding your own GP can be tricky as a doctor, but it's well worth the effort. Indeed, it's essential for anyone who wants a sustainable and fulfilling career in medicine over the long haul. ■

Dr Dana Phang is a GP at Garema Place Surgery. She was previously on the expert advisory committee for Drs4Drs.

Self-care isn't selfish, it's a vital parenting skill

DR ALAN RALPH
Head of Training,
Triple P International

Juggling busy schedules, dealing with the ups and downs of family life, and consistently prioritising others' needs over their own can lead to parental stress or even burnout. Here are some ideas to help GPs support parents and carers in understanding the importance of looking after themselves, too.

Reframing self-care

Self-care is often misunderstood as a luxury or optional extra, but it's a vital parenting skill that benefits everyone. In fact, "taking care of yourself" is one of Triple P's five core steps to positive parenting. It's like the oxygen mask on a plane. We put on our own mask first before helping others. In the same way, it's important to prioritise self-care to be a calmer, more capable and consistent parent. This isn't selfishness; it's necessary.

Small moments add up

For parents with limited resources or energy, self-care can seem like one more thing to add to their long list of responsibilities. It can help to break down the concept and show how it can be incorporated into their daily routine, little by little. Rather than being a grand gesture, it can be any small, sustainable action that nurtures their physical, social, mental or emotional wellbeing. Even just a few minutes to have a coffee with a friend or take a few quiet moments for themselves can make a difference. These small acts can incrementally add up to create new, positive patterns that help mitigate stress.

Seeking support

Self-care also means seeking support when needed, and GPs can provide guidance and resources to help manage the demands of family life. Free online support from the Triple P – Positive Parenting Program can be a trusted, additional resource to refer patients to.

Triple P Online supports parents and carers of children up to age 12, helping them feel more prepared and empowered to handle everyday challenges. For parents who have children aged 6+ who experience frequent worry or anxiety, **Fear-Less Triple P Online** provides practical solutions.

For new and expecting parents, **Triple P Online for Baby** helps them adjust to this new chapter.

Thanks to Government funding, these programs are free for all families in the ACT. All offer evidence-based strategies to help navigate the ups and downs of parenting. This can ultimately lead to less stress, more confidence, and positive family environments for parents and children alike. ■

Referral made easy

GPs can get free promotional resources by emailing contact@triplep.net

Parents and carers can access free online parenting programs at triplep-parenting.net.au

ANU MedRevue turns eighteen

APRIL THOMPSON
Future doctor and current fart-joke-writer*

ANU med students hard at work, rehearsing for this year's Revue.

This year marks MedRevue's eighteenth birthday, and like all eighteenth birthdays it's a ripe time to get teary and remember. I sat down with Grant Pegg and Sarah Goulding, the (now) doctors who created, directed and performed in the first MedRevues, to discuss the early days.

ANU MedRevue was conceived in the dingy carpark outside the ANU law revue. A thought passed through Grant's head – 'Surely if the law students can do that, we can do better.' Okay, he might not have said those exact words, but I get what he meant. This was the perfect opportunity to lean into some friendly competition, given his musical theatre experience. And he was right! To this day, the MedRevue is a massive production that raises thousands for charity, and we have the local medical community to thank for that.

From the early rehearsals, it was evident that they had created something special. "There wasn't something that brought people together from every year in the same way that the revue did," Sarah reflects. Not everybody wants to don novelty scrubs and throw up in the gutter outside Mooseheads, but everybody can sing a silly ditty or gently take the mickey out of a colleague in the revue.

Some things never change. Our shows still feature cameos from beloved members of the medical school and Canberra medical community. Our shows still ruin popular songs for years to come, like for Sarah who will forever be cursed to hear "Hey There Delilah" as "Hey There Vagina". Our competitive streak hasn't changed either. The 2023 law revue had an original song for the first time, so naturally our 2024 show has two. Surprisingly, we still have a crazy proportion of medical students who play the flute. To all parents of future doctors, please suggest your little ones learn a brass instrument.

Alongside medicine, creativity and performance have continued to be a major part of Sarah and Grant's lives. Arguably, Grant "studied medicine on the side" of his musical theatre career, and even won a CAT (Combined Area Theatre) award recently for his role directing 'Dogfight' here in Canberra. Sarah writes and releases music, and credits the revue with her enthusiasm for theatrics – "I wouldn't have gotten into musical theatre otherwise".

A dark truth becomes evident during our discussion, however. That is, the 'MedRevue to Public Health pipeline'. Despite the school of population health featuring as the main villain in 2009's revue, both Grant and Sarah have moved to non-clinical work in public health.

Altogether, I have two main takeaways. Firstly, I should work harder on my population health project since I will inevitably join their ranks at the TGA. The second and more important lesson however, is that MedRevue teaches us what medical school cannot; how to do 'not medicine'. Perhaps missing placement to practice your rendition of 'Hey There Vagina' is actually high-yield, and zoning out in lectures because you're writing fart jokes is shaping us into well rounded people. ■

**April Thompson is a fourth-year medical student and producer of this year's MedRevue.*

Healthcare is about to change dramatically

PROFESSOR STEVE ROBSON
AMA President

Artificial intelligence will begin to have a dramatic impact on healthcare and health services in 2024 – but will it make things better or worse?

We are about to see the start of a quiet revolution that will, in the long run, be almost as transformative as the introduction of technologies such as antibiotics, blood banking and safe anaesthesia.

The rollout of AI as a routine part of medical care has the potential to deliver mind-blowing innovation in healthcare in Australia. It has the potential to be transformative for patients, doctors, other health professionals and the whole economy.

Moving past the role of simply acting as a repository of information about patients, AI will begin to assist with the diagnosis and – importantly – the types of treatments offered to patients.

This will be just as big a culture shock for doctors as it will be for their patients. The most advanced AI that most doctors use at the moment is often Siri, or their Netflix preference guides.

Radiology

The first doctors to embrace the potential of AI have been the radiologists who specialise in reading our x-rays, ultrasounds and MRI scans. For several years now, AI software applications have been introduced to assist with image recognition and, increasingly, with decision-support.

The use of AI to assist radiologists as they work to read multiple images has been shown to enhance accuracy and improve outcomes for patients. There is, however, an important drawback that has major implications for patients. AI is so powerful in its capabilities that it may detect subtle changes in human tissues that elude the human eye. It has the potential to detect changes in brain structure long before any disease becomes evident, or even is suspected.

This situation has the potential to lead to several possible consequences. What happens when AI unearths subtle changes that may not ever cause significant health problems, such as neurological diseases? There is enormous potential to cause distress and ongoing concern for patients, and to further unnecessary tests or even surgery.

Pathology

Another area where AI has enormous potential to improve patient care is in pathology. An excellent example is the diagnosis of cancers by specialist pathologists. Accurate interpretation of cancers under the microscope is the cornerstone of modern cancer care. AI technologies have the potential to improve the precision and accuracy of such a diagnosis, and to pave the way for bespoke cancer treatments that reflect subtle patterns in the architecture of cells in a cancer.

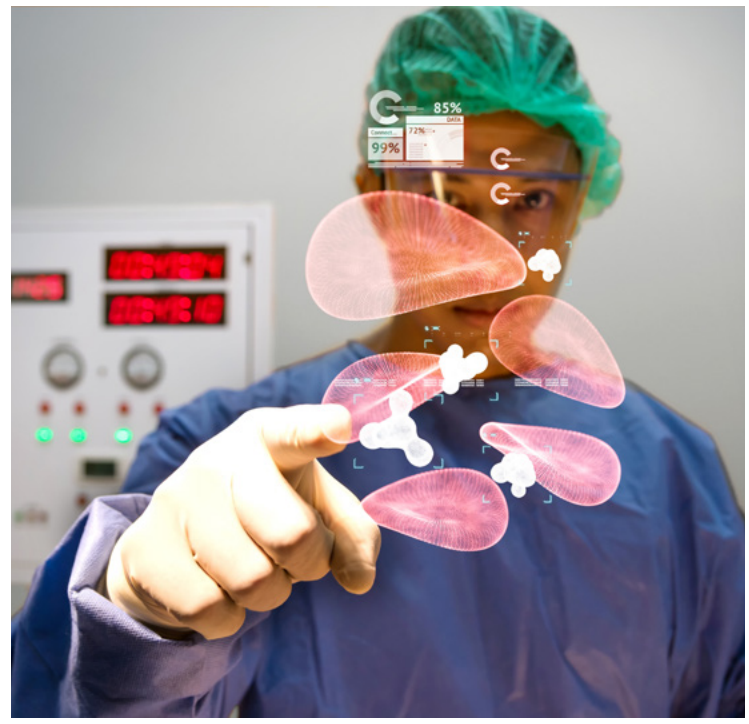
At a time when the pathology workforce is under great pressure, the introduction of AI technologies that act as a co-pilot and assist the pathologist in dealing with high workloads will be attractive to health services.

But it will be vital to harness the potential power of AI in a way that does not introduce diagnostic confusion or uncertainty. We must also ensure that processes are in place to confirm that the AI technology is actually improving care, not just adding to its complexity.

Safeguards needed

AI applications will be introduced across the health system to both improve patient care and to compensate for healthcare worker shortages. It will be vital that the cure is not worse that the disease, though.

The introduction of clinical decision support systems — where AI systems tell healthcare workers how to treat patients — is likely to be rapid from this point forward. There is no doubt that, in a time when the pressures on our health system are unprecedented, help will be welcome.



The lure of AI to solve workforce shortages in healthcare will be irresistable.

As this rollout of AI technology occurs, it may not be visible to patients receiving care or, indeed, to the doctors, nurses and healthcare workers being directed by computer. For this reason, the community must have trust in the systems and processes that we have in place to monitor just how well AI is achieving these aims.

At a time when the demands on our health system are overwhelming, the system is under-resourced, and staff are under more pressure than ever, the lure of AI to solve these problems will be irresistible.

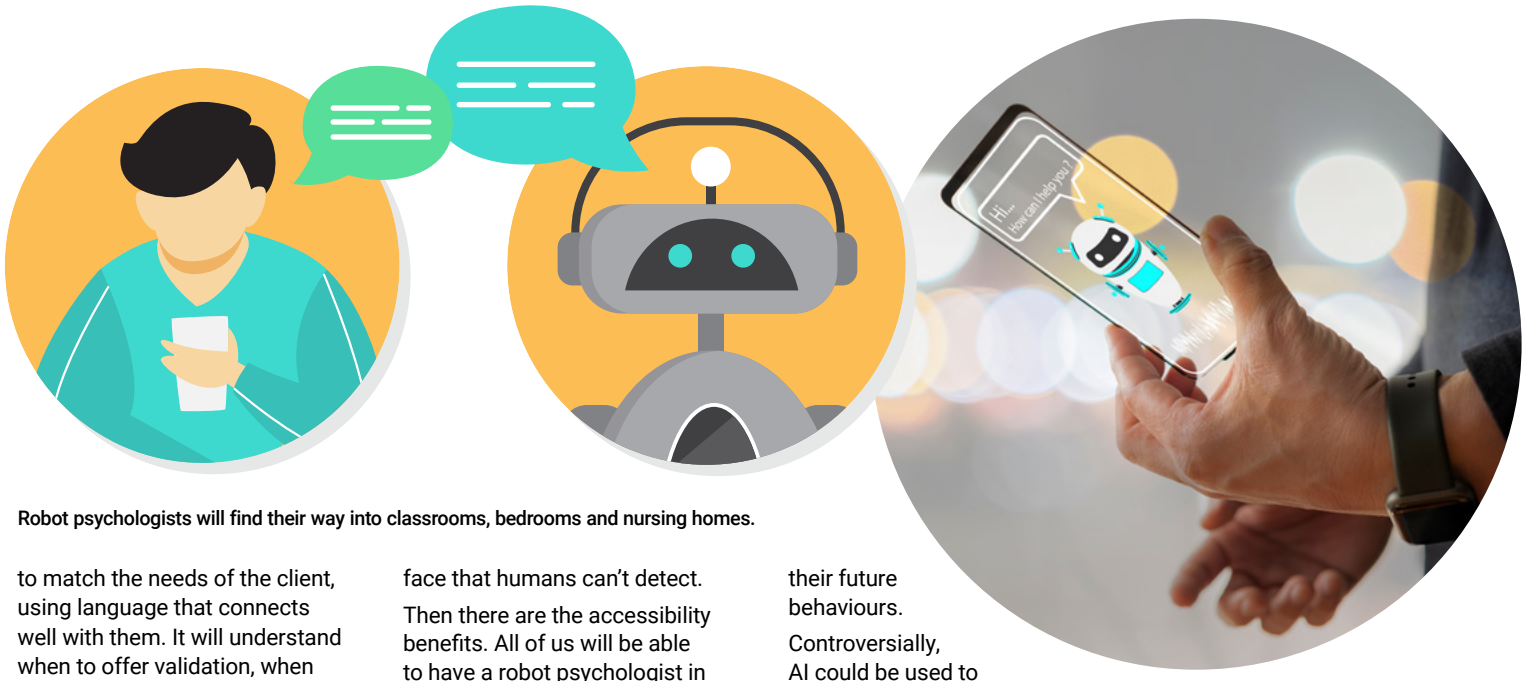
The AI revolution is upon us and gathering momentum at an extraordinary pace. If we are to harness its power for the greatest good, then we need to ensure it is a safe and trustworthy co-pilot in human health care, and never takes over the controls.

It is going to be an exciting ride. ■

This is an edited version of an article originally published in The Canberra Times on 5 January, 2024.

The robot psychologist is coming

NESH NIKOLIC
Strategic Psychology



Robot psychologists will find their way into classrooms, bedrooms and nursing homes.

Anyone who's spent any time playing around with Chat GPT knows how powerful Artificial Intelligence (AI) is becoming. AI can consume an amazing amount of data and respond in a way that is indistinguishable from a human being.

From where I'm sitting, it's clear it won't be long before software starts interpreting what a client says according to programmed psychological therapy modes, whether that's cognitive behaviour therapy, acceptance and commitment therapy or schema therapy, and offering suggestions to the client accordingly.

AI will be able to get a really good client history and provide therapy to match the needs of the client, using language that connects well with them. It will understand when to offer validation, when to challenge, when to offer psychoeducation, when to be therapist-led and when to be client-driven. It will be able to pick up on a client's emotional needs and understand when to wrap up the consultation.

The robot psychologist is going to be absolutely incredible in terms of their access to data. I've got 20,000+ hours of one-on-one consultation experience, but a computer can get that every 3 minutes. AI will be able to see micro-expressions on a client's face that humans can't detect.

Then there are the accessibility benefits. All of us will be able to have a robot psychologist in our phone. They'll look exactly the way we want them to look – Brad Pitt? Grandma? – and speak in a voice we love to hear.

What will it mean for psychologists like me? Perhaps the human psychologist and the robot psychologist will work together, with the robot reporting back data on how the client has responded to an in-person session, and how they're going with their homework. The robot could interrogate the client's language and propensities and use this information to predict their future behaviours.

Controversially, AI could be used to make a digital model of someone's difficult relationship. The client could talk to an avatar of their spouse while being coached by their psychologist. Role-playing conversations is a strategy that's played out in psychology sessions every day, but one which could take on a more realistic edge with AI.

Of course, there are dark sides to all this. The potential for data leaks is highly problematic. Then there's the issue of dependency. Some clients will form really strong bonds with the psychologist in their pocket. Software developers and regulators will need to find smart ways to minimise the harms.

Robot psychologists will find their way into classrooms, bedrooms and nursing homes, bringing with them all sorts of strange developments that we can't even conceive of at the moment. They will solve problems and create new ones. There's a world of risks, but there's also a world of opportunities. ■

Canberra Ash turns 40

DR ALAN SHROOT
Founder, Canberra ASH (Action on Smoking and Health)

I have been a lifelong anti-smoker, having grown up in a family and community of smokers. The first occasion I went shopping was when I was 4 and my mother sent me to buy a packet of 10 Players. By the time I was 7, I refused to buy cigarettes.

The evidence about the harms of tobacco smoking has been clear since the 1950s, when Professor Sir Richard Doll from Oxford published his epic work. In 1969, as a medical student, I wrote a dissertation on tobacco smoking and found around 30,000 articles in reputable medical journals.

Tobacco promotion of sport and the unrestricted advertising of smoking always annoyed me. I thought I represented a tiny minority of the population. Then the floodgates opened. In 1983, Prince Charles, the Princess of Wales and their infant son Prince William were visiting Australia. There were full page photographs in all the national dailies. The photos were surrounded with a coloured advertisement for a cigarette. The baby was almost holding it. The Prince and Princess were non-smokers, the Palace went wild and my blood pressure went sky high. Local teacher and activist, Gareth Smith had a television interview and I realised I was not alone.

Together, Gareth and I called a public meeting at the Griffin Centre; 40 people attended and an advertisement about banning tobacco advertising and smoking in public places was placed in *The Canberra Times*, to which we had about 70 responses. Canberra ASH was born.

Our activities included lobbying representatives, writing letters, press releases, demonstrations, floats at the Canberra Festival and an outstanding newsletter, *Ashes to Dust*.

With the tobacco industry, it is always two steps forward and one backwards. The industry have successfully marketed the practice of vaping in recent years. In time, I am convinced that vaping will be shown to be as dangerous as tobacco smoking and Federal Health Minister, Mark Butler, is to be congratulated on his initiatives in this area.

I had hoped that by now Canberra ASH would have outlived its usefulness but regrettably not so. ■

Tobacco Taskforce members at the 2023 Art in Butt Out competition: (L-R) Terri Henderson and Alan Shroot of Canberra ASH; Verity Hawkins and Mark Ginswick of Cancer Council ACT.

Save the date

Canberra ASH are having a 40th anniversary dinner on Wednesday 5th June at 7pm at the Cinnabar Restaurant in Kingston. The speaker for the night is Professor Emily Banks from ANU, who has led a number of published studies on vaping. Tickets are $45.

For more information and to RSVP email ashroot@webone.com.au

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Giant magpie swoops on health crisis

A serious TV interview about the health system in crisis recently provided some unexpected comic relief, as a monstrously large magpie appeared in the background during a live cross to Brisbane. Today Show host, Karl Stefanovic interrupted emergency physician Dr Kim Hansen to warn her: "There's something very big behind you. It looks like you're going to need an emergency department after that." ■

Grab your tickets to this year's MedRevue

Nothing in this life is certain, except death, taxes, and medical students insisting you watch their rendition of 2000s pop anthems. This year's show, 'Lill and Ted's Medcellent Adventure', follows two bright eyed medical students on a journey through time in order to learn about the legendary figures of medicine.

All proceeds from the show will go to supporting Companion House.

Venue: Erindale Theatre

Dates: May 23-25

Time: 7-10pm

Ticket prices: $25 (student), $35 (GA)

events.humanitix.com/anu-medrevue-2024-lill-and-ted-s-medcellent-adventure-uywnnsf9

What's to love about Canberra?

Visit Namadgi

Namadgi National Park is a great location for different activities, especially during the cooler months.

Some activities include:

- A short walk or a hike, maybe at sunrise with a thermos of hot tea or coffee. The various trig points across Canberra, including in Namadgi, can be located here: **parks.act.gov.au/things-to-do/trig-pointing**
- Go birdwatching with a pair of binoculars, where you may spot one of the many varieties of a robin moving down the mountains for the winter season. You may also hear the calls of the lyrebird.
- Go on a camping trip, but make sure to bring your warmest sleeping bag and be prepared for changing conditions. If you are camping and plan to light a fire, make sure you only use constructed fireplaces provided and bring your firewood with you.
- Take photos of fog rising on waterways and glistening webs and frost.

Visitors should keep up to date on the latest safety messaging and check for alerts before heading out. **For updates on road closures and conditions, check the Roads ACT website, or contact Namadgi Visitor Centre staff on 6237 5307.**

Namadgi in the cooler months. *Courtesy of the Environment, Planning and Sustainable Development Directorate.*

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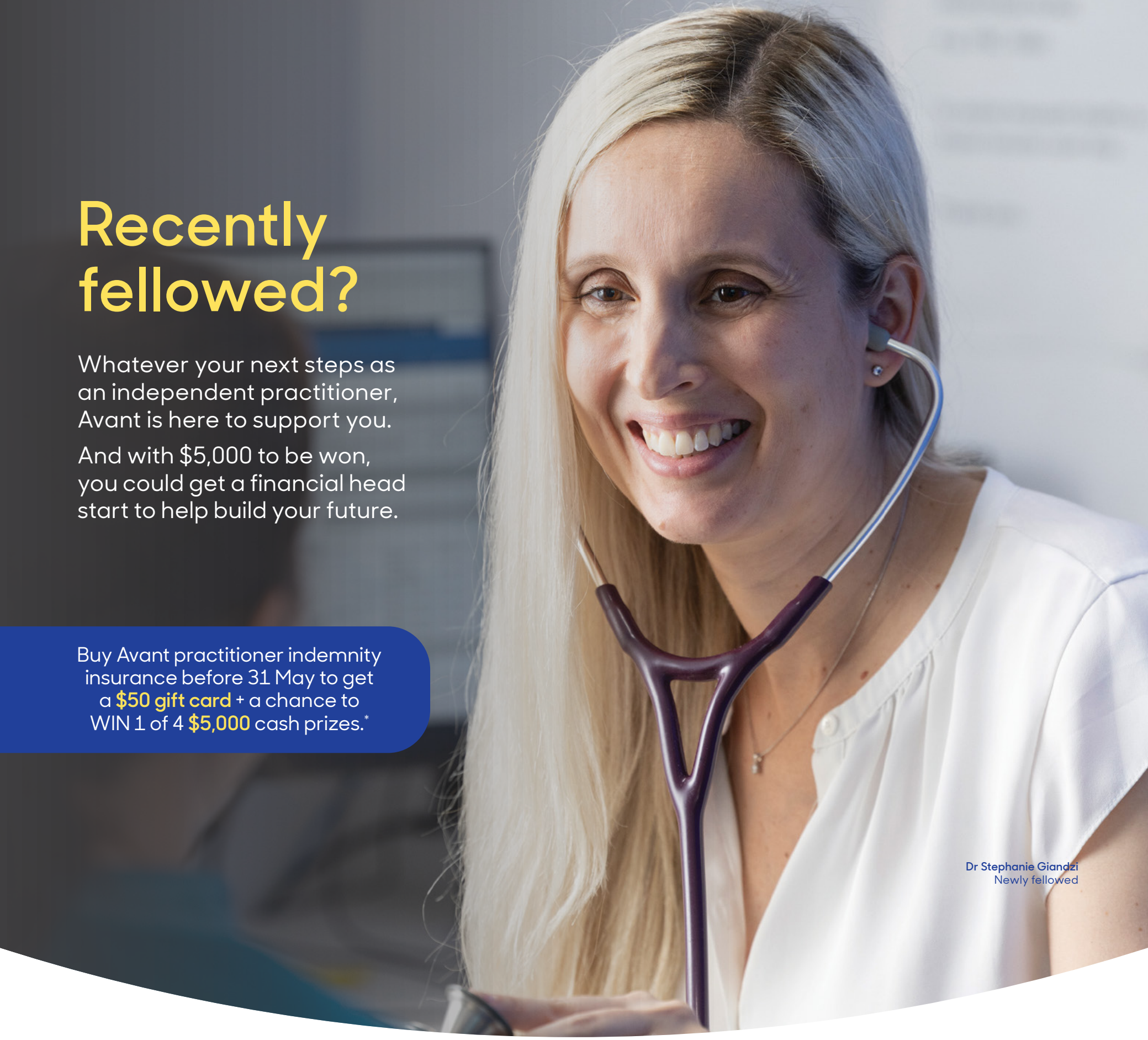

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