From: Anne Shanahan
To: medboardconsultation
Subject: Public consultation on Good medical practice.
Date: Friday, 3 August 2018 4:00:54 PM

Re: Public consultation on *GOOD medical practice*'.

1. Strengthening the code in relation to bullying etc.

   The degree of regulation that already exists is excessive and further impositions not supported.

   practice. Despite training as a female cardiothoracic surgeon between 1962 and 1971 I did not experience bullying, discrimination etc. nor did I do so in subsequent specialist practice.

   I perceive the major problem to be the standard of medical record keeping and this requires further regulation and education of practitioners.

2. The standard of medical records.

   I have a cumulative 53 year experience of working in Tribunals as well as actively practising surgery. I have been a part-time Member of the Commonwealth Administrative Appeals Tribunal for 27 years; the Superannuation Complaints Tribunal for 16 years and VCAT Review and Regulation list hearings MBA matters for 10 years.

   I have recently retired having progressively shed these appointments over 18 months.

   In all three Tribunal roles the bulk of the work related to matters requiring assessment of medical records provided on summons and medical expert and general practitioner oral evidence at hearing. This involved workers' compensation, disability support pension and Veteran's entitlement matters, these being the bulk jurisdictions in the AAT and partial and total permanent disablement claims in the SCT. Since 2002 I would have read 100 summonsed GP records per year as many applicants had several GP's or their longstanding GP moved group practice every 5 years or so. Lesser numbers of public hospital records were summonsed and considered. These also are often deficient. Since the widespread uptake of electronic record keeping the standards have fallen astronomically.

   Currently most (90%) of the GP records are next to useless. Each visit entry records the date, hour and length of consultation and the name of the doctor. The receptionist enters a "reason for attendance" such as *cough*, *tired, needs work certificate.* There may then follow a blood

pressure and pulse rate recording entered by a practice nurse followed by the G.P.'s entry – for example, *cough 2/7, Amoxil.* At hearing, under oath or affirmation, the doctor when challenged on the paucity of the record and zero examination entries, at times up to 20 years, relating to the subject health issue of their claim the answer invariably is either *I can't type or I only have 6 minutes to deal with the problem.* It is regrettably rare to find any entries recording examination findings.

The pre-electronic i.e. hand-written records, while often difficult to decipher, usually contained examination findings that assisted the Tribunal in its deliberations.

My personal experience in this area i.e. attending a GP was so poor I stopped after 18 months. [redacted] The software used by the GP I consulted did not provide for the medical conditions I had nor the surgical procedures performed. I was asked to change both the diagnosis and the name of the procedure to fit the software! I told the GP to type it in accurately. My BP was taken with me wearing a jumper and a coat.

Many of the matters referred to above have been addressed in my AAT and SCT decisions. These can be accessed on Austlii or the references can be provided.

Yours faithfully,

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