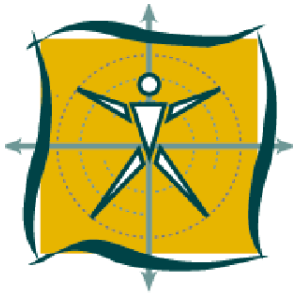

Australian Association
of Musculoskeletal Medicine

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Submission to Senate Community Affairs Committee

Review of the Professional Services Review (PSR) Scheme

Dr Geoffrey Harding,
President, AAMM.
1st Floor, 67 Brighton Rd,
Sandgate, Qld, 4017.
Phone: 07 3269 5522 Fax 07 3869 6407
Email:drgeoffw@bigpond.net.au

Summary

1. **Musculoskeletal Medicine is not General Practice.**
2. **There are certain characteristics of "Musculoskeletal Pain" consultations in musculoskeletal medicine including the need for longer consultation times, the use of expert diagnostic, examination, investigation and treatment techniques not normally used by GPs but nevertheless supported by the world-wide literature in musculoskeletal pain.**
3. **Adverse findings of "inappropriate practice" have been made against doctors practising in the area of musculoskeletal medicine which display a lack of appreciation of the evidence-base in musculoskeletal pain diagnosis and treatment on behalf of the members of the PSR Committees.**
4. **The Australian Association of Musculoskeletal Medicine calls for the Senate to consider the changing of procedure where PSR Committee members making judgements and recommendations in regard to those actively engaged in treating musculoskeletal pain conditions, should be true peers of those practitioners and not GPs who have no (or minimal) experience in the treatment of musculoskeletal pain.**
5. **The Association makes that recommendation based on the fact that Musculoskeletal Medicine is not general practice even if the practitioners are not considered to be Specialists under Medicare legislation.**
6. **The Association calls for the establishment of natural justice where an appeal against adverse findings is enabled to consider both legal argument and medical evidence which might be brought before an appeal tribunal.**
7. **The Association appreciates the role of the PSR in the investigation of fraud and unethical medical practice. It appreciates the role that the PSR has in ensuring that public health monies are spent in an appropriate manner.**
8. **The Association appreciates the Senate's consideration of these matters.**

The Australian Association of Musculoskeletal Medicine (AAMM), is making this submission to the Inquiry and thanks the Committee for the opportunity to present this response at this time.

Brief Background:
The AAMM is a non-profit organisation that was formed by a group of medical practitioners in 1971 with the aim of promoting the education of doctors in the area of spinal pain disorders. It has as Members, medical practitioners (both GPs and Specialists) who have an interest in the treatment of painful musculoskeletal conditions. Some of these members practice full-time in the area of musculoskeletal medicine but most practice as GPs but have an interest in musculoskeletal medicine. The membership is currently 220. The AAMM has as one of its main aims the teaching to GPs of skills in the assessment and treatment of painful musculoskeletal conditions in the Australian community. It pursues this goal using the best-available evidence from the world literature as its guide. This organization was instrumental in the setting-up of the first Australian Post-Graduate Diploma in Musculoskeletal Medicine at Flinders University in 1991. The AAMM is a member organization of the International Federation of Manual Medicine (FIMM). The Association publishes the Journal *"Musculoskeletal Medicine"* which is an Australian peer-reviewed Journal dealing with the issues of musculoskeletal pain conditions.

The Australasian Faculty of Musculoskeletal Medicine (AFMM) was constituted in 1993, and formally incorporated in 1995, as a result of negotiations between the Australian Association of Musculoskeletal Medicine and the New Zealand Association of Musculoskeletal Medicine. The inception of formal postgraduate courses in musculoskeletal pain medicine in three Australasian universities (Otago, Flinders and Newcastle) and one in Physical Medicine (Sydney) led the two national associations to believe that a separate and independent body was required to develop and promulgate standards of practice in the discipline based on a responsible, academic analysis of the scientific literature. Its membership is open to either specialist medical practitioners (Anaesthetists, Rheumatologists, Radiologists, Occupational Physicians etc) or to those GPs who have completed a recognized post-graduate Diploma in Musculoskeletal Medicine from an approved University. To become a Fellow of the Faculty, one has had to sit a comprehensive Fellowship Exam which has a standard equivalent to that undertaken by candidates of most of the Specialist Medical Colleges.

There are many members of the AAMM who are also members of the Australasian Faculty as they have gained a Post-Graduate Diploma in Musculoskeletal Medicine, and many are also Fellows of the Faculty having passed the Fellowship requirements of that organisation. In spite of their further, significant post-graduate study, these doctors are still considered as GPs as there is no recognised specialty in Musculoskeletal Medicine in this country.

The recently constituted RACGP (Royal Australian College of General Practitioners) Faculty of Special Interest in Musculoskeletal Medicine was set up on the basis of an application by Dr Scott Masters (Caloundra) who is a Past-President of the Australian Association of Musculoskeletal Medicine. The majority of the founding members of this Faculty are members of the Australian Association of Musculoskeletal Medicine.

Definition of Musculoskeletal Medicine
Musculoskeletal medicine is a branch of medical science concerned with the functions and disorders of the musculoskeletal system, including the muscles, aponeuroses, joints and bones of the axial and appendicular skeletons and those parts of the nervous system associated with them.

Various parts of this global field are addressed by basic scientists, orthopaedic surgeons, rheumatologists, occupational physicians, rehabilitation physicians, pain medicine physicians, sports and exercise physicians and musculoskeletal physicians. Musculoskeletal Physicians in Australia have not been granted specialist recognition and are thus considered as General Practitioners.

Basic scientists provide the essential elements of anatomy, biomechanics, physiology, pathology and pharmacology on which the clinical disciplines depend.

Orthopaedic surgeons provide diagnostic and therapeutic resources for patients with conditions that require surgical management, particularly fractures, major trauma and joint replacement surgery.

Rheumatologists focus on the management of patients with specific diseases that affect the joints, such as inflammatory arthropathies and systemic conditions with joint involvement.

Occupational physicians provide resources for the management of patients in an occupational setting; some of which involve musculoskeletal medicine.

Sports and exercise medicine can be divided into two general areas: clinical sports medicine and the physiology of exercise. Sports medicine does involve some components of musculoskeletal medicine, but does not deal with non-sports related injuries and general aches and pains which are the major burden to society.

Rehabilitation medicine provides care for the rehabilitation of patients in three main areas - neurological (strokes), cardiac (heart attacks) and prosthetics (amputees). Minimal training is provided in the assessment and treatment of common pain complaints. Once graduated there are a handful of rehabilitation specialists that have chosen to practice in physical medicine rehabilitation – overlapping with musculoskeletal medicine and pain medicine.

Pain medicine specialists have mixed backgrounds, predominantly in anaesthetics and treat a variety of pain conditions – acute post operative pain, cancer pain and in conjunction with physiotherapists in pain clinics they also treat chronic pain of musculoskeletal origin. It is ironic that the pain medicine submission to the Australian Medical Council quoted the urgent need for more resources to treat musculoskeletal pain, yet their training involves little in this area and they have rejected an amalgamation proposal from the AFMM.

Applying an evidence based medical approach, musculoskeletal physicians have recognized the majority of acute pain complaints do not require expensive radiological investigations to make the diagnosis, they are not caused by rare immunological diseases requiring expensive medications, they are caused by dysfunctions of the musculoskeletal system – a concept taught poorly to medical practitioners. The musculoskeletal specialist focuses on diagnosing and managing these common problems including neck pain; headache derived from the neck; back pain and sciatica; frozen shoulder, tennis elbow, housemaid's knee, hip and buttock pain, and stiffness related to osteoarthritis. The musculoskeletal physician is in the ideal position to initially triage patients from GPs and direct them appropriately to other specialist services as needed.

International Recognition

In New Zealand musculoskeletal medicine is recognised as a separate vocational branch of medicine and fees paid to practitioners by the ACC are in line with other treating specialists.

In the USA the field comes under the recognized specialty called "physiatry". It is related to rehabilitation medicine in Australia however in the USA specialists complete basic training in rehabilitation medicine and

then go on to complete further specific training – one such field being musculoskeletal rehabilitation. No such specific training occurs in Australia.

In England the field is known as Orthopaedic Medicine and there is a push towards specialization there also.

Brief history of specialisation in this area of medicine in Australia

- A body known as the Australian Association of Physical and Rehabilitation Medicine was formed in the 1960's and a sub-group of its members formed the Australian Association of Musculoskeletal Medicine (AAMM) in 1971.
- 1971 - First annual scientific meeting
- 1971 – commencement of training course for GPs
- 1989 - under the guidance of Dr. Barrie Tait, rheumatologist and Founding President of AFMM, the University of Otago offered its Diploma in Musculoskeletal Medicine
- 1991 - under guidance of Assoc Prof Norman Broadhurst, past-president of the AAMM, the Grad Dip Musc Med was commenced at Flinders University
- 1993 - Australasian Faculty of Musculoskeletal Medicine was constituted as a result of negotiations between the AAMM and the NZAMM. They believed that a separate and independent body was required to develop and promulgate standards of practice in the discipline based on a responsible, academic analysis of the scientific literature. The Faculty was made up of various medical specialists including musculoskeletal physicians, rheumatologists, neurologists, rehabilitation physicians, interventional radiologists, anaesthetists and pain management specialists who considered the current medical training and existing medical specialties were not addressing the main burden of musculoskeletal conditions. The main intention of the Faculty was to co-ordinate the development of the scientific, academic and educational aspects of Musculoskeletal Medicine with the common goal of improving the quality of care for patients with musculoskeletal health problems.
- 1995 - under guidance of Prof Nikolai Bogduk, past-president of the AFMM, the Grad Dip Musc Med was commenced at Newcastle University
- 1995 - Australasian Faculty of Musculoskeletal Medicine was formally incorporated
- 1996 – the AFMM was commissioned by the Australian Federal Minister of Health to conduct the National Musculoskeletal Medicine Initiative. This project involved the development of evidence-based clinical practice guidelines for the management of acute musculoskeletal pain problems; the evaluation of the safety, efficacy, and cost-effectiveness of evidence-based practice for these problems; and an audit of how these problems were managed in usual care. A Report on the Initiative was provided to the Commonwealth in October 2001. Political and craft group interference prevented the dissemination of the findings which were strongly supportive of the value of evidence based musculoskeletal care.
- 1998 – first Faculty examinations. The Faculty deliberately eschewed the concept of 'grandfathering' of its members. It determined instead that any recognition given should be based solely on objective examination of a standard comparable to that of the learned Colleges. A process was developed and a Board of Censors was appointed. The first examination was held in 1998. Those who passed the examination then, and subsequently, became Fellows of the Faculty. The Fellowship has evolved as the academic arm of the Faculty. This examination process alienated some members who were existing specialists many of whom later joined the Faculty of Pain Medicine.
- 1999, the Medical Council of New Zealand recommended to Government that Musculoskeletal Medicine be recognised in New Zealand as a vocational branch (discipline) of medicine. This was incorporated into the New Zealand Medical Practitioners Act in April 2000. Vocational registration requires both completing the accreditation process of the New Zealand Association of Musculoskeletal Medicine, and gaining Fellowship of the Australasian Faculty of Musculoskeletal Medicine. Since then, the Accident Compensation Corporation (ACC) of New Zealand has recognised those practitioners with both Vocational Registration in Musculoskeletal Medicine and Fellowship of the Faculty as specialist providers in Musculoskeletal Medicine

- 2001 – under the guidance of Fellows of the AFMM the Post Graduate Diploma of Pain Medicine and Masters Degree in Musculoskeletal Pain Medicine was commenced at Newcastle University.

AFMM fellows (most of whom are members of the Australian Association of Musculoskeletal Medicine) have continued to contribute to the literature. A robust training program has been developed in New Zealand where vocational registration has lead to demand for places. A MOPS (Maintenance of Professional Standards) program is also established and monitored by the New Zealand Medical Council.

Current status and relationship to other branches of medicine

This is largely described above. In essence, musculoskeletal medicine requires the development of skills as outlined in the syllabus so as to provide first contact specialist help to general practice. The skills required have been developed in University post-graduate diplomas and Masters degrees in Musculoskeletal Medicine and Pain Medicine. The style of practice, in the community rather than hospital based medicine, is already in place in New Zealand in a formal sense, and exists as a well used resource in Australian medical practice. Currently in Australia most fellows see patients on a referred basis from GPs, numerous specialist groups and form allied health practitioners. Some fellows are working in established multidisciplinary pain clinics performing similar work as fellows of the Faculty of Pain Medicine – but without the same recognition.

The scientific basis of the discipline

The scientific base of musculoskeletal medicine extends across several domains, and these domains are covered in the comprehensive syllabus of the AFMM.

- The Anatomy and Biomechanics that underlie the normal function of the Musculoskeletal System,
- The Anatomy, Biomechanics, and Pathology of disorders of the Musculoskeletal System
- The Anatomy and Biomechanics of the assessment and treatment of painful disorders of the Musculoskeletal System.
- The Anatomy and Physiology of pain in general
- The theoretical principles of reliability and validity of diagnostic techniques, both clinical and imaging.
- The theoretical principles of efficacy and effectiveness of treatment.
- The psychosocial consequences of pain in general and musculoskeletal pain in particular.
- The theoretical basis of manual, physical, pharmacological, behavioural, and surgical treatment of musculoskeletal pain.

This science is recorded in the textbook literature and journal literature available to the Faculty.

Members and Fellows of the faculty have been actively involved in creating this literature, both with respect to research and to teaching. These activities create and reflect the standards of practice to which the Faculty aspires and adheres, and which the Faculty seeks to promote amongst GPs and specialists, for the benefit of the public. Publications of the Faculty reflect these endeavours, and provide many of the seminal references in this field.

Medical Schools

As stated by the Australian Core Competencies in Musculoskeletal Basic and Clinical Science taskforce, less than 5% of the undergraduate curriculum is devoted to the teaching of musculoskeletal conditions though up to 25% of the GPs workload involves musculoskeletal conditions. Until recently, trainee medical

students received their "5%" instruction in musculoskeletal conditions from orthopaedic surgeons (and to some extent rheumatologists). The teaching was thus heavily weighted towards surgical and inflammatory conditions. Skills in the diagnosis (and treatment) of the more common conditions affecting the bulk of the population were left to "post-degree experience".

The push which led to the current teaching of undergraduates came from members of the Australian Association of Musculoskeletal Medicine. These were: Prof John Murtagh (Monash), Prof Norm Broadhurst (Flinders), Prof Nik Bogduk (Newcastle), and then at University of Queensland, Prof Michael Yelland.

Currently, medical students at the University of Queensland, Griffith University, University of Newcastle, Flinders University, and Monash University receive their exposure to Musculoskeletal Medicine from Fellows of the Faculty. This is done via formal lectures and workshops as part of the undergraduate curriculum.

Post-Graduate Diplomas in Musculoskeletal Medicine.

Both the New Zealand and the Australian Co-ordinators of the University of Otago Post-Graduate Diploma in Musculoskeletal Medicine are Fellows of the Australasian Faculty of Musculoskeletal Medicine. The Flinders University Post-Graduate Diploma in Musculoskeletal Medicine was , until recently, coordinated by Prof Norm Broadhurst, another founding member of the AFMM. The University of Newcastle Masters in Pain Medicine is coordinated by Prof Nik Bogduk – the first president of the Faculty. All of the above are active teachers in these University programs.

Post-Graduate Workshops/Short Courses:

Since 1981, the AAMM has been conducting training courses for GPs throughout Australia. Initial courses addressed practical examination skills which were seen to be essential tools for GPs to treat patients not suffering from surgical conditions. Since then thousands of GPs including rural doctors have attended various courses. Most of these workshops have been evaluated by the RACGP and have been rated consistently in the "excellent" range, fulfilling their expectations for knowledge and skills in the treatment of common spinal pain problems.

Fellows have regularly presented workshops for the Annual Scientific Conferences of the RACGP and the Australian and New Zealand Pain Societies. Trainees in rehabilitation medicine have been taught by fellows of the AFMM for many years. In Adelaide Assoc Prof Norm Broadhurst ran the post grad diploma course there with rehabilitation medicine trainees rotating through the musculoskeletal medicine outpatient clinic he ran. Only some years later was he invited to be a fellow of the Faculty of Rehabilitation Medicine – as they recognised the value of the training but it was embarrassing to be trained by a non- Vocationally registered GP!! Other AFMM fellows have supervised Rehab trainees in their practices as approved training posts – and yet are not formally recognized as specialist, but GPs.

MAJOR POINTS FOR THE ENQUIRY TO CONSIDER:

Musculoskeletal Medicine is not General Practice.

Musculoskeletal medicine is not general practice – whilst there are many doctors who operate primarily in the area of General Practice, their approach to patients suffering from musculoskeletal pain is informed by their education and experience in Musculoskeletal Medicine. Some doctors practice primarily or solely in the area of Musculoskeletal Medicine. These doctors, although considered as General Practitioners, (since there is no specialist recognition in Australia in this discipline) should not be "peer reviewed" by General Practitioners who have little or no experience in the discipline.

Peer review in these cases should be by doctors who have substantial experience and education in the discipline of Musculoskeletal Medicine.

Many patients are referred to us by their GPs because the GP recognises our expertise in treating musculoskeletal pain problems. Many others of our patients self-refer because they have found that the standard approach to their pain problem – either medical or by allied health practitioners – has not properly addressed their problem. For PSR Committee members to argue that musculoskeletal practitioners should persist with the "standard" approach is out of step, not only with the evidence but also with the experience of many thousands of patients.

Longer Consultations are not Inappropriate Practice

Chronic (Persistent) Pain represents a major cost to the Australian society – up to $34 billion pa. Approximately 60% of persistent pain problems are musculoskeletal in nature. The National Pain Strategy initiated by PainAustralia has recommended that government treat this as a national priority and has made recommendations covering a broad area of disciplines. It argues for example, for the appropriate training of GPs and the facilitation of more effective consultations than are currently the norm for general practice. Musculoskeletal Medicine practitioners are an important part of the solution to Chronic/Persistent pain and their mode of practice should be encouraged, not discouraged by ill-advised adverse findings within the PSR process.

One of the recommendations made by Pain Australia was the recognition that a "pain" consultation needs adequate time to be allocated by the doctor to the patient. A musculoskeletal pain consultation takes a good deal of time to complete – more than a standard consultation.

One of the most common findings by PSR Committees against GPs who practice in this area is that they have performed too many long consultations. Yet the appropriate allocation of time for these patients is exactly in accordance with international guidelines. Members of the PSR who do not have experience or formal training in musculoskeletal pain problems do not seem to recognise this and make adverse findings against GPs who perform "too many" long consultations – because they fit in the wrong part of the Bell Curve.

Physiotherapists and Chiropractors often see patients for numerous repeat visits (even the Enhanced Primary Care (EPC) programme allows for blocks of 6 visits to allied health practitioners. Many musculoskeletal physicians see patients for a maximum of three or four visits in total for any one episode yet they perform most of the work done by these all of these practitioners. In addition they must take a full <u>medical</u> history, including a full review of <u>all</u> of the past diagnoses and treatments (both successful and unsuccessful) order advanced investigations, make a <u>medical</u> diagnosis, prescribe and carry out medical treatment and design and certify rehabilitation programmes. Yet, in spite of this, the PSR has used its findings of "inappropriate practice" not only to penalise doctors who perform longer consultations, but also to actively discourage many more doctors from doing the same (even though they would improve the quality of the consultation in accordance with international guidelines in pain and musculoskeletal medicine). The evidence is that spending adequate time with a patient initially will lead to better outcomes and less cost to the public purse in the long run.

"Inappropriate Note-Taking"

Long consultations are not always reflected in the length of notes taken, yet the PSR on numerous occasions has made adverse findings against doctors who have taken "inadequate notes". Longer consultations take place because the workload in assessing a patient with musculoskeletal pain is already substantial. It involves a full assessment of the patient's general medical history, a full history of the pain problem, a complete review of the investigations which might have been carried out over a number of years in pursuit of the source of the pain, a complete evaluation of prior interventions performed by other practitioners to diagnose the pain, and a full psychological evaluation of the patient's response to the pain problem. This means a complete biopsychosocial evaluation of the patient. To insist that full notes of such consultations are taken without the use of generally-accepted shorthand notes and symbols would mean the extension of what are already long or prolonged consultations into "super-long" consultation times. Medical notes are for the use of the writer to use as *aides memoir*. Whilst they might be useful for bureaucrats wishing to review the performance of doctors, they are primarily meant to serve the patient and the treating doctor.

PSR Committee members have commented that notes should be able to be read by other GPs. The reasoning for this is difficult to follow. In any event, most notes use traditional symbols and short-hand which have been used for many decades within the medical (and pharmaceutical) professions. They can be deciphered by those with a medical educaton with minimal explanation. The insistence on fully expanded text by the Committee members simply represents pedantry.

Much treatment of chronic pain includes varying degrees of counselling – cognitive behavioural therapy (CBT), explanation, education, reassurance, advice re specific exercises and cooperative discussion to plan return to work plans. These aspects of a consultation can often be summarised in notes by such codes as "ERA – RTW" (explanation, reassurance activation – return to work") yet it might take 20 or 30 minutes to perform all of these tasks. The Committee has in the past seemed such short-hand recording as "inadequate note-taking".

Extensive note taking is not possible when one is conducting an effective counselling consultation. It is counter-productive to be looking at a computer key board or writing notes instead of giving the patient one's full attention and eye contact. The use of templates in a computer programme has been (rightly) seen as a sham and yet it seems that the Committtee members would prefer this to the short-hand notes traditionally recorded by doctors. With respect to musculoskeletal medicine in particular, there are a number of well-recognised symbols used in the physiotherapy and physical medicine professions which have been deemed by the PSR Committee as "inappropriate" note-taking.

Many procedures in manual medicine (mobilising, manipulation and home-exercises) can take many minutes to perform during a consultation. Often many different techniques are used in one session. They often can be summarised by short notes and symbols and two words might represent 20 or 30 minutes consultation time. The Committee's insistence on "adequate notes" is simply demanding writing for the sake of writing to satisfy its requirements and not adding (in fact detracting) from the quality of the musculoskeletal consultation.

"Inappropriate Practice"

There is an extensive worldwide peer-reviewed body of evidence recommending the types of procedures/approach used by Musculoskeletal Physicians in the treatment of Musculoskeletal Pain. One need only to refer to Journals such as *"Pain", "Spine", "Clinical Journal of Pain", "Anesthesiology", "Journal of Pain Symptom Management", "Pain Physician", "European Spine Journal", "Clinical Journal of Pain", "Archives of Physical Medicine Rehabilitation", "Pain Practice", "Anesthesia and Analgesia", "British Journal of Rheumatology", "Journal of Spinal Disorders", "American Journal of Physical Medicine and Rehabilitation", Rheumatology and Physical Medicine", "Pain Digest",* and dozens of other related journals to see that the treatment of musculoskeletal pain problems is much more specialised than general practice.

<u>Injections</u>

These techniques might include the injection of anaesthetic into tender tissues and joints to "short-circuit" the transmission of pain messages within the nervous system The PSR has distinguished itself in recent years by delivering astonishing findings of "inappropriate practice" where some doctors have used these

procedures – because they are not commonly used in this way in General Practice (though they are in the specialties of Anaesthetics and Pain Medicine). The various procedures however are in accord with the world literature.
Some of the adverse findings of "inappropriate practice" made against musculoskeletal practitioners represent an ignorance of the world-wide body of evidence in musculoskeletal and pain medicine. If PSR Committee members are to sit in judgement of those dealing with these pain problems, they should be familiar with the literature or excuse themselves in favour of more suitable "peers". Using members who are true peers for the review of practice of musculoskeletal medicine would substantially minimize these curious findings.

Other Procedures used in Musculoskeletal Medicine

In the same way that adverse findings regarding injections have been made by PSR Committee members, there have been findings of "inappropriate practice" when musculoskeletal doctors have used various manual diagnostic techniques which rely on the detection of skin hypersensitivity, muscle tightness and tenderness and bony tenderness. Some PSR Committees have criticised doctors for using these techniques without understanding the physiological basis behind their use. Simply because the majority of GPs do not use these techniques does not mean they are not valid – and certainly does not mean that they represent "inappropriate practice".
Could (would) PSR committee of GPs oversee and give expert advice on the suitability of a surgeon's work – or psychiatrist? So why advise with respect to thise having expertise in musculoskeletal medicine? One weekend course doesn't qualify Committee member as experts in these matters.

Adherence with "General Practice" Guidelines.

Guidelines set down for General Practice are just that – recommendations regarding investigation and treatment of all manner of problems. Guidelines are designed to make the whole process of diagnosis and treatment effective and efficient and to help use resources in a cost-effective manner.
It should be remembered that the guidelines are there to be interpreted in individual cases – and especially where the treating doctor has special expertise in certain areas, they should be allowed to go outside the guidelines because of the individual presentation. Thus it certainly **is** appropriate practice for Cat Scans of the lumbosacral spine to be ordered in certain pain conditons, and it **is** appropriate practice for plain X-rays to be ordered (or not ordered) in certain circumstances. The more expertise one has, the more likely one is to depart from guidelines which are published to help the non-expert find a diagnostic (and treatment) pathway. Thus, guidelines in the GP management of ischaemic heart disease are not meant for rigid adherence by cardiologists who are able to interpret the nuances of various presentations. (Even GPs should be able to modify the guidelines as needed). The PSR Committee's record of finding any variations/individual judgements as "inappropriate practice" is ill-informed.
It should be noted that many of the members of the task force which **wrote** the guidelines for the management of musculoskeletal conditions for the RACGP were members of the Australian Association of Musculoskeletal Medicine!

I would be happy to provide any further information required by any members of the Inquiry.

Yours Sincerely,

Dr Geoffrey Harding,
President, Australian Association of Musculoskeletal Medicine.