CANBERRA
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AMA endorses new position on euthanasia

In a major development, the AMA Federal Council has adopted an updated *Position Statement on Euthanasia and Physician Assisted Suicide*. The new position statement comes at a time when the euthanasia debate is again in full swing with the recent one-vote defeat of a euthanasia bill in the South Australian parliament.

The updated Position Statement is the result of a comprehensive year-long policy review including a survey of AMA members.

AMA President, Dr Michael Gannon, said it is important that the AMA, as the peak medical organisation in the country, has its views heard as part of this debate, especially as some State Parliaments are currently considering euthanasia legislation.

Better end of life care

"The key outcome from our policy review – and the core message from our updated Position Statement – is that there needs to be much greater investment in quality end of life care, especially nationally consistent palliative care services."

"We believe that governments must do all they can to improve end of life care for all Australians by properly resourcing palliative care services and advance care planning, producing clear legislation to protect doctors in providing good end of life care, and developing enhanced palliative care services to support doctors, nurses, and carers who provide end of life care.

"Greater investment in improved end of life care must be accompanied by a comprehensive education and information campaign to raise community awareness of the care, compassion, and medical and nursing assistance and expertise that is available to assist patients in the final stages of their lives.

Dr Michael Gannon.

Continued page 4...

Medical Musings

WITH PRESIDENT, **PROFESSOR STEVE ROBSON**

A good death

My mother's death was ghastly and memories of it are still upsetting almost a decade later. She was diagnosed with cancer and succumbed within about six months, most of that time filled with oncology treatment that robbed her of vitality and left her a husk. If it is possible to have a good death – and lím sure that it is – then her passing was the opposite. Many of us will have had similar experiences within our families. Such things are deeply affecting.

The AMA has just released its position statement on *Euthanasia and Physician-Assisted Suicide* and this will be of interest to many of us and I think this statement cuts to the heart of what we do as doctors. For this reason, I would like to highlight some points from it and try to put it in some perspective. Some will not agree – indeed, it would be impossible to write a meaningful position statement with which everyone agreed. But, hopefully, this will generate debate and discussion and this can only be good for those we care for.

No matter how medical technology advances, doctors will be present at the end and can provide compassionate care at the end of life. Dying patients deserve to pass from this life without suffering and with dignity – attending to these most fundamental needs is perhaps the highest calling in medicine. Indeed it is our ethical duty to care for the dying such that they have comfort and dignity.

There is much that we can offer in this situation, to relieve pain and other causes of suffering at the time. Treatment can have a double effect in this setting – relieving pain and suffering, but also hastening death. Such treatment is ethical and legal: providing compassionate care that meets these aims really is our duty as doctors when realistically we can no longer be healers.

To assist doctors in this most difficult of roles, it is important the Governments at all levels provide adequate resources for high-quality palliative care services and advance care planning systems. To aid this it is important that the legislative framework provides clear, nationally-consistent protection for doctors to allow them to provide good end-of-life care. Care that stops pain and suffering must be unequivocally legal, even when such care brings forward the end of life. However, the considered position of the AMA is that doctors should not be involved in interventions that have a primary intention of ending life. This is a subtle but important distinction. Cessation of life-sustaining treatment that has no other benefit for the dying is different to actively taking action to end life.

The AMA, as an organisation of individuals, recognised that a wide range of views exist not only within our own profession, but more broadly across society and that euthanasia and physician-assisted suicide are widely discussed. There can never ever be consensus in this most important of areas. Ultimately, the laws that regulate this difficult area are a matter for our community and, through elected representatives, our Governments.

If the law is to change, it is vital that our own profession take a leadership role to protect the vulnerable from malign influences or coercion. Simply being a burden to a family, carers, or society in general is not enough reason to end life. Doctors active in the area of end-of-life care must have the necessary legal protections to act with confidence. These are likely to be difficult legal waters to navigate.

Ultimately, all of us hope for a 'good death.' After a professional life dedicated to care of our patients, and (hopefully) a fulfilling retirement, then the final chapter should have a satisfactory ending – there's no earthly sequel for any of us! The area is very important and we would very much like to hear from you.

A new beginning too...

I would like to welcome, and introduce you to, Anish Prasad as AMA ACT's new Hospital Organiser. Anish will be working closely with our DIT members, building our membership and effectiveness at both Canberra and Calvary public hospitals. A major focus for him will be ensuring that we have skilled representation readily available in the workplace for DIT members. Anish comes to us as a graduate in arts and law and is currently undertaking a Masters degree in labour law and relations.

AMA (ACT) is now on Facebook!

AMA (ACT) has jumped into the wide world of Facebook so please get online and like us. It's a great way to find out what's going on quickly and keep up to date with events. Recent posts have featured the decision by Fair Work Australia to retain one agreement for ACT hospital doctors and the meeting with ACT Health Minister, Simon Corbell. It's easy – just search for AMA ACT.

VAL E

The President , Prof Stephen Robson, Board Members and staff of AMA ACT extend their sincere condolences to the family, friends and colleagues of their late esteemed colleague,

Dr Graham Kaye

Medical board moves on revalidation

In 2012, the Medical Board of Australia (MBA) "started a conversation" about how to "make sure" doctors in Australia maintain the skills to provide safe and ethical care to patients throughout their working lives. The MBA is pursuing these goals by introducing a system of revalidation for Australian medical practitioners.

Dr Joanna Flynn, Chair, Medical Board of Australia.

As part of this process, the MBA has established a Consultative Committee to provide it with feedback on issues related to the introduction of revalidation in Australia. The AMA has two representatives on this Committee.

In addition, the MBA appointed an Expert Advisory Group to propose a revalidation model that can be evaluated for effectiveness, feasibility and acceptability. Members of the Expert Advisory Group have been selected for their "expertise and not as representatives of any organisation or stakeholder group". The Expert Advisory Group is tasked with providing the Board with technical advice about revalidation and how any models recommended by the group can be evaluated for effectiveness, feasibility and acceptability.

The Expert Advisory Group's interim report has been published on the MBA's website with consultation fora having been held nationally to hear the views of the profession and stakeholders.

The Interim Report

The report proposes an approach that aims to improve competence and screen practitioners who may be at greater risk. To do this, the interim report identifies a two-part approach:

- Strengthened CPD through changes to regulation. An intention to define three core types of CPD, with activities designed to strengthen individual performance. CPD it to be evidence based in order to maintain and enhance the performance of physicians.

  An intention to introduce 'high quality programs' that are interactive, use multiple methods, provide feedback (peer and patient reviews) and provide an opportunity for self-reflection.

- Prevention of harm. The board is proposing a system that identifies groups of practitioners at most risk of poor performance and to develop a tiered approach to assessment to match the risk identified. This could include multi-sourced feedback, peer review or formal performance assessment.

ACT Forum

Recently, Dr Kerrie Bradbury, Chair of the ACT Medical Board and Dr Joanna Flynn, Chair of the MBA, held a consultation forum in the ACT. Professor Liz Farmer, Chair of the Expert Advisory Group, also made a presentation to the forum on the interim report.

AMA (ACT) and other representatives were present at the Forum.

Consultation on the interim report will close on 30 November 2016 with a view to a final report being due mid-2017.

The interim report can be found at www.medicalboard.gov.au/News/Current-Consultations.aspx

Position on euthanasia...*continued*

...from page 1

Euthanasia – not at this time

Dr Gannon said that the AMA maintains its position that doctors should not be involved in interventions that have as their primary intention the ending of a person's life.

"This does not include the discontinuation of treatments that are of no medical benefit to a dying patient. This is not euthanasia," Dr Gannon said.

Care of dying patients

"The compassionate care of dying patients is the priority of every doctor. Doctors have an ethical duty to care for dying patients so that they can die in comfort and with dignity. We are always there to provide compassionate care for each of our dying patients so they can end the last chapter of their lives without suffering.

Euthanasia is a societal issue

"We also believe that euthanasia legislation is a societal issue. If new legislation does come into effect, doctors must be involved in the development of the legislation, regulations, and guidelines to protect doctors acting within the law, vulnerable patients, those who do not want to participate, and the wider health system."

Dr Gannon said the AMA recognises that good quality end of life care can alleviate pain and other causes of suffering for most people, but there are some instances where it is difficult to achieve satisfactory relief of suffering.

"There is already a lot that doctors can ethically and legally do to care for dying patients experiencing pain or other causes of suffering," Dr Gannon said.

"This includes giving treatment with the intention of stopping pain and suffering, but which may have the secondary effect of hastening death. This is known as the principle of double effect," Dr Gannon said.

The full position statement can be found at https://ama.com.au/position-statement/euthanasia-and-physician-assisted-suicide-2016

The AMA Position Statement on Euthanasia and Physician Assisted Suicide 2016 states that:

- The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient.
- The AMA recognises there are divergent views within the medical profession and the broader community in relation to euthanasia and physician assisted suicide.
- The AMA acknowledges that laws in relation to euthanasia and physician assisted suicide are ultimately a matter for society and government.
- If governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect:
  - all doctors acting within the law;
  - vulnerable patients – such as those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society;
  - patients and doctors who do not want to participate; and
  - the functioning of the health system as a whole.
- Any change to the laws in relation to euthanasia and/or physician assisted suicide must never compromise the provision and resourcing of end of life care and palliative care services.
- Doctors are advised to always act within the law to help their patients achieve a dignified and comfortable death.

Updating the AMA policy involved taking into account:

- the views of individual AMA members;
- the views of the AMA State and Territory organisations;
- the policies of the major national and international medical organisations and associations;
- national and international community attitudes to euthanasia and physician assisted suicide; and
- national and international legislative initiatives in relation to euthanasia and physician assisted suicide.

Medical Board Research: doctors most trusted profession

Doctors are the most trusted profession in Australia, along with nurses and pharmacists, according to social research published by the Medical Board of Australia into community and doctorsí views about trust, confidence and fitness to practise in the medical profession.

The independent social research was designed to help the Board understand what the public expects doctors to do to demonstrate ongoing fitness and competence, and what medical practitioners believe they need to do to maintain and enhance their knowledge and skills.

'It's fantastic to know that patients trust their doctors and there is no doubt that the vast majority of doctors work really hard to be good at what they do,' said Medical Board of Australia Chair, Dr Joanna Flynn AM.

'It's up to the medical profession as a whole, and the Medical Board as the regulator, to ensure this trust is well founded,' Dr Flynn said.

Community and Profession feedback

The research analysed feedback from 3,000 doctors and 1,000 members of the community. It found there are some gaps between what doctors now do, and what the community expects. Key findings include:

- 90% of community trust doctors and nurses, 85% trust pharmacists and 7% trust politicians
- doctors and the community agree that the most important attributes for building confidence and trust with patients are effective communication and doctors explaining their diagnosis and treatment
- 39% of doctors and 72% of the public think doctors' practice should be reviewed at least every five years and
- 40% of doctors and 5% of the public think doctors should only be reviewed if there are concerns about their practice.

Most doctors say they are doing a range of continuing professional development (CPD) activities, but less than half reported being involved in clinical audit or peer review. Almost all are confident they are maintaining their professional competence.

Sixty two per cent of doctors thought that all doctors should be reviewed from time to time, and 20% disagreed.

According to the report, Australians are unaware of how doctors are currently reviewed but think it is important that they are reviewed at least from time to time.

More than half the doctors surveyed support demonstrating their capacity to provide high quality medical care as a requirement of their annual registration renewal.

'The research gives us some great information about what doctors are doing now to keep their skills and knowledge up to date, and about what doctors and the community think they should be doing,' Dr Flynn said.

The full report can be found at http://www.medicalboard.gov.au/News.aspx

Not quite straight?

A long time ago in a medical school far far away… two students fell in love

BY **DR JOO-INN CHEW,** INTERCHANGE GENERAL PRACTICE

They snuck a kiss in the lift on the way up to surgical ward rounds. They scribbled sweet nothings on the margins of their neuroanatomy notes. They danced together shyly at the medical students ball. They were like any other aspiring Dr Romeo and Dr Juliet – except they were Dr Juliet and Dr Juliet. They were two girls in love, and they hardly knew of any others in the big heterosexual medical world they were to become a part of.

Fast forward twenty years, and me and my then girlfriend have since gone separate ways. The world has changed a lot, but many medical students and doctors can still feel like 'the only gay in the village'.

It can be isolating having a different sexual orientation or gender identity to most of your medical colleagues around you. You might wonder whether it is safe to be out to your colleagues, or better to stay closeted at work. You might be questioning your sexuality or gender, or you might just want the good company of others who have had similar experiences.

Canberra Queer Doctors Group offers support and networking for doctors and medical students who identify as lesbian, gay, bisexual, transgender, intersex or questioning.

We meet every few months for a meal or afternoon tea, with partners and children welcome.

To find out more (and feel The Force is with you) contact: cbrlgbtiqdocs@gmail.com

Social media and the workplace

Social media is here to stay and can be a valuable asset to both employer and employee. It can also represent a significant liability to employers and risks to employees when it comes to the employment relationship.

It is worthwhile and timely to have a brief look at some recent judgements and decisions coming out of the Fair Work Commission;

Being 'at work' does not necessarily mean being in the workplace

A Fair Work Commission Full Bench decision in December 2014 ruled that bullying claims can occur regardless of whether the alleged bullying took place 'at work' at the time of the relevant conduct. In essence this decision means that if bullying takes place against another worker whilst engaged in an activity which is authorised or permitted by the employer, regardless of whether the employee was at work (which can include meal breaks, work-related social functions, regardless of location) then this type of conduct can be regarded as workplace bullying.

Can out-of-hours conduct be controlled by employers?

Can an employer take disciplinary action in relation to an employee's out-of-hours conduct, especially concerning the use of social media?

Recent FWC decisions tend to indicate that disciplinary action including termination of employment may occur where the conduct is of *"such gravity or importance as to indicate a rejection or repudiation of the employment contract by the employee"*. In the absence of such serious considerations, an employer has no right to control or regulate an employee's "out-of-hours conduct". This is a high bar for employers seeking to discipline an employee for inappropriate out-of-hours use of social media.

Linkedin – who owns the connections?

Many employees now use Linkedin in connection with their work. Often over time, an employee's Linkedin account can become a portable directory of the employee's clients and contacts. Linkedin grants ownership of a Linkedin account to the individual in whose name it is held.

In the United States it has been determined that Linkedin connections are *"not protectable trade secrets on the basis that the information is either generally known in the wider business community of capable of being easily derived from public information"*.

In the United Kingdom courts have ruled that Linkedin can constitute confidential information, particularly where an employer encourages an employee to use it for the benefit of the employer.

In 2013 when considering an unfair dismissal application, the FWC considered a claim made by a senior employee who was dismissed for attempting to solicit his employer's clients through Linkedin so as to promote his own private business. In this case the FWC's determined that the employee *"owed an obligation to his employer to faithfully promote his employer's interests"* and that sending a Linkedin message to connections seeking to solicit the employer's clients/customers for his own interests was "conduct contrary to that obligation".

It is accepted that this case may indicate a tendency of industrial tribunals to look critically at an employee's conduct having regard to an employee's duties to an employer, it is important to note however, that the employment case law involving the use or misuse of social media in the workplace continues to evolve.

We acknowledge Michael Dawson, of Madgwicks for the substance of this article, published in November 2016.

AMA Career Advice Service launches its latest addition ...

THE SPECIALITY TRAINING PATHWAY GUIDE

With over 64 different medical specialties to choose from in Australia, making the decision to specialise in a speciality can seem daunting.

AMA members now have access to a new resource – one designed to assist in making decisions about which specialty pathway to follow. We know that concerns about length of training, cost of training and work-life balance are important factors in making these decisions, and information on the new site will help here too.

The absence of a comparative and definitive guide was raised by our doctors in training and medical students.

Responding to this need from our doctors in training and medical students, the AMA Career Advice Service has developed a comprehensive guide to the specialties and sub-specialities which can be trained for in Australia. The Guide will be updated annually to reflect changes made by the Colleges and the 2017 update will be uploaded shortly.

The web-based Guide allows AMA members to compare up to 5 specialty training options at one time.

Information on the new website includes:

- College responsible for the training;
- An overview of the specialty;
- Entry, application requirements and key dates for applications;
- Cost and duration of training;
- Number of positions nationally and the number of Fellows
- Gender breakdown of trainees and Fellows

The major specialities are there as well as some of the lesser known ones – in all over 64 specialities are available for comparison and contrasting.

For example, general practice, general surgery – and all the surgical sub-specialities, paediatrics, pathology – and its sub specialities, medical administration, oncology, obstetrics and gynaecology, immunology and allergic medicine, addiction medicine, neurology, dermatology and many, many more.

To find out more visit www.ama.com.au/careers/pathway

This new addition to the Career Advice Service enhances the services already available which include one-on-one career coaching, CV template and guide, interview skills "tips" and of course the rich information available on the Career Advice Hub: www.ama.com.au/careers

For further information and/or assistance, feel free to call the AMA Career Advisers: Annette Lane and Christine Brill – 1300 133 665 or email: careers@ama.com.au

Please note current information within the guide relates to 2016 requirements. Information will be updated to reflect 2017 requirements soon.

Let the AMA's specialty training pathways guide help inform your career decisions.

Parental Leave – what is it and how to get it

Parental Leave is a broad term covering maternity leave, paternity leave, partner leave, adoption leave and the right of an employee to return to work to the same position.

Parental leave entitlements arise under the National employment Standards (NES) which forms part of the *Fair Work Act 2009* (the Act) and, applies to most Australian employers.

Members should be aware that service with other public sector entities across the Australian public health sector, **does** count when considering an employee's length of service and consequently whether an employee is eligible for Parental Leave. With this case in mind, it is timely to remember how the Federal parental leave arrangements work.

Parental Leave basic entitlement

The basic entitlement is for 12 months' unpaid parental leave. This can be for either parent, provided the parent is to be the child's carer, and can be shared if both parents are employees of the same employer. It does not matter if the parents are in a de-facto relationship, rather than being married, and the rights extend to the adoption of infant children. The Act does not require the whole period to be taken, but does require the leave to be taken in a single unbroken period. Unpaid parental leave can be taken in conjunction with other forms of accrued leave. An employee may request an additional period of unpaid leave beyond the 12 months entitlement. The employer is not obliged to grant this additional leave, but it can only be refused on *"reasonable business grounds"*.

There is a requirement that an eligible employee must have completed 12 month's continuous service prior to taking parental leave.

Right to return to the same position

Most employers are able to find a suitable temporary employee to fill the employee's role while parental leave is taken.

There is a basic obligation on an employer to ensure that the employee returns to work after the leave to the **same position** held prior to taking leave. This may not always be possible especially if there are changes to the employer's business during the parental leave. If the pre-leave position no longer exists , there is an obligation on the employer to return the employee to an available position for which the employee is fit and qualified. There is no obligation on the part of the employer to grant an extension of the 12 month parental leave, although quite often an employer would be wise to consider such a request.

Obligation to consult with employee when on leave

The parental leave arrangements are structured around an obligation that an employer having granted parental leave, must consult with the employee during the absence. This is especially where there are changes to the structure and composition of the workplace taking place during the absence. The obligation to consult works both ways. If there are changes to the employee's domestic situation, there is an obligation to let the employer know what's happening.

Flexible working arrangements

Job-sharing can be a good option especially during the period after the return to work.

Members are advised to keep your own records when making these decisions about parental leave and to ensure that you consult with your employer before making decisions.

If you require any advice or support on this subject or any other workplace issue, please contact the ACT AMA's Workplace Relations Staff on (02) 6270 5410 or by email: industrial@ama-act.com.au

A Happy Outcome for our Member

In a recent ACT long-running case one of our own DiT members was informed that no Parental leave was available due to the operation of a series of 'fixed term' contracts of employment. The employer argued that as employment would cease on the date of the final fixed term contract, there was no parental leave available due to our member *"not having the requisite 12 months service"*. In challenging this opinion it was pointed out that there were earlier *"fixed term"* contracts which the employer had overlooked.

Happily as a result of the AMA ACT's advocacy our member received her lawful entitlements and the recognition of her earlier service and received her full leave benefit to paid maternity leave.


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Hertz

CLINICAL CASE STUDY

Pitfall of Renal Scintigraphy

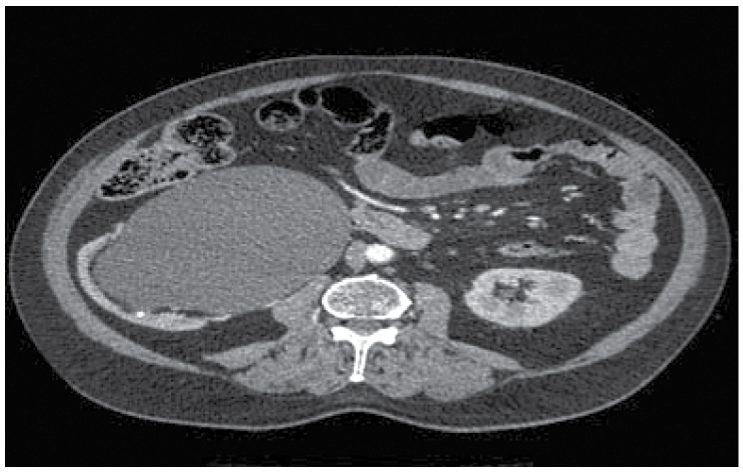
BY **DR YII SONG WONG,** MBBS FRANZCR FAANMS

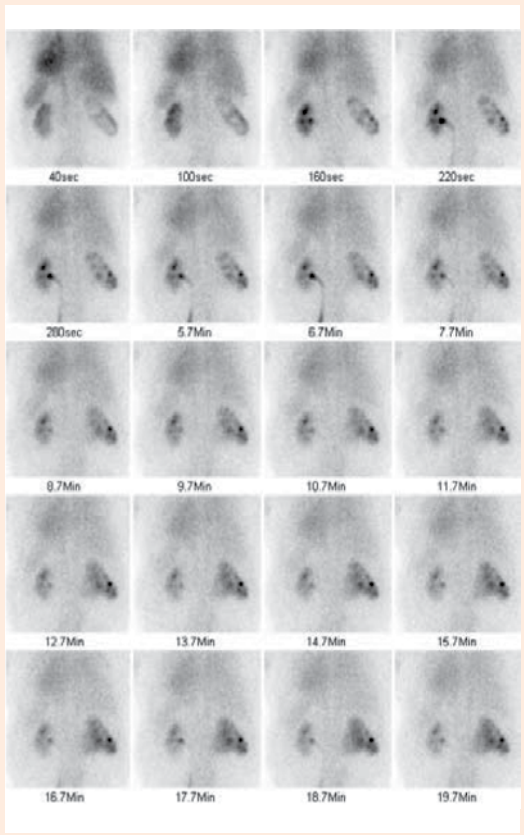
This is a case of a patient presenting with a history of right hydronephrosis due to chronic pelvi-ureteric junction (PUJ) obstruction with a current ureteric stent in-situ. A DTPA nuclear medicine scan with a Lasix challenge was performed to assess for obstruction.

The 1st phase of the examination was performed without Lasix over a standard 20 minutes to assess relative renal function between the kidneys including perfusion and uptake in the renal cortex. The 2nd phase of the study was performed after IV 40mg Frusemide, with a further 20 minutes of scanning. The 2nd phase is mainly utilized to exclude obstruction.

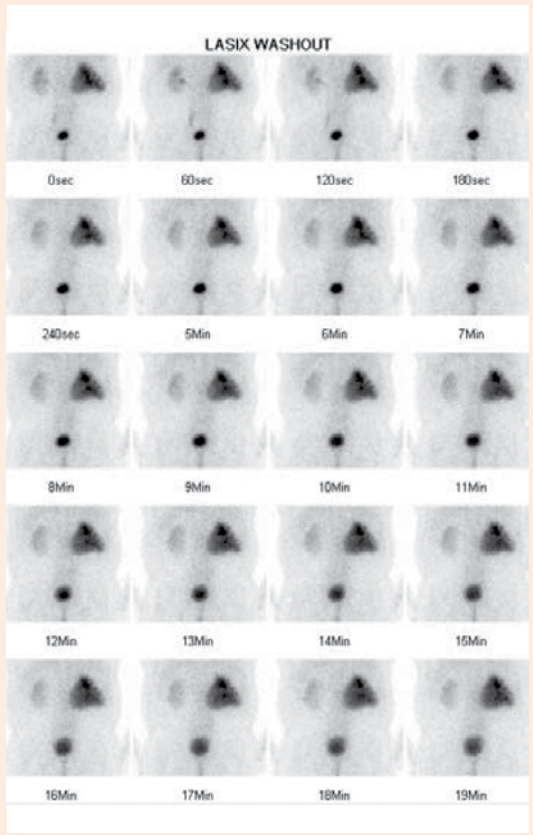
Mean transit time through the collecting system is determined by volume of system and flow rate ie. Transit time (T) – Collecting system volume (V) / urine flow rate (F)

Baseline urine flow rate in a normal person is 0.5ml/min over 24 hours. This may increase to 2ml/min with good hydration (hence, the need to have patients well hydrated prior to a renal DTPA or MAG3 scan) and up to 10-20ml/min with frusemide. From the above equation, it can be seen that the larger the collecting system volume, the longer it takes for urine (or radiotracer) to transit the system.





From the 1st phase, relative renal function was 56% left and 44% right kidney, which is essentially a normal distribution of function. The right kidney shows marked retention of the radiolabelled DTPA in a severely dilated pelvis



From the 2nd phase, post Lasix, there was no effective draining of the radiotracer from the right pelvis. By the usual criteria, this would be confirmatory of severe obstruction of the right collecting system. However, how would the relative renal function of the "chronically obstructed" right kidney be similar to the left kidney?

In this instance, from the CT, volume of the right pelvis is approximately 1500mls (ellipsoid volume with radii of 8.5 x 7.5 x 5.5 cm) and with a urine flow rate post Lasix of 10-20ml/min, the transit time would be 75 – 150 minutes, just to transit the pelvis. To drain via the ureter would mean additional time. As such, the criteria for obstruction in this case is not typical and cannot be confirmed even with delayed imaging. *The comparable function of the right kidney (with its chronically dilated system) to the normal left side suggests that function of the right kidney is within normal limits and therefore cannot be obstructed*. This is often the case in the paediatric population where patients have been followed prospectively for months to years with an "obstructive" picture but stable differential function.

"It was just a peek": improper access of medical records

BY **AVANT LAW**

Dr Holiday* is a consultant in a public hospital and is currently going through a nasty divorce. His young daughter recently told him that her mother had been crying all the time and had stayed at the hospital where he worked. Concerned with the welfare of his children, Dr Holiday surreptitiously accessed his ex-wife's medical record to understand her medical condition and treatment. He discovered that she had been admitted for treatment of a mental health condition.

A couple of days later, Dr Holiday received a letter from his employer asking him to explain why he had accessed his ex-wife's medical records. The letter warned that his employment might be terminated if he was found to have engaged in misconduct and that the matter may be referred to the Medical Board of Australia.

Rise in improper access of medical record cases

Although it may be tempting for doctors to access a patient's medical record without consent or authority for whatever reason – it is never appropriate. The increasing use of audits and electronic records has also made it easier for practices and hospitals to discover unauthorised access.

We have recently assisted a number of members in employment and disciplinary matters where it was alleged they improperly accessed patient medical records. These matters reinforce the risks that you face when you access medical records (including your own records and those of your family) if the access is not required for the medical treatment of the patient or consent/authority is not obtained prior to access.

Dos and don'ts

Most hospitals have detailed policies in place about accessing medical records which typically say that you cannot access confidential patient information without consent or authority and when it is not a requirement of your role. Medical records can generally only be accessed for the purpose of providing treatment to a patient.

In some circumstances, you may have authority to access medical records for research or teaching purposes. However, you may face disciplinary action if you access a medical record, even your own, if that access is not authorised by the employer's policy.

In Dr Holiday's case, he accessed his ex-wife's medical record for a purpose other than providing clinical care to her and without her written consent. He could also use the information for ulterior purposes such as in divorce and custody proceedings.

A cautionary tale

The Medical Board investigated Dr Holiday's conduct, including the reasons why he accessed his ex-wife's medical records. He was ultimately cautioned and ordered to undergo education on decision-making in patient confidentiality.

In some extenuating cases, the Medical Board has suspended the doctor's registration for up to six months.

Accessing medical records without consent and authority can also result in:

- a patient complaint to the hospital, Medical Board or Privacy Commissioner
- issues about the admissibility of the information in legal proceedings, such as Family Court proceedings
- police prosecution, for example if a Domestic Violence Order was breached.

Key lessons

The Medical Board's *Good Medical Practice: A Code of Conduct for Doctors in Australia* emphasises the importance of protecting patients' privacy and right to confidentiality. Patients have a right to expect that doctors and their staff will hold information about them in confidence unless release is required by law or in the public's interest.

Avoid the risks outlined in the scenario above by treating patients' information as confidential and only accessing medical records:

- in accordance with your employer's policies; and
- for the purpose of providing medical treatment to the patient at the time. You cannot access the record of a patient you have treated for a reason unrelated to that treatment.

Also ensure that you do not access your own medical record or any family member's records unless you do so in accordance with your employer's policy.

Need advice? Avantís Medico-legal Advisory Service on 1800 128 268

** This scenario is a compilation of several cases with details changed to ensure privacy.*

Canberra office opening

Avant has recently opened a new office in Canberra to provide a physical presence for Avant members. The office staff includes Harry McCay, senior solicitor and Dr Peter Henderson, Senior Medical Advisor. Avant can be contacted on 1800 128 268.

Breast reduction surgery: cosmetic or remedial procedure?

As a result of her consistent use of the computer a Tax Department employee began suffering from intermittent neck pain and the employee submitted a workers' compensation claim in September 2005.

In July 2005 the employee experienced constant neck and shoulder pain and as a result liability was accepted by Comcare for *"intervertebral disc disorder – cervical region, sprain of the shoulder and right arm, sub acromial bursitis (right arm) and erosion of her teeth (caused by grinding of her teeth in response to the pain)"*. The employee claimed that the weight of her breasts increased the pain in her neck and right shoulder, and that she had also put on weight due to the effect of the medication she was taking.

The employee sought opinions from various specialists and claimed that each doctor advised her that having breast reduction would assist in minimising pain associated with her accepted injuries. On 2 November 2009, the claimant underwent a breast reduction, the total cost of which was $19,956.80

The Law

In 2012 the employee claimed reimbursement for the cost of the breast reduction surgery under s 16 of the *Safety, Rehabilitation and Compensation Act 1986* (the SRC Act). The issue went before the Worker's Compensation Tribunal (AATA) and considered whether Comcare was liable under s 16 of the SRC to pay the employee for compensation associated with the surgery.

Section 16 (1) of the SRC provides that where an employee suffers an injury, Comcare is liable for medical treatment obtained in relation to the injury, provided that the treatment is reasonable in the circumstances.

Medical Evidence

The Tribunal heard that there was no evidence that the patient had received medical advice from her treating Orthopaedic Surgeon that breast reduction might reduce her pain. Further expert independent medical evidence provided to the Tribunal said that as a result of various scans and x-rays taken of the employee's cervical spine between 2005 and 2010, it was considered that breast reduction surgery would not have affected the claimant's neck and radicular pain.

The claimant reported shortly after her surgery that she had continued to experience the symptoms, albeit to a lesser degree. Medical evidence to the Tribunal also suggested that the symptoms *"could resolve spontaneously and improve, or get worse for no particular reason"*.

Decision

The Tribunal concluded that the surgery was not medical treatment obtained in relation to compensable injuries and the surgery was not considered reasonable treatment in the circumstances. Comcare was therefore not required to compensate the employee for the surgery.

Lessons

Requests for compensation for medical treatment especially for non-standard treatment, should be considered provided that there is persuasive medical evidence to support the claim.

Rural general practice grants

The Federal Government, through the Assistant Minister for Rural Health Dr David Gillespie, has recently announced a new Rural General Practice Grants (RGPG) program.

The RGPG program replaces the former Rural and Regional Teaching Infrastructure Grants program to "better respond to the needs of rural communities and support the work of rural general practices. A new, more streamlined and simplified two-step application process will make the process easier and quicker for general practice." Dr Gillespie said.

"General practice in rural Australia faces unique challenges in healthcare including the ability to attract and retain a health workforce.

"The RGPG program will enable existing health facilities to provide teaching and training opportunities for a range of health professionals within the practice and for practitioners to develop experience in training and supervising healthcare workers.

"I believe that strong, accessible primary care in regional Australia helps alleviate pressure on the public hospital system and at the same time it also provides opportunities for earlier intervention and better patient outcomes."

Grants may be used for a range of infrastructure projects, including construction, fit-out and/or renovation of an existing general practice building, supply and installation of information and communication technology equipment or medical equipment.

Grants of up to $300,000 will be provided to successful applicants in 2017. All successful applicants will be required to match the Commonwealth funding contribution.

"Our Government wants Australians, no matter where they live, to have access to quality health services," Dr Gillespie said.

"I also want our health professionals who live and work in rural, regional and remote Australia to have access to teaching and training opportunities so they remain in general practice and in the communities that need them the most."

Grant documentation will be available from the Department of Health's Tenders and Grants page at www.health.gov.au/tenders.

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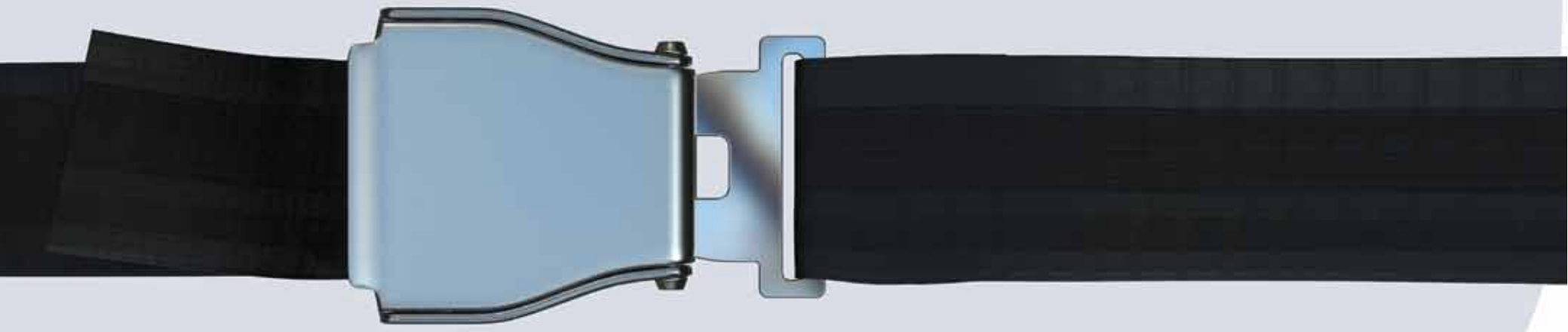

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AMA Indigenous Health Report Card 2016: Target Rheumatic Heart Disease

The AMA has called on all Australian governments and other stakeholders to work together to eradicate Rheumatic Heart Disease (RHD) – an entirely preventable but devastating disease that kills and disables hundreds of Indigenous Australians every year – by 2031.

AMA President, Dr Michael Gannon, said that RHD, which starts out with seemingly innocuous symptoms such as a sore throat or a skin infection, but leads to heart damage, stroke, disability, and premature death, could be eradicated in Australia within 15 years if all governments adopted the recommendations of the latest AMA Indigenous Health Report Card.

The 2016 Report Card - *A call to action to prevent new cases of Rheumatic Heart Disease in Indigenous Australia by 2031* - was launched in late November.

Dr Gannon said the lack of effective action on RHD to date was a national failure, and an urgent coordinated approach was needed.

The AMA Report Card on Indigenous Health 2016 calls on Australian governments to:

- commit to a target to prevent new cases of RHD among Indigenous Australians by 2031, with a sub-target that, by 2025, no child in Australia dies of ARF or its complications; and
- work in partnership with Indigenous health bodies, experts, and key stakeholders to develop, fully fund, and implement a strategy to end RHD as a public health problem in Australia by 2031.

"The End Rheumatic Heart Disease Centre of Research Excellence (END RHD CRC) is due to report in 2020 with the basis for a comprehensive strategy to end RHD as a public health problem in Australia," Dr Gannon said.

"We need an interim strategy in place from now until 2021, followed by a comprehensive 10-year strategy to implement the END RHD CRC's plan from 2021 to 2031.

"We urge our political leaders at all levels of government to take note of this Report Card, and to be motivated to act to solve this problem."

AMA Federal President, Dr Michael Gannon.

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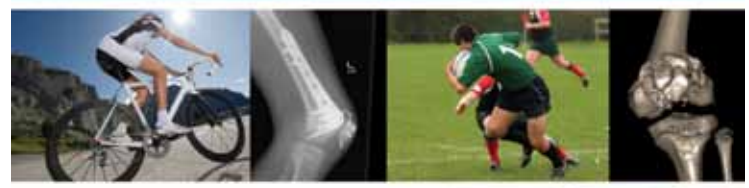

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