CANBERRA Doctor

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**May/June 2017** | Canberra Doctor is proudly brought to you by the AMA (ACT) Limited. Circulation: 1,900 in ACT & region

# ACT Budget: good but more focus on mental health needed

AMA (ACT) President, Prof Steve Robson has welcomed the increased health spending in the ACT Government's 2018 Budget, "Overall, there's been some encouraging progress in specific areas including mental health, upgrading the Centenary Hospital, the new 'SPIRE Centre' and capital grants for general practice and I commend the ACT Government on these increases."

"The Centenary Hospital will receive welcome additional funding for more maternity beds, more paediatric high-dependency unit beds and new services including a new paediatric intensive care treatment space, an adolescent gynaecology service and child and adolescent sleep labs." Prof Robson said.

"Of course, the redevelopment of the Canberra Hospital site with the building of the 'SPIRE Centre' will be a key issue for the next several years. The budget has seen initial funding for feasibility and early forward design included."

## General practice grants

"I welcome the ACT Government's budget commitment to offer capital grants encouraging general practices to set up in under-served areas of Canberra. In principle it is a good idea although $1m over three year is not a lot of money."

"The next step should be consultation with stakeholders, including the AMA (ACT), to determine the basis on which the grants are allocated."

"In my view, the ACT Government should look to encourage a range of different practice models – from an integrated model through to the traditional family practice. It's important we don't unfairly include or exclude corporate practices, co-ops or traditional family practices from this process."

"I know there's interest out there we just have to ensure we get the process right."

## Mental health

While the budget announcements, including an increase in funding for child and adolescent mental health services, additional beds at Dhulwa and, importantly, establishing an Office for Mental Health, are very welcome, the major immediate need is better access to child and adolescent psychiatrists and to fix the looming crisis in acute adult mental health services.

AMA (ACT) President, Prof Steve Robson, said "I commend the Government on these new initiatives, including physical and psychological check-ups for year seven students, but we really must improve access to specialist services."

*Prof Steve Robson, AMA (ACT) President.*

"Our GPs tell us how incredibly difficult it is to get young patients into see child and adolescent psychiatrists and the concerns of managing those patients themselves without the support of specialist care. There are simply not enough child and adolescent psychiatrists in the ACT to meet the local need." Prof Robson added.

"There's no doubt screening will assist early detection, but there needs to be enhanced access to child and adolescent psychiatry as a matter of urgency. In the ACT we have less than 3 FTE child psychiatrists and no workforce plan about how to increase that number." Prof Robson said.

*Shane Rattenbury, Minister for Mental Health.*

***Continued page 7...***

# Medical **Musings**

WITH PRESIDENT, PROFESSOR STEVE ROBSON

## Caring for the carers

Since my last column for Canberra Doctor, two important events have occurred. The first was our Annual General Meeting (AGM), held at the Realm Hotel at the end of May. The second, the ACT Government budget.

The AGM was an excellent night, and was well-attended. We were fortunate to have some VIP guests, among them our guest speaker Professor Brendan Murphy, Australia's Chief Medical Officer. Professor Murphy gave a thought-provoking talk covering a lot of ground, including the issue of medical workforce and the vexed My Health eHealth record. It was a great pleasure to give the President's Award to well-known Canberra General Practitioner Dr Martin Liedvogel, from Fisher Family Practice.

Of the issues we discussed that night, the wellbeing of doctors was an important one. Canberra's doctors provide an outstanding service to the patients they serve across the ACT – but it can be a very stressful and difficult role. You will be aware that the AMA (ACT) – led by our excellent workplace experts Tony Chase and Anish Prasad – are representing junior doctors in award negotiations with ACT Health. We also have a broader role in advocating for a workplace culture we can be proud of. This was discussed on the night, and all present indicated their strong support for our Doctors in Training.

### Mandatory reporting

An important issue that was discussed was the unintended consequences of 'mandatory reporting,' consequences now widely recognised as being bad for doctors. Although well-intentioned, it is clear that these laws need reform. The national reporting legislation came into force with creation of the Medical Board of Australia back in 2010, and in the wake of the fallout from events involving one of my craft group in Bega. Political pressure was brought to bear at the time, taking the position that the harms perpetrated by Dr Reeves would have been prevented if doctors had to report concerns about their colleagues. Doctors thereafter had an explicit legal obligation to report colleagues who could be 'putting the public at risk.' The exception was the state of Western Australia, to their credit.

At the time, the AMA voiced alarm that by interfering with the doctor-patient relationship when doctors treated their own, colleagues with mental health issues, or substance misuse problems would avoid the treatment they needed for fear of coming before the Medical Board.

Many professional groups now see the fatal flaw in mandatory reporting laws, and I was pleased to see my friend and fellow obstetrician Dr Greg Kesby, Chair of the Medical Board of NSW, publicly support changes to mandatory reporting laws to exempt doctors reporting colleagues under their care. According to Dr Kesby, "such changes would not diminish protection of the public but instead ... enhance the level of protection by encouraging medical practitioners to seek and engage in appropriate healthcare." Hear hear!

### Budget blues

The ACT Government budget was a mixed bag, with some good and some disappointing aspects. While additional funding for the Centenary Hospital for Women and Children is certainly welcome, it is overdue. Lessons from that project need to be learned when designing the so-called SPIRE Centre. Engaging those who actually work in the facility, and valuing their input, is fundamental to the success of the project.

The Government earmarked just over one million dollars in capital grants over three years to assist Canberra's general practices deliver bulk-billing to certain parts of the territory. For those Canberrans to whom bulk-billing is particularly important – people with chronic diseases and those under financial stress – the funding available doesn't exactly seem like very much. It is, however, a start and an admission from the ACT Government that general practice is not just a Commonwealth issue and that it can offer incentives to Canberra's busy GPs.

*Dr Martin Liedvogel, Canberra GP and recipient of the 2016 President's Award.*

### Mental health

Of greater concern is the true crisis in mental health services of the ACT. There was increased funding for mental health services in the budget, but the well-recognised crisis in child and adolescent mental health services seems no closer to being addressed properly. In the wake of the budget's release I spent time speaking on ABC local radio and the stories from listeners in families who were struggling with mental health issues were absolutely heartbreaking. Initiatives such as the Office of Mental Health (of which not much is known at the moment) and new physical and psychological check-ups for year seven students are, again, positive signals but they do little to solve the major problems facing Canberrans.

It is no exaggeration to use the term 'crisis' when talking about mental health services here in the ACT. This is a great concern to the AMA (ACT) and to local representatives of the College of Psychiatrists. There is an urgent need for a comprehensive medical workforce strategy in both public and private settings, and this must include planning for the all-important leadership roles. Expect to hear a lot more about these issues over the coming weeks.

### David Nott

In this edition of *Canberra Doctor*, we feature an article by David Nott on the History of Cardiac Surgery in Canberra. I commend the article to you and thank David for his contribution.

### One year down...

I am now well into my second year as President of the AMA (ACT). The learning curve has been tremendous, but I have such a broad appreciation of the issues facing Canberra's doctors that the experience has been fantastic. Everybody has been extremely supportive and keen to share their stories. Thanks again for a wonderful year.

# AMA calls for marriage equality

**The AMA has called on the Australian Parliament to legislate for marriage equality, and to end the divisive public debate over same-sex marriage.**

*A/Prof Karen Phelps AM, past AMA president (second from left), with other supporters of marriage equality.*

AMA President, Dr Michael Gannon, has written to Prime Minister Malcolm Turnbull and Opposition Leader Bill Shorten, urging a bipartisan approach to marriage equality.

*AMA President, Dr Michael Gannon.*

Releasing the AMA Position Statement on Marriage Equality 2017, Dr Gannon said that excluding same-sex couples from the institution of marriage has significant mental and physical health consequences for lesbian, gay, bisexual, transgender, intersex, and queer/questioning (LGBTIQ) Australians.

## Time to change

"Discrimination has a severe, damaging impact on mental and physiological health outcomes, and LGBTIQ individuals have endured a long history of institutional discrimination in this country," Dr Gannon said.

"This discrimination has existed across the breadth of society; in our courts, in our classrooms, and in our hospitals.

"Many of these inequalities have been rightly nullified. Homosexuality is no longer a crime, nor is it classified as a psychiatric disorder. The 'gay panic' defence is no longer allowed in cases of murder or assault, and same-sex couples are allowed to adopt children in most jurisdictions.

"However, LGBTIQ-identifying Australians will not enjoy equal treatment under Australian law until they can marry.

"It is the AMA's position that it is the right of any adult and their consenting adult partner to have their relationship recognised under the Marriage Act 1961, regardless of gender.

"There are ongoing, damaging effects of having a prolonged, divisive, public debate, and the AMA urges the Australian Parliament to legislate for marriage equality to resolve this."

While there is no definitive data on the number of Australians who identify as LGBTIQ, same-sex couples made up approximately 1 per cent of all Australian couples in the 2011 Census, and more than 3 per cent of respondents to a 2014 Roy Morgan survey identified as homosexual.

## Health consequences

People who identify as LGBTIQ have significantly poorer mental and physiological health outcomes than those experienced by the broader population. They are more likely to engage in high-risk behaviours such as illicit drug use or alcohol abuse, and have the highest rates of suicidality of any population group in Australia.

"These health outcomes are a consequence of discrimination and stigmatisation, and are compounded by reduced access to health care, again due to discrimination," Dr Gannon said.

"The lack of legal recognition can have tragic consequences in medical emergencies, as a person may not have the right to advocate for their ill or injured partner, and decision-making may be deferred to a member of the patient's biological family instead. 2

## Move now

"Marriage equality has been the subject of divisive political and public debate for the best part of the past decade.

"It is often forgotten that, at the core of this debate, are real people and families. It's time to put an end to this protracted, damaging debate so that they can get on with their lives.

"As long as the discrimination against LGBTIQ people continues, they will continue to experience poorer health outcomes as a result.

"LGBTIQ Australians are our doctors, nurses, police officers, teachers, mothers, fathers, brothers, and sisters. They contribute to this country as much as any Australian, but do not enjoy the same rights.

"It is time to remove this discrimination."

The AMA Position Statement on Marriage Equality 2017 is at https://ama.com.au/position-statement/marriage-equality-2017.

# AMA (ACT) Annual General Meeting

This year's Annual General Meeting of the AMA (ACT) was again held at the Hotel Realm and featured an address by Prof Brendan Murphy, the Chief Medical Officer for the Australian Government and principal medical adviser to the Federal Minister for Health and the Department of Health. Prior to his appointment Professor Murphy was the Chief Executive Officer of Austin Health in Victoria.

*AGM dinner guests enjoy pre-dinner drinks in the foyer of the Hotel Realm.*

The AGM was preceded by drinks in the foyer of the Hotel Realm, featuring a new Mercedes Benz car provided by Mercedes Benz Canberra. Our thanks to Mr Alex Turbin from Mercedes Benz Canberra for his attendance on the night and also for the prize of a weekend away and the use of a new car. The prize draw was conducted amongst the AMA members present and was won by Dr Antonio Di Dio.

*Dr Andrew Miller, delivers the AMA (ACT) Treasurer's Report.*

After dinner, and following Prof Steve Robson declaring the meeting open, Prof Murphy delivered an address on 'Medical Leadership in Health System Reform' and then took questions.

## Dr Martin Liedvogel

After delivering his report, Prof Robson then announced the winner of the President's Award. This is an award presented annually to a person who, in the opinion of the President, has made a significant contribution to the AMA (ACT) and to the profession in the ACT.

The 2016 award recipient was announced as Dr Martin Liedvogel.

*Prof Brendan Murphy, left, with Dr Iain Dunlop AM.*

*From left, Dr Antonio Di Dio, AMA (ACT) President-elect, Dr Rajeev Jyoti and Dr Uche Menakaya.*

*From left, Dr Catherine Drummond, Dr Kylie Scott, Dr Georgina Flanagan and Dr Jenny Weekes.*

*Prof Steve Robson delivers the AMA (ACT) President's report.*

*Prof Brendan Murphy addresses the AGM dinner.*

*Mr Alex Turbin, from Mercedes Benz Canberra, left, congratulates Dr Antonio Di Dio on winning the prize of a weekend away including the use of a Mercedes Benz car.*

# Dr Martin Liedvogel wins 2016 AMA (ACT) President's Award

The AMA (ACT)'s recent AGM saw President, Prof Steve Robson present Dr Martin Liedvogel with the 2016 President's Award. The citation for Dr Liedvogel's award reads:

"After completing his undergraduate medical degree at the University of Newcastle and working for five years in public hospitals, discovered his true calling in general practice. His RACGP Fellowship followed in 2004 and he moved to Canberra in 2005 and then took over the running of the Fisher Family Practice in 2006.

Martin's commitment to his colleagues and the profession has been clear throughout his career, from his time as a GP registrar, lecturing at the UNSW Rural Clinical School and as a Director of GP Registrars Australia, through to his teaching and mentoring roles with up-and-coming GPs and on to his appointment to the boards of the ACT Medicare Local and then the Capital Health Network.

Dr Liedvogel is currently Chair of the Capital Health Network.

Martin has special interests in chronic disease management, especially in the area of diabetes and heart disease and has long advocated the need for partnerships encouraging access to multidisciplinary care to deliver superior health outcomes.


*Dr Martin Liedvogel, left, winner of the President's Award with Prof Steve Robson.*

Over his career, Dr Martin Liedvogel has given freely of his time to colleagues and primary care and other representative organisations, advocating the key role primary care plays in ensuring the best possible health outcomes for patients. He is collaborative, empathetic and an outstanding leader in both primary care organizations and his chosen field of general practice."

Dr Liedvogel responded to the award by thanking the AMA (ACT) and acknowledging the work of colleagues and organisations he had worked for and with. He emphasized the enjoyment and satisfaction that both his clinical and volunteer work had given him.

In particular, Dr Liedvogel thanked his wife and family for their support and encouragement in all that he does.

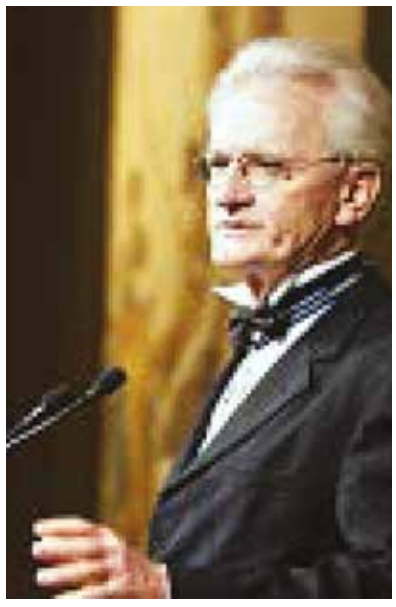
# AMA National Conference – doctors' health a focus

The recent AMA National Conference saw a significant focus placed on doctors' health and 'caring for the carers'. In particular, the second day of the conference featured a panel chaired by Dr John Zorbas, chair of the AMA Council of Doctors in Training, examine 'Doctors Health and Wellbeing'. Once again, the panel discussion emphasized that the effect that mandatory reporting may be having in dissuading doctors from seeking help.

*AMA (ACT) representatives at the Gala Dinner, from left, Dr Kieran Barr, Dr Iain Dunlop, Dr Liz Gallagher and Dr Andrew Miller.*

The conference proceedings also featured a number of politicians, PM Malcolm Turnbull, who was in the audience during part of the 'Doctors Health and Wellbeing' panel, Opposition Leader Bill Shorten, Health Minister Greg Hunt and Shadow Health Spokesperson, Catherine King.

A number of awards were made during the conference with Dr Bill Glasson, past AMA President, being awarded the AMA Gold Medal, Prof Bernard Pearn-Rowe from WA, the President's Award and Prof Brian Owler, past AMA President and A/Prof Tim Greenaway being made AMA Fellows.



*Dr Bill Glasson, winner of the AMA Gold Medal.*

# Doctors' health and mandatory reporting: time for change

The recent announcement from Federal Health Minister, Greg Hunt, of $47m in funding for suicide prevention is very welcome. Of that amount, $1m has been specifically set aside to support mental health and reduce suicide in the health workforce.

*Greg Hunt, Federal Health Minister.*

Suicide and all its effects is a tragedy and felt even more keenly by the medical profession when it is another doctor. The recent suicides of young doctors in Victoria and NSW, in particular, have highlighted the issue and given considerable pause for thought.

While there is a wide range of factors involved in suicide, we know that early intervention is likely to be critical in avoiding many of these tragic losses. Unfortunately, the reality is that there are significant barriers, real and perceived, that prevent some doctors from seeking access to formal health care.

## Mandatory reporting

Both at the AMA National Conference and via the general and industry media, the likely adverse impact of mandatory reporting has had on doctors' willingness to seek care has been raised.

Mandatory reporting for doctors was introduced by most states and territories, including the ACT, in 2010 by adopting the uniform National Law. While concerns had been expressed in regard to mandatory reporting at the time of the introduction of the National Law, with the exception of Western Australia, all Australian state and territory jurisdictions moved to adopt mandatory reporting as part of the National Law.

In WA, the AMA WA successfully lobbied for a provision to exempt treating practitioners from the requirements of mandatory reporting.

While the intention of the mandatory reporting part of the National Lawon was to ensure

*ACT Health Minister, Meegan Fitzharris.*

the protection of the public by requiring doctors and other health practitioners to report colleagues under defined circumstances, the AMA, medical colleges, and the medical defence organisations have been concerned for some time that this provision creates a barrier to health professionals in accessing health care, particularly in relation to mental illness.

An extensive study of over 12,000 doctors undertaken by beyondblue in 2013 revealed that one of the most common barriers to seeking treatment for a mental health condition were concerns about the impact of this on medical registration.

## AMA Response

The Federal AMA has written to Health Minister, Greg Hunt, seeking his support to amend the National Law so as to not dissuade medical practitioners from seeking necessary medical treatment or assistance. In response, a spokesman for the Minister has said the Federal Government will work with state governments to ''establish a common national standard to protect the mental health of doctors''.

AMA NSW has also been in discussions with the NSW Health Minister who has undertaken to raise the matter at the Health Ministers' Council.

Locally, the AMA (ACT) has written to Health Minister Meegan Fitzharris expressing our concerns in regard to mandatory reporting and urging the ACT Government to support change that would facilitate medical practitioners accessing care.

The Federal AMA President, Dr Michael Gannon, while renewing calls for WA-style exemptions, had the last word when he said ''I think the changes will happen in NSW and I'm very hopeful it will be in the other states. It's not a difficult change [making changes to mandatory reporting]. ''My only fear is that the government will think that's doctors' health is ticked. It's far more complicated than this.''

*...from page 1*

## Adult mental health service

"In addition, the recent resignations of two psychiatrists from the acute adult mental health service has the potential to severely impact the service. The worst case scenario would see part of the service being shut down – an outcome everyone would wish to avoid." Prof Robson added.

"There's no doubt that many factors play in to these issues. There's also no doubt that the use of 'Area of Need' positions by ACT Health and lack of a workforce plan are some of those issues." Prof Robson said.

"In the case of 'Area of Need' positions, it seems almost inevitable that once fully qualified, an 'Area of Need' appointee will leave Canberra. Similarly, for longer term stability we need a workforce plan for our psychiatry workforce – consultants and registrars – that goes beyond a short term fix,"

"So far our dealings with Health Minister Meegan Fitzharris have been very positive and, in that same spirit of goodwill, we are meeting with Mental Health Minister Shane Rattenbury to offer AMA (ACT)'s assistance to deal with these important issues." Prof Robson said.

# A history of cardiac surgery in Canberra

BY DAVID NOTT*

On 23 February 2008, a ceremony in the cardiac surgery ward at The Canberra Hospital marked the first decade of the cardiac surgery unit under the direction of Dr Peter Bissaker. The unit, while not the largest in Australia, is one of the country's most successful and efficient; this is how it became so.

*Royal Canberra Hospital in the early 1960s, at about the time David Nott returned to Canberra.*

## Canberra 1962...

I returned to Canberra in 1962 after four years in the UK and the USA learning what I could about chests and hearts. I set up as a thoracic surgeon, with an interest in cardiac trauma. The environment was welcoming and warm, as the Canberra Community Hospital was keen to see more specialists. One of the general surgeons, Peter Blaxland, was very helpful and provided welcome encouragement.

Of the few surgeons then in Canberra most felt there was probably no future for thoracic surgery and even less for open-heart surgery. To explore the future possibilities of cardiac surgery I put a number of proposals to the hospital board but there was no real support from physicians or cardiologists.

The standard response was that cardiac surgery was not for the ACT then, and probably never; there would never be sufficient work load. This attitude ignored the predicted future expansion of the city and region.

The start of my surgical practice in Canberra was slow, largely hernias, varicose veins and haemorrhoids and it was nine months before a friendly and perhaps courageous general practitioner referred a healthy young adult male with a large intra-pulmonary hydatid. What a good start – the first thoracotomy in Canberra, with a very satisfactory outcome. This young patient marked the beginning of a fairly busy thoracic surgical practice.

## Preparing the ground

I maintained my interest in the chest and heart by visiting the Page Chest Pavilion, RPAH, and keeping up with the intra-cardiac anatomy. I had managed many stab wounds and blunt trauma to the heart, both in England and in Canberra, but without bypass capability and equipment and especially as my training was not adequate for open heart surgery, the major problem I was most likely to face was massive pulmonary embolism.

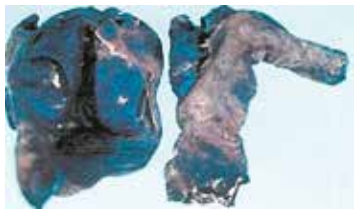
Such a crisis sometimes indicated the Trendelenburg operation, gaining control of the inflow to the heart by clamping the pulmonary veins making it possible to open the pulmonary artery for embolectomy. I had never even seen one. It can be life-saving but is often unsuccessful. In fact, it is fairly straightforward, requiring speed and some familiarity within the open chest.

Consequently, I organized pulmonary embolectomy training sessions with the help of all the nursing staff, rehearsed the procedure in theatre, and established an emergency instrument tray and trolley just in case I was asked to help with such a case. We practised in the operating room, becoming familiar with the instruments until we felt we could make a reasonable attempt to save a dying patient.

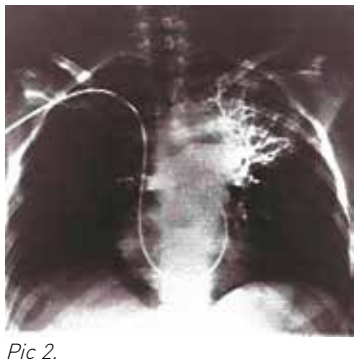
## Canberra's first almost intra-cardiac operation

In the late 1960s a massive pulmonary embolism occurred in one of my own patients, a very fit, slim, 28-year-old country woman. I had resected large right intra-pulmonary and right hepatic hydatids six days before. She did very well, and as she was getting ready to go home she experienced sudden crushing chest pain and profound dyspnoea. She was moribund when seen less than three minutes later. She appeared to have sustained a massive obstruction to the pulmonary circulation and was clearly dying. Surgical removal was the only way her life could have been saved.

Fortunately for us all, this disaster happened at 7am on a weekday, which meant there was a theatre free and staff on site. Our emergency plan worked well, the team was mobilized, the patient was transferred to theatre and I performed embolectomy using inflow occlusion. Two very large firm clots, one completely occluding the right main pulmonary artery, the other jammed in the left main and obstructing all but the left upper lobe were removed. She recovered well and after a fairly torrid postoperative course, she went home on the twentieth day. She had an uncomplicated convalescence.



*Pic 1.*



*Pic 2.*

Picture 1. shows the two very organized clots, the clot on the left of the picture filling the right main PA, and on the right shows how the blood could only pass to the LUL. Picture 2., the pulmonary angiogram, demonstrates that the circulation is completely limited to LUL

Over the next few years I was asked to see five more patients with massive postoperative cardiovascular collapse due to pulmonary embolus, with three successful embolectomies.

## A second surgeon

In the early 70's, distinguished cardio-thoracic and vascular surgeon Mr Lindsay Grigg arrived in Canberra. Lindsay had had a distinguished and most successful life as a cardiac and pulmonary surgeon. He had trained in Britain with some of the greats of British cardiac surgery, and had an enviable record as a cardiac surgeon at the Royal Melbourne Hospital, and in Entebbe, Uganda. It was a great joy to welcome

*Dr David Coles OAM, cardiologist.*

a colleague and wonderful support and he has been an asset for Canberra.

Until he arrived I was on call all the time for thoracic emergencies, and now we could share the on-call roster. But even with support from cardiologists Marc Faunce and David Coles, we were still unable to persuade management, physicians and some other cardiologists to think about an

*Dr Marc Faunce, a key supporter of the cardiac surgery unit.*

open-heart unit to serve the predicted increase of the ACT population.

Later, the concept was presented to Dr Ron Wells, then Acting General Superintendent of Canberra Hospital. Dr Wells was enthusiastic and during his brief stay in that position supported the project and even said it might be possible to use one of the operating theatres for limited preparatory work.

## Obtaining the equipment

The success we had with pulmonary embolectomies raised much interest. The hospital board sought the opinion of Marc Faunce and of Sir Harry Wunderly, one of the country's most senior thoracic physicians. They congratulated the team on its success and enthusiastically supported the recommendation to investigate the feasibility of an emergency cardiac support unit.

This was good news. Marc Faunce, Ken Downes, anaesthetist, and I made a number of trips to Sydney to gather information and talk to cardiac surgery teams. We visited Royal Prince Alfred, St Vincents and Prince Henry hospitals and Tuta instrument makers to discover what was available. All were extremely helpful and a selection of emergency equipment was examined.

After some consideration, it became apparent that the portable equipment seen would be unsuitable and consequently, SARNS modular units were purchased. Considerable cost saving was achieved by presenting the Canberra Hospital workshops with some of the basic constructional work of trolleys, heat exchangers etc. Electronic intravascular pressure monitors were also purchased, as was a locally produced heat exchange control unit. Stainless steel sheeting and even the wheels for the trolleys were purchased. The purchases were made and the hospital workshop commenced constructing trolleys.

## Training – then more delays

Training was obviously required. TCH assisted by allowing the old hospital mortuary to be adapted as an experimental operating theatre and Professor Bede Morris, John Curtin School of Medical Research assisted in the setup.

There were still problems. One of the first occupied us all for some time. After preparing the way for the use of our new equipment many of the specialists went cool on the project and there seemed to be inexplicable delays in getting the equipment organized and ready. Various staff changes seemed to complicate matters and then it was realized that most if not all the equipment was missing.

Lindsay Grigg and I and many others initiated a lengthy search. Was the equipment shifted to a new venue, had it been deemed unserviceable, or had it mysteriously found its way elsewhere? The ACT Police agreed that the mystery seemed insoluble. The question was never answered and the equipment never found.

## A third surgeon and a move

In 1991 I departed for a sabbatical year but before departing, I was fortunate in persuading Dr John Tharion to come to Canberra as my locum. John was a very experienced cardiothoracic surgeon, running open-heart units in India before coming to Australia. This was a most successful arrangement, particularly as, on my return we were able to persuade him to stay on as the third thoracic surgeon.

Then the Royal Canberra Hospital closed and I believe this had a lot to do with some of our difficulties.

The saviour of the cardiac surgery unit was Dr Janet Mould, the clinical superintendent of Woden Valley Hospital, (soon to become The Canberra Hospital). She had a clear vision of the potential for cardiac surgery in Canberra and was aware of not only the benefits for cardiac patients but also of the power of an open heart unit to raise the morale of the whole hospital.

In 1994 I was asked to form a wide-ranging committee to determine the needs in medical, nursing, allied health professional, and infrastructure required to establish a unit. My responsibilities as chair were shared with Dr Paul Christie, director of the anaesthetic department.

*Continued page 10...*

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The first task was to have input into the design of a dedicated operating suite, initially to be part of the developing National Capital Private Hospital. To be involved with the architects from the beginning was a great help. The completed operating suite included space for ancillary monitoring equipment and the pump. There was office space and a dedicated pump room, television and a surgeon's room. When the first procedures when done in 1998, the design proved most effective. Subsequently, in the development of TCH, much of the plan from NCPH was adapted to produce another very effective cardiac surgery suite.

## Real progress

Advertisements for the positions of Cardiac Surgeon, Anaesthetist and Perfusionist were prepared and published. It was important to have the professional team involved at this stage. The committee received helpful advice from both Royal Prince Alfred and St Vincent's hospitals. Drs Harry Windsor and Mark Shanahan offered access to their theatres, not only to examine the equipment but also for Canberra nursing staff to work with the St Vincent's staff.

The committee had a lot of ground to cover. All the major equipment would require input and advice from the cardiac surgeon, yet to be appointed. It was heartening to read the replies to our first advertisement but the interview panel recommended that the positions should be readvertised. Several more surgeons applied but no-one was appointed. Some of the applicants found that the job was in the 'bush', the unit was not yet a going concern, too far from other units or from the University, or indeed 'too far from civilization'.

## A unit at last!

I sought help from Drs Mark Shanahan and Alan Farnsworth at St Vincent's. Mark briefed me on Dr Peter Bissaker who was then at John Hunter Hospital, having set up the Cardiac surgery unit there in 1974. Peter was described as great asset to Newcastle, who was very happy with life there, and probably would not be interested in leaving. But I knew that Peter was a Canberra boy who might be persuaded to come south.

I tried headhunting and spent some time in Newcastle, visited the John Hunter and met Peter and his very effective team. I spent many very happy days in the operating room rapidly discovering that this unit was very, very good. The figures, results and particularly the morale were excellent. Later, I recounted to Peter the work we were doing to prepare for a new unit and that all we needed was a surgeon, and that there was a job in Canberra, setting up and running a new unit. Was he interested?

Peter had obviously given the matter much thought and told me he would enjoy the challenge, but there were some conditions. He would consider the offer if we could offer a post to his perfusionist, Ms Kay Collins. We were very happy to include Kay, who is a great support to both Peter and the unit and has been a total success. It was quite clear that Canberra had the nucleus of a top cardiac surgery team.

Another bonus was Dr Tim McKenzie. Early in his training he had worked as my registrar, but had gone to America to refine and add to his experience in cardiac surgery. He was in Boston specializing in limited access aortic valve surgery. He had heard about the nascent unit and when I contacted him to sound out his possible return to Canberra he was delighted, and I offered him the position as the second cardiac surgeon. He arrived soon after and proved to be most complementary to Peter. In 1998 the Cardiac Surgery Unit, The Canberra Hospital was born.

*David Nott (left) with Dr Peter Bissaker, Director of Cardiothoracic Surgery.*

## Acknowledgements

That this world-class cardiac surgery unit ever became a reality was the result of input from far too many professionals and experts to mention and thank, but whose involvement made this most effective unit possible. Special thanks go to Director, Dr Peter Bissaker, Drs Tim McKenzie, Keshav Bhattarai, and the senior perfusionist, Kay Manning and to all members of the unit.

* The *Canberra Doctor* acknowledges and thanks Dr John Donovan, whose considerable time, effort and expertise was contributed in editing David Nott's original draft.

# David Nott – a true Canberra Citizen

David Nott knew from an early age that he wanted to be a surgeon. David's father, Dr Lewis Nott, physician, hospital superintendent, veteran of the First World War, mayor and Federal MP, had brought the family to Canberra in the late 1920s where David was born in 1931.

David Nott undertook his undergraduate medical training at the University of Sydney and then worked in general practice before travelling to England to train as a surgeon. Following three years of post-graduate surgical training in England and then further periods in Scotland and the United States, David returned to Canberra in the early 1960s.

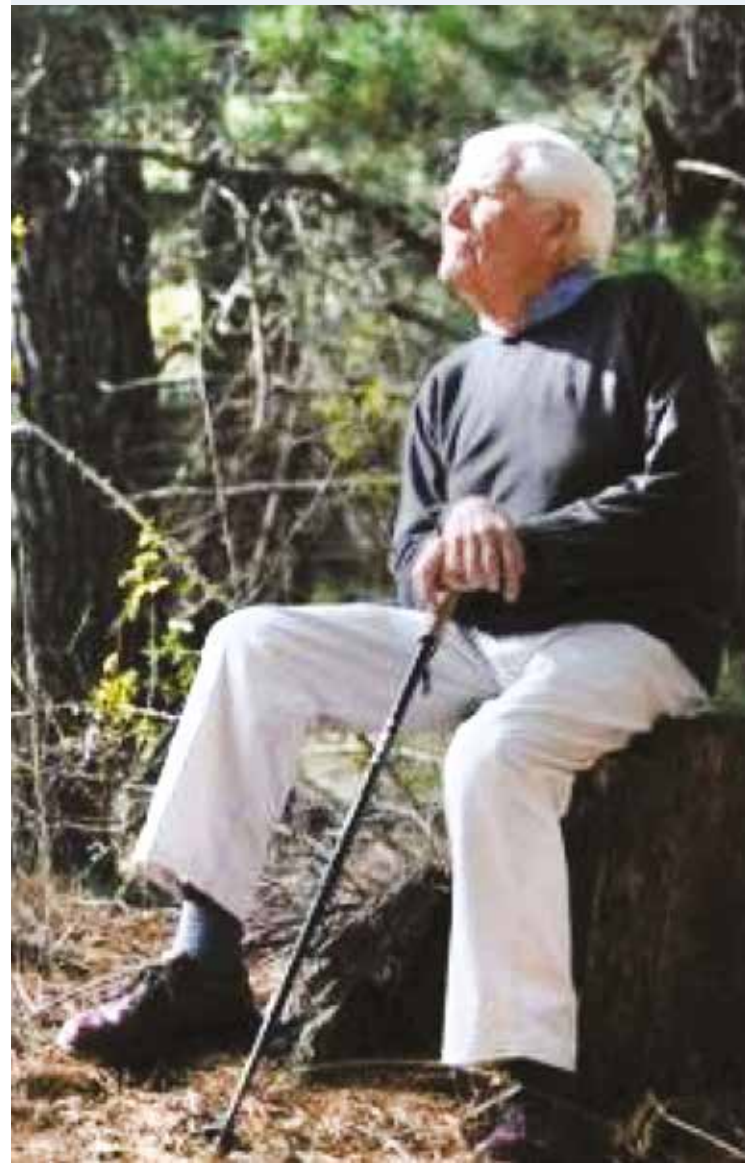
Davis Nott's early surgical career paralleled the development of cardiothoracic surgery and he pioneered development of the speciality in Canberra. Subsequently, he was a prime mover in the development of a heart unit for the national capital and he tells that story in the attached article.

David went on to serve as a surgeon in the RAAF Reserve of Officers, was twice called up for full time duty completing tours in Butterworth, Malaysia, and retired after many years as a Wing Commander in the RAAF Reserve, earning the Reserve Forces Decoration.

In addition to his surgical career, David spent time on the ACT Medical Board and the ACT Committee of the Royal Australasian College of Surgeons.

Following his retirement from surgical practice, he continued to contribute to the Canberra community as a volunteer at the Australian War Memorial.

A true Canberra citizen.



*Dr David Nott in 2013.*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# CanDoc Q&A with Dr Andrew Miller

For the first in a series of quick Q&As with doctors in the Canberra region we thought we'd ask Dr Andrew Miller, a former AMA (ACT) President and incoming President of the College of Dermatologists, a few questions about his career, his take on current health issues and his favourite comfort foods.

*Dr Andrew Miller.*

**Q: Why did you pursue a career in medicine and why did you choose dermatology?**

- My parents tell me that I idolised our family doctor; apparently as a small child I wondered out loud that he must have been very clever because his head was growing out through his hair.
- Medicine just seemed a natural fit, it was never a conscious decision, I never had any doubt that I would not be a doctor
- As for dermatology; as a medical student at St Vincents in Sydney I was struck by the amazing clinical skills and confidence of the dermatologists there; the impression never left me and after a period in general practice I felt myself drawn back to it.

**Q: If you weren't a Doctor, what would you be?**

- Apparently before I announced at about three that I was going to be a doctor it was a policeman.

**Q: Tell us about an event or person that has had a lasting influence on your career.**

- It was my worst ever day as a doctor: PGY3 in a country town, the only RMO in a base hospital with all the other doctors in town actually out of town. Simultaneous severe car accidents at each end of town and suddenly a department full of serious injuries and an infarct walking through the door (he had to walk to hospital because there were no emergency services left).
- I had to make the decision as a 26 year old to not attempt to treat a young girl appallingly injured in one of the accidents because we did not have the staff to deal with her as well as everyone else. She died. The decision I had to make haunted me for years although I know it was the only way I could prevent other deaths; but it taught me that at the end of the day we all need to be able to make decisions and stand by them. That is why we are doctors. There is good stuff and bad stuff every day, there is great responsibility but it is also an incredible privilege. I wouldn't be doing anything else for quids.

**Q: In your view, what are the pressing issues facing the profession? And for Dermatology?**

- For medicine in general I am concerned about the commoditisation of our craft; increasingly policy makers see us as just interchangeable cogs in a wheel and we have allowed the community to believe that seeking medical care is as significant as getting a hair cut.
- For dermatology, the single biggest threat relates to our workforce. Every medical administrator in the country wants to be able to access dermatology services; few are willing to pay for trainees and we are not meeting our workforce targets despite an incredible effort by the College and dermatologists around the country.

**Q: Notwithstanding the importance of living a healthy lifestyle, what would you say is your favourite comfort meal and will you bring a plate to the next Board meeting?**

- I have to admit to a weakness for fish and chips.
- Out of concern for my fellow Board members any plate would have to be high fibre, low GI, low salt...

# AMA Family Doctor Week 23-29 July 2017

AMA Family Doctor Week highlights the role of GPs – our family doctors – and their value to the community and the health system as they deliver high-quality holistic health care.

Family Doctor Week will run from Sunday 23 July to Saturday 29 July 2017. The theme for this year's event is Your family doctor: all about you.

## Value of Family Doctors

The Organisation for Economic Co-operation and Development (OECD) says Australia has one of the best health systems in the world. Its strength stems from general practice and the pivotal role of the general practitioner. GPs are the first port of call when Australian feel unwell, and GPs manage 90 per cent of the problems they encounter.

Australians already know the benefits of having a regular family doctor, with 85 per cent of the population visiting a GP at least once a year. Ninety three per cent of Australians return to same practice, and 66 per cent return to the same GP. GPs are also the most used and trusted source of child health information.

*Dr Suzanne Davey, AMA (ACT) Board member and well-known Canberra GP..*

Events and activities leading up to and during Family Doctor Week will focus on the benefits of having a family doctor and the invaluable role they play in Australia's health system.

*Dr Tuck Meng Soo OAM and Dr Rashmi Sharma OAM enjoying last year's Family Doctor Week Dinner.*

## AMA (ACT) Family Doctor Week Dinner

AMA members are invited to join Prof Steve Robson, AMA (ACT) President, to celebrate 2017 Family Doctor Week. Guests of Honour at the dinner will be the ACT Health Minister, Meegan Fitzharris, MLA and ACT Mental Health Minister, Shane Rattenbury MLA. The dinner will be held on Wednesday 26 July at AMA House and is complimentary for AMA members.

Further information is available in this edition of Canberra Doctor.

# Case Study

BY DR KHIMLING TEW, MBBS FRACS FRANZCR

**Positron Emission Tomography (PET) scans demonstrate tissue metabolism using the tracer fluorine-18 deoxyglucose (FDG). FDG is a glucose analogue which cannot be metabolised further by many malignancies and therefore accumulates in the cells.**

A patient with a past history of melanoma presented with inguinal lymphadenopathy. Biopsy showed metastatic melanoma. FDG PET/CT scan demonstrated extensive metastatic disease in the liver and skeleton. Some of the skeletal lesions were not visible on CT, despite being markedly hypermetabolic (fig. 1). FDG PET/CT changes management in malignant melanoma in more than 35-59% of high risk patients.

Another patient with newly diagnosed non-Hodgkin lymphoma showed extensive bone marrow involvement without CT abnormality (fig. 2). PET scans can be positive before a skeletal lesion develops on CT.

PET is also useful in assessing treatment response to chemotherapy and new immunotherapy agents.

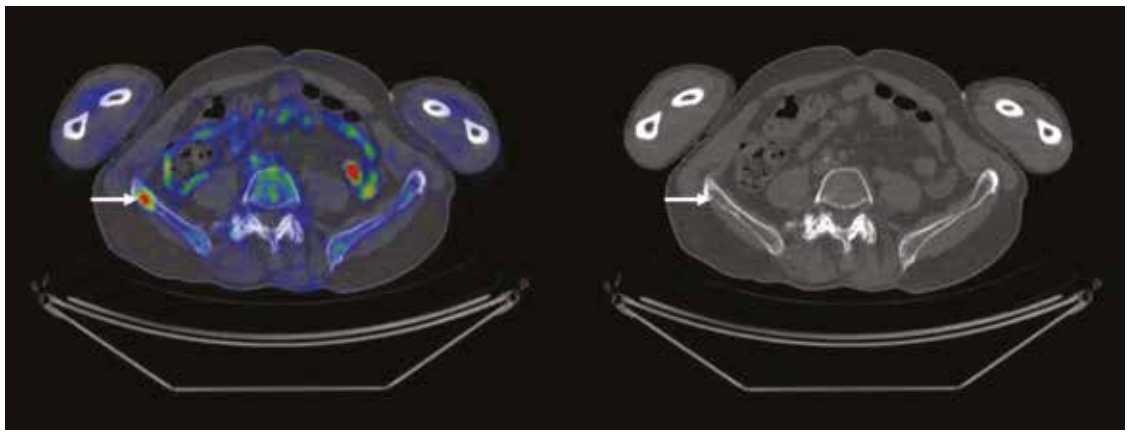


*Figure 1.*

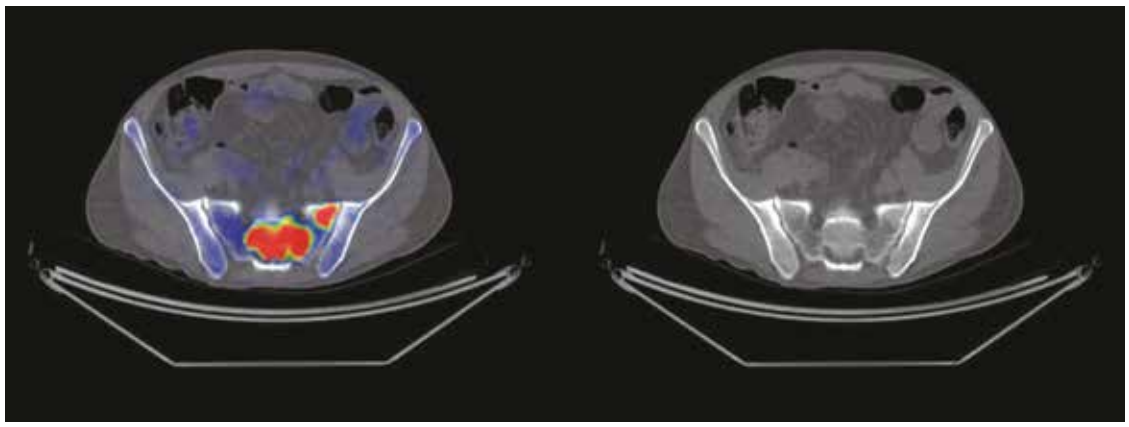


*Figure 2.*

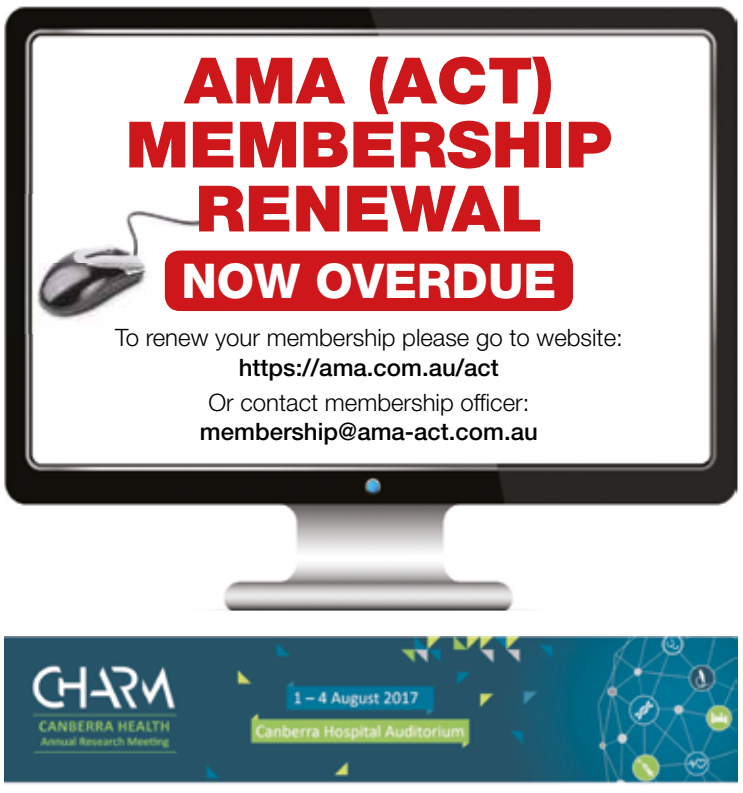
# AMA National

*Dr Rebeka Stepto, left, Co-chair of the AMA (ACT) Council of Doctors in Training with a colleague at the AMA Leadership Dinner.*

# Conference

*Dr Liz Gallagher, AMA (ACT), Dr Tony Sara, AMA (NSW) and ASMOF and Dr Andrew Miller, AMA (ACT).*














**SAVE THE DATE**

CHARM is the premier conference for the communication and translation of health-related research in the ACT, and provides networking, collaboration and capacity building opportunities.

To register for this meeting go to:

http://www.health.act.gov.au/research-data-and-publications/research/charm-2017/charm-registration

**Keynote Speakers**

Tuesday 1 August, 12-1pm
**Dr Craig Jenne**
*Assistant Professor, Department of Microbiology, Immunology and Infectious Diseases and Department of Critical Care Medicine at University of Calgary, Canada*

Wednesday 2 August, 12-1pm
**Professor Peter MacDonald**
*Head of the Transplantation Research Laboratory, Victor Chang Cardiac Research Institute*

Thursday 3 August, 12-1pm
**Professor Katie Allen**
*Paediatric Gastroenterologist and Allergist and Director of Population Health Research, Royal Children's Hospital, Melbourne*

Friday 4 August, 12-1pm
**Professor Alison Kitson**
*Dean of Nursing and Head of School, University of Adelaide*

**Program Highlights**

- 3 Minute Thesis session – Finalists from University heats to compete for $1000 prize money
- From bench to bedside – Gut microbiome: how laboratory research translates into the clinical setting
- Partnering in care – Palliative care in the ACT
- NHMRC update on the review of the Australian Code of Practice for the Responsible Conduct of Research
- Poster viewing evening – Thursday 3 August
- Awards Dinner – Friday 4 August
  Cash prizes awarded to winning oral and poster presentations

**For more information:**

Web: http://health.act.gov.au/research-publications/research/charm-2017
Email: health.research.office@act.gov.au Phone: 02 6174 5257




CANBERRA Doctor

**A News Magazine for all Doctors in the Canberra Region**
ISSN 13118X25
Published by the Australian Medical Association (ACT) Limited
42 Macquarie St Barton
(PO Box 560, Curtin ACT 2605)
**Editorial:**
Peter Somerville
Ph 6270 5410 Fax 6273 0455
execofficer@ama-act.com.au
**Typesetting:**
Design Graphix
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**Editorial Committee:**
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**Advertising:**
Ph 6270 5410, Fax 6273 0455
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**Articles:**
Copy is preferred by email to execofficer@ama-act.com.au in "Microsoft Word" or RTF format, (not PDF) with graphics in TIFF, EPS or JPEG format.
Next edition of Canberra Doctor – July 2017.