Canberra DOCTOR
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In the sixth in a series on Canberra's hospitals, we visit the private sector and Barton Private Hospital – "A unique model of care in 5 star accommodation"

Centrally located near the Parliamentary Triangle in Canberra, Barton Private Hospital is a part of a new approach – the Barton Medical Precinct.

The precinct contains the Barton Private Hospital, Barton General Practice, Barton Pharmacy, Capital Pathology, Sports Care Physio, Capital Eye Optometrist, a dental clinic, a fertility and gynaecology clinic, a plastic and reconstructive surgery clinic, a cosmetic clinic, a hearing clinic and the Barton Specialist Centre.

Previously known as Capital Day Surgical Centre, Barton Private Hospital (BPH) opened in October 2008, performing over 25,000 operations since that time and close to 4,000 cases in the 2015 financial year. BPH has 55 staff from admission through to discharge ensuring, as BPH CEO, Jessy McGowan says, "high quality care before, during and after surgery."

Quality, of course, is a focus and BPH is licensed by ACT Health authorities and accredited by Global-Mark under the AS/NZs ISO 9001-2008. "We continue to benchmark against 20 other similar health facilities nationally to make sure our services are of the highest standard," Ms McGowan added.

While BPH has recently negotiated new contracts with all private health funds, Jessy McGowan says "It's sometimes overlooked that both insured and non-insured patients can access Barton Private Hospital. While non-insured patients will need to fund their surgery themselves, BPH welcomes inquiries."

The hospital is affiliated with a range of well-respected surgeons from different specialities, "we pride ourselves on delivering excellent customer service to our patients," Ms McGowan says.

"Our surgeons practise in three operating theatres and specialise in a range of surgery: Plastic and Reconstructive Surgery, Orthopaedic surgery, Urology, Fertility/IVF, Pain Management Ophthalmology, Gynaecology, Dentistry, General Surgery, Cosmetic Surgery, Ocular-Plastic Surgery, Vascular Surgery, Periodontal Dental Surgery, and Ear Nose and Throat Surgery".

"Barton Private Hospital actively involves patients in decision making and policy review via its consumer committee. We recently won the 'Healthy Workplace Competition' conducted by the ACT Government. Healthy staff equals happy staff, and this in turn leads to increased productivity and satisfied customers" she says.

The hospital has undergone major changes in the past two years with further new and exciting initiatives planned for the coming months and years. Surgeons can now admit patients to "The MediHotel" offering a new model of care in a 5 star-style accommodation ensuring a nurse to patient ratio of 4:1 and a minimum of 2 nurses on at all times.

Located within the 5 Star Realm Hotel, rooms are individual, spacious, include an ensuite and often a kitchenette. Meals are provided from the Hotel Realm in-room dining menu and patients who stay overnight can be accompanied by a companion at no extra cost including breakfast and dinner.

…Continued page 8.

Capital Conversations with President, Dr Elizabeth Gallagher

Welcome to the September/October edition Canberra Doctor – but don't worry – there will be two further editions before the end of the year! On behalf of myself, my board and AMA members I welcome our new CEO Peter Somerville who started in the role on 14th September to what must have at times seemed like a baptism of fire. One of his first jobs was to get this edition of Canberra Doctor together as well as trying to get a grip on all the other roles the CEO of AMA-ACT must play.

The failure to launch the VMO contract negotiations was also one of the first things we had to brief him on. The negotiation period was supposed to start with fortnightly meetings between the VMOA, AMA-ACT and ACT Health from the 12th August to 6th November. Although the first meeting was held on 7 October, after ACT Health and the VMOA resolved their differences, we will now only have 3 meetings before the end of the bargaining period. Any unresolved issues at that point will be sent for arbitration in February.

One thing the delay has done is to give me time to reflect, and while my reflections may be controversial to some, it seems to me that, in the end, we are all on the same side. That is, we as doctors and ACT Health need to work together to provide quality health care to the Canberra population. We do not need to be constantly battling as I sometimes feel we are, but looking at mutually beneficial ways to provide the environment to look after patients to the best of our ability at a time when budgets are getting tighter. This will require give and take on both sides.

On another important matter for our members who are Doctors-in-Training and Salaried Staff, we continue to wait for the decision of Fair Work Australia on "scope orders" that would result in the proposed enterprise agreement to be split between juniors and seniors. I am hopeful that a decision will be handed down shortly as members have been waiting for almost six months.

Things have remained relatively quiet on the home front without a CEO, but I now look forward to stepping up the pace and restarting dialogues with our local health community and government. I will therefore just mention some issues that have been floating around recently.

The ACT government has released a discussion paper seeking submissions from key stake holders about the ACT Pharmacist Vaccination Program. They are proposing to change the Medicines, Poisons and Therapeutic Goods Regulation 2008 to allow community pharmacists to administer a vaccine without a prescription. Initially they are proposing seasonal flu vaccine, and the vaccines they administered would not be subsidised under the National Immunisation Program. Therefore I assume those high risk groups who qualify for the free vaccine would still have to see their doctors. The biggest concern of the AMA is of "role substitution" where there is a risk is fragmentation of care undermining the central role of the Family GP in providing holistic and co-ordinated care. As the Flu vaccine is now offered to Public Servants at work and Health workers in Hospital, and usually administered by nurses, I cannot see a good argument against Fluvax as long as all the appropriate training, backup and reporting is undertaken, but we need to watch where else this may lead. I recently spoke in the media to criticise the announcement of the availability of pharmacy testing for Coeliac disease. This was one example of how care could get fragmented if the family GP is excluded. A screening test without pre-test counselling, proper medical assessment and follow-up could lead to missed diagnoses, misdiagnosis and inappropriate interventions and self treatment. The Primary Health Network is making a submission, and we will do likewise.

Changes to general practice training are still not finalised, but are starting to take shape. Since my last column I have been informed by the Department of Health that Queanbeyan has now been brought into the same area as Canberra which is very sensible. However, this still excludes the Far South Coast where the ANU and ACT Health have strong ties both in terms of education and training and also patient flows. The tenders have not been officially announced but it looks like NSW may have a whole of state provider which, if appropriately managed, may allow more freedom across the nominal boundaries. Given that the provider is Sydney based, it seems to me that the most important consideration is that it does not end up Sydney-centric. This is a space to watch.

At a Federal level, earlier in the year, government changes to primary healthcare was the major focus, the MBS review is now in the spotlight. Earlier in August, the AMA hosted a meeting of more than 60 leaders from across all medical specialties to discuss the medical profession's participation in the Governments' Medicare Benefits Schedule (MBS) reviews. At a doorstep press conference on the day, Brian Owler made the following statement: "The AMA supports having a schedule that allows patients access to modern medical procedures, and reflects the modern-day treatments that are provided in our hospital system, both in the public and private sectors. The MBS review does have the potential, however, to run off the rails if it becomes a cost-cutting exercise. We need to make sure that the Government continues to work with clinicians, that this is a clinician-led process that is based on evidence, and that the process is held in conjunction with the colleges and specialist societies where the knowledge base and expertise lies. We also need to make sure that we can have the ability to put new procedures, new treatments on the schedule. This should not just be about taking procedures off."

Quite a media fight developed between Minister Susan Ley and the AMA over their opinion that as the process moves forward it is turning into a cost cutting exercise with criticism of the medical profession for ordering "un-necessary tests or doing unnecessary procedures" as justification. And there still appears no scope for adding new more modern procedures to the schedule during the review. Again, watch this space.

Finally, I was sad to hear of the passing of Dr Keith Barnes AM. He was one of our life members, and had been a member of the AMA since 1953. I wish to pass on our sincere condolences to his family from the whole of AMA-ACT.

Best wishes to you all,
Liz Gallagher

Bullying and harassment: TCH review and RACS expert advisory group

On 8 October, ACT Health released the long awaited KPMG review into the clinical training culture and incidents of bullying and harassment at the Canberra Hospital.

The Review, while not aimed at investigating specific instances of inappropriate behaviour, nevertheless revealed some sobering statistics – 76% of written submissions either reported observing bullying, harassment or sexual discrimination or believed the culture condoned or accepted it, 52% rated compliance with local policies as poor or very poor and the vast majority of contributors rated the TCH strategy to resolve bullying as not very effective or not effective at all.

Of course, given the ongoing national focus and feedback on bullying, sexual harassment and discrimination in the workplace, these statistics are entirely consistent with the national picture.

AMA ACT welcomed the release of the review and, while we know that discrimination, bullying, and harassment are prevalent across the whole of society, it's unsettling to realise it's happening so close to home.

While the problem is much broader than the TCH, the medical profession needs to take the lead in ensuring that speciality trainees – and other medical colleagues – can practise without being faced by this type of unacceptable behaviour.

The review itself is a wake-up call for ACT Health in that it identifies four factors that have led to the Canberra Hospital accepting or condoning such behaviour at Canberra Hospital:

- Lack of demonstrable leadership
- Acceptance of the behaviour over time – "we survived it so should you".
- Low level understanding of bullying, harassment and discrimination policies.
- Little or no faith in the processes to resolve these issues or that the Canberra Hospital was serious about doing so.

There is currently a perception that making a complaint can have serious consequences for a trainee's career and that the person complained about will face little or no penalty. That perception must be removed.

Given the nature of specialty training, we also need to make sure there's close co-operation between TCH and speciality colleges. It can be very confusing for trainees when both their college and their employer have policies and procedures in identifying who to turn to in attempting to sort out the problem.

AMA ACT believes that the complaints process also needs to have senior people involved who have the capacity to make decisions so people are confident they can get an outcome.

While AMA ACT welcomes the Review's recommendations for further education and training, we really need to move to some concrete actions. Although the authors of the KPMG Review and Health Minister Simon Corbell seem to believe that the problem can be solved internally, we need to move beyond that to include the major stakeholders.

There's no doubt that effectively addressing these issues

requires a strong collaboration between ACT Health, ACT AMA, the colleges and unions. In addition, it also seems sensible to extend the process to include Calvary Hospital as they are a significant employer of medical staff in the ACT.

Indeed, this is the process already underway in NSW where the NSW Ministry of Health has already decided to pursue a number of initiatives in this area, working with relevant stakeholders including AMA NSW, the Australian Salaried Medical Officers Federation, Colleges and Junior Medical Officer representatives.

With strong leadership from the NSW Secretary of the Ministry of Health (equivalent to the ACT Director General), there appears to be a willingness to review existing policies, improve education, and strengthen complaints processes so that they are seen as being more accessible and independent – with the capacity to properly address allegations that come forward.

For the ACT, the only effective way is to include all parties in fixing the problem, possibly using the same model as NSW, and AMA ACT has written to Minister Corbell seeking precisely this.

The Review can be accessed on ACT Health website www.health.act.gov.au

RACS Expert Advisory Group

The KPMG Review comes at an important time with the Royal Australasian College of Surgeons ('RACS') Expert Advisory Group ('EAG') releasing its final report on discrimination, bullying and sexual harassment. While expressing its shock at what it had heard, the EAG determined that the "time for action has come." and that the "College must be bold."

The EAG then laid out its recommendations dealing with cultural change and leadership, surgical education and complaints.

…Continued page 4.

Bullying and harassment …*continued*

…From page 3.

Cultural change and leadership

With the active support of all Fellows, the College and Specialty Societies can lead the way to a future in which there is no place for discrimination, bullying and sexual harassment in the practice of surgery. This will take courage, resources and a commitment to change. It will take enforcing the law and imposing sanctions as needed. It will take the College showing how to prevent and address discrimination, bullying and sexual harassment and how to hold people to account for their behaviour, working with the medical profession, employers and the healthcare sector more widely.

Effective partnerships will be essential. It will take witnesses ending their silence and speaking out. To achieve the necessary fundamental cultural change, the College must also shine the light of independent scrutiny and greater transparency on its own assumptions and approaches. Critical self-reflection, fearless questioning of old habits and inherited practices, and a looser grip on tradition will be needed to shift the status quo.

The risk to patient safety from discrimination, bullying and sexual harassment must be top of mind.

Surgical education

Surgical education needs to improve. Bullying, intimidation and harassment are not acceptable approaches to educating adults. Profound changes to surgical education are therefore needed to address and prevent discrimination, bullying and sexual harassment in the practice of surgery. All students learn best when they feel safe and supported.

Surgical education at all levels needs to be reconfigured on the principles of respect, transparency and broad professional excellence. In surgical education, the College and Specialty Societies must foster, ensure and celebrate excellence in teaching and a broad understanding of professionalism, as well as technical skill.

Independent oversight, individual and collective accountability for professional behaviour and external scrutiny at all levels are needed.

Complaints management

There needs to be a fundamental change in the management of complaints about discrimination, bullying and sexual harassment in the practice of surgery. Independent scrutiny in complaints processes at all levels is non-negotiable, if trust and confidence is to replace fear of retribution and silence. There must be processes that are transparent, robust and fair. They must enable people to raise concerns without fear of victimisation and deal with both the causes and the effects of discrimination, bullying and sexual harassment. Lodgement of complaints must be centralised across the College and independent oversight maintained.

Consistent policies and agreed standards of behaviour are needed across the practice of surgery. Knowledge must be shared by those responsible for dealing with the issues, with information exchanged between the College, Specialty Societies and employers. The College must hold individuals to account against its own standards, leading the way and supporting employers to follow suit.

Of course, as with the KPMG review in the ACT, the proof will really lie in how well these proposals are turned into reality in the workplace and how that flows through to a change in the culture.

70% of ED patients wait more than 8 hours to be transferred

Research undertaken earlier this year at the Canberra Hospital found that older patients who wait more than four hours to be transferred to a bed in the main body of the hospital are 51% more likely to die than patients who waited less than four hours.

In a follow up survey, from the Australasian College for Emergency Medicine (ACEM) it was found that 70% of patients in Australian emergency departments are waiting over eight hours to be moved to a hospital bed after receiving emergency care.

The survey – which covered all 121 Australian emergency departments accredited by ACEM – paints a stark picture of a hospital system at breaking point.

"These figures are consistent with surveys we've collected over the past five years which show that too many patients are waiting too long to receive the proper care," said Associate Professor Drew Richardson, who conducted the study, "They reflect a hospital system that is critically overburdened and that is putting patients into the firing line."

Over half of the hospitals surveyed reported that they had at least one patient who had been waiting for a bed for more than 12 hours, the point at which the NHS in the UK requires a report to the Minister.

"A statistic like that should be sending an alarm bell to healthcare authorities across the country," said Associate Professor Richardson, "It's completely unacceptable."

Longer stays in the ED are associated with poorer health outcomes, especially among older patients.

"Figures like this bear out the day-to-day experience of many emergency medicine doctors, which is that our hospitals nationwide are overburdened," said Dr Anthony Cross, President of ACEM, "This leads to increasing staff stress and burn-out. However, the worst aspect of this is that patients are being put at risk and that is not acceptable."

CORBELL: ACT spending more on mental health

The ACT Government is looking after the mental wellbeing of Canberrans with above-average investment in mental health in the territory, Minister for Health Simon Corbell recently announced.

This financial year the ACT is investing 9% of its $1.5 billion health budget on mental health. According to Australians for Mental Health just 7% of health spending nationally is on mental health.

"The ACT Government is taking the responsibility of looking after the mental health of Canberrans seriously," Mr Corbell said.

"The $133 million dollar investment the ACT Government is making in mental health this financial year, represents an increase of $26.1 million over the past four years."

"Mental health is one of our priority areas as a government.

As part of this year's mental health spend, the ACT Government has provided targeted funding in the acute and community services that complement investment in new and improved mental health facilities through the government's $900 million Health Infrastructure Program."

Minister Corbell explained that further services for mental health consumers would also be included as part of the ED expansion at Canberra Hospital and the Adult Mental Health Unit, opened in 2012, will provide specialised care and treatment for people with mental illness who need short-term intensive therapy where less restrictive options aren't suitable or available.

"And soon these important facilities will be complemented by significant new mental health facilities for the territory in the new Secure Mental Health Unit at Symonston, which is currently under construction, and the new University of Canberra Public Hospital, which will provide residential rehabilitation treatment services to assist mental health consumers recover and transition back into the community."

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Aussie women turn blind eye to cancer risk

A new national survey points to a surprising number of Australian women still living in the dark about their personal breast cancer risk. While almost two-in-three women know someone diagnosed with breast cancer, a mere 23% admit to undertaking adequate self-detection steps, and just under half with an immediate family member diagnosed is unaware of their heightened risk.

The findings are concerning, as having an immediate blood relative (mother, sister, daughter) with breast cancer not only doubles a woman's risk but lack of timely detection at an early stage increases the chance of the cancer spreading, which may make it harder to treat and beat.

To help combat the complacency, media personality Tracey Spicer has fronted a new documentary to encourage women to arm themselves with knowledge of their personal health profile and take action. Called Let's Talk About Breasts, the documentary follows Tracey, who confesses to going seven years without a mammogram, on a very personal quest through her own detection experience and showcases a group of her closest friends sharing their deepest fears, hopes and encounters with the disease.

Tracey Spicer notes, "I am on a mission to empower as many women as I can to take action to get to know their breasts and cancer risk.

"I took the bold move to have my 3D mammogram filmed knowing something might be found, but I thought, if there is something ominous lurking then I want to get it early. Thankfully it was clear.

"I think others need to embrace the same mindset. Sharing my experience and talking to other women was a privilege but also an eye opener. The 'it won't happen to me' mentality must stop because complacency is the worst enemy of a woman at high risk," Tracey added.

Cancer is a topic close to Tracey's heart, with one side of her family decimated by the disease, her own breast cancer scare, and dense breast tissue putting her at heightened risk, Tracey, 48, was referred by her doctor for a 3D mammography exam.

While the national breast screening program invites women from the age of 50 to undergo traditional 2D mammograms, accepted as the gold standard in screening, there are limitations for diagnostic testing.

Breast Radiologist at the Royal Women's Hospital in Melbourne, Dr Clair Shadbolt explains, "Breast structures can overlap in a traditional 2D mammogram, which can cause some cancers to be missed or produce 'false alarms' as normal tissue can appear as abnormal. This can lead to unnecessary further testing and increased patient anxiety.

"Whilst screening is the best option for most women, there is a group of women at a higher risk, such as those with a strong family history and women in their 40s with dense breasts, who may benefit from a diagnostic test such as a 3D mammogram. It's important high risk women know their options for the most beneficial detection method for their situation. My advice to women is to talk to your doctor to determine your risk level and the most appropriate course of action," said Dr Shadbolt.

Although survival rates continue to improve, now 96% at 5 years, the fact remains that breast cancer is still a harsh reality faced by many women and their families and vigilance is vital. And while women may know that the initial steps to breast cancer detection are three-fold; physical exams, screening and diagnostic mammography for those at high risk, many are failing at the first hurdle. Close to 8-in-10 are not regularly performing self-checks as recommended.

Barton Private Hospital – "A unique model of care in 5 star accommodation"…*continued*

…From page 1.

Patients who are not residents in the ACT often have a family member with them so the additional accommodation is often very welcome. Barton Private Hospital provides this service in addition to any contribution from health funds to ensure that the post-operative experience is first-rate.

CEO Jessy McGowan also explained that "we are working closely with our surgeons and medical imaging to broaden our scope of practice. Two new procedures can now be performed exclusively at Barton Private Hospital: an innovative laser technique for prostate surgery and fusion biopsy."

"The purchasing of new equipment and instruments to meet the need of our surgeons has allowed us to introduce the new laser technique for prostate surgery. It delivers side-firing high temperatures quickly and efficiently. The advantages to the patients are that it can be used even with those patients on anticoagulants. There needs to be no change of medications. The laser simply vaporises the tissue so there is no need for removal of tissues or risk of obstruction. There is no bleeding afterwards as it seals the vessels as it goes" she said.

"This is another reason why I'm proud to lead such a committed team. And why I'm also proud to be associated with the high calibre surgeons, physicians, anaesthetists, surgical assistants and others who work at Barton Private Hospital"

Ms McGowan also extended an invitation for new – or existing – surgeons in the Greater Canberra area to contact her if they'd like to inspect the hospital and ward.

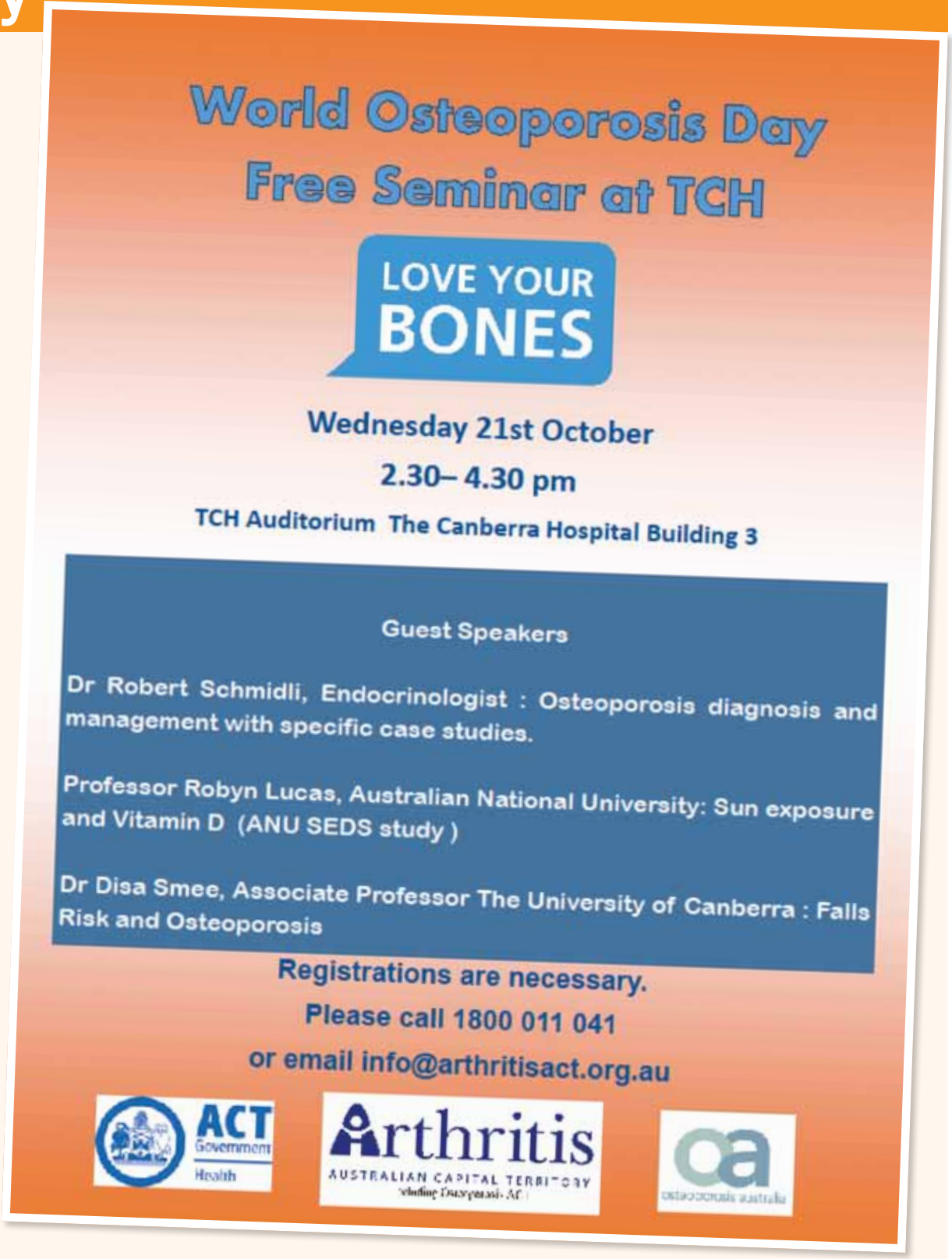
"Feel free to call me 02 61528980 or send an email to jessy.mcgowan@bartonprivate.com.au. I'll look forward to the opportunity to show you our hospital and why we are so proud of welcoming you and your patients."

World Osteoporosis Day

1.2 million Australians are affected by osteoporosis, which means that their bones are fragile and at risk of fracture. A further 5.4 million people have low bone density (osteopenia), a possible precursor to osteoporosis.

Osteoporosis is largely preventable. Targeted health interventions now could drastically curb the incidence of osteoporosis and fracture morbidity, which currently stands at a fracture every eight minutes and increasing. One woman in two, and one man in three, over 60 will suffer a bone fracture because of osteoporosis. The most common fracture is the hip and one in two people will require long term nursing care as a result. One in five will die from complications within 12 months of fracturing their hip. By 2020 one in three hospital beds will be taken up by people with osteoporosis. The cost of osteoporosis to the community is estimated at $2 billion per annum in health costs.

Arthritis ACT (Including Osteoporosis ACT) are holding a free seminar to mark World Osteoporosis Day on 21 October 2015. Please see the flyer attached for details, and Love Your Bones.



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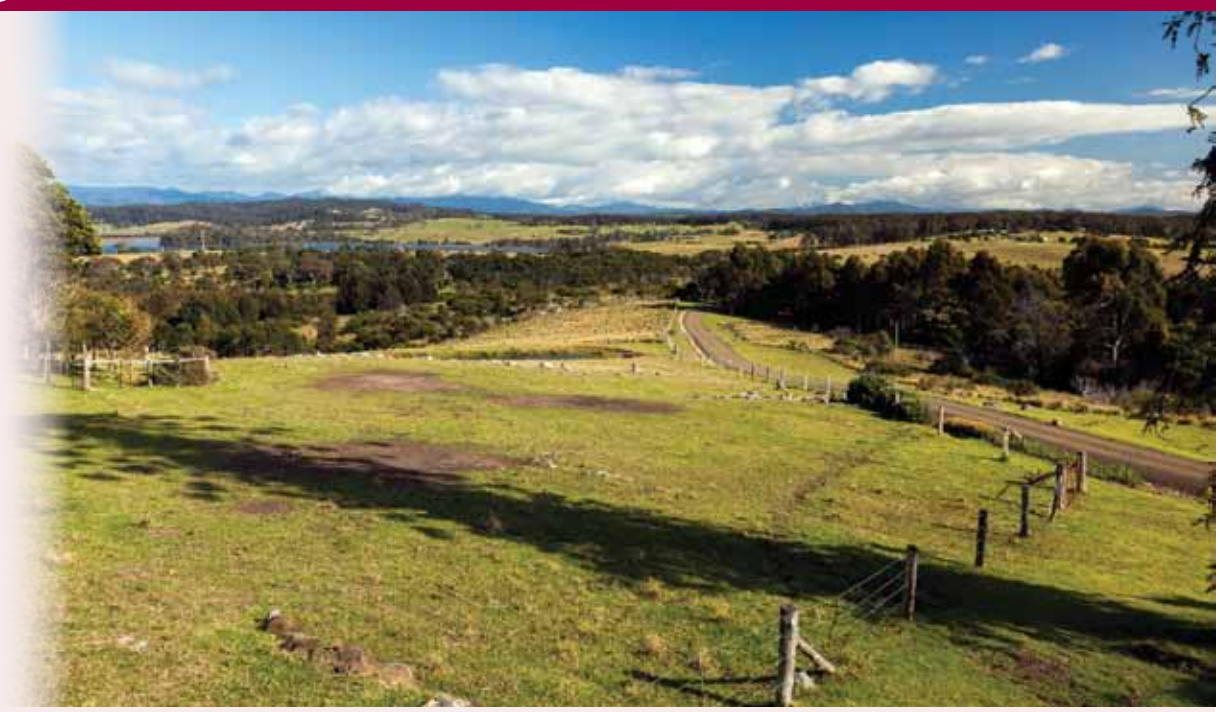
OPINION:
A further step in fixing the rural workforce crisis*

By Flt Lt Shaun Vaughn, ANU Medical Student

Australia is currently facing severe shortages in the rural medical workforce. The shortage of medical professionals in Australia's remote regions contribute to the poorer health outcomes and higher out-of-pocket expenses that remote populations experience when compared with major cities.



To address this issue, the Australian Government has developed an increasing series of monetary incentives and return-of-service initiatives for Australian-Trained Doctors (ATDs). These initiatives have failed to attract appropriate numbers of ATDs, and growth in rural employment has been almost exclusively due to return-of-service obligations on International Medical Graduates (IMGs).

Research has shown beyond doubt that retention rates positively correlate with rural exposure; however, only 21.7% of ATDs are bonded to regional areas. Despite this, the Australian Medical Association (AMA) and Australian Medical Student Association (AMSA) continue to push for greater monetary incentives and the relaxation of rural return-of-service initiatives for ATDs.

Ethical Considerations – IMGs

The primary Government initiative to reduce rural workforce shortages is to utilise International Medical Graduates (IMGs). In accordance with relevant legislation, IMGs are only eligible for a Medicare provider number if they work in areas of workforce shortage for a period of 10 years. In my view the Australian Government's reliance on IMGs is unethical for two main reasons. Firstly, approximately 40 per cent of the doctors are sourced from countries of lower economic ranking. This means that Australia is guilty of promoting global health inequity by removing qualified doctors from less-developed countries in order to reduce local health capability gaps.

Secondly, immigrating IMGs have yet to incur a debt to Australian society through cost associated with education, healthcare and other forms of social welfare. In comparison to IMGs, local graduates cost the Government $85,000 per year to train, of which only $10,000 is billed to the student under the Higher Education Contribution Scheme. This brings the total government contribution over the minimum 7-year degree in excess of $300,000 before taking into consideration the cost of pre-vocational training.

Universities, in conjunction with the Government, have a responsibility to train individuals to meet existing and predicted workforce requirements. It is therefore reasonable for the government to obtain a return on its investment in order to meet the needs of the rural community. In addition, due to the disproportionate investment in ATDs in comparison to IMGs, it would is reasonable for local graduates to carry the burden of Australia's rural return-of-service commitment.

Further Ethical Considerations – Autonomy

The expansion of return-of-service obligations for ATDs may potentially breach medical students' autonomy – an ethical and human rights concern of very real concern. In my view, however, autonomy could be maintained if the obligations do not impose unreasonable control over the individual. One means of doing this is to reduce the term of obligation for all medical graduates, an achievable goal considering the increased number of obligated individuals.

AMSA has raised concerns that current arrangements are coercive as they divide applicants into tiers with different entry requirements. This concern would disappear if all students were subject to the same obligation.

Civil Conscription?

Section 51(xxiiiA) of the Australian Constitution gives the government the power to make laws with respect to the provision of medical services; however, not so as to authorise any form of civil conscription. In general terms, 'civil conscription' can be thought of as any law that requires the medical provider "to work for the federal government or any specified State, agency or private industrial employer" but not those laws that regulate the manner in which work is undertaken.

The expansion of return-of-service initiatives for ATDs could be structured to avoid the civil conscription problem if individuals were required to work in rural regions, but not for a particular employer. This implementation is similar to current arrangements for medical internships and current return-of-service initiatives.

Conclusion

Remote regions will continue to experience health inequity for the near future due, inter alia, to the governments' failure to attract sufficient ATDs to rural and remote regions. The expansion of return-of-service obligations to include more, if not all of, ATDs should be considered to supplement current initiatives in an effort to bolster the rural workforce.

** This is an edited version of a paper submitted to the Canberra Doctor. A full version with references is available by contacting AMA (ACT) Limited.*

A career in Psychiatry – worth looking at again

Recently, the Canberra Doctor was contacted by (Dr) Tania Mathewson whose husband, Dr Paul Maguire had recently received his PhD (Medical Science). Prior to completing his PhD, Paul had worked for thirteen years as a GP in the community.

Tania's view was simple "there is no doubt in my mind that curiosity can be a catalyst for life-long learning. The thesis research project, pandemic influenza in people with schizophrenia, arose out of his interest in, and commitment to, improving the physical health of people with a mental illness. This focus was generated by him pursuing a career in clinical and academic psychiatry".

In Paul's case, an interest in psychiatry saw him change careers at a point where other people might have been more concerned with planning for older children and even retirement. While Paul's interest in academic and clinical psychiatry has seen him take one path, the Royal Australian and New Zealand College of Psychiatry (RANZCP) has been following another path. The RANZCP has started the 'Psychiatry Interest Forum' to both actively promote a career in psychiatry and to combat a projected shortage of psychiatrists.

A recent article in the Fairfax press saw Dr Margaret Aimer, the chair of the education committee of the RANZCP, talking about the general view of psychiatrists listening to a Woody-Allen-style depressive neurotic talk through his issues and how even some medical students and young medical graduates share this mistaken view. "They view it as more 'nebulous' and not as scientific as other specialities," says the expert on old age psychiatry.

This misapprehension, coupled with the fact that psychiatry is not as lucrative as other specialities has made it less popular than surgery or anaesthetics. In fact, according to a Griffith University survey, medical students, asked to rank specialities by "prestige", voted psychiatry 12th, just above "rural medicine". "Public health" came in at 19.

As a result, the College started the Psychiatry Interest Forum in 2013, both to actively promote a career in psychiatry to medical graduates and junior doctors and to combat a projected shortage of psychiatrists, especially in such "growth" areas as geriatric care and child and adolescent psychiatry, as well as in rural and regional areas, where psychiatrists are already in short supply.

Last year 224 new trainees joined the RANZCP training programs across Australia and New Zealand, the largest number since the College was established in 1963 when there were fewer than 10.

Every year since 2011 around 140 trainees have passed their final assessments and obtained "fellowship" of the College of Psychiatrists. After the year 2020, the number of new fellows joining each year should rise to 200.

There have been significant changes to the practice of psychiatry since 1994, when Dr Aimer completed her training.

These days, she says, there is more emphasis on involving patients and carers, less of the "the doctor is God" approach, and more integration of psychiatry with the work of GPs and other health professionals.

National Complex Needs Conference

The Public Health Association of Australia – in conjunction with the National Complex Needs Alliance – is holding the Second National Complex Needs Conference in Canberra

This will be the second Australian conference to showcase successful programs/approaches in addressing complex needs – with the broader purpose of identifying what works and how. The first conference in 2013 was a huge success – leading to the establishment of the National Complex Need Association.

For further information:

https://phaa.eventsair.com/QuickEventWebsitePortal/second-national-complex-needs-conference/2ncncwebsite

NATIONAL COMPLEX NEEDS ALLIANCE

Public Health Association AUSTRALIA

Clinical case study

Dynamic renography using Technetium (Tc) – 99m DTPA (Diethylene-triamine-pentaacetic acid) or MAG3 (Mercapto-acetyl-triglycine) is a nuclear medicine study performed for a wide range of indications including urinary tract obstruction, renovascular hypertension and renal transplant functional assessment. Assessment and exclusion of functional obstruction in a dilated collecting system is a common indication for the test.

The study is usually acquired in 2 parts (or 3 parts for a diuretic renography). Renal blood flow is assessed in the first pass of the radio-tracer bolus to the kidney. Over the subsequent 20 minutes, uptake and clearance (both excretion and drainage) are assessed. Finally, if on the initial images, the collecting system is dilated and clearance is poor, frusemide is given and a further 20 minutes of imaging is performed to exclude a true obstruction (eg. Pelvi-ureteric junction obstruction) as opposed to a capacious or hypotonic renal pelvis.

For the study, being well hydrated is a key factor. While blood flow and cortical uptake are not affected, excretion and drainage can be delayed by dehydration, simulating obstruction or poor function. All patients therefore will be orally hydrated with 300-500mls of water 1 hour prior to the examination. Bladder will also be emptied prior to injection, to relieve retrograde pressure.

The resultant time-activity curve (TAC) or renogram (Fig. 1) that is produced represents a summation of uptake and excretion or a convolution of the input function (renal arterial supply) and the impulse response (the renal function). The TAC must be interpreted in conjunction with the images because the curves may be affected by many factors, such as retained activity in hydronephrosis, which can alter the slope.

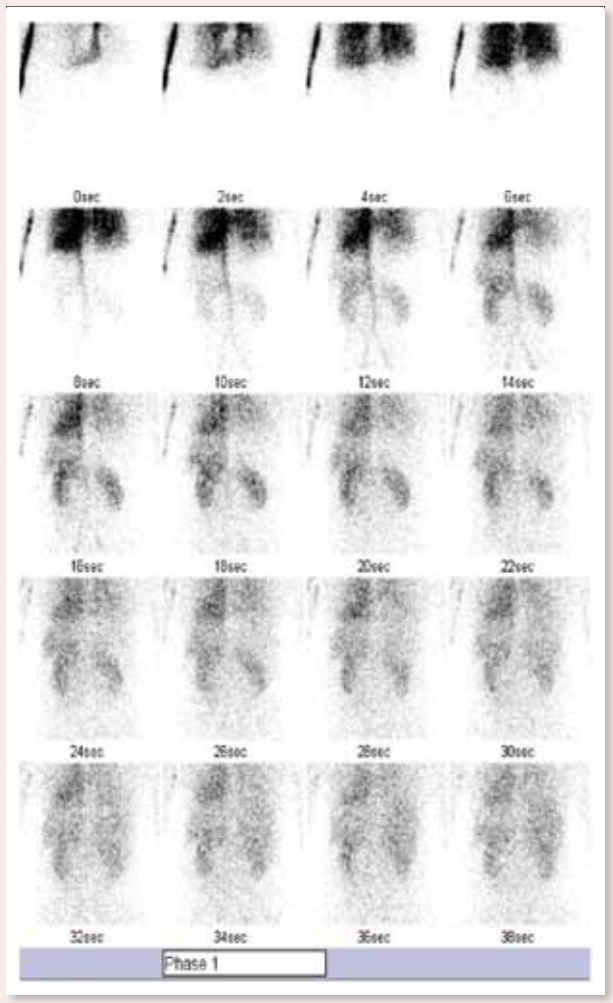


Fig 2: Blood flow

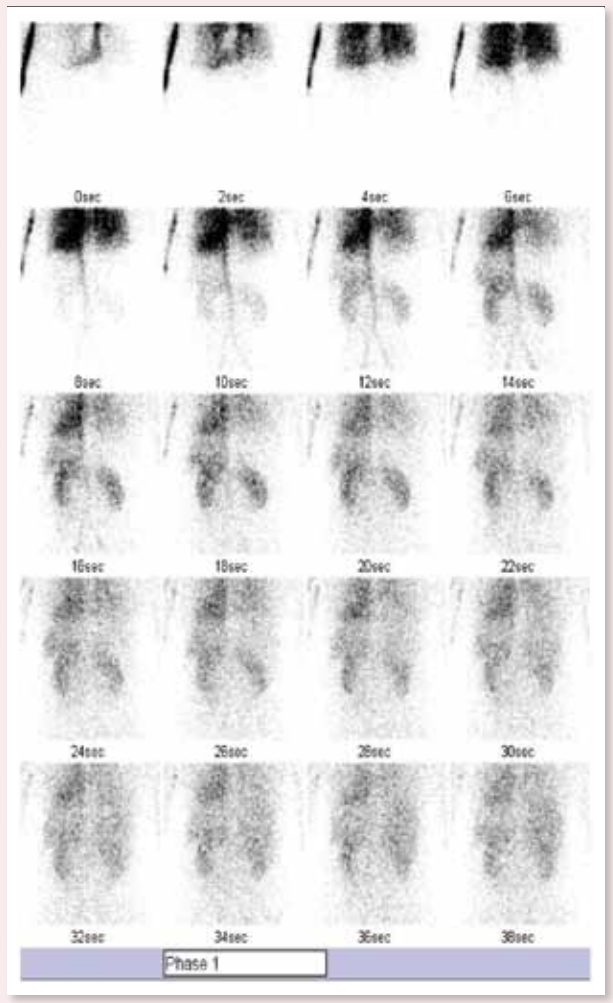


Fig 3: Nephrographic phase

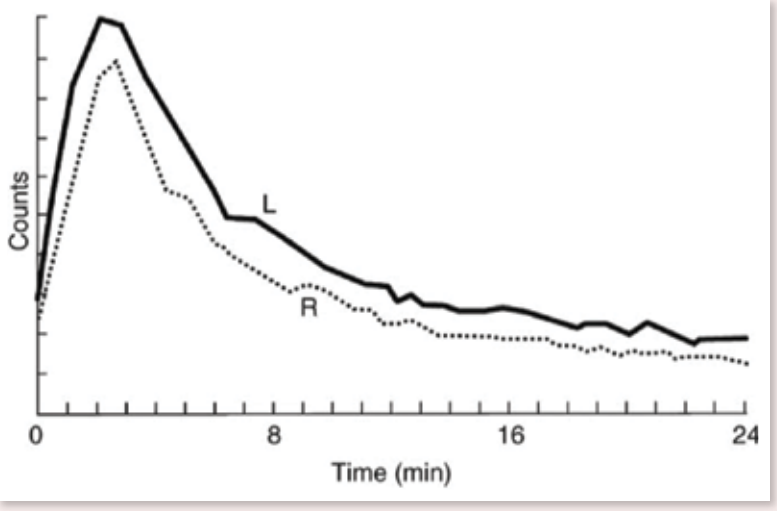
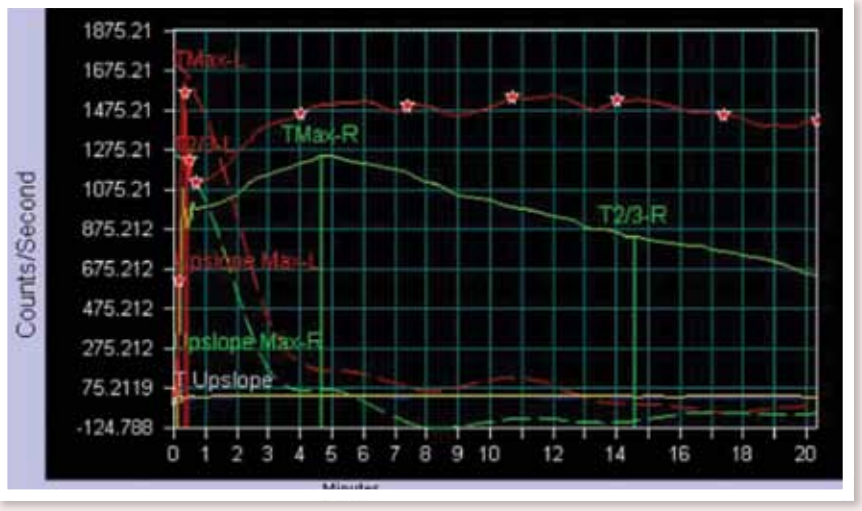


Fig: 1 Normal Renogram

Here is a patient with a left dilated system with normal perfusion and uptake on the blood flow (Fig. 2) and nephrographic phase (Fig. 3) of the study. The renogram of the left kidney (red line) has an obstructive pattern, steadily increasing compared to the normal right (green line) kidney. The function of both kidneys are normal, as demonstrated by the normal cortical uptake and arterial flow bilaterally.



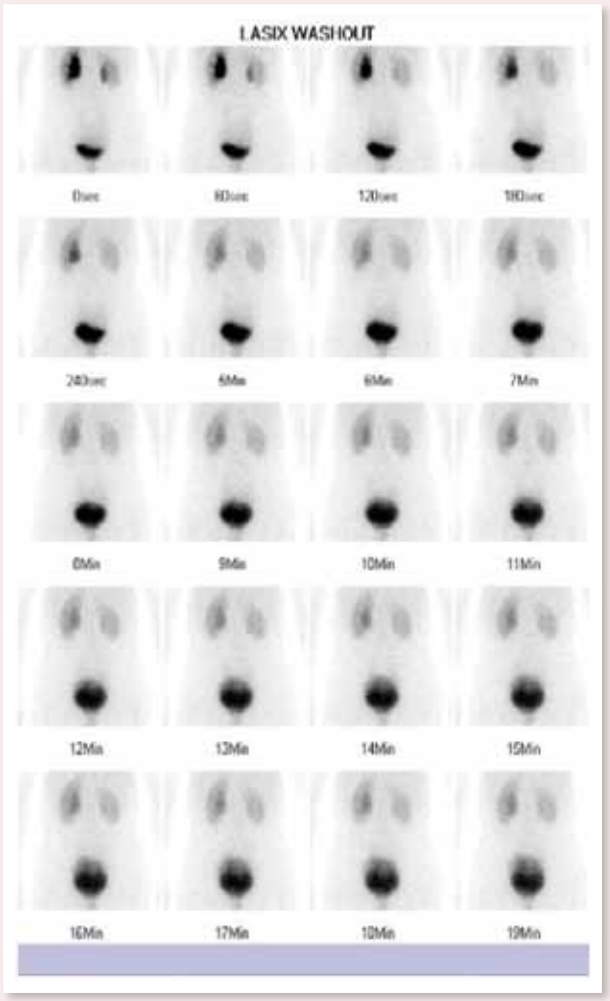
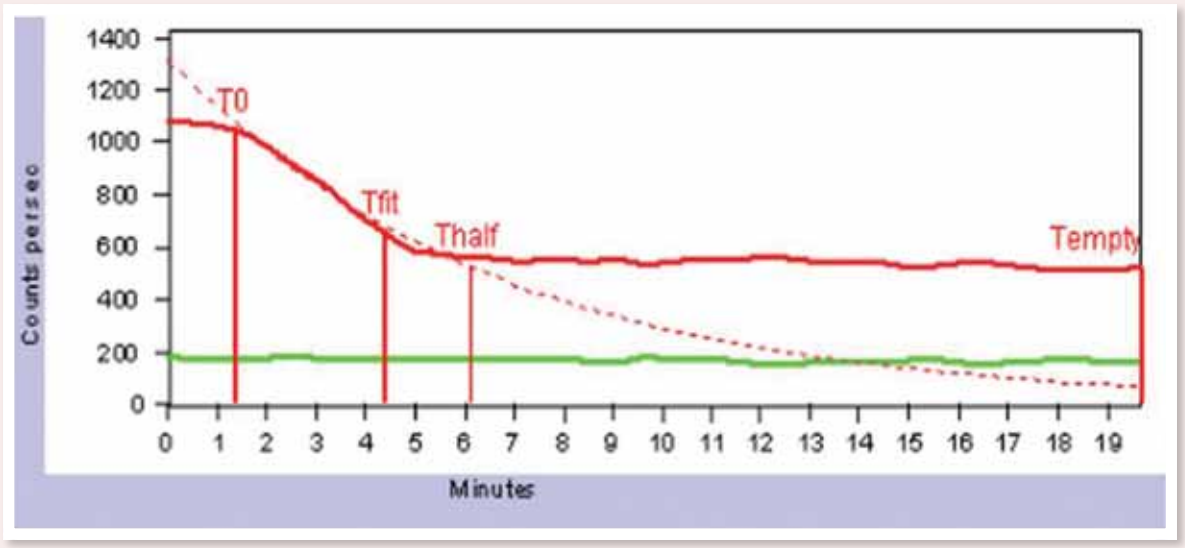


Fig 4: Post Lasix

Post Lasix (40mg IV), there is prompt drainage of the radiotracer from the dilated left renal pelvis, excluding any functional obstruction (Fig 4).

Fig 5: Lasix emptying curve

Lasix emptying curve (Fig. 5) with T ½ of 5 minutes (normal less than 10 minutes) of the left kidney, which effectively excludes any obstruction.



VALE

The President, Dr Elizabeth Gallagher, Board members and staff of AMA ACT extend their sincere condolences to the family, friends and colleagues of their late esteemed colleague, **Dr Keith Reginald Barnes AM**.

BOOK REVIEW:
First Fleet Surgeon *by David Hill*

ISBN: 9780642278623
AUD$ 44.99

Although I now use the *psychic* scalpel to cut away unwanted and troublesome material, there was a time in the past when I regularly wielded the metal variety in a range of operations. As such, and combined with an unflagging interest in Australian history, I relished the opportunity to peruse David Hill's account, *First Fleet Surgeon*, of Arthur Bowes Smyth's experiences and observations during his two and a half year voyage from England to Port Jackson and back, in the late 1780s.

David Hill, with previous books such as *The Forgotten Children* and *The Gold Rush*, is no newcomer to portraying riveting aspects of Australian history. Perhaps he even saw a fine parallel thread between himself and Bowes Smyth, as Mr Hill himself was transported from England to Australia in a sailing ship, under the Fairbridge Child Migrant Scheme.

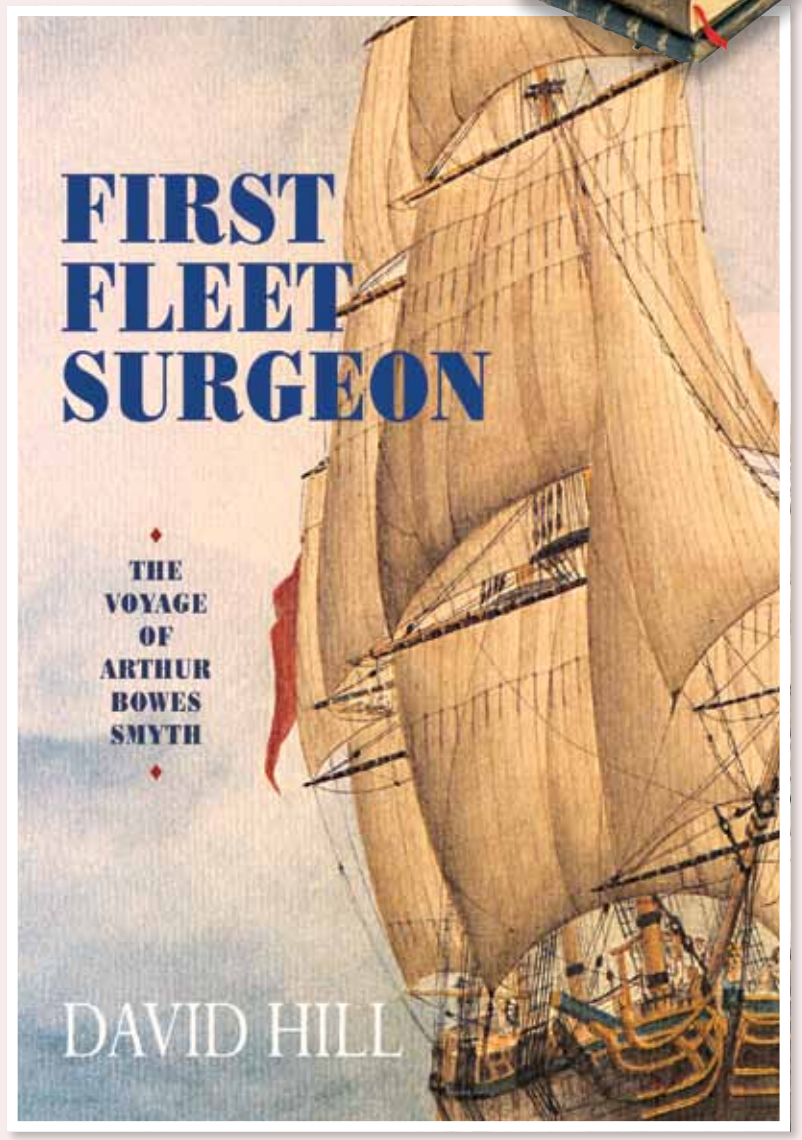
Bowes Smyth, as surgeon to the crew and more than 100 convict women aboard the *Lady Penrhyn* (one of the eleven ships of the First Fleet) provides intelligent and fascinating commentary on a myriad of observations ranging from the avid collection of flying fish (which had landed on the deck) for food, tempestuous storms at sea, a dead whale mistaken for a giant rock in the middle of the ocean, and passengers falling overboard, to the punishment of hapless non-conforming convicts, with thumb screws, floggings with a cat-o'-nine-tails, gagging, and head shaving (female convicts' most dreaded penalty).

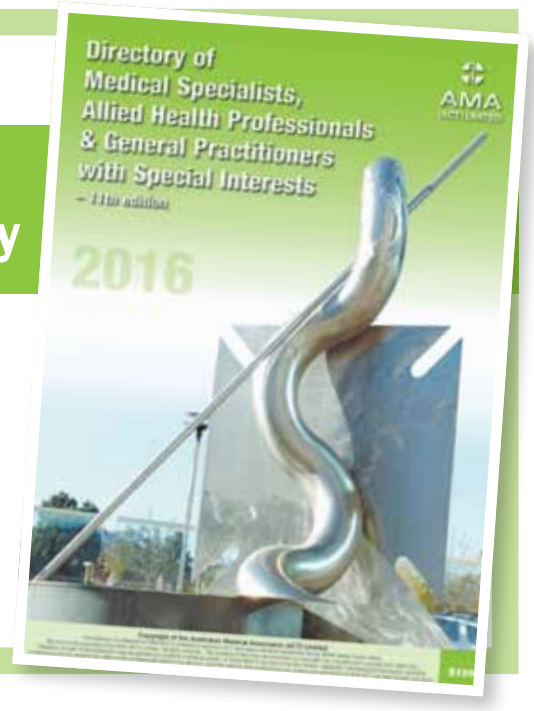
The book contains captivating descriptions of stopovers including Portuguese hospitality at the slave port of Rio de Janeiro, the charm and generosity of inhabitants of the tropical paradise of Tahiti, the intriguing dome-capped monolithic stones of Guam (which reminded Bowes Smyth of the Stonehenge), and the stark remoteness of St Helena, where Napoleon was to eke out his final years.

Not being aligned with government or the military class enabled Bowes Smyth to be extremely candid in his views, including at times proffering stinging critiques of Captain Arthur Phillip's decision-making, such as splitting the fleet into two groups as it approached Australia, to enable his advanced assessment of the coast-line for selection of the best site for settlement. Despite this criticism, Bowes Smyth acknowledges that Phillip's rejection of Botany Bay and his choice of Port Jackson was very sound. He describes Port Jackson as a place of "enchantment" with "singing of the various birds" and the"... most stately trees I ever saw in any nobleman's grounds in England cannot exceed in beauty those which nature now presented to our view."

In addition to the broader social and human contexts, there is an absorbing focus in the book on medical and surgical themes. These include references to the scourge of scurvy (treated by Bowes Smyth with lime juice, fermented cabbage, pulverized cinchona bark, and essence of malt juice), miscarriages and infant deaths at sea, relieving the "excruciating pain" of a woman's fractured leg, venereal disease and the extraction of a "jigger worm" from his own foot, followed by the application of a petroleum bandage (for the doubting reader it should be noted that far from being an antiquated treatment this remedy is congruent with 2009 WHO clinical guidelines). These accounts are supplemented with beautiful and relevant illustrations of contemporary knowledge of anatomy and surgical instruments.

I unhesitatingly recommend *First Fleet Surgeon* to any potential reader who desires vicarious entry into a rich and robust adventure packed full with colourful details and anecdotes in handwritten diary entries and drawings, supplemented by relevant maps, lithographs and paintings. Be prepared for a long night if you embark on this enthralling journey as you may well, like me, find it difficult to put this book down.





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