CANBERRA Doctor

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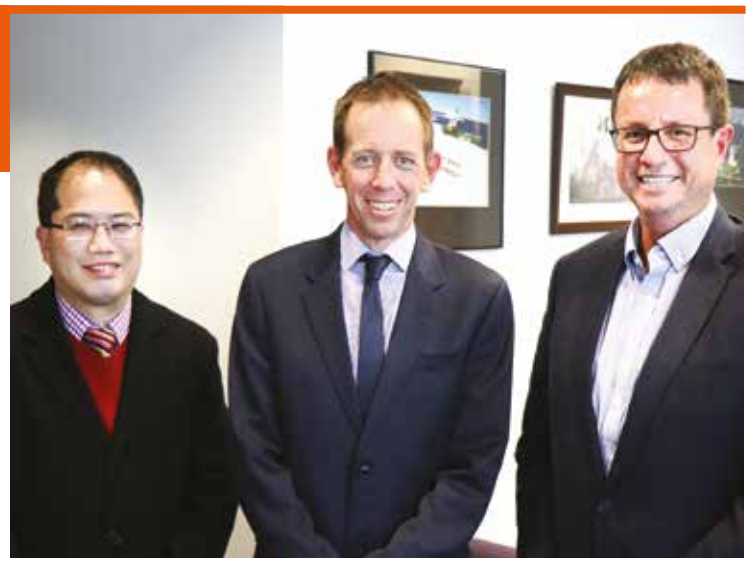
Mental Health front and centre

AMA (ACT) President, Prof Steve Robson and ACT Chair of the Royal Australia and New Zealand College of Psychiatrists, A/Prof Jeff Looi, have met with Mental Health Minister, Shane Rattenbury, to lay out their shared concerns about the state of the psychiatry workforce and other mental health issues in the ACT.



Mental Health Minister, Shane Rattenbury, centre, with the RANZCP's A/Prof Jeff Looi, left, and Prof Steve Robson, AMA (ACT) President.

The meeting was both cordial and constructive, with the Minister listening carefully to the issues raised and demonstrating a willingness to engage. While mental health is a new portfolio brought into existence after the last ACT election at the initiative of the ACT Greens, several other Australian jurisdictions have established specific mental health portfolio responsibilities.

Psychiatric workforce

The major issue raised with the Minister was both the immediate and medium term future of the psychiatric workforce in the ACT.

AMA (ACT) believes there are ongoing and serious difficulties in the ACT's public sector psychiatric workforce. The situation is currently being held together by the use of locums and the considerable goodwill and dedication of local consultants and psychiatric trainees, together with mental health service management.

Away from the immediate crisis, the use of 'Area of Need' appointments and locums continues to be the primary means of dealing with the shorter and medium term issues in public sector psychiatric staff recruitment – a situation AMA (ACT) would like to see rectified.

The private sector workforce, while not in a similar short-term crisis, is still deficient in consultant psychiatrists and particularly so when it comes to the child and adolescent subspecialty. As discussed with the Minister, the lack of local private sector workforce is puzzling given the many attractive features working in Canberra provides to medical practitioners.

Workforce plan needed

While there seems to be little alternative to the public sector's use of Area of Need appointments and locums in the short term, AMA (ACT) believes it should be an urgent priority to draft a comprehensive workforce plan for the combined ACT public and private sector psychiatric workforce, both specialist and trainee. The workforce plan should emphasise recruitment and retention and specifically consider safety, working conditions and incentives to work and remain in the ACT.

It would make sense, given similar work previously undertaken by the RANZCP for the Victorian Government, if the College was involved in the ACT workforce plan, at least in relation to the public sector workforce.

Mental Health Advisory Council

AMA (ACT) and the RANZCP both expressed concern over the lack of either a psychiatrist or GP on the Council. The Minister responded by stating that he recognized the need for suitable input to the Council from medical practitioners.

Further discussions with the Minister are to be held in order to determine how it is – whether through co-opting or other means – input from medical practitioners can be made available to the Council.

Office of Mental Health

The Minister has recently released a 'conversation starter' that seeks the views of stakeholders on the role and function of the new Office of Mental Health. The 'conversation starter' is designed to seek the views of stakeholders on the role and function of the new Officer of Mental Health.

All in all, a constructive meeting with Minister Rattenbury. Now the hard work starts.

Medical **Musings**

WITH PRESIDENT, PROFESSOR STEVE ROBSON

Me and you and ANU

I have had the privilege of working with the ANU Medical School (ANUMS) since its first intake of students. The transition from the old Canberra Clinical School to the ANUMS went well and the standard of medical students we graduate is high. One of the major challenges of opening a new medical school is in the way it integrates with the health services that provide clinical teaching.

Many general practices in Canberra and the region host medical students for their rotations, and many of Canberra's experienced family doctors provide teaching. One of the rewards of a lifetime of clinical practice is being able to mentor our future young doctors, and see them develop from relatively raw recruits into the mature clinicians the community expects.

All medical schools need a strong and mutually beneficial relationship with hospitals. For the ANUMS those relationships are with Canberra Hospital and Calvary Public Hospital in particular. Canberra's medical students also rotate to smaller hospitals in New South Wales, but the primary rotation is with Canberra's own hospitals.

Many of the doctors working across Canberra's public hospitals – including me – have academic positions with the ANUMS. We work to teach medical students on behalf of the ANU, to contribute to research, and take positions in leadership and advocacy for health across the community more generally. This will necessarily mean a division of time between work for ACT Health and the University.

At the moment, a review of that working relationship that has been commissioned by ACT Health is underway. The timeline for the review, what information it seeks, and what outcomes are expected remain, to some extent, unclear. This is a source of concern for many of Canberra's doctors who contribute to clinical and other work in the public system, but also help to nurture the next generation of doctors and to foster research into health.

The AMA (ACT) has been seeking information about the review and where it might lead, including discussions at face-to-face meetings at ACT Health. While detail is short at the moment, as someone who greatly values a close working relationship between the University and ACT's public hospitals, I would be sad to see negative changes. This is something all of us who care about 'town-and-gown' relationships should take a keen interest in.

Mental Health Day

Many of you will be familiar with the creation of the Ministry for Mental Health by the ACT Government. The Minister for Mental Health is Mr Shane Rattenbury, and there's no doubt he is keen to make this a signature initiative of the Government. Along with AMA (ACT) CEO Peter Somerville, and Board member Professor Jeff Looi who was also representing the College of Psychiatrists, we recently met with the Minister.

In the first instance, there is a clear and community-wide recognition that mental health is one of the key issues in health for Canberrans, and indeed all Australians. Because of its importance, mental health needs appropriate resourcing. At the moment, there are major problems with access to mental health services in the ACT. One of the reasons for this situation is the lack of specialist psychiatrists here in Canberra.

I am pleased to report that the meeting with Minister Rattenbury and his senior staff was productive, and the Minister was engaged and willing to address the issues. We spent some time, with Professor Looi leading the discussion, dissecting the difficulties facing families needing mental health care here in Canberra. The talks were frank and forthright.

AMA (ACT) President, Prof Steve Robson with a portrait of Maj Susan Felsche.

I am not sure how things will progress from here – there is a lot of work to be done to reach a standard of access to mental health services that Canberra's families and their doctors need. The AMA (ACT) is committed to working with all concerned to improve access and promote the highest standards of mental health care in the ACT.

...and Military Medicine

By the time you read this, I will have had the honour of laying a wreath in memory of Major Susan Felsche at the War Memorial. Susan was two years ahead of me at Medical School in Queensland, and her loss still is sorely felt. Major Felsche was the first Australian woman to die on an overseas military operation since the Second World War. It serves as a reminder that many of Canberra's doctors are either serving officers or reservists with the Australian Defence Force.

I was a Medical Officer with the Royal Australian Navy, and served in the first Gulf War in HMAS SYDNEY during my period of full time service. It is very remiss of me not to have mentioned our uniformed doctors to date. We should all be very proud of the hard work and dedication of the medical officers of our Defence Forces, and I hope that I will honour the work of all of them when I represent the AMA the wonderful War Memorial.

Major Susan Lee Felsche, Royal Australian Army Medical Corps*

The following story of Maj Felsche life and career was told by Air Vice-Marshall Tracy Smart at the Last Post Ceremony on 14 September 2017.

"Today we remember and pay tribute to Major Susan Lee Felsche.

Susan Lee Stones was born in Brisbane on 24 March 1961. An excellent student, at 17 she began studying medicine at the University of Queensland. Here she pursued her interest in military medicine, and enlisted in the Naval Reserve, rising to the rank of petty officer.

Her family encouraged a strong sense of community service from an early age. In 1983 she joined the army undergraduate scheme, which offered the prospects of challenging and rewarding service for medical officers. Following her graduation in December 1984 Dr Stones spent two years working in remote Queensland before being posted to the 5th Military Hospital at Duntroon in 1987.

The Last Post Ceremony

It was here that she met, and later married, fellow army officer Klaus Felsche. Susan combined a busy military career with part-time study and after hours work in the emergency departments of local hospitals. In 1991, she was promoted to major and became a Fellow of the Royal Australian College of General Practitioners. She was posted to the Directorate General of Army Health Services before being posted as the Medical Officer in Charge of Clinical Services at the 1st Military Hospital at Yeronga. Her commanding officer there described her as "a spirited woman with a great love of life, a doctor protective of her patients and an officer with a shining career ahead of her".

On 17 May 1993, at the age of 32, she deployed as the medical officer to the 4th Australian Staff Contingent to Operation Cedilla, the Australian presence with the United Nations Mission for the Referendum in Western Sahara. The UN Mission involved monitoring the ceasefire between rebel separatists and the Moroccan army, and the identification and registration of voters, largely in refugee camps. The proposed referendum would resolve whether the Western Sahara would become independent or be incorporated as part of Morocco.

Felsche coped admirably with the challenges of living in the Sahara, living in basic conditions and driving through the shifting sands with the ever-present threat of landmines. Her commander noted: "I am yet to meet a more professional and competent doctor in the Army. She was totally dedicated to her profession and the well-being of our contingent." She was attached to the Swiss Medical Unit based in the Western Sahara Capital, Layounne. In June Major Felsche was based in the remote Awsard post, some 800 km from United Nations

Accidentally killed 21 June 1993. Maj Susan Lee Felsche.

Headquarters, and conducted many of her medical visits to the southern team sites by air.

On the morning of 21 June, she boarded the plane for a routine visit to the Dougaj team site with her Swiss and Norwegian UN colleagues. Shortly after take-off the plane veered to the left and the nose dropped; the aircraft cartwheeled into the ground and the spare fuel tanks caught fire. A civilian UN employee saw the crash, extinguished the flames and pulled her free, but she died that morning in the medical treatment room of a Moroccan Army camp. She became the first Australian woman to die on overseas service since the Second World War, and the second Australian soldier to die on a peacekeeping mission.

Her remains were returned to Australia, where she was buried at Cleveland with full military honours following a service at the Trinity Uniting Church, where she had taught Sunday school for 15 years and had been married five years earlier.

The Australian contingent renamed its "Kangaroo Club" canteen the "Major Susan Felsche Bar" in her honour, and on 6 May 1994, shortly before it withdrew from Western Sahara, a remembrance ceremony took place at a memorial dedicated to her and the other crew who had died in the accident.

Each year the Royal Military College awards the Major Susan Lee Felsche Memorial Trust prize to the best RAAMC graduate. She was posthumously awarded the United Nations Dag Hammarskjöld medal.

Her name is listed on the Roll of Honour on my left, along with the names of 102,000 Australians who died serving their country in operations overseas.

This is but one story of the many stories of service and sacrifice told here at the Australian War Memorial. We now remember Major Susan Lee Felsche, who gave her life for us, for our freedoms, and in the hope of a better world."

** information compiled by Miesje de Vogel, Historian, Official History of Peackeeping, Humanitarian and Post-Cold War Operations.*

Prof Steve Robson, representing the AMA, lays a wreath to commemorate Australian Peacekeepers and Maj Susan Felsche, at the Australian War Memorial's Last Post Ceremony.

Making sense of the 'vaginal mesh scandal'

BY STEVE ROBSON

"Pelvic devices developed in Australia from the 1980s and 1990s are at the centre of a global medical scandal that includes regulatory failure, and allegations of research fraud and experimental surgery on women in multiple countries."

Sydney Morning Herald, March 14, 2017

"The biggest medical scandal for Australian women since thalidomide..." was the way Senator Derryn Hinch described the use of vaginal mesh kits by gynaecologists. He implored that the use of mesh be "halted" because it was "crippling people for life."

In Scotland, the use of mesh was banned in 2014 in response to calls from the Scottish Mesh Survivors campaign. The Scottish Health Secretary Shone Robison issued a national apology to women "left in severe pain" by mesh operations.

In New Zealand, the support group *Mesh Down Under* has been vocal in its condemnation of mesh. Member Lyn Blucher told *The Guardian* that her life has been a "living hell" since she underwent vaginal mesh surgery. She has been left with "no control over her bowel or bladder." Ms Blucher said that she was too ashamed to leave her home, had to sell her business, and has been unable to have intercourse for eight years.

More than 700 women have joined a class action, run by Shine Lawyers, against mesh kit manufacturer Johnson&Johnson. A Senate Inquiry into transvaginal mesh is underway in Australia. Most of the popular mesh kits have been withdrawn from the market.

Allegations have been made that Australian women were used as "guinea pigs" and that after the 'experimental surgery' they felt that they were "dying a very slow and agonising death."

The use of vaginal mesh was "one of the greatest ... abuses of mothers in Australia's history," said Senator Hinch in a speech to Parliament.

How on earth has it come to this? And how have Australia's gynaecologists found themselves caught up in such a terrible situation?

A common problem

Pelvic organ prolapse and stress urinary incontinence can be dreadful problems for women and are common. It has been estimated that half of all women will have either symptoms or signs of prolapse after the menopause. Studies suggest that somewhere between 10 and 15% of women in developed countries will undergo surgery for prolapse during their lives.

Most of the 'traditional' surgical treatments for prolapse and incontinence were thought to yield uninspiring results for women.

According to Professor Malcolm Frazer, one of Australia's foremost urogynaecologists, "towards the end of the 1990s, publications appeared that seemed to confirm what now seems set as a dogmatic assertion: all conventional vaginal surgeries for the correction of prolapse have unacceptably high failure rates."

Many gynaecologists had the experience of operating next to general surgeons, and would see mesh used liberally in hernia repair procedures, "the evidence appeared overwhelming that new procedures were required to replace the seemingly dated and unsatisfactory vaginal repairs – and the key to increased durability would be polypropylene mesh," says Professor Frazer.

Prof Steve Robson, RANCOG President.

First things first

Mesh was first introduced in the form of 'tapes' or 'slings' used to treat urinary incontinence. The older operations, most notably the Birch procedure, were notorious for complications. They were also not particularly effective for many women.

The surgical treatment of stress urinary incontinence – placing a tape behind the pubic bones, in the space in front of the bladder, then looping in across the mid-urethra – was a revolution for many gynaecologists. The procedure was relatively easy to master, had few immediate complications, and produced good results. For many women, confidence and continence were restored after years of embarrassing and unpleasant symptoms.

The success of mid-urethral tapes in treating the previously difficult-to-manage problem of stress incontinence inspired many to take up the use of mesh kits as part of their surgical approach to incontinence. With the enthusiastic embrace of mesh kits for prolapse surgery, newer kits were developed and released onto the market.

It is an old maxim in medicine that when there are many treatments for a problem, none of them are perfect. So it was with mesh. In particular, the early 'heavy' meshes were knitted, multifilament, and microporous. All of these qualities made them more likely to harbor infection. The newer mesh kits were lighter, woven, monofilament, and microporous.

Prof Steve Robson appears before Australian Senate Inquiry.

The role of the TGA

The role of the TGA – or Therapeutic Goods Administration – is to regulate medical devices, and ensure they are safe and fit for their intended purpose. Mesh had a long history of safety in general surgery, and there were few barriers to new mesh kits being released onto the market in Australia.

The TGA first approved mesh kits for use in prolapse surgery in 2003, but in retrospect the data used to attest to safety and efficacy were threadbare. According to Dr Chris Maher, a Queensland urogynaecologist and prominent author and mesh researcher, "innovation and patient safety could have been far more closely aligned... if both the TGA and specialists themselves had more thoroughly evaluated transvaginal meshes."

The current situation, with thousands of women suffering mesh complications, represents "a collective failure of both the TGA and specialists," according to Dr Maher. Those are damning words, and during evidence to the Senate Inquiry, TGA officials confirmed that more than 100 mesh devices were cleared for use, but had either cancelled the registration of more than 40 kits and placed conditions of sale on others.

What does it all mean?

Mesh for use vaginally has been around for more than 15 years now with more than 100,000 women having had tapes placed for urinary incontinence and close to 50,000 as part of a prolapse repair. What are the lessons from a story that has played out over a decade-and-a-half, and has led to a Senate Inquiry and wholesale litigation? As I write, another 'implantable' – the *Essure™* device – has been recalled by the TGA in Australia amid worrying claims about its long-term effects. The stakes are very high for Australian women.

In the first instance, it is important to understand *why* mesh became so popular so quickly. Prolapse and urinary incontinence are common and many gynaecologists see women with these problems and try to help them. A sense that the older 'native tissue repairs' and suspension procedures, all using the woman's own tissues and suture material, gave sub-optimal results drove uptake.

For many, the mere fact that an implantable 'mesh kit' had been approved by the TGA brought reassurance. The sheer volume of mesh kits that came onto the market – I got the impression it was impossible to move at a gynaecology conference trade display without bumping into a mesh booth – was soothing as well.

However, by 2007 RANZCOG had released warnings to those who were using mesh. The warnings covered all of the issues that subsequently have come out during the litigation and Senate Inquiry. That women needed to be very carefully assessed before the use of mesh was contemplated, that consent and documentation had to be scrupulous and that training in the use of mesh needed to be good.

The most recent Cochrane Review of mesh for prolapse surgery is blunt – there is little or no evidence that mesh improves outcomes of prolapse surgery over traditional native tissue repair. Indeed, the Cochrane reviewers were so concerned after they reviewed the best available evidence that they recommended **mesh surgery should only be performed as part of a properly-run clinical trial with ethics approval.** This is an extraordinary position for a product that was easily available and heavily marketed.

The situation is, fortunately, different with tapes for urinary incontinence. Even in Scotland, where all mesh was banned, the final report to the Scottish Independent Review was released earlier this year – after an exhaustive investigation process – and among its conclusions:

"In the case of surgical treatment for SUI, a review of the different sources of evidence has led us to recommend that **women must be offered all appropriate treatments (mesh and non-mesh) as well as the information to make informed choices.**"

"No surgical procedure is without risk," says urogynaecologist Professor Malcolm Frazer. "But what is an 'acceptable' risk and what is an 'unacceptable' risk? This is a critical topic and goes to the heart of this discussion. Everything comes at a price."

Fortune favours the lily-livered...

I well remember going to a RANZCOG surgical meeting in 2008 and being berated by a 'mesh expert' that because I didn't use mesh in prolapse surgery, I was a 'late adopter' who was denying women the best treatment. It was a shock to be told this at the time, but I held firm and am very glad that, ultimately, I opted not to use mesh in prolapse surgery.

There was a pervading sense in the media (and social media especially) that 'the profession' had let some of the most vulnerable women in Australia down. One of my first actions as RANZCOG President was to issue an apology to women who had adverse outcomes from mesh surgery. Because of my profile in mesh surgery, I am now asked to assess women who have had mesh surgery and are worried about their long-term fate.

The Senate Inquiry is due to report at the end of this year. By the time you read this, I will have appeared before the Inquiry to give evidence as College President. RANZCOG is one of the last groups to give evidence, and I'm definitely not looking forward to it.

Hopefully, though, out of the entire 15 year saga, improvements will arise in the way medical implantables are released to the market, how their use is taught to doctors, and how their long-term outcomes are monitored.

"If a simple and safe surgical method of treatment wasn't quite as 'good' at fixing the problem, how do we trade off the simplicity – and lack of patient morbidity – against the lesser effectiveness?" asks Malcolm Frazer. "What tools can be used to perform such a balancing act? How 'less effective' is it allowed to be before a technique is discredited and we say, 'it's not worth it'? Are there worse things following a pelvic floor repair than failure?"

Hospital Doctors enterprise bargaining update: "Are we there yet?"

For most Canberrans the drive up to Sydney is a familiar journey. Along the way you pass a couple of major attractions (think Gungahlin and Goulburn) but by the time you pass the McDonaldís at Sutton Forest most of us are asking ourselves, "Are we there yet?" Sadly you're not, you still have about another 97km before you reach the M5 and experience what life is really like being a Sydneysider.

The drive up to Sydney is bit like how enterprise bargaining is going for hospital doctors; it's now September and we've reached our "Are we there yet?" moment. For those of you keeping tabs, the ACT Government formally initiated enterprise bargaining way back in December 2016. We submitted our log of claims on 28 April 2017, had our first meeting with ACT Health on 5 May and have since met on 21 July, 11 August, 7 September and 18 September.

From 6 October we expect to be in a bargaining meeting every fortnight.

So, are we there yet?

The simple answer is NO, we're not.

While bargaining inevitably has its stops and starts, the first half of 2017 was full of inactivity and meeting cancellations. Since then, our meetings with ACT Health and the ACT Government have given us some encouragement from their willingness to review some parts of the current agreement that are no longer fit for purpose.

The AMA (ACT) believes that now is the time to tackle several long-standing industrial issues that are detrimental to hospital doctors, their families and their patients. The message we're getting from our members is that they're not interested in 'kicking the can' down the road for four more years and believe that a small jurisdiction, such as ours, should be able to tackle some of the big issues and come up with an agreement that's innovative, industry leading and mutually beneficial.

A few of the major items we've put on the table include:

Rosters

With the Federal AMA leading the way, AMA branches around Australia have been working tirelessly to promote the case for fundamental change in how public hospitals roster doctors. From interns to consultants, we believe public hospitals need to do a better job of ensuring their rostering practices aren't contributing to fatigue and burnout let alone negatively impacting on patient safety.

Here in the ACT, we've proposed that rosters should be released a minimum 28 days before they are due to commence and should be inclusive of overtime and on-call/re-call. The often quoted 'true and verified emergent situation' need to be appropriately defined, particularly when we hear from our members that administrators rely on this to justify last minute roster changes.

AMA (ACT) has also proposed the introduction of a hospital-wide 'graduated rest period' for doctors who work consecutive nights. A similar arrangement is already in operation in local Emergency Departments where doctors work 7 nights on followed by 7 days off. Our proposal seeks to introduce a similar arrangement generally, meaning that if a doctor works 4 nights they should get a minimum of 48 hours rest from all duties (5 nights = 72 hours, 6 nights = 96 hours and 7 nights = 120).

Finally, and perhaps most importantly, we've proposed that a set of rostering principles be developed across the ACT Health network and that the principles be developed with the direct input of the doctors who work on the hospital floor, the AMA and department heads. The principles should be developed with fatigue and burnout in mind and they should provide each department, and every doctor working in that department, a better balance between work and adequate rest.

Access to leave

Another area that AMA (ACT) has identified as a problem for hospital doctors is access to annual leave. Our enterprise bargaining survey revealed that, in 2016 many hospital doctors did not get reasonable access to annual leave. Over the course of this year, we continue to hear about the difficulty our members are experiencing in accessing annual leave – even when applications have been made well in advance.

Given that hospital doctors are expected to work long hours, often including nights and weekends, be on-call and be recalled, find time to study and time with family and friends, we believe that annual leave applications should be considered in light of:

- The amount of annual leave accrued;
- The last time annual leave was taken;
- The length of notice given to the employer;
- The amount of leave requested; and
- Operational requirements.

Finally, we've also asked for an additional week of leave for those who work 10 Saturdays or Sundays (currently it is available only where 10 Sundays are worked). Since other health professions who work similar hours receive a minimum 5 weeks per annum, we believe this is a very reasonable proposal.

Splitting of agreements

The last round of bargaining saw the Fair Work Commission rule against splitting the current single agreement into two agreements – one for Staff Specialists and one for all other hospital doctors. The unsuccessful action was brought on by two, separate groups of staff specialists and opposed by ASMOF. In this round of bargaining, ASMOF itself is pursuing a claim for separate agreements that are also proposed to cover Staff Specialists in one and all other hospital doctors in the other.

When AMA (ACT) canvassed the issue with our members earlier this year, the feedback was that we should continue to have a single agreement but with distinct parts covering the different groups. While separate agreements exist in the larger states, at the present time, there don't seem to be compelling reasons to have two agreements covering hospital doctors in the ACT.

Given the outcome from the last case before the FWC on the issue and ACT Health's likely opposition to two agreements, we think the issue may be more of a hindrance than a help in the current negotiations.

Protected teaching time

Another issue identified in our enterprise bargaining survey concerned access to protected teaching time. Doctors told us that it was difficult to access teaching time away from all clinical duties and all too frequently they were required to attend teaching sessions both after hours and on an unpaid basis.

The current hospital doctors' agreement does not provide for protected teaching time and, on that issue, is lagging other jurisdictions, such as Victoria, where doctors have a guaranteed five hours of paid, protected teaching time each week. To ensure that the ACT Health remains an attractive place to work and to learn, we've proposed that hospital doctors here have an identical arrangement to that in Victoria.

Future bargaining

Regular meetings have now been scheduled and so, hopefully, we will get to the end of our bargaining road in the not-too-far distant future.

Canberra High student wins 'Art In, Butt Out'

Canberra High School Year 8 student, Austin Turnbull has taken out the tenth annual 'Art In, Butt Out' competition with MLA, Bec Cody, presenting the winning entry today.

Bec Cody MLA (third from left) with Tobacco Taskforce representatives.

Prof Steve Robson presenting Austin Turnbull with his prize.

'Art In, Butt Out' is an initiative of the AMA (ACT) and its Tobacco Task Force, that asks local Year 8 students to put their design and marketing skills to the test and come up with an advertisement that will help reduce the number of young people who smoke.

"This year we had more than 40 entries entries from Year 8 students and schools across Canberra, including Canberra High School, Amaroo High School, Orana Steiner School and a home schooled student," AMA (ACT) President Prof Steve Robson said.

"All the entries were of an exceptionally high quality and I'd like to commend all the budding art, design and marketing stars who submitted a design and got involved with 'Art In, Butt Out' this year."

"Austin's winning entry had all the elements we were looking for and I believe the artwork clearly sends a message that will help influence teenagers to think twice about taking up smoking or convince them to quit.' Prof Robson said.

"Austin's design will be displayed on Canberra Milk bottles for four weeks, which means it will potentially be seen by tens of thousands of people."

Anti-smoking message

"'Art In, Butt Out' encourages young people to think about their health and well-being and to support peer-to-peer education about the harmfulness of smoking and tobacco products," Prof Robson added.

"The 'Art In, Butt Out' competition can help in the fight against smoking because the public health messages being created are designed by teenagers for teenagers. These students know what motivates their friends and how to most effectively convince them to make the smart choice."

"Finally we'd like to thank Health Minister Meegan Fitzharris and ACT Health, Bec Cody MLA, the ACT Education Directorate and Canberra Milk for their continuing support and making 'Art In, Butt Out' possible." Prof Robson said.

The AMA (ACT)'s Tobacco Task Force includes: Cancer Council ACT, Heart Foundation ACT, Canberra ASH, Winnunga Nimmityjah AHS and ACT Health.

...more photos on page 12.

Family Doctor Week dinner

At this year's Family Doctor Week dinner we were fortunate to have both Minister for Health, Meegan Fitzharris and Mental Health Minister, Shane Rattenbury as part of the celebration. In addition, we were joined by Ms Julie Tongs, CEO of Winnunga Nimmityjah Aboriginal Health Service and Dr Martin Liedvogel from the Capital Health Network.

A lot of love.

Following dinner, AMA (ACT) President Elect, Dr Antonio Di Dio then welcomed guests and Minister Fitzharris and Minister Rattenbury took questions. While Q&A sessions can sometimes be a little unpredictable, both ministers demonstrated not only their knowledge of the issues but a strong commitment to Canberra's general practitioners and they vital role they play in our health system.

Our thanks to Specialist Wealth Group, a preferred partner of AMA (ACT), for their support of the evening.

...more photos on page 12.

Dr Suzanne Davey, left, and Dr Karen Flegg.

Health Minister Meegan Fitzharris with, from left, Dr Martin Liedvogel, Dr Bill Coote and Dr Mel Deery.

Mental Health Minister, Shane Rattenbury, responds to a question from the floor.

Doctors' health resources

Are you looking for a GP?

If you're a junior doctor or medical student and looking for a GP please contact AMA (ACT) and we will assist you to find a local GP.

Doctors' Health Resources online

AMA's Doctor Portal:

https://www.doctorportal.com.au/doctorshealth/resources/

JMO Health:

http://www.jmohealth.org.au/

Partly funded by DHAS and a range of other organisations.

Doctors Health Advisory Service

http://dhas.org.au/resources/resources-for-junior-medical-officers.html

On the DHAS website itself.

AMSA students and young doctors:

http://mentalhealth.amsa.org.au/about-the-campaign/

http://mentalhealth.amsa.org.au/keeping-your-grass-greener/

The new Calvary Bruce Private Hospital opens

ACT Minister for Health, Meegan Fitzharris and Calvary Board Chair the Hon. John Watkins AM have officially opened the new $77 million Calvary Bruce Private Hospital. The opening was preceded by the Blessing of the hospital by the Most Reverend Christopher Prowse, Archbishop of the Archdiocese of Canberra-Goulburn.

ACT Health Minister, Meegan Fitzharris.

"We are committed to creating a better health system in the ACT, and this new $77 million Calvary Bruce Private Hospital offers the community the latest in medical facilities while retaining close working relationships with the public hospital Calvary also operates, " Minister Fitzharris said.

Hon John Watkins AM, Chair of Calvary, said today's opening marked a 30 year milestone for Calvary ACT.

"Calvary believe that the community is best served by a singular health system where the public and private sectors play complimentary roles to serve the long term needs of our communities," he said.

"Thirty years after Calvary Private Hospital was first established and with further population growth and projected demand, Calvary has responded with a brand new state of the art private hospital fulfilling its obligations under the Calvary Network Agreement with the ACT Government."

Preview for medical staff

Immediately prior to its opening Calvary Bruce Private Hospital held an industry event for Visiting Medical Officers, General Practitioners and other related medical professionals. The evening was designed for local practitioners to be briefed on the new facility, including eight state-of-the-art theatres and private rooms with ensuites.

Calvary Bruce Private Hospital CEO, Kim Bradshaw, has been involved in every aspect of the new hospital and has drawn on her formative nursing experience, "I'm a theatre trained by specialty and that's where my passion lies, ensuring our patients receive excellent multidisciplinary care and a healthcare journey they are very pleased with."

"I've been involved in every detail of the new hospital complex, along with ensuring the quality of the new staff who have now joined us." Ms Bradshaw added.

Hospital features

The preview evening included an inspection of the eight digitally integrated theatres, including one with a hybrid cath lab, which can accommodate everything from day procedures to complex surgery.

Hon John Watkins AM.

Other features of the new hospital include:

- 118 beds with ability to expand to 182 beds as Canberra's population grows;
- 74 surgical and medical beds with private rooms and ensuites;
- 16 bed post-anesthetic care unit;
- Eight recovery beds plus an additional 17 chairs in second stage recovery;
- 12 bed maternity suite providing new families with specialised care and support after birth; and
- Eight bed critical care department.

The new hospital is complemented by recent upgrades to the Hyson Green Mental Health Facility, increasing capacity from 20 to 28 beds, and Calvary Clinic for Specialists.

Coronary CT Angiography

BY DR ROBERT GREENOUGH, MBBS FRAC

In patients presenting with chest pain, or other symptoms consistent with myocardial ischaemia, CT Coronary Angiography (CTCA) has become an important additional investigation when pretest clinical risk is low or intermediate.

The last 10 years has seen rapid advances in CT technology for the assessment of Coronary Artery Disease (CAD). Newer scanners have high spatial resolution and allow for rapid interpretation of coronary anatomy with low exposure when compared to other radiation based techniques.

The extremely high negative predictive of CTCA (96-99%)[1] makes it an ideal 'rule out' test, and in the appropriate setting has shown itself to reduce hospital attendance time and reduce cost when compared to standard diagnostic algorithms[2]. In clinical practice the same test benefits can be applied to assist in triaging patients, either as an adjunct to inconclusive stress test results or as the primary diagnostic investigation. The accuracy of CTCA is reduced in the setting of significant coronary calcification, where seeing the artery lumen can be more difficult. High heart rates also preclude optimal coronary visualization – why most patients require preliminary Beta Blocker administration – usually on the day of the test. In CTCA's favour, as a 3-dimensional technique, is the ability to assess coronary vessels from any angle and even in cross section.

Figure 1 shows images for a 52 year old male with atypical chest pain but clinical risk factors of hypertension, family history of CAD (father), and elevated cholesterol. TIMI clinical risk was 1 (low). The CTCA demonstrates normal coronaries, and his Calcium Score (usually done prior to a CTCA) was zero. In this patient coronary disease has effectively been ruled out as a cause of symptoms, and his test result also confers an extremely low annualized event rate (<0.1%)(1). Figures 2 and 3 show the LAD vessel of another patient with atypical chest discomfort, demonstrating 2 stenoses correlating extremely well with the subsequent angiogram. Also note that in Figure 2 the presence of Coronary calcification has not precluded assessment of the vessel in this case.

Figure 1

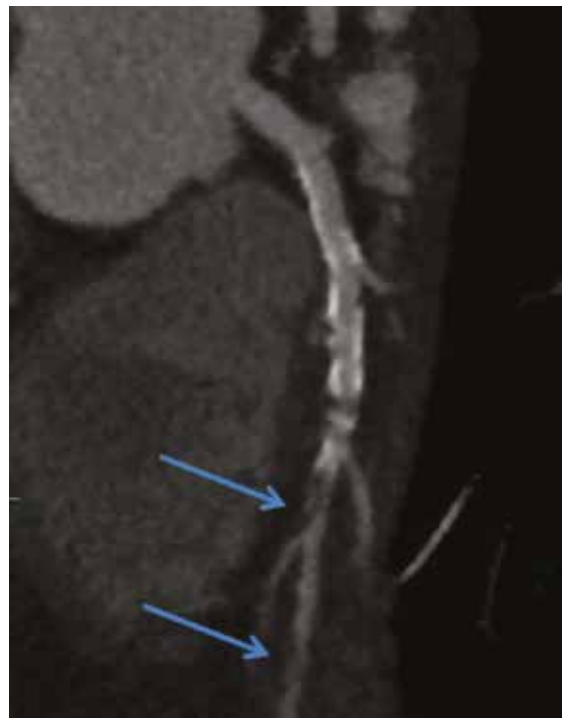


Figure 2

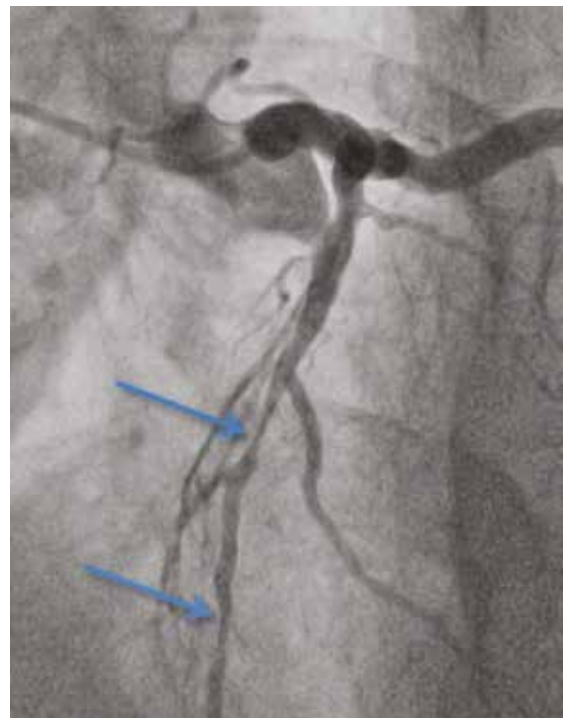


Figure 3

1. Habib et al, Int J Cardiol. 2013; 169(2): 112-20

2. Curry RC et al, JCCT. 2013;7(2):79-82

...'Art In, Butt Out'

Students and teachers from Canberra High School.

Austin Turnbull and family with, far left, Bec Cody MLA and, far right, Prof Steve Robson

...Family Doctor Week dinner

Minister Rattenbury, DR Antonio Di Dio and Minister Fitzharris.

Dr Sean White, Health Minister, Meegan Fitzharris and Winnunga CEO, Julie Tongs

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Building surgical education in the ACT

Junior doctors and registrars participated in a surgical skills workshop organised by the Royal Australasian College of Surgeons in August.

The workshop was the third of its kind since September 2016, and provides an opportunity for doctors in training to focus on core surgical skills in an interactive setting with direct teaching and supervision from surgeons.

Non-clinical and Clinical

The non-clinical component on Friday 11 August focused on delivering bad news. The course was convened by A/Prof Siva Gananadha with assistance from surgical trainee Dr Rudyard Wake and included insights from the clinical perspectives of psychiatrist Dr Anna Burger, intensivist Dr Simon Robertson and medical oncologist Dr Nicole Gorddard.

The hands on component of the workshop was held on 12 August at the Skills Training Centre at The Canberra Hospital and included sessions on general surgical skills such as suturing, knots, simple excisions, chest drain insertions and laparoscopic skills. A mix of presentations and hands on activities were held throughout the day. More advanced surgical registrars were guided through a range of procedures with an emphasis on safe technical execution.

The workshops, supported by ACT Health and the medical industry give participants the opportunity to practice and refine their skills in a supervised environment, and extend their knowledge and skills in advanced and less common procedures.

Feedback on all the workshops has been positive, with the next scheduled for March 2018. For more information contact college.act@surgeons.org.

A/Prof Siva Gananadha, second from right.

Participants at the workshop.

Feuding parents access to children's medical records*

BY DR PETER HENDERSON, SENIOR MEDICAL ADVISOR, AVANT AND HARRY MCCAY, SENIOR SOLICITOR, AVANT LAW

You have been treating a married couple and their three children for several years, when suddenly the marriage becomes acrimonious and the couple file for divorce. Next thing you know, the father is demanding access to one of the children's medical records. However, when pressed, he admits that he's not the primary carer.

Understandably, doctors are often concerned about breaching privacy requirements when facing requests like these. We frequently receive calls to our Medico-Legal Advisory Service for advice on this difficult issue. These situations are often further complicated by the fact that childcare is often provided by grand-parents or other family members.

The scenario above raises a number of questions:

- Who has the right to access children's medical records?
- What if there is a court order?
- Is there a conflict of interest when all family members are patients of one doctor?
- Does the mature minor need to be consulted?

While every situation should be considered on a case-by-case basis, the basic principles outlined below provide a useful guide.

Parents' rights and grounds for refusal

Under the common law and the *Family Law Act 1975*, parents have a right to receive information about medical treatment which has been or is intended to be, provided to a parent's child. Denying access to a child's medical record when there is no valid reason not to, may lead to a complaint. The Office of the Australian Information Commissioner may impose a fine if they consider that the practice has unreasonably refused a request for information.

Members often raise concerns that they believe the medical records may be used as ammunition during custody battles and not for valid health-related reasons. However, the grounds to refuse a request for access to medical records are based on the health and safety of individuals or the unreasonable impact disclosure may have on another person's privacy, rather than the reason behind a request. Therefore, being suspicious of a parent's reason for requesting a child's records is not sufficient grounds to refuse.

Court orders and custody

Generally speaking, a doctor may assume that the person accompanying the child to a consultation who identifies themselves as the child's parent is the child's present guardian/parent and their medical treatment can be discussed with them. In situations where it's clear the relationship has broken down, it's prudent to ask if there is a court order regarding custody and care arrangements. This may guide the practice around who is provided with access to the child's medical records. The court order should also be placed in the child's medical records.

It's unusual for a court to remove a parent's right to receive information about their child's medical treatment. Even in cases where a parent is restricted in the amount of access they have to the child, or has no access, the parent may be entitled to information about the child's treatment.

It's only in circumstances where providing information may pose a risk to the health or safety of an individual, or a court order specifically prohibits one parent receiving such information, that a practice may be justified in refusing to supply information, or only providing limited information. Usually, the court states that one parent should inform the other if medical treatment is provided to the child. In this situation, there is an implied expectation that both parents can receive information from the practice. In circumstances where the order stipulates that both parents need to consent to the child's treatment, the practice should obtain the court order and written evidence of the joint consent.

Some treatment, which is significant and permanent in nature, for example, sterilisation, cannot be consented to by the child's parents and needs the approval of a court.

Conflicts of interest

There is a real risk that a conflict of interest issue may arise if a doctor continues to treat both parties who are feuding. Conflicts can eventuate when parents attempt to convince the doctor to support their cause. We frequently assist members where there has been a suggestion that the doctor has taken sides. It's very important to remain neutral and to understand that your role is to assist your patient to maintain good health.

If a doctor believes that a relationship breakdown between partners or a domestic violence situation is placing them in a position of conflict, the doctor should cease treating both partners. The doctor can continue to treat one partner if the other partner doesn't object, but this often leads to a perception of bias. The *AMA's Supporting Patients Experiencing Family Violence – A Resource for Medical Practitioners*, offers guidance for doctors dealing with domestic violence situations.

Where there are children in the relationship there may not be a conflict in continuing to treat the children. However, the doctor should make it clear to both parents that their sole interest is the health of the child. And if the parents or one of them by their actions or demands prejudices the ability of the practice to provide good care to the child, the practice will have no choice but to terminate the treating relationship.

Mature minors and consent

In some states, minors can consent to treatment from the age of 14 or 16. If there is no legislation which applies, the practice must apply the common law. This states that if a child has a sufficient level of intelligence and maturity to be able to understand the nature of

proposed treatment, the consequences of having the treatment or not having the treatment, the risks involved and alternative options to the treatment, the child can give valid consent to treatment. This patient is known as a mature minor or 'Gillick-competent'. A corollary to this principle is that the mature minor can refuse to consent to one or both parents receiving their medical record. The practice must honour this wish.

If treatment is urgent or the child will suffer harm if it's not provided in a timely manner, under the doctrine of necessity, treatment can be provided without the consent of a parent. However, except in cases of direst urgency, members should consult with Avant before providing treatment.

Key points

- Generally speaking, a parent or guardian has a right to access a child's medical records.
- Where the practice is aware of a relationship breakdown between parents, it's a good idea to ask if there is a court order in place and to obtain a copy.
- Information can be withheld if the practice believes that giving information to a parent will pose a serious and imminent threat to a person or unreasonably impact the privacy of another person.
- If the risk from disclosing a child's records can be addressed by redacting or covering parts of the record, or providing a summary of treatment, this should be done rather than not providing any information.
- It's not advisable to care for both parties in a relationship breakdown as conflicts of interest may arise.

Useful information

Download Avant's Privacy Essentials factsheet at avant.org.au/avant-learning-centre/ to understand your privacy obligations.

*references available on request.

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