CANBERRA
Doctor

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JUNE/JULY 2016 | Canberra Doctor is proudly brought to you by the AMA (ACT) Limited. Circulation: 1,900 in ACT & region

Prof Steve Robson looks to the future as AMA (ACT) President

Earlier in May, I had the privilege of taking over the Presidency of AMA (ACT) from my colleague, Dr Liz Gallagher. Liz has been an extremely popular and effective president and it was with some trepidation that I stepped into her shoes. We all owe Dr Gallagher a heartfelt vote of thanks for the wonderful job that sheís done.

For those who don't know me well, and those who are wondering what direction a clinical academic might wish to take your AMA, I thought a good start would be to introduce myself and let you know where I think our organisation should be focussed for the next two years.

Back in Black

For anybody of my vintage – shall we say I'm in my mid-50s and leave it at that – the three words "Back in Black" will be instantly recognisable. The AC/DC album was released when I was at high school and I don't think a week has gone by since then when I haven't listened to at least one track from the album. It has endured over almost four decades and become the biggest-selling popular record of all time. It seems to me that there are three reasons for this: the music is completely unpretentious; all of the songs have memorable riffs; and, it is done with a tremendous sense of fun.

I hope we can capture some of these enduring qualities at AMA (ACT) over the next couple of years.

A sustainable health system

In 1984 when I first joined the AMA as a medical student, health spending was just over 6.5% of GDP. Thirty years later, the proportion has grown to 8.8% of GDP or around $150 billion annually.

With the Australian Government spending about $40 billion more than it actually receives each year and no mining boom around the corner to save us, it is clear that health expenditure must be justified. There is absolutely no point in doctors calling for more and more spending without conceding that funding will have to be taken away from something else to pay for it.

Spending on the health of Australians is undoubtedly a good investment, but like all investments a careful due diligence must be undertaken. I am part of the Australian Government's Review of the Medicare Benefits Schedule and have a keen sense of how important it is that spending is appropriate and benefits our patients and the community as a whole. If we, as a profession, expect funding for the work we do then we need to be able to demonstrate that we provide clinically effective and cost-effective care.

With the Federal Coalition having been returned, we face an election for the ACT Legislative Assembly by mid-October. Health is the largest single expenditure item for all state and territory governments, a situation that provides us with both an opportunity and a threat. Our opportunity is to engage with government and those seeking election to help shape the approach to health spending and provide maximum benefit for Canberrans. The threat? That we deal ourselves out of negotiations and end up having to accept what we are given.

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AMA National Conference – a new President and much more

While the key outcome of the conference was the election of Dr Michael Gannon as the new AMA President, Dr Suzanne Davey writes that was one highlight of many in a conference that offered so much.

Assisted dying

The ABC's Tony Jones moderated a Q & A style panel of experts to discuss assisted dying. The panel consisted of Em Prof Bob Douglas in a role as a potential aging consumer, Ms Georgie Haysom, head of advocacy at Avant, Dr Karen Hitchcock, author and doctor working in acute and general medicine at the Alfred hospital, Professor Malcolm Parker, Professor of Medical Ethics at University of Queensland and Assoc Prof Mark Yates, geriatrician and authority on dementia.

The AMA position is that the doctor's role is to alleviate pain, even when that treatment may shorten life. Not initiating or continuing life-prolonging measures does not constitute euthanasia or physician assisted suicide.

The US state of Oregon's Death with Dignity Act, passed some 19 years ago, was also similarly a focus of the discussion. The Act sets up a framework for assisted dying – the patient must be 18 or older, mentally competent and diagnosed with a terminal illness that will lead to death within 6 months

In these circumstances, a doctor may prescribe a life-ending medication which is to be self-administered by the terminally ill patient. This medication can only be prescribed after a 15 day cooling off period between two requests by the patient.

The situation in Oregon was compared with the very different model in some European countries where the physician actually assists in the suicide of a patient, at the patient's request.

As might be expected, both the panel and questioners from the floor, presented a variety of views, with all agreeing the role of the law was to very clearly draw the line between palliative care that may hasten a patient's death and the physician actually killing the patient at their request. The debate, of course, is exactly where this line should be drawn.

Closing the gap

The AMA remains committed to trying to reduce disparities in indigenous life expectancy and chronic disease outcomes and reducing rates of indigenous incarceration and supporting indigenous medical education. Facilitator and Political reporter Brooke Boney gave a moving account of the experiences of her own indigenous family and their lack of health care and opportunities.

Bullying and harassment

Dr Ruth Mitchell, neurosurgical trainee, and barrister specialising in discrimination law, employment law and administrative law, made the points that doctors must be trained in performance management of their trainees and that any complaints must be investigated quickly and thoroughly by an independent investigation team. The Royal Australian College of Surgeons have announced a zero-tolerance approach to bullying and harassment and they have appointed an independent advisory group to investigate the issue and advise the RACS how to address and prevent discrimination, bullying and sexual harassment in the practice of surgery. Other colleges may learn from their approach to deliver a safer, healthier and more respectful work environment.

Politicians, policy and pundits

Of course, an AMA Conference in an election year is bound to attract politicians and discussion on the election. While I'm pleased to say we now have a government, a quick recap on the politicians and their party's positions put to the conference is worthwhile – even if it's only for the record:

Shadow Minister for Health, Catherine King announced several ALP initiatives including establishing an independent medical panel to advise the Department of Immigration on matters concerning asylum seeker health; unfreezing the Medicare rebate and rejecting the rise in script costs for all PBS scripts; setting up a permanent commission to advise the Australian, State and Territory governments on healthcare reform – to be done in consultation with clinicians.

The leader of the Australian Green's, Dr Richard Di Natale, stated that the Greens would aim to close offshore refugee processing centres. He supported the continuation of Medicare and rejected the concept of a Medicare rebate freeze.

He stated that the Greens would support primary care in order to reduce hospital admission rates by providing a need method of funding the care of chronic care patients.

Health Minister, Sussan Ley, was guest speaker at the Gala Dinner.

The panel of pundits, facilitated by senior journalist Paul Bon-

Assisted Dying Panel.

ALP Health Spokesperson, Catherine King.

Dr Paul Bauert, AMA medal winner for significant contribution (third from right), with AMA past presidents, Drs Pesche, Hambleton, Capolingu and Prof Owler.

giorno, comprised Sue Dunlevy, Malcolm Farr, Andrew Probyn and Laura Tingle in the mode of an 'Insiders'-type programme where the experts fielded questions from the floor.

The feeling amongst the group was that the election result would be very close, but would probably go the way of the Coalition based on their assessment of the way votes would fall in marginal electorates.

They felt that, although Prime Minister Turnbull had failed to live up to his early promise, Australian electors simply did not have the appetite for a fifth prime Minister in as many years. Health and Education would remain the most important issues for most electors.

Prof Brian Owler with Health Minister, Sussan Ley.

New AMA Fellows (left), Drs Bartone, Mara, Sharley, Rudd and Gannon and Prof Brian Owler.

Women in Medicine Breakfast

On the Friday morning of the AMA National Conference held in late May, the AMA (ACT) held its inaugural Women in Medicine Breakfast. The WIM Breakfast was sponsored by Tress Cox Lawyers and featured an address by Dr Sue Packer AM. A edited version of Sue's speech features in this edition of *The Canberra Doctor.*

The breakfast was a great opportunity to meet new people and renew acquaintances with a varied group present – from medical students and Doctors in Training through to local GPs and specialists. Of course the highlight of the day was Dr Sue Packer's address with Sue holding the room spellbound as she described the living conditions of asylum seeker children in the Inverbrackie detention centre in the Adelaide Hills. A truly unforgettable moment.

Special thanks to the Federal AMA for assisting us in holding the breakfast, to Tress Cox Lawyers for sponsoring the event, Rolfe BMW for providing the prize of a weekend use of a BMW car and Dr Sue Packer for being the guest speaker.

BELOW: Dr Sue Packer and Dr Suzanne Davey.

RIGHT: Guests at Breakfast.

Prof Steve Robson...*continued*

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Looking after ourselves

Doctors are very good at looking after their patients, but in my experience not so good at looking after themselves and especially their colleagues. These are areas where the AMA is ideally placed to make a big difference.

I have seen colleagues give their own health and wellbeing a low priority. This is a very bad situation for three reasons: patients look to their doctors for an example of how to look after themselves; to provide good care the doctor must be functioning at an optimal level; and, reduced productivity from doctors is bad for the community. We need to look after ourselves if we are to make the most of the training and experience we have. Don't forget we have the Doctors Health Advisory Service that you can call at anytime for help or just a confidential talk to a colleague. The contact number is 0407 265 414.

Helping the disadvantaged

Despite our prosperity and relative comfort, there are many members of our community who are at great disadvantage. As a caring profession this should shock us and move us to action. Just as it is the role of your AMA to advocate for the profession, so it is that we should provide a strong voice for those at disadvantage. In particular, women tend to have the greatest influence on the health of their families – they influence the health of children, of their spouse or partner, and often of their parents too. The AMA is not fulfilling its role unless it is standing up and providing strong advocacy for those at greatest need.

I am really looking forward to meeting and working with as many of Canberra's doctors, and indeed all those interested in health, over the coming two years. If you have any issues at all, please make sure you contact the AMA office here in Canberra – we would love to hear from you.

AMA (ACT) is now on Facebook!

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

Some things i've learnt along the way

Dr Sue Packer AM FRACP was the guest speaker at the AMA (ACT)'s inaugural Women in Medicine Breakfast held in conjunction with the AMA's National Conference. Sue has been a paediatrician since 1972 and has worked as a Community Paediatrician, with a special interest in both child abuse and neglect and their prevention, since 1990. The following is an edited version of her speech to the Breakfast.

"50 years ago, on Australia Day, I graduated from Sydney University; one of about 50 women graduates in a cohort of 320 students being the survivors of a record-breaking intake of 650 students, six years earlier.

For our 50 year reunion this year, we produced a progress yearbook in which we were invited to contribute what we would like others to know about our lives. We made great efforts to include accounts of the lives of those who have died, with contributions from friends and families.

Compared to today there were so few women. As a student, I was not aware of overt signs of the sexism which had curtailed earlier women in medicine, but I was bewildered and bemused anyway, having come to university from country NSW. We seemed to have the same opportunities as the men. Some tutors were "difficult" with women. Some were just plain "difficult" with everyone.

Of great concern, reading the 50 year updates, is the realisation that a number of women graduates from my year never practiced medicine. This seems to have been because of the rigid hospital employment requirements and the non-existent childcare options. But the end result was that they gave up and abandoned their medical careers before they had even begun. They have done many wonderful things in their subsequent lives, but given different chances, I know they would also have done so in medicine and their regret is palpable in their accounts of their lives, despite their successes.

Our lack of curiosity and compassion for our fellow students is so glaringly apparent considering our student years in retrospect.

Post-war cohort

There was a very sizeable cohort who were completely invisible and unconsidered in our undergraduate years that were those students who had come to Australia as migrants and refugees in the aftermath of WW2. We were a year of war (and even pre-war) babies.

Reading the accounts of their early lives now, 50 years later is moving and sometimes harrowing and heartbreaking. Many of these, my co-students in medicine, only reached Australia because of the involvement of people smugglers, bribery and false identity documents. Some are still making their own journeys of discovery about their own true circumstances and identities, and those of their parents, 50 years later, as they shared with us at our reunion. Their contribution to the richness of Australia, in every sense but especially resulting from their generous medical careers, has been truly remarkable and deserving of recognition.

With a longer lens, our year also numbered outstanding doctors with verified convict ancestry, which they now celebrate.

Most of us come from somewhere else

So, Australia is a country whose entire non-indigenous population is made up of migrants, refugees and convicts and their descendants. We are a wealthy, successful country. This all makes it harder for me to understand how we can remain intransigent and paltry in the face of so much human suffering in our region. Even worse, how can we continue to knowingly inflict harm on a relatively small number of people, most already confirmed to be refugees, who have happened to end up being in the wrong place at the wrong time, because of our change in policies, and who are now condemned to languish without hope in indefinite detention, with such uncertain rights and provisions, at our leisure.

My work in paediatrics for the last 30 or so years has all been related to abuse, neglect, emotional trauma and all of its life altering ramifications and how to avoid these ills. Because of this, I offered to be part of the health assessment teams organised to visit the detention centres within Australia and offshore, as part of the Australian Human Rights Commission National Inquiry into Children in Immigration Detention.

Dr Sue Packer addresses the audience.

Inverbrackie Detention Facility

In the event, I participated in one such visit. On Monday, May 12, 2014, I visited Inverbrackie in South Australia as one of the HRC investigative party. We only had one short day there and I have never worked under such sustained pressure- conducting interviews via interpreters. In all, I saw eight families, all with two parents and with a total of 18 children from 24 years to 2 months. They were from three language groups and all were accompanied by excellent interpreters but conducting semi-structured interviews simultaneously in two languages to three or four troubled families at a time was bewildering and exhausting.

All the families were desperate to put across their cases and all were so similar, with so much trauma and distress – and real fear – reflected in all the anticipated clinical signs and symptoms which we tried to document.

Inverbrackie, in terms of location and facilities, at first glance was unremarkable- even favourable. It was the "showcase facility" for the Department of Immigration. But I learned so much about the "devil in the detail", which transformed this reasonable place into a centre of emotional disintegration.

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The families had no control over any aspect of their lives, despite living in houses with their own cooking facilities, with health services, access to school and counselling and lovely outdoor playgrounds and other facilities. But all the houses had to be shared, even though there were enough houses for each family to live alone, and families had no choice who to share with.

The facilities could only be used strictly as directed, so many fine things like the playgrounds were scarcely used at all.

Many medical appointments were conducted without interpreters and all access to appointments and even minutiae like children's clothes and computer time was totally controlled by the guards, who could give or withhold at will. Similarly there were excursions but always accompanied by uniformed guards and there was never any say as to where and when excursions occurred.

Roll calls and late night transfers

More intrusively, despite this being a recognised low risk facility, all detainees, including the babies, had to be roll called four times each 24 hours and two of these were photo checks. The last check was at night. Many children would be asleep. The guards would enter each home without knocking and shine a torch on the sleeping infant's face. No wonder the children were in such parlous emotional states.

Three of the women I saw were pregnant. Subsequent to my visit, after the birth of their infants, I read that they had been moved out of Inverbrackie at 3am for transfer to Darwin. How would this additional trauma be experienced by these already traumatised, apprehensive women?

Dr Suzanne Davey, AMA (ACT) Secretary.

These were the mothers who soon afterwards went on hunger strike in Darwin and attempted suicide in the hope that their infants could then stay in Australia rather than being moved to Manus or Nauru. The fear of that possible fate, at the time I interviewed them, prevented any of the families from being able to enjoy the relative calm of their time in Inverbrackie.

This facility was closed within months of our visit and the inmates moved on, in keeping with their worst fears.

What can we do?

I admire the brave continuing efforts of so many medical organisations and individuals, including the AMA, working to address this shameful situation. It takes a special kind of courage to persevere in this way in an environment of determined inaction and suppression of all aspects of the situation so we are made to feel crazy for caring.

In some ways it is not so different from my work with abused and neglected children and their families and carers over so many years. How much do we really know and care about these struggling individuals, both the children and their families and carers?

At a superficial level there is real community distress at the thought of our suffering children, but there is also an anxious willingness to see it as someone else's problem; "*they*" ought to do something about it.

The enduring positive changes achieved are so often the result of quiet sustained efforts, most often by one or a few individuals. A prime example of this is an old ex-neighbour of mine who died a few years ago. At his funeral I met a young woman, who obviously knew me well but I couldn't place her. I then realised that she had been a child in just the sort of family who is reported to child protection and she had lived next door to this old man and his wife.

After school, when her siblings were getting into mayhem, she would visit the neighbours for a quiet, civilised afternoon tea and a chat. She loved the calm, welcoming environment and went there very frequently. Her family moved on a few years later, but she maintained an intermittent connection with her old friends. As a young adult she has a good job and is happily married with a young family. She has been able to support her siblings in their various, foreseen mishaps and it was a real delight to meet her again.

Guest speaker, Dr Sue Packer, second from right.

I attribute so much of her success to the caring, perceptive and socially competent neighbours helping her to see life differently. Her coming to the funeral makes me think she sees it this way too.

Teachers and GPs so often can exert similar enduring influences because they have the skills and opportunities to show that they care and actually like the person for him or herself, despite many challenges. This is the side of medicine and child protection which can be so fulfilling and worthwhile.

Child Aware Approaches

Earlier this week I attended the Families Australia conference in Brisbane "Child Aware Approaches". At the conference I heard from two of the most inspired Indigenous women I have been privileged to meet and the inspiration was their collective vision for a future for their children and our children and grandchildren, by working from the past traumas and their present legacies to a future enabling all children to delight in their lives. Their visions were inclusive, community initiatives.

The women were Professor Kerry Arabena, whom some of you might know from her time in ACT earlier in her career and June Oscar AO, already well known for her work at Fitzroy Crossing in Western Australia addressing the overwhelming issues of Foetal Alcohol Spectrum Disorder.

Kerry spoke of her vision for the Australian model of the First 1000 Days: Making the World of Difference for Aboriginal and Torres Strait Islander Children. Her proposal did achieve some very modest funding in the latest federal budget but it requires so much more to make this inspirational, but achievable plan a reality.

June spoke of the tragedy of FASD in her community and the devastating impact it has had, particularly on the capacity of so many of the children to learn and develop. She helped lead the brave plan to ban takeaway alcohol from the community, with inspirational results which have been well publicised. She then moved on to determine the true incidence of FASD in her community, the first time this has been done, and discovered that one in five of their children is affected. Her community is now developing trauma informed supports to enable these children to develop and learn as well as possible in a caring, committed community and at the same time prevent the birth of further affected children by controlling access to alcohol.

Beth Altson from sponsors, Tress Cox Lawyers.

It is the courage and inspiration and determination of women such as these which encourages me to continue in my sometimes depressing work, that and my ongoing learning and enjoyment from my encounters with children.

Learning from children

I will finish with my thoughts on encounters with children. There are the things we "*do*" to children (and doctors figure large in this) – things like immunisations and painful procedures. Things beyond the child's capacity to intervene. These dealings can easily become abusive and need our constant vigilance.

Then there are the things we do "*for*" children – things like providing food, clothing, toys, driving them to sport and parties and to say nothing of cleaning, shopping and cooking.

Then there are the things we do "*with*" children – the magical and memorable occasions when you and a child share things together on an equal footing and with mutual enjoyment. They are the memories we keep with us forever and we should make time for more of them; they can't be rushed.

As I learned from a wise school principal: "If you haven't learned anything from your children today, then you haven't been listening!"

The Medical Benevolent Association of NSW celebrates 120 years

The Smith family* were referred by a palliative team. Brian Smith was an intern at the time he was diagnosed with oesophageal cancer. Medicine was Brian's second career and the familyís financial resources had been stretched during his years of study. At the time of referral their emotional resources were also stretched because family support was in the UK. There were three children, the oldest had just started high school.

Brian passed away three months after referral. The Medical Benevolent Association of NSW (MBANSW) assisted with a contribution towards rent and utilities which continued for some months until Brian's wife was able to find childcare and return to work.

The above case study is a prime example of why the Medical Benevolent Association of NSW exists. The organisation was originally set-up in 1896 as the Medical Benevolent Fund of New South Wales with the vision "to afford assistance to any duly qualified medical man, widow or orphan children of such whom the committee deem worthy". It then officially became known as the Medical Benevolent Association of NSW in 1926, but the vision has remained the same.

We are proud to be celebrating the 120th anniversary of the MBANSW this year. Over the past 120 years the MBANSW has helped thousands of beneficiaries with financial assistance in the millions of dollars, as well as countless hours of dedicated social work counselling. There have only ever been four social workers employed in the history of the MBANSW, all of whom have been tirelessly supported by councils made up of volunteer medical professionals. The underlying motivation from all involved in the MBANSW is to help their careers in times of need, which is reinforced by the MBANSW's slogan: "by doctors for doctors".

MBANSW has consistently grown over the past 120 years. This has been possible due to the support from donors. To ensure the MBANSW continues to grow over the next 120 years the association needs your continued support. All donations are tax deductible.

How you can donate:

The MBANSW's Annual appeal has started, you can donate:

- Online - www.mbansw.org.au
- Telephone - 0405 244 544
- Fax - 02 9987 2970 or
- Mail - PO Box 1660, Dee Why NSW 2099

If you, or someone you know, are in need of assistance, please contact our social worker, Meredith McVey on **(02) 9987 0504** or through the MBANSW website **www.mbansw.org.au**

CARING FOR 120 YEARS...

...and with your help we will keep caring for 120 more

Testimonial

"I would like to thank the board for the generous and continued support that you provided for me over the period of my two operations and time away from work. Your support and the contact with the social worker was wonderful at a time of financial distress. I am now back on my feet – literally – and working full time, and I am very appreciative of the role you played in my recovery.

** Not their real names.*

Pregnant Pause – FARE's campaign for alcohol free pregnancies

The Foundation for Alcohol Research and Education ('FARE') is shortly to re-launch "Pregnant Pause", its innovative health promotion campaign that asks participants to take a break from alcohol during their pregnancy or the pregnancy of a loved one.

FARE is asking Canberra residents to "give the gift that truly lasts a lifetime".

Supported by the ACT Government under the ACT Health Promotion Grants Program, the campaign will be working closely with local partners over the next three years (2016-2019) to encourage as many Canberrans to make the pledge to go alcohol free and contribute to healthier ACT kids.

The campaign features an extensive digital and social media component coupled with broadcast advertisements on television and radio, community activities and events leading up to International Fetal Alcohol Spectrum Disorders (FASD) Awareness Day on 9 September.

Local Canberra media personalities, Kristen and Rod from the popular Mix106.3FM breakfast radio program have come on board to lend their support to the cause as Pregnant Pause Ambassadors and to help raise awareness that there is no safe type, safe amount, or safe time to consume alcohol during pregnancy.

Building a stronger support system

Pregnant Pause wants to make it easier on mums-to-be, and aims to build a strong support system which will help women achieve an alcohol free pregnancy and raise awareness of this important health message.

We recognise that this seemingly easy task of giving up alcohol can be challenging – especially in an environment where alcohol and socialising so often goes hand-in-hand.

And there's also a lot of anecdotal misinformation adding to the confusion.

But mums-to-be don't have to do it alone; like getting fit, changing diet or moving house, life is easier when you have support.

In fact, a recent study found that 31 per cent of Australian women would be less likely to drink alcohol during pregnancy if their partner or spouse also stopped drinking.

That's why FARE believes Pregnant Pause is a campaign that everyone can take part in.

Aiming for zero alcohol during pregnancy

The Pregnant Pause campaign promotes the idea that, for women who are pregnant or planning a pregnancy, no alcohol is the safest option.

The campaign will also raise awareness of the consequences of alcohol consumption during pregnancy; such as miscarriage, still or premature birth, low birth weights and FASD (the umbrella term for a range of lifelong learning and developmental disabilities).

At its heart, Pregnant Pause is a positive and empowering campaign. It's never too late to cut down or stop drinking alcohol during pregnancy, and even a small change can make a big difference for both mum and baby.

How you can get involved in your practice

FARE's range of Pregnant Pause printed materials have everything you need to pass on this important health message to patients and other contacts in your network.

Please contact FARE if you would like to receive free posters, flyers and postcards which you can display and distribute to spark conversations with your patients and show support.

Email Kamara at kamara.buchanan@fare.org.au to place your order today.

To keep up to date with all that is happening in the world of Pregnant Pause check in with their Facebook page at PregnantPauseAU or follow the campaign on Twitter @PregnantPauseAU.

Why not try a slice of LIME seminar?

Have you heard of LIME – Leaders in Indigenous Medical Education? The LIME Network is a program of the Medical Deans Australia and New Zealand that aims to ensure the quality and effectiveness of teaching and learning of Indigenous health in medical education.

The aims of the LIME Network are designed to:

- Enable the continuing development and implementation of quality Indigenous health curriculum to improve medical education for all medical students
- Build on and strengthen appropriate recruitment and retention initiatives for Indigenous students
- Build the capacity of those working in Indigenous health at medical schools
- Develop pathways for vertical integration of Indigenous health curriculum and student recruitment strategies with specialist colleges
- Strengthen Indigenous health initiatives across health disciplines
- Facilitate key relationships between Indigenous community controlled health organisations and medical schools to improve collaboration, student placement opportunities and research initiatives

The LIME Network has also developed a seminar series that can be accessed via youtube at www.youtube.com/user/LIMENetwork-Program:

Slice of LIME Seminar 1:

Admissions criteria for diverse student cohorts.

Slice of LIME Seminar 2:

Having the hard conversations, using deconstruction to work successfully with resistant, uncritical and reacist responses to indigenous health curriculum.

Slice of LIME Seminar 3:

Ngara...deep listening...seeing two ways; what can indigenous knowledge, mindfulness and observational skills training bring to medical practice?

Slice of LIME Seminar 4:

Finding common ground – avoiding the terminology trap.

Slice of LIME Seminar 5:

Health literacy.

Slice of LIME Seminar 6:

Traditional Aboriginal healing and western medicine – the missing gap.

Doctors in Training update

The past couple of months have seen quite a lot happening with the AMA holding its National Conference here in Canberra and also seeing the election of a new AMA Federal President.

Dr Nushin Ahmed (centre), Chair of AMA (ACT)'s Council of DITs at the Leadership Development Dinner.

AMA National Conference

Tony Jones, from ABC TV's Q&A program facilitated a session on assisted dying, hearing not only panellists' perspectives, but from AMA members too. Sessions were also held looking at the *Medical Profession's Role in Closing the Gap and Bullying and Harassment.*

Doctors in Training issues were also at the forefront of discussions throughout the weekend, with Federal AMA presidential candidates addressing Council of Doctors in Training members individually and as a group to hear what matters were most important in the DiT sphere.

The Leadership Development Dinner, held at The Boathouse by the Lake, saw Dr Nick Coatsworth give an engaging account of his time in *Medicines Sans Frontiers* and lessons learnt as a doctor in training.

New AMA President

Dr Michael Gannon, Western Australian obstetrician and gynaecologist, was elected as the new President of the Federal AMA during the AMA National Conference, replacing Professor Brian Owler.

Dr Nick Coatsworth, guest speaker at the Leadership Development Dinner.

Dr Gannon has a long history with the AMA including as past-chair of the Council of Doctors in Training.

Dr Michael Gannon, AMA President.

Updates on EBA

With the negotiations for the next EBA coming up in early 2017, we want to make sure Doctors in Training are fully informed and mobilised to ensure their views are well represented in the negotiations.

We encourage you to take part in the dialogue during the lead-up to the negotiations and the negotiating process itself. Information and feedback sessions are being planned to cover certain segments of the EBA to allow DiTs to share their opinions on specific matters – keep an eye out for these sessions and be sure to come along to get better informed!

If you have any comments, questions, or concerns, contact AMA ACT Manager of Workplace Relations and General Practice, Tony Chase, at industrial@ama-act. com.au.

A message from the AMA (ACT) CEO: new workplace services for ACT DITs

From earlier this year, the Board of AMA (ACT) has been looking at ways to improve the workplace relations services we provide to Doctors in Training. Consequently, I'm pleased to advise you that from 4 July we have employed Tony Chase to the new position of Manager of Workplace Relations and General Practice. Tony is a vastly experienced Workplace Relations Practitioner and has worked across Territory, State and Commonwealth jurisdictions in the private and public sectors. He has for many years worked at a senior level for industrial membership-based associations and has appeared as an Industrial Advocate in most Australian industrial tribunals. Tony is also an experienced workplace mediator.

In the very near future, we will also be employing a "Hospital Organiser" whose job will be to support DITs by being a regular presence in your hospital workplace and on the phone to deal with issues around membership, communications and workplace relations. The Hospital Organiser will be employed on a full-time basis.

To accommodate these changes, Andy Ozolins has finished up with AMA (ACT) and we wish him well for his future endeavours.

CLINICAL CASE STUDY

Parathyroid 4D CT

BY **DR JOHN CONNORS,** MBBS FRANZCR

In the clinical setting of hypercalcaemia and elevated parathyroid hormone levels, imaging for the presence of pararthyroid adenoma(s) helps to localize the tumour to a quadrant and thus facilitate minimally invasive surgery.

Neck ultrasound and Technetium-sestamibi SPECT scintigraphy alone, or in combination, are the traditional first-line investigations for this localization. Sensitivities for these are approximately 55% and 62% respectively when deployed individually, increasing to 73% when used in combination.[1]

More recently, 4D CT has been proven to be a useful secondary modality when clinical and biochemical suspicion remains despite negative first-line imaging. In experienced hands 4D CT has an accuracy of 87-94% in localizing an adenoma to a quadrant.[2]

4D CT combines detailed 3-dimentional cross-sectional imaging together with changes in enhancement over time providing the fourth dimension. Pre-contrast scans are followed by arterial and delayed (washout phase) contrast imaging.

The characteristic findings are intense arterial-phase enhancement (Image 1) with rapid washout on the delayed scan. An adenoma is typically low attenuation with respect to thyroid on the pre-contrast scans due to the iodine content of the former (Image 2). The presence of a so-called 'polar vessel' (Image 3) entering at the upper or lower pole can be present in up to two thirds of parathyroid adenomas.

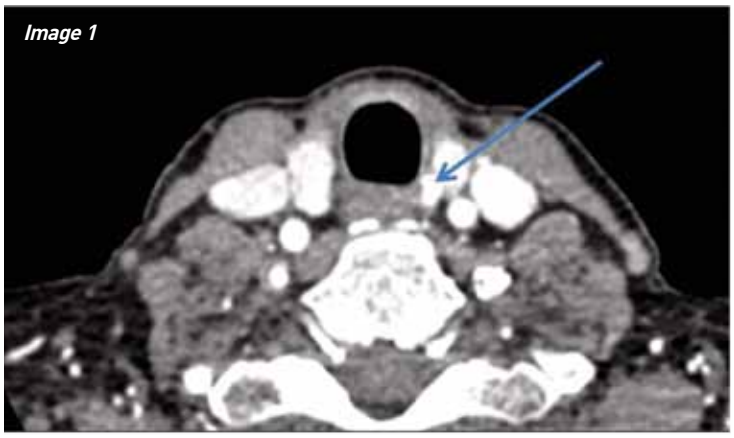

Image 1

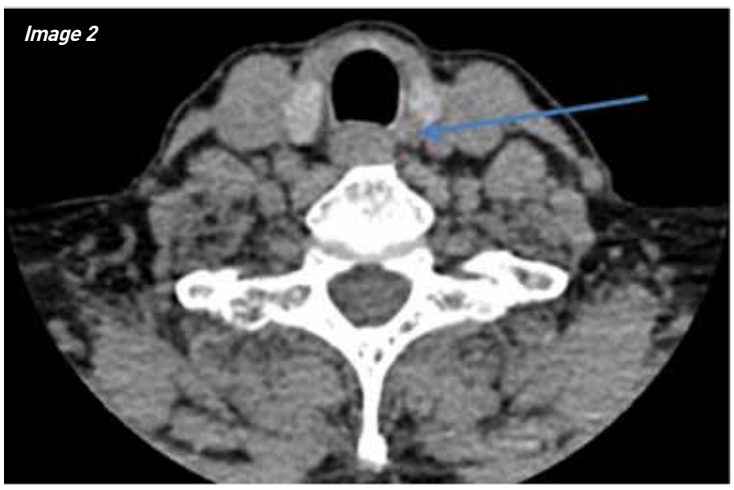

Image 2

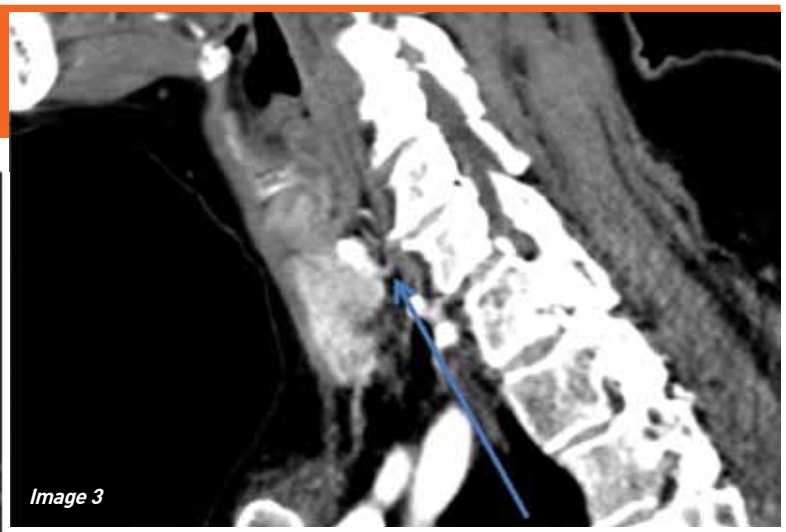

Image 3

The advantages of 4D CT are high accuracy and the ability to detect adenomas in ectopic positions. It has been suggested that it be satisfactory as the sole presurgical localization method. The disadvantages are a higher radiation dose to the thyroid and a definite learning curve for the imaging specialist.

We have been performing this study for over 2 years and maintain a close relationship with our multidisciplinary clinical colleagues.

1. Hunter et al, Radiology Vol 264 Sept 2012

2. Houang et al Radiology Vol 270 Jan 2014

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Small business unfair contract terms – medical practices need to be aware

BY **KAREN KEOGH,** PARTNER AT TRESSCOX LAWYERS

Medical Practices need to be aware that from 12 November 2016, the unfair contract terms under the Australian Consumer Law will also cover standard form small business contracts entered into, or renewed, on or after 12 November 2016.

What does this mean?

If your practice has:

- entered into a contract for the supply of financial goods or services; and
- at least one of the parties is a 'small business'; and
- the upfront price payable under the contract does not exceed $300,000, or $1 million if the contract is for more than 12 months

then you may have a legal remedy if you believe the contract is unfair.

What is a Small Business?

A 'small business' employs fewer than 20 people, including casual staff who may be employed on a regular and systematic basis. Accordingly, it is possible that both parties to a transaction will be able to rely on the unfair contract terms.

What is a standard form contract?

A standard form contact is usually characterised as an agreement pre-prepared by one party with standardised terms which is presented on the basis that the other party can "take it or leave it" with no effective opportunity to negotiate the terms. For instance, a mobile phone contract or a contract for medical supplies.

When is a term unfair?

The Australian Consumer Law does not provide a specific definition of what is to be considered an unfair term. In general, a term will be considered unfair if it would cause a significant imbalance between the rights of the parties or if it is not reasonably necessary to protect the legitimate interests of a party. The following kinds of terms may be considered unfair:

- automatic roll over for excessive periods;
- restrictions on the right of one party to terminate the contract;
- unilateral variation; and
- excessive cancellation fees.

The Court will also consider whether the terms and the contract as a whole is transparent. This involves looking at whether the terms are expressed in plain language, presented clearly and readily available. Terms are unlikely to be transparent when they are phrased in legal, complex or technical language.

What happens if a term is found to be unfair?

In the event the Court finds a term to be unfair it has the power to declare the term void and not binding on either party. The rest of the contract will continue to bind the parties if it is capable of operating without the unfair term.

The Court may also vary the contract, direct a party to refund money to the affected party or direct a party to provide services at that party's expense.

Conclusion

We recommend that you review all agreements (whether these are agreements with customers, suppliers or independent contractors) to work out which contracts are affected by the new provisions of the Australian Consumer Law.

It is important to note that your medical practice itself may also be subject to the Australian Consumer Law if you enter into standard form contracts with other small businesses.

Should an issue arise then advice should be sought at the earliest possible time to ensure your rights are protected. If you have any questions about the impact of the Australian Consumer Law please contact TressCox Lawyers' Health & Aged Care Team.

A short reflection

The following is an adapted text of a brief speech given by A/Prof. Jeffrey Looi, outgoing Psychiatrist Federal Council representative, at the Soapbox session of the AMA National Conference held in Canberra at the end of May:

A paraphrase of Dante's *Inferno*, First Canto:

> Midway on the journey of life,
> I found myself in a dark forest,
> The way forward uncertain.

The Australian Medical Association needs to carefully consider and methodically map a way forward in a time of dwindling membership of professional organisations through the dark forest of the future.

In discerning a way, the AMA should avoid: being swept into the churning whirlpool of the new media and political cycle; steer away from the dangerous rocks of technological utopianism and digital solutionism; and be ever mindful of the history of the medical profession in purpose and action.

I advocate for two particular priorities for the AMA.

Aged Care for those who loved, grieved, fought for and nurtured so that their futures and our present have become manifest. The youth of today will live long and yet need the care of the young and not so young born after them. Thus ever has been the way of human life and the AMA should advocate for careful provision of health care.

Those who suffer from mental illness, their lay and professional carers still eke out life under stigma, under-resourcing and plain neglect as do the aged. The AMA must also advocate for their just and compassionate care.

Baltasar Gracian, from his *Oracle of Worldly Wisdom*, had a useful observation about medicine:

> The art of medicine lies in knowing what not to do.

In planning forward, the AMA should be mindful that we exist: not to protect unwarranted professional privileges; not as a vehicle for the vainglorious political self-promotion or NGO careerism of members; nor for the hubristic over-reach to right all of humanity's wrongs and heal the world's pain beyond our ken and expertise.

Our medical skills and expertise are hard won, difficult to maintain and challenging to improve. Therefore, the AMA should carefully consider our vocation as doctors in mapping a through the dark woods: to learn, teach and care for the common health of humanity."

(The quotations are paraphrases. Otherwise, the text represents the author's academic opinion on health advocacy)

CANBERRA Doctor

A News Magazine for all Doctors in the Canberra Region

ISSN 13118X25

Published by the Australian Medical Association (ACT) Limited
42 Macquarie St Barton
(PO Box 560, Curtin ACT 2605)

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Articles:
Copy is preferred by email to execofficer@ama-act.com.au in "Microsoft Word" or RTF format, (not PDF) with graphics in TIFF, EPS or JPEG format. Next edition of Canberra Doctor – August 2016.