CANBERRA
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Canberra Hospital wait times continue to lag

The latest data released by ACT Health continues to show stubbornly high emergency department and elective surgery wait times leading to questions about funding priorities.

The latest emergency department quarterly data shows small quarter-on-quarter declines in four patient categories out of five. In particular, data for category three, urgent patients, shows that only 28% of patients started treatment on time against a target of 75%.

The most recent emergency department data shows a continuing trend towards longer wait times that now extends over several years.

Performance in elective surgery also continued a disappointing trend with none of the targets being reached however, the data did show an overall improvement with a reduction in the total number of patients waiting for surgery.

The Canberra Health Service latest data for the January to March quarter for 2019 tells us that patients in every other emergency department triage category - except resuscitation, waited longer than the previous quarter. The percentage of "seen-on-time" patients dropped by 6 six per cent for the urgent category at 30 per cent, well below the target of 75 per cent.

In the last national comparison, ACT was already the worst performer, especially in the urgent category, but the figures have not improved and appear to have further deteriorated. The number of presentations only increased by 0.01 per cent from the previous quarter, so the recent drop in performance may not be attributed to a jump in patient numbers. The median waiting time for patients for treatment also significantly jumped in the quarter, while urgent patients wait time increased also by 24 per cent, at 61 minutes, emergency by 17 minutes.

The most recent data from the Australian Institute of Health and Welfare (AIHW) also showed that although Canberra Hospital performed on par with its peers for treatment times of category (2) two patients, but it was among the worst performing for category three to five patients.

President's **Notes**

WITH PRESIDENT, DR ANTONIO DI DIO

AMA (ACT) calls for more beds

AMA (ACT) President, Dr Antonio Di Dio, responded to the release of the latest emergency department data by describing performance as disappointing and reflecting a longer-term issue.

"The usual reasons are apparent – insufficient inpatient beds to get patients out of the emergency department and into the hospital. This reflects the fact that significant parts of Canberra Hospital are overdue for replacement and an expansion of capacity is needed."

"While we acknowledge that additional space is being developed for the emergency department at Canberra Hospital, it really can't come quickly enough. At the most though, it postpones the problem of being able to get patients out of the ED and into the hospital."

Expansion of TCH facilities

The planned SPIRE Centre now becomes the centerpiece of the ACT Government's attempts to address the problems on the Canberra Hospital site.

"A significant expansion of Canberra Hospital really can't come soon enough, and we have to hope that the 2023/24 opening date of the SPIRE can be achieved," Dr Di Dio said.

"Ideally, it would be preferable to get it online earlier but that will be a tough ask."

"The bottom line is that funding for a scoping study for a new facility at TCH was set aside by former Chief Minister, Jon Stanhope, in 2012. It didn't proceed after he left office and it's hard to avoid the conclusion that, since that time, there's been a major failure to plan properly." Dr Di Dio added.

Walk in Centre's not the answer

Dr Di Dio also made it clear that Walk-in Centre's were not the answer to emergency department waiting times.

"Now more than ever it's apparent that the $50m spent on Walk in Centre's since their introduction could have been used in better and more innovative ways to deal with after hours and non-urgent matters." Dr Di Dio said.

"Each time a patient is treated at a Walk-in Centre, it costs the ACT taxpayer $180. Our view is that the money could be better spent and it's an issue we have raised with the former Health Minister and that we will continue to raise with new Health Minister, Rachel Stephen-Smith." Dr Di Dio added.

VMO contract heads to arbitration

With the VMO contract bargaining period coming to end in mid-September, the remaining issues between the parties will now head to arbitration. The negotiations between AMA (ACT) and the Visiting Medical Officers Association, on one side, and Canberra Health Service, were productive and many of the lesser claims were resolved during the negotiations.

At the end of the negotiating period, any claims that are not agreed or withdrawn will be considered as part of the arbitration.

Compared to the last VMO contract round, Canberra Health Service's list of claims was both less comprehensive and less ambitious, notwithstanding the CHS claim to significantly reduce the FFS rate. In addition, CHS has responded positively to issues raised by the VMOs including the prospect of a period of fixed workload, significant engagement on a 'digital recall' provision and a process to develop a statement of inclusion covering VMOs in the ACT public hospital system.

Mr James Macken, a leading Canberra barrister, has been appointed as arbitrator, with dates set for the arbitration that should see the hearing concluded by mid-December 2019.

New Private Practice Scheme

Although now withdrawn, the other major CHS claim was for a 'No out of pocket cost' private practice scheme ('NoPEX'); an interesting proposition and one that was discussed in some depth. The proposal would have seen CHS attempt to maximise private patient revenue by encouraging patients to utilise private insurance for inpatient episodes.

Mr James Macken, appointed arbitrator for VMO contract.

The scheme was to be analogous to the current staff specialists' scheme but, as VMOs are independent contractors, in one sense it would have been 'cleaner'. However, CHS have decided to withdraw the claim.

Negotiation versus Arbitration

In an overall sense, it's usually preferable for the parties involved – AMA (ACT), the VMOA and CHS – to reach a negotiated settlement in this type of process. The parties know the intricacies of the arrangements better than an arbitrator and are better placed to determine a suitable outcome than the inevitable compromises an arbitrated outcome imposes.

Of course, in some situations, particularly in the determination of remuneration or irreconcilable differences, the option of arbitration can facilitate a speedier resolution and a more acceptable outcome for the parties.

FFS Remuneration

Similarly to the last round, CHS has proposed a significant cut to FFS remuneration and also similarly to the last round, have based the claim on the difference in rates between the ACT and NSW and the relative reduction on workforce shortages in the ACT.

While both AMA (ACT) and the VMOA have rejected the CHS claim on FFS remuneration, it remains the major claim that CHS will be making.

AMA (ACT) Preferred Outcome

While the negotiating process thus far has resolved several of the lesser issues, AMA (ACT) has reduced the major remaining claims to be:

- 2.5% increase in both sessional and FFS rates
- Fixed workload for initial 12 months of contract
- 'Digital Recall' payment
- Cross-border Indemnity issues resolved
- A tripartite process to develop and publish a joint statement recognising the key role that VMOs play in ACT public hospitals

In our view, it is realistic for AMA (ACT) to achieve all of these outcomes in either an abitrated decision or in further discussions between the parties prior to the arbitration.

Canberra High student wins 2019 'Art In, Butt Out'

Canberra High School Year 8 student, Ally McCallum has taken out the twelfth annual 'Art In, Butt Out' competition with Health Minister, Rachel Stephen-Smith announcing the winner.

Now in its 12th year, '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 a poster that will help reduce the number of young people who smoke.

Health Minister, Rachel Stephen-Smith said peer to peer messaging is very important in spreading the campaign's message and encouraging young people not to take up smoking,

"Young people know how to speak to one another and what works with their peers. 'Art in, Butt Out' taps into this and provides a positive approach to reducing smoking among young people in the ACT. Campaigns like this can make a lifelong difference to our younger generation."

Health Minister, Rachel Stephen-Smith with Canberra High students.

Praise for Young Designers

Dr Antonio Di Dio, AMA (ACT) President 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."

"Ally's winning entry has all the elements we were looking for and the artwork sends a clear message that will help influence teenagers to think twice about taking up smoking or convince them to quit.' Dr Dio said.

Health Minister Rachel Stephen-Smith with 2019 winner, Ally McCallum.

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

Winner, Ally McCallum and her family.

"'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," Dr Dio 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 Rachel Stephen-Smith and ACT Health, the ACT Education Directorate, Canberra Milk and Tobacco Task Force members, Canberra ASH, the ACT Cancer Council and the ACT Heart Foundation for their continuing support." Dr Dio said.

AMA: climate change is a health emergency

The AMA has joined other health organisations around the world – including the American Medical Association, the British Medical Association, and Doctors for the Environment Australia – in recognising climate change as a health emergency.

Dr Tony Bartone., AMA President.

At its August meeting in Canberra, the AMA Federal Council declared that climate change is real and will have the earliest and most severe health consequences on vulnerable populations around the world, including in Australia and the Pacific region.

The Federal Council Motion reads:

The Federal Council recognises climate change as a health emergency, with clear scientific evidence indicating severe impacts for our patients and communities now and into the future. The AMA commits to working with government agencies and other organisations to prioritise actions in line with the AMA's 2015 Position Statement on Climate Change and Human Health.

AMA President, Dr Tony Bartone, said "the AMA accepts the scientific evidence on climate change and its impact on human health and human wellbeing,"

"The scientific reality is that climate change affects health and wellbeing by increasing the situations in which infectious diseases can be transmitted, and through more extreme weather events, particularly heatwaves. Dr Bartone added.

"Climate change will cause higher mortality and morbidity from heat stress. Climate change will cause injury and mortality from increasingly severe weather events. Climate change will cause increases in the transmission of vector-borne diseases. Climate change will cause food insecurity resulting from declines in agricultural outputs." Dr Bartone said.

"These effects are already being observed internationally and in Australia. There is no doubt that climate change is a health emergency. The AMA is proud to join the international and local chorus of voices urging action to address climate change on health grounds."

The AMA is calling on the Australian Government to:

- Adopt mitigation targets within an Australian carbon budget.
- Promote the health benefits of addressing climate change.
- Develop a National Strategy for Health and Climate Change.
- Promote an active transition from fossil fuels to renewable energy.
- Establish a National Sustainable Development Unit to reduce carbon emissions in the healthcare sector.

Call to Action

In April 2019, a group of Australian health and medical associations, including Doctors for the Environment, the Climate and Health Alliance, the Royal Australian College of Physicians, and the Australian Medical Students' Association wrote an open letter to all political parties emphasising the "significant and profound impacts climate change has on the health of people and our health system."

In June 2019, a group of 70 American health organisations, including the American Medical Association and the American College of Physicians, recognised climate change as a health emergency, releasing a call to action on climate, health, and equity.

In July 2019, the British Medical Association declared a climate emergency and committed to campaign for carbon neutrality by 2030.

Background and Australia-specific effects include:

- The significant health impacts of climate change have been evident for some time. The AMA has held a position on climate change and health since 2004.
- In 2015, the World Health Organisation rated climate change as "the greatest threat to global health in the 21st century."
- The Lancet Countdown on health and climate change's 2018 report and the Australia-specific report and the Intergovernmental Panel on Climate Change's 1.5 degrees report all outline the serious health effects of climate change, internationally and in Australia.
- Significant linear associations between exposure to higher temperatures and greater mortality in Sydney, Melbourne, and Brisbane.
- Estimated annual productivity losses from heat stress of $616 per employed person in Australia.
- 2177 deaths from extreme weather events in Australia between 1900 and 2017.
- An observed 13.7 per cent increase in the ability of Aedes aegypti (dengue-carrying mosquito) to transmit disease to humans in Australia from 1950-2016.

Counselling about reproductive carrier screening made ... well, as ea

Earlier this year the College of Obstetricians released national guidance that all women and couples planning pregnancy, or in early pregnancy, should be offered genetic carrier screening for conditions such as cystic fibrosis (CF), spinal muscular atrophy (SMA), fragile-X syndrome (FRAX), and haemoglobinopathies. This complemented similar advice from the College of GPs.

By Professor Steve Robson.

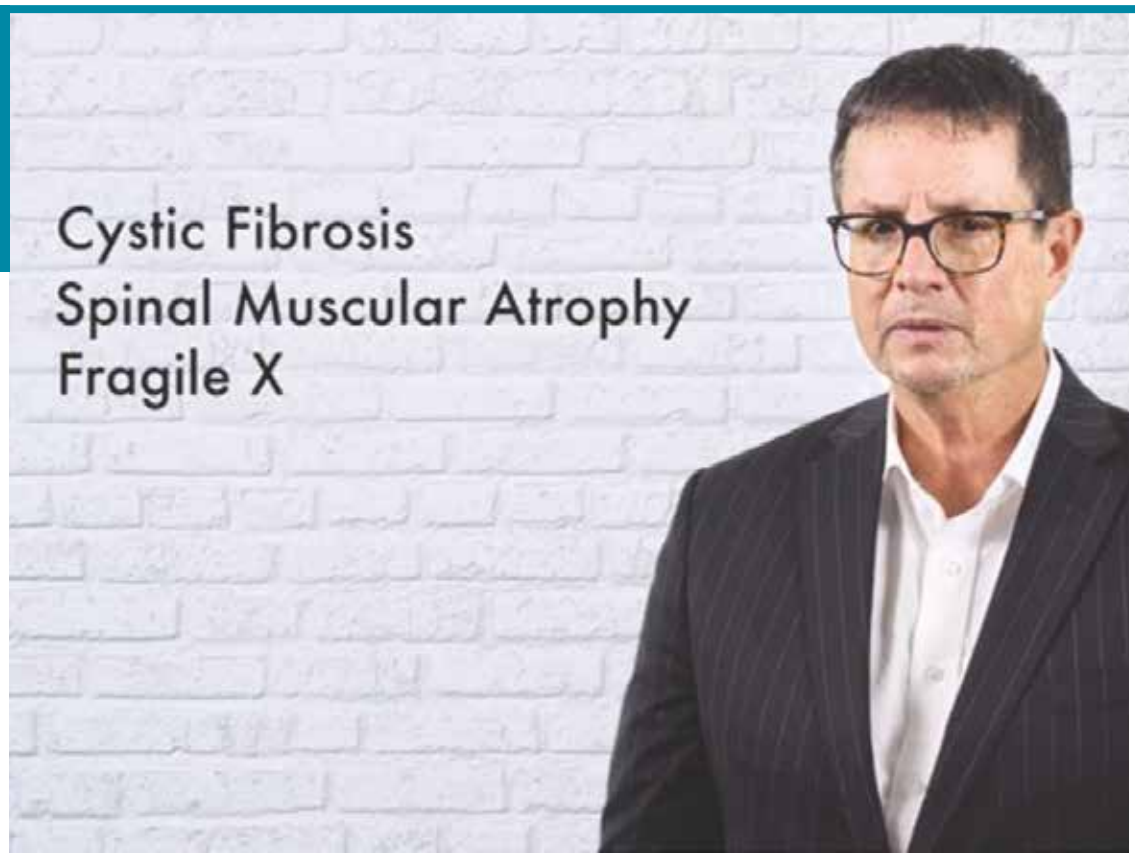
The guidance provoked rather a negative response, particularly from busy GPs. Indeed, it featured in newspaper headlines, where it was described as a 'radical shift.' While the tests are technically simple these days, the counselling that goes with offering a genetic test in an asymptomatic young person seems fearsome. To make matters worse, there is no rebate for carrier screening through the MBS, so women have to pay well over $400 out of their own pockets.

I have to confess that as the Chair of the group that made these new recommendations – a group that included genetic specialists and consumers – I feel responsible for the burden that many family doctors now feel rests on their shoulders. For that reason, I wanted to offer my tips on how to make the pre-test counselling a little easier. Admittedly, it is difficult to complete in a short consultation. However, it is important and the consequences of missing a couple can be dire.

First... know your diseases!

It is impossible to counsel a woman or couple about screening if they don't understand the diseases being tested. Being about to describe them, and how common the underlying mutations are, is vital. It is important to make it clear that the woman and her partner aren't at risk, but that the testing is all about their potential child. To help, I have put descriptions of the disease in nutshell form (see, The diseases in a nutshell).

I usually start with a sentence something like this: "A reproductive carrier screen is a test to determine whether you carry genes that could cause serious health problems in your child." It is worth reminding your patients that the genes tested for cause conditions that (1) have their onset when a child is young, and (2) have a very serious impact on a child's health, quality of life, and how long they live for. They are not frivolous.



To see the patient video, search YouTube for 'Reproductive Carrier Screen Canberra.'

Genetics can be difficult for all of us to understand – I certainly struggle. However, another important concept is that both of a child's parents must carry the gene for the child to be affected. If one member of a couple – usually the woman, for the reason that FRAX will affect the X-chromosome – is clear, then the chance of a child being affected is minimal. For this reason 'cascade testing' – testing one partner in the first instance, and the other partner only if a recessive mutation is found – is the usual practice.

Next... explain that the screening test is for well people in healthy families

Many people presume that because they are healthy, and there is no inherited disease (that they're aware of, anyway) in the family, that they are not at risk. It is worth reminding people that in about 80% of cases where a child is affected by a genetic condition, there is no family history. When there is a family history of a genetic condition, screening is not the correct test. It can be phrased something like this: "If inherited genetic con-

sy as possible

ditions are already known to be present in your family, the testing process is very different."

Talking about the test results ...

Because these conditions are all uncommon, the most likely test result is a negative one – couples will have a low chance of having a baby affected by one of the genetic conditions. While that is good news, it is worth reminding your patients that a negative result does not guarantee a healthy baby, and it doesn't mean that they don't need to consider testing for conditions such as Down syndrome once pregnant.

Sometimes the test results might show that both partners carry the same recessive gene. Before having the test, it is important the couple understand the options available to them in that situation. There are four options available:

- To consider IVF treatment with testing of the embryo.
- To become pregnant and then have testing. It is possible, but can leave scant time to reach a diagnosis.
- Another option is to consider the use of donated eggs or sperm.
- Finally, some couples may choose not to become pregnant.

Receiving such test results is usually a shock, and the couple will need genetic counselling and general support if this happens. As well, results could potentially have implications for other members of the family. It is worthwhile for couples to think about how health information is shared in their family, and how they might tell other family members about results that could affect them too.

Testing is good but not perfect

All medical tests have limitations, and genetic testing is no different. Sometimes the testing won't work first time and a second sample will be required. In some cases, the test won't be able to identify an abnormality, even though an abnormality may be present. This might be due to a gap in scientific knowledge, or perhaps an inability for the laboratory to identify certain types of changes in genes. There can be other reasons too. Couples need to understand these limitations before agreeing to have testing.

The take-home message

Genetic testing can detect uncommon but important genes that have the potential to cause severe conditions in children. These tests are best done before becoming pregnant, but this is a counsel of perfection. Even in a genetic-savvy country like Israel, only about a quarter of carrier screen tests are done pre-pregnancy. Patients planning to have the test need to have thought about how the results will affect them, and their family. And everyone needs to remember that the testing is not perfect.

It is easy to forget all of this, so a checklist can help. For my own patients, I have made a brief video containing the key points. It is freely available for anyone to watch on YouTube – just search for 'Reproductive Carrier Screen Canberra' and it should come up. Good luck!

THE DISEASES IN A NUTSHELL:

Cystic Fibrosis (CF)

A malfunction in the production of saliva, sweat, tears, and mucus. People with CF have thick and sticky mucus in the lungs, airways, and digestive system that interferes with nutrition and causes lung infections and damage. One in 24 of us carry a CF mutation.

Spinal Muscular Atrophy (SMA)

A group of neuromuscular disorders causing the loss of motor nerves, with progressive muscle wasting with resulting severe disease and death in childhood. Caused by an inherited defect in the SMN1 gene. One in 45 of us carry an SMA mutation.

Fragile X Syndrome (FRAX)

Fragile X-associated conditions result from expansions in the FMR1 gene on the X chromosome. The effects of FRAX syndrome include a wide range of physical, intellectual and behavioural symptoms including intellectual disability and premature menopause. About one in 200 women carry a FRAX premutation.

Thalassaemias

Thalassaemias are a group of conditions in which the body makes an abnormal form, or inadequate amount, of haemoglobin. This can result in red blood cells being destroyed, leading to anaemia. The carrier frequency depends on ethnicity.

AMA 50 Year member: Dr Graeme Moller AM

BY DR JOHN DONOVAN

It may be that one of our 50-year members was almost dragooned into the AMA.

Dr Graeme Moller AM.

When Dr Graeme Moller graduated in medicine from Monash University in 1968 all graduates were taken to the Victorian Medical Board to be registered as medical practitioners and immediately following that, to the Australian Medical Association where membership forms were handed out and duly completed.

Already having funded his last three years as an undergraduate on a Royal Australian Air Force undergraduate scholarship Graeme served in the RAAF from 1970. His lengthy service included time as an Exchange Officer with the United States Air Force based at Nellis Air Force Base in Nevada (and living in Las Vegas for two and a half years). He held several other RAAF posts before becoming Director-General of Air Force Health Services, then finally becoming Surgeon General of the Australian Defence Force. He was appointed a Member of the Order of Australia (Military Division) in 1999.

During his time in the RAAF Graeme attained Fellowship of the Royal Australian College of General Practitioners, Fellowship of the Australian College of Occupational Medicine (later the Faculty of Occupational and Environmental Medicine) and Foundation Fellowship of the Australian Faculty of Public Health Medicine.

GP Education and Training

Immediately after retiring from the Air Force in 1998 Graeme became State Director of training for the Royal Australian College of General Practitioners for the ACT and Southern New South Wales region. As part of that role he worked sessions in several general practices in Canberra. During this time he also served on the Board of the AMA (ACT).

Subsequently he joined the newly established General Practice Education and Training (GPET) as a senior medical adviser, continuing his sessions in General Practice. Towards the end of his time with GPET he commenced at the new ANU Medical School as a tutor in Problem Based Learning, moving from that to tutor in clinical skills at The Canberra Hospital campus of the Medical Faculty. He was actively involved in that latter role until retirement in 2016. He retired from general practice in 2012.

Graeme has been married to Alison for 51 years. They have two daughters and three grandchildren (two of whom live in Canberra and one in the UK). His hobbies include golf, photography and travel (which usually includes the UK to see his daughter, son-in-law and grandson).

We wish Graeme and Alison a long and happy retirement.

Are you a practice owner in a partnership?

BY MATTHEW PRAIN, REGISTERED FINANCIAL TAX ADVISOR SPECIALIST WEALTH GROUP

If you're a practice owner in a partnership with one or more other doctors, it may be important to consider what would happen to the ownership of the business if one of the owners died, became disabled or had to exit.

Business owners will sometimes establish a legal agreement, such as a Buy-Sell agreement in order to provide more certainty if these type of events were to occur.

A Buy-Sell agreement is a document which commonly sets out the wishes of the business owners should one of them die, become incapacitated or trigger any one of a range of specified events. It can be drafted in a number of ways to suit your circumstances, and those of your business. For example, if your business partner dies, a Buy-Sell agreement can be structured to give you the legal right to buy their share of the business, for a specified amount.

The agreement could also give you (or your beneficiaries) the right to sell your share of the business to the other business owner(s), should one of these events happen to you. The purchase can be funded in a number of ways, but the most common one is by life insurance policies, taken out on the lives of each owner.

A Buy-Sell agreement, coupled with an insurance policy, can be useful for a number of reasons:

- If an owner dies, you may not want to work with their spouse or partner, but you may have no choice if he or she inherits the deceased owner's share of the business and wants to manage the business with you.
- Alternatively, you may want to buy that owner's share of the business on their death or disablement, but may not be able to afford it. The spouse may then sell the business share to a third party who you may not want to work with either.
- The agreement can also set out a business valuation, helping you to avoid arguments about the value of the exiting owner's share.
- The insurance policy can be structured so it provides the funding that allows the surviving owner(s) to purchase the exiting owner's share and retain 100% ownership of the business.

Continued page 10...

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/

Are you a practice owner in a partnership...*continued*

...from page 9

Valuing your Business

If you were to sell your business today, what price would you ask for it? If you were to buy your business partner's share of the business, how much would you pay?

Valuing your business is an essential part of business succession planning. A proper valuation can reduce the likelihood of potentially awkward or unfair negotiations on price, or even disputes with an exiting business partner or their beneficiaries.

A proper valuation can also give the parties to the agreement, and their beneficiaries, much greater clarity about what their interest in the business is worth and how much they would need to pay to purchase an outgoing owner's share.

It is generally a good idea to update the valuation each year, or when the circumstances of the business change. A regularly updated valuation may reduce the risk of disagreements and help enable a smooth transfer.

It is also important that you see your financial adviser regularly, as changes in the valuation of the business will normally require a corresponding change to the amount of cover in your insurance policies. Without this adjustment, there can be a gap between the value of the business to be transferred and the amount of insurance cover to pay for it.

The Importance of Advice

Strategies to transfer business ownership can be complex and the needs of each business and its owners will be different. It is important that you seek taxation and legal advice from a professional tax adviser and suitably qualified lawyer in relation to your specific needs. Specialist Wealth Group can assist in setting up the right insurance policies to support your buy sell agreement, and guide you on the right ownership structures of the cover to ensure the rights and obligations contained in a Buy-Sell agreement reflect the wishes of the parties.

For further information please contact Specialists Wealth Group on 1300 008 002. Specialist Wealth Group is a preferred partner of AMA (ACT).

CASE STUDY

Dr Khan and Dr Chen are co-owners of a GP practice in Canberra. They have been operating the business for a number of years and work very well together, running a very successful and busy practice.

If either of them were to die or become disabled, they would like to have the option of purchasing the other's share of the business, however neither would be able to afford to do this at short notice.

Whilst Dr Khan is single and has no dependants, Dr Chen has a husband named Robert, and two children.

If Dr Chen died, all of her assets would pass to Robert under her will, including her share of the GP Practice.

Dr Khan is deeply concerned about this. Robert works as an Engineer and has no experience in running a business, let alone a GP Practice In addition, as he is not a doctor and could not see patient's, revenue would drop with him as an owner.

First, their adviser arranges for the business to be valued by an independent valuer – and a business value of $3 million is established – Dr Khan and Dr Chen each own 50%.

Next, their adviser recommends that Dr Khan and Dr Chen each establish a life and OWN occupation Specific TPD insurance policy of $1,500,000 – this is to ensure that each will have enough money to purchase the other's share of the business.

Finally, their lawyer drafts a Buy-Sell agreement, giving both Dr Khan and Dr Chen the right to purchase the other's share of the GP Practice should a 'trigger' event, such as death or disability occur.

The Buy-Sell agreement will give Dr Khan the right to acquire Dr Chen's share of The GP Practice. In the event that Dr Chen dies, Dr Khan would acquire full ownership of the business, and Dr Chen's family would get their share of the value of the business in the insurance proceeds.

Family Doctor Week Dinner 2019

At this year's Family Doctor Week dinner, we were fortunate to have Dr Tony Bartone, Federal AMA President as our guest of honour. Tony, a Melbourne GP, was fresh from his earlier appearance at the National Press Club where he laid out his vision for general practice and primary care reform, public hospitals, aged care and indigenous health.

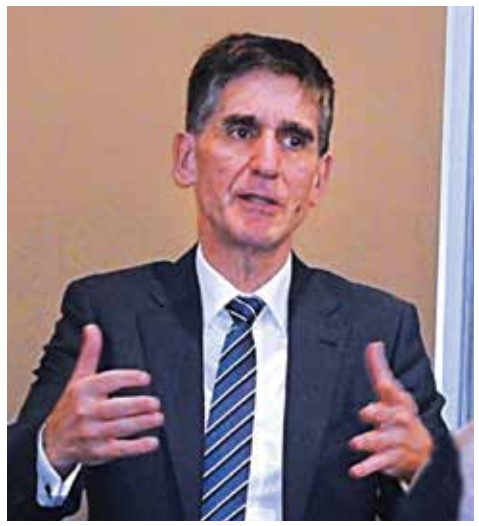
In the eighteen months of Dr Bartone's presidency he's made it clear to all parties that one of the hallmarks of his presidency would be advocating strongly for significant investment in general practice.

Dr Bartone addressed the dinner – continuing his themes from the earlier National Press Club address – and then took questions.

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

AMA (ACT) President, Dr Antonio Di Dio, left, with AMA President, Dr Tony Bartone.

Dr Alan Shroot, left, with Dr Doug Rogers and Dr Liz Gallagher.



AMA President, Dr Tony Bartone, addressing the dinner.

Dr Emma Adams: Unbreakable Threads

ISBN: 9781760633103

'Unbreakable Threads is the true story of an Australian mother, a refugee boy and what family really means.'

Dr Emma Adams.

When Canberra psychiatrist and mother of three, Emma Adams, travelled to Darwin as an observer of conditions for mothers and babies in immigration detention centres, she expected the trip to be confronting. What she didn't expect was to return to Canberra consumed by the idea that she had to help a sixteen-year-old unaccompanied Hazara boy from Afghanistan – Abdul. He and his brother Ahad, moved in with her, her husband Rob and their young boys in 2015 when Abdul was finally let out and all of their lives changed forever.

The story of Emma and Abdul's connection, and her fight to get him out and provide him with an Australian home, a family and a future, forms an important testimony in Australia's treatment of asylum seekers.

Excerpt: Remembering

We have a small and humble Persian carpet in our house. Nestled into its worn and faded red background are the most beautiful bright-blue and yellow flowers and birds. When the boys were little, they all loved to sit on it as Rob told them his magic flying carpet stories. Mysteriously, the stories always happened to three little boys, who also happened to have the same names as our boys, but in the 'magic carpet world' they had switched roles. Sometimes, if the carpet went too fast in their imagination, the two eldest would hold tight to either side of the rug while baby Toby sat content in Rob's lap. The stories always ended with the three of them zooming away to their next adventure, snuggled together in the safety of their daddy and the carpet.

At the same time Rob was telling bedtime stories, 11,000 kilometres away on the other side of the world in Afghanistan Ahad and Abdul had also been young children, but their world was very different. While my boys were playing in their nice, warm house with their imaginary stories on their magic carpet, Ahad and Abdul were making carpets for twelve to fourteen hours a day.

They were Hazaras, a minority group of people in Afghanistan who, because of their ethnicity and religion have been targeted by the Taliban and other terrorist groups with bombings, kidnappings and murder. Because of attacks by heavily armed gangs, the family had fled their village in Hazarajat. With no land to farm and no home, they worked side-by-side each day weaving carpets to eke out enough money to live by. Abdul told me with great pride that he was put in charge of making the flower patterns on the carpets, and sometimes embroidery around the little round mirrors that adorn clothing and other textiles, because his small hands were more dexterous than the adults.

I heard this story one evening as we were sitting on our tiny carpet eating a pre-dinner snack of biscuits and soft cheese. When Ahad started laughing, I asked him why. The small mound of cheese we were casually eating, he said, was about the same amount of food they had to eat as a family of seven when they were carpet-weaving. He took another mouthful of cheese with a huge grin on his face.

This family had not fled their land and mountain village to escape poverty. If it had been safe to stay in their home, they too could have

and had enough to eat—as farming families had for generations before—and they could have remained sitting on their carpets with their parents and lived as children should, in a world of safety, imagination and play. Abdul and Ahad's family fled because their lives were in danger and their poverty was a result of this need to flee. In the same way, Abdul and Ahad also did not flee to Australia because of the family's poverty. They fled because they weren't safe, and what they were forced to leave behind was the most precious thing in the world to them – Family.

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Australasian Stroke Society meets in Canberra

BY DR YASH GAWARIKAR

For the first time, in early September, Canberra hosted the Annual Scientific Meeting of the Stroke Society of Australasia. I had the pleasure of being the convener and conference chair of what was the 29th annual scientific meeting .

It was great to have the support of the ACT Health Minister, Rachel Steven-Smith who inaugurated the conference and announced that there will be a 24/7 Endovascular Clot Retrieval Service at Canberra hospital from end of this year. Currently we have to send patients to Royal Prince Alfred Hospital in Sydney after hours when there is no interventionalist on call at the Canberra Hospital

Guest of Honour General Sir Peter Cosgrove (second from left) Lady Cosgrove and Dr Yash Gawarikar (right) and other guests at the gala dinner.

General the Honourable Sir Peter Cosgrove, former Governor General and an ambassador for the National Stroke Foundation, was guest of honour at the gala dinner.

Meeting Highlights

The meeting highlighted important research and advances in acute stroke care in not only adults but also in the paediatric population, which is even more devastating.

The 2019 meeting looked at the most recent, robust research nationally and internationally, investigating stroke's mechanisms, consequences, diagnosis, prevention, management and recovery.

Innovations showcased at Stroke 2019 included Australia's first Mobile Stroke Unit or Stroke Ambulance, extending the window for time-critical stroke treatments and the impact of imaging, stroke in young people, breaking down geographical barriers to stroke treatment and rehabilitation through telehealth and clinical interventions to support stroke recovery.

Keynote Speakers

Our international keynote speakers were Professor Lee Schwamm, Professor of Neurology at Harvard Medical school and Director of Stroke Service at Boston Mass General and Professor Tudor Jovin, Professor of Neurology and Neurosurgery at Cooper Medical School.

In total, we had almost 450 delegates, including international delegates from US, Canada Japan, China, India and other Asian countries. Overall it was a great opportunity to highlight our nation's capital.

More information is available at http://www.strokesociety.com.au/

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1. Interim Report of the Disability Committee, Institute of Actuaries of Australia 2000. 2. Australia's Health 2015, Australian Institute of Health and Welfare, 2015. 3. Cancer in Australia, an overview, Australian Institute of Health and Welfare, 2014-2015

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