medical link

THE OFFICIAL PUBLICATION OF THE GOLD COAST MEDICAL ASSOCIATION INC.

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Advances in Breast Cancer

Voluntary Assisted Dying is Coming to Queensland

Travel Medicine Updates

Coming Together to Raise Vital Funds for Cancer Care

Gold Coast Private Marks its 5th Birthday

SOUTH COAST RADIOLOGY
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SOUTH COAST RADIOLOGY

Contents

04 **A Message From the GCMA President**
Prof Philip Morris AM

SOCIALS

08 **GCMA August Monthly Meeting**

EDITORIALS

10 **Advances in Breast Cancer**
A/Prof Rhea Laing

18 **Coming Together to Raise Vital Funds for Cancer Care**
Icon Cancer Care

22 **Gold Coast Private Marks its 5th Birthday**
Press Release

24 **Travel Medicine Updates**
Dr Simon Thatcher

30 **How to Use Your Practice Data to Improve Your Processes & Patient Experience**
Avant Mutual (Practice Hub)

34 **Voluntary Assisted Dying is Coming to Queensland**
Dr Gretchen Hitchins

A Message from the GCMA President

Prof Philip Morris AM, President GCMA
MB BS BSc PhD FAChAM (RACP) FRANZCP FPOA FFP ABPN
info@drphilipmorris.com | 0422 545 753 | www.drphilipmorris.com

Dear GCMA Colleagues,

We have two more monthly Thursday evening clinical meetings for this year. In September we have Dr Hanlon Sia speaking on 'What's New in Multiple Myeloma'. On 20 October we have Dr Tom Huang from Mermaid Molecular Imaging talking on the most up-to-date nuclear medicine imaging methods.

Towards the end of this year we plan a Gala Social Entertainment and Dinner Evening Event in November. We have three options. We could visit the Tiger Island facility and show at Dreamworld. Or we could go to the Outback Spectacular evening show at Helensvale. Or we could run a 'Fawlty Towers' show and dinner evening at the Southport Golf Club dining room. I would like GCMA members to indicate their preference about which one of these functions would be most enjoyable and best attended. Please call or text me your preference on my mobile phone 0422545753, or email me at pmorris@iprimus.com.au.

Planning continues for our 2023 Pacific Island joint conference with the Samoan Medical Association, the Oceania University of Medicine, the University of Samoa, and the Samoan Department of Health. The meeting will be held in Apia, Samoa in 28 to 30 September 2023 (a time within the Queensland school holiday period). I hope many GCMA members will offer their services as speakers for this meeting and consider mentoring a medical student from the Oceania University of Medicine in their practices. A 'fact-finding' tour of Samoa is going ahead from 8 to 15 October this year to begin planning for this conference. Any GCMA member who is interested in participating in this preparation visit is welcome to be involved. Please contact A/Prof Stephen Weinstein (stephenweinstein@bigpond.com) or me (pmorris@iprimus.com.au) for details.

We are always looking to expand our membership. I encourage you to invite your doctor colleagues to join the GCMA. It is very easy to do. Just go to the GCMA website (www.gcma.org.au) and click through to the 'Become a Member' page to join. The registration page can take credit card payments. The $150 annual membership is extremely good value. It covers 10 monthly evening meetings where salient updates on clinical and professional matters are presented as well as a two-course meal and complimentary beverage, and the opportunity to interact with colleagues from all professional disciplines.

Planning continues for our 2023 Pacific Island joint conference with the Samoan Medical Association, the Oceania University of Medicine, the University of Samoa, and the Samoan Department of Health.

I look forward to seeing you at our next GCMA meeting.

Yours sincerely,

Prof Philip Morris AM
President GCMA

AN EVIDENCE-BASED MULTIDISCIPLINARY APPROACH TO TREATING CHRONIC PAIN

OUR MULTIDISCIPLINARY TEAMS ARE AVAILABLE TO TREAT AND MANAGE CHRONIC PAIN ACROSS OUR GOLD COAST LOACTIONS.

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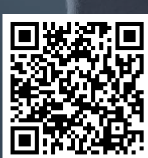

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A MULTIDISCIPLINARY APPROACH TO PAIN:

GP: GATE KEEPERS
- Appropriate referral & pain medication
- Appropriate investigations
- Opportunities to reduce threat of pain via communication

PHYSIOTHERAPISTS: EDUCATION
- Empower and reduce catastrophizing
- Restore normal movement/posture
- Monitor & advise on exercise rehab program

EXERCISE PHYSIOLOGISTS: RE-INFORCE EDUCATION
- Help develop & implement graded exercise program
- Restore normal movement & posture with physiotherapist

OCCUPATIONAL THERAPISTS:
- Assist with aids/home setups/RTW plans
- Work closely with allied team to provide an effective pathway to functional outcomes

DIETITIAN:
- Reduce diet-induced pro-inflammatory state, weight management

PSYCHOLOGISTS:
- Tackle beliefs & address past trauma
- Manage stress, depression, anxiety, tools to help cope

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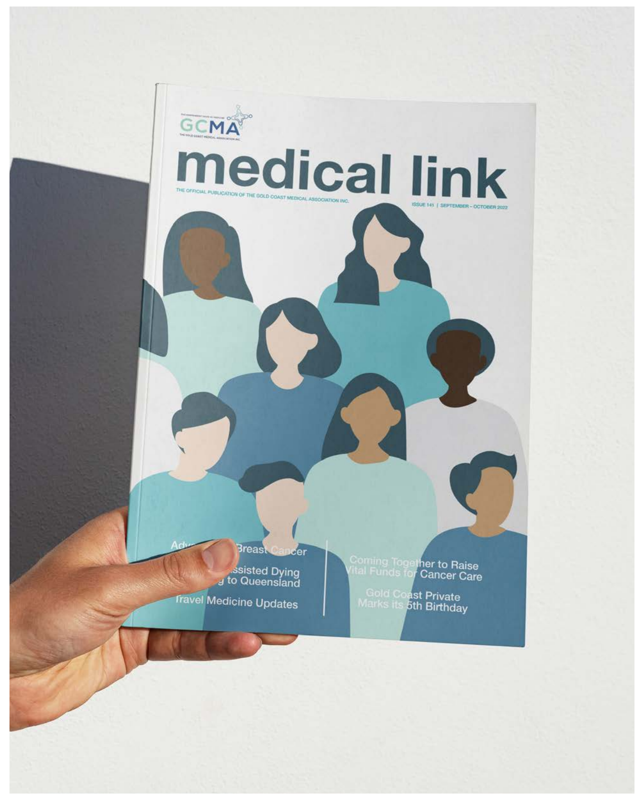

The Medical Link enriches the Gold Coast medical community by uniting the voice of its doctors.

Here you will find insightful stories and the latest trends in field research conducted abroad, and of course, right here on the Gold Coast. Keep informed of new health services, developments in the medical profession, and general interest items.

We invite you to submit your company updates, new recruits and promotions to the following email: admin@themedicallink.com.au

And if you would like to advertise your products or services, positions vacant, rooms for rent etc. in The Medical Link, please feel free to contact us admin@themedicallink.com.au.

The GCMA August Meeting

Dr Tom Huang & Dr Mark Doudle

Dr Shayne White & Dr Gregory Aroney

Dr John Kearney, Prof Philip Morris & A/Prof Rhea Laing

Naomi Wright, Prof Gordon Wright, Dr Michelle Fryer & Dr Wai Ling Choi

Dr Tulasi Ramanarasiah & Dr Alison Sprague

Lis Weinstein, Dr Gretchen Hitchins & Carole Morris

Event Sponsor Dr Tom Huang, Clinical Director of Mermaid Molecular Imaging

Guest Speaker A/Prof Rhea Laing

"As a breast surgeon, it pains me say this, but: the less we operate, the better the survival from breast cancer."

Advances in Breast Cancer

A/Prof Rhea Laing
MBChB, BA(Ed), MSurgEd, FRACS, FACS, FFSTEd
rhea.liang@health.qld.gov.au

As a breast surgeon, it pains me say this, but: the less we operate, the better the survival from breast cancer [Fig 1].

Halsted did the first radical mastectomy, removing the pectoralis and leaving just skin and ribs, in 1882. This led to the best survival rate in the day, and was likely the only potentially curative approach at a time when adjuvant therapies did not exist and the lack of screening meant that women presented late. Some members of this association will still have elderly patients who underwent this extremely disfiguring operation- proof of its efficacy but also its morbidity. The Halstedian paradigm of 'more is more' was the standard treatment for more than 100 years.

Dr Bernard Fisher did the groundwork for challenging the Halstedian paradigm in the 1960s and 1970s, and by the late 1970s surgeons were starting to perform a 'modified radical mastectomy', which left the pectoralis muscle in situ, with equivalent survival rates to a radical mastectomy[1]. This was soon followed in the mid-80s by the finding that a 'segmental mastectomy' (now termed a 'wide local excision') could also give equivalent survival as long as radiotherapy was also delivered. It is worth noting that the survival without radiotherapy was almost one-third lower than with radiotherapy (63.8% vs 97.9%)[2], a finding that still holds true today. If a patient says they would like 'lumpectomy but without the radiotherapy'- perhaps through fear of 'radium' or the potential effects on implants- please do your best to reassure them that modern radiotherapy is both less morbid and more effective than the radiotherapy of the past, and will be lifesaving for many.

At around the same time, it was being shown that sampling the lower axillary nodes was as accurate and safe as performing a full axillary dissection[3], a procedure that was further refined in the late 1990s by the development of the sentinel lymph node procedure, using a selection of dyes or tracers to find the first draining lymph node(s) from the breast[4]. I was simultaneously terrified and honoured to be part of the team performing the first sentinel lymph node procedure in New Zealand in 2001; that's me on the left, in a still taken from the broadcast of this procedure on national television [Fig 2]. We were incredibly nervous because, if the procedure failed, our nearest technical support was in Sydney. Thankfully all went well!

It was initially standard procedure that if cancer was found in the sentinel lymph node, the patient would proceed to the traditional full axillary dissection. This made logical sense within the thinking of the day; if there was residual cancer, shouldn't it be cut out if possible? However, with progressive improvement in adjuvant chemotherapy, radiotherapy, hormonal and biological treatments, it was becoming more widely understood that the mortality of breast cancer more often related to distant metastasis, not local spread, and that this was more effectively addressed by systemic treatments rather than by more local surgery. By 2010 there was evidence that patients with minimal axillary disease could be spared a second operation for axillary dissection[5].

In 2014, a further landmark paper showed that margins were not required in surgical excision- even a single cell between the edge

Figure 2

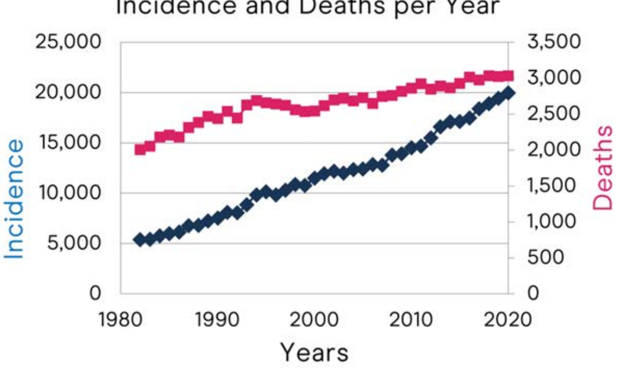

Figure 1

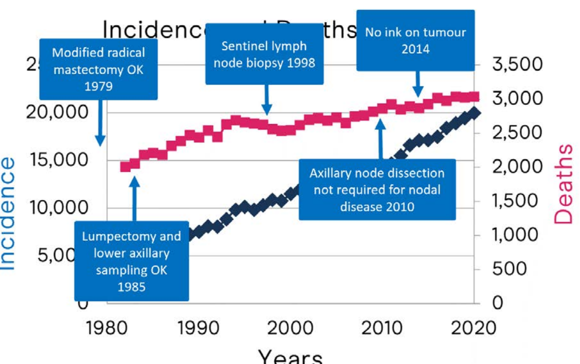

Figure 3

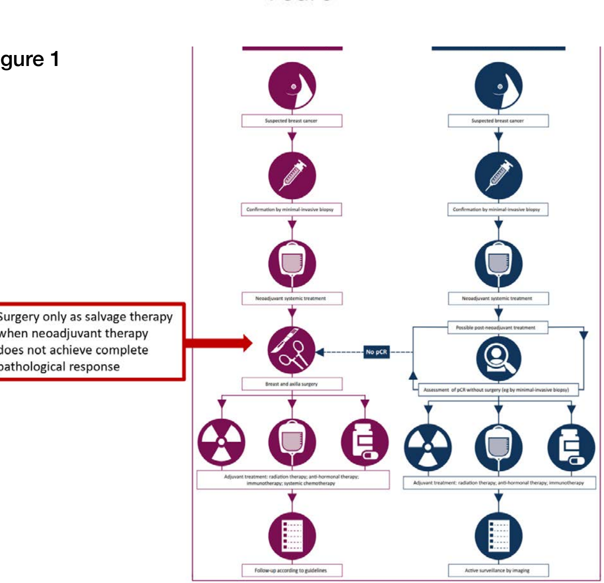

Figure 4

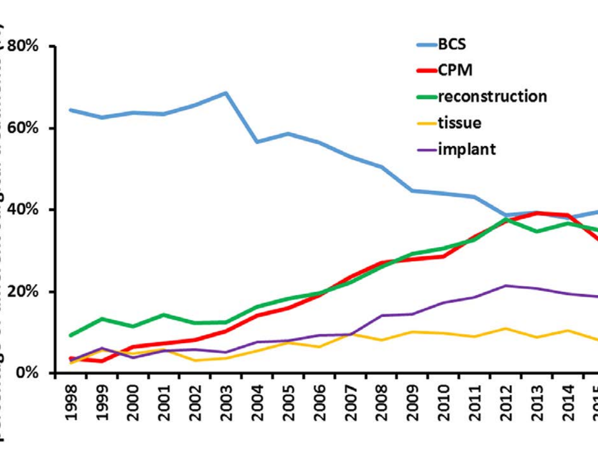

Figure 5

of the cancer and the ink that the pathologist used to orientate the surgical specimen gave equivalent outcomes to achieving wider margins[6]. This became known as 'no ink on tumour' margins and has greatly reduced the volume of breast requiring excision, because those with a maths bent will recall that the volume of a sphere is proportional to the cube of the radius (V=4/3πr3). For a 2cm tumour, excising 'no ink on tumour margins' (a sphere of, say, 2.2cm) rather than 5mm margins on all sides (a sphere of at least 3cm) reduces the volume excised by over 60% (5575.3 mm3 instead of 14137.2mm3).

Figure 3 shows the same graph as Figure 1, with the key timepoints marked. It can be seen that survival rates continue to rise inexorably, despite a gradual increase in breast cancer incidence and a progressive reduction in the extent of surgery [Fig 3]. Should we operate even less?

There are certainly suggestions that older patients (>70) with early breast cancer may be spared the morbidity of any axillary surgery (not even a sentinel lymph node biopsy)[7] and there is already 10-year data suggesting that it is safe, to be borne out in larger trials. There are also at least six trials currently under way to assess if 'surgery as salvage' (upfront adjuvant therapy, with no surgery if there is complete response) is similarly safe[9] [Fig 4] We await the outcomes of these trials with caution and equipoise, as we always do.

It is interesting, and somewhat perplexing, that despite the evidence supporting less radical surgery, patients are choosing to have more radical surgery, not less[10]. This trend is particularly marked in younger women with the smallest tumours- exactly the group who would have an excellent survival with less radical surgery [Fig 5]. Some of this is undoubtedly to the progress in reconstructive techniques, and research also suggests that avoidance of ongoing lifetime screening and the associated fear of future cancer is a significant factor[11].

One of my Masters students Dr Rhys Youngberg, a plastic surgical trainee, has also investigated factors influencing women on the Gold Coast and come to some surprising conclusions (thesis available on request):

1. Women come to their breast surgery consultations with firm ideas already of what they will and won't accept as treatment. The communication during the consultation is understood within that framework. It does not seem to be a problem with information provision by the specialist, but more about what the patient chooses to 'take away' from the consultation that may confirm or change their prior decisions.

2. Personally meaningful anecdotes form the basis of what treatment options women are willing to receive. Connection matters more than scientific robustness or data- hence the importance of specialists establishing good rapport. If trust is not established, the patient may well put more weight in the words of a relative, or a person with a prominent public profile who is not a doctor.

3. There is a high level of satisfaction with the communication patients receive at all levels, even if their treatment choices differ from what is recommended. This finding surprised us most of all, as we had anecdotally felt this situation negatively impacted the doctor-patient relationship. It is reassuring that patients do not feel the same way!

So where does this place us in 2022? There are two forces moving in opposite directions- research supporting less radical surgery and patient choice for more radical surgery. As we go forwards, it will be important to balance patient autonomy against the harms and benefits of treatment. It seems, despite all the changes in breast surgery, that this tenet of practicing medicine remains as true as it ever was.

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"By working with Cancer Council Queensland, Icon patients benefit from holistic support that allows them to focus on their treatment."

Coming Together to Raise Vital Funds for Cancer Care

Icon Cancer Centre
Gold Coast Private Hospital
Lower Ground 3, 14 Hill Street Southport
(07) 5634 2400 | admin.goldcoastprivate@icon.team

Icon Cancer Centre staff, patients and supporters from the Southport, Gold Coast University Hospital and Gold Coast Private Hospital sites recently celebrated the Cancer Council's Biggest Morning Tea.

All funds raised from the events will go towards cancer research, prevention and support services for patients and their families.

Icon Cancer Centre and Cancer Council Queensland have a long-standing partnership in supporting Queenslanders affected by the disease.

By working with Cancer Council Queensland, Icon patients benefit from holistic support that allows them to focus on their treatment.

The partnership helps Icon to provide credible, up-to-date information and resources, along with the practical and emotional support networks our patients need during their cancer journey.

In a state as big as Queensland, distance and travel costs are often two of the biggest barriers faced by cancer patients.

The Transport to Treatment service is the result of Icon and Cancer Council Queensland's strong partnership.

Icon is proud to donate and fund vehicles for this service and Cancer Council Queensland volunteers run the door-to-door service at no cost to patients.

Icon is committed to delivering the best cancer care possible, to as many people as possible, as close to home as possible.

For more information about Icon Cancer Centre, visit www.iconcancercentre.com.au

"Icon Cancer Centre Gold Coast Private is celebrating five years of providing world-class cancer care to local patients."

Gold Coast Private Marks its Fifth Birthday

Icon Cancer Centre
Gold Coast Private Hospital
Lower Ground 3, 14 Hill Street Southport
(07) 5634 2400 | admin.goldcoastprivate@icon.team

Icon Cancer Centre Gold Coast Private is celebrating five years of providing world-class cancer care to local patients.

Over 26,600 treatments have been delivered and nearly 1900 patients have been treated at the centre since it opened in 2017.

The Icon Gold Coast Private team have been successful in making state-of-the-art treatments and technology available at the centre.

In 2018 the centre became the first in Australia to treat patients using Varian's HyperArc technology, which delivers precise radiation therapy and enables treatment to be delivered with greater efficiency, accuracy and comfort.

Amara Fonesca has been part of the team from the start.

"The Gold Coast Private team have been early adopters of many other stereotactic techniques for liver, spine, lung and prostate cancers and recently introduced lymphoedema screening for breast cancer patients, allowing us to provide a really comprehensive service to the Gold Coast community," Amara says.

"Over the years the team have done an amazing job celebrating with patients when they finish their treatments. We often see friendships form between patients in the waiting room as they see each other most days. About a year ago a couple of patients finished their treatments close together and one of them came back for the other's last day dressed up as wonder woman. It was such a lovely gesture."

Cliff was diagnosed with prostate cancer in mid-2017 and was the fourth patient to be treated at the centre. Cliff was the first patient to have the gold seeds - fiducial markers, which help to accurately locate the prostate gland during radiation therapy.

Michael was also treated at Icon Gold Coast Private shortly after it opened. The 66-year-old engineer continued working full time during his treatment for prostate cancer.

World-class radiation therapy on the Gold Coast

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iconcancercentre.com.au

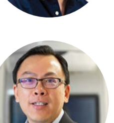
DOCTORS

Specialist and GP referrals are accepted for all cancer types. Special interests are indicated below.

Radiation Oncologists
Based at Icon Gold Coast Private

Dr Pretti Bagga
Head and neck, gynaecological, breast, lower gastrointestinal and prostate cancers

A/Prof Jim Jackson
Brain, head and neck, gynaecological, genitourinary, lung, breast and skin cancers


Dr Eric Khoo
Head and neck, colorectal, prostate and skin cancers

Dr Dominic Lunn
Brain, central nervous system, breast, gynaecological, lung cancers and palliative care

Dr Andrew Oar
Central nervous system, gastrointestinal, lung, skin and genitourinary cancers

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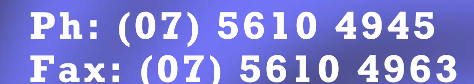

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Welcome Elle Pidgeon
Women's Health and Continence Physiotherapist

We are delighted to welcome APA Titled Women's Health and Continence Physiotherapist, **Elle Pidgeon,** to our Grace Private team. Now consulting from our Ferry Road practice, Elle's special areas of interest include:

- Pregnancy including pelvic floor care, back and pelvic girdle pain, abdominal separation and postnatal recovery
- Pelvic organ prolapse
- Urinary and bowel symptoms including incontinence, bladder pain, and frequency and voiding dysfunction.

No referral necessary. For appointments and details, see **graceprivate.com.au** or phone **07 5594 7632**.

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> **At Grace, we believe every woman deserves to live her best life .... and that includes being free from vaginal atrophy.**

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For details and referrals
(07) 5594 7632

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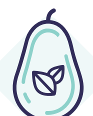
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Our Team

Dr Adriana Olog
Maternal Fetal Medicine Specialist, Obstetrician

Dr Tania Widmer
Fertility Specialist Obstetrician & Gynaecologist

Dr Tina Fleming
Fertility Specialist Obstetrician & Gynaecologist

Dr Helen Green
Gynaecological Oncologist

Dr Yasmin Pilgrim
Obstetrician & Gynaecologist

Dr Bridget Gilsenan
Obstetrician & Gynaecologist

Dr Aakansha Zala
Endocrinologist

Dr Elise Turner
Specialist Women's Health GP

Dr Anna Alderton
Specialist Women's Health GP

Dr Frances Knight
Specialist Women's Health GP

Elle Pidgeon
Women's Health Physiotherapist

Debra Miller
Women's Health Physiotherapist

Kerryn Blunt
Clinical Psychologist

Karen White
Clinical Psychologist

Sharnie Dwyer
Dietitian

"Running a healthcare practice is a continual quality improvement journey."

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Running a healthcare practice is a continual quality improvement journey. Your practice's data can streamline this process, giving you insights to help you measure and enhance business performance, your daily running processes and ultimately, your patients' satisfaction and outcomes.

Staying across your practice data helps you keep doing what works and change what doesn't.

If your practice still uses spreadsheets, and shares files via email or folders on hard drives, then tracking, measuring and implementing insights from your practice data could be time consuming and potentially error-prone. Digital technology makes this process quicker and simpler. A practice management platform such as PracticeHub lets you easily create, store and update your policies and procedures, manage daily tasks and equipment maintenance, and train your staff. Coupled with a data analytics platform like Cubiko, your practice's data becomes a meaningful guide for your quality improvement strategy.

Let's look at some strategies for using your practice data to achieve excellence in your services and processes.

What key metrics have the greatest impact on your practice?

This will look different for every practice, but broadly, the most important data are around practice efficiency, profitability and quality of care. Specifically, here are some examples you would need to monitor, at least monthly, quarterly and annually:

- online bookings vs in-person bookings
- patient waiting times
- nurse to doctor to allied health team ratios
- staffing and rostering – does it cover you at busy times?
- billing: bulk bill vs mixed billing

Turning your data into actionable quality improvement

Once you have a handle on your practice data, how do you use it to make improvements? Setting key performance indicators (KPIs) is the easiest, most meaningful way to translate data into making decisions about quality improvement, then into action and results.

But before that, you need to know your practice's strategy and goals. Your KPIs are how you achieve those goals, and help you measure progress. A data analytics platform like Cubiko can help you easily see if you're hitting your targets on time or not.

To make the process more relevant and less overwhelming, start by choosing those (e.g. from the key metrics list above) that are

most meaningful to improving your practice operations, quality of service and business performance.

Engage your team in practice data for better performance

When you think of your practice data as being more than graphs on a report for the practice owner or accountant, but as a guide to improving processes so you save time and money, and provide better patient outcomes, it makes more sense to everyone in your practice.

Using your KPIs to guide you, the next step is to get your team on board. By incorporating practice data into assigning and managing tasks for your team, they engage with it better, because they can see how it makes their job easier, and improves services (for happier patients) and financial outcomes (for better business performance).

Include updates on metrics and how your practice is tracking in your staff meetings, so everyone feels involved and has an opportunity to contribute ideas and feedback on even more ways to improve.

Document and share

Of course, documenting how you transform your practice data into KPIs and tasks can be essential to managing performance and progress, while keeping your team engaged and up to date. PracticeHub can be an important tool for your quality improvement processes. Its built-in policies and procedures, registers and training modules help increase your operational efficiency and team development. It provides data such as audit history and staff sign-off on policy updates and completed training modules, so you can easily track compliance and improvements. This then makes accreditation easier, as well as providing evidence at assessment time.

The registers are an easy way to enhance your quality improvement efforts. Some examples are a register to log patient complaints and suggestions. This is a great opportunity to allow patients to suggest ways you can improve their experience at your practice. A risk register will help you better manage clinical, business and health and safety risks.

The Resources templates included in PracticeHub can help you manage your quality improvement activities, linking them to your overall quality improvement register; whether it's activities like decreasing waiting times, improving your patient recall system or billing processes.

Team development can be an important part of quality improvement and PracticeHub's eight pre-configured training modules let you train your team on-site. Staff members receive a certificate on successful completion of their training too, which provides incentive and satisfaction. And in PracticeHub, you can track their training progress and pull data to demonstrate that your practice meets the quality improvement component of your compliance.

Learn how PracticeHub simplifies using data to create processes for a better quality practice.

Book a consultation or call 1300 96 86 36.

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References:
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"After two years of essentially no overseas travel... what has changed?"

Travel Medicine Updates

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After two years of essentially no overseas travel what has changed?

Malaria – large parts of SE Asia have partly or completely eliminated malaria (no local transmission in last 4 years). Many of these areas are in Indonesia, Laos and Philippines and are frequently visited by travellers. It is does not mean the risk is zero but below the threshold where prophylaxis is recommended so prevention and early testing of any fever may be the more appropriate strategy.

Just as worldwide wild polio had been reduced to two countries (Nigeria and Afghanistan) two problems have occurred – frequent vaccine related polio cases in multiple countries due to the use of oral polio vaccine and new wild polio outbreaks in several African countries. A single adult polio booster for travel is a good idea and can be mixed with dTpa (diphtheria-tetanus-acellular pertussis vaccine). There have also been several diphtheria outbreaks in unvaccinated populations so another old disease with increasing risk is covered as well.

Yellow fever (YF) is still required for east and west Africa and Amazonian South America and we just need to be careful with increasing numbers of patients on the newer immunosuppressive medications. If you have a patient who is about to start one of those medications it would be great if you could ask them if they are planning to travel in the future to Africa or South America so they can have the vaccine before commencing therapy. You must stop immunosuppressives for long periods if they need YF vaccine after starting therapy which is usually inconvenient or sometimes impossible.

The recent outbreaks of Japanese Encephalitis have made travellers more aware of the risks overseas. It is still an expensive vaccine for a rare disease for short trips so reminding travellers of the importance of repellants and covering up is often the more likely course of action but for longer trips hopefully more travellers will get the vaccine.

No we still don't have monkeypox vaccines and probably limited amounts won't make it a common vaccine for travellers so discussions on safe sex (particularly not with someone who has a nasty looking rash) are recommended.

Tuberculosis is an increasing problem worldwide with drug resistant and extended drug resistant forms making treatment increasingly long and complicated. Children under the age of 5 will have risk of death and hospitalisation from tuberculosis decreased by 75% if they have had BCG (Bacillus Calmette–Guérin vaccine). BCG takes three months to reach full effect so if you have families with infants visiting high risk countries then we do need some time before travel to get the best response. We do a clinic every two weeks.

"Voluntary Assisted Dying (VAD) will be available for eligible Queenslanders from the 1st of January 2023."

Voluntary Assisted Dying is Coming to Queensland

Dr Gretchen Hitchins
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Voluntary Assisted Dying in Australia

Voluntary Assisted Dying laws have now been passed in all Australian States, with New South Wales the most recent (May 2022). A Territories Rights Bill is currently before the Senate, having been passed by the members of the House of Representatives 99-37. This is the final hurdle to reverse a 25 year ban blocking the Northern Territory and ACT from passing their own voluntary assisted dying laws.

Voluntary Assisted Dying Act (Queensland)

The Voluntary Assisted Dying Act 2021 (the Act) was passed in September 2021. Voluntary Assisted Dying (VAD) will be available for eligible Queenslanders from 1 January 2023.

Purposes of the Act

1. To give people who are suffering and dying, and who meet eligibility criteria, the option of requesting medical assistance to end their lives
2. To establish a lawful process for eligible people to exercise that option
3. To establish safeguards to ensure Voluntary Assisted Dying (VAD)
    i. is accessed only by people who have been assessed as eligible
    ii. to protect vulnerable people from coercion and exploitation
4. To provide legal protection for health practitioners who choose to assist, or not to assist, people to exercise the option of ending their lives in accordance with they Act
5. Establish the Voluntary Assisted Dying Review Board and other mechanisms to ensure compliance with the Act

The law respects the rights of healthcare workers to not participate in voluntary assisted dying. All medical practitioners, healthcare workers and health services need to be aware of their rights, roles and responsibilities as detailed in the Act.

Implementation

A number of resources are now available:

1. Queensland Voluntary Assisted Dying Handbook
2. Private Entity Guidance - for private hospitals, residential aged care facilities and hospices
3. Managing, Storing and Disposing of Voluntary Assisted Dying Substances Guidance for Health Services
4. List of authorised disposers

Find out more at www.health.qld.gov.au/system-governance/legislation/voluntary-assisted-dying-act/explained/overview

Eligibility

To be legible for voluntary assisted dying, a person must have a disease, illness or medical condition that is:

- Advanced, progressive and will cause death
- Expected to cause death within twelve months
- Causing suffering that the person finds intolerable

The person has decision-making capacity (at every stage of the process). This rules out the use of an Advanced Health Directive or a substitute decision maker in voluntary assisted dying. The person is assessed as acting voluntarily and without coercion and is aged at least 18 years.

To be eligible, the person needs to be an Australian citizen or permanent resident who is ordinarily resident of Australia for at least three years before the first request, as well as ordinarily resident of Queensland for at least twelve months immediately before the person makes the first request.

There are criteria that medical and other health practitioners need to fulfil to participate in VAD as well as mandatory training.

An overview of the process

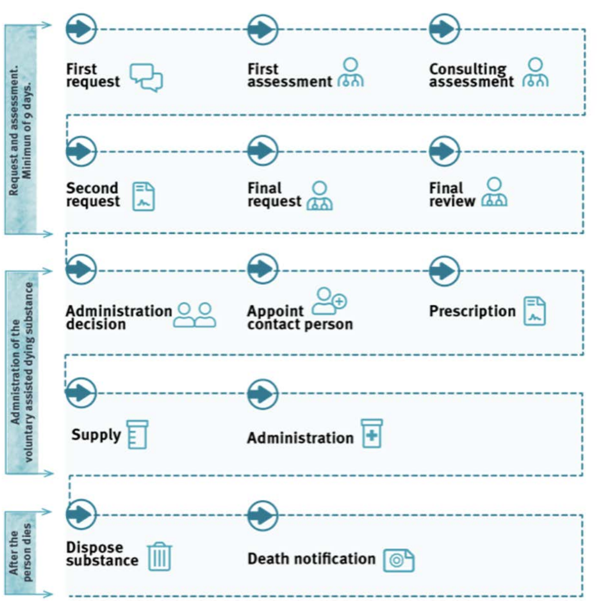

Figure 1. Flowchart outlining a simplified version of the process for voluntary assisted dying

The Request & Assessment

There is no obligation for a person to continue the voluntary assisted dying process after the request and assessment phase has been completed. The person can stop the process at any time.

Before a person can access voluntary assisted dying, they must make three separate requests, one of which is in writing. They need to be assessed by at least two different medical practitioners. There must be at least 9 days between the first and final request. This allows time for the person to reflect on their choices while ensuring their suffering is not drawn out. (In practice, the process is patient-driven and can take weeks to months to complete.)

The Voluntary Assisted Dying process

1. Request and assessment process
   - First request
   - First assessment - performed by coordinating practitioner to check against the eligibility criteria
   - Consulting assessment - a second medical practitioner independently assesses the person against the eligibility criteria
   - Second request - written, needs to be done in the presence of two eligible witnesses. There are criteria if the person is unable to write
   - Final request
   - Final review
2. Administration of the voluntary assisted dying substance
   - Administration decision - self-administered or practitioner administered
   - Appointing a contact person - will receive the substances on behalf of the person, be responsible for disposing of any unused substance and for notifying the coordinating medical practitioner of the person's death
   - Prescription of voluntary assisted dying substance
   - Supply of the voluntary assisted dying substance
   - Administration and death
3. After the person dies
   - Disposal of the substance
   - Death notification
   - Under the Act, there is no mention of voluntary assisted dying on the death certificate

Full details of the process can be found here: www.health.qld.gov.au/system-governance/legislation/voluntary-assisted-dying-act/explained/process

Learnings From Victoria

Access to VAD commenced in Victoria in June 2019. In the two years up to June 2021:

- 900 people registered in VAD portal
- Median age 73 years
- 82% currently accessing palliative care

Of those 900:

- 836 assessed for eligibility for VAD
- 597 eligible after first and consulting assessments
- 331 died following administration of VAD substance (282 self-administered, 49 practitioner administered)
- 157 died without administration of VAD substance
- 83% of people had a malignancy and 7.3% had a neurodegenerative condition
- 85% of VAD occurs in primary care setting, at home - not in hospital

Services that will be involved in Voluntary Assisted Dying in Queensland:

1. QVAD Support Service
   - Information, education and support
   - For individuals & and families, health practitioners, HHS, NGOs
2. QVAD Pharmacy
   - Preparation and supply of VAD substances
3. Travel service to ensure equity of access to VAD for all Queenslanders
4. Community of practice for VAD practitioners
5. Counselling resources

The Voluntary Assisted Dying Implementation Conference will be held in Brisbane on Saturday 29 October. There will be an address from Andrew Denton; presentations from clinicians with experience in provision of VAD in Western Australia and Victoria; and insights in what it means to support a family member through VAD. Attendance is both in person and virtually, it is free to attend.

More information from the VAD website: www.health.qld.gov.au/system-governance/legislation/voluntary-assisted-dying-act

Medical practitioners wanting more information, including details of how to become an authorised voluntary assisted dying practitioner - email the Voluntary Assisted Dying Unit on: VADImplementation@health.qld.gov.au

Helix Health is excited to announce that we are now accepting referrals for TMS.

Our rTMS service (repetitive Transcranial Magnetic Stimulation) will be up and running from early February. Please forward your referrals to Dr Sandeep Chand, Helix Health Specialist Clinic – reception@hhsc.net.au or via Medical Objects.

In addition to our new rTMS Service, Helix Health has a team of experienced Clinical Psychologists that are available to conduct the following testing:

- Cognitive Testing for Adults & Children (6+ years)
- Diagnostic Assessment for Autism – Adults
- Diagnostic Assessment for ADHD – Adults & Children (6+ years)
- NDIS Assessments

CONTACT US TODAY (07) 5527 0190 reception@hhsc.net.au www.hhsc.net.au

Helix Health has availability for a full-time or part-time Psychiatrist or Psychologist to join our team. For more information please contact our Practice Manager at manager@hhsc.net.au.

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