Royal Australasian
College of Surgeons

Morning Session Transcript

RACS/ANZCA/ACEM JOINT SYMPOSIUM

Family Violence:
Health System Response

Thursday 10 November 2022 – 9.00am– 4.00pm
Jubilee Room, NSW Parliament House, 6 Macquarie Street, Sydney

Dr Sally Langley

Welcome to the annual RACS Trauma Symposium. Thank you for taking time off your busy schedules to be here with us today. I thank the Australasian College of Emergency Medicine and the Australia and New Zealand College of Anaesthetists for joining us in hosting this important symposium. It has been a truly collaborative effort with hard work done by the planning committees and the three colleges. The symposium brings together trauma health professionals from around Australia and Aotearoa New Zealand and incorporates a one-day symposium on a topic pertaining to trauma prevention and trauma care. This year, the committee selected Fighting Family Violence, an area affecting all communities, especially women and children. The tragic effect of family violence on the community is an area of grave concern that affects us all. We have a comprehensive program for today and I thank our speakers, conveners and planning committee who have worked tirelessly to deliver this symposium to highlight this important issue. The program will address the responsibility of health professionals to respond to family violence to affect improved health outcomes. In many cases, healthcare providers are the first professional contacts for victims of family violence. Surgeons and trainees, especially those specializing in trauma, general surgery, Otolaryngology head and neck surgery, Orthopaedics, Vascular, Obstetrics and gynaecology, neurosurgery, plastic surgery, oral and maxillofacial dentists are best placed to assess the patient's risk of serious harm to life.

They therefore are a key bridge between a victim whose life is at risk and support services such as police, legal authorities and the social support system. The Trauma Committee of the Royal Australasian College of Surgeons has a long and proud history with trauma and road trauma prevention. It has been influential with policymakers and legislators and led the way in the 1960s and 70s, relentlessly advocating for safety measures such as alcohol limits for drivers, mandatory seatbelts and bicycle helmets. The resulting legislation saw the road toll dramatically fall. The RACS Trauma Committee continues to play an active role in trauma prevention, hosting annual trauma symposiums such as this one, engaging with the media, supporting research, preparing submissions to government inquiries, promoting trauma training to health professionals, and advocating for safety across all areas, including quad bikes, e-scooters and alcohol related harm. These annual Trauma symposiums create an opportunity for stakeholders to get involved and have a say in the areas of trauma care and trauma prevention. I would like to thank the many trauma specialists, including emergency physicians, intensivists anaesthetists, trauma nurses, social workers, psychiatric services, as well as surgeons. And also, we mustn't forget primary care, general practice, all giving their time and energy to the cause of the prevention of trauma.

We appreciate the involvement from government officials, health organizations, medical colleges and other key stakeholders, providing input and feedback, and ensuring a diverse range of views and requirements are heard, particularly when we finalize the outcomes. Last but not least, I would like to thank the National Critical Care and Trauma response centre for their generous sponsorship with the symposium and RACS Trauma Week. We are grateful to Len and Michelle and all of those at the National Critical Care and Trauma Response Centre, which I had the pleasure of visiting in August, and the continuing support and commitment they have provided over many years to trauma prevention and to trauma care. Once again, thank you for all of you for attending.

A/Prof Payal Mukherjee

Thank you, Sally. That was lovely and next I have the honour to introduce the independent member of Wagga Wagga, Dr. Joe McGirr. We are really grateful for Joe's support, not only for helping us organize this, but also for drawing to our attention, the voice for rural Australia to be incorporated in this and to put it front and centre in our minds. Joe is an emergency physician and has also got a background in health administration and is an academic. So all of these skills are highly relevant to this forum. So, thank you, Joe.

Dr Joe McGirr

Thank you very much, Payal and to you and Ken as co conveners. Can I acknowledge and thank Michael for his welcome to country and I also pay my respects to the elders, past, present, and emerging. And can I particularly welcome Sally Langley, president of the College of Surgeons, and particularly, welcome Minister Ward, who's attending here this morning. I won't take up too much of your time, but Michael, in his introduction, did talk about the growing issues around inequality in our world. And there's no doubt that we live in troubled times. And this morning I was fortunate to be part of a group of Parliamentarians who heard Elizabeth Broderick participate in the discussion (former Commonwealth Sex Discrimination Commissioner) and currently a rapporteur within the United Nations on women and children. And she's undertaken a review here in the Parliament of workplace behaviour and in particular as it affects relationships, obviously affecting women. And that's been a salutary exercise for this Parliament. Next week we'll be actually having an apology on November the 15th in relation to what's happened. So that's been a big learning here. But she pointed out that we are in troubled times. There is a rise across the world of violence, and Michael referred to this, and it comes from a right-wing extremism.

It's probably the result of growing inequality, the disruption of COVID the manipulation of information, the spread of disinformation, but it is resulting right across the planet in increased levels of violence, particularly against women. And so, the work that you do here today is important. We don't recognize what is happening in the global context. We tend to think of the work that we do as being small, but it's not small. This is an important stand that you are taking today about raising these issues. And it's in a context where these issues more than ever need to be raised. Because of this rise of uncertainty, people are worried. And when people are worried, they return to fundamentals. And unfortunately, in our world that can often mean, sadly, religious fundamentalism and violence against women. That's the context in which we're operating. And as Australians we need to stand up against that. And you are leaders in this field. And as Elizabeth Broderick said this morning, it is important that leaders have the courage to see what has not been seen. And I think that's what you are doing. And I have to say, having listened and read about the background to this, that clearly Anaesthetists, surgeons, emergency physicians I congratulate you; I congratulate you on coming together. And doctors have probably been a bit blind to this as an issue in trauma. It is an issue of now seeing what has not been seen. And that takes courage and I congratulate you on that. And I think what you're doing here today is to try and make all of us, all your trainees, aware of what has not been seen. That will mean challenging them and it will also mean their growth as individuals. But hopefully when that awareness grows, then action will follow. Clearly you can't solve all the issues associated with this, but I

sincerely believe that with the awareness we will be taking major steps forward in terms of prevention. So I congratulate you on that and thank you very much for the work that you're doing. Thank you.

A/Prof Payal Mukherjee

Thanks a lot Joe. Now I would like to introduce Natalie Ward. She is the minister for metropolitan roads and women safety and the prevention of domestic and sexual violence. And I particularly want to thank her for her leadership in the build around coercive control that's currently before parliament. Thank you very much Minister.

Minister Natalie Ward

Thank you everybody and thank you Uncle Michael for that beautiful welcome to country and that lovely conversation. Can I also acknowledge the traditional custodians of the beautiful land on which we meet and gather together today and pay my respects to Elders, past, president and emerging of the Gadigal people of the Eora Nation and thank them for sharing this magnificent country with us today. And Good Morning everybody and welcome to the oldest Parliament. This is your parliament. I'm really pleased that you are here today. Can I Acknowledge, John Crozier, our Chair of the Royal Australia College of Surgeons Trauma Committee and Associate Professor Payal Mukherjee, Dr. Ken Harrison, co-conveners of today's symposium. What a magnificent job you have done. Can I echo Dr. Joe McGirr's comments. What you've done in bringing together the colleges and ensuring that you have this symposium today is incredibly important. I'll talk about that more in a moment. But I really want to be absolutely clear that it is magnificent step and I'm very deeply grateful that you are taking this step today. Dr. Joe McGirr is a magnificent member of Parliament. It's a joy and a pleasure to work alongside him, not only to have an inhouse speed dial doctor and there's a lot of A-type personalities in this place, but he's just a very genuine and sincere and absolutely wonderful Member of Parliament. So thank you for that Joe.

When we had a conversation about this, you were absolutely clear that you wanted to facilitate this in the Parliament so that we can listen and understand and facilitate the opportunity to address this very difficult issue. So, thank you for your advocacy. It's a great pleasure to be with you today and I'm sorry I can't stay for the entire day, you'll hear the bells ringing, we'll be ducking in and out, but I will put my head in now and then to see how you're going. My two portfolios of roads and women's safety both have, sadly, something in common and that is trauma. And so I'm very pleased that you are having conversations to address those issues today. And I feel humbled to be asked to open up the settings where your focus of your discussions will be on those important health concerns in our community today; domestic and family violence. What we know about domestic and family violence is it doesn't discriminate, doesn't discriminate by postcode or demographic the regions or the cities. It is everywhere. And it's so wonderful that we have people that are prepared to come together to have that conversation about it and about what we can do better to address it. I feel privileged to be a dedicated minister for this. I'd love to put myself out of the job and there'd be no need for this, but while ever I'm here, I will be the strongest possible advocate for ensuring that we do better and we can. And in partnering with you, we can do better. Of course, as you well know, domestic sexual and family violence affects the psychology, the physical, the social health of so many, mainly women, I'll say the vast majority of women and children. But forgive me for being brief, and that is something that the

health system plays such an important role in. You are absolutely critical to addressing this issue and responding to not only family violence, but domestic and sexual violence. And you are uniquely placed to identify and at a very early opportunity take some steps to provide that appropriate care.
As trauma health professionals, you're likely to encounter people experiencing domestic and family and sexual violence in the normal course of your work. I'm sure you already have. Sadly, it's often when things escalate to the point that the victim survivor has been seriously injured. When you're talking about trauma, they're at the point where very often they will have been through a whole lot more before they even present to you. And that is something we're becoming very aware of. You each hold an incredibly important position where you can influence the outcome and the pathway and see that person and that patient to hopefully a safer pathway. And I'm pleased to see that you're taking a collaborative approach to the symposium because recognizing that we all need to work together on this, it's not something one organization can do, one minister can do, one college can do. Coming together is an incredibly important part of our response. We can't be working in silos, in government. We know that this is a health response, a police response, frankly a financial response from the treasurer. And all of us come together to try and work across housing, homelessness and risk to make sure that we have our role to play as part of a collaborative team in this response. I'll just give a very quick overview of what the government is doing alongside in this area.

Our landmark program at the moment is called Core and Cluster. And that program is to almost double the number of women's shelters. In New South Wales at the moment, there are 86 women's shelters, some run by government, some privately, but we aim to almost double those with another 75. Numbers don't matter. What matters is providing a safe place to women and their children. And that's a record investment for almost half a billion dollars in that program. That's a serious investment, 484.3 million dollars, and particularly targeted at areas of most need. I'm really proud of that program. We have learnt that Core and Cluster provides shelters for women where they have their own contained space and, at the centre of that, they have services that come to them. So that means that they can have their own facilities. We learnt from COVID you need your own kitchen facilities, your own laundry facilities, share facilities, are great in good times, but people need to recover and rest in their own space and to bring those services to them.

The Core and Cluster is a great way of ensuring that we're providing the best possible customer service, as I call it. And today we will be addressing later in the upper house the landmark coercive control legislation. This is something I've worked on for a number of years with the Attorney General and we've had a lot of consultation. I know we've had input from the health sector, which has been incredibly important as well. That bill hopefully this evening will be passed potentially with some amendments or not. It might come back to you, Dr. McGirr, but this is something that I'm just humbled to be a part of. We know that coercive control is a pattern of behaviour which seems to cumulatively, deprive the victim survivor of their autonomy. And we know that is a red flag for domestic violence homicide. The Domestic Violence Death Review team conducted a review of 112 domestic violence deaths. And of those hundred and twelve, all but 1 were preceded by coercive control. Hannah Clark wasn't able to wear the colour pink, had to be home at a certain time, had to go to the gym every day. All of these things were indicators along the way. Preethi Reddy, a dentist, completely independent, financially independent, was murdered overnight when she decided to pull back. We know that this is a red flag. We know this is something, as a government, we need to do. We talk about in my portfolios coming together. And I say to anyone that either doesn't know about

coercive control or is concerned about it coming into their homes or interfering in their relationships, that we as a government, as a parliament, will be putting a line in the sand to say this behaviour is not acceptable. We know this is a risk for homicide and there was time when you could perhaps drive your car without a seatbelt, you could just jump in the car and that was perfectly acceptable. We know that that was a risk and we took steps. We knew there was a time when you could have a few drinks and hop behind the wheel of the car, potentially with the kids and your family in the back. And we know that was a risk and we did something about that. This is exactly the same. And so, I hope tonight to be on the other side of this legislation.

I don't doubt there will be a lot going on in the meantime. I'll turn just briefly to Safer Pathway, which is where you have such a role to play. And Safer Pathway is a program that we have offered to you and you can utilize it as medical practitioners as part of your role of connecting a victim survivor with support services. Safer Pathway ensures that we provide a wraparound service that's comprehensive to the victim survivor to assist them to escape etc. So they don't need to ring each service individually, neither do you. They simply are referred to Safer Pathway, and they'll be put on a program that is bespoke for them in the area that suits them with the needs that they have. You know, it's not just homelessness, it's not just financial, it's not just a shelter. It's not just kids. It's a comprehensive service. And I'm proud that that service is in place. We can get you some more information about that, but that is there. I'm pleased that the treasurer has assisted that by further funding of $43.6 million to expand that. And so that is in place now. Finally, Staying Home, Leaving Violence, something that is an incredible program. We very often talk about removing the woman and her children from their home. Staying home, leaving Violence removes the perpetrator. And we know that removing children quickly takes them out of their support circle, away from their school, takes the mum out of her support circle. Removing the perpetrator allows the family to stay there and to rely on those support networks, family and friends and community. So we work closely with police, and we will be asking to work closely with you for those sort of support services, women and their children back on the path to recovery. But you have such a critical role at that entry level to be able to identify this. And I commend you for being so brave and having a conversation and saying we need to do better in this space. Together, we can recognize this, we can do something about it, and we can, with your help, eliminate this. So I commend you on today. Our best wishes. I hope it's a magnificent day. Thank you for being brave and thank you for all the work that you continue to do. I'm humbled to work alongside you. And thank you again for being in Parliament.

A/Prof Payal Mukherjee

Thank you, Minister Ward. It's so inspiring, gives me goosebumps, to know that we're within the four walls of the very institution having the symposium where a group of laws are going to be passed. As Minister Ward and Joe said, surgery is a team sport, trauma is a team sport. However, as colleges, even though we have a lot of call to action from the WHO report in family violence or commission on family violence, we're still playing catch up, and that's not good enough. So I just want to thank you for all of your time. We know there's a wealth of expertise around, and most of you we've contacted earlier just to help us, but we also are willing to rise to the challenge and work together. For every hour of help that you give us, we just make sure that we deliver three times the impact. Thank you.

Dr Ken Harrison

The next introduction I'd like to make is to Talie Star. She's a singer songwriter, consultant, speaker, specializing in trauma and trauma informed training and in domestic violence. And she is talking to us from her point of view and she actually also works training journalists in this field. So welcome, Talie.

Talie Star

Thank you so much for the privilege to be able to speak to such an incredible collection of people, many, not personally you, but your professions, I have engaged with over the years. And so, it's actually quite an honour to be able to speak and to see a room full of people who really want to understand what trauma is. I call my talk "Physician, Do No Harm", because we know that's the oath that we all come into working in this profession, to do no harm. I want to ask us, what we end up doing… Do we do no harm? Do we tell someone to sit on a chair the whole day because we don't believe that they're actually telling the truth, that they can't walk? Do we say to them, even though something's in scans, there's nothing going on? Do we say to them, you'll be fine, just get over it? Do we tell them, you're a bit too pain focused? Do we tell them, well, maybe if you just go home and do exercise and get fit and lose some weight, you'll be okay. Is this doing no harm? We haven't lifted a hand to somebody. Have we verbally assaulted someone because we didn't like that? They told us that what happened didn't work? And what if I said every one of those experiences I have had in my lifetime, and what if I said they did harm? And what if I said concurrently with that, I was experiencing domestic and family violence growing up and in my marriage? We don't understand the complexity of people's lives when they walk into the room, we don't understand all of what's going on and we don't understand the full impact of our language. We come into the room with different biases and different thoughts. We don't always understand that we've got them until they come up. And I think most of us, if not all of us in this room, would not want to do this intentionally.

I want to introduce you to two women. One woman, she's on a pension, she's homeless, she's dishevelled, she gets quite distressed, and she can't articulate what's going on. The other woman owns her own home, runs her own business, is quite successful, quite articulate, can tell us the things that are going on for her. Which of these two women do we tend to prefer to work with? Which of these two women are more comfortable for us? What if I was to tell you that both of those women were me? What if I was to tell you that anyone in this room could be a victim of domestic and family violence? What we come into with our work follows how we interact with people. And that interaction does harm even when we think it doesn't. I had a friend who was of Fijian Indian background. She went through horrendous domestic and family violence. She went to the courts, she went through the processes, and her papers disappeared. They couldn't prove what it was. But we know that her perpetrator had connections whilst all of this was going on. She then found out that she had cancer. She had been trying to explain to the specialist that after the test they did, she had more pain, but because her demeanour was culturally very different and she was more expressive with her emotions and she didn't have the European I'm holding it together look. The physician actually dismissed her. And in that time of dismissing her, she asked me would I go with her. I

went with her. I explained what was happening. Went through all the options. What could be happening here for her? He was like she's nuts. She's just fine. But actually, her cancer had metastasized and by the time they found it, it was too late. Are we doing no harm when we don't believe people, when they're telling us? Behaviour is always an indicator of something going wrong, of something that someone is trying to tell us. When a child acts out, they're not just being difficult, they're saying something's wrong. And I don't know how to tell you what is wrong. We need to be listening to that.
We need to understand what the perpetrator looks like, because the problem is that the perpetrator, sadly, could be anyone in this room. And I say that not to make us uncomfortable, but for us to think, well, it could be my colleague, it could be my friend, it could be my neighbour, it could be my surgeon, it could be the police officer, it could be the person who's serving you drinks today. It could be any one of us and we need to be aware of that. We need to understand the signs. And Natalie Ward also brought up for us previously, about coercive control and how that is used. It is so insidious that you can't always even see it happening until you're fully drawn in. Perpetrators are charming. They're lovely people. They're upstanding citizens in society. They like to be the hero. There's occasionally some that look a little different to that. But if you ever you find your feeling like, he's such a charming man (and I say him because 95% of perpetrators are male). We need to understand it as a gendered issue. We need to understand that men are using these positions of power, are using privilege to do what they want to be able to do. They know exactly how to target women. They know exactly what the victim will need. They will play into that.

My perpetrator was a musician. I'm a musician. We worked together. There was one incident you would never have noticed, coercive control, where I said to him, I don't want you to play that particular line. It sounds corny. On stage, he played the line. No one else knew. But he set it up for me because he knew I would know that he was in control. Because it's all about power and control. And the problem is the systems that we are going into in the health system is all about power and control. It is a dysfunctional system. It's set up for people to come in quickly, check and throw out again. It isn't set up for us to fully comprehend what is going on. I'm sure the limitations of this must cause enormous frustrations for you. It does for patients. And when we actually come together, we can make a difference. But till then, we're working with systems that create more trauma. So if you've got someone fleeing domestic and family violence and they're coming into your system and your system is causing more trauma to them because they're saying, we don't believe you, we can't find it on the scans, there's nothing wrong with you. Go home.

I had a severe accident at the beginning of this year smacking my body and heading to concrete twice. The fact that I had a serious concussion was never considered part of the equation. Why do we miss the obvious? Because we're so busy needing to churn people out. And I do understand the limitations of the system, but we need to understand it differently. Is that doing no harm when you send me home? In fact, I was able to advocate for myself and say, no, do you want me to pass out at home? And they hadn't even taken into a note that I was passing out. So we need to think about this. We need to think about are we being coerced by the perpetrator? Are we complicit in this? Are we sitting there while the perpetrator tells us all the things that are wrong with the person? Are we letting him set up a pattern of abuse even in front of us? Do we know the red flags? Natalie Ward mentioned earlier, are we aware of what's happening? Are we really considering that we are doing no harm? And one of the things that perpetrators do is they not only target the victim, so women we're specially focusing on, but there are victims in the LGBTIQ community

and other communities, and they also target children. And children are used as pawns by perpetrators. They are also directly impacted and directly perpetrated against. And when we don't listen to children, are we again doing no harm? When the ambulance men arrived at my home and I said to them, “he didn't dislocate his shoulder throwing something across the throwing a ball across a room, he took a shoe to throw it at someone”, did they believe me? Children are silent. We don't listen to them. Do they make up stories? We know they do not. Children do not make up stories. Was that doing no harm when that was not listened to? When I presented with a tear in my hip from falling down the stairs. And I indicated that I didn't think I fell and no one believed me and said, it's just because you have a spinal condition, was that doing no harm? And I think this is the dilemma that we're in. There's so many things that happen. There's so many ways in which we miss the signs because we're not aware. And that's what today is so fantastic about. Our awareness can be raised. We can think about how we're doing harm, mostly unintentionally, because we know that we go in to do no harm.

I think we also have to think about our own privilege. Like, to be able to go and study and to have the skills and develop your natural abilities is incredible and it's a privilege. And sometimes we want to feel more important because of the study we've done, and that's only natural. But when we lift ourselves above somebody else, are we really doing no harm? Because in that room, aren't we meant to be the same? Aren't we meant to be equals? I used to run music therapy classes. Well, they were music singing classes, but they were more like therapy. And I would say to them, no one can tell me what you do for work and no one can tell anyone else what they do for work. At the end of the class, it's a totally different story. And what was amazing was people who were homeless and people who were CEOs of massive corporations all were equal in this one room. And what they achieved together was absolutely incredible. And I'm glad that I've set that up because that sense of equality made everyone feel safe and made everyone open up and be willing to take part in the process. When you hear physicians do no harm, I really hope that our eyes are open and we start to see the unintentional harm we've done and we start to look at how we can change that. Thank you very much.

A/Prof Payal Mukherjee

Thank you. That was a very appropriate wakeup call and take action moment. And on the back of that, I'd really like to introduce Michelle Atkinson. She's an orthopaedic surgeon and chair of RACS New South Wales. And I'd like to say that it's a committee that's been advocating in this space for quite some time.

Dr Michelle Atkinson

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Thanks, Talie, for making us look at ourselves because we all need to do that. We need to reflect on our own behaviour and how we contribute to the problem. So when Ken and Payal started organising this symposium and I got involved, I hoped to be standing here presenting to you how we had incorporated this into surgical education. And we're still getting there, sadly. So some years ago, I approached a group and requested that we include domestic and family violence into the curriculum. It went absolutely nowhere. It took a few months and then I received an email saying, we're not planning it. That was just another Face

Palm moment and I aim to use today to change that. There's so many good people in the room and I want to harvest the knowledge that's in this room and take this further forward.
If we look at orthopaedic surgery, there was a study done where they looked at 250 people presenting to a fracture clinic and found 32.4% on the initial presentation in the clinic related that they had experienced in their lifetime domestic and family violence. Then there were further 12.4% who didn't disclose at that time, but it obviously resonated within them and in a later moment in the first year did disclose. So there's a high prevalence of people experiencing this in fracture clinics and therefore we need to get the word out there and we need to start teaching this to orthopaedic surgeons.

A survey of 186 Canadian orthopaedic surgeons showed that most of them felt that the prevalence in their clinics was less than 1%. So that shows our own ignorance and that we have to do more. And let me put a few facts out there. I try to put these facts out there every time I have an opportunity to speak. Across Australia, 95% of orthopaedic surgeons are men. If you look around this room, there are no male orthopaedic surgeons in the room. There are two female orthopaedic surgeons, Kerin Fielding, and I from New South Wales. Now, if it's 95% across Australia, in Australia's biggest state, what do you think a percentage is? Karen was the third female through, so across New South Wales, it's 97.3%. Now, consider that and then think about where the fracture clinics are held. They're held in the big city hospitals. If you look in Sydney, across Sydney public hospitals where the fracture clinics are held, 99% of the orthopaedic surgeons are men and they're not engaging. So we do have a problem. They did a study, and a lot of these studies come from Europe, Canada and the USA. They did a study about what were the barriers to orthopaedic registrars asking questions in the fracture clinic. And the common response was they'd never asked one question. They'd also never seen the surgeon that was running the clinic raise the issue. They felt they just needed to get through the clinic. They just felt the need to deal or the desire to deal with the orthopaedic issue. And this is the same problem I see when trying to manage Osteoporosis in fracture clinics, is that they're not interested. It's a female issue, “the GP should sort it out”, but it's actually really easy.

There was a study amongst nurses that showed they just had to ask one question and not everybody disclosed at the time, but for many, it gave them the courage to disclose at another moment. They just asked, did your partner hit you? That was it. And sadly, while we're seeing presentations due to intimate partner violence, we also know that vulnerable women and vulnerable people in general are more at risk of interpersonal violence. And so as well as being vulnerable when women are pregnant, they're also vulnerable when they have an injury. And often when that injury stops them running away or stops them putting their hand up and protecting themselves. So there's another place that exposes people to interpersonal violence. In this study, patients in the clinic that had been asked about it were screened at the later date as to whether they thought it was appropriate and helpful. And the overwhelming response was yes. These didn't just happen in the English speaking world. They looked at a study in India at the feasibility of screening for it and they found similar results, that the prevalence was 30% to 40%. There are two scales that can be used that can be given to women to fill out. They found that of these people that had it, 39% had fractures. So there we go again. Orthopaedic surgeons need to know, and those injuries were greatest to the spine and the neck. Orthopaedic surgeons have a misconception about intimate partner violence. And a lot of these misconceptions are also those things that we see when people start talking

about rape, that the person must be getting something out of this relationship, it's their fault, and it's only related to alcohol. And if the person wasn't using alcohol, they'd be an angel. But that's not actually true. In North America, they developed a tool to teach about this in fracture clinics. And then a year after teaching people, they assessed whether they were ready to manage it. And of course, they were. So, Orthopaedic registrars can learn, despite what some of you might think. We also need to think along a different line and we have to think about our colleagues in the workplace that maybe have experienced or witnessed interpersonal violence and how it affects them when they have to engage with the person who's working in this space. So we are not immune. Surgeons are not immune. Any health care worker is not immune. So we have to recognize our colleagues are experiencing violence. We have to educate ourselves, we have to acknowledge there's an issue, listen to the person, support the person, and we have to follow up with that person and we actually have all the information we need here in Australia already and we have to start using it. The Victorian Royal Commission in 2016 covered so many aspects of these issues and we can use that information and take it further.

When I went to council, which is the surgeons that meet in Melbourne, that are above the state committees, that run everything that Sally is the president of, and I raised the issue that I couldn't get engagement, the chief examiner said to me, Mich, just write an exam question. If there's an exam question, it will be incorporated into teaching. Now, I'm not a surgical educator. I don't know how to write an exam question. It's 20 years since I saw an exam question. So I asked the educators. Now, we actually haven't had a reply to the email. I've asked an educator on our committee who hasn't engaged on the topic with me and that's been over months and endless emails. But I'm hoping people in this room will help me with this issue and we can set up a little working party and take this further. And that's why I am for today. Thank you.

Morning tea break

Dr Lai Heng Foong

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My name is Lai Heng. Thank you for inviting me to come and talk about this. This is a topic that I'm really passionate about and it started in Darwin, Northern Territory in 2007 when I was an emergency trainee and I did a research project on domestic violence in patients presenting to emergency department. And I screened people, men or women between 16 to 60, who have experienced domestic violence in the past or present. And my study found a 30% point prevalence of domestic violence, mostly women. And based on that, our emergency department managed to fund a social worker. 24/7, seven days a week. And they also introduced a few support services for victims. So I moved to Sydney in 2008 and did finish my training here. And it's now 2022. How are we doing? I would say that we're not doing too well. Today I'm going to talk to you about the extent of the problem. I like to dispel a few myths about domestic violence. And because this is a trauma symposium, I'll try to do some acute care. And also I like to highlight a special case of non fatal Strangulation, because too many acute care physicians don't know much about it, don't screen for it and don't investigate enough, and victims of domestic violence have to suffer in silence. So then after that, I will end on a positive note on solutions.

So what do we know so far? One in six women, according to the Australian Institute of Health and Welfare, have experienced physical and or sexual violence by a current or previous partner since age 15. One in six women. So I'm a sexual assault forensic physician as well, and I certainly do see domestic violence intersect with sexual violence. One woman per week is killed by a current or previous partner. I think actually the data has increased a little bit. So they say it's one to two is killed by a current or previous partner. Domestic violence is the greatest health risk factor for women age 25 to 44. So that's when we are the most productive, and it's the greatest health risk factor. Domestic violence can have lasting effects. And due to time constraints here, I won't be talking about the effects on children. I'm focusing on the women, because the children is part of women experiencing violence. Children who are abused before age 15 are three times as likely to be victims of domestic violence in adulthood. So it crosses generations. So 97% of women that are killed by a family member turns out to be killed by their husbands in the United States. And the cost of intimate partner violence exceeds $5.8 billion. And as I mentioned, adults are not the only victims. 15 million plus children are witnesses to domestic violence each year.

You can see on the screen some of the photos of missing Aboriginal women. There are 300 women, Aboriginal women who are missing, presumed deceased due to domestic violence. So I'd like to propose to you that this is trauma, but it's just hidden. Domestic violence is our hidden epidemic. Violence against women, unfortunately, is tragically common in all communities. I'm going to talk about the myths a little bit later. But it doesn't just happen to women who are from lower socioeconomic status or culturally and linguistically diverse women. It happens to everyone. And it's really difficult to distinguish who are the victims. Aboriginal and Torres Strait Islander women are eleven times more likely to be killed due to family violence compared with non-indigenous women. So that's a startling statistic. So why do we still have this problem? Because there are many myths that kind of circulate around our community. People think that domestic violence is a criminal or police matter. They think that it only happens in couples from lower socioeconomic class. They also think that it's a personal matter between intimate partners and we shouldn't interfere. And the common narrative is, if he's so bad, why doesn't the women just leave? And there's so many complex reasons why they cannot leave. They want to, but they can't. And I'll touch on it a little bit later and there are some people who even ask, well, if she would just stop picking on him or challenging him, this would all stop. But it doesn't explain or wish away the violence that we see. Victims are also more likely to experience pregnancy loss. Female children who witness domestic violence are three times more likely to be victims of domestic violence themselves and male children witnessing domestic violence are more likely to become abusive men. Domestic violence continues to cause harm not just the women, but the children. People who have experienced trauma, they're more likely to commit suicide. They're more likely to become an alcoholic, they're more likely to develop STDs, they're more likely to use antidepressant medications. They also show behaviours that could increase their risk of mobility and mortality.

How are we doing at identifying domestic violence? We're not very good at it. Either we don't ask it or we don't see the tell-tale signs, or we ask in front of a partner, which is a complete no no for identifying domestic violence. So we miss most of the domestic violence that present to emergency. Unless you ask, you won't know. And very few women seeking care for DV are being appropriately assessed and receiving care that they need. And thank you, Talie, for sharing your story, because there are so many more stories out there about how we fail as health practitioners. How can we improve? I think we just need to think cross

sectionally, because domestic violence is one of those conditions that affects and influences so many different health conditions. And the social determinants of health really come to play in perpetuating domestic violence. We need to educate our healthcare workers. I'll help you write a question Mich, we can work together. And having a multi-agency approach to domestic violence is absolutely crucial. And as Natalie Ward mentioned that it needs to be funded. That's our problem, which I'll address a little bit later. You can have all the problems identified, all the programs, but unless they're funded every year, we start from zero every time. And we need to dispel the prevalent myths about domestic violence. We need to care enough to ask because my last domestic violence patient came in with a black eye, but she said she had fallen down in the stairs. So I asked her partner to leave. I said, oh, I just need to talk to her by herself. And I said, you don't just fall down the stairs and have a black eye. Tell me what happened. And it all came pouring out. And then we have the problem of how do we stop the partner from finding out that I'm referring her to domestic violence support services? So there are so many barriers for us to identify and support them.

There are higher rates of domestic violence in rural areas compared to capital cities. And 80% of incarcerated women, if you ask them, have reported prior experience of family and domestic violence. So how do we identify them? If the signs and symptoms are so hidden, how do we do it? There is a role of screening in emergency departments. It only takes three questions, it takes less than five minutes. The tool that I used had seven questions and it did take ten to 15 minutes, but you can do it faster. And there's now some screening tools that have been validated that takes a shorter time and we need to, as a minimum screen, high risk areas, and it's being done already in antenatal clinics.

I just want to quickly talk about social determinants of health, because we need to address the social determinants of health to help victims of domestic violence. And I just want to show these two photos, you wouldn't think they have something in common but they are both victims of domestic violence. So of the people that come in with domestic violence, more than 50% show no signs at all. Trauma in domestic violence is mostly concentrated in the head and neck area but they also can have thoracic abdominal injuries and certainly orthopaedic injuries as well. Domestic violence and the trauma surgeon - what is the link? I would just like to say that one day you'll be tasked to operate on someone who might have spleen injuries, liver injuries, and there might be a neurosurgeon here who might have to operate on someone, but you might also just talk to the woman, believe in her, and support her through the process, because you might not see any visible injuries. So that's the challenge I would like to send out to all of us here.

I just wanted to also talk briefly about nonfatal Strangulation, because someone who comes in after a nonfatal Strangulation episode might not have anything on their neck, but you need to ask them questions because a victim of NFS has a seven times much higher risk of a homicide after they present. So we must ask the questions. I know that in the Sexual assault service, as in RPA where I work, we already have a screening tool for every sexual assault patient that we see, and unless you ask, they won't reveal.

I'll also talk a little bit about the policy directions, but I'm out of time but just briefly, there's been lots of policies, including one national plan to end violence against women and children, that's just been announced. But the problem remains that these policies do not come with a budget. A budget for homes,

secure education for kids, trauma informed psychological care cost and it has to be continued for as long as the woman needs it and that could be ten years, whereas most funding is a one to two year cycle. And that's simply not good enough. So I just wanted to finish by saying that domestic violence is all about power and control. It's not about injuries that you see, it's about someone exerting power over the other. And it's here to stay, unless we view domestic violence differently, unless we stop looking for only obvious injuries, it is a hidden trauma epidemic. And most importantly, as healthcare workers, believe her, because that is the most important thing you can do to a woman who comes to you in times of vulnerability. Thank you.

A/Prof Payal Mukherjee

Next we have got another amazing subject matter expert, Mayet Costello, whose PhD is in this area. Mayet is a manager in the Prevention and Response to Violence, Abuse and Neglect in the Ministry of Health and she has worked in this area for many, many years and has helped us in the past. So thank you so much.

Mayet Costello

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Thank you to all of you for having me today as well. I would like to start by acknowledging the traditional owners of this land where I have great privilege of living. Now, my conversation today, I was asked to go through some of the data and what we know about violence and neglect, particularly domestic and family violence. But I am aware that Lai Heng has gone through a lot of what I do in my presentation, so what I want to actually do is skip through some of that. So I'll cover it really briefly, but really focus in on the second main part of my presentation, which is how we can better respond during integrated public health approach. So, as I said, violence abuse and neglect and domestic family violence is very prevalent in the Australian community. What these facts tell us, just to take it a little bit further than just that it's very prevalent, is that we are likely to be seeing how many people present into the health system for DV. Also, it tells us that not all people who've experienced violence is given a specialist VAN, (Domestic & Family violence service.) Sometimes they need to come into a hospital to have their baby or have their surgery and receive an appropriate trauma informed response without ever having to be referred on. So it's important that all of our health clinicians have the experience and skills to provide helpful, supportive and most importantly, as Talie said, services that don't do harm.

The first thing I must say really briefly too, is as helpful as these statistics are, and I can talk for hours on crime victimization surveys, they are a bit limited in what they tell us, in that what we actually expect from these statistics is that the experience of violence is much more prevalent than even these stats suggest. Because just to use as one example the definition of intimate partner violence, it's a definition that only uses physical and sexual violence. It's only a study for the Australian Bureau of Statistics Personal Safety survey and it also is limited to an incident based definition of violence. So if we pull into this, things like what Minister Ward was saying around coercive control, emotional abuse, other forms of financial, spiritual abuse, etc, that we know exist in domestic and family violence then we're looking at much greater prevalence even than these stats suggest. The other thing I want to briefly mention is the importance of having a lens of priority populations being right at the forefront of how we think about and how we respond to domestic and family violence, often historically, particularly in policy context, and what we do in

government, we often develop some wiz bang new policy approach, and then go, oh wait, what about everyone else? And we have this kind of concept that we can just tack on aboriginal experiences or people with disability at the end. What we need to know though, and what we need to make sure we do, is right at the very beginning think about the needs, experiences and expertise of people from what we call our priority populations. This is people who may have a particular vulnerability to the prevalence of violence or the impacts of violence in terms of the severity of the violence these population groups experience. But also, quite critically, if we turn around on ourselves, these are people who we are more likely to discriminate against, we're more likely to put up barriers for them accessing our health services, we're less likely to believe, we're more likely to discount. So it's also important that we remember these experiences right at the very beginning and address the barriers, including the barriers that we ourselves create.

Now, I'm not going to go too much through the definition of violence, except just to say, again, challenging crime victimization Surveys, domestic and Family Violence we often use an incident based definition of violence when we do statistical, quantitative surveys. It's really important to note that although there are lots and lots of different definitions of domestic family violence, as Sally pointed out, a key concept in all of them is about power and control. So it's not just an issue of one partner has perpetrated violence against another. It is actually usually a pattern of behaviours that are really intended to control, to enforce fear, dominance, coercion against the victim or victims of that violence. Why this is important is when we talk about things like the gendered nature of domestic and family violence? When we talk about how we can respond better as health professionals, we have to be really careful not to collude, but we have to be also really careful to understand that solely an incident of violence does not necessarily equal domestic violence. Particularly if you think about it in the context of a victim who might be a victim of domestic violence, who might use violence in self-defence, who might use violence to help manage their experience of violence. So that just because they have used violence against a partner does not necessarily mean that they are not a victim of domestic and family violence. And I think this is really important. I have a slide a bit later on in New South Wales and that shows sometimes a partner is actually murdering the perpetrators of violence in some instances.

Really briefly I will touch on twhat I often get asked "what about men?" And it is important to acknowledge that men have experiences of violence as well. But I think it's also really critical to acknowledge that men do have greater experiences of violence if we look at physical violence like any type of violence, however, women tend to have greater experiences of the form of violence termed abuse and neglect, which is domestic and family violence, sexual assault and sexual abuse, and child sexual abuse/neglect in addition to child sexual assault. So when we often go down a pathway of "what about men/not all men" kind of arguments, it's important to remember that many men are victims, they're just victims of different types of violence and need an appropriate different response. But it usually is not the prevalent experience in the kind of gendered domestic violence sexual assault context. I think the other thing just to note with this that when women experience violence it often tends to be more frequent, more severe and more likely to result in serious injury and death, including hospitalization than when men are experiencing violence from their partners. So apart from the prevalence difference, there's also a qualitative difference in the violence that men and women experience. With the nature of violence though, is really important to acknowledge that everyone has a right to feel safe and be free from violence and that most of the responses that we have in

the public system are really gender mutual responses and that's the vast majority of responses to violence happening in the mainstream health, social welfare and justice systems.
Now I'd like to talk a bit about high risk factors of domestic violence. Really just to I guess, emphasize a point about in tailoring in how we actually respond and tailor our responses to domestic or family violence. Health workers really do need good skills training and experience to support appropriate responses and need to do things like have a really sound understanding of what domestic and family violence is and screen for and ask questions about domestic violence. So this goes beyond knowledge and into skills. Respond to disclosures which goes beyond just referring them to social work. Although social workers of course have extensive experience, we really need all health professionals to be able to appropriately respond, identify and respond to things like high risk factors; factors where we know that you need to urgently intervene because of the risk of lethality (so lethal violence or more severe violence). Take care not to collude with perpetrators of violence; as a few people have mentioned including Talie, perpetrators often are very charismatic, are very good at working systems against victims, are very good at manipulating people to ensure that the victim is not supported, not believed so they can maintain their power and control. We as health professionals have a huge opportunity to actually intervene but we also have a huge potential to collude and actually make someone more at risk if we collude with the perpetrator. And then finally to also be able to report and appropriately respond to colleagues who are experiencing violence, who are perpetrating violence and who are perhaps experiencing vicarious trauma or other challenges in terms of being able to appropriately respond and provide good response.

So often people mistakenly think of violence, abuse, neglect as a single incident. What we know is it's rarely a single incident. Most people experience multiple forms of violence, abuse, neglect that are either co-occurring or across their life stage and critically the health and wellbeing consequences are cumulative. So it's not just one more assault, it's not just one more incident. We actually see a cumulative effect. Our health system is currently very satisfied and fragmented and disconnected. We have what we call, what I call, the disease model or we could say the body part model or the violent type model. We respond to a body part or a disease or sexual assault or domestic violence. We don't look at a whole person and services that we can better provide for them. I'm not going to go into this detail around the health outcomes because I think they handled this very well. But I will just note that extensive research now tells us absolutely unequivocally that violence, abuse and neglect, including domestic family violence is an absolute key social determinant of health. The research in particular has shown us, and I think this is where it is especially useful for the young surgeons and trauma specialists in this room has connected violence, abuse and neglect to chronic and acute health issues that we haven't historically associated with violence. So although things like mental health issues, alcohol and other drug issues are very well connected, we're also seeing a whole range of issues that we have not previously associated with vulnerability to or increased risk. Things like chronic obstructive pulmonary disease, heart disease, diabetes, autoimmune cancer etc. Yet despite this we continue to take quite a siloed and fragmented approach to violence, abuse, neglect.

So what do we actually need to do? We need to take a public health response. We can't leave these responses to violence, abuse, neglect entirely to our special sector. Not only do they not have the resources to do it. But not all of the victims that we see in our practices need a specialist response. As I said, they need an appropriate healthcare response to their presenting issue. We need to also be able to recognize

that not only is our issue a key social determine of health, but we're really uniquely positioned in the health system to provide an appropriate and really impactful response for the whole sector.
How we are trying to do this in New South Wales health is what we term shorthand, I guess, an integrated public health response. The response where we look at violence from preventing the health consequences during primary prevention early intervention through to minimizing health consequences when domestic violence occurs by providing an appropriate trauma informed, trauma specific response and supporting recovery from violence. In doing this, we need to look at four different, separate levels. I think our ability to actually change our individual practice is really important. Yet we also need to look at the service delivery level, how we actually operate our services, how we work together, how we collaborate, how we do our referral pathways, how we don't just jump and run and refer people on, but actually maintain involvement, including new services, how we structure our systems not to inadvertently do things we don't want to see in terms of things like only counting individual clinical practice and not counting things like collaborative work or working with other professions, social workers, other doctors in providing a better service, and really critically to our workforce: acknowledging that our workforce does and may have experiences of violence, abuse, neglect, both as victims and importantly, as somebody pointed out earlier, as perpetrators. What can we do as a system to support people who have experienced violence so that they can be the best health worker they can be as well as tackling within systems and structures that support and maintain accountability around perpetration of violence when that occurs as well.

In New South Wales, we're really trying to embed these principles in practice in terms of taking a collaborative approach and a whole of system integrated approach to violence abuse and neglect. The framework that we've developed under this program of work really does provide detailed guidance for all of New South Wales health practitioners, as well as more detailed guidance particularly for our violence specialist services. I think it's really important to note that although this is really focused on New South Wales health, what our responses are also trying to do and what they're able to do, is the evidence and the approaches we have underpinning this is relevant for all health workers. And by that I mean not capital "H", but all clinicians working both inside our system as well as more broadly, either in private practice or also within other states and territories. You can see this in our redesign principles, where really they should be the principles underpinning your practice generally that some is a central role for health. The importance of taking person centred and family focused approaches to violence, abuse, neglect, where you don't just look at the client or the patient in front of you, think about others, think about where are their children, are their children safe? Where's the perpetrator? If you're seeing the perpetrator, how can you not collude? How can you hold them accountable while providing an appropriate and positive health response to them? How can you intervene to support the family, the children, even if they're not your primary client?

Our VAN services model in New South Wales health is really important to acknowledge not just that we have special services in health and respond to violence abuse and neglect, but one of the key responsibilities of these services is in one of the far circles here around professional consultation and support. You do not have to do this alone. We have a number of services across New South Wales and I'm sure other states are similar in their approach where you can approach those services for help, for professional support, for debriefing. Sometimes they provide training and other levels of support and then just finally proving trauma informed and trauma specific care and by this I mean psychosocial trauma in a

lot of ways rather than I know a lot of trauma surgeons here are probably thinking of more physical trauma, although of course these do intersect. Change can start with your individual practices providing stuff like trauma informed care. However, to be truly trauma informed and responsive to people with experienced violence abuse and neglect. We really need organizational assistance change. An important role for the doctors and the leaders in this room is to promote and advocate change towards an integrated, a holistic and trauma informed care and systems and service delivery as well as to support other things like the structures and the workforces that are needed to do this. But really happy to talk to people in the breaks and Thank you.

A/Prof Payal Mukherjee

Thankyou Mayet. It' s an absolute honour to call upon Professor Hegarty. The College of GPs has actually taken the leadership on this and made really amazing milestones that we all have to follow. Professor Hegarty is a GP. She's the Joint Chair of Family Violence Prevention at the University of Melbourne and Hospital.

Prof Kelsey Hegarty

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I'd like to begin my talk by acknowledging the survivors in the room for their strength and resilience and hope what I say resonates with your experiences. And I'm not going to go through this because we've had beautiful examples of this, but this is how the World Health Organization views it. And I think we've spoken about all of these, including chronic disease that can result from trauma. So I'm not going to go through all that. But I did want to highlight the strangulation and the traumatic brain injury because I think there are particular things that this group of colleges and people in those colleges will see. And again, it's really to remind yourself that these are important things, particularly the traumatic brain injury. So what I'm going to do in the next ten minutes is really try and distil the global evidence on this for all health practitioners. And we looked at the studies of all around the world and asked them what did they want from you as health practitioners? They wanted to be provided universal education. And I think that this is an interesting thing to think about in your system change that you're going through.

There's certainly places in the US where everybody gets given some information about healthy relationships because it affects health. So it's not that, you know, I'm asking and she's not telling me, it's about creating a safe and supportive environment for disclosure. What stops you asking about DV in one word or one phrase? If you're not a clinician, think about if you knew a friend or a family member. Just have a quick turn to the person next to you. What stops you asking? Around one in ten health professionals actually asked about it. And some of the barriers are system issues. Lack of time or skills or referral options. This belief about I can't interfere, you know, it's a personal matter or "I don't have control". There's frustration when women don't follow their advice when they don't leave or they return to the partner after leaving. So there's issues around control within us and then I won't take responsibility. Social records, like I know obstetricians who say to me, I know that's not my right. So we need to convince and win the hearts and minds of people around that. And asking about domestic violence is quite tricky - is there one question or the three questions? But this funnelling approach, this is how we train inject for the GPS and for other health

practitioners. And what we do is sometimes multi agency risk assessment and management. And this is the identification tool. No identification because we're not supposed to screen in every place. We're not supposed to ask everybody. I think women are clearly saying they want universal education. But act if we see indicators, perhaps afraid control threatens physically hurt. Some Pretty good questions can include things like: Are you safe to go home? Do you feel safe? And trust what they're saying to you. if you do have to do an appointment through telehealth, there are tips that you need to do to be able to check that the patient is alone, if you hear or see someone in the background etc. These are the things we had to adjust to through COVID.

What is really very clear is that the survivors tell us they want very simple things. Listen/inquire about our needs, validate by believing, enhance safety. And that's often the piece that I have to train [enhance safety] because all of us can listen inquire and validate - all of us can do that. So it's the safety piece that often they haven't been taught in medical school. So this is LIVES (Listen, Inquire, Validate, Enhance Safety) really easy to remember. There are the validation statements like “you do not deserve to be hit or hurt, it's not your fault, you're not to blame” etc. Its simple language that may not be in our vocabulary. We're taught other vocabularies, but not this one. And then the safety questions may have showed the risk factors, but these turned into questions with the focus being on the perpetrator because it's their behaviour, so questions like do you believe they are capable of killing or seriously harming you again? That is one of the best predictors (probably similar to some issues around suicide) and then build a mental health care plan around that.

When we ask women what response they want, they want choice and control. They want action and advocacy. They want you to be their ally, they want recognition and understanding, and they want emotional connection. So you can actually do the wrong thing (slightly), but as long as you're actually doing it in a kind way or realizing or checking in and giving them choice and control, it will actually mean so much to them. Ten minutes of listening is just gold. Who listens to all of you? Your partner? Maybe your children? So it's sort of thinking through what you can give as a surgeon or an emergency department, you can actually give some of these in the way that you deliver your practices. You don't have to do it all at one time, but you can do it in bits and pieces. If they're safe to go home, of course, if it's like a cardiac arrest, are they safe to go home? We think about it at the clinical level, asking some questions.

So if you put some of these on emergency departments, how aligned is your emergency department to the core principles of safety, trustworthiness, choice, collaboration and empowerment? But then also at an individual level, how tuned in are you personally, how do you do a strength-based approach, not a vulnerability approach, and what could you do to change? So these are good reflective questions and that was the things that helped health practitioners become ready. We heard about readiness. One is having a commitment and many of you will display these in child rights, human rights, feminists - personal experiences are bringing you to commit to this work. Adopting that sort of advocacy approach to DV - survivors really like it. Trusting that health is a good place to do it. And you do have a bit of a team around you. But if you don't have any health system support, if you don't have leadership in governments, if you don't have health workforce development, if you don't have protocols, you don't have coordination, you don't have financing, as other people have mentioned, and you don't have feedback systems and

monitoring, evaluation and the environment, or there's no privacy. These are structural things. But even the best person can't then do the work.
So these are what I think we need to think about and concentrate on changing so that we are enabled to do the work. I urge you to look at our website, the Safe Family's website. We also have a whole program of work both from Safe Family and the College. And there's a space in the breakout today to talk about how we got there and what we did. So I'd like to thank you for your time.

Dr John Sammut

I'd like to start my talk today by acknowledging the traditional owners of the land on which we meet and pay my respects to their elders, past present and emerging. Just to frame the talk - accountability and perpetrator. We're turning the tables in this talk. I'm here on behalf of the medical council, talking about what do we do when we learn that medical practitioners have engaged in family violence or in fact, not responded in a way that we would like to think they should, having been made aware of family violence? And so that's the purpose of my talk to you today. By way of background, when I say I work for the Medical Council, just so that you know who we are, there is a national body that looks after things like registration and accreditation across the country. But in New South Wales, we have the New South Wales Medical Council, which is the regulatory body responsible for assisting in the protection of the health and safety of the public in their dealings with medical practitioners who practice in New South Wales. It's a job we've been doing since 1838, and it's supported by New South Wales Health Law. It's a huge task, given that one third of all registered medical practitioners are actually in New South Wales, and that represents about 35,000 of us. We see ourselves first and foremost as a standards body with the aim of being to ensure our members of the profession keep themselves self-relevant and up to date. And we achieve this in part by dealing with complaints that are made against medical practitioners. We assess these complaints against acceptable peer related standards and relevant sections of health law, collaborating closely with the Healthcare Complaints Commission. Ultimately, complaints fall in one of three groups. There are issues dealing with the health of practitioners, particularly when there's been impairment, when there's full performance or perhaps relevant to today, when there's been conduct related issues which are defined as reckless, unethical, willful or criminal behaviour. So you might say that all sounds good, but what has that got to do with perpetrator accountability in the profession? Unfortunately, it's a reality in the Medical Council that over the very recent years, we've seen a significant and increasing number of notifications related to medical practitioners who have either failed to respond appropriately to request for assistance by survivors of family violence, or who have unfortunately themselves been perpetrators of family violence.
I suspect this rise in notification, if you're also wondering how does this come to be, is due to the efforts of many like you in the audience, who are having the conversations in society that bring to light the terrible prevalence of this appalling behaviour in an attempt to shift cultural expectations and ultimately save lives and achieve better outcomes for survivors. These notifications come to us sometimes by the survivors themselves who have disclosed family violence to the doctor and have been very disappointed to discover the doctor has inadequately managed them by, for example, encouraging them to return to their abusive partner and work it out. Or to blame the victim or to disbelieve the victim and refuse to assist or to fail to complete adequate medical records of how the patient presented and what was said. That, of course, can affect them down the line, particularly in legal proceedings. Unfortunately, as I've said, however, we also

have seen applications where the practitioner themselves has been involved in family violence from so called minor altercations, such as pushing a teenage child with a subsequent AVO being issued through to physical altercations at the lower end of the scale right through to more serious cases that result in actual bodily harm.

Perhaps you're wondering, how does the medical counsel come to know these things that occur outside the practice of medicine and largely in the home? Under the law, there are certain notifiable events that medical practitioners are obliged to notify the medical council within seven days. They include, but are not restricted to if you've been charged with an offense punishable by twelve months imprisonment or more, or if you've been convicted of an offense punishable by any form of imprisonment. So it's a reality that, faced with the increasing number of notifications in my time as president, we've decided to establish a specific, dedicated family Violence Committee to specifically review these matters. In doing so, we are looking to develop expertise in helping us to respond in a consistent, nuanced way to this complex and abhorrent conduct issue. We meet weekly as a committee if required, and we have strong community as well as peer representation. We in fact have four women and two men, and I chair that committee. We review each case on its particulars, and we apply some basic principles that help determine how we believe we should respond in a consistent and effective way within the constraints of the law.

We also reached out to our national partners at the Medical Board of Australia to see what they were doing in other states and territories to share the learnings and ensure we provide a national consistency in our response as regulators. For those practitioners who fail in their response, care or management of survivors who disclose, we believe the way forward is reasonably clear for us, this is a standard issue and clearly one of underperformance. When thinking about what is an appropriate response that medical practitioners should make to these disclosures. I think the AMA, in fact, sums it up best in their position statement, now six years old, where they said the medical profession has key roles to play in the early detection, intervention and provision of specialized treatment for those who suffer the consequences of family and domestic violence, be it physical, sexual or emotional. Medical practitioners must encourage attitudes and actions necessary to prevent family and domestic violence identify women, men, families, children at risk, prevent further violence and assist patients to receive appropriate health and protection. We generally deal with these practitioners under the performance pathway, and we encourage them to first complete a self-reflection piece looking for their insights into why their behaviour was inappropriate and what they may have done to remediate. Occasionally we may then call them in for a formal counselling interview to ensure they've understood the issues and have remediated effectively. Some of the other strategies we've adopted in the past include recommending they work with their indemnity to ensure on better medical recordkeeping. We will occasionally request that they attend a course doing a deeper dive and gaining a better understanding of all the issues related to family violence.

You might ask but what about those that are themselves charged or convicted with family violence matters? The landscape is difficult and far less straightforward. We are mindful that we must fulfil our obligation as a regulator under the law in dealing with these notifications. That is, we must always turn our mind to how does this notification intersect with our primary purpose of ensuring the health and safety of the public? It may not surprise you to know that health law has not in fact turned its mind specifically to this egregious

behavior that occurs principally outside the practice of medicine. So we began by asking what is our role in the space? How would the law expect us to respond to these perpetrator offenses? I can tell you when we started we are and still remain and challenged by people who would say to us why does the Medical Council concern itself with these events since they occur outside the practices of medicine? If the practitioner is competent in their work and has a previously unblemished record of performance, why do you need to intervene? Are these issues not already dealt with by the criminal courts? Is this regulatory overreach subject to challenge by appeal in a higher court? It won't surprise you to know that I believe strongly, as does the council, that we do have a purview for several reasons. I've said to you our remit is the protection of the health and safety of the public. We believe that this may be put at risk if the practitioner dealing with the victims of family violence are themselves a perpetrator. We take very seriously the notion that in the community the victims of family violence should be encouraged to seek support and it adds a layer of complexity if the professional they're seeking assistance from has themselves been charged with family violence offenses. One worries about the notions of empathy and the provision of appropriate psychological support to the survivor. We know how crucial those early interactions are in determining how the survivor might continue to reach out to the profession to gain the necessary support. Empathetic referrals and support services that may result in life interventions to cycle of abuse. Clearly, doctors have a crucial role in this space and it begins with the recognition of an abhorrence of the behaviour. Furthermore, we believe it is in the public interest to act - a reputation of protection is crucial to the effect of us as medical practitioners. They must be ethical. Patients must trust their doctors because they believe that in addition to being confident, the doctors take advantage of them and will display quality, truth, dependability. A public that believes we would tolerate such behaviours and feel welcome amongst those that are perpetrators of these offenses, is not in the public interest.

So, having determined us to have a role in this space, we had to work through a number of subsequent issues. We dealt with these complex questions. We look not only at the severity of offences, so whether there were convictions, the time of offences, whether they have attended or completed counselling for themselves. As part of the assessment process, we also needed to assess the impact on their own mental health facing charges in going through a court process and how this might affect how they do their job. Some will have issues related to alcohol or drugs or financial pressures that impact on their ability to do their professional job. And where we believe this may be the case under the law, we'll call for a council appointed practitioner, usually a psychiatrist or drug or alcohol specialist to assess these issues. Ultimately, the kinds of actions I can tell you we have taken and will continue to take include things like beginning with a completion of a self-reflection piece that asks them to describe the incident, talk about how the incident made the victim and their family or carer feel or how they think they might have felt or feel. The questions, including things like how has the issue impacted on their practice? Whether they discussed it with any other organization or service provider, what input they may receive from their peers and colleagues and looking forward based on their reflections, what areas of practice do they think they could improve? And importantly, since the incident, what have they done to inform themselves of the abhorrence of the behaviour and how they plan to remediate. We may in fact and have often called for a counselling interview to further explore the issues face to face and gauge an insight into the remorse and motivation for change. We can direct their involvement in and satisfactory completion of behavioural change programs. We sometimes ensure they seek and engage with counsellors or psychiatrists on a regular basis and we continue to monitor that

throughout their treatment. For some we refer them to an impaired Practitioner's program for specific treatments or remediation in relation to drug and alcohol issues and infrequently the offence may be of such severity or the nature of the offense together with the nature of the practice might mean that we take urgent interim action under the law, acting for the protection of the health and safety of the public and in the public interest to suspend the practitioner pending the outcome of various criminal proceedings. Although I have to say to you, that has been challenged in more recent times in higher appeal courts who have challenged our purview in this regard and feel that there may be some form of regulatory overreach. And so I would finish here hoping to have successfully illustrated to you how the Medical Council of New South Wales takes these notifications very seriously and believes in the importance of ensuring perpetrator accountability, most importantly for the protection of the health and safety of the public, but also to maintain the standards of and trust in the profession. Thank you.

End Transcript