vicdoc

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. **APRIL/MAY 2017**

Skin of colour dermatology

THUNDERSTORM ASTHMA REVIEW

NEW PUSH FOR SUPERVISED INJECTING FACILITY

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FRONT COVER: A portrait of Winnie Harlow, model and vitiligo spokesperson. Artist: Sara Leal (drawme_saraleal@hotmail.com)

Magazine of the Australian Medical Association Victoria

293 Royal Parade
Parkville Victoria 3052
T: (03) 9280 8722
F: (03) 9280 8786
Country Freecall 1800 810 451
amavic.com.au
Editor: Barry Levinson
E: BarryL@amavic.com.au

Advertising:
Marc Wilson
T: 0419 107 143
E: MarcW@amavic.com.au
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Chief Executive Officer
Frances Mirabelli

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Welcome from the editor

The urgent need to improve support in schools for children with type 1 diabetes. See page 24.

Dr Peter Goss is a paediatrician and AMA member who is passionate about improving the lives of children with type 1 diabetes (T1D). Australia is a long way behind other developed nations in providing the appropriate support in schools for T1D and in this edition of Vicdoc, Dr Goss outlines the reasons why governments around the country need to lift their game.

Dermatologist Dr Michelle Rodrigues is another AMA member keen to raise awareness about her field of medicine. She explains some of the different issues faced by people with skin of colour.

Your Vicdoc also includes analysis from TressCox Lawyers on an assisted dying legal fight, an update on the review into last year's thunderstorm asthma response, a renewed push for Victoria to have a supervised injecting facility, plus more policy and workplace relations news. Our Workplace Relations team is just a phone call away for our members (03 9280 8722) and they've been receiving multiple calls from GP registrars transitioning into new roles.

Great strides have been made in treating and managing blood borne viruses, but despite these advances, many people living with these conditions are not receiving treatment, even once they have been diagnosed. North Western Melbourne PHN is leading a group working hard to change this.

You may also be interested to learn about Victoria's first mother and baby alcohol and drug withdrawal service that recently opened in Ivanhoe and find out more about the changes to legislation which now gives people conceived by donor sperm or eggs more rights to find out details about their donor.

We want to feature more stories about our members, so if you would like to tell us about an achievement or an interest others might enjoy reading about, please contact me on the details below.

Vicdoc will be sent to members every two months, so look out for the next edition in your mailbox in June.

Barry Levinson

Editor
(03) 9280 8722
BarryL@amavic.com.au

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President's message

In earlier editions of Vicdoc, I have provided an overview of some of the State Government advisory groups on which I represent you, our members, but I had not elaborated on the weight of issues addressed.

At first thought, it can seem better to distance ourselves from some – especially where there is a project which exposes a risk of blurring boundaries between one health profession and another. An example is the Chronic Disease Management in Pharmacy Pilot Study, which has rightly caused considerable concern for GP members.

Pragmatism dictates that where a project will be undertaken regardless, it is better for the AMA to be at the table and aware of the direction projects are taking. We use the opportunity to challenge assumptions made outside medical practice about what good patient care looks like, and push to represent the safety, the evidence-base and cost-effectiveness of the work done by the profession. We are committed to asserting the importance of general practice – to ensure we maintain the best standards of care for the public, our patients.

One current advisory group is of particular significance for the profession – The Real-Time Prescription Monitoring External Advisory Group. AMA Victoria supports the concept of real-time prescription monitoring in order to identify drug-seeking behaviour and protect users from overdose of prescription medication. How this program will play out, however, has complexities beyond the simple identification of at-risk behaviour.

From setting the threshold for alerts, the interface of prescribing and dispensing software with the system, regulation and notification of prescribing and dispensing activity and then – perhaps the most important of all – resourcing health services to manage the potential increased load of patients requesting opioid replacement therapy and specialised addiction services, all these issues and more are discussed in depth. Through participation in the group I am on the inside of the process and will continue to highlight the practical implications of any new legislation and the potential consequences to practices and health services in time, safety, resources and financial costs.

There is potential for new regulations to impact reporting to AHPRA of "aberrant" prescribing and dispensing practices, with all the consequences that may flow from this. Because of AMA Victoria's engagement with this issue, we have the opportunity to be ready to keep the membership informed and educated around any legislative change, and use our established connections with the Department of Health and Human Services to ensure our members are given opportunities to understand the process as it evolves.

Forthcoming advisory group engagements will include the implementation of the new *Medical Treatment and Decision Making Act*. Given the content of the Act and the requirement for all attending health professionals to make efforts to identify the existence of, and comply with, advanced care directives, the burden this may impose on us all is considerable. Since criminal penalties will apply for not complying with the law, its implementation must be managed with the utmost attention to detail. We will be working hard for you all in representing the practical implications for our members and our patients as this unfolds and may seek your input as the process evolves.

Sometimes as I write about these matters I reflect on the scope of medical practice and the dedication of those who practise medicine. Adapting to and keeping up to date with not just clinical medicine but the regulatory framework in which we operate can feel burdensome. AMA Victoria, through its work on advisory groups and depth of understanding of the changes proposed and implemented by various governments, ensures you are supported as much as possible to relieve that burden.

Dr Lorraine Baker
President

From the CEO

AMA Victoria's inaugural Congress 'Future in Medicine' was a tremendous event and I would like to thank the many of you who attended the Melbourne Convention and Exhibition Centre on the last weekend of February. I would also like to thank the weekend's major sponsors for their support: TAC, MyHealth1st, MDA National, BMW Melbourne and AMA Insurance.

This year's Congress looked into changes in medicine that arise through technology, and changes to service delivery methods that are transforming and could transform the way we treat patients and address health issues at large. There were so many great speakers across the weekend, but I want to highlight the importance of the talk by the Chair of the Medical Board of Australia, Dr Joanna Flynn, who covered the revalidation changes to medical registration and just how much training is now required by doctors each year.

The panel on voluntary assisted dying had a thought-provoking discussion, covering many different perspectives on the very emotive issue which will continue to be prominent this year, with assisted dying legislation set to be debated in the Victorian Parliament. On page 12 you can see some photos from the Congress, which also included a gala dinner. But rather than hear more from me, social media was buzzing about the Congress and here's a sample of what was said over the weekend.

Frances Mirabelli
CEO

Jill Tomlinson
@jilltomlinson

Keep discharge & event summaries succinct & clutter free - like tweets! #Congress2017 @AuDigitalHealth @amavictoria

> **AMA Victoria** @amavictoria
> "A lot of GPs will complain about discharge summaries because they're five pages of crap. It shouldn't be a War and Peace size"#Congress2017

grant phelps
@grant_phelps

Really interesting 2 days @amavictoria #Congress2017. Time 4 bold action from docs on deeply u/standing societal needs & future healthcare.

Seb Belfrage
@Seb_Belfrage

Forget car accidents and cancer. The riskiest thing we do in our lives (three times a day) is eat the wrong food (guilty!) #Congress2017

Tony Bartone
@tbbart1

#Congress2017 we need to refocus on prevention and understand the politics of health" @amavictoria

Dr Sandro Demaio
@SandroDemaio

The wonderful @drjennyjam talking #resilience in #globalhealth & emergency #medicine, incl w @MSFAustralia.
At... twitter.com/i/web/status/8...

Doctor who promised Nembutal to patient not a risk to the public

In December 2016, a medical practitioner, Dr Rodney Syme, who promised Nembutal to a terminally ill patient was found not to pose a serious risk to persons generally or his patient.

The Victorian Civil and Administrative Tribunal (the Tribunal) reviewed the doctrine of double effect. When applied to palliative care, this doctrine permits medical treatment that is designed to relieve suffering where death is an unintended but foreseeable consequence. The doctrine is consistent with the AMA's position that all dying patients have the right to receive relief from pain and suffering, even where this may shorten their life, but that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life.

Facts of the case

Dr Syme's conduct was investigated by AHPRA following the notification by a patient's general practitioner. The notification alleged that the doctor was assisting his patient, a 71 year-old male who was terminally ill with tongue and lung cancer, to end his own life.

The Medical Board investigated Dr Syme's conduct and in January 2016 wrote to him advising that it proposed to take immediate action pursuant to the National Law to impose a Condition on his registration. The Condition was to:

> *'not engage in the provision of any form of medical care, or any professional conduct in his capacity as a medical practitioner, that has the primary purpose of ending a person's life'.*

The doctor was invited to make submissions in relation to the proposed action and the patient also provided submissions stating he was not at risk from the doctor. Dr Syme attended a meeting before the Immediate Action Committee and it was determined that it was necessary to take immediate action to protect public health or safety. A Condition was put on his registration as outlined above with immediate effect.

The doctor appealed the decision of the Medical Board to the Tribunal.

The doctor's position

Dr Syme confirmed that he had agreed to support the patient in the terminal phase of his illness, including by providing him with Nembutal in the future if requested to do so. The doctor admitted that he had counselled approximately 1700 patients in relation to end of life care, of whom approximately 10% were given Nembutal and 40% of those who had been given Nembutal actually took the drug.

He explained that the subset of patients he provides assistance to is very unique and they have exceptional circumstances. He said he is contacted by patients for assistance and he provides assistance only to those with cancer in the terminal phase and those with severe neurological illnesses. Patients are screened by the doctor to ensure they are rational, competent, not influenced by family, and to assess their degree of suffering. His treatment is not limited to end of life counselling, but also includes taking a detailed history, contacting the treating medical team if necessary and encouraging the patient to take advantage of options for further treatment and palliative care.

Dr Syme stated that when he first started providing end of life care, it was his intention to allow a person to end their life. As time went on, however, his intention changed to relieving, to the extent possible, the psychological suffering of those with terminal illnesses.

In relation to the provision of Nembutal, the doctor submitted that it was his primary intention to give patients a sense of control, thereby reducing their suffering. He explained that the provision of Nembutal had a direct palliative effect, as giving patients the option to end their own life had a profoundly positive psychological impact.

Most importantly, he stated that he will typically tell his patients that it is not his intention that they in fact take the drug and it is his hope that they will not need to take the drug.

Independent experts

Two palliative care experts provided reports and evidence before the Tribunal. The first expert provided a significant amount of information about barbiturates and explained that Nembutal is not an approved drug in Australia. He agreed that obtaining a 9g dose of Nembutal may provide some sense of 'control' for the patient, however, he said that ingesting the drug had only one purpose and that was to end life. He told the Tribunal that he had difficulty accepting that obtaining Nembutal would relieve patient suffering and the doctor did not intend that the patient would actually use Nembutal to end his life.

The second expert was supportive of the treatment and advice provided by Dr Syme to the patient. He noted that the patient was 'fiercely independent and strong minded' when confronting his illness and was aware of the options available to him. This expert concluded that it was reasonable to assume that the 'primary purpose' of the doctor's conduct was to relieve suffering rather than to cause death. The expert noted that the intention of the clinician is inherently subjective, but it can also be inferred from the type of care provided.

Outcome

The question the Tribunal determined when considering the appeal was whether there was sufficient evidence before the Medical Board to form a reasonable belief that the conduct of the doctor posed a serious risk to persons and as a consequence immediate action was warranted to protect public health or safety.

The Tribunal considered it significant that both experts who gave evidence agreed that there was a role for palliation of psychological distress and existential suffering through the provision of control. The Tribunal was also 'significantly assisted' by the statements provided by the patient in support of Dr Syme's treatment.

The Tribunal rejected the Board's argument that the only purpose of the doctor providing Nembutal was to cause death. It was found that there was a logical analogy with the principle of double effect used in palliative care, which is where treatment can be administered to relieve suffering even if it is known that that treatment may hasten death. The Tribunal found the only difference in this case was one of timing. The Tribunal held that Dr Syme's approach was entirely inconsistent with a primary intention to end a patient's life. It said that those patients who chose to take the drug did so by independent voluntary decision, without the presence, knowledge or assistance of the doctor. As such, the intention to end their life was the patient's own and not the subjective intention of the doctor.

The Tribunal considered whether Dr Syme would be a risk to the public and determined that since only a small subset of patients sought out his care, and only those facing death from a terminal disease were provided care, the overall risk to the public was low. It therefore found that the doctor did not pose a serious risk to persons that warranted immediate action to be taken.

Current situation

Currently, if medical practitioners expedite a patient's death they are at risk of criminal prosecution, such as a charge of murder, manslaughter or aiding and abetting suicide. In June 2016, the Victorian Legislative Council published an Inquiry into End of Life Choices (Inquiry). The Inquiry recommended that the State Government enact the common law doctrine of double effect into legislation to strengthen the legal protection for medical practitioners who provide end of life care.

While this case was a vindication for the doctor and his patient, it involved a very unique set of circumstances. In particular, the doctor promised the provision of a drug that remains illegal to import and prescribe in Australia, he comprehensively assessed and counselled patients over a long period of time and only a small subset of patients could be promised or given Nembutal.

This case was also a review of a decision by the Medical Board to take immediate action and it was not concerned with questions as to whether the doctor's conduct was legal or whether it constituted professional misconduct or unprofessional conduct. The investigation in relation to the doctor's conduct will therefore not be at an end as a result of the Tribunal's decision.

The legal landscape in relation to end of life care may change at the end of 2017, when the Victorian Government will introduce a Bill to legalise assisted dying.

Conclusion

This case represents a small step forward for euthanasia advocates as it recognises that having the choice about time and place of death can relieve the psychological suffering of those with a terminal illness.

Despite this, medical practitioners providing palliative care should not view the case as a blanket right to provide any measures that are intended to relieve psychological suffering when those measures unintentionally hasten a patient's death.

Anjali Woodford
Senior Associate
(03) 9602 9723
Anjali_Woodford@
tresscox.com.au

Beth Altson
Senior Associate
(03) 9602 9720
Beth_Altson@
tresscox.com.au

TressCox LAWYERS

References available from the Editor on request.

Review of response to thunderstorm asthma event

One of the legislated roles of the Inspector-General for Emergency Management (IGEM) under the *Emergency Management Act 2013* is to provide assurance to government and the community in respect of emergency management arrangements in Victoria.

The thunderstorm asthma event that occurred on 21–22 November 2016 affected the health of thousands of Victorians and sadly, is thought to have contributed to the death of nine people.

While the deaths attributed to this event will be investigated by the State Coroner, the Minister for Emergency Services, and Minister for Health and Minister for Ambulance Services have asked me to review the emergency response to the event.

The objective of this review is to identify opportunities to learn from this event in order to improve future preparedness and response arrangements and performance. This includes my recommendations, where required, for potential improvements to future public health emergency planning and response arrangements.

The rapid onset of this emergency and the scale of its consequences were unprecedented. The event tested the ability of Victoria's emergency management system to consider and respond to Class 2 emergency health consequences arising from a Class 1 emergency – in this case, a storm.

While thunderstorm asthma is known to have occurred in Victoria in the past, the events of 21 November 2016 were unprecedented in scale. Never before have the Emergency Services Telecommunications Authority (ESTA), Ambulance Victoria (AV) or Victorian hospitals experienced this level of demand in such a condensed time period and dispersed over such a large geographical area.

Based on the evidence analysed to date, ESTA, AV and hospitals acted swiftly to increase the scale of their respective operations. I commend the work of all involved in the emergency response – including the assistance of the Metropolitan Fire Brigade, Victoria Police and other agencies – in responding quickly, flexibly and professionally to the unforeseen circumstances commencing on the evening of 21 November 2016.

An early observation is that thunderstorm asthma is not well understood. Similarly, nor are the factors that enable thunderstorm asthma to be predicted.

The 'Review of response to the thunderstorm asthma event of 21-22 November 2016' documents some of what is known about thunderstorm asthma and the facts relating to the emergency response, and includes my preliminary observations. The predictability of this event is also a focus of this review, particularly in the context of triggers for the provision of public information and warnings.

My final report to be provided to government in late April will explore these matters in greater depth and provide recommendations to support improved preparedness and response to future rapid onset, time critical health emergencies.

The full preliminary report can be found at igem.vic.gov.au

Tony Pearce

Inspector-General for Emergency Management

Source: Review of response to the thunderstorm asthma event of 21–22 November 2016 – Preliminary Report (c) State of Victoria, 2017

New funding for pollen monitoring and thunderstorm asthma research

The Victorian Government will fund new research to better understand and predict the phenomenon of thunderstorm asthma, as well as a new and expanded pollen monitoring network as part of a $1 million package.

To ensure we are armed with the best information and the best science to better understand, predict and respond to events like this in the future, the Government is investing $700,000 to support research into the underlying causes of thunderstorm asthma and the best processes for forecasting these events.

$300,000 will also be spent to expand the state's current pollen monitoring network. Agencies will be invited to tender for five more monitoring sites from October, and this data will be used as part of the new research.

The expanded pollen monitoring service in Victoria will:

- help understand the phenomenon of thunderstorm asthma and better forecast the risk
- help more Victorians better manage their hay fever and asthma
- provide the Victorian community with information to assist susceptible groups
- educate Victorians about the trigger for asthma and hay fever, encouraging use of their prescribed medications and asthma action plans.

"Our thoughts and condolences go out to the many families affected by this extraordinary event," Minister for Health and Ambulance Services Jill Hennessy said.

"We want to assure all Victorians that every lesson to be learnt will be learnt, and the right systems, resources and measures will be put in place so we can better prepare for, and respond to similar events like this in the future.

"More research and expanded pollen monitoring will make sure we have the best information and science to better predict thunderstorm asthma events ahead of this year's pollen season."

There will also be a major overhaul of the way the Department of Health and Human Services manages and escalates emergency situations into the future, and the State Health Emergency Response Plan (SHERP) is being revised and rewritten.

VICTORIA
State Government

AMA Victoria Congress: Future in Medicine

AMA Victoria's inaugural Congress, 'Future in Medicine', was held at the iconic Melbourne Convention and Exhibition Centre on February 24 - 26, 2017. It was an extraordinary experience and its success reaffirms AMA Victoria's commitment to the medical profession. The conference was attended by over 300 delegates, speakers and industry experts and new concepts, procedures and systems worldwide were showcased, explored and debated.

Plenary session highlights included Dr Alessandro Demaio, a Medical Officer with WHO, presenting on the Future of Medicine and the Challenges of Obesity and Noncommunicable Diseases and Dr Elizabeth Sigston, Surgeon, CEO and entrepreneur, presenting on the Vision for Healthcare of the Future. Without a doubt, the voluntary assisted dying panel discussion chaired by Dr Sally Cockburn, generated the most interest and delegates were not disappointed by the frank and honest opinions of the panel.

The social program drove further the collaboration and networking among delegates with the AMA Victoria Gala being the highlight. Entertainment provided by Dr Duke Band had delegates up and dancing and Charlie Pickering's comedy performance sparked fits of laughter.

AMA Victoria is proud of the strong support from our corporate partners, industry suppliers and service providers for this Congress and, through these partnerships, the annual Congress is positioning itself to become the leading event for medical professionals in Victoria.


FUTURE IN MEDICINE


FUTURE IN MEDICINE

AMA Victoria supports Coroner's recommendation for supervised injecting facility

16 December 2016

Coroner Jacqui Hawkins
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Email: courtadmin@coronerscourt.vic.gov.au

Dear Coroner

RE: Supervised injecting facilities

Please find attached the Australian Medical Association (Victoria)'s policy position on supervised injecting facilities.

AMA Victoria supports a trial of supervised injecting facilities and has found no reason to change its position since the writing of this policy in 2012. Progress on this issue is regarded as of the utmost importance.

Yours sincerely,

Lorraine Baker

Dr Lorraine Baker
PRESIDENT

In late February, Coroner Jacqui Hawkins made the recommendation "that the Honourable Martin Foley MP as Minister for Mental Health take the necessary steps to establish a supervised injecting facility trial in North Richmond".

AMA Victoria supports a trial of supervised injecting facilities and wrote to Coroner Hawkins in December 2016, confirming this position, which was first stated in 2012.

Key points from the 2012 policy position

A trial of supervised injecting facilities in Victoria would provide:

- sterile injecting equipment and associated material
- a means of safe disposal of injecting equipment
- medical and counselling services
- trained personnel in attendance to provide assistance in case of overdose
- a direct telephone line to an ambulance service
- drug rehabilitation services.

A trial has significant potential to:

- lessen the public impact of street-based injecting
- improve clients' access to primary medical care, drug treatment and health and other welfare services
- reduce the incidence of fatal heroin-related overdose
- assist in reducing blood-borne viral transmission.

The trial would occur, with local community support, in areas with a high level of injecting drug users.

Evidence

A number of reports suggest that supervised injecting facilities have the capacity to reduce the number of deaths from drug overdose, reduce ambulance call-outs and hospital admissions, improve patient outcomes, enhance referral to drug treatment programs, and improve public order (e.g., by reducing injecting drug use and syringe disposal in public locations).

The National Drug Strategy Household Survey 2010 indicated that the majority of the Australian population support supervised injecting facilities.

There have been no overdose deaths at any supervised injecting centre to date, and the number of non-fatal overdose episodes relative to the number of supervised injections is very low.

Research in Frankfurt has shown that the likelihood of an overnight hospital admission for one night is 10 times greater for a person who overdoses on the street compared with one who overdoses in a safe injecting centre.

Open letter

The open letter on the following page, co-signed by AMA Victoria, appeared in the *Herald Sun* on 9 February 2017.

Let's start saving lives

We, the undersigned, support a trial of a Medically Supervised Injection Centre in Victoria.

WE ARE SURE this will save lives – let's remember: while there's life, there's hope.

We call upon the Members of the Victorian Parliament to support a rigorously evaluated trial in Richmond, the epicentre of Melbourne's crisis with heroin, other opioids, and other street drugs including methamphetamine.

There have not been any deaths from a drug overdose in any of the 90 Medically Supervised Injection Centres operating in the world. The first opened in 1986.

There were 172 heroin related overdose deaths in Victoria in 2016. Of these, 19 people died in North Richmond and a further 15 died after apparently obtaining heroin in the City of Yarra. Despite the best efforts of current services, people are still dying preventable deaths.

Each of those drug overdose deaths was preventable. North Richmond needle exchange distributes 70,000 syringes each month. If those people had instead injected drugs in a supervised facility, possibly none would have died from a drug overdose.

A Medically Supervised Injection Centre was opened in Kings Cross, Sydney in 2001. After one million injections, there have been 6,500 drug overdoses but no one has died.

Trialling a facility would help some of Melbourne's most vulnerable. It would introduce them to health and social services, including drug treatment, and will help some get their lives back on track.

Today people inject drugs on streets, in car parks, doorways, lanes and toilets. Many are homeless, have severe physical and mental health problems, are very isolated, while some are suicidal and estranged from their families.

Providing a Medically Supervised Injection Centre also helps residents and businesses in some of our more troubled neighbourhoods by improving amenity. It will also reduce pressure on police, ambulance services and emergency departments in hospitals.

Leading health and medical organisations, Yarra Council and most residents in the proposed trial area support a trial. According to the most recent National Drug Strategy Household Survey, a majority of Australians also favour this type of facility.

The Parliament of Victoria should not delay.

Laurence Alvis
CEO, UnitingCare Regen

Dr Lorraine Baker
President, Australian Medical Association Victoria

Sam Biondo
CEO, Victorian Alcohol and Drug Association

Andrew Bruun
CEO, Youth Support and Advocacy Service

Scientia Professor David Cooper
AO FAA, Director, Kirby Institute, Faculty of Medicine, UNSW

Major Michael Coleman
State Social Commander, The Salvation Army State Social Command (Victoria)

Levinia Crooks
CEO, Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine

Greg Denham
EO, Yarra Drug and Health Forum

Phil Dunn QC

Professor Michael Farrell
Director, National Drug and Alcohol Research Centre

Bernie Geary AO

Dr Stefan Gruenert
CEO, Odyssey House, Victoria

Professor Margaret Hamilton AO

Dr Nicole Highet
Centre of Perinatal Excellence

Luke Hilakari
Secretary, Victorian Trades Hall Council

Dr Jennie Hutton
Emergency Physician, St Vincent's Hospital, Melbourne

Dr Marianne Jauncey
Medical Director, Uniting Medically Supervised Injecting Centre, Sydney

Dr Simon Judkins
Clinical Director of Emergency Medicine, Austin Health

Anne Maree Kaser
CEO, Windana Drug and Alcohol Recovery Inc

Demos Krouskos
CEO, North Richmond Community Health Centre

Judy Leitch
Retired, former CEO of Wesley Mission Melbourne

Professor Simon Lenton
Director, National Drug Research Institute

Dr Cameron Loy
Chair, Royal Australian College of General Practitioners, Victoria

Professor Dan Lubman
Director, Turning Point and Professor of Addiction Studies, Monash University

Paul MacDonald
CEO, Anglicare

Professor Lisa Maher AM
Program Head, Viral Hepatitis Epidemiology and Prevention Program, The Kirby Institute

Peter Marshall
Branch Secretary, United Firefighters Union Victorian Branch

Dr Mike McDonough
Head of Unit, Addiction Medicine, Western Health

Steve McGhie
Secretary, Ambulance Employees Australia-Victoria

Michael Moore
World Federation of Public Health Associations

Dr David Morawetz,
Psychologist, Economist, Founder and Director, Social Justice Fund

Lyn Morgain
CEO, cohealth

Robert Richter QC
President, Australian Drug Law Reform Foundation Victoria

Professor Alison Ritter
Director, Drug Policy Modelling Program

Professor Ann Roche
Director, National Centre for Education and Training on Addiction

John Rogerson
CEO, Alcohol and Drug Foundation

Brian Rolfe
Retired Barrister and Solicitor

Simon Ruth
CEO, Victorian Aids Council

Judy Ryan
Victoria Street Drug Solutions, Abbotsford

Darren Smyth
President, Drug and Alcohol Nurses of Australasia

David Stanley
Australian Drug Law Reform Foundation

Amanda Stone
Mayor, City of Yarra

David Templeman
President, Public Health Association of Australia

Professor Carla Treloar
Director, Centre for Social Research in Health

Tony Trimingham
CEO and Founder, Family Drug Support

Mathew Townsend
Barrister

Gino Vumbuca
CEO, Harm Reduction Australia

Dr Alex Wodak
Emeritus Consultant, Alcohol and Drug Service, St Vincent's Hospital, Sydney

Specialists identify issues of concern in public hospitals

In late 2016 the Chairs of Senior Medical Staff Associations of major hospitals (Chairs) undertook a survey of senior doctors with the intent of identifying issues of concern around employment. We wish to share the results with AMA Victoria, in support of its current 2017 enterprise bargaining campaign.

Over the past year, the AMA has conducted a significant number of meetings with both junior and senior medical staff around the state. Indeed at my own hospital (The Alfred) the team has run more than 10 meetings in the last eight months.

We thought it was important to (separately) gauge the expectations of Senior Medical Staff (SMS) in relation to the current enterprise bargaining campaign conducted by the AMA on behalf of members. There has been no campaigning by Chairs for any specific change to the agreement, however, some themes emerged.

The survey was sent out by the Chairs to SMS in major public hospitals. The replies were from November 2016 to January 2017, with 53% being from full time specialists (FTSS) and 37% from Visiting Medical Officers (VMOs). A total of 1138 replies were received.

The thoughts of full-time specialists

- 79% spent more than 30 hours doing public work in public hospitals, while 78% spent up to 20 hours doing private work in public hospitals.
- Of FTSS, 70% reported working over 40 hours per week in public hospitals.
- Of all respondents, 6.75% believed they were paid under award rates.
- Over 63% had not taken entitled sabbatical leave for more than eight years.
- At least 53% claimed less than 75% of entitled CME allowance in the last financial year.
- The loss of salary packaging entitlements was estimated to cost 45% of SMS over $15,000 per annum. Of all respondents, 75% believed this was at least 6% of income, 44% believed this loss to be over 10% of income.
- Of 10 factors impacting on negotiation of the new EBA, the most important was seen to be base salary (91%).
- In addition, 81% saw salary packaging as having been an important part of work conditions.
- Expected pay increase from this EBA was 4.5% per annum or higher (53% respondents).
- Expected working hours remaining at 38 hrs/week was agreed by 77%.
- A majority (74%) wanted flexibility to complete worked hours within four days, while few (13%) agreed to shift work over five days per week.

Visiting Medical Officers expectations

- 20% performed at least 10 hours of privatised work in public hospitals.
- 8% believed they were paid under award.
- 71% had not taken sabbatical leave in over eight years.
- Over 40% of VMOs believe that they had lost more than $15,000 per annum with changes in salary packaging legislation.
- Only 45% claimed more than 75% of possible CME allowance in the last year.
- Over 90% rated base salary as being of high importance or of very high importance in negotiating the EBA.
- Of VMO respondents, 52% have expectations of a pay increase of 4.5% per annum or higher.
- More respondents supported working four days out of five (74%) than other options, including five day week or shift work (less than 20%).
- Concerning factors important for good working conditions, VMOs rated restoration of salary packaging (80%), backfill for long-service leave (75%) and backfill for sabbatical leave (69%) as the three highest priorities.

Summary

This survey is estimated to represent 25% of SMS in Victorian public hospitals. While the responses from FTSS and VMO staff differed in some respects, common themes were:

- salary packaging losses had caused significant concern
- many had not received previous EBA entitlements, such as sabbatical leave
- CME reimbursement was still problematic, with many not receiving full entitlement
- the contribution by SMS to hospitals through privatised practice was substantial
- more than half of respondents expect to negotiate for at least a 4.5% per annum increase in base salary.

For further information, please contact the AMA Victoria Workplace Relations team on (03) 9280 8722 or eba@amavic.com.au. More details will shortly be available on the AMA Victoria website. Your support for the AMA will assist with delivering the consensus outcome we all seek.

Prof John Wilson

Chair
Committee of Chairs of SMS

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Skin of colour – An emerging subspecialty in dermatology

Vitiligo in an adolescent North Indian boy

Australia is one of the most multicultural countries in the world. In June 2015 the Australian Bureau of Statistics revealed 28.2% of Australian residents were born overseas. China, India, the Philippines, Vietnam and Malaysia are among the top 10 countries of birth.

These statistics are important to note because skin of colour (pigmented, ethnic, dark skin) is biologically, functionally and structurally different to Caucasian skin. Skin of colour (SOC) is a term that emerged in North America. It describes a heterogeneous group of people with skin that is darker than Caucasian skin. People of Chinese, Indian, African and Hispanic origin and the indigenous Oceanic population are all examples of those with SOC.

This section of the population presents a challenge in dermatology because the first phase of modern dermatology was developed in continental Europe, Great Britain and the USA and was therefore developed in reference to those with Caucasian skin. Training and education in this specialty has naturally followed this Caucasian-based model with over 80% of Australian dermatologists revealing in a recent survey that they would have liked more education and training in SOC during their postgraduate studies.

Morphological descriptions in dermatology are based on features noted in Caucasian skin that may be difficult to appreciate or even absent in SOC. Some conditions are seen exclusively in this population and many treatment regimens that are safe and effective in Caucasian skin are risky in SOC. Cultural competence on the part of the treating clinician is essential to develop rapport with patients and to improve patient outcomes.

Differences in morphology: Atopic dermatitis

Atopic dermatitis (AD) is a common chronic inflammatory skin condition that affects patients of all skin colours but its morphology is often very different in those with SOC. While AD presents with erythematous, scaly plaques predominantly in flexural regions, AD in SOC is more papular and lichenified with prurigo nodules and post-inflammatory pigmentation commonly noted. Patients with very dark skin display a more persistent disease course and an increased tendency to dry skin due to increased transepidermal water loss.

Clinicians often underestimate the degree of inflammation in those with SOC because erythema is replaced by a grey-coloured appearance to the skin. This grey-colour is often mistaken for post-inflammatory pigmentation or not recongised at all. Therefore, for those not treating large cohorts of patients with SOC, something as simple as eczema can become a real diagnostic and management challenge.

A unique treatment approach: Melasma

With more biologically active melanocytes, facial pigmentation is one of the most common presenting complaints in the SOC population. Facial pigmentation can be caused by many conditions but melasma (chloasma, mask of pregnancy) is one of the most common culprits.

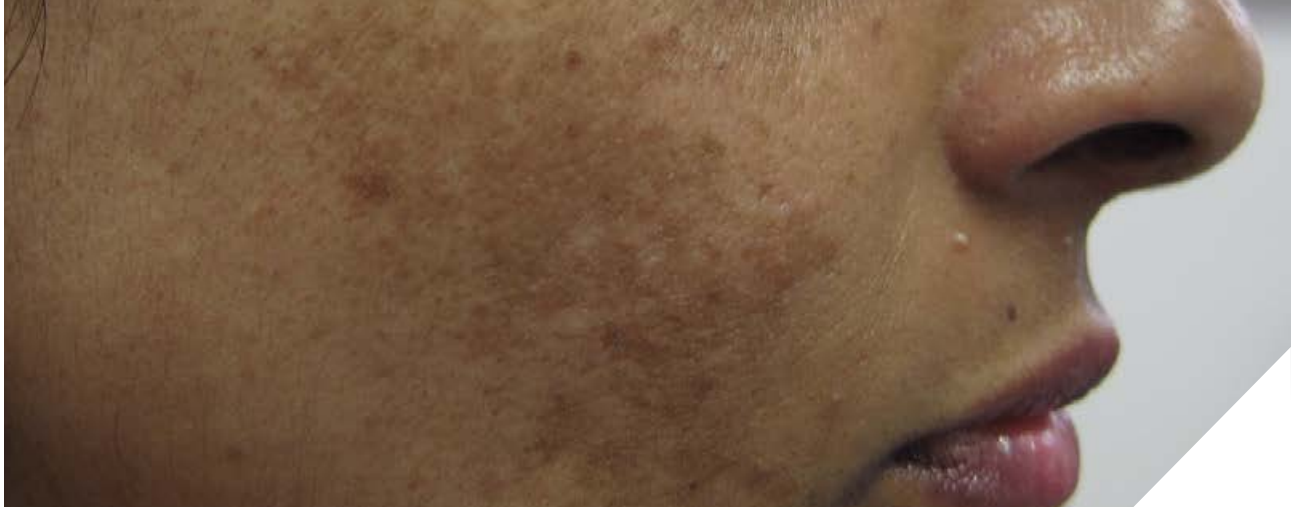
This acquired, chronic and relapsing condition presents with light to dark brown macules on the forehead, cheeks, upper lip and chin and is exacerbated by ultra-violet light exposure and estrogen (oral contraceptive pill, hormone replacement therapy). Simply encouraging sun protection, however, is not enough for those with SOC. Research demonstrates sustained skin darkening occurs in those with darker skin types after exposure to visible light. Protection against visible light is therefore one of the key components of a melasma management plan in this group of patients. While cosmetically camouflaging dark patches of skin with cover-up make-up is acceptable for many with lighter skin types, asking those with dark skin to utilise cosmetic camouflage that makes their skin even darker is difficult and often culturally unacceptable. Finally, skin-directed therapies such as peels and lasers should be used with extreme caution and only in very selected cases with the risk of complications being at the forefront of the clinician's mind at all times.

A cultural context worth understanding: Vitiligo

Vitiligo is a chronic, acquired, autoimmune condition that causes destruction of melanocytes in the skin causing white patches of skin in affected areas. Although it affects people of all skin types, the psychosocial burden may vary depending on a person's ethnic and cultural background. Certain cultures have strongly held beliefs about the pathogenesis and transmissibility of the condition and some may mistake it for conditions like leprosy. These beliefs have an impact on the patient's desire to seek and comply with treatment and will influence doctor-patient consultations.

In some cultural groups in India, for example, a diagnosis of vitiligo in one child may render all children in the family unworthy of marriage. This may lead to a lifetime of seclusion and a sense of family 'shame'. Thus, it is not uncommon for an entire family to present to the clinician with the desire to learn about the condition and embark on treatment irrespective of the logistic or financial burden.

CONTINUED ON PAGE 20



Melasma in a patient with skin phototype 4

The first step for the clinician is to understand the cultural roots and social implications of the diagnosis for the patient and explore these delicately and empathically during the consultation. Secondly, it is important to appreciate that vitiligo is not "just a cosmetic disease". Patients are told all too often "there is nothing that can treat this condition" and that they should "just learn to live with it." This autoimmune condition is treatable, especially when the appropriate treatment regimen is initiated early. Finally, it is critical to appreciate that any patient with vitiligo may experience a range of negative emotions including lowered mood, poor self-esteem and anxiety as a result of their constantly changing appearance and the social stigma attached to the diagnosis. Building rapport with the patient and taking the time to discuss their beliefs, psychological wellbeing and expectations will lead to improved patient outcomes.

On a personal note, as a first generation Australian of Indian origin, I have experienced, first-hand, the many skin issues that people with SOC face and the challenges it can present. A unique approach with a detailed understanding of how SOC is different to Caucasian skin is necessary for making an accurate diagnosis, and delivering a safe, effective and culturally-appropriate management plan.

Learning from colleagues abroad during and after my dermatology training has fueled my passion to continue to educate the medical and broader community about these important dermatologic issues, conduct research in the Australian context and to utilise the skills and lessons learned to optimise patient outcomes.

References available from the Editor on request.

Dr Michelle Rodrigues

Dermatologist

After graduating with Honours from Monash University and embarking on dermatology training in Melbourne, Dr Rodrigues worked in world-renowned institutions abroad where she developed expertise in skin of colour dermatology and pigment disorders.

Dr Rodrigues serves as a consultant dermatologist at St Vincent's Health and the Royal Children's Hospital and works in private practice in Box Hill. She is the founder of Chroma Dermatology, a dedicated pigment and skin of colour centre, which will open later this year.

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Improving access to treatment for blood borne viruses

Great strides have been made in treating and managing blood borne viruses such as hepatitis B, C and HIV in recent times, meaning people living with these conditions can lead full, healthy lives. But is the promise of these treatments being fulfilled for patients, asks North Western Melbourne PHN CEO Adj/Associate Professor Christopher Carter?

Up until recently attempts to cure hepatitis C involved lengthy interferon-based treatments, along with which came serious side effects and relatively poor success rates. Newly available hepatitis C treatments have significantly more efficacy with up to 90% clearance rates for patients with minimal side effects.

HIV treatment and care has made huge strides since the advent of highly active antiretroviral therapy (HAART) which became available in the late 1990s. HIV is now, in the main, a manageable chronic condition with a current strong community debate focusing on potential HIV eradication through the combined effects of undetectable viral load (UVL), pre-exposure prophylaxis (PrEP), and post exposure prophylaxis (PEP).

While there is no cure for hepatitis B, there is strong evidence showing that early detection, follow-up and treatment of chronic hepatitis B can slow the progression to liver failure and the development of liver cancer. A very effective vaccine against hepatitis B also exists with over 90% of Australian children fully immunised.

Despite these advances, many people living with these conditions are not receiving treatment, even once they have been diagnosed. Nearly half of the approximately 219,000 people in Australia living with chronic hepatitis B (CHB) infection remain undiagnosed, and of those with a diagnosis, 87% are not receiving adequate care. Without access to appropriate care, up to a quarter of people living with CHB will die from their condition.

Treatment rates are even lower for hepatitis C. More than 70,000 Victorians currently live with the hepatitis C virus, and before the release of new treatments only 1.3% of them received treatment; left untreated, chronic hepatitis C can lead to cirrhosis, liver cancer and death.

There has been a substantial boost in treatment rates since new treatments were listed on the Pharmaceutical Benefit Scheme in March 2016, with some figures suggesting as many as 13% of people living with hepatitis C received treatment in the first few months of the program. The boost in treatment rates are an encouraging start – however as many as eight in every 10 people with hepatitis C are still not being treated.

Why people are not receiving treatment is a question with many potential answers. All three conditions may be present with no or minimal symptoms, especially in the early stages of infection, meaning many people simply do not know they have the condition.

Levinia Crooks, CEO of the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) says that there is a range of systemic barriers to healthcare for people living with viral hepatitis or HIV.

"Widespread hepatitis C-related stigma and discrimination in the healthcare sector – mostly directed towards injecting drug use – impedes access to services and impairs the quality of healthcare delivery for people living with hepatitis C and other key populations," Ms Crooks said. "It directly undermines efforts to eliminate the disease."

ASHM is working on a two-year project to address stigma, discrimination and structural barriers to accessing healthcare and prevention services. Training programs and policies designed to be taken up across different health services and settings aim to provide clinicians in training with the skills to identify and address stigma and discrimination in their own practices and in the systems in which they work.

It's not only stigma that is holding people back from treatment. A lack of access to services, especially outside of metropolitan Melbourne, and the serious side effects associated with some older treatments may also be putting patients off seeking care.

While the challenges are significant, the example of HIV in Melbourne shows they can be overcome through a coordinated approach between governments, service providers, health professionals and the community.

Melbourne became a Fast Track City in 2016, joining a global network of cities committed to ending the global AIDS epidemic by 2030 through better awareness, prevention and access to treatment. Early results are encouraging, showing Melbourne is meeting or exceeding Fast Track Targets in all areas:

- 90% of people living with HIV know their HIV status
- 94% of people with diagnosed HIV infection are receiving sustained antiretroviral therapy

- 93% of people receiving antiretroviral therapy have viral suppression.

Extending this success to the treatment of other blood borne viruses is the aim of the newly launched Victorian HIV Hepatitis Integrated Training and Learning (VHHITAL) program. VHHITAL provides s100 prescriber training to GPs for both HIV and hepatitis B drugs, as well as education, training and support for all primary health professionals to take an active role in BBV care.

Currently there are only 60 HIV and 10 hepatitis B s100 prescribing GPs in Victoria, the vast majority of whom are based in Melbourne. Boosting these numbers will mean more people will be able to access the care they need, at a location and environment they are comfortable in.

Increasing prescriber numbers is even more of an issue in regional and rural areas of Victoria, with very few GP prescribers of either HIV or hepatitis B drugs located outside of Melbourne. Country regions rely on visiting specialists who don't always have the capacity to see all potential patients in their limited time in each location. Patients may also be less comfortable seeking treatment with a visiting specialist than with a trusted local GP.

While the program only officially began late last year, it is already having an impact at community level. An excellent example is in the Murray River town of Mildura, where VHHITAL recently held an information session on viral hepatitis for local health professionals.

Inspired by the session, a local GP has set up a dedicated hepatitis clinic in the town, giving residents with hepatitis the chance to receive ongoing treatment without having to wait for infrequent specialist visits. As well as providing the initial inspiration, VHHITAL is also delivering practical support, helping the new clinic source a fibroscan machine and assisting GPs from Mildura to attend s100 hepatitis B prescriber training in Melbourne.

This is just the beginning. Supported by partners including North Western Melbourne PHN (program lead), ASHM, Peter Doherty Institute for Infection and Immunity, Alfred Health and the Victorian PHN Alliance, VHHITAL is rapidly rolling out information sessions and organising prescriber training across Victoria.

It's not just about boosting GP prescriber numbers, though of course that is a key goal. It's about supporting all GPs, and primary care professionals in general, to take on a greater role providing care for people living with BBVs.

There is an enormous opportunity to eliminate hepatitis C, prevent new transmissions of HIV and limit the impact and spread of hepatitis B – and general practice has a huge part to play in turning these opportunities into reality.

Adj/A/Prof Christopher Carter

CEO
North Western Melbourne PHN

The urgent need to improve support in schools for children with type 1 diabetes

Dr Peter Goss (left), Shinnarra Connolly and her sister Luellyn Connolly, who both have type 1 diabetes, demonstrating their insulin pumps, and Jenny Goss, Credentialed Diabetes Educator.

"To hand over care of your most treasured possession, your child with a serious medical condition, to untrained school staff is the most terrifying experience."

Such statements from parents of children with type 1 diabetes (T1D) are unfortunately commonplace in Australia. We lag well behind other developed nations in providing adequate support in schools for children with T1D, in part, because governments do not comply with current legislative requirements.

International guidelines recommend that all children and adolescents with T1D are managed by a specialist multidisciplinary team with use of intensive insulin therapy (IIT) in the form of either multiple daily injections or insulin pump therapy to reduce morbidity and mortality. It is now clear that metabolic memory of poor glycaemic control during childhood is irreversible, while research demonstrates that normal blood glucose levels (BGL's) are essential to maximise learning ability.

If the child's time at school does not allow for quality contemporary diabetes care, the ensuing risk of poor outcome provides exposure for governments or organisations that obstruct or do not facilitate international standards of care. In turn this places medical teams and treating practitioners in a position where they are responsible and fully accountable for health outcomes of their patients regardless of whether governments choose to comply with their obligations.

Despite T1D being recognised at common law as a disability, most State Governments have excluded T1D from funding, leaving schools to

manage with limited support. Parents report that they have been told that T1D is "not disability enough" to be provided funding! While many schools do wonderfully well and go to extraordinary lengths to provide very high quality team-based diabetes management, the legally required authorisation for insulin administration which requires formal training and accreditation does not exist and free informed consent from parents and transparent delegation by the treating medical team is frequently lacking.

The Australian Diabetes Data Network (ADDN) notes that only 27% of Australian children in paediatric diabetes centres are meeting the recommended HBA1C target. ADDN identified that 18% of children in Australia are still not managed with IIT, and this is particularly overrepresented in Victorian centres with 38% not managed with IIT presumably to remove the requirement for a school to make reasonable adjustments to cater for the child medical/medication needs at school. Anecdotally, clinicians and educators from those centres state the prime reason for not using IIT is that many Victorian schools are not able or not prepared to give insulin at school. School staff are not authorised or equipped with the necessary staff or training and accreditation to administer or supervise administration of insulin. Some families are forced to change schools due to lack of support, with over 40% of parents reporting having to modify or cease employment to provide the care required for their child in school. There remains a common misconception that students with T1D can manage and fully participate in school activities without support. This is untrue, even at secondary school level.

Leading T1D advocacy group Type 1 Voice states: "The current situation for children with type 1 at school is illegal and immoral. Unethical practices along with human rights breaches have been facilitated and enabled by organisational agendas and representations which do not represent the voice of the consumer or provide genuine sponsorship."

Prominent law firm Arnold Bloch Leibler (ABL) provided pro bono legal advice on this issue in 2014, citing the "important public interest law nature of the matter". Key points of reference from the ABL legal opinion include:

- Parents are legally bound to enrol their child in school and must ensure that the child attends school.
- Parents have common law duty to make decisions on behalf of children to age 18.
- Schools owe a non-delegable duty of care to their students and teachers to take reasonable care to protect them from harm which is reasonably foreseeable. There are obvious foreseeable risks associated with not providing the proper management of the medical condition while (the child) attends school.
- The Government Departments of Education and Training owe a similar if not the same duty. Government duty owed to the child will continue as the child passes through his/her education.
- Teachers cannot be required to exercise their own discretion in respect to attending highly complex needs.
- Justice Mason of the High Court confirmed in Commonwealth v Introvigne that: "A duty is not discharged by merely appointing competent teaching staff and leaving it to the staff to take appropriate steps for the care of the children. It is a duty to ensure that reasonable steps are taken for the safety of the children, a duty the performance of which cannot be delegated".
- Insulin is S4 Commonwealth SUSDEP. In Victoria, the possession, treatment, supply, storage and administration of Scheduled poisons are regulated under the *Drugs and Poisons and Controlled Substance Act* and the *Drugs, Poisons and Controlled Substances Regulations 2006 (Vic)*. The state limits the possession, administration and approval for use of insulin to a registered medical practitioner or a Div. 1 Registered nurse. Or the agent of a person who has the care of, or who is assisting in the care of a person.
- The restricted class of persons approved under the *Drugs, Poisons and Controlled Substances Regulations 2006 (Vic)* for use of insulin are further restricted by the imposition of specialised requisite training before specific professionals can be regarded as suitably qualified.
- The required skills and expertise prescribed by law are clearly beyond the ordinary competencies of teachers.
- It is illegal for a teacher lacking the prescribed authority pursuant to the regulations to assume responsibility for administering S4 medications such as insulin.
- Parents have a legally recognised duty to care for their child and are obliged to provide for the maintenance, protection and education of their child, and must exercise their parental power and care for their child in the child's best interests.
- Given their legal obligations to their child, parents are legally obliged to withhold their consent to the medical treatment of the child at school if there is any real risk that such treatment will be performed by an unqualified teacher.

The Federal Health Minister has understood the need to address this compliance issue nationally and requested diabetes health professionals, with genuine concerns regarding their own professional exposures in the current system, to submit a fully costed proposal to urgently remedy this deficiency. Consequently, clinicians from the Australian Diabetes Educators Association, Australian Paediatric Endocrine Group and Australian Paediatric Society have decided to roll up their sleeves and establish a clinician-led national multi-tiered training and accreditation program. The proposal has gained support from other stakeholders including Type 1 Voice, Australian Diabetes Society, JDRF and Diabetes Australia.

To ensure the probity of the program, the health professionals who are directly accountable and liable for the health outcomes of their patients are to be chartered with ownership of the training program. This will facilitate true individualised medical care of the patient regardless of the environment they are in, whether at school or at home. It will also provide the foundation for lawful delegation by the health professional and consent by parents which promotes school participation in the healthcare of child with T1D under the agent provisions of the regulations. The content of national training and accreditation program will be based on international best practice guidelines. The program will be mandatory for all T1D children at school under the age of 18 years to address the compliance, moral, ethical and health issues identified. The proposed funding model is for the cost of the program and service to be directly linked to the child, eliminating wastage, ensuring accountability and enabling

CONTINUED ON PAGE 26

"The school is great, but I feel my daughter, being in grade six and quite mature and responsible, is left to manage her diabetes on her own, which becomes a problem when things go wrong. They assume she will know what to do, which is an incorrect assumption because it's when things go wrong that she doesn't know what to do as her brain is not functioning well at these times."

Mylee Gocentas, who has type 1 diabetes, and her mother Sarah

the child's treating team to foster good relationships and support of school staff, while monitoring performance. We aim to work in close collaboration with the education sectors to implement the proposal and create models that allow appropriate resources to be committed to making the model a success.

The clinicians are steadfast in demanding the State Governments comply with their current legislative requirements to ensure children with T1D are given the option of international best practice standards of care. This requires the treating medical team's support for the schools and school staff and the education departments fulfilling the reasonable adjustments required so that a child with T1D can participate at school on the same basis as their peers.

We expect full support from AMA members, given these clinical issues are the domain of medical staff who accept responsibility and liability for clinical outcomes and the profession upon which these needy families rely upon for advocacy and fairness.

Dr Peter Goss
Paediatrician
Co-Chair
Australian Paediatric Society Diabetes Working Party

References available from the Editor on request.

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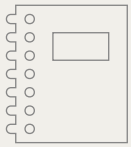

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Challenging times for general practice

At the last AMA Victoria GP section AGM I was given the honour and pleasure of becoming the Chair for the GP section for 2017. I would like to thank the outgoing Chair, A/ Professor Ralph Audehm for his work, commitment and enthusiasm over the past year and am delighted that he has taken up the role of secretary for the GP section. My heartfelt thanks to all members of the Committee – some who have been involved for many years and others who have recently joined.

As the old Chinese curse goes – we live in challenging times. With the rise of chronic and complex conditions that affect the whole of a person's body, health, function and wellbeing; rising inequities in the burden of disease; and an increasingly complex healthcare system, the broad and deep knowledge, skill sets, experience and relationships provided by general practitioners and general practice have never been more important to the wellbeing of our community.

Even though patients highly value and trust their GP and the positive health impact, cost effectiveness, and equity of having a strong GP sector is highly evidence-based; we do seem to face seemingly overwhelming challenges in having our voice heard by funders and policy setters.

On his first day on the job as Federal Health Minister, Greg Hunt signalled he wanted to establish a better relationship with the nation's GPs amid the conflict over the Government's decision to maintain a freeze on the Medicare rebate. He then went on to state "I want to re-establish that value – their role, their importance, their trust in the community".

I'm afraid he hasn't got it (yet). The reality is that we are highly important to, valued and trusted by the community. We are just enormously undervalued by the Government (and at times by other organisations). We don't just need to unfreeze the rebate - we need a big, big catch up. Without it, the health of our community will suffer as diminishing and inequitable access to healthcare bites even more and the coffers of Government are further stretched as more patients seek hospital and specialist care as they become more unwell and can't afford care by their GP. It's false economy. In addition, Government health policy needs not only to be seriously informed by, but led by the voice of GPs. Each one who has the wisdom of a collective experience of the stories of their patients, carers and communities in illness, health and their experiences of the health system.

There are currently a number of pivotal health reform strategies being undertaken at both the State and Federal Government level - health care homes, aged care and mental health to name a few.

The Victorian GP section intends to work with its various specialist colleagues at AMA Victoria and the Federal AMA to further advance the strength and centrality of general practice in order to achieve the best health outcomes for our community.

I invite you to contact me with your thoughts and input at ines.rio@optusnet.com.au

Dr Ines Rio

Chair, Section of GP
AMA Victoria

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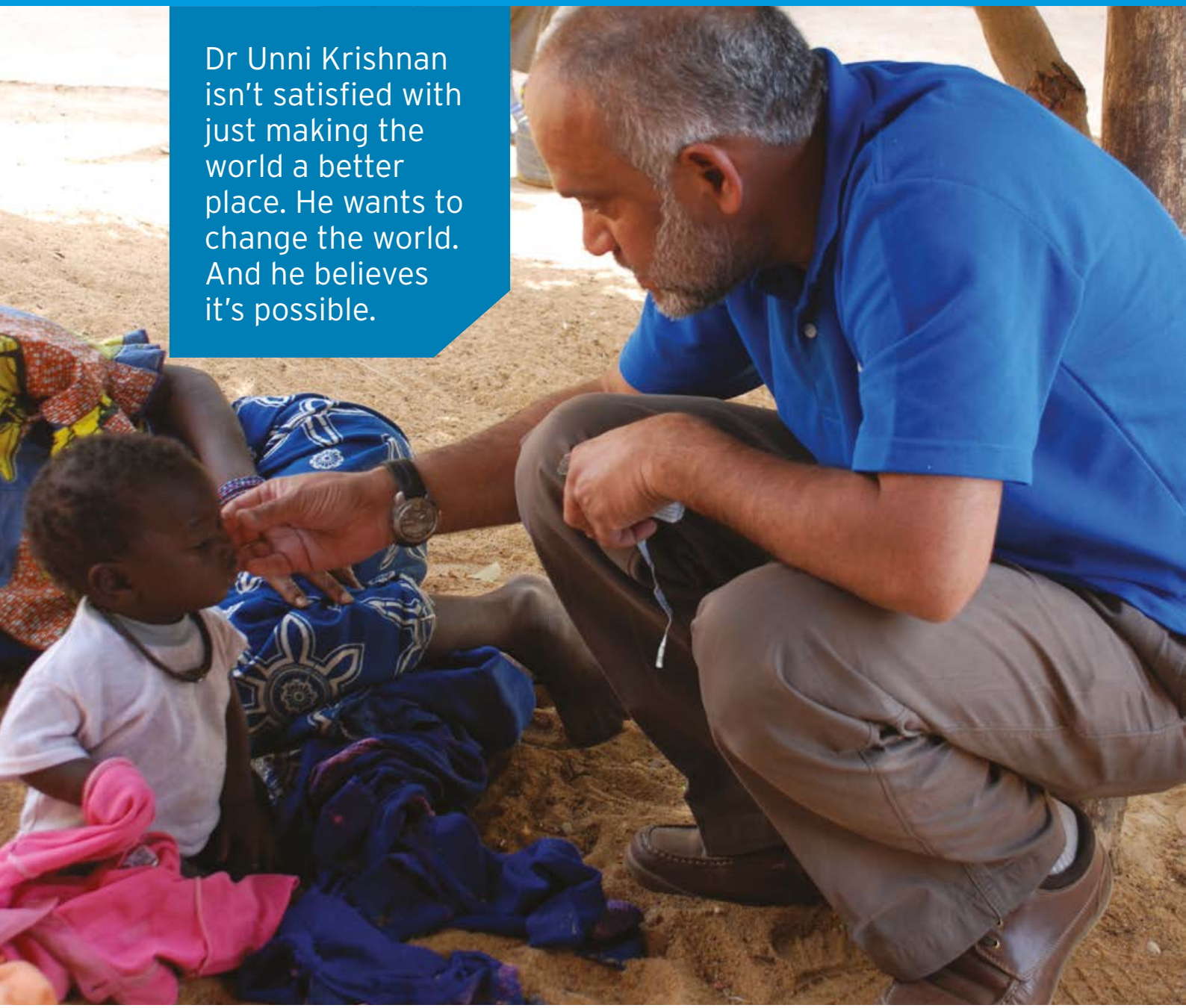
Doctor Unni – Man on a mission

Dr Unni Krishnan isn't satisfied with just making the world a better place. He wants to change the world. And he believes it's possible.



Mali conflict response 2012-13: Psychosocial care for children and food crisis response. Dr Krishnan checks on a mother and child in Mali, where conflict and violence resulted in the displacement of thousands of people. Photo: Plan International.

Unni Krishnan describes himself as a 'possibilist'. Twenty-five years of saving lives and finding solutions in some of the world's most desperate situations has taught him not to dwell too much on blind optimism.

"It's important to understand that it is always possible to do something. If you just wait for the world to make things happen by being an optimist nothing will change."

He speaks with a calm intensity. Passionate but gentle. It's almost hard to imagine how someone who has looked so much tragedy directly in the eye can be so cheerful.

"Take cholera for example," he tells me. "It's a race against time. Six hours. A child could die from dehydration in six hours. You can't waste time thinking everything will be okay, it'll all just go away. Nor can you throw your hands in the air and say there's nothing we can do. You have to start thinking you can make a difference and that it's possible to make a difference."

As a boy growing up in Kerala, India, Unni remembers the monsoon season. He remembers the futility of umbrellas against the rains. And he recalls when the puddles became ponds and then lakes that might as well have been oceans.

In some places the water was black with mud. But Unni's mother would point out the lotus flowers blooming in the middle of the filth. "Unni, you can choose to see the darkness of the water," she would say, "Or you can see the beautiful flower that has emerged. The choice is yours."

It's a message Unni has carried with him all over the world. To the remnants of villages ruined by cyclones and earthquakes, to communities ravaged by killer viruses and to camps of frightened children sheltering from violent conflict.

It was after a monster earthquake – Latur, India, 1993 – that Unni began to see things in a different light. He was leading a response team on the ground in the aftermath of the quake. Fifty-two villages destroyed, 30,000 injured and about 10,000 dead. Among the debris and the chaos, Unni began to think about the invisible impact of disaster on the human mind.

"Disability you can see. People in a wheelchair or on crutches. But how do you actually tell the story of someone who is traumatised?"

One day, Unni was thinking about how the children were not coming out from their houses. Not going to school or coming out to play. He decided this was a serious problem.

From the back of a cab he was struck by the sound of about two hundred children in one of the slums by the side of the road. Having not seen children together for weeks he told the driver to stop.

"There was a bear charmer," he told me, matter-of-factly. "He had a ring of fire and the bear would jump through it. The children would laugh and clap and the charmer went around collecting coins in a hat."

Unni offered the charmer double his rate if he would perform in a village 300 kilometres away. They began the journey two hours later.

"In the front seat there was the driver, the bear charmer and the bear," he continued, smirking. "The driver refused to let the bear into the back seat! I knew the driver was tired but he never slept. You don't sleep when you're driving and there's a bear sitting next to you!"

The next morning the troupe reached the village. They used a loudspeaker to announce that the first show would begin at 10am.

"We were a smash hit! There were children coming from all over. We set up a makeshift performance area and this would become our 'temporary learning space'. School classes started soon after."

But of all the calamity Unni has witnessed, it's the conflict that concerns him the most. "The hatred that triggers bitter conflict is the number one most difficult and frightening issue," he explains. "This is born of a thing in people's minds. I've worked in countless earthquake zones, hurricanes, flood – if you look at these natural disasters, they can sometimes bring the best out in people, it binds people, they want to help their neighbours, their communities, even sometimes the neighbouring countries.

"But conflict and violence and war, it polarises people. So even the neighbours who used to like each other, start hating each other. Remember what happened in Rwanda."

Unni was working in South Sudan during the bloody 'civil war' in 2013 when he met two children he says he'll never forget in his life. "I could see them sitting together involuntarily hugging each other every few seconds. Of the hundred children in the space, these two... there was something about them."

I detect a slight quiver in his voice. "They told me their story. One was four and the other was nine. They both had been playing a few days before in a place called Bor, Jonglei State.

"They heard some noise, shouting. Then they saw a group of people marching in. They hid. A few minutes later they saw the mob pulling several people out and they shot two people point blank. One woman and one man. It was the father and mother of these two children.

"Immediately the elder child grabbed the smaller one. Suddenly she was transformed into the mother of her four year-old sister. They started running, joining a wave of people heading towards the River Nile. In the night they got on a boat and crossed the river. And from there they ended up in our refuge where I met them."

It's from children like this that Unni appears to draw his energy and determination to create change. Not that he's immune to the emotions that are bound in this line of work.

He admits that he cries on certain days, wishing that the world could be a little more generous. More compassionate. He also admits that the moment he stops feeling those feelings – pain, frustration, compassion, hope, desperation - this will be the moment he'll switch careers.

Unni can't tell me how many crises he's been deployed to. "But I remember playing football and flying kites and painting in crayon with children in 40 different countries worldwide."

Unni is here in Australia working for Save the Children on the launch of an Emergency Health Unit, a new global capability to provide frontline medical and health assistance in crises. Part of the project involves developing a platform that he hopes will tap into the good intentions of doctors, nurses and students. It aims to facilitate the people who want to apply their expertise to the cause of saving lives and protecting children's rights in disaster zones.

"It's really great to feel that you are part of something bigger and better than your individual self. That there is something driving us, working as this centripetal force – pulling everybody together into the centre – which, in our case, is children.

"I think that's a very important and powerful thing to remember, knowing there's a community that backs us and supporters who believe in us and our ambassadors who are talking about us. And they know we're not into something small like 'making a difference', we are actually into changing the world. It's comforting to know we have that support, because we can't fight this battle alone."

Sam Aiton

Save the Children

Save the Children's Emergency Health Unit can deploy world class teams of doctors, nurses and other medical personnel quickly to provide health and medical assistance in humanitarian settings and save lives. If you would like to get involved or learn more about EHU visit savethechildren.org.au/ehu or email EHU@savethechildren.org.au

Member profile: Serving the community and country

Dr Jackson Harding runs a specialist anaesthetic practice in Bendigo, but when he's not in theatre, he's serving his country as a 26-year member of the Army Reserve. His wife Jo, who has extensive experience in critical care as a nurse, academic and now scientist, is also a long-serving member of the Australian Defence Force (ADF). Vicdoc spoke to Dr Harding to learn more about his two jobs.

Why did you want to join the Army Reserve?

It was something that just seemed to be the right thing to do. Both my wife's family and my family have had many members who have served over the years, so it was something that always had been there as something that was worthwhile pursuing. The idea of service is something that runs deep in the family. I was approached while I was still an anaesthetic registrar by some of my senior colleagues who asked if I'd like to join and I thought, "Why not!"

What is your rank and role?

Colonel and I'm presently Director of Clinical Governance and the Senior Medical Officer for the 17th Combat Service Support Brigade. I'm the senior clinician for the brigade. The brigade contains much of the army's field deployable health assets and as a result I provide clinical direction, clinical leadership and oversight of the activities of the brigade from a health perspective.

How big is your commitment to the army?

In my current position, my commitment is actually quite significant. I'm in a senior staff officer position within a fairly big part of the ADF organisation. I am fortunate that I am able to do much of this remotely. I have remote access to the defence email network and much of the work I do is essentially office type work. I tend to do a lot of that in my spare evening hours. The unit that I am posted to currently has headquarters that are based in Sydney, so I travel there quite regularly and we have units all around the country, so I travel interstate quite a bit.

Have you served overseas?

Not in this posting but in other postings I've deployed overseas in operations on a number of occasions. I deployed to Rwanda in 1995, a couple of times to both Bougainville and East Timor, the Solomon Islands in 1996 and I also had an opportunity to do a brief exchange with the British Army in 2001.

Have you been in areas of combat and dangerous situations?

Yes, very much so. They've all been classed as war-like operations or non-war-like in the case of Bougainville and the Solomon Islands, but both Rwanda and East Timor were classified as war-like. There was a constant level of threat. It's hard to define but it was something that was ever present and always in the back of your mind. The ADF trains you for just this situation, you learn how to deal with it, how to respond to direct threats. You come to rely very much on the people around you, and they on you. Being in these sort of environments and working hard with good people forges some very strong bonds.

Have you had to treat injured troops in serious situations?

I have had those roles in the past.

To be in the army for as long as you have, you must find it quite rewarding?

I have got a great deal of satisfaction and reward out of all of the army jobs I've had and I've had quite a number now as I've progressed through the ranks. Each one has presented its own unique challenges and each one has presented its own rewards – right from when I was a brand new army medical officer in a large hospital type unit and being a medical officer in an infantry battalion, before moving up through more senior medical positions to the position I'm currently residing in. They've all had their moments, but they've all been immensely rewarding.

How difficult is it combining the defence role with your regular work as an anaesthetist?

It's always a matter of striking a balance and over the course of my defence service I have moved from being a full-time specialist to being a private practitioner in a large group, to now being a solo private practitioner. As a staff specialist it's actually relatively easy – there are provisions within the awards for military leave. When I was in a large group my then partners were also very accommodating. Now I'm in a situation where I've had to set aside certain days in my schedule so that I can fulfil army commitments. I also find that the surgeons that I work with are all very supportive. They all see that it's an important job and if I say to them I need to organise something for the army on a particular day and need to get somebody else to cover my list, they are all very accommodating.

It must be hard to find time for life outside of your two professions, along with family time. Is it difficult to juggle all of that?

Surprisingly not, actually. We're in the fortunate situation that our two boys are now grown up and have left home, but even so, we still have plenty of time to spend with them and their partners. We have a wide range of friends in Bendigo who we socialise with regularly. We just seem to be able to combine the two and make the most of every day and manage to have quite a full and rewarding life.

Is it something you would encourage other doctors to do?

Very much so. To be fair, it is not for everyone and I'm well aware of that. But if you are at all inclined to give something back to the community in a particular way, defence is a very, very good way and a very rewarding way. It's a chance to practise medicine in an environment that is very different and sometimes very challenging.

Do you feel like your experiences in the army have enhanced your development as a doctor?

Without any doubt at all. The exposure I've had to command, management and leadership has had direct relevance and crossover back into my civilian practice. I was fortunate enough to be selected to go to Australian Command and Staff College where I gained a graduate diploma in management and that has also had direct relevance to my civilian work as well.

Dr Jackson Harding

Supporting GP registrars

AMA Victoria's Workplace Relations Team has been busy fielding enquiries from GP registrars commencing their semester one placements for 2017.

It is important when commencing a new placement you feel confident that your workplace arrangements will facilitate the best learning experience. For GPT1 registrars transitioning from the hospital system to private practice, this is particularly important.

There are a range of situations where our Workplace Relations Team can provide information, advice and advocacy.

Negotiating your employment agreement

Negotiating your agreement can be challenging. Practices generally utilise the template employment agreements available from GPRA or GPSA, and registrars are often led to believe this leaves no scope for adjustments.

You are free to negotiate improved terms and conditions, provided you consider what might reasonably be accommodated by the practice, and ensure changes do not interfere with your training requirements. For example, you might negotiate flexibility around unpaid study leave or a request to work after hours. You should also negotiate to have any overly restrictive clause modified or removed. For example, a restraint of trade clause should be no be wider than is reasonably necessary to protect the employer's interests.

Changes should be discussed with the practice and must be explicitly included in the contract. AMA Victoria's Workplace Relations Team can provide advice and support during the negotiation process to ensure you and the employer reach an agreement which reflects the needs of both parties.

Compliance with the NTCER

The National Terms and Conditions for the Employment of Registrars (NTCER) set out the minimum entitlements for general practice training (with the exception of registrars covered by an applicable Award or Industrial Agreement). It is vital that these conditions are met, both in the contract and in practise.

Our Workplace Relations Unit has seen recent examples of contracts which have been modified in ways that do not comply with the NTCER. Entitlement to SIPs and PIPs, recommended administrative time, and the difference between the base rate and the percentage of billings, are common examples.

As part of your membership, our workplace advisers can review your contract and note any inconsistencies with the NTCER. We can then discuss strategies for having the conversation with your employer to address these inconsistencies. Often a discussion is sufficient to resolve concerns, but if further assistance is needed, AMA Victoria can liaise directly with the practice and your regional training organisation (RTO).

Performance management

Our Workplace Relations Team receives calls from registrars concerned about feedback they've received, or worried about an upcoming performance meeting.

We advise registrars that seeking regular feedback is essential during your placement. By the time the supervisor's report is lodged, there are limited options to address any areas 'below expectations'. Feedback on any report should never come as a surprise, which is why maintaining an open dialogue with your supervisor is vital.

If you are called into a meeting to address a performance matter, you can always request a support person attend with you. As an AMA Victoria member, you can request our workplace advisers fill this role. Meetings must follow a fair process and allow you to address any concerns.

In some instances, where a decision has been made you do not agree with, complaints and appeals avenues can be pursued via the Australian General Practice Training (AGPT) and RTO policies. Our Workplace Relations Team can assist with this process.

Seeking assistance

Your practice, RTO staff and registrar liaison officers can all provide guidance and support when you have concerns. However, it is also important to speak with an experienced Workplace Relations Adviser when employment issues arise.

As well as workplace advice, there are a range of other support services AMA Victoria can provide, including:

- **Doctors in Training Mentoring Program** – Discuss career and professional development opportunities by engaging with an experienced doctor.
- **Careers Advisory Service** – Ensure your interview techniques and CV are up to professional standard for the next practice match round.
- **Peer Support Service** – For anonymous and confidential support call 1300 853 338.

To speak with a Workplace Relations Adviser or to access other support services, contact AMA Victoria on (03) 9280 8722.

Katherine Stewart

Workplace Relations Adviser

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Are you at risk with your contractor arrangements?

It has been common over many years for medical practices to engage doctors as contractors. While this has its advantages we are seeing that practices are putting themselves at risk of being audited by not having the correct legal contracts in place. In addition to this, practices often have a mix of contractors, associates and employees which further blurs the lines.

Contractor versus employee

It is important that you understand the relationship difference between being a contractor and an employee. There is a general belief that if a contractor has an ABN and issues invoices then they are an independent contractor. However the law looks beyond this to the particular circumstances of each relationship. There are fundamental differences between the two and if you get it wrong, it can lead to potential employee related expenses, back pay and penalties.

The most common situation we see is a doctor contracting their services to the medical centre for an agreed rate or percentage of patient fees generated. Quite often this is done on a 'handshake' or verbal agreement and we see time and time again that no formal written agreements are completed.

If the medical centre exerts control over when the doctor works, their hours, assumes the risk or liability, and provides tools and equipment among other things, then it is more likely they are considered a common law employee and as such any payments to them will be subject to:

- worker's compensation premium assessments
- superannuation guarantee charge of 9.5%
- leave entitlements
- where the practice is large enough, state Payroll Tax of 4.85% for the year of 2017 (Victoria).

When assessing the employee versus contractor status both the Australian Taxation Office (ATO) and the State Revenue Office (SRO) look through any company or trust arrangements in place, so this does not provide any real protection from the above.

Recent developments

In recent years there have been a few cases which have reinforced the issues further. The main developments from these cases are that the court decided that as employees, the contractors were entitled to statutory annual leave and sick leave. This decision by the court overrode any private agreement where it may have been stated to the contrary.

We are also seeing an increase in ATO, SRO and Fair Work Ombudsman (FWO) audit activity in this area. The audits can be wide in scope and cover unpaid payroll tax (SRO), unpaid superannuation (ATO) and pay and work conditions (FWO). Most government organisations share information and an audit in one area can trigger an audit elsewhere.

In addition to this the ATO is also scrutinising applications for Australian Business Numbers (ABNs) for individual contractors more closely and in some cases have even requested copies of the contracts with the medical practice. So now more than ever the importance of having appropriate contracts in place is crucial.

There are numerous checklists provided by the ATO, WorkSafe and Fair Work that you can use to determine your circumstances and obligations. Ultimately each situation should be assessed independently to determine whether the doctor is a contractor or employee.

What should you do now?

If you are currently paying contractors then you should consider a full review of the contracts you have in place and assess what risk your practice has.

The adoption of an updated service agreement and some minor changes to your bookkeeping in relation to the recording of income and service fees, should have minimal impact on your practice and reduce any exposure to audit activity in this area.

If you are concerned about your contractor arrangements and the impact upon your medical practice, please contact Belinda Hudson on (03) 9824 8555 or by email belinda.hudson@williambuck.com

Belinda Hudson

Director, Health Services

William Buck

William Buck

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Addictive medication - Australia's fastest growing drug problem

Pharmaceutical drugs such as benzodiazepines, oxycodone and codeine are responsible for more deaths than all illegal drugs combined – and the majority of these overdoses are accidental. A new report by the Alcohol and Drug Foundation (ADF) released in February this year explains that while there have been a number of good initiatives to tackle this issue, the harm continues to grow. As the prescribers of medicines, doctors need to be particularly mindful of appropriate and inappropriate use of these drugs given the growing harms associated with them.

The ADF's report highlights a number of serious issues including the over prescription of addictive medicines and the lack of safer choices given to Australians to treat chronic pain, anxiety, stress and insomnia.

Are benzodiazepines the best treatment?

There is now overwhelming evidence that benzodiazepines are usually not the best treatment for anxiety, stress and insomnia. While benzodiazepines may be useful in acute settings and can be lifesaving, for example in complicated withdrawal from alcohol, they have significant side effects. With long term use, the harms outweigh the benefits. There is increasing evidence that relaxation practises, mindfulness, counselling, regular exercise and a healthy diet are more successful at treating these conditions.

When do opioids do more harm than good?

While opioids are an important part of treating acute pain, the evidence indicates their use in chronic pain treatment is highly controversial. Chronic pain is better actively managed with physiotherapy, relaxation techniques, mindfulness and other diet and lifestyle advice, with the judicious adjunctive use of non-opioid medications. General practitioners are in a position to support their patients in the active management of chronic pain, however they need the ongoing support of multidisciplinary pain clinics, specialists and allied health providers. Given these services can often be hard to access, governments are increasingly investing in online tools (see ADF's website), which have been proven to be effective. For example, MindSpot a free online and telephone counselling service that focuses on cognitive behavioural therapy.

Key messages for patients

Following the release of its report, the ADF is focusing on educating Australians about these addictive pharmaceutical drugs so they can make more informed decisions. It recommends that doctors share the following key messages with patients considering taking or currently taking opioid painkillers or benzodiazepines:

- When these medications are used regularly for a long time, the negative side effects can often outweigh any positive effects.
- These medications should only be used for short periods of time. They can stop working if they are used for too long and have serious side effects including, but not limited to, drowsiness, constipation, reduced sex drive, fertility problems, headaches, dental and stomach problems, moodiness, decreased bone density, fatigue, impaired thinking, paranoia and addiction.
- Consider how these side effects will impact your ability to do things like drive, work or look after children.
- There are safer treatments for stress, anxiety and insomnia that don't have negative side-effects. Regular exercise, counselling, a well-balanced diet, and mindfulness and relaxation practises are proven to be effective at treating these conditions.
- Mixing medication and mixing it with alcohol can increase your chances of negative side effects and overdosing.
- Don't share medication with family or friends. No drug is safe.
- If you want to restart taking a medication consult with your doctor first rather than using leftover drugs.

At risk patients

To prevent medication addiction problems, doctors can target patients in one or more of the following situations with information about how to manage their ailments in the long term without medication.

- About to have surgery and experience acute pain.
- Recently had an accident or experienced trauma.
- Experiences issues related to anxiety or sleep.

- Has a history of drug (including alcohol) dependency.
- Has headaches, muscle soreness or other bodily pain.
- Experiences work and/or family related issues that may increase the risk of anxiety, difficulty sleeping and/or physical pain.
- Is less well connected socially, lacks strong social support networks, faces employment challenges (under-employed, casual/unstable employment), lives in poor housing, has low health literacy.

What else can doctors do?

There are other practical steps doctors can take to prevent further harm from pharmaceutical drugs.

- Increase understanding of addictive drugs like opioid painkillers and benzodiazepines including appropriate and inappropriate use, and their side effects. There is supplementary training in pain management and addiction medicine available, including through the Royal Australian College of General Practitioners, Royal Australasian College of Physicians, State/Territory Governments, universities, and there are a range of online options.
- To help identify patients suffering from the side effects of medication, ask them about their daily lives. For example, "Have you had trouble remembering things?", "Do you ever feel dizzy or tired at work?" It's important to think about how you ask these questions, so patients feel like they will be supported and won't be judged, especially if they have become dependent on the medication. If you feel uncomfortable asking these important questions, you should consider some further training in treating addiction.
- Check whether pharmaceutical drugs can be managed differently. For example, are the drugs part of a regularly reviewed health plan? Do they need to be used at all?
- Understand alternative treatments, where they are available from (including free online, evidence-based tools) and develop ways of explaining the benefits of them to patients (see ADF's website).
- Refer to specialists where required i.e. pain clinic, headache clinic, psychologist, dietician, and/or physiotherapist.

Too many people become addicted from unnecessary prescriptions for mental health, insomnia and minor pain issues. Doctors can help to intervene before pharmaceutical drugs adversely affect more Australian's lives.

For more information visit adf.org.au/addictivemedication

ADF | Alcohol and Drug Foundation

References available from the Editor on request.

Liquor laws must seek to minimise alcohol related harm

AMA Victoria recently made a submission to the *Liquor Control Reform Act 1988 (Victoria)* review. Our submission focused on the role of the Act in harm minimisation. This article covers some of the key components of the submission, which can be read in full on our website.

It is widely agreed among medical professionals that Victorians are consuming alcohol at unacceptably high levels and that the pattern of excessive consumption has become part of the Australian way of life. Strategies must be implemented to limit the flow-on effects of this culture – the benefits from doing so would be both socially and economically impactful.

The *Liquor Control Reform Act (LCRA)* review's consultation paper noted the Royal Commission into Family Violence findings, that "although alcohol use is associated with a relatively small proportion of family incidents, it is widely regarded as increasing the severity and incidence of family violence". A 2011 review of homicides in Australia over 53 years found many were strongly linked to alcohol, and especially beer consumption. This review found that every one-litre increase per capita in alcohol consumers was followed by an 8% rise in the rate of male deaths by homicide and a 6% rise in female deaths by homicide.

The estimated cost of harm caused by alcohol on the Australian community – ranging from street violence, car accidents, and domestic violence through to poor health, absenteeism and premature deaths – is $36 billion a year. This clearly highlights that Australia has a serious problem with alcohol, and State and Commonwealth Government action is needed.

Reducing the widespread availability of alcohol

A major problem in Victoria is the rising number of liquor outlets, which has made alcohol increasingly available and cheaper to buy through competition. Alcohol manufacturing, sales and purchasing should be heavily regulated, monitored and far more stringently policed.

The *LCRA* review's consultation paper confirms that, as at 30 June 2016, there were 21,607 renewable liquor licences and 9,552 temporary liquor licences in Victoria. To help understand these numbers, research undertaken by the Foundation for Alcohol Research and Education (FARE) in 2015 found that Victoria has:

- Seen the most dramatic change in the number of liquor licences, with the most deregulated alcohol market across Australia.
- From 1998 to 2013 licensed premises in Victoria more than doubled, from 8,965 to 19,978.
- From 2003 to 2012 alcohol harms increased in Victoria with:
    - a 44% increase in alcohol-related hospital admissions
    - a doubling of ambulance attendances from 3,395 to 8,349
    - a 28% increase in alcohol treatment episodes.

A VicHealth / VicLANES project conducted an audit on outlets selling liquor for off-premise consumption. The study found that:

> *Having access to a greater number of outlets increased the risk of drinking at levels associated with short-term harm. Having eight or more stores within a one kilometre network distance of respondents' home more than doubled the odds of consuming alcohol at levels associated with short-term harm at least weekly.*

These studies and statistics confirm the extraordinary high number of liquor licences for Victoria's population of 5.74 million people and the harm this is having on the community. AMA Victoria does not support the expansion of liquor licences and recommends the Victorian Government examines reducing the number of liquor licences across the state.

Stronger penalties for licence holders

AMA Victoria supports improving the enforcement of existing regulations and stronger penalties for licence holders who are found to be in breach of their licence conditions. It is our view that the current penalties are not strong enough to act as a deterrent, especially in regard to selling alcohol to intoxicated people and to minors.

The widespread sale of alcohol to intoxicated people is evident by the significant number of alcohol-related injuries and accidents. A 2014 snapshot study by the Australasian College of Emergency Medicine (ACEM) found that during peak alcohol drinking times, such as the weekend, one in eight presentations to emergency departments were alcohol-related. The study noted that the sheer volume of alcohol-affected patients created more disruption to emergency departments than those patients who were affected by ice.

AMA Victoria recommends improving the enforcement of existing regulations and stronger penalties for in-breach licence holders, as this will help promote the responsible service of alcohol and minimise harm.

RSA training for all licences

The Victorian Government recognises the importance of Responsible Service of Alcohol (RSA) training, noting on its website that "undertaking an approved RSA program gives participants the skills and knowledge necessary to contribute to a safe, enjoyable environment in licensed premises... The RSA program covers a range of topics including:

- problems associated with excessive consumption
- alcohol and the law
- facts about alcohol
- handling difficult customers."

The *LCRA* review's consultation paper confirms that mandatory RSA training applies to "holders of a general, packaged liquor, on premises and late night licence but not to the holder of a limited, wine and beer producers, major event and restaurant and café licence". This is unacceptable – RSA training must apply to all liquor licences.

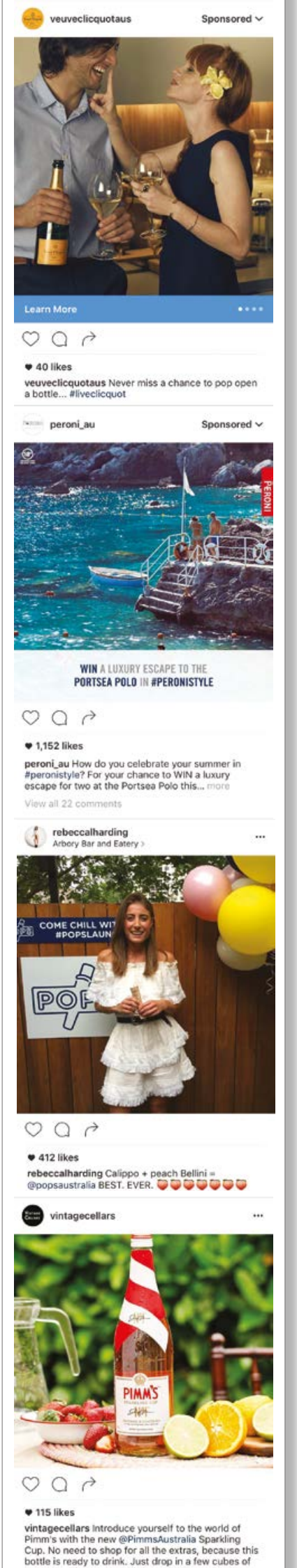
Lock-out laws

The Victorian Government should review and consider all policies that have been effective in reducing the harm of alcohol. AMA Victoria was extremely disappointed by the *LCRA*'s review consultation paper which declared that this review would not "consider or recommend introducing lock-outs for late-trading licensed premises."

AMA Victoria views such a refusal to even consider lock-out laws to be at odds with the objectives of the *LCRA*, which states:

> *It is the intention of Parliament that every power, authority, discretion, jurisdiction and duty conferred or imposed by this Act must be exercised and performed with due regard to harm minimisation and the risks associated with the misuse and abuse of alcohol.*

Lock-out laws successfully led to a 33% reduction in violence in Newcastle and a 40% reduction in assaults in Sydney's CBD. The



ACEM study previously referenced in this submission acknowledged the importance of lock-out laws. At the time of the study's release, Associate Professor Diana Egerton-Warburton, Chair of ACEM's Public Health Committee and clinical lead for ACEM's Alcohol Harm program, said that "for every additional late trading hour, there's a 20% increase in serious assaults and injuries. States like NSW and Queensland are already taking a lead on introducing early last drinks to help address this tide of human tragedy that arrives in our EDs."

These statistics warrant that the Victorian Government considers and reviews lock-out laws as a harm minimisation policy.

The Queensland Government confirms that their state's "lock-out is in place to protect patrons, the community and hospitality workers from alcohol-related harm in and around licensed venues." AMA Victoria supports a trial introduction of lock-out laws in Victoria, and praises the Queensland Government for its unwavering leadership in this area.

Marketing and promotion

As a final point, AMA Victoria urges the Victorian Government to monitor and regulate the new frontier of alcohol promotion which has arisen through social media advertising and PR events. Social media channels popular with young people, such as Facebook and Instragram, are awash with alcohol advertisements that promote alcohol to all, including young people (see left). This is achieved through straight advertisements (sponsored posts) or through celebrity endorsements (also often sponsored posts).

As the *LCRA* is responsible for providing adequate controls over the supply and consumption of liquor, it is necessary that appropriate action is taken to control traditional and social media advertising of alcohol in Victoria.

The full submission can be read on AMA Victoria's website (this includes a full list of references).

Felicity Ryan

Manager,
External Affairs

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War – A global health issue

Why, as a doctor, should you care about war? Why does it matter? What can an individual do about it?

I'm going to start with a recent win, where doctors joining together have made a difference. Just before Christmas the UN General Assembly voted overwhelmingly for nuclear weapons ban treaty negotiations in March and June this year. Despite Vladimir Putin and Donald Trump's posturing on nuclear weapons, we are suddenly as close as we have been in decades to making these weapons of mass destruction illegal.

The Medical Association for Prevention of War (MAPW) worked with the AMA, whose Federal Council voted unanimously to support a World Medical Association resolution calling for a ban treaty. This WMA resolution in turn helped persuade many countries of the urgency of a ban treaty. A major catalyst has been ICAN – the International Campaign to Abolish Nuclear weapons. ICAN was launched by MAPW in Melbourne in 2007, and now has over 440 partner organisations in 100 countries. Many people have worked for many years – but doctors working together have been a big part of this major step forward.

We have bans for biological and chemical weapons, cluster munitions and land mines. For these, prohibition was the essential first step leading towards their elimination. Many said the relatively recent landmines treaty would make no difference, but it has had a huge impact.

Stigmatising nuclear weapons will result in loss of funding. Many companies (among them, shamefully, Australia's Future Fund) will be forced to no longer profit from illegal trade. Along with massive divestment there will be identification and verification of stockpiles, and then a decade or more dismantling weapons systems.

War is clearly a global health issue. It represents a potentially preventable outbreak of death and disease, and has massive impacts – both for those in the war zones and for those in the countries sending in troops. The war in Iraq is a clear example – not just for the death and destruction caused, but also because this was an optional war fought on flawed intelligence. It is a

The Medical Association for Prevention of War (Australia) is a professional, not for profit organisation, working for the elimination of all weapons of mass destruction and the prevention of armed conflict.

MAPW is the Australian affiliate of the International Physicians for the Prevention of Nuclear War, winner of the Nobel Peace Prize.

We promote peace through research, advocacy, peace education and partnerships. And with the support of our members, have local MAPW branches in every state.

Visit our website mapw.org.au to view our many resources on nuclear weapons, waste and power, peace and conflicts. You can find your local branch and support our work by becoming a member, or by making a donation.

You can contact our national office by calling (03) 9023 1958, or by emailing eo@mapw.org.au or via mapw.org.au

MAPW - Health Professionals Promoting Peace

war that destabilised a region, and its catastrophic damage still reverberates in the Middle East.

The 2015 report "Body Count" by the International Physicians for Prevention of Nuclear War found that one million (655,000 – 1.7 million) Iraqis died. This is a shocking figure. A generation of children remain unvaccinated and ill-educated due to the subsequent breakdown of society. The resulting destabilisation contributed to the rise of ISIS and conflict in neighbouring countries. There are 65.3 million refugees worldwide.

So what can we do? Health professionals are well respected and can be powerful advocates. We can work to change how Australia goes to war. Any decision to deploy troops should no longer be a "captain's call" by the Prime Minister, but require both parliamentary approval (as happens in the US and UK) and the legality of joining the conflict supported by independent legal advice. In addition, afterwards, all military campaigns need detailed strategic review. Putting military and civilian lives at risk is serious business, and without analysis we will never learn from our mistakes.

We also need a more independent foreign policy. Blindly following our allies is not good enough. The behaviour of Donald Trump underlines the necessity of making decisions independently. With US threats to blockade the South China Sea, we risk being dragged into another ill-advised conflict. We should look to New Zealand, who remains a US ally while consistently acting in its own national interest.

Defence spending has been "decoupled" from the fiscal restraint of the Australian economy, with generous increases in funding. It is now on target to reach 2% of GDP by 2021, significantly earlier than initially planned. This massive increase may undermine peace in our region as nations compete to have the biggest armamentarium. It is in no one's interest to have a regional arms race.

The increases in our military spending are all the more remarkable in light of last year's Defence White Paper which reported that "there is no more than a remote prospect of a military attack by another country on Australian territory in the foreseeable future". Why then are we spending many tens of billions of dollars on submarines and on the over budget and underperforming Joint Strike Fighter planes?

In contrast to defence spending, healthcare for Australians remains significantly underfunded. Indeed, the Federal Government is more concerned with threats abroad than addressing the family violence which kills an average of one Australian woman every week. Critical specialist domestic violence services and community legal centres remain inadequately resourced.

So what does MAPW do? We work in many ways: by visiting MPs, writing letters and open letters to ministers and the Prime Minister, educating people about the trade-offs that happen when war is prioritised over community wellbeing.

We are encouraging Australia to join the UN nuclear weapons ban treaty negotiations – at the time of writing the Government had not committed. We campaign to increase diplomacy and foreign aid and to protect health workers under fire. We are working to stop large armament advertisements at Canberra airport, and protesting against the arms trade fair now linked to the Avalon Airshow. We have worked to stop the importation of one-third of the world's nuclear waste into South Australia, and are concerned about poor quality plans regarding Australia's own nuclear waste.

As healthcare, education and many other critical services struggle with inadequate resources, and our diplomatic service and overseas aid are cut to shameful levels, we need to be clear what we want as a society. Do we want to focus on preparing for war, and risk starting a regional arms race, or prioritise diplomacy and aid, and building good relations with other nations?

Join us, and help promote peace. Heavens knows in this world of "alternate truths", the reality that war is a major and at times preventable cause of morbidity and mortality has to be understood.

Dr Margaret Beavis

President
Medical Association for Prevention of War, Australia

Testamentary capacity

An all too common scenario faced by doctors is when they are either asked to comment retrospectively on the testamentary capacity of a deceased patient, or to provide a prospective report for someone who is contemplating writing a will. Providing an opinion on testamentary capacity is a very complex area that can land you in considerable difficulty – as a witness being cross-examined for your views, disciplinary findings, or even judicial review. Fortunately, adverse outcomes arising out of negligent assessments are uncommon. This article aims to provide some clarity on the issues involved.

Case history

Violet was elderly and wealthy when she died. She had loyally attended your practice for the last 20 years, although she had been a bit vague and doddery of late. Sadly, even before the family's mourning had ended, the war for her assets began.

The Executor of her estate writes and asks for your opinion on Violet's prior testamentary capacity. "That's easy", you think to yourself, optimistically hoping that the Mini Mental State Examination (MMSE) you performed last year would be enough for the lawyers as you begin to put pen to paper.

Capacity

Capacity (or competence) is a legal concept and refers to an adult's ability to make their own decisions. Adults are presumed to have capacity, although the presumption is able to be disproved. While cognition (a medical concept) and capacity are intertwined, impairment of cognition does not mean that a patient will lack capacity.

Capacity is time and decision specific, so fluctuating cognitive states and varying decision tasks will alter the assessment of the patient's capacity. Subsets of capacity can also be determined, such as financial capacity, consent to medical treatment, testamentary capacity, and capacity to stand trial. A more detailed article on capacity can be found in the Spring/Summer 2015 edition of *Defence Update* on **mdanational.com.au**.

Prospective assessment of testamentary capacity

Testamentary capacity is a specific legal concept, and it is not a medical diagnosis. It refers to the ability of a patient to make a will. The required capacity will vary with the complexity of the proposed will and potential claimants involved. As such, doctors should be very sure of what they are doing if they are to provide opinions regarding testamentary capacity.

Testamentary capacity assessment requires very specific understanding and skills, and should generally only be performed by those with the relevant knowledge and experience. It involves far more than an assessment of cognition. Given that testamentary capacity assessment requires consideration of the proposed will, a solicitor should be involved in providing instructions including the necessary background information.

The legal test is surprisingly old – found in the English 1870 case of *Banks v Goodfellow* and still relied on by lawyers today. It is clever in that it recognises the interaction of medical factors (cognition/mental health) and individual facts of the matter (assets and benefactor). The case related to the writer of a will who had delusions – but were the delusions enough to invalidate the will? The court concluded they were not.

The person making the will must:

- understand the nature of making a will and its effects
- understand the extent of the assets they are bequeathing
- comprehend and appreciate the (moral) claims to which they must give effect
- not be affected by a disorder of the mind that "perverts the sense of right" or decision-making.

Formal assessment of testamentary capacity thus requires some understanding of the assets and potential beneficiaries involved, and will also involve working through the scenario with the patient.

Doctors should generally avoid signing a pre-prepared statement (affidavit) prepared by lawyers involved in testamentary (will) disputes without first seeking advice from their medical indemnity insurer and/or ensuring that their own views are accurately reflected.

A doctor is not obliged to provide an opinion on a patient's testamentary capacity and, as noted above, such opinions should be reserved for those with the necessary expertise.

Doctors generally conceptualise "cognitive assessment" when considering capacity issues and need to be careful that the two are not confused. As an alternative, it may be that factual information about the patient's cognitive state can be provided without making any comment about testamentary capacity.

Consent to provide a retrospective assessment of testamentary capacity

Appropriate authority to disclose confidential patient information should be carefully considered prior to any discussion or the provision of a report to third parties. Doctors still have a

professional and legal duty to maintain patient confidentiality even when a patient is deceased or no longer has decision-making capacity.

For an incompetent patient, the legal guardian or substitute decision maker will likely have this authority. For deceased patients, appropriate authority will typically reside with the appointed Executor/Administrator of the will. Any dispute over the patient's testamentary capacity may invalidate the appointment of that Executor/Administrator if the will was made at the time the patient was incompetent. These can be challenging cases to unravel and advice should be sought where there is any doubt as to whether appropriate consent has been obtained.

Retrospective assessment of testamentary capacity

It is generally very difficult to retrospectively provide detailed information about testamentary capacity, e.g. after death, particularly if there is no detailed assessment to refer to. Such a situation might flow from an entry on a death certificate indicating a patient had dementia (often without a limiting timeframe) that was relevant to the period the patient made a decision in relation to bequeathing assets.

We strongly recommend that doctors refrain from providing a retrospective opinion about testamentary capacity unless a historic formal assessment has already occurred. However, a doctor may be able to offer relevant facts as to the state of the patient's cognition at the specific time, if available (see sample letter pictured right).

Although similar information regarding the patient's cognitive state might be relevant to a prospective assessment, doctors may additionally choose to refer the patient to a relevant expert.

Conclusion

Matters involving testamentary capacity can be particularly complex, especially in the context of a background dispute. They are often best discussed with your medical indemnity insurer.

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Dear Solicitors

I refer to your request as to the testamentary capacity of Violet Smith (deceased). I cannot provide any information about Violet's "testamentary capacity", because this is a specific legal test rather than medical diagnosis, and no historical assessment of testamentary capacity was undertaken. However, I can provide the following facts in relation to Violet's cognitive state which might enable a third party to conclude as to her testamentary capacity at the relevant time.

Violet's relevant past history included:

(Consider focusing on history that affected cognition, alertness and mental health. Be specific and provide accurate dates.)

- physical illness
- mental illness
- medications
- imaging/pathology
- assessments (refer to specific dates and times, indicating if a screening test, e.g. MMSE/CACS assessments, and what the results indicate)
- demeanour as at critical dates (particularly any indirect clinical information, e.g. ability to keep appointments, recollection of past appointments and discussions, clarity of thought)
- past history – depression/anxiety/cerebral events (e.g. delirium, seizures, CVA, dementia, head injuries).

(Consider whether you are able to state an opinion – for example:)

Based on the above limited assessments and retrospective information, I was not able to discern any impairment in the patient's cognition as at [specific] date.

Yours sincerely

Dr X

Dr Julian Walter

Medico-legal Adviser

MDA National

MDA National

Support Protect Promote

This article is provided by MDA National. They recommend that you contact your indemnity provider if you need specific advice in relation to your insurance policy.

Victoria's first Mother and Baby Withdrawal Service

Victoria's first Mother and Baby Residential Alcohol and Other Drug (AOD) Withdrawal Service commenced operations in October last year. Co-located with UnitingCare ReGen's Adult Residential Withdrawal Service (Curran Place) in Ivanhoe, the Mother and Baby service fills a longstanding gap in Victoria's AOD treatment system.

ReGen CEO Laurence Alvis said the new service will significantly improve the accessibility of AOD treatment for women with young children. "For most people, withdrawal is the first step in the treatment process," he said. "It's only after withdrawal that people then move on to longer term interventions like counselling or rehabilitation programs.

"Until now, for women with caring responsibilities (particularly for babies and infants), the lack of a withdrawal service that allowed them to remain with their children during their treatment created a major access barrier. Through our adult withdrawal service, we observed that, for many women, the prospect of being separated from their children for a week or more (or the difficulties of arranging alternative care arrangements) was enough to prevent them from commencing treatment. Of those who were admitted to our service, most struggled with the separation and found it difficult to focus on their treatment. Early exits (incomplete treatment) were common."

Anne's* experience highlights the impacts of this access barrier on mothers and their families:

I didn't drink during the pregnancy. I started drinking when the babies were six months as I had post-natal depression.

I lived because of them. I was so traumatised but I loved them so much that I had a reason to live on.

We wanted to do the journey as a family. My addiction was a family thing. Not just my issue.

At a day care I went to, a woman was honest about her addiction and was told not to come back.

Stigma around addiction is a barrier, but there's a double stigma when you have children, especially if you're a mother. If I didn't have kids, then I would have gotten help a lot earlier. You try and put a brave face on because you don't want people to know.

Finding a facility that can help – I found that difficult – even though I had a supportive husband, but there were times when I couldn't find a facility.

When I first started to find out information about rehabs, I had to turn up to an information session at 9.30 in the morning

and that was tricky when you have newborn babies. Going to information sessions was tricky. If you didn't turn up, then you would miss your spot. I was lucky with a supportive husband.

The barrier is that the baby comes first always. For my first point of contact I couldn't bring a baby with me for assessments. Assessments don't work with a baby. Then there's withdrawal.

I used (ReGen's) Curran Place four times. You can't have your kids there. This threw me as I couldn't focus on myself. It is hard to go through a detox when you are thinking about your children.

Nurse Practitioner and Mother and Baby service manager Rose McCrohan said the service has admitted 10 mothers with babies since the four-bed unit opened in October. "We're starting to develop a wider awareness of the Mother and Baby service among health and family service providers," she said. "It's still very early days, but we're already seeing some remarkable transformations.

"Women's time with us isn't just focused on getting through the physical process of withdrawal. We're able to work with them on their parenting skills and understanding of child development. It's also a terrific opportunity to engage women with some of our partner health and family services to strengthen their support networks and help put the pieces in place to support sustainable changes to their AOD use.

"The mothers love this new building. It's beautiful and it makes them feel safe. It's a wonderful place to undertake the first stage of their treatment."

Commenting on the new service, Anne said, "A service like this would have made a huge difference for me. I would have been able to come straight here, with my babies, and get started with my recovery a lot earlier. It would have saved my family a lot of grief.

"I'm so glad this service is here now for women in the same boat. Look at it. It's beautiful."

Service and referral information about the Mother and Baby unit are available on ReGen's website: regen.org.au/treatment-support/withdrawal/mother-and-baby

* Name has been changed

UnitingCare

ReGen™

Internship - My year of learning and building confidence

On my first day of internship while driving to work I witnessed a minor accident between two cyclists. After pulling my car over I approached a young lady who had fallen off her bike on to the ground.

"Hi," I said shakily. "I'm a doctor on my way to work, are you alright?"

"Yes I'm fine," she replied, with a quizzical look. I suspect she didn't believe me. Honestly I don't think I believed myself.

So when did I become a doctor? Was it the day I graduated from medical school and took the Geneva Oath? Or was it when I showed up for my first day of work? Despite my title on paper, it took well over six months of internship before I finally really believed that I was and could be a doctor.

It is said that learning medicine is the equivalent to learning a whole new language. What they don't mention is that the language is constantly expanding and growing, making it impossible to ever be 100% across every topic. But while we can never know everything, the art of practising medicine improves with experience.

At the start of internship everything was a challenge. Deciding even to prescribe paracetamol required serious thought processes (What's the dose? How often? Oh wait, do they have liver problems? OMG! I'm going to be the first intern ever to kill someone with paracetamol!). Even simple requests to review patients were enough to induce palpitations. While reviewing patients still isn't easy, my increasing clinical acumen makes it easier to distinguish the deteriorating patient from the demanding. Surprisingly, asking for help has also become easier with time. Maybe it is because my communication skills have improved or because I've finally learnt there is no such thing as a silly question if you are concerned about a patient.

In medicine, the moments that really test you seem to sneak up behind you. They never happen first thing Monday morning but rather hour 11 of a 14 hour cover shift with a constantly beeping pager and a difficult cannulation in an angry and frustrated patient. In those moments, when we feel inadequate it is easy to turn to self blame, thinking everything would be better if we only knew more or were better skilled. And while we can all strive for continual improvement it is important to realise that we are often working in a system pushed to the brink that sets us up for difficulty.

With health budgets continually stretched, junior medical staff are often left covering higher numbers of patients with less direct supervision. But onward we push, supported by our registrars and consultants, together in our goal to provide safe and effective medical care.

Beyond all this, the work we do is a real privilege. For many doctors in training the ward is home, a place where we work hard but also laugh, many of us friends as well as colleagues. It is easy to forget that for our patients each admission is a sentinel evidence in their lives and that hospital is often a foreign and frightening place.

When reviewing patients on a busy shift with constant pages, it is easy to be brisk and see each patient as rapidly as possible, choosing to prescribe rather than talk. But for me, the times where I really felt I made a difference as an intern was when I went back to take additional history that helped to make a diagnosis, paused to answer a family member's additional questions or simply sat by a patient's bedside and talked about their worries rather than just prescribing a temazepam.

While internship had its challenges it is just the first stage in what I hope will be a long career in medicine. Now as a resident I see the new interns hurrying around the hospital, clipboard in hand, looking frazzled at a buzzing pager. They might doubt themselves now, but I know that they are real doctors and a crucial part of the healthcare team.

Dr Danielle Panaccio

Communications Officer
DiTs subdivision
Medical Resident
St Vincent's Hospital

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Donor conception - The desire to know more

Around 8,000 children have been conceived in Victoria using donor eggs, sperm or embryos, making donor conception an increasingly common way for people experiencing medical or social infertility to have children. Experience has shown that donor-conceived people, their parents, and donors often want to learn more about one another and are willing to share information about themselves. People may be interested in medical history, personality, appearance, hobbies, and interests.

New donor conception legislation

On 1 March this year, new donor conception laws were introduced that give all donor-conceived people born in Victoria the right to receive identifying information about their donor, without the donor's consent being required. This ground-breaking new law brings the rights of donor-conceived people born as a result of sperm or egg donations made before 1998 into line with the rights of donor-conceived people born from donations made after 1998. Until now, pre-1998 donor identities could only be released with a donor's consent while after 1998 gamete donations could only be made if the donor agreed to the release of their identity when their donor offspring turned 18.

While the new legislation changes the rights of pre-1998 donors, it also gives these donors the option to lodge the type of contact they would prefer, in the event any donor offspring applies for information about them. Contact preferences can also include an option for no contact.

Donor conception register

Whenever a donor-conceived child is born in Victoria, information regarding the child, the parents, and the donor is provided by the treating clinic for inclusion on the Central Register. The new donor conception laws require that both the Central and the Voluntary donor conception registers are managed by the Victorian Assisted Reproductive Treatment Authority (VARTA). People seeking information about those with who they are connected via donor treatment will need to apply through VARTA rather than the Registry of Births, Deaths and Marriages (BDM), which previously held the registers.

VARTA offers a confidential advice and support service to people applying to the donor conception registers for information and to those people contacted as a result of an application. People seeking assistance from VARTA's Donor Conception Register Services include donor-conceived people, donors, parents of donor-conceived people, and the families of all. With the recent incorporation of management of the donor registers to its responsibilities, VARTA can now provide a 'one-door-in' information and support service to the public, the like of which does not exist anywhere else in the world.

Who can apply for information from the Central Register?

Donor-conceived adults (or those who are younger and deemed sufficiently mature by VARTA staff) and their descendants are entitled to receive identifying information about a donor.

Parents of children younger than 18 years can apply at any time for identifying information about their child's donor. However, a donor's identifying information will only be released to parents if the donor consents.

Donors too can apply for identifying information about their donor-conceived offspring. This information will only be released with the consent of the offspring or their parents' consent if a donor-conceived person is younger than 18 years. Donor-conceived adults (or parents of children) can also lodge a contact preference, including the option of no contact.

Connecting via the Voluntary Register

The Voluntary Register contains information lodged by individuals about themselves as well as their wishes with regard to information exchange or contact with other people on the register.

The Voluntary Register enables connections to be made that are not possible though the Central Register, including those between donor-conceived people who have been created by the same donor (donor siblings) and parents who have used the same donor.

Donor linking

While some people applying to the donor conception registers may only seek information, others may be interested in corresponding with or

meeting people with whom they are connected via donor treatment.

This process of connecting people linked by donor treatment is often referred to as donor linking. Although donor linking is still relatively new across the world, VARTA staff are skilled in assisting with the early stages of contact or information exchange. They are also neutral in their approach, respectful of people's choices and opinions, and maintain confidentiality at all times.

Time to tell

It is important for all people who have experience with donor conception to know how to discuss the matter with their family. Many donors have not told their partners or children about their donation. VARTA has resources that can assist donors with this issue. VARTA staff can help enable discussions among couples and families about being a donor and assist with clarifying the implications for everyone involved.

Many recipient parents who received donor treatment in the 1970s, 80s and 90s followed the prevailing advice of the time not to tell their children they are donor-conceived. Research now indicates this was not necessarily best for the child. Furthermore, while it is not common for donors to lodge applications to the Central Register for information about their offspring, it does happen. As a result, there are people who may learn of their donor-conception via a telephone call from a staff member at VARTA notifying them of an application about them.

VARTA understands that conversations about donor treatment may be difficult for some people, especially those with adult children, but evidence shows that it is best for everyone if donor-conceived people learn about their conception from their parents. Research conducted with teenagers on their opinions about telling revealed that they thought donor-conceived people had a right to know; they preferred their parents tell them; they appreciated there is no easy way to tell other than to say it; and they recognised the need to talk as a family together with all the children being told at the same time. They also suggested that parents should explain why they had not told them before, that they feel they are old enough to understand and now want their children to know the truth.

Doctors with patients who had donor treatment in the past can refer them to VARTA for information on how best to talk to children (including adult children) about their donor conception. VARTA encourages parents who have questions to contact it directly.

Keeping up-to-date

For anyone whose information is recorded on the Central or Voluntary Registers it is important to ensure that this information is accurate and up-to-date, including name changes and contact details. People needing to update their details on either register should contact VARTA.

For more information about the new laws and VARTA's Donor Conception Register Services visit varta.org.au or call (03) 8601 5250.

Louise Johnson

CEO
Victorian Assisted Reproductive Treatment Authority

VARTA
Victorian Assisted Reproductive Treatment Authority

Celebrating 20 years at AMA Victoria

In February, AMA Victoria's Legal Services Officer Annie Morrison celebrated 20 years working at the AMA! Over the years she has helped countless members with medico-legal enquiries, from how long to keep medical records, item numbers, fees guides, AHPRA, the National Law, registration, and indemnity insurance to advertising rules. Annie is a legend around the AMA hallways and when her phone was unusually silent for a few minutes, Vicdoc caught up with her for a quick chat.

Tell us about your role at AMA Victoria...

I answer all the incoming legal enquiries from members. The issues can sometime be very broad, but very often there are specific issues common to many doctors at the same time and I can get a lot of phone calls on a particular issue. The core issues are often the same over the years, but on top of that I get new issues popping up all the time. I'm the first point of contact for legal enquiries but if needed, I will refer members to a law firm or depending on the issue, sometimes their medical indemnity insurer.

Any memorable issues that stand out for you in your 20 years?

The changeover from the Medical Board to AHPRA in 2010 triggered many calls from members at the time. Plus when the medical indemnity insurer levy was imposed, I received many requests for assistance to work through the changes.

On a lighter note, one that sticks in my mind was when an elderly doctor called about his possession of a real human skeleton from his training days, but because of downsizing at home, his wife had given him an ultimatum to get rid of the skeleton from his cupboard. He didn't want to put the skeleton out onto the street, in case it looked suspicious to police, plus the doctor said that back in the day it had cost him a lot of money, so he was very keen to find it a new home and approached us for help. So I made a few phone calls to universities and in the end one of the top universities was happy to take on the skeleton for training purposes. So in the end, the doctor was happy, the university was happy and so was the skeleton!

Your phone is ringing again, is there anything else you quickly want to add?

Just to say that I keep a collection of some very nice thank you letters that I have received from members over the years. They are much appreciated.

The practice manager – A change agent for healthcare practices

Professional healthcare practice managers are ideally placed to be positive change agents within practices and an important government interface.

Private healthcare practice in Australia has evolved considerably over recent decades and the pace of change is continually increasing. External forces and changes in practitioner preferences are resulting in a shift away from smaller practitioner owned practices to larger corporately run practices. An increasing number of these practices include multidisciplinary care models, with doctors working in a team alongside nurses, allied health professionals, and pharmacists. Smaller practices must become more competitive and cost efficient to be sustainable.

This transformation of the healthcare practice has necessitated the need for the role of the practice manager to evolve. The new breed of practice managers are now running large multidisciplinary practices and responsible for a range of activities including scheduling and billing, practice accreditation and compliance, financial and technology management, human resource and risk management. They are able to take responsibility for the administration of the practice, allowing the healthcare professionals to focus on the clinical aspects. Ultimately, this results in improved patient care and health outcomes.

There are currently several drivers of change in healthcare practice in Australia which impact practice management. These drivers centre around three factors – increasing complexity, changing demand for services and cost pressures. They include an ageing population with a corresponding rise in chronic diseases, growing consumer expectations, greater collaboration between healthcare professionals, rapid technological change, greater emphasis on quality assurance, accreditation and clinical governance, changing business structures, increased focus on patient outcomes and changing healthcare business structures.

These reforms and the pressures they are likely to create will test the viability and resilience of many practices. Practice managers and the industry more generally must ask themselves, "How is your practice going to manage these changes?" and "Who within your practice is taking responsibility for driving the changes necessary to navigate this successfully?"

The practices that can be expected to adapt well to the changing dynamics of the healthcare industry will be characterised by a focus on strategic and business planning, highly efficient business and financial systems which are adaptable to new funding models and a commitment to quality and risk management. They require an openness to new and innovative models of practice by readily adopting and utilising digital health technology. Furthermore, these practices will be engaging a range of different stakeholders in various ways, including, governments, Primary Health Networks, peak bodies, insurers, and more.

Practice managers are well placed to act as change agents to drive positive change while enabling clinicians to focus on patient care. This will require practice managers and the profession as a whole to mobilise and engage a number of stakeholder groups, including practice owners, clinicians, and government.

This involves understanding the factors which are driving change and the potential impact on the practice's business model, and developing a strategic response to this change. Professional and well informed practice managers are able to support practice owners through this process and help them develop and execute a strategy best placed to navigate the change ahead.

Many practice owners fail to understand or acknowledge the value of a professional practice manager – often equating their responsibilities with that of a purely administrative role. As they develop a greater awareness and recognition of the value of a well-informed practice manager, practice owners are also more likely to appreciate that education and training for practice managers represents a sound investment for their business. Practice manager education days and team education days with streams for reception staff, mid-level and high-level practice managers provide training in all core principle areas and topical health industry issues. Broad range eSeminars and online training modules are another vital resource for rural and remote managers or those too busy to leave their desks.

Keeping abreast of changes in the industry through regular email bulletins, respected practice management publications and networking with fellow professionals safeguards the potential for growth and ensures the practice remains sustainable.

Practice managers must be equipped for the changes ahead so that they, and their practices, are ready to successfully navigate the impact of the changes to come.

Gillian Leach

CEO
Australian Association of Practice Management

Celebrating 40 years

The Doctors' Health Fund is now in its 40th year, with plenty of reasons to celebrate. We take a look back to its beginnings when a group of AMA doctors started the Fund, how it has remained dedicated over the years to the medical community and why there's never been a better time to join.

The backstory

The Fund's beginning was an innovative response by AMA members to significant changes in the Australian healthcare landscape in the mid-1970s. Until then, "when doctors treated other doctors or their families, it was unthinkable for them to charge anything for a medical service," explains the Fund's former Chairman and former President of AMA Victoria, Dr Paul Nisselle.

The introduction of the taxpayer-funded Medibank (later renamed Medicare) triggered the practice of doctors beginning to charge colleagues the Medibank rebate for in-hospital treatment. In late 1976 the NSW Branch of the AMA incorporated its own AMA NSW Health Fund as one way of resolving embarrassment among doctors in the cases where the treating doctor's bill exceeded the Medibank rebate. "By then, doctors providing gifts as a way of saying 'thank you' to their treating doctor was no longer practical," says Dr Nisselle.

Dr Phillip Cocks, who is credited with the initial concept for the Fund, says "it developed its own impetus," once it was on the AMA NSW Branch's agenda. "The support from my colleagues on Council ensured that the suggestion became a reality," explains Dr Cocks. The group played a key role in designing the Fund's products at the time to meet the particular requirements of medical practitioners and providing the high quality cover the profession would expect. Dr Cocks notes a defining feature from the Fund's early days was the payment of benefits up to the AMA's list of services and fees for in-hospital treatments. This remains in place today with our flagship hospital Top Cover which is still an offering unmatched by any other health insurer.

Between the mid-1980s when the Fund was opened to AMA members nationally and 2005 when it was renamed The Doctors' Health Fund, coverage remained under 5,000 people. To broaden membership, eligibility to join was expanded to family and staff of doctors and a new period of growth ensued.

The Avant advantage

Fast forward to 2011 when Avant Mutual, recognising the synergy between its support of the medical profession as a mutual, not-for-profit medical defence organisation and Doctors' Health Fund as a health insurer for doctors, proposed a union. Following a resounding favourable vote by Fund members, Doctors' Health Fund became part of Avant Mutual in May 2012. By the end of June that year, membership jumped by 20% and the Fund now insures over 33,000 people.

Commenting on the 40th birthday, Doctors' Health Fund CEO, Peter Aroney, says "the healthcare landscape is changing quickly today, as it was in the 1970s when the Fund began. It makes supporting our members as both patients and providers just as important now as it has ever been. Our performance is an indication of how much this support is valued by the medical community."

An enduring ethos

The "by doctors for doctors" ethos of the Fund remains strong with:

- high quality benefits supporting freedom of choice, clinical independence and fair payment for medical professionals' expertise
- personalised, quality customer service with satisfaction levels rated in the latest member survey at over 95%
- benefits only available for clinically evidenced treatments
- advocacy and support for the medical profession and collaboration with professional bodies.

When asked what sets the Fund apart from other health insurers, Dr Nisselle says, "we were established with very high quality service and very innovative ideas about how to provide it. The service today remains second to none – I don't know anyone else who offered a claims app for their members when we introduced it".

Join Doctors' Health Fund today, the only health fund serving the medical community with health cover tailored to your needs that is encapsulated by: "Dedicated to you, dedicated to the profession".

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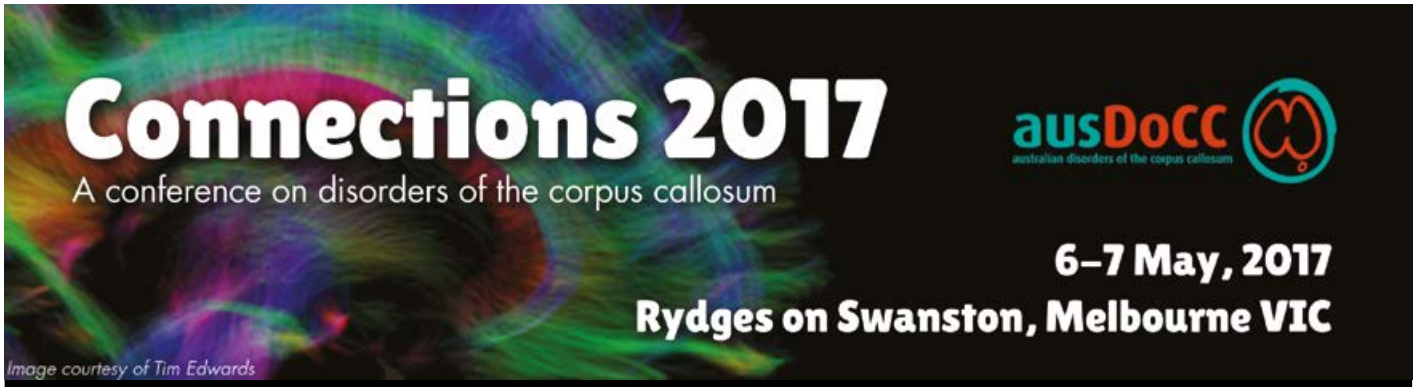


In placental mammals, the corpus callosum is the major cerebral commissure and plays a key role in the communication between the brain's hemispheres. When agenesis of the corpus callosum (ACC) is diagnosed in-utero, termination is a consideration. However, ACC still occurs in approximately 1:4000 live births. Information is scarce. New parents are told to 'wait and see,' while adults who discover they have the condition are largely advised to ignore it. This produces frustration and confusion within families.

As the peak family support organisation, Australian Disorders of the Corpus Callosum (AusDoCC) aims to change this. We know that brain development is rapid in the early years of life and early intervention is vital. Accurate knowledge and effective management and support for ACC have been fragmented and difficult to access in Australia. Until now, many families have travelled to America for support and information. We are initiating change by bringing together the world's pre-eminent corpus callosum scientists, clinicians and educators, with families, for one compelling weekend.

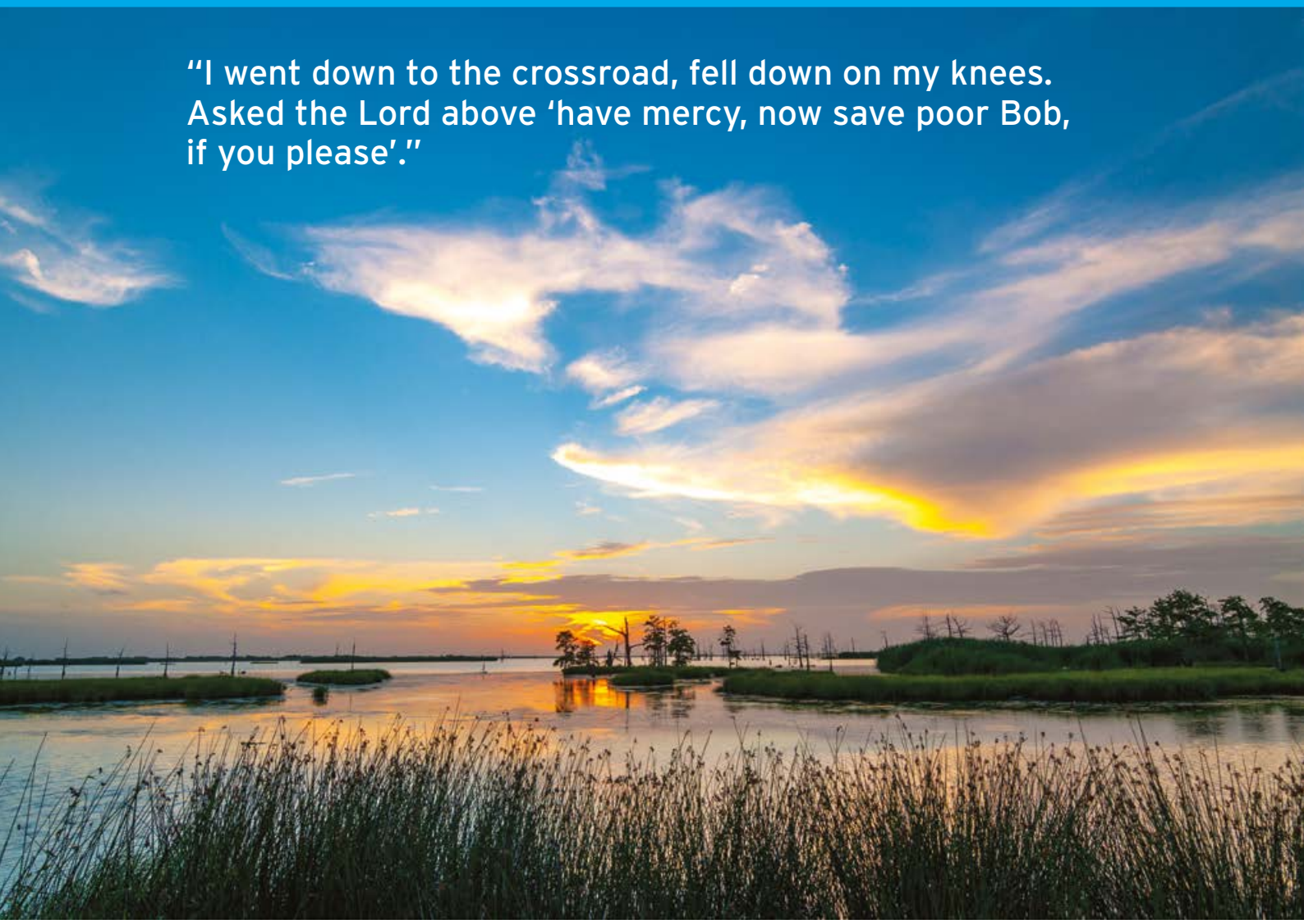
AusDoCC presents Connections 2017, a conference for disorders of the corpus callosum (DCC), in Melbourne, on May 6 and 7. We aim to unite families and give everyone the opportunity to form national alliances and gain understanding about this misunderstood brain condition. We welcome GPs, families and individuals to come and learn from the best and help us to gain strength and volume for a stronger voice for all those affected by a DCC. Informed management is vital for our families and individuals to flourish. Our theme will be "ACC Matters."

For those of you who feel inspired, the weekend Connections conference is preceded by Cortical Connections, a science conference hosted by Melbourne Children's campus, presenting world renowned scientists who specialise in corpus callosal research.

For more information, visit ausdocc.org.au, email info@ausdocc.org.au or phone 0428579216.

Looking for Robert Johnson – A journey through Mississippi

"I went down to the crossroad, fell down on my knees. Asked the Lord above 'have mercy, now save poor Bob, if you please'."



So sang Robert Johnson in 1936 prior to his untimely death due to poisoning in 1938 at the age of 27. Johnson's brief contribution of 29 songs recorded prior to his death later had a profound influence on rock and roll with artists such as Eric Clapton, The Rolling Stones, Led Zeppelin and the new Nobel Laureate Bob Dylan all acknowledging their debt. The "official" site of the crossroads where Johnson reportedly made a deal with the devil to play the finest blues guitar is at the intersection of Highways 49 and 61 outside of Clarksdale, Mississippi. However, everyone knows that the real truth is out there somewhere. So, what better excuse for a week's driving holiday in Mississippi between New Orleans and Memphis?

A walking tour of the French Quarter of New Orleans, which included a visit to the crypt of Marie Laveau, the famous voodoo priestess in the St Louis Number One Cemetery, laid the foundation for future adventures. I then travelled towards Mississippi in a rented little blue Toyota Yaris with Nevada plates, nicknamed "RJ" for the trip. The first night was spent in a dog-friendly hotel in Hattiesburg, Mississippi, where I was greeted by two enormous hounds as they emerged from the lift ahead of their owner.

The next morning I trekked across Mississippi from Hattiesburg to Natchez on State Highway 98, a much more pleasant rural driving experience than the busy freeways of New Orleans with large numbers of trucks and SUVs competing for the available lane space at speed.

Natchez, on the Mississippi River, was once one of the richest towns

in the south, courtesy of the slave cotton economy. It still has considerable charm as no civil war battles were fought in the area. Lots of beautiful old southern homes, churches and a synagogue remain, although it's a sobering thought that the beautifully-restored Stanton Hall, one of the finest homes in the town, was built by 400 slaves located on the Stanton plantation in adjacent Louisiana.

Smoot's Grocery is a juke joint (a local music venue where Robert Johnson used to perform), but unfortunately local musician Deak Harp performed the night before I arrived.

The next day RJ and I ventured up the Natchez Trace National Parkway to Vicksburg. The Parkway is an ancient transit route used by dinosaurs and First Nations before becoming popular with European settlers travelling into the south. Tranquil stretches of forest line the current road with little other passing traffic apart from the occasional highway patrol officer checking that RJ and I did not exceed the 50mph speed limit.

Vicksburg was very much involved in the American Civil War. General Ulysses S. Grant established his military reputation with a union victory over the confederacy (and control of the Mississippi) with most of Vicksburg being destroyed in the process. A very impressive and moving military memorial park at Vicksburg commemorates the battle. My B&B accommodation in Vicksburg, the Duff Green Mansion, was crucial to the survival of part of the town. Mr Green turned his grand residence into a hospital for both union and confederate troops, placing the union troops on the second floor to dissuade the union gunboats on the Mississippi from strafing the mansion and adjoining area. This strategy worked, although there's a commemorative cannon ball hole in one of the ceilings.

On to Greenwood where Robert Johnson once had three potential grave locations, being initially buried in an unmarked grave that became a major point of interest after the release of his collected songs on CD in the mid-1990s, with more than one million copies sold.

Recent information has reliably placed the grave under a shady tree next to the Little Mount Zion Church, a church built by slaves over 200 years ago as they ferried the timber up the adjacent Tallahatchie River (where Billy Joe McAllister jumped off the Tallahatchie Bridge according to the song by Bobbie Gentry). Sylvester Hooper (deltablueslegendtours.com) runs tours out of his store in Baptist Town in Greenwood of the relevant Robert Johnson sites in the area (the grave, the site of the Juke Joint where he was playing when he was poisoned, and the site of the "real crossroad").

From Greenwood, it was on to Clarksdale up Highway 61. Clarksdale has a good blues museum (that contains the actual cabin where Muddy Waters grew up), adjacent to the Ground Zero restaurant and music venue part owned by Morgan Freeman. The next day I made a brief visit to Friars Point, a small riverside community, passing the fields of raw and harvested cotton, about 20 minutes north of Clarksdale. Friars Point does not appear to have changed much since Robert Johnson was reported to have had a particularly good time there (commemorated in his "Travelling Riverside Blues" and Led Zepplin's "Lemon Song").

Then I drove on, past Robinsonville where Robert Johnson first experienced the blues, and Tunica which houses his marriage registration to Virginia Travis. From there, I travelled on to Memphis where RJ and I parted company. The great music on Beale Street along with visits to Graceland, Sun Records and the excellent National Civil Rights Museum (situated behind the Lorraine Motel, the site of Martin Luther King's assassination) provided a fitting finale to the "Robert Johnson in Mississippi" travel experience.

A/Prof Robert Parker

AMA (NT) President

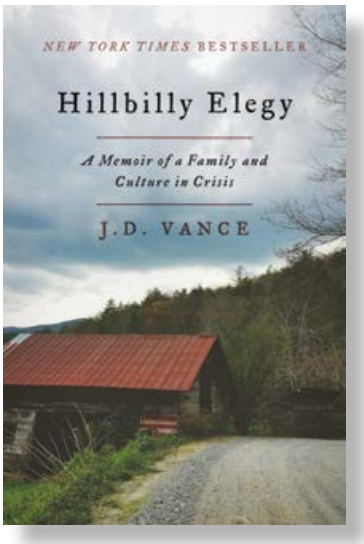
Avid blues fan

If you're an AMA member and you'd like to share an article about your travels, please email BarryL@amavic.com.au

First published in *The NSW Doctor* January/February 2017.

Book reviews

The iconic, independent Sun Bookshop has been a hub for readers in Melbourne's inner-west and beyond for 19 years. Here's a taste of what they've been reading.



Sarina, Sun Bookseller, has been reading *Hillbilly Elegy* by J.D. Vance.

This has become a runaway success in America topping the *New York Times* bestseller lists and what a timely memoir this is. By his own admission, J.D. Vance is 31 years old, and "I'll be the first to admit I've accomplished nothing great in my life".

J.D. grew up in the rust belt of America, in an Ohio steel town. Raised mostly by his hillbilly grandparents as his mother slipped further into numerous addictions and unable to properly care for J.D. and his sister Lindsay, he is shunted between relatives, doing poorly at school and potentially becoming one of the vast number of poor, disillusioned Americans that feel forgotten by government.

This is a probing look at the struggles of America's white working class but what I found so illuminating is the inside knowledge he has because this is where he is from. These are his family, his people, he instinctively understands their decisions and behaviours and provides a timely analysis of culture – the decline of this group that has been disintegrating for 40 years.

J. D. Vance tells the true story of what a social, regional, and class decline feels like when you were born with it hung around your neck. This is a moving memoir with colourful figures throughout but most importantly for readers, an insight into a country in turmoil and what the 'American Dream' means.

Kate, Sun Bookshop Manager, has been reading *The Girl Before* by J.P. Delaney.

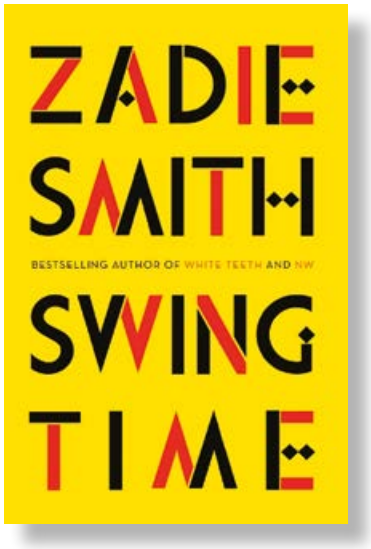
Thanks to Steig Larsson, Gillian Flynn and Paula Hawkins (and plenty of others) there has been a spate of highly successful novels in recent years that have "girl" in the title. It could almost be seen as passé for another author to jump on this bandwagon, and I wouldn't blame you for thinking, "here we go again!". However, when it comes to this psychological thriller, don't get dissuaded by the title, and don't count on it being the same as the other "girl" books.

One Folgate Street is a modern architectural and technological masterpiece. With a surprisingly reasonable weekly rent for such a beautiful home, many applicants are baffled that it is unoccupied. That is, until they discover living there will cost you much more than money.

Emma needs a fresh start after a traumatic break-in. The apartment she shares with her boyfriend no longer feels safe, or like home. She jumps at the opportunity to feel transformed by the blank canvas that this seemingly perfect house and it's strictly enforced minimalist lifestyle offers.

After being struck by a personal tragedy, Jane discovers a similar solace in the clean lines and harmonious atmosphere of One Folgate Street. She sheds her material possessions and moves in. But when a stranger starts leaving floral tributes at her door addressed to Emma, she starts to question: What happened to Emma? What happened to the girl before?

The Girl Before by J.P. Delaney is a perfectly balanced, thrilling tale that will get under your skin, into your head and cement you very firmly on the edge of your seat.



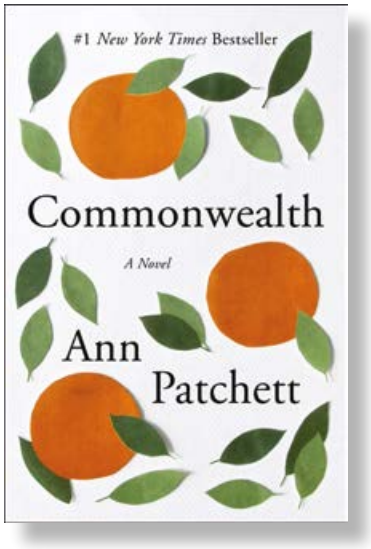
Zoe, Sun Bookseller, has been reading *Swing Time* by Zadie Smith.

Zadie Smith's absorbing new novel, *Swing Time*, grapples with race, class, and the fragility of relationships in an intimate portrait of two women, spanning North London to West Africa.

The novel begins in North London, in 1982, where our narrator meets Tracey, another "brown girl", at a dance class, marking the beginning of a turbulent friendship. Growing up in the same low-income project, their friendship stretches into the girls' adolescent years where we see them negotiate familial difficulty and identity in a working class, biracial London.

As they mature, the women's lives diverge. Tracey becomes a professional dancer and our narrator becomes personal assistant to an Australian pop star, allowing her an unrestricted view into how the 1% live. The novel, literally swinging time, shifts back and forth between the narrator's past and present, contrasting her direct experience of poverty in London and North Africa with her observation of the unbridled power and privilege that wealth offers.

Smith moulds her characters honestly and intricately, with all of their complexities and contradictions, in a detailed examination of the enduring memory of childhood friendship. A potent commentary on race, feminism and globalisation, and a must read for anyone who loved *White Teeth*.



Jess, Sun Bookseller, has been reading *Commonwealth* by Ann Patchett.

Bert Cousins rocks up alone to Franny Keating's christening with a bottle of gin, no idea who the hosts are and a desire to avoid a day spent with his own family. After locking eyes and stealing a kiss from Beverly Keating, Franny's mother, so begins a series of events that simultaneously careers two families together while yet pulling their members further apart. Over several decades, Patchett explores how the actions of two people reverberates along family lines, including having their torrid family history made into a bestselling novel.

Patchett blends humour and tragedy to create a novel that is deeply human. The shifts in time throughout the novel leave you desperate to know more; how each of the adult siblings came to be connected the way they are, how the parents handled the betrayal – the sense of suspense is as compelling as the cast itself.

Patchett creates robust characters, some of which are drawn from her own life experiences. The characters are so relatable; they could be your own family, I found myself wanting them to be my family. Family is the crux of this novel, how families are affected by great events, how families are formed and ultimately – how families stay together.

Given the number of people living in large, mixed families, the messages this book delivers resonates for many. From the pressures the parents face, to the community the step-siblings create, *Commonwealth* seems to suggest that for better or worse, families are in it together. It is a tender and fascinating insight on how change affects people's lives and how fulfilment can be found from even the most thrown-together of connections.

Loved it.

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VICTORIAN DOCTORS WHO SERVED IN WARS

The AMA Victoria Archives & Heritage Committee is currently compiling information on Victorian doctors who have served in wars, up to and including World War I.

If you have any information, anecdotes, letters or pictures about any relevant Victorian doctors please get in touch.

The archives project team, which is made up of a small group of volunteers who have been working tirelessly on the cataloguing, archiving and conservation of historical records and memorabilia, is always looking for more volunteers.

Please contact Dr Gerald Segal for more information
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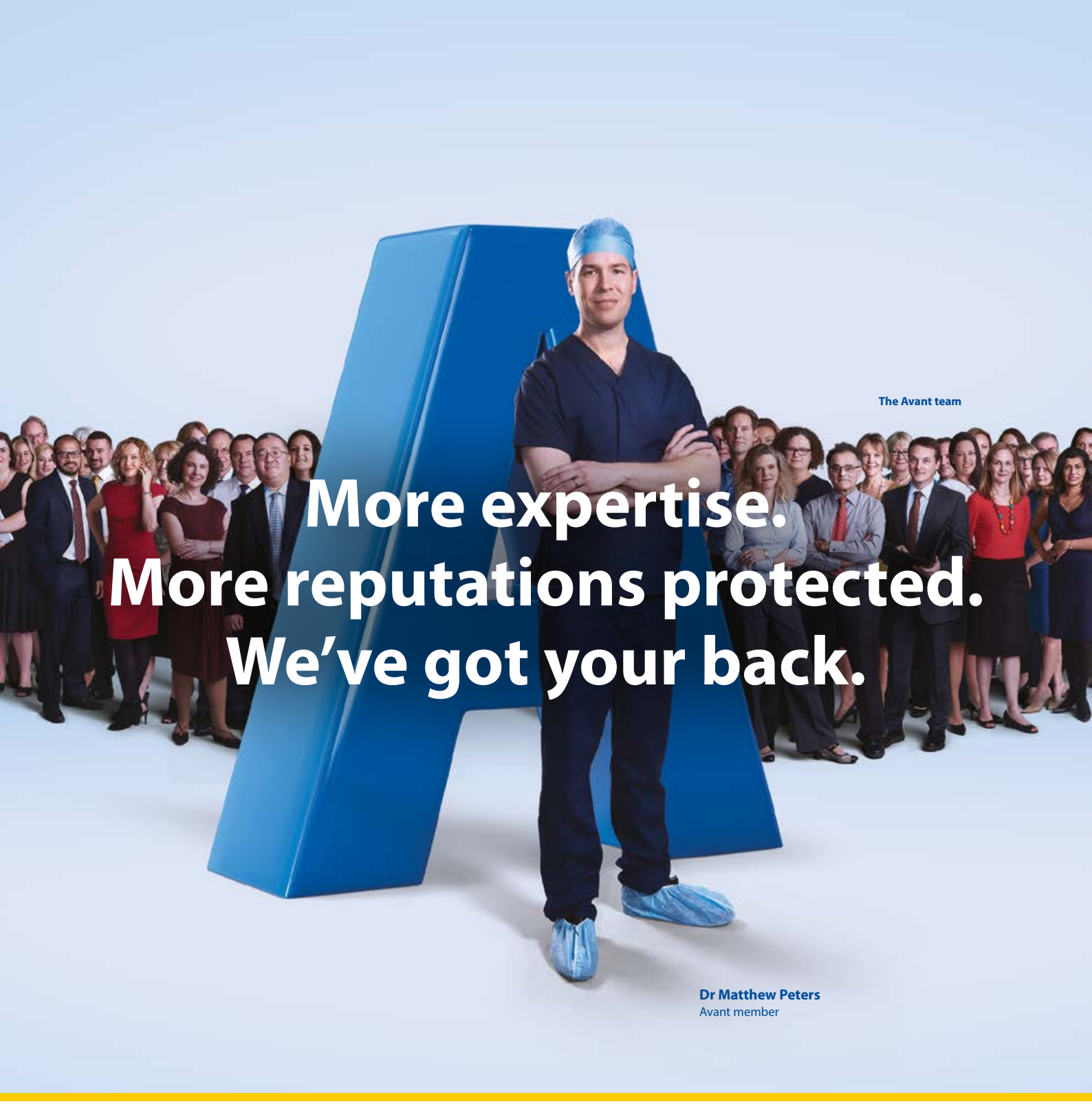

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