vicdoc

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. **JUNE/JULY 2017**

Volunteer hand surgery in Laos

STEPPING UP ON FAMILY VIOLENCE EDUCATION

IMPROVING COMMUNICATION WITHIN MEDICINE

INSIDE BENDIGO HOSPITAL'S PATIENT TRANSFER

BREAKFAST FEATURING GUEST SPEAKER CRAIG JAMES, COMMSEC

CRAIG JAMES
Chief Economist

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Friday, 9 June 2017
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Time: 7:00pm to 9:30pm
Menu: 4-course degustation menu with matching wines
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FRONT COVER: Dr Khamsouk operating on an upper limb utilising donated loupes in Laos, under the tutelage of Mr Philip Slattery.

Magazine of the Australian Medical Association Victoria

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Closing date for August 2017 issue submissions:

Editorial: 21 June 2017
Advertising: 1 July 2017

Welcome from the editor

All smiles after the Bendigo Hospital patient transfer. See page 44.

We like to feature stories in Vicdoc about the interesting work achieved by members and in this edition we are taken to third world Laos by Mr Philip Slattery, who is a long-time volunteer surgeon with Interplast. Mr Slattery performs life-changing hand surgery on burns victims and is also sharing some of his skills with local doctors.

A/Prof Jan Coles was concerned about the lack of adequate teaching on family violence in medical schools and along with a few of her colleagues decided to do something about it. Now students and those who have missed out on training can access an online learning module called "PACTS". In this edition, we learn about the program's evolution.

Your Vicdoc also includes articles on the challenges of treating patients with WorkSafe claims, changes to the Medical Board's Registration Standards, a blueprint for improving communication within medicine, and thought-provoking contributions on some of the personal difficulties that doctors can experience.

Our Workplace Relations team is regularly out and about meeting members and they're also just a phone call away (03 9280 8722) to discuss any issues. In this edition the team provides advice for practices dealing with unfair dismissal claims, along with a reminder for doctors in training about their entitlements to training time.

We've also received analysis from the Royal Children's Hospital on vaccine misconceptions held by Australian parents, a forensic look at deaths from legal drugs, heart-warming stories about health professionals helping out overseas and on the seas, plus we explore the health impact of the recently closed Hazelwood power station in the Latrobe Valley.

If you would like to tell us about an achievement in medicine or a personal interest others might enjoy reading about, please contact me on the details below.

Vicdoc is sent to members every two months, so look out for the next edition in your mailbox in early August.

Barry Levinson

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President's message

Since I last wrote much has happened. We have bade farewell to three Board members and elected new Board members. I would like to thank retiring Treasurer Dr Robert (Bob) Conyers, retiring Chair of Council Dr Roderick McRae and retiring Board member Dr Leon Massage for their many years of service. It would take all the words I have available and more to pay tribute to their individual contributions and I am glad I have had the opportunity to thank them more comprehensively on other occasions, including at our Annual General Meeting in May.

Our three new Board members Mr William Blake, Dr Jill Tomlinson, and Dr Vladimir Vizec have now commenced and we are all grateful that members are willing to spend so much of their time for the benefit of their colleagues, the profession and patients.

So change is happening at AMA Victoria, and the Budgets both State and Federal have brought further changes that require our attention and ongoing input (see more about this on the next page). The cliché of constant change is never better exemplified than in technological change – yet we are still frustrated by the lack of coordinated technology-based communications between health services and doctors. The *10 Minimum Standards for Communication between Health Services and General Practitioners and other Treating Doctors* has been presented to health services both private and public, the Department of Health and Human Services and our members, and received very positive feedback which we hope will be a catalyst for improvement. Thanks go to our Section of General Practice which developed these standards over many meetings. I have been proud to promulgate them on behalf of AMA Victoria and you can read more about this on page 28.

Seamless integration of encrypted communication of health information between one health service and another, between practitioners and health services, and practitioner and practitioner can be achieved, but has not occurred in a systematic way. Once it is achieved (and may that be soon!) we will also be exposed to more information to review. This is where our own individual contributions may begin to come under greater scrutiny. What is the quality of the content of our own communications? Is there too much? Is there too little? Will it affect referral patterns from one doctor to another if the technological interface provided by one colleague is superior to another, allowing easier and more timely communication? These questions are already being asked and more will evolve over time.

Two of the State Government advisory groups on which I represent AMA Victoria's members are discussing the technological aspects of their projects. The Real-Time Prescription Monitoring Advisory Group must address the integration with practice software used in general practice, specialist practice and in emergency departments. Without input from the medical software industry providers to achieve the best integration, the monitoring is vulnerable to taking a really long time rather than manageable "real-time". Given the regulatory consequences for doctors and pharmacists, this is a very important aspect of the project – not just the decisions around which drugs to monitor.

The second group is working on the implementation of the *Medical Treatment Planning and Decisions Act (2016)*. The critical issue here is timely access to confirm whether a patient who has a life-threatening illness or injury has made an instructional (rather than a values-based) Advanced Care Directive (ACD). Instructional ACDs are legally binding on registered health practitioners (not just medical practitioners) and may contain instructions which, if not followed, could result in treatment for which the patient may have refused consent. Getting timely and certain access to these instructional ACDs (where they exist) is one of the challenges we will face. Technology will certainly have a part to play, including the MyHealth record. The logistics of access to a reliable technological interface will be more pressing than ever.

Some of the aspects of technology to which I have been exposed in my role as President have at times seemed daunting, but also fascinating. I have been heartened by meeting experts in information technology who are excellent verbal communicators and willing to push for better systems. With some irony I write that meeting face-to-face in a group to discuss all the ramifications has yet to be improved upon by technology, but I am happy to engage on your behalf to assist the process of better technological innovation in communication, where it delivers better information in a timely and systematic way.

Dr Lorraine Baker
President

From the CEO

AMA Victoria's Workplace Relations team works hard for members every day. Many members have benefited from our IR and workplace services. This is a snapshot of some of the recent issues we've been supporting our members with.

$65K back-pay victory

AMA Victoria's detailed analysis of a member's pay structure led to a doctor in southwest Victoria receiving $65,000 in back-pay. Our IR team identified that the member had been paid below the Enterprise Agreement rate, after the doctor had varied their employment contract from full time to a fractional Visiting Medical Officer (VMO). The health service agreed with our analysis and paid the significant shortfall to the member.

Helping GPs with fixed term contracts

AMA Victoria's Contract Review Service has recently identified a number of contracts which do not allow an employee to resign with the standard 1-3 months' notice, but instead lock practitioners into the agreement for a number of years. We advise GPs of the risks associated with these agreements and strategies to negotiate fair terms. Unfortunately exiting a 'fixed term contract' early can result in significant lawsuits for breach of contract – AMA Victoria is currently advising on one such case.

Working for public hospital doctors on the new EBA

The Enterprise Bargaining Agreement (EBA) for Senior Doctors and Doctors in Training (DiTs) is negotiated by AMA Victoria on your behalf. It determines your salary, annual leave, after hours and on-call, your training, education and clinical support time, study leave, maternity, paternity and adoptive leave, car parking, dismissals and many, many other conditions and entitlements.

Public hospital doctors, please see our website and keep an eye out for emails detailing when our team is visiting your hospital. This is a great opportunity for you and your colleagues to speak to us and also get an update on what we are working on for you.

Defending unfair dismissal claims

AMA Victoria recently helped a practice win an unfair dismissal claim against a medical receptionist. The receptionist had resigned, alleging she was undervalued. The AMA helped show that the receptionist had not been forced to resign and the receptionist withdrew their claim. The matter is still to undergo mediation, as the former staff member is now claiming they were underpaid. AMA Victoria's representation has already saved the practice a significant amount in legal costs.

Payments for non-clinical work

The AMA stepped in to ensure a VMO won an increase to their fractional allocation, after the member had been forced to complete the majority of their non-clinical work in their own time, without payment. The VMO had not been receiving a sufficient entitlement to clinical support time.

Ensuring DiTs receive their training entitlements

AMA Victoria has achieved significant improvements for DiTs to access their training entitlements, after disputes were raised at several hospitals. Some DiTs have also received payments for not having their training time correctly allocated in their rosters, as per the existing EBA Agreement (negotiated by AMA Victoria).

AMA Victoria has also:

- Assisted two DiTs with accessing paid maternity leave in the first year of their employment.
- Assisted specialists who have been having their fractional allocation cut, without appropriate consultation and without a lowering of expectations in relation to work.
- Argued for VMOs who have not had their service with another hospital recognised.

These are just some of the matters AMA Victoria has been working on for its members. I encourage you to speak to our team about any issue you are facing in your workplace. And of course, I urge you to tell your non-member colleagues about the important work we do.

Frances Mirabelli
CEO

Farewell Judith Clark

AMA Victoria recognises and pays tribute to Judith Clark, who was the Executive Assistant to the CEO. Judith first started at AMA Victoria in 2008.

Many members have had the pleasure of working with Judith through their involvement with AMA Victoria's events, sub-committees and Council. In particular, Judith worked closely with the Board, past Presidents and Fellows.

The AMA Victoria Board, executive and staff wish Judith all the best.

Making an impact on family violence education

The Victorian Royal Commission into Family Violence identified the lack of health professional training in family violence as a major obstacle to women and children who experience family violence and seek help from their doctors. This was not really surprising, because despite the growing evidence of the severe health impacts of violence, undergraduate teaching in family violence has remained stagnant.

In 2009, the majority of Australian medical schools had less than two hours of teaching on intimate partner violence in their entire curriculum. This problem is exacerbated by the gaps in postgraduate training. With the exception of the RACGP, the leading Australian specialist colleges offer little or no comprehensive education across the spectrum of family violence for their trainees.

The intersection between health, behaviour and society is never an easy one to address in medical curricula, particularly when there are negative medical attitudes to its inclusion. In spite of the evidence, we still hear "This is a social problem, not a medical one". As recently as last week, a senior colleague commented – quite dismissively – that "Family violence is certainly flavor of the month at the moment".

A group of us from primary health care at Monash University set out to change this. Over a coffee, we discovered we were all facing a similar problem. We had students in placements all over Victoria, we often lacked experts to deliver the family violence teaching and when this happened it "dropped off" the curriculum. Most of our teaching was done in an episodic way, it lacked a clear structure and was frequently dependent on having teaching champions interested in presenting the materials available. Vital teaching and learning knowledge was often "lost" to the curriculum when staff champions left.

We resolved to work together, bravely crossing our discipline silos to create an interprofessional learning resource for those who are commonly the "first responders" in primary healthcare. We drew on each other's discipline knowledge, we were inspired by each other's work and had fun working together, even as we addressed a difficult topic. The teamwork to create PACTS (Primary care program Advancing Competency To Support family violence survivors) lessened the burden for each of us as individuals and helped us develop a better more comprehensive resource that is effective for primary healthcare students.

The traditional lecture format is not particularly suited to addressing student/trainees' attitudes or their emotional response to family violence. Evidence suggests that a blended learning approach is far better in this regard. Victim-centred learning that incorporates victim/survivor experiences by seeing or listening to victim/survivors of family violence talk about their experience helps doctors to better understand and support survivors. Having professional champions who lead by example, model supportive behaviours and a safe learning environment further enhances learning. We cannot forget that nearly 25% of the young women we teach and a smaller percentage of the young men will have very personal experiences of family violence, as will a proportion of our tutors and teachers.

Our solution was to create an open access online learning module called "PACTS" as a training resource for students and those who have missed out on family violence training. The training package is a basic introduction to family violence that covers the evidence, responding well to victim survivors, through to self-care for those responding. It includes simulated victim stories and a variety of professional scenarios for doctors, nurses, social workers, occupational and physiotherapists and paramedics.

Piloted across three states and territories and four universities, our evaluation with students shows that students who undertook the module felt better prepared to respond to family violence. They valued the simulated stories and being able to pace their learning and take time out, particularly when they had had their own experiences of family violence. Learning with other disciplines modelled a team response and there was relief that individuals, regardless of discipline, were not expected to "go it alone".

The resource has won a number of awards. It is open access and available at pactsproject.org

We are currently seeking financial support through grants and partnerships to develop further modules on sexual violence, child abuse and culturally respectful responses to family violence. In the meantime, just in case we had time to smell the roses, we are developing a GIVE RESPECT program with the support of Monash University to promote respectful and safe relationships for university students, a pre-PACTS prevention program, if you like!

We appreciate those colleagues who understand the imperative of family violence training, and have supported the PACTS program. We look forward to a time when family violence training for undergraduate medical students does not seem like a radical idea, and when basic first response skills to one of the major contributors to ill health in women is firmly embedded in medical curricula across Australia.

A/Prof Jan Coles
Project Lead
Department of General Practice
Monash University

Dr Debbi Long
Research Fellow
School of Primary & Allied Health Care
Monash University

Acknowledgements

The Monash University School of Primary Health Care and School of Nursing staff who created the PACTS project, Dr Heather McKay who managed us and the project and the staff from our partner Universities; The University of Newcastle, Australian National University and the University of Melbourne.

The following medical student contributions are acknowledged to the development of the PACTS family violence education project: Dr Elizabeth Prime, Dr Sarah Rockefeller, Dr Mehul Srivastava and Ms Annabel Jones, inspiring young medical women.

Vaccine myths and misconceptions among Australian parents

While the 'vaccination debate' is often reduced to a polarised notion of 'pro' and 'anti', the reality is far more complex. In the latest Australian Child Health Poll we asked a nationally representative sample of almost 2,000 Australian parents about their experiences, beliefs and opinions on childhood vaccination.

The vast majority of parents (93%) indicated that they prefer their children to receive all recommended vaccines on the National Immunisation Program (see Figure 1). A minority indicated a preference for selective or partial vaccination (6%) or complete refusal of all recommended vaccines (1%). These figures are in keeping with current immunisation coverage figures from Immunise Australia. Importantly though, despite high levels of vaccine acceptance and reported uptake by parents, this poll found that almost a third (30%) of parents have some concerns about vaccination for their children; 6% having 'major' concerns and 24% reporting 'minor' concerns.

While on the face of it we have strong levels of parental support for vaccination in Australia, our research, in keeping with that of others, suggests that parents' confidence in the safety and need for vaccination is best thought of as a spectrum. The majority of parents holding vaccine-related concerns still vaccinate their children, with those refusing all vaccines representing a very small minority. While it's the 'refusers' or those holding a strong 'anti-vaccination' position that we hear most about, it is in fact the parents who comply with vaccination, but hold a position of caution or hesitancy that we should direct our attention towards. Research done by others suggests that it is the parents who hold vaccine-related concerns, but still proceeding with vaccination, who are most likely to change their position. With over a quarter of parents in our poll sitting in this group, it's a group that warrants further attention.

What then, are parents worried about and what can we as medical practitioners do about it? The Australian Child Health Poll found that vaccine-related concerns held among parents relate primarily to vaccine safety. All vaccines currently available in Australia must pass stringent safety testing before being approved for use by the Therapeutic Goods Administration (TGA), and yet 12% of parents indicated that they were unsure whether vaccines are safe for their children and 1% felt they are not safe.

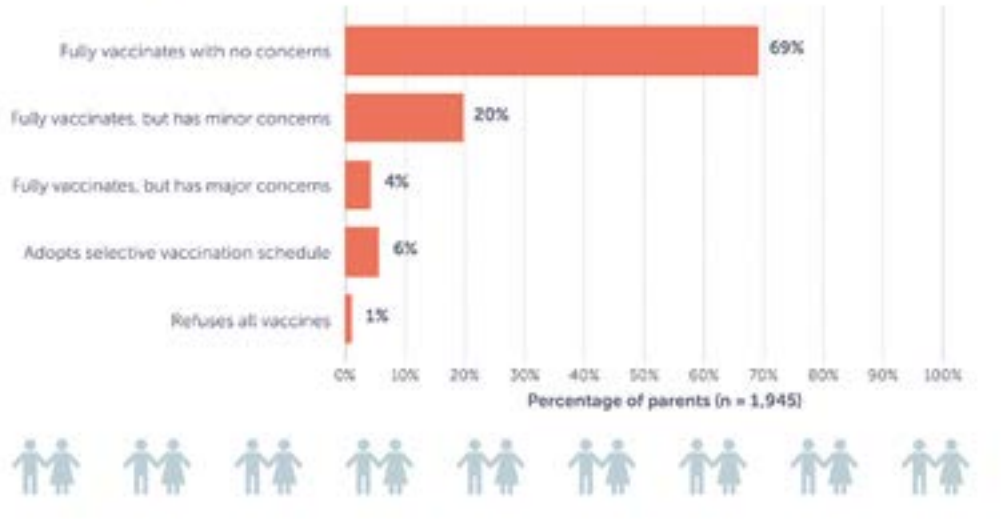
Around one in six parents (16%) believe vaccines contain ingredients that can cause serious harm, such as mercury and aluminium, despite the fact that vaccines available on Australia's National Immunisation Program have not contained the mercury-containing preservative thiomersal since the year 2000. One in eight (12%) parents erroneously believe that children's immune systems could be weakened by vaccines.

It is well known within the medical community that extensive research has shown no causal link between autism and vaccines. Yet our poll found that 9% of Australian parents still believe that vaccines can cause autism, with a further 30% being unsure about this. The effect of this persisting vaccine myth on herd immunity has contributed to measles outbreaks across the globe including the UK, the USA and even here in Victoria last year.

In this internet and digital technology age, parents can readily access a myriad of information sources about childhood vaccination, some of which may be inaccurate and amplify concerns. This poll found that families without a regular GP were considerably more likely to hold vaccine-related concerns, suggesting the importance of a good relationship with a healthcare practitioner in providing health education to families.

Figure 1

Vaccine uptake and level of concern among Australian parents



Communication with parents about immunisation can be complex. Other research suggests that different parents have different needs when it comes to communication about vaccination and presenting parents with information about the seriousness of vaccine-preventable diseases is rarely effective in alleviating their concerns and may in fact further entrench them. The National Centre for Immunisation Research and Surveillance has recently developed a collaboration to provide support to parents and health professionals in the sharing of knowledge about immunisation and to optimise communication about vaccine-related concerns (ncirs.edu.au/research/social-research/sarah-project/).

The poll results serve as an important reminder that while most parents follow the National Immunisation Program for their children, the level of vaccine-related concern and misconceptions among parents is significant. Parents, for the most part, are genuinely trying to do what's best for their child, and those who are concerned about vaccine safety may be less likely to vaccinate their children.

Ongoing education and effective communication to tackle these concerns among vaccine-hesitant parents is vital if we are to continue to see high levels of uptake of vaccination among Australian families. Given that healthcare providers, particularly GPs, are the most trusted and frequently accessed resource regarding vaccine concerns, this poll highlights the need to ensure they are adequately resourced to address this need.

Data source

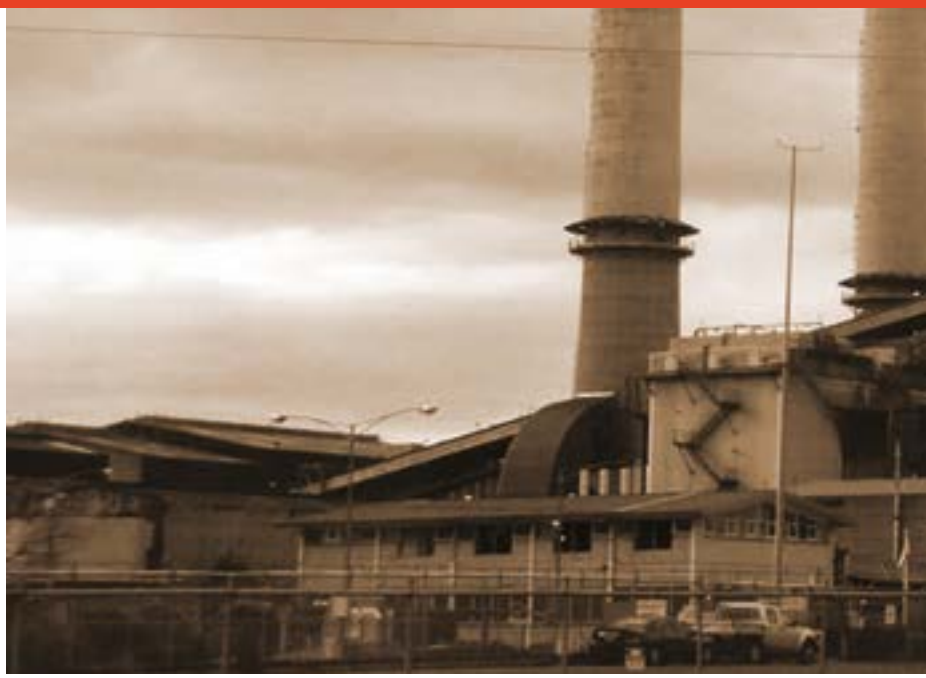
This article presents findings from the Australian Child Health Poll, a nationally representative household survey conducted every quarter by the Online Research Unit for The Royal Children's Hospital, Melbourne. This survey was administered from 17 January to 6 February 2017, to a randomly selected, stratified group of adults aged 18 and older (n=1,945). All respondents were parents or caregivers to children aged less than 18 years. Collectively respondents had a total of 3,492 children. The sample was subsequently weighted to reflect Australian population figures from the Australian Bureau of Statistics. The completion rate among Online Research Unit panel members contacted to participate was 65%.

More details, including the full poll report, can be found at childhealthpoll.org.au

Dr Anthea Rhodes
Director, Australian Child Health Poll
Paediatrician
Royal Children's Hospital Melbourne

References available from the Editor on request.

Counting the true cost of Hazelwood's shutdown



Hazelwood, in Victoria's Latrobe Valley, was noted for being the most carbon polluting coal-fired power station in Australia. The plant ceased operations in March – five months after majority owner, Engie, announced the decision to close when it became clear that it could not meet the estimated $400 million to maintain health and safety standards ordered by WorkSafe Victoria.

What has this closure meant for the health of residents of the Latrobe Valley?

Hazelwood over its lifetime of 53 years burnt 730 million tonnes of brown coal with emissions of sulfur dioxide, oxides of nitrogen, mercury, volatile compounds and small particles. These particulates are divided into two groups, tiny particles less than 2.5 micron in diameter and slightly larger ones up to 10 micron. The latter accumulate in airways to cause symptoms of respiratory irritation such as cough, wheeze and asthma while the smaller particles can enter the circulation and have been implicated in heart and vascular disease, lung cancer, and neurological disorders. Even short exposures to particulate matter (a few hours to weeks) can trigger cardiovascular deaths and illness, while longer-term exposure greatly increases the risk for cardiovascular mortality and reduces life expectancy by several months to a few years.

Monitoring of these compounds has not been performed diligently over the years but has been stepped up since the coalmine fire of 2014. The incidence of health effects has also been poorly documented although it is known that residents of the Latrobe Valley have a reduced lifespan of several years, both for males and females, compared with those in other regions in Gippsland and with Victorians in general. However, there are confounding factors which could influence these figures such as smoking and social status.

The retirement of Hazelwood is a step in the right direction.

Do emissions from all the existing coal-fired power stations in the Latrobe Valley adversely impact other communities? This question is difficult to answer without careful studies but it has been found that pollutants from power plants can travel a long way. A CSIRO study has found half the sulfates in Sydney air could be traced back to coalmines up to 140km away.

Health effects come at a cost to society. The costs are not covered by the power station operators or the purchasers of electricity but are subsumed by the country's healthcare budget. These healthcare costs include "externalities", such as industry subsidies and social costs.

The healthcare costs from Hazelwood emissions alone are estimated at $900 million per year while the air pollution health cost of coal burning in Australia is estimated at $2.6 billion annually. If greenhouse gas damage was included, the true price of coal-fired electricity would be close to double the nominated amount. On a larger scale, the cost to the world's economies from insufficient action on carbon emissions leading to run-away global warming will be much greater than the cost of action taken now. No country will be immune from the costs of damage repair and adaptation.

But there is a cost to be paid in closing down power stations as well. For Hazelwood, the mine site rehabilitation could cost over $700 million in addition to redundancy costs. As well, the company is facing charges by WorkSafe for safety breaches during the mine-fire in 2014 and prosecutions by EPA Victoria are also a possibility. Federal and state governments are contributing to support workers in transferring to other mine sites and are providing funds for the community to help start-up new projects.

Hazelwood workers and their families and communities deserve a fair go.

Disenchantment with the power companies and the so-called loss of "social licence" is not new – it began when the power industry was privatised in Victoria in 1996 and 6000 workers lost their jobs through restructuring. Over the subsequent 10 years, there has been high unemployment (currently 9%), a reduced population as people moved away from the area, and depressed local business. Because of fewer job opportunities and low family incomes, there is early school leaving and a high incidence of sole parent families.

In addition, there has been difficulty attracting new businesses, or relocating businesses to the area given the dominance of the power industry which may have prevented smaller entrepreneurial businesses from emerging.

Matters were not helped by the coalmine fire in 2014 which burned for 45 days and caused much physical and mental suffering of local residents and possibly contributed to up to 11 extra deaths. The residents of nearby Morwell in particular suffered from the effects of smoke inhalation and from the frustration of being unable to convince the company and the State Government of their plight at the time. Monitoring of pollutants was lacking but when measurement of carbon monoxide was commenced some five days into the fire, levels were exceedingly high. As a result of the second coalmine fire Inquiry, long-term monitoring of affected residents has been promised.

Medical group Doctors for the Environment Australia (DEA) has often highlighted the risks to communities from coal-fired power, not only in the Latrobe Valley but across Australia. DEA has stated that closing power stations should be a public health priority and has called on governments to make an urgent phased closure of power stations within the next decade.

How this can be achieved without government intervention when many are privately owned and have supply contracts is unclear. Fortunately the price of power from renewable sources is on parity with that from coal and will soon be cheaper, even without an impost on coal for the externalities mentioned above.

A transition from fossil fuels to renewable energy sources such as sun and wind will lead to significant, immediate and long-term local community health and public health cost benefits.

Dr John Iser

Victorian Chair
Doctors for the Environment Australia

References available from the Editor on request.

The breadth and depth of AMA advocacy

I came under fire recently because of comments I made about the closure of the power plant at Hazelwood in Victoria, which were misinterpreted in *The Guardian.*

The story in *The Guardian* set off a chain of emails and social media posts, instigated for the most part by Doctors for the Environment Australia (DEA), which were critical of my reported comments and claiming that the AMA President was downplaying the health impacts of pollution and climate change. Nothing could be further from the truth.

I do not blame DEA members for their actions. That is their job. They read something that they believed was against their charter, vision, values, and purpose, and responded accordingly. I admire and support the work of DEA. Many of their members are also AMA members.

Let me set the record straight. When asked by *The Guardian* journalist to comment on the Hazelwood closure, I clearly referenced and reiterated the AMA's strong and long-held position on climate change and health, embodied in the A*MA Position Statement on Climate Change and Health 2015*, which has been championed by myself, and former AMA Presidents and Vice Presidents. No story there.

As a responsible health advocate, I also raised the issue of care and concern for the people who lost their jobs because of the closure, and the broader impacts on their families and communities. I acknowledged the long-term effects of pollution in the Latrobe Valley. I also cited the work of doctors, led by DEA, in highlighting the health effects of the Morwell fire in 2014.

I raised the very real outcomes that stem from unemployment such as mental health, loss of self-esteem, alcohol and drug misuse, domestic violence, self-harm, suicide, and on it goes. These health effects are well documented in scientific studies around the world.

I also told *The Guardian* that I believed that governments and industry must be aware of, and make plans for, the impacts of transition – from employment to unemployment, from old energy sources to new energy sources, and for the ongoing impact of climate change on public health. Sadly, only a few of these observations made it into the story.

Unfortunately, *The Guardian* story wrongly projected that I, as AMA President, was more concerned about job losses at Hazelwood than about the global impacts of climate change or the transition from heavily polluting brown coal to renewable energy sources. Again, nothing could be further from the truth. I was simply and responsibly pointing out that there were health impacts and societal impacts on many levels, at varying degrees, from situations like the Hazelwood closure. This is the job of the AMA.

AMA advocacy is very broad and very deep. It has to be. No other medical or health organisation in the country can even come close to initiating or influencing change across the health system and society.

Single issue or narrow focus groups like DEA and Doctors for Refugees do great work. So do the learned Colleges, the Societies, and Associations. And the other health professions, the public health groups, consumer representatives, and other groups all do their jobs and do them well. But the AMA's mission goes so much further.

If you look at the AMA Federal website (ama.com.au), we have around 150 Position Statements, which include:

- Workplace Bullying and Harassment
- Indigenous Health
- Sexual and Reproductive Health
- Women's Health
- Men's Health
- Obesity
- Human Cloning
- End of Life Care
- Family and Domestic Violence
- Female Genital Mutilation
- Concussion in Sport
- Firearms.

These issues cover many facets of society and many ideologies. Some are regarded as progressive, some are conservative, but most are controversial – and therefore potentially divisive.

We do this on top of our other core business – Medicare, the PBS, public hospital funding, the PSR, medical workforce, private health, rural health, doctors' health, and the broad range of public health issues.

The AMA has to always tread a fine line, and we do that willingly. And so it is with the issues at hand here – climate change, pollution, air quality, and renewable energy. The AMA believes that climate change poses a significant worldwide threat to health, and urgent action is required to reduce this potential harm.

We have been vocal about the need for urgent government action, and have repeatedly called for the development of a National Strategy for Health and Climate Change. The *AMA Position Statement Climate Change and Human Health 2015* is a very strong document. It was developed from the ground up, with input from AMA members at grassroots level around the country.

The AMA wants to see a national strategic approach to climate change and health, and we want health professionals to play an active and leading role in educating the public about the impacts and health issues associated with climate change. Human health is ultimately dependent on the health of the planet, and the AMA lobbies governments for urgent measures to mitigate the evolving effects of climate change, including the transition to non-combustion energy sources. The evidence is clear – we cannot sit back and do nothing.

There is considerable evidence to encourage governments around the world to plan for the major impacts of climate change, which include extreme weather events, the spread of diseases, disrupted supplies of food and water, and threats to livelihoods and security.

Our stance is not limited to the Position Statement. We are actively engaged in advocacy on climate change and health. We attended the Health Leaders Roundtable at Parliament House in 2016, where health advocacy bodies met with Members of Parliament to discuss the health impacts of climate change and the need for urgent action.

We make regular submissions to relevant parliamentary inquiries, where we take every opportunity to highlight the connection between climate change and human health. We have further submissions to the parliament underway, which are in line with the AMA's official position.

In regard to air quality, there is considerable evidence documenting the substantial health impacts of air pollution, which range from acute and chronic effects, reproductive and neuro-cognitive defects, through to premature mortality. There is strong evidence for the significant health effects of particulate matter, and that these effects are even more pronounced than was previously thought.

The AMA told the 2013 Senate inquiry into the *Health Impacts of Air Quality* that occupational and workplace standards for hazardous air pollution are inconsistent and poorly enforced, and major sources of hazardous air pollutants are not currently regulated, as illustrated by the lack of standards for off-road diesel engines.

I make no apologies for speaking out about the broader health issues that come from events like the Hazelwood closure. It is unfortunate that the headline of an online article misrepresented the facts, and undermined the AMA's strong record on climate change, pollution, air quality, renewable energy, and human health. On the other hand, this episode has given me the opportunity to restate our very strong credentials in this and many other areas of public health.

Dr Michael Gannon

AMA Federal President

State Budget analysis

Boosts for tackling workplace bullying, reducing elective surgery wait lists

The Victorian State Budget 2017/18 will see specific health projects underway that support the recommendations made in AMA Victoria's pre-budget submission.

The wins

The Victorian Government has invested $1.5 million to crackdown on occupational violence and workplace bullying in the medical workforce. AMA Victoria is very pleased to inform members that this funding was allocated as a direct result of our Setting the Standard strategy which was launched in April 2016. This strategy addresses bullying, discrimination and harassment in the medical workforce.

Timely access to elective surgery has been a high priority for AMA Victoria for many years and we are pleased with the Victorian Government's $174.3 million to reduce the elective surgery wait lists in 2017/18, and $428.5 million towards hospital upgrades and medical equipment.

The State Government announced record spending of $1.9 billion to tackle family violence. Of this funding, $38.4 million will be directed to training hospital staff to identify and respond to family violence, as well as a specific funding stream allocated to support medical research.

AMA Victoria was part of the family violence industry task group and has been working on reforms that support improvements in workforce capabilities, staff retention and career pathways for family violence workers.

What's missing

In AMA Victoria's pre-budget submission and in our meetings with the Victorian Government, we have always made it clear that truly significant funding in mental health is paramount. In our opinion, the Budget has failed to make a significant investment in mental health services, despite years of underfunding. This omission represents a lack of understanding of the dire situation for mental health services in Victoria.

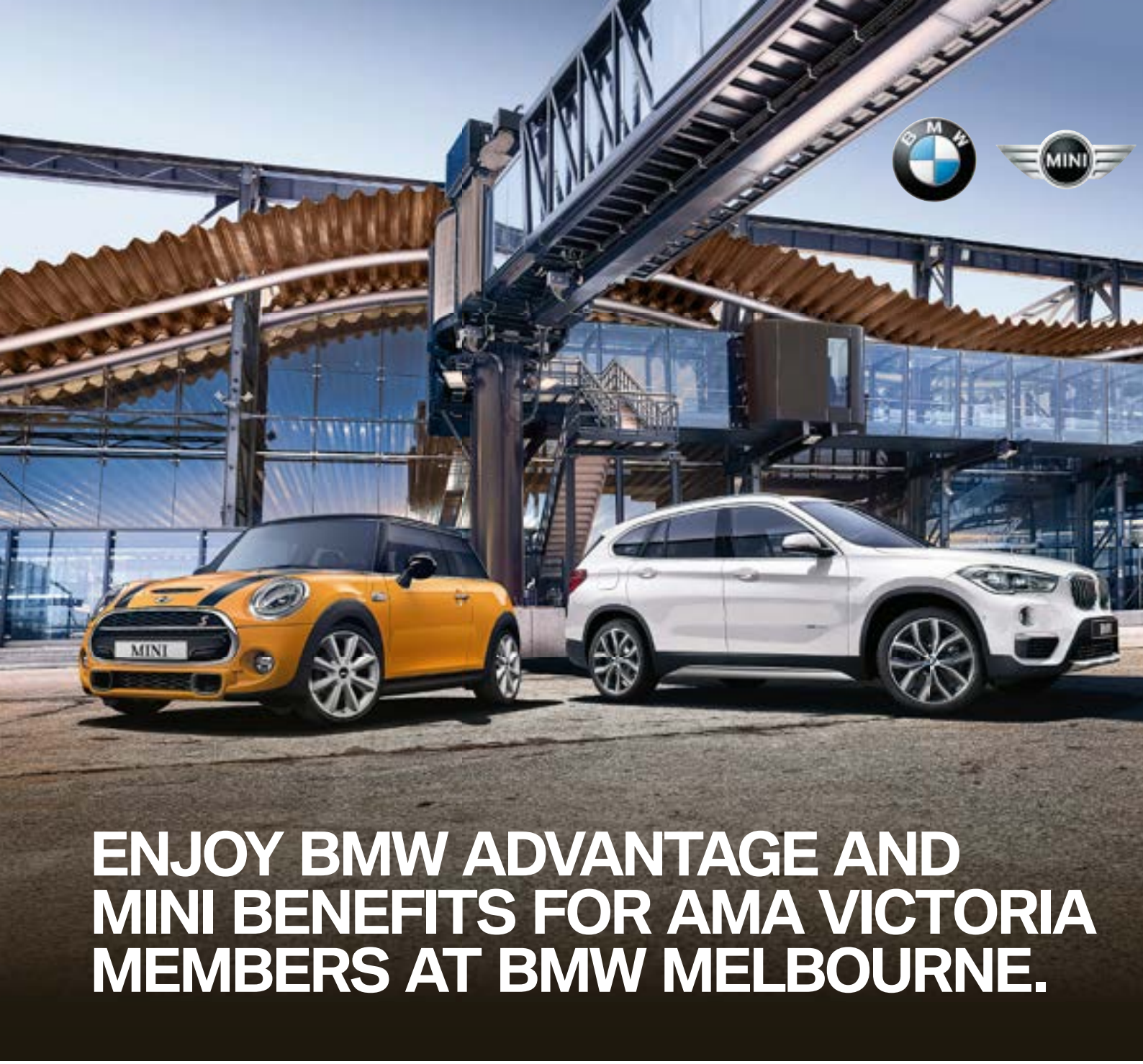
The State Budget's investment in alcohol and drug services is heavily focused on programs targeting ice. There is scarce funding for alcohol harm minimisation.

Funding has been allocated to palliative care services under a broader heading of 'meeting hospital services demand'. However it is unclear what proportion of this bundled funding will be targeted towards community palliative care and end of life care services.

AMA Victoria President Dr Lorraine Baker speaks to the media about the State Budget.

Nada Martinovic

Senior Policy Adviser



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Member profile: Hand surgery in Laos

Mr Philip Slattery loves his job as a hand surgeon. His enthusiasm for his craft was very much evident when he spoke to Vicdoc about his career in medicine, which has spanned more than 40 years.

"I've always liked the fine, intricate work and it's quite varied," Mr Slattery said, when explaining what drew him to his speciality. "I like to be able to sit down and concentrate and do the best job I can for each patient. Every hand problem is different. With a work hand injury (for example), you often only get one chance to get it right when the patient first presents, so you have to make sure that you do the very best you can to make the hand function as best as possible.

"With the hand, usually your work is on display. For someone to have a good hand, they've got to be pain free, all the bits have to function and it has to look good. I really enjoy it."

At his private practice in Hawthorn, the doctor appreciates a broad scope of work. "With hand surgery it covers everything from arthritis, to compressed nerves, cut tendons, amputated fingers, Dupuytren's contracture and burnt hands – every operation is different so there's a huge spectrum there."

The skilled surgeon also takes his work overseas to Southeast Asia, in a completely different environment.

Laos is a landlocked country bordered by Thailand, Vietnam, China, Cambodia and Myanmar. With a population of around six and a half million, it is a

communist state with large amounts of poverty. And with poverty comes a high number of burns victims. Outside of the towns, many people cook with open fires, often exposing themselves and children to flames and boiling water. An unsophisticated electrical supply system also contributes to a significant number of electricity burns.

Philip Slattery has been visiting Laos for the past 11 years as of a member of an Interplast team of volunteers, seeing as many patients as possible who require hand surgery over a very busy fortnight. Interplast is an Australian-based not-for-profit organisation that provides life-changing surgery and medical training in 17 countries across the Asia Pacific region.

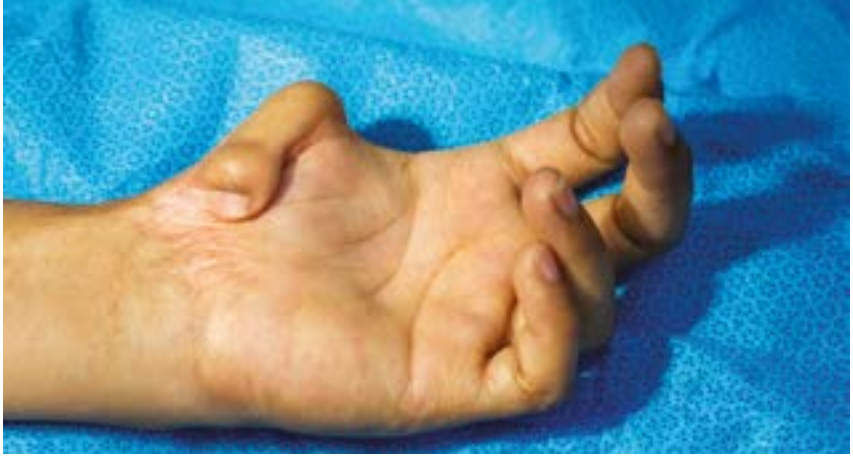
"We go to the capital city, Vientiane. It's a very interesting place, it's a third world, communist country, but it is developing. Interplast has been going there for about 30 years now," he explained. "They don't have a proper burns service and there are so many patients who have suffered severe burns that have been neglected.

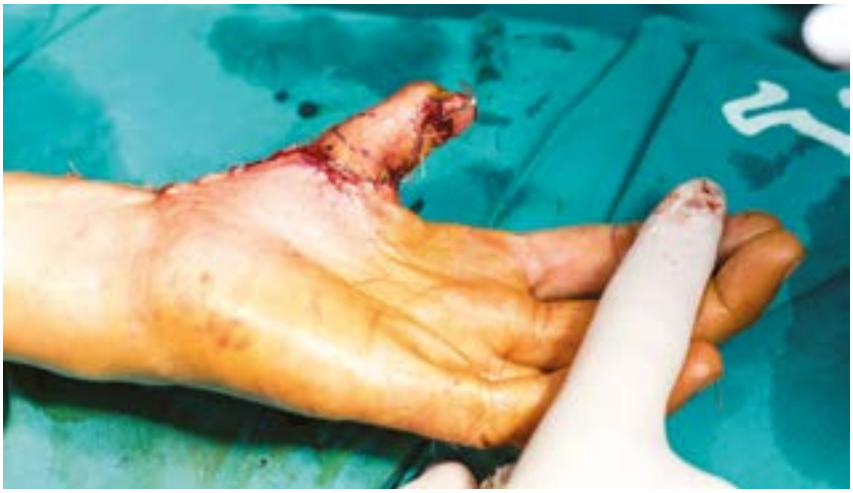
"We are basically doing burns reconstructive surgery. These patients have very major disabilities – they can't use their hands. On a burnt arm or hand, the skin heals up by secondary intention, where it just contracts, so all the fingers get pulled in towards the wrist; and the wrist, elbow and shoulder can become very deformed because of a shortage of skin."

Mr Slattery is the hand surgeon in an Interplast team that also includes another surgeon, two anaesthetists, two theatre nurses, a dressing nurse for the ward and a hand therapist. They also fly-in with 22 boxes of medical equipment.

"During our two-week stint there, we usually average about 60 operations. The aim of the trip is two-fold - firstly as a service to treat as many patients as we can. The other aim is to teach the local surgeons how to operate on these problems as well. Due to language barriers, communication is usually done through interpreters. The locals also complete a fairly basic medical course and just don't have the basic knowledge of anatomy and healing that we have, so we are really starting from scratch. A lot of the surgery we do is fairly difficult involving joint releases and operating around nerves."

The Australian Embassy in Laos usually advertises the Interplast visit two weeks before Mr Slattery and his team arrives. There is a huge demand from the locals.





Pictured opposite page: Mr Philip Slattery (right) with Laos surgeon Dr Khamsouk.
Above: Before and after surgery: an old burn to a thumb causing a severe contracture and inability to use the hand.

"Being a communist country, people still have to pay for their healthcare. When we're not there, they only do a limited amount of surgery, because if patients don't have the money to pay for it, they don't get the operations. When we visit, everything is funded by Interplast Australia and New Zealand. Patients travel from all over the country to see us and some even spend two to three days on a bus just to make it."

Mr Slattery first volunteered with Interplast in 1986 and finds the work in Laos immensely rewarding. "It's really good, we all work together as a team and everyone wants to do the best job they can for these patients. If we don't fix them, they don't get any other chance. Many of them are children who can't use their hands. Without us, they'd just lead terrible lives. We've operated on some adults with hand deformities and then seen them several years later and they're working. The locals are very stoic. They put up with a lot."

Returning to the same place year after year sometimes enables an opportunity to catch-up with previous patients.

"One guy was about 20 (when we operated on him) and for many years had severe bilateral hand burns. He couldn't get his fingers or his thumbs to work – he couldn't even get the zipper down on his own pants to be able to go to the toilet by himself. We operated on both hands and saw him a couple of years later and he was managing very well and had a job. That was a really good win.

"Some of the children with burns had hands like clubs before they had their fingers released. Seeing them again a year or two later with full movement is something you remember."

Mr Slattery enjoys the challenge of the visits and playing a leading role. "It's a whole team effort. The nurses, the anaesthetists and all the support people back in Australia who pack the equipment, and coordinate fundraising. I'm fortunate to be able to do the work but all the people supporting us make it all happen."

The workload in Laos is intense, but when he returns to Melbourne, it's with a feeling of satisfaction. "It's about triple (the amount of hours) we do at home in a fortnight. We usually come back pretty tired, but it's very rewarding. It's far from a holiday."

Barry Levinson

Editor

Annual General Meeting Dinner

AMA Victoria officially welcomed three new Board members at the Annual General Meeting held at the Rialto's Intercontinental Hotel on 3 May.

Dr Vladimir Vizec has been elected for a two-year term, while Mr William Blake and Dr Jillian Tomlinson have both been elected for one-year terms.

Dr Sue Abhary and Dr Sarah Whitelaw have both been re-elected for new two-year terms.

We would also like to thank retiring Board members Dr Robert Conyers, Dr Roderick McRae and Dr Leon Massage for their highly valued insights and outstanding years of service.

The 2016 Annual Report can be viewed on the AMA Victoria website.

Dinner

WITH STATE HEALTH MINISTER, THE HON. JILL HENNESSY

THURSDAY 20 JULY 2017

AMA Victoria invites all members and their guests to an evening with the State Health Minister, Hon. Jill Hennessy.

Jill Hennessy is the Minister for Health and Minister for Ambulance Services in the Victorian Government. Minister Hennessy entered the Victorian Parliament as the Member for Altona District in 2010, and held a number of Shadow Ministerial roles before Labor was elected to government in 2014, including Public Transport, Anti-Corruption, Corrections, Crime Prevention and Women.

Park Hyatt Melbourne 1 Parliament Place East Melbourne	7:00pm Pre dinner drinks 2-course dinner	$40 AMA members $100 Non members

Upcoming Member Events
Reservations at www.amavic.com.au/events

DOCTORS IN TRAINING SUPPER CLUB @ HELLENIC REPUBLIC

JUN 14 Wed

14 June, 2017
6:30pm to 9:00pm

The best way to finish off a hectic day is with good food and good company.

A private dinner has been arranged at the Hellenic Republic in Kew for DiT members to enjoy a traditional greek feast with a modern twist.

CBA FIRST HOME BUYERS SEMINAR @ RGF 385 BOURKE ST. MELBOURNE

JUN 22 Thu

22 June, 2017
6:00pm to 7:30pm

Owning your first home is a daunting process and with the recent federal budget changes for first home owners, CBA's presentation will examine the usual structures that are utilised in purchasing your first home/apartment, and will also examine financial requirements and tips for buying your first home.

WOMEN IN MEDICINE COCKTAIL EVENT @ THE BMW SHOWROOM

JUN 22 Thu

22 June, 2017
6:30pm to 8:30pm

AMA Victoria is proud to celebrate and acknowledge the women that work in medicine.

Our popular Women in Medicine cocktail event this year will be held at the BMW Melbourne Showroom.

PRIVATE PRACTICE ARRANGEMENTS BY TRESSCOX SEMINAR@L9,469 La Trobe St.

AUG 23 Wed

23 Aug, 2017
6:00pm to 7:30pm

Interested in starting your own private practice?
This presentation by Tresscox will examine the usual structures that are utilised in general and specialist medical practices, and will also examine contractual relationships with colleagues, staff, suppliers and other third parties.

BUILD YOUR PRACTICE CONFERENCE AND EXHIBITION@ MCEC

SEP 23 Sat

23 SEPTEMBER, 2017
9:00am - 5:00pm

Stream 1: Build Start-Up.
Stream 2: Build Sustainability.
Stream 3: Build Succession.

Arm yourself with the knowledge, tools and support in developing and managing private practices no matter what stage you are at.
This conference attracts fully recognised industry CPD points for health professionals.

AMA VICTORIA MEMBERS GOLF DAY @ KINGSTON HEATH

OCT 17 Tues

17 October, 2017

Enjoy a day on the green with members at the Kingston Heath Gold Club.

Kingston Heath Golf Club is one of the premier golf clubs in Australia in the sandbelt region in the southeast suburbs of Melbourne.

Catering for all skill levels, this is an event for all members.

Deaths from prescription and over-the-counter analgesics

Over the last decade in Australia, the number of prescriptions for opioid analgesics has dramatically increased, correlating with a concerning rise in opioid-related harms.

Opioid analgesics are among the most commonly detected substances in unnatural deaths in Victoria, comprising a large portion of deaths investigated by the Coroner. They are also increasingly reported in ambulance attendances, emergency department presentations and hospitalisations, as well as mental health and addiction treatment facilities. In addition to the substantial health impacts on the community, the financial costs of opioid overdose to Australians are significant.

While the range of opioids seen in deaths ranges from those available over-the-counter (OTC) to others restricted to post-operative pain relief only, there are a few substances that have raised particular concern among death investigators in recent years; namely oxycodone, fentanyl and codeine.

Oxycodone

Oxycodone has remained one of the most problematic prescription opioids over the past decade in the USA, Canada and Australia. Once boldly marketed as an advantageous formulation providing long-acting analgesia with low abuse potential (resulting in a multi-million dollar fine to Purdue Pharma for misbranding), oxycodone's 'heroin-like' euphoria was responsible for an unprecedented surge in addiction, morbidity and mortality throughout the western world. Between 1999 and 2008 alone, there was a 13-fold increase in the amount of oxycodone prescribed by doctors in Australia. Diversion of these legitimate prescriptions has since presented a major problem, with self-reported illicit injection of oxycodone almost doubling in Australia between 2005 and 2013.

Our recent study examining oxycodone deaths across Australia found that most were unintentional and caused by the co-administration of oxycodone with other depressant drugs, including alcohol, benzodiazepines and other opioids. The findings showed a clear correlation between oxycodone prescriptions and the number of deaths over the study period. Interestingly, of the cases where a legitimate prescription for oxycodone was described, the majority involved an appropriate indication for oxycodone therapy; while we anticipated that oxycodone would predominantly be used to obtain a drug high, this did not appear to be the case. Most people were misusing the drug to achieve better pain relief. This highlighted the need for better pain management in patients, with treatment alternatives to long-term opioid use. Other studies throughout Australia have reported similar trends, indicating diversion and misuse among younger individuals, and misuse for improved analgesia in older chronic pain patients, with the majority of deaths reported as unintentional.

Fentanyl

Fentanyl has presented a more recent problem since its expansion of PBS indications in 2006 to include the treatment of chronic non-cancer pain. It is usually prescribed for chronic opioid users and delivered by slow-release transdermal patches, but is also available as a lozenge or injection. Given its potent opioid effects (up to 100 times more potent than morphine), misuse has become a major problem. Discarded patches retain a substantial dose of active drug, and have been reported as being appropriated from aged care facilities and later chewed or swallowed for drug effect. Some individuals extract the retained fentanyl from patches for intravenous injection. Others extract it from patches prescribed to them. This is a particularly risky practice because of fentanyl's potency and the difficulty of controlling the dose extracted. Other means of misuse include applying multiple patches or applying patches to mucous membranes at either end of the gastrointestinal tract. Child deaths have occurred where a patch has fallen off a co-sleeping parent onto the child.

Fentanyl prescriptions have soared over the past decade, particularly among older Australians. A recent Australian study revealed 136 fentanyl deaths between 2000 and 2011, with a staggering 62% having injected fentanyl at the time of death. It appears that while fentanyl prescriptions are increasing among older Australians, fentanyl diversion is a major problem, particularly among younger injecting drug users.

A recent study of Victorian Coroners' cases indicated that fentanyl has recently been used on the illicit drug market to increase the potency of diluted heroin. Unfortunately this is often not known by the heroin user, leading to unintentional overdose often requiring huge doses of naloxone by treating paramedics and clinicians. In 2015, fentanyl-laced heroin led to the deaths of nine Victorians which occurred in two distinct clusters around Melbourne. There is concern that this trend may also be mirrored in other jurisdictions. There are also reports of clandestinely produced acetyl fentanyl combined with street heroin, which has been linked to a number of fatal poisoning outbreaks in the USA and Canada.

Similarly concerning are reports that carfentanil has hit Australian shores. This ultra-potent synthetic opioid was first developed as a sedative for large animals; it is 10,000 times more potent than morphine with 1 gram sufficient to cause roughly 50,000 human overdoses. Australian healthcare professionals are concerned that it may be used in a similar way to lace heroin for increased potency, which translates to a better price on the street.

Regardless of the contaminants used to cut or lace heroin in the illicit drug market, a recent spike in heroin use and harms in the past couple of years has led to speculation that individuals previously addicted to prescription opioids are transitioning to heroin. Recent rescheduling and greater restrictions placed on prescribing and dispensing of pharmaceutical opioids may ironically mean that heroin is a cheaper and more accessible alternative for addicts, regardless of their initial opioid of choice. A 2015 report by the Centre for Disease Control and Prevention (CDC) reported that the number of fatal heroin overdoses in the USA had quadrupled over the previous 10 years. Given our drug trends generally mirror those in the USA, this presented a major concern for Australia. Unfortunately recent Victorian Coroners Court data indicates that this trend might already be taking form – heroin deaths jumped 20% in 2015 compared with the previous year – an increase equivalent to one extra death each fortnight. However some attribute this rise to changes in heroin markets, providing easier access to cheaper heroin rather than better controls on prescription opioid availability.

Codeine

The availability of codeine in Australia has been the focus of much debate in recent years, particularly in relation to the OTC formulations which are combined with ibuprofen, or paracetamol with doxylamine. While higher codeine doses (>30mg) are confined to prescription only, we are one of the few developed nations that still provides low dose codeine (<15mg) without prescription.

People begin treatment for moderate pain, progress to addiction and escalate tablet consumption to 40-80 tablets a day or more, and many continue despite having serious side effects; some life-threatening. Most disturbingly, there have been a number of deaths associated with misuse of OTC codeine combination painkillers. A recent study showed that deaths in Australia linked to codeine doubled between 2000 and 2009. What was particularly concerning was that unintentional deaths, which predominantly involved a diagnosis of chronic pain and substance abuse, jumped 9% each year, indicating a potential opportunity for intervention. These findings reiterated a conclusion revealed in many studies investigating opioid-related harms – that there is a need for expertise or specialist care in chronic pain, addiction medicine and mental health, when prescribing these potent painkillers.

In addition to increasing codeine-related deaths, there have been increases in calls to poison centres, hospital admissions and emergency department presentations, and opioid replacement therapy for codeine addiction. This has occurred despite rescheduling to Pharmacist Only in 2010. It is these public health concerns and a lack of conclusive evidence that combining low dose codeine with non-opioid analgesics provides additional analgesic benefit that led to the TGA's 2016 decision to reschedule codeine to prescription only from February 2018.

While rescheduling may not be the only answer to reducing the toll of opioid-related harms in our community, it certainly helps, by providing prescribers with an opportunity to change patient treatment to non-opioid alternatives, ultimately benefiting the patient down the track. And in the case of pain patients previously treated with OTC codeine, newer alternatives containing paracetamol ibuprofen, without the risk of addiction and toxicity, are now available OTC.

What next?

Use and abuse of prescription opioids carries a significant dilemma for patients, doctors, and drug policy makers. Our current Medicare structure prioritises quick appointments, which often translates to a drug prescription rather than lengthy consideration of non-pharmacological treatment alternatives. Once the rescheduling of codeine takes effect in February 2018, GPs may be faced with new patients demanding codeine prescriptions. They need to feel empowered to implement treatment programs to help patients taper or cease long-term opioid therapy where it is not indicated.

Treating pain requires a multi-factorial approach treating the patient in pain - not pain in the patient - including physical and psychological therapy, opioid replacement pharmacotherapy, and practical lifestyle changes such as diet, exercise and sleep. Prescribers need a system that supports them to implement alternative treatment programs rather than simply prescribing due to time pressures and patient demands. Avoid sole reliance on opioids.

Opioids are effective when used appropriately, however their use is being increasingly questioned for the treatment of uncomplicated chronic non-cancer pain, and carries significant risks, including addiction, toxicity and death. We need to ensure that people who need opioids for pain have access to them – but prescribers need to be more selective about which patients to prescribe these drugs to; prescribe lower doses and shorten treatment periods.

We also need more research that examines the risk factors for opioid misuse in order to identify ways to reduce demand and minimise harms. It's a long road ahead for patients, prescribers and policy makers to address opioid misuse in the community. But given the alternative is more Coroners' cases attributed to preventable opioid overdose, this is an issue worth tackling.

Dr Jennifer Pilgrim, PhD

Forensic pharmacologist and toxicologist
Head, Drug Harm Prevention Unit
Monash University

References available from the Editor on request.

Registration Standards – Are you complying?

The Medical Board of Australia's Registration Standards set out the requirements that medical practitioners need to meet in order to be registered. With the exception of medical students and non-practising registrants, the following standards apply to all medical practitioners:

- Recency of Practice
- Continuing Professional Development
- Criminal History
- English Language Skills
- Professional Indemnity Insurance Arrangements.

On 1 October 2016, the revised standards for Recency of Practice, Continuing Professional Development and Professional Indemnity Insurance standards came into effect. The revised standards are on the Medical Boards' website at medicalboard.gov.au/Registration-Standards.aspx.

Recency of Practice

Significant changes have been made to the Recency of Practice registration standard with respect to the minimum number of practice hours required to meet the standard. To meet the revised standard, medical practitioners must practise within their scope of practice at any time for a minimum total of:

- four weeks full-time equivalent in one registration period – a total of 152 hours; or
- 12 weeks full-time equivalent over three consecutive registration periods – a total of 456 hours.

Full-time equivalent is 38 hours per week. The maximum number of hours that can be counted per week is 38 hours. Possible consequences for not meeting this standard include imposition of conditions on registration or disciplinary proceedings.

For medical practitioners with non-practising registration or who are not registered, but have two or more years' clinical experience, and who wish to return to practice, the following requirements must be met:

1. No additional requirements are needed for those with non-practising registration or who have not been registered for a period up to and including 12 months.
2. For a period between 12 months and up to 36 months, at a minimum, before recommencing practice, the equivalent of one year's CPD activities relevant to the intended scope of practice must be completed. The CPD activities must be designed to maintain and update knowledge and clinical judgement.
3. For a period greater than 36 months, a plan for professional development and re-entry must be submitted to the Board for consideration and approval.

For medical practitioners with less than two years' clinical experience who are returning to practice after either not having been registered for more than 12 months, or who have not practised for more than 12 months, Board approval for working under supervision in a training position needs to be sought.

The Medical Board has provided further clarification in relation to frequently asked questions on its website at medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-Recency-of-practice.aspx.

Continuing Professional Development (CPD)

The revised standards for CPD requirements have not significantly changed, other than the requirement for international medical graduates (IMGs) to complete a minimum of 50 hours CPD per year – including the CPD outlined in their supervision plan and work performance report. If this totals less than 50 hours, IMGs must complete additional CPD to reach a minimum of 50 hours per year. In the past, there was no minimum hour requirement for IMGs.

The Medical Board has provided further clarification in relation to frequently asked questions on its website at medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-for-CPD-for-IMGs.aspx.

Professional Indemnity Insurance (PII)

All medical practitioners are now required to have appropriate retroactive PII cover for otherwise uncovered matters arising from prior practice undertaken in Australia. This requirement was effective from 1 October 2016.

It is recommended that you contact your medical indemnity insurer to ensure that appropriate retroactive cover is included in your professional indemnity insurance policy.

We encourage you to take the opportunity to review the revised registration standards and frequently asked questions published by the Medical Board of Australia to ensure these are met, especially if an extended break from practice is being contemplated. Guidance on planning leave can also be found on the Medical Board's website at medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-Recency-of-practice.aspx#leave.

Dr Helen Havryk
Claims Manager
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 professional indemnity insurance policy.

An AMA Victoria initiative

FIRST RESPONSE

A free, confidential
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1300 AMA DOC

Improving communication within medicine

Every GP I know has the same frustration. The call to the hospital switchboard. "I'm after some information about my patient's recent admission..." or discharge, emergency department attendance or when they will be seen in outpatients. Followed by the almost invariable irritation of being put on hold or being diverted to a few departments or people before you get to the right person.

At this point you might get "lucky" and be provided with the information you should have received long before and need to provide the care your patient needs. Or you may have to cross the next hurdle – usually done by gentle cajoling as you explain that it really is OK to provide you with the information "because I am the patient's GP", or "but I referred the patient in... even though it may not be on your system". Sometimes it still doesn't work, so you grind your teeth as you organise to send a letter (sometimes only the hospital prescribed form will do the trick) with your patient's written permission to get the information.

Meanwhile your patient is incredulous. "But they said they would let you know," or "don't you all work together?", or "but they told me to come to you for follow-up". At the very best, it's a waste of time and effort by all. At the worst it's dangerous. And somewhere in between is a loss of patient confidence in the system and the overwhelming feeling that there is no healthcare system, just independent pieces and that there is little understanding or respect for your role in it.

Likewise hospitals have their own frustrations – the referral letter for outpatients that asks "please undertake the needful". Add to this little detail on what the problem is, the relevant examination and investigation findings, the management to date and what the objective is of a referral to the hospital. Or the referral letter for pregnancy care that has the "pill" and roacutane listed as medication – really, or does this require urgent follow-up? Or the elderly patient who has to wait hours at their outpatient appointment because the referring GP didn't let the hospital know an interpreter was required.

Each one of us on the AMA Victoria GP Section has had too many of these experiences over too many years. As a GP who works in both community general practice and in a hospital, I have seen both sides of the coin. As such we have recently developed and had endorsed by the AMA Victoria Board *10 Minimum Standards for Communication between Health Services and General Practitioners and other Treating Doctors*. It outlines minimum standards for a range of issues, including the quality of a referral from a GP to a health service, the capture of a patient's GP details by a health service, timely and appropriate provision of information about care and appointments and discharge care planning.

To guide health services as they develop their eHealth systems it also includes a standard for expectations for electronic information transmission to and from GPs. The AMA is in the process of promoting the standards to relevant stakeholders. Take a look on the following page and let me know what you think by emailing ines.rio@optusnet.com.au. If you like it, please refer to it and spread it around.

Dr Ines Rio

Chair, Section of GP
AMA Victoria

Twitter: @InesRio1

10 Minimum Standards for Health Services and General Treating Doctors

Standard 1: Referral information from a practitioner to a health service

A referral to a health service includes information for an assessment of the need for care in their setting, triage, and the requirements for the patient's access to the health service.

Elements of this information include, where appropriate to the needs and circumstance of the patient:

- demographic and contact information.
- reason for referral to the health service.
- findings, investigations; medical summary, medicines and allergies.
- an Advance Health Care Plan (when appropriate).
- the person's need for interpreter and cultural support.
- any disability support needs, including advocates and/or alternative decision makers.

Supporting standards and corroborating guidelines for this Standard are:

- The RACGP Standards for general practices (4th edition) Criterion 1.5.2 Clinical handover.
- The RACGP Standards for general practices (4th edition) Criterion 1.6.2 Referral documents

Standard 2: General Practitioner Details

The name and contact details of a patient's General Practitioner and/or practice is verified and updated on the patient record at each episode of care by the health service.

The preferred criteria is the name of the General Practitioner, while the minimum criteria is the name of the practice.

Standard 3: Supported Access to a General Practitioner

When patients do not have a regular General Practitioner, the health service has a process to support patients to locate a General Practitioner and/or practice and to attend for follow-up care.

Minimum criteria for the process includes:

- Relevant staff have access to up to date contact details for General Practitioners for their catchment area.
- Assistance is available for the patient to choose a General Practice and to make a follow up appointment.

Standard 4: Timely Communication

The health service has a system for timely communication directly to a patient's General Practitioner and other treating doctor(s) on the conclusion of every episode of care, after sentinel events and periodically during ongoing care.

Criteria for timely formal communication:

Circumstances/Timing - Within 24 hours

- Unplanned inpatient admission
- Discharge from an inpatient admission
- After attendance at an emergency department or short-stay setting
- On patient death or other sentinel events

Circumstances/Timing - Within 7 days

- Initial Specialist outpatient consultation
- Changes in health status or medication at a specialist outpatient service
- Discharge from Specialist outpatient clinic

Standard 5: Handover back to a General Practitioner

The health service provides General Practitioners with clear and appropriate information to support safe and meaningful clinical handover of patient care.

Supporting standards and corroborating guidelines for this Standard are:

- National Safety and Quality Health Service Standards Standard 6 – Clinical.
- AMA Position Statement - General Practice/Hospitals Transfer of Care Arrangements – 2013.

Standard 6: Information Transmission

The health service has secure and reliable electronic systems to send and receive information to and from the health service and General Practitioners and other treating doctor(s).

These should interface with patient information management systems commonly used by General Practitioners and other treating doctors in private or community clinic settings.

Standard 7: Outpatient services intake and appointment systems

Specialist Outpatient Services have transparent intake and appointment systems that provide appropriate information and notifications to patients, General Practitioners and other treating doctor(s).

Communication between Practitioners and other

Minimum criteria include:

- a single point for referral to all specialist outpatient services.
- a publically available system that informs patients and referring doctors of the expected wait for various outpatient specialist services.
- a tracking system to enable patients and referring doctors to determine the prioritisation and status of a given specialist outpatient referral.
- clear, timely and responsive administrative and clinical processes, triggered by notification from a General Practitioner/referring doctor to review the scheduling of a patient's appointment according to clinical circumstances.
- referral from doctor acknowledged within 3 working days of being received.
- a patient's non-attendance of an appointment is notified to referring doctor within 3 working days.
- re-scheduling or cancellation of an appointment initiated by the patient or the health service is notified to a referring doctor within 7 working days.

Standard 8: Outpatient Services Communication

There is a system for ongoing and timely clinical communication about patient care between a health care service's Specialist Outpatient Services, other ambulatory and day services and the patient's General Practitioners and other treating doctor(s).

Minimum criteria include systems:

- for the receipt of updating advice from the General Practitioner or referring doctor about the patient's progress, changes in management, clinical condition or care requirements.
- to enable scheduled secondary consultation with or without the patient directly present at the health care service or general practice.
- to enable telehealth outpatient consultations from the General Practitioner's Clinic when the patient resides in a rural or aged care residential setting.

Standard 9: Discharge Planning Processes

The health service has discharge care planning processes for patients with complex needs that involves their General Practitioner and other treating doctor(s).

Minimum systems for discharge planning processes for patients with complex needs include:

- the ability to undertake telephone, video conference or face-to-face case conferencing prior to discharge that includes the General Practitioner and/or referring doctor.
- outpatients appointment date (if required) scheduled prior to discharge.
- a documented plan of care and support to be provided to the General Practitioner in addition to discharge summary if Post-Acute Care services are put in place.

Standard 10: Managing Quality

These standards are incorporated into the Policies and Quality Systems of General Practices and Health Services.

Minimum requirements include incorporation of requirements for:

- documentation of policies, procedures, systems and processes that support the attainment of these Standards.
- appropriate Quality Indicators for these requirements are developed, which enable performance monitoring and the measurement of performance improvement initiatives.

To view the full document and a list of references, visit amavic.com.au/policy-and-advocacy/10-minimum-standards-for-communication

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call 1300 853 338

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8.00am-10.00pm

(for the cost of a local call)

AMA Victoria is working to improve conditions for all doctors

AMA Victoria is working hard to support a safe work environment and work/life balance for doctors in current negotiations for changes to the Enterprise Bargaining Agreement. The claims we have made in support of this include:

For all doctors

- Payment for online/telephone consultations
- Backfill of positions when entitled to leave
- Clinical support time protection and clarification
- Strengthen the 'right to request' flexible working arrangements including job share
- Job sizing to ensure proper allocation of duties
- Child care support when working nights
- Administrative support provided where more efficient to do so
- Improve safe hours' clause with protocol and definition

For specialists

- Limitations on unilateral variation to VMO hours and work patterns
- Unsociable hours penalty allowance
- Increase 12.5% shift penalty to 50% until midnight then 100%, night shift allowance
- Ordinary hours can be worked over four days per week

For doctors in training

- Maximum daily hours of 16 other than at the request of the doctor
- 10 hour break to occur between work on one day and the next
- Ordinary hours can only be averaged over a pay fortnight
- Mandatory break of 48 hours when moving between rotation hospitals
- Restriction of night shifts to no more than seven days straight
- Minimum 48 hours break after coming off a night shift
- Conditions for job sharing / part-time
- Annual and conference leave at times of employee request
- If on leave, hospital will be responsible for swapping doctor out of 'on call' roster

Setting the Standard on bullying and harassment

AMA Victoria has been at the forefront of addressing bullying, discrimination and harassment in the medical profession.

In 2015 we held a summit aimed at shifting the culture of the medical profession to realise its potential. The outcomes included:

- Raising awareness of the need to change
- Pushing for accountability in hospitals
- Setting up our First Response hotline to assist doctors facing workplace bullying, discrimination and harassment.
- The establishment of the Setting the Standard strategy in 2016.

Change and courage needed to tackle mental illness in medicine

Let us begin with a straightforward proposition: that it is unacceptable for the demands of work and training to be contributing to the suicides of junior doctors.

Of course, every individual scenario is complex. It is not our place to pry further into the personal lives of those in our profession who have so tragically taken their own lives this year. Work as a doctor may not always be the sole or even the dominant contributor. But we would be naïve to think that the reality of medical training does not play any role at all in exacerbating mental illness.

Because sadly, the news that doctors and medical students suffer a comparatively higher burden of mental illness is not new. The 2013 *beyondblue* National Mental Health Survey of Doctors and Medical Students reported 12.3% of interns and 12.4% of trainees surveyed had suicidal thoughts in the previous year.

That is one of every 10 interns you see scurrying around a hospital attending to patients while managing seemingly endless administrative tasks. One of every 10 physician trainees working regular unpaid overtime and then using their remaining waking hours studying for looming exams. One of every 10 unaccredited surgical registrars working even longer hours with the suffocating knowledge that they swim amidst a tsunami of graduates who the training system was unprepared to support.

As members of the medical profession, it is very much our place to deeply contemplate the way in which the demands of employment as a junior doctor can drive bright and capable young women and men to end their lives. It is our place to call out the unreasonable rostering, the lack of flexibility and the training bottleneck. It is our place to identify the contributory factors, and to raise them at all levels from hospital administration to Federal Government, as a matter of urgency.

Because it is unacceptable that lives have already been lost.

We must begin to ask frank and sometimes difficult questions. How do some workplaces and training programs sink vulnerable individuals into the depths of mental illness? What support services exist to pull those who suffer from mental illness back into good health? And what barriers may prevent people from accessing these services when they need them the most?

It could be a misallocation of resources that results in some units being unmanageably understaffed while others are overstaffed. It could be inflexible rosters that force doctors to sacrifice and neglect their personal lives on a regular basis. It could be a lack of investment into training places that leave intelligent, conscientious doctors feeling like there may not be any light at the end of their training tunnel. It could be the fear of accessing support services in case confidentiality is breached, or in case one's registration comes into question.

There is not enough space here to explore all the possible answers. Individually, each point is complex. Training must be difficult to ensure the quality of trainees. Some training positions may be scarce because community need is not high enough. Hospital budgets are tight, and sometimes reinforcements simply cannot be found for understaffed units. And reporting doctors with mental illness is ultimately aimed at maintaining public safety.

But rather than succumbing to such counterarguments, perhaps we ought to dig deeper to find more nuanced solutions. There are certainly examples of healthy workplace policies in many hospitals – we should champion and emulate these. It is our duty to our colleagues to do so. Because it is unacceptable for the demands of working in this profession to be a contributing factor to the suicide of any junior doctor. Change is needed, and we must demonstrate the courage to make difficult changes for a far more noble cause than the tightness of hospital budgets: the lives of this country's medical trainees.

Support services for doctors

AMA Victoria provides peer support for doctors by doctors. For anonymous and confidential support call the AMA Victoria Peer Support Service on 1300 853 338 (for the cost of a local call). It's available 365 days of the year from 8am to 10pm.

The Victorian Doctors' Health Program (VDHP) is a confidential service for doctors and medical students who have health concerns such as stress, mental health problems, substance use, or any other health issues. Sensitive to the needs of doctors and medical students, it's a non-judgmental service dedicated to improving the health and wellbeing of those within the profession. Call (03) 9495 6011.

First Response is a free, confidential telephone support service for all Victorian doctors who may be facing workplace bullying, discrimination or harassment. First Response is part of AMA Victoria's strategy – Setting the Standard. For support, counsel or advice on your rights and options, call First Response on 1300 AMA DOC (1300 262 362).

The AMA has a crucial role to play in this space. In January 2015 we, as a community, had a discussion on mental health in medicine in sadly similar circumstances. Let us hope that we are not discussing this same issue again in a year or two years' time without having seen tangible change.

Dr Kunal Luthra

President

DiTs subdivision

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The good news is that as an AMA Victoria member, you are entitled to use our free AMA Auto Solutions service – our buyers' advocate and auto tendering service tailored especially for our members. AMA Auto Solutions makes the process of buying a car incredibly easy. Since launching in early 2016, AMA Auto Solutions has already saved members hours of time, and on average, thousands of dollars off the retail price of their desired vehicle.

Each month, around 20 members receive unbiased, qualified advice on what vehicle they should purchase. Because AMA Auto Solutions is a buyers' advocate service, members are assured that the advice offered, as well as the tenders presented, are the absolute best available.

AMA Auto Solutions guides members through the pros and cons of any desired vehicle and even finds the best financing options based on the member's financial circumstances. Once a vehicle has been chosen, AMA Auto Solutions then tenders out the desired model to dealers throughout Victoria – ensuring that every buyer receives the best price possible.

Even members sceptical of vehicle tender services have been pleasantly surprised at the service offered. This included one salaried medical officer who carried doubts about whether he would be offered any significant saving from the service after receiving what he considered to be a good quote from a prestige German car dealer. After enquiring through AMA Auto Solutions, the member was quoted $9,000 less than his initial quote! Plus AMA Auto Solutions showed the member how he could save even further by salary packaging his vehicle.

Another member saved over $5000 on her new Mazda SUV, and praised the support she received from AMA Auto Solutions in helping her negotiate with her dealer.

If you're thinking of buying a new car, why not try out AMA Auto Solutions? Simply visit autotender.com.au/amav/ or call (03) 9280 8722 for more information.

AMA VICTORIA

proudly presents

MEDICAL CAREERS EXPO 2017

AMA Victoria's Medical Careers Expo was held at the iconic Melbourne Convention Centre on 29 April 2017. It was a wonderful experience especially for AMA Victoria to have over 1,000 attendees to our Medical Careers Expo this year.

The Medical Career Expo is an annual milestone event in the AMA Victoria calendar and attests to AMA Victoria's continued commitment to the profession as it ensures medical students are afforded the opportunity and convenience to find out what employers are looking for in their selection of prevocational doctors.

The flurry of attendees moving between the speaker sessions and exhibition hall across the day provided the perfect backdrop to the Medical Career Expo with every opportunity to meet, greet and listen maximised by all with the occasional break to take a 'selfie'. Take a moment to view the selection of photos!

AMA Victoria is proud of the strong support from our medical students and professionals, speakers, hospitals, health services, colleges and professional services. Through this support, the Medical Careers Expo continues to be the leading event for medical students in Victoria. We look forward next year's event!

Updated handbook clarifies confusion on new asthma and COPD drugs

Development of treatment plans for asthma has become easier for general practitioners, with the newly updated Australian Asthma Handbook clarifying facts on the latest medications on the market for asthma and chronic obstructive pulmonary disease (COPD).

Released in late 2016 by the National Asthma Council Australia, version 1.2 of the Australian Asthma Handbook has been developed by an interdisciplinary team of medical experts and incorporates feedback from primary care providers.

"New asthma and COPD drugs have come on the market over the last two years, and doctors have expressed confusion about when to use which medication as well as the long-term safety of various options," Professor Amanda Barnard, Chair of the National Asthma Council Australia Guidelines Committee and General Practitioner said.

"The updated Australian Asthma Handbook provides factual information on all the latest medications, including what conditions they treat, how they differ from existing drugs and clarification of their suitability for long versus short-term use."

Building on the handbook's ground-breaking online publication format, the update also includes new website features, including printable PDFs of each section of the handbook.

Alongside the handbook revision, the National Asthma Council Australia has updated its popular Asthma and COPD Medications wall chart. As well as including all the latest inhalers available in Australia, the updated version specifies each medication's current PBS reimbursement status for asthma and/or COPD.

A new Allergic Rhinitis Treatments wall chart has also been developed in the same style. The new chart shows the main intranasal treatment options available in Australia for allergic rhinitis. Effective management of allergic rhinitis is an important component of good asthma control. Prescription-only, pharmacy-only and non-prescription products are all included.

These two wall charts are intended as useful education tools for health professionals to help with identification and explanation of different treatments.

Highlights of the updated Australian Asthma Handbook (version 1.2)

1. **Consensus advice against use of e-cigarettes,** recommending that people with asthma should be discouraged from using e-cigarettes, even for smoking cessation, until further evidence on the risks is available.
2. **Clarification of rationale for long-term use of low-dose inhaled corticosteroids,** emphasising that this is the recommended treatment for most adults with asthma and aims to reduce risk of flare-ups, even if day-to-day symptoms are infrequent.
3. **Evidence-based advice on the roles and uses of new add-on treatment options,** including mepolizumab, omalizumab and tiotropium, plus new specific allergen immunotherapy preparations
4. **Update of inhaler technique and spacer priming advice** to reflect the Asthma Council's recent information paper on this topic, noting that most patients do not use inhaler devices correctly, providing guidance on how to improve patient technique, and introducing a new table to help clarify which spacers require priming before first use.
5. **Increased emphasis on written asthma action plans,** highlighting the central recommendation that every adult and child with asthma should have a personalised written asthma action plan

PDF copies of the Asthma and COPD Medications wall chart and Allergic Rhinitis Treatments wall chart are available from nationalasthma.org.au

The updated Australian Asthma Handbook version 1.2, including a full list of amendments, is available from asthmahandbook.org.au

The corresponding Quick Reference Guide v1.2 is also downloadable as a PDF from the website.

National Asthma Council Australia

The National Asthma Council Australia maintained strict editorial independence in developing these resources. The handbook's revision was partially supported by unrestricted educational grants from sponsors AstraZeneca, Mundipharma and Novartis. Revision of the Asthma and COPD Medications chart was supported by AstraZeneca, Boehringer-Ingelheim, GlaxoSmithKline, Mundipharma and Novartis. Development of the Allergic Rhinitis Treatments chart was supported by Meda Pharmaceuticals.

Rescuing refugees at sea with Médecins sans Frontières

Dr Rachel Tullet is a medical doctor with Médecins sans Frontières (MSF). She first joined MSF in 2009 and has recently returned from a one month assignment on board the MSF Mediterranean search and rescue boat, the Bourbon Argos. Dr Tullet is based in New Zealand and has a Fellowship in Wilderness Medicine.

Médecins Sans Frontières (MSF) Australian doctor, Rachel Tullet, treating a patient on board the MSF Bourbon Argos. Copyright: Sara Creta/MSF

Can you explain the MSF search and rescue operations and your role on board the Bourbon Argos?

In 2016 alone, 200,000 people risked their lives at sea to get to Europe. With the closure of the Balkan road, the extremely dangerous Central Mediterranean is now one of the last ways to reach Europe. By June last year more than 2,800 people died at sea, 1,000 more than in the same period last year.

MSF currently has teams on three search and rescue ships – the Bourbon Argos, the Dignity and the Aquarius which is operated in partnership with SOS Méditerranée – that are prepositioned in international waters north of Libya and actively searching for boats in distress. Our medical teams are made up of doctors, nurses, and midwives, as well as non-medical staff (logisticians, water and sanitation experts, cultural mediators) that provide lifesaving emergency care as well as treat dehydration, fuel burns, hypothermia and skin diseases.

On the Bourbon Argos we were a team of 11 from Italy, Norway, Sweden, Czech Republic, US, Canada, France, UK and NZ. As the medical doctor I worked closely with the midwife, nurse and project medical referent to provide emergency medical care during the rescue and following journey to Italy. We also coordinated with onshore medical services in Italy to refer patients for further care if needed.

Often we would have around 500 people on board. So there was no shortage of jobs to be done to keep the whole project running, including the massive clean-up operation of the deck and bathrooms once everyone was off the boat.

How did you prepare for the project?

I have previously worked as a ship's doctor on expeditions to the Southern Ocean and Siberia, and enjoy living at sea. I was pleased to find the Mediterranean waves were smaller!

What would a typical day involve?

Rescues went in cycles. We would typically leave port in the evening and sail through the following day to arrive in the search and rescue area near Libya by the morning of the next day. This search area is in international waters, close to known departure points from where people smugglers launch boats. The MRCC (Maritime Rescue Coordination Centre) in Rome relays information and coordinates all the rescue boats in the area.

Once a boat in distress is identified our rigid inflatable boat launches to go alongside. The boats are very overloaded and of poor quality, and were often already taking on water. The team provides reassurance and life-jackets – it is essential to keep people calm.

On my first rescue we received 649 people on board, from only five boats. One by one people are brought onto the Bourbon Argos and welcomed. Most have no possessions with them, and their clothes are soaked with seawater. All are given a backpack containing clothes, soap, a blanket, food etc.

The journey to Italy usually takes two days and nights, arriving into a designated port in the morning. Disembarkation procedures are complex and long, before everyone is sent to reception centres either in the port of arrival or to a different location in Italy. Then it's time to clean and prepare the boat for the next rescue.

What were the medical needs for those people who were rescued?

The Bourbon Argos has a specially designed hospital on the deck made from converted shipping containers. Guests are triaged on arrival to identify those needing immediate medical care. All are exhausted, dehydrated, and in pain from being cramped inside the boat. Seasickness, respiratory tract infections, and puncture wounds to the soles of the feet from metal spikes in the rubber boats were common.

Fuel spills cause chemical burns and the women are especially at risk as they are often sitting in the bottom of the boat. Once the serious cases had been identified and treated, I worked with the nurse and midwife to do outpatient rounds on the deck. This was the first time that many of those on board had seen a doctor, and the burden of acute and chronic illness is high. There were many old injuries – poorly healed fractures, soft tissue injuries, scars from stab and gunshot wounds. Special care was given to the babies, children and women. We were able to offer medical care and support in a quiet environment, for women who had suffered gender-based violence.

For those who had been forcibly imprisoned and abused the process of restoring human dignity and control over their basic human rights was especially important, and the MSF team worked hard to provide an atmosphere of care and safety.

Top: Dr Tullet treating a patient on board the MSF Bourbon Argos. Middle: Dr Tullet (right) with MSF colleagues. Bottom: Lucie Brazdova, a midwife with MSF aboard the Bourbon Argos gives a consultation. Copyright: Sara Creta/MSF.

Are there any people you rescued who really made an impact on you?

Honestly every single person we rescued made an impact, as I thought about the potential for these lives to have been lost.

Some people wanted to talk and I listened to stories of family members being killed, separation from children, torture, and overwhelming feelings of being powerless to escape. For others the pain was obvious to see even without words. I wished that they would be going to a situation where their physical and emotional health needs could be fully assessed and treated. A mother who had travelled with her three young girls said 'I want my family to have a chance to live in peace. What else is there?' I couldn't agree more.

At MSF, we're calling for safe and legal alternative passages for refugees and asylum seekers so they aren't forced to risk their lives at sea. There should also be adequate, dignified and human reception conditions.

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Unfair dismissal

Having an unfair dismissal application served against your practice can be a stressful time. While you can never stop an ex-employee lodging an application for unfair dismissal you can minimise the prospect of a successful application and increase the chances of a case being dismissed by the Fair Work Commission (FWC).

If an employee is at risk of being dismissed, ensure a proper protocol is followed and supported by your practice policies and procedures. Staff should be provided with a copy so that they know when their behaviour may lead to disciplinary action or termination of employment.

Small businesses – those who employ, on head count, less than 15 people including casual employees who work on a regular and systematic basis – will not have unfairly dismissed an employee if the dismissal is consistent with the Small Business Fair Dismissal Code. The code prescribes a number of procedural requirements for dismissing an employee:

- The employer must give the employee a reason why they are at risk of being dismissed. The reason must be valid and related to the employee's conduct and/or capacity.
- The employee must be warned verbally or preferably in writing that there is a risk of dismissal if there is not an improvement.
- The employer must provide the employee with an opportunity to respond to the warning.
- The employer must allow a reasonable chance for the employee to rectify the problem, while having regard to the employee's response. Providing additional training and support and explaining the expectations of the job to the employee can help assist an employee to improve their performance.
- The employee may have a support person present at the meeting, however, the person must not be a lawyer acting in a professional capacity.

The code is a valuable guide to dealing with employees who may be facing termination of employment.

What happens when you are served with an unfair dismissal application?

To make a claim, the ex-employee must lodge their application within 21 days of the dismissal taking effect. Once the ex-employee makes an application to the FWC, the matter is listed for conciliation and a copy of the application is sent to the employer.

An employer must respond to the FWC within seven days of receiving the ex-employee's application. An AMA Victoria Workplace Relations Adviser can assist you with compiling a response to the application and submit any jurisdictional objections you may have to the claim. The response must include:

- the dates the employee started work, was dismissed and finished work
- reasons for dismissing the employee
- your response to the employee's arguments about why they think the dismissal was unfair
- any jurisdictional objections you wish to raise
- your signature.

You should also include copies of any supporting documents such as relevant policies, written warnings and the letter of dismissal. A copy of the response is then sent to the ex-employee and to the FWC.

At conciliation (usually held via teleconference), the conciliator will try to help the employer and the ex-employee resolve the matter. If the matter is resolved, both parties will be asked to sign a Deed of Release setting out the negotiated settlement.

If the application cannot be resolved at conciliation, the matter will go to a formal hearing or conference. This involves both parties making submissions and giving sworn evidence, and provides an opportunity to challenge or cross-examine the other party's evidence. The outcome will be decided by a member of the FWC and will be binding for both parties.

Members seeking assistance with unfair dismissals should call AMA Victoria's Workplace Relations Unit on (03) 9280 8722.

Aspa Papas

Workplace Relations Officer

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amainsurance.com.au to learn more...

Doctors in Training: Registrar training time

AMA Victoria constantly receives phone calls from Doctors in Training asking about access to training. The AMA is currently in dispute with a number of health services over the way they are interpreting registrars' right to five hours of training per week. We felt it was timely to remind doctors of their rights in this regard. Training time applies to ALL registrars in the Victorian public health service, whether or not you are in a training position.

Training time is a very important benefit for registrars as it gives them paid time to complete their training requirements in order to become fully trained specialists and better doctors. The intention of the training time clause is for doctors to have access to five hours a week free from service. It is not intended to be a device for hospitals to get an extra five hours of work from doctors without paying overtime.

The AMA Victoria DiT Agreement 2013 (the Agreement) is very explicit in its definition of what constitutes training time. The following are some of the most important aspects:

- training time must be agreed between a doctor and the hospital
- training time must be shown in the roster
- training time must be free from service, this means that you should not be required to see patients during this time unless there is a genuine medical emergency
- where a doctor is unable to attend training due to an emergency the time must be reallocated.

The Agreement is clear about the obligations of the hospital and there are severe penalties for both the hospital and individual managers who do not comply with these obligations. But this means nothing unless a doctor is prepared to enforce their rights under the Agreement. If you are not receiving your five hours off service training time as required above you should raise this with your training supervisor in the first instance or you can come directly to AMA Victoria. If you are not satisfied with the response then you are entitled to escalate the matter with the assistance of the AMA.

If you have any questions about this or other rights in the Agreement please contact the AMA Victoria Workplace Relations Team on (03) 9280 8722 or amavic@amavic.com.au.

The clause from the agreement is below. You will see this has much detail about what constitutes training time. Please take the time to read and understand what this means for you.

11.24 Training time means: time dedicated for training that is free from service calls, with the exception of calls about genuine medical emergencies or disaster situations, as follows:

11.24.1 Training time is five (5) hours per week and it is expected that blocks of training time will be at least 30 minutes duration on each occasion.

11.24.2 Training time can include lectures, tutorials, other situations where formal teaching of the hospital registrar(s) occurs in a non-service situation, clinical meetings organised by a specialist or university staff equivalent for the purposes of training and education, personal reading and study, and research activities where a hospital or university staff specialist is directly involved in supervision and the results of the research are intended for publication. Grand (teaching) ward rounds can be included if specifically designed for teaching purposes and attended and run by an eminent medical person.

11.24.3 Where training time is interrupted due to a genuine medical emergency or disaster situation, then that period of interruption is not training time and must be reallocated.

11.24.4 Current training time protocols in hospitals should at least reflect the following factors:

(a) the content of the training must be agreed between the doctor and the hospital and can be on or off site

(b) blocks of training time must be identified in the roster

(c) a doctor may agree to participate in unplanned or impromptu training opportunities which may be considered to be part of the doctor's training time

(d) any change to rostered training time shall be recorded in writing by the hospital

(e) where practicable the hospital should implement procedures to limit the interaction a doctor has with other hospital employees and/or administrative obligations during allocated training time

(f) hospitals should consider practises that assist in the provision of training time for the doctors who are rostered on nights or weekends.

Grant Forsyth

Workplace Relations Adviser

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AMA-EH Embley Memorial Medal

At the Monash University Health Sciences Student Awards Ceremony held in April 2017, Ms Nasreen Bahemia was presented the AMA-EH Embley Memorial Medal for her work in preparing the best essay in anaesthesia for 2016, during her third year medical studies.

Ms Nasreen Bahemia with AMA Victoria Vice President Dr Xavier Yu.

Nasreen is currently studying her fourth year in medicine at Monash University and undertaking clinical placements at Bendigo Hospital. She is an international medical student from Mauritius, having been awarded a State Of Mauritius National Scholarship Laureate in 2012. Nasreen is passionate about global health, especially access to healthcare in developing countries. Her medical interests include cardiology, endocrinology and anaesthetics. She enjoys badminton and writing in her spare time.

Nasreen's award-winning essay, "A Brief Overview Of Intra-Operative Hypotension", discussed the peri-operative and intra-operative issues surrounding the use of controlled hypotension and the factors relating to the incidence of undesired intra-operative hypotension (IOH), including patient-related, anaesthesia-related or surgery-related factors.

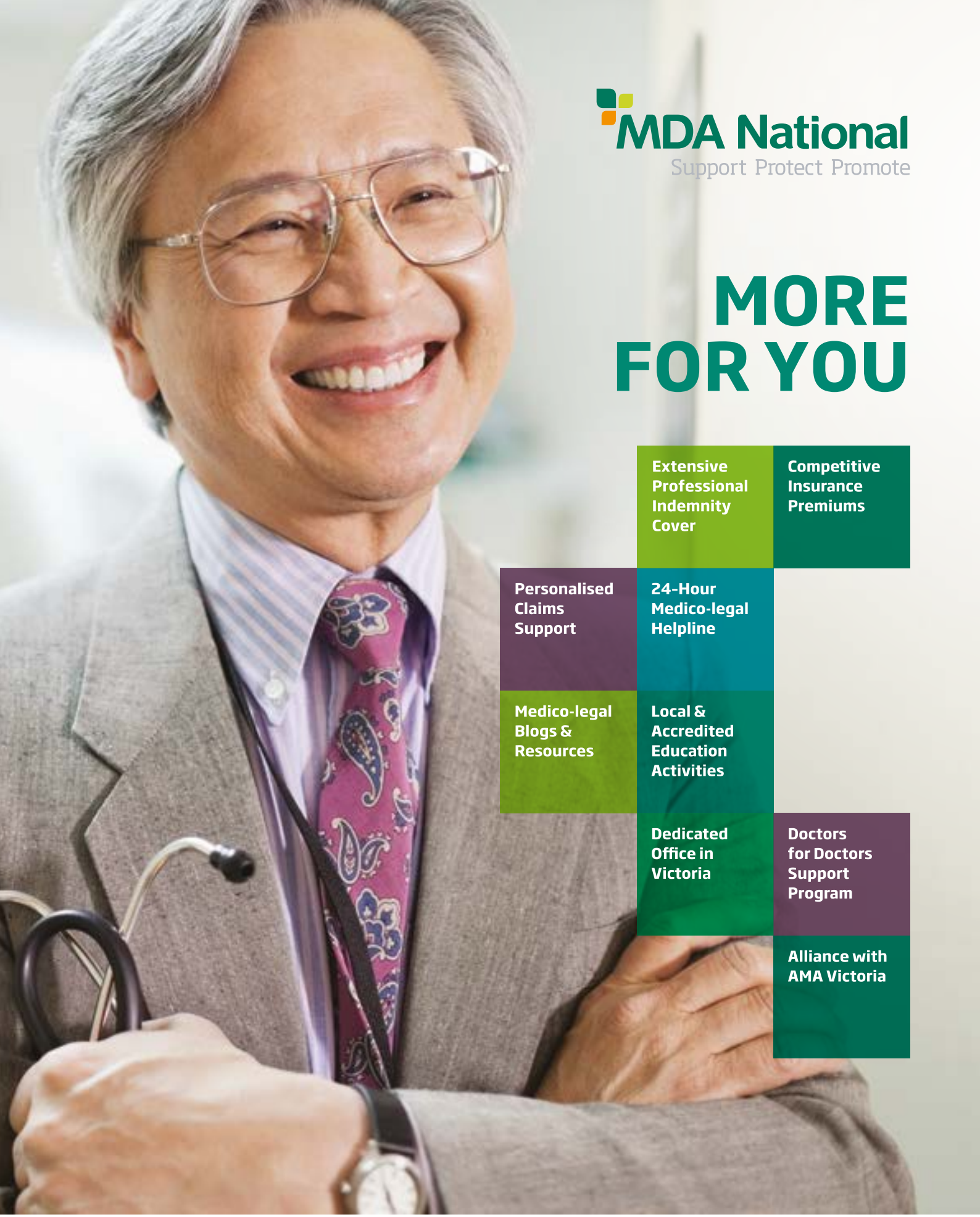
As well as a receiving the gold medal, Nasreen was also the recipient of $500 from the EH Embley Memorial Trust Fund. The prize is awarded to a medical student for the best case report or essay related to anaesthesia, pain medicine or perioperative medicine.

About the award

Henry Embley trained as a pharmacist before undertaking medical training at the University of Melbourne, graduating in 1889, and establishing a general practice. In the late 1890s, seeking a purer form of ether for anaesthesia than was then available, he started working part-time in the University of Melbourne Physiology Department with CJ Martin. This led to an interest in the cause of death in chloroform anaesthesia, and eventually to original research.

The research refuted the claim that death during chloroform anaesthesia was due to respiratory failure and instead demonstrated that the action of chloroform on heart muscle was to blame. In 1895, Embley was appointed Honorary Anaesthetist at the Melbourne Hospital and in this capacity gave instruction to University of Melbourne medical students until his resignation in 1917.

Embley was the first recipient of the David Syme Prize for Research in 1906 and after his death in 1924, the EH Embley Memorial Medal was established. In 1929, the Council of the British Medical Association Victorian Branch (now AMA Victoria), 'with a view to perpetuating the memory of Professor Embley and at the same time forwarding the advancement of medical science' solicited subscriptions to a trust fund for the delivery of lectures triennially on recent researches, principles and practices in anaesthesia. It also provided a gold medal to be offered annually for competition among undergraduates in medicine in Melbourne in some test of knowledge and skill in the science and practise of anaesthesia.



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Inside Bendigo Health's patient transfer

The new Bendigo Hospital at night.

On January 24, 2017 Bendigo Health moved into its brand new $630 million hospital. 174 patients were moved in under six hours. This milestone was the culmination of years of lobbying, planning, designing and building the new hospital.

It was a complicated move that required additional staff and volunteers to be rostered on. More than 20 patient transport vehicles were available to assist with transferring patients between the two sites. Traffic management was in place around the precinct and the community had been politely asked to refrain from visiting the precinct on the day unless they required urgent medical attention.

The patient mix was complex with patients from acute, subacute and psychiatric services moving into the one facility. The move also involved labouring women, special care babies, intensive care patients and a mix of patients across both the lifespan and various specialities. To assist with the move, no outpatient appointments were scheduled on the day and patient numbers were reduced in the days leading up to move day to ensure we moved as few as was practical.

An Emergo train simulation of the move was run five months prior to identify any weak areas in the planning that required improvement and to help prepare staff for their roles on the day. This was followed up with a real time simulation of the first three hours of move day, including a rehearsal of the go/no go decision for the executive team so that everyone felt secure in both the planning and the execution.

With months of familiarisation sessions, scenario training in clinical areas and training on new equipment, finally patient move day was here. The emergency department on the old site closed to new patients at 8am and the new emergency opened at the same time, so for several hours we operated two emergency departments. The very first patient to arrive at the new hospital was a new presentation in an ambulance, which was one of the many things that we could not plan for on the day.

Top: Nurse Mel Patching with patient Shirley Gaul after the Bendigo Health patient transfer
Bottom: Tammy Brown (left) and her baby Jordana, with Benidigo West MP Maree Edwards, Bendigo East MP Jacinta Allan and Bendigo Health Board Chair Bob Cameron.

The control room was set up in the new hospital boardroom with a number of key staff located in the room for the day which was led by Clinical Move Director, Robyn Lindsay. The room had a screen displaying patient numbers and transfers in real time with patients moved from the old hospital discharged to the 'in transit' status and then readmitted to the new hospital once the transfer had been completed successfully. A second screen provided live streams from several CCV cameras in the new hospital, allowing the team to see patients moving and to monitor any access issues or blockage points.

Communication from the control room to on site 'Move Leads' at each campus was coordinated through the WhatsApp mobile messaging application, facilitating two way communication between key personnel.

The day progressed very smoothly and the full patient transfer was complete in under six hours. It was a day of mixed emotions with staff saying goodbye to their work homes of many years, buildings where babies had been welcomed and people had died. Staff said goodbye in different ways and a photographer and videographer were on hand to record it all.

The patient move finished with an impromptu avenue of honour for the final patient, a five-month old baby boy. Some 200 staff and volunteers clapped as he passed by and with that, it was all over and the decommissioning of the old wards could begin.

To see our video of the day please visit youtube.com/watch?v=CbzmoTmicH0

BENDIGO HEALTH

John's story: A doctor who didn't receive the help he needed

Doctors can face several challenges when they need help. Some who are very good at looking after the welfare of their patients find it hard to seek assistance when they require it themselves. AMA Victoria was recently contacted by the widow of a doctor who struggled with these challenges. She hopes that by sharing John's* story, others who need support don't face similar problems.

John was a rural GP working in the Mallee area of Victoria. He thrived on the variety and challenge of this work – long term relationships with families, delivering babies through to palliative care, admitting rights at the local hospital, minor surgical procedures and GP anaesthesia. However his youngest child was born with a disability, and more support was available in the city. Greater educational choices in the city would also benefit his other children, so he and his wife agreed that they needed to relocate to Melbourne. Also at this time his ageing parents, who lived in the city, were starting to need more practical help.

After relocating to suburban Melbourne, John decided to specialise in O&G and commenced training. However, he found the loss of autonomy difficult and reporting to younger doctors with many years' less experience was demoralising for him and he also had to adjust to a significant reduction in salary, while still needing to support his family. As a result, he discontinued the training program.

Subsequent to some locum work, John found his niche in after-hours work in ED, and particularly enjoyed working at nights when he was independent with minimal interference from administrators. This work also paid well which helped the family. He found ED work at night was the closest match to the practice of a rural GP and found a rhythm doing nights at several hospitals for the added benefits of salary packaging at each workplace. He continued working nights for almost 14 years, averaging five or six nights a week, for the majority of this time.

Over time John developed a sleep disorder and work colleagues obliged him by writing prescriptions for sedatives. When not at work he was often irritable and lacking in energy. On his days off he loved getting out of the city and going bushwalking, however, this meant driving long distances and going straight into night shift on his return. John remained driven at work, loving the unpredictable nature of the ED and the opportunity for procedural work. He also felt locked in to night shift work at this stage and couldn't see any alternatives. The ED day shifts were reserved for FACEMs.

After working all night John went to his mother's house one morning to clean her gutters, before a forecasted storm. However, he fell from the ladder hitting his head on brickwork before landing on the ground. He sustained a significant head injury as well as a fractured shoulder, becoming a patient in a major city hospital for a brief acute period. After surgery for each of his injuries he was discharged without any rehabilitation and was not encouraged to do so by anyone involved in his care. About six weeks after discharge, having passed his neuropsychological assessment and having a clear brain CT scan, John returned to work.

John began to struggle with pain and fatigue. He found seeking help difficult and was very concerned that whenever he consulted a doctor he was under scrutiny. He saw a rehab physician who referred him to a psychiatrist. Neither asked about his working hours, or consulted his wife regarding his premorbid condition. It was presumed that because he had been working as an ED doctor he must have been functioning well.

John was advised that his health issues related to his head injury and to allow more time for full recovery. But he was unsure about what his problem was or how he would know what recovery would look like. While the doctors were well-meaning in trying to encourage him to slow down, he perceived that they were trying to have him discontinue practising altogether and that he faced a very uncertain future. In John's mind, his treating doctors became his adversaries. In despair he even sought a second opinion, from another rehabilitation service, to be told they wouldn't accept the referral as their opinion wouldn't differ from the practitioner he had already engaged.

John felt crushed by his situation, but was eventually permitted to make a gradual return to work under "supervision", even some night work. Twelve months after his fall, without any improvement in his condition, he was discharged by his rehab physician, being told he was free to do as he liked, as he had now recovered.

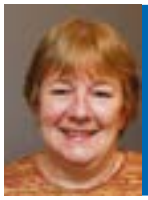
John resolved not to do night shifts, but did some long day shifts in country EDs, a few at a time, every few weeks, interspersed with rural ED locum work. His disability insurer required regular reports from his GP, and John felt the pressure from them to be working more. On returning from one locum, he contracted a virus which had him bed

resting for a few weeks. It was like his body shut down, but he did recover, and returned to his commitments.

Fatigue and sleep difficulties increased for John but he was reluctant to seek further help, telling his wife, "Everyone I have seen has said that my symptoms are related to my fall. I don't need any further opinions, I have seen enough doctors and I'm not going through what I went through before." He put his fatigue down to his head injury, but his wife blamed lack of sleep and sedative medication. John still maintained contact with his GP, as he needed the forms for his insurance completed. These documents, however, became the focus of visits.

John was thought to be depressed and put on antidepressants. His mood improved with medication and he ventured on a holiday with his wife. Sadly during his holiday John died while snorkelling. An autopsy showed significant cardiomegaly and the coroner reported that John's death was most likely due to a cardiac arrhythmia associated with these findings. John was in his mid-50s.

* Story told with the permission of John's widow. Name has been changed.



Kay Dunkley

Coordinatior of Doctor Wellbeing

Expert commentary

There's so many reasons why doctors can find it hard to seek and obtain appropriate healthcare. We spend five years in undergraduate and more in postgraduate studies learning how to be the "care-giver", but it's hard to accept the role reversal and be the "care receiver". We know all about health and are so good at looking after others that there's a feeling of shame or failure if we can't look after ourselves. Needing help, particularly if related to mental health may be associated with stigma.

Taking time off, away from medicine can be a threat to our identity as a doctor. We are prone to denying that we are unwell, or when we do seek help, guilty of "selective disclosure" – telling only the part of the story we are comfortable with. The longer we are unwell without getting proper help, the harder it becomes. Being overtired, exhausted and "burnt out" make it all too common to despair that nothing can be done. If depression begins to take hold, feelings of hopelessness make getting help seem pointless and too hard.

Getting help when you're a time poor doctor is hard enough anyway – we don't want to let our patients down and we don't want to burden our colleagues. We don't want to let our families down. There may be financial constraints to seeking help.

Knowing who and where to go to for help is a challenge for many doctors. We worry about confidentiality, especially where the local medical community is small. We need to be able to trust that the treating doctor will treat us as a patient (albeit a "special" one). Ideally as doctors we should all have our own GP, one who knows us and our past medical history well.

Dr Kym Jenkins
Consultant Psychiatrist
Medical Director, Victorian Doctors' Health Program
Adjunct Senior Lecturer, Monash University
Honorary Senior Fellow, Melbourne University
President-elect Royal Australian and New Zealand College of Psychiatrists

Expert commentary

Shift work is associated with adverse health, safety and performance outcomes. Circadian rhythm misalignment results in inadequate and poor quality sleep as opportunities to sleep fall during the circadian peak period, akin to jet lag. This rarely corrects, even in regular night workers, resulting in chronic inadequate sleep. In combination with work periods occurring during the circadian nadir, when alertness is at its lowest, this results in a more than 50% increase in risk of occupational and road accidents and increases medical errors. Individuals may experience excessive sleepiness, symptoms of depression or anxiety and impaired cognitive function. John was likely to have been impacted by "shift work disorder" during his many years of regular night shift work when he was irritable with reduced energy and it may have contributed to his accident. A range of approaches can be used to increase sleep (at least seven hours per day) and enhance alertness in shift workers including: sleeping during the circadian nadir (night) or afternoon "siesta" period; short naps minimising sleep inertia; shift design - reducing sequential night shifts and allowing at least 11 hours between shifts for sleep; screening and treating sleep disorders; melatonin to promote sleep during the daytime; and wakefulness-promoters such as caffeine during shifts.

Dr Mark Howard
Deputy Director, Department of Respiratory and Sleep Medicine, Austin Health
Institute for Breathing and Sleep
CRC for Alertness, Safety and Productivity
Adjunct Associate Professor, Monash University

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Developing the first village-based rehab program on Fiji's Coral Coast

Fiji is the happiest country in the world according to WIN/Gallop International's 2016 survey. When you add to the mix a gold medal winning Olympic rugby team, amazing beaches, beautiful weather and the freshest of fruits, why wouldn't one be happy? Fijian people are amazingly joyous, friendly and inviting – even those living with illnesses share their Australian neighbour's notion that 'she'll be right'.

During several holidays in Fiji, we were naturally led to conversations with the local people about their way of life in the villages, family structures, and existing health programs (or lack of). One common theme presented: although they seemed happy, there was an alarming number of people that either had family members living with a disability at home or were caring for a family member living with a disability. Disabilities arising from stroke, diabetic complications including amputations, head injuries, arthritis, and manual labour injuries were prevalent. Yet despite the struggles families faced, there were no rehabilitation or therapy programs available, and limited consideration towards those with disabilities developing their independence. Opportunities for rehabilitation after acute illness or injury simply did not exist for the people in the villages, and access to basic healthcare was limited or fragmented.

It was difficult for us to continue holidaying in Fiji while the people were so clearly disadvantaged. The next step in the pathway of change was to take action, but this would not be without overcoming cultural, ethical, trust and hierarchical barriers. Creating change in developing nations is not an easy task - it requires significant community consultation. During this initial phase we were faced with challenging, value-based questions including: "There is a need but are we prepared to do something about it?", "Can we do something more with our medical and health expertise?", and lastly, "If our family lived in Fiji and needed rehabilitation would we want them to have the best healthcare opportunities available?"

What followed was reflective thinking and discussions on our motivations for wanting to make a difference: what we were prepared to sacrifice, and whether we were prepared for the potential challenges. This culminated in the life-changing journey of developing 'Coral Coast Rehabilitation' (CCR), a community focused rehabilitation service on the Coral Coast of Fiji.

To succeed we needed to engage the Coral Coast community who were willing to receive a proposed 'rehabilitation' service, to identify what the need was and how we could structure a program that would make a lasting impression on the community, empower local health providers and villagers and promote independence.

5 year-old Api taking his first steps using a new four-wheeled frame following three years of intensive therapy and home programs.

Our first stakeholder, as chance would have it, was the daughter-in-law of the region's Chief (the highest ranking clansman for the district and influential decision maker). Following several meetings and widespread village surveys to identify what the disability management and rehabilitation needs were, a plan was made to develop a rehabilitation service that focused on a 'ground up' (Village Up) approach. This would be unique in Fiji as not only would we be developing the first community-focused rehabilitation service, but we would also be enabling a significant power shift from the typical health institutions that often intimidate the everyday Fijian. Our initiative sought to create a conduit relationship between the local villages and the local health centre, with a service centered around the existing volunteer village nurse program.

The volunteer village nurses are pivotal to the success of CCR.

Fiji has a unique system where each village has its own volunteer nurse. These nurses have very little training and limited access to health education, but they are passionate about their people's wellbeing, dedicated to their roles and motivated to learn. The village nurses are integral to the success of our program as they are the eyes and ears in each of their communities. We established means to provide them with education regarding rehabilitation and basic healthcare, including preventative practises and resources to conduct health checks (including vision assessments and diabetes monitoring).

The nurses were included in all decision-making and implementation of therapy programs. What time would later show was that centering the programs around the village nurse empowered their role and position in the community, and a blue CCR logo symbolised the endorsement and competency of their skills by trusted and friendly Australian medical professionals.

In 2014 we sent our first team over to assess, treat and educate community members with disabilities or health conditions that had been selected by the nurses. The team comprised of a rehabilitation medicine physician, an occupational therapist, a physiotherapist, and an orthoptist. We saw 520 patients in two weeks who presented with conditions including arthritis, upper and lower limb amputations, diabetic foot complications, stroke, undiagnosed Parkinson's disease, myelitis and children with developmental delay, cerebral palsy and progressive neurological conditions.

The following year, we took a team of seven health professionals (including GPs) and saw over 1000 patients. Such numbers are not manageable, particularly in hot, humid, and sometimes poor conditions, with team members seeing diseases and illnesses that are now either rarely or never seen in Australia following successful vaccination and health promotional campaigns.

A key focus has been transferring skills to the village nurses required for facilitating the therapy programs and caregiver training, monitoring and educating diabetic patients, and screening for vision problems, including the provision of medical supplies required to provide such healthcare.

Due to the unmanageable number of patients attending the rehabilitation and vision clinics, the village nurses triaged the patients most in need of our services for the subsequent 2016 program. A decision was made to focus on children with disabilities, people with neurological conditions, and those impacted by diabetes, in particular diabetic feet (including pre or post-amputation), providing core rehabilitation services previously not available to these groups.

The 2016 program saw two priority goals successfully achieved. The first was to provide more therapy time to patients with attainable rehabilitation goals. This was enabled by a greater understanding of the village nurses in identifying those who would benefit from and be motivated for rehabilitation. This allowed us to improve the quality of service by prioritising greater therapy time for patients and their families to enable development of individualised home programs and training caregivers and village nurses to facilitate such programs after we returned to Australia.

Our second goal was to build two 'therapy playgrounds' that could not only be used for exercise and a place for people to complete their therapy programs, but additionally serve as a social area for children and adults, given the lack of playgrounds in Fiji. The participation of Fijian locals in constructing the playgrounds has given them a strong sense of ownership and responsibility for the facilities.

Moving forward we are now starting to see an emergence and realisation of what 'rehabilitation' means to Fijians and what is possible in the island nation. The relationships between the local GP, health clinic staff and village nurses have grown through their involvement in the rehabilitation program, thus improving healthcare for the villagers. The nurses are not only feeling supported and respected, but empowered by their new skills and witnessing first-hand the positive impact therapy programs are having for individuals and their families.

We are at the start of a long journey that involves teaching the Fijian communities that rehabilitation and independence is possible through achieving functional goals with an individualised therapy program, when previously living with a disability was considered the end of the road. After three years we are seeing smiles return to so many people experiencing an improved quality of life and a generational change is occurring. Children that previously were unable to crawl are learning to walk, adults are relearning how to dress and look after themselves, and others are finding solutions to return to work, enabling them to earn an income and support their families. We have been privileged to share in the joyous lives of the happy Fijian people.

For more information on Coral Coast Rehabilitation we welcome you to join our Facebook page, visit coralcoastrehabilittion.org.au, or email info@coralcoastrehabilitation.org.au. We welcome any questions, ideas, and even medical or first aid equipment stock to help support our village nurse dispensaries.

Shane McSweeney

President
Coral Coast Rehabilitation
Occupational Therapist

Dr Marina Demetrios

Rehabilitation Physician

ADVERTORIAL

Structuring your car ownership

We all want a brand new car and the car salesman agrees we need one, however, being aware of the small differences in the how you finance the purchase can significantly change your tax and GST implications.

Should I pay cash or finance the purchase?

Paying cash outright for the car is the simplest method of funding the purchase and means that there are no monthly payments or interest to worry about. However if you don't have a lump sum of cash available you will need to look at finance. Many people who can afford to pay cash still choose to use a finance method as there are often better uses for the cash that pay a higher return than the interest you pay on a loan.

If you choose to borrow to finance the loan there are a number of options available.

Car Loan

A secured car loan allows you to take ownership of the car at the time you purchase it. The finance company takes an interest in the car via security (to cover default on the loan). Once the loan is repaid the security is removed. Assuming you are using the car for business use or in the course of your employment you can claim the interest and depreciation as a tax deduction (based on business log book percentages).

Home Loan

It can be tempting to draw down on equity in your home via your mortgage to fund your car purchase as the interest rates are lower. However you need to consider the repayments are now spread over a longer period (eg. 20 years), also you can lose any tax deductibility on the interest as you mix deductible and non-deductible purposes. If you are planning on financing the purchase then a separate loan or other financing option is preferred.

Chattel Mortgage/Finance Lease/Commercial Hire Purchase

Other financing options vary the terms slightly. A chattel mortgage is the most similar to a loan as the legal ownership of the vehicle transfers at the time the mortgage is entered into. As per above you will be able to deduct your depreciation and running costs as normal. If you are registered for GST you can claim input tax credits upfront on the total cost of the car (subject to the luxury car limit).

Finance Lease and Commercial Hire Purchase differ to a Chattel Mortgage as the ownership is retained by the Finance Company and transfers at the time the liability is fully extinguished. There are various different options on term length and balloon payment at the end. With a finance lease you generally claim the payment as a tax deduction rather than the interest and depreciation.

Novated Lease

A novated lease is an agreement between your employer, your financier and yourself. Effectively, you enter into an agreement with your financier to purchase the vehicle, you then enter into a second agreement in order to transfer some of the operating obligations to your employer. In doing so, you agree to pay a fixed rate (partially from pre-tax dollars) from your salary to cover both your lease obligations and some of your operating expenditure such as fuel and maintenance costs.

As the main advantage is a reduction in your taxable salary, employees on higher tax brackets find this more suitable than others.

How can William Buck assist?

As you can see there is not a one type fits all option and we urge you to get advice before entering into any arrangement to ensure the option is the best for you and your personal circumstance.

Please contact us to ensure you understand the differences and what you are committing to before signing on the dotted line.

Belinda Hudson

Director, Health Services

William Buck

William Buck

Disclaimer: The contents of this article are in the nature of general comments only, and are not to be used, relied or acted upon without seeking further professional advice. William Buck accepts no liability for errors or omissions, or for any loss or damage suffered as a result of any person acting without such advice. Liability limited by a scheme approved under Professional Standards Legislation.

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ADVERTORIAL

There's more to your health cover than meets the eye

Many patients are understandably surprised when they receive a large bill after a hospital admission for treatment covered under the terms of their health insurance policy. The rise in customer complaints to the industry Ombudsman in recent years is testament to this.

People in this situation learn the hard way that knowing what treatments are, or are not, covered in a health insurance policy is only half the story. The other half is about the performance of the policy – what benefits are available when the need for hospitalisation arises.

For some time now I've argued for greater transparency in the health insurance industry around the performance of products at the time of purchase. This is because two principles we value highly at Doctors' Health Fund are clinical independence and freedom of choice. If a fund pays poor benefits and has a restricted number of hospitals it works with, it effectively reduces clinical independence by limiting the number of practitioners who are able to provide their services to members. Policy holders in these instances have reduced choice unless they are willing to pay large gaps.

Current data

Currently the only piece of health fund performance data consumers are given (usually after they have made the purchase) is the ratio in a policy's Standard Information Statement showing the proportion of medical services paid by the fund that have no out-of-pocket expenses.

This statistic might be better than nothing, but it is still a very high level number. Even if a fund has a good ratio, it's no guarantee of performance of anyone's particular product or the service they are claiming. Plus, because it only relates to service numbers, it says nothing about the size of out-of-pocket costs incurred by the member. A fund may have a higher proportion of low-value services fully covered while limiting benefits on more expensive services. These nuances are not borne out in this kind of information.

Website enables comparison

A website prepared by the Private Health Insurance Ombudsman uses more detailed data to show each fund's performance across a few measures including medical benefits. Putting aside the shortcomings mentioned above, the website does show comparative information by health fund. Go to PrivateHealth.gov.au > Health funds tab > select health fund > select Performance tab.

For each state and territory it shows how the selected fund performs compared to the industry average for:

- hospital related charges covered
- medical services with No Gaps
- medical services with No or Known Gaps
- extras charges covered
- private hospital agreements
- day hospital agreements.

In the interests of transparency at point of purchase, provision of this information would be more enlightening to the consumer than the single ratio currently on the Standard Information Statement.

We will continue to advocate for industry reform that makes it easier for consumers to determine the real value of their health insurance and avoid the unexpected bill shock that too many members continue to experience.

Peter Aroney
CEO
Doctors' Health Fund

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- We support only medically-evidenced treatments – we don't pay benefits for non-medically proven therapies
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- We are owned by doctors – we've been operating for over 40 years and we are a preferred provider of **AMA Victoria.**

"Being a doctor has given me the opportunity – and I see it as a big opportunity – to be involved with a fund that has never let me down. Whenever I've required to draw on the fund for admissions to hospital for myself or my family there has never been a question about my cover, or a payment, a refund, whether or not cover applies, and for that reason I've never needed to look elsewhere."

Dr Lorraine Baker
AMA Victoria President and
Doctors' Health Fund member since 1981

"When you call, a person answers the phone and they are friendly and know what they are talking about. When you make a claim it's processed promptly. The simple things really matter (and its Top Cover) is still an offering unmatched by any other health insurer and enables doctors to show mutual respect to their colleagues."

Dr Steve Hambleton
Former Federal President of the AMA and
Doctors' Health Fund member since 2012

Visit **doctorshealthfund.com.au** or call us on **1800 226 126**

Treating patients accompanied by the Victorian WorkCover Authority

We all know that treating patients who have WorkSafe claims is challenging. All too often the response from colleagues is that we are "second guessed" by insurers, complete unnecessary documentation, are not paid enough and fight insurer roadblocks to recovery. Many therefore avoid dealing with these people. As doctors we want to treat the sick and injured, so how do we deal with the challenge of treating compensable patients and is the level of payment an issue?

I originally wrote this article in 2014. Some things have changed in the compensation landscape, but much more is needed if we are to significantly improve the treatment of our patients who happen to also be supported by WorkSafe. I've updated the figures, but in regards to the problems and solutions, little has changed.

A key question for workers' compensation funders is why do workers (patients) with compensable conditions take more time to regain health relative to those with similar illnesses or injuries treated privately? The answer to most clinicians is clear – treat these patients the same way as a policy holder of private health insurance and you are more likely to move toward similar outcomes.

However, compensation arrangements are different. For example, the statutory obligation is to fund only treatment and care related to the compensable injury or illness. The "system" operates within an adversarial environment that can influence patient/insurer behaviours. The insurer is also responsible for funding loss of income, which is the major cost of the scheme.

Doctors are primarily about helping sick people, called 'patients', get better. Employers and WorkCover have different names for these people, such as 'worker' and 'employee'. Insurers talk about 'claimants'. It's an interesting mix when WorkSafe talk about working together to get the patient back to work.

It is clearly a multi-player act. However, a number of observations can be drawn:

- Insurers can cause harm when attempting to manage the treatment of the patient. Doctors are good at this and are recognised experts. We do this every day.
- Doctors should focus treatment to the compensable injury or illness and communicate this to the insurer. Employers are paying for the treatment of the injury.
- Insurers should ensure that employers (and employees) understand and accept their return to work obligations, without questioning or seeking to manipulate the opinion of the doctor.
- Doctors should be enquiring about a patient returning to work as part of their return to health. Employers (and patients) are paying for the time off work and returning to work can be an important step in returning to health.
- Doctors must understand that the system can be adversarial – try not to advocate for the patient (or insurer) in this space. Maintain a professional objectivity to give a fair opinion if required.

I am sure that you will see other parts to this balancing act. These comments about the complexity of the system do not address the issue of costs of treating patients with compensable injuries.

What is the right level of payment to meet the costs?

This is a very difficult question and an individual issue for us as clinicians and providers of healthcare services. We tend to individualise our patients with some bulk billed, no gapped, known gap or simply 'private'.

Compensation schemes around Australia take different approaches. Some states such as Tasmania and the Northern Territory have no set level of fees but simply pay "reasonable costs". Presumably the benchmark is around the AMA List of Fees. Others set their own such as in Victoria and South Australia. The remaining states utilise the AMA List of Fees or better.

Table 1 highlights the differences using the most utilised item numbers across the systems. The table needs to be treated with care as in some jurisdictions, such as NSW, bespoke schedules see some craft groups paid above the standard rate. What is obvious is that Victoria falls behind the whole of Australia.

Does this impact on the scheme and our patients?

Given the aim is to move patients with compensable injuries to recovery (and return to health/work) in a manner similar to those privately insured, a logical conclusion is to ensure that benefit payments are at least comparable to the level of a typical private patient. However, compensation schemes have different requirements, and the payments must also recognise unavoidable additions – for example, increased paperwork, dealing with insurers, other providers, and employers, delays in accessing services, potential involvement in litigation, as well as managing the injury and the patient. This will move payments into the "ballpark"

Table 1. Payments of Key Services by Workers' Compensation Schemes in Australia, April 2017

CMBS Item	SERVICE DESCRIPTION	PAYMENTS								
		VIC (July 16)	NSW (Nov 16)	SA (Jul 16)	QLD (Dec 16)	WA (Nov 16)	NT* (Nov 16)	TAS* (Nov 16)	ACT* (Nov 16)	COMCARE (Nov 16)
General Practitioner										
3	Level A Surgery Consultation	$29.19	$38.50	$32.70	$41.00	$75.05	$38.50	$38.50	$38.50	$38.50
23	Level B Surgery Consultation	$59.64	$78.00	$72.80	$78.00	$75.05	$78.00	$78.00	$78.00	$78.00
36	Level C Surgery Consultation	$109.35	$142.00	$126.10	$142.00	$137.10	$142.00	$142.00	$142.00	$142.00
44	Level D Surgery Consultation	$163.80	$220.00	$192.80	$220.00	$210.60	$220.00	$220.00	$220.00	$220.00
Specialist										
104	Initial Referred Consultation at Surgery	$159.88	$170.00	A $150.00 B $178.40	$170.00	$161.95	$170.00	$170.00	$170.00	$170.00
105	Each subsequent attendance in a single course of treatment	$80.11	$91.00	$82.70	$91.00	$84.50	$91.00	$91.00	$91.00	$91.00
Consultant Physician										
110	Initial Referred Consultation at Surgery	$264.91	$325.00	$249.90	$325.00	$284.90	$325.00	$325.00	$325.00	$325.00
116	Each subsequent attendance in a single course of treatment	$132.58	$148.00	$128.50	$148.00	$142.50	$148.00	$148.00	$148.00	$148.00
Consultant Psychiatrist										
320	Professional attendance < 15 min.	$76.93	$89.00	$82.80	$90.00	$83.55	$90.00	$90.00	$90.00	$90.00
322	Professional attendance 15-30 min.	$153.82	$178.00	$163.70	$178.00	$166.70	$178.00	$178.00	$178.00	$178.00
324	Professional attendance 30-45 min.	$222.80	$270.00	$247.10	$270.00	$249.70	$270.00	$270.00	$270.00	$270.00
Anaesthetist										
17610	An attendance of 15 minutes or less duration. 2 units.	$119.80	$166.00	$82.40	$166.00	$168.50	$166.00	$166.00	$166.00	$166.00

*NT, TAS and ACT have no specific guidelines as noted in their respective legislation. For comparative reasons the 1 November 2016 AMA List of Medical Service and Fees book has been used.

of benefits needed to ensure the patient has access to the right treatment by the widest range of doctors and in the most effective and efficient manner.

This alone is not enough. The baseline is to ensure these patients are treated privately but in addition by their doctor in a way that maximises their chances of early and safe return to work. For a profession that is paid by 'service type' this requires additional item numbers that reflect the cost of time and effort spent by doctors on facilitating early access, diagnosis, treatment and safe return to work. WorkSafe has recognised some of this work with the introduction or updating of payments for:

- a GP Return to Work case conference
- a Return to Work phone call with an employer
- a site visit.

The payments are a start but with more work to be done.

The Victorian WorkCover Authority appears to have improved its relative performance in relation to Return to Work (RTW) – see Figure 1 (page 58). The RTW rate comes from research of comparative schemes commissioned by Safe Work Australia. The metric is based on the proportion of workers with 10 or more days off work and who returned to work for any period of time. Victoria, with a rate of 88%, lies between NSW and Queensland. However, this result is not overly evidence of a trend. WorkSafe has identified results for the last five years which indicate a high of 21.9% (2011/12) of workers not yet back at work after six months, a low of 19.39% (2014/15) to 19.77% (2015/16).

In the same report, the Authority announced a negative $135m actuarial release and a massive surplus (from insurance operations) of $280m. So is there a relationship between relatively low payments in Victoria and poorer return to work rates? One would suggest that it is the area that requires the most focus. In particular the relationship between higher rebates, early access, earlier treatment and earlier return to health and work.

From my perspective, the aims of any change should be to:

- ensure that you start to treat/ continue to treat compensable patients referred to you
- communicate with insurers and employers on an equitable basis
- encourage at every opportunity conversations around safe return to work.

CONTINUED ON PAGE 58

Figure 1. Returned to Work Rate 2015/16 by Country and Australian jurisdiction (%)

Source: Return to Work Survey 2016, Headline Measures Report (Australia and New Zealand) July 2016

Obviously payment is not the only factor. I do hear anecdotes of increased incidents of WorkSafe/insurers interfering in the treatment of patients. Unnecessary delays are still reported in areas such as:

- payments of invoices for treatment
- decisions on liability for the medical condition as a work injury
- decisions to accept liability for treatment once the injury claim is accepted.

Increasing benefits to patients, delivering earlier return to work opportunities and cutting through some of this bureaucracy will be important for any meaningful change to occur. Your engagement and feedback is important in properly advising WorkSafe on changes that should occur to the benefits scheme and encouraging greater participation from the profession. Better access to treatment by workers is key to ensuring good outcomes for the patient and their doctor.

Dr Gary Speck

Chair, AMA Victoria WorkSafe TAC Subcommittee

References available from the Editor on request.

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Spinal Impairment Guides Modification Document (the SIGMD)

Get SIGMD accreditation to perform spinal impairment assessments for the TAC jurisdiction!

New accreditation for SPINE TAC Claims where the date of the transport accident is 14 December 2016 or later.

Legislation was passed by the Victorian Parliament in December 2016 which has resulted in a change to the method of assessing spinal impairment for TAC claims.

The change does not have any effect on the methodology of assessment of spinal impairment for WorkSafe or the *Wrongs Act*.

The changes for the TAC have seen the adoption of the Spinal Impairment Guides Modification Document (SIGMD), but only for transport accidents which occur on or after 14 December 2016.

What does the SIGMD do?

The SIGMD modifies the method of assessing spinal impairment by reference to Structural Inclusions, including modification by substituting new descriptors of structural inclusions. The new descriptors for structural inclusions deal with single fractures, multiple fracture patterns, as well as spinal surgeries.

The SIGMD also simplifies and amends some other aspects of the instructions for the assessment of spinal impairment.

As an accredited spine assessor, what does this mean for me?

You are encouraged to attend the new module of training on the SIGMD which will add the new accreditation to your existing spine accreditation.

All assessors who perform spinal impairment assessments for the TAC jurisdiction are asked to attend one of the forthcoming modules so that they will be accredited to perform spinal impairment assessments which will require use of the new methodology.

Assessors who do not currently perform spinal assessments in the TAC jurisdiction may be interested to attend to remain fully up to date and to learn more about this new methodology, and to be in a position to accept referrals for this work in the future.

In addition to teaching the SIGMD, the module will include the roll out of a comprehensive new document with updated advice by the Spine Reference Group. This document will assist spine assessors to better understand the assessment process as required for TAC, WorkSafe and *Wrongs Act* assessments.

Assessors may also be interested to know the initial Spine Training (Stream 1) this year will teach both the existing Guides approach and the SIGMD.

Why has this new methodology been adopted in the TAC jurisdiction?

The change is aimed at addressing issues with spinal impairment assessment which arose from the decisions of the Victorian Supreme Court in the cases of *TAC v Serwylo*, and, *Elsdon v Victorian WorkCover Authority*.

Most assessors should be aware of the impact of the judgements from these cases via the newsletters from the Training Program. The relevant newsletters are from December 2012 and November 2014 which can be found at iatvic.com.au/newsletters.aspx

The decisions have meant that the presence of fractures of two or more vertebrae in a spinal assessment region is deemed to satisfy Structural Inclusion (2) of DRE Category IV, regardless of consideration of the nature of the fractures. The decisions have also seen Structural Inclusion (2) of DRE IV variably interpreted by assessors to account for spine fusion procedures.

Has the new methodology been adopted for WorkSafe and/or Wrongs Jurisdictions?

No

How was the new methodology developed?

The SIGMD is based on work done by a panel of expert spinal specialists in 2014. The spinal expert panel included:

Mr Gary Speck (Chair) (Orthopaedic surgeon)

Mr David Brownbill (Neurosurgeon)

Mr Robert Dickens (Orthopaedic surgeon)

Associate Professor Stephen Hall (Rheumatologist)

Associate Professor Richard Stark (Neurologist)

Mr Peter Wilde (Orthopaedic surgeon)

When are the modules?

The SIGMD module dates are:

- Tuesday 13 June: 6-9pm
- Tuesday 17 October: 6-9pm

Book the next available SIGMD (stream 1) module

To register for one or more Stream 1 modules please visit iatvic.com.au/registration.aspx and complete the registration form. For more information, contact us via email at iat@amavic.com.au or phone (03) 9280 8722.

Open up to new professional opportunities with medico-legal training

AMA Victoria would like to introduce our new impairment assessment training program (AMA4) designed to provide a comprehensive understanding and methodology for determining impairment of an individual with a permanent medical condition.

What is medico-legal training?

Medico-legal training promotes an awareness of the intersection between the medical profession and the law, and provides medical professionals with the qualifications (required by law) to make assessments and claims in a legal capacity.

What is impairment assessment training (IAT)? What are the benefits for you?

Impairment assessment training is an important aspect of medico-legal training. Successful completion of a course in IAT allows you to assess impairments for TAC, WorkSafe and personal injury claims under the *Wrongs Act 1958*. **Practitioners in the state of Victoria must undertake this training in order to make these assessments.**

AMA Victoria's courses cover not only the technical elements but the role of the assessor in relation to the patient, the administrative decision-maker and the law.

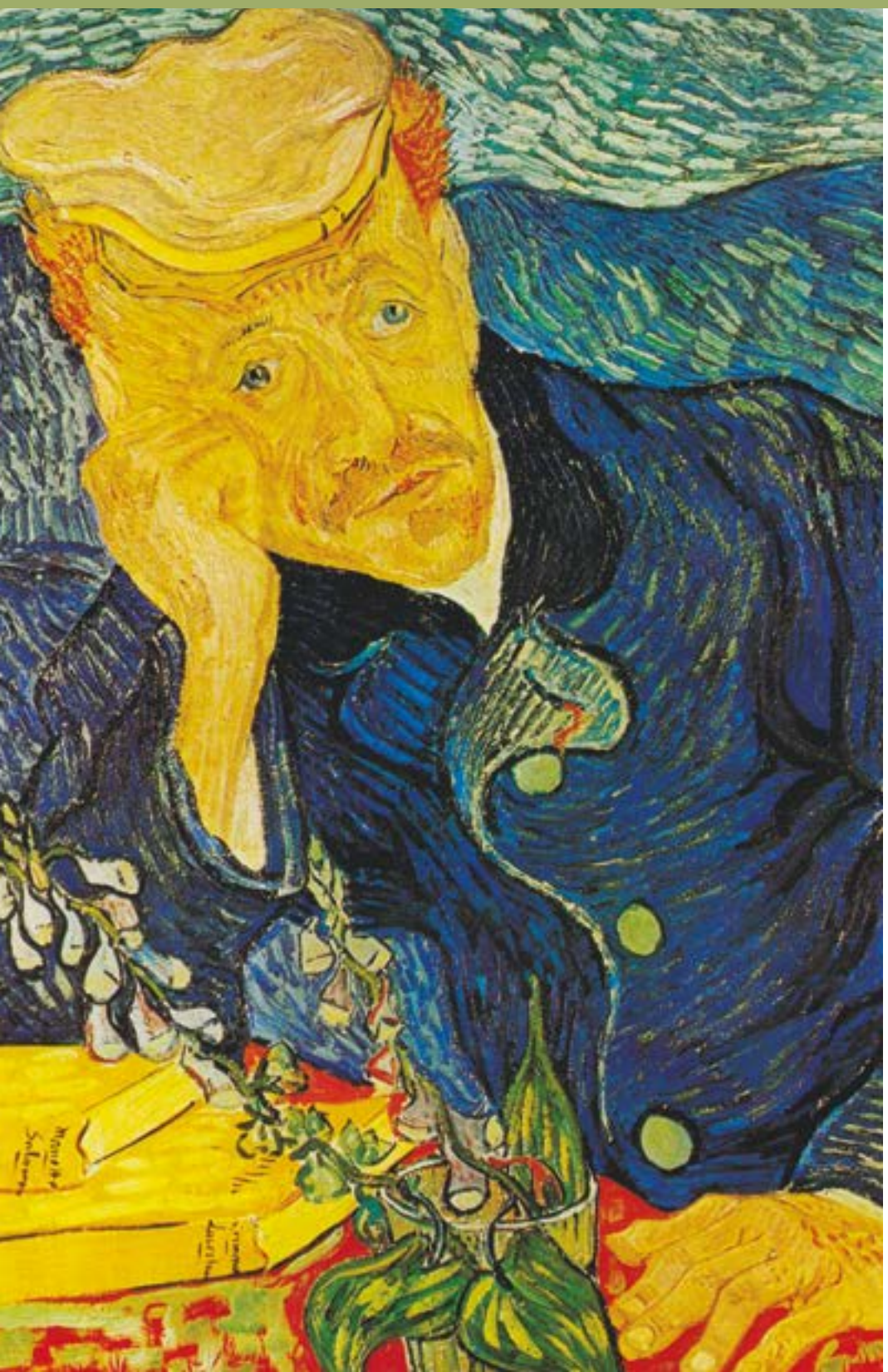
The course is comprised of a core module and at least one elective, for example, the Nervous System. The core module covers the legislative requirements of impairment assessment and electives are chosen on the basis of the practitioner's specialties.

See our calendar here and book at iatvic.com.au/registration.aspx

For more information, contact us via email at iat@amavic.com.au or phone (03) 9280 8722.

Date	Time / Duration	Module
Tuesday 16 May	6:00pm - 9:00pm	Core (Stream 1)
Tuesday 30 May	6:00pm - 8:30pm	Nervous (Stream 1)
Tuesday 6 June	6:00pm - 8:30pm	Spine SIGMD (Stream 1)
Tuesday 13 June	6:00pm - 8:30pm	Spine SIGMD (Stream 1)
Wednesday 14 June	6:00pm - 9:00pm	Psychiatry GEPIC (Stream 1)
Tuesday 20 June	6:00pm - 9:00pm	Core (Stream 1)
Tuesday 4 July	6:00pm - 9:00pm	Hand & Upper Extremity (Stream 1)
Wednesday 19 July	6:00pm - 8:30pm	Cardiovascular (Stream 1 & 2)
Wednesday 26 July	6:00pm - 9:00pm	Lower Extremity (Stream 1)
Tuesday 1 August	6:00pm - 8:00pm	Visual System (Stream 1 & 2)
Wednesdy 2 August	6:00pm - 8:30pm	Spine (Stream 1)
Tuesday 8 August	6:00pm - 8:00pm	Obstetrics and Gynaecology (Stream 1 & 2)
Wednesday 9 August	6:00pm - 8:30pm	Spine (Stream 2)
Tuesday 15 August	6:00pm - 8:00pm	Respiratory (Stream 1 & 2)
Wednesday 16 August	6:00pm - 8:30pm	Nervous System (Stream 2)
Tuesday 22 August	6:00pm - 9:00pm	Urology (Stream 1 & 2)
Wednesday 30 August	6:00pm - 8:30pm	Psychiatry (Stream 2 - GEPIC)
Tuesday 19 September	6:00pm - 8:00pm	Digestive (Stream 1 & 2)
Tuesday 26 September	6:00pm - 8:30pm	Ear, Nose & Throat (Stream 1 & 2)
Tuesday 3 October	6:00pm - 8:30pm	Core (Stream 2)
Tuesday 17 October	6:00pm - 8:30pm	Spine SIGMD (Stream 1)
Tuesday 24 October	6:00pm - 8:30pm	Lower Extremity (Stream 2)
Tuesday 31 October	6:00pm - 8:30pm	Dermatology - Skin & Scarring (Stream 1 & 2)
Wednesday 8 November	6:00pm - 9:00pm	Hand & Upper Extremity (Stream 2)
Tuesday 14 November	6:00pm - 8:00pm	Haematology & Infectious Occupational Disease (Stream 1 & 2)
Tuesday 21 November	6:00pm - 8:00pm	Endocrinology (Stream 1 & 2)

How can Vincent van Gogh make professional development hours more intriguing and memorable?



It is often said, "a picture speaks a thousand words."

Contemporary medical technology provides intricate pictures of external and internal human anatomy. However, technology does not communicate holistic representations of the social, behavioural and psychosocial impacts associated with illness and healing. Studies have shown that increased reliance on reports from expensive laboratory tests, radiology and specialised diagnostic technology has resulted in inadequacy of physical examination skills, decline in patient empathy, and less effective doctor/patient communication.

Having commenced in May, continuing professional development workshops which explore and promote the value of art expression in the development of observation skills, human sensitivity and relevant healthcare insights are being presented by Dr Jim Chambliss at St Vincent's Hospital, with a subsequent visit to the NGV International exhibition of the original works of Vincent van Gogh. The program, independently conducted by Art for Insight, will run until 8 July 2017 and incorporate empirical research and works from 30 living artists with epilepsy to illustrate the way medical and psychological conditions can influence art and creativity. The objectives of the workshops are to:

- advance understanding of the impact of medical, psychological and social issues on the health and wellbeing of all people
- promote deeper empathy and compassion among a wide variety of professionals
- enhance visual observation and communication skills
- heighten creative thinking.

Background

During the last two decades, the observation and discussion of visual art has emerged in medical education, as a significantly effective approach to improving healthcare practice. Pilot studies of implementing visual art to teach visual diagnostic skills and communication at Harvard and Yale were so greatly effective that now more than 48 of the top medical schools in the USA integrate visual arts into their curriculum and professional development courses are conducted in many of the most prestigious art galleries and hospitals.

The work of Vincent van Gogh profoundly illustrates the revelations of what it means to be uniquely human in light of neurological characteristics, behavioural changes and creative expression. It is speculated by numerous prominent neurologists that Vincent suffered a brain lesion at birth or in childhood while others opine that it is absinthe consumption that caused seizures. Two doctors – Felix Rey and Théopile Peyron – diagnosed Vincent with epilepsy during his lifetime. Paul-Ferdinand Gachet also treated Vincent for epilepsy, depression and mania until his death in 1890 at the age of 37. After the epilepsy diagnosis by Dr Rey, Vincent stated in a letter to his brother Theo, dated 28 January 1989:

"I well knew that one could break one's arms and legs before, and that then afterwards that could get better but I didn't know that one could break one's brain and that afterwards that got better too."

Vincent did not demonstrate artistic genius in his youth. He started painting at the age of 27. In fact, his erratic line quality, unusual compositional skills and lack of apparent control were judged in his February 1886 examinations at the Royale Academy of Fine Arts, Antwerp to be worthy of demotion to the beginners' painting course. His original drawings and paintings were copies from others' art, while his later works showed remarkably different characteristics.

In Paris he was exposed to the works of many of the most famous impressionistic and post impressionistic painters, but so much of his new techniques and imagery were distinctly innovative in detail without traceable influences from others. He also had more exposure to seizure triggers (absinthe, smoking and sleep deprivation) following his move to Paris in 1886. His work transitioned from drab, sombre and realistic images to the vibrant colours and bold lines.

His ebb-and-flow of creative activity and episodes of seizures, depression and mania were at their most intense in the last two years of his life when he produced the greatest number of paintings. The increased frequency of neuropsychological phenomena he experienced accompanied increasingly more breathtaking innovation, following his move to Arles, France in 1888 until his death by apparent suicide in 1890 at the age of 37.

Opposite page: Portrait of Dr Gachet (1890) by Vincent van Gogh.
Above: Dr Jim Chambliss at the NGV with workshop students Sandy and Ricko.

His works are among the most emotionally and monetarily valued of all time. Vincent's painting of Dr Gachet (1890) in a melancholy pose with digitalis flowers – used in the treatment of epilepsy at that time – sold for $US82.5 million in May, 1990, which at the time set a new record price for a painting bought at auction.

Healthcare professionals and art historians have written from many perspectives of other medical and/or psychological conditions that impacted Vincent's art and life with theories involving bipolar disorder, migraines, Meniere's disease, syphilis, schizophrenia, alcoholism, emotional trauma and the layman concept of 'madness'. What was missing as a basis to best resolve disputes over which mental or medical condition(s) had significant impact on his life was a comprehensive foundation of how epilepsy or mental illness can influence art and possibly enhance creativity based on insights from more than 140 contemporary artists with neurological conditions.

The foundation of this workshop is from the world's first dual PhD combining Visual Arts, Medicine and Art Curation at the University of Melbourne. My PhD Creative Sparks: Epilepsy and enhanced creativity in visual arts (2014) provided:

- objective and subjective proof that epilepsy can sometimes enhance creativity - supported by brain imaging illustrating how that can occur
- a comprehensive inventory of the signature traits of neurological and psychological conditions that have significant interpretive value in healthcare practice
- comparative data to distinguish epilepsy from other medical and mental conditions.

Melbourne University Medical School subsequently sponsored an innovative series of Arts and Health workshops through which to teach neurology, empathy, communication skills and visual observation by an intriguing new approach that was tested through a pilot study. Surveys collected from participating students found:

- quality of the workshop with 10 as the highest = 8.68
- belief practise with interpreting art can improve medical practise = 100%
- want more arts & medicine workshops = 97.56%
- the most appreciated element was the interpretive value from the stories behind art influenced by a health condition.

Certificates of assessment, research supporting the value of art observation and written assessments are provided for self-reporting CPD credits.

See artforinsight.net or artandepilepsy.com for more information on costs and scheduling.

Dr Jim Chambliss, PhD
Melbourne Medical School
The University of Melbourne

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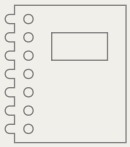

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Slide the screen of the fancy remote key (it looks like a miniature smartphone) and the engine fires to life, select D for Drive and gently roll forward. You don't even have to worry about banging into things. Cameras, sensors and radar are all on the lookout, taking control of the steering or brakes to avoid an embarrassing mishap.

The ability to park (and unpark) a car remotely adds another dimension to the whole 'driving' experience. That was my introduction to what is the most technically advanced BMW ever produced, the all new 5 Series.

It's an important mainstay of the sprawling BMW range, a model that has been instrumental in defining the Munich-based brand for almost half a century. The 5 Series has always been about pampering the driver as much as its passengers. Great to drive and great to ride in.

Parking party tricks aside, the 5 Series also does all you expect of a BMW. It's fantastic through corners, comfy, impressively refined and, if you go for one of the six-cylinder engines there's plenty of poke (the 530d diesel will take you more than 1000km on a tank and has an addictive torque rush when you stomp on the accelerator).

My challenge for the day was to challenge the car. First up was controlling the infotainment system without the need of touching a button. The Bowers & Wilkins sound system includes gesture control functionality. Twirl your hand mid-air and things get louder. With 16 speakers (two of which are "diamond tweeters", so they must be good) it's like standing at the front of the stage as AC/DC's Angus Young unleashes on the electric guitar. Granted, you do get the odd sideways glance in traffic while furiously waving fingers in the air.

Next stop, sat-nav: Voice control is commonplace in cars these days, especially once linked to a smartphone. But the BMW steps it up by dealing with everyday phrases, so there's no need to shuffle through the owner's manual to memorise carefully concocted phrases.

HIGHLIGHTS

- BMW display key.
- Extra set of eyes: 6 and radar to monitor every angle.
- Parking Assistant Plus: 360-degree camera and advanced autonomous parking.
- New connections: World first wireless application of Apple CarPlay.
- Sizing up: New large colour head-up display for speed and navigation data in the driver's line of sight.
- Driving Assistant Plus: Semi-autonomous steering and braking control to avoid crashes.
- Unrivalled driving dynamics making the vehicle amazing to drive.

Just request a "take me to" or "find a restaurant nearby" and the car will begin its search for your answers. You can even drive the car without a hand on the wheel or a foot near a pedal. It's part of the extensive driver assist technology, which takes a giant leap towards autonomous driving. The 5 Series can accelerate, brake and partially steer autonomously, monitoring other vehicles, even speed limits, to take the chore out of peak hour.

It's this sort of technology that reaffirms the 5 Series as a pioneer of technology that will help shape the future of autonomous mobility.

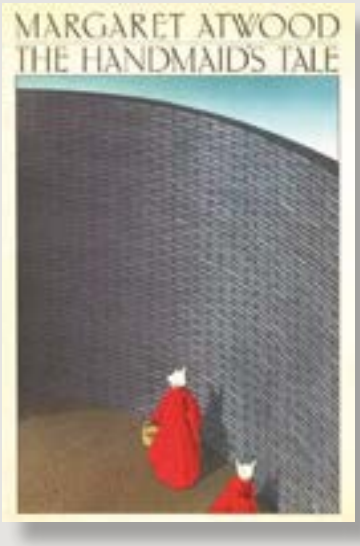
After hours of buttonless car play I relent and grab the iDrive controller, which brings additional functionality to the 10.25-inch high-def screen. A refreshingly logical menu system, complete with the ability to customise your 'home' screen, makes it a snip to find your way around. Which is lucky, because there's layer upon layer in those menus. I wind up the bass on the sound system, adjust the sensitivity of the collision and lane change warning before mucking around with the navigation settings.

Despite so much being onboard and ready to make your driving life easier there's a modern twist to some old school thinking that is just plain cool – advice from a real person. No, they're not tucked in the boot, but on the other end of a phone line as part of the Concierge Services. It's like having your own personal Google assistant.

"What's the twistiest road in NSW?" I ask. It stumps the bloke on the other end, but only briefly. Within a few taps I'm given a choice of three, one of which is messaged to the car to be added to the navigation system – at the click of a button.

Time to have some real fun. Want to come along for the ride? Find out more at bmwmelbourne.com.au or call to book a test drive on (03) 9268 2222.

Culture club



Read

The Handmaid's Tale - Margaret Atwood

You'll find The Handmaid's Tale in the classics section of your local bookstore, and for good reason. Atwood's 1985 novel is well celebrated, but has found itself with a new wave of fans in 2017. This frightening plausible dystopia is set in the near future, where the oppressors begin their regime with restrictions on travel, work and relationships of the oppressed, and progress to executive orders to enforce the segregation of gender and labour. Arguably the most prolific of Atwood's novels, the book has had a lift due to the glimmer of reflection in the wake of the 2016 US election, and the announcement of a 10 episode adaptation by American television subscription service Hulu. While the series has been created with the approval and consultation of Atwood, and she even has a cameo, the original text can't be beaten. Highly recommended.

Available in all good bookstores.

Listen

Desert Island Discs with Kristy Young

Most readers would have had a version of this conversation around the dinner party table: if you could only take eight recordings with you to your desert island, what would they be? In it's 75th year, this beloved radio program is broadcast on the BBC, but currently available to voyeurs worldwide via podcast channels. Current host Kristy Young (Sir Michael Parkinson was once in the chair) does a wonderful job of curating the guests, corralling their anecdotes and coaching out the very best connections between guest and music. Sometimes predictable, but more often surprising, the wide array of choices, and the guests of all occupations is always entertaining. A great place to start is with the Bruce Springsteen episode (18/12/2016) or Maya Angelou (20/03/1978). With over 500 episodes available online, you could request their back catalogue on your own island, and be happy for years to come.

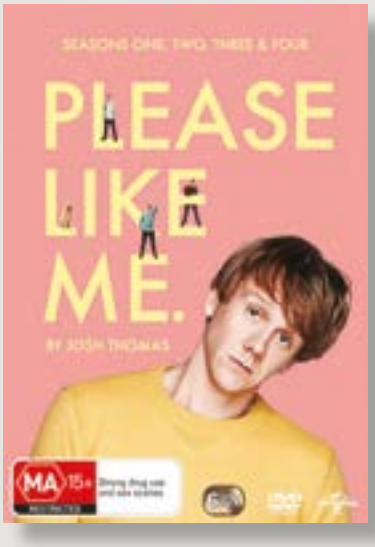
Available on iTunes or through your chosen podcast app.

Listen

Ironbark - The Waifs

The opening banjo twangs of the title track recall vintage Waifs. Their eighth studio album feels like a return to their roots – rather than taking a detour through the deep south of the United States, Ironbark brings Josh, Donna and Vicki back to rural Western Australia. The album is made for long drives, tapping along on the steering wheel, waiting for the ocean to open up around the bend. Touring the album on the occasion of their 25-year anniversary provides lots of opportunity for reflection of their journey, both literal and figurative. New recordings of three old favourites to round out the album feels like a gift to their fans that is more than appreciated. The Waifs are one of Australia's most beloved, but still somehow under the radar bands, and their latest album does nothing to disappoint fans both old and new.

Available on CD, digital download and streaming.

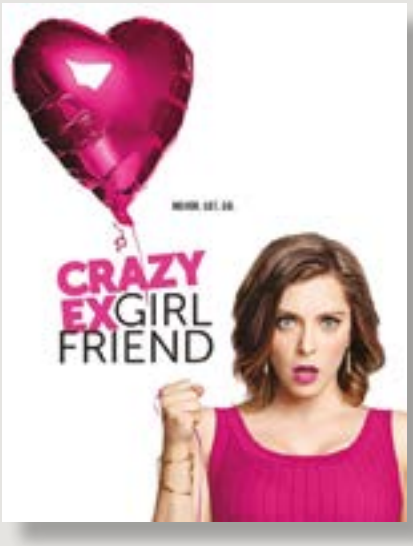


Watch

Please Like Me

This comedic drama series is, quite simply, one of the best shows of the past few years. Created by and starring Josh Thomas, Please Like Me has become a gold standard for portrayals of mental health, sexuality, family and friendship. Simultaneously achingly sad and hilarious, it follows the life of the fictional Josh, finding his way in the inner north of Melbourne in his early twenties. Never before have we seen this city so well rendered on the small screen. We chart Josh's life over the course of four seasons, watch his mother (incredibly rendered by Debra Lawrence) deal with crippling depression, and watch his dog John grow up. Please Like Me has won critical praise, and this year won the Logie for the Most Outstanding Comedy after years of nominations, in its final season. While some may say Thomas is a polarising actor and personality, it's impossible to ignore the contribution he, and his show have made to the Australian television landscape. More specifically, his honest and real representation of mental health and suicide are a vastly important contribution.

Full series available on DVD or ABC iView.

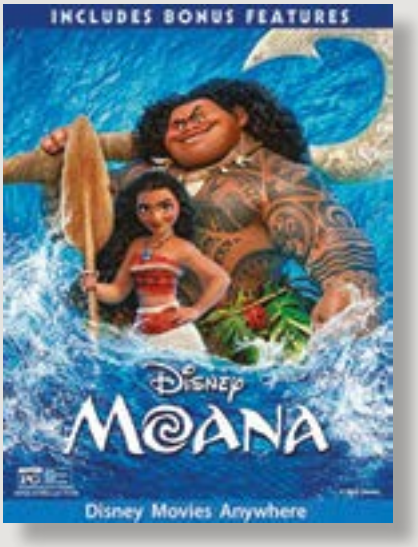


Watch

Crazy Ex-Girlfriend

Don't let the title put you off – this clever, hilarious and biting musical comedy is one of the best shows of the last two years. Written by and starring Rachel Bloom, the series follows attorney Rebecca Bunch, who should be happy. But when she's offered the chance to partner at her prestigious law firm, a panic attack turns into an existential crisis. When was the last time she was really, truly happy? Summer camp, when she was 15, and dating Josh Chan. What follows is an ironic, nuanced and award-winning exploration of infatuation, love and friendship – with ridiculous musical detours. Songs like the Cole Porter-inspired 'Settle for Me', or the Disney-villain homage 'I'm the Villain in My Own Story' take the audience through the neuroses of Bunch's mind in an incredibly self-aware way. Season Two only gets better, and with Season Three landing in late 2017/18, now's the time to fall in love with Crazy Ex-Girlfriend.

Available on Netflix.



Movie

Moana

There's a new Disney princess in town, and she's not a princess, she's a chief-in-waiting. Moana is the newest offering from Walt Disney Animation Studios, and is poised to overtake Frozen in the soundtrack earworm charts. The titular Moana is the daughter of the chief of a Polynesian village, who longs to travel the ocean but must stay on their island and lead her people. Moana's magic comes from her connection with the sea and the legends of her people. When her village is threatened, she embarks on her heroes' quest with the arrogant but suave demi-god Maui in tow. Maui is played with swagger and humour by Dwayne 'The Rock' Johnson, in a role that seems as made for him as his original WWF persona. With original songs by certified genius Lin Manuel Miranda alongside Opetaia Foa'i and Mark Mancina, you'll be humming the South Pacific songs along with your kids or grandkids, and maybe planning a trip to Fiji, Samoa or Tonga.

Available on DVD and digital download.

Classifieds

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RETIREMENT

MORNINGTON

Dr Ian Haywood has retired from active medical practice. Medical records will stored as per legislative requirements.

CLOSURE OF PRACTICE

MORNINGTON

Dr Hannah Mendelson wishes to announce the closure of Ninox Clinic, Mornington. Medical records will stored as per legislative requirements.

GYNAECOLOGICAL ONCOLOGIST

EAST MELBOURNE

Dr Adam Pendlebury has commenced practice as a gynaecological oncologist. He has recently returned from fellowship training in Melbourne, Brisbane, Perth and Cleveland Clinic, USA. Special interests include gynaecological oncology, robotic surgery, advanced laparoscopic surgery, complex pelvic surgery, colposcopy, laser, family history of gynaecological cancer. Consulting at Epworth Freemasons in East Melbourne and Mercy Hospital for Women in Heidelberg.

Call (03) 9418 8128.

NOTICES

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 gerald.segal@bigpond.com

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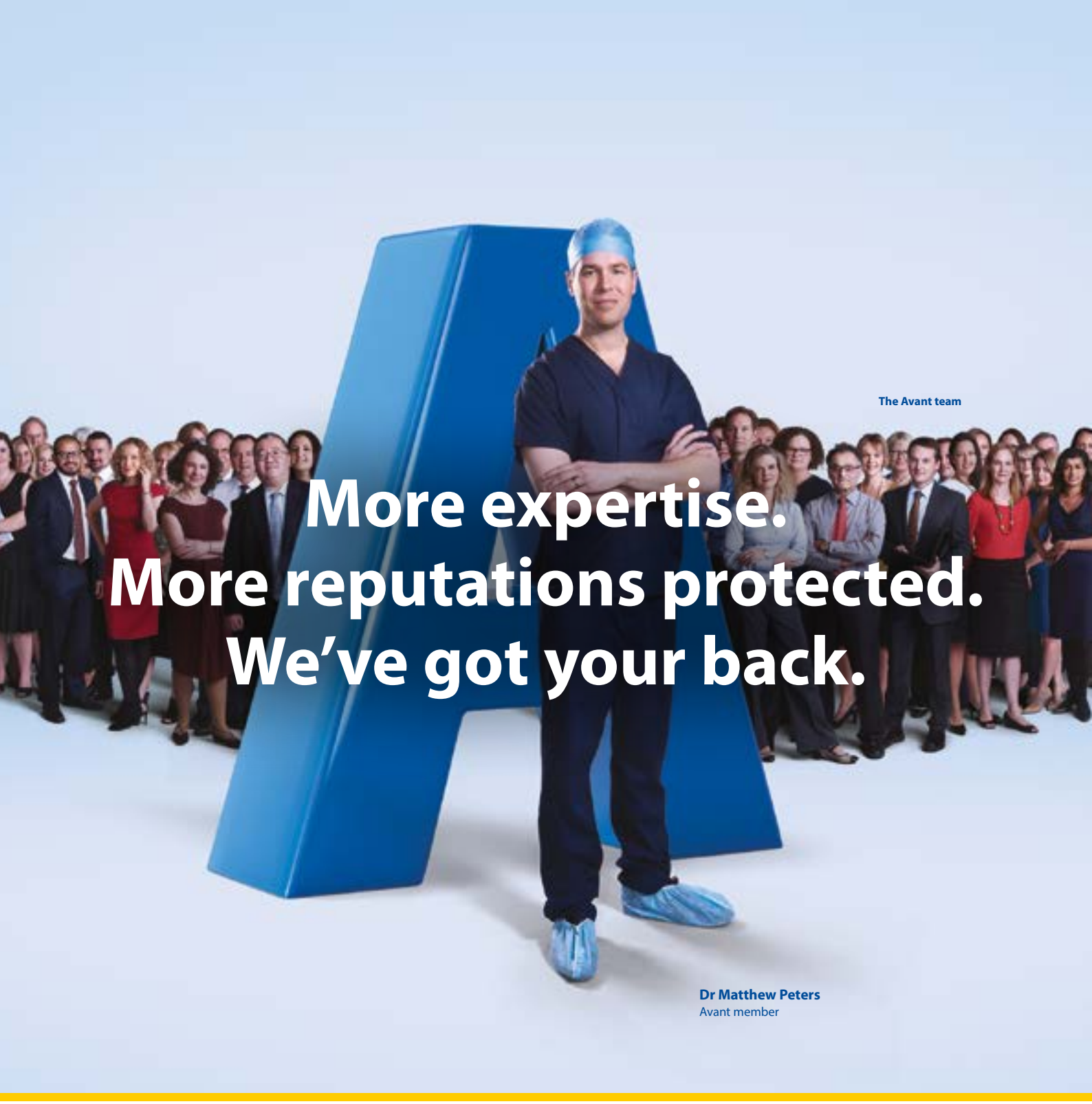

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