

vicdoc

A detailed scanning electron micrograph (SEM) of a cluster of rod-shaped bacteria, likely Bacillus anthracis spores, showing their characteristic blue color and the intricate orange filamentous structures (flagella) extending from their surfaces. The bacteria are arranged in a dense, overlapping group against a dark background.

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION VICTORIA LTD. APRIL/MAY 2019

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Welcome from the editor



Meet some of our dedicated current and future medical leaders in our International Women's Day profile series. Begins on page 28.

As we prepare for the Royal Commission into Mental Health, I encourage you to read the President's Message on page 7. A/Prof Julian Rait provides an update on some of the themes and key points AMA Victoria has been hearing in our consultations with members.

People who are currently being let down by the Victorian mental health system include the 'missing middle' - patients whose needs are too complex for primary care alone but who cannot currently access a psychiatrist. Some of our most complex and vulnerable patients end up in emergency departments and experience 'revolving door' stays in hospitals. It's a desperate problem that emergency physician and Australasian College for Emergency Medicine President, Dr Simon Judkins is all too familiar with. Dr Judkins emotively explains on page 12 just how frustrating it is being unable to adequately look after this 'missing middle'.

Some of the state's best medical and scientific minds are working hard to explain and hopefully reverse the recent rise in cases of Buruli ulcer in Victoria. You can

learn about the 'Beating Buruli in Victoria' project on page 8.

AMA Victoria's 2019-20 State Budget Submission was recently provided to the Victorian Government. You can read the full submission in the policy section of our website, but in this edition of Vicdoc, we highlight our goal to ensure equal access to high quality and comprehensive health services for rural and regional Victoria, compared with the greater metropolitan areas.

If you would like to tell us about an achievement in medicine or a personal interest others might enjoy reading about, please contact me. We are also very keen to hear any other feedback on Vicdoc - particularly your ideas on how we might improve the publication. Vicdoc is sent to members every two months, so look out for the next edition in your mailbox in June.



Barry Levinson

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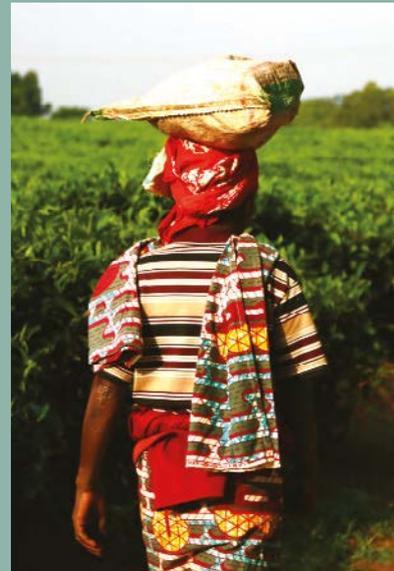
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President's message



As you would know, the Royal Commission into Mental Health was established in March. AMA Victoria is pleased we have had the opportunity to be consulted by government on the Terms of Reference (ToR) for the Commission and we have congratulated the four commissioners on their appointment to lead the inquiry.

Thankfully, the Andrews Government appears to have listened to AMA Victoria on many aspects of the ToR, including a focus on all age groups; the real needs of the workforce; the problems of dual diagnosis; the challenges for regional and rural communities; the need for greater accountability; and especially our desire to see improvements in the governance of the mental health system.

Members can be reassured that AMA Victoria will advocate for a broad interpretation of these ToR, rather than them being too narrowly applied. In particular, the ToR have an explicit focus on prevention which is certainly important for many illnesses such as depression and anxiety, although this aim does not apply universally. Indeed, it's equally important for the Royal Commission to focus on how the mental health system treats and meets the health needs of people with psychotic disorders, such as bipolar disorder and schizophrenia. These illnesses are not as amenable to prevention and usually require long-term care - an area in which our mental health system is currently failing.

In over 30 reports and inquiries into Australia's mental health system between 2006 and 2012, the common finding has been that our mental health system is inadequate to meet the needs of the community. A key reason for this is the 'missing middle' - these are patients whose needs are too complex for primary care alone but who cannot currently access a psychiatrist. This 'missing middle' represents some of our most complex and vulnerable patients, who frequently go without access to appropriate psychiatric care, deteriorate and inevitably end up in emergency departments and experience 'revolving door' stays in hospitals. Long-time emergency physician Dr Simon Judkins has written a very emotive article about this issue on page 12 of this Vicdoc. AMA Victoria anticipates long-term reform and improvements for these patients resulting from the 2019 Victorian Royal Commission into Mental Health.

We have also indicated to the State Government that while such a wide-ranging inquiry is imperative,

it must not distract government from further investment into the mental health system ahead of the interim recommendations of the Royal Commission by this November and its final report by October 2020.

Many of Australia's government-operated psychiatric hospitals and specialist outpatient services were closed down in the 1990s. It is now widely accepted that Australia failed to invest adequately in a replacement model of community mental health care. This has meant that for people seeking mental health services, and without the means to access private psychiatric treatment, there are few alternatives between a visit to a GP and presenting to the hospital emergency department.

Community mental health services (except for private psychiatrists and GPs) provide short to medium term treatment and support to either prevent further escalation of problems leading to hospitalisation or smooth the transition to home following hospital discharge. However, this model might not be optimally effective for people at all levels of acuity, for example those people who display a high risk of engaging in self-harm or suicide. Furthermore, this setting is not adequately resourced and funded for people requiring longer-term treatment and support arising from their condition.

Non-government organisations provide much needed psycho-social support but these services cannot respond in a crisis or offer the clinical psychiatric diagnosis and treatment, case management and acute support services needed by highly complex patients. While Primary Health Networks (PHNs) are able to facilitate access to psychologists and mental health nurses, they are not funded to enable referral to psychiatrists.

Last year AMA Victoria welcomed the State Government's announcement of 89 new acute inpatient psychiatry beds. However, the number of beds in the state system has grown by 7 per cent, while the state's population has increased by 15 per cent over eight years. The availability of beds per 100,000 people has fallen by 9 per cent. There is thus a significant shortage of acute hospital services for patients in need of psychiatric care in Victoria.

AMA Victoria continues to call on the Victorian State Government to urgently address the needs of complex patients across regional and metropolitan

areas by funding 477 new public mental health beds (including over 100 acute beds) and a minimum of four new pilot specialist outpatient psychiatry services over the next three years.

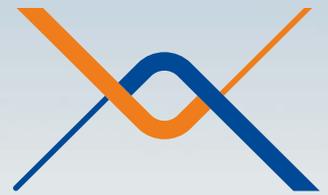
An evidence-based and transparent approach to mental health spending would also be advantageous. Governments can lose traction on maintaining acceptable levels of investment and services over the longer term. This neglect in system capacity partly reflects changing policy directions with inadequate strategies or policy implementation, including monitoring of population size, incidence and prevalence of conditions, distribution patterns

of conditions within the population and across the state, and social and economic conditions under which people are becoming unwell and attempting to recover.

Clearly, the long-term goal should be to fund an evidence-based monitoring and planning framework incorporating capacity and performance measures, and which underpins continuing investment by government on mental illness prevention and treatment.

**A/Prof Julian Rait OAM
President**

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Beating Buruli in Victoria



With more than 340 cases of Buruli ulcer notified in Victoria last year there is growing concern about the exponential growth of this little known disease. But what do we know about this disease and what is being done to better understand its spread locally?

Buruli ulcer (also known as Bairnsdale ulcer) is an infection of the skin and soft tissue caused by *Mycobacterium ulcerans*. *M. ulcerans* produces a potent cytotoxin called mycolactone that induces necrosis and ulceration. Initially infection may cause localised erythema and swelling, or the formation of a papule, which then in most cases progresses to an ulcer.

Buruli ulcer has been reported in 33 countries around the world including rural West Africa, Central Africa, Papua New Guinea, Latin America, tropical regions of Asia and Japan. In Australia, Buruli ulcer was first diagnosed in the Bairnsdale area of East Gippsland in the 1930s and later seen in Philip Island. From the turn of the century, a growing number of cases have been reported on the Bellarine Peninsula.

Since 2012, there has been a significant increase in Buruli ulcer cases on the Mornington Peninsula and more recently, the south eastern bayside suburbs closer to Melbourne. It

is a disease that does not discriminate and people of any age can become infected. People who live in endemic areas of Victoria are considered at greatest risk, but as these areas are some of our most popular holiday spots, the many visitors each year to these areas mean that all Victorians must remain vigilant.

Transmission

Although it is understood that *M. ulcerans* is picked up from certain environments, it is not yet known exactly how humans become infected with the bacteria, or exactly where in the environment the bacteria prefer to live. It is not thought to be spread from person-to-person and it appears that the mode of transmission in Australia may differ to the spread of disease in African countries.

Victoria's Department of Health and Human Services (DHHS) has supported research into how Buruli ulcer is transmitted for more than two decades, it

Findings from a previous case-control study showed that getting bitten by mosquitoes was a risk factor for getting Buruli ulcer.

including providing funding to develop an internationally recognised molecular test (PCR) that has enabled detection of Buruli ulcer in the environment and much earlier diagnosis and treatment of the disease.

This local research has shown that possums and mosquitos are likely to be involved in spreading the disease, however, the local epidemic could involve more than one transmission pathway and additional factors that remain to be defined. The risk of infection appears to be seasonal, with a higher risk in the warmer months (November to April).

Diagnosis

The hallmark of Buruli ulcer is a non-healing sore, which slowly enlarges over weeks to months. It can occur anywhere on the body but it is most common on exposed areas of the limbs, such as the ankles, the backs of the calf, around the knees, on forearms or around the elbow.

In the very early stages, the infection may start as a spot that looks like a mosquito or spider bite. This can be itchy and is usually painless, however, some patients do complain of pain on initial presentation.

The spot usually gets bigger over days or weeks and may form a crusty, non-healing scab. Occasionally it can develop more rapidly. Over time, the scab turns into a nodule and then an ulcer that continues to increase in size and is ringed by erythematous swelling. The edges of the ulcer are often undermined with the dead tissue extending far beyond the actual ulcer on the skin surface.

Ulcers are usually single, but they can be multiple or recurrent. Some patients can get a lot of swelling in the infected area and this may affect a whole limb, with the infection presenting as persistent cellulitis with localised pain and swelling.

PCR testing of lesion material from a swab or biopsy is the most important diagnostic method, however, it is important that swabs are taken with the correct sampling technique. Follow the guidance in the Chief Health Officer Advisory on diagnosis and testing, making sure to take a dedicated swab reserved for polymerase chain reaction (PCR) testing for the infection.

Treatment

These lesions do not respond to

standard antibiotics for skin infections. As ulcers get bigger over time, early diagnosis and effective treatment are vital to minimise tissue loss and reduce the time until the ulcer heals.

Buruli ulcer can be effectively treated with specialised antimicrobials similar to those used in the treatment of tuberculosis, taken orally for two to three months. Surgery is sometimes used in combination with antibiotic therapy to improve healing and repair skin defects. Regular dressings are usually required. Complete healing usually takes between three and six months depending on the size of the ulcer.

Prevention

Although it is not known exactly how humans become infected, we do know it is acquired from contact with the environment in endemic areas so it makes sense for people to protect themselves from potential sources, particularly biting insects. Gardeners and outdoor workers at risk from minor penetrating injury should wear protective clothing and cover existing cuts or abrasions before starting work.

Suggestions to reduce the risk of infection include:

- Avoid insect bites by using suitable insect repellents and long clothing, especially during the warmer months.
- Wear gardening gloves, long-sleeved shirts and trousers when gardening or working outdoors.
- Protect cuts or abrasions with sticking plasters.
- Promptly wash and cover any scratches or cuts you receive while working outdoors.

The highest risk is associated with the active transmission areas of Rye, Blairgowrie, Tootgarook, Rosebud and Sorrento on the Mornington Peninsula. There is a moderate risk associated with areas in the Bellarine Peninsula (Ocean Grove, Barwon Heads, Point Lonsdale, Queenscliff and St Leonards), Frankston and Seaford areas. There is a low but material risk associated with the rest of the Bellarine and Mornington Peninsula, the south eastern bayside suburbs and East Gippsland. Together, all these areas are considered the endemic parts of Victoria for Buruli ulcer transmission. Anyone living or travelling to these areas should ensure they protect themselves in the warmer months.

Beating Buruli in Victoria: the research project

Comprising a series of epidemiological, field and laboratory-based studies, the *Beating Buruli in Victoria* project hopes to actively disrupt disease transmission for the first time and lead to the development of evidence-based policies and guidelines that can help stop the spread of Buruli ulcer around Victoria and even globally.

This innovative two-year project, supported by a substantial National Health and Medical Research Council grant, is a collaborative partnership between DHHS, the Doherty Institute, Barwon Health, Austin Health, CSIRO, Agriculture Victoria, The University of Melbourne and Mornington Peninsula Shire.

Beating Buruli: a case-control study

The Beating Buruli case control study aims to investigate a range of risk and protective factors associated with Buruli ulcer. As well as the use of a standardised questionnaire to gather data from both cases and controls, the case-control study team is conducting field surveys at the properties of study participants where a range of environmental samples will be collected and then tested for *M. ulcerans* in the laboratory.

The team hopes to identify factors that increase a person's risk of getting Buruli ulcer by comparing questionnaire responses and field survey results from both cases and controls, and ultimately determine factors that can protect against infection. The study will run for a total of two years from September 2018.

Beating Buruli: the mosquito control study

Findings from a previous case-control study conducted in 2004 on the Bellarine Peninsula showed that getting bitten by mosquitoes was a risk factor for getting Buruli ulcer, while wearing insect repellent was protective. Other protective factors include wearing long trousers and immediately washing minor skin wounds sustained outdoors. The multivariate analysis found that insect repellent use and being bitten by mosquitoes on the lower legs were independently associated with Buruli ulcer. More recent research, including mosquito field surveys, laboratory studies and mapping the distribution

Continued on page 10



of Buruli ulcer lesions in human cases, has strengthened the evidence that mosquitoes might play a significant role in transmission in Victoria.

These findings are the basis for the second major research focus of this project, the Beating Buruli mosquito control study, which aims to investigate the effect of mosquito control on the transmission of Buruli ulcer.

Through the Beating Buruli mosquito control study, the research team will test the idea that a multifactorial mosquito control program will reduce Buruli ulcer in humans. It will use a cluster randomised control design based on residential clusters in Mornington Peninsula Shire.

Everybody living in the study areas will receive information on how to protect themselves from mosquito bites and the diseases mosquito bites might transmit - like Buruli ulcer. Intervention areas will also receive an intensive mosquito control program, which will involve mosquito surveillance, pesticide administration and mosquito trapping.

The Beating Buruli mosquito control study will be conducted over two years, with mosquito surveillance commencing in early 2019 and the intervention being rolled out later in the year.

Take action now

Early diagnosis is critical to prevent skin and tissue loss, so the diagnosis should be considered in all patients with a persistent ulcer, nodule, papule, or oedema and cellulitis - especially on exposed parts of the body. Once diagnosed, referral for treatment to

doctors experienced in the management of this condition is recommended.

People of any age can get infected and symptoms can occur four weeks to nine months after exposure to any endemic area. Always consider a detailed travel history when diagnosing a non-healing ulcer.

Buruli ulcer is a routine notifiable condition and must be notified to the DHHS within five days of diagnosis.

The RACGP has produced targeted information and a professional educational activity aimed at helping GPs identify and manage the ulcer. 'Identifying and managing Buruli ulcer' is designed to help GPs with the diagnostic challenge of distinguishing the rare Buruli ulcer from far more common skin ulcers.

With clinicians, public health specialists, researchers and governments all working together, it is hoped that we can prevent the further spread of this debilitating disease and ensure that those unlucky enough to develop Buruli ulcer are treated quickly and effectively.

For more information about Buruli ulcer and the *Beating Buruli in Victoria* project head to www2.health.vic.gov.au/beatingburuli

Written by 'Beating Buruli in Victoria' research partners Dr Simon Crouch (Department of Health and Human Services), Prof Tim Stinear (Peter Doherty Institute), Prof Paul Johnson (Austin Health), Prof Dan O'Brien (Barwon Health) and Prof Eugene Athan (Barwon Health).

References available from the Editor on request.



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We must provide better care for mental health patients



I am a pretty optimistic person. I think the job that I have is incredibly rewarding, but can also be incredibly draining. What keeps me going is the people I work with; the team in my emergency department, but also the enormous team of dedicated doctors, nurses, PSAs and clerical staff who rock up to work every day, 24 hours a day, to keep our emergency departments, the coalface of public health, accessible to all people who need care, when they need it.

Being part of a team keeps us all going. We look forward to working together, combining our strengths and skills; tackling anything that comes our way. Determination. Tick. Compassion. Tick. Support. Tick. It is in our DNA.

Drawing strength from this optimism, I want to make a difference in patients' lives. We all do. So, when I arrive at work, before every shift I make it a habit to tell myself, "I can make a difference today. Whether it's one patient, a family, a staff member, I have an opportunity to help people when

they most need it". What can be more rewarding than that?

Every patient who comes through the emergency department is looked after with the skill, care, professionalism and compassion you would expect from specialist doctors, trainees and nurses. But having spent more than 20 years in public hospitals across Melbourne and regional Victoria, I recognise one particular group of people who desperately need our help in providing better access to appropriate healthcare; those with mental health needs.

The care for these patients is being compromised because of the dysfunctional state of our mental health system. Patients come to emergency departments for help that they often can't find elsewhere. We do our bit; triage, assess, address acute needs and involve specialist colleagues when needed. Many need admission, but that is often when things grind to a halt; patients wait in emergency departments for an inpatient bed often

for hours and, in increasing numbers, for days.

They are in the wrong place. Staff are heartbroken in having to look after them in a sub-optimal environment. An environment that is unable to respond and cater for their needs in a timely way, unable to provide any semblance of a therapeutic environment to meet patients' needs.

Every emergency department doctor in Victoria - across Australia, for that matter - can tell you a distressing story about how the health system is failing. The plight of Indigenous Australians and those living in rural and regional areas are particularly confronting. Each year, more than a quarter of a million Australians present to emergency departments seeking help for acute mental and behavioural conditions.

I have previously told my story about Nathan*. A kid who had an unimaginable, but all too common, history: abused by an uncle, his father

had died when he was very young and his mother was drug addicted and on the streets. With a provisional diagnosis of borderline personality disorder, he would regularly come to the emergency department, but the care and attention we tried to provide was completely inadequate, though through no fault of any one individual. Anyway, this kept on happening over many visits until the visits stopped. News came through he had killed himself.

Colleagues tell of starting a shift and coming across a dishevelled patient, who has been in a trolley for days with no privacy, no dignity, and feeling guilty about not giving them the care and respect they deserve. Again, not because of a lack of compassion from staff, but because they are not supported by an adequately resourced system. Instead, it's a system which is in a state of functional failure.

There are good days and bad days, as with any job. What I have described above is the bad; the despair. This is what drives many staff to the point of burnout; of questioning their choice of career. To ask people to provide acute, emergency care *and* have to constantly

fight against a system which isn't providing the resources they need to carry out their job drives the best of us to the lowest point.

But the good, the hope, the cause for optimism is the will and actions of emergency department teams in fighting for what is right.

The College of which I am President, the Australasian College for Emergency Medicine (ACEM), has a commitment to maintain the highest standards of medical care for patients in emergency departments across Australia and New Zealand. We have been outspoken in calling for better patient care for the community's most vulnerable people.

We have seen and heard from individuals and groups; those who have confronted poor patient outcomes, spoken up and been voices of change.

And the College, following a successful summit in Melbourne late last year that saw more than 170 emergency doctors, psychiatrists, consumers, clinicians and key decision-makers discuss and agree on key principles to tackle this mental health crisis, is working on a range of measures to address in a mental health

consensus statement that we will use as a driver for change when we discuss these issues with state and territory health ministers.

I love the work that we do. The variety of patients, the amazing people you meet and the team I work with. But the team I want to build now, the team we all need to build so we can change the way we deliver care, goes way beyond the walls of any emergency department in the country. It needs all of us to understand our roles and have a common sense of purpose. That our job is to work together to make our system as good as it can be for the sake of our communities.

I'm seeing that happen, slowly but surely. That's why I am optimistic that we will do better.

** Nathan is not his real name.*



Dr Simon Judkins
President
ACEM

Dr Simon Judkins has been a doctor for close to 30 years and has worked as an emergency physician for 22 of those. He has worked in emergency departments across Melbourne and regional Victoria. He is the President of the Australasian College for Emergency Medicine and a member of AMA Victoria.

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Private health insurance – where to from here?

The AMA has supported some of the Federal Government's recent attempts to improve private health insurance and health literacy. Helping people to understand what their insurance covers across insurers, policies, and clinical definitions is a step forward.

These reforms should help build some confidence for people that their insurance has true value. But the Government reforms do not address affordability – this problem is starkly obvious with the last round of premium increases.

The rate of increase in premiums has slowed, but still outstrips inflation and, more importantly, outstrips wages growth. How much longer can private health insurance stay affordable with increases in premiums averaging 4 to 5 per cent a year when wages growth is firmly stuck around 2 per cent?

Private health insurance (PHI) is in trouble, with a dozen or so successive quarters of decreasing coverage to 44.6 per cent. Further reforms are required.

But any such changes should not compromise patient care or cede decision-making power to the insurance company. Managed care – the stealthy goal of payers – is anathema to high quality medicine.

Loss of a doctor's clinical independence is unacceptable to the AMA and I hope Australians would realise the risks if this trend continues. It would drive a reaction that is negative to the value proposition of private health insurance.

The AMA believes that the next round of reforms – and there must be more reform – needs to focus on protecting the independent clinical decision-making by clinicians, who are chosen freely by the patient, with consultations conducted in an appropriate facility; and the abolition of poorly indexed, differential insurance rebates.

I suspect that the insurance companies will tell you that reforms need to be about costs, particularly the costs of doctors.

The health insurers are worried about a possible 2 per cent cap on premium increases for two years and how this will impact their bottom line. You must

remember that doctors and patients have faced a zero per cent increase in Medicare rebates for several years.

The AMA acknowledges that the system needs to change if we are to improve patient confidence. Out-of-pocket costs are negatively affecting consumers' perception of the value of insurance. The AMA realises we have some heavy lifting to do in this regard. We do not support egregious billing or the use of administrative and booking fees. They are inappropriate, and unacceptable.

Let us be clear about what constitutes out-of-pocket costs to patients. This is not a conversation that can be limited to what doctors' charge. It must necessarily include the other components of payment from the Medicare Benefits Schedule (MBS) and the health funds.

Nationally, in 2016-17, Australians spent \$29.4 billion on out-of-pocket health-related expenses. Most of this was on:

- prescription and non-prescription medications (\$10.8 billion or 37 per cent)
- dental services (\$5.7 billion or 19 per cent)
- other healthcare such as aids and allied health services outside Medicare (\$6.7 billion or 23 per cent).

Medical costs make up only 21 per cent of out-of-pocket expenditure for individuals.

In terms of outlays by funds for private specialists, again, the amount spent on doctors is only a small percentage. Of the \$3,965 million in the December 2018 quarter paid by insurers for hospital treatment benefits, only \$613 million – around 15 per cent – was for medical services.

The answer to the affordability problem is not 'doctor bashing'. The statistics

and the facts do not support it. If it continues, this malicious diversionary tactic will backfire on the entire industry.

In 2005, the 'for profit' health insurers made up 16 per cent of the market. Today, this figure is nearly 70 per cent. Profit before tax of the industry for the year up to December 2018 was \$1.6 billion.

By extension then, insurance companies are plausibly worried about reporting to shareholders and maintaining profits. If feeling threatened, insurance companies may resort to increased use of selective contracting and increased pressure on healthcare providers or hospitals to sign contracts, or be left out in the cold with disadvantaged patients.

As doctors, we are worried about this. We are worried that this enables insurers to influence, even dictate, the healthcare pathways available to their customers. The nature of healthcare funding and gaps cannot be shrouded in complexity or hidden from the consumer.

I hope that in transitioning existing policies over to the new classifications, insurers improve health literacy, and minimise covert reductions in coverage. I am certain that doctors and private hospitals both want a strong private health system. I'm sure we can work together to preserve it.



Dr Chris Zappala

AMA Federal
Vice President

This is an excerpt from a speech delivered by Dr Zappala at the Australian Private Hospitals Association (APHA) Conference held in Melbourne in March. Visit ama.com.au/media/speeches-transcripts to read the full transcript.

The importance of listening in the doctor-patient relationship



"When people talk, listen completely. Don't be thinking what you're going to say. Most people never listen. Nor do they observe. You should be able to go into a room and when you come out know everything that you saw there and not only that. If that room gave you any feeling you should know exactly what it was that gave you that feeling."

- Ernest Hemingway

Listening starts with making a connection

Listening well in the doctor-patient relationship starts with finding a point of contact or connection with a patient. That might be knowing their occupation or something else about them that reminds us that they are foremost a person, not a patient. Then it becomes easy, not tiring, to listen.

When we've made a real connection, we too have the patient's attention and they are more likely to hear what we are saying and follow treatment and advice that we suggest. An alchemy occurs when we listen - both speaker and listener are changed, transformed by the other. This is part of the healing of listening - feeling heard, acknowledged, our problem shared. What was two becomes one.

Listening as observing

Listening and observing go hand in hand - both involve focusing our attention and expanding our awareness. Both are a form of inquiry.

When we listen to a patient speak, it is not just their choice of words that we notice, but their tone of voice, the speed of their speech and the emotions behind their words. As doctors, we are acutely aware that often the most important things may be left out of the patient discourse - for example, fear of cancer, domestic abuse and loneliness, to name just a few.

Listening is an active process; a practice. To listen we must suspend our judgement of the other.

While we listen our attention is directed both outwards to our patient, but at the same time inwards, noticing what is going on within ourselves. Am I judging this person, am I understanding their meaning, how does this person make me feel, could there be something going on that I am missing?

What gets in the way?

Time is often thought to get in the way of truly listening. Clinicians are always pressed for time and it is often assumed that taking the time to elicit the patient's agenda will be even more time-intensive; time clinicians can't bear to waste. Conversely, when patients think their doctor is under time pressure they are also much less likely to engage and seek information.

Since the early 1980s, the uninterrupted time patients get to speak freely at the start of encounters has declined. In 1984 patients were interrupted after 18 seconds, while in 2018 they only got to speak for a median of 11 seconds before their doctor broke in.

Yet using patient-centred communication skills, including active listening, can help doctors to collaborate on setting an agenda

with the patient. This joint exercise of building bedside rapport and trust does not necessarily prolong the entire encounter, compared to interactions where no joint agenda was set.

Looking at our listening

So how can clinicians learn about their own listening? Awareness of what 'doing listening' looks like is a good first step. Applied linguists have analysed audio and video recorded consultations and described a repertoire of patient-centred verbal and/or non-verbal active listening strategies. Mirroring everyday conversation, clinicians can use backchannels (feedback tokens such as 'yup', 'yes', 'mm-hmm' or nodding to signal they are listening and that the patient has their attention. Repeating part of the patient's narrative to clarify, summarise or collaborate (for example, while dictating a letter in the presence of the patient) further cements the listening impact, rapport and trust. It is hardly surprising that clinicians using patient-centred communication, including active listening, have less malpractice claims against them.

One step beyond awareness is reflection. Clinicians looking at their own listening via video recording can see how they listen *and* how they might be sabotaging themselves. Clinicians can display active listening yet still be perceived as not giving their full attention. Reflecting on their own video recording, clinicians might catch themselves looking at the computer not the patient, crossing their arms, hovering rather than sitting, unintentionally creating a physical barrier with furniture, or signalling listening with nods but then dismissing the patient narrative with a non-sequitur clinical question rather than a personal comment.

Creating listening environments in medicine

Listening in the doctor-patient relationship involves creating a space where the patient is comfortable to give

feedback. Patient feedback is really important to calibrate our diagnoses, but patients need to be made comfortable to give that feedback.

In the Royal Victorian Eye and Ear Hospital emergency department, we start each day with the morning handover, which is a beautiful ritual of listening. The night doctors tell the day team about all the patients they have seen overnight. We hear the patient stories and we're reminded each morning of the importance of listening to our patients, as we listen to our colleagues and give them feedback on their night diagnoses. Listening together as a group somehow weaves an invisible thread around us, binding us into a team for the day ahead.

Once a week our CEO attends and listens to our patient stories, hears the work our doctors and nurses perform overnight and listens to concerns we might have as a team and a department.

Listening is one of the cornerstones of medicine. Some clinicians have an ability to make us feel so completely heard that we remember conversations with them decades later. Perhaps not the details of the conversation, but the *feeling of being completely heard* - this is what we should strive for with our patients.



Dr Carmel Crock
Director, Emergency
Department
Royal Victorian Eye
and Ear Hospital



Dr Mary Dahm PhD
(Applied Linguistics)
Research Fellow
Australian Institute of
Health Innovation
Macquarie University

References available from the Editor on request.

The theme of the 2nd Australasian Diagnostic Error in Medicine Conference is 'Communicating for safer diagnosis'. It will be held in Melbourne, 28-30 April, 2019. Dr Mary Dahm is one of the keynote speakers and Dr Carmel Crock is conference convener. Themes covered include cognitive biases, test result communication, over versus underdiagnosis, physician wellbeing and resilience and medical error. Visit www.improvediagnosis.org/ausdem2019/ for more information.

Graphic campaign shows the lasting effects of alcohol

A graphic campaign that outlines how alcohol makes its way through the body, damaging the healthy cells it passes along the way, aims to highlight the devastating link between alcohol and cancer to help Australians make more informed decisions about what they drink.

The campaign, Drink Less, Live More, from Cancer Council Victoria, is an effort to reveal the hidden toll that booze is having on our bodies.

Alcohol is linked to more than 3,200 cancer cases every year in Australia and approximately 770,000 worldwide. It is known to cause cancers of the mouth, throat (pharynx and larynx) oesophagus, bowel, liver and breast cancer for women post menopause. There is also probable evidence that it increases the risk of cancers of the stomach and breast cancer before menopause in women.

Yet new research from Cancer Council Victoria's Centre for Behavioural Research in Cancer has found just 19 per cent of Australians are aware of

the link between breast cancer and alcohol and only 23 per cent of people are aware of the link between mouth cancer and alcohol.

Cancer Council Victoria CEO Todd Harper said despite the World Health Organization (WHO) International Agency for Research on Cancer (IARC) labelling alcohol a class one carcinogenic in 1988 this new research shows that we need to be doing more to get the message through to Australians.

"The IARC declared alcohol a carcinogen just over 30 years ago, and yet most Australians are still unaware of the link between alcohol and cancer," Mr Harper said. "We need campaigns like Drink Less, Live More to

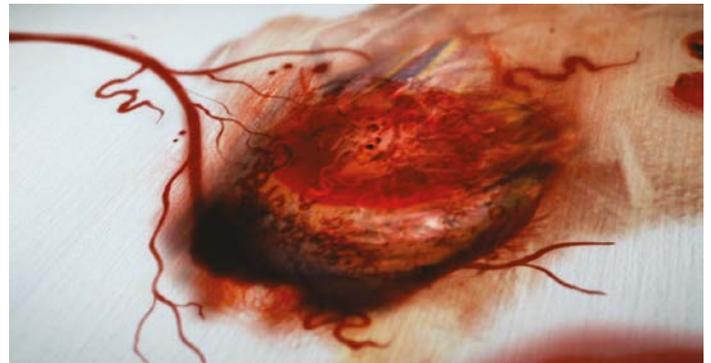
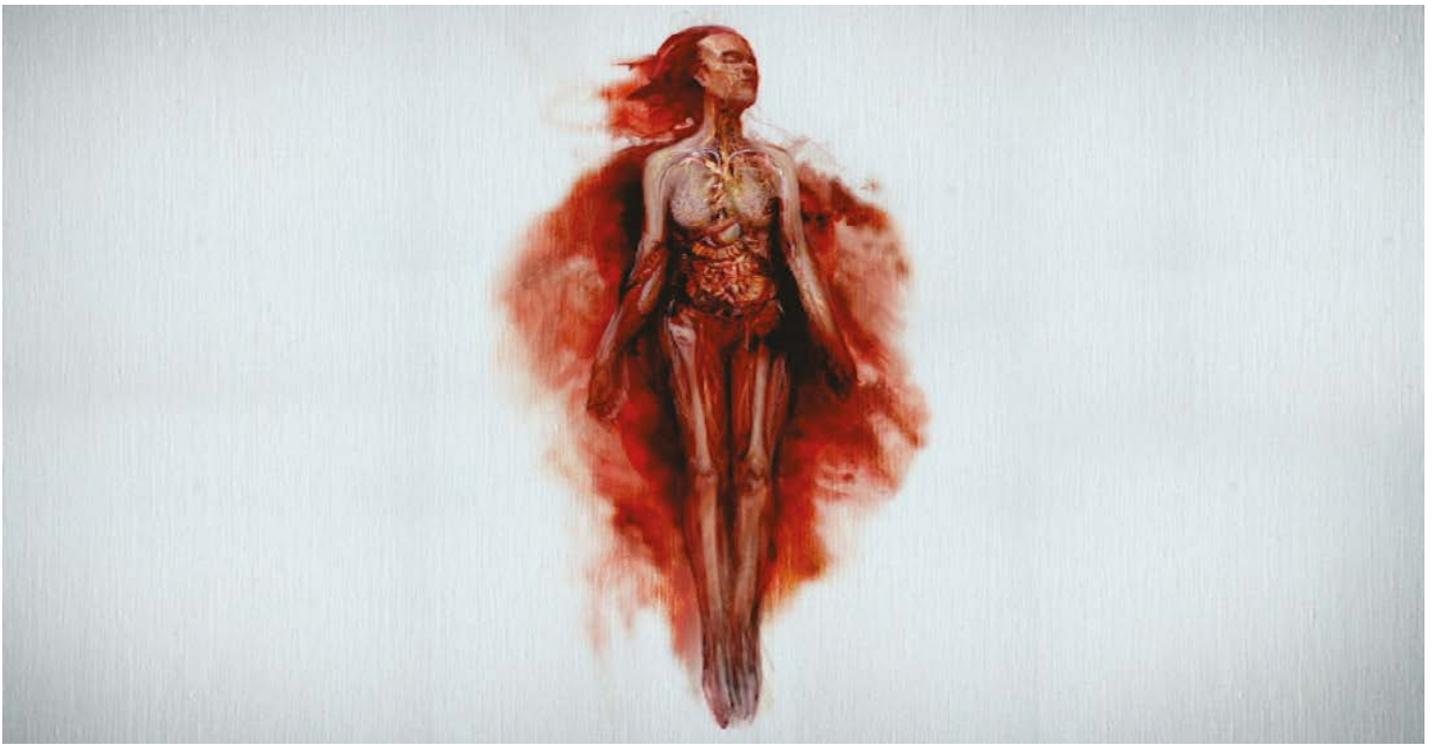
show people the real damage alcohol leaves behind.

"An average of 30 Victorians will die from cancer every day, and yet some of those cancers, including those related to alcohol, could be prevented if people were more aware of the risks."

Cancer Council Victoria Alcohol Policy Manager and Co-Chair of the National Alliance for Action on Alcohol, Jane Martin said these sobering statistics were evidence far more needed to be done to ensure people were aware of the link between alcohol and cancer.

"The big alcohol companies are very good at creating a façade of alcohol as glamorous, making us feel like having a drink with friends will make any event





Images from the Drink Less, Live More advertising campaign.

more fun," she said. "But the reality is quite the opposite. More than just a headache or a hangover the next day, this damage can have very real and long-term devastating consequences.

"It's appalling that, much like the tobacco companies did 60 years ago, the big alcohol companies are keeping the public in the dark about the impact of their products. We need more hard-hitting campaigns like Drink Less, Live More to ensure people know the reality of the health impacts associated with alcohol and have the knowledge needed to make an informed decision about what they're putting into their bodies."

According to the Australian Bureau of Statistics, the average person drinks 9.4 litres of alcohol in a year, that's the equivalent of each person drinking:

- 224 stubbies
- 38 bottles of wine
- 17 bottles (375ml) of cider
- Four bottles (700ml) of spirits, and
- 33 cans (375ml) of premixed ready to drink varieties.

But not everyone drinks, and some people drink much less, which means some people are drinking a lot more than the average.

Every 375ml stubby includes 17ml, or half a shot of ethanol - the same harmful substance we use to fuel our cars - while a 150ml glass of wine has about 19ml, or just over half a shot of ethanol.

The National Health and Medical Research Council recommends no more than two standard drinks a day with an absolute maximum of four in any one day. "What they mean by that is - don't think you can abstain from drinking all week and then drink 14 standard drinks on a big Saturday night out," Ms Martin said.

Radiation oncologist and CEO of Tobacco Free Portfolios Dr Bronwyn King said Australians need to be more aware of the link between alcohol and cancer. "Reducing or cutting out alcohol is important for people who want to lower their risk of cancer," Dr King said. "Many of my cancer patients have been surprised to learn of this

particular risk factor so it's important to increase awareness."

First developed in 2010 by the Drug and Alcohol Office, Cancer Council Western Australia and the Injury Control Council of Western Australia, the campaign advertisement 'Spread' was recognised by a Cancer Council Victoria study published in the *British Medical Journal* in 2017 as the most effective advertisement globally for motivating drinkers to cut back on the amount of alcohol they consume.

The campaign has recently featured on television, digital advertising and social media. People wanting to know more can go to the Drink Less, Live More website - www.cancervic.org.au/preventing-cancer/limit-alcohol/drink-less-live-more for details.



In profile: Choosing a specialty

Choosing a specialty is one of the most important career decisions for a doctor. Some study medicine with a clear career pathway in mind; others commence with no idea of the direction they might head. In this series, we profile a range of specialists who reflect on their careers and selected fields, with the aim of helping others who are still to make a decision.



Dr Clare Collins, Head of Neonatology at Western Health

Why and how did you choose your specialty?

I was attracted to the field of neonatology by the positive experiences I had during clinical rotations as a medical student. A neonatologist cares for sick newborn infants who require intensive care. The range of patients is really very extensive; they may be extremely small premature infants weighing less than 500g or full-term infants with congenital abnormalities or other complex medical conditions.

The mixture of skills needed for this population is quite unique. The specialty combines the need for acute emergency care and technical therapeutic interventions, together with the ability to develop relationships with babies and their families over the many weeks and months of their admission.

Premature babies provide a unique challenge to manage because their physiology changes as they mature. This obviously normally occurs in utero but we need to adapt medical care to the growing baby who may have been born many weeks early. This means treatments such as medications, for example, need to be continually altered for weight, gestation and age after birth. It is important to have a good grasp and working knowledge of physiology and fetal development.

All babies are born with a family; the structure and nature of this may vary significantly, but it means that we care for the whole family unit. Neonatal units are great social levellers; it doesn't matter if you are a CEO of a multi-million dollar corporation or a recently arrived refugee. All parents with babies admitted to the neonatal unit are living in an extremely emotional and stressful environment and it is important to allow parents to feel connected with their baby.

Skills within the specialty are varied and this gives scope for a wide variety of research and development opportunities. I completed a PhD investigating a new technique of non-invasive respiratory support in pre-term infants and undertook a clinical trial as part of that. However, there are many other opportunities for research, ranging from science-based laboratory bench research and clinical trials, to qualitative research involving parents, babies and other healthcare providers. Qualitative research is becoming more important and, given the respect it deserves, important work looking at parent-led models of care within NICU have the potential to improve both the experiences of parents and babies in NICU, but also improve outcomes. There are a number of clinicians collaborating with the medical device industry to improve the technical equipment we use.

What personal qualities and skills/strengths do you think are integral to reaching your potential in your role?

I think the ability to think clearly under pressure, have good communication skills and a somewhat obsessive attention to detail are the hallmarks of all successful neonatologists.

It is an emotionally challenging speciality, as we are involved with families at one of the most intense periods of their lives. There are often many complex ethical issues at play and the decisions that one family may make for their baby may be completely different from that of another. The need to be compassionate, empathic and respectful of different views and cultures is essential.

It can be very confronting when babies die, but I feel very strongly that the palliative care aspect of the specialty and helping families deal with grief and loss is an equally important aspect of the job.

The multidisciplinary teamwork that is needed to look after these sick babies and their families cannot be underestimated. No single healthcare provider group can meet the needs of these patients individually.

The ability to work closely with colleagues is essential and it is this team environment that is also what provides the supportive culture that we need to care for ourselves.

However, seeing parents wave goodbye as they leave the unit after many weeks and months with their baby or having ex 24-week gestation baby who is now two years old running amok in the outpatient clinic playroom is extremely rewarding.

What do you love and what do you find challenging about your role?

I personally love not knowing what is going to come through the door at any time and having to use first principles of anatomy and physiology to direct interventions and treatment strategies. It is a privilege to be able to be involved with families and care for their babies.

Describe your typical day as a neonatologist.

The day starts with morning handover from the night team on the progress of the babies in intensive care overnight and any expected admissions are discussed. The ward round then usually takes place and the workload planned for the day, which may include procedures, a multidisciplinary team meeting and updating family members. Parents are encouraged to be present on ward rounds so they can be involved directly in the care of their baby.

The rest of the day tends to be taken up with teaching, research and administrative activities. All of which can be interrupted by an emergency in the birthing suite and a new admission to the neonatal unit.

I have recently joined Western Health to lead the neonatal unit at the new Joan Kirner Women's and Children's Hospital, which will be opening soon

in St Albans. Part of my role includes increasing the capability of the neonatal unit to establish intensive care for newborns, as they currently all have to be transferred out.

What advice do you have for those doctors considering your specialty?

I would encourage medical students to consider an elective placement within a neonatal unit; the extended time will give you a better of idea of what actually goes on in this somewhat overwhelming world. Get involved in research and quality improvement projects as a trainee so you can see the breadth of practice within the specialty. Babies are not good at being born within normal office hours so there is no doubt it is a speciality that will always have a significant out of hours component! It is, however, an exciting, intense and extremely rewarding speciality.

We would love to hear from you if you want to share your story about choosing a speciality, or if you would like assistance in navigating your career path. Please contact our Careers Consultant Carolyn Speed on CarolynS@amavic.com.au

Interested in becoming an Impairment Assessor for TAC, WorkSafe or the Wrongs Act?

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For medical practitioners; by successfully completing the assessment, you will become an approved Impairment Assessor for TAC, WorkSafe and the Wrongs Act (for the purposes of Part VBA; personal injury).



AMA Victoria and PIEF presents this Ministerially approved training program in the application of the American Medical Association Guides to the Evaluation of Permanent Impairment (4th Edition), (AMA 4 Guides), for the Department of Treasury and Finance in accordance with Section 91(1)(b) of the Accident Compensation Act 1985, Section 46A(2)(b) of the Transport Accident Act 1986 and for the purposes of Part VBA of the Wrongs Act 1958 (personal injury).

Funding priorities for rural and regional health

AMA Victoria recently submitted to government its priorities for the 2019-20 State Budget. Victoria's health system is ranked one of the best in the world and yet it is routinely marked down on indicators relating to health equity. AMA Victoria calls for this particularly to be addressed in mental health and rural and regional health, so that every person across Victoria has equitable needs-based access to high quality and timely healthcare.

We are also advocating for a state-wide obesity strategy, improvements to public hospital culture, drug and alcohol rehabilitation services and palliative care. AMA Victoria will maintain sustained advocacy on these goals and will continually monitor the delivery of change and outcomes.

You can find our full State Budget Submission in the policy section of amavic.com.au but the following is an excerpt focusing on our priorities for rural and regional health.

Goal: Ensure equal access to high quality and comprehensive health services for rural and regional Victoria compared with the greater metropolitan areas.

The 2018-19 Victorian Budget committed to bridging the gap in health inequalities between the 23 per cent of Victorians who live in rural and remote areas and the remaining 77 per cent who live in the cities. Notable were the \$461.6 million investment to redevelop the Ballarat Base Hospital and the additional \$50 million boost to the Regional Health Infrastructure Fund.

Decreases to the scope of services

delivered in smaller public rural hospitals has adverse impacts on the provision of health services to rural communities. This results in many unintended consequences including:

- patients not seeking care
- greater financial and non-financial costs of seeking care
- poorer preventative health
- reduced opportunity for doctors and other staff to maintain their skills.

This leads to poorer health outcomes, greater inequity and impacts on the viability of living in rural communities.

Greater focus is needed on key initiatives aimed at addressing health workforce shortages in rural and remote regions of the state by allocating funding to support teaching, training, recruitment and retention of medical practitioners, in particular general practitioners.

General practice plays an integral role in supporting rural and regional Victorians to be healthy and productive members of society. There is significant variability in the density

of GP services in rural and regional areas. In many regional areas, GP practices are concentrated in larger towns and this creates access issues for people living in more remote parts of rural Victoria. For example, older men in rural areas are less likely to attend a doctor compared with men in urban areas.

In regional Victoria, especially the smaller cities and towns, GPs working as Visiting Medical Officers (VMOs) are the backbone of the medical workforce in public hospitals. AMA Victoria is concerned about the challenges of attracting and supporting GPs, as well as other specialist doctors to Victorian regional areas.

AMA Victoria calls on the Victorian State Government to provide greater



General practice plays an integral role in supporting rural and regional Victorians to be healthy and productive members of society.

support for rural GPs so that they can deliver quality care for their communities.

Rural GPs, specialists and hospitals need to be supported to safely maintain and increase their scope of services. Improved networking and communication between primary care and other public and tertiary health services is needed. Victorian rural GPs could be better supported through access to expert and timely specialist advice from dedicated public hospitals, including in emergency scenarios. Further, GPs should be able to access relevant professional development and skills maintenance and upskilling from larger rural, regional and tertiary hospitals.

Targeted subsidies for the provision of mental health care and whole of

maternity and family planning care by GPs is needed to ensure these services are provided in rural and regional areas.

The discrepancy of remuneration and conditions between registrars at the same level in hospitals and general practice settings is considerable. In order to attract and retain young GPs in rural and regional areas of Victoria, GP registrars should be provided with equitable training, remuneration and conditions to their hospital colleagues.

While the ultimate goal is to retain well-trained GPs in rural areas, AMA Victoria supports employment models and arrangements that facilitate continued mobility between urban and rural opportunities over the span of a GP's career.

Recommendations

AMA Victoria calls on the Victorian State Government to:

Workforce

- Provide subsidies to GP registrars in rural and regional settings so that they can have equivalent conditions to hospital specialist registrars
- Provide subsidies for general practitioners for the provision of mental health services, maternity care and family planning support
- Invest in adequate training for overseas trained doctors in rural and regional settings
- Invest in individual support and mentorship programs for overseas trained doctors in rural and regional settings and in both hospital and general practice settings.

Telehealth

- Invest in telehealth for rural GPs including phone and email advice from dedicated public hospitals to ensure optimal care, timely referral and assistance in urgent and semi-urgent scenarios.

Pathways of care

- Provide GPs working in rural hospitals with priority access to regional hospital hubs and streamlined pathways of care for emergency advice and transfer.

Goal: Support medical workforce planning to ensure current and future health needs of Victorians can be met.

The Victorian Government is strongly advised to work with the Federal Government to support medical workforce planning to ensure that the current and future health needs of Victorians can be met.

Workforce planning will lead to the appropriate investment in the training of doctors and it will also identify areas of need across the state (both geographic and medical specialty).

The Victorian Government should support appropriate planning that will lead to the identification of the:

- number of doctors required in Victoria both now and in the future
- types of doctors (specialists and generalists) required now and in the future
- locations experiencing a shortage of doctors, noting type and specialty; and identifying appropriate measures to rectify the maldistribution of Victoria's medical workforce
- incentives and opportunities required to encourage doctors (and their families) to relocate to areas of need
- employment patterns and intentions of prevocational doctors.

Recommendations

AMA Victoria calls on the Victorian State Government to:

- Provide funding for medical workforce planning to ensure Victoria has the necessary medical numbers, training, specialty skills and distribution across the state.
- Provide funding for specific medical workforce planning and healthcare system development to ensure that rural and regional Victorian communities have access to the health services they need in their communities.

For further information on AMA Victoria's rural and regional medical workforce planning policy, visit amavic.com.au/policy-and-advocacy/rural-health-



References available from the Editor on request.

Harnessing the immune system to combat disease



Dr Alicia Chenoweth (left), Ms May Lin Yap and Professor Mark Hogarth. Photo by Corey Wright Photography/Burnet Institute.

When Professor Mark Hogarth and his mentor Professor Ian McKenzie became some of the first Australians to make monoclonal antibodies (mAb) in a lab in the 1970s, they hoped the technology would create new medicines. Forty years on, these immune system products have revolutionised the treatment of many once incurable diseases and they remain one of the hottest topics in medical research and clinical medicine today.

In recent years, monoclonal antibodies have made international headlines thanks to their role in 'immunotherapy' treatments for cancer. In Australia, for example, AFL footballer Jarryd Roughead became a poster boy for Nivolumab, a monoclonal antibody that is now destroying melanoma for many.

"Melanoma was once a lethal disease," Burnet Institute's Head of the Immune Therapies group, Prof Hogarth said. "It is early days, but for many patients, most of their disease is controlled or eliminated and around 20 per cent of patients with advanced cancer are cured ... it's been a spectacular success."

Nivolumab is one of about 80 mAb therapies available to treat diseases

including cancers such as chronic lymphocytic leukemia, Hodgkin's lymphoma, multiple myeloma and also inflammatory diseases such as rheumatoid arthritis, making them a USD\$150 billion industry.

Behind these immunotherapy medicines is a lot of hard work in research laboratories, typically over decades, to find biological pathways that can be exploited to combat disease. Prof Hogarth and his team at Burnet are at the forefront of this science and now they're focused on creating the next generation of monoclonal antibodies to treat intractable illnesses. Disease targets include some types of breast, colon and ovarian cancers, as well as autoimmune diseases such as lupus and infectious diseases such as HIV, malaria and Ebola.

"I think we know about 10 per cent of what the immune system does at the moment, so there's a fair way to go with a lot of opportunity," Prof Hogarth said.

The expertise of the group lies in understanding the way mAb (genetic clones of antibodies that naturally fight disease as part of our immune system) interact with the white blood cells to harness the immune system. Prof Hogarth and his team are particularly focused on 'Fc receptors' which are powerful molecular switches. They interact with mAb to either switch on the immune system to attack cancer cells or alternatively switch off the immune system if it's being overactive and causing illness, as is the case with inflammation and autoimmune diseases like allergy or lupus.

Using their pioneering knowledge of these receptors, Prof Hogarth and his team, which includes Dr Alicia Chenoweth and PhD student May Lin Yap, are engineering and testing novel forms of mAb to make them more effective disease killers. The group's work of three decades has revealed how these 'on/off' switches work, so it is now possible to modify the antibodies as 'super killers' or 'super inhibitors'.

"We can now convert antibodies to make them 100 times more potent, which is better than the best antibodies out there in the clinic," he said. "That opens up new avenues into the next generation of therapeutic antibodies."

While trying to find new medicines is the priority, Prof Hogarth said this work also has the potential to improve lacklustre antibodies that could now be engineered to have more of an effect. There are also antibodies that

have been dumped from clinical trials because they've been too potent.

"There is one antibody that nearly killed six people in a phase one clinical trial. It failed because it was too potent, so we're working on that antibody to see if we can remove that adverse reaction," he said.

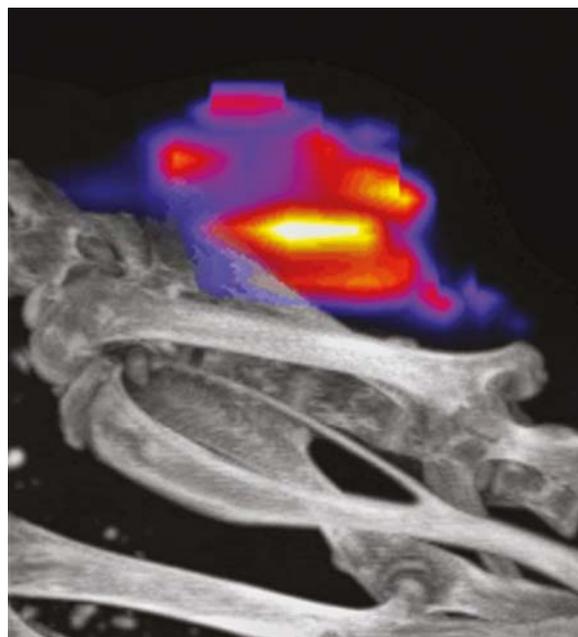
On a daily basis, the team evaluates the new antibodies for their potency and how they can be manipulated to activate the Fc receptor switches and therefore direct the immune system to treat various diseases. For targets and disease models, they collaborate with other national and international researchers and bio-tech companies such as Genmab in Europe, which is using some of the Hogarth group's discoveries as part of their cancer research and development programs. Importantly, close collaboration with such companies is essential, as new medicines must be developed through clinical trials in people, which typically cost more than USD\$100 million.

Another pioneering advance has been the work of PhD student May Lin Yap who has found new ways to see the mAb working in the body. Cancers in the body are complex and variable in their characteristics. Ms Yap uses a special protein, made by Dr Bruce Wines and Ms Sandra Esparon in the Immune Therapies group, to visualise the mAb only if they are able to kill the cancer cells.

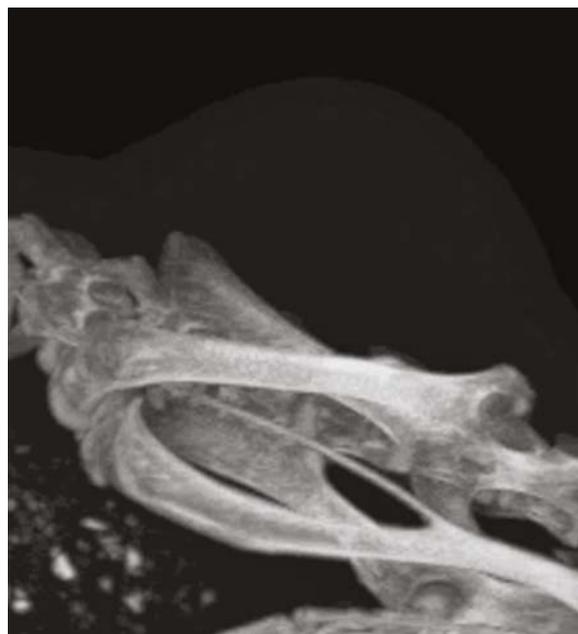
It is hoped the imaging technique that has been demonstrated in animals will be able to show doctors which patients are responding to mAb therapies. This would make treatment more efficient because people who do not respond can move on to other therapies sooner and be spared any side effects from an ineffective intervention. If Burnet can access funding for postdoctoral fellows to pursue these studies, the team hopes to refine this science in coming years, with a goal to apply it to human studies.

While there is great enthusiasm for immunotherapy at the moment, Prof Hogarth said the Australian industry has been slow to respond to the mAb revolution. It's a trend he hopes will end soon.

"There's been some fantastic people who have made great advances in this technology and the application of it to human disease, but the commercial uptake has been poor," he said. "I'd like to make sure we don't lose any opportunities again."



The cancer mass shows striking (brightly coloured) localisation of the Fc receptor to therapeutic antibody in the cancer mass. Photo: Dr Alicia Chenoweth & Prof Mark Hogarth.



The growing cancer cells have no Fc receptor mAb present. Photo: Dr Alicia Chenoweth & Prof Mark Hogarth.



Burnet Institute
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Bullying and unrostered overtime still key concerns for junior doctors



Junior doctor welfare in Victoria remains affected by pervasive issues of bullying, overtime and poor hospital support. Despite advocacy by the Australian Medical Association and attempts by hospitals to address these issues, recent data shows that working conditions for junior doctors in Australia remain poor.

Media coverage pertaining to junior doctor burnout, such as that of Dr Yumiko Kadota, and the recent withdrawal of training accreditation from departments at Royal Prince Alfred Hospital and Westmead Hospital in Sydney last year highlight the persistence of these issues. Quantitative data regarding junior doctor welfare has been critical to advocacy efforts. A key source of data in recent years has been the Hospital Health Check (HHC).

Originally developed in 2015 by the AMA WA Doctors-in-Training (DiT) Committee, the HHC is a confidential, self-reported survey of DiTs that seeks to quantify issues affecting junior doctor welfare, assess hospitals' adherence to industrial, accreditation and education standards, and guide further advocacy efforts. Notably, HHC data was recognised as a contributing factor to the withdrawal of training accreditation from Westmead Hospital

ICU in 2018. Since its inception, HHCs have now been conducted in other Australian states, including New South Wales, Queensland and Victoria. In subsequent years, the AMA Council of Doctors-in-Training (CDT) aims to unify state-led efforts into a federal HHC. This process will standardise survey questions across states, centralise the process of survey delivery and take advantage of increased resources available through the Federal AMA.

The AMA Victoria DiT subdivision will soon publish the finalised results of the 2018 Victorian Hospital Health Check with the hope of continued efforts toward a healthy workplace for all trainees. In contrast to a pilot HHC survey conducted in early 2018, its second iteration received over triple the number of respondents, with 686 junior doctors completing the survey.

Preliminary data from the 2018 HHC is concerning and reflects the persistent, endemic nature of these issues within the medical profession. 30 per cent of respondents rated morale among medical staff as poor, with 37 per cent reporting inadequate hospital support for mental health/wellbeing. Furthermore, 41 per cent of respondents reported experiencing unacceptable behaviours at work, such as discrimination, harassment or bullying.

Commonly cited barriers to reporting such behaviours included a fear of negative career consequences (58 per

cent), a lack of anonymous reporting processes (41 per cent) and disruption of team dynamics (35 per cent). 58 per cent of respondents reported never being paid for unrostered overtime, citing workplace cultural expectations (59 per cent) and obstructive claiming processes (47 per cent). It is alarming that while 86 per cent of respondents believe attending work when unwell endangers patient health, 50 per cent reported doing so due to concerns of burdening colleagues with extra work (87 per cent) and inadequate coverage for their absence (75 per cent).

Preliminary data from the 2018 HHC continues to demonstrate poor working conditions for junior doctors in Victoria. Issues of bullying and harassment, unrostered unpaid overtime and poor morale remain pervasive. On release of the full 2018 HHC report, we call upon all doctors, both junior and senior, to utilise this information to raise awareness about the endemic issues that affect our profession.

Many, if not all junior doctors, have either experienced these issues first-hand or know of a colleague who has. As a profession with the purpose of caring for others, it is fundamentally important that we also care for ourselves. The stark truth is that these issues will not simply resolve with time and passivity. Instead, it is our responsibility to actively engage with them head-on, stand in solidarity with our peers and advocate for real, meaningful change. We hope that publication of the 2018 Victorian Hospital Health Check will empower you to raise awareness about these issues - whether this be through sharing the results on social media or discussing them with colleagues - and encourage you to engage with local advocacy efforts to address them.



Dr Chris Lim
DiT subdivision
Hospital Medical
Officer
Royal Melbourne
Hospital

The full findings of the 2018 AMA Victoria Hospital Health Check will be published shortly on www.amavic.com.au. AMA Victoria DiT subdivision meetings are held monthly. All AMA members are welcome to attend. Please email [Grant Forsyth on GrantF@amavic.com.au](mailto:GrantF@amavic.com.au) for more information.

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Profiling our members for International Women's Day

We celebrated the achievements of our female members to mark International Women's Day on Friday 8 March. This year's theme was 'Better the balance, better the world' and AMA Victoria strongly supports a more gender-balanced medical profession. For those who didn't spot our International Women's Day profile series on amavic.com.au, here's an introduction to some of our dedicated current and future medical leaders.

Dr Amy Touzell

What is your current role in medicine?

- 1) Orthopaedic surgeon at Frankston Public Hospital, Frankston Private Hospital and Beleura Private Hospital
- 2) Adjunct senior lecturer - Monash University
- 3) RACS Victorian Branch Committee Member
- 4) ASSET instructor

Why did you choose to study medicine?

I had an excellent career counsellor in year 12 who (quite sensibly) suggested my previously chosen career path of accounting and actuarial studies probably was not for me! She suggested I apply for medicine and I was asked to interview in Newcastle, so I went up for a weekend. I was living in Melbourne at the time and I fell in love with the beach, the lifestyle and culture of Newcastle. To be honest, it was more the town of Newcastle rather than the medical degree that steered me in that direction. It was the only place that offered me a first-round offer to study medicine, so off I went!

What is the best part about your work?

The variability. As an orthopaedic surgeon with an interest in foot and



Dr Amy Touzell

ankle and trauma, I see everyone from children with curly toes to elderly patients with severe osteoporotic fractures to middle-aged diabetics with charcot deformities. Every case and weekend on-call is different and I love the variety.

I also like the opportunity to teach and develop trainees. Working in a combination of public and private practice allows me to teach registrars, residents and medical students but also learn new techniques and ideas from the registrars as well.

I also enjoy the comradery. I have been lucky to work in a very collegiate department with lots of support, and was invited to join a medium-sized private practice group, which as a junior consultant I found incredibly helpful. I also had a great study group and we studied right through from

our first interview to get onto the surgical training program, right up to the fellowship exam. I still ask them for advice now, both with clinical and non-clinical situations.

What is the hardest part about your work?

Learning how to run a small business has been really challenging. I have found there is little preparation for private practice in the training program and most of what I learned was from making my own mistakes! Every surgeon sets up private practice a little differently and what worked for someone else was not necessarily right for me. I also find financially consenting patients a bit awkward, especially if patients ask for a discount or to be bulk-billed during the consultation. I'm getting better at valuing myself but it's still difficult.

Dealing with surgical complications is also tough, both for the patient and myself. I find I worry about complications at home as well as at work. I am slowly improving by leaving work stressors at work rather than taking them home with me, but this is definitely a work in progress.

Do you have any advice for others pursuing a career in medicine?

Medicine is a long road - if someone had told me in year 12 that I would have still been studying 15 years later, I probably would have swapped back to accounting! I do think there are more junior doctors coming through now, resulting in shift-work rostering, increased competitiveness for training program positions and, in my opinion, more burnout. I would advise to keep options open and have a back-up plan - not being selected for your training program of choice does not make you a failure and may open up other

opportunities in medicine instead.

If you were Health Minister for a day, what changes would you make to the health system?

I think improving regulation for non-FRACS doctors in private hospitals is important. I do feel that surgical podiatrists are operating in an unregulated environment at the moment and I feel that we should encourage a more robust peer review process, both from surgeons and podiatrists. I also feel this area should be more transparent - it is difficult for the general public to understand the difference between a surgical podiatrist and fully-trained orthopaedic surgeon. I understand the Australian Orthopaedic Association and the Foot and Ankle Society are delicately addressing this as well and am watching this space with interest.

I would also increase the amount of

paternity leave currently offered to junior doctors - in some states it is as little as five days. The culture of medicine is changing and I feel that more junior doctors want to prioritise family life as well as pursue a career in medicine. Equalising paternity and maternity leave entitlements helps foster diversity in medicine and promotes the involvement of both parents when raising children.

What do you enjoy doing away from medicine?

I've always been physically active and try to keep this up as much as possible. I've just got into Crossfit and love the power-lifting side (less so the gymnastics given that at 75kg I'm not exactly built for it...!). I'm also very lucky to be able to work a four-day week most weeks, and have a five-year-old and a three-year-old, so sometimes it's nice to be 'Ollie and Lachie's Mum' rather than Dr Touzell for a day.

Associate Professor Eleanor Flynn

What is your current role in medicine?

Very recently retired as Associate Professor in Medical Education at the University of Melbourne, which I did half-time from 1999 to 2019. Clinically I also worked in palliative care at St Vincent's Health and Melbourne Health, from 1999 finishing up in 2017.

Why did you choose to study medicine?

I was interested in biology in year 12 and, being an extrovert, I love chatting to people so I thought I might combine these aspects of my life. And all the other young women in my biology class wanted to do medicine, which I hadn't thought of until then, because all my family are teachers. Also, my father died suddenly of heart disease when I was 15 so I may have also been thinking of helping other people so they wouldn't die too early.

What was the best part about your work?

Clinically it was working in a team with patients and families helping them to cope with death, whether impending or more distant, and ensuring that as much as possible their symptoms and concerns were dealt with. Palliative care uses all the biopsychosocial and spiritual skills we learn as doctors and while

distressing at times can be very fulfilling. Plus, working with trainees and students helping them to see the benefits of a palliative approach to people with chronic and life-threatening illness.

As an educator I loved working with students in small groups helping them to see different aspects of medicine, like the interactions with humanities, and how patients with the same disease will be very different because of their background and personal development as well as the manifestations of the disease.

I have also been an informal mentor to several trainees, a point of reference when things seem tricky, which is very rewarding when they become consultants and start mentoring themselves.

Do you have any advice for others pursuing a career in medicine?

Do what you love. If that means quitting something and starting again, do that even though it will be difficult. Because we are really only of benefit to our patients when we are fully engaged in their care.

What do you enjoy doing away from medicine?

Lots of things. I am currently transforming myself into a medieval



Associate Professor Eleanor Flynn with grandson, Theodore Joseph.

historian, combining my passion for travel to Europe to look at galleries and churches with my love of illuminated manuscripts. I am co-teaching a course in second semester this year for the University of Divinity on how death has been seen through art since early Christian times. I also love music, cooking and gardening - though mostly suggesting plans to my gardener. And being a grandmother, a very new excitement!

Continued on page 30

Dr Trupti Prasad

What is your current role in medicine?

I am a Community Child Health paediatrician working at Melton Health, part of the Djerriwarrh Health Service, as the Clinical Lead in Community Paediatrics. I mostly see children with developmental and behaviour issues, with a focus on the diagnosis and management of Autism Spectrum Disorder and ADHD. We do a number of multidisciplinary autism assessments and work closely with allied health teams on a range of issues.

I also am one of the Social Media Editors for the *Journal of Paediatrics and Child Health* and have a strong involvement with the Neurodevelopmental and Behavioural Paediatric Society of Australia and New Zealand, currently working on a diversity project.

Finally, I spend a fair bit of time moderating and contributing to peer support networks on social media, in particular, the Medical Mums and Mums to Be of Australia and New Zealand, an 8,000 member strong Facebook group which supports medical parents but also participates in a large range of advocacy issues, most recently related to the removal of children from detention.

Why did you choose to study medicine?

Medicine is in my family and my father never really presented it as a choice, if we got in! I grew up with it, hearing my GP parents talking about it and working regularly at their practice. Two of my older sisters went into medicine and when it was my turn, after a few stumbles and hurdles, I eventually got a place at the University of Melbourne and didn't look back. Those hurdles and knockbacks actually made me more determined to do medicine and made me realise that being a doctor was something I wanted to do.

What is the best part about your work?

In equal first place are my team and colleagues and the families I work with. My team is amazing! We are an almost all women team, with a couple of exceptions, including our wonderful and supportive Clinical Director. I am proud to work alongside these amazing, clever and brilliant women who work so hard for children and families. Equally, helping families is a joy, because investing in children is



Dr Trupti Prasad

absolutely the best investment we can make as a society.

What is the hardest part about your work?

I do a lot of work with very vulnerable families and there are some amazing support services out there, but similarly, there are many systematic hurdles that make it impossible for families to break the intergenerational cycles of vulnerability. When I see a school aged-child who cannot access publically-funded speech therapy, or an educational assessment, and who becomes disengaged with school and learning, I feel incredibly frustrated by a system that is incredibly short-sighted. A relatively small investment of resources in early childhood pays huge dividends far into the future.

Do you have any advice for others pursuing a career in medicine?

A degree in medicine opens many doors! There are many clinical and non-clinical pathways out there. Get on social media and find out about them. Importantly, find a mentor or two - people who can talk to you when you're trying to make big decisions, or small decisions. Take care of yourself - no-one else will, and medicine can be a very tough career. Maintain interests outside of work - this is so important - even if it just means reading a few pages of a novel every night, or playing a game of tennis once a week.

Having children while studying medicine and beyond is increasingly common and doable, although hard, for

sure. People with life experience are invaluable in medicine.

If you were Health Minister for a day, what changes would you make to the health system?

Pie in the sky thinking here... I would increase investment in early childhood intervention services and ensure that all school-aged children who need speech and language therapy and assessments could access them. I would invest more heavily in mental health services for young people, increasing the number of Medicare-rebated psychology sessions to at least 20 per calendar year. I would place teaching aides in every classroom to provide both learning support and extension. Banning all packaged food advertising and corporate food sponsorships at sporting events would also be high on the agenda.

What do you enjoy doing away from medicine?

Gardening is a big hobby of mine - both indoor and outdoor - and growing my own vegetables. This brings me a lot of joy. Sustainability is an important part of my life - composting, recycling, reducing and reusing. Climate change is a huge threat to our future.

I love to spend time with my husband and my two children. My husband is a very equal parent and we enjoy our lives together as a family, eating yum cha, wandering the neighbourhood, playing board games and catching up with friends, as well as taking holidays together as regularly as we can.

Dr Laura Raiti

What is your current role in medicine?

Paediatric Senior Resident Medical Officer (SRMO) - Basic Paediatric Trainee year 2 (BPT2).

I am a PGY 4, paediatric resident currently in my second year of the Victorian Basic Paediatric Training Program.

Why did you choose to study medicine?

I came into medicine wanting to specialise in paediatric oncology. My childhood best friend died from leukaemia, and I wanted to go into medicine to practise in this very field and help make a difference to the lives of children living with cancer. I was lucky enough that my personal reason to study medicine was matched with a deep curiosity in the biological sciences and a passion for learning and studying medicine. I am very grateful to be training in paediatrics and love all aspects of this area of medicine.

What is the best part about your work?

It is truly a privilege to look after young people and their families. I have enjoyed every rotation I have had within my paediatric training so far, and regardless of the particular rotation, the opportunity to look after children and their families when they are most vulnerable, is very special.

I loved working in neonatal intensive care where I had the opportunity to look after babies and their families during their time with us in NICU. For premature babies, this can be for quite a long time and their journey can be complex and challenging for them and their families. It is incredibly rewarding to care for them and help them through this critical time.

As a paediatric trainee, I am rotated to different health services and work within different paediatric units. I genuinely love coming to work every day and working as part of a very supportive team helping to look after children and their families.

What is the hardest part about your work?

Working with young infants and children who are very unwell can be challenging and it is incredibly difficult to experience the death of a young patient. We are lucky to work in very supportive teams of senior and junior medical staff, nursing and allied health staff to support each other through these difficult situations.

Do you have any advice for others pursuing a career in medicine?

Follow your passions and area of interest. Medicine is an incredibly rewarding career with so many different paths open for us to explore. Pursue what you find most interesting and where you

feel you can make a difference. Take the opportunities available to you within medicine to develop leadership skills and devote your time to advocate in areas that you are passionate about. We are provided with a wonderful platform to help create change within our workplaces, for our patients and society.

What do you enjoy doing away from medicine?

I love music and love to sing, dance and act! I have had the wonderful opportunity to perform in a number of musical theatre productions, to sing in choirs and even use my creative skills to direct the Royal Children's Hospital annual comedy revue. Whilst music and performing is what I enjoy outside of medicine, I also feel that the arts has a role within our profession. I have always felt very strongly that medicine is both a science and an art, and that the art of medicine lies within our communication and experiences; storytelling, connectivity, an understanding of the human condition and vulnerability. I feel there is a role for music in medicine and in healing, and enjoy being able to still find moments to sing whilst practising medicine.



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Early detection of chronic kidney disease saves lives

With Kidney Health Week taking place in April, now is a great time to start thinking about the impact of kidney disease in your practice and how this affects the day-to-day interactions you are having with patients.

In Australia, kidney disease really tends to fly under the radar - despite 1.7 million people having signs of kidney disease, most of them don't know it and up to 90 per cent won't experience any symptoms until it is too late.

I have worked for Kidney Health Australia for nearly 10 years now and in that time, I have seen the difference that proactive care can make - it can be the difference between travelling for hours, multiple times a week to attend dialysis sessions or peace of mind knowing that a loved one is less likely to experience a cardiovascular event like a heart attack or stroke.

During Kidney Health Week, we are spreading the message 'Don't Be Blind to Kidney Disease'. The campaign asks people to know if they are the '1 in 3' at risk of chronic kidney disease (CKD) and if they are to do something about it. People identified as being at high risk of CKD are encouraged to visit their GP and undergo a kidney health check (blood test for eGFR, urine albumin /creatinine ration and a blood pressure check). That's why we're keen to keep doctors updated on our work.

CKD is defined as the occurrence of kidney damage and/or reduced kidney function that lasts for three months or more. CKD usually develops over a number of years and, if detected early and managed appropriately, the otherwise inevitable deterioration in kidney function can be reduced by as much as 50 per cent. That's quite a difference! And one that can have a huge impact on a patient's outlook and quality of life.

Preventing CKD from developing or progressing is a key activity that primary care health professionals can address. The steps are simple and tie in well with activities you are already undertaking:

1. Identify who is at risk of CKD

GPs and their practice team play a key role in identifying people who are at risk of CKD and ensuring that they have the tests needed to identify or exclude a CKD diagnosis.

THERE ARE NINE RISK FACTORS FOR CKD

- DIABETES
- HIGH BLOOD PRESSURE
- HEART PROBLEMS OR STROKE
- FAMILY HISTORY OF KIDNEY FAILURE
- HISTORY OF ACUTE KIDNEY INJURY
- SMOKER
- ABORIGINAL OR TORRES STRAIT ISLANDER
- OBESITY
- 60+
60 YEARS OR OLDER

2. Perform a kidney health check on those at risk

Individuals identified as being at increased risk of CKD should undergo an annual kidney health check every one to two years.

There are three components to a kidney health check and these are easy to build into your existing practice. Primary care practices are the usual setting for initial assessment and diagnosis of CKD and are well-placed to conduct kidney health checks led by either the GP or the primary healthcare nurse.

Continued on page 34



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3. Implement best practice CKD management

The goals of best practice CKD management are to firstly prevent the condition developing, secondly to detect CKD in its earliest stages, and thirdly to implement optimal management strategies that delay progression and the development of other comorbid conditions.

Key prevention activities include managing cardiovascular risk, blood pressure and diabetes appropriately and also encouraging lifestyle modification and providing people with resources and education to assist them with their self-management goals.

For people diagnosed with CKD, halting further progression is vital. CKD is a major independent risk factor for cardiovascular disease, and for people with CKD, the risk of dying from cardiovascular events is up to 20 times greater than the risk of requiring dialysis or transplantation. Interestingly, the increased cardiovascular risk is noted from the time a patient first develops albuminuria, again highlighting the importance of early detection.

First line management strategies for CKD include recommending lifestyle changes (SNAP - smoking, nutrition, alcohol, physical activity) and prescribing ACE Inhibitors or ARBs to lower blood pressure and slow the progression of albuminuria. CKD management information including CKD staging, colour-coded action plans and referral guidelines can be found in the publication *CKD Management in General Practice*.

4. Access Kidney Health Australia education, resources and services

Kidney Health Australia has a large range of resources, education and support available to assist in the management of kidney disease in your practice. We run a comprehensive Primary Care Education Program which provides access to free online and face-to-face learning, quality improvement programs and the well-regarded guideline handbook *CKD Management in General Practice* and app CKD Go! In addition, we have a huge range of fact sheets and books available to support people

living with kidney disease and these are translated across 19 different languages.

Two key resources that GPs can provide their patients are *My Kidneys, My Health* (a free handbook and app designed to help people navigate a CKD diagnosis and assist them with self-management and support) and a referral to the Kidney Helpline (a free national phone-support service offering information, support, referral and advice to patients, their families and health professionals - 1800 454 363). Many GPs find these resources beneficial as part of the care planning process.

Download free patient resources from our website www.kidney.org.au/resources-library and access our education and resources for GPs at www.kidney.org.au/health-professionals

5. Get involved!

Kidney Health Week is our major awareness campaign and is from 8 - 14 April, 2019. This is a fantastic time to focus on CKD in your practice, run some activities with your team and help us spread the prevention message. Look out for our social media content and visit our website to access free resources and materials.

Alternatively, keep in touch with Kidney Health Australia by subscribing to our quarterly newsletter - Your Kidney Connection www.kidney.org.au/about-us/ subscribe, drop us a line at info@kidney.org.au or call us on 1800 454 363.



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National Education
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Australia

References available from the Editor on request.



Photo courtesy Tourism Western Australia



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Online and cyber risk in healthcare

Medical practices and practitioners hold large amounts of sensitive personal information. Growing reliance on technology and the internet has increased the risk of this information being lost, exposed or held to ransom. In the health sector, human error is the leading source of cyber incidents, followed by malicious or criminal attacks.

Risk management and prevention

Preventing an incident is always the best strategy and there are some simple steps that can help doctors and medical practices avoid cyber events and reduce their impact. Training and regularly reminding staff about email and internet-safe practices are essential, as is backing-up data regularly and storing backups securely. Other important steps include having strong passwords, maintaining quality virus protection, updating systems and software with patches and restricting administrator access to systems.

What to do in a cyber incident

Identifying a cyber incident and responding quickly is also important to minimising harm. After a cyber incident it is important to seek immediate help from your IT service provider or forensic specialist. Avant's Medico-legal Advisory Service provides general advice for our members about responding to cyber incidents and on continuity of practice following an incident. A cyber incident that leads to possible unauthorised access to, or disclosure of personal information, may also require reporting obligations under the Notifiable Data Breach Scheme and Avant provides guidance on identifying and responding to these notifiable breaches.

Avant insurance cover for cyber incidents

Avant's medical indemnity insurance policies provide a solid base of cover for some online and computer-related risks. Avant offers two types of medical indemnity policies: Practitioner Indemnity for individual

doctors, and Practice Indemnity for medical practice businesses.

- **Civil Liability:** all Avant indemnity policies cover legal fees and third-party damages arising from civil liability claims due to privacy breaches or loss of data.
- **Breaches of Law:** all Avant indemnity policies cover legal fees for defending complaints in relation to breaches of privacy laws. The Avant practitioner policy also covers privacy breach fines and notification costs if you are required to notify patients of a breach.
- **Loss of Documents:** the Avant practice indemnity policy covers the cost of replacement or restoration of documents that have been destroyed or damaged, but does not cover electronic documents.

Other cyber insurance

An additional cyber insurance policy is generally needed to cover you for your own direct losses from a cyber incident such as recovery or repair costs from lost data, damage to computer software, ransom costs and the costs of business interruptions. Cyber insurance is an emerging product, with less than 20 per cent of Australian small businesses currently purchasing cyber cover. The best way to see if cyber insurance is right for you is to ask an insurance broker.



References available from the Editor on request.

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Career conversation

An emerging pattern in recent years has seen some doctors looking to explore alternate and non-traditional careers both within and outside of clinical medicine. In this Career Conversation series, we are profiling a range of doctors who have transitioned to non-traditional paths - either instead of, or in parallel with a traditional clinical path. These stories can help other doctors understand that medicine can present diverse, often untapped career options.



Dr Louise Teo: Career Medical Officer, Epworth HealthCare; Founder, themedicalstartup.com

How would you summarise your career path in medicine?

Unexpected, challenging, and rewarding. I'm a Basic Physician Trainee; a Career Medical Officer at Epworth HealthCheck; a locum in breast medicine, occupational health, and radiation oncology; founder and editor of themedicalstartup.com; an advisor for start-ups and other companies; and a songwriter, producer and session musician. I'm also working on fashion projects.

I spent most of my life thinking it was wrong to have so many interests, feeling pressured to "just pick one". But each project energises me and complements each other. It does get tiring as I FIFO (fly-in fly-out) a lot, but I'm very happy.

I aimed to become a neurologist, but had many setbacks as a busy registrar in Melbourne, trying to process huge life events while studying like everyone else, failing exams and feeling trapped by the system. To pass exams, I needed time for other interests and to be with loved ones; but training currently isn't built for that. It's contradictory. How can, "Physician, heal thyself" if the system doesn't support you?

I also saw people complain about their jobs after exams, but not recognise their power to change. What's the point of finishing training and being unhappy? You shouldn't feel pressured to stay, despite what institutions say. The hospital goes on without you; you can resit exams; but you never regain your time.

I started locuming. People interstate were very supportive, and I enjoyed medicine without exam pressure. I also travelled, attending Berklee College of Music summer school (in Boston) and fashion industry events. These experiences inspired my blog; exploring entrepreneurial, creative thinking as a tool for resilience. Interviewing founders and STEM (Science, Technology, Engineering, and Mathematics) workers who are jewellery designers and photographers helped my confidence.

I worked with BreastScreen Cairns as a Senior Medical Officer training to be Clinical Director, which was extraordinary considering I still saw myself a "BPT failure". That taught me that clinicians do value experience over letters. I learnt tons, but even in a career-making role, it wasn't sustainable flying years on end to see loved ones. I left Cairns with no clear plan, open to seeing what I'd do next.

Life's become even more extraordinary. After two days on the Gold Coast, I met my first music collaborator; who's like a mentor, I found the Epworth job by chance on their website and I resumed start-up advising. They're not disparate. Skills I use in each industry are solutions-based and creative. They refresh me as a doctor. Everyone should have a hobby that refreshes you.

Why did you choose to study medicine?

I've always enjoyed learning people's stories, how they survive challenges and their lessons. Also wanting to help after growing up with unwell family. It's why I like physician training - discipline and long cases help when you're building new projects.

What have been the main influences on your career pathway choices?

Renaissance thinking. Leonardo da Vinci studied anatomy, architecture and art; why don't we learn from him? A modern-day example is Virgil Abloh, who's not a doctor, but an engineer, fashion designer, architect and DJ. Studying his career, you see how his interests nourish each other.

What inspired/prompted the career pathway choices you have made?

People falling ill before working on their dreams. I know what it's like to be a doctor; but I'd always regret not trying other interests just because I was scared of what people think. Your choices should fulfil, not deplete you. Failing's part of growth. Entrepreneurship's very project-based. People perform several roles wearing many hats. We can do this in medicine.

What would you change or do differently if you had the opportunity?

Worry less! But life wouldn't be the same if things hadn't happened this way.

Do you foresee any further changes in career paths in your future?

Yes, not because I'm unhappy, but because life has many variables. Not expecting change is unwise. Even in traditional clinical careers, you should expect transformations through digital health.

What advice would you offer to other doctors in managing/navigating their career in medicine?

Be patient with yourself, learn mindfulness, choose experiences you'd like and build self-awareness. Beware of negative self-talk.

Your career is your start-up. Sometimes, you're the only one who believes in you. If you take a break from medicine, it could be your wisest decision. Don't feel guilty if it takes a while or you decide not to return. Medical skills are transferable. The AMA has been tremendously helpful in supporting me and many other doctors with events, one-on-one assistance and advocacy. Remember Victorian Doctors Health Program, workplace Employee Assistance Programs and non-medical resources.

Learn widely. Attend events in other industries; some are even free. It's okay not knowing everything when you start.

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The desperate need for a more humane medical workforce system

Like the broader community, I was horrified to read about the recent experience of Dr Yumiko Kadota - a young, aspiring surgeon having to endure working conditions beyond any person's reasonable capacity to sustain. As an unaccredited surgical registrar, Dr Kadota was working 70-hour weeks and on call for 24 hours a day, up to seven days straight. It is a failure of our system that despite identifying she was struggling and attempting to seek help, the unsafe hours were not addressed until she resigned from her job; unwell and in significant distress.



Dr Yumiko Kadota. Photo: mindbodymiko.com

Dr Kadota's story is a vivid reminder of some of the underlying issues within our medical training systems. Despite significant gains for junior doctors with the recent EBA, a culture remains within many specialty programs that demands working hours that are incompatible with true work-life balance.

The negative impact of excessive working hours and high workload on the physical and mental wellbeing of employees is well-established. Burnout (a state of emotional, physical and mental exhaustion) remains a significant issue within the medical workforce. It is devastating that every year trainee suicides continue to occur in the context of incredible workplace pressure. It is clear too, that a workforce of overworked, chronically-stressed doctors has a negative impact on patient care. Empathy towards patients and their families, as well as respect and kindness in interactions with colleagues, is inevitably eroded when an individual is struggling with exhaustion and not able to practice basic self-care.

When considering the workload of junior doctors, it is important to remember that on top of long hours worked on the wards, trainees are expected to be preparing presentations, studying for fellowship exams, completing research and taking on additional courses to increase their chances of getting into competitive specialist fields. Indeed, many specialties require you to have passed entry exams

or have higher degrees or PhDs to attain accredited positions within their training programs. It is not surprising that work can become incredibly all-consuming.

I remember being told as a medical student that general practice was a good choice for women because of the balance with family life it provided. At the time I felt frustrated by the implication that there were limited options available to me if I really did want to live a balanced life. Even when not expressed explicitly, I graduated with a strong feeling as a young doctor that I needed to choose between a balanced lifestyle and certain training pathways that simply didn't cater for such things. In light of the devastating experience of Dr Kadota, it is worthwhile examining what these barriers to work-life balance are and consider whether they need to exist.

One barrier is the deeply engrained view that our prowess as clinicians is developed through intense hard work and volume of cases seen as trainees. The exposure to cases we get in an 80-hour busy week on-call is seen as invaluable, particularly as it's the way our consultants were trained. It is accepted that increased exposure to patients results in improved clinical skills and critical thinking. But this engrained view fails to consider that over a longer period of working fewer hours, these same skills could be developed and an equally-capable clinician could emerge at the other end. Indeed, it would be likely that

the registrar working less intensely would be a more well-rounded, compassionate and happier doctor. Importantly, providing the option of flexible working hours would create a fairer system more accessible to trainees with children or those hoping to start families.

With ever-growing rates of chronic disease, population growth and increased complexity of medical interventions available, Australia's public health system is faced with ever-growing demands. Increased staffing is an easy solution to excessive working hours but this remains a challenge that hospital managers and policy makers continue to grapple with. Despite the challenges, it is an essential part of creating a more sustainable and humane medical workforce system.

On some level, the culture within medicine is also a barrier towards truly embracing work-life balance. We are trained to see medicine as a calling; that dedication to a patient's care should be absolute - and prioritised over our own interests. The idea of leaving on time, even if it is to pick-up a

child from care or attend an important occasion, seems inappropriate if it's at the expense of supporting a patient through a difficult admission. In a busy overworked system, we grow to believe that setting aside time for our own families and for ourselves is selfish, even lazy, and detrimental to our colleagues working hard around us.

Achieving change is also difficult with a significant power imbalance. In competitive specialties where junior doctors are desperate to be selected for limited accredited training positions, it can be very difficult to demand changes to work hours or seek flexible training options. In this regard, I applaud the courage of Dr Kadota for speaking out about her experiences and wonder how many more trainees have experienced similar situations, but remain quiet.

There are many factors contributing to the currently accepted system of difficult working conditions but I am not convinced that any of them are beyond change.

Could we develop a more humane medical workforce system? One

where work is not all-consuming; where we still develop our skills and provide excellent patient care but do so under less pressure, at a slower pace. It would be a system where men and women are on an equal playing ground; where working fewer hours or choosing flexible training pathways doesn't change the value we place on clinicians and their potential for growth in their training.

It would also be a system where burnout is less common and junior doctors are able to develop richly in their careers and in other aspects of their lives. I just hope we don't need to read of too many more stories like Dr Kadota's before we truly devote ourselves to seeking this change.



Dr Sally Egan
AMA Victoria
Women in Medicine
Committee
Doctor in Training

For anyone experiencing stress at work there are a number of resources available including the AMA Victoria Peer Support service, phone: 1300 853 338 - a confidential, anonymous phone support service for doctors; the Victorian Doctors Health Program, phone: 9280 8712 and beyondblue, phone: 1300 22 4636.

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An unforgettable experience at the Villers-Bretonneux Anzac Service



My father was a World War 2 serviceman from the New Guinea and Bougainville campaigns but my grandsons' Great-Grandfather on their mother's side, Arthur Pownall, served at Villers-Bretonneux - from Lemnos during the Gallipoli campaign, right through the Western Front till the end of the war. Unbelievably, he also enlisted and served in World War 2 in Borneo. In both wars he was a stretcher bearer in the Australian Medical Corps - a remarkable man who was a deeply religious conscientious objector, but still insisted on serving. In fact, he was awarded the Military Medal twice for bravery.

Last year, I was accompanied by my younger son, Andrew and his two sons, Noah, almost 12, and Raphael, 10, at the Anzac Day Centenary Dawn Commemorative Service at Villers-Bretonneux.

Our time in France started in Paris and on the first day, as we were

walking to the Eiffel Tower, we saw a huge poster of Sir John Monash advertising the forthcoming opening of the Sir John Monash Centre at the Villers-Bretonneux cemetery. The boys were astonished and most impressed to see this on their very first day in France. On our second day we went to Versailles where the treaty officially ending World War 1 was signed.

On our final day in Paris, we headed to Isle de La Cite to the famous central flower market, looking to purchase two wreaths. After much searching, we settled on two beautiful ivies in pots that had been grown in a circle; a living wreath. With the addition of ceramic pots, they looked almost ideal. I decided to purchase some poppies the day before the Anzac service.

On 24 April we headed up to Amiens by car. Our first stop was Villers-Bretonneux and we were amazed to find every house and shop there

flying an Australian flag, while it seemed almost every second person in town was an Australian. We headed to the World War 1 Museum, adjacent to the Villers-Bretonneux Primary School. This museum is well worth visiting as it has an amazing display from World War 1, with many photos of Australian diggers in action.

We then went next door to the primary school, which was specially opened by the local mayor for Australian visitors on a public holiday. Everything at the school was about Anzac Day, including drawings done by the students - one displayed a stretcher bearer and field ambulance. The boys were very taken with this and also the very big sign on the shelter shed which read, "Never Forget Australia".

Before leaving Villers-Bretonneux, I remembered that the wreaths we bought in Paris still needed poppies. In my very poor French, I explained to an elderly lady florist what I needed but she said there were no poppies

Dr Segal at Villers-Bretonneux with grandsons Noah (left) and Raphael.



in April, but instead suggested some red carnations and interwove them beautifully into the wreaths.

Then it was off to the ancient city of Amiens, situated on the Loire. It's a really beautiful place with much of its medieval history preserved; especially the huge cathedral of Notre Dame, which is much bigger than its namesake in Paris. Amiens was also completely decked out in French and Australian flags. After a quick look around to get our bearings, we had an early dinner so we could get a few hours sleep before the big day.

At 11pm we woke up headed off to the train station; a very vital transport hub during World War 1. We were amazed to see the very new Town Hall tower being used for a light show continuously displaying the diggers in the Great War and their crucial role in defending the region and the town.

I must say all credit to the Australian Government and Department

of Defence for the unbelievably efficient and friendly arrangements surrounding the organisation of the Anzac Day centenary commemoration. There were buses to take us all to a security centre after everyone had been pre-issued with beautiful holographic passes. The staff very smoothly and precisely moved us all through the very tight security screening, then onto another set of buses and off to the Villers-Bretonneux war memorial and cemetery. At the welcoming centre we received a package with programs, ponchos and very warm commemorative beanies before we made the long walk up to the memorial site.

By then it was 2am and we settled in to wait for the dawn service. The army band and singers performing World War 1 music, along with a succession of films from the Australian Film Archive kept us occupied. These films were brilliantly put together and narrated.

A most amazing scene happened around 3.30am. We noticed a huge throng of people walking over the fields coming towards the memorial and were overwhelmed to find that this was almost the entire population of Villers-Bretonneux, young and old, coming to the service. They have certainly not forgotten Australia.

Then just before dawn, the award-winning short film "The Telegram Man" was screened. This is a very moving portrayal of the job of the telegram delivery man - played by Jack Thompson - to distribute the very unwelcome news about a son or husband being wounded, missing, or killed in action. This film was so moving there was not a dry eye in the audience. Then the dawn service began.

During the ceremony the wind was blowing, it began to rain and it was bitterly cold. We put on our ponchos and pulled down our very warm

Continued on page 44



Dr Segal's grandsons Raphael (left) and Noah at the Villers-Bretonneux Primary School.

beans. It really brought home what our forebears had been through - all this miserable cold was insignificant compared to a constant hail of bullets likely to wound or end your life in a moment. They were indeed very brave, but oh what the cost. The cemetery at Villers-Bretonneux is small compared to many others on the Western Front, but there were so many graves marking the lives abruptly cut short.

Every part of the night and service was bilingual, in French and English, and just so beautifully done, including the story of an Australian serviceman, moving speeches - especially by the French Prime Minister, Édouard Philippe - and finally the haunting notes of the Last Post and then, after a few minutes silence, Reveille. My grandsons were so proud, wearing replicas of their Great-Grandfather's medals, to lay a wreath. After all the descendants, it was the turn of representatives of organisations and I then placed my wreath on behalf of the Australian Medical Association - a great honour.

This was my second dawn service; my first was at Gallipoli for the 90th Anniversary of Anzac Day where I was able to really understand and feel what Anzac Day is all about. Here,

exactly 100 years after the battle of Villers-Bretonneux, and three years after the first Anzac Day, we knew that the diggers already understood the importance of the day. Our generation owes them an immense and unrepayable debt. Just as at Gallipoli, I felt very humble here.

With the ceremony over we, along with the huge crowd, wandered around looking at the numerous graves, many with heartbreaking inscriptions. We took photos and reflected. My grandsons asked many questions about what had happened here 100 years ago, to really understand and appreciate for the first time what their Great-Grandfather had been through and done.

The hour or so wait in the queue for the bus trip back to Amiens was not wasted. We, and everyone else there, proudly recounted the stories about our relatives. We were all mates, sharing a common bond and heritage. I felt very proud and very humble to be an Australian.

Dr Gerald R Segal
AMA Victoria Fellow
Council member
Heritage & Archive Committee
Chair
Past President

Call for Heritage & Archive volunteers

The Heritage and Archive Committee is tasked with showcasing and preserving the fascinating history of AMA Victoria, from its foundation as the Port Phillip Medical Association in 1846 to the present day. A huge amount of work has already been accomplished but there is much more to do. Amongst the tasks at present are the computerising of our huge paper-based archive, the "translation" of the old minute books from the 1850s, gathering a photographic collection of all our presidents for display and writing a history of AMA Victoria members who have served in war.

It is proposed that the history of doctors in war will be a three-book series, with the first book on World War 1, the second on World War 2 and the third on all other wars from 1846 till today. Dr Mai Maddisson dedicated much of her time writing the first book on World War 1 until her sad passing in January. We are now looking for someone to continue Mai's work and complete the book. The layout, style and all the names have been done. In fact, the book is more than two-thirds completed. The two other books could also be done more easily with additional volunteers.

We would make very welcome volunteers for any of the projects mentioned - not just doctors, but family and friends also. Volunteers may come on any day of the week, during working hours at AMA Victoria House in Royal Parade, Parkville, to do as little or as much as they are able. At present many of us come in on a Wednesday and the camaraderie in our new archive centre is fantastic.

So please come along and help with this fascinating work, just ring (03) 9280 8722, leave your name and I will be in contact.

Dr Gerald R Segal
Honorary Archivist and Chair
AMA Victoria Heritage &
Archive Committee



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Financial assistance for doctors in need



VMBA committee and staff members (left to right): John Fletcher (Executive Officer), Diana Cooper (Client Manager), Dr George Santoro, Dr John Mathew, Dr Dominic Barbaro (President) and seated Dr George Tippett (Secretary). Absent: Dr Tony Bartone (Vice-President), Dr Paul Woodhouse (Treasurer), Dr Tony Bajurnow, Dr Paula Sullivan.

The Victorian Medical Benevolent Association (VMBA) provides short-term financial support in a time of crisis and need to medical practitioners and immediate family, as well as medical students in their final year who reside or practise in Victoria.

The VMBA is not a service provider, but works alongside the Victorian Doctors Health Program (VDHP) and AMA Victoria's portfolio of services, including the Peer Support Service, the Peer Visitor Program, the Mentoring Program and the Medical Career Service.

The VMBA was formed at a time when the medical profession in Victoria was still struggling to establish itself, in 1865. Doctors were confronted by many issues in the towns and rural districts of 19th century Victoria: isolation, remuneration, collegiality, training and registration. As part of what was a very difficult world, many of them had their own personal struggles in establishing a viable livelihood.

The profession has been well-established in Victoria for well over a century now, but the numbers of doctors whose professional expertise does not extend to the world of business or financial management is no more or less than in the general community. And those issues facing the profession 150 years ago remain, even if cast in a different light.

The ability of doctors to self-medicate, combined with their detailed knowledge of drugs and ability to access them, has helped create problems of substance abuse. Narcotic addiction has always been present within the medical fraternity, but in recent decades illicit substance abuse amongst a younger cohort of professionals, with the complex and varied difficulties associated with such a state, has become more common. Alcoholism, of course, is another disabling factor that has appeared in the case books since the very early years.

Over the previous 154 years, the VMBA has helped many hundreds of distressed practitioners and their families. However, the recipients are still a very small percentage of the Victorian medical population - there were 812 registered doctors in 1892, and 22,000 in 2010, and there have never been more than a handful of recipients at any given time.

How can the VMBA endure for so long when there appears to be so little need for it? This question is considered by

chronologically discussing some of the professional concerns and issues raised by practitioners in the medical press, surveying the cases that have come before the committee and studying the attitudes and concerns of the VMBA towards these doctors and their families.

Ultimately, however, the best explanation for the longevity and endurance of the Victorian Medical Benevolent Association is that doctors are a community unto their own and the empathy required to deal with their particular problems is best found amongst their colleagues.

Requests for assistance can be made by direct contact with the VMBA, or through a family member, a medical colleague, the VDHP or AMA Victoria.

All requests for assistance should be made to the VMBA's Client Manager Diana Cooper (see contact details below). The Client Manager will ascertain if the assistance is within the VMBA's constitution. Before a request proceeds, the client will be asked to complete an application form which includes assets, income and expenditure.

All request for assistance are discussed at a committee meeting and outcomes are confidential. The VMBA does not provide urgent or emergency assistance.

For further information on the VMBA support program visit www.vmba.org.au or contact Ms Diana Cooper, Client Manager on dianac@vmba.org.au or Mr John Fletcher, VMBA Executive Officer on johnf@vmba.org.au or call 0476 473 058.



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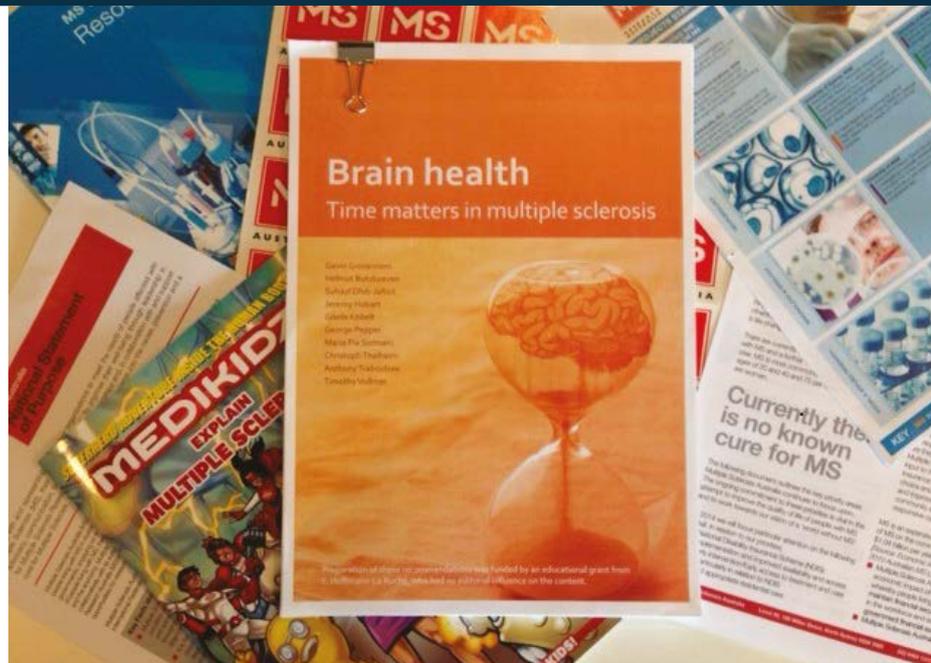
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Time matters in multiple sclerosis: Diagnose early to maximise brain health

Multiple sclerosis is now a highly treatable disease. A short guide for general practitioners and primary care providers (PCPs) offers advice to help diagnose and manage patients with multiple sclerosis.



Early diagnosis is crucial to long-term brain health. However, symptoms of multiple sclerosis are varied and it is therefore difficult to diagnose. There is also a perception that little can be done to treat multiple sclerosis. This is not the case.

This concise guide (available online from www.bit.ly/2SMWzB5) provides advice for GPs and PCPs, including how to:

1. Identify symptoms that may indicate multiple sclerosis in a timely manner.
2. Refer patients to a specialist neurologist and MS clinic.
3. Follow-up with patients to provide ongoing care and support their brain healthy lifestyle.

The guide is based on an evidence-based international consensus report, *Brain Health: time matters in multiple sclerosis*, which describes a strategy to maximise lifelong brain health and includes recommendations on how to achieve this goal. Key points of relevance to GPs and PCPs are highlighted in the short guide.

The diagnosis, treatment and management of multiple sclerosis is changing rapidly. There are more than 12 medications available on the PBS in Australia, with more in the pipeline.

By minimising delays in diagnosis and referral to a specialist, you can help to maximise brain health and improve the lives of people with MS. It is hoped that GPs and PCPs will find this guide useful and will share the information widely.

To find out more, read the full *Brain Health: time matters in multiple sclerosis* report and check out other useful resources, please visit www.msbrainhealth.org



KEY FACTS

Multiple sclerosis

- Is a neurological condition affecting the central nervous system (brain, optic nerve and spinal cord) that affects more than 25,600 Australians.
- Is the most common chronic neurological condition diagnosed in young adults.
- Is most commonly diagnosed between the ages of 20 and 40.
- Affects mainly women, with three in every four diagnoses.
- Varies significantly from person to person; for some people, it is a disease that comes and goes in severity with periods of unpredictable relapse and remission, while for others it means a progressive decline over time.
- Includes a variety of symptoms such as severe pain, walking difficulties, debilitating fatigue, partial blindness and thinking and memory problems.
- Is more treatable and manageable than ever before, especially with a swift diagnosis and take-up of new treatment options.

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The land of avocado and expensive property

Richard Glover recently published *The Land Before Avocado*, a wonderful and witty journey back in time to life in the early 1970s. For a start, he deftly reclaims the book's title fruit from those who have positioned it as a proxy for all that is wrong with today's supposedly feckless and spendthrift young adults. Rather than maligning the avocado (and young people), he cleverly appropriates the fruit as an exemplar of how far we have come since the 1970s.

The book is both funny and forensic in the evidence he presents. He charts the shortcomings of 1970s life across a range of areas: crime, attitudes to and restrictions on women and minority groups, entertainment, health, safety, economic wellbeing and cuisine. I found his case against the food of the time especially hilarious, having myself first landed in Australia in 1973.

The place was not the land of abundance I was promised. Rather, too often mealtimes were dominated by processed meat: pies, pasties, Dagwood dogs and Pluto pups. And if you didn't want to drink beer, then you were generally stuck with terribly sounding and tasting wine called 'Cold Duck' or 'Asti Spumante'.

Glover doesn't pretend to suggest that today is perfect. Half-way through the book he lists the things he misses from the 70s. Most of his laments can be categorised under simplicity: the relief of less choice in the 70s, be it at the supermarket, the bar or deciding appetisers when cooking for guests.

He acknowledges early on in the book the change in housing costs since the 1970s. "Houses were cheaper," he writes. "A lot cheaper. No really: a lot." But, refreshingly, while he does not endorse high prices, he holds back from the usual knee-jerk critique that this is an awful state of affairs (conspicuously, cheap housing isn't in his list of things he misses about the 70s).

You understand why Glover doesn't romanticise the cheap housing of the time when you read the chapters focused on the economy, the workplace and on women. It becomes

blindingly obvious why housing was so cheap. Longstanding protectionist economics had damaged productivity and incomes resulting in consumer staples and household appliances that were expensive and of poor quality. Total output was curtailed by the shocking restrictions on female participation, especially for mothers. Not only did the high cost of living make it hard to cope on the fortnightly pay packet, but a lack of consumer credit meant there were few financial options in an emergency. More generally, it was incredibly tough to borrow to buy a home.

While Glover is silent on the direct linkage between progress and high house prices today, I am not. The societal change I have witnessed in my 45 years here is simply astonishing. We are a nation transformed. But decisions that have pushed up houses prices - such as the rise of the double income household and easier access to credit - had to happen anyway to deliver the societal progress we enjoy today.

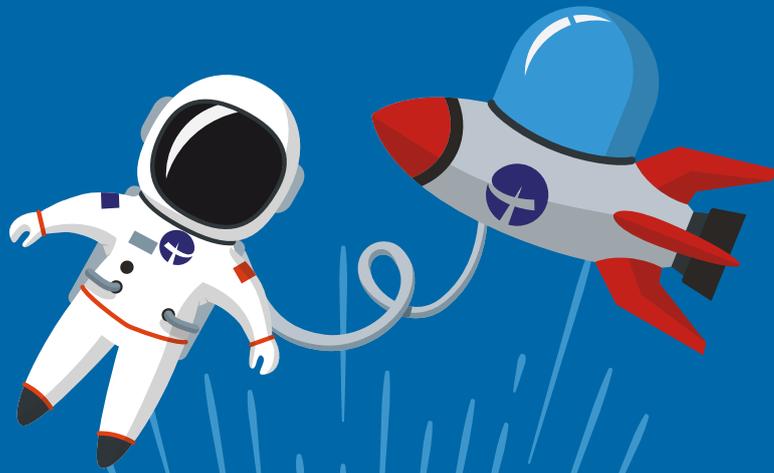
We are currently experiencing softer house prices. But unless we have reached the end of societal progress, which seems extremely unlikely, then history tells us that this will only be a short-term affair.



Richard Wakelin
Founder
Wakelin Property
Advisory

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Changes in medical billings and collections over the years

Prushka started life as a specialist medical debt collection agency 43 years ago. Over that time, we have been observing changes in the way practices invoice and collect their money. This article will briefly review the major changes which have taken place and provide some comments on how practices can benefit from the changes.

Increase in in-house collections

Traditionally, practices outsourced collections at about 60 days and did little collection activity internally. Today, more collection activity is being handled by the practice and generally, the only debts being outsourced are those which refuse to pay or require skip tracing.

Most practices now have a single person who is responsible for the collections processes, even if they do not personally handle any debt collection work. This is definitely best practice.

Medicare

Changes to Medicare which provide for automatic payment after 90 days have had a dramatic impact.

Increased financial pressure

We have noticed a marked increase, over the years, in tighter financial controls being imposed by practices. This is no doubt a result of more practices being run by business people, rather than practitioners and by rising cost pressure.

Direct credit of Medicare refund

Increasing numbers of practices are obtaining the gap at the time of service and are processing the Medicare refund online. This results in the refund being paid into the patient's bank account with usually a 24-hour turnaround. It is a surprise that not more practices are following this system.

Practices are more savvy

There is no doubt that practices today are much more business-like than in the past. However, there are still many practices which provide manually-generated invoices. There are still too many practices which post invoices to patients and which don't automatically obtain the email address and mobile number for the patient.

Attitude of patients

Over the years, the attitude of patients toward paying their medical accounts has improved. The major reasons we find for non-payment are:

- incomplete patient details
- incorrect patient address

- failure by the clinic to obtain work details
- no email address or mobile number
- the patient has moved.

Medical accounts were the only accounts Prushka Fast Debt Recovery handled 43 years ago, but as a business we have since branched out to cover all accounts. However, we still have a dedicated medical collections team.

There are few debt collection agencies which now specialise in medical accounts; in most cases due to the reasons outlined above, which have resulted in there being less outstanding medical accounts.



Roger Mendelson
CEO
Prushka Fast Debt Recovery

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Prushka acts for in excess of 57,000 small to medium size businesses across Australia and operates on the basis of NO RECOVERY - NO CHARGE. www.prushka.com.au Free call 1800 641 617. The writer is also the author of The Ten Mistakes Businesses Make and How to Avoid Them and Business Survival, both published by New Holland Publishers. Prushka is a member benefits partner of AMA Victoria and offers AMA members an ongoing discount of 10% on its products and services.



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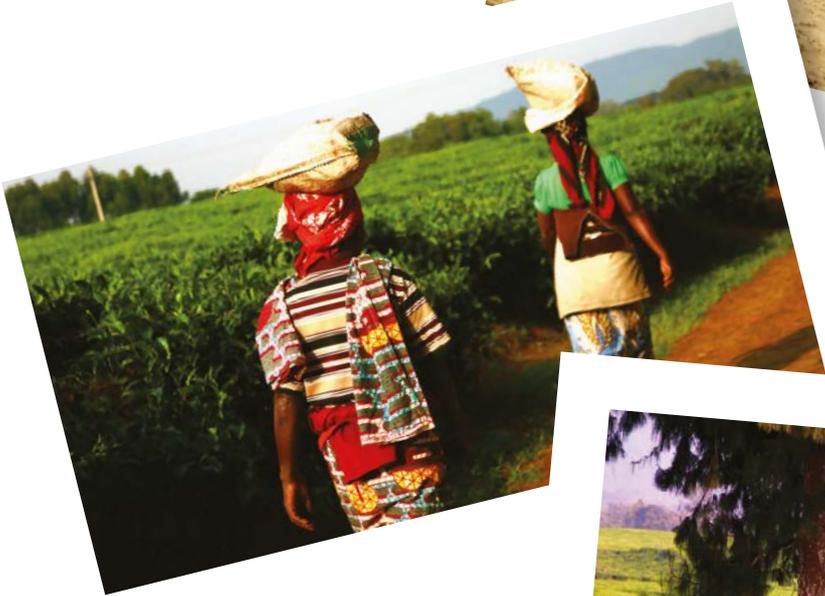
¹ Average rate increases as published by the Department of Health 2013-2019 ² Doctors' Health Fund Member Satisfaction Survey 2011-2018

*To be eligible for the offer, the cover start date and join entry date must be between 12.59 AM (AEST) 4 March 2019 and 11.59 PM (AEST) 30 April 2019. This offer is only available to those eligible to join Doctors' Health Fund and who do not currently hold, or have in the last 12 months held, insurance with Doctors' Health Fund. The new member must take out combined Hospital and Extras cover to be eligible for the Gift Card, and must be active and financial for 12 continuous weeks before the gift card will be issued. Only one Westfield XS Eftpos Gift Card will be provided per policy as follows: a) \$200 when purchasing a single Smart Starter Bronze Plus hospital cover and any extras cover policy; b) \$400 when purchasing a couples Smart Starter Bronze Plus hospital cover and any extras cover policy; c) \$300 when purchasing a single Prime Choice Gold hospital cover and any extras cover policy; d) \$600 when purchasing a couples/family/single-parent Prime Choice Gold hospital cover and any extras cover policy; e) \$400 when purchasing a single Top Cover Gold hospital cover and any extras cover policy; or f) \$800 when purchasing a couples/family/single-parent Top Cover Gold hospital cover and any extras cover policy. If the level of cover changes within the first 12 weeks, the value of the gift card will be determined by the lowest level of cover held in that period. Member must remain on combined hospital and extras cover to receive the gift card. This offer is not available with other offers. You should look to the product issuer for all warranties, terms and conditions. The Westfield XS Eftpos Gift Card is valid for redemption 3 years from issue. Westfield Gift Card terms and conditions apply, for more terms and conditions, visit www.westfieldgiftcards.com.au.

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Travel: Rejuvenated Rwanda

From the moment you cross the border into Rwanda, it feels like you have stepped out of Africa. In physical terms, for sure, as you are confronted by rolling green hills that remind you of Switzerland. However, there is something else; the country is thinking ahead, playing the long game, considering the community, the environment and practising responsible governance. There is no rubbish to be seen and community pride is evident everywhere.



It could be a result of Umuganda Day, which occurs on the fourth Saturday of every month when communities come together to clean streets, dig ditches, build schools or assist their neighbours. Although this is now law, it is an ancient Rwandan tradition that was brought back when there was an overwhelming need to bring a country that had been destroyed by genocide back on its feet again. Umuganda means 'coming together for a common purpose to achieve an outcome'.

Throughout the country there is evidence that the vision is working, with a parliament where over 60 per cent of members are female, it seems that a focus on innovation is paving the way forward. The government prides itself on zero tolerance for corruption and this flows down through business and on to the individual. The population has become more health conscious as legislation determines that on a Friday afternoon, businesses must close so everyone can go out and exercise. Solar lights line the highways, once a month is a car free day, drones deliver blood and its food surplus makes it a rarity amongst African nations.

Rwanda is known as the land of a thousand hills; the rich soil, altitude and temperate climate means that most things grow naturally, which puts the

country in a solid position given the strong movement around the world toward organic products.

Rwanda has a diverse range of world class national parks. In the north we spent a night in a luxury tented camp at Akagera National Park and the variety of game was as good as the more crowded parks in Kenya or Tanzania. Hippos bellowed into the night just metres away; a thin piece of canvas our only protection from the most dangerous animal in Africa.

In the south we spent a few days in the rainforest of Nyungwe National Park, Africa's largest mountain rainforest. It's a remarkable pristine park where the Nile River starts as a tiny inconspicuous trickle on its 6,853km journey to the Mediterranean. We trekked for hours to find chimpanzees and enjoyed observing them in their natural habitat. To them we must have looked awfully clumsy in our gaiters, day packs and walking

sticks. Above us they swung in the trees with abandon, occasionally dropping down to sprint through the thick forest that we had struggled through, despite the guides hacking a path for us with their machetes.

As we drive to the airport, I take one last look at the lights and say, "How good is it to be among people that after so much hurt and suffering, put it behind them and come together for a common purpose to achieve an outcome."



Exhibition: Meet your microbes!

An illuminating new exhibition at Melbourne Museum, *Gut Feelings: Your Mind, Your Microbes* proves that a healthy mind takes guts.

Microbes have gone mainstream. Gut health is having a zeitgeist moment. Kombucha and kimchi are currently gracing every café menu worth its weight in smashed avocado. Mental health is on our collective minds and we are getting better at talking about it every day. But whilst we all know that swigging kefir and eating our greens is “good for us”, new science shows that our gut and mental health are linked in ways researchers are only just discovering.

Gut Feelings: Your Mind, Your Microbes, is a new exhibition developed by Melbourne Museum delving into just that. It draws on a diverse body of research to separate the real from the hype.

Gut Feelings explores new revelations that our minds, guts and microbes are inextricably linked. Visitors will be introduced to cutting edge research that articulates the far-reaching impact of gut microbes in the body; illustrating a new level of understanding of how the human body works. Made

possible by advances in technology and stringent research, this visually stunning exhibition aims to separate scientific facts from the hashtag fads.

Gut Feelings isn't some stuffy old-fashioned museum exhibit with labels and things in glass cabinets. This multi-sensory experience is a prime example of how museums are engaging with visitors in new and unexpected ways. Art installations and object displays will leave you awestruck at the power of your own ecosystem; the helpful microbiome. There will be things to touch, splendid sounds and unexpected sights. Move through spaces that use real science as a basis to challenge assumptions about what is inside you and the way that it works.

Consider this: you have more microbes inside you than there are stars in the Milky Way. You are not just you. You are a host for trillions of microbes, some are even beautiful. And it's clear that we are only just scratching the surface. *Gut Feelings* invites visitors along on this journey of discovery.

“Around 1-2kgs of you is microbes and we're just now discovering the powerful reach of these little helpers”,

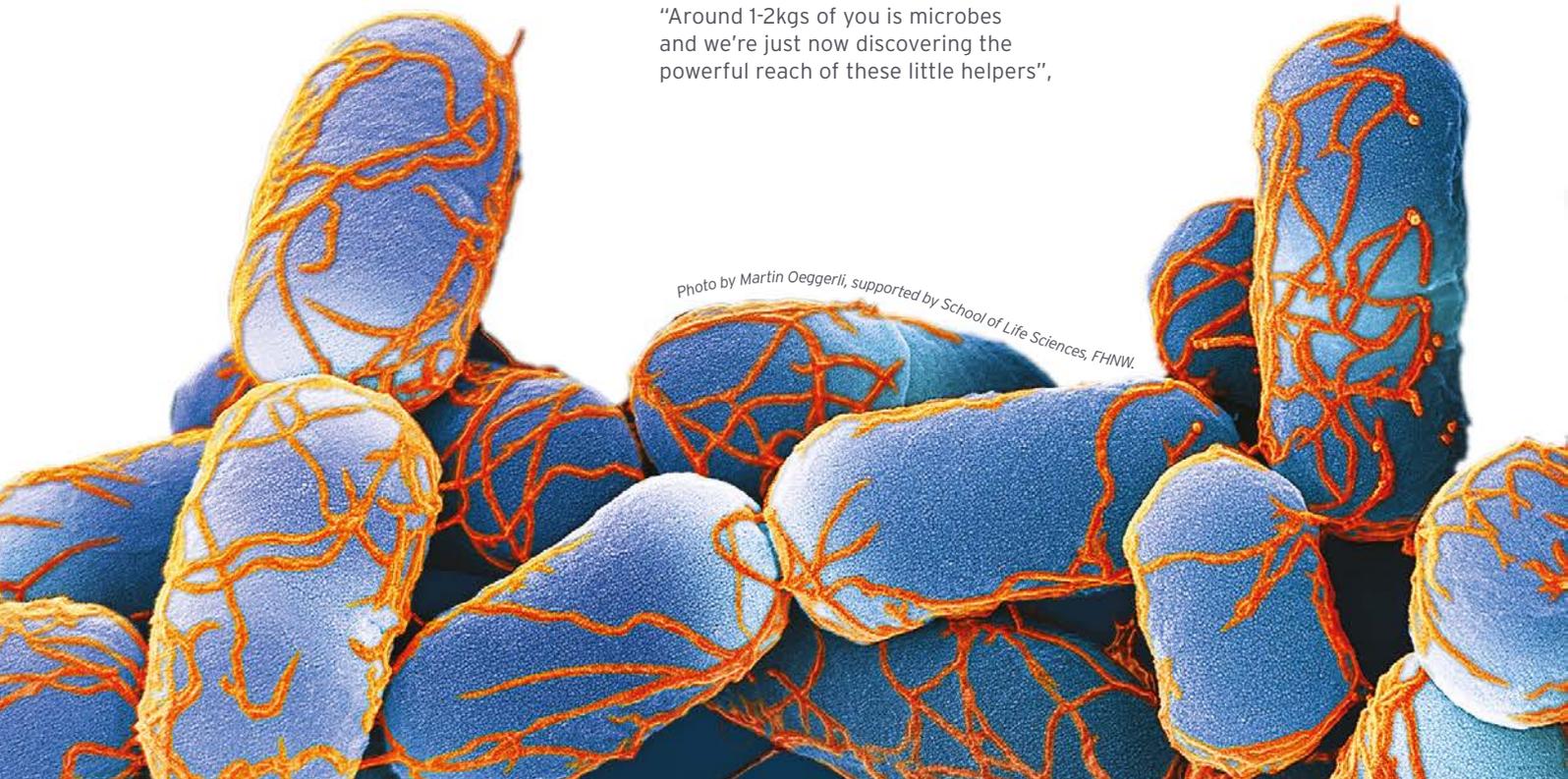
Dr Johanna Simkin, senior curator of human biology and medicine says. “Every month, new research further reveals the detail and precision of these microbe effects - it's given us a whole new understanding of how the human body works.”

From poo transplants to probiotic rich diets, potential health applications could cure peanut allergies, decrease anxiety and even form future autoimmune therapies. “We don't know if there is a single ultimate microbiome - yet,” Dr Simkin says. “Fecal microbe transplants are an amazing research tool revealing these details and are being used as a therapy for serious gut problems.”

Gut Feelings: Your Mind, Your Microbes is open now at Melbourne Museum until 2 February 2020.

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Photo by Martin Oeggerli, supported by School of Life Sciences, FHNW.



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